

Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia

Prepared by the Suicide Prevention Interagency Advisory Group

October 2016

Dear Stakeholders,

The Virginia Department of Health's Youth Suicide Prevention Program and the Department of Behavioral Health and Developmental Services' Office of Behavioral Health Wellness are pleased to present the updated Virginia Suicide Prevention across the Lifespan Plan. This document has been updated to reflect current data, statewide programming and to align Virginia's Suicide Prevention efforts with U.S. Surgeon General's 2012 National Strategy for Suicide Prevention. This update would not have been possible without support of the Virginia Suicide Prevention Interagency Advisory Group. Further, the Department of Behavioral Health and Developmental Services and the Virginia Department of Health have expressed their approval of the plan.

Suicide is the second-leading cause of death for Virginia citizens between the ages of 10 to 34, and is a major public health issue across the lifespan. Effective suicide prevention efforts require the engagement and commitment of multiple sectors and agencies. Statewide, there exists a shared responsibility to identify at-risk individuals and ensure that they receive essential services for mental health care and crisis stabilization. Also important are collaborative efforts to raise the awareness of community risk factors for suicide and reduce the associated stigma of mental health issues.

This update of the Virginia Suicide Prevention across the Lifespan Plan has been a true collaborative effort among many stakeholders. This plan will be our guide as we work throughout Virginia to strengthen capacity across multiple agencies to reduce the risk of suicide across the lifespan. We look forward to working together to continue to address this issue that affects all of our citizens.

Respectfully,



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TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

HISTORY OF STATEWIDE SUICIDE PREVENTION EFFORTS IN VIRGINIA 2

SIGNIFICANT EVENTS IN VIRGINIA AND NATIONAL SUICIDE PREVENTION 5

EPIDEMIOLOGY OF SUICIDAL BEHAVIORS IN VIRGINIA: 2003 TO 2012 9

 SUMMARY 9

 OVERALL TRENDS 10

 AGE 11

 RACE AND SEX 12

 MEANS OF INJURY 13

 GEOGRAPHIC DISTRIBUTION 14

 LIFESPAN CHARACTERISTICS OF SUICIDE DEATH IN VIRGINIA 14

 RISK FACTORS FOR SUICIDE 14

 SELF HARM HOSPITALIZATIONS 18

**DIRECTIONS FOR SUICIDE PREVENTION: GUIDANCE FROM NATIONAL
TASK FORCES 23**

 BELIEFS AND ATTITUDES 23

 SYSTEMS MANAGEMENT 24

 EVIDENCE-BASED PRACTICES AND EVALUATION 25

 ADDITIONAL CONSIDERATIONS 26

 2012 NATIONAL SUICIDE PREVENTION STRATEGY 26

THE SUICIDE PREVENTION PLAN FOR VIRGINIA 31

 GOAL 1 31

 GOAL 2 32

 GOAL 3 34

 GOAL 4 35

 GOAL 5 37

 GOAL 6 38

 GOAL 7 39

REFERENCES 41

RESOURCES 43

SUICIDE PREVENTION REGIONAL SUMMITS 201146
MEMBERS OF THE 2016 ADVISORY GROUP48
MEMBERS OF THE 2001 ADVISORY COMMITTEE.....49
REPORT AUTHORS.....50

Executive Summary

This report describes current and proposed efforts by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the Virginia Department of Health (VDH), as well as other suicide prevention partners, to reduce suicide in the Commonwealth of Virginia. The report utilizes data from the VDH Virginia Violent Death Reporting System (VVDRS) and Virginia Hospital Information (VHI) to quantify the problem of suicide in the Commonwealth, including identifying areas of high suicide burden and risk factors for self-harm. The goals and objectives described here 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.

A central tenet of this plan is that ***suicide is preventable***, and this core belief should be adopted throughout the Commonwealth. This report recognizes that ***risk and protective factors for suicide vary over the lifespan***, and that some groups have particularly high suicide risks that warrant targeted intervention planning, including active military and veterans, persons with psychiatric and substance use disorders, adolescents, and older adults. The high risk groups are identified in the 2012 National Strategy for Suicide Prevention. This plan is also intended to ***enhance coordination of care and related organizational and stakeholder effort*** around preventing suicide. Finally, the recommendations of this report focus on ***use of evidence-based and evidence-informed approaches*** to reduce self-harm behaviors and suicide risk.

The Plan presents seven goals to reduce and prevent suicide across the Commonwealth of Virginia:

- (1) To foster leadership, collaboration and partnerships among public, private, non-profit and community entities, including the integration and coordination of suicide prevention efforts across multiple sectors;
- (2) To promote research-informed communication designed to increase acceptance, understanding and recovery for mental, emotional and behavioral well-being;
- (3) To provide training and education to enable communities to recognize and respond to suicide risk and educate support systems of those at risk for suicide;
- (4) To ensure a seamless continuum of care for those at risk for suicide and their support networks;
- (5) To reduce barriers and increase access to mental/behavioral health services and supports;
- (6) To cultivate resources and leadership among attempt survivors and survivors of suicide loss and provide support and care for these individuals, while also implementing postvention strategies within communities; and
- (7) To refine and expand data collection and evaluation of suicide prevention initiatives.

The Plan describes how these goals can be achieved by a coordinated effort among three key groups, namely *State Agencies and other entities of the Commonwealth; Early Learning Centers, Schools, Colleges and Universities;* and *Community, Non-profit and Faith-based Organizations* throughout Virginia.

History of Suicide Prevention Efforts in Virginia

Suicide prevention has been a goal in Virginia prior to codification of prevention efforts in any formal Plan.^a In 1988, a Joint Subcommittee established by the General Assembly reported on strategies to prevent youth suicide in the Commonwealth. Similarly, the then-Department of Aging produced a report focusing on suicide among the elderly, resulting in a Suicide and Substance Abuse Prevention Plan for the Elderly in 1990. Even before state-led suicide prevention initiatives, community hotlines, largely supported by volunteer work, were established to provide support for callers in crisis. Concurrently, many areas saw the creation of suicide loss support groups which continue to provide assistance and support to bereaved persons today.

In 2000, a series of focus groups including representatives from various state agencies, mental health providers, survivors of suicide loss, school and law enforcement personnel and crisis hotline staff were assembled to assess suicide prevention efforts in Virginia. The resulting Senate Document No. 16, *A Study of Suicide in the Commonwealth*, outlined state and local strategies for reducing suicide risk. At approximately the same time, the first *National Strategy for Suicide Prevention (NSSP): Goals and Objectives for Action* was being formulated and was released in 2001. The NSSP provided goals and objectives to form a comprehensive guide to prevention activities in the U.S. Among these national objectives was the establishment of comprehensive state plans for suicide prevention that coordinate between government and private sector agencies in developing, implementing, and evaluating plans among local communities.^b

Also in 2001, the Virginia Commission on Youth produced a *Youth Suicide Prevention Plan*, published in 2002 as House Document No. 22. A key recommendation of this plan was the designation of VDH as the lead agency for youth suicide prevention. DBHDS subsequently received appropriations for youth suicide prevention including statewide training, development and distribution of materials, and organization of statewide conferences. In 2002, VDH also received major funding for youth suicide prevention in the form of a grant from the Centers for Disease Control (CDC). VDH and DBHDS subsequently initiated Applied Suicide Intervention Skills Training (ASIST) and Question, Persuade, Refer (QPR) training to provide suicide prevention education to community gatekeepers across the state.

In 2003, the Secretary of Health and Human Resources headed a cross-government effort to develop a plan to expand Virginia suicide prevention efforts beyond youth suicide prevention to include the entire lifespan. This led to the *Suicide Prevention across the Lifespan Plan for the Commonwealth* (Senate Document No. 17, 2004). Following recommendations from the NSSP, the *Lifespan Plan* recommended actions to develop suicide prevention infrastructure, promote awareness, and implement evidence-based strategies of suicide prevention at all points of the life-course.^a

Following publication of the 2004 plan, DBHDS was designated in the Code of Virginia as the lead agency for suicide prevention across the lifespan in Virginia. VDH successfully obtained federal CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA) grant support in 2005 for youth suicide prevention activities under the Garrett Lee Smith Memorial Act. With this funding, VDH has provided support to local organizations and service providers as well as continued training to suicide prevention and awareness training among schools and providers across Virginia.

Numerous other developments and initiatives have strengthened Virginia's efforts in suicide prevention. In 2003, the Office of the Chief Medical Examiner (OCME) joined the National Violent Death Reporting System (NVDRS), which has enabled more in-depth data collection and surveillance capability for suicide deaths in Virginia. The Virginia Department of Veterans Services (DVS) has also established Veterans and Family Support (formerly the Virginia Wounded Warrior Program) which provides a network of health, behavioral health, education and other community-based services for military veterans and families in confronting challenges of stress-related and traumatic brain injuries. Furthermore, state training efforts have expanded to include not only Question, Persuade, Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), Suicide Intervention for Everyone (safeTALK) and Response programs, but also prevention education for clinicians through the Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR) program. In late 2009, The Campus Suicide Prevention Center was established. Supported by VDH and James Madison University, the Center aims to reduce risk for suicide among higher education settings in Virginia by providing campuses with training, consultation and prevention resources. The Campus Suicide Prevention Center is further supported by an appropriation in the 2016-2018 Appropriation Act.

In 2009, DBHDS and VDH reconvened a Suicide Prevention Interagency Committee to establish a new collaborative structure to plan and implement suicide prevention activities in the Commonwealth. This group currently includes DBHDS, VDH (including the Office of the Chief Medical Examiner), Virginia Department of Education (DOE), Virginia Department of Criminal Justice, Virginia Department of Juvenile Justice, the Virginia Association of Community Services Boards (VACSB), the Virginia Suicide Prevention Coalition, the U.S. Department of Veterans Affairs, as well as other organizations with a mission to promote awareness of and access to suicide prevention resources in their respective communities. In the same year, a suicide prevention resource directory was established to provide reference to suicide prevention programs in Virginia. This resource is maintained and updated through the VDH website. The directory was most recently updated in August 2016.

In addition to coordination of interagency activities, the Suicide Prevention Interagency Committee has completed a statewide assessment of local Community Services Boards (CSB) suicide prevention partnerships and activity. In 2011, the Committee hosted a series of regional suicide prevention summits which brought community stakeholders together to understand how suicide is affecting their own communities, and what suicide prevention resources and services are available to them. The summits also provided an opportunity for regional stakeholders to identify their communities' needs in regard to suicide prevention and to initiate planning to address those needs. Regional summits were also conducted in seven sites through Virginia in 2012. Efforts in 2013 and 2014 have strengthened the network of suicide prevention trainers with

the provision of ASIST Train the Trainer trainings and anticipated safeTALK Train the Trainer sessions. Additionally, training efforts have expanded to include Mental Health First Aid Training (MHFA). There are currently 338 certified Adult MHFA Instructors and 318 certified Youth MHFA Instructors in Virginia. As a result of these instructor trainings, MHFA has been delivered throughout the Commonwealth, giving Virginia residents the skills needed to recognize and respond to individuals experiencing a mental health crisis.

As of November 2016, approximately 28,800 residents throughout the Commonwealth of Virginia have participated in trainings that teach the skills needed to recognize and respond to individuals experiencing a mental health crisis. The Regional Suicide Prevention Initiative plans are updated yearly and implement multiple strategies to extend the reach and impact of suicide prevention efforts in Virginia.

Significant Events in Virginia and National Suicide Preventionⁱ

- 1988** • Report by the Joint Committee Studying Youth Suicide Prevention.
- 1989** • Report by the Virginia Department for the Aging (VDA) on suicide and substance abuse among the elderly.
- 1990** • Statewide Suicide and Substance Abuse Prevention Plan for the Elderly by the Department for the Aging.
- 1994** • Local child death review teams were established in the Piedmont Region, Fairfax County, and Hampton Roads.
- 1995** • Virginia State Child Fatality Review Team was established by the General Assembly.
- 1999** • Surgeon General’s Call to Action to Prevent Suicide.
- Virginia legislation passed directing the Board of Education, in cooperation with DBHDS and VDH, to develop guidelines for licensed school personnel to use in contacting parents or, if conditions warrant, the local or state services agency when they believe a student to be at imminent risk for attempting suicide.
- Suicide Prevention Guidelines were written and disseminated to school personnel by DOE.
- 2000** • Appropriation of \$75,000 each to VDH and DBHDS for each year of 2000-2002.
- Focus groups examined suicide prevention efforts in Virginia and made strategy recommendations to reduce suicide risk.
- ‘A Study of Suicide in the Commonwealth’ was produced by the VDH.
- Report on Suicide Fatalities among Children and Adolescents in Virginia 1994-1995, by the State Child Fatality Team.
- Healthy People 2010, national goals and objectives, by the U.S. Department of Health and Human Services.
- 2001** • National Strategy for Suicide Prevention: Goals and Objectives for Action.
- Youth Suicide Prevention Plan by the Virginia Commission on Youth, with the assistance of the VDH; DBHDS and DOE.
- VDH was designated as lead agency for youth suicide prevention in the Commonwealth, by amendment to the Code of Virginia (§ 32.1-73.7). VDH was mandated to report annually to the Governor and the General Assembly on its youth suicide prevention activities.

ⁱ The section has been adapted and updated from the 2004 *Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia* state document

- DBHDS initiated the proclamation of Childhood Depression Awareness Day, declared by the Governor on May 8, 2001.
- Interagency Youth Suicide Prevention Coordinating Committee was formed by VDH with representation from DBHDS, DOE, community services boards, and local health departments.
- Virginia Youth Suicide Prevention Advisory Committee was established to advise DBHDS on mental health recommendations from the Youth Suicide Prevention Plan.
- The Virginia Suicide Prevention Council was established as a public-private partnership.
- Position of Youth Violence Prevention Consultant filled by the Center for Injury and Violence Prevention at VDH.
- Applied Suicide Intervention Skills Training (ASIST) and Question, Persuade, Refer (QPR) training initiated by VDH and DBHDS.

2002

- Suicide prevention award of \$966,992 over three years to VDH by the Centers of Disease Control and Prevention.
- Third Annual Virginia Suicide Prevention, Intervention and Healing Conference held, sponsored by DBHDS, the Virginia Suicide Prevention Council, and VDH.
- Senate Joint Resolution No. 108 directed the Joint Commission on Behavioral Health Care, in cooperation with DBHDS and VDH, to develop a plan and strategy for suicide prevention in the Commonwealth.
- Funding received to implement the National Violent Death Reporting System in Virginia through the Office of the Chief Medical Examiner (OCME).
- DBHDS initiated the proclamation of Childhood Depression Awareness Day declared by the Governor on May 7, 2002.
- Website on suicide prevention was created by VDH (www.vdh.virginia.gov/livewell/programs/suicide/).
- Report on Suicide Associated Deaths and Hospitalizations, Virginia 2000, by the Center for Injury and Violence Prevention, VDH.
- Report on Child Death in Virginia: 2001, by the Virginia State Child Fatality Review Team.

2003

- Developing a Plan and Strategy for Suicide Prevention in the Commonwealth by the Joint Commission on Behavioral Health Care. Recommended establishment of an interagency and cross-secretarial effort to formulate a comprehensive Suicide Prevention across the Lifespan Plan for the Commonwealth.
- Senate Joint Resolution passed by the General Assembly requested the Secretary of Health and Human Resources to formulate a comprehensive Suicide Prevention across the Lifespan Plan for the Commonwealth.
- DOE Suicide Prevention Guidelines were revised to include criteria for following up with parents of students expressing suicidal intentions after initial contact has occurred.

- Interagency Youth Suicide Prevention Coordinating Committee's name was changed to Interagency Suicide Prevention Coordinating Committee and was expanded to cover the lifespan and representation was broadened to include the Virginia Department for the Aging, the Virginia Commission on Youth, and the Department of Corrections.
 - Regional Planning Sessions for Suicide Prevention were held in Abingdon, Lynchburg, Arlington, Prince William County, and Norfolk and with representatives of faith-based organizations, higher education institutions, and with the Interagency Suicide Prevention Coordinating Committee.
 - Office of the Chief Medical Examiner (OCME) joined the National Violent Death Reporting System, which enabled more in-depth data collection and surveillance capability for suicide deaths in Virginia.
- 2004**
- Suicide Prevention across the Lifespan Plan for the Commonwealth (Senate Document 17, 2004) was released.
 - DBHDS was designated in the Code of Virginia as the lead agency for suicide prevention across the lifespan in Virginia.
 - Garrett Lee Smith Memorial Act (GLSMA) was signed into law.
- 2005**
- VDH obtained SAMHSA grant support for youth suicide prevention activities.
- 2008**
- The Governor and Virginia General Assembly statutorily established the Virginia Wounded Warrior Program as a component of the Virginia Department of Veterans Services and provided on-going funding for behavioral health and rehabilitative services for veterans, National Guard and Reserves and their families.
- 2009**
- DBHDS and VDH reconvened the Suicide Prevention Interagency Committee to establish a collaborative structure for planning and implementing suicide prevention activities.
 - VDH established the Campus Suicide Prevention Center of Virginia, which provides strategic planning, training and technical resources to 72 college and university campuses.
- 2011**
- Suicide Prevention Workgroup completed a statewide assessment of local suicide prevention partnerships and activities.
 - Regional suicide prevention summits were conducted.
- 2012**
- Input from the Suicide Prevention Interagency Committee was incorporated into an updated Virginia Suicide Prevention across the Lifespan Plan.
 - VDH obtained new SAMHSA grant support for youth suicide prevention activities.

- 2013/14**
- Trainer network strengthened through ASIST and safeTALK T4Ts.
 - MHFA Adult and Youth Instructor trainings conducted.
- 2016**
- Further updates made to Virginia Suicide Prevention across the Lifespan Plan.
 - As of November 2016, approximately 28,800 residents throughout the Commonwealth of Virginia have participated in trainings that teach the skills needed to recognize and respond to individuals experiencing a mental health crisis.
 - VDH awarded an allocation in the 2016-2018 Appropriate Act to support the Campus Suicide Prevention Center of Virginia in providing all public and private institutions of higher learning throughout Virginia with training, consultation and prevention resources.

Epidemiology of Suicide and Self-Harm Injuries in Virginia: 2003 to 2014

Summary: Suicide Death

The Virginia Violent Death Reporting System (VVDRS), part of the National Violent Death Reporting System (NVDRS), provides data regarding death by suicide in Virginia. In 2013 there were 1,048 suicide deaths among Virginia residents.^c The overall incidence of suicide for the Commonwealth in the same year was 12.7 per 100,000 residents (with an age-adjusted rate of 12.6 per 100,000).ⁱⁱ In 2013, suicide was the 11th leading cause of death in Virginia; it was the second leading cause of death among those 25-34 years of age and among those 15-24 years of age.^d For comparison, the overall rate of homicide in Virginia in 2013 was 4.0 per 100,000, making it the 18th leading cause of death.^d

The demographic characteristics of suicide decedents and methods of fatal injury among Virginia residents in 2013 were similar to prior years.^a Distribution of these characteristics is broadly described below for the 1,048 total suicide deaths in Virginia in 2013:

- Race and sex
 - 817 (78%) were by men
 - 925 (88%) were by White individuals, 94 (9%) by Black individuals
 - 711 (68%) were by White males
- Age
 - 385 (37%) among persons aged 35-54 years,
 - 182 (17%) by those 65 and older
- Method of injury
 - 579 (55%) by firearm
 - 233 (22%) by hanging, strangulation or suffocation
 - 158 (15%) by poisoning

Contrary to national objectives regarding suicide put forth in 2000,^e the overall suicide rate in the United States has not decreased in the time period from 2000 to 2013 (Table 1). In 2013 suicide was the 10th leading cause of death overall in the US.^d Paralleling national trends, suicide incidence in Virginia was as high or higher in 2010 than in any prior year in the decade (Table 1).^{c,d} In 2013, the suicide rate in Virginia was the 34th highest among states.^f

Unless otherwise specified, all Virginia state-specific data come from the Virginia Violent Death Reporting System

Table 1: Suicide Death Rates per 100,000 in Virginia and the United States, 2003-2013

Year	United States	Virginia
2003	10.9	10.8
2004	11.1	11.0
2005	11.0	11.3
2006	11.2	11.4
2007	11.5	11.3
2008	11.9	12.0
2009	12.0	12.1
2010	12.4	12.3
2011	12.7	12.8
2012	12.9	12.7
2013	13.0	12.7
2014†	13.4	13.3

†2014 state rate provided is a provisional estimate.
 State data source: Virginia Violent Death Reporting System
 National data source: CDC WISQARS

Overall Trends in Suicide Death

The total number of suicides annually in Virginia increased from 2003 to 2013 (Figure 1). Likewise, the overall rate of suicide also increased steadily from 10.8 to 12.7 per 100,000 residents from 2003 to 2013 (Figure 2). The number and rate of suicide was higher among men than women and the suicide rate among men also showed a more pronounced increase from 17.0 to 20.1 suicide deaths per 100,000 residents. The trend of increasing number and rate of suicide parallels gender-specific and overall trends nationally.

Figure 1: Number of Virginia Resident Suicide Deaths by Sex, 2003-2013

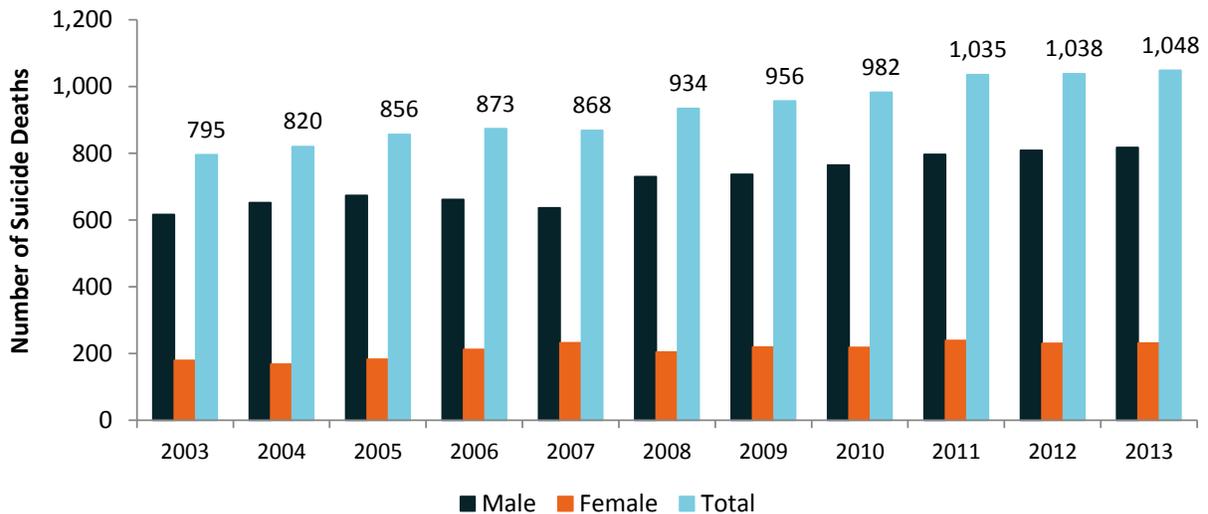
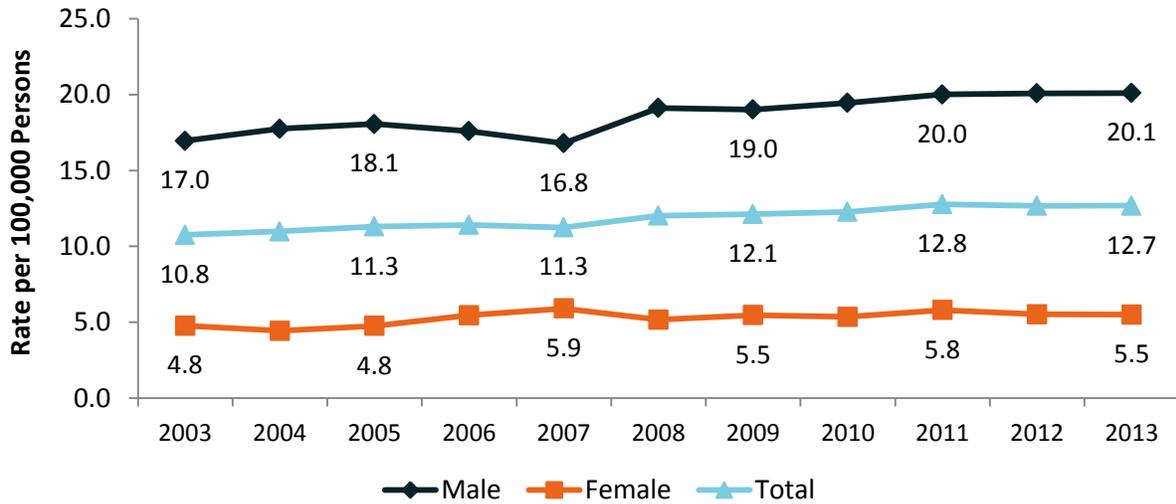


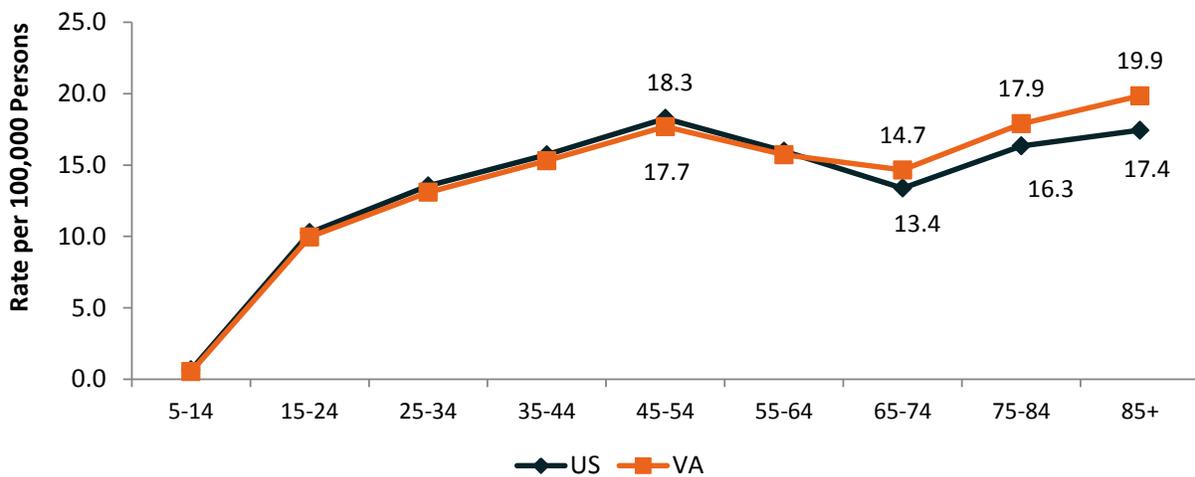
Figure 2: Virginia Resident Suicide Death Rates per 100,000 Persons, Overall and by Sex, 2003-2013



Age-related Trends in Suicide Death

The distribution of suicide rate by age group was similar in Virginia and the US when comparing aggregated data from 2003-2013 (Figure 3). The highest rates of suicide in Virginia occurred among adults age 45-54 (17.7 per 100,000), adults age 85 and older (19.9 per 100,000), and adults age 75-84 (17.9 per 100,000). As in years prior to 2003,^a suicide rates in the Commonwealth were generally higher than national rates among adults over the age of 65 and generally lower among younger adults, but these differences were slight and subject to variability. Yearly trends suggest that while most group-specific rates remained relatively constant over the time period, certain groups, such as those aged 45-64, showed steadily increasing suicide rates. In particular, the rate among those aged 55-64 increased from 12.0 to 18.2 suicide deaths per 100,000 in the time period from 2003 to 2013.

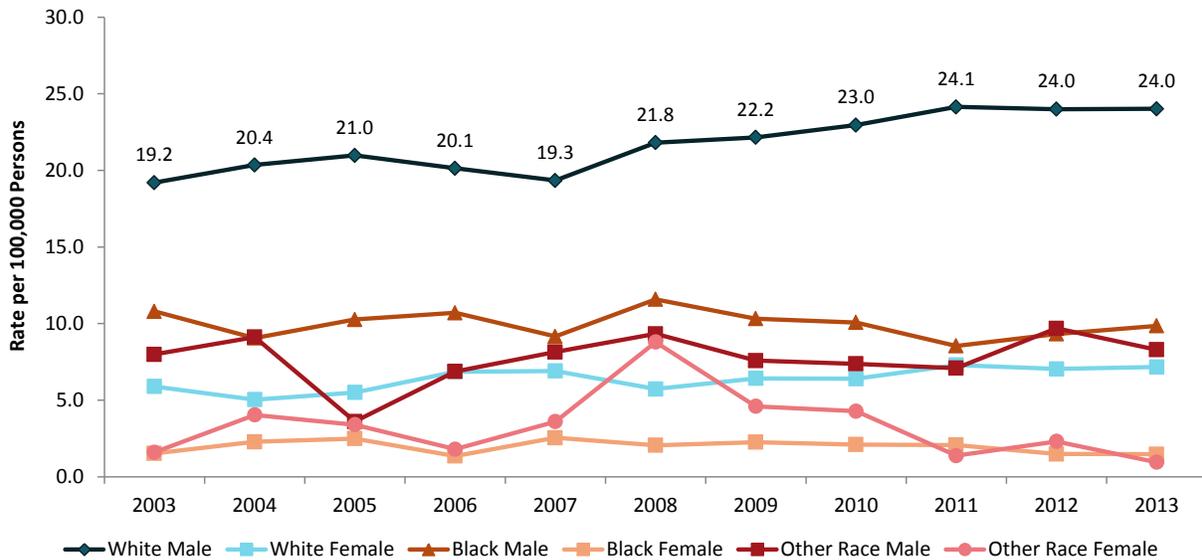
Figure 3: Average Age-Specific Suicide Death Rates per 100,000 Persons, Virginia and U.S., 2003-2013



Race and Sex-related Trends in Suicide Death

Data regarding suicide rates in Virginia from 2003 to 2013 suggest that race and sex are closely associated with suicide rates. Suicide rates were consistently highest among white males, with black males, males of other races, and white females having the next highest rates of suicide over the same time span (Figure 4). The data also suggest that, while suicide rates remained consistent from year to year for most race and sex groups, the rate among some groups increased considerably. For instance, the rate among white males increased from 19.2 to 24.0 per 100,000 residents.

Figure 4: Virginia Resident Suicide Death Rates by Race and Sex: Virginia, 2003-2013



Note: Suicides among persons of Asian descent are rare in Virginia, and are therefore included in the “Other Race” categories due to small numbers of cases. Persons of Hispanic descent are classified in the figure above by their race and not their ethnicity. Hispanic people who completed a suicide are predominantly white, and are therefore included in the “White Male” and “White Female” categories.

The association between age and suicide rate is not uniform across all race-sex categories and in fact varies markedly as seen in Figure 4. With respect to suicide rates, differences of race and sex within and between age groups are revealing of complex interactions between these factors. Consistent with previous findings for the Commonwealth,^a the suicide rate among white males increased steadily across the lifespan, reaching a peak in later life (Figure 4). Among white males 85 and older, the rate of suicide was the highest among any age-sex-race group at 62.1 per 100,000 residents. For white females, the suicide rate peaked in middle age (45-54 years) but diminished in later life. Among non-white males, the suicide rate peaked in early adulthood (ages 20-34) and then again in late life. For non-white females the suicide rate was consistently low across the lifespan. After adjustment for age, suicide rates remained highest among white males followed by non-white males (Table 2).

Table 2: Age-Adjusted Average Annual Suicide Rates per 100,000 by Race and Sex: Virginia, 2003-2013

	White	Non-White
Male	22.0	9.4
Female	6.4	2.3

Means of Injury in Suicide Death

The most common means of suicide in Virginia from 2003 to 2013 was firearm (55.7%), followed by hanging, strangulation or suffocation (20.6%), poison (16.8%), and other methods as described in Table 3. These proportions remained mostly consistent across each year during the 2003-2013 period. Firearm was the most common method of suicide among white and black males of all adult ages.^b Among white females across most ages, the most common method of suicide was poisoning.^b Among black females, suicides by firearm and poisoning were equal in number. As displayed in Table 4, the rates of suicide by each method remained generally consistent across year. Use of firearm increased slightly from 6.1 to 7.0 per 100,000, but it is not clear whether this increase reflects a trend or random variation.

Table 3: Total Number and Percentage of Fatal Agents in Suicide Deaths, by Group: Virginia, 2003-2013

Fatal Agent	Number	%
Firearm	5,750	55.7
Hanging, Strangulation, Suffocation	2,122	20.6
Poison	1,738	16.8
Fall	204	2.0
Sharp Instrument	171	1.7
Drowning	144	1.4
Other	193	1.9

More than one method of fatal injury may be reported per suicide. Methods of fatal injury will not sum to the total number of suicides, nor sum to 100%.

Table 4: Rates of Fatal Agents in Suicides by Year: Virginia, 2003-2013

Fatal Agent ¹	2003 Rate ²	2004 Rate	2005 Rate	2006 Rate	2007 Rate	2008 Rate	2009 Rate	2010 Rate	2011 Rate	2012 Rate	2013 Rate
Firearm	6.1	6.5	6.7	6.4	6.2	6.6	6.6	7.0	7.3	7.1	7.0
Hanging/Strang./Suff.	2.1	2.2	2.1	2.0	2.2	2.5	2.7	2.7	2.9	2.8	2.8
Poison	2.0	1.7	1.9	2.1	2.3	2.1	2.1	1.8	2.0	2.2	1.9
Fall	0.2	0.1	0.3	0.3	0.2	0.2	0.2	0.2	0.3	0.2	0.3
Sharp Instrument	0.1	0.2	0.3	0.2	0.2	0.3	0.2	0.2	0.2	0.1	0.2
Drowning	0.2	0.2	0.1	0.2	0.1	0.2	0.1	0.2	0.1	0.2	0.2
Motor Vehicle	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.1	0.0	0.1	0.2
Other Transport Vehicle	0.1	0.0	0.0	0.1	0.1	0.0	0.1	0.1	0.1	0.1	0.1
Fire or Burn	0.0	0.0	0.1	0.1	0.1	0.0	0.1	0.1	0.0	0.1	0.1
Non-powder Gun	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Blunt Instrument	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Intentional Neglect	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Total	10.8	11.0	11.3	11.4	11.3	12.0	12.1	12.3	12.8	12.7	12.7

¹ More than one method of fatal injury may be reported per suicide. Methods of fatal injury will not sum to the total number of suicides, nor sum to 100%.

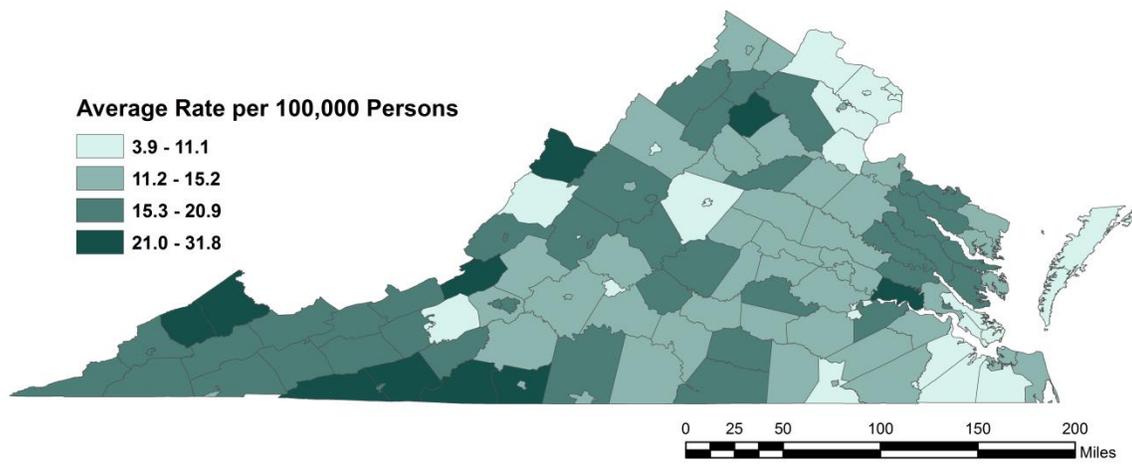
² Rates reflect risk per 100,000 persons.

Source: Virginia Violent Death Reporting System

Geographic Distribution of Suicide Death in Virginia

At the county/locality level, there were six localities with rates at least twice as high as the state average (Map 1). The highest rates in this period occurred in Dickenson County, Rappahannock County, Patrick County, Craig County, Buchanan County, and Grayson County (in descending order). Also consistent with previous reports, more densely populated localities such as Fairfax County, Henrico County and Virginia Beach City, which combined produced 18% of all suicides in the state over the eleven-year period, had rates similar to or lower than the state average

Map 1: Average Annual Suicide Rates by Locality: Virginia, 2003-2013



Lifespan Characteristics of Suicide Death in Virginia

Many risk and protective factors for suicide and suicidal behavior are well known (below). Only 30-45% of those who die by suicide have contact with a mental health care professional in the year before death and even fewer report suicidal ideation.^b Mental health conditions thought to contribute to risk of suicide are depression and other mood disorders, schizophrenia, certain personality disorders and substance abuse disorders.^b Data from Virginia further underscore the relationships between mental health disorder and suicide risk. For instance, in the period between 2003 and 2013, approximately 55.4% of suicide decedents in Virginia had a diagnosed mental health disorder at the time of death. Furthermore, 28.2% of suicide decedents had a problem with alcohol or other substance use at the time of death. Approximately 40% of those who died from suicide were receiving mental health treatment at the time of death.

Risk Factors for Suicideⁱⁱⁱ

Biopsychosocial Risk Factors:

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness

ⁱⁱⁱ Adapted from USDHHS *National Strategy for Suicide Prevention: Goals and Objectives for Action* & Virginia DBHDS *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia*

- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors:

- Job or financial loss; low socio-economic status
- Relational or social loss
- Easy access to lethal means
- Contagious influence of suicide clusters

Sociocultural Risk Factors:

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health care, mental health care and substance abuse treatment
- Certain cultural and religious beliefs
- Exposure to, including through the media, and influence of others who have died by suicide.

While some risk factors and characteristics of suicide appear to be universal, there is great variability in these factors across the lifespan. As Table 5 suggests, there are complex and dynamic relationships between risk factors and suicide at different periods of the life course. While characteristics of suicide are by no means exclusively related to one age group of individuals, patterns of characteristics and previous research literature suggest that some characteristics are of greater significance at certain ages. An examination of risk factors within age groups is thus informative of these relationships and reveals potential avenues for intervention and prevention.

Table 5: Selected Characteristics of Suicide Decedents: Virginia, 2003-2013

Age Group	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
	%	%	%	%	%	%	%	%	%	%
Crisis Within Two Weeks	67.3	50.1	45.9	47.1	44.8	38.4	28.8	23.0	27.8	22.2
Non-intimate Partner Problem	50.9	32.0	15.5	9.4	8.9	10.0	7.6	6.8	4.9	6.6
Any MH Problem	41.8	44.2	49.4	54.5	58.1	60.9	60.3	53.5	43.0	36.2
Diagnosed Depression	29.1	31.1	35.8	39.1	43.6	48.6	48.9	44.3	35.0	29.2
Intimate Partner Problem	12.7	34.4	41.4	49.6	45.3	35.7	23.5	14.0	8.2	4.9
Death of Family Member (Past 5 Years)	5.5	6.6	5.4	5.0	5.5	6.1	7.0	11.3	11.5	14.8
Problem with Alcohol or Other Substance	3.6	19.8	28.4	36.3	36.2	34.3	24.3	15.5	5.9	3.3
Job Problem	1.8	4.0	10.5	13.9	16.9	18.0	16.0	3.8	1.2	0.4
Physical Health Problem	0.0	1.2	3.0	5.2	9.7	15.4	25.1	45.9	64.2	62.1

Youth (10-19 Years)

Epidemiologic studies have found a lower proportion of psychiatric diagnoses among youth who died of suicide than among adults who died of suicide.^{h,i} This is also true in the Virginia data, where approximately 42% of youth who died by suicide had been diagnosed with a mental health disorder. Some suggest that the low rate of diagnosis among youth may reflect under-diagnosis.^g Improved surveillance and diagnosis of youth mental health disorders may thus be a potential target to impact youth suicide rates.

Other risk factors for suicide and suicidal behavior found to have particular significance in youth include poor family relationships and family functioning,^{g,j,k} problems at school, and alcohol intoxication.^j In Virginia, problems at school (38%), problems with non-intimate partner relationships (51%), and having a crisis within two weeks of suicide (67%) were prevalent among youth (ages 10-14) who died of suicide. While alcohol and criminal legal problems were not prevalent among youth ages 10-14 in Virginia, approximately 20% of suicide decedents ages 15-19 had alcohol and/or substance use problems and 13% had recent criminal legal problems.

Early to Middle Adulthood (20-44 Years)

Data from Virginia suggest that those who died from suicide in this age group were likely to have had problems with intimate partner relationships. For instance, 50% of suicide decedents aged 25-34 and 45% of those 35-44 had such problems at the time of death. Recent evidence from studies of the characteristics of suicide among persons in this age group revealed that having intimate partner problems were common characteristics among suicide decedents.^l

Furthermore, suicide decedents in this age category had an elevated likelihood of problems with alcohol and/or other substances at the time of death. Approximately a third of those who died of suicide in Virginia at ages 20 to 44 had such problems. The overall prevalence of substance abuse problems underscores the importance of efforts to increase the detection and treatment of alcohol and substance use disorders, and to promote efforts to reduce stigma associated with being a consumer of substance abuse services, especially among those aged 20-44.

Military Personnel

Within this age group, military personnel warrant special mention, as the majority of suicide decedents in the military are between the ages of 20 and 44. For instance, from 1998 to 2011 over 90% of active and reserve military personnel who died of suicide were between the ages of 20 and 44. The characteristics of military suicide decedents were also similar to civilians in this age group. For instance, the characteristics most common among Army active duty personnel were intimate partner problems, military-related stress, and current job problems.^m Since 2010, suicide has been the second leading cause of death among US military service members.ⁿ While rates of suicide among active-duty soldiers in the US Army decreased for the first time in six years in 2010, suicide rates among National Guard and Reserve soldiers have seen major increases.^{o,p} High suicide rates among military service members are thought to be the result of the convergence of risk factors (e.g. male gender, firearm ownership), as well as unique factors such as military-related stress.^{m,p}

Middle to Later Adulthood (45-64 Years)

Previous research based on national suicide data suggests that this age group may account for much of the increase in the overall suicide rate up to 2005, especially increases among white persons.^q The Virginia data reveal that those who died by suicide in this age group were the most likely to have a current diagnosis of depression among all age groups. Furthermore, along with those aged 20-44, suicide decedents in this age group were likely to have had a previous suicide attempt. That is, approximately 18-27% of suicide decedents ages 20-64 had a previous suicide attempt compared, for instance, to approximately 7-12% among older adults. This finding stresses the importance of providing appropriate mental health care and follow-up for persons diagnosed with depression and other mental health disorders, as well as follow-up care for those who have attempted suicide.

Suicide decedents in the 45-64 year age group in Virginia were the most likely to have had financial problems, job problems, or to have experienced eviction, foreclosure or loss of housing. This finding is consistent with previous research showing that financial stressors such as job loss and other economic difficulties are important factors for suicide in midlife, particularly among men.^r

Older Adults (65+ Years)

Among older adults the most common characteristic factors for suicide include affective disorders, past history of suicidal behavior, hopelessness, physical illness, loss of a spouse and functional impairment.^s The overall percentage of all older adult suicide decedents with depression was lower than among some other age groups, however the lower prevalence of depression may again be an issue of under-diagnosis, especially considering that older adults are less likely to seek mental health care and to be diagnosed with mental health disorder such as depression.^t On the other hand, physical illness was highly associated with suicide among older adults in that it was present in 56% of suicide decedents over the age of 65. Despite a high likelihood of contact with primary care physicians, older adults have a low likelihood of being diagnosed with and treated for mental health illness such as depression in these settings.^t Primary care physicians often lack specialized training in recognizing suicide risk, evaluating mental health and coordinating appropriate mental health care, indicating another avenue for training and intervention.^t Primary care settings represent important points of engagement at which to find seniors at risk and to coordinate care with mental health services.^u

Social factors which contribute to suicide risk are also distinct among older individuals. In the Virginia data, older suicide decedents were more likely to have experienced the death of a family member in the past 5 years, yet less likely to have had problems with intimate partner relationships. Other common social disturbances in later life thought to contribute to suicide risk are bereavement, financial loss, retirement changes, family discord and loss of social support.¹

Summary: Self-Harm Hospitalizations

VDH uses inpatient discharge data provided by Virginia Hospital Information (VHI)^v to track hospitalizations attributable to self-harm injuries and suicide attempts. These data represent all inpatient discharges of Virginia residents occurring in Virginia’s non-federal, acute care hospitals. All of the data presented in this section of the report come from this data source. It should be noted that data on inpatient cases will not reflect the total burden of self-harm and suicide attempts in Virginia, as an unknown number of cases would be expected to be treated in the emergency department and discharged before admission to inpatient status or to result in an injury that did not require medical attention. Furthermore, it is impossible to distinguish from these data whether the hospitalization was an attempted suicide or an attempt at self-harm without suicidal intent. Therefore, these hospitalizations are conservatively referred to here as self-harm events.

According to VDH’s analysis of these data, the rate of self-inflicted injury increased between 2003 and 2013 to a crude rate of 43.1 per 100,000, and then decreased to a rate of 38.9 per 100,000 in 2014 (Figure 5). The total number of these hospitalizations exceeded 3,700 in 2012, a steep increase from the 2,584 recorded in 2003 (Figure 6).

Figure 5: Self-Harm Hospitalization Rate per 100,00: Virginia, 2003-2014

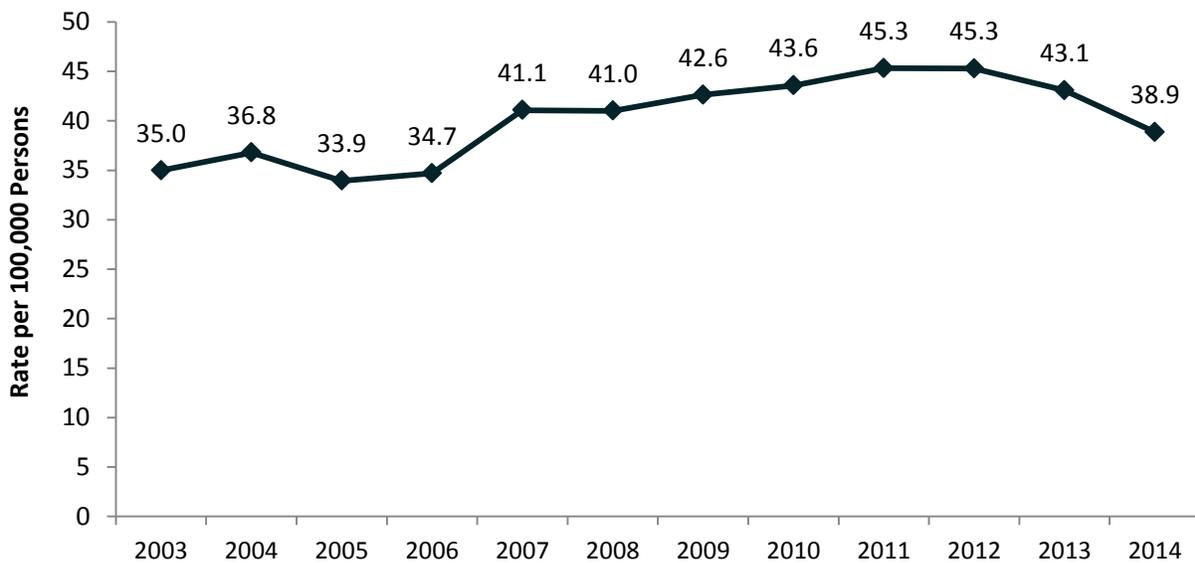
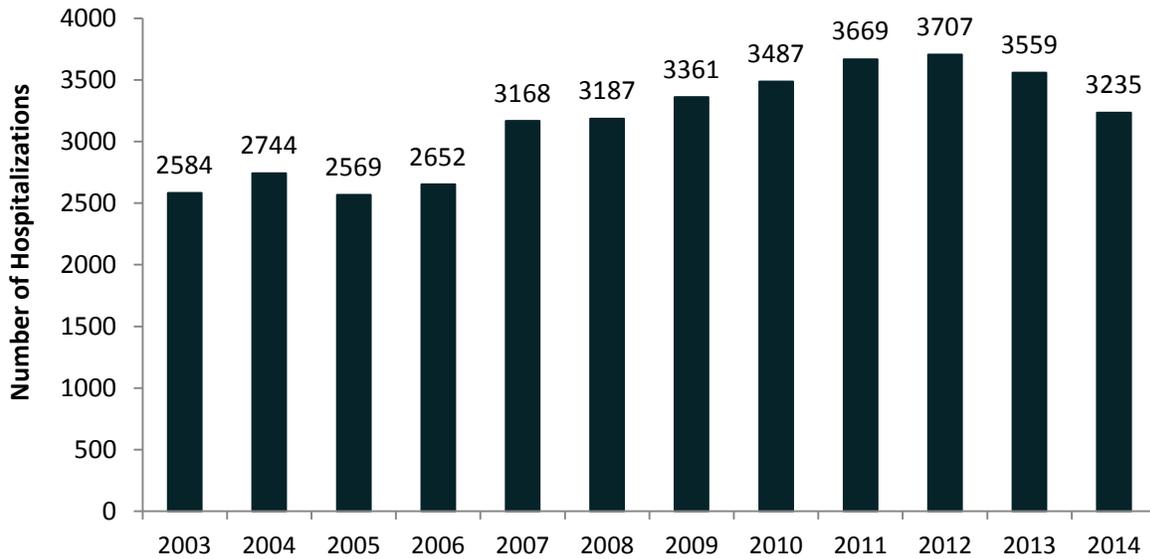
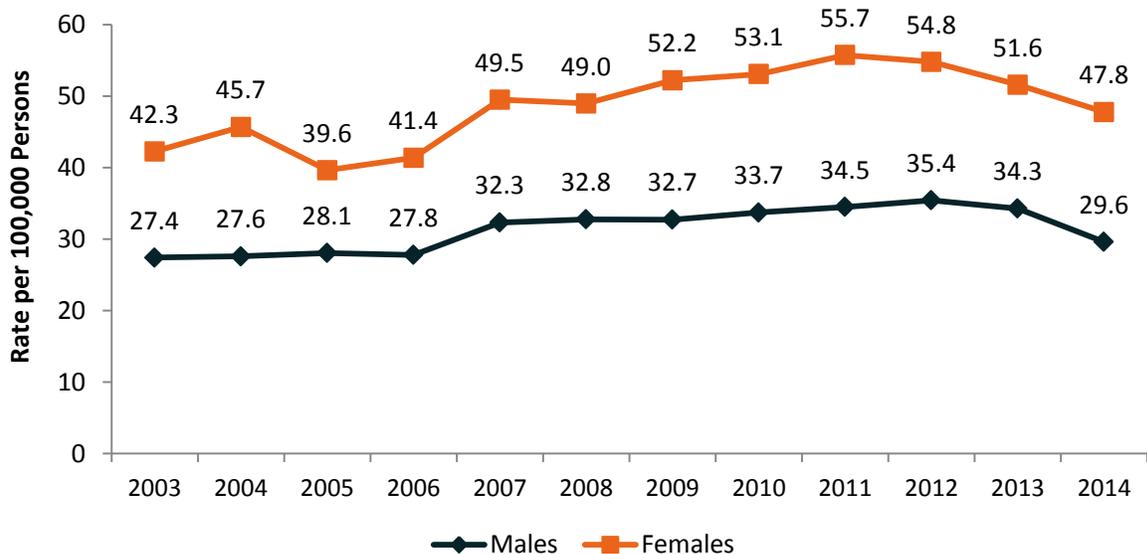


Figure 6: Number of Self-Harm Hospitalizations by Year: Virginia, 2003-2014



Furthermore, although suicide death is more common among men, the crude rate of self-harm hospitalization is consistently higher among women than men in Virginia (Figure 7). Similar annual trends are apparent in the period shown, but the overrepresentation of females in these inpatient cases is evident in each year's data. In 2003, the crude female self-harm hospitalization rate was 1.5 times higher than the male rate. In 2014, female rates were 1.6 times higher than male rates. It should be noted that differences between male and female suicide rates and male and female self-harm hospitalization rates may represent differential access to or use of lethal means among these populations.

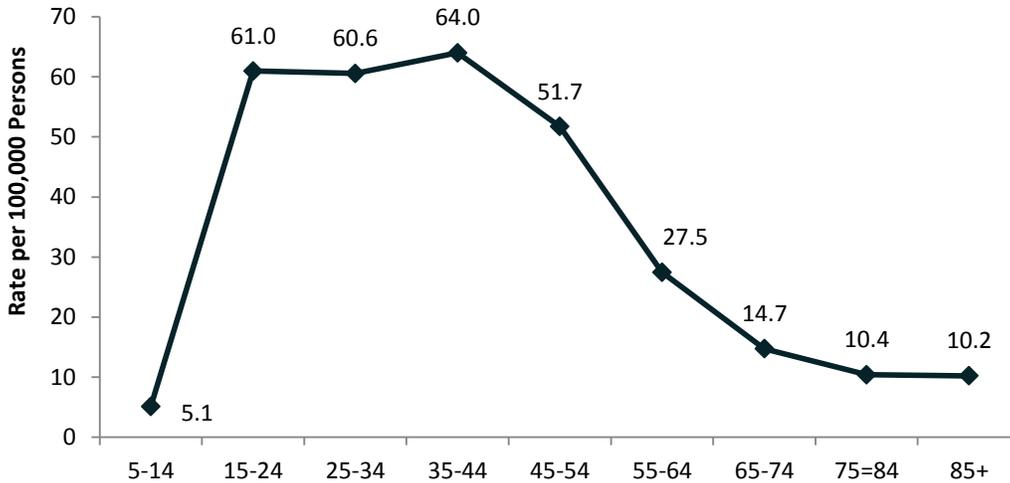
Figure 7: Self-Harm Hospitalization Rates by Sex: Virginia, 2003-2014



Age-related Trends in Self-Harm Hospitalizations

Comparing data averaged across the 2003-2014 period, the highest rates of self-harm hospitalization occurred for individuals between the ages of 35 and 44 years, 15 and 24 years, and 25 and 34 years (Figure 8). Rates among younger children and youth were the lowest of any age group. Unlike suicide death rates, rates of self-harm hospitalization were generally also low among older adults.

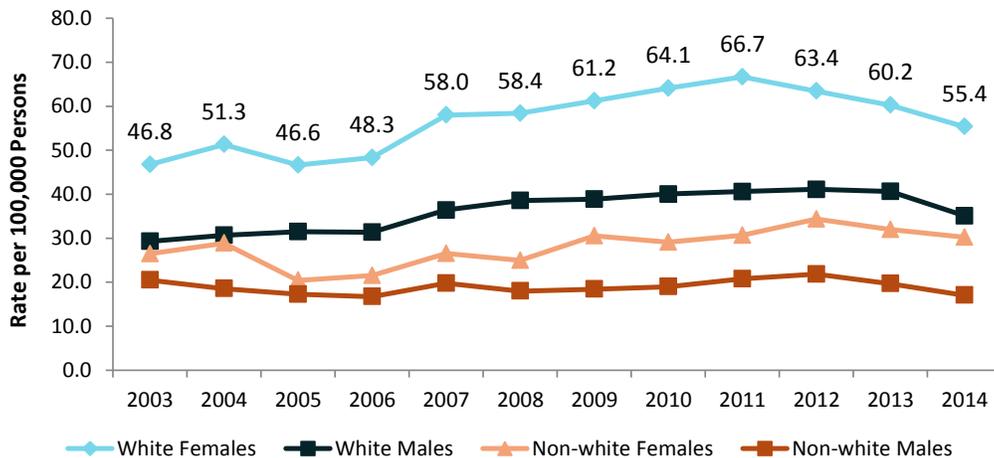
Figure 8: Average Age-Specific Self-Harm Hospitalization Rates per 100,000: Virginia, 2003-2014



Race and Sex-related Trends in Self-Harm Hospitalization

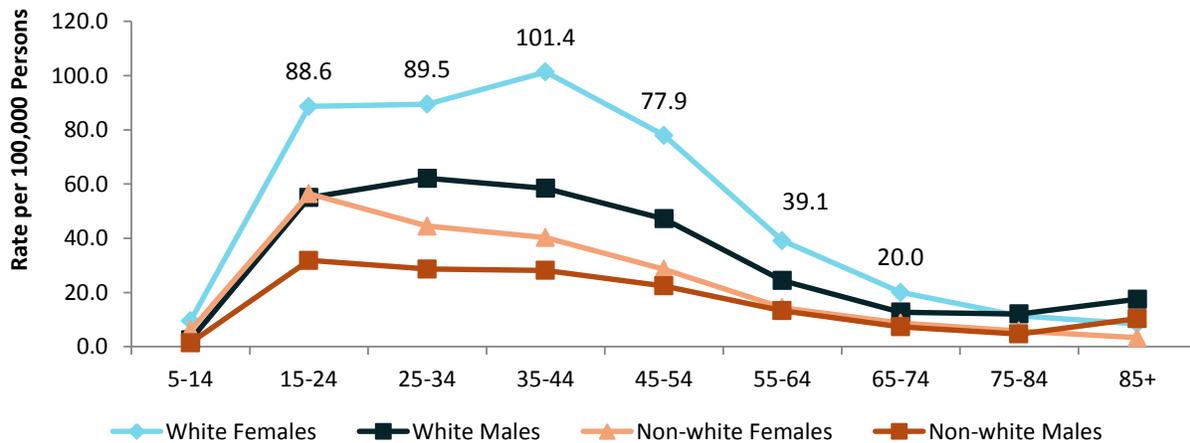
White females had the highest rates of self-harm hospitalization across the 2003-2014 period, rising to a high of 66.7 per 100,000 in 2011 before dropping to a rate of 55.4 per 100,000 in 2014 (Figure 9). White male rates were also elevated in comparison to rates for non-white males and females, ranging from a low of 29.3 per 100,000 in 2003 to a high of 41.1 per 100,000 in 2012 before declining to 35.1 per 100,000 in 2014. Female rates for both whites and non-whites exceeded rates for the males of the same racial group across the entire period.

Figure 9: Self-Harm Hospitalization Rates per 100,000 by Race and Sex: Virginia, 2003-2014



When average rates for these same race/sex groups are calculated by age group for the period of 2003 to 2014, general trends emerge. White females experience very high rates of self-harm hospitalization between the 15 and 54 age groups, with the highest rates among those ages 35-44, where the average rate across the 2003-2014 period was 101.4 per 100,000 (Figure 10). While rates among the different race/sex groups were more similar (and consistently lower) later in the lifespan, the disparity in self-harm hospitalization rates between these groups in young adults and those at middle age is visible.

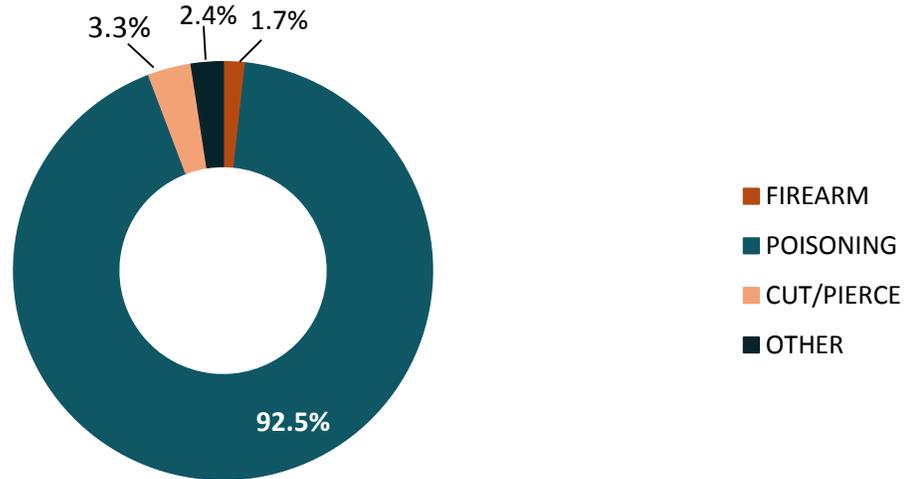
Figure 10: Average Annual Age-Specific Self-Harm Hospitalization Rates per 100,000, by Race and Sex: Virginia, 2003-2014



Means of Injury in Self-Harm Hospitalization

More than 90% of the self-inflicted injury hospitalizations in Virginia between 2003 and 2014 were attributable to poisoning, followed by cutting/piercing (3.3%) and firearms (1.7%) (Figure 11). All other mechanism categories accounted for only 2.4% of all self-harm discharges in this period. This distribution of mechanism categories for self-inflicted injury hospitalizations may reflect differences in both the frequency with which a given mechanism is chosen for self-harm as well as the lethality of the mechanism and the more intensive nature of treatment for particular injury types. As self-harm injury hospitalizations only represent cases where an injury was both serious enough to require an inpatient admission and where the patient survived to the time of admission, they are not a representative cross-section of all self-inflicted injury attempts. While not depicted here, the percentage distributions of these mechanism categories did not substantially differ across time between 2003 and 2014. In each data year in this study period, poisonings accounted for 90% or more of the total hospitalizations.

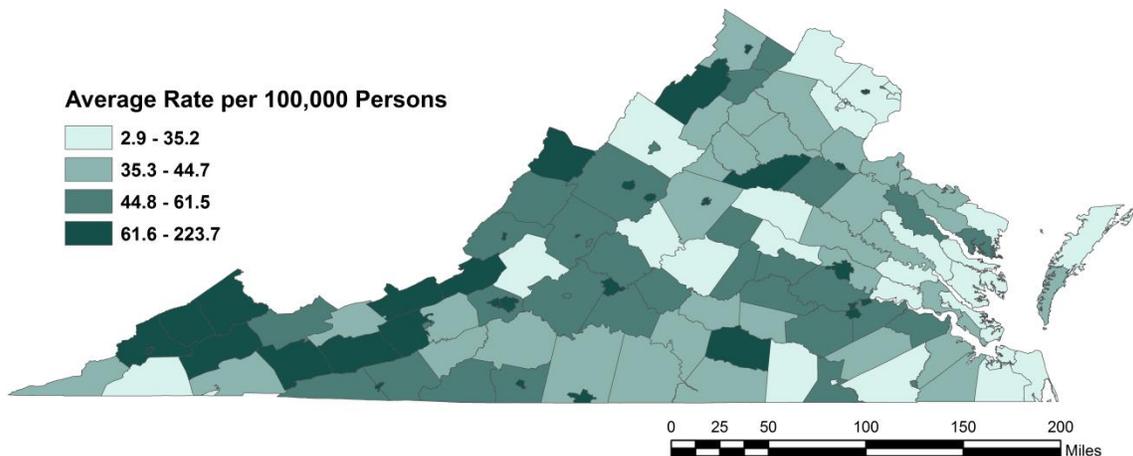
Figure 11: Distribution of Primary Injury Mechanisms among Self-Harm Hospitalizations: Virginia, 2003-2014



Geographic Distribution of Self-Harm Hospitalization in Virginia

Mapped average annual rates of self-harm hospitalization for the 2013-2014 period are given below by locality (Map 2). The highest rates in this period occurred in Norton City, Galax City, Covington City, Bedford City, and Highland County (in descending order). These generally represent localities with smaller populations in more rural areas; therefore, while rates in these areas were higher than in other localities in Virginia, the absolute count of self-harm hospitalization cases was not necessarily substantial, given the smaller size of the population at risk in any area. More populated areas of the state, including Fairfax County, Chesterfield County, Virginia Beach City, Richmond City and Henrico County account for the highest number of cases over this two year period, though these high case counts did not necessarily translate into higher rates, given the fact that these are larger, metropolitan, suburban or urban areas where population totals are higher.

Map 2: Average Annual Self-Harm Hospitalization Rates by Locality: Virginia, 2013-2014



Directions for Suicide Prevention: Guidance from National Task Forces

In the 10 years since the publication of the *Suicide Prevention across the Lifespan Plan for the Commonwealth*, a great deal has been accomplished in strengthening and expanding the Commonwealth's suicide prevention efforts and in working towards the objectives described in the plan. As knowledge and awareness related to suicide prevention grows, attention has turned to updating national and state objectives to reflect evolving emphases, to address shortcomings and to refocus efforts toward the most effective strategies. At the national level, the *2012 National Strategy for Suicide Prevention* and *Suicide Care in Systems Framework* has been developed to provide guidance and a framework for suicide prevention work nationwide over the next decade.

Suicide Care in Systems Framework

In, *Suicide Care in Systems Framework*, the Clinical Care and Intervention Task Force provides a framework by which healthcare systems may organize suicide prevention efforts for proven effectiveness.^w The themes and objectives proposed by the task force and outlined below extend beyond the systems context and help to signify directions for suicide prevention going forward in Virginia and elsewhere.

Beliefs and Attitudes^{iv}

Leadership Leading to Cultural Transformation

Many health and behavioral health practitioners believe that ultimately, suicide is unavoidable and therefore inevitable. This false belief creates a culture of acceptance that works against effective suicide prevention. A central tenet of the current model of suicide prevention is the need to instill, throughout organizations and systems, an alternative understanding of suicide, namely, that suicide is a preventable and unacceptable occurrence. Cultivating this belief starts with leaders, but organization members must all share this understanding, and service systems must organize the provision of care around this core belief.

Continuity of Care and Shared Service Responsibility

In their review of the *National Strategy for Suicide Prevention* (NSSP) entitled *Charting the Future of Suicide Prevention*, the Suicide Prevention Resource Center (SPRC) and Suicide Prevention Action Network (SPAN) identify the lack of coordinated care as a major shortcoming of current suicide prevention. For instance, though educational efforts have given physicians the ability to screen for suicidal patients in primary care or emergency room settings, those at risk are infrequently connected with follow-up or outpatient care to address the underlying mental illnesses or substance abuse problems.^x Collaborative arrangements linking care providers will help focus on patients' complete well-being as opposed to treating only immediate symptoms.

^{iv} Headings are adapted from *Suicide Care in Systems Framework*, a document by the Clinical Care and Intervention Task Force of the National Action Alliance on Suicide Prevention.

Immediate Access to Care

Behavioral health organizations should provide timely access to services and eliminate, to the highest extent possible, barriers to service availability. One option is through use of technology such as tele-mental health counseling, short message services (SMS), texting and internet to extend the reach and availability of counseling and therapy services.^w

Productive Interactions between Persons at Risk and Care Providers

The Clinical Task Force Report stated, “Care for persons at risk of suicide should be person-centered, where their personal needs, wishes, values, and resources become the foundation of developing a plan for their continuing care and safety.” In forming therapeutic relationships, a key concept is *cultural competence*—i.e., tailoring care to defined and culturally diverse patient groups.^x As the national prevention strategy indicates, strengthening health systems requires increasing the cultural and communication competence of health care providers and organizations.^y Likewise, this principle extends toward all prevention efforts, including those focused on promoting greater understanding and awareness of suicide. Education and awareness efforts must keep in mind not only safe messaging, but also targeted and specific messaging designed with a particular audience in mind.

Evaluation for Quality Improvement

Any systems and organizations that focus on suicide prevention should have a built in capacity to evaluate, adapt and improve performance. Evaluation is needed along every level of the care continuum, to identify effective strategies and therapies, and to evaluate system effectiveness as well as training and education practices.

Systems Management

Policies and Procedures

One major impediment to suicide prevention is the use of inconsistent and often inadequate practices in clinical care, screening, treatment, training, intervention and prevention.^x Training in and implementation of policies and procedures which specifically address suicide risk will assist organizations and care systems in appropriately responding to and caring for persons at risk of suicide. Encouraging the extension of policies and procedures regarding suicide to settings beyond health care systems is another way to ensure consistent practices. “When all sectors (e.g., human services, housing, transportation, labor, education, defense) promote prevention-oriented environments and policies, they all contribute to health.”^y

Collaboration and Communication

Successful examples of suicide prevention demonstrate that health systems can provide a more caring response to persons at risk of suicide when there is a shared and collaborative responsibility for care. For example, screening for suicide risk will be successful to the extent that those who screen patients, students, employees, or others can be assured that persons found

to be at risk for suicide will receive adequate treatment and follow-up. Whether it involves the sharing of data, cross-sector partnerships in designing care plans, or other communication between care providers, future prevention involves fostering these collaborations.

Trained and Skilled Work Force

The Clinical Care and Intervention Task Force recommended training for clinical staff to promote direct assessment and treatment of suicidality and, importantly, to promote treatment of possible underlying disorders. The same recommendation has been extended more generally to the training of key gatekeepers in the community. Training members of the community such as school personnel, clergy and law enforcement has been incorporated into many suicide prevention systems and remains an important tool by which to instill competence and confidence with respect to caring for those at risk for suicide. Going forward, core objectives should include evaluation and refinement of gatekeeper, clinical and other training programs as well as continuous quality improvement.^x

Evidence-based Practices and Evaluation

The *Suicide Care in Systems Framework* report states, “Important research to guide practice does exist. Tools and methods to help detect risk, conduct assessments, intervene for safety, and deliver quality treatment and support are available. Again, they are not widely employed, and, many practitioners are unaware of these tools.”

Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's SPRC, and supported by SAMHSA. The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. The challenge and implementation of a Zero Suicide approach cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps.

SPRC maintains a best-practices registry at www.sprc.org, which includes evidence-based programs focusing on, among other things, collaborative care, emergency room recognition, training and education within health systems. Promotion of evidence-based practices at all potential points of influence, from screening to intervention to treatment to follow-up care, will be important for the success of suicide prevention. Development, evaluation, implementation and establishment of accreditation standards of these programs are keys to creating consistent and effective care for persons at risk for suicide.

Additional Considerations

Survivor Support

Support programs for those who have suffered loss of loved ones to suicide are important resources. Such ‘postvention’ initiatives provide information and peer support to the bereaved and have existed in various forms in Virginia for many years. A key objective for the future is

establishing consensus guidelines for development and implementation of such support programs for survivors of suicide loss.^{aa} Likewise, research to determine the effectiveness of such programs should also be encouraged.

Suicide Attempt Survivors

One of the Action Alliance for Suicide Prevention goals is the development of “A consumer-driven (i.e. attempt survivor perspective) technical guidance document which will provide a framework of action steps for national, state, and local stakeholders to use when developing resources and initiatives that engage and empower suicide attempt survivors.”^z While effectiveness and best-practice guidelines regarding programs for suicide attempt survivors is lacking, a suicide attempt is one of the strongest predictors of subsequent suicide attempt; therefore, initiatives targeted toward attempt survivors may be an important future avenue of research and practice.

Special Populations

A significant principle in providing culturally-competent care is the development of programs which have culturally-specific target audiences in mind. Culture in this context means more than ethnicity and may include boundaries defined by profession, geography, age and other factors.^x Unique populations which have been identified as important for suicide prevention efforts include youth, military and veterans, older adults, ethnic minorities and attempt survivors. Developing policies and services targeted towards these groups is an important element in a community driven approach to suicide prevention.

National Strategy for Suicide Prevention

Through the combined efforts of the National Strategy for the Suicide Prevention Task Force, the National Action Alliance for Suicide Prevention and the National Council for Suicide Prevention, the *2012 National Strategy for Suicide Prevention* was developed and published. This document looks at suicide as a public health problem, and takes a comprehensive public health approach to address issues related to suicide.

The development of the first National Strategy for Suicide Prevention in 2001 was informed by *The Surgeon General’s Call to Action to Prevent Suicide*. This document set forth a national agenda for suicide prevention consisting of 11 goals and 68 objectives. Following the implementation of these goals, SAMHSA commissioned the report *Charting the Future of Suicide Prevention* in 2011. This report identified substantial improvements in suicide prevention in the years following the publication of the National Strategy. These improvements included the enactment of the Garrett Lee Smith Memorial Act, the creation of the National Suicide Prevention Lifeline and its partnership with the Veterans Crisis Line, and the establishment of the SPRC. The report also described remaining challenges and identified priority areas for action. Informed by this assessment, the above coalition was convened to revise and update the national strategy. The goals and objectives described in the 2012 National Strategy for Suicide Prevention extend beyond the systems context and help provide national direction for suicide prevention going forward in Virginia and elsewhere. Intrinsic in this strategy is *A Comprehensive Approach to Suicide Prevention*, a model of care in which a person who is struggling with

depression and thoughts of suicide is given the services and supports that he or she needs in the community to recover from mental health challenges and regain a sense of complete physical, mental, emotional, and spiritual health and well-being. The *2012 National Strategy for Suicide Prevention* represents a comprehensive long-term approach to suicide prevention with the end goal of saving lives.

The National Strategy is organized into four interconnected strategic directions under which 13 goals and 60 objectives are organized. These strategic directions and the subsequent goals and objectives informed the development of Virginia's State Suicide Prevention Plan and are outlined briefly below:

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities.

The goals and objectives in this strategic direction seek to create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems. A wide range of partners and stakeholders contribute to supportive environments and all of these partners should integrate suicide prevention into their work.

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

Suicide prevention should be integrated into the work and culture of the diverse programs and organizations that do work in communities. Additionally, the coordination of these efforts, including the coordination of work across public, private and non-profit sectors and at all governmental levels, can have increased impact in communities. It is also important to take advantage of existing programs and efforts that address risk and protective factors which are co-occurring with suicidal behavior. Healthcare reform is a key area in which suicide prevention work should be integrated.

Goal 2: Increase communication efforts conducted online that promote positive messages and support safe crisis intervention strategies.

Emerging and existing media provide new opportunities for suicide prevention, particularly for persons who may be socially isolated or otherwise difficult to reach. Examples include chatlines and social media, like Facebook. Suicide prevention efforts must consider the best ways to use existing and emerging communication tools and applications to reach communities effectively. These efforts should be conducted at multiple levels and align with other suicide prevention efforts in the community. Additionally these efforts should be designed to reach defined segments of the population, including isolated and/or at risk populations and policy makers. Finally, all communication efforts should promote best practice in safe messaging, include information on warning signs and support best practice in crisis intervention.

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Despite an increase in research on effective treatment for mental and substance use disorders, the stigma associated with these disorders and concurrently with suicide continues to prevent many individuals from seeking help. At the same time, there is need to reduce the prejudice and stigma associated with suicidal behaviors and mental and substance use disorders, while at the same time promoting effective programs and best practice that increase connectedness and thus

protection from suicide risk.. Underscoring all of these efforts should be the understanding that recovery from mental and substance use disorders is real and possible for all.

Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry and the safety of online content related to suicide. News organizations and members of the entertainment industry that develop and implement policies that are in line with best practice for messaging and reporting should be encouraged and recognized. Additionally, there is need for the development and dissemination of guidelines on consistent and safe messaging including guidance specifically relating to online content and new and emerging technologies.

Strategic Direction 2: Clinical and Community Preventative Services

The factors that contribute to suicide are multiple and complex. Effective suicide prevention requires that support systems, services, and resources be in place to promote wellness. Clinical and community-based programs and services play a key role in the promotion of wellness. Furthermore, clinical preventative services, including suicide assessment and screening are crucial to assessing suicide risk and connecting individuals at risk to the appropriate resources.

Goal 5: Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.

As described above, coordination between state and local programs suicide prevention programming is essential, including the coordination of evaluation efforts. This includes the encouragement and support of communities to implement programming which strengthens efforts to increase access to and the delivery of effective programs and services for mental health disorders and targets at risk populations.

Goal 6: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

This is another area in which the coordination of various stakeholders is essential. Providers should be encouraged to routinely assess for access to lethal means when an individual is identified as at risk for suicide. Firearms dealers and gun owner groups should be partnered with to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm membership. Additionally, there is need for the development and implementation of new safety technologies to reduce access to lethal means.

Goal 7: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

All community-based and clinical prevention professionals whose work brings them into contact with persons with suicide risk should be trained on how to address suicidal thoughts and behaviors and how on how to respond to those who have been affected by suicide. These efforts should include training for community groups and mental health and substance abuse providers, the development and promotion of core education and training guidelines, and the development and implementation of programs and protocols for clinical settings.

Strategic Direction 3: Treatment and Support Services

Individuals at high risk for suicide require clinical evaluation and care to identify and treat mental health and medical conditions and to specifically address suicide risk. A growing body of research indicates that suicide prevention is enhanced when specific treatments for underlying conditions are combined with strategies that directly address suicide.

Goal 8: Promote suicide prevention as a core component of healthcare services.

The integration of suicide prevention into the delivery of mental health services is a key element in the creation of a comprehensive systems level prevention plan. The goal of “zero suicide” should be promoted as an aspirational goal for healthcare providers; this is bolstered by the development and implementation of protocols for delivering services for individuals with suicide risk. Individuals at risk for suicide should have timely access to assessment, intervention, and effective care. Furthermore, continuity of care should be a priority. Healthcare delivery systems should be encouraged to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvements.

Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as at risk for suicide.

Effective clinical and professional practices in the assessment and treatment of individuals with high suicide risk can help prevent these individuals from acting on their despair and distress in self-destructive ways. These practices should be grounded in evidenced based care or best practices in cases where promising approaches have been identified but more research is needed.

Goal 10: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.

The mental health and medical communities often fail to provide needed services to individuals who have attempted suicide and to those who have been affected by a suicide attempt or death. In order to effectively serve these individuals, guidelines should be developed for comprehensive support programs for the bereaved and appropriated clinical care for those affected by a suicide attempt or bereaved by suicide, including healthcare providers and first responders. The emergent community of attempt survivors should be engaged in any prevention planning efforts. Procedures for responding effectively to suicide clusters and contagion should be developed and implemented in communities.

Strategic Direction 4: Surveillance, Research, and Evaluation

Effective research and evaluation are the underpinnings of any effective prevention program. When used in this context, surveillance refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. Research and evaluation are activities that assess the effectiveness of particular interventions and add to the knowledge base of suicide prevention.

Goal 11: Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

The regular collection and rapid dissemination of suicide-related data are needed to guide public health action. To this end, the timeliness of reporting vital records data, the usefulness and

quality of suicide-related data, and the capacity of state and local public health organizations to collect data must be improved. Additionally, the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors and exposure to suicide should be increased.

Goal 12: Promote and support research on suicide prevention

Research on suicide prevention and on the treatment of mental and substance use disorders has increased considerably. Continued improvements will lead to the development of better assessment tools, treatments, and preventive interventions. These continued improvements will be bolstered by the development of a national suicide prevention research agenda, and the development and support of a repository of research resources.

Goal 13: Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

Program evaluation is a driving force for planning effective suicide prevention strategies, improving existing programs, informing and supporting policy, and demonstrating the results of resource investments. Interventions should be guided by specific, testable hypotheses and implemented among groups of sufficient size to yield reliable results. Measureable outcomes should be emphasized, in addition to other outcomes and process measures. Findings should be disseminated in timely manner and the impact on the reduction of morbidity and mortality should be emphasized.

The Suicide Prevention Plan for Virginia

The *Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia* is based on the broad goals outlined in the 2004 Plan, namely,

- (1) Prevent deaths due to suicide across the lifespan.
- (2) Reduce occurrence of other self-harmful acts.
- (3) Increase recognition of risk factors and improve access to care.
- (4) Promote awareness of suicide and reduce stigma of mental health problems.
- (5) Promote healthy community development, enhancing interconnectedness, resources, and resilience.

The following section sets forth the Commonwealth's suicide prevention goals and recommendations. For each goal and associated recommendation(s), potential implementation strategies are described. These strategies are organized according to the entity that is most appropriate for these actions, namely,

- (1) The Commonwealth of Virginia;
- (2) Early learning centers, schools colleges and universities; and
- (3) Community, non-profit and faith-based organizations.

Goal 1: Foster leadership, collaboration and partnerships among public, private, non-profit and community entities, including the integration and coordination of suicide prevention efforts across multiple sectors and settings.

Collaboration between all stakeholders is critical to the success of Virginia's suicide prevention effort. Through this collaboration, gaps in services can be identified and addressed. Additionally, greater coordination of efforts among different stakeholders and settings can increase the reach and effect of suicide prevention activities.

Recommendations:

1.1 DBHDS and VDH should maintain leadership and provide support for the *Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia*, including planning, implementation, monitoring and evaluation.

1.2 Continue to pursue federal, state and private funding to support the *Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia*.

The Commonwealth of Virginia will:

- Sustain and expand state funding to support comprehensive suicide prevention efforts in the Commonwealth.
- Provide funding to support a full-time suicide prevention manager within DBHDS.

- Identify communities and coalitions that are working together on suicide prevention and assist coalitions to sustain and grow community partnerships.
- Provide financial support to localities for suicide prevention.
- Maintain and expand resource directories to include faith-based associations like Partners in Care (VANG).
- Identify grant opportunities to support suicide prevention and intervention efforts.
- Provide resources to support grants management and performance reporting.
- Utilize the Suicide Prevention Interagency Advisory Group to ensure concerns of older adults are represented.
- Support and sustain the Suicide Prevention Interagency Advisory Group and ensure that the group is representative of the lifespan.
- Form a committee to address mental illness-related suicide.

Early Learning Centers, Schools, Colleges and Universities can:

- Create a comprehensive, best-practice-based suicide intervention and postvention plan for these campuses and school districts.

Community, Non-profit and Faith-based Organizations can:

- Expand and sustain community coalitions to address suicide prevention.
- Work with stakeholders to develop and submit consolidated grant proposals.
- Promote wellness education.
- Teach and promote help seeking skills.
- Train helpers in culturally appropriate suicide prevention models.
- Examine how suicide impacts their constituents and how to partner to address those needs.

Goal 2: Promote research-informed communication designed to increase acceptance, understanding and recovery for mental, emotional and behavioral well-being.

It is widely believed that stigma and misinformation create barriers to help-seeking for mental health problems. Community messages regularly reinforce isolation and a lack of acceptance for the person in an emotional crisis. The *Suicide Prevention across the Lifespan Plan for the Commonwealth of Virginia* attempts to address these roadblocks in its many different settings, including the promotion of responsible media reporting of suicide. Resiliency has been proven to increase mental wellness and quality of life.

Recommendations:

2.1 Improve mental health literacy of Virginia's citizens and professionals through intentional educational efforts that promote appropriate messaging about suicide.

2.2 Increase collaboration among public service agencies and organizations and increase the number of communities that are working together on suicide prevention to enhance individual, family and community resilience.

2.3 Reduce the stigma associated with mental or emotional distress and facilitate support necessary to maintain positive mental well-being.

The Commonwealth of Virginia will:

- Sustain best-practices training (RRSR, ASIST, QPR and other best-practice programs).
- Partner with organizations currently working to increase mental health literacy where possible, including the military, federal and state agencies and advocacy groups.
- Ensure that programs and literature are culturally competent, by ensuring that both programs and literature are translated and/or that interpreter services are available where possible.
- Develop and maintain the capacity to provide on-line dialogue with stakeholders to increase awareness of prevention information.
- Increase collaboration between lead agencies and other community-based stakeholders including first responders, the Department of Social Services, the Department of Veteran Services, primary care physicians, psychiatrists, emergency rooms, and services providers for housing/homeless.
- Increase stakeholder utilization of *Recommendations for Safe Reporting on Suicide* (www.reportingonsuicide.org).
- Promote social media opportunities to develop and expand healthy communities, by responding to individual community needs and culture.
- Promote programs and literature that support person-first language.
- Ensure that community events, forums and materials promote safety and help-seeking.
- Continue process of certification for peer services.

Early Learning Centers, Schools, Colleges and Universities can:

- Promote programs and literature that support person-first language.
- Promote educational opportunities to include the national suicide prevention awareness and mental health awareness week.
- Increase stakeholder utilization of *Recommendations for Reporting on Suicide*. (www.reportingonsuicide.org).

Community, Non-profit and Faith-based Organizations can:

- Promote educational opportunities to include national suicide prevention awareness and mental health awareness week.
- Increase stakeholder utilization of *Recommendations for Reporting on Suicide*. (www.reportingonsuicide.org).

- Promote social media opportunities to develop and expand healthy communities that promote help-seeking behavior.
- Promote mental wellness through faith-based communities.
- Facilitate the support necessary to maintain positive mental well-being.
- Offer education targeted for families to support healthy communities collaboratively with existing peer run organizations.
- Offer education targeted for individuals to support resilience, help-seeking behavior and mental well-being.
- Explore the process of reimbursement through Medicaid for peer services.
- Reach out to diverse communities and increase collaboration with those non-traditional entities and key community informants.

Goal 3: Provide training and education to enable communities to recognize and respond to suicide risk and educate the support systems of those at risk for suicide.

Over the past 10 years, considerable effort has provided evidence-based training for many key gatekeepers in the community. These training efforts distinguish the Commonwealth as a leader in creating communities that are safer from suicide and aim to increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery. Continued training to the community and clinical service providers and the expansion of education requirements are essential to maintaining this leadership. Training should be expanded to include health professionals, law enforcement and Crisis Intervention Team (CIT) officers, and behavioral health service workers.

Recommendations:

- 3.1 Expand and sustain evidence-based, best-practice suicide prevention, risk assessment and intervention training. Encourage evaluation of innovative practices to expand best-practice knowledge.
- 3.2 Support public and community education about suicide and suicide prevention.
- 3.3 Sustain a coordinated central point of access where suicide prevention resources and training are accessible to the community.
- 3.4 Collaborate with programs licensed by DBHDS to promote a culture that reflects that suicide is preventable.
- 3.5 Collaborate with practitioner licensing and certifying organizations to ensure that healthcare and other professionals receive formalized training in suicide prevention and/or intervention as part of the credentialing process.

The Commonwealth of Virginia will:

- Devote state and federal funds to support evidence-based suicide prevention and risk assessment training.
- Increase and sustain a network of trainers and collaboration between resources.
- Utilize local capacity to promote community forums for suicide prevention.
- Support innovation in awareness, prevention and intervention.
- Use targeted data provided by the VVDRS to inform public outreach materials and events.
- Determine, with the Department of Health Professions, whether legislation and regulations are needed to implement suicide prevention and intervention training as a part of licensing for healthcare and other professions as appropriate.
- Encourage all certifying entities working within the Commonwealth to include formal suicide prevention and/or intervention training.
- Partner with the Department of Criminal Justice Services (DCJS) to increase the use of training in suicide prevention for their personnel.
- Encourage the inclusion of evidence-based, best-practice programs for CIT curricula.

Early Learning Centers, Schools, Colleges and Universities can:

- Require health and behavioral health academic institutions to include best-practices suicide prevention training in their curriculum across disciplines as appropriate.
- Require that on-going support and education is available to professionals who have an opportunity to intervene with persons at risk for suicide.
- Recommend educational curricula to incorporate best-practice information to help educators recognize and respond to suicide risks.
- Incorporate follow-up procedures for at-risk students who present in counseling offices, to aid them in treatment access and recovery.

Community, Non-profit and Faith-based Organizations can:

- Promote wellness trainings.
- Provide peer-support programs.
- Fund, participate and disseminate information in a variety of settings on wellness, help-seeking behavior and suicide prevention.
- Host best-practice prevention trainings for their members.

Goal 4: Ensure a continuum of care for those at risk for suicide and their support networks.

There are gaps in services which persons at risk must navigate during a time in crisis. When these gaps can be identified and addressed through a seamless continuum of care of services and providers, safety is increased and lives are saved. Coordinated efforts involving all care providers, family and social supports are essential to this effort. Also essential is the

development, implementation, and monitoring of effective programs that promote wellness and prevent suicide and related behaviors. Healthy interpersonal relationships and connectedness are essential elements within this continuum.

Recommendations:

- 4.1 Promote early identification of mental health needs and access to quality services.
- 4.2 Develop, ensure and promote evidence-based and best-practice protocol for all points of service between clinical and professional behavioral health services.
- 4.3 Foster collaboration and partnerships among public, private, non-profit and community entities. Ensure that supports and resources are available for individuals at risk (specifically including suicide attempt survivors) and their families, friends, loved-ones and caregivers.
- 4.4 Develop or expand relationships between Community Service Boards and Behavioral Health Authorities (CSBs and BHAs) and local health and related service providers such as clinics and health centers, hospitals and emergency departments, nursing facilities, rehabilitation centers, the Departments of Social Services, schools, veteran services agencies, local agencies on aging, faith-based organizations, military resources and others.
- 4.5 Collaborate with the licensing entities to ensure that healthcare and other professionals receive formalized training in suicide prevention and/or intervention as part of the credentialing process.

The Commonwealth will:

- Cultivate a culture based on the belief that suicide is preventable.
- Support community collaboration with existing and new peer -run organizations and services in the community.
- Develop a best-practice protocol for all points of service that provides seamless comprehensive linkages for persons at risk of suicide across all levels of care.
- Research and disseminate existing protocols and information related to the prevention of suicide to care providers at facilities.
- Require the inclusion of person-centered suicide prevention and intervention protocols in health and behavioral healthcare standard operating procedures and licensing regulations.
- Encourage family and social supports to participate in discharge planning for persons at risk.
- Explore the feasibility of establishing anonymous points of access to provide safe resources and access to crisis intervention.

Early Learning Centers, Schools, Colleges and Universities can:

- Create partnerships between community mental health and academic settings to provide linked services.
- Maximize efficiency and effectiveness of on-campus services.

- Support best-practice protocols for all points of services that provide seamless comprehensive linkages for persons at risk of suicide across all levels of care.

Community, Non-profit and Faith-based Organizations can:

- Enhance peer supported and facilitated suicide attempt survivor groups throughout the Commonwealth.
- Continue to support and expand existing suicide prevention hotlines and warmlines through collaboration with other agencies.
- Continue to support and expand programs that teach personal coping, resilience and relational health.
- Incorporate follow-up services with persons at-risk of suicide in order to support their independent recovery.
- Disseminate literature designed to help individuals and families recover from a suicide attempt or death.
- Increase partnerships between hotlines and emergency departments to include follow-up with those referred and discharged from emergency departments.

Goal 5: Reduce barriers and increase access to mental/behavioral health services and supports.

Geographical, social, economic, language and other barriers are deterrents to help-seeking behavior. In order to promote an environment where mental health services are open and available to all in need, careful planning is needed to identify and address barriers. When barriers to care are removed and suicide prevention is a core component of mental and healthcare services, persons in crisis and their families are more likely to seek assistance.

Recommendations:

- 5.1 Fund additional local behavioral health services to sufficient capacity.
- 5.2 Promote tele-health and other technology applications for expanding access to behavioral health services and supports to those who are geographically distant from mental health centers.
- 5.3 Address the need for cultural and linguistic competence, both individual and organizational, in all community services to military, refugees and other cultural and social groups.
- 5.4 Develop, sustain and expand peer-support services that can assist systems to aid a person in crisis as they navigate the many layers of services available to them.

The Commonwealth will:

- Provide funding to increase broad-band accessibility for those who must use tele-health in order to be connected to behavioral health services, particularly in rural areas.

- Designate locations and funding for adequate equipment to increase accessibility to behavioral health services and supports.
- Identify corporate sponsorships and resources to increase tele-health accessibility.
- Support and collaborate with community-based peer-run organizations, programs and services.
- Address the need for cultural awareness and sensitivity in all community services by supporting organizational strategic planning that builds capacity for working effectively with diverse communities.
- Ensure hotlines and emergency services have the capability to provide support in the dominant languages present in the community where possible.

Early Learning Centers, Schools, Colleges and Universities can:

- Promote availability of anonymous initial contacts for persons at risk.
- Utilize satellite mental health check-in stations in academic settings.
- Create a system of triage and accommodating walk-in services to address persons at risk.
- Promote a culture of mental health literacy by utilizing organizations focused on changing the dialogue to acceptance and wellness.

Community, Non-profit and Faith-based Organizations can:

- Utilize peer-service within traditional service agencies; including employing peer-recovery specialists as well as collaborating with existing peer- and consumer-run organizations and volunteers.
- Provide advocacy for those at risk to help them navigate mental health services during times of acute crisis.
- Provide support to individuals and family members to obtain services.
- Ensure treatment services are culturally appropriate.

Goal 6: Cultivate resources and leadership among attempt survivors and survivors of suicide loss and provide support and care for these individuals, while also implementing postvention strategies within communities.

People with lived experience (survivors of suicide attempts and suicide loss) are an invaluable and underused resource to the prevention community. These individuals provide insight into helping both persons at risk and their support networks. People with lived experience are strong sources of advocacy and many have a unique opportunity to advance suicide prevention efforts in the Commonwealth. This resource should be cultivated to continue prevention efforts.

Recommendations:

6.1 Identify community outlets that might be positioned to support families in the immediate aftermath of a suicide loss. Identify, assess and fund suicide loss support models at the local community level.

The Commonwealth will:

- Use the statewide suicide prevention resource directory to identify and support community leadership.
- Support the implementation of best-practice programs that support safe messaging and leadership within the survivor of the suicide loss community.
- Support community and campus awareness events, such as Out of the Darkness Community Walk, that raise awareness around suicide prevention and survivor supports with materials.
- Provide funding to train community volunteers to provide support services to families and individuals dealing with the aftermath of suicide using models such as Local Outreach to Suicide Survivors (LOSS) Teams or National Organization for Victim Assistance (NOVA).

Early Learning Centers, Schools, Colleges and Universities can:

- Promote best-practices protocols regarding postvention planning and preparation in school and university settings.
- Adapt postvention protocols to reflect the needs of their school settings.
- Encourage tabletop exercises to effectively disseminate postvention protocols.
- Participate in awareness events that utilize safe messaging.
- Encourage campus news sources and journalism students to incorporate *Recommendations for Reporting on Suicide*.

Community, Non-profit and Faith-based Organizations can:

- Develop, expand and publicize local survivor leadership groups for community peer supports.
- Develop and provide culturally and linguistically sensitive survivor resources.
- Bring the Survivor Voices training to your community.
- Provide meeting space for survivors of suicide loss and survivors of suicide attempt support and recovery groups.
- Utilize resources of volunteer organizations active in responding to disasters to promote the coordination of services for crisis intervention and survivors of suicide loss.

Goal 7: Refine and expand data collection and evaluation of suicide prevention initiatives.

Surveillance data and evaluation are fundamental elements of suicide prevention, and essential to meeting the needs of the individuals, families and communities. Evaluators and epidemiologists enable Virginia to remain competitive for grant funding. Data allows stakeholders to develop a comprehensive, informed approach to suicide prevention.

Recommendations:

- 7.1 Promote the open use of fatal suicide and non-fatal suicide attempt data for health promotion, suicide prevention, policy making, training and resource allocation.
- 7.2 Ensure continued support for data collection through VDH's Office of the Chief Medical Examiner and the VVDRS in order to sustain a comprehensive suicide surveillance database.
- 7.3 Consolidate data reporting at the state level of state and local suicide prevention activities.
- 7.4 Support the development of tools for tracking information from suicide intervention to better understand how systems can improve services.
- 7.5 Support qualitative and quantitative evaluation of training programs.

The Commonwealth will:

- Continue to provide funding support for the VVDRS.
- Continue to support funding for the collection and use of fatal and non-fatal suicide attempt data.
- Establish and fund a public health-focused statewide Suicide Fatality Review Team through the Office of the Chief Medical Examiner.
- Encourage the use of both qualitative and quantitative information to continue to improve safety for those at risk.

Early Learning Centers, Schools, Colleges and Universities can:

- Target education programs that have incorporated data to support learning.
- Cooperate with agencies to provide data on suicide, suicidal behavior and intervention with high risk individuals.
- Encourage the development of innovative methodologies that provide qualitative and quantitative data to examine suicidal behavior, fatalities and intervention.

Community, Non-profit and Faith-based Organizations can:

- Use data to support program and services.
- Use data to understand and target groups of at-risk individuals.
- Conduct program evaluation to add to knowledge base.
- Evaluate training programs to be sure the guidelines and outcomes are consistent with the agenda.

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Resources

VDH’s Division of Injury & Violence Prevention maintains a directory of suicide prevention resources, Virginia Suicide Prevention Resources Directory (available at www.vdh.virginia.gov/livewell/programs/suicide/documents/2016SuicidePreventionResourceDirectory4thEdFINAL.pdf). The resource directory provides information pertaining to various programs for suicide prevention throughout Virginia. Among the resources described are crisis hotlines, veteran services, survivor support groups, internet resources mental health centers and other services.

Apart from these resources described in the resource directory, VDH maintains a list of additional resources and organizations for suicide prevention. Below is a list of the selected links which can be found through the VDH Suicide Prevention website (www.vdh.virginia.gov/livewell/programs/suicide):

Training Programs

Question, Persuade, and Refer (QPR)	www.qprinstitute.com/
safeTALK	www.livingworks.net/programs/safetalk
Applied Suicide Intervention Skills Training (ASIST)	www.livingworks.net/programs/asist
Recognizing and Responding to Suicide Risk (RRSR)	www.suicidology.org/training-accreditation/rrsr
RESPONSE	www.columbiacare.org/response.html
Society for the Prevention of Teen Suicide	www.sptsnj.org
Suicide Prevention Resource Center	http://training.sprc.org
American Foundation for Suicide Prevention	https://afsp.org/

Military and Veteran Resources

Virginia Veteran and Family Support, Virginia Department of Veteran Services	www.wearevirginiaveterans.org/
Department of Veteran Affairs Suicide Prevention	www.mentalhealth.va.gov/suicide_prevention/
National Suicide Prevention Lifeline: Veterans	www.veteranscrisisline.net/
Army Suicide Prevention	https://phc.amedd.army.mil/topics/healthyliving/bh/pages/suicidepreventioneducation.aspx
Air Force Suicide Prevention	www.af.mil/SuicidePrevention.aspx

Suicide Prevention Across The Lifespan Plan for the Commonwealth of Virginia

U.S. Marine Corps Suicide Prevention	www.med.navy.mil/sites/nmcphc/health-promotion/psychological-emotional-wellbeing/Pages/suicide-prevention.aspx
Navy Suicide Prevention	www.public.navy.mil/BUPERS-NPC/support/21st_century_sailor/suicide_prevention/Pages/default.aspx
Military OneSource	www.militaryonesource.mil
Army OneSource	www.myarmyonesource.com

Primary Care Providers

Recognizing and Responding to Suicide Risk in Primary Care	www.suicidology.org/training-accreditation/rrsr-pc
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Emergency Department Health Care Providers

Emergency Department Means Restriction Education	http://legacy.nreppadmin.net/ViewIntervention.aspx?id=15
Emergency Room Intervention for Adolescent Females	http://legacy.nreppadmin.net/ViewIntervention.aspx?id=33

Mental Health Professionals

Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR)	www.suicidology.org/training-accreditation/rrsr
Lethal Means Counseling	www.hsph.harvard.edu/means-matter/recommendations/clinicians/index.html
Tip 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment	https://store.samhsa.gov/shin/content/SMA13-4793/SMA13-4793.pdf

Other Materials

The Campus Suicide Prevention Center of Virginia	www.campusuicidepreventionva.org/
Means Matter	www.hsph.harvard.edu/means-matter/
Suicide Prevention Resource Center: Finding Programs and Practices	www.sprc.org/strategic-planning/finding-programs-practices

Suicide Prevention Across The Lifespan Plan for the Commonwealth of Virginia

National Suicide Prevention Wallet Cards	www.suicidepreventionlifeline.org/getinvolved/materials.aspx
Guide to Engaging the Media in Suicide Prevention	www.sprc.org/sites/default/files/migrate/library/media_guide.pdf

Suicide Prevention Regional Summits 2011

In 2011, a series of regional suicide prevention summits were hosted by the DBHDS and VDH. These summits brought together community and regional stakeholders to learn about the impact of suicide in their communities and to survey stakeholders regarding their resources and needs with respect to suicide prevention. During these summits, participants identified many of the same resources detailed in the resource directory and on the VDH website. Participants also identified certain areas which could be improved with additional resources.

Needs identified by summit participants fell into major categories:

- Lack of funding
 - Funding for additional suicide prevention activities such as training, awareness, dissemination of prevention materials.
 - Funding to support expansion of training to community gatekeepers such as teachers clergy, parents, etc.
 - Funding to hold additional conferences/summits in Virginia.
 - Funding for post-prevention efforts.
 - Knowing where best to invest limited resources.
- Expanding training audience and availability of training
 - Participants identified examples such as training clergy members, family/peer training, and graduate students as possible audiences for additional training.
 - Training could be incorporated as a mandatory part of professional recertification or graduate school curricula.
- Lack of awareness
 - Awareness of available resources.
 - Awareness of what other organizations, regions were doing in regard to suicide.
 - Need to incorporate social media and other technology to awareness campaigns.
- Infrastructure and leadership
 - Need to have dedicated suicide prevention managers/coordinators within state and regional agencies.
 - Strategic planning partnerships between community organizations.
- Barriers to care
 - Lack of access to mental health, family and other services.
 - Stigmatized activities create barriers to care.
 - Cultural and language barriers.

Suicide Prevention Regional Summits 2011

<u>Locations</u>	<u>Dates</u>	<u>Total Participants</u>
Abingdon	May 10	52
Roanoke	May 11	86
Harrisonburg	May 24	89
Fredericksburg	May 25	58
Chesterfield	June 1	106
Annandale	June 6	99
Hampton	June 15	87

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