COMMONWEALTH of VIRGINIA

MIRA SIGNER
ACTING COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

December 10, 2019

TO: The Honorable Ralph S. Northam, Governor

and

Members, Virginia General Assembly

Fr: Mira Signer
Acting Commissioner

Pursuant to §37.2-312.1 of the Code of Virginia (HB569, 2018 General Assembly Session) which instructs the Department of Behavioral Health and Developmental Services to report by December 1 of each year to the Governor and General Assembly regarding "*the Department's activities related to suicide prevention across the lifespan'*.

Please find attached the report in accordance with that language.

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

Sincerely,

Mira Signer

Enc.

Cc: The Honorable Wendy W. Gooditis, Member House of Delegates
The Honorable Daniel Carey, M.D.
Marvin Figueroa
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

DBHDS Annual Report on Activities Related to Suicide Prevention

(HB 569, *2018 Session*)

December 1, 2019

DBHDS Vision: A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

DBHDS Annual Report on Activities Related to Suicide Prevention

Preface

House Bill 569 (2018) requires the Department of Behavioral Health and Developmental Services (DBHDS) to report annually on its activities related to suicide prevention. The language reads:

> ***§ 37.2-312.1. Department to be lead agency for suicide prevention across the lifespan.***
>
> *A. With such funds as may be appropriated for this purpose, the Department, in consultation with community services boards and behavioral health authorities, the Department of Health, local departments of health, and the Department for Aging and Rehabilitative Services, shall have the lead responsibility for the suicide prevention across the lifespan program. The Department shall coordinate the activities of the agencies of the Commonwealth pertaining to suicide prevention in order to develop and carry out a comprehensive suicide prevention plan addressing public awareness, the promotion of health development, early identification, intervention and treatment, and support to survivors. The Department shall cooperate with federal, state, and local agencies, private and public agencies, survivor groups, and other interested persons to prevent suicide.*
>
> *B. The Commissioner shall report annually by December 1 to the Governor and the General Assembly on the Department's activities related to suicide prevention across the lifespan.*

DBHDS Annual Report on Activities Related to Suicide Prevention

Table of Contents

Executive Summary

The Centers for Disease Control and Prevention (CDC) states that suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. Suicide, by definition, is fatal. Suicide also affects the health of others and the community. When people die by suicide, their family and friends often experience shock, anger, guilt, and depression. Many people are impacted by knowing someone who dies by suicide or by personally experiencing suicidal thoughts. Additionally, being a survivor or someone with lived experience increases one's risk of suicide.

A report, released by CDC in November 2018, stated since 2008, suicide has ranked as the 10th leading cause of death for all ages in the United States. From 1999 through 2017, the age-adjusted suicide rate increased 33% from 10.5 to 14.0 per 100,000. The average annual percentage increase in rates accelerated from approximately 1% per year from 1999 through 2006 to 2% per year from 2006 through 2017.[1] While the causes of suicide are complex and determined by multiple factors, the goal of suicide prevention is to reduce factors that increase risk and increase factors that promote resilience (i.e. protective factors). Ideally, prevention addresses all levels of influence: individual, relationship, community, and societal. Effective prevention strategies are needed to promote awareness of suicide and encourage a commitment to social change.

A comprehensive evidence-based public health approach to prevent suicide addresses risk before it occurs, identifies and supports persons at risk, prevents reattempts, and helps friends and family members in the aftermath of a suicide is needed. This report provides an overview of the Department's activities related to suicide prevention across the lifespan.

The goal of DBHDS is to continue to address suicide prevention across the lifespan on a statewide level and in congruence with our state plan, *"Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia."* A combination of interventions at several levels will be required in order to implement an effective, comprehensive program. We will continue to strengthen capacity across multiple agencies and organizations to impact our ability to reduce the risk of suicide across the lifespan.

Hedegaard, H., Curtin, S., & Warner, M. (n.d.). Products - Data Briefs - Number 330 - September 2018. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db330.htm.

Introduction

DBHDS is pleased to submit the FY 2019 Annual Report on Activities Related to Suicide Prevention pursuant to § 37.2-312.1 of the Code of Virginia (HB 569, 2018). In general, suicide deaths have been slowly increasing since 1999, although the number of suicide deaths in 2017 compared to 2016 was nearly identical. The largest number of victims are male (78.0%), white (85.0%), and aged 55-64 years of age (18.0%). Males 85 years of age and older as well as white males had the highest rates of suicide compared to other groups (46.7 and 28.8 per 100,000 persons, respectively).

- Whites died by suicide at a rate 5.0 times that of Hispanics, 4.0 times that of Asians, 3.2 times that of Blacks, and 2.4 times that of Native Americans.
- Males are 3.5 times more likely to die by suicide than females.
- Firearms (specifically handguns), asphyxiation, and drug use were the three most commonly used methods of suicide, with these deaths representing 57.3%, 21.4%, and 11.5% of all suicides, respectively

The Federal Department of Veterans Affairs (VA) estimates that 20 veterans die by suicide every day. Of the 20, only six were connected with the VA for healthcare prior to their deaths. Suicide rates vary across the nation, and the veteran rates mirror trends of the general population. However, veterans and service members are at a greater risk for suicide than civilians. The Virginia Violent Death Reporting System (VVDRS) reported that 3,250 veterans and service members died by suicide in Virginia (from 2003 to 2017). The use of a firearm is the leading means in suicide deaths for veterans and the general public.

The data reported in Appendix A of this report represents numbers and rates of suicide deaths in Virginia by DBHDS Regions from 2003-2017. 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 DBHDS regions.

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.

Lock and Talk Virginia

Lock and Talk Virginia was developed in May 2016 as a Department of Behavioral Health and Developmental Services (DBHDS) Region 1 suicide prevention initiative. Led by the Prevention Teams of Region 1 Community Services Boards, the initiative has expanded to 29 Community Services Boards across the Commonwealth.

Promoting safe and responsible care of lethal means – while encouraging community conversations around mental wellness – is vital to the mission of preventing suicides and promoting wellness.

The foundation of Lock and Talk Virginia is based directly on the National Strategy for Suicide Prevention and the input of key consultants involved in suicide prevention strategy and research.

Key components include:

- Limiting access to lethal means for a person in crisis is an essential strategy for preventing suicide. Any objects that may be used in a suicide attempt, including firearms, other weapons, medications, illicit drugs, chemicals used in the household, other poisons, or materials used for hanging or suffocation, should not be easy for someone at risk to access. In crisis, objects such as firearms should be temporarily removed from the vicinity of the vulnerable individual.

- People at risk for suicide should be part of the lethal means safety conversation, as should their families. Safe handling and secure storage of lethal means at home at all times is encouraged, even after a crisis has passed. Lock and Talk Virginia distributes safety devices and instruction for locking medications and firearms. Safety devices provided include gun trigger locks, gun cable locks, medication lock boxes, and medication deactivation kits.

- Talking about the problem of suicide helps to save lives and reduce stigma. Talking encourages help-seeking behaviors and helps attempt survivors and survivors of suicide loss in their personal healing.

Lock and Talk Virginia gives community members the opportunity to become educated about the signs of suicide risk and how to act as a catalyst to care. Available trainings include: Mental Health First Aid; Youth Mental Health First Aid; Applied Suicide Intervention Skills Training (ASIST); and safeTALK.

Lock and Talk Virginia includes the Gun Shop Project in consultation with the Means Matter Campaign. Suicide prevention education is disseminated through firearm retail and range partners. Identifying possible signs of suicide risk, who will be a trusted individual to temporarily hold on to firearms, and connecting to crisis resources are key messages relayed through retail partners and firearm safety instructors.

“We are a Lock and Talk Family” campaign is underway. Lock your guns, lock your medications, talk safety, and talk often is the primary message of the campaign. We are

promoting the importance of everyone recognizing the benefit of becoming a Lock and Talk Family. A Lock and Talk Family may be in the home, work organization, school, or community. This campaign is used in conjunction with safety campaigns, and in DBHDS efforts for the Governor's Challenge (aimed to prevent veteran and service member suicides).

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 and other suicide prevention 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 2019, $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 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:

- Trainings in ASIST, MHFA, and safeTALK based on community need and capacity to implement
- Activities for September National Suicide Prevention Month
- Activities for May Mental Health Awareness Month

The regions also develop an evaluation and sustainability plan, including cultural considerations and competency actions, and develop a budget for implementation. The following are highlights and accomplishments that occurred as a result of the regional suicide prevention initiatives in FY 2019.

DBHDS Region 1

DBHDS Region 1 Suicide Prevention Committee continues to expand Lock and Talk Virginia (Suicide Prevention Initiative) efforts across their region and across the Commonwealth. Efforts this year included Lethal Means Safety presentations to coalitions, first responders, parents, teachers, military families, and behavioral health care providers. Region 1 continues their partnership with firearm retailers as part of the Gun Shop Project, and support of Suicide Awareness Walks/Events in their community.

Region 1 in partnership with Blue Ridge Poison Control provided 77,000 local pharmacy customers with educational materials and information on upcoming trainings and events across the region. They hosted one of six Military Culture and Suicide Prevention Summits held across the state. Additionally, in partnership with DBHDS, they also provide technical assistance to all CSBs participating in Lock and Talk Virginia.

The "We are a Lock and Talk Family" media campaign has increased visibility of the initiative. The message is promoted via social media, billboards, print and bus ads, posters, presentations, and suicide prevention events across the region. Lock and Talk families demonstrate a commitment to safety and encourage help-seeking behaviors through community conversations.

The Community Services Boards represented in Region 1 reported the following trainings provided during FY19 (total number of participants listed); Applied Suicide Intervention Skills Training (ASIST) – 284 participants, Mental Health First Aid (MHFA) – 1,200 participants, Youth Mental Health First Aid (YMHFA) – 419 participants, Teen Mental Health First Aid – 280 participants, safeTALK – 61 participants, and Crisis Intervention Training (CIT) – 229 participants. They also reported distribution of 1,980 medication lock boxes and 3,421 gun locks.

DBHDS Region 2

The Suicide Prevention Alliance of Northern Virginia (SPAN) has been working to expand their reach through multiple workgroups. Their focus areas include: Veterans and Military Service Members; Older Adults; Youth; Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ); and Multicultural communities. Workgroups provide the

opportunity for different voices to be heard and included in planning of suicide prevention efforts for the region.

Lock and Talk Virginia is promoted across the region. A start-up kit of materials which included trigger locks, cable locks, and smart pill bottles, were provided for each of the community services boards in the region and they worked within their locality to develop a strategic plan to implement Lock and Talk. SPAN also worked with COMCAST Spotlight, to develop and promote Public Service Announcements (PSA) for the regional Lock and Talk initiative. The PSAs aired from May 20, 2019 through June 30, 2019.

Youth Led Mini Grant Opportunities were offered to promote mental health awareness and suicide prevention in the schools and community. Twenty-six projects were funded by SPAN across the region. There were numerous strategies incorporated into the mini grants, all with an effort to educate their peers and empower them to reduce the stigma of mental health in their community as well as focusing on suicide prevention.

SPAN continues to offer the online mental health self-assessment package in English and Spanish. The online screening was promoted via CSB home pages, the SPAN website, and on promotional material distributed throughout the region. The tool covers a total of ten mental health issues, including psychosis, gambling behavior, depression, anxiety disorder, adolescent depression, bipolar disorder, alcohol use disorder, posttraumatic stress disorder, and substance use disorder. The screening tool can be accessed here: http://screening.mentalhealthscreening.org/northern-virginia

The community services boards represented in Region 2 reported the following trainings were provided during FY19 (total number of participants listed); Applied Suicide Intervention Skills Training (ASIST) –102 participants, Mental Health First Aid (MHFA) – 1,070 participants, Youth Mental Health First Aid (YMHFA) – 796 participants, Crisis Intervention Training (CIT) – 666 participants, Question, Persuade, Refer (QPR) 33 participants, Signs of Suicide (SOS) – 19,245, and KOGNITO (on-line simulations) – 11,713 users. They also reported distribution of 1,127 medication lock boxes and 1,262 gun locks.

DBHDS Region 3 East

DBHDS Region 3East continues to promote the #askingsaves campaign. #Askingsaves is a suicide awareness and prevention campaign centered around educating people on ways to approach loved ones who have concerns regarding their mental health wellness. While their featured campaign is #askingsaves, they distribute information on other suicide prevention campaigns, offer local trainings, and organize events that provide suicide prevention education and awareness for the community.

Localities partner with the American Foundation for Suicide Prevention to promote awareness and educate the community on how to prevent suicide. They collaborate on trainings, presentations, “Out of Darkness” events, and the distribution and promotion of suicide prevention resource. In addition, they are expanding partnerships with local

coalitions to expand initiatives. Blue Ridge partners with the Suicide Prevention Council of Roanoke Valley, Danville-Pittsylvania and Southside work Suicide Education Awareness Support, New River Valley with New River Valley Suicide Prevention Collaborative, and Piedmont with Southside Survivors Response Center.

The community services boards represented in Region 3East reported that the following trainings were provided during FY19 (total number of participants listed); Applied Suicide Intervention Skills Training (ASIST) – 245 participants, Mental Health First Aid (MHFA) – 1,017 participants, Youth Mental Health First Aid (YMHFA) – 435 participants, safeTALK – 57 participants, More than Sad – 38 participants, and Crisis Intervention Training (CIT) – 192 participants. They also reported distribution of 1,208 medication lock boxes and 13 gun locks.

DBHDS Region 3 West

DBHDS Region 3West continues to implement the "Are You Okay" program. 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 region partners with the Bristol Crisis Center to implement the program.

The "Are You Okay" media campaign provides resource information across the community in the form of magnets, coasters, door hangers, posters, and various other objects that advertise the campaign along with the National Suicide Prevention Lifeline. They reported total population exposure of 125,161 through the media campaign.

The 2019 Help, Hope, Healing Conference recorded a diverse audience of 226 concerned and caring professionals, community members and family members who represented the fields of education, prevention, recovery, crisis services, law enforcement, behavioral health, physical health and wellness, children and youth services, families and the faith based communities.

The Community Services Boards represented in Region 3West reported the following trainings were provided during FY18 (total number of participants listed); Mental Health First Aid (MHFA) – 596 participants, Youth Mental Health First Aid (YMHFA) – 175 participants , suicideTALK – 22 participants, and safeTALK – 22 participants.

DBHDS Region 4

DBHDS Region 4 is proud to be a partner in both the Mayor's Challenge and the Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Family Members (SMVF). Key action items for the Mayor's Challenge include:

- Enhancing military cultural competency (MCC) among community services providers and first responders.
- Increasing collaboration between civilian and military/veteran specific resources.

- Expanding community-based peer services for SMVF to promote help-seeking and treatment access.
- Establishing caring contacts after psychiatric hospital discharge for SMVF.

The region collaborated with the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia this year to host their annual suicide prevention conference. This year's title was 2019 Let's Talk Hope: The Crossroads between Substance Use Disorder and Suicide Prevention. The conference was an opportunity for providers to network and develop strategies to address suicide and discuss the value of community resilience and the value of peer support as part of the recovery process.

The BeWellVA website is used to promote the message that everyone has a role to play in preventing suicide. They highlight the following points to help you understand your role:

1. How you can help someone in crisis
2. How to access local resources to connect someone in crisis
3. Promotion of mental health literacy, and
4. What you can do to support your community

The Community Services Boards represented in Region 4 reported the following trainings were provided during FY19 (total number of participants listed); Applied Suicide Intervention Skills Training (ASIST) – 32 participants, Mental Health First Aid (MHFA) – 875 participants, Youth Mental Health First Aid (YMHFA) – 263 participants, safeTALK – 25 participants, general Suicide Prevention and Mental Health Wellness presentations – 116 participants, and Crisis Intervention Training (CIT) – 98 participants. They also reported distribution of 1,419 medication lock boxes and 1,041 gun locks.

DBHDS Region 5

DBHDS Region 5 hosted their 4th annual "Shatter the Silence" event. Suicide Awareness: Shatter the Silence is a collaborative prevention event bringing youth and community partners together to celebrate wellness and raise awareness of suicide in our community. This year's event featured an array of activities that focused on signs and symptoms, normalizing the conversation surrounding suicide, and learning effective coping skills. The event also encourages teens and young adults to increase their mental health literacy to promote suicide safer communities.

The Heath Planning Region V (HPR-V) Prevention Council collaborated on their first comprehensive media campaign for Lock and Talk Virginia, featuring radio and billboard advertising. A combination of fourteen stationary and digital billboards on suicide awareness and prevention are strategically placed in local neighborhoods and on the interstate throughout the region The total number of expected impressions is 3,508,874. Lock and Talk suicide awareness and prevention media messaging on radio stations will have a reach of 2,137,200 adults (18+) over the course of the campaign.

The Community Services Boards represented in Region 5 reported the following trainings were provided during FY19 (total number of participants listed); Applied Suicide

Intervention Skills Training (ASIST) – 285 participants, Mental Health First Aid (MHFA) – 932 participants, Youth Mental Health First Aid (YMHFA) – 320 participants, Talk Saves Lives – 80 participants, suicideTALK – 156 participants, More than Sad – 205 participants, and Signs of Suicide (SOS) – 1,644 participants. They also reported distribution of 755 medication lock boxes and 260 gun locks.

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 March 2019. The March training certified 15 trainers. DBHDS currently has 77 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 2019 budget included $500,000 for suicide prevention initiatives. There were 837 individuals who participated in the training between October 2018 and September 2019. As of June 30, 2019, ASIST training has been delivered to 3,140 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 2019 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, budget monitoring, and 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 September 24, 2019, Virginia has 572 MHFA instructor certifications in MHFA. There are 418 trained Adult MHFA instructors, 289 individuals trained as Youth MHFA instructors and 149 instructors are certified in both Adult and Youth MHFA. Of the certified instructors, 153 are trained in the public safety designation, 31 are trained in the fire fighters/EMS designation, 34 are trained in the veteran designation and 53 are trained in the higher education designation.

Currently Virginia has 59,934 individuals trained in Mental Health First Aid. Of the 59,934 trained, 39,941 are trained in Adult MHFA and 19,993 are trained in Youth MHFA. As for the designation under the Adult MHFA - 5,210 are trained in the public safety module, 2,243 are trained in the higher education module, 386 trained in the veteran module, 696 trained in the older adult module and 152 trained in the rural adult. We also have 305 individuals that were trained in the Spanish adult MHFA program.

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.

Suicide Prevention Resource Materials

DBHDS provides mental health promotion and suicide prevention education resources at events throughout the state. The tables are staffed by the suicide prevention coordinator or the Mental Health First Aid program coordinator. The resources are offered free of charge to participants. Materials are representative of those mental health issues most commonly diagnosed across the lifespan and promote mental health wellness across the lifespan. The goal is to increase awareness of and access to resources to promote wellness through prevention, advocacy, and education.

This year, resources were provided at several events including community activities across the state supported by the localities, the Be Well Virginia Suicide Prevention Conference, Regional Military Culture and Suicide Prevention Summits, Department of Education Conference, Veterans Administration Resource Fair, Virginia Fire and Rescue Conference, Department of Criminal Justice Conferences, Southwest Virginia Help, Hope, Healing Conference, and the Virginia Association of Community Service Boards Conferences.

The resources are primarily available through the Substance Abuse Mental Health Services Administration (SAMHSA), the National Institutes of Health (NIH), and the National Institutes on Mental Health (NIMH). Additional materials that promote trainings offered by DBHDS are also provided.

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 partnership with the Virginia Department of Health (VDH), we have been able to continue funding (approximately $150,000) from the Garrett Lee Smith Grant to five CSBs to implement the Zero Suicide initiative. The goal is to decrease suicide ideation, attempts, and deaths. Their implementation and evaluation processes will be used to guide other sites in efforts towards adoption of the 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.

Mayor's and Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families

Building on the work of the Richmond Mayor's Suicide Prevention Challenge for Military Service Members, Veterans, and Families (SMVF), Governor Northam accepted Virginia's invitation to host a Governor's Challenge to Prevent Suicide among SMVF. The Governor's Challenge is sponsored nationally by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Veterans Affairs (VA). The Challenge brings together interagency teams from around the Nation to develop and implement a strategic action plan to improve statewide suicide prevention efforts for Military Service Members, Veterans, and Families (SMVF).

The VA estimates that 20 veterans die by suicide every day; of the 20, only six were connected with the VA for healthcare prior to their deaths. Veterans and service members are at a greater risk for suicide than civilians. The Veterans Health Administration (VHA) reported that the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults in 2017 (after adjusting for population differences in age and sex). VHA also reported that there were 919 suicides among never federally activated former National Guard and Reserve members in 2017, an average 2.5 suicide deaths per day. The Virginia Violent Death Reporting System (VVDRS) reported that 3,250 veterans and service members died by suicide in Virginia (from 2003 to 2017). The use of a firearm is the leading means in suicide deaths.

Virginia was chosen as one of the first seven states nationwide (also including: AZ, CO, KS, MT, NH, and TX) to host this Challenge. The Virginia Governor's Challenge is co-led by the Secretary of Veterans and Defense Affairs and the Secretary of Health and Human Resources. The team membership includes federal agencies, including Veterans Affairs (VA) and the Department of Defense; state agencies, including the Virginia Department of Veterans Services (DVS), the Virginia National Guard, the Virginia Department of Behavioral Health and Developmental Services, the Virginia Department of Health, the Virginia Department of Social Services, the Virginia Department of Medical Assistance Services, Virginia State Police, and Virginia Department of Education; and other critical partners including the Virginia Hospital and Healthcare Association and National Alliance on Mental Illness, and Richmond Behavioral Health Authority.

The theme of the Virginia Governor's Challenge is the "3Cs – Care, Connect, and Communicate":

- *Care:* The provision of accessible and culturally competent behavioral health services.
- *Connect:* Bringing military/veteran specific and community services together; forming systemic partnerships.
- *Communicate:* Educating the SMVF population on resources and behavioral health providers on military culture and suicide prevention best practices.

Key Strategy Highlights for 3Cs:

- *Care Strategy:* Identify and support SMVF at risk of suicide through asking the question, "*have you or a family member served in the military?"* and suicide risk screening in community services.
- *Connect Strategy***:** Increase engagement between Veterans Health Administration (VHA), Virginia Department of Veterans Services (DVS), and partner organizations for SMVF referrals.
- *Communicate Strategy:* Expand lethal means safety (particularly firearm safety) training to community stakeholders.

It is imperative that community organizations know if their services are reaching our military and veteran families. Screening for military/veteran/family member status and suicide risk is an essential first step in getting behavioral health and support services to Military Service Members, Veterans, and their families (SMVF). Once identified, there must be efficient connections to services, as SMVF seek assistance through various sources.

The Virginia Governor's Challenge team is ensuring that initiatives are in place to meet military and veteran families where they *live, work, and thrive*. The Richmond Mayor's Suicide Prevention Challenge continues and the regional team serves as an implementation partner for Governor's Challenge action items. Building suicide safe communities with efficient access to care is essential to ensure that the Commonwealth of Virginia is the most military and veteran-friendly state in the Nation.

Suicide Prevention Interagency Advisory Group (SPIAG)

The Suicide Prevention Interagency Advisory Group currently includes DBHDS, VDH (including the Office of the Chief Medical Examiner), Virginia Department of Education (DOE), Virginia Department of Criminal Justice (DCJS), Virginia Department of Veterans Services (DVS), American Foundation for Suicide Prevention (AFSP), the Virginia Association of Community Services Boards (VACSB), the Campus Suicide Prevention Center of Virginia, 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 Department coordinates the activities of the agencies of the Commonwealth pertaining to suicide prevention in order to develop and carry out a comprehensive suicide prevention plan addressing public awareness, the promotion of health development, early identification, intervention and treatment, and support to survivors. SPIAG meets bimonthly utilizing the *Suicide Prevention across the Lifespan Plan for the Commonwealth* as their framework.

Suicide Prevention across the Lifespan Plan for the Commonwealth

The *Suicide Prevention across the Lifespan Plan for the Commonwealth* 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 (VHI) 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 *Virginia Suicide Prevention Resource 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. 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

Suicide is complicated and tragic; there are almost always multiple contributing factors. Each person has their own story as to what led them to these extreme measures - it is our responsibility to intercept along the way and ensure they receive the services needed. It is important to maximize prevention and intervention services to minimize the number of suicides and suicide attempts in our communities. Providing support services, talking about suicide, reducing access to means of self-harm and following up with loved ones are just some of the actions we can all take to help save a life.

Effective suicide prevention efforts require the engagement and commitment of multiple sectors and agencies. DBHDS continues to be 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 will continue to strengthen capacity across multiple agencies and organizations to impact our ability to reduce the risk of suicide across the lifespan.

Appendix A: Suicide Death Data

The data reported in the following tables represents the number, percentage, and rate of suicide deaths in Virginia by DBHDS region from 2003 to 2017. Suicide decedents are reported based on locality of residence. These tables include breakdowns for demographics, injury, and select decedent and incident characteristics.

Data were drawn from the National Violent Death Reporting System (NVDRS), which documents violent deaths occurring within a state's borders. It compiles information from sources involved in violent death investigations, and links victims to circumstances of their deaths, such as drug and alcohol use, mental illness, intimate partner violence, and the other events leading up to and contributing to the violent death. 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 July 9, 2019. Data may continue to be entered and updated in VVDRS after this date.

The Office of the Chief Medical Examiner's Annual Report, 2017 provides the following data on suicide deaths:

- Number and Rate of Suicide Deaths by Year of Death, 1999-2017
- Number and Rate of Suicide Deaths by Age Group and Gender, 2017
- Percentage of Suicide Deaths by Race/Ethnicity, 2017
- Number and Rate of Suicide Deaths by Race/Ethnicity and Gender, 2017
- Number of Suicide Deaths by Cause and Method of Death, 2017
- Number of Suicide Deaths by Age Group and Ethanol Level, 2017
- Number of Suicide Deaths by Gender and Ethanol Level, 2017
- Number of Suicide Deaths by Manner of Death and Ethanol Level, 2017
- Number of Suicide Deaths by Month of Death, 2017
- Number of Suicide Deaths by Day of the Week, 2017
- Number and Rate of Suicide Deaths by Locality of Residence, 2017
- Number of Suicides Deaths by Locality of Injury and Year of Death, 2006-2017

The Office of the Chief Medical Examiner's Annual Report, 2017 can be downloaded at, http://www.vdh.virginia.gov/content/uploads/sites/18/2019/04/Annual-Report-2017.pdf.

Table 1: Selected Demographics of Suicide Decedents in Virginia by Region: 2003-2017

	Virginia			Region 1			Region 2			Region 3: East		
	N= 14,649			N= 3,153			N= 2,821			N= 1,673		
	Num.	%	Rate[1]	Num.	%	Rate	Num.	%	Rate	Num.	%	Rate
Sex												
Male	11,311	77.2	19.2	2,475	78.5	22.5	2,071	73.4	12.5	1,333	79.7	24.0
Female	3,338	22.8	5.5	678	21.5	5.9	750	26.6	4.5	340	20.3	5.9
Age Group[2]												
10-14	95	0.6	1.2	32	1.0	2.2	18	0.6	0.8	6	0.4	0.9
15-19	656	4.5	8.2	133	4.2	8.1	164	5.8	8.1	65	3.9	8.2
20-24	1,137	7.8	13.3	214	6.8	12.2	232	8.2	11.9	110	6.6	11.9
25-34	2,266	15.5	13.7	439	13.9	15.3	505	17.9	9.8	236	14.1	17.5
35-44	2,575	17.6	15.3	540	17.1	18.4	496	17.6	9.1	295	17.6	21.0
45-54	3,064	20.9	17.6	696	22.1	21.5	583	20.7	11.6	333	19.9	20.8
55-64	2,330	15.9	16.6	501	15.9	18.6	454	16.1	12.2	258	15.4	17.3
65-74	1,308	8.9	15.1	297	9.4	16.5	194	6.9	10.4	195	11.7	18.5
75-84	847	5.8	17.9	214	6.8	21.1	130	4.6	15.1	118	7.1	18.8
85+	370	2.5	19.7	87	2.8	22.1	45	1.6	12.6	57	3.4	22.8
Unknown	1	0.0	-	0	0.0	-	0	0.0	-	0	0.0	-
Race												
White	12,715	86.8	14.6	2,960	93.9	15.5	2,300	81.5	9.6	1,532	91.6	17.0
Black	1,428	9.7	5.8	165	5.2	5.8	230	8.2	5.4	126	7.5	6.0
Asian	400	2.7	5.6	19	0.6	4.2	277	9.8	5.7	12	0.7	6.1
Native American	21	0.1	3.5	3	0.1	3.2	2	0.1	0.9	0	0.0	0.0
Other	6	0.0	-	0	0.0	-	0	0.0	-	0	0.0	-
Unspecified	23	0.2	-	0	0.0	-	1	0.0	-	0	0.0	-
Two or More	56	0.4	-	6	0.2	-	11	0.4	-	3	0.2	-
Ethnicity												
Hispanic[3]	382	2.6	4.2	44	1.4	3.8	188	6.7	3.5	16	1.0	5.2
Military												
Veteran[4]	3,250	22.2	-	643	20.4	-	539	19.1	-	348	20.8	-
Year												
2003	797	5.4	10.8	166	5.3	12.3	138	4.9	7.1	100	6.0	13.4
2004	818	5.6	11.0	178	5.6	12.9	132	4.7	6.7	100	6.0	13.5
2005	857	5.9	11.3	176	5.6	12.5	170	6.0	8.4	113	6.8	15.2
2006	873	6.0	11.4	181	5.7	12.6	158	5.6	7.7	105	6.3	14.1
2007	867	5.9	11.2	184	5.8	12.6	166	5.9	8.0	118	7.1	15.8
2008	936	6.4	12.0	200	6.3	13.6	190	6.7	9.0	107	6.4	14.2
2009	956	6.5	12.1	191	6.1	12.9	206	7.3	9.5	87	5.2	11.5
2010	982	6.7	12.3	212	6.7	14.0	191	6.8	8.6	112	6.7	14.6
2011	1,036	7.1	12.8	218	6.9	14.3	188	6.7	8.2	120	7.2	15.7
2012	1,037	7.1	12.7	219	6.9	14.2	200	7.1	8.5	111	6.6	14.5
2013	1,047	7.1	12.7	225	7.1	14.5	225	8.0	9.4	111	6.6	14.5
2014	1,112	7.6	13.4	248	7.9	15.8	223	7.9	9.2	109	6.5	14.2
2015	1,074	7.3	12.8	263	8.3	16.6	188	6.7	7.7	106	6.3	13.8
2016	1,126	7.7	13.4	236	7.5	14.8	226	8.0	9.2	139	8.3	18.2
2017	1,131	7.7	13.4	256	8.1	15.9	220	7.8	8.8	135	8.1	17.7
TOTAL	**14,649**	**100.0**	**12.3**	**3,153**	**100.0**	**14.0**	**2,821**	**100.0**	**8.4**	**1,673**	**100.0**	**14.7**

[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.

Table 1: Selected Demographics of Suicide Decedents in Virginia by Region: 2003-2017 (cont.)

	Region 3: West			Region 4			Region 5			Unknown		
	N= 1,302			N= 2,436			N= 3,235			N= 29		
	Num.	%	Rate	Num.	%	Rate	Num.	%	Rate	Num.	%	Rate
Sex												
Male	1,045	80.3	35.7	1,856	76.2	20.0	2,507	77.5	18.7	24	82.8	-
Female	257	19.7	8.6	580	23.8	5.9	728	22.5	5.2	5	17.2	-
Age Group[2]												
10-14	2	0.2	0.6	15	0.6	1.2	22	0.7	1.2	0	0.0	-
15-19	32	2.5	9.2	106	4.4	8.0	154	4.8	8.1	2	6.9	-
20-24	70	5.4	19.9	192	7.9	14.4	315	9.7	14.1	4	13.8	-
25-34	177	13.6	24.8	357	14.7	13.8	548	16.9	14.1	4	13.8	-
35-44	244	18.7	31.5	429	17.6	16.2	563	17.4	15.6	8	27.6	-
45-54	287	22.0	32.8	519	21.3	18.4	642	19.8	16.9	4	13.8	-
55-64	218	16.7	26.3	430	17.7	18.6	465	14.4	15.3	4	13.8	-
65-74	159	12.2	26.5	211	8.7	15.3	250	7.7	12.9	2	6.9	-
75-84	87	6.7	25.4	121	5.0	15.8	177	5.5	16.0	0	0.0	-
85+	26	2.0	21.4	56	2.3	17.5	99	3.1	22.9	0	0.0	-
Unknown	0	0.0	-	0	0.0	-	0	0.0	-	1	3.4	-
Race												
White	1,269	97.5	22.2	1,971	80.9	16.2	2,663	82.3	15.5	20	69.0	-
Black	30	2.3	17.4	398	16.3	6.5	473	14.6	5.3	6	20.7	-
Asian	2	0.2	7.7	35	1.4	5.5	53	1.6	5.1	2	6.9	-
Native American	0	0.0	0.0	13	0.5	13.3	3	0.1	2.0	0	0.0	-
Other	0	0.0	-	2	0.1	-	4	0.1	-	0	0.0	-
Unspecified	1	0.1	-	6	0.2	-	14	0.4	-	1	3.4	-
Two or More	0	0.0	-	11	0.5	-	25	0.8	-	0	0.0	-
Ethnicity												
Hispanic[3]	14	1.1	16.4	41	1.7	4.7	79	2.4	5.8	0	0.0	-
Military												
Veteran[4]	245	18.8	-	481	19.7	-	989	30.6	-	5	17.2	-
Year												
2003	78	6.0	19.7	133	5.5	11.4	181	5.6	10.2	1	3.4	-
2004	94	7.2	23.7	123	5.0	10.4	191	5.9	10.7	0	0.0	-
2005	94	7.2	23.7	132	5.4	11.0	172	5.3	9.6	0	0.0	-
2006	75	5.8	18.9	156	6.4	12.8	197	6.1	11.0	1	3.4	-
2007	83	6.4	21.1	127	5.2	10.3	189	5.8	10.5	0	0.0	-
2008	86	6.6	21.8	145	6.0	11.6	208	6.4	11.5	0	0.0	-
2009	99	7.6	25.0	179	7.3	14.2	194	6.0	10.7	0	0.0	-
2010	84	6.5	20.9	145	6.0	11.3	236	7.3	13.0	2	6.9	-
2011	90	6.9	22.5	178	7.3	13.8	241	7.4	13.3	1	3.4	-
2012	84	6.5	21.1	178	7.3	13.7	242	7.5	13.2	3	10.3	-
2013	86	6.6	21.7	189	7.8	14.4	202	6.2	11.0	9	31.0	-
2014	77	5.9	19.6	185	7.6	13.9	265	8.2	14.4	5	17.2	-
2015	95	7.3	24.3	175	7.2	13.1	243	7.5	13.1	4	13.8	-
2016	87	6.7	22.6	192	7.9	14.2	244	7.5	13.1	2	6.9	-
2017	90	6.9	23.6	199	8.2	14.6	230	7.1	12.4	1	3.4	-
TOTAL	**1,302**	**100.0**	**22.0**	**2,436**	**100.0**	**12.8**	**3,235**	**100.0**	**11.9**	**29**	**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.

Table 2: Selected Injury Characteristics of Suicide Decedents in Virginia: 2003-2017

	Virginia		Region 1		Region 2		Region 3: East		Region 3: West		Region 4		Region 5		Unknown	
	N= 14,649		N= 3,153		N= 2,821		N= 1,673		N= 1,302		N= 2,436		N= 3,235		N= 29	
	Num.	%[1]	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%	Num.	%
Mechanism of Injury[1]																
Firearm	8,274	56.5	1,925	61.1	1,177	41.7	1,058	63.2	918	70.5	1,376	56.5	1,808	55.9	12	41.4
Asphyxia	3,161	21.6	568	18.0	786	27.9	311	18.6	193	14.8	517	21.2	783	24.2	3	10.3
Poison	2,348	16.0	531	16.8	602	21.3	222	13.3	160	12.3	361	14.8	464	14.3	8	27.6
Drowning	200	1.4	27	0.9	39	1.4	15	0.9	7	0.5	47	1.9	63	1.9	2	6.9
Sharp Instrument	263	1.8	36	1.1	83	2.9	31	1.9	11	0.8	46	1.9	56	1.7	0	0.0
Fall	291	2.0	36	1.1	124	4.4	27	1.6	5	0.4	54	2.2	43	1.3	2	6.9
Motor Vehicle	113	0.8	32	1.0	27	1.0	5	0.3	6	0.5	24	1.0	16	0.5	3	10.3
Fire/Burns	63	0.4	15	0.5	11	0.4	7	0.4	3	0.2	15	0.6	12	0.4	0	0.0
Other Transport Vehicle	68	0.5	16	0.5	25	0.9	8	0.5	2	0.2	7	0.3	9	0.3	1	3.4
Intentional Neglect	2	0.0	0	0.0	1	0.0	0	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	0	0.0
Blunt Instrument	3	0.0	1	0.0	1	0.0	0	0.0	0	0.0	0	0.0	1	0.0	0	0.0
Other	37	0.3	8	0.3	9	0.3	6	0.4	2	0.2	3	0.1	9	0.3	0	0.0
Premise of Injury																
House	10,998	75.1	2,391	75.8	2,074	73.5	1,275	76.2	1,060	81.4	1,781	73.1	2,411	74.5	6	20.7
Vehicle	1040	7.1	238	7.5	186	6.6	115	6.9	83	6.4	188	7.7	224	6.9	6	20.7
Natural Area	781	5.3	192	6.1	150	5.3	75	4.5	56	4.3	139	5.7	165	5.1	4	13.8
Hotel or Motel	341	2.3	59	1.9	91	3.2	26	1.6	10	0.8	58	2.4	95	2.9	2	6.9
Jail or Detention Center	241	1.6	42	1.3	18	0.6	39	2.3	22	1.7	53	2.2	67	2.1	0	0.0
Street, Road, or Sidewalk	171	1.2	41	1.3	22	0.8	21	1.3	16	1.2	30	1.2	40	1.2	1	3.4
Park or Playground	147	1.0	12	0.4	58	2.1	13	0.8	4	0.3	37	1.5	22	0.7	1	3.4
Public Parking Lot or Garage	156	1.1	30	1.0	46	1.6	18	1.1	7	0.5	25	1.0	28	0.9	2	6.9
Other	759	5.2	145	4.6	174	6.2	87	5.2	44	3.4	122	5.0	180	5.6	7	24.1
Unknown	15	0.1	3	0.1	2	0.1	4	0.2	0	0.0	3	0.1	3	0.1	0	0.0
Injured at Decedent's Home	10,853	74.1	2,389	75.8	2,084	73.9	1,245	74.4	1,030	79.1	1,751	71.9	2,353	72.7	1	3.4

[1]More than one mechanism of injury can be used in a fatal agent. The number of mechanisms (N=14,825) exceeds the number of decedents. Totals will exceed 100.0%.

Table 3: Selected Decedent and Incident Characteristics Among Suicide Decedents in Virginia: 2003-2017

	Virginia		Region 1		Region 2		Region 3: East	
	N= 14,264		N= 3,074		N= 2,777		N= 1,629	
	Num.	%[1]	Num.	%	Num.	%	Num.	%
Mental Health and Addiction								
Mental Health Diagnosis[2]	8,121	56.9	1,772	57.6	1,865	67.2	816	50.1
Depression	578	*7.1*	*101*	*5.7*	*146*	*7.8*	*68*	*8.3*
Anxiety	1,939	*23.9*	*408*	*23.0*	*503*	*27.0*	*194*	*23.8*
Bipolar	1,243	*15.3*	*298*	*16.8*	*284*	*15.2*	*101*	*12.4*
Received Treatment	6,949	85.6	1,494	84.3	1,596	85.6	679	83.2
Treated, Within Two Months	5,883	*72.4*	*1,260*	*71.1*	*1,286*	*69.0*	*609*	*74.6*
Treated, Prior to Two Months	1,066	*13.1*	*234*	*13.2*	*310*	*16.6*	*70*	*8.6*
Alcohol Problem	2,716	19.0	660	21.5	596	21.5	249	15.3
Substance Problem	2,369	16.6	540	17.6	434	15.6	292	17.9
Relationship Problems								
Intimate Partner[3]	4,803	33.7	1,040	33.8	908	32.7	534	32.8
Argument	1,344	9.4	320	10.4	250	9.0	151	9.3
Family Member	1,414	9.9	335	10.9	414	14.9	135	8.3
Other Relationship[4]	315	2.2	53	1.7	98	3.5	44	2.7
Life Stressors								
Crisis within Two Weeks	5,833	40.9	1,334	43.4	1,204	43.4	651	40.0
Physical Health Problem[5]	1,051	7.4	233	7.6	227	8.2	99	6.1
Job Problems	1,844	12.9	359	11.7	600	21.6	129	7.9
Criminal Legal Problems	1,673	11.7	372	12.1	306	11.0	183	11.2
Financial Problems	1,840	12.9	409	13.3	560	20.2	135	8.3
Suicide Characteristics								
Current Depressed Mood	5,367	37.6	1,195	38.9	1,231	44.3	538	33.0
Left a Suicide Note	5,121	35.9	1,094	35.6	1,100	39.6	546	33.5
Disclosed Intent[6]	5,739	40.2	1,268	41.2	1,264	45.5	619	38.0
Prior Attempts	3,076	21.6	641	20.9	727	26.2	266	16.3

[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 longer).

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

Table 3: Selected Decedent and Incident Characteristics Among Suicide Decedents in Virginia: 2003-2017 (cont.)

	Region 3: West		Region 4		Region 5		Unknown	
	N= 1,260		N= 2,367		N= 3,129		N= 28	
	Num.	%	Num.	%	Num.	%	Num.	%
Mental Health and Addiction								
Mental Health Diagnosis[2]	685	54.4	1,337	56.5	1,626	52.0	20	71.4
Depression	*51*	*7.4*	*93*	*7.0*	*114*	*7.0*	*5*	*25.0*
Anxiety	*171*	*25.0*	*279*	*20.9*	*379*	*23.3*	*5*	*25.0*
Bipolar	*75*	*10.9*	*222*	*16.6*	*260*	*16.0*	*3*	*15.0*
Received Treatment	551	80.4	1,207	90.3	1,407	86.5	15	75.0
Treated, Within Two Months	*495*	*72.3*	*1,042*	*77.9*	*1,180*	*72.6*	*11*	*55.0*
Treated, Prior to Two Months	*56*	*8.2*	*165*	*12.3*	*227*	*14.0*	*4*	*20.0*
Alcohol Problem	194	15.4	432	18.3	577	18.4	8	28.6
Substance Problem	237	18.8	414	17.5	441	14.1	11	39.3
Relationship Problems								
Intimate Partner[3]	431	34.2	782	33.0	1,098	35.1	10	35.7
Argument	118	9.4	232	9.8	271	8.7	2	7.1
Family Member	102	8.1	199	8.4	220	7.0	9	32.1
Other Relationship[4]	13	1.0	51	2.2	54	1.7	2	7.1
Life Stressors								
Crisis within Two Weeks	495	39.3	972	41.1	1,161	37.1	16	57.1
Physical Health Problem[5]	93	7.4	194	8.2	203	6.5	2	7.1
Job Problems	67	5.3	299	12.6	387	12.4	3	10.7
Criminal Legal Problems	141	11.2	323	13.6	344	11.0	4	14.3
Financial Problems	76	6.0	303	12.8	349	11.2	8	28.6
Suicide Characteristics								
Current Depressed Mood	429	34.0	846	35.7	1,120	35.8	8	28.6
Left a Suicide Note	386	30.6	876	37.0	1,108	35.4	11	39.3
Disclosed Intent[6]	512	40.6	941	39.8	1,125	36.0	10	35.7
Prior Attempts	198	15.7	566	23.9	671	21.4	7	25.0

[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 longer).

[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