



MISSISSIPPI

Suicide **Prevention** Plan

FY17-FY19



Supporting a Better Tomorrow...Today

DMH
Mississippi Department of Mental Health

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Mississippi is ranked 23rd among U.S. states for completed suicide. From 2004 to 2010 there were 2,612 suicide deaths.



Acknowledgements

Mississippi Suicide Prevention Plan Workgroup Members

MARIA ALLEN

Department of Mental Health
Division of Alzheimer's Disease and
Other Dementia

WENDY BAILEY

Department of Mental Health
Bureau of Outreach, Planning, and
Development

JOHN BARTKOWSKI

University of Texas San Antonio

DONNA BOUTWELL

South Mississippi State Hospital

JACKIE CHATMON

Department of Mental Health
Division of Children and Youth

KATHY VAN CLEAVE

Department of Mental Health
Division of Alzheimer's Disease and
Other Dementia

ANDREW DAY

Department of Mental Health
Division of Adult Services

JOHNNY HANSELL

DREAM of Hattiesburg

TINEEKA NICOLE HARDY

Lamar County School District

FRANKIE JOHNSON

Central Mississippi Residential Center

PATTI MARSHALL

Office of the Attorney General

TAMMY MCKENNA

Mississippi Chapter of the American
Foundation for Suicide Prevention

ADAM MOORE

Department of Mental Health
Bureau of Outreach, Planning,
and Development

MICHAELA MOORE

Young Adult Representative

TERESA MOSLEY

Board of Mental Health

MOLLY PORTERA

Department of Mental Health
Office of Consumer Support

KIMELA SMITH RUNNELS

Department of Mental Health
Bureau of Outreach, Planning,
and Development

GLORIA SALTERS

Office of the Attorney General

MITZI SPEARS

The Shafer Center

LINDA VASQUEZ

DREAM of Hattiesburg

THIA JASMINE WALKER

Department of Mental Health
Division of Prevention

ESTELLE WATTS

Department of Education

JEANIE WHALEY

Mississippi National Guard

JASMINE WILLIAMS

Department of Mental Health
Division of Prevention

MELODY WINSTON

Department of Mental Health
Division of Prevention



When
studying
suicide, we
like to look
at statistics;
however,
those
statistics
don't really
make it
real. It's
real when
you love
one of the
numbers.

~Teresa

Letters of Support

DEPARTMENT OF MENTAL HEALTH State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201



(601) 359-1288
FAX (601) 359-6295
TDD (601) 359-6230

Diana S. Mikula - Executive Director

Mississippi's Suicide Prevention Plan represents an important step for our state to take as we work to ensure mental health and wellness for all citizens. Our public mental health system has worked for years at prevention efforts and to fight the stigma of mental illness. Whether we realize it or not, many of our friends and neighbors have been affected by mental illness or suicide.

Having good mental health is an essential component of good physical health, but in Mississippi, mental health problems are more common than many people realize. One in five people will experience a mental illness during their lifetime, and one family in four has a member who has a mental illness and who will require some type of treatment. Suicide is a leading cause of death in our nation and in our state, and it affects people of all ages, races and backgrounds. It is also a preventable cause of death.

Over the last several years, our agency has focused efforts on educating the public about the warning signs and risk factors of suicide. We have also educated young adults on shattering the silence surrounding suicide and stressed the importance of sharing with others when you experience suicidal feelings. Many survivors of suicide attempts tell us that in the moment after their attempts, they regretted their decision. They also share how they may have changed their minds if more people had recognized they needed help. That is why we are developing this plan. No matter what is happening in someone's life, there are people who care and who want to offer support and help however they can.

By collaborating, sharing resources, and working together towards common goals, we can prevent the tragedy of suicide. This plan would not be possible without the support and involvement of stakeholders from across the state and in numerous fields. Mental health professionals, state agencies, educators, and advocates have all helped in developing this plan. I would like to thank everyone for their participation and contributions. I look forward to seeing the results. I know this is an important step to take as we work to provide a better tomorrow for our state.

Sincerely,

A handwritten signature in cursive script that reads "Diana S. Mikula".

Diana S. Mikula
Executive Director

STATE OF MISSISSIPPI



Office of the First Lady
DEBORAH BRYANT
JACKSON, MISSISSIPPI

Dear Readers,

The Mississippi Department of Mental Health's efforts to develop a Statewide Suicide Prevention Plan is a project I am proud to support. A variety of state agencies, family members, non-profits and other groups are partnering to look at ways our state can address the critical issue of suicide. Considerable challenges and opportunities lie ahead as our state leaders and agencies work together to help decrease the number of suicides in Mississippi. Each and every Mississippian is special and has value, and it is our job to help them realize their potential.

It is imperative that we encourage the citizens of Mississippi to change the way they think about mental health. We need to educate communities on the importance of shattering the silence that often surrounds suicide and encourage people to seek help. Many times, families feel alone in this fight, but the truth is no one is alone. One in five Mississippians are affected by a mental illness. Suicide is now the 12th leading cause of all deaths in the state of Mississippi, and the 3rd leading cause of death among people from the age 15 to 24 in Mississippi. We are all in this together.

Most likely, you know someone who has been affected by a mental illness or impacted by suicide. It touches families from one end of our great state to the other end – including my own family. I have seen first-hand the effect that suicide has on people's lives, and my hope is that we do all we can to prevent unnecessary deaths by suicide. By working together, we can strive to ensure that people are aware of the warning signs and risk factors of suicide. Then we can show them how to seek help if needed. With increased understanding, people will be more likely to reach out for assistance as they begin to see symptoms either in themselves or their loved ones.

Suicide affects people from all walks of life. It does not discriminate based on age, gender, race or any other factor. That is an important key to this Statewide Suicide Prevention Plan. People from all populations – young adults, military, older adults, males, and females – will be impacted by the goals and objectives in this Plan. An integrated and coordinated effort is essential to prevent suicide attempts and deaths, and to save the lives of those we love.

I greatly appreciate the hard work and dedication of those who helped develop the Plan. I want to thank you, who will continue to work on implementing the Plan. It is my hope that this Plan will help increase the number of conversations we have about the impact of suicide in our state. I am hopeful to continue to work with the Suicide Prevention Workgroup and to see the progress that will be achieved in the future.

God Bless the Great State of Mississippi!

A handwritten signature in blue ink that reads "Deborah Bryant".

First Lady
State of Mississippi

Letters of Support

STATE OF MISSISSIPPI



JIM HOOD
ATTORNEY GENERAL

July 21, 2016

Mississippi Department of Mental Health
C/O Ms. Wendy Bailey
239 North Lamar Street, Suite 1101
Jackson, Mississippi 39201

Re: Letter of Support

Dear Ms Bailey :

I am in full support of the Mississippi Department of Mental Health's implementation of the Mississippi Suicide Prevention Plan. Suicide is listed as the third leading cause of death among teens in Mississippi, and as the father of three, this is of grave concern to me. Over the years, our agency has worked closely with the Jason Flatt Foundation to raise awareness, and in 2009, the Attorney General's office assisted in passing the Jason Flatt Foundation Act.

The Mississippi Department of Mental Health has worked together with its many partners to protect families and prevent them from suffering the tragedy of suicide, the "Silent Epidemic." The Mississippi Suicide Prevention Plan is a comprehensive strategic plan that will address coordinating and accessing prevention activities; improving suicide prevention training opportunities; promoting identification, intervention and care for people at-risk for suicide; and improving suicide literacy. I appreciate the resilience and dedication of all who work to save precious lives and provide families with the help needed in addressing this silent killer.

We look forward to working with the Mississippi Department of Mental Health and other partners in this collaborative effort to prevent suicide.

Sincerely yours,

A handwritten signature in blue ink that reads "Jim Hood".

Jim Hood
Attorney General

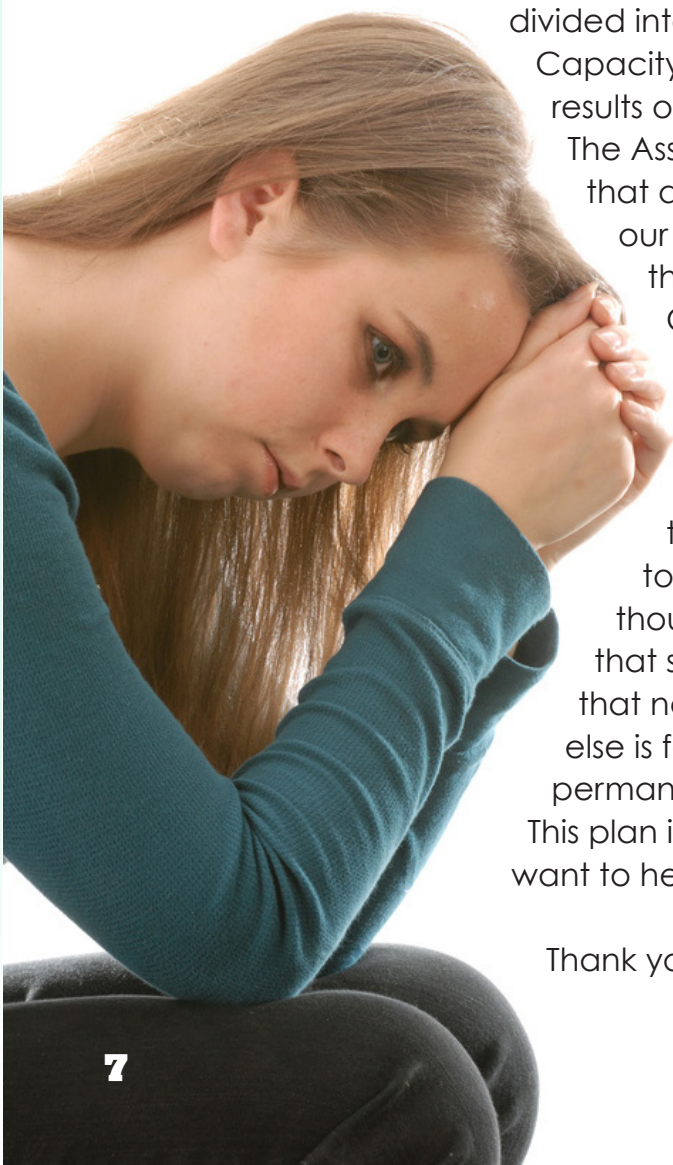
Introduction

The Mississippi State Suicide Prevention Plan Workgroup was formed in April 2016 to finalize the state's efforts in developing a formal plan to help end a public health issue that affects people of all ages, races, and gender – suicide. Though strides have been made in developing awareness and increasing knowledge about suicide in recent years, there is still significant progress to be made. Suicide is now the third leading cause of death among adolescents and young adults aged 10 to 24 years of age in Mississippi. Unfortunately, older adults are not immune from this issue either. Every day in the United States, 17 adults over the age of 65 die by taking their own lives – the highest suicide rate of any demographic group. No matter the age, any person who feels the need to take his or her own life is one too many.

Professionals in the fields of mental health, education, strategic planning, education and more began meeting monthly as a workgroup in May 2016 with the goal of finishing this plan by September. Members

divided into committees focused on Assessment, Capacity, Goals and Objectives, and Stories. The results of that work are presented here in this plan. The Assessment portion of the plan gathers data that addresses demographic information about our state and trends that have occurred over the years in the mental health field. The Capacity section examines current state resources that are available to address this public health issue at the current time. The Goals and Objectives are data-driven targets that point to the progress we hope to make with this plan. The Stories are there to help shatter the silence around suicide – thoughts of taking your own life are not thoughts that someone should keep inside. Remember that no matter the problems you or someone else is facing, they are temporary, but suicide is permanent. There is always someone willing to help. This plan is here to make sure many more people who want to help find those who need it.

Thank you to everyone who contributed to this plan.



Introducton of Stories

Thank you for reading the Mississippi State Suicide Prevention Plan. As you read through this document, you notice the several pages throughout the plan that are personal stories of people who have been affected by suicide. As the workgroup that developed this plan began meeting in the spring of 2016, the members realized the importance of sharing these stories. They come from not just those who have lost someone, but from those who have attempted or considered taking their own lives as well. What you have read, and the stories that are to follow, are the personal experiences of Mississippians who have found themselves facing profound situations.

Thank you for everyone who has shared their experiences through these stories. Some names have been changed, but these are all people – husbands and wives, parents and children, friends and family members – who have lived through a tragedy. Sharing their stories is an act of bravery that is working to make a difference in the hopes no one else has to go through what they did.

Suicide prevention is a challenge that can be faced together, but too many people struggle in silence. If you are struggling, please call the National Suicide Prevention Lifeline at 1-800-273-8255, or visit the Department of Mental Health online at www.dmh.ms.gov.

I am a suicide survivor. Not because I attempted to take my own life, but because my daughter, Elisabeth, made the decision to commit suicide ten years ago at 15 1/2 years of age.

She had struggled with depression and anxiety for 3 years, despite medication and therapy. I feel that she finally decided that the pain of living outweighed the fear of dying and so she left us. I felt so guilty that I was not able to "fix her."

The morning that I found Elisabeth, I dropped to my knees and prayed that God would use me in any way that would keep her death from being in vain. From that moment on, I became an advocate for suicide prevention. I began traveling around the state speaking to schools, church youth groups, civic groups, and other suicide survivors.

Through this tragedy, I began relationships with people working in the Mississippi Department of Mental Health. They provided me support, comfort, and allowed me to participate in suicide awareness programs. There was such a stigma attached to suicide and I wanted to share Elisabeth's story in an attempt to start a conversation with individuals whose lives had been touched by this tragedy. When I shared her story, I felt like I was doing what God wanted me to do in order to make a difference in the lives of other people with mental illness. This past year I was appointed to the Mississippi Board of Mental Health, and I hope to be able to see changes in suicide prevention practices in our state.

When my Elisabeth left, she took a part of my heart and soul with her; however, as a Christian I know I will see her again one day and she will be healed, whole, and happy.

When studying suicide, we like to look at statistics; however, those statistics don't really make it real. It's real when you love one of the numbers.

-Teresa

Suicide has no prejudices. It occurs in all ages, races, sexes, sexual orientations, religious denominations, and in all socioeconomic situations. It is a devastating act. Unless you are a suicide survivor, you have no idea how someone else feels.

My name is Angie. My life changed forever on Monday, September 14, 2015. It was just another morning when I went to wake our son, Casey, for school. Yes, he had turned 18 on July 1, but I still made sure he was up and cooked his breakfast every morning. It was our ritual. He was our only child and was loved with every ounce of our being.

Casey had gotten back Sunday evening from a weekend trip to a college town. He seemed very tired and didn't have a whole lot to say. He said he was going to take a nap, which was not unusual for a Sunday after a weekend away. I remember him coming into the living room later that evening, lying on the couch and putting his head in my lap. That was unusual. He hadn't done that in a long time. I rubbed his beautiful hair and enjoyed having him so close. When he got up to go back in his room, I begged him to stay longer. I missed him doing that. He went on into his room. He got up a little after 10 p.m. to fix himself something to eat, and told his Daddy, Chris, goodnight and said he loved him. I had already fallen asleep. It was a normal night at our house.

I didn't sleep well, which wasn't unusual. That night, however, I woke up at 1:10, 2:10, 3:10 and 4:10 a.m. I am a very early riser, so I just stayed up. I went outside to do what I do every morning - drink coffee and watch the world come alive.

At around 7:15, I went to wake Casey up. He didn't answer when I knocked on his bedroom door. I banged louder, calling his name. Then louder and louder until it woke my husband. Casey always locked his bedroom door, so I ran into the kitchen to get the scissors to unlock it. I had a terrible feeling in my gut. I heard my husband call his name. I ran into the room, where I saw him lying in his bed, on his stomach. I don't remember noticing much, just seeing his back; he looked okay. We couldn't jar him awake, so I grabbed his head. I felt a gun with my right hand. Only later would I remember having to move pillows out of the way. Panicking, I grabbed the gun and threw it behind me. I tried to turn him over and screamed at Chris to help me. He was so heavy! Some type of instinct to save him took over. It never crossed my mind that he might be dead. I immediately started CPR and screamed at Chris to continue as I ran to get the phone to call 911.

As the operator answered the phone, I was trying to be as calm as possible so they could get my address and send the ambulance. I was crying uncontrollably, shaking, and I couldn't catch my breath. I remember few things about that call; the operator kept telling me to calm down in a very monotone voice. I felt like he didn't realize how important this call was! I kept telling him to hurry.

The police got there, came into Casey's room and said we had to leave the house. There were so many officers and people in my house! I could see them all walking around, in no hurry. I continued to ask why we had to be outside. I felt totally intruded upon, without any rights whatsoever. To this day, I still do not understand this. There has to be a better way to handle this type of situation.

In his notes, Casey told us that he had gotten into trouble while out of town for using a fake ID and being publicly drunk on Friday night. Saturday afternoon, he was searched and had 10 ADHD pills he had taken from the girlfriend of one of his friends. "I have never felt so ashamed in all my life, over this," he wrote. He told us he loved us more than anything, but he couldn't continue disappointing us and making bad decisions and hurting people. He thanked us for so many years of great times, but he said he wasn't happy enough in this world. He had lost all types of feelings and was so sorry for what he did. He asked for our forgiveness and told us none of this was our fault.

The detective was kind enough to take pictures of the letters and send it to our phones. We never were able to get the original notes back, although we asked for them several times. Once the investigation was over, we were called in to get the final report. They gave us back his computer, his phone, pens they had taken . . . and the gun. You cannot imagine what it felt like looking at that gun. We did not expect that and were utterly revolted by it. He had used my pistol, out of my purse. We couldn't get our son's final letters, but we could get the gun he used to end his life.

continued on next page

It was all such a blur. With cell phones and social media, there were people everywhere within minutes. I couldn't figure out how they found out so fast. My mind was spinning, and I was numb -- in total shock. Everyone was. Why, why, why? Casey was so handsome! He was popular. He had lots of friends. He excelled in school and on the baseball field. He was a pitcher who received an academic scholarship and a baseball scholarship. He was funny and had a heart of gold. I could go on and on.

Friends and family stayed with us 24-7 the week after Casey died. There were pictures of him everywhere we looked. Family and friends took all the flowers out and put all the pictures away. We felt very guilty about having to take the pictures down, but all we could see were all the smiles he had. And we were looking into his eyes in every picture, trying to see something we missed. That's when the guilt really began to set in. Guilt. More guilt every day. What didn't we see? I should have seen how depressed he was!! I have battled depression for most of my life. Why didn't I see the self-medicating? The excessive drinking? I'm a recovering alcoholic, for God's sake. Why didn't he share what was going on with SOMEBODY? Anybody. Were we too hard on him? Expect too much? Put too much pressure on him? Not tell him we loved him enough? Not have enough family time? Did he feel like he couldn't talk to us? Why didn't he tell us about the trouble he was in? We would have gotten through all that! Why? What did I do wrong? What could we have done different? Oh God, WHY?

It takes a great deal of energy to try to find some inkling of hope, happiness or serenity. It is exhausting trying to make myself not think of the bad things - those feelings of extreme loss, grief, and the images that pass through my head in living color. That is the worst, for me. I have a much harder time with that than Chris does. I have a very busy mind. The guilt I suffer is often unbearable.

We found an awesome therapist who helps us deal with everything. She specializes in PTSD, which I didn't fully understand until now. There are lots of things I never understood until now. She has been instrumental in keeping us on this earth.

We struggle through every day, praying for it to get better. Our lives will never be what we dreamed and hoped for. The only way to survive is to realize that it will always be different. I constantly am reminded of our loss, everywhere I go. Certain places are worse than others. And you never know when it will hit. The grocery store, where I still find myself shopping for what Casey likes. Then I realize I'll never get to cook breakfast for him again. I still start to call him when it's time to take the garbage out. I still carry my phone with me wherever I go, in case Casey calls. Everywhere we look, we see what isn't and what will never be. We'll never get to see our son experience love and marriage; we'll never have grandchildren. We will always think of what he could've done or what he might be doing now, if only he was still here.

I miss his smile, his smell, his laughter and his voice. I miss his wicked sense of humor and keen wit. I miss laughing at his craziness. I miss him coming up behind me and putting his arms around my neck. I miss hearing him say, "I love ya Mama." I miss the sound of his truck pulling into the driveway, stereo blasting, him coming in from school and hollering "Hey, Mom." I miss rubbing his whiskers on his chin. I miss hearing him beep the horn, twice, every time he left the driveway. I miss washing, drying and folding his clothes. I miss making him sweet tea. I miss cooking his breakfast every morning. I miss seeing him excited about life. I miss everything. Every single thing, every single day. I hate that every time I think or talk about my child, I feel like someone is punching me in the gut. I hate that I cry so uncontrollably at times, that I can't talk or breathe. I would give anything to have him back. Anything.

My son was in a tremendous amount of pain. He was in a place where he could see no hope, no light at the end of the tunnel. He was in such Hell, that he just couldn't take it anymore. His pain was much greater than his ability to see what immense pain his death would bring to so, so many people. I get angry at him from time to time. I can't stay angry long. After all, this is my child.

- Angie

Assessment of Mississippi

State Population

Mississippi has the 32nd largest population among US states and territories. Mississippi's population increased from 2,844,658 in 2000 to 2,968,103 in 2010 and was estimated at 2,992,333 in 2015. Mississippi has 82 counties and 297 incorporated cities, towns and villages. Over 50% of the state's population resides in rural areas. Approximately **25% of the Mississippi population is under 18 years old** and 14% are age 65 or older. Sixty percent of Mississippi's population is non-Hispanic white, and 37% is African American, with the latter as the highest proportion of any state.

Mississippi has one federally recognized tribe, the Mississippi Band of Choctaw Indians. Based on 2015 US Census estimates, there are approximately 17,810 Native Americans in Mississippi. Only 3.9% of Mississippians speak languages other than English at home.

Mississippi is **predominantly a rural state with 51% of residents living in designated rural areas** where the link between poverty, mental health, and substance use is robust. Of the 82 counties in Mississippi, 65 are rural. Rural living creates barriers to the prevention and treatment of substance use and mental health disorders. National data documents similarities between the prevalence of clinically defined mental health problems and co-morbid conditions such as substance use among rural and urban populations.

Other state demographics are featured in **Table 1**.

Table 1: Statewide Demographic Profile of Mississippi

		Gender		Race/Ethnicity				
	Total Pop. 2015	Male	Female	White	Black	Native American (AI/AN)	Hispanic	Other
All Ages	2,992,333	1,451,850	1,540,483	59.5%	37.6%	.6%	3.1%	2.4%
< 9	399,464	203,781	195,683	207,905	172,564	3,248	15,716	15,747
10-19	410,093	209,435	200,658	217,695	176,988	2,894	12,282	12,516
20-29	421,108	211,087	210,021	228,934	177,808	2,738	13,388	11,628
30-39	378,138	184,605	193,533	215,934	150,649	2,746	14,525	8,809
40-49	365,491	176,605	188,886	221,726	134,368	2,061	9,530	7,336
50-59	400,969	192,334	208,635	251,161	141,481	2,022	5,713	6,305
60-69	327,742	154,516	173,226	220,475	101,653	1,281	3,046	4,333
≥ 70	289,328	119,487	169,841	215,953	69,364	820	2,223	3,121

Mississippi lacks sufficient data on sexual orientation and gender identity. Mississippi has made vigorous efforts to include sexual identity questions on the state's existing youth survey (SmartTrack). The Mississippi Department of Mental Health will continue to petition for inclusion of these indicators which are subject to approval from the Mississippi Department of Education. Mississippi has developed a young adult survey that includes sexual orientation and gender identity indicators to try and fill the data gap. This survey will be fielded within the next year and annually after the initial data collection contingent upon the availability of funds.

American Human Development Project

- Mississippi has the lowest ranking on the Human Development (HD) Index, a numerical measure of health, education, and income indicators. On a scale of 0-10 (0 = lowest development), Mississippi's current HD Index of 3.81 is **developmentally lower than the United States' score in the late 1980s** of 3.82.³
- On state rankings, Mississippi ranked last. On rankings of the country's 435 congressional districts, Mississippi's four districts ranked 357, 359, 421, and 431.³
- Mississippi has the lowest life expectancy of any and is among states with the lowest rates for adults 25 or older who have completed high school or its equivalent, a four-year bachelor's degree, or a graduate degree; and has the lowest average per capita income** (\$28,337 in 2015).³
- Mississippi has the highest poverty rate.³ **An estimated 22% of the state's population lives in poverty.**⁴

Table 2: Child Well-being Indicators		Statistics		Change from previous year	Rank
		US	MS		
% of children in poverty (2014)		22%	29%	decreased	49th
Teen birth rate (Births per 1,000 females ages 15-19) (2014)		24	38	decreased	46th
Infant mortality rate (Death per 1,000 live births) (2014)		5.8	8.2	decreased	49th
% of children in single-parent families (2014)		39%	47%	decreased	49th
% of teens not attending school and not working (Ages 16-19) (2014)		7%	10%	decreased	45th
% of teens who are high school dropouts (Ages 16-19) (2013)		4%	6%	unchanged	42nd
Child death rate (Deaths per 100,000 Children Ages 1-14) (2014)		16	23	decreased	42nd
Teen death rate (Deaths per 100,000 teens ages 15-19) (2014)		45	82	increased	48th
Overall child well-being by State (2016)				unchanged	50th

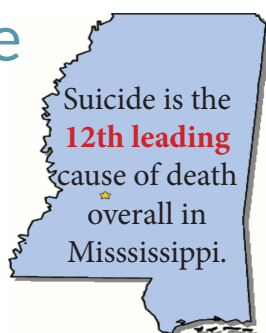
Source: Annie E. Casey Foundation's 2016 KIDS COUNT⁵

Table 3: Adult Well-being Indicators		Statistics	
		US	MS
Premature Death (Years of potential life lost before age 75 per 100,000 population) (2013)		5,200	10,100
Poor or fair health (Percentage of adults reporting fair or poor health) (2014)		12%	21%
Poor physical health days (Average # of physically unhealthy days reported in past 30 days) (2014)		2.9	4.0
Poor mental health days (Average number of mentally unhealthy days reported in past 30 days) (2014)		2.8	4.3
Uninsured (% of population under age 65 without health insurance) (2013)		17%	20%
Sexually transmitted infections (# of newly diagnosed chlamydia cases per 100,000 population) (2013)		287.7	585.1
Unemployment (% of population aged 16 and older unemployed but seeking work) (2014)		6.0%	7.8%
Violent crime (# of reported violent crime offenses per 100,000 population) (2012)		199	267
Severe housing problems (% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities) (2012)		14%	17%

Source: University of Wisconsin Population Health Institute. County Health Rankings 2016⁶

Suicide

Figure 1:
Mississippi
Suicide Rank



Source: CDC/NCHS, National Vital Statistics System, Mortality 2014⁸

Figure 2: Suicide Statistics



Source: American Foundation for Suicide Prevention, <http://afsp.org/about-suicide/suicide-statistics/>¹⁰

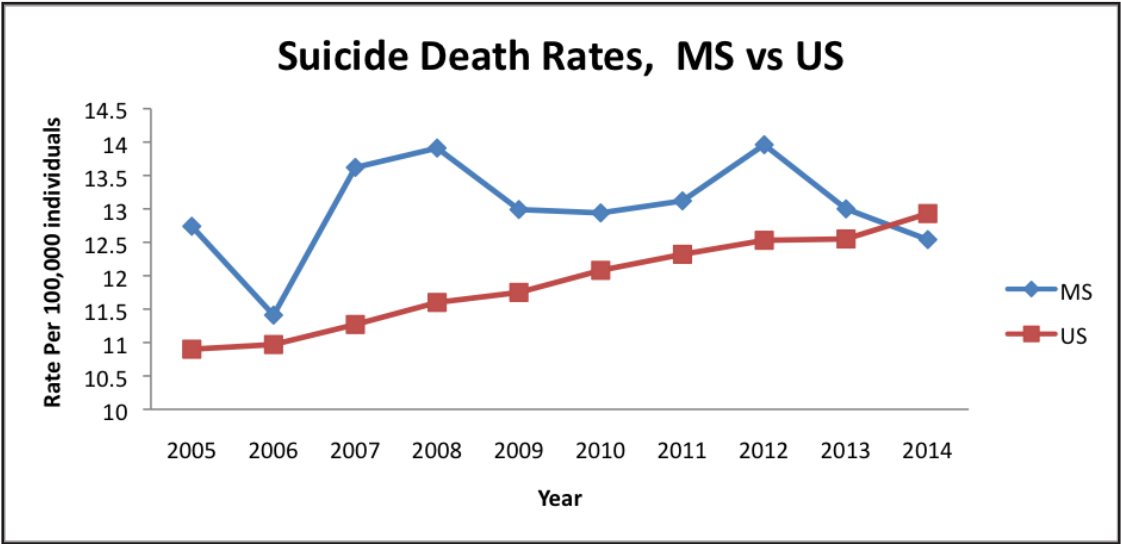
Suicide is the 10th leading cause of death in the US occurring at a rate of 13.4 per 100,000 persons in the population.⁷ In 2014, suicide was the 12th leading cause of death among Mississippians, accounting for 380 deaths and occurring at a rate of 12.7 per 100,000 persons in the population.⁸ From 2005-2014, there were 3,790 suicide deaths in Mississippi.⁹ Of those, poisoning accounted for 358 deaths; hanging, strangulation and suffocation accounted for 658 deaths, and firearms accounted for 2,640 deaths.⁹

From 2010-2011, 2,481 individuals attempted suicide in Mississippi, of which 1,452 (59%) were suicide attempts among drug users with 362 (15%) relating to opioids misuse.¹¹

Mississippi suicide rates surpassed the US suicide rates from 2005 to 2013

The chart below reveals suicide death rates for Mississippians of all ages from 2005-2014, as compared to the suicide death rates for the same population in the United States.

Figure 3: Suicide Mortality Rates in MS and US, 2005-2014



\$ Suicide cost Mississippi a total of **\$456,045,000** of combined lifetime medical and work loss cost in 2010, or an average of **\$1,175,372** per suicide death.

Figure 4: Economic Impact of Suicide in MS

Table 4: Mississippi Suicide Rank for the Leading Causes of Death by Age Group, 2014

	Age Groups					
	10-14	15-24	25-34	35-44	45-54	55-64
MS Rank	6th	3rd	4th	5th	8th	11th
US Rank	2nd	2nd	2nd	4th	4th	8th

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, WISQARS™ 12

Table 5: Years of Potential Life Lost (YPLL) Before Age 75 due to Suicide, 2014

Black		White	
Males	Females	Males	Females
1,601	198	6,896	2,046

Source: National Center for Health Statistics (NCHS), National Vital Statistics System, WISQARS™ 12

- o White males in Mississippi have the highest years of potential life lost attributable to suicide.¹²
- o The number of years of potential life lost is about five times higher for white Mississippians than black Mississippians.¹²
- o White males' number of years of potential life lost is 3 times higher than white females.¹²

Multiple factors contribute to the high rates of suicide in Mississippi. These factors are as follows:

- **Substance Use**

- o Alcohol Use
- o Drug Use

- **Mental Health**

- o Mental Illness
- o Serious emotional disturbances
- o Adverse Childhood Events (ACEs)

- **Household or Peer Influences**

- o Family disruption
- o Suicidal behavior of others

- **Structural Factors**

- o Pervasive Poverty
- o Widespread Unemployment
- o Entrenched discrimination
- o Historical Trauma

- **Environmental**

- o Parental unemployment
- o Poverty
- o Single parent homes
- o Domestic violence exposure

- Mississippi is ranked 23rd among US states for completed suicides. From 2004 through 2010 there were 2,612 suicide deaths.¹²
- 2010 accounted for 388 completed suicides.¹²

- o 2010 alone equates to \$1.6 million in medical costs and \$454 million in lost work productivity for a combined total of \$456 million.¹⁰

Table 6: CDC WISQARS Suicide Death Data: 2004 - 2010

STATE	# OF DEATHS	AGE-ADJUSTED RATE	STATE	# OF DEATHS	AGE-ADJUSTED RATE
Alaska	1046	21.82	Wisconsin	4964	12.41
Montana	1415	20.50	South Carolina	3867	12.17
Wyoming	761	20.11	North Carolina	7729	11.95
New Mexico	2659	19.16	New Hampshire	1145	11.91
Nevada	3457	19.15	Louisiana	3635	11.64
Idaho	1755	17.25	Iowa	2445	11.58
Colorado	5747	16.83	Pennsylvania	10423	11.42
Utah	2777	16.63	Michigan	8088	11.40
Arizona	6945	16.32	Ohio	9307	11.37
Oregon	4189	15.50	Virginia	6324	11.34
South Dakota	853	15.47	Georgia	7065	11.00
Oklahoma	3856	15.18	Delaware	684	10.97
Arkansas	2855	14.31	Texas	17750	10.94
West Virginia	1902	14.23	Minnesota	3983	10.75
Tennessee	6229	14.14	Hawaii	991	10.39
Kentucky	4232	13.99	Nebraska	1290	10.33
Vermont	628	13.66	California	25021	9.84
North Dakota	632	13.49	Rhode Island	699	9.07
Kansas	2613	13.43	Maryland	3545	8.76
Missouri	5544	13.33	Illinois	7785	8.65
Florida	18150	13.31	Connecticut	2136	8.28
Washington	6093	13.13	Massachusetts	3508	7.44
Mississippi	2612	12.83	New York	9471	6.78
Maine	1259	12.73	New Jersey	4205	6.69
Alabama	4204	12.61	District of Columbia	245	5.80
Indiana	5564	12.43	Source: CDC WISQARS* Suicide Data: 2004-2010		

Source: Center for Disease Control and Prevention, Web-based Inquiry Statistics Query and Reporting System (WISQARS™)12

United States versus Mississippi

Figure 5: Suicide Attempts by High School Students, MS vs US

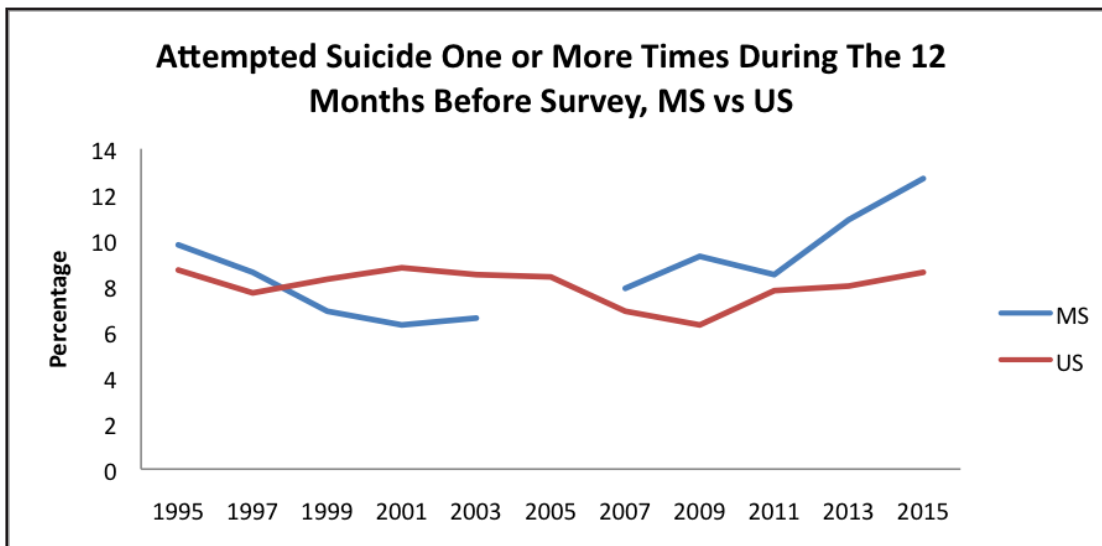
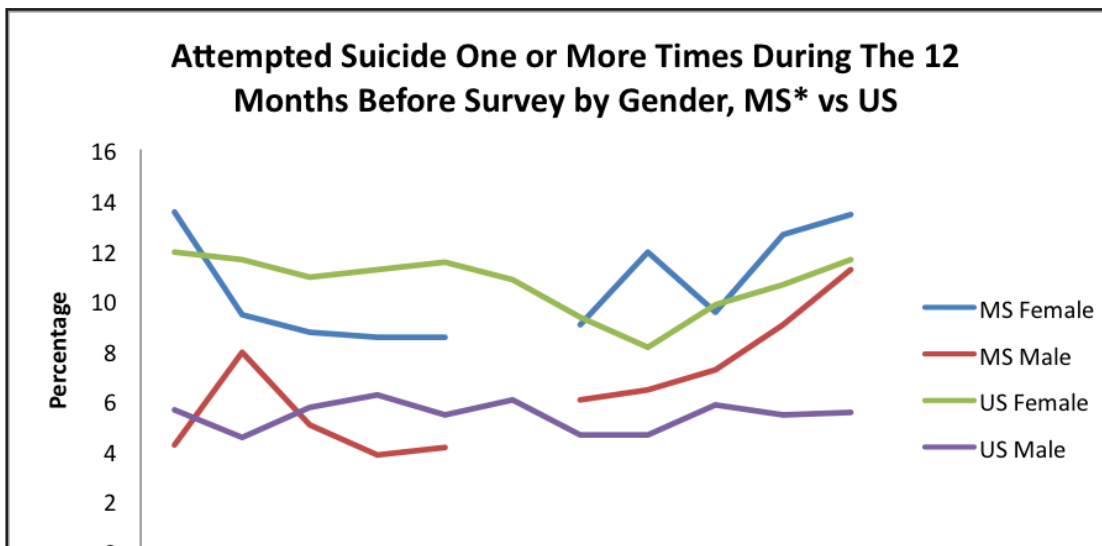


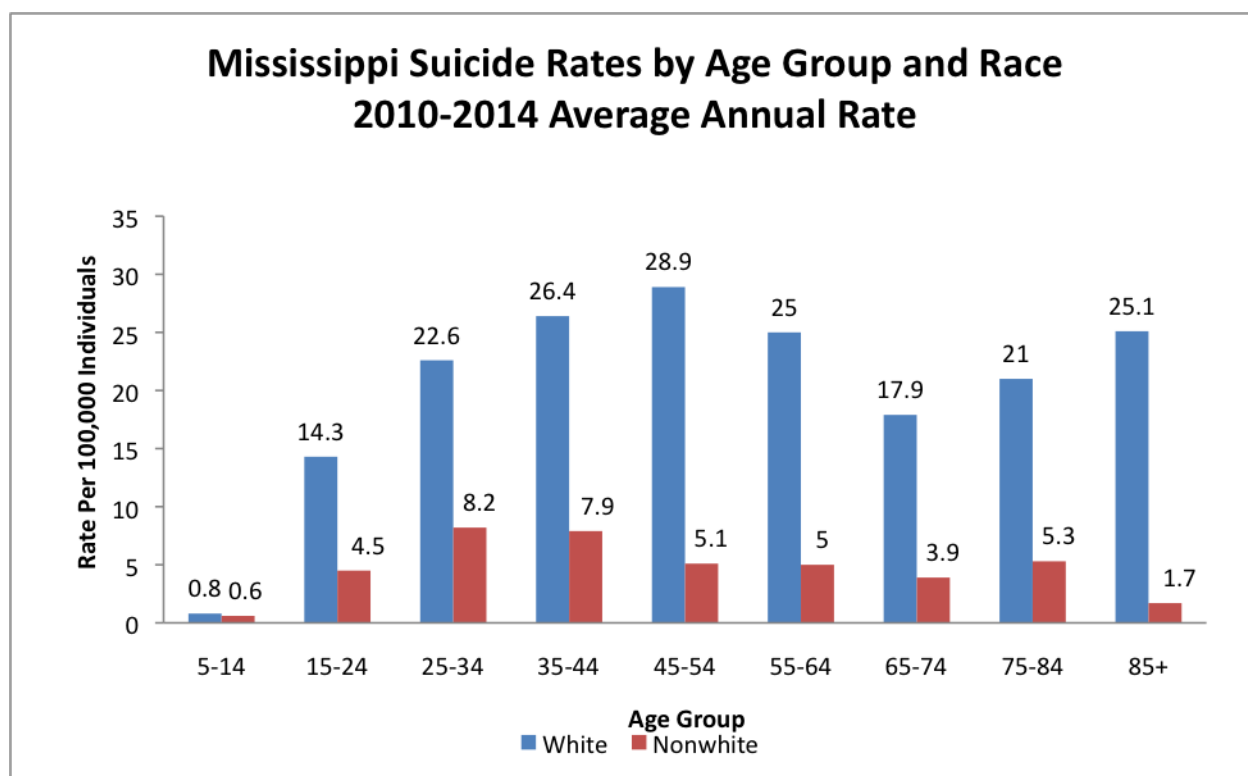
Figure 6: Suicide Attempts by High School Students by Gender, MS vs US



- A suicide attempt is not always a strong predictor of completed suicide.
 - o Four out of five people (80%) who die by suicide are male.
 - o However, three out of four people (75%) who make a suicide attempt are female.
- Suicide rates generally increase with age, with the highest rates among those in the midlife years.

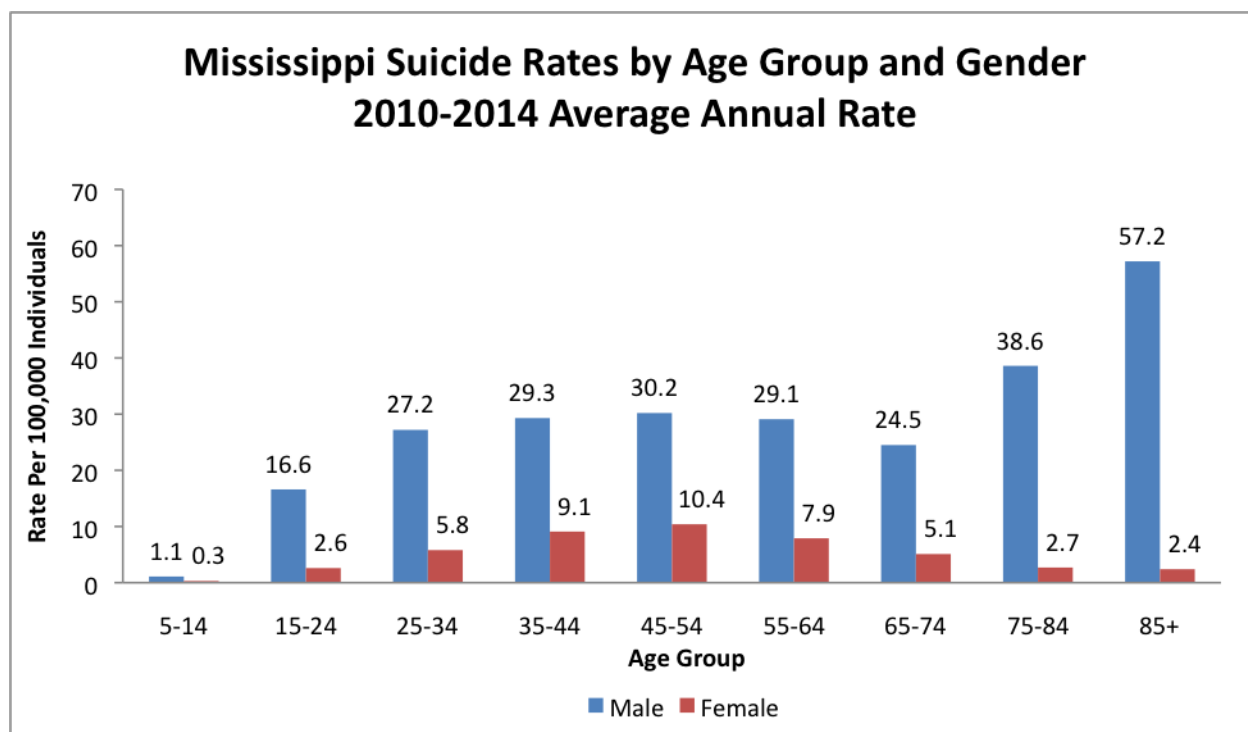
Although suicide rates are lower among younger age groups than older adults, suicide is one of the top four causes of death among people ages 44 and younger. (SPRC)

Figure 7



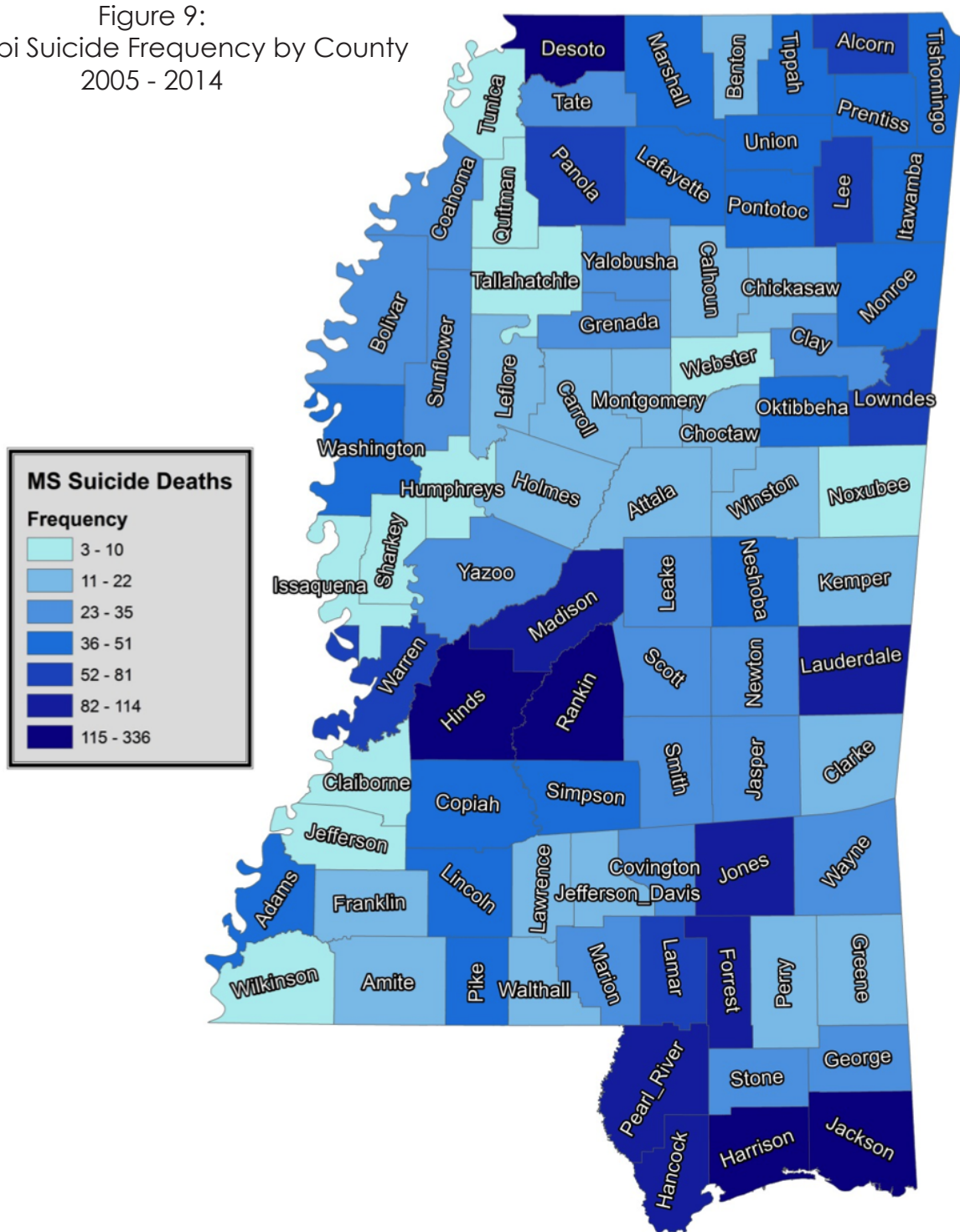
Source: Mississippi State Department of Health, Mississippi Statistically Automated Health Resource System (MSTAHRs)⁹

Figure 8



Source: Mississippi State Department of Health, Mississippi Statistically Automated Health Resource System (MSTAHRs)⁹

Figure 9:
Mississippi Suicide Frequency by County
2005 - 2014



Source: Mississippi State Department of Health, Mississippi Statistically Automated Health Resource System (MSTAHRs)⁹

Table 7: Past Year Mental Health Measures in Mississippi, by Age Group

Indicator	12-17*	18-25*	26+*			
Major Depressive Episode	10.6%	26,000	8.1%	27,000	6.9%	127,000
Serious Mental Illness	--	--	4.2%	14,000	5.1%	95,000
Any Mental Illness	--	--	16.3%	55,000	19.8%	367,000
Had Serious Thoughts of Suicide	--	--	6.6%	22,000	3.6%	66,000

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014.¹⁴

- o 109,000 Mississippi residents over the age of 17 had a Serious Mental Illness (SMI) in the past year (NSDUH, 2013-2014)¹⁴
 - o 4.2% (14,000) were between the ages of 18-25¹⁴
 - o 5.1% (95,000) were over the age of 25¹⁴
 - o Rates for any mental illness were 4 times the rates of SMI (NSDUH, 2013-2014)¹⁴

Youth & Suicide

Suicide is the second leading cause of death among youth 10-14 years old in the US, accounting for 425 deaths in 2014.¹² In Mississippi, among those 10-14 years old, suicide is ranked sixth.¹² Suicide is also the second leading cause of death among US teenagers and young adults ages 15-24, accounting for 5,079 deaths.¹² In Mississippi, there were 45 deaths that occurred among this population in 2014.⁹

A significant relationship exists between adverse childhood experiences and risk of attempted suicide throughout the life span. Environmental factors such as parental unemployment, severe deprivation due to poverty, single parenthood, and regular exposure to domestic violence or abuse puts children at higher risk for the development of mental health problems, creating a ripple effect that can lead to suicide.¹⁵ Nearly 35,000 of Mississippi's children and youth have severe and persistent mental health needs. Reports from the 2011-2012 National Survey of Children's Health indicate that about 20% of Mississippi adolescents (12-17 years old) have one or more emotional, behavioral, or developmental conditions.¹⁶ This alarming statistic represents a sharp increase from the 13% reported in 2007.¹⁶ This survey also reports that only 52.9% of Mississippi children ages 2-17 who needed mental healthcare treatment or counseling received it.¹⁶

There are still parts of me that are mad. Hurt. Sometimes I still don't even believe it. Other parts of me are so sad. Sad that you didn't get to experience life the way you should have.
~Lesli

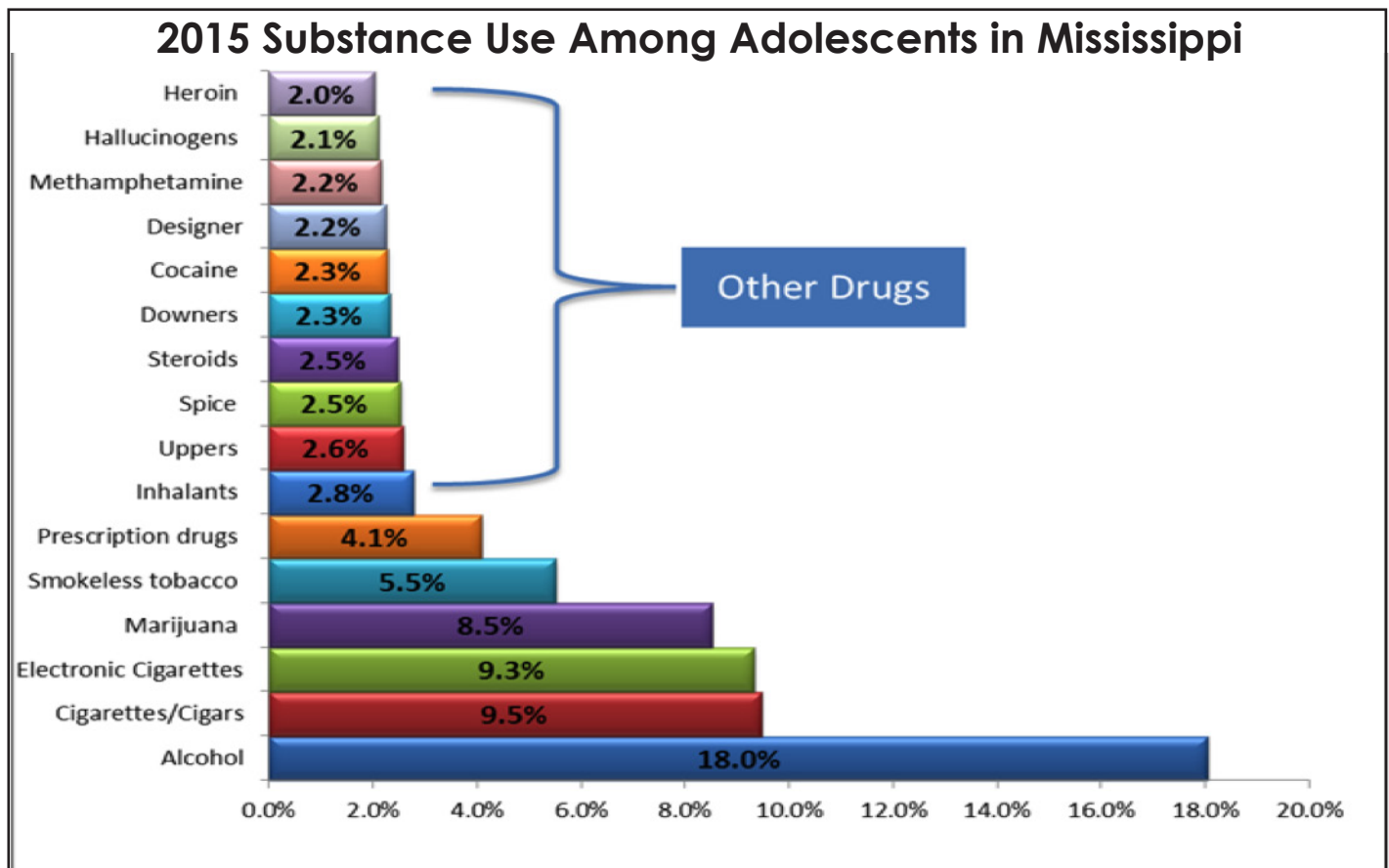
Data from the 2015 Youth Risk Behavior Surveillance System (YRBSS) indicates that approximately **15.1% of high school students** in Mississippi made a **plan to attempt suicide** within the twelve months before the survey; **17.0% seriously considered attempting suicide**; **12.7% attempted suicide** once or twice; and **5.7% attempted suicide that had to be treated by a medical professional** because of an injury, poisoning, or overdose; a rate that was **significantly higher than the US average rate of 2.8%**.¹³ According to the YRBSS, adolescent suicide rates in Mississippi were on a steady decline from 1993 to 2001. However, rates began to increase in 2003 and have steadily risen, with Mississippi suicide rates surpassing national rates in 2007.¹³

The transition from childhood to adult life can be very challenging as individuals attempt to move into unfamiliar roles that must then be maintained during adulthood. This transition can involve completing school, securing employment, becoming financially independent, establishing a residence, maintaining stable relationships, and becoming a parent. To accomplish these feats, young adults must have good interpersonal skills, sound judgment, and a sense of personal responsibility and purpose.¹⁷ These tasks are even more complex and daunting for the 78,718 children (ages 0 to 17) who have one or more emotional, behavioral, or developmental conditions (i.e., a serious emotional disturbance [SED]) that requires treatment or counseling.¹⁸ This population exhibits higher rates of dropout, arrest, and unemployment than their peers without an SED. Young adults with an SED are nearly 14 times less likely to complete high school and are 34-82% more likely to be unemployed after exiting high school than their peers without an SED.¹⁹

Substance use is one risk factor for suicide, and rates among youth in Mississippi are alarming.

- o Substance use has been identified as a significant risk factor in nonfatal and fatal suicides during adolescence.
- o The percentage of substance abuse reported by youth in MS is featured in Figure 4.

Figure 10: Past 30 day Alcohol, Tobacco, & Other Drug Use among Mississippi Students



Source: 2015 MS Student Survey (SmartTrack™)²⁰

- o Behavioral problems are often linked to drug use and together can significantly elevate suicide risk.
- o About 23% of Mississippi students reported having major fights with their parents, and about 43% reported that they could not ask their parents for help if they had a personal problem.
- o When alcohol is added into the equation, 7% of Mississippi students reported having major fights with their parents, and about 10% reported that they could not ask their parents for help.
- o When marijuana is added into the equation, 6% of Mississippi students reported having major fights with their parents, and about 5% reported that they could not ask their parents for help.

Table 8: Adolescents Suicide Ideation Measures in Mississippi, 2015

Indicator	6th -11th graders
Seriously thought about committing suicide during past 30 days	19.8%
Attempted suicide during the past 12 months	11.1%
Not aware of the National Suicide Prevention Hotline	57.4%
Received help from a counselor or adult at school for a personal issue	23.5%
Received school referral for professional counseling to resolve personal issues	9.5%
Felt sad during past 30 days	47.4%
Felt nervous during past 30 days	62.3%
Felt restless or fidgety during past 30 days	53.2%
Felt hopeless	34.4%
Felt worthless	32.3%

Source: 2015 MS Student Survey (SmartTrack™)²⁰

For the longest time I associated suicide with selfishness. I've said numerous times that suicide is one of the most selfish decisions a person could make. I put so much blame on myself over the past eight years that sometimes it's unbearable. Not a day goes by that I don't question the details of that day, week and year. I can still hear your voice and our last conversation. Even after eight years I still remember so clearly. I see the signs. I see the depression and anger. I see you telling me a final goodbye. I see it so clearly now.

I hate myself for not seeing it sooner. I catch myself replaying details over and over in my head until I scream. I wanted to end my own life. I don't ask myself why anymore because there is no reason other than a true illness. You wouldn't have hurt your family and friends the way you did if you weren't sick.

There are still parts of me that are mad. Hurt. Sometimes I still don't even believe it. Other parts of me are so sad. Sad that you didn't get to experience life the way you should have. With each stage of life I pass through, I think about all the things you missed out on. College, career, marriage and now children. I think about the person you would be today. After losing you, suicide went from not even being a reality in my mind to being one of my biggest fears. I never imagined being able to move on from the hurt. Only the Lord could use something as awful as this for His good. I will always feel guilt. There isn't a part of me that doesn't blame myself for at least part of your pain. But a new part of that guilt is my life now. I feel so guilty being happy sometimes. I know I don't deserve the husband that loves me unconditionally and our beautiful daughter. Your life was so precious. You are still loved so deeply. Your life impacted me in a way I will never fully be able to explain. But your death is something that I carry with me daily.

We didn't get to say goodbye. The last conversation we had seemed so uneventful at the time. I didn't get to apologize for all the hurt I caused you. Your family didn't have the opportunity to say final words. You made a decision to leave. You decided. You caused unbelievable pain to people who would lay down their lives for you. I have never felt so out of control. After the countless fights and days without talking, you were always just a five-minute drive away. Or a phone call away. There was nothing I could do to bring you back. You chose to leave. There are questions that will never be answered. Guilt that will never end. Unimaginable loss. And you aren't here to deal with any of it. You left.

I can't imagine losing someone I love so much to an accident, but the fact that you chose to leave so many people who loved you and a life full of opportunities breaks my heart.

- Lesli

Lesbian, Gay, Bisexual, Transgender, & Questioning (LGBTQ) Youth in the US

Research indicates that mental health problems, misuse of alcohol and other drugs, and suicidal thoughts and behaviors are more common in this group than in the general population.²¹

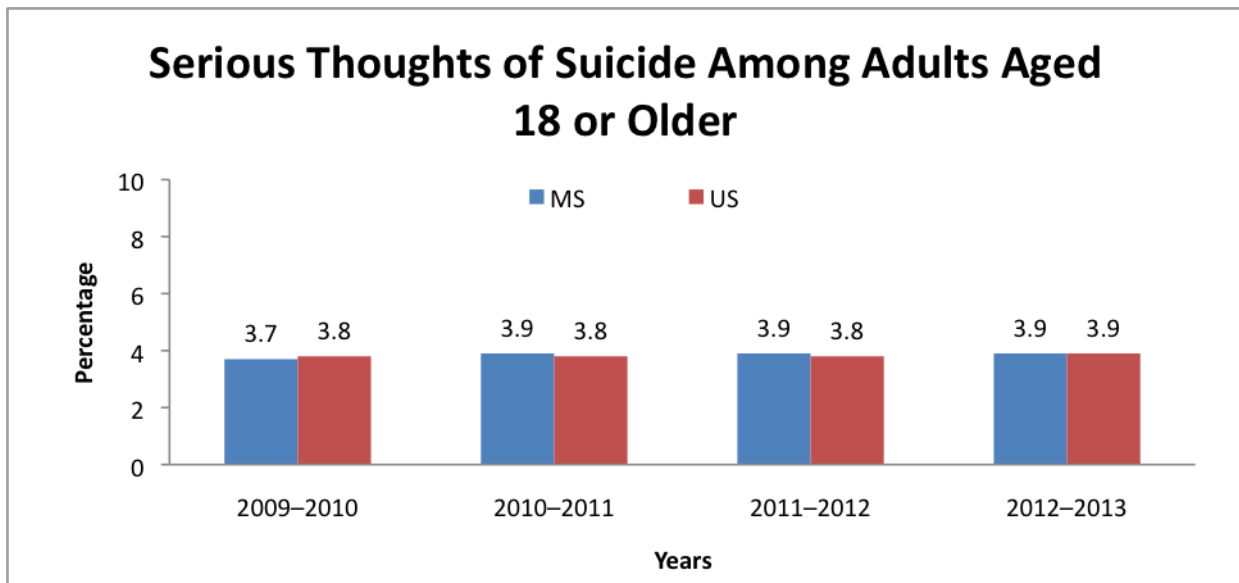
- Risk factors among LGBTQ youth include:
 - Depression and other mental health problems
 - Alcohol or drug use
 - Stress from prejudice and discrimination (family rejection, harassment, bullying, violence)
 - Feelings of social isolation
- Lesbian, Gay, & Bisexual youth have much higher levels of suicidal ideation than their heterosexual peers.²²
- Lesbian, Gay, & Bisexual youth are 4 times more likely, and questioning youth are 3 times more likely, to attempt suicide as their straight peers.²³
- Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers.²³
- Nearly 50% of young transgender people have seriously thought about taking their lives, and 25% report having made a suicide attempt.²³
- LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.²³
- LGBT youth experiencing family rejection are also 3.5 times more likely to use illegal drugs²²
- Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average.²³
- Transgender youth have a high risk for developing substance dependency issues. Transgender people have higher rates of usage for some drugs and may have higher rates of methamphetamine, injectable drug, and tobacco usage.²³

Very little to no state level data exists on the LGBTQ population in Mississippi.

Adults & Suicide

- Suicide rates are highest in old age:
 - 20% of the population and 40% of suicide victims are over 60
 - After age 75, the suicide rate is 3 times higher than average
 - Among white men over 80, the suicide rate is 6 times higher than average
- In 2013, the highest suicide rate (19.1%) was among adults 45 to 64 years old. The second highest rate (18.6%) occurred in those 85 years and older. According to the CDC, an estimated 10,189 older Americans (ages 60 and up) died from suicide in 2013.¹²
- In Mississippi, about 71,000 adults in 2009-2013 had serious thoughts of suicide.²³
 - Mississippi's percentages were similar to the national percentage during this time period.²³

Figure 11: Past-Year Serious Thoughts of Suicide among Adults Aged 18 or Older in Mississippi vs US (2009-2013)



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013²³

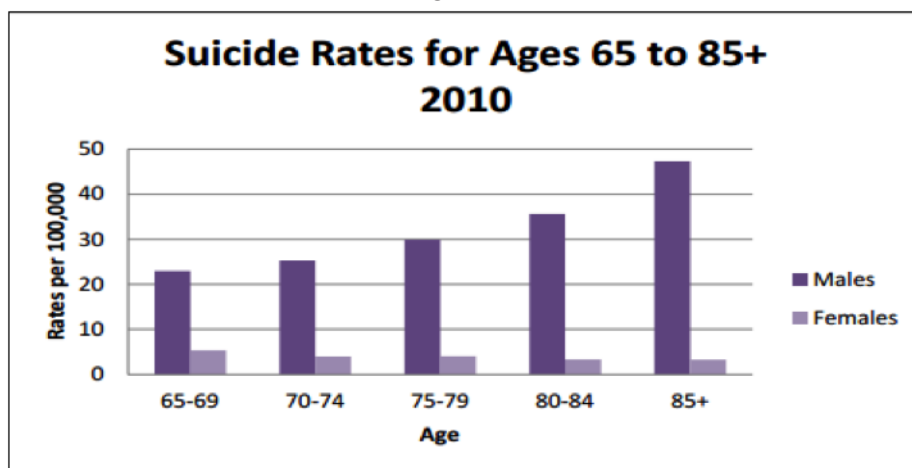
- In Mississippi, suicide is the:
 - o 4th leading cause of death for those ages 25-34¹²
 - o 5th leading cause of death for those ages 35-44¹²
 - o 8th leading cause of death for those ages 45-54¹²

Elderly & Suicide

Older adults make up 13.0% of the population; however they account for almost 15.6% of all suicides.¹²

- Notably, the suicides are particularly high among older, white males (32.74 suicides per 100,000 individuals).
 - o The suicide rate in older, white men is more than four times higher than the nation's overall suicide rate.
 - o The suicide rate in older white men is about 29 suicides per 100,000 individuals each year.

Figure 12



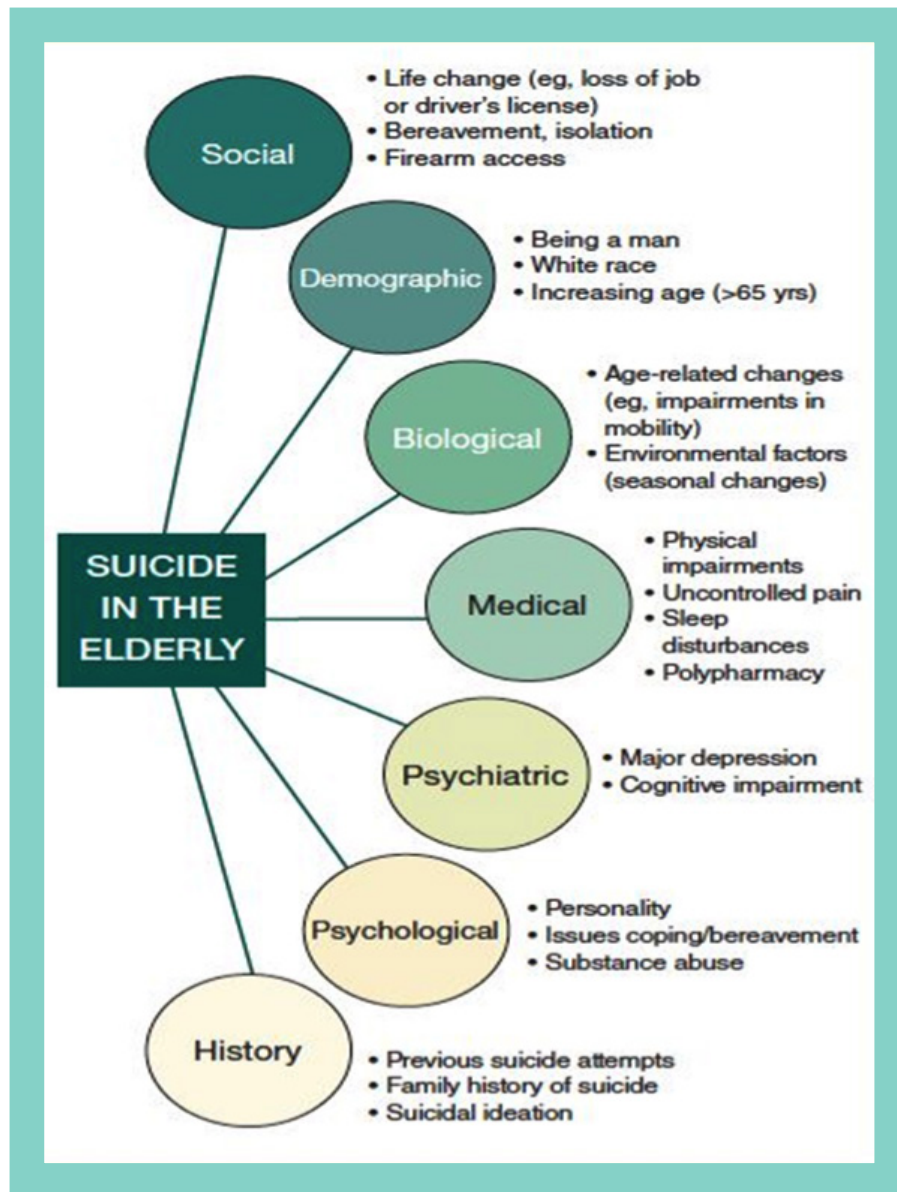
Source: National Center for Health Statistics (NCHS), National Vital Statistics System, WISQARS™¹²

Older Adults Die More Often in a Suicide Attempt²⁴

- Young people: 100-200 attempts = 1 death
- Older adults: 4 attempts = 1 death

- An estimated 20% of older adults who committed suicide visited a physician within 24 hours of their act²⁵
- 41% visited a physician within a week of their suicide²⁵
- 75% had been seen by a physician within one month of their suicide²⁵

Figure 13: Primer on Suicide and Older Adults



I have learned to keep a close watch on my own feelings of depression, talk to others, and take measures to not get consumed. I know today that suicide is a permanent solution to a temporary problem. ~Amy

My name is Dale. I am a person in long-term recovery from a substance use disorder and mental health diagnoses. I am also a suicide survivor. My suicide story begins in 1999, when I had moved from California and was adjusting to returning back home to Mississippi with a state of growing sadness and confusion in my life. Long had I been self-medicating to make myself feel better, or not to feel at all, depending on the day of the week.

Moving back to Mississippi that summer was too much for me to handle. Several small occurrences in my life had created a lot of stress and some threatened legal ramifications. As a result, I retreated one night to my childhood home with the intention of taking my own life. I knew I would not be disturbed there since my mother lived in another town and would not return for a few more days. I made everything ready for the next day, when I planned to use a razor blade to end my life.

The next afternoon, I was lying on my bed after having made several deep cuts into my wrist when my bedroom door flew and one of my friends was standing there, very red faced and out of breath.

I woke up in the hospital the next day and felt horrible. I barely remember him breaking into my mom's house, and I remember nothing about going to the hospital. He had tied a tourniquet around my arm, which I was told had saved my life. The worst part was lying there and feeling so ashamed. I felt like a failure for being interrupted, for not succeeding, for all of the questions that were now being asked by so many people. The very worst thing that happened, the greatest shame in my life, was when my mother arrived to see me on the second day. She looked me over in the bed with tubes and restraints and asked, "Are you happy with yourself?"

Her directness was not something I was ready for. Neither was her anger. The long conversations following that question eventually formed a relationship of honesty and respect between my mother and me that we had never had before in our lives.

My life seemed to improve somewhat from that point on until the summer of 2001, when my boyfriend Donnie chose one morning to commit suicide. Donnie suffered from several issues that were buried under his affection for alcohol. His death was one of the worst pains I have ever felt. It hurt more than when my own father passed away from cancer. Three days after his funeral, I remember returning to work and being somewhat in a fog, as if the world were only a dream. I poured myself into my work to keep busy, and I poured myself a drink very often to keep myself from screaming and crying over all of the anger and confusion I felt. For many years I was so angry with him for not talking to me about how much he hurt. I tried to hate him for leaving me to explain all of this to our friends, to his family, and my family.

These two events contributed to my pain and anguish for many more long days until I finally entered treatment for my addictions in 2009. I was diagnosed with depression, bipolar mood disorder, anxiety, and ADHD. I spent two years in therapy learning how to express and identify my true feelings and how to survive my life with how I felt. That was when I began my recovery.

- Dale

Donnie suffered from several issues that were buried under his affection for alcohol. His death was one of the worst pains I ever felt.

Strategic Goals & Objectives

FY17 - FY19



GOAL 1: COORDINATE AND ASSESS SUICIDE PREVENTION ACTIVITIES/EFFORTS ACROSS STATE AGENCIES

Objective 1.1 Develop a Mississippi Suicide Prevention Workgroup to help implement the goals and objectives of the Mississippi Suicide Prevention Plan

Objective 1.2 Increase the number of organizations that demonstrate a commitment to suicide prevention through collaboration, coordination, and resource-sharing

Objective 1.3 Conduct an inventory of evidence-based and best practices in suicide prevention being used in Mississippi

Objective 1.4 Identify unmet needs, emerging, or undetected problems, and opportunities to use resources more efficiently and strategically

Objective 1.5 Conduct an inventory of existing data with respect to suicide ideation, suicide attempts, and suicide deaths with a focus on identifying gaps in existing data points (specific indicators or measures) and data sources (types of data)

Objective 1.6 Review and assess legislation mandating suicide prevention for school professionals

GOAL 2: IMPROVE THE STATE'S SUICIDE PREVENTION CAPACITY THROUGH INTER-ORGANIZATIONAL PARTNERSHIPS, TRAININGS AND THE USE OF EVIDENCE-BASED/BEST PRACTICES

Objective 2.1 Increase the number of persons in organizations such as mental health, substance use, education, foster care systems, juvenile justice programs, hospitals, law enforcement, faith-based community, and workplaces trained to identify and refer people at risk for suicide

Objective 2.2 Establish and sustain trainers of evidence-based/best practice suicide prevention gatekeeper training through existing health, mental health, and substance use prevention structures

Objective 2.3 Ensure Certified Peer Support Specialists receive suicide prevention training to recognize warning signs and risk factors

Objective 2.4 Conduct trainings to increase the number of health, mental health, and substance use providers capable of utilizing evidence-based or promising practices to assess, manage and treat people at risk for suicide

Objective 2.5 Integrate suicide prevention information in appropriate trainings for all populations

Objective 2.6 Ensure that state agencies have information about suicide prevention and training opportunities

GOAL 3: PROMOTE IDENTIFICATION, INTERVENTION AND CARE FOR PEOPLE AT RISK FOR SUICIDE

Objective 3.1 Ensure that data systems are implemented to identify individuals at risk for suicide across the lifespan

Objective 3.2 Expand the available cross-agency surveillance system, SmartTrack, to include additional survey questions related to youth suicide prevention and its risk factors

Objective 3.3 Identify a free screening tool to link from state agency websites

Objective 3.4 Increase the number of state survey instruments that include questions on suicide

Objective 3.5 Require Mobile Crisis Response Teams to implement the Early Identification, Referral, and Follow-up (EIRF) protocol

Objective 3.6 Implement the use of an evidence-based suicide prevention screening tool within health, mental health, and substance use settings

Objective 3.7 Ensure emergency room/hospitals are linked to outpatient providers

GOAL 4: IMPROVE MENTAL HEALTH LITERACY THROUGH PUBLIC INFORMATION ACTIVITIES BY INCREASING KNOWLEDGE OF SUICIDE PREVENTION AND CHANGING ATTITUDES TOWARDS MENTAL HEALTH AND SUICIDE

Objective 4.1 Increase the promotion of the National Suicide Prevention Lifeline in Mississippi

Objective 4.2 Develop suicide prevention messages targeting different age groups and racial and ethnic populations

Objective 4.3 Promote suicide prevention in high schools and colleges across the state through the Shatter the Silence youth suicide prevention campaign and other activities

Objective 4.4 Expand the Shatter the Silence older adults suicide prevention campaign

Objective 4.5 Enhance partnership with National Guard for Operation Resiliency Suicide Prevention Campaign for the military

Objective 4.6 Engage existing health, mental health, and substance use prevention structures to incorporate suicide prevention into their mission and activities

Objective 4.7 Encourage media and journalism/communications students in higher education to responsibly cover the issues of suicide and mental health

Objective 4.8 Promote the adoption of "Zero Suicides" (National Strategy for Suicide Prevention) as a goal for Mississippi's health care and community support systems

Sue is still mad, even though it has been six years since her husband's suicide.

"Does it ever go away?" she said. "Maybe I had my head in the sand, but I had no idea he would really kill himself.

"Jerry battled depression most of his life. Family members told me he had been suicidal before we met, but things were good between us. Well, they were until fairly recently. In hindsight, he probably started to decline within a year after Hurricane Katrina."

Jerry retired in 2002, and he and Sue bought a place in Bay St. Louis with a pontoon boat and a fishing boat. It was Jerry's retirement dream. When Katrina hit the Mississippi Gulf Coast in 2005, it washed all Jerry's dreams away. The house was totally submerged; all that was left was the fishing boat, Jerry and Sue. They moved to a house Sue owned in Sumrall and tried to start over.

Jerry did all the chores; he kept the place up and pampered Sue. But he had started drinking, and when he was drunk, she found that he just clammed up and wouldn't talk to her. He gained a lot of weight and began having problems with asthma and his heart. Still, Sue felt that they had a good marriage.

On the afternoon of July 16, 2010, they were grilling out. Jerry had cooked steaks and potatoes, and Sue was inside making a salad when a man came by to look at the fishing boat Jerry had decided to sell. When the man left, Sue was aggravated at Jerry and fussed at him for letting the man talk him down more than \$1,000 on the price.

Without a word, Jerry left the kitchen and went to the bedroom. Sue continued making the salad as Jerry came back and went out on the front porch. Seconds later she heard the gun. Thinking he was shooting squirrels, she went out to remind him the neighbors were at home. She found him in a chair on the porch.

Sue panicked and ran to her neighbor's house down the road, but when she got almost there, she realized she didn't want to upset them and ran back home. She called 911. A deputy arrived first and then an ambulance; then the

coroner came, and family and friends started coming in.

Sue held a memorial service the following Saturday. His children arrived just in time for the service, but only one of them came by the house after the service. They had not been close to their father since he and their mother divorced, and they never talked to Sue about their father's suicide.

She went into shock after it happened; she couldn't believe it had happened to them. Their life wasn't bad. There was no note left behind, and she had so many questions. "I can't understand," she said. "Am I to blame? What did I do? Why did he have to leave our life?"

Sue believes Jerry's suicide was a spur of the moment decision, but the consequences of it are forever.

During this time, Sue's only sister was sick. Six weeks after Jerry took his life, her sister went into respiratory failure and lost her battle with lymphoma on Sue's birthday.

Sue was devastated but returned to work to keep from being home with all her thoughts and memories. Torn between anger at Jerry and grief at losing her sister, she didn't know where to turn. One afternoon, she went to get her nails done, and the nail tech suggested that she make an appointment with a psychologist in Hattiesburg who counsels out of her home, which gave Sue a sense of comfort. She began seeing the psychologist once a week for about six months and then tapered the sessions off.

"She was a lifesaver. I could talk to her like a friend," Sue said. "She is very loving. Her mother committed suicide, so she understands."

She helped Sue understand that Jerry's suicide wasn't her fault.

Sue has since married a man she dated in high school. She is doing well, but still has anger at Jerry. She went into shock after it happened; she couldn't believe it had happened to them. Their life wasn't bad. There was no note left behind, and she had so many questions.

"I can't understand," she said. "Am I to blame? What did I do? Why did he have to leave our life?"

Sue believes Jerry's suicide was a spur of the moment decision, but the consequences of it are forever.

- Sue

Risk Factors & Warning Signs

Risk Factors for Suicide

A combination of individual, relational, community, and societal factors contribute to the risk of suicide. Risk factors are those characteristics associated with suicide—they might not be direct causes.

RISK FACTORS

- Family history of suicide
- Family history of child maltreatment
- Previous suicide attempt(s)
- History of mental disorders, particularly clinical depression
- History of alcohol and substance abuse
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts

Protective Factors for Suicide

Protective factors buffer individuals from suicidal thoughts and behavior. To date, protective factors have not been studied as extensively or rigorously as risk factors. Identifying and understanding protective factors are, however, equally as important as researching risk factors.

PROTECTIVE FACTORS

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support (connectedness)
- Support from ongoing medical and mental health care relationships

- Skills in problem solving, conflict resolution, and non-violent ways of handling disputes
- Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

Information provided by <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>

Suicide Warning Signs

TALK

If a person talks about:

- Being a burden to others
- Feeling trapped
- Experiencing unbearable pain
- Having no reason to live
- Killing themselves

BEHAVIOR

Specific things to look out for include:

- 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

Information provided by <http://afsp.org/about-suicide/risk-factors-and-warning-signs/>

Austin, my son, was 21 years old and a senior at the University of Southern Mississippi when he took his own life in his fraternity house bedroom on January 14, 2007.

His suicide came as a total shock to us. I knew he drank but was not aware of his drug use.

Austin did leave a note. He said he could not stand the pain anymore. He had a smile that lit up the room. I still cannot imagine the pain he hid behind that smile.

My life was shattered and forever changed on that day. I immediately realized I needed help dealing with my grief and loss. My preacher recommended a Christian counselor on the coast. The counselor was so helpful. I continued to see him for about a year.

Four weeks after Austin died, I made a trip to Atlanta to visit a friend and attend a survivor group at the Link Center. My friend gave me the book "My Son, My Son" by Iris Bolton, the director of the Link Center. I saw myself in her writing. I knew she had felt what I was feeling.

I discovered my Survivor of Suicide group in Hattiesburg shortly after that trip. This group was my life saver! Sitting there with other survivors made me realize I was not alone. These survivors had felt the same feelings I was feeling. Someone even laughed during that first meeting. I could not believe it, but I even came to laugh and smile as I attended more meetings.

I took about seven weeks off from my job teaching fourth grade. The school administration worked with me as I struggled to return to work. Here I am more than nine years later. Some days I still struggle and just give in to the grief. Those days are fewer and further apart. I am at a different stage in my grief now. I'm not sure how to describe it . . . just different. I still do not work on the day before or the anniversary date of Austin's death. I go away, generally stay in my hotel room, and let the days pass. Some things I have to do by myself, and that is one of them. I can work on his birthday, and I celebrate it on my own.

The good memories of Austin are finally coming back. All I could do at first was think about his suicide. For some reason, I do not like adult birthday parties and large family gatherings anymore. I guess it makes it too visible that Austin is not with us anymore.

I don't attend group as often as I did in the beginning. Sometimes I go for me and sometimes I go to support others in group.

The stress is monumental, but I knew in the beginning I would survive. I wasn't sure how except moment by moment and then day by day. Life is good, and life goes on if we choose to let it.

- Dawn

I had everything I wanted – graduation with honors, a new job offer, and a wonderful husband, but I still longed for death. I had no idea why I felt the way I did. Maybe because I had been working toward my goal of acquiring a biology degree for so long that I was depressed I was actually finally graduating. A bright future for us both was beginning, but it all came to a screeching halt suddenly and with massive shock. Just a few weeks after my graduation and the day I started my new research job, my husband dropped dead in a parking lot. Even more devastating was never learning why since the autopsy findings could find nothing wrong with his young, seemingly healthy body. I had only been living with a serious mental health diagnosis for a couple of years and my husband was my everything. For the first time in my life, I truly wept. My whole mind, body, and soul wept.

It was when I experienced this great loss that my true path to recovery would begin. At the time I was struggling with my religion and spirituality, but now I was forced to try and find a God that I had been trying to deny. I began writing poetry; I began reading scripture; I began to really explore who I was, and the fact that I needed something more powerful than myself. At one point I swallowed pills, but it was a cry for help because I could not cope with the overwhelming feelings of loss. I was a control freak, and there was nothing more debilitating to me than the loss of control that comes with death.

As I write this, the feelings of grief from 13 years ago resurface, but now I can find great strength in the sorrow. The power of prayer saved me as so many lifted me up in my time of despair. I look back on the experience now and realize how blessed I am to have loved and lost so strongly. It was only after his death that I realized what marriage truly was and only a great God could cure my intense feelings of guilt.

I was the one that wanted to die, but He took my husband instead. It was a long-lived battle to come to terms with the guilt and sorrow I felt, but I eventually did. I like to believe that my husband died so I could be saved, and now my husband is one of God's mighty angels. He didn't really die because his memory and the best part of him is incorporated within me now, and I never would have gotten where I am today . . . working as Certified Peer Support Specialist!

- Monica

“As I write this, the feelings of grief from 13 years ago resurface, but now I can find great strength in the sorrow.” ~Monica



Current Programs, Partnerships, and Activities in Mississippi

Across Mississippi, a number of statewide organizations, partners, and advocacy groups are working together to promote mental health awareness and suicide prevention in our state. Below is a summary of the prevention efforts that since their inception have been sustained in Mississippi by stakeholders who are dedicated to the work of education, support, advocacy, and treatment around the subject of suicide prevention and awareness.

National Suicide Prevention Lifeline

The Department of Mental Health was approached by the National Suicide Prevention Lifeline in 2008 to become a network provider due to the fact that only seven counties in Mississippi were being covered by a provider in Mississippi. Before DMH was selected as a network provider, calls from other counties were sent to call centers in other states. DMH's Office of Consumer Support now has primary coverage over all 82 counties in Mississippi. Coverage is provided 24/7 to individuals in need of crisis support or emergency care. For more information about the National Suicide Prevention Lifeline, contact the Department of Mental Health's Office of Consumer Support at 1-877-210-8513.

Mobile Crisis Response Teams

In Mississippi, emergency care for individuals identified as being at immediate risk for suicide or suicide attempts can be accessed through the local Community Mental Health Centers (CMHCs), which are certified by the



Department of Mental Health. CMHCs have established Mobile Crisis Response Teams (MCeRTs) who must provide emergency/crisis services twenty-four hours a day, seven days a week. All MCeRTs have a toll-free number that is advertised to their communities in which people can access mental health representatives to speak with. Additionally, face to face contact with mental health professionals is available to the public when requested.

Program staff are able to triage and make appropriate clinical decisions, including assessing the need for inpatient services or less restrictive alternatives. The individual must be seen within one hour of initial time of contact if in an urban setting and within two hours of initial time of contact if in a rural setting. Appointments for individuals whose crisis is resolved over the telephone must be scheduled the next day. For more information about Mississippi's Mobile Crisis Teams, contact the Department of Mental Health at 601-359-1288.



Operation Resiliency Military Outreach

While our military and its members are strong, there are times when they too struggle with stress, anxiety, depression and even thoughts of suicide. Sometimes military men and women feel embarrassed or hesitant to seek help and others may not know what help is available. In 2010, the Mississippi Department of Mental Health (DMH) teamed up with the Mississippi National Guard to launch a mental health awareness campaign, Operation Resiliency, for the military and their families. Operation Resiliency aims to dispel the stigma associated with mental illness, educate about mental health and stress, recognize signs of duress and share knowledge about available resources.

To help spread this message, each year the VA Centers across the state are sent a packet making them aware of free educational materials, including a brochure focusing on stress, a resource guide with Community Mental Health Center information, and posters that can be displayed and include a tear-off card with the National Suicide Prevention Lifeline information. For more information about Operation Resiliency Military Outreach, contact the Mississippi Department of Mental Health at 601-359-1288 or visit www.dmh.ms.gov/operation-resiliency/.

Shatter the Silence Youth Campaign



In 2008, DMH launched a statewide youth suicide prevention campaign entitled "Shatter the Silence – Suicide, The Secret You Shouldn't Keep." The campaign targets young adults in Mississippi. The campaign encourages youth to speak out if they or someone they know is thinking, writing or talking about suicide. DMH created brochures and posters that are distributed statewide. The campaign consists of the following components:

- Reaching schools and colleges in all 82 counties in Mississippi
- Creating Think Again/Shatter the Silence presentations for students, parents and educators
- Hosting a train-the-trainer for presentations
- Providing posters and flip cards to schools and colleges statewide
- Offering presentations to schools and colleges statewide
- Developing press releases and letters to the editor about suicide prevention
- Developing press releases about suicide prevention for college newspapers
- Developing radio and television Public Service Announcements
- Including information in the mental health packet sent yearly to school nurses and counselors in all school districts
- Including information on web sites
- Partnering with the military to develop a Think Again/Shatter the Silence campaign specifically for members of the military
- Developing a Shatter the Silence campaign for older adults
- Creating a Shatter the Silence page on DMH's web site
- Installation of billboards across the state
- Advertising at football games

For more information about the Shatter the Silence youth campaign, contact the Mississippi Department of Mental Health at 601-359-1288.

Mississippi Partners in Prevention Coalition

The Mississippi Partners in Prevention Coalition provides trainings at three universities and two community colleges in Mississippi. Coalition members were provided materials to begin a social media campaign that addresses suicide prevention. This campaign kicked off at the start of school and continued through the fall semester.

Coalition members were also trained in Question, Persuade, Refer (QPR), an emergency mental health gatekeeper training intervention that teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting

suicide warning signs and behaviors. For more information about the Mississippi Partners in Prevention Coalition, contact University Health Services at Mississippi State University at 662-325-7545.

Shatter the Silence Older Adults Campaign



The Department of Mental Health launched a statewide suicide prevention and awareness campaign targeting older adults and their caregivers. Often times, older adults don't want to admit they are having problems with depression or thoughts of suicide. To target this population, DMH developed a card that focused on the warning signs for depression, and risk factors and warning signs for suicide. The information cards are distributed at the annual Alzheimer's Conference, physicians' offices, and other events across the state. This information is also included in presentations by DMH's Division of Alzheimer's Disease and Other Dementia, including guest lectures at universities and the Bioethics Summer Fellowship program at the University of Mississippi Medical Center. Information has also been included as part of a mandatory Basic Training Curriculum for law enforcement cadets. For more information about the Shatter the Silence older adults campaign, contact the Mississippi Department of Mental Health at 601-359-1288.

Mandated Suicide Prevention Training for Educators

In January 2010, licensed teachers and principals in Mississippi received suicide prevention training. The training was a result of Senate Bill 2770 and enabled teachers and principals to better identify risk factors

and warning signs that indicate a student may be considering taking his or her life. The Mississippi Department of Mental Health and the Mississippi Department of Education (MDE), Office of Healthy Schools worked together to prepare local school districts in this very important endeavor.

DMH and MDE selected the Yellow Ribbon, Be a Link! Suicide Prevention Gatekeeper Training Program to be used in the elementary school settings. DMH and MDE selected the Signs of Suicide (SOS) Program for the middle and high school settings. The program is recognized by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices. The two hour minimum training was provided by each school district. DMH and MDE asked school districts to identify a training team of a school counselor, school nurse, and professional development staff. DMH and MDE conducted three regional trainings in January 2010 to train the district teams, which were then responsible for conducting the suicide prevention in-service training within their own districts. For more information about Suicide Prevention Training for Educators, contact the Mississippi Department of Education's Office of Healthy Schools at 601-359-3513.

Trauma Conference

In 2014, several Mississippi state and local agencies began hosting an annual statewide Trauma Informed Care Conference. The goal of this conference is to build professionals' skills, knowledge and awareness in order to respond effectively and appropriately to various aspects of child, adolescent and adult trauma on introductory, intermediate and advanced levels. Each year, the premiere conference has brought together more than 600 participants representing a diverse group of individuals with a common goal of providing the best and effective services and supports to those who have experienced trauma. Many of the presenters at the Trauma Informed Care Conference incorporate suicide prevention into their 90-minute session

topics. For more information about the Trauma Informed Care Conference, contact the Mississippi Department of Mental Health at 601-359-1288.

I Got U! Healthy Life Choices for Teens



I Got You! Healthy Life Choices for Teens (IGU) is a health

outreach program developed by Central Mississippi Residential Center in partnership with area schools, local law enforcement, Mississippi State University Extension Service, Care Lodge Domestic Violence Shelter, the Department of Mental Health and Attorney General's Office in Mississippi. The National Registry of Evidenced-based Programs and Practices have given IGU an evidence rating of "promising," meaning that evaluation data has produced sufficient evidence of a favorable effect.

I Got You! teaches students how to better cope with challenging situations, why it is important to seek help, and what resources are available. Schools that have participated in IGU have observed an improvement in academic performance and an increase in coping skills as well as a decrease in office-related referrals. For more information about I Got You! Healthy Life Choices for Teens, contact Central Mississippi Residential Center at 601-683-4210.

Evidence-Based Programming Utilized in Mississippi:

Question, Persuade, Refer (QPR)

Question, Persuade, Refer (QPR) trainings have been conducted throughout Mississippi. QPR is recognized in the Suicide Prevention Resource Center's Best Practice Registry and is defined as "an emergency mental health gatekeeper training intervention that

teaches lay and professional gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors."

One of the distinctive benefits of the QPR model is the brief duration of the training and ability to provide participants with all of the essential information and knowledge needed to recognize risk signs related to suicide, intervene, and then refer the young person to appropriate resources. To date, thousands of Mississippi gatekeepers have been trained in suicide prevention and referral. For more information about QPR, visit: <https://www.qprinstitute.com/>.

at-Risk On Campus

University and College personnel as well as fellow students and student leaders are in an ideal situation to identify the stressors that often negatively affect students, however many feel uncomfortable broaching the topic or unsure how best to connect students to appropriate resources.

At-Risk for University and College Faculty & Staff and At-Risk for College Students and Student Leaders are a pair of online, interactive courses that prepare users to recognize signs of psychological distress such as depression, anxiety, and substance abuse.

Users learn how to approach at-risk students and make appropriate referrals to campus support services for screening and assessment. Through role-play conversations with virtual students, learners attain hands-on practice managing challenging, and often sensitive, conversations surrounding mental health and master skills necessary to identify and connect students to help.

For more information about at-Risk On Campus, contact info@kognito.com.

Early Identification, Referral, and Follow Up (EIRF)

Suicides are commonly preceded by the early identification of warning signs. However, early identification alone is insufficient. The timely provision of mental health services is

also critical. As part of the Department of Mental Health's Shatter the Silence campaign, school counselors and Community Mental Health Center's Mobile Crisis Response Teams (MCeRT), also known as "completers," were trained to implement the Early Identification, Referral, and Follow Up (EIRF) as a way to confidentially collect data for youth, ages 10-24, who identified as at risk for suicide.



monitored more than 1,500 suicidal callers to crisis lines found that callers who spoke with ASIST-trained counselors were 74% less likely to be suicidal after the call, compared to callers who spoke with counselors trained in methods other than ASIST. Callers were also less overwhelmed, less depressed, and more hopeful after speaking with ASIST-trained counselors.

The purpose of the EIRF is to ensure that mental health services are delivered to youth who need them. These services can include therapy, substance use treatment, crisis hotline, Programs of Assertive Community Treatment (PACT) Teams, and/or inpatient treatment. Follow up contact is made within 3 months to track whether the person received services after the first referral and any subsequent services.

Since DMH started collecting EIRF data in 2014, 447 referrals for mental health services have been made. Two-hundred of those people received services and 162 of those 200 people returned for follow up services. For more information about Early Identification, Referral, and Follow up, contact the Department of Mental Health's Office of Consumer Support at 1-877-210-8513.

ASIST (Applied Suicide Intervention Skills Training)

As the world's leading suicide intervention workshop, LivingWorks' ASIST program is supported by numerous evaluations, including independent and peer-reviewed studies. Results demonstrate that ASIST helps participants become more willing, ready, and able to intervene with someone at risk of suicide. ASIST is also proven to reduce suicidality for those at risk. A 2013 study that

The Mississippi Department of Mental Health employs 5 ASIST trainers who provide ASIST to staff members of Community Mental Health Centers, including therapists, crisis workers, and peer support specialists, as well as other community stakeholders and state agencies.

safeTALK (Suicide Alertness for Everyone)

safeTALK is a training developed by LivingWorks Education, a leading world provider of suicide intervention training. safeTALK is designed to complement ASIST (Applied Suicide Intervention Skills Training), LivingWorks' suicide intervention skills workshop. safeTALK is consistent with LivingWorks' view that the training needs of a suicide-safer community require a comprehensive approach. Both safeTALK and ASIST participants have an important role to play in helping to achieve this goal.

safeTALK training focuses on using the TALK steps—Tell, Ask, Listen, KeepSafe—to engage persons with thoughts of suicide and help to connect them with life-affirming resources, while using ASIST skills helps these resources provide safety from suicide for now. In effect, safeTALK and ASIST-trained helpers work together with individuals to help them keep safe from suicide. For more information about ASIST and safeTALK, contact the Mississippi Department of Mental Health at 601-359-1288.

Signs of Suicide (SOS)

The Signs of Suicide Prevention Program (SOS) is a universal, school-based depression awareness and suicide prevention program designed for middle-school (ages 11–13) or high-school (ages 13–17) students. The SOS curriculum includes lessons on raising awareness of depression and suicide, helping students identify the warning signs of depression in themselves and others, identifying risk factors associated with depression and suicidal ideation, and using a brief screening for depression and/or suicidal behavior. Students are taught to seek help using the ACT (Acknowledge, Care, Tell) technique. This technique teaches students to acknowledge when there are signs of a problem in themselves or a peer, to show that you care and are concerned about getting help, and to tell a trusted adult. Upon completion of the program, students are given response cards to indicate if they would like to speak to a trusted adult about themselves or a friend. For more information about SOS, contact <https://mentalhealthscreening.org/>



Mental Health First Aid

Mental Health First Aid is an 8-hour course that teaches individuals how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training provides the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. Mental Health First Aid is an international program proven to be effective. Peer-reviewed studies published in Australia, where the program originated, show that individuals trained in the program:

- Grow their knowledge of signs, symptoms and risk factors of mental illnesses and addictions.

- Can identify multiple types of professional and self-help resources for individuals with a mental illness or addiction.
- Increase their confidence in and likelihood to help an individual in distress.
- Show increased mental wellness themselves.

Studies also show that the program reduces the social distance created by negative attitudes and perceptions of individuals with mental illnesses.

Cognitive Behavioral Therapy

Cognitive Therapy for Suicide Prevention is a cognitive-behavioral psychotherapy program designed for patients who have previously attempted or thought of suicide. The intervention teaches patients skills to use alternative ways of thinking and behaving during episodes of suicidal crises and assists them in building a network of mental health services and social supports to prevent future suicide attempts. It is designed to be provided by individual therapists on a one-to-one basis. For more information about Cognitive Behavioral Therapy, visit [http://nrepp.](http://nrepp.samhsa.gov/ProgramProfile.aspx?id=65)

[samhsa.gov/ProgramProfile.aspx?id=65](http://nrepp.samhsa.gov/ProgramProfile.aspx?id=65)

Advisory for Suicide Prevention Activities in Mississippi:

Mississippi Prevention Network Executive Council (MPNEC)

The Mississippi Prevention Network Executive Council (MPNEC) has served to enhance institutional linkages between state prevention agencies, mental health agencies, and grassroots organizations (e.g., community prevention coalitions) for more than 30 years. The mission of MPNEC entails strengthening substance use prevention in Mississippi to

ensure that evidence-based approaches to drug prevention and mental health wellness promotion are adopted throughout the state.

State Epidemiological Outcomes Workgroup (SEOW)

The Department of Mental Health utilizes the State Epidemiological Outcomes Workgroup (SEOW) to gather comprehensive information about the prevalence of alcohol and drug use as well as suicide prevention surveillance data throughout Mississippi. The SEOW is vital to ensuring that all activities and processes are data-driven. Under the leadership of the SEOW Project Manager, the Evidence-Based Workgroup (EBW) is charged with examining data related to alcohol, tobacco and other drugs as well as a full gamut of risk factor data, including suicide ideation, attempts, and deaths.

Among its other duties, the SEOW will oversee the inclusion of additional suicide-related items to the SmartTrack School Survey. These various data sources are utilized to determine the scope and magnitude of social adversities within the state of Mississippi. Many of the communities in Mississippi's rural areas lack the ability to track and analyze data. The SEOW uses its resources to assist providers in gathering and analyzing data, while fostering cross-agency collaboration at the state and grassroots level to address significant data collection and coordination gaps. The SEOW brings together public health and mental health professionals across a range of state and local agencies, including academic institutions. It allows agencies to work together in securing and sharing data needed for state prevention and treatment planning.

Think Again Network

In 2008, DMH established the Think Again Network. The Network is made up of DMH staff, Community Mental Health Center

staff, schools and colleges, mental health providers, non-profits, and others. The Network encourages people to think again about some of the negative attitudes they may have about mental health. The Network urges people to speak out and tell others about mental health and oversees the Think Again campaign, which targets teens by encouraging them to support their friends who have mental illness and increase help-seeking behaviors.

The campaign seeks to increase awareness of suicide warning signs, encourage teens to shatter the silence around suicide by speaking out if they or someone they know are having

thoughts of suicide, and link teens to help. The campaign also has suicide prevention information for educators and parents.

DMH and Think Again developed a Mental Health Media Guidebook for Mississippi journalists that provides tips and helpful information regarding coverage of the often sensitive topics of mental illness and suicide. The media guide acts as a tool and resource to help journalists in their work of providing fair and comprehensive news coverage when covering stories about suicide or mental health issues. Additionally, the guide aides journalists, especially journalism students, in providing appropriate news coverage that can help break down the stigma surrounding mental health.

The guide builds on the Associated Press Stylebook entry on mental illness. The AP Stylebook is a writing guide for journalists that is published and updated each year, but the entry on mental illness was only added in 2013. However, research has shown that many people do not have much information on behavioral health issues other than what they have perceived from the mass media.

"The stress is monumental, but I knew in the beginning I would survive. I wasn't sure how except moment by moment and then day by day. Life is good, and life goes on if we choose to let it." ~Dawn

My name is Andree. My daughter died of suicide on April 19, 2009. Even though she had attempted numerous times, I never dreamed that she would actually die of suicide.

Karen was in Florida, and we live in Mississippi. My granddaughters agreed to have the funeral here, so that was one comfort I received. My pastor and the counselling I received at my church were instrumental in my healing process.

I was given a journal to use. The name of it is "The New Day Journal: A Journey from Grief to Healing." I was seeing a therapist and using this journal.

I cried most of the time. For a long time, I could not talk without crying.

I could not drive for about two weeks or longer. I went into a local pharmacy and picked up an item without paying. They knew what was going on with me. It is so good to have people who understand.

In October of that year, my niece told me about the Out of the Darkness walks. I was also invited to the suicide survivor group. The group was so helpful to me because everyone there understood what I was going through. The seventh anniversary was in April.

Time does not heal all wounds, but time has helped to ease the pain.

Another thing that has helped me is being a member of a twelve-step program. I have good, understanding friends there. They were here for me right away, and most of them came to the funeral.

My other daughter lives in California, and she got here the day after Karen died. She has come twice a year until this year. We always go and put flowers on the grave.

I want to help other survivors in whatever way I can. I can say that Karen's death brought our family closer. My husband has Alzheimer's disease, so that keeps me focused on his health.

The most important thing I have learned is self-care. I know that if I don't take care of myself, I won't be here for anyone else. I will be 80 years old in October. Karen was 51 when she died.

- Andree

I lost my son, Josh, on September 17, 2001. He was only 16 years old. To say it was a shock is an understatement.

Although it's been almost 15 years, this is something you live with every day. If you start to dwell on it, it will honestly take you back to when it first happened. You have to learn to get yourself out of those moments. It's very hard sometimes to do that.

I have joy, of course, because of my other children, and now a granddaughter, and also being a Christian.

But you still long for that child who is not there anymore. There's no future that should have been.

You still picture them in a certain chair at the table, or in their vehicle, or when you see friends they used to hang out with. People that haven't lost a child have no idea what an ongoing battle it is.

The sad thing is, most family and friends don't ever bring up your child's name. You feel like that child never existed to them. I now know so many people who have lost children, and have made good friends with them. It's comforting to have these special friends. We have to be strong and have endurance like no other. It depletes you of your energy and can make you physically ill. There again, people don't understand.

I wouldn't wish this on anyone. So if you know someone that has lost a child, be there for them, and be there for them a lot.

- Tina

Although it's been almost 15 years, this is something you live with every day. If you start to dwell on it, it will honestly take you back to when it first happened. You have to learn to get yourself out of those moments. It's very hard sometimes to do that.

I lost my friend Debby to suicide in 2011. She was a beautiful soul, although she was unable to see the beauty others saw in her. I met Debby when I was introduced to Alcoholics Anonymous. She had been sober for a year at that time. She watched me struggle for years and always gave me encouragement to keep trying. Some tragedies happened in Debby's life, then relapse. I loved Debby through it all.

I kept going back into the rooms of AA and every once in a while Debby came in too. I had hope for myself and for Debby. I got sober as Debby continued to struggle. She was never able to fully love herself but always managed to give others a smile, a joke, or a much needed hug. I don't quite know what happened that sad autumn day, but I can imagine the hurt, hopelessness, and overwhelming sorrow she must have felt, for I have been there too. The hopeless pain that consumes someone with depression can be crippling; it is unbearable at times.

I wish my friend had reached out, said something, or called someone! She didn't, and my heart still hurts for her. The pain of losing my dear friend was devastating. I can still remember it like it was yesterday, and yes, I still grieve over the loss of her life.

Time heals the pain and life continues, but I remember her warm smile and keep memories of her close to my heart.

I have learned to keep a close watch on my own feelings of depression, talk to others, and take measures to not get consumed. I know today that suicide is a permanent solution to a temporary problem.

-Amy



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Call to Action: What Can You Do?

- Remain aware of suicide warning signs, and don't hesitate to recommend mental health services to a family, friend, or colleague who exhibits them.
- Resist efforts to stigmatize mental health conditions and suicide. You wouldn't hesitate to seek help for a physical health problem, and you shouldn't hesitate to seek help for a mental health problem either.
- If you haven't been trained in suicide prevention, contact the Mississippi Department of Mental Health to learn about training options available in your area.
- If you have been trained in suicide prevention, spread the word about the value of such training.
- Consider resources in your community that could be enlisted in suicide prevention. These can include faith communities, workplaces, schools, parent-teacher associations, clinics, local support groups, and other community organizations.

**If you or someone you know needs help,
call the National Suicide Prevention Lifeline at
1-800-273-8255.**

**You can also call the Mississippi Department of
Mental Health at 1-877-210-8513.**



Supporting a Better Tomorrow...Today



MISSISSIPPI DEPARTMENT OF MENTAL HEALTH

1101 Robert E. Lee Building
239 N. Lamar Street
Jackson, MS 39201

Phone: 601.359.1288
Fax: 601.359.6295
TDD: 601.359.6230
Toll-Free Helpline: 1.877.210.8513