COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

DEPARTMENT OF
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Post Office Box 1797
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www.dbhds.virginia.gov

December 3, 2020

Governor Ralph S. Northam
Patrick Henry Building
111 E Broad Street
Richmond, VA 23219

Dear Governor Northam:

§ 37.2-312.1 of the Code of Virginia requires the Department of Behavioral Health and Developmental Services (DBHDS) to report annually on its activities related to suicide prevention. The language reads:

> *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.*

In accordance with this requirement, please find enclosed the report for regarding suicide prevention activities. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE
Commissioner
Department of Behavioral Health & Developmental Services

CC:
Daniel Carey, MD
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

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December 3, 2020

Lieutenant Governor Justin E. Fairfax
102 Governor Street
Richmond, VA 23219

Dear Lieutenant Governor Fairfax:

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December 3, 2020

The Honorable Eileen Filler-Corn, Speaker
Virginia House of Delegates
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Speaker Filler-Corn:

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Sincerely,

Alison G. Land, FACHE
Commissioner, Department of Behavioral Health & Developmental Services

CC:
Daniel Carey, MD
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

DBHDS Annual Report on Activities Related to Suicide Prevention

(§ 37.2-312.1)

December 3, 2020

DBHDS Vision: A Life of Possibilities for All Virginians

DBHDS Annual Report on Activities Related to Suicide Prevention

Preface

§ 37.2-312.1 of the Code of Virginia requires the Department of Behavioral Health and Developmental Services (DBHDS) to report annually on its activities related to suicide prevention. The language reads:

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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 the tenth leading cause of death in the United States and the second leading cause of death for people 10 to 34 years of age. The impact of suicide and suicide attempts on the community has been shown to affect over half of the population and is estimated to cost billions per year in lost productivity. Additionally, being a survivor or someone with lived experience increases one's risk of suicide. For these reasons it remains imperative that efforts are undertaken to ensure a comprehensive, evidence-based system is in place to respond to this need.

In a report released by the Virginia Department of Health (VDH) in July 2020, stated that in 2018 (the most recent data available) suicide was the tenth leading cause of death in Virginia. Furthermore, the report noted a 25 percent increase in suicide deaths from 2010 to 2018 with a slight decrease in 2019. While the causes of suicide are complex and determined by multiple factors, the goal of suicide prevention is to engage with these complexities on a variety of social-ecological levels, that is, individual, relational, communal, and societal. This work primarily occurs through the identification of factors that help to reduce the risk of suicide to individuals, (i.e. protective factors), and the factors that increase risk of suicide to individuals (i.e. risk factors). While the research, development, and implementation of these efforts remains critical, it is important to recognize that these efforts will not be effective unless they are supported through robust campaigns designed to increase awareness, promote help-seeking strategies, and support healing across communities.

In recent years, research has continued to build on the evidence base for factors associated with increased risk of an individual dying by suicide. Some of these risks include alcohol use, feelings of hopelessness, isolation, barriers to mental health access, and loss. While rates of suicide continue to increase, the impact of Covid-19 and the necessary response to reduce deaths as a result of this pandemic must acknowledge the potential catalyzing effect on risk factors in the Virginia community. Furthermore, due to concerns surrounding community spread of the Covid-19 virus, many in-person trainings to build capacity for gatekeepers within communities were cancelled; stressing the importance of continued efforts to improve internet connectivity throughout the state. While the true impact of Covid-19 will likely take years to understand, it is imperative that Virginia recognize the serious and continued need for mental health resources. A comprehensive, evidence-based public health approach to prevent suicide risk before it occurs (prevention), identify and support persons at risk (intervention), prevent reattempts, and help friends, family, and community members in the aftermath of a suicide (postvention) is needed. This report provides an overview of the Department's activities related to suicide prevention across the lifespan.

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

Introduction

DBHDS is pleased to submit its FY 2020 Annual Report on Activities Related to Suicide Prevention pursuant to § 37.2-312.1 of the Code of Virginia. In general, suicide deaths have been slowly increasing since 1999. The number of suicide deaths in 2018 compared to 2017 increased 4.7 percent. The largest number of victims were male (76.5%), White (81.4%), and aged 55-64 years of age (19.4%). Males 75-84 years of age and older as well as white males had the highest rates of suicide compared to other groups within the total population (39.9 and 28.3 per 100,000 persons, respectively).

- Whites died by suicide at a rate 4.2 times that of Hispanics, 3.1 times that of Asians, and 2.5 times that of Blacks
- Males were 3.4 times more likely to die by suicide than females
- Firearms (specifically handguns), hangings, and drug use were the three most commonly used methods in suicides, with these deaths representing 55.6 percent, 23.5 percent, and 11.3 percent of all suicides, respectively

The Federal Department of Veterans Affairs (VA) estimates that 17 veterans died by suicide every day in 2017; of this number, 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.

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. Due to delays in data collection and the retrospective nature of fatality surveillance, Virginia Violent Death Reporting System (VVDRS) data beyond 2017 will not be available until later in 2021.

In FY2014, a $1,100,000 ongoing appropriation was allotted to 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 promote suicide prevention, reduce stigma, and promote help-seeking behaviors.

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: Lethal Means Safety Initiative

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 35 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 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 (Suicide Alertness for Everyone).

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.

Lock your guns, lock your meds, talk safety, and talk often is the primary message of the "We are a Lock and Talk Family" 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 your home, work organization, school, or community. This campaign is used in conjunction with safety campaigns, and in DBHDS efforts for the Virginia Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families. Media messages are in the form of billboards, bus ads, PSAs, newspaper ads, social media posts as well as a variety of other platforms.

Of the participating CSBs in the Lock and Talk Initiative, 31 reported the following from October 1, 2019 – September 30, 2020:

- Number of Medication Lock Boxes Distributed – 9,727
- Number of Gun Locks Distributed – 5,248
- Number of Firearm Retail Partners (to promote suicide prevention) – 204

As a celebratory end to Suicide Prevention Awareness month, DBHDS partnered with the Virginia National Guard to expand lethal means safety for Service Members and their families with the purchase of 3,744 trigger locks for firearms and 939 medication lock boxes. This bolstered the National Guard inventory significantly which only contained cable locks for firearms. Putting time and distance between a loved one and their access to lethal means during a crisis can reduce suicide rates. The Governor's Challenge and the Lock and Talk Virginia initiative prioritize lethal means safety because approximately 70 percent of suicides among veterans are by firearms. 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.

Regional Suicide Prevention Initiatives

DBHDS currently funds regional suicide prevention initiatives across the Commonwealth. 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 2020, $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.
- DBHDS 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. There were significant shifts and changes required due to COVID-19 in regards to program offerings, community events, and training opportunities. However, the communities are resilient and the teams are creative. They used this time to continue to build relationships and to enhance and refine communications and community supports. The following are highlights and accomplishments that occurred as a result of the regional suicide prevention initiatives in FY 2020.

DBHDS Region 1

In partnership with the Office of Behavioral Health Wellness, DBHDS Region 1 Suicide Prevention Committee continues to expand the Lock and Talk Virginia (Lethal Means Safety Initiative) efforts across the Commonwealth. The Lock and Talk Virginia training manual was updated in February 2020. It includes new materials, edits and updates to messaging, and official guidelines for using Lock and Talk. A regional training was held March 2020. A Lock and Talk newsletter is being distributed to keep partners aware of updated resources and to share the work happening across the state.

Virtual training was provided for current and new partners to support their implementation efforts. Topics discussed in the training included Lock and Talk website updates, the four main components of the Lock and Talk Initiative (gatekeeper trainings, lethal means safety distribution, the Gun Shop Project, and the "We are a Lock and Talk Family" media campaign). Currently, 35 CSBs have signed contracts as official Lock and Talk partners. Additionally,

several states participating in the Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Families have inquired regarding using the Lock and Talk Initiative as a part of their action plans.

Region 1 shifted their annual suicide prevention awareness event to virtual format this year. The event titled "Opioid Addiction, Suicide Risk, and Recovery" was held August 12, 2020. The speaker addressed 128 virtual attendees, speaking to both personal and professional experience with addiction and suicide. Suicide awareness events and trainings have also shifted to virtual formats. Events hosted in Region 1 included the following: virtual awareness walks, webinars focused on decreasing mental health stigma, radio interviews sharing the impact of COVID-19 and social distancing on families and mental health, posts promoting positive coping strategies, virtual community discussions, and Suicide Prevention month podcasts.

The Community Services Boards represented in Region 1 reported the following trainings provided during FY20 (total number of participants listed):

- Mental Health First Aid (MHFA) – 767 participants
- Youth Mental Health First Aid (YMHFA) – 141 participants
- Teen Mental Health First Aid – 210 participants
- safeTALK – 72 participants
- Crisis Intervention Training (CIT) – 101 participants

DBHDS Region 2

The Suicide Prevention Alliance of Northern Virginia (SPAN) continues to share and promote an array of public supports and resources across the region. Their implementation timeline identified four key priorities for the year: Lethal Means Safety (specifically the Lock and Talk Initiative), Suicide Prevention Awareness – with a focus on their military population, Communications (including the SPAN website and newsletter), and promoting suicide prevention and mental health wellness trainings for the community.

The SPAN website offers links to emergency services, a community events calendar, and access to online mental health screenings among other resources. From October 1, 2019 through September 30, 2020, there were 1,891 completed screenings. There are 13 screening categories available. The website link is http://www.suicidepreventionnva.org/. They continue to market and promote locally-produced suicide prevention video PSAs through Facebook & Twitter. The PSAs direct viewers to the PRS Crisis Link Textline - "CONNECT" to 85511. Lock and Talk Virginia is promoted across the region. SPAN produced Lock and Talk PSAs that can be found on their website along with a link to the Virginia www.lockandtalk.org website.

Virtual activities hosted by SPAN this year included the following: 'Strengthening Resiliency and Preventing Suicide During COVID-19" Forum, Youth Suicide Prevention Facebook Live event, 'How You Can Prevent Opioid Misuse in Your Community' webinar, 'The Developing Brain Virtual Workshop on Adverse Childhood Experiences', and a weekly social media plan to promote September Suicide Awareness Month activities. SPAN team meetings are also hosted virtually at this time.

The Community Services Boards represented in Region 2 reported the following trainings were provided during FY 20 (total number of participants listed):

- Applied Suicide Intervention Skills Training (ASIST) –27 participants
- Mental Health First Aid (MHFA) – 564 participants
- Youth Mental Health First Aid (YMHFA) – 707 participants
- Crisis Intervention Training (CIT) – 112 participants
- Signs of Suicide (SOS) – 157
- safeTALK – 19 participants
- KOGNITO (on-line simulations) – 15,115 users

DBHDS Region 3 East

In April 2020, Region 3E completed a Data Assessment and Regional Suicide Prevention Implementation Plan with the support of staff at Virginia Tech Center for Public Health Practice and Research. The outcomes included are comprehensive for the entire five-year goals and objectives period of the Regional Suicide Prevention Plan. The community-driven suicide prevention plan incorporates the beliefs and perspectives of key suicide prevention stakeholders throughout the region, to provide a framework supporting effective and appropriate local prevention strategies for the years to come.

This year Region 3E started a website at the domain of https://askingsaves.org. The website provides resources, highlights suicide prevention events, and offers access to various help lines. It also connects viewers to each of the five CSBs for additional support if needed. Additionally, they promote awareness and provide training opportunities for community.

Virtual events hosted by Region 3East include the following: Talk Saves Lives training, Adverse Childhood Experiences training, promotion of September Suicide Prevention Awareness Month activities, and team meetings. Social media was utilized to promote a self-care campaign and a 'Spreading Kindness' campaign (outreach by youth to the older adult population).

The Community Services Boards represented in Region 3East reported that the following trainings were provided during FY20 (total number of participants listed):

- Applied Suicide Intervention Skills Training (ASIST) – 219 participants
- Mental Health First Aid (MHFA) – 415 participants
- Youth Mental Health First Aid (YMHFA) – 304 participants
- safeTALK – 191 participants
- More than Sad – 30 participants
- Talk Saves Lives – 30 participants.

DBHDS Region 3 West

The "Are You Okay" program continues to operate at the Bristol Crisis Center serving all of Southwest Virginia. Call answer capacity has potential for increase with Mount Rogers and CMCSB staff now trained in ASIST. This will allow them to answer overflow calls during the

COVID-19 pandemic. The "Are You Okay" program is advertised on social media, in faith-based communities, and to CSB consumers to address individuals who may be isolating or sheltered-in due to social distancing requirements.

The Region 3 West Suicide logo continues to be distributed through the regional information dissemination campaign. Logo dissemination is a standard strategy promoted through the local coalitions around the thirteen (13) county region. The logo advertises the National Suicide Prevention Lifeline number as well as information for the Bristol Crisis Center in Southwest Virginia. Community partners that promote the campaign include local businesses and restaurants, libraries, schools, and other community organizations.

The 2020 Help, Hope, Healing Conference was hosted virtually on August 6-7, 2020. There were 325 virtual attendees 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 3 West reported the following trainings were provided during FY20 (total number of participants listed):

- Applied Suicide Intervention Skills Training (ASIST) – 36 participants
- Mental Health First Aid (MHFA) – 425 participants
- Youth Mental Health First Aid (YMHFA) – 179 participants

DBHDS Region 4

DBHDS Region 4 launched a robust social media campaign on July 1, 2020. They redesigned and launched their updated website, www.bewellva.com. One of the ways they promoted awareness of BeWellVA was through radio interviews during September Suicide Prevention Awareness Month. Their BeWellVA Facebook page has launched as well highlighting tips on how to connect to resources if you or someone you care about has a mental health concern.

Local suicide prevention campaigns promoted by this region are ATQ-Ask the Question, the In-View Campaign, and Calm, Connected, Caring Chesterfield. Local activities include hosting an *International Survivor of Suicide Loss Day* event, distribution of safety deterrent devices and community resources, and implementation of an equity survey to help understand barriers to suicide prevention and access to mental health services. Virtual events included the following: mental health resource fairs, 'Raise Your Voice about Suicide' training, resiliency training (for Emergency Communications staff), and Mental Health Awareness training (for Residence Advisors at Randolph-Macon College).

The Community Services Boards represented in Region 4 reported the following trainings were provided during FY20 (total number of participants listed):

- Applied Suicide Intervention Skills Training (ASIST) – 13 participants
- Mental Health First Aid (MHFA) – 397 participants
- Youth Mental Health First Aid (YMHFA) – 43 participants
- safeTALK – 41 participants
- general Suicide Prevention and Mental Health Wellness presentations – 402 participants

- More Than Sad – 26 participants
- Crisis Intervention Training (CIT) – 79 participants

DBHDS Region 5

Region 5 developed a Suicide Prevention Media Campaign under the direction of Cox Media Communication. Lethal means safety and general Suicide Prevention Awareness is highlighted in the PSAs. The campaign (30-second PSAs) aired this summer continuing through the end of September across the Cox Media footprint including satellite television. Streaming placements were included to capture the more rural areas in the region. Community messaging in the form of billboards are present in rural areas as well. Social media use has also improved their communication for sharing trainings and community events.

Virtual events included the following: webinars to adapt to technology as a learning platform, "Mental Health Mondays" series on local radio talk show, "Heart to Heart" (parent education sessions offered in Spanish), resilience webinars on trauma, self-care, and mindfulness, "Navigating the Future with Hope, Healing and Optimism" webinar.

Curb side pick-up and drive-through events were organized to provide suicide prevention and mental health wellness resources, lethal means deterrent devices, care packages (which included personal protective equipment), and school supplies.

The Community Services Boards represented in Region 5 reported the following trainings were provided during FY20 (total number of participants listed):

- Applied Suicide Intervention Skills Training (ASIST) – 110 participants
- Mental Health First Aid (MHFA) – 529 participants
- Youth Mental Health First Aid (YMHFA) – 256 participants
- Talk Saves Lives – 30 participants
- safeTALK – 169 participants
- Question, Persuade, Refer (QPR) – 43 participants
- More than Sad – 97 participants
- Signs of Suicide (SOS) – 340 participants
- Crisis Intervention Training – 22 participants

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 February 2020. The February training certified 15 trainers. DBHDS currently has 76 actively 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 2020 budget included $500,000 for suicide prevention initiatives. There were 394 individuals who participated in the training between October 2019 and March 2020. As of September 30, 2020, ASIST training has been delivered to 3,565 Virginia residents through DBHDS funding, providing them with the skill set to help create suicide safer communities.

Due to the impact of COVID-19, DBHDS has not been able to host ASIST Training-for-Trainers nor ASIST classes since March 2020. ASIST developers have not created a virtual option.

safeTALK (Suicide Alertness for Everyone)

safeTALK helps participants become alert to suicide. Suicide-alert people are better prepared to connect persons with thoughts of suicide with life-affirming help. safeTALK teaches participants to recognize invitations, engage with the person with thoughts of suicide, and connect them with resources to help them be safer from suicide. These resources could include health care professionals, first responders, or crisis line workers—among many others who have suicide intervention training.

Over the course of their training, safeTALK participants will learn to:

- Notice and respond to situations where suicide thoughts may be present
- Recognize that invitations for help are often overlooked
- Move beyond the common tendency to miss, dismiss, and avoid suicide
- Apply the TALK steps: Tell, Ask, Listen, KeepSafe

- Know community resources and how to connect someone with thoughts of suicide to them for suicide-safer help

The DBHDS Suicide Prevention Coordinator is responsible for the coordination, monitoring and oversight of safeTALK trainings. DBHDS currently has 22 certified trainers throughout Virginia. DBHDS also provides materials for ASIST trainings throughout the Commonwealth. The funding for the safeTALK 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 2020 budget included $500,000 for suicide prevention initiatives. There were 530 individuals who participated in the training between October 2019 and March 2020. As of March 31, 2020, safeTALK training has been delivered to 2,530 Virginia residents through DBHDS funding, providing them with the skill set to help create suicide safer communities.

Due to the impact of COVID-19, DBHDS not been able to host safeTALK Training-for-Trainers or safeTALK classes since March 2020. A virtual option is currently not available.

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 Mental Health First Aid (MHFA) initiatives across Virginia. As a result, the FY 2020 budget included $600,000 specifically for MHFA.

The DBHDS 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 MHFA Instructor trainings are currently being provided each year.

MHFA is a national public education program that introduces participants to risk factors and warning signs of mental illnesses, builds understanding of their impact, and reviews 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.

MHFA 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 30, 2020, Virginia has 536 MHFA instructor certifications. There are 418 trained Adult MHFA instructors, 289 trained Youth MHFA instructors, and 149 instructors

certified in both Adult and Youth MHFA. Of the certified instructors, 130 are trained in the Public Health module, 36 trained in the Fire Fighter/EMS module, 30 trained in the Veteran module, 28 in the Older Adult module, 6 trained in the Rural module, 50 trained in the Higher Education module, and 12 trained in the Spanish Adult module.

Responding to COVID-19, the National Council for Behavioral Health developed a Virtual/Blended version of MHFA. In June 2020, the Virtual/Blended instructor training became active, and DBHDS has trained 102 instructors in both the Adult and Youth MHFA. DBHDS has contracted with the National Council to provide two additional Youth MHFA instructor trainings scheduled early November. The decision to add two Youth trainings is to assist in training DOE personnel and to increase the number of MHFA certified teachers, school counselors, and other school staff.

As of September 30, 2020, Virginia has trained 68,921 individuals in MHFA. Of those trained, 45,762 are Adult MHFA and 22,806 are Youth MHFA. As for the modules under Adult MHFA – 6,302 are trained in the Public Safety module, 2,517 are trained in the Higher Education module, 533 trained in the Fire Fighter/EMS module, 495 trained in the Veteran module, 1,007 trained in the Older Adult module, and 189 trained in the Rural Adult module. There are also 336 individuals that were trained in the Spanish Adult MHFA program.

A data report is provided to DBHDS monthly from the National Council for Behavioral Health. The report provides the number of MHFA Instructors in Virginia and the number of people trained in MHFA across the state. 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 MHFA 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. This included conferences offered by the Department of Education, Veterans Administration Resource Fair, Department of Criminal Justice, 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.

With the shift to virtual trainings and resource fairs, DBHDS provided a list of free and/or low cost suicide prevention and safety planning trainings that are available for all audiences as well as trainings for behavioral health, medical, and other clinical professionals such as (but not limited to) case managers, nurses, social workers, counselors, psychiatrists, and psychologists.

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

In December 2018, Virginia was chosen as one of the first seven states nationwide (also including: AZ, CO, KS, MT, NH, and TX) to host the Governor's Challenge to Prevent Suicide. 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 implement a comprehensive public health approach to suicide prevention for Military Service Members, Veterans, and Families (SMVF). The Governor's Challenge initiative is now in twenty seven states nationwide.

The Virginia Governor's Challenge team is co-led by the Secretary of Veterans and Defense Affairs, Carlos Hopkins, and the Secretary of Health and Human Resources, Dr. Daniel Carey. 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 the Virginia Department of Education; as well as other critical partners including the Virginia Hospital and Healthcare Association and National Alliance on Mental Illness, and Richmond Behavioral Health Authority.

The VA estimated that 17 veterans died by suicide every day in 2017, and 11 of these veterans were not engaged with VA healthcare prior to their deaths. Community services providers are key partners in suicide prevention among SMVF because they have access to veterans that are not in VA care.

Key Priorities for the Governor's Challenge to Prevent Suicide:

- Identify Military Service Members, Veterans, and families (SMVF) and screen for suicide risk
- Promote connectedness and improve care transitions
- Increase lethal means safety and safety planning

The Virginia team designed a Pilot that addresses all the Governor's Challenge priorities. **V**irginia's **I**dentify SMVF, **S**creen for Suicide Risk, and **R**efer for Services (VISR) Pilot. VISR Pilot agencies include Community Services Boards, hospitals, Local Departments of Social Services, Virginia Department of Veterans Services, and a Cohen Veterans Network Military Clinic. VISR agencies trained staff in military culture, suicide prevention and safety planning

and implemented risk screening in their services to identify SMVF that need behavioral health and/or crisis services.

The first VISR Pilot data report period is from February to April 2020 and 22 agencies submitted preliminary data (this is about half of the expected agency reports due to the impact of COVID-19 on partner agencies, many of which are treatment providers and first responders). Pilot agencies served 2,048 military service members, veterans, and families from February to April 2020. Of those, 1,305 (64% of total served) were screened for suicide risk and 302 (or 23%) screened positive for suicide risk, indicating a higher level of need for behavioral health services.

With the current level of screening (the Pilot team continues to work toward universal screening where 100% of those served are screened for suicide risk), VISR Pilot agencies are successfully identifying individuals that are struggling with behavioral health needs and/or suicidal ideation (that may have gone unidentified without pilot efforts) and delivering treatment and supportive services (and in some cases lifesaving support). In addition to meeting SMVF needs internally, VISR Pilot agencies are also working to increase referrals to Veterans Health Administration, Military Treatment Facilities, and Virginia Department of Veterans Services (DVS) to maximize Federal and State services access. Final VISR pilot data is expected in November 2020.

Additional Governor's Challenge Team Activity Highlights:

- Hosted regional crisis services strategic planning sessions (Crisis Intercept Mapping from SAMHSA) with Salem VA Medical Center (VAMC), Richmond VAMC, and Hampton VAMC
- Hosted Regional Military Culture and Suicide Prevention Summits in: Radford, Abingdon, Fairfax, Lexington, Suffolk, and Henrico
    - Over 500 community services providers were trained at these inaugural events;
    - DVS now offers virtual Military Cultural Competency (MCC) webinars and has trained over 1,400 community services providers from March to September 2020.
- Distributed the Veteran Crisis Line on Governor's Challenge resource cards statewide to offices, agencies, Veterans Service Organizations, and care providers
- Collaborated with the Department of Education and the *IServe2* campaign to raise awareness on needs and resources for military-connected children
- Launched the *Together with Veterans* initiative (national best practice from VHA) in Southwest Virginia to bolster grass roots, veteran-led, suicide prevention in rural communities
- Collaborated with the Virginia Army National Guard to revise the Suicide Prevention Training in a Warrior Task format that promotes core resiliency skills and expand Lethal Means Safety (training and distribution of firearm locks and medication lock boxes) for Service Members and families
- Hosted online training on the Columbia Suicide Risk Screening protocol from Columbia University to increase utilization in community settings
- Launched suicide awareness campaign with General Assembly Military and Veterans Caucus
- Distributed COVID-19 safety and resource information and collaborate regularly to increase access to care during this pandemic

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, access to, and capacity for suicide prevention resources while identifying the root causes of suicide in their respective communities and throughout the state.

The goal of the group is to recruit partners working in suicide prevention and suicide prevention-adjacent areas to address suicide prevention in a coordinated effort, through a strategic process, across the lifespan of Virginians. The DBHDS Suicide Prevention Coordinator and Virginia Department of Health (VDH) Violence and Suicide Prevention Coordinator serve as co-chairs for the advisory group. We provide a platform to share strategies and best-practices 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.

This year DBHDS was able to support DOE with updating "The Suicide Prevention Guidelines for Virginia Public Schools". The document was adopted by the Board of Education in June 2020, providing information to assist local school boards in revising policies to help prevent suicide with procedures to intervene when suicidal threats are present and managing the crisis response when a death by suicide occurs in the school community. The guidelines are available for download at: http://www.doe.virginia.gov/support/prevention/suicide/suicide-prevention-guidebook.pdf.

SPIAG meets bimonthly utilizing the *Suicide Prevention across the Lifespan Plan for the Commonwealth* as their framework. It has transitioned from in-person meetings to virtual meetings as of June 2020 due to COVID-19. Topics covered at meetings this year included the mental health of first responders, peer-driven support for mental health challenges, evaluation of the current state plan to address needed updates, epidemiology of self-harm and suicide in Virginia, and the needs of LGBTQ+ youth in Virginia.

Suicide Prevention across the Lifespan: A Plan for the Commonwealth of Virginia

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 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:
https://www.vdh.virginia.gov/content/uploads/sites/53/2016/11/2020-SuicidePreventionResourceDirectory-5thEd.pdf

Conclusion

Despite its complex etiology, suicide is preventable. The current state of our nation, as it grapples with the COVID-19 pandemic, has explicitly drawn attention to serious gaps in our health systems that need immediate attention. By working to ensure the necessary resources are available to address these needs, we can effectively reduce the number of Virginians who die by suicide. This effort will not only require adequate attention and sustained funding but necessitates the type of coordination the Suicide Prevention Interagency Advisory Group exhibits every day. Although a continued state effort to develop and implement a comprehensive suicide prevention plan is essential, this work cannot be done without the active support and engagement of all Virginians. Providing community resources, talking about suicide prevention to decrease stigma, working to reduce access to lethal means, following up with individuals experiencing mental health crisis; we can all take part in helping save lives.

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, increase mental health resources, address social determinants of health that result in increased risk, 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.

Appendices

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. Due to delays in data collection and the retrospective nature of fatality surveillance, Virginia Violent Death Reporting System (VVDRS) data further than 2017 - with the specifics listed by region as seen in the charts on the following pages - will not be available until later in 2021.

The Office of the Chief Medical Examiner's Annual Report, 2018 provides the following data on suicide deaths:

- Number and Rate of Suicide Deaths by Year of Death, 1999-2018
- Number and Rate of Suicide Deaths by Age Group and Gender, 2018
- Percentage of Suicide Deaths by Race/Ethnicity, 2018
- Number and Rate of Suicide Deaths by Race/Ethnicity and Gender, 2018
- Number of Suicide Deaths by Cause and Method of Death, 2018
- Number of Suicide Deaths by Age Group and Ethanol Level, 2018
- Number of Suicide Deaths by Gender and Ethanol Level, 2018
- Number of Suicide Deaths by Manner of Death and Ethanol Level, 2018
- Number of Suicide Deaths by Month of Death, 2018
- Number of Suicide Deaths by Day of the Week, 2018
- Number and Rate of Suicide Deaths by Locality of Residence, 2018
- Number of Suicides Deaths by Locality of Injury and Year of Death, 2006-2018

The Office of the Chief Medical Examiner's Annual Report, 2018 can be downloaded at, https://www.vdh.virginia.gov/content/uploads/sites/18/2020/07/Annual-Report-2018-FINAL.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