



# Scudder Intervention Services Foundation, Inc. The Suicide Institute and Suicide Center

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Your Mental/Behavioral Health and Emotional Wellness Intelligence  
Services, Support, Training and Resources Provider

~24/7 Abuse and Suicide Crisis Intervention and Prevention Support Lifeline~

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My name is Brett A. Scudder and I am a suicide attempt survivor who has experienced the challenges of seeking services and care from health and mental health systems, social services and practitioners for my emotional pain, abuse, addiction, anxiety, depression, homelessness, loneliness, trauma and mental health conditions and had firsthand experience at how they can push people over the edge or deeper into despair. Over the past 16yrs of living with these experiences I have learned so much about the hard realities and impacts of them and how the healthcare systems and social services are structured to try and meet the needs of those in crisis but often are doing more harm than good because we truly don't understand the emotional weight, pain and suffering the person experiences which can lead to suicidal thoughts and behaviors. There is a serious inequity of services for males versus females, especially single males and is one of the reasons why suicide rates for males are higher than females because there isn't enough tangible support for males in crisis. My efforts to address suicide so openly, realistically and publicly has given me the title of "The Suicide Man" wherever I go.

As a society we still fear the word suicide because we know what it means, death, but don't know enough about the experience to be able to effectively help people and prevent the ideations or completion. Suicide rates have been increasing for 18years straight and is isn't for lack of mental health services but culturally sensitive and appropriate services and specialization available 24/7 everywhere. Some of the providers are very disrespectful, inhumane and untrained in working with people experiencing emotional pain and so the effectiveness of services is losing ground and people are no longer seeking care from them. We need to retrain healthcare and mental health practitioners on new and different ways of working with people who are experiencing anxiety, depression and emotional pain. I have witnessed many people going into systems of care for services and seen and heard the way they are treated and how desensitized and dehumanizing the care and services are. This is not helping people who are in crisis and despair, and only pushing people deeper into their despair and pain.

The World Health Organization says that Depression is the leading cause of disability worldwide, and is a major contributor to the overall global burden of disease, but we're still not talking about it enough nor providing enough awareness about it so people can be empowered with knowledge of how to manage it and support their loved ones before they lose themselves to it and suicide. In 2011 I met the first 4year old who attempted suicide and the impacts of that reverberated through me and everything I do. Since then I have been seeing more young children in crisis and sounding the alarm that our children at younger ages are exposed to unhealthy and unhappy environments and experiences causing them to feel depressed and suicidal. There aren't many services or providers who address the ages of 4-10years old which is where we are seeing more completed suicide of late.

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Abuse/Bullying, Domestic/Gun Violence, Sexual Abuse, Workplace Violence/Abuse, Health and Wellness, Homelessness, Suicide Intervention & Prevention, Motivational Speakers, Public Speaking, Radio Shows/Hosts, Workshops, Conferences, Lunch-n-Learns, Mentoring, Counseling, Personal/Professional Ethics, Etiquette and Grooming

I have seen 5year old go into the ER and had full psychiatric evaluations done and put on medication simply because he said he felt like going to sleep and never waking up. Is this how we are treating our children at such young ages, and are we paying close attention to them and their emotional state this early. Bullying is a serious issue for our children at that age, and so are other social factors that are affecting parents that they are witnessing and feeling the transfer of emotions from. In our home visits we see the realities of the environments many of our children are living in and understand why they think, feel and act they ways they do. Many are emotional because they are feeling the impacts from hardships of their parents. Many are traumatized from the things they hear and see parent do unbeknownst to them. sadly. The addiction to technology and mobile devices by our children is a very serious one even more than the opioid crisis. Yet, unchecked, we are still not aware of the real psychological impacts and depths of it until a child kills themselves as a result of it. Too many of our children are exposed to technology and mobile devices too early and with no boundaries or limitations and so they become addicts with deep emotional attachment issues. Many parents fear ACS involvement in their lives and risks of losing their children than getting the appropriate help needed for their children. This is a growing trend we need to pay very close attention to and address publicly and openly or we will lose more of our children at younger ages.

One of the biggest challenges that we face in our society with suicide is the need for us to humble ourselves to learn of the real experiences living with it and come together collectively, open-heartedly and non-judgmentally about the realities of mental health, mental illness, emotional pain, depression, loneliness and not look at each other by our diagnosis or illnesses or conditions but by the simple fact that we are all human beings susceptible to pain suffering and the challenges of life that sometimes we cannot bear or struggle with alone. Loneliness and depression are results of hurt, pain, disappointments, unmet needs, unrealistic expectations and fear, and too often many of us fear seeking help because of the judgment labels an ostracization that comes from love one's, family members and co-workers.

What we need is to be more understanding and supportive but before we can do that we need to listen carefully and non-judgmentally to the experiences people are feeling and how those experiences are affecting and changing their lives one breath at a time. This is not about class, race, color, religion or status, it is about basic human life, basic existence, basic needs and sustaining the innate altruistic values and meaning of life that matters to a person. So as we go through life and formulate the things that we consider most important values that makes us want to live, makes life worth living, and enhances our quality of life and what we desire, let us remember that the social construct and things within the social construct that sometimes may not be within our reach or attainable, or lost may be the triggers that pushes us over the edge in those times when life no longer seems worthwhile or worth living . It is in that moment, that precise moment, in a breath, someone loses their mind, becomes brokenhearted, broken spirit and now no longer values life and living. That's the moment that matters the most in our efforts to be effective in helping to prevent suicide ideation and acting on them.

From my personal experiences with abuse, depression, homelessness, addiction, Post-Traumatic Stress Disorder " PTSD", trauma and suicide attempts, I created a 24/7 humane, emotional and behavioral health services organization in NY named Scudder Intervention Services Foundation, Inc. "SISFI" that serves people who are abused (physically, verbally, sexually, emotionally, domestically), substance abusers, lost a loved one to suicide and violence, homeless, suicidal, and victims and survivors of disasters with mental/behavioral health, psychological, trauma and suicide first aid care. After one of my suicide attempts in 2005 I decided to dedicate my life fulltime to helping people prevent or manage emotional pain, crisis and distress to prevent suicide ideations

and attempts. I have had Trauma Informed Care and realized that there needs to be something deeper that touches the core of our soul and the pain that resides there and I created the Emotional Pain Informed Care model to address the real pain in our hearts, minds, bodies, souls and broken spirit. We are not funded but offers weekly ongoing services, support groups, healing and meditation sessions, wellness workshops and resources that meets the needs of people in crisis and despair. Our mobile crisis response service meets people wherever they are in crisis and despair needing support without them having to go through the hassles or challenges of coming to us and our centers. Imagine what more we could accomplish with funding and the ability to hire and train more specialized people to work on the ground in communities.

However, today is not about me, but about the thousands of lives that have invited me into their darkness, victimization, traumatization, grief, loss and pain to share their experiences in hopes that I would be able to help them overcome, heal, recover and live a happy and healthier quality of life because they see me as someone who has walked the walk, lived the experience and can articulate it in ways that makes meaningful sense to them and their experiences. Their lives had meaning, and then something happened and changed everything instantly or over time causing them to lose hope in themselves, their children, loved ones, healthcare systems and our social construct.

I have been with people on a bridge or building ready to jump off, people with rope/cord around their neck ready to hang themselves, people with substances in hand ready to ingest, on phone with people driving on highways ready to close their eyes and let go of the wheel, people with gun to their heads ready to pull the trigger, and people with health conditions who knew the risks but didn't care because the labels or diagnosis was more painful to live with and they couldn't bear the thought. I work with people who lost family members and loved ones to murder-suicide and now having to live with and deal with the aftermath and trauma of the experience. Some of them survived the heinous act and now are living with the PTSD and survivor guilt of it. The pain they experience and live with changes them in many ways that may be considered risky but is a safety net for them. I work with attempt survivors who now have to face the truth of their pain and experiencing the physical and psychological impacts and scars of the attempt. Life after an attempt just doesn't get better or becomes less stressful just because the attempt fails; it often gets much harder and can force someone into trying again and succeeding.

These are the lived experiences and realities I face every day in dedicating my life to helping people avoid the pain and suffering I experienced that pushed me over the edge and almost completed my suicide. I tell them I'm not here to stop you from killing yourself but to let you know you are not alone and I am here to share the darkness and pain with you in the moment so if you allow me to, we can work on the pain together so you can be the light, hope and strength needed to step out of the darkness and into the light and life you truly desire for yourself. I do this because I know that I can't stop them from completing the act if their heart and mind truly is made up but if one small glimmer of hope is open I can be a light to illuminate their darkness and start healing and easing their pain. This is one of the most fundamental things we misconstrue about suicide in our belief that we can prevent people from killing themselves when we truly don't know or understand the real heartaches and pains of their experiences and how long they have been dealing with it.

I have had the honor of working with thousands of them because they saw or heard me talk publicly and openly about my suicidality and living with it after attempts. They shared their experiences and how suicide has impacted their lives in so many ways that often you have to wonder how they survived and are still surviving. Many talk about the power of connectedness to shared experiences while in the care of a psychiatrist and/or psychologist who they couldn't connect with but was able to get pharmaceutical resources to help manage or ease their pain. What mattered the most was the

connection to someone who could relate to the experience and offer real tangible lived experience solutions that they can relate to our implement in their lives.

What mattered the most to the attempt survivors was not feeling alone or being labeled with a diagnosis but having support outside of the visits to their clinicians which often are too long of a wait time. What mattered the most was having access to specialized support groups that offered ongoing connectedness to like-minded people and peers that are accessible 24/7 if needed. What mattered the most for loss survivors was connectedness to attempt survivors who through their experience with pain and suffering could offer closure for the loss of a loved one they never knew or realized was hurting and in that much pain.

What matters to many high-functioning people in high positions of power, politics, law enforcement, healthcare and education is to be seen and understood as a human being with emotions and life challenges like everyone else and not their titles and roles which now prohibits them from expressing their pain and suffering without judgement and risk of losing their jobs, titles and roles. The mandated reporting policies of many institutions and healthcare systems is a deterrent to them utilizing the services of because they don't want anyone knowing of their pain and suffering. People shouldn't be penalized for simply stating their emotions and seeking help for it. How can we prevent suicide if we force people into fear of speaking out about their feelings.

What is needed and works well are non-clinical alternatives to psychiatric and mental health care for people experiencing emotional pain and suicide ideations. Not everyone who is suicidal has a mental health or mental illness diagnosis and is one of the main reasons why many people don't seek help or get the appropriate care needed because of this misguidance and misdiagnosis. When they talk about their suicide ideations the first thing they are asked is what are you diagnosed with. How about life, a hard life, or a broken heart, loss of a loved one or child. That's the diagnosis. Often the realities of why people are suicidal are innate values and needs that does not require medication or institutionalization but instead time and patience to listen and be heard and understood. When someone is suffering from a broken heart whether from an intimate relationship, losing a child or loved one, or losing their quality of life for whatever reason, they have a good reason to feel pain and despair which too often is considered a risk to their health and then prescribed medication or hospitalization out of fear of them hurting themselves. This may not be the proper solution but fear of the person killing themselves and it becoming a liability on the institution is the priority; not the real value of the person's life and overall wellbeing.

The general response to people with suicidality and emotional distress is to be taken to the emergency room and be seen there for immediate assessment, treatment and needed referral to more specialized care. This is not the best place for someone to be in while facing their demons and pain and seeing, hearing and feeling the pain and suffering of others. Many of us who have been in that environment and experienced the horrifying ways in which we are treated and having to wait to be seen and we just gave up and said we're ok just to be released from there. Many of us have left the ER and completed our suicide ideation because the experience added more trauma and validated the lack of support and understanding of our condition. Many of us have been in the ER and walked out feeling ten times worse than when we went in. The ER should not be the place for someone experiencing an emotional crisis and wanting to die. There needs to be a specialized unit for this condition because unlike any other health or human crisis, suicide is a fight with oneself against oneself and needs the proper accommodation of peace, quiet and focus to calm the beast, control the emotions, understand the reality of pain and be able to breathe. Every breath a person takes while in the experience of suicide is pain and suffering. This is why they believe that only death can ease the pain.

This doesn't mean that a clinical approach is the only solution for this experience. Peers with lived experiences can make a significant impact on the person in that moment because of shared experience, understanding the language and translating the behaviors into meaningful strategies. There needs to be non-clinical people with lived experiences working in healthcare systems that meets with people in emotional distress to help them breathe and navigate the systems of care, referral and aftercare.

We must remove the fear of people killing themselves from the efforts to help them manage their pain and despair; instead, we must focus on tangible resources to alleviate the cause of the pain and provide meaningful support. We don't have an opioid crisis; we have a pain crisis that people are using opioids as a way to suppress and manage it. Opioid misuse is a leading cause of overdose deaths because the need to suppress and ease the pain outweighs the thoughts of the possibilities of death from it. Now people are taking stronger opioids for faster relief and mixing with other substances and alcohol. A deadly combination on so many levels with so many lives lost. The same for the synthetic drugs like K2 and new emerging ones. There is a demand and the people using the most are the ones in pain suffering unending discomfort from it and needing an end to it.

That said, so much money and funding is put into healthcare systems and not into community-based organizations that offers programs that works directly with many people in emotional pain and despair. So much funds are wasted in systems of care that are underutilized because people don't trust the system or people who work in them because of policies like mandated reporting. More funding needs to be available for non-clinical community-based services that provide on-the-ground services and support for people where they live and work. More funding needs to be available for training non-clinical crisis response teams in churches and schools. Our churches are filled with people struggling, hurting and suffering from emotional pain, anxiety, depression and trauma that causes suicide ideations yet isn't being addressed or addressed enough effectively. Our schools are overwhelmed with children in emotional pain and distress but policies and requirements by the Department of Education are more focused on academics and grades than emotional wellness and trauma and is preventing access to outside services and care that can extend support services afterhours for students and families.

In 2013 I founded and launched The Suicide Institute to provide research, specialized education, intervention, postvention and training in Crisis Intervention, Response and Management, and various First Aid skillsets such as; Mental Health, Psychological, Trauma, Domestic Abuse and Suicide and Psycholinguistics. My vision for the Institute is to take training to people in places where they work, worship, study and on the ground in communities on these skillsets so we will have a better system in place to handle early detection, intervention and prevention of mental/behavioral health crisis and mental illnesses.

In 2014 I brainstormed the idea of the NYC Suicide Council collective specifically focused on research, awareness, training, response and support for and about suicide due to the increase in work I was getting from people in crisis and distress. In 2015 I launched the Council with strong support from mental health professionals, clergy leaders, educators, community-based orgs and non-profits that I has been working with over the years. My vision is to create a better way for people to work together on the human conditions of suicide whether in the mental health field or not. The motto for the Council is "Suicide is a human condition that requires Love, humane support, patience and ongoing care to understand, heal, overcome and prevent." In 2018 the Council has grown to over 1400 actively engaged organizations, churches, agencies, educational institutions, healthcare providers, survivors and practitioners focusing more specifically on emotional pain, depression and suicide. What was most interesting about the Suicide Council and our meetings was

the increase in mental health practitioners who came out to seek help and support for their own mental and emotional well-being. This was a serious eye-opener for us and recognizing that many are also hurting and needing care which we were able to assist it through a collective effort of providers and resources.

I am a member of and consultant for the Westchester Suicide Task Force that was convened and run by the Westchester Government Office of Community Mental Health to address mental health, mental illness, trauma and suicide awareness and prevention across Westchester. The task force comprises of people with various specialties, accreditations, and interests from various local and state agencies, non-profits, community-based orgs, law enforcement, health and mental health institutions, educational institutions and churches. The task force meets every month to look at data, reports and trends across the county and strategize on solutions and resources to mitigate them.

My recommendations based on the success of what we do at SISFI and wanting this to be a policy and procedure across the State.

- Every school should have a safe space for students in emotional crisis to be able to kick, holler, scream, vent and get the time and attention needed to focus on their emotional wellness. Schools should host weekly Emotional Wellness Support Groups for students in emotional pain needing support. What is shared in the groups shouldn't be held against the students when they express how they are feeling and their experiences. No retaliation for it
- Businesses should offer emotionally safe places for employees to vent and express their emotions. This is a safe place that what is shared there shouldn't be held against them for it because of the need to focus on their emotional and overall wellness. Businesses should promote monthly emotional wellness days that focuses on emotional health and safety
- Have peer advocates in emergency rooms to check on the emotional well-being of people while waiting for services so they aren't just sitting there feeling isolated, alone, hurting more and not being given the immediate attention to their suffering and pain that may not be visible.
- A person should never be discharged by themselves without being accompanied by someone who can safely assist them home and help with their referrals and follow-ups. The person is already in a state of pain, despair and incoherent to be able to manage these important things when all they want is to be able to rest, relax and breathe due to overwhelming emotions and impacts of it. We understand the added trauma and distress in trying to schedule appointments when calling around, talking with numerous people and being transferred to the right person just to get an appointment which may not be right away but weeks or months ahead. I've seen this happen too often and know of people who completed suicide after being discharged and having a hard time getting help and managing referrals and schedules of appointments. The assigned advocate or peer would assist with these challenges and needs so the person can focus on feeling better and relieved.
- There are support assistance programs for people with domestic violence and substance abuse to get housing, healthcare and other services, but nothing like that for people experiencing suicide. We need this level of support.
- Create specialized units in emergency rooms and hospitals for people coming in with suicide ideations and after attempts
- Retrain everyone in healthcare and mental health systems about depression, suicide and suicidality
- Offer training to churches, community-based organizations and civic groups on depression and suicide so they can be first line of defense in times of crisis for people in crisis

➤ **Creating funding for specialized services and care**

I am truly grateful for the opportunity to testify to these committees on this topic so that the knowledge and experiences I have shared will also be yours to help in formulating effective and meaningful solutions for many of us living with emotional pain, anxiety, depression and suicide every day. I still live with my suicidality every day and wake up asking myself for one reason to keep living in this world and society that I don't see worth living like 98% of people do. What keeps me safe and able to manage my suicidality is to continue doing the work I do helping others and normalizing the topic so effective support services can be had and created. That's what's keeping me alive. My suicide is a part of me, and I don't fear it, I embrace it. Let's work together to save lives from emotional pain and suffering; not increase it. Thank You.

~Brett A. Scudder

President/Chairman/Founder of 'SISFI'

President/Chairman ~ The Suicide Institute and NYC and Yonkers Suicide Councils

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