REPORT OF THE DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

Report on Activities Related to Suicide Prevention (HB 2258, Chapter 464, 2017 Acts of Assembly)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 18

COMMONWEALTH OF VIRGINIA
RICHMOND
2017

COMMONWEALTH of VIRGINIA

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December 1, 2017

TO: The Honorable Terry R. McAuliffe, Governor

and

Members, Virginia General Assembly

Fr: Jack Barber, MD
Interim Commissioner

Pursuant to House Bill 2258 (Filler-Corn) which instructed the The Department of Behavioral Health and Developmental Services to "*report by December 1, 2017, to the Governor and the General Assembly on its activities related to suicide prevention across the lifespan pursuant to § 37.2-312.1 of the Code of Virginia.*" In accordance with that language, please find attached the *DBHDS Annual Report on Activities Related to Suicide Prevention*.

Staff at the department are available should you wish to discuss this report.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
The Honorable Eileen Filler-Corn, Member, House of Delegates

Virginia Department of Behavioral Health & Developmental Services

DBHDS Annual Report on Activities Related to Suicide Prevention

(HB 2258)

December 1, 2017

DBHDS Vision: A Life of Possibilities for All Virginians

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DBHDS Annual Report on Activities Related to Suicide Prevention

Preface

House Bill 2258 requires the Department of Behavioral Health and Developmental Services (DBHDS) to report on its activities related to suicide prevention. The language reads:

> *§1. The Department of Behavioral Health and Developmental Services shall report by December 1, 2017, to the Governor and the General Assembly on its activities related to suicide prevention across the lifespan pursuant to § 37.2-312.1 of the Code of Virginia.*

DBHDS Annual Report on Activities Related to Suicide Prevention

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Introduction

DBHDS is pleased to submit its FY 2017 Annual Report on Activities Related to Suicide Prevention pursuant to HB 2258. The total number of suicides annually in Virginia increased from 2003 to 2013. Likewise, the overall rate of suicide also increased steadily from 10.8 to 12.7 per 100,000 residents from 2003 to 2013. The number and rate of suicide was higher among men than women and the suicide rate among men also showed a more pronounced increase from 17.0 to 20.1 suicide deaths per 100,000 residents. The trend of increasing number and rate of suicide parallels gender-specific and overall trends nationally.

The data reported in Appendix A of this report represent numbers and rates of suicide deaths in Virginia by Health Planning Regions from 2003-2015. The tables include a breakdown by select demographic and injury characteristics as well as select decedent and incident characteristics. Suicide decedents are reported based on Health Planning Region of residence.

Governor McDonnell signed into law the FY 2014 budget, which included a $1,100,000 ongoing appropriation to the Department of Behavioral Health and Developmental Services (DBHDS) to expand and support Suicide Prevention and Mental Health First Aid (MHFA) initiatives across the Commonwealth of Virginia. The funding is under the purview of the Office of Behavioral Health Wellness; $600,000 to expand MHFA and $500,000 to develop and implement a comprehensive statewide suicide prevention program. Funding for the Suicide Prevention and the MHFA Program Coordinators is included in this appropriation. Resources were allocated in an effort to prevent suicide and reduce the stigma of mental illness and seeking help.

It is a priority for DBHDS to have local participation in the development of community level strategies in suicide prevention and mental health promotion. Descriptions of the Regional Suicide Prevention Initiatives and other strategies related to suicide prevention are included in this report. Descriptions of the Suicide Prevention Interagency Advisory Group (SPIAG) and the Suicide Prevention across the Lifespan Plan are also included in this report.

Regional Suicide Prevention Initiatives

DBHDS currently funds regional suicide prevention initiatives across the Commonwealth of Virginia. These initiatives extend the reach and impact of suicide prevention efforts, afford greater access to suicide prevention resources by affected communities, and leverage and reduce costs for individual localities related to training or other suicide prevention action strategies. DBHDS has been funding these suicide prevention initiatives since 2014 from the ongoing appropriation from the General Assembly to DBHDS to expand and support Suicide Prevention and Mental Health First Aid initiatives across the Commonwealth of Virginia. In FY 2017, $625,000 was allocated for the regional suicide prevention initiatives. The DBHDS Suicide Prevention Coordinator is responsible for the monitoring and oversight of regional suicide prevention initiatives, as well as availability for technical assistance relating to the initiatives. Community services boards (CSBs) that represent each of the regions are included below:

- DBHDS Region 1 includes the following CSBs: Alleghany Highlands, Harrisonburg-Rockingham, Horizon, Northwestern, Rappahannock Area, Rappahannock-Rapidan, Region Ten, Rockbridge Area, and Valley. Region 1 is known as Region 1 Suicide Prevention Committee.
- DBHDS Region 2 includes the following CSBs: Alexandria, Arlington, Fairfax-Falls Church, Loudoun County, and Prince William County. Region 2 is known as the Suicide Prevention Alliance of Northern Virginia (SPAN).
- DBHDS Region 3 decided to split into eastern and western halves to better serve their provider areas. Region 3 East is known as Health Planning Region III East and includes the following CSBs: Blue Ridge, Danville-Pittsylvania, New River Valley, Piedmont, and Southside. Region 3 West is known as Region 3 West Wellness Council and includes the following CSBs: Cumberland Mountain, Dickenson County, Highlands, Mt Rogers, and Planning District 1.
- DBHDS Region 4 includes the following CSBs: Chesterfield, Crossroads, Goochland-Powhatan, Hanover, Henrico Area, District 19, and Richmond. Region 4 is known as the Region 4 Suicide Prevention Initiative.
- Region 5 includes the following CSBs: Chesapeake, Colonial, Eastern Shore, Hampton-Newport News, Middle Peninsula-Northern Neck, Norfolk, Portsmouth, Virginia Beach, and Western Tidewater. Region 5 is known as HPR 5 Suicide Prevention Task Force.

Each regional initiative is responsible for developing a collaborative organizational body, establishing need within the region and identifying target areas and populations, and building community capacity to address the issue from a prevention standpoint. Additionally, they develop a plan that has measurable goals and objectives along with an implementation guide that includes the following strategies and activities:

- Training provisions including Applied Suicide Intervention Skill Training (ASIST),Mental Health First Aid (MHFA),
- Suicide Alertness for Everyone (safeTALK),
- Online health simulation trainings developed by KOGNITO based on community need, and
- Activities for Suicide Prevention Awareness Week.

The regions also develop an evaluation and sustainability plan, include cultural considerations and competency actions, and develop a budget for implementation. Following are specific activities and accomplishments that occurred as a result of the regional suicide prevention initiatives in FY 2017.

Lock and Talk Virginia Campaign

While reviewing data from the Virginia Violent Death Reporting System, DBHDS Region 1 found that firearms were associated with 61 percent of suicides in their catchment area, and self-poisoning with 19 percent of suicides. In response, Region 1 established “Lock and Talk Virginia,” a project to prevent suicides by (1) restricting access to firearms and poisons during a mental health crisis and (2) educating members of the public how to recognize and respond to the warning signs of suicide.

Lock and Talk Virginia was developed in 2015 in partnership with and is an expansion of the National Means Matter campaign. The mission of the Means Matter campaign is to increase the proportion of suicide prevention groups who promote activities that reduce a suicidal person's access to lethal means of suicide and who develop active partnerships with gun owner groups to prevent suicide. The Lock and Talk Virginia campaign was highlighted by a key figure in the Means Matter campaign during the 50th Annual American Association of Suicidology Conference in April 2017. The Suicide Prevention Resource Center (SPRC) highlighted the Lock and Talk Virginia campaign for their efforts to reduce access to lethal means in an article on their website. The article can be accessed at http://www.sprc.org/news/virginia-lock-talk-virginia.

Another facet of the Lock and Talk Virginia campaign is the Gun Shop campaign. Currently, Lock and Talk Virginia works with 110 gun shop retailers, firing ranges, and pawn shops to display and discuss suicide prevention messages with clientele. The region reported that 90 percent of the gun retailers and firing ranges that were approached agreed to participate in the campaign.

Lock and Talk Virginia and its partners have provided 8,040 gun locks and 2,435 medication boxes beginning October 1, 2015 - August 31, 2017. The medication boxes have a medication safety tip sheet, poison control phone number, and the National Suicide Prevention Lifeline Phone Number. The free gun locks are accompanied by the message that the best strategy for protecting a person at risk is to remove firearms from the home until a mental health crisis has passed. The partners helping dispense the devices include sheriff's departments, mobile crisis units, domestic violence shelters, clinics, mental health agencies, hospitals, and rural mobile food pantries.

In addition, Lock and Talk Virginia information was presented to professionals during FY 2017 including at the Virginia Association of Community Services Board (VACSB) Conference in Portsmouth, VA and at the Region 5 Annual Conference, "Suicide Prevention: Connections Matter." in Portsmouth, VA. Furthermore, Crisis Intervention Team (CIT) partners delivered Lock and Talk Virginia information at the CIT Conference in Blacksburg, VA, and the CIT International Conference in Ft. Lauderdale, FL.

Suicide Prevention Alliance of Northern (SPAN) Virginia Website

During Suicide Prevention Month in September 2016, DBHDS Region 2 SPAN launched a new website and a coordinated suicide prevention campaign titled, "Reach Out. Find Hope". The website compiles resources from each CSB in Region 2 to provide a single point of entry for any community member who may be struggling with mental health issues or contemplating suicide.

The SPAN website received 9,125 unique visitors with 54,762 hits from October 2016 - August 2017. The most popular downloads were the Older Adult publications on aging, mental wellness and depression. Since November 2016, Public Service Announcements (developed by the region) experienced 512,327 impressions through Facebook newsfeeds

distributed in the northern Virginia region. Also, there were over 91,949 views of at least half of the 30 second spots; and of those, 49,953 were watched to 95-100 percent completion. The website is available at: http://www.suicidepreventionnva.org/.

SPAN continued to offer screening for mental health online brief screenings for depression, substance abuse, bipolar disorder, and post-traumatic stress disorder among others during FY 2017. The online screenings provide an assessment of the user's mental health, information on whether the user's assessment results are consistent with a mental health disorder, an overview of the signs and symptoms of treatable mental health disorders, and how to access local resources. These screenings are anonymous and confidential, and results are provided immediately following the brief questionnaire.

SPAN data reports show a range of between 100 and 150 individuals per month access the screening questionnaires. Typically, the depression and generalized anxiety disorder screens are the most utilized. During the calendar year 2017 (January – July) 944 screenings were completed.

Suicide Prevention Awareness Month Toolkit

Health Planning Region 3 East developed a Suicide Prevention Awareness Month toolkit as a component of their regional initiative during FY 2017. The toolkit is intended to raise awareness of suicide prevention and provide information on ongoing efforts in the local community. The goal of the toolkit is to provide community advocates with the necessary tools to develop and implement successful suicide prevention initiatives. The toolkit includes a challenge to the community to encourage people to pledge to check in on a friend or family member who is exhibiting the warning signs of suicide. The hope is to mobilize the community into action, and take the steps necessary to develop a suicide safer community. The toolkit includes the following:

1) Suicide Prevention and Awareness Proclamation
2) Suicide Facts and Figures
3) Warning Signs of Suicide
4) Free Community Trainings, Support Groups, and Resources
5) National Suicide Prevention Lifeline Information
6) Information on the #askingsaves 'Take the Pledge' Initiative
7) Suicide Prevention Awareness Month Activities

The Suicide Prevention Toolkit can be downloaded at:
https://drive.google.com/open?id=0B4gYIxMXOuU8WnBRMVRwSVpUNTQ.

Are You Okay Program Initiative

The Southwest Virginia Region 3 West Suicide Prevention Initiative has worked diligently the past 14 months to develop the "Are You Okay" program. The newly developed program provides contact and support during high-risk times for individuals recently released from

hospitalization. This population was targeted as a result of research demonstrating that some of the highest risk periods for suicide are immediately after hospital discharge.

The Are You Okay program mission is to help individuals feel *heard* by providing volunteers who make a sincere connection with individuals to prevent suicide. Volunteers empower individuals to make successful care transitions by focusing on the individuals' personal values, beliefs, strengths, and resources. Reducing isolation and providing an avenue to be heard between services is essential in helping to prevent suicides. The Are You Okay program works by providing:

- Voluntary referral
- 24-hour initial call-back with follow up calls to connect to first follow-up appointment.
- Individualized care and transition planning
- Scaling for Evaluation

Program data will be managed online over a secure web-based portal designed to track Are You Okay participant data. Evaluation measures for the program are embedded to monitor progress of participants after each call. On-line portal use allows Are You Okay volunteer callers to operate from multiple sites increasing the potential for volunteers in a large geographical area.

Region 3 West launched the program by means of a presentation to the Regional Emergency Services Directors meeting held at the Mount Rogers Community Services Board Office in July 2017. The region will pilot the program with the Southwestern Virginia Mental Health Institute. The hospital is a 179-bed state psychiatric institute serving adult and geriatric populations in Southwest Virginia.

Comcast Spotlight Partnership

In an effort to promote awareness that suicide is a public health problem that is preventable, Region 4 developed a partnership with Comcast Spotlight. This strategy included a comprehensive six month cable TV and premium digital video campaign with the goal of building awareness for the Be Well VA website as a resource for those struggling with depression and suicidal thoughts. Be Well VA is a collaboration of the seven Community Service Boards in Region 4. The focus of the site is to bring awareness to the increasing number of deaths by suicide and to promote wellness for life.

The ads were strategically designed with the intent to change the public interest by raising awareness of suicide, impact the public attitude around the stigma associated with depression and suicide, and offer a call to action. The media campaign, targeting older white men, military personnel and teens, included 1,301 30-second commercials and 343,000 targeted digital video impressions. Comcast Spotlight provided additional public service announcements support including 12,270 30-second commercials and 200 10-second commercials.

- Cable networks included A&E, AMC, BET, CNN, Discovery, ESPN2, Fox Sports, Golf, History, MASN, NBC Sports and Spike (Target audience - older white men, and military)
- Cable networks included ABC Family, BET, Cartoon, Comedy, E!, FX, MTV, TLC and TruTV (Target audience - teens)

For the premium digital video campaign engagement, the video ads were delivered 215,742 times within premium online content through June 2017. Of the video ads, 81.22 percent were viewed in their entirety, exceeding the industry standard of 70 percent viewing before closing the ad.

In addition to the archival data compiled during the first year of this collaborative, Region 4 has been able to enhance its understanding of community needs through the use of social media analytics. The data and accompanying priorities continue to inform planning and implementation of regional suicide prevention efforts. In addition, Region 4 has learned much about the needs in their local communities as their suicide prevention capacity continues to develop and mature. For example, two at-risk groups will be prioritized in 2018 as a result of the community assessment, the LGBTQ and Hispanic populations.

Connections Matter Conference

The DBHDS Region 5 Suicide Prevention Task Force held the 2nd Annual Suicide Prevention Conference: Connections Matter on May 24, 2017 in Portsmouth, Virginia. There were approximately 235 participants from local CSBs, local school districts, the health department, mental health agencies, and various community members.

Social media was utilized as a component of the conference. Using the Twitter platform, a Tweet Wall was created that reached 62,016 individuals. The Tweet Wall, #SPCM2017, was sponsored by the Sarah Michelle Peterson Foundation. The absolute reach of the wall was 101,464. A youth volunteer with the Sarah Michelle Peterson Foundation ran the Tweet Wall station the day of the conference. The Tweet Wall provided a means for individuals who were not current users of Twitter to utilize the social media platform to tweet about the conference. Reports from users were positive and plans for future events were documented.

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a two-day workshop designed for members of all caregiving groups. Family, friends, and other community members may be the first to talk with a person at risk, but have little or no training on how to recognize someone at risk and how to respond. ASIST can also provide those in formal helping roles with professional development to ensure that they are prepared to provide suicide first aid help as part of the care they provide.

The emphasis is on teaching suicide first-aid to help a person at risk stay safe and seek further help as needed. Participants learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe

plan based upon a review of risk, be prepared to do follow-up, and become involved in suicide-safer community networks.

In the course of the two-day workshop, ASIST participants learn to:

1. Understand the ways personal and societal attitudes affect views on suicide and interventions.
2. Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety needs.
3. Identify the key elements of an effective suicide safety plan and the actions required to implement it.
4. Appreciate the value of improving and integrating suicide prevention resources in the community at large.
5. Recognize other important aspects of suicide prevention including life-promotion and self-care.

The DBHDS Suicide Prevention Coordinator is responsible for the coordination, monitoring and oversight of ASIST trainings. DBHDS was able to strengthen the network of suicide prevention trainers by providing an ASIST Training-for-Trainers program in June 2016. The June training certified 24 trainers. DBHDS currently has 60 certified trainers throughout Virginia. DBHDS also provides materials for ASIST trainings throughout the Commonwealth. The funding for the ASIST trainings and materials is provided through the annual appropriation from the General Assembly to expand and support suicide prevention and MHFA initiatives across Virginia. As a result, the FY 2017 budget included $500,000 for these suicide prevention initiatives. There were 420 individuals who participated in the training between January 2017 and September 2017. As of September 2017, ASIST training has been delivered to 1,800 Virginia residents through DBHDS funding, providing them with the skill set to help create suicide safer communities.

Mental Health First Aid (MHFA) Training

The FY 2014 budget included a $1,100,000 ongoing appropriation to DBHDS to expand and support suicide prevention and MHFA initiatives across Virginia. As a result, the FY 2017 budget included $600,000 for MHFA.

The DBHDS Mental Health First Aid (MHFA) Program Coordinator is responsible for the coordination, monitoring and oversight of MHFA activities, trainings, and budget monitoring as well as researching best practice/evidence based programs available to reduce the number of suicides and attempted suicides. Four Mental Health First Aid (MHFA) Instructor trainings are currently being provided each year.

Mental Health First Aid is a national public education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports. This 8-hour course uses role-playing and simulations to demonstrate how to offer initial help in a mental health crisis and connect persons to the appropriate professional, peer, social, and self-help care.

Mental Health First Aid is the initial help offered to a person developing a mental health problem or experiencing a mental health crisis. The first aid is given until appropriate treatment and support are received or until the crisis resolves. Mental Health First Aid teaches participants a five-step action plan, ALGEE, to support someone developing signs and symptoms of a mental illness or in an emotional crisis:

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies.

As of August 31, 2017, Virginia has 759 MHFA Instructor certifications in MHFA. 432 trained as Adult MHFA Instructors, 327 individuals trained as Youth MHFA Instructors and 259 Instructors are certified in both Adult and Youth MHFA. Of the certified instructors, 139 are trained in the Public Safety designation, and 39 are trained in the Higher Education designation.

Current comparison between states places Virginia with the 11th highest number of consumers trained with a total of 34, 855 (as of 09/01/2017) consumers certified as Mental Health First Aiders. Virginia also has the 6th highest number of instructors for MHFA in the country.

A data report is provided to DBHDS monthly from the National Council of Behavioral Health. The report provides the number of MHFA Instructors in Virginia, number of people trained in MHFA in the state, and Virginia's ranking compared against other states. This data is provided from the National Council's website database. The number of instructors carrying other designations is also included within the report. Other designations include certification in the following modules; public safety, higher education, veterans, rural areas, and older adults.

Zero Suicide Initiative

Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the U.S. Substance Abuse and Mental Health Services Administration. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems based on a foundational belief that suicide deaths for individuals under care within health and behavioral health systems are preventable.

In 2017, DBHDS and VDH were invited to participate in the SPRC 2017 Zero Suicide Community of Practice (January – September 2017). The goal of the Community of Practice is to provide training and technical assistance to state suicide prevention and mental/behavioral health programs in order to build capacity and to promote the spread and adoption of Zero Suicide.

In early 2015, Arlington Community Services Board identified suicide prevention as a high priority initiative. As a result, they began implementation of the Zero Suicide Initiative. The Zero Suicide Committee consisted of staff throughout the CSB, as well as individuals with lived experience with suicidal behaviors. Efforts focused on risk identification, training and client engagement. Accomplishments included community surveys to better identify training and resource needs, Assessing and Managing Suicide Risk (AMSR) training of supervisory staff, community and staff education in ASIST and MHFA. Additionally, safety cards and toolkits were created to promote client engagement. Arlington CSB implemented universal screening with the Columbia–Suicide Severity Rating Scale, and also used existing functionality within the electronic health record to create alerts for high risk individuals and those with active risk management plans.

DBHDS has been able to provide financial support in the amount of $12,200 of general funds to the Arlington County Department of Human Services Behavioral Healthcare Division to implement Collaborative Assessment and Management of Suicidality (CAMS) training. The CAMS training is a therapeutic framework for suicide-specific assessment and treatment of a patient's suicidal risk.

Other CSBs have begun early implementation stages of the Zero Suicide Initiative. DBHDS serves as a liaison to partners across Virginia to assist in the development and implementation of work plans for their locality, encourage sharing of ideas, and promote best practices for successful implementation.

Suicide Prevention Interagency Advisory Group (SPIAG)

In 2009, DBHDS and VDH convened the SPIAG to establish a new collaborative structure to plan and implement suicide prevention activities in the Commonwealth. This group currently includes DBHDS, VDH (including the Office of the Chief Medical Examiner), Virginia Department of Education (DOE), Virginia Department of Criminal Justice, Virginia Department of Juvenile Justice, the Virginia Association of Community Services Boards (VACSB), the Virginia Suicide Prevention Coalition, the U.S. Department of Veterans Affairs, as well as other organizations with a mission to promote awareness of and access to suicide prevention resources in their respective communities.

The goal of the group is to continue to address suicide prevention across the lifespan on a statewide level. The DBHDS Suicide Prevention Coordinator and Virginia Department of Health (VDH) Violence and Suicide Prevention Coordinator serve as co-chairs for the advisory group.

The Suicide Prevention Interagency Group bases its work in congruence with Virginia's state suicide prevention plan. The plan, "*Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia*," was finalized December 2016. The plan describes current and proposed efforts by DBHDS and VDH, as well as other suicide prevention partners, to reduce suicide in Virginia. The goals and objectives represent the consensus of the lead agencies as well as suicide prevention stakeholders from other government agencies, non-governmental

organizations, community partners, and private citizens. The plan presents seven goals to reduce and prevent suicide across the commonwealth. The group believes in the importance of expanding on the past efforts of the group, including developing in-depth data collection for suicide deaths in Virginia, conducting state training efforts to address suicide prevention education, providing the Suicide Prevention Resource Directory, and working with regional stakeholders to implement suicide prevention efforts in their communities.

The report utilizes data from the VDH Virginia Violent Death Reporting System and Virginia Hospital Information to quantify the problem of suicide in the Commonwealth, including identifying areas of high suicide burden and risk factors for self-harm. The plan is available for download on the Suicide Prevention Resource Center website, found at: http://www.sprc.org/sites/default/files/Virginia%20Suicide%20Prevention%20Across%20the%20Lifespan%20Plan.pdf.

The next major task of the Suicide Prevention Interagency Workgroup in FY 2017 was to update the *Virginia Suicide Prevention Resource Directory*. The directory is designed to provide an easy to use reference of programs available in Virginia to assist individuals seeking suicide prevention resources. Studies show that people who know the signs of suicide and how to access resources are more likely to take action that could save a life. This directory provides a list of available resources that are needed when people are impacted by suicide. The directory is organized into the following categories: hotlines, community mental health centers, statewide mental health facilities, coalitions, support groups, and resources. The directory update was completed in September 2016. SPIAG members will share the directory on their websites, as part of presentations, at conferences and trainings and other venues as appropriate. Copies of this document are available on the VDH website at: http://www.vdh.virginia.gov/content/uploads/sites/53/2016/11/2016SuicidePreventionResourceDirectory4thEdFINAL.pdf.

Conclusion

Effective suicide prevention efforts require the engagement and commitment of multiple sectors and agencies. DBHDS is Virginia's lead agency for suicide prevention across the lifespan, and continues to provide leadership in order to promote suicide awareness, and reduce the incidence of suicide. Statewide, there exists a shared responsibility to identify at-risk individuals and ensure that they receive essential services for mental health care and crisis stabilizations. The collaborative efforts related to suicide prevention in this report raise awareness of community risk factors for suicide and promote suicide prevention awareness and mental health literacy. DBHDS looks forward to continuing our work with stakeholders to strengthening capacity and efforts to ensure suicide-safer communities across Virginia.

Appendices

Appendix A: Suicide Death Data

The data reported in the following tables represent numbers and rates of suicide deaths in Virginia by Health Planning Regions from 2003-2015. The tables include breakdown by select demographic and injury characteristics as well as select decedent and incident characteristics. Suicide decedents are reported based on Health Planning Region of residence.

Data were drawn from the National Violent Death Reporting System (NVDRS), which documents deaths occurring within the state's borders. The Virginia Violent Death Reporting System (VVDRS) is the operation and reporting system of the NVDRS within Virginia and uses the methodology, definitions, coding schema, and software of the NVDRS.

The data provided here is for Virginia residents only. The research files for this report were created on August 30, 2017. Data may continue to be entered and updated in VVDRS after this date.

The Office of the Chief Medical Examiner's Annual Report, 2015 provides the following data on suicide deaths:

- Number and Rate of Suicide Deaths by Year of Death, 1999-2015
- Number and Rate of Suicide Deaths by Age Group and Gender, 2015
- Percentage of Suicide Deaths by Race/Ethnicity, 2015
- Number and Rate of Suicide Deaths by Race/Ethnicity and Gender, 2015
- Number of Suicide Deaths by Cause and Method of Death, 2015
- Number of Suicide Deaths by Age Group and Ethanol Level, 2015
- Number of Suicide Deaths by Gender and Ethanol Level, 2015
- Number of Suicide Deaths by Manner of Death and Ethanol Level, 2015
- Number of Suicide Deaths by Month of Death, 2015
- Number of Suicide Deaths by Day of the Week, 2015
- Number and Rate of Suicide Deaths by Locality of Residence, 2015
- Number of Suicides Deaths by Locality of Injury and Year of Death, 2006-2015

The Office of the Chief Medical Examiner's Annual Report, 2015 can be downloaded at, http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/Annual-Report-2015-FINAL.pdf.

Table 1: Selected Demographics of Suicide Decedents in Virginia by Health Planning Region: 2003-2015

	Virginia			HPR I: Northwest			HPR II: Northern			HPR III: Southwest			HPR IV: Central			HPR V: Eastern			HPR Unknown		
	N= 12,394			N= 2,183			N= 2,375			N= 2,850			N= 2,198			N= 2,762			N= 26		
	Num.	%	Rate[1]	Num.	%	Rate[1]	Num.	%	Rate[1]	Num.	%	Rate[1]	Num.	%	Rate[1]	Num.	%	Rate[1]	Num.	%	Rate[1]
Sex																					
Male	9,583	77.3	19.0	1,697	77.7	21.9	1,731	72.9	12.3	2,305	80.9	27.2	1,692	77.0	19.9	2,137	77.4	18.5	21	80.8	-
Female	2,811	22.7	5.4	486	22.3	6.0	644	27.1	4.5	545	19.1	6.1	506	23.0	5.7	625	22.6	5.2	5	19.2	-
Age Group[2]																					
10-14	74	0.6	1.1	20	0.9	1.9	12	0.5	0.6	11	0.4	1.1	15	0.7	1.3	16	0.6	1.0	0	0.0	-
15-19	547	4.4	7.9	87	4.0	7.5	135	5.7	7.9	101	3.5	8.5	94	4.3	7.7	129	4.7	7.7	1	3.8	-
20-24	937	7.6	12.7	143	6.6	11.6	188	7.9	11.3	168	5.9	12.6	170	7.7	13.9	264	9.6	13.6	4	15.4	-
25-34	1,882	15.2	13.3	292	13.4	14.2	415	17.5	9.5	405	14.2	19.6	318	14.5	13.6	451	16.3	13.6	4	15.4	-
35-44	2,239	18.1	15.3	362	16.6	17.0	439	18.5	9.3	540	18.9	24.4	393	17.9	16.1	497	18.0	15.7	8	30.8	-
45-54	2,681	21.6	17.8	534	24.5	23.3	504	21.2	11.7	588	20.6	23.5	478	21.7	18.4	573	20.7	17.2	4	15.4	-
55-64	1,935	15.6	16.3	349	16.0	19.2	374	15.7	11.9	453	15.9	19.9	362	16.5	17.3	393	14.2	15.4	4	15.4	-
65-74	1,081	8.7	15.1	204	9.3	17.3	160	6.7	10.5	311	10.9	19.7	200	9.1	16.1	205	7.4	12.7	1	3.8	-
75-84	712	5.7	17.8	137	6.3	20.4	110	4.6	15.3	204	7.2	21.6	108	4.9	14.9	153	5.5	16.1	0	0.0	-
85+	303	2.4	19.2	55	2.5	21.5	38	1.6	12.9	69	2.4	18.9	60	2.7	20.2	81	2.9	22.1	0	0.0	-
Race																					
White	10,752	86.8	14.3	2,051	94.0	15.1	1,939	81.6	9.4	2,694	94.5	18.0	1,776	80.8	16.0	2,273	82.3	15.3	19	73.1	-
Black	1,221	9.9	5.8	111	5.1	6.1	195	8.2	5.4	138	4.8	6.5	369	16.8	6.4	403	14.6	5.2	5	19.2	-
Asian	338	2.7	5.7	15	0.7	4.5	231	9.7	5.7	14	0.5	6.3	28	1.3	5.3	48	1.7	5.5	2	7.7	-
Native American	18	0.1	3.6	2	0.1	3.2	2	0.1	1.1	0	0.0	0.0	11	0.5	13.0	3	0.1	2.3	0	0.0	-
Two or More Races	40	0.3	-	4	0.2	-	7	0.3	-	3	0.1	-	6	0.3	-	20	0.7	-	0	0.0	-
Other	6	0.0	-	0	0.0	-	0	0.0	-	0	0.0	-	2	0.1	-	4	0.1	-	0	0.0	-
Unknown	19	0.2	-	0	0.0	-	1	0.0	-	1	0.0	-	6	0.3	-	11	0.4	-	0	0.0	-
Ethnicity																					
Hispanic[3]	313	2.5	4.1	31	1.4	3.5	158	6.7	3.6	27	0.9	7.4	39	1.8	5.3	58	2.1	5.1	0	0.0	-
Military																					
Veteran[4]	2,771	22.4	-	450	20.6	-	447	18.8	-	580	20.4	-	445	20.2	-	844	30.6	-	5	19.2	-
Active Duty[5]	*258*	*9.3*	-	*13*	*2.9*	-	*33*	*7.4*	-	*11*	*1.9*	-	*24*	*5.4*	-	*174*	*20.6*	-	*3*	*60.0*	-
Year																					
2003	797	6.4	10.8	138	6.3	12.6	138	5.8	7.1	196	6.9	15.0	143	6.5	11.4	181	6.6	10.2	1	3.8	-
2004	818	6.6	11.0	153	7.0	13.7	132	5.6	6.7	202	7.1	15.4	140	6.4	11.0	191	6.9	10.7	0	0.0	-
2005	857	6.9	11.3	141	6.5	12.2	170	7.2	8.4	229	8.0	17.4	145	6.6	11.3	172	6.2	9.6	0	0.0	-
2006	873	7.0	11.4	147	6.7	12.5	158	6.7	7.7	201	7.1	15.3	169	7.7	13.0	197	7.1	11.0	1	3.8	-
2007	867	7.0	11.2	159	7.3	13.3	166	7.0	8.0	215	7.5	16.2	138	6.3	10.5	189	6.8	10.5	0	0.0	-
2008	936	7.6	12.0	163	7.5	13.6	190	8.0	9.0	218	7.6	16.4	157	7.1	11.8	208	7.5	11.5	0	0.0	-
2009	956	7.7	12.1	150	6.9	12.3	206	8.7	9.5	219	7.7	16.4	187	8.5	13.9	194	7.0	10.7	0	0.0	-
2010	982	7.9	12.3	164	7.5	13.3	191	8.0	8.6	228	8.0	16.8	161	7.3	11.8	236	8.5	13.0	2	7.7	-
2011	1,037	8.4	12.8	175	8.0	14.0	188	7.9	8.2	244	8.6	18.0	187	8.5	13.6	242	8.8	13.3	1	3.8	-
2012	1,038	8.4	12.7	181	8.3	14.3	200	8.4	8.5	224	7.9	16.5	188	8.6	13.6	242	8.8	13.2	3	11.5	-
2013	1,047	8.4	12.7	191	8.7	14.9	225	9.5	9.4	221	7.8	16.3	199	9.1	14.2	202	7.3	11.0	9	34.6	-
2014	1,112	9.0	13.4	212	9.7	16.4	223	9.4	9.2	211	7.4	15.6	196	8.9	13.9	265	9.6	14.4	5	19.2	-
2015	1,074	8.7	12.8	209	9.6	16.0	188	7.9	7.7	242	8.5	17.8	188	8.6	13.2	243	8.8	13.1	4	15.4	-
TOTAL	**12,394**	**100.0**	**12.1**	**2,183**	**100.0**	**13.8**	**2,375**	**100.0**	**8.3**	**2,850**	**100.0**	**16.4**	**2,198**	**100.0**	**12.6**	**2,762**	**100.0**	**11.7**	**26**	**100.0**	**-**

[1]Rates are per 100,000.

[2]There were no suicides by persons younger than 10 years.

[3]Hispanic persons can be any race.

[4]Veteran includes both current and former military service.

[5]Active duty represents a subset of veterans, only those currently performing military service. The percent is based on the number of veterans.

Data Source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Table 2: Selected Injury Characteristics of Suicide Decedents in Virginia by Health Planning Region: 2003-2015

	Virginia		HPR I: Northwest		HPR II: Northern		HPR III: Southwest		HPR IV: Central		HPR V: Eastern		HPR Unknown	
	N= 12,394		N= 2,183		N= 2,375		N= 2,850		N= 2,198		N= 2,762		N= 26	
	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%
Mechanism of Injury[1]														
Firearm	6,976	56.3	1,307	59.9	978	41.2	1,898	66.6	1,265	57.6	1,518	55.0	10	38.5
Asphyxia	2,636	21.3	383	17.5	661	27.8	463	16.2	444	20.2	683	24.7	2	7.7
Poison	2,065	16.7	406	18.6	527	22.2	382	13.4	329	15.0	413	15.0	8	30.8
Drowning	180	1.5	21	1.0	33	1.4	21	0.7	46	2.1	57	2.1	2	7.7
Sharp Instrument	219	1.8	24	1.1	67	2.8	39	1.4	41	1.9	48	1.7	0	0.0
Fall	235	1.9	22	1.0	101	4.3	32	1.1	45	2.0	33	1.2	2	7.7
Motor Vehicle	90	0.7	23	1.1	25	1.1	11	0.4	18	0.8	10	0.4	3	11.5
Fire/Burns	56	0.5	12	0.5	10	0.4	12	0.4	13	0.6	9	0.3	0	0.0
Other Transport Vehicle	59	0.5	10	0.5	21	0.9	13	0.5	7	0.3	7	0.3	1	3.8
Intentional Neglect	2	0.0	0	0.0	1	0.0	0	0.0	0	0.0	1	0.0	0	0.0
Non-Powder Gun	2	0.0	2	0.1	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Blunt Instrument	2	0.0	1	0.0	1	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Other	29	0.2	6	0.3	8	0.3	7	0.2	1	0.0	7	0.3	0	0.0
Premise of Injury														
House	9,334	75.3	1,636	74.9	1,774	74.7	2,247	78.8	1,604	73.0	2,067	74.8	6	23.1
Vehicle	862	7.0	166	7.6	147	6.2	188	6.6	174	7.9	182	6.6	5	19.2
Natural Area	663	5.3	140	6.4	120	5.1	124	4.4	134	6.1	142	5.1	3	11.5
Hotel or Motel	292	2.4	46	2.1	73	3.1	35	1.2	52	2.4	84	3.0	2	7.7
Jail or Detention Center	206	1.7	29	1.3	17	0.7	47	1.6	54	2.5	59	2.1	0	0.0
Street, Road, or Sidewalk	146	1.2	27	1.2	19	0.8	38	1.3	24	1.1	37	1.3	1	3.8
Park or Playground	122	1.0	8	0.4	49	2.1	15	0.5	33	1.5	16	0.6	1	3.8
Public Parking Lot or Garage	120	1.0	23	1.1	33	1.4	22	0.8	20	0.9	20	0.7	2	7.7
Other	637	5.1	108	4.9	141	5.9	129	4.5	101	4.6	152	5.5	6	23.1
Unknown	12	0.1	0	0.0	2	0.1	5	0.2	2	0.1	3	0.1	0	0.0
Injured at Decedent's Home	9,211	74.3	1,635	74.9	1,775	74.7	2,197	77.1	1,578	71.8	2,025	73.3	1	3.8

[1]More than one mechanism of injury can be used in a fatal agent. The number of mechanisms (N=12,551) exceeds the number of decedents. Totals will exceed 100.0%.

Data Source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Table 3: Selected Decedent and Incident Characteristics Among Suicide Decedents in Virginia by Health Planning Region: 2003-2015

	Virginia		HPR I: Northwest		HPR II: Northern		HPR III: Southwest		HPR IV: Central		HPR V: Eastern		HPR Unknown	
	N= 12,054		N= 2,128		N= 2,337		N= 2,757		N= 2,135		N= 2,672		N= 25	
	Num.	%[1]	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%
Mental Health and Addiction														
Mental Health Diagnosis[2]	6,799	56.4	1,239	58.2	1,570	67.2	1,398	50.7	1,186	55.6	1,388	51.9	18	72.0
Depression	5,277	*77.6*	*979*	*79.0*	*1,246*	*79.4*	*1,109*	*79.3*	*874*	*73.7*	*1,057*	*76.2*	*12*	*66.7*
Anxiety	1,471	*21.6*	*277*	*22.4*	*414*	*26.4*	*251*	*18.0*	*223*	*18.8*	*301*	*21.7*	*5*	*27.8*
Bipolar	1,035	*15.2*	*210*	*16.9*	*243*	*15.5*	*170*	*12.2*	*193*	*16.3*	*216*	*15.6*	*3*	*16.7*
Received Treatment	5,739	84.4	1,036	83.6	1,342	85.5	1,110	79.4	1,066	89.9	1,170	84.3	15	83.3
Treated, Within Two Months	4,875	*71.7*	*869*	*70.1*	*1,092*	*69.6*	*999*	*71.5*	*915*	*77.2*	*989*	*71.3*	*11*	*61.1*
Treated, Prior to Two Months	864	*12.7*	*167*	*13.5*	*250*	*15.9*	*111*	*7.9*	*151*	*12.7*	*181*	*13.0*	*4*	*22.2*
Alcohol Problem	2,346	19.5	486	22.8	508	21.7	440	16.0	400	18.7	504	18.9	8	32.0
Substance Problem	1,961	16.3	370	17.4	364	15.6	475	17.2	358	16.8	384	14.4	10	40.0
Relationship Problems														
Intimate Partner[3]	4,052	33.6	718	33.7	762	32.6	924	33.5	706	33.1	932	34.9	10	40.0
Family Member	1,048	8.7	212	10.0	331	14.2	220	8.0	114	5.3	163	6.1	8	32.0
Argument	916	7.6	183	8.6	180	7.7	207	7.5	153	7.2	191	7.1	2	8.0
Other Relationship[4]	345	2.9	53	2.5	77	3.3	50	1.8	100	4.7	63	2.4	2	8.0
Life Stressors														
Crisis within Two Weeks	4,794	39.8	894	42.0	965	41.3	1,100	39.9	846	39.6	975	36.5	14	56.0
Physical Health Problem[5]	2,374	19.7	495	23.3	462	19.8	544	19.7	413	19.3	457	17.1	3	12.0
Job Problems	1,578	13.1	284	13.3	498	21.3	188	6.8	264	12.4	341	12.8	3	12.0
Financial Problems	1,567	13.0	326	15.3	475	20.3	189	6.9	273	12.8	296	11.1	8	32.0
Criminal Legal Problems	1,442	12.0	266	12.5	256	11.0	316	11.5	300	14.1	300	11.2	4	16.0
Suicide Characteristics														
Disclosed Intent[6]	4,767	39.5	876	41.2	1,068	45.7	1,041	37.8	833	39.0	941	35.2	8	32.0
Current Depressed Mood	4,680	38.8	884	41.5	1,049	44.9	967	35.1	787	36.9	986	36.9	7	28.0
Left a Suicide Note	4,307	35.7	759	35.7	932	39.9	878	31.8	789	37.0	939	35.1	10	40.0
Prior Attempts	2,568	21.3	443	20.8	625	26.7	449	16.3	488	22.9	556	20.8	7	28.0

[1]Percentages are based on the number of decedents with at least one known characteristic. More than one characteristic may apply per decedent, therefore, totals will exceed the number of decedents and percentages will exceed 100%.

[2]A diagnosed mental health condition at the time of death. A decedent may be diagnosed with multiple conditions (e.g. both depression and anxiety), and so the totals of specific diagnoses will exceed the number of decedents.

[3]Refers to conflict, including, but not limited to, violence between current or former intimate partners.

[4]Examples include friends and co-workers.

[5]The existence of a physical health problem by itself does not constitute a problem, it must have contributed to the suicide (e.g. the decedent couldn't handle the pain of his terminal cancer any

[6]Refers to decedents who, prior to the suicide, informed someone of their intent to commit suicide with time to intervene.

Data Source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health