Suicide Prevention and Survivor Resources

This packet contains suicide prevention and survivor resources that could be helpful to parents and caregivers. The following resources are included:

Michigan Association of Suicide Prevention (MASP) – Statistics: This handout includes current statistics regarding the prevalence of suicide both nationally as well as in Michigan as well as warning signs.

Suicide Warnings and Risk Factors: This handout provides detailed information on common warning signs related to suicide as well as common risk factors. The handout also identifies subpopulations that have elevated risk factors .

Talking To Your Kids About Suicide: This handout gives parents tips and information on how to talk to their children if they have concerns about suicide. It dispels the myth that talking about suicide that simply bringing up the topic of suicide somehow could plant the idea into child's head. Tips are given on how to structure the conversation as well.

I Am Worried About My Child: This handout gives guidance in helping parents sort through their feelings and worries. It describes various mental health interventions that could be used in treating someone who is struggling with suicidal thoughts or who has attempted suicide (outpatient care, psychiatric care, intensive outpatient programs, partial inpatient programs, inpatient hospitalization). It also shares info on how to coordinate accessing services with insurance companies.

Teen Suicide Prevention Video: In this video created by Mayo Clinic, teens describe common signs that a teen is considering suicide and provide encouragement for communicating directly and immediately for support and safety. It also Includes suggestions for what to say to a teen who may be at risk for suicide and ways to keep them safe. Things can get better. **To access the video go to: http://youtu.be/3BByqa7bhto**

Survivors of Suicide Support Groups: Listing of support groups for survivors impacted by suicide.

What To Tell Children: How To Explain A Suicide Death: This handout gives tips on how to talk with your children when someone they know dies as a result of suicide. It also offers suggestions on children's books that might support the discussion.

Local Crisis Contact Resources: This info sheet provides info on what steps to take if a child has attempted suicide or is in an immediate crisis that you feel may result in a suicide attempt. Includes contact information for community health services, Kent School Services Network (KSSN), Cherry Street Health Center, etc.

Suicide Prevention Resources Hotlines & Websites: Listing of national hotlines and websites that provide prevention and crisis information.

Michigan Association of Suicide Prevention (MASP) – Statistics

- Over 41,000 Americans (including 1,100 in Michigan) die by suicide each year.

- According to current estimates, there are 12 attempts for every death.

- Suicide is the tenth cause of death in the United States overall, but the second leading cause among young people aged 15 through 34 years old.

- Each death by suicide leaves behind an estimated 6-10 survivors or as many as 410,000 in the U.S. (including 11,000 in Michigan) every year.

- Surviving family and friends not only suffer the trauma of losing a loved one to suicide, but are at higher risk themselves of attempting it and developing other emotional problems.

- Most suicidal people desperately want to live, but can't see alternative solutions to their problems.

What Are The Warning Signs For Suicide?

The following signs may mean someone is at risk for suicide. The risk of suicide is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change. If you or someone you know exhibits any of these signs, seek help as soon as possible by calling the Lifeline at **1-800-273-TALK** (8255).

- 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.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

http://masponweb.org/

Suicide Warning Signs & Risk Factors

Suicide Warning Signs

People who kill themselves exhibit one or more warning signs, either through what they say or what they do. The more warning signs, the greater the risk.

Talk

If a person talks about:

- Killing themselves.
- Having no reason to live.
- Being a burden to others.
- Feeling trapped.
- Unbearable pain.
- Feeling like a burden to others Sleeping too little or too much. Acting anxious or agitated; behaving recklessly Increasing the use of alcohol or drugs. Talking about feelings of hopelessness Searching for methods online Talking about wanting to die Withdrawing or feeling isolated. Talking about feeling trapped or in unbearable pain.

Behavior

A person's suicide risk is greater if a behavior is new or has increased, especially if it's related to a painful event, loss, or change.

- Increased use of alcohol or drugs.
- Looking for a way to kill themselves, such as searching online for materials or means.
- Acting recklessly.
- Withdrawing from activities.
- Isolating from family and friends.
- Sleeping too much or too little.
- Visiting or calling people to say goodbye.
- Giving away prized possessions.
- Aggression.

Mood

People who are considering suicide often display one or more of the following moods.

- Depression.
- Loss of interest.
- Rage.
- Irritability.
- Humiliation.
- Anxiety.

Risk Factors

Suicide does not typically have a sudden onset. There are a number of stressors that can contribute to a youth's anxiety and unhappiness, increasing the possibility of a suicide attempt. A number of them are described below.

Depression, mental illness and substance abuse

One of the most telling risk factors for youth is mental illness. Mental or addictive disorders are associated with 90% of suicides. One in ten youth suffer from mental illness serious enough to be impaired, yet fewer than 20 percent receive treatment. In fact, 60% of those who complete suicide suffer from depression. Alcohol and drug use, which clouds judgment, lowers inhibitions, and worsens depression, are associated with 50-67% of suicides.

Aggression and fighting

Recent research has identified a connection between interpersonal violence and suicide. Suicide is associated with fighting for both males and females, across all ethnic groups, and for youth living in urban, suburban, and rural areas.

Home environment

Within the home, a lack of cohesion, high levels of violence and conflict, a lack of parental support and alienation from and within the family.

Community environment

Youth with high levels of exposure to community violence are at serious risk for self-destructive behavior. This can occur when a youth models his or her own behavior after what is experienced in the community. Additionally, more youth are growing up without making meaningful connections with adults, and therefore are not getting the guidance they need to help them cope with their daily lives.

School environment

Youth who are struggling with classes, perceive their teachers as not understanding them or caring about them, or have poor relationships with their peers have increased vulnerability.

Previous attempts

Youth who have attempted suicide are at risk to do it again. In fact, they are eight times more likely than youth who have never attempted suicide to make another suicide attempt.

Cultural factors

Changes in gender roles and expectations, issues of conformity and assimilation, and feelings of isolation and victimization can all increase the stress levels and vulnerability of individuals. Additionally, in some cultures (particularly Asian and Pacific cultures), suicide may be seen as a rational response to shame.

Family history/stresses

A history of mental illness and suicide among immediate family members place youth at greater risk for suicide. Exacerbating these circumstances are changes in family structure such as death, divorce, remarriage, moving to a new city, and financial instability.

Self-mutilation

Self-mutilation or self-harm behaviors include head banging, cutting, burning, biting, erasing, and digging at wounds. These behaviors are becoming increasingly common among youth, especially female youth. While self-injury typically signals the occurrence of broader problems, the reason for this behavior can vary from peer group pressure to severe emotional disturbance. Although help should be sought for any individual who is causing self-harm, an appropriate response is crucial. Because most self-mutilation behaviors are not suicide attempts, it is important to be cautious when reaching out to the youth and not to make assumptions.

Situational crises

Approximately 40% of youth suicides are associated with an identifiable precipitating event, such as the death of a loved one, loss of a valued relationship, parental divorce, or sexual abuse. Typically, these events coincide with other risk factors.

Elevated Risk Factors

Although there is no such thing as a suicidal type of young person, the statistics on youth suicide do suggest that there are certain behaviors or characteristics that can alert you to a possible elevated risk of suicidal thought. Some of the most common elevated risk factors are listed below:

Perfectionist Personalities

The pressure, often on oneself or from others, to be perfect may causes feelings of inadequacies. These young people are often the high achievers and/or school leaders that overextend themselves to exhaustion. These youth set high expectations for themselves and if those expectations become impossible to achieve, depression and eventual thoughts of suicide may occur.

GLBTQ

These young people are considered to be at high risk for suicidal behavior because they are the targets of a great deal of victimization. They report not feeling safe in their schools, feeling confused about their sexuality and suffering some form of verbal or physical abuse.

Learning Disabled

Youth who constantly struggle to understand concepts that are easily understood by others can become depressed and feel defeated. Their struggle to perform in school is present for them daily. Youth with learning disabilities had twice the risk of emotional distress, and females were at twice the risk of attempting suicide and for violence involvement than their peers.

Loners

These young people appear to have no social or emotional support systems.

Low Self- Esteem

Feelings of worthless, shame, overwhelming guilt, self-hatred, "everyone would be better off without me."

Depressed Youth

90% of those who complete suicide suffer from undiagnosed and treatable mental health issues.

Students in Trouble

A recent literature review of youth corrections shows that detention has a profoundly negative impact on young people's mental and physical well-being, their education, and their employment. One psychologist found that for one-third of incarcerated youth diagnosed with depression, the onset of the depression occurred after they began their incarceration, and another suggests that poor mental health, and the conditions of confinement together conspire to make it more likely that incarcerated teens will engage in suicide and self-harm.

Abused, Molested or Neglected

Abused youth in a study by the AMA showed significantly greater risk factors for youth suicide, including family disintegration, diagnoses of depression, disruptive behavior disorders and substance abuse and dependence.

Abusers of Drugs and Alcohol

Alcohol and drug use clouds judgment, lowers inhibitions and worsens depression, and in turn can heighten the risk considerably. **http://jasonfoundation.com/prp/whos-at-risk/elevated-risk-factors/**

SOCIETY for the PREVENTION of TEEN SUICIDE

PARENT AWARENESS SERIES:

Talking to your Kids About Suicide

Every parent would like to believe that suicide is not relevant to them or their family or friends. Unfortunately, it's all too relevant for all of us. It's the 3rd leading cause of death in adolescents and the 2nd for college aged students. Even more disturbing are national surveys that tell us that 16% of high school students admit to thinking about suicide and almost 8% acknowledge actually making an attempt. The unfortunate truth is that suicide can happen to ANY kid in ANY family at ANY time!

So how do you deal with this reality? Once you acknowledge that suicide is as much risk for your child as not wearing a seat belt while driving, or using alcohol or drugs, or engaging in risky sexual behavior, you've taken the first step in prevention. You talk to your children about these other behaviors which can put them at personal risk, and suicide is no different. It's something you CAN and SHOULD talk about with your children!

Contrary to myth, talking about suicide CANNOT plant the idea in someone's head! It actually can open up communication about a topic that is often kept a secret. And secrets that are exposed to the rational light of day often become less powerful and scary. You also give your child permission to bring up the subject again in the future.

If it isn't prompted by something your kid is saying or doing that worries you, approach this topic in the same way as other subjects that are important to you, but may or may not be important to your child:

- Timing is everything! Pick a time when you have the best chance of getting your child's attention. Sometimes a car ride, for example, assures you of a captive, attentive audience. Or a suicide that has received media attention can provide the perfect opportunity to bring up the topic.
- Think about what you want to say ahead of time and rehearse a script if necessary. It always helps to have a reference point: ("I was reading in the paper that youth suicide has been increasing..." or "I saw that your school is having a program for teachers on suicide prevention.")
- Be honest. It this is a hard subject for you to talk about, admit it! ("You know, I never thought this was something I'd be talking with you about, but I think it's really important"). By acknowledging your discomfort, you give your child permission to acknowledge his/her discomfort, too.
- Ask for your child's response. Be direct! ("What do you think about suicide?"; "Is it something that any of your friends talk about?"; "The statistics make it sound pretty common. Have you ever thought about it? What about your friends?")

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- Listen to what your child has to say. You've asked the questions, so simply consider your child's answers. If you hear something that worries you, be honest about that too."What you're telling me has really gotten my attention and I need to think about it some more. Let's talk about this again, okay?"

- Don't overreact or under react. Overreaction will close off any future communication on the subject. Under reacting, especially in relation to suicide, is often just a way to make ourselves feel better. ANY thoughts or talk of suicide ("I felt that way awhile ago but don't any more") should ALWAYS be revisited. Remember that suicide is an attempt to solve a problem that seems impossible to solve in any other way. Ask about the problem that created the suicidal thoughts. This can make it easier to bring up again in the future ("I wanted to ask you again about the situation you were telling me about...")

Here are some possible warning signs that can be organized around the word "FACTS":

FEELINGS that, again, seem different from the past, like hopelessness; fear of losing control; helplessness; worthlessness; feeling anxious, worried or angry often

ACTIONS that are different from the way your child acted in the past, especially things like talking about death or suicide, taking dangerous risks, withdrawing from activities or sports or using alcohol or drugs

CHANGES in personality, behavior, sleeping patterns, eating habits; loss of interest in friends or activities or sudden improvement after a period of being down or withdrawn

THREATS that convey a sense of hopelessness, worthlessness, or preoccupation with death ("Life doesn't seem worth it sometimes"; "I wish I were dead"; "Heaven's got to be better than this"); plans like giving away favorite things, studying ways to die, obtaining a weapon or stash of pills; suicide attempts like overdosing or cutting

SITUATIONS that can serve as "trigger points" for suicidal behaviors. These include things like loss or death; getting in trouble at home, in school or with the law; a break-up; or impending changes for which your child feels scared or unprepared

If you notice any of these things in kids who have always been impulsive, made previous suicide attempts or threats or seem vulnerable in any way, you really should get consultation from a mental health professional.

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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SOCIETY for the PREVENTION of TEEN SUICIDE

HIGH FOCUS CENTERS

PARENT AWARENESS SERIES:

I am Worried About My Child

Prepared By: Dara Gasior, PsyD, Director of Freehold High Focus Centers and Maureen Underwood, LCSW, SPTS Clinical Director

I am worried about my child, but a little embarrassed to talk about it with anyone and have no clue how to get help. Where do I start?

There is no need to be embarrassed about asking questions or reaching out for help. It is okay to be concerned about your child and it is your job as a parent to make sure that you are doing everything you can to get them the support they need. As a parent, you have instincts about your child, and if your instinct tells you that something is wrong and this is not "just a phase" then you should listen to yourself. Sometimes our embarrassment comes from not knowing where to turn. The mental health system can be confusing for people who are reaching out to get help and the goal of this article is to assist you in better knowing what resources are available and then finding out how to access them.

The first thing you need to do is get some clarity about what is worrying you. One of the best ways to try to pinpoint the specific behaviors or feelings that have you concerned is to think about the ways in which these behaviors are 'changes' from the way your child normally acts. Are things different just at home or also at school? How about with friends? siblings? Listing examples of the behaviors that have fueled your concerns is a concrete and objective place to start.

The next question is to determine just how concerned you are. How intense are the behavior and mood changes that you are seeing? Using a 1 to 10 scale can help you get specific. For example, if you think your child is mildly depressed you might consider a 3-5 score on the scale; if you are concerned that they are at risk to harm themselves your score would be in the 8-10 range. The reality is that the clearer you can be about both the specific behaviors that concern you and the level of your concern, the easier it will be to get your child into the correct level of care.

Once you are a little clearer about your concerns, you'll want to have your child evaluated for mental health treatment. A 'mental health evaluation" means an assessment by a mental health professional to determine whether or not your child has an issue or problem that would benefit from mental health treatment. The mental health system, unfortunately, can seem a bit confusing because it consists of a number of different tiers of treatment, from the least restrictive to the most restrictive. Here's some information to help you get a clearer understanding of the different levels of care.

Outpatient Therapists

The outpatient therapist is someone who can not only make that initial mental health assessment but can also treat mild to moderate symptoms of depression, anxiety, some experimentation with drugs or alcohol, attentional issues, acting out behaviors and family conflict. Just as portrayed in movies or on television,

the therapist usually sits across from an individual patient or client, and asks questions or makes comments. These meetings or sessions typically last from 45-60 minutes and take place about once a week. The frequency can vary, though, from 2-3 times per week to once every other week depending on the therapists' availability and the severity of the problems.

Therapists can have any number of different degrees and credentials, which can be confusing when you are trying to figure out which professional to see. A licensed social worker (LSW or LCSW), licensed family counselor (LMFT), licensed associate or professional counselor (LAC, LPC) all have Masters Degrees in the mental health field. A psychologist (PhD or PsyD) has advanced training and a doctorate in the mental health field. Psychologists are the only mental health professionals qualified to administer and interpret psychological tests that can be helpful in diagnosing and understanding complex cases. From a practical viewpoint, it does not matter which degree or letters therapists have after their names; they are all trained to provide clinical care in the community. What matters is how comfortable you and your family member feel with them.

Outpatient therapists also may provide group therapy that is designed to allow individuals of similar ages and problems to be treated within a group setting. Many of these groups occur for 1-1.5 hours a week and generally deal with specific topics. Some of the most common groups for adolescents include social skills groups, and groups to assist teenagers with attentional difficulties .For example, if you are concerned that your child is struggling socially, group therapy can be a great resource to assist with development of these skills in an appropriate and therapeutic setting.

Psychiatrists

These are medical doctors (MD) with advanced training in dealing with serious mental illness. Most psychiatrists primarily prescribe and monitor medications. Often the psychiatrist will see individuals for an initial evaluation, and then follow up monthly for medication management sessions. Some psychiatrists will see patients weekly while others will provide both individual talk therapy sessions and medication management sessions. However, this varies from doctor to doctor.

Many people who are seeking help for the first time will try to make their initial appointment with a psychiatrist. In general, psychiatrists often do not take insurance and usually have longer waiting- lists for appointments than other therapists. So if you are concerned about a family member, it can be easier and quicker to get them in to see an outpatient clinician first. They can begin talk therapy and if the clinician believes that medication is necessary or should be considered, they can assist with making a referral to a psychiatrist.

Intensive Outpatient Programs (IOP)

These programs, which meet for multiple hours, multiple days per week have higher levels of care and are designed to treat individuals who are experiencing moderate to severe symptoms. Most IOP's are scheduled from 3 – 5 times per week and typically run for about 3-4 hours per treatment day for approximately 2-3 months. However, all IOPs are designed with a strong emphasis on group work to assist clients in developing specific skills to improve their level of functioning. There are usually a variety of groups that address particular problems like substance abuse, eating disorder or psychiatric disorders (such as mood, anxiety and psychotic disorders).If your child is using drugs or alcohol on a semi-regular to regular basis, then this is most likely the appropriate level of care for them. Similarly, many individuals who are struggling with eating disordered symptoms are often referred to this level of care.

If you have a child who has been in therapy with an outpatient clinician and has not made the progress you were hoping for, then an IOP may be the next step. Conversely, if your family member has not been in treatment before, but their symptoms are raising safety concerns (for example, you have recently discovered that they are harming themselves through cutting or burning) or if they are struggling with suicidal thoughts, then an IOP may be a more appropriate level of care for them than just outpatient therapy.

Partial Care Programs/Partial Hospitalization Programs (PCP/PHP)

This level of care is the step between an IOP and an inpatient hospitalization program. This program is designed for individuals who are not at immediate risk of harming themselves, but are experiencing significant symptoms which make it difficult for them to function in their daily lives. PCPs usually run 5 days a week for 5-6 hours. Like IOP's, they are group based programs but also provide family work, individual work as well as medication management with a psychiatrist. Patients usually attend these programs from 2- 4 weeks, with the specific goals of getting their medications adjusted, improving level of functioning, addressing any safety concerns and creating an appropriate aftercare plan. Many Partial Care patients will go directly to an IOP once they are more stable. If your child is not attending school, not functioning well, having severe depressive symptoms, self injuring, or expressing suicidal thoughts with regularity, then this may be the appropriate level of care for them.

Inpatient Hospitalization

Just like you'd do if your child broke an arm or leg, when you are worried that your child is in immediate danger the best thing to do is take them to the emergency room for an evaluation. Any suicide gesture or attempt should be taken seriously, so if your child is telling you or someone else that they want to die or have a plan to harm themselves, this is the level of care you may need. When you take your child to the emergency room, they will be medically cleared first, and then evaluated by a therapist/social worker who will determine the next step. Many times children who are suicidal will be recommended for admission to the hospital for a week or so. Although this recommendation may sound scary, it really is the best course of action for someone who is in crisis. As an inpatient, your child will attend groups, family sessions and be seen regularly by the psychiatrist for medication management. Once your child is more stable and no longer at high risk for self-harm, there will be an assessment by the clinician to assist you with determining what level of care is appropriate for follow up.

What's the Next Step??

If you have insurance, the best thing to do first is to call your insurance company and find out what type of mental health benefits you have. You want to know if you need something called 'preauthorization' and whether or not you have "out-of-network' coverage. If you have this type of coverage, your choice of providers will greatly increase. Almost all plans have outpatient coverage as well as coverage for inpatient hospitalizations. However, not all insurance packages have IOP or PCP benefits, so it is good to ask about this. If you have the benefit, then the next step is to get a list from the insurance company of in-network providers that meet the level of care you are seeking.

BEFORE you make an appointment, do not hesitate to call ahead and ask questions about the program or the therapist, the types of services rendered, as well as the way in which initial appointments are scheduled. Remember, you are technically a consumer who will be purchasing an important service for your child. It helps, of course, to frame your request in a courteous way. For example, "I don't know much about mental health counseling and I'm trying to approach this process as an educated consumer. I'd like to ask you a few questions to help me better understand how you work."

While you probably already have a list of questions in your head, here's a few more that you may want to include:

- My child has been having some problems in the following areas...(briefly provide examples of the behaviors that concern you). Can you give me an idea of what your approach to dealing with these types of problems might be?
- Do you involve parents (or guardians) in the counseling process?
- Do you provide family therapy? How do you decide if this is needed?
- What criteria do you use to determine whether or not my child needs medication?
- To whom do you refer for this type of assessment?
- If my child needs special accommodations at school, do you assist in making these arrangements?
- How flexible is your appointment schedule? Do you offer after school/ evening/Saturday appointments?
- If you or I decide that you and my child might not work well together, will you be able to suggest other referrals?
- You should also ask about that initial appointment: who will it be with, how long will it take, what will happen during it and how long after that initial evaluation will services start? You, as the consumer, have a right to make sure that the people you are calling will meet your needs, so ask them.

If you do not have insurance, most counties and states provide services to adolescents through county and state programs. In New Jersey, the provider of these services is Perform Care, and the best way to get help for the uninsured is to call them. The phone number to call is 877-652-7624. When you call them, you will give them basic information and get your child registered. You will be given a number that is your registration number. Once this first step is completed, they will assign a counselor to complete a needs assessment, which consists of a professional coming out to the home to interview you and your child and gather information to create a treatment plan. This treatment plan could include in-home therapies, a behavioral assistant who comes over consistently to assist with parenting, or possibly a mentor (someone to take your child out on social gatherings). They can also provide referrals to programs out of the home if that seems necessary. Many parents are reluctant to call Perform Care due to concerns about having strangers come to their homes. Please keep in mind that these people are professionals who are there to help you, not judge you or cause you additional stress. Reaching out to them for help is a sign that you are doing the best thing you can for your child, and they will respect that, so please allow them to opportunity to help.

Prepared By: Dara Gasior, PsyD, Director of Freehold High Focus Centers and Maureen Underwood, LCSW, SPTS Clinical Director

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Society for the Prevention of Teen Suicide, Inc. | www.sptsusa.org | sptsusa@gmail.com | (732) 410-7900

Teen Suicide Prevention Video

In this video created by Mayo Clinic, teens describe common signs that a teen is considering suicide and provide encouragement for communicating directly and immediately for support and safety. It also Includes suggestions for what to say to a teen who may be at risk for suicide and ways to keep them safe. Things can get better.

To access the video go to: http://youtu.be/3BByqa7bhto

Survivors of Suicide Support Groups

Grand Rapids

West Michigan Survivors of Suicide
2548 Newberry S.E. * Kentwood, MI 49508
Meets at: Park Congregational Church * 10 Park Pl., N.E. (Ransom St. entrance) * Grand Rapids, MI 49508
Facilitator: Jim Sailors * 616.957.3466 or 616.204.9671
Facilitator Type: Peer
*1 Mtg./Month: 2nd Thursday * 7:00-8:30 pm*
No charge

Ele's Place
http://www.elesplace.org/
Provides support groups for children on site at their location. Call for group times
2000 Michigan NE, Grand Rapids, MI 49503
Phone: 616-301-1605
Email: grandrapidsinfo@elesplace.org

Rockford

Rockford HOPE
Meets at Rockford Schools – Freshmen Center – Room 115; All ages are welcomed
4500 Kroes St. NE, Rockford, MI
Email: info@rockfordhopegroup.org

Greenville

Survivors of Suicide Loss
Greenville Community Church * 6595 South Vining Road * Greenville, MI 48838
Connie Wright * 616.824.5130 * **gregorsgirl@yahoo.com**
Greg Wright * 616.894.0840 * **gawright1981@gmail.com**
Facilitator Type: Peer
*1 Mtg./Week: Thursday * 7:00-8:00 pm*

Muskegon

West Michigan Survivors of Suicide
Calvary Church * Room C-102 * 5873 Kendra Road * Fruitport, MI * 231.724.6639
*1 Mtg./Month: 2nd Tuesday * 6:30-8:00 pm*

Big Rapids

Survivors of Suicide
400 Perry Street * Big Rapids, MI 49307
Facilitator: Tangela Zielinski, LMSW * 231.796.7371 or 800.837.3630 * tzielins@hom.org
Facilitator Type: Professional
*1 Mtg./Month: 2nd Monday * 5:30-7:00 pm*
No charge

What to Tell Children: How To Explain A Suicide Death

What children might feel after losing someone they love to suicide:

- Abandoned - that the person who died didn't love them.
- Feel the death is their fault - if they would have loved the person more or behaved differently.
- Afraid that they will die too.
- Worried that someone else they love will die or worry about who will take care of them.
- Guilt - because they wished or thought of the person's death.
- Sad.
- Embarrassed - to see other people or to go back to school.
- Confused.
- Angry - with the person who died, at God, at everyone.
- Lonely.
- Denial - pretend like nothing happened.
- Numb - can't feel anything.
- Wish it would all just go away.

A child or adolescent may have a many mixed feelings or may feel "numb." Whatever they are feeling, remember your role as an adult is to help them and be supportive. Reassure the child whatever feelings they might experience, they have permission to let them out. If they want to keep to themself for a while, let them. Don't tell a child **how they should or should not feel**. Also, don't discourage them from expressing negative emotions like anger.

How do we explain suicide to children or young people?

Age is a factor in understanding the type and amount of information to provide. Some children you can talk to about suicide with a 1- or 2-sentence answer; others might have continuous questions which they should be allowed to ask and to have answered. The most important thing to remember is to be honest. Children will always find out about what happened at some point, so be honest.

When a child hears that someone "committed suicide" or died of suicide, one of their first questions might be, "What is suicide?" One way to explain is that people die in different ways - from cancer, heart attacks, car accidents, or old age for example. Suicide simply means that a person caused his or her own death intentionally, it doesn't have to mean more than that. However, also explaining that the person they loved caused their own death because they had an illness in their brain can also be helpful. If they press for more detail, use your discretion to help the child understand as much as is age appropriate.

Some examples of explaining why suicide happens might be:

- "He had an illness in his brain (or mind) and he died."
- "Her brain got very sick and she died."
- "The brain is an organ of the body just like the heart, liver and kidneys. Sometimes it can get sick, just like other organs."

- "She had an illness called depression and it caused her to die."

If someone the child knows, or the child herself, is being treated for depression, it's critical to stress that only some people die from depression, not everyone. Remind her there are many options for getting help, like medication, psychotherapy, or a combination of both.

A more detailed explanation might be:

"Our thoughts and feelings come from our brain, and sometimes a person's brain can get very sick - the sickness can cause a person to feel very badly inside. It also makes a person's thoughts get all jumbled and mixed up, so sometimes they can't think clearly. Some people can't think of any other way of stopping the hurt they feel inside. They don't understand that they don't have to feel that way, that they can get help."

It's important to note that there are people who were getting help for their depression and died anyway. Just as in other illnesses, a person can receive the best medical treatment available and still not survive. This can also be the case with depression, bipolar disorder, and schizophrenia.

A child needs to understand that the person who died loved them, but that because of the illness he or she may have been unable to convey that or to think about how the child would feel after the death. The child needs to know that the suicide was not their fault, and that nothing they said or did, or didn't say or do, caused the death.

Some children might ask questions related to the morals of suicide - good/bad, right/wrong. It is best to steer clear of this, if possible. Suicide is none of these - it is something that happens when pain exceeds resources for coping with that pain.

Whatever approach is taken when explaining suicide to children, they need to know they can talk about it and ask questions whenever they feel the need. They need to understand they won't always feel the way they do now, that things will get better, and that they'll be loved and taken care of no matter what.

Suggested Reading for Kids

- *Bart Speaks Out: Breaking the Silence on Suicide* by Linda Goldman, M.S.
- *When Dinosaurs Die - A Guide to Understanding Death* by Laurie Krasny Brown & Marc Brown
- *The Grieving Child: A Parent's Guide* by Helen Fitzgerald
- ***Talking About Death: A Dialogue between Parent & Child** by Earl A. Grollman*

http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=EB8CDAFC-7E90-9BD4-CDB77DB42FD5C2CE

Local Crisis Contact Resources

If you are concerned about your child, there are many resources that are accessible for help. In the event of needing immediate crisis response contact 911.

To help your child receive the non-emergent help they need, your primary care doctor or current mental health care provider should be contacted.

If your child is not currently enrolled in Mental Health counseling, there are several options available. For those who have private insurance, check the back of your insurance card for their help line. Medicaid consumers can receive help through their local community mental health agencies. Below is a grid to help you choose what is right for you.

ACCESS:

EMERGENCY	**Contact:** **911**
If you have a CURRENT PROVIDER	**Contact:** **PRIMARY CARE PHYSICIAN** **CURRENT MENTAL HEALTH PROVIDER***
If you are in need of a Mental Health Provider	**Contact:** **KSSN** – services provided at Cedar Middle School 616-696-7326, Cedar View 616-696-9102 **CHERRY STREET HEALTH CENTER** - 616-696-3470 If you are interested in offsite community resources contact: **PRIVATE INSURANCE** – CONTACT THE NUMBER ON THE BACK OF YOUR HEALTH CARD for referral **MEDICAID or NO INSURANCE** – CONTACT YOUR COMMUNITY MENTAL HEALTH (see below)

*if your child is currently involved in mental health counseling, be sure the school has a release and contact information to alert the provider in the case of an emergency at school

COMMUNITY MENTAL HEALTH RESOURCES:

Allegan County Community Mental Health Services 3283 122nd Avenue, Allegan, MI 49010 • Phone: 269-686-5124

Muskegon HealthWest 376 E Apple Ave, Muskegon, MI 49442 Phone: (231) 724-1111

Network180 Access Center (Kent) 790 Fuller Avenue NE, Grand Rapids, MI 49503 Phone: (616) 336-3909 Toll Free: (800) 749-7720

Ottawa County Mental Health 12265 James Street, Holland, MI 49424 Phone: (616) 392-1873

Suicide Prevention Resources Hotlines and Websites

HOTLINES:

1-800-273-TALK (8255) http://www.suicidepreventionlifeline.org/
The National Suicide Prevention Lifeline is a free, confidential, 24-hour, 7-day a week hotline available to anyone in suicidal crisis or emotional distress; connects the caller to certified help from nearest crisis center; can call for self or someone individual cares about.

1-866-4-U-TREVOR or 1-866-488-7386 http://www.thetrevorproject.org/
The Trevor Lifeline is a national, confidential 24-hour toll-free suicide prevention hotline aimed at lesbian, gay, bisexual, transgender, and questioning youth. If a young person is looking for someone to listen and understand without judgment or if he/she is feeling suicidal, The Trevor Lifeline is available at 866-488-7386. All calls are handled by trained counselors.

1-800-448-3000 http://www.boystown.org/national-hotline
The Boys Town National HotlineSM is open 24 hours a day, 365 days a year and staffed by specially trained Boys Town counselors. Parents, teens and families can find help with the following: Suicide Prevention, Runaways, Parenting troubles, School issues, and more. Spanish-speaking counselors and translation services, representing more than 140 languages, are available, along with a TDD line (1-800-448-1833) that allows counselors to communicate with speech-impaired and deaf callers.

WEBSITES:

Youth Suicide Prevention Website http://www.youthsuicide.ca/
This website is aimed towards teens and their parents. For parents and adults, it gives suggestions on what to say if they observe the suicidal risk signs in their children. For youth, it gives suggestions on what to say and who to call if a friend is contemplating suicide.

Society for the Prevention of Teen Suicide
Parent Section: http://www.sptsusa.org/parents/
This website's parent section provides information to help you talk with your teens about suicide or the death of a friend by suicide. It includes a link to the video *Not My Kid: What Every Parent Should Know,* which features eight parents from culturally diverse backgrounds asking two experts common questions about youth suicide.

YES Institute http://www.yesinstitute.org
YES Institute provides education that gets at the source of why youth are harassed. Their mission is to prevent suicide and ensure the healthy development of all youth through powerful communication and education on gender and orientation. Their mission is accomplished through powerful communication and education with people in all segments of the community—throughout the U.S. and Latin America.