COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
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

Monday, December 6, 2021

The Honorable Ralph S. Northam, Governor
Patrick Henry Building
1111 East Broad Street
Richmond, VA 23219

Dear Governor Northam,

Chapter 370 of the 2018 Acts of Assembly requires the Department of Behavioral Health and Developmental Services to report annually on its activities related to suicide prevention. The language states:

> *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 item, please find enclosed the report. Staff are available should you wish to discuss this request.

Sincerely,

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

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
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

Monday, December 6, 2021

The Honorable Justin Fairfax, Lieutenant Governor
Oliver Hill Building
102 Governor Street
Richmond, VA 23219

Dear Lieutenant Governor Fairfax,

Chapter 370 of the 2018 Acts of Assembly requires the Department of Behavioral Health and Developmental Services to report annually on its activities related to suicide prevention. The language states:

> *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 item, please find enclosed the report. Staff are available should you wish to discuss this request.

Sincerely,

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

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
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

Monday, December 6, 2021

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

Dear Speaker Filler-Corn,

Chapter 370 of the 2018 Acts of Assembly requires the Department of Behavioral Health and Developmental Services to report annually on its activities related to suicide prevention. The language states:

> *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 item, please find enclosed the report. Staff are available should you wish to discuss this request.

Sincerely,

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

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Annual Report on Chapter 370 of the 2018 Acts of Assembly, HB569

Activities Related to Suicide Prevention

December 1, 2021

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

Chapter 370 of the 2018 Acts of Assembly (HB569, Gooditis) 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.*

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 made to ensure a comprehensive, evidence-based system is in place to respond to this need.

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 the risks include alcohol use, feelings of hopelessness, isolation, barriers to mental health access, and loss. While rates of suicide continue to increase, the continued 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, continue to be limited; stressing the importance of continued efforts to improve internet connectivity throughout the state. While the true impact of COVID-19 will 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 DBHDS' activities related to suicide prevention across the lifespan.

Moving forward, the goal 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: 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 the ability to reduce the risk of suicide across the lifespan.

Introduction

The Department of Behavioral Health and Developmental Services (DBHDS) is pleased to submit its FY 2021 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. Suicide deaths in 2019 compared to 2018 decreased 4.3 percent. The largest number of victims were male (77.5 percent), white (80.9 percent), and aged 55 to 64 years of age (17.3 percent). Males 85 years of age and older, as well as white males had the highest rates of suicide compared to other groups within the total population (47.5 and 27.6 per 100,000 persons, respectively).

- Whites died by suicide at a rate 4.4 times that of Hispanics, 3.3 times that of Asians, and 2.3 times that of Blacks
- Males were 3.6 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 57.5 percent, 22.5 percent, and 10.4 percent of all suicides, respectively

The U.S. Department of Veterans Affairs (VA) estimated that 17 veterans died by suicide every day in 2019 (6,261 total veteran suicide deaths in 2019); and 10 of these veterans were not engaged with VA healthcare prior to their deaths. The adjusted suicide rate for veterans was 52 percent greater than non-Veteran U.S. adults in 2019. 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 VA reported 188 veteran deaths by suicide in Virginia in 2019. The use of a firearm is the leading means in all suicide deaths.

The data reported in Appendix A 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 further than 2017, is not currently available. The data reported in Appendix B represents number, percentage, and rate of suicide deaths by DBHDS region for years 2018-2020. The tables include a breakdown by gender, age group, race/ethnicity, and year of death. The VDH Office of the Chief Medical Examiner provided the data in these tables.

The FY 2014 state budget included $1,100,000 ongoing appropriation to DBHDS to expand and support Suicide Prevention and Mental Health First Aid (MHFA) initiatives across the Commonwealth of Virginia. The funding included $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 also 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 DBHDS Region 1 suicide prevention initiative. Led by the Prevention Teams of Region 1 Community Services Boards (CSBs), the initiative has expanded to all 40 CSBs 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. Lock and Talk Virginia provides community members the opportunity to become educated about the signs of suicide risk and how to act as a catalyst to care.

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 safety devices (now including boxes, pouches, timer-top pill bottles and medication deactivation kits).

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

Lock and Talk Virginia includes the Gun Shop Project in consultation with the Harvard School of Public Health Means Matter Campaign. Suicide prevention education is disseminated through firearm retail and range partners. Identifying 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. DBHDS is promoting the importance of everyone recognizing the benefit of becoming a Lock and Talk Family. A Lock and Talk Family may be someone’s 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, 38 reported the following from October 1, 2020 – September 30, 2021:

- Number of Medication Locking Devices Distributed – 15,025
- Number of Gun Locks Distributed –10,528
- Number of Firearm Retail Partners (to promote suicide prevention) – 289
- Lock and Talk Literature Distributed—147,253

Lock and Talk Virginia participants collaborated with Virginia Department of Education Workgroup for Suicide Prevention Awareness Month. This was a multi-agency and organization collaboration to benefit all school systems K-12 during September. DBHDS presented Lock and Talk Virginia education during week three of a five-week series of webinars aimed at providing instruction and resources to school counselors and psychologists on youth suicide prevention. Lock and Talk Virginia created social media post messages and posters in English and Spanish appropriate to each school level. Some CSBs chose to extend the VDOE campaign by tailoring and providing the Lock and Talk Virginia education and materials to teachers, staff, parents, and students.

The New Americans Workgroup, facilitated by the Office for New Americans and DBHDS, collaborated with Lock and Talk Virginia developers to provide five translations for suicide prevention materials. These include medication and firearm safety guidelines and suicide prevention resources in Spanish, Arabic, Vietnamese, Nepali, and Korean. The goal is to reach refugees in relocation areas and provide Lock and Talk Virginia materials to increase their opportunities to promote safe and responsible care of firearms and medications.

COVID-19 necessitated an extreme shift in the way prevention professionals accomplished Lock and Talk Virginia work. Since this program historically involves direct community contacts, it became necessary to find new ways to get safety devices into the hands of those in need, as well as continue to educate the public on suicide prevention skills. Innovative solutions to COVID-related barriers this year include expanded social media campaigns and multiple partnerships with pharmacies to provide literature in or on prescription packaging, a strategy that was responsible for the significant increase in education available to the public. Other innovative outreach strategies include printing the suicide prevention hotline on pizza delivery boxes, and providing materials and devices at food banks, libraries, and drive-through events. Community skill building moved to virtual platforms, which led to an increase in suicide alertness education to niche audiences such as customer service professionals (hair stylists and barbers are examples), and suicide postvention education to funeral home directors.

Regional Suicide Prevention Initiatives

DBHDS currently funds regional suicide prevention initiatives across 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 MHFA 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. CSBs that represent each of the regions are included below:

- DBHDS Region 1: 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: 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: 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: 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: 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, 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
- Strategies for September National Suicide Prevention Month
- Strategies 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 regarding program offerings, community events and

training opportunities. However, our communities and prevention teams are resilient and creative. They used this time to continue to build relationships and to enhance and refine communication strategies and community supports. The following are highlights and accomplishments as a result of the regional suicide prevention initiatives in FY 2021.

DBHDS Region 1

In partnership with DBHDS, Region 1 Suicide Prevention Committee continued to expand the Lock and Talk Virginia (Lethal Means Safety Initiative) efforts across the Commonwealth. As a part of their strategic planning process, they have partnered with OMNI Institute to update their current logic model and action plan, as well as develop evaluation outcomes for Lock and Talk Virginia. The website link is https://lockandtalk.org/.

Media campaigns were developed and ran across various platforms for May Mental Health Awareness Month, September Suicide Prevention Month, and November National Family Caregivers Month (focused on Veterans and their Caregivers). In July 2021, The Lock and Talk graphics library was updated to include new graphics for the following target audiences: teachers/educators, healthcare workers, first responders, and all branches of the military (including National Guard). The graphics are used primarily in social media posts, billboards, bus ads, and newspaper/magazine ads.

Region 1 provided a virtual speaker series throughout the summer to continue to promote conversations focused on mental health wellness and suicide prevention. Attendees included prevention staff, direct treatment professionals, educators, parents, and community members. Over 500 people across the Commonwealth participated in the virtual events. In efforts to continue distribution of safety devices (medication lock boxes, trigger locks, and cable locks), they partnered with Food Banks, scheduled contactless appointments, participated in drive thru pick-up events, and set up tables at vaccine clinics.

Additional activities across the region included the following: development and distribution of community resource guides; participation in National Drug Take Back Day; virtual events promoting self-care, lethal means safety, community conversations about mental health wellness, and suicide prevention awareness; partnered with community health workers to provide care packages during wellness visits; and participation in events such as National Night Out, Back-To-School Open House, and Health and Wellness Fairs.

The CSBs represented in Region 1 reported the following trainings provided during FY 2021 (total number of participants listed); Mental Health First Aid (MHFA) – 229 in-person and 312 virtual participants, Youth Mental Health First Aid (YMHFA) – 29 in-person and 52 virtual participants, safeTALK – 29 participants, and Crisis Intervention Training (CIT) – 32 participants.

DBHDS Region 2

The Suicide Prevention Alliance of Northern Virginia (SPAN) continued to share and promote an array of public supports and resources across the region.

The SPAN website has been updated and offers a variety of information to include links to local mental health centers, resources and data relating to suicide prevention, a community events calendar, and access to online mental health screenings among other resources. Brief screenings are the quickest way to determine if someone should connect with a behavioral health professional. The screenings are completely anonymous and confidential, and immediately following the brief questionnaire participants see their results, recommendations, and key resources. From October 1, 2020, through September 30, 2021, there were 2,117 completed screenings. The website link is http://www.suicidepreventionnva.org/.

For September Suicide Prevention Awareness Month, SPAN participated in the national #BeThe1To Campaign and created social media posts for partners to customize for use in their locality. They sponsored suicide prevention awareness walks and provided resources to promote the website in order to increase engagement on the site. SPAN continued to provide youth mini-grants to engage youth in schools and other community settings to assist in developing strategies to promote mental health wellness and suicide prevention. One successful mini-grant project provided "Buttons for Change" which promoted positive messages and imagery for mental health wellness.

Additional activities across the region included the following: community tabling events to provide resources; virtual events promoting conversations on suicide; mental health wellness/suicide prevention walks; National Night Out; and Spring Break wellness sessions for middle and high school students. Yard signs and posters throughout the community have been a way to continue to promote awareness because of decreased in-person events.

The CSBs represented in Region 2 reported the following trainings were provided during FY 2021 (total number of participants listed); Mental Health First Aid (MHFA) – 42 in-person and 135 virtual participants, Youth Mental Health First Aid (YMHFA) – 12 in-person and 114 virtual participants, Crisis Intervention Training (CIT) – 70 participants, Question, Persuade, Refer (QPR) – 221 participants, and KOGNITO (on-line simulations) – 20,763 users.

DBHDS Region 3 East

Region 3 East continued to promote and update their website, https://askingsaves.org. The website provides resources, highlights community 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, it promotes awareness and provide training opportunities for community. The CSB localities across the region share the responsibility to update the website content. During May Mental Health Wellness month, they utilized social media (Facebook and Instagram) to promote the importance of self-care. Region 3 East launched a social media campaign for September Suicide Prevention Month which highlighted Lunch and Learn events primarily addressing first responders.

Additional activities across the region included the following: virtual trainings and presentations highlighting May Mental Health Wellness and September Suicide Prevention Awareness initiatives; partnership with clinical staff to develop the First Responder Initiative; school partnerships to promote support for faculty and staff who are managing anxiety and other mental health concerns; serving on panels at events that promote mental health and suicide prevention awareness; and community tabling events where they distribute resources and safe storage devices.

The CSBs represented in Region 3 East reported that the following trainings were provided during FY 2021 (total number of participants listed); Mental Health First Aid (MHFA) – 99 in-person and 142 virtual participants, Youth Mental Health First Aid (YMHFA) – 116 in-person and 107 virtual participants, and Talk Saves Lives – eight in-person and 48 virtual participants.

DBHDS Region 3 West

The "Are You Okay" program continues to be advertised throughout the region promoting the National Suicide Prevention Lifeline and access to the Appalachian Substance Abuse Coalition (ASAC) regional website. Region 3W partners with the coalition to provide suicide prevention resources and promote the Southwest Virginia Suicide Prevention Continuum of Care implementation model. The "Are You Okay" program is advertised on social media and in faith-based communities, as well as in local business that promote the effort.

The Region 3 West Suicide logo continues to be distributed through their regional information dissemination campaign. 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 2021 Help, Hope, Healing Conference was hosted virtually on August 5, 2021. There were 437 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 faith-based communities. The conference evaluation provided the following information:

- 97 percent of respondents were very likely or likely to use the information/strategies presented
- 92 percent reported an increase in knowledge
- 71 percent reported a change in attitude towards mental health and suicide in the community
- 66 percent reported a development in new community connections

Additional activities across the region included the following: community tabling events to provide resources and safe storage devices (medication lock boxes, cable locks, and trigger locks); distribution of materials at trainings and community coalition meetings, resource tables at

community Health Expo events; and partnerships with food banks to distribute materials (smart pill bottles, and safe disposal pouches for prescription medications).

The CSBs represented in Region 3West reported the following trainings were provided during FY 2021 (total number of participants listed); Applied Suicide Intervention Skills Training (ASIST) – 18 participants, Mental Health First Aid (MHFA) – 252 in-person participants, Youth Mental Health First Aid (YMHFA) – 16 in-person participants, and Question, Persuade, Refer (QPR) – 63 participants.

DBHDS Region 4

DBHDS Region 4 is identified as Be Well VA. They continued to enhance and update their website, www.bewellva.com, to be more user friendly and provided resources for identified populations of focus. Recent enhancements include links to Lock and Talk Virginia, Domestic Violence resources, and Vaccinate Virginia resources. Be Well VA has increased collaboration on virtual training and awareness events, as well as cross-promotion of these events through bewellva.com and their social media platform. During the month of September, they ran a robust social media campaign promoting suicide prevention awareness that highlighted positive mental health promotion messaging. They also hosted a 'Community Conversation' on the book, What Happened to You, which promotes conversations on trauma, resilience, and healing.

Additional activities across the region included the following: distribution events for lethal means safety devices and prescription drug safe disposal kits; provide wellness education in partnership with parenting classes offered in organizations; collaboration with local libraries to distribute resources and promote books with resiliency themes; and a sticker campaign with local pizza establishments and local pharmacies to promote resources available on the BeWellVA website.

The CSBs represented in Region 4 reported the following trainings were provided during FY 2021 (total number of participants listed); Mental Health First Aid (MHFA) – 97 in-person and 218 virtual participants, Youth Mental Health First Aid (YMHFA) – 39 in-person and 393 virtual participants, general Suicide Prevention and Mental Health Wellness presentation – 15 participants, and More Than Sad – 10 participants.

DBHDS Region 5

DBHDS Region 5 continued to be innovative in their strategies to promote awareness throughout their communities. All localities provided trainings, promoted safe messaging via social media platforms, and collaborated with various organizations to continue to create suicide-safer communities. The Eastern Shore CSB received national attention for their pizza box suicide prevention campaign. They distributed pizza boxes to local restaurant owners with special messaging highlighting basic suicide statistics, reinforcing the message of 'you are not alone,' and providing resources if someone or their loved one needed support. This idea was shared across the Commonwealth leading to other localities engaging in similar strategies.

This was the 6th Annual Shatter the Silence Youth Suicide Prevention event for the region. There was an in-person and virtual opportunity to participate in this event which focused on suicide prevention and awareness strategies for youth across the region. The theme this year was "Hope Heals" with a total of 99 attendees (58 participants between the ages of 5-20; and 41 participants age 21+).

Additional activities across the region included the following: providing training to community college students that counted as credit towards graduation; virtual events promoting mental health wellness and suicide prevention; billboard campaigns to promote mental health messaging aimed at reducing stigma and promoting community resources; partnerships with local senior centers and youth centers to provide resources and wellness presentations; community tabling events providing lethal means safety devices and prescription drug safe disposal kits; community newsletters during May Mental Health Awareness Month; Lock and Talk public service announcements promoted in local cinemas; partnerships with peer recovery and school partners to provide resources at community events; and facilitated youth leadership group topics highlighting mental health and resiliency.

The CSBs represented in Region 5 reported the following trainings were provided during FY 2021 (total number of participants listed); Applied Suicide Intervention Skills Training (ASIST) – eight participants, Mental Health First Aid (MHFA) – 214 in-person and seven virtual participants, Youth Mental Health First Aid (YMHFA) – 74 in-person and 43 virtual participants, Talk Saves Lives – five participants, Question, Persuade, Refer (QPR) – 62 in-person and 48 virtual participants, and Crisis Intervention Training – 77 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 currently has 60 actively certified trainers throughout Virginia. 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 2021 budget included $500,000 for suicide prevention initiatives. As of September 30, 2021, ASIST training has been delivered to 3,664 Virginia residents through DBHDS funding, providing them with the skill set to help create suicide safer communities.

Due to the impact of COVID-19, we have not been able to host ASIST Training-for-Trainers to increase our training capacity across the Commonwealth. ASIST developers do not provide a virtual option. Additionally, COVID-19 protocols reduced opportunities to provide in-person trainings.

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.

Over the course of their training, safeTALK participants 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, and
- 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 was able to host a safeTALK T4T in October 2021. DBHDS currently has 35 certified trainers throughout Virginia. 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 2021 budget included $500,000 for suicide prevention initiatives. As of September 30, 2021,

safeTALK training has been delivered to 2,575 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 2021 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. There were five MHFA Instructor trainings provided this year. DBHDS plans to offer additional instructor trainings in early December as the interest for MHFA continues to increase.

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 overviews common supports. The course was initially only facilitated as an 8-hour in-person course that 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.

In response to COVID-19, the National Council for Mental Wellbeing, formerly the National Council of Behavioral Health, developed a Virtual/Blended version of MHFA which helped maintain continuity of trainings virtually when in-person sessions were not possible. During the Virtual/Blended training sessions learners complete a 2-hour, self-paced online course, and participate in a 4.5- to 5.5-hour, Instructor-led training. In June 2020, the Virtual/Blended instructor training became active; and since being active DBHDS has trained 257 individuals in the Virtual MHFA version and 258 in the Blended MHFA version.

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. MHFA 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 22, 2021, Virginia has 687 MHFA certified instructors. There are 460 trained Adult MHFA instructors, 391 trained Youth MHFA instructors, 257 Virtual MHFA instructors and 258 Blended MHFA certified instructors. Of the certified instructors, 134 are trained in the Public Health module, 37 trained in the Fire Fighter/EMS module, 34 trained in the Veteran

module, 32 in the Older Adult module, seven trained in the Rural module, 52 trained in the Higher Education module, and 13 trained in the Spanish Adult module.

As the interest for MHFA continues to grow, MHFA instructor training was offered to staff at a variety of organizations, including the University of Richmond, Fairfax Police Department, Goochland and Powhatan Public Schools, Virginia Commonwealth University (VCU), VCU Police, The Virginia Department of Judicial Services, Central Virginia Criminal Justice Academy, Emory & Henry College, the Virginia Department of Veteran Services, and A Peace of Mind Counseling Services LLC. Additionally, DBHDS was able to support a variety of partners that offered MHFA training to communities across Virginia, these partners included Bishop Ireton High School Staff, Bishop Ireton Diocesan of School Nurses, Old Dominion University, Baptist General Convention of Virginia, the Virginia Department of Human Resources, Central Shenandoah Criminal Justice Academy and Cardinal Criminal Justice Academy.

As of September 22, 2021, Virginia has trained 79,054 individuals in MHFA. Of those trained, 52,187 are Adult MHFA and 26,514 are Youth MHFA. As for the modules under Adult MHFA – 7,518 are trained in the Public Safety module, 2,783 are trained in the Higher Education module, 570 trained in the Fire Fighter/EMS module, 495 trained in the Veteran module, 1,019 trained in the Older Adult module, and 197 trained in the Rural Adult module. There were 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 Mental Wellbeing. The report includes 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 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.

Even though in-person opportunities were limited this year, resources were provided at four National Guard Yellow Ribbon (Pre-mobilization events) and a Department of Criminal Justice conference reaching 5,000 participants across events.

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 increasing presence of 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 (also including Arizona, Colorado, Kansas, Montana and Texas) to host the Governor's Challenge to Prevent Suicide. The Governor's Challenge is sponsored nationally by 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 thirty-five states nationwide.

The Virginia Governor's Challenge team is co-led by the Secretary of Veterans and Defense Affairs and the Secretary of Health and Human Resources. Federal and state agencies and other critical partners are among the team members. Membership includes Veterans Affairs (VA), the Department of Defense, Virginia Department of Veterans Services (DVS), the Virginia National Guard, DBHDS, 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, Virginia Hospital and Healthcare Association, National Alliance on Mental Illness, and Richmond Behavioral Health Authority.

The VA estimated that 17 veterans died by suicide every day in 2019 (6,261 total veteran suicide deaths in 2019); and 10 of these veterans were not engaged with VA healthcare prior to their deaths. The adjusted suicide rate for veterans was 52 percent greater than non-Veteran U.S. adults in 2019. Community services providers are key partners in suicide prevention among SMVF because they have access to veterans that are not in VA care.

Key National 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

Tying into the National priorities, the Virginia Team focuses on the "3 C's theme – Care, Connect, Communicate":

- **C**are: Accessible / culturally competent behavioral health services

- **C**onnect: Bring SVMF-specific and community services together and form systemic partnerships
- **C**ommunicate**:**
    - Educate the SMVF population on resources
    - Educate behavioral health providers on military culture and suicide prevention best practices

From December 2019 to September 2020, the team implemented ***V****irginia's* ***I****dentify SMVF,* ***S****creen for Suicide Risk, and* ***R****efer for Services* (or VISR) Pilot. The goal of the VISR pilot is to develop military culture, suicide prevention, and safety planning infrastructure in community agencies (including hospitals, local departments of social services, community service boards, and the Up Center Cohen Veterans Network Clinic).

Across VISR pilot partner agencies, 3,014 SMVF were identified, 2,311 were screened for suicide risk, and 30 percent of those screened were at risk of suicide (defined as at least low risk, but also includes individuals at moderate and high risk). At risk individuals were linked to behavioral health and supportive services responsive to their level of need.

VISR SMVF Totals for February - August 2020 (Totals Across Sectors)	
Served	3,014
Screened for Suicide	2,311
Screened at Risk	696
Safety Plan Established	619
Referred to VHA	42
Referred to Military Treatment Facility (MTF)	18
Referred to VDVS	104

As part of the VISR initiative, DBHDS continues to lead the effort to promote and provide suicide prevention trainings and mental health wellness trainings. VVFS continues to lead the effort to train state and community agencies in Military Cultural Competency and Transition Awareness Training. DBHDS, CSBs, VVFS, and the VA have continued to distribute VDVS/VA resource business cards that list the VA Suicide Crisis Hotline on one side and VVFS contact information for non-crisis services on the other. The cards have been distributed to State Police, local police departments, first responders, and other service providers across the Commonwealth. Since the original implementation, agencies have worked to expand pilot activities and the team anticipates a VISR 2.0 launch in Spring 2022.

Additional Governor's Challenge Team Activity Highlights:

- Hosted regional crisis services strategic planning session (Crisis Intercept Mapping from SAMHSA) with the City of Suffolk including Western Tidewater CSB and key partners.
- Collaborated with the Virginia Army National Guard to expand Lock and Talk Virginia Lethal Means Safety (training and distribution of firearm locks and medication lock boxes) for Service Members and families.

- Sustained the *Together with Veterans (TWV)* initiative (national best practice from VHA) in Southwest Virginia to bolster grass roots, veteran-led, suicide prevention in rural communities; TWV team regularly hosts art therapy and community meetings to keep local Veterans and families engaged.
- Launched suicide awareness campaign with General Assembly Military and Veterans Caucus.

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 is an on-going effort, 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, from a diverse array of sectors, to strengthen a comprehensive suicide prevention response throughout the Commonwealth. This is done by supporting suicide prevention through a coordinated effort, utilizing 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. These roles help to maintain a platform for the sharing of strategies and best-practice suicide prevention, intervention, and postvention efforts.

SPIAG meets bimonthly utilizing the *Suicide Prevention across the Lifespan Plan for the Commonwealth* as their framework. The SPIAG remained virtual during the 2021 year due to ongoing efforts to limit the spread of COVID-19. Topics covered at meetings this year included the Virginia Crisis System Transformation, review of the Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention, data trends related to the National Suicide Prevention Lifeline, a presentation on the Child Fatality Review teams within the Office of the Chief Medical Examiner, and highlighting the Handle with Care program, an innovative approach to caring for children who experience a traumatic event. Finally, the SPIAG is working in partnership with DBHDS and VDH staff to update the Suicide Prevention across the Lifespan: A Plan for the Commonwealth of Virginia. This update is scheduled for completion late 2021.

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

The *Suicide Prevention across the Lifespan: A Plan for the Commonwealth of Virginia* 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 five goals to reduce and prevent suicide across the Commonwealth. SPIAG believes in the importance of expanding on past efforts within the suicide prevention field while exploring innovative ways to address drivers of suicide and self-harm, including developing in-depth data collection for suicide deaths in Virginia, conducting state training efforts to address suicide prevention education, maintaining the Suicide Prevention Resource Directory, and working with regional stakeholders to implement suicide prevention efforts in their communities.

The plan 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* provides an easy-to-use reference of programs available in Virginia to assist individuals seeking suicide prevention and intervention resources. Studies show that people who know the signs of suicide and where to access resources are more likely to take action that could save a life. The directory has 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 complex etiology, suicide is preventable. The current state of our nation, as it continues to navigate the COVID-19 pandemic, has explicitly drawn attention to serious gaps in our health systems that need immediate attention. By working to ensure that necessary resources are available to address these needs, the number of Virginians who die by suicide can be effectively reduced. 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. People throughout the Commonwealth can take part in helping save lives by 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.

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.

Appendix A: Suicide Death Data: 2003 - 2017

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 do not go 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

Appendix B: Suicide Death Data: 2018 – 2020

The data reported in the following tables represents the number, percentage, and rate of suicide deaths in Virginia by DBHDS region from 2018 to 2020. The tables include a breakdown by gender, age group, race/ethnicity, and year of death. The data provided here is for Virginia residents only.

Table 1: Number, Percentage, and Rate of Suicide Deaths by DBHDS Region, Gender, Age Group, Race/Ethnicity, and Year of Death, 2018-2020

Demographic	State of Virginia			DBHDS Region 1			DBHDS Region 2			DBHDS Region 3		
Gender	N	%	Rate	N	%	Rate	N	%	Rate	N	%	Rate
Female	808	22.6	6.2	169	21.6	6.7	154	25.6	4.0	143	21.8	8.3
Male	2771	77.4	22.0	613	78.4	25.4	448	74.4	11.9	512	78.2	30.5
Total	**3579**	**100.0**	**14.0**	**782**	**100.0**	**15.9**	**602**	**100.0**	**7.9**	**655**	**100.0**	**19.2**
Age Group (years)												
10-14	45	1.3	2.9	5	0.6	1.7	11	1.8	2.2	7	1.1	3.7
15-19	192	5.4	11.8	45	5.8	13.2	42	7.0	9.0	32	4.9	15.0
20-24	333	9.3	19.4	54	6.9	15.0	60	10.0	13.5	54	8.2	23.3
25-34	563	15.7	15.8	116	14.8	18.7	108	17.9	9.8	98	15.0	24.4
35-44	567	15.8	17.0	121	15.5	20.9	86	14.3	7.4	98	15.0	26.3
45-54	568	15.9	17.2	125	16.0	20.1	103	17.1	9.6	89	13.6	20.3
55-64	626	17.5	18.7	129	16.5	19.3	102	16.9	11.4	136	20.8	27.6
65-74	339	9.5	14.1	93	11.9	18.5	47	7.8	8.4	68	10.4	16.3
75-84	259	7.2	21.5	65	8.3	24.7	32	5.3	12.3	57	8.7	25.3
85+	87	2.4	18.8	29	3.7	29.7	11	1.8	10.7	16	2.4	19.1
Total	**3579**	**100.0**	**14.0**	**782**	**100.0**	**15.9**	**602**	**100.0**	**7.9**	**655**	**100.0**	**19.2**
Race/Ethnicity												
Asian	109	3.0	5.8	9	1.2	7.4	71	11.8	5.5	3	0.5	5.1
Black	405	11.3	7.9	56	7.2	8.9	50	8.3	5.1	42	6.4	9.3
Hispanic	103	2.9	4.1	15	1.9	4.1	49	8.1	3.6	3	0.5	2.8
Native American	4	0.1	5.1	1	0.1	6.5	0	0.0	0.0	1	0.2	13.2
White	2874	80.3	17.9	690	88.2	18.3	409	67.9	10.4	600	91.6	21.6
Other	84	2.3	ND	11	1.4	ND	23	3.8	ND	6	0.9	ND
Total	**3579**	**100.0**	**14.0**	**782**	**100.0**	**15.9**	**602**	**100.0**	**7.9**	**655**	**100.0**	**19.2**
Year of Death												
2018	1211	33.8	14.2	279	35.7	17.0	213	35.4	8.4	235	35.9	20.7
2019	1159	32.4	13.6	243	31.1	14.8	195	32.4	7.7	191	29.2	16.8
2020	1209	33.8	14.2	260	33.2	15.9	194	32.2	7.7	229	35.0	20.2
Total	**3579**	**100.0**	**14.0**	**782**	**100.0**	**15.9**	**602**	**100.0**	**7.9**	**655**	**100.0**	**19.2**

* Denominator values for rate calculations use 2019 population estimates extrapolated for three years of data. Rates for the 'Year of Death' category use 2019 populations for denominator values

** 'ND' represents no denominator for which to calculate rate

Table 1: Number, Percentage, and Rate of Suicide Deaths by DBHDS Region, Gender, Age Group, Race/Ethnicity, and Year of Death, 2018-2020 (cont.)

Demographic	DBHDS Region 4			DBHDS Region 5			Out of State Resident		Unknown Residence	
Gender	N	%	Rate	N	%	Rate	N	%	N	%
Female	138	23.2	6.5	178	22.7	6.3	25	16.7	1	9.1
Male	456	76.8	22.7	607	77.3	22.1	125	83.3	10	90.9
Total	**594**	**100.0**	**14.3**	**785**	**100.0**	**14.1**	**150**	**100.0**	**11**	**100.0**
Age Group (years)										
10-14	11	1.9	4.5	8	1.0	2.4	3	2.0	0	0.0
15-19	29	4.9	11.2	34	4.3	9.8	9	6.0	1	9.1
20-24	55	9.3	21.1	89	11.3	21.2	19	12.7	2	18.2
25-34	86	14.5	14.3	122	15.5	14.4	30	20.0	3	27.3
35-44	98	16.5	18.6	129	16.4	18.6	34	22.7	1	9.1
45-54	99	16.7	18.6	126	16.1	19.6	23	15.3	3	27.3
55-64	108	18.2	19.3	130	16.6	17.8	20	13.3	1	9.1
65-74	53	8.9	13.0	69	8.8	13.3	9	6.0	0	0.0
75-84	43	7.2	22.4	60	7.6	22.5	2	1.3	0	0.0
85+	12	2.0	15.6	18	2.3	17.5	1	0.7	0	0.0
Total	**594**	**100.0**	**14.3**	**785**	**100.0**	**14.1**	**150**	**100.0**	**11**	**100.0**
Race/Ethnicity										
Asian	15	2.5	8.6	4	0.5	1.6	7	4.7	0	0.0
Black	106	17.8	8.2	129	16.4	7.3	21	14.0	1	9.1
Hispanic	14	2.4	5.2	19	2.4	4.8	3	2.0	0	0.0
Native American	1	0.2	6.6	1	0.1	4.2	0	0.0	0	0.0
White	451	75.9	18.9	604	76.9	19.2	113	75.3	7	63.6
Other	7	1.2	ND	28	3.6	ND	6	4.0	3	27.3
Total	**594**	**100.0**	**14.3**	**785**	**100.0**	**14.1**	**150**	**100.0**	**11**	**100.0**
Year of Death										
2018	185	31.1	13.4	261	33.2	14.0	36	24.0	2	18.2
2019	197	33.2	14.3	272	34.6	14.6	57	38.0	4	36.4
2020	212	35.7	15.4	252	32.1	13.6	57	38.0	5	45.5
Total	**594**	**100.0**	**14.3**	**785**	**100.0**	**14.1**	**150**	**100.0**	**11**	**100.0**

* Denominator values for rate calculations use 2019 population estimates extrapolated for three years of data. Rates for the 'Year of Death' category use 2019 populations for denominator values

** 'ND' represents no denominator for which to calculate rate

Table 2: Number and Percentage of Grouped Causes of Suicide Deaths by DBHDS Region, 2018-2020

Grouped Cause of Death	State of Virginia		DBHDS Region 1		DBHDS Region 2		DBHDS Region 3	
	N	%	N	%	N	%	N	%
Gun-Related	2051	57.3	462	59.1	270	44.9	428	65.3
Hanged	823	23.0	172	22.0	170	28.2	124	18.9
Drug/Poison	385	10.8	83	10.6	79	13.1	68	10.4
Asphyxia (Other)	90	2.5	23	2.9	22	3.7	11	1.7
Sharp Force Injury	73	2.0	16	2.0	19	3.2	6	0.9
Jump/Fall from Height	62	1.7	7	0.9	21	3.5	9	1.4
Motor Vehicle-Related	45	1.3	7	0.9	10	1.7	4	0.6
Drowned	28	0.8	7	0.9	7	1.2	2	0.3
Fire and/or Inhalation Injury	15	0.4	4	0.5	3	0.5	3	0.5
Other	5	0.1	1	0.1	1	0.2	0	0.0
Blunt Trauma (Other)	2	0.1	0	0.0	0	0.0	0	0.0
Total	**3579**	**100.0**	**782**	**100.0**	**602**	**100.0**	**655**	**100.0**

Table 2: Number and Percentage of Grouped Causes of Suicide Deaths by DBHDS Region, 2018-2020 (cont.)

Grouped Cause of Death	DBHDS Region 4		DBHDS Region 5		Out of State Resident		Unknown Residence	
	N	%	N	%	N	%	N	%
Gun-Related	347	58.4	463	59.0	77	51.3	4	36.4
Hanged	131	22.1	187	23.8	34	22.7	5	45.5
Drug/Poison	64	10.8	75	9.6	14	9.3	2	18.2
Asphyxia (Other)	15	2.5	15	1.9	4	2.7	0	0.0
Sharp Force Injury	13	2.2	14	1.8	5	3.3	0	0.0
Jump/Fall from Height	10	1.7	11	1.4	4	2.7	0	0.0
Motor Vehicle-Related	8	1.3	8	1.0	8	5.3	0	0.0
Drowned	2	0.3	8	1.0	2	1.3	0	0.0
Fire and/or Inhalation Injury	3	0.5	2	0.3	0	0.0	0	0.0
Other	1	0.2	2	0.3	0	0.0	0	0.0
Blunt Trauma (Other)	0	0.0	0	0.0	2	1.3	0	0.0
Total	**594**	**100.0**	**785**	**100.0**	**150**	**100.0**	**11**	**100.0**

Data Source: Statewide Forensic Epidemiologist, Office of the Chief Medical Examiner, Virginia Department of Health