SUICIDE PREVENTION ACROSS THE LIFESPAN:
A 2023 PLAN FOR THE COMMONWEALTH OF VIRGINIA

SPIAG
Suicide Prevention
Interagency Advisory Group

Prepared in Partnership with the Virginia Department of Health, Department of Behavioral Health and Developmental Services, and the Suicide Prevention Interagency Advisory Group

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DEDICATION

Many people and communities have been affected by suicide. This Virginia state plan is dedicated to the memory of those who have died by suicide, their friends, family, and colleagues. We would also like to thank the leaders in the field of suicidology, those who remain on the front lines of behavioral health care year after year, the survivors of suicide attempts, those with lived expertise, and those who experience ongoing thoughts of suicide. We acknowledge and appreciate the courage of loss survivors and suicide attempt survivors who came forward to share their lived experience so others may find a path to hope and healing. We will continue to work together to build resilient communities.

If you or someone you know needs support, there is help. Please dial 988 to speak with a trained crisis counselor or text TALK to 741741.

VISION STATEMENT AND PRINCIPLES

The Suicide Prevention Interagency Advisory Group (SPIAG) is building a comprehensive suicide prevention framework that centers the promotion of meaningful and empowered lives worth living. The following principles have been identified as core beliefs that must be upheld to achieve this vision.

- Everyone can play a role in addressing suicidal experience.
- Suicide is a complex public health problem that must be addressed by using data driven interventions.
- To help those experiencing suicidal thoughts we must all have basic knowledge of how to support someone in crisis, a strong supportive behavioral health system, and sustained funding.
- Taking an active role in reducing stigma surrounding suicide deaths, suicidal thoughts, and families who have lost members to suicide is essential; communities often feel the impact of suicide death in different ways.
- Social movements that include social reform and social justice components work to help build protective factors for suicide prevention.
- As a community we have the power to change the fabric of our society to protect Virginians from suicide through creating greater connection, reducing trauma and adverse childhood experiences, empowering our youth, and improving access to behavioral and general health care.
- Suicide prevention includes the recognition that structural issues within institutions can help or hinder suicide prevention, these issues must be addressed at all levels of an ecological approach, including building in protective factors and eliminating risk factors at individual, family, institution, community, and systems/cultural levels.
- These efforts must be based on the best available research in the field of suicidology.
- Suicide prevention efforts should be culturally informed, have an understanding of the intersectionality and diversity of perspective that individuals bring, and be developed in collaboration with groups for whom they are designed.
- We hold respect for those whom this issue most directly affects, and understand that intervention and prevention of suicide necessitates engagement and partnership with individuals who have lived expertise. This lived expertise may also include living with suicidal thoughts.

DEAR STAKEHOLDERS

Suicide Prevention across the Lifespan: A Plan for the Commonwealth of Virginia, was developed by the Virginia Department of Health (VDH), the Department of Behavioral Health and Developmental Services (DBHDS), and the Suicide Prevention Interagency Advisory Group (SPIAG). 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.

This document outlines the current state of suicide in Virginia, the techniques and strategies used to help reduce suicide deaths and incidents of self-harm, and the importance of the role of community members building connectedness. This report includes a general overview of strategies employed in the support of a comprehensive suicide prevention model.

Public and behavioral health practitioners understand that an individual's relationships, the community in which they live, and the policies that impact their lives, all factor into self-harm, suicidal thoughts, and suicide death. This means that interventions from an individual level through the policy level, contribute to either protecting an individual from suicide death or harm, or potentially increasing an individual's risk for suicide death or harm. As such, successful suicide prevention planning is comprehensive, equitable, and multifaceted. Successful implementation of such planning relies on the cohesion and consistency of community response.

Efforts to address health and suicide are impacted by the COVID-19 pandemic. While the response of many communities in supporting each other has been herculean, the pandemic has further highlighted serious issues with our public health and behavioral health systems, including health care, which were already occurring prior to the pandemic. The fallout of these underfunded systems can be felt by public and behavioral health practitioners and suicide preventionists, and most importantly, those being served. To achieve our objectives we must address these issues head-on.

We continue to address stigma around mental health care, reduce access to lethal means when individuals are in crisis, and build a society that prioritizes the individual, their lived expertise, and their health.

The SPIAG Working Group

RECOMMENDED APPROACH: BRIEF

Objective 1
Lead a diverse and inclusive group to build comprehensive suicide prevention systems throughout Virginia

GOAL
Foster leadership, collaboration, and partnerships throughout communities and with a variety of stakeholders, prioritizing the engagement of those with lived experience, to stand up sustainable, comprehensive suicide prevention efforts that meet the needs of those who utilize them.

Strategies

1. Engage people with lived experience in all aspects of suicide prevention
2. Use effective communication to educate and employ diverse sectors in suicide prevention
3. Pursue federal, state, and private funding to support planning, implementation, monitoring, and evaluation of suicide prevention efforts
4. Standardize the integration of suicide prevention and mental health supports into all aspects of policy decisions

Objective 2
Prioritize upstream factors that impact suicide prevention

GOAL
Promote research informed suicide prevention interventions with a focus on addressing upstream factors that impact suicide.

Strategies

1. Promote and enhance social connectedness
2. Strengthen economic supports
3. Engage and support priority populations and underserved groups
4. Improve the mental health literacy of communities by providing guidance related to appropriate messaging and incorporating successes in suicide prevention into media messaging
5. Build on community strengths to increase protective factors and decrease risk factors on an individual, relational, communal, and societal level

Objective 3
Ensure all Virginian's know they have a role to play in suicide prevention; ensuring access to training

GOAL
Provide culturally and linguistically appropriate training and educational opportunities to bolster suicide prevention efforts; ensuring everyone knows they have a role to play in preventing suicide death.

Strategies

1. Empower every individual and organization to play a role in suicide prevention
2. Empower communities to implement proven approaches
3. Increase the use of lethal means safety and counseling on access to lethal means
4. Increase clinical training in evidence-based care for suicide risk
5. Expand and sustain evidence-based suicide prevention, risk assessment, and intervention training.
6. Sustain a coordinated central point of access where suicide prevention resources and training are accessible to the community

Objective 4
Enhance the continuum of care for suicide prevention

GOAL
Enhance the continuum of care for those at risk of suicide prioritizing the reduction of barriers to care, including structural racism, and implementation of universal screening, referral, linkages, and follow-up. This must include active efforts to build capacity within communities.

Strategies

1. Improve suicide risk identification in health care settings including local health departments, community services boards, and behavioral health authorities
2. Establish baseline safety planning efficacy within staff who support patients with increased risk of suicide
3. Increase the use of suicide safe care pathways in health care systems for individuals at risk
4. Increase the use of caring contacts in diverse settings
5. Ensure safe care transitions for all patients regardless of risk assessment
6. Ensure adequate crisis infrastructure to support implementation of the national 988 number
7. Improve collaboration with licensing entities to ensure healthcare and other professional licensing organizations have formalized training in suicide intervention as part of credentialing process
8. Address systems of structural racism which have historically limited access to services among communities of color

Objective 5
Improve the quality, timeliness, exchange, and use of suicide and self-harm data

GOAL
Improve the quality, timeliness, exchange, and use of suicide and self-harm related data between and within state and local partners.

Strategies

1. Increase access to near real-time data related to suicide
2. Improve the quality of data on causes of death
3. Expand the accessibility and use of existing federal and state data systems that include data on suicide attempts and thoughts
4. Improve coordination and sharing of suicide-related data across the state and local levels
5. Use multiple traditional and non-traditional data sources to identify priority populations and to inform action
6. Support efforts to increase data literacy within communities

CONNECTION

"We can lower the rate of suicides in our communities by building connectivity, making sure people know how to help and what to look for and how to be there for someone. We need to educate people to let them know it is okay to reach out when they are concerned about someone."

Ames Hart, Suicide Prevention and Intervention Trainer and Founder of Enter Hope, LLC

INTRODUCTION: THE STATE OF SUICIDE IN VIRGINIA

Suicide is death caused by injuring oneself with the intent to die. In 2020, Virginia ranked 34th in the U.S. for the rate of suicide deaths[1]; however, suicide was the 11th leading cause of death in Virginia in 2020.[2]

There are several factors that increase risk for suicide, including a history of mental health disorders or alcohol and substance misuse, barriers to accessing mental health treatment, and any type of loss, physical illness, or social isolation. To prevent suicide or self-harm, one must address risk factors and increase protective factors, such as family and community support and effective clinical support for mental health conditions. One must also assess data trends to identify and address priority populations at higher risk for suicide and to inform suicide prevention program planning and development.

DEATHS BY SUICIDE

Deaths by suicide in Virginia remained stable from 2017 to 2021, with an average of 1,167 deaths each year. Deaths by suicide peaked in 2018, at 1,226 deaths (Figure 1).

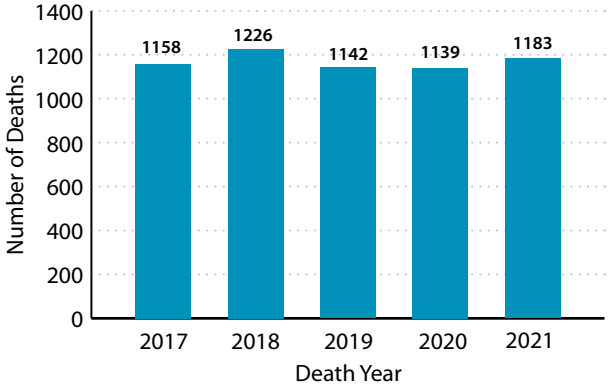
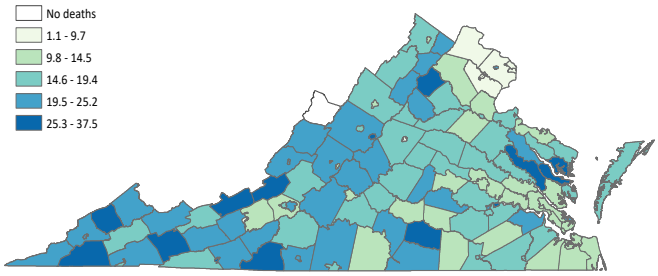


Figure 1: Deaths by suicide among Virginians, 2017-2021

Figure 2 shows the average annual rate of deaths by suicide per 100,000 population by city or county (locality) in 2017-2021. Dark blue localities have the highest rates of death by suicide. Although suicide affects almost all localities in Virginia, in 2017-2021, Galax City had the highest average annual rate of death by suicide at 37.5 per 100,000 population, followed by Dickenson County (34.8), Rappahannock County (32.9), Middlesex County (32.0), and Scott County (31.4). The light yellow localities, like localities in Northern Virginia, have lower rates of death by suicide per 100,000 population. Localities with larger population sizes, like those in Northern Virginia, may report larger numbers of deaths by suicide. However, rates offer a standardized measure of comparison for localities with varying population sizes.



Deaths represented here are based on Virginia residence at time of death (Virginia residents only). Rates for counts less than 20 should be considered unstable and should be interpreted with caution.
Data are from Vital Event Statistics Program, Office of Information Management. Data analyzed by Injury and Violence Prevention epidemiology team, Office of Family Health Services, Virginia Department of Health, September 2022. 2017-2020 National Center for Health Statistics population estimates were used for crude rates for this map. 2020 estimates were used for 2021 rates.

Figure 2: Average annual rate of death by suicide among Virginians, 2017-2021

Over the five-year period of 2017-2021, almost eight out of 10 (79%) deaths by suicide were male. Deaths by suicide affected all age groups in Virginia during 2017-2021. Over half (52%) of deaths by suicide were among people aged 45 years or older at time of death (Figure 3).

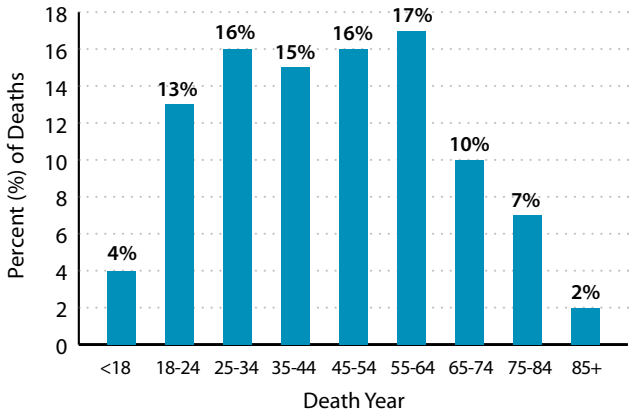


Figure 3: Percent of deaths by suicide by age group among Virginians, 2017-2021

Eighty-three percent of deaths by suicide were non-Hispanic White, followed by 10% Black or African American, 4% Hispanic/Latino(a)/Latinx (all races), and 3% Asian or Pacific Islander in 2017-2021. American Indian or Alaska Native Virginians represent less than 1% of deaths by suicide in 2017-2021. From 2017 to 2021, the number of deaths by suicide increased among specific age groups. In particular, deaths by suicide increased by 25% and 24% among the 10-19 (63 in 2017 to 79 in 2021) and the 65-74 age groups (109 in 2017 to 135 in 2021), respectively. Finally, of the deaths by suicide with available information on military affiliation (4,487; 77% of total deaths in 2017-2021), 16% of suicide deaths during 2017-2021 were in the Armed Forces (either current or previous service).

1 https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

2 https://www.cdc.gov/injury/wisqars/index.html

SUICIDE DEATHS BY MECHANISM

Mechanism is the cause or method of the injury. The top three mechanisms for deaths by suicide over the five-year period of 2017-2021 were by firearm, suffocation, and poisoning. In 2017-2021, 58% of deaths by suicide were by firearm, followed by 23% suffocation, and 12% poisoning. The highest number of deaths by suicide due to firearm in 2017-2021 was in 2021 (707).

Thirty-nine percent of deaths by suicide among females in 2017-2021 were due to firearms, 25% were due to suffocation, and 29% were due to poisoning. Whereas, 63% of deaths by suicide among males were due to firearms, 23% were due to suffocation, and 7% were due to poisoning. The highest percentage of deaths by suicide during 2017-2021 for both males and female groups were due to firearms; however, more deaths by suicide among females were due to poisoning than deaths by suicide among males (29% versus 7%), and more deaths by suicide among males were due to firearms than deaths among females (63% versus 39%).

SELF-HARM AND HOSPITALIZATION

Self-harm, or self-injury, is defined as anything that a person does with the intent to hurt or cause an injury to themselves, including death. In 2017-2021, there were 14,371 self-harm-related inpatient hospitalizations in Virginia; 2% were fatal. From 2017 to 2021, self-harm-related hospitalizations declined by 24% (3,271 in 2016 to 2,501 in 2021) (Figure 4).

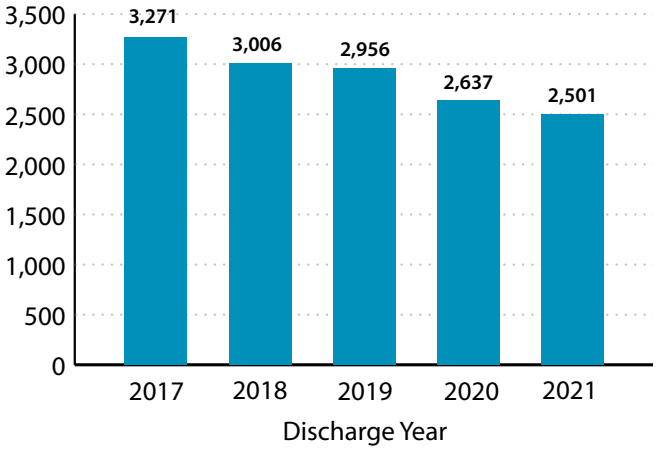
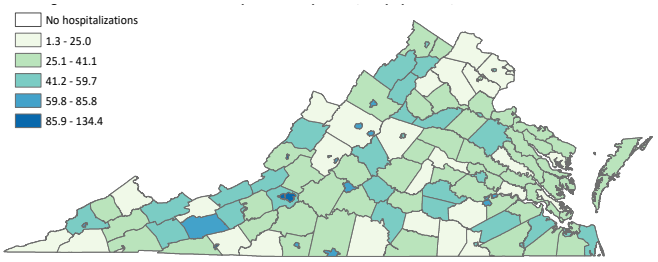


Figure 4. Self-harm-related hospitalizations among Virginians, 2017-2021

Sixty-one percent of self-harm-related hospitalizations were female; 39% were male in 2017-2021. Of the 14,371 self-harm-related hospitalizations in 2017-2021, 32% were aged 24 years or younger. By race/ethnicity, 70% of the self-harm-related hospitalizations in 2017-2021 were non-Hispanic White, followed by 18% Black or African American.

Figure 5 shows the average annual rate of self-harm-related hospitalization per 100,000 population by city or county (locality) in 2017-2021. Dark blue localities have the highest rates of self-harm-related hospitalization. Although self-harm-related hospitalizations affect almost all localities in Virginia, the five localities with the highest average annual rates for self-harm hospitalization in 2017-2021 were: the cities of Galax (134.4 per 100,000), Roanoke (98.2), Covington (93.5), Salem (90.2), and Waynesboro (85.8).



Self-harm-related hospitalizations represented here are based on the zip code of the patient's residence at time of hospitalization. Some Virginia zip codes may cross city/county boundaries. This may cause under- or over-reporting of hospitalizations at the city/county level for those localities with zip codes that cross boundaries.
Rates for counts less than 20 should be considered unstable and interpreted with caution.
Data are from Virginia Health Information and analyzed by Injury and Violence Prevention epidemiology team, Office of Family Health Services, Virginia Department of Health, September 2022.
2017-2020 National Center for Health Statistics population estimates were used for crude rates for this map.
2020 estimates were used for 2021 rates.

Figure 5: Average annual rate of self-harm-related hospitalization among Virginians, 2017-2021

During 2017-2021, 87% of the self-harm-related hospitalizations were due to drug poisoning, 8% to non-drug poisoning (like alcohol, smoke, noxious gasses, or other non-drug substances), 8% to other mechanisms (including firearms, suffocation, and jumping or falling), and 6% to cutting or piercing, respectively.

In 2021 alone, the average length of stay for a self-harm-related hospitalization was almost five days, and the average cost was almost $45,000. Virginia residents were hospitalized for a self-harm-related injury a total of 12,293 days with over $112 million dollars in hospitalization costs in 2021. Approximately 37% of self-harm-related hospitalizations were paid through Medicaid in 2021, followed by 16% paid through Medicare.

SUICIDAL IDEATION AMONG VIRGINIA YOUTH

The Virginia Youth Risk Behavior Surveillance System (YRBSS) is a survey of students in randomly selected public middle and high schools statewide. YRBSS is administered every odd year and gathers information about students' health behaviors to help develop prevention strategies to support healthier behaviors and outcomes of students in Virginia. YRBSS asks questions about sadness or hopelessness, suicidal thoughts, planning, and attempts. In 2019, the most recent data available, 16% of high school and 22% of middle school students reported seriously considering attempting suicide. Further, 12% of high school and 14% of middle school students reported making a suicide plan, and 9% of high school and 7% of middle school students reported attempting suicide in 2019.[3]

POOR MENTAL HEALTH AMONG VIRGINIA ADULTS

The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey of randomly selected adults ages 18 years and older asking about their health behaviors. BRFSS is administered every year to identify prevention strategies to improve health outcomes for adults statewide. Although the

3 https://www.cdc.gov/healthyyouth/data/yrbs/results.htm

currently available BRFSS data does not include responses about self-harm or suicidal thoughts, there are responses about mental health status.

In 2020, 17% of adult Virginians reported being told that they had some form of depression. Twenty-two percent of females reported yes, whereas 12% of males reported yes to having depression.

One of the BRFSS questions asks whether respondents experience frequent poor mental health days, meaning 14 or more days out of a month, where the person experiences stress, depression, and problems with emotions. In 2019, adult females were 1.5 times more likely to have frequent poor mental health days than adult males. There was no significant difference by race/ethnicity and frequency of poor mental health days. High school graduates had 2.4 times the odds of having frequent poor mental health days than college graduates with a 4+ year degree. Finally, people who were unable to work were 4.2 times the odds, people who were out of work for more than a year were 3.7 times the odds, people who were out of work for less than a year were almost 1.8 times the odds, and people who were students were 1.7 times the odds of having frequent poor mental health days than people who were employed with wages.[4]

PRIORITY POPULATIONS

Recent data indicate that there are some trends among priority populations about self-harm and suicide to consider when developing suicide prevention programs.

Black Virginians

Deaths by suicide among Black or African American Virginians increased by 56% from 2017 to 2021 (91 in 2017 to 142 in 2021). Overall, deaths by suicide among Black or African American Virginians was the highest in 2021 in a full decade (2012-2021). Notably, Black or African American youth and young adults aged 18-34 years increased 69% from 2017 to 2021 (48 in 2017 to 81 in 2021).

Virginia YRBSS results also show that Black middle school students were significantly more likely to make a suicide plan (17% versus 12%) and make a suicide attempt (13% versus 7%) than White middle school students in 2019. Black high school students were also significantly more likely to attempt suicide than White high school students in 2019 (10% versus 4%).[5]

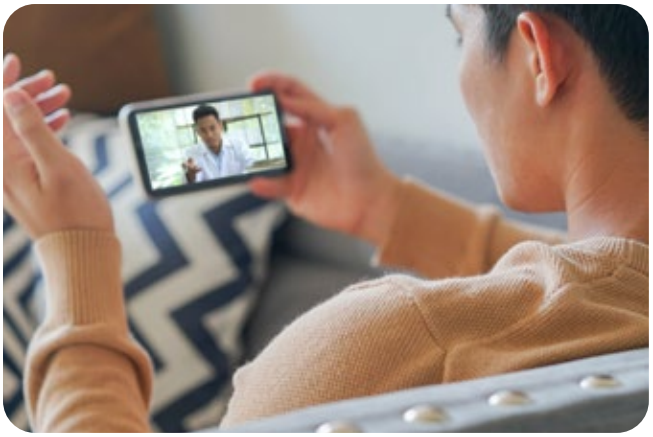
Youth and Younger Adults

Youth and young adults aged 10-24 years overall represented 32% of the self-harm-related hospitalizations during 2017-2021. However, the proportion of self-harm-related hospitalizations among the 10-24 age group in Virginia increased from 2017 to 2021. In 2017, self-harm-related hospitalizations among 10-24 year olds were 29% of the total; this increased to 39% in 2021. There were 937 deaths by suicide among Virginians aged 10-24 years, representing 16% of the total suicide deaths, in 2017-2021. There was an average of 187 deaths among the 10-24 age group each year from 2017 to 2021. Deaths by suicide among 10-24 year olds increased 23% from 2017 (167) to 2021, with a peak of 206 deaths in 2021.

Results from the Virginia middle school YRBSS also indicate that Virginia middle school students were significantly more likely to think about suicide (22% versus 18%), make a suicide plan (14% versus 11%), and make a suicide attempt in 2019 (9% versus 6%) compared with 2013 responses. Virginia high school students did not present these same trends; Virginia high school YRBSS respondents were less likely to make a suicide plan in 2019 (12% in 2019; 15% in 2013) or attempt suicide (7% in 2019; 10% in 2013) than in 2013. However, high school respondents in 2019 did report significantly more feelings of sadness and hopelessness (32%) compared to 2013 (26%), which is a risk factor for suicide.3

Rural Communities

Rates of death by suicide and self-harm-related hospitalization in 2017-2021 were higher in Virginia localities that are defined as more rural, either noncore localities or small and medium metros that are surrounded by more rural communities. For example, Galax City is a rural (noncore) locality[6] and had the highest average annual rate of death by suicide and self-harm-related hospitalization in 2017-2021 (Figure 3 and Figure 5). Four out of five localities (Galax City, Roanoke City, Covington City, Salem City) with the highest average annual rates of self-harm-related hospitalization in 2017-2021 were in the Southwest health region of Virginia, which is considered more rural. This trend was also similar for deaths by suicide; three out of five localities with the highest average annual death rate in 2017-2021 were in the Southwest health region (Galax City, Dickenson County, and Scott County). More rural localities in Virginia experience more poor mental health days than the state overall.[7] In addition, more rural localities in Virginia rank lower than the state for economic social determinants of health that can lead to higher risk of suicide, like unemployment, educational attainment, and children in poverty, according to 2022 County Health Rankings.[7]



4 https://nccd.cdc.gov/weat/#/analysis

5 https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=VA

6 https://www.cdc.gov/nchs/data/series/sr_02/sr02_166.pdf

7 https://www.countyhealthrankings.org/app/virginia/2022/overview

COMMUNITY

"When we work together, we can really identify what the needs are and addressing those needs becomes both part of the school and part of the community."

Martha Montgomery, School Psychology Specialist, VDOE

COMPREHENSIVE SUICIDE PREVENTION

The comprehensive suicide prevention plan must respond to the dynamic nature of our environment and the needs of the people who function within it. The human need for connectedness and belonging make healthy, thriving communities essential. The relationship is reciprocal. Healthy, thriving individuals build strong, supportive communities. National resources that provide detailed discussion on building a comprehensive approach to suicide prevention are available at the end of this document. This section highlights five key components that inform the comprehensive suicide prevention plan. These are the Social Ecological Model, the Social Determinants of Health, Shared Risk and Protective Factors, Adverse Childhood Experiences, and Trauma.

SOCIAL ECOLOGICAL MODEL

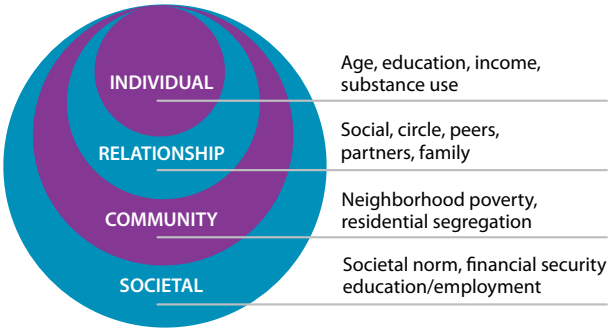


Diagram 1. Social Ecological Model

The heart of the social ecological model is the diagramming of a complex interplay between various levels of a society. First introduced in the 1960's, this model has helped to create understanding around how individuals function in their environments and moved the focus from solely individual intervention to a broader concept of ecology. That is, a study of relationships between organisms or people, and their physical environments. This recognition has proven essential as public and mental health practitioners attempt to address the drivers of suicide within communities. This includes such concepts as the social determinants of health explored in the next section as well as shared risk and protective factors discussed later in this document. Diagram 1 demonstrates the relationship between the various levels in a social ecological model. Each level brings unique challenges and interventions which suicide prevention programs must consider and utilize to address suicide deaths and intentional self-harm. Below are definitions adapted from the CDC which provide some detail about each level.[8]

Individual

The first level identifies biological and personal history factors that increase risk factors around suicide and self-harm. Some of these factors are age, education, income, substance use, or history of abuse. Prevention strategies at this level *promote attitudes, beliefs, and behaviors that prevent violence*. Specific approaches may include conflict resolution and life skills training, social-emotional learning, and safe dating and healthy relationship skills programs.

Relationship

The second level examines close relationships that may increase the risk of suicide or self-harm. A person's closest social circle-peers, partners, and family members-influences their behavior and contributes to their experience. Prevention strategies at this level may include *parenting or family-focused prevention programs* and mentoring and peer programs designed to strengthen parent-child communication, promote positive peer norms, problem-solving skills and promotion of healthy relationships.

Community

The third level explores the settings, such as schools, workplaces, and neighborhoods, in which social relationships occur and seeks to identify the characteristics of these settings that are associated with risk and protective factors around suicide and self-harm. Prevention strategies at this level focus on *improving the physical and social environment in these settings* (e.g., by creating safe places where people live, learn, work, and play) and by addressing other conditions that give rise to violence and injury in communities (e.g., neighborhood poverty, residential segregation, instability, high density of alcohol outlets).

Societal

The fourth level looks at the broad societal factors that help create a climate in which suicide and self-harm is exacerbated or inhibited. These factors include social and cultural norms that atomize and alienate society, reduce connectedness, and perpetuate narratives of "pulling yourself up by your bootstraps". Other large societal factors include the health, economic, educational, and social policies that help to maintain economic or social inequalities between groups in society. Prevention strategies at this level include efforts to *promote societal norms that protect against violence and efforts to strengthen household and financial security, education and employment opportunities, and other policies* that affect the structural determinants of health. A key component of which is the Health in All Policies approach to policy making or HiAP. This approach incorporates health considerations of communities that may be impacted by policy making. Historically, the process of conducting a cost-benefit analysis has not weighted concerns of a community or unintended

8 The Social Ecological Model: A Framework for Prevention https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html

consequences as heavily as other factors, such as, financial concerns, capacity issues, etc. This process could also consider elements of the precautionary principle which has four elements, taking preventive action in the face of uncertainty; shifting the burden of proof to the proponents of an activity; exploring a wide range of alternatives to possibly harmful actions; and increasing public participation in decision making.[9] All of these elements, HiAP, cost-benefit analysis, and precautionary principles, should be considered when working on the societal level within the social ecological model.

HEALTHY PEOPLE 2030: SOCIAL DETERMINANTS OF HEALTH

In the 2010 Secretary's Advisory Letter on National Health Promotion and Disease Prevention, the authors note that many of the societal determinants of health lie outside of the traditional health sector and that achieving health will require more than the control of disease, but the creation of conditions where people can be healthy.[10]

This acknowledgment remains as important today as a decade ago. As a community, we must work together to change the very fabric of our social and physical environments to ensure that all individuals have the resources necessary to live their lives. As an example, many rural populations may have limited or no access to primary care doctors. This can result in these groups utilizing the emergency room to meet their needs, and only when those needs are immediate. Due to a perceived over use of emergency resources, this may result in policy which treats these "super utilizers" as engaged in inappropriate health seeking behavior. To truly recognize the value of thinking about public health and suicide prevention through the lens of the social determinants of health, we must address root causes of social inequity, such as a lack of funding for primary care providers who may wish to work in more remote areas of Virginia, instead of solely engaging these utilizers in interventions designed to educate them away from health service utilization.

Healthy People 2030, and more specifically the social determinants of health, help to address some of the issues related to individual characteristics, how we create a shared risk and protective factor environment, and how we think about health more broadly. These factors will be touched on in the following section. Below we highlight the overarching goals of Healthy People 2030, which is one of many frameworks that influence suicide prevention in Virginia.

1. Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
2. Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
3. Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
4. Promote healthy development, healthy behaviors, and well-being across all life stages.
5. Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Access to education and health care, as well as the quality of these determinants, can shape how individuals grow and thrive in their communities. Economic stability, such as jobs that pay a living wage, neighborhoods that are safe and have plenty of greenspace, and a community's connectedness, all play a role in creating a healthy society. These things are all influenced by funding and policy choices that we make within our communities and society. At first glance, these things may seem a distant concern as it relates to suicide prevention, however, community safety, the ability to provide for families, and the connections we have to support each other; all protect against trauma and build communities that value the individual, potentially creating protective environments which reduce risk of self-harm and suicide.

9 Kriebel, D., Tickner, J., Epstein, P., et.al. The Precautionary Principle in Environmental Science. Environmental Health Prospect, 2001, Sept. 109 (9) 871-876.

10 Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. https://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm#twentysix

SHARED RISK AND PROTECTIVE FACTORS

As our understanding of mental health and suicide has changed over time, so has our focus. Risk factors are characteristics that are associated with a higher likelihood of negative health outcomes. Protective factors are characteristics associated with a lower likelihood of negative health outcomes, or that reduce a risk factor's impact. While there will always be a need to prioritize individual risk and protective factors through funding robust public and mental health services like mobile crisis units, respite care facilities, and inpatient/outpatient therapy, there is an additional need to consider shared risk and protective factors in the context of the social-ecological model discussed in a previous section.

The CDC released a technical package that provides several strategies to address shared risk and protective factors within this context.[11] From strengthening access to and delivery of suicide care to creating protective environments by changing organizational policies, we can ensure an environment that has resilient properties as part of a societies DNA. To further illustrate this point, take a look at the table below, adapted from the CDC's Risk and Protective Factors, which separates these factors by social-ecological level.[12]

While this list has been adapted and is not comprehensive, it provides a good starting point for thinking about shared risk and protective factors on a variety of levels. This table can also assist in thinking through ways organizations, coalitions, and programs can ensure they have this approach baked into their interventions.

11 Centers for Disease Control and Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices, (2017). https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf

12 Suicide Prevention: Risk and Protective Factors. Centers for Disease Control and Prevention. https://www.cdc.gov/suicide/factors/index.html

Risk Factors		Protective Factors	
Societal			
• Economic downturn/depression • Locations with less restrictive firearm laws • Stigma about mental health and treatment • Viruses/parasites • Poverty		• Healthy economy • Locations with more restrictive firearm laws • Mental health funding	
Community			
• Exposure to community violence • Local suicide epidemic • Barriers to healthcare access		• Crisis support lines/hotlines • Healthcare/mental healthcare access • Effective mental healthcare • Trained gatekeepers • Community involvement • School-based support and intervention programming	
Interpersonal/Relationship			
• Living in household with firearm • Exposure to suicide/ contagion • Family violence • Family history of suicide/ attempt	• Relationship instability • Death of a loved one • Severing of romantic relationship • Social isolation/ withdrawal • Combat exposure	• Presence of social support • Use of social support • Perceived social support • Concerns suicide is harmful to child/family • Help-seeking behavior	• Children present in the home • Caring letters • Social connectedness • Contact with caregivers • Support for connection with healthcare providers • Collaborative Assessment and Management of Suicidality (CAMS)
Individual			
Biological: • Family history of suicidal behavior **Social-Demographic:** • Older adult age • Firearm ownership • Incarceration • Stress/Job loss • Financial strain • Recent discharge from psychiatric hospital • Bullying • ***Psychiatric:*** • Mental health diagnoses • Substance use/misuse • Alcohol misuse	**Psychological:** • Prior suicide attempt • Current suicidal thinking • Presence of suicidal intent/plan • Access to/presence of lethal means • Preparatory behaviors • Hopelessness • Low self-control/high impulsivity • Childhood abuse • Feelings of burdensomeness • Chronic illness • Acute health symptoms • Sleep disturbance • Homelessness • Internalized stigma	**Biological:** • SSRI usage • Lithium/mood stabilizer treatment • Clozapine usage **Social-Demographic:** • Religiosity/spirituality (i.e., beliefs about being wrong)	**Psychiatric:** • Treatment motivation **Psychological:** • Coping skills • Problem solving skills • Moral objections to suicide • Survival beliefs/desire to live • Fear of suicide/death • Fear of social disapproval • Hopefulness • Life satisfaction • Intact reality testing • Resiliency • Extraversion • Additional reasons for living

ADVERSE CHILDHOOD EXPERIENCES

The environment plays a role in shaping how we manage and navigate experiences in our lives. In some cases, with adequate medical care, shelter, food, and education, people come away with the skills and support to navigate challenges that result from our current systems. While it is essential that public health continues to play a role in building and maintaining these supports, pushing systemic change, there are significant gaps which can create situations that may result in individuals experiencing what are termed adverse childhood experiences (ACEs). The CDC defines ACEs as "potentially traumatic events that occur in childhood (0-17 years)."[13] These traumatic events have been linked to chronic health problems, mental illness, substance use in adulthood, and are shown to negatively impact education, job opportunities, and earning potential.[14] The CDC developed a technical package to address the prevention of ACEs which can be found in the footnotes. Primary prevention strategies (intervention before negative effect can occur) fall into six broad categories which can be seen in Table 1. This technical package further details activities that can be used in communities to prevent ACEs.[15] While individuals and organizations may not be able to address all of these areas, awareness of and coordination between the various approaches that community partners utilize can help create a safe and supportive environment for generations to come.

1. Strengthen economic supports for families
2. Promote social norms that protect against violence and adversity
3. Ensure a strong start for children
4. Teach skills
5. Connect youth to caring adults and activities
6. Intervene to lessen immediate and long-standing harms

TRAUMA AND TRAUMA RESPONSIVE CARE

Trauma is a widespread, harmful, and costly public health problem which occurs as a result of abuse, neglect, loss, disaster, war, and other emotionally harmful experiences.[16] As ACEs are potentially traumatic events, the two are linked. Many individuals and organizations are becoming more and more familiar with the concept of becoming trauma informed. However, there is a need to go beyond understanding what trauma is and begin to reshape our communities and society to become trauma responsive. This trauma responsive approach is outlined by SAMHSA through four key assumptions or the four R's. "A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**."[17] This approach has been further developed by Dr. Stephanie S. Covington and Dr. Sandra L. Bloom in their work to move organizations towards a trauma responsive framework.[18] In this work, there is a recognition that it is not enough to simply understand what trauma is but to take action to heal and protect against it. This includes everything from developing self-assessments, to creating implementation teams and plans, to changing the physical environments of organizations and communities. When implemented, organizations and communities should see and feel the difference as individuals but also as part of continued quality improvement and assessment.

You can take action to increase your knowledge and awareness surrounding ACEs. Virginia has several trainers that can provide additional information or hold training to suit your orgaizational needs. The more people we have who understand what ACEs are, the better we will be at reducing trauma responsive infrastructure in our communities. Visit **https://www.vdh.virginia.gov/suicide-prevention** for more information.

13 Centers for Disease Control and Prevention. What are Adverse Childhood Experiences? www.cdc.gov/violenceprevention/aces/index.html

14 Centers for Disease Control and Prevention. Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence (2019). https://www.cdc.gov/violenceprevention/aces/index.html

15 Ibid

16 Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) xx-xxxx. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. https://s3.amazonaws.com/static.nicic.gov/Library/028436.pdf

17 Ibid

18 Moving from Trauma-Informed to Trauma-Responsive. A Training Program for Organizational Change. Covington S.S., PhD, Bloom S.L., MD. Hazelden Publishing. 2018.

CONNECTION ON COLLEGE CAMPUSES

"College campuses are great for increasing social connectedness [an important aspect of suicide prevention], there are so many choices for clubs, interest groups and sports groups for people to get involved."

Danette Gibbs, PhD. Director, The Campus Suicide Prevention Center of Virginia

STRATEGIES FOR SUICIDE PREVENTION, INTERVENTION, AND POSTVENTION

PREVENTION

When we think about common health recommendations, such as exercise to improve cardiovascular health, brushing teeth to avoid cavities, or something as common as taking the trash out to reduce the build-up of garbage in a home or apartment, we are thinking about prevention. In the public health field this is commonly referred to as primary prevention, that is, intervening before negative health effects occur.

Virginia utilizes a variety of strategies to help reduce suicide death and self-harm prior to it occurring. This section will highlight several of those strategies, including work to increase connectedness in communities, lethal means safety, and responsible media reporting.

A Note on Language: While the term Suicide Prevention has received some criticism as it alienates members of our community and does not necessarily center the actual conditions which devalue the individual, resulting in suicidal thoughts, we use it here to describe efforts to reduce death related to suicide in a non-coercive way.

Connectedness

The social-ecological model is often used to understand levels of intervention. One of the benefits of connectedness is that it can function on a variety of these levels.[19] From the connection individuals may feel as they work to pick up litter in a park, to connections between faith communities, and even a society as a whole. Connectedness can also provide individuals with better access to formal support and resources, mobilize communities to meet the needs of its members, and provide collective primary prevention activities to the community as a whole.[20]

Connectedness is not only important from the standpoint of suicide prevention but also plays a role in reducing injury and violence in other areas. While this document focuses on self-directed injury, it must be noted that many of these interventions have cross-cutting applicability, specifically as it relates to interpersonal violence. There is a growing body of literature that demonstrates the overlap between various types of injury and violence and the benefits of taking a shared risk and protective factors approach when addressing injury and violence prevention efforts.[21]

Lock & Talk Virginia

Lock

We promote the importance of limiting access to lethal means for a person with suicidal thoughts. Our partners provide free safety devices to secure guns and medications. They also offer free educational materials and guidelines about storing and securing lethal means. We consult and partner with businesses and helping agencies to build communities safer from suicide.

Talk

We teach anyone how to have conversations that can save lives using a variety of evidence-based skills trainings. Talking encourages people with thoughts of suicide to seek the help they need to stay alive. Discussing suicide changes the societal outlook on suicide and increases our awareness and ability to help those in emotional pain. Talking about suicide helps heal the survivors of a loss or an attempt by opening the door to hope and recovery.

Visit **https://www.lockandtalk.org** for more information.

In Virginia, the Department of Behavioral Health and Developmental Services in partnership with the Virginia Department of Health help facilitate the SPIAG which brings partners from all sectors and advocates together to promote connectedness. We recognize that these efforts can help us address multiple forms of injury and violence, SPIAG is a key tool used to accomplish this.

19 Centers for Disease Control and Prevention (CDC). Connectedness as a strategic direction for the prevention of suicidal behavior. Retrieved July 8, 2021 from https://stacks.cdc.gov/view/cdc/11795

20 Centers for Disease Control and Prevention. Strategic direction for the prevention of suicidal behavior: promoting individual, family, and community connectedness to prevent suicidal behavior. 2009; Retrieved July 8, 2021 from: https://www.cdc.gov/violenceprevention/pdf/suicide_strategic_direction_full_version-a.pdf

21 Swahn MH, Simon TR, Hertz MF, et al. Linking dating violence, peer violence, and suicidal behaviors among high-risk youth. Am J Prev Med. 2008;34(1):30–38.

Lethal Means Safety

Lethal means safety has become a primary way in which communities work to reduce suicide death. Lethal means is a phrase used to describe the means individuals use to cause harm or death. Because suicidal thoughts can often be brief, - survey data on the process of moving from thoughts to action indicates that this time period lasts for less than 10 minutes - reducing a person's access to a lethal means (lethal means safety) can be an extremely valuable intervention for preventing suicide deaths.[22] [23]

Lethal means safety can be broken down into three categories 1) physically impeding access (e.g., using gun locks and bridge barriers); 2) reducing the lethality or toxicity of a given method (e.g., reducing carbon monoxide content of motor vehicle exhaust; or 3) reducing "cognitive access," that is, reducing a particular method's appeal or cognitive salience.[24]

In Virginia we prioritize this strategy through our Lock and Talk Virginia initiative. Information on Lock & Talk Virginia is included at the end of this document.

INTERVENTION

Screening for Risk and Risk Assessment

A providers knowledge of risk and protective factors for suicide and their training, familiarity, and comfort with talking about suicide and suicidal thoughts with patients all play into the effectiveness of these interventions.[25] One tool that is commonly used to screen patients is the Ask Suicide-Screening Questions (ASQ). This simple, validated, five-question screener can help providers understand if their client may need further assessment by a trained clinician[26]

The Columbia Suicide Severity Rating Scale (C-SSRS) is a commonly used tool to screen for risk. The C-SSRS is evidence-based and can easily be accessed for free. Each of the forty DBHDS-supported Community Services Boards in the Commonwealth are required to utilize the C-SSRS. These resources can be found at the end of this document as well as additional information on the web, including free training on how to utilize each instrument.

When screening for risk, it's important to remember screening should not be used to limit the amount of support given to individuals. Particularly if they are requesting additional support. Additionally, these tools cannot be used to predict suicide death. The best use for a risk screener is to match available interventions of the organization to the needs of the patient.

Risk assessment can be an important tool to help detect the risk of suicide within the individual. There are many ways in which risk assessments can be conducted and, while several best practice approaches exist, there is not currently a universally accepted process for conducting a risk assessment. In a 2014 review of clinical practice guidelines, Bernert et.al., reviewed 101 clinical practice guidelines based on 13 content areas emphasizing the need to provide more training to clinicians to increase comfort with completing risk assessments as well as establishing risk level standardization.

Gatekeeper Training

The term gatekeeper refers to individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. Gatekeepers are trained to "identify persons at risk of suicide and refer them to treatment or supporting services as appropriate".[27] For example, gatekeeper programs in schools focus on training teachers and school staff to identify students who may be at-risk for suicide. In healthcare settings, primary care and emergency department staff have been trained to be gatekeepers for their patients. Gatekeeper trainings address participants' reluctance to intervene and improves their self-efficacy to identify and facilitate a referral for a person at risk of suicide.

A multi-site evaluation assessed the impact of community-based suicide prevention programs that included Garrett Lee Smith (GLS) gatekeeper trainings as a major component of their programs. Suicide attempts and deaths were compared to the change in suicide rates and nonfatal suicidal behavior among young people aged 10–24 with similar counties that did not implement the trainings. Counties implementing the GLS trainings had significantly lower suicide rates the year after GLS training than similar counties that did not implement GLS training.[28] It is important to note that gatekeeper training and screening are not enough to prevent suicide death, communities must have systems with the capacity and referral resources in places to support comprehensive suicide prevention efforts.

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22 Drum D, Brownson C, Denmark A, Smith S. New data on the nature of suicidal crises in college students: shifting the paradigm

23 Deisenhammer EA, Ing CM, Strauss R, Kemmler G, Hinterhuber H, Weiss EM. The duration of the suicidal process: how much time is left for intervention between consideration and accomplishment of a suicide attempt? J Clin Psychiatry 2009;70(1):19–24.

24 Barber CW, Miller MJ. Reducing a Suicidal Person's Access to Lethal Means of Suicide

25 Bernert, R. A., Hom, M. A., & Roberts, L. W. (2014). A review of multidisciplinary clinical practice guidelines in suicide prevention: toward an emerging standard in suicide risk assessment and management, training and practice. Academic psychiatry : the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, 38(5), 585–592. https://doi.org/10.1007/s40596-014-0180-1

26 National Institute of Mental Health. Ask Suicide Screening Question (ASQ) Toolkit. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

27 The Surgeon General's Call to Action: To Implement the National Strategy for Suicide Prevention. A Report of the U.S> Surgeon General of the National Action Alliance for Suicide Prevention. (2021).

28 C. Walrath, L.G. Garraraz, H. Reid, et.al. (2015). Impact of the Garrett Lee Smith Youth Suicide Prevention Program on Suicide Mortality. Am J Public Health. 2015 May; 105(5):986-993.

Safety Planning

Safety planning is essential and the use of a collaborative safety planning process and follow-up has been shown to reduce the risk of suicide deaths in certain groups.[29] While many people are now familiar with safety planning which prioritizes the patient voice, individuals who work in this space may also be familiar with no-suicide contracts. Historically, no-suicide contracts were used as a way to have patients "promise" through signing their name, that they would not harm themselves. This was thought to provide legal protection should the client die by suicide and has limited evidence to suggest it was useful for patients.[30] It is strongly recommended that individuals no longer utilize the safety contract and active steps should be taken to train staff on safety planning as a collaborative partnership between clinician and patient. An example of a safety plan developed by Dr. Barbara Stanley and Dr. Gregory Brown can be found at the end of this document. While use of a safety plan is a worthwhile approach to reducing suicides, systems using safety plans should ensure that staff are properly trained and that regular audits for fidelity are completed.

Collaborative Assessment and Management of Suicidality (CAMS)

In the *2021 Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*, section 4.1 identifies the importance of increasing clinical training in evidence based care for suicide risk.[31] While several strategies are highlighted, including Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT), a new and promising approach is the Collaborative Assessment and Management of Suicidality (CAMS). This approach attempts to get at "drivers" that may lead to someone wanting to die. While we do not recommend any single approach over others in this document, the CAMS framework may be something that works for your organization or community. Training is available through the Virginia Department of Health. If your organization is a higher education institution, you may be able to provide training to staff and graduate students at no cost. Please contact the Campus Suicide Prevention Center of Virginia for more information.

> *The Campus Suicide Prevention Center of Virginia works to reduce risk for suicide on Virginia's college and university campuses. Specifically, we support the individuals and teams on each campus as they work to build the infrastructure necessary to promote wellness and safety for all students, identify and support those in distress and effectively respond to individuals who are at risk for suicide.*
>
> Jane Wiggins, PhD, Director of Training, The Campus Suicide Prevention Center of Virginia.

POSTVENTION

A great deal of attention is paid to the prevention of suicide death with research often focusing on the best interventions for individuals experiencing suicidal thoughts or crisis. Postvention is a vital part of a comprehensive suicide prevention model. Its inclusion helps to heal those recovering from a suicide attempt or have recently lost someone to suicide, and can prevent future suicides among these groups. Many individuals may not know where to reach out after a suicide event, and the following two examples are potential postvention frameworks that could be employed to support a community. While these examples include volunteers and paid staff supporting families, communities should consider increasing postvention education to the first responders, who often act as the catalyst to care for those who have lost someone to suicide.

StandBy Response Service

The CDC's technical package for preventing suicide outlines several strategies for supporting postvention efforts. One promising approach is the StandBy program operating in Australia. This program is a face-to-face community response to supporting individuals impacted by suicide. The program consists of outreach and telephone support programs that utilize a professional crisis response team which develop customized case management plans for referring people to existing community services that match their needs. The services are accessible 24/7 and offer continued contact for up to 2 years.[32] In Virginia, the Unite Us program works to coordinate a care network of health and social service providers. This program could be integrated with StandBy to improve referrals and reduce individuals lost to care.[33]

LOSS Team

The Local Outreach to Suicide Survivors (LOSS) team is a similar concept to the StandBy model employed in Australia. The primary difference being that these teams can be developed solely with volunteers and other members of the community who have the lived expertise of losing a loved one to suicide. This model was originally created by Dr. Frank Campbell at the Baton Rouge Crisis and Trauma Center in 1998 after identifying loss survivors waited 4 years (on average) before they reached out for support. More information on how to implement the LOSS team model can be found at https://losscs.org/launch-a-loss-team/.[34]

29 B. Stanley, G.K. Brown, L.A. Brenner, et. al. (2018). Comparison of the Safety Planning Intervention with Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department. JAMA Psychiatry. 2018 Sep. 1;75(9):894-900.

30 K.T. Kelly, M.P. Knudson. (2000). Are no-suicide contracts effective in preventing suicide in suicidal patients seen by primary care physicians? Arch Fam Med. Nov-Dec 2000;9(10):1119-21.

31 The Surgeon General's Call to Action: To Implement the National Strategy for Suicide Prevention. A Report of the U.S> Surgeon General of the National Action Alliance for Suicide Prevention. (2021). https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf

32 StandyBy Program About Us Page. Accessed December 2021. https://standbysupport.com.au/what-we-do/

33 Unite Us Program About Us Page. Accessed May 2022. https://virginia.uniteus.com/about/

34 LOSS Community Services. What is a LOSS team and why is it important. Accessed June 2021. https://losscs.org/launch-a-loss-team/

LIVED EXPERIENCE

"I'm one of many who have lost family to suicide. We need to do a better job understanding and addressing why people die and not just call it 'mental illness'."

Virginia Resident

KEY ELEMENTS FOR COMPREHENSIVE COMMUNITY-BASED SUICIDE PREVENTION

This section adapts concepts outlined in the Action Alliance's document *Transforming Communities Key Elements for the Implementation of Comprehensive Community Base Suicide Prevention*.[35] In an effort to work towards a community based suicide prevention plan this document provides recommendations for five focus areas:

1. The Commonwealth of Virginia
2. Early Learning Centers, Schools, Colleges, and Universities
3. Community, Non-profit, and Faith-based Organizations
4. Service Members, Family, and Veterans
5. Hospital Systems

This structure allows for prioritization of sectors that influence lives while also working to implement the principles of community-based suicide prevention as outlined by the National Action Alliance for Suicide Prevention (Action Alliance). The following section will highlight some key elements from this document which can be used to guide work within communities across Virginia. The Action Alliance document on community-based suicide prevention also includes a number of useful resources around suicide prevention and planning. Some of these items will be included in the planning tools section of this document, however, we encourage you to check out the Action Alliance's website here.

Comprehensive community-based suicide prevention:

1. Unity— Attainment and maintenance of broad-based momentum around a shared vision
2. Planning— Use of a strategic planning process that lays out stakeholder roles and intended outcomes
3. Integration— Use of multiple, integrated suicide prevention strategies
4. Fit— Alignment of activities with context, culture, and readiness
5. Communication— Clear, open, and consistent communication
6. Data— Use of surveillance and evaluation data to guide action, assess progress, and make changes
7. Sustainability— A focus on long-lasting change

Unity

Suicide is a complex problem that requires a variety of interventions to observe reductions in it. The concept of "collective impact" received increased attention in the last decade. Collective impact says that positive momentum is better achieved when various systems and organizations have a shared vision, goals, and metrics. Collective impact is key to the Action Alliance's concept of Unity. The process for building collective impact within a movement is also naturally diverse in its approach. This diversity strengthens solutions. In working towards a unified approach, communities should consider involving the following groups.

- Concerned and caring community members, including individuals with lived experience (e.g., suicide attempt survivors, persons bereaved by suicide)
- Representatives from the public and private sectors, including the business community
- Members of community-based organizations, including local crisis centers Representatives from various settings serving diverse groups (e.g. schools, college campuses, workplaces, places of worship)
- Representatives and leaders from health care and behavioral health care systems Academic partners
- The local and regional news media
- Representatives from the local/state justice and corrections systems
- Spiritual and faith leaders
- First responders (e.g., law enforcement, emergency medical technicians)
- Individuals representing and working with underserved and at-risk population who can advocate for changes in policies, systems, and environments that will help prevent and reduce suicide

Planning

When planning for community-based suicide prevention it is important to collect information on the problem as well as explore available resources. This can be accomplished by completing a strategic planning process which includes gap analysis. The Action Alliance recommends using the *Suicide Prevention Resource Center's Planning Approach*.[36] The six planning steps are as follows:

1. Describe the problem and the context
2. Choose long-term goals
3. Identify key risk and protective factors on which to focus your prevention efforts
4. Select or develop interventions
5. Plan the evaluation
6. Implement, evaluate, and improve

35 National Action Alliance for Suicide Prevention: Transforming Communities-Community-Based Suicide Prevention Priority Group. (2017). Transforming communities: Key elements for the implementation of comprehensive community-based suicide prevention. Washington, DC: Education Development Center, Inc

36 Suicide Prevention Resource Center Planning Approach. Accessed May 2021. https://www.sprc.org/effective-prevention/strategic-planning

Integration

Many factors can influence the final outcome of a suicide death. It is therefore important to address suicide death with a variety of integrated strategies, which address risk factors and strengthen protective factors on a number of social-ecological levels. While there are a number of models, frameworks, and approaches to integrating suicide prevention work, we highlight the *CDC's Preventing Suicide: A Technical Package of Policy, Programs, and Practice.*[37] Key strategies and approaches are below.

Strategy	Approach
Strengthen economic supports	• Strengthen household financial security • Housing stabilization policies
Strengthen access and delivery of suicide care	• Coverage of mental health conditions in health insurance policies • Reduce provider shortages in underserved areas • Safer suicide care through systems change
Create protective environments	• Reduce access to lethal means among persons at risk of suicide • Organizational policies and culture • Community-based policies to reduce excessive alcohol use
Promote connectedness	• Peer norm programs • Community engagement activities
Teach coping and problem-solving skills	• Social-emotional learning programs • Parenting skill and family relationship programs
Identify and support people at risk	• Gatekeeper training • Crisis intervention • Treatment for people at risk of suicide • Treatment to prevent re-attempts
Lessen harms and prevent future risk	• Postvention • Safe reporting and messaging about suicide

Fit

The term "fit" is used to highlight the importance of considering the community perspective, their readiness for change, strengths (within the community and individual), and needs. It is not enough for an intervention to be evidence-based. Notable researcher and Pawnee Nation member, Abigail Echo-Hawk, declared evidence-based interventions historically tested on white males cannot be considered appropriate for interventions with indigenous groups. This example serves as a reminder to consider a myriad of factors when supporting communities in the prevention of suicide.

While data informed preparation and planning are essential components of a comprehensive suicide prevention model, it cannot be successful without the participation of the community for which the intervention is designed. Even today, involvement of the focus community often occurs during the implementation phase of an intervention. It is essential to locate natural helpers, advocates, or champions within the community who can provide or connect you to individuals that provide perspective on the culture, readiness, strengths, and needs, during the planning phase.

37 Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

One common strategy is incorporating participatory and collaborative methods for engaging the community such as Participatory Action Research (PAR) or Community-Based Participatory Research (CBPR).

Communication

Communication is essential in delivering sustained comprehensive suicide prevention models. Communication must be as transparent as possible, include internal and external channels, and remain consistent. The act of communicating intention is not necessarily effective communication. The importance of ensuring that your message is heard and the intent is digested by the recipient means messaging may need to be adapted based on the audience. This can include limiting use of jargon or technical language as well as ensuring messaging is culturally sensitive, the message is relevant to the recipient, and that the language being used is shared by all participants or stakeholders. An excellent tool for addressing communication topics can be found through the University of Kansas' Community Toolbox under chapter 6, Communications to Promote Interest.[38]

Data

The collection and review of suicide and self-harm related data is an important piece to informing comprehensive suicide prevention efforts. Data collection should also include capacity building and use of non-traditional data sources to inform suicide prevention efforts. Further, work to build data literacy within communities to ensure data is collected with fidelity and understood to prevent misuse; should be prioritized. The Suicide Prevention Resource Center provides an overview of how to locate and understand data related to suicide prevention on their website.[39] Some of these tools are included at the end of this document under the planning tools section. Additionally, there is a matrix of data available to community members within Virginia in Appendix E.

Sustainability

While funding is often a primary concern for the sustainability of suicide prevention efforts, there are various approaches that can help sustain programs more easily. As an example, gatekeeper training is essential for any comprehensive suicide prevention program. However, this training relies heavily on a funder to provide training for master trainers and laypersons. Other approaches to sustain suicide prevention efforts should be considered not only in addressing suicide prevention on multiple levels of the social-ecological model but simply because they may be more likely to be sustained over time. The CDC's technical package suggests several approaches that may help sustain work around suicide prevention. These include ensuring mental health parity in insurance plans, that is, coverage received by individuals through their insurance company for physical health reasons should be matched if the reason for an appointment happens to be mental health related.[40] With an eye towards system transformation, whether in a hospital system or across a statewide behavioral health system, it is important to look towards interventions that increase return on investment and are likely to become integrated into the wider culture of a community.

38 Community Tool Box. University of Kansas. Accessed May 2021. https://ctb.ku.edu/en

39 Suicide Prevention Resource Center. Locating and Understanding Data for Suicide Prevention. Accessed December 2021. https://sprc.org/state-suicide-prevention-infrastructure/examine/

40 Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

STRATEGY

"Centering social drivers of suicide and expanding our understanding of suicide beyond the individual are the two most impactful things we can do to create lives worth living, reducing suicide death."

Justin Wallace, MPH, Suicide Prevention Coordinator, Virginia Department of Health

THE NATIONAL STRATEGY ON SUICIDE PREVENTION

In 2012, the U.S. Surgeon General and the National Action Alliance for Suicide Prevention identified four strategic directions to address suicide throughout the U.S. These strategies and goals are listed below.

While the Virginia recommended approach pulls from the national strategy, not all goals are identical due to the unique needs of Virginia. However, these strategies and goals can be prioritized as needed based on the dynamic needs of Virginians.

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities
GOAL 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.
GOAL 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and ehaviors
GOAL 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
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.
Strategic Direction 2: Clinical and Community Preventive Services
GOAL 5. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
GOAL 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.
GOAL 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
Strategic Direction 3: Treatment and Support Services
GOAL 8. Promote suicide prevention as a core component of health care services.
GOAL 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
GOAL 10. Integrate and coordinate suicide prevention activities across multiple sectors and settings.
Strategic Direction 3: Treatment and Support Services
GOAL 12. 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.
GOAL 13. Promote and support research on suicide prevention.

STIGMA

"We want to normalize talking about suicide because most of us just don't know how to talk about it. If you had a headache, we would not hesitate to offer you some sort of relief. Talking about suicide in an open-ended direct way gives us the opportunity to take some kind of action."

Christy Letsom, Suicide Prevention Advocate and Gatekeeper Trainer

RECOMMENDED APPROACH: DETAILED

This plan, Suicide Prevention across the Lifespan: A Plan for the Commonwealth of Virginia, has five broad objectives.

1. Lead a diverse and inclusive group to build comprehensive suicide prevention systems throughout Virginia
2. Prioritize upstream factors that impact suicide prevention
3. Ensure all Virginians know they have a role to play in suicide prevention; ensuring access to free or low-cost training
4. Enhance the continuum of care for suicide prevention
5. Improve the quality, timeliness, exchange, and use of suicide and self-harm data.

The following section sets forth the Commonwealth's suicide prevention goals, strategies, and approach. For each goal and strategy(s), potential implementation approaches are described. A table indicates possible sectors that may be able to implement the suggested approaches as well as potential partners. However, these are recommendations and we encourage creative approaches to adapting them to fit your needs.

1. The Commonwealth of Virginia
2. Early learning centers, schools, colleges, and universities
3. Community, non-profit, and faith-based organizations
4. Service Members, Veterans, and their Families (SMVF)
5. Hospital Systems

Goal 1: Foster leadership, collaboration, and partnerships throughout communities and with a variety of stakeholders, prioritizing the engagement of those with lived experience, to stand up sustainable, comprehensive suicide prevention efforts that meet the needs of those who utilize them.

INTRODUCTION:

Collaborative partnerships are essential to the development and sustainability of a comprehensive suicide prevention approach. This priority allows for a variety of systems to coordinate a collective response to behavioral health and suicide in communities. Leadership, collaboration, and partnership, with those who have lived experience, can have a multiplying effect. Additionally, these efforts help to bring light to gaps in our infrastructure, funding, knowledge base, and many other areas.

STRATEGY:

1. Engage people with lived experience in all aspects of suicide prevention
2. Use effective communication to educate and employ diverse sectors in suicide prevention
3. Pursue federal, state, and private funding to support planning, implementation, monitoring, and evaluation of suicide prevention efforts
4. Standardize a health in all policies approach with integration of suicide prevention and mental health supports into all aspects of policy decisions
5. Maintain and support communities, coalitions and advisory groups working to address suicide

Approach	State	Non-Profit	Schools	SMVF	Hospital
Maintain state suicide prevention coordinator positions which actively pursue federal, state, and private funding to support and sustain the comprehensive suicide prevention work across the state	✓				
Craft funding opportunities that require active recruitment of individuals with lived experience	✓	✓	✓	✓	✓
Craft funding opportunities which prioritize stakeholder partnerships that are engaged in work through a health equity lens informed by evidence-based tools	✓	✓	✓	✓	✓
Support statewide communication campaigns to raise awareness and attract a diverse group of stakeholders to suicide prevention work	✓				
Prioritize the recruitment of staff with diverse backgrounds through actively pursuing best practices for interviewing and onboarding new hires	✓	✓	✓	✓	✓
Support and sustain the Suicide Prevention Interagency Advisory Group (SPIAG)	✓				
Conduct annual needs assessments and gap analysis related to comprehensive suicide prevention work	✓				
Increase the public workforce's understanding of suicide and suicide prevention including the reduction of stigma through training and policy	✓	✓	✓	✓	✓

Goal 2: Promote research informed suicide prevention interventions with a focus on addressing upstream factors that impact suicide.

INTRODUCTION:

Effective suicide prevention requires a multimodal approach. This includes thinking about ways to address structural factors in our society that can contribute to stress, anxiety, mental health, and suicidal thoughts or self-harm. By considering strategies to address upstream factors, such as, job stability, employee mental health and family benefits, and working to build connectedness, we can address risk to prevent a crisis.

STRATEGY:

1. Promote and enhance social connectedness
2. Strengthen economic supports
3. Engage and support priority populations and underserved groups
4. Improve the mental health literacy of communities by providing guidance related to appropriate messaging and incorporating successes in suicide prevention into media messaging
5. Build on community strengths to increase protective factors and decrease risk factors on an individual, relational, communal, and societal level

Approach	State	Non-Profit	Schools	SMVF	Hospital
Support and sustain evidence-based suicide prevention best practices to include gatekeeper trainings	✓	✓		✓	
Partner with organizations to increase mental health literacy addressing and promoting the needs of priority populations	✓	✓	✓	✓	
Develop and maintain the capacity to provide on-line dialogue with stakeholders to increase awareness of best practices in suicide prevention	✓	✓	✓	✓	✓
Increase collaboration between lead agencies and their community-based stakeholders including first responders, the Department of Social Services, the Department of Veteran Services, primary care physicians, psychiatrists, emergency rooms, and service providers for housing/homeless	✓				
Increase stakeholder utilization of Recommendations for Safe Reporting on Suicide	✓	✓	✓	✓	✓
Increase multi-platform communication efforts that promote positive messages and support safe crisis intervention strategies	✓	✓	✓	✓	✓
Promote programs and literature that support person-first language	✓	✓	✓	✓	✓
Support and promote community events, forums, and materials to raise awareness around safety and help-seeking behaviors	✓	✓		✓	✓
Increase collaboration with peer support and peer run organizations	✓	✓	✓	✓	✓
Provide educational opportunities that promote resilience, help-seeking behaviors, and mental health wellness	✓	✓	✓	✓	✓
Prioritize the development of communication efforts that support priority populations including SMVF and black, indigenous, and people of color (BIPOC)	✓	✓	✓	✓	✓

Goal 3: Provide culturally and linguistically appropriate training and educational opportunities to bolster suicide prevention efforts; ensuring everyone knows they have a role to play in preventing suicide death.

INTRODUCTION:

Ensuring Virginians have access to culturally and linguistically appropriate training and educational opportunities is essential. This includes work to engage additional partners such as healthcare professionals, first responders, as well as the local community. These efforts will ensure that awareness, training, and education in recognizing and responding to risk factors for suicide in our communities is as familiar as receiving a blood pressure reading.

STRATEGY:

1. Empower every individual and organization to play a role in suicide prevention
2. Empower communities to implement proven approaches
3. Increase the use of lethal means safety and counseling on access to lethal means
4. Increase clinical training in evidence-based care for suicide risk
5. Expand and sustain evidence-based suicide prevention, risk assessment, and intervention training
6. Sustain a coordinated central point of access where suicide prevention resources and training are accessible to the community

Approach	State	Non-Profit	Schools	SMVF	Hospital
Ensure programming adheres to the Culturally and Linguistically Appropriate Service Standards (CLAS) providing training where appropriate	✓	✓	✓	✓	✓
Increase, sustain, and deploy a network of trainers and volunteers to build out opportunities throughout the state	✓				
Support the integration of suicide prevention gatekeeper training into graduate level programs	✓		✓		
Support innovation in awareness, prevention, intervention, and postvention programming and research	✓		✓		✓
Explore with partner organizations the legislative and regulatory needs required to integrate suicide prevention and intervention training into licensing for healthcare and other professions as appropriate	✓		✓		
Encourage all certifying entities working within the Commonwealth to include formal suicide prevention training	✓				
Support Virginia's community college campus system in promoting mental health and suicide prevention services within their community, establishing formal contract where applicable (Memorandum of Agreement)	✓		✓		
Aid in the development of a statewide dashboard to track suicide prevention resources and trainings	✓				
Develop linkages of care and follow-up models for Virginia schools to ensure students have access to treatment and support	✓		✓		
Continue to strengthen peer support programs and engage those with lived experience	✓	✓	✓	✓	
Work to expand the use of the Zero Suicide framework to reduce suicide death across and within systems	✓	✓			✓
Develop staff resources to address stress, anxiety, and vicarious trauma as a result of work related responsibilities	✓	✓	✓	✓	✓

Goal 4: Enhance the continuum of care for those at risk of suicide by prioritizing the reduction of barriers to care, including structural racism, and implementation of universal screening (where appropriate), referral, linkages, and follow-up. This must include active efforts to build capacity within communities.

INTRODUCTION:

Regardless of the level of need or the location of service we must continue to work towards building, enhancing, and supporting our continuum of care for individuals who find themselves experiencing suicidal thoughts, are engaged in self-harm behavior, or have made a suicide attempt. This continuum must actively identify individuals who may be at risk for suicide, getting them the necessary supports that meet their needs in a timely and appropriate manner. Strengthening our ability to screen, refer, and link individuals is an essential element of a comprehensive suicide prevention plan. This effort must include increasing access through capacity building and reducing administrative barriers to care.

STRATEGY:

1. Improve suicide risk identification in health care settings including local health departments, community services boards, and behavioral health authorities
2. Establish baseline safety planning efficacy within staff who support patients with increased risk of suicide
3. Increase the use of suicide safe care pathways in health care systems for individuals at risk
4. Increase the use of caring contacts in diverse settings
5. Ensure safe care transitions for all patients regardless of risk assessment
6. Ensure adequate crisis infrastructure to support implementation of the national 988 number
7. Improve collaboration with licensing entities to ensure healthcare and other professionals receive formalized training in suicide prevention and intervention as part of their training and credentialing process
8. Address systems of structural racism which have historically limited access to services among communities of color

Approach	State	Non-Profit	Schools	SMVF	Hospital
Develop guidance to inform integration of suicide prevention care within in-patient facilities	✓				
Support expansion of Zero Suicide framework elements where appropriate	✓	✓	✓	✓	✓
Continue research of best-practice protocol for all points of service within the suicide prevention continuum of care	✓				
Encourage the use of the tools which support racial equity in funding opportunities	✓				
Support an integrated framework for caring contacts	✓	✓	✓	✓	✓
Create and maintain partnerships between partners supporting the continuum of care	✓	✓	✓	✓	✓
Prioritize the support and establishment of postvention programs throughout Virginia	✓	✓	✓	✓	✓
Ensure SMVF have access to community-based resources as appropriate	✓	✓	✓	✓	✓
Prioritize the engagement of historically marginalized groups in planning and implementation efforts	✓	✓	✓	✓	✓

[continued]

Approach	State	Non-Profit	Schools	SMVF	Hospital
Assist in coordinating the 988 and crisis care infrastructure through active participation in work groups and committees as appropriate	✓	✓	✓	✓	✓
Support efforts to increase school-based counselors and psychologists available to students	✓	✓	✓		
Work to address barrier crime legislation which prevents peer support specialists from accessing job opportunities	✓	✓			
Work to integrate schools, hospitals, and the behavioral health systems response to suicide risk in an effort to reduce use of ER rooms for psychological assessments and holding	✓	✓	✓		✓

Goal 5: Improve the quality, timeliness, exchange, and use of suicide and self-harm related data between and within state and local partners.

INTRODUCTION:

Commitment to a data informed approach is paramount to ensuring a comprehensive suicide prevention framework is effective while remaining flexible when presented with new information. Organizations taking a data informed approach should also invest in data literacy training for staff members to ensure steps are taken to collect quality information. Information exchange is also a key component of this goal as federal, state, and local partners can benefit from a bidirectional flow of information.

STRATEGY:

1. Increase access to near real-time data related to suicide
2. Improve the quality of data on causes of death
3. Expand the accessibility and use of existing federal and state data systems that include data on suicide attempts and thoughts
4. Improve coordination and sharing of suicide-related data across the state and local levels
5. Use multiple traditional and non-traditional data sources to identify priority populations and to inform action
6. Support efforts to increase data literacy within communities

Approach	State	Non-Profit	Schools	SMVF	Hospital
Support and expand suicide and self-harm related data systems to include survey questions and modules as appropriate	✓	✓	✓	✓	✓
Establish a public health-focused statewide Suicide Fatality Review Team through the Office of the Chief Medical Examiner	✓				
Develop opportunities for community prevention coalitions to participate in data collection and evaluation	✓	✓	✓		
Explore the feasibility of creating an office of suicide prevention within state government	✓				
Explore the creation of standard suicide death reporting procedures for college and universities throughout Virginia	✓	✓	✓		

[continued]

Approach	State	Non-Profit	Schools	SMVF	Hospital
Develop programs that are data driven and regularly evaluated to ensure efficacy	✓	✓	✓	✓	✓
Build data collection and evaluation into all suicide prevention related training and programming	✓	✓	✓	✓	✓
Prioritize equitable data analysis throughout systems	✓	✓	✓	✓	✓
Engage in qualitative and quantitative data collection and dissemination	✓	✓	✓	✓	✓
Regularly evaluate programs and services based on the best available data	✓	✓	✓	✓	✓
Partner across systems to share suicide death and self-harm related data	✓	✓	✓	✓	✓
Regularly conduct needs assessments and gap analysis to ensure to include feedback from those with lived experience	✓	✓	✓	✓	✓

BEHAVIORAL HEALTH REDESIGN AND 988

"988 is a really important piece of what we're doing to build out the crisis care continuum in the state of Virginia. Right now, there's a number that goes to mobile crisis. You have regional crisis lines. You have acute mental health service lines. It's hard to get a good grasp of what peoples' needs are when all these things are living in different spaces. 988 will become the central number."

Laura Clark, Senior Director, PRS CrisisLink

APPENDIX A: PROGRAMS AND RESOURCES

VDH's Division of Injury & Violence Prevention 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	
Strengthen economic supports 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
Suicide Prevention Resource Center	www.sprc.org
American Foundation for Suicide Prevention	https://afsp.org/
The Columbia Protocol (C-SSRS)	https://cssrs.columbia.edu/training/training-options/

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/
Air Force Suicide Prevention	https://www.resilience.af.mil/Suicide-Prevention-Program/
U.S. Marine Corps Suicide Prevention	www.med.navy.mil/sites/nmcphc/healthpromotion/psychological-emotionalwellbeing/Pages/suicide-prevention.aspx
Military OneSource	www.militaryonesource.mil

Primary Care Providers	
Recognizing and Responding to Suicide Risk in Primary Care	https://suicidology.org/training-accreditation/rrsr-primary-care/

Teachers & School Staff	
Virginia Department of Education Suicide Prevention Resources	https://www.doe.virginia.gov/home/showpublisheddocument/32845/63804730718290000

Mental Health Professionals	
Assessing and Managing Suicide Risk (AMSR)	https://solutions.edc.org/solutions/zero-suicide-institute/amsr/amsr-services/amsr-training
Lock & Talk Virginia (Lethal Means Counseling)	https://www.lockandtalk.org/

Other Materials	
The Campus Suicide Prevention Center of Virginia	www.campussuicidepreventionva.org/
Means Matter (Harvard University)	https://www.hsph.harvard.edu/means-matter/
National Recommendations for Depicting Suicide	https://theactionalliance.org/messaging/entertainment-messaging/national-recommendations
Reporting on Suicide	https://reportingonsuicide.org/
University of Kansas' The Community Toolbox	https://ctb.ku.edu/en/table-of-contents

APPENDIX B: PLANNING TOOLS

NATIONAL RESOURCE LINKS

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action	https://theactionalliance.org/resource/revised-national-strategy-suicide-prevention-2012
Best Practices and Recommendations for Reporting on Suicide	https://reportingonsuicide.org/
Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence	https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf
Preventing Suicide: A Technical Package of Policy, Programs, and Practices	https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf
Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines	https://theactionalliance.org/resource/responding-grief-trauma-and-distress-after-suicide-us-national-guidelines
SAMHSA's Concept of Trauma and Guidance for Trauma-Informed Approach	https://s3.amazonaws.com/static.nicic.gov/Library/028436.pdf
Screening and Assessment for Suicide Prevention: Tools and Procedures for Risk Identification among Juvenile Justice Youth	https://theactionalliance.org/sites/default/files/jj-6-r2-screening-assessment.pdf
State Suicide Prevention Infrastructure	https://sprc.org/state-suicide-prevention-infrastructure/
The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention	https://theactionalliance.org/our-strategy/national-strategy-suicide-prevention/call-action
Transforming Communities: Key Elements for the Implementation of Comprehensive Community-Based Suicide Prevention	https://theactionalliance.org/sites/default/files/transformingcommunitiespaper.pdf

VIRGINIA CROSSWALK: SUICIDE PREVENTION INFRASTRUCTURE

Essential Elements	Recommendations	Lead Agency
Authorize	Designate a lead division or organization	VDH DBHDS
	Identify and secure resources required to carry out all six essential functions	VDH DBHD
	Maintain a state suicide prevention plan that is updated every 3-5 years	VDH DBHDS
	Authorize the designated suicide prevention agency to develop, carry out, and evaluate the suicide prevention plan	VDH DBHDS
	Require an annual report to the legislature or governor on the state of suicide and prevention efforts, the extent and effectiveness of any statute or rule related to suicide, and emerging needs	DBHDS
Lead	Maintain a dedicated leadership position	VDH DBHDS
	Identify and fund core staff positions, training, and technology needed to carry out all six essential functions	VDH DBHDS
	Develop capacity to respond to information requests from officials, communities, the media, and the general public	VDH DBHDS
	Where interests intersect, establish a formal connection between the relevant government divisions or offices	VDH DBHDS VDOE DCJS VDVS
	Build staff capacity to effectively communicate across multiple audiences and formats	VDH DBHDS
	Develop division/agency commitment to spur cross-discipline collaboration and integrate programs across funding sources	VDH DBHDS
Partner	Form a statewide coalition representation from broad public and private sectors	VDH DBHDS
	Adopt a shared vision and language across partners	VDH DBHDS
	Build partner capacity to integrate suicide prevention efforts into their structures, policies,and activities	VDH DBHDS
	Develop written agreements with partners detailing each party's commitment	VDH DBHDS

Essential Elements	Recommendations	Lead Agency
Examine	Ensure that sufficient funding and personnel are allocated to support high quality, consistent, privacy-protected suicide morbidity and mortality data collection and analysis	VDH
	Identify, connect with, and strengthen existing data sources	VDH
	Ensure that high-risk and underserved populations are represented in data collection	VDH
	Develop the skills and a plan for regularly analyzing and using data to inform action at the state and local levels	VDH
	Link data from different systems while protecting privacy	VDH
Build	Build a multi-faceted, lifespan approach to suicide prevention across the state, in concert with the state plan: • Understand, develop, and enforce expert-informed policies and regulations that support suicide prevention • Strengthen the crisis system and policies, including mobile response and hotlines • Establish policies and model practice in preparation for post-suicide response, including in the event of a suicide cluster • Promote "upstream" strategies that proactively reduce suicide risk and enhance protective factors	VDH DBHDS
	Designate sufficient funding to carry out or support a multi-faceted approach	VDH DBHDS VDOE VDVS
	Develop the ability to evaluate and share results	VDH
	Embed expectations for suicide prevention within relevant state-funded contracts	VDH DBHDS
Guide	Ensure the ability to plan, provide, and evaluate guidance for state, county, and local efforts	VDH DBHDS
	Identify and allocate resources needed to support consultation and capacity-building training for state, county, and local efforts	VDH DBHDS
	Identify and maintain an updated list of available trainings that meet relevant state requirements or recommendations	VDH DBHDS

ECOLOGICAL MODEL WITH INTERVENTION EXAMPLES

Social-ecological Model Level	Sample Intervention and Prevention Programming
Societal	1. Firearm laws or regulations concerning storage, mental health background checks, etc. 2. Public awareness campaign focused on mental health and therapy stigma reduction 3. Suicide-specific federal funding initiatives
Community	1. Crisis support lines 2. Free mental health screenings provided by community mental health centers or in clinics treating priority populations 3. School-based programs on diversity-related social norms, mental health care access, or suicide awareness
Relational	1. Group psychotherapy 2. Individual psychotherapy 3. Gatekeeper training
Individual	1. Adoption of positive health behaviors (e.g., exercise, food choices, sleep hygiene) 2. Mental health literacy courses 3. Positive coping skills training/adoption

APPENDIX C: HISTORY OF SUICIDE PREVENTION IN VIRGINIA

The original Virginia Suicide Prevention Plan was published in 2004 and shortly after DBHDS was designated in the Code of Virginia as the lead agency for suicide prevention across the lifespan. In 2005 VDH successfully obtained federal CDC and Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding for youth suicide prevention activities under the Garret Lee Smith Memorial Act. With this funding, VDH has provided support to local organizations and service providers, sustained suicide prevention and awareness training, and supported suicide prevention and mental health capacity building efforts across Virginia.

The State's efforts to end suicide deaths in Virginia are further strengthened by a number of historical developments. 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. Furthermore, state training efforts have expanded to include Mental Health First Aid (MHFA), 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 was further supported by an appropriation in the 2016-2018 Appropriation Act.

In 2009, DBHDS and VDH reconvened a Suicide Prevention Interagency Committee (currently the Suicide Prevention Interagency Advisory Group or SPIAG) to establish a new collaborative structure to plan and implement suicide prevention activities in the Commonwealth. The group currently includes DBHDS, VDH (including the Office of the Chief Medical Examiner), Virginia Department of Education (DOE), Virginia Department of Veterans Services (DVS), Virginia Department of Criminal Justice Services (DCJS), Virginia Department of Juvenile Justice (DJJ), the Virginia Association of Community Services Boards (VACSB), as well as other organization 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 developed as a reference for suicide prevention programs throughout the State. This resource is maintained and updated through the VDH website. The directory was most recently updated in 2020.

In addition to coordination of interagency activities, SPIAG completed a 2011 statewide assessment of local Community Services Boards (CSB) by hosting a series of regional suicide prevention summits which brought community stakeholders together to understand how suicide is affecting their own communities and identify suicide prevention resources and services available to them. The summits also provided an opportunity for regional stakeholders to identify needs in regard to suicide prevention and to initiate planning to address those needs. Regional summits were also conducted in seven sites across Virginia in 2012. Efforts in 2013 and 2014 have strengthened the network of suicide prevention trainers with the provision of ASIST Train the Trainer sessions and safeTALK Train the Trainer sessions. Additionally, training efforts have expanded to include Mental Health First Aid training (MHFA). There are currently 502 certified Adult MHFA instructors and 416 certified youth MHFA instructors in Virginia. As a result of these instructor training, 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 October 2021, approximately 138,300 residents throughout the Commonwealth of Virginia have participated in training that teaches 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.

APPENDIX D: SIGNIFICANT HISTORICAL EVENTS TIMELINE

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 of Aging

1994

- Local child death review teams established in the Piedmont Region, Fairfax County, and Hampton Roads

1995

- Virginia State Child Fatality Review Team established by the General Assembly

1999

- Virginia State Child Fatality Review Team was established by the General Assembly

2000

- Yearly appropriation of $75,000 to VDH and DBHDS for 2000-2002
- A Study of Suicide in the Commonwealth is produced by VDH
- Report on Suicide Fatalities among Children and Adolescents in Virginia 1994-1995 produced by 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 is released
- Youth Suicide Prevention Plan developed by Virginia Commission on Youth in partnership with VDH, DBHDS, and DOE
- VDH is designated as lead agency for youth suicide prevention in the Commonwealth by amendment to the Code of Virginia (§ 32.1-73.7).
- DBHDS initiated the proclamation of Childhood Depression Awareness Day, declared by the Governor on May 8, 2001
- Interagency Youth Suicide Prevention Coordinating Committee is formed by VDH with representation from DHBDS, DOE, community services boards, and local health departments
- Virginia Youth Suicide Prevention Advisory Committee is established to advise DBHDS on mental health recommendations from the Youth Suicide Prevention Plan
- The Virginia Suicide Prevention Council is 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 can be found 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 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.

2006

- 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

- Trainer network strengthened through ASIST and safeTALK T4Ts.
- MHFA Adult and Youth Instructor training conducted.

2014

- Department of Behavioral Health and Developmental Services establishes the Suicide Prevention Coordinator position

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 training sessions 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.

2017

- VDH awarded the Garret Lee Smith FINISH

2018

- The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs (VA) announced the Mayor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families (SMVF).
- Lock and Talk, a comprehensive suicide prevention program developed in Region 1 with DBHDS funds, expanded to become a statewide initiative.

2019

- Virginia was selected as one of the first seven states to participate in the inaugural Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families (SMVF). The challenge is hosted by the United States Department of Veterans Affairs (VA) and the Department of Health and Human Services' (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA).

2020

- Updated Department of Education Suicide Prevention Guidelines

2021

- Creation of the Virginia Lock & Talk Coordinator within the Department of Behavioral Health and Developmental Services to expand lethal means safety programming

2022

- Release of Virginia's update Suicide Prevention Across the Lifespan: A Plan for Virginia

APPENDIX E: DATA MATRIX

VDH DATA SOURCES

Data collected:	Data source:	Brief description of data:	Where data is located (agency, office, etc.):	Estimated data lag timeframe:	Data limitations:
Emergency department (ED) visits	Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE)	ED visits related to self-harm or suicide attempts from 100% of hospital-based EDs, 61 urgent care centers, and 19 free-standing EDs; chief complaint data - why did the person seek care in the ED?; Syndromic surveillance (data collected for near real-time surveillance of public health issues)	Virginia Department of Health, Office of Epidemiology, Division of Surveillance and Investigation	Near real-time (no real lag)	Chief complaint is free text field; chief complaint varies across healthcare facilities; transmission of diagnosis data is generally delayed and not 100% complete (although it's at around 90% complete); fluctuations in data reporting to VDH may result in decrease in data volume
Pre-hospital data	Virginia Pre-Hospital Information Bridge (VPHIB)	Patient care reporting by hospitals that provide emergency services, reports information on any injured person that requires admission to the hospital, transfer to another acute care hospital, or dies in hospital prior to admission	Virginia Department of Health, Office of Emergency Medical Services	Near real-time (no real lag)	Data are not standardized – not all EMS agencies use the same VDH data system; Accuracy of data varies by agency and EMS provider; System performance issues can occur
Trauma registry data	Virginia Statewide Trauma Registry (VSTR)	Patient care reporting by EMS agencies and staff; assesses EMS needs and emergencies, effectiveness of clinical interventions, etc.	Virginia Department of Health, Office of Emergency Medical Services	Near real-times (no real lag)	Data are not standardized – not all EMS agencies use the same VDH data system Accuracy of data varies by agency and EMS provider System performance issues can occur
Inpatient hospitalizations	Virginia Health Information (VHI)	Data on inpatient hospitalizations of Virginia residents from 100% of Virginia-licensed hospitals; discharge billing data on each inpatient, including 18 available diagnoses	Virginia Department of Health, Office of Family Health Services; Division of Population Health Data	Approx. 9-12 months	Data do not include federal entities; ICD-9-CM to ICD-10-CM transition- challenges with trending from 2015 - historical to 2016 - present data; currently, no PHI to link data to other data sources

Data collected:	Data source:	Brief description of data:	Where data is located (agency, office, etc.):	Estimated data lag timeframe:	Data limitations:
Death certificate data	Vital Records	Death certificate data on Virginia residents who have died. Includes Virginia residents who have died out-of-state. Does not include out-of-state residents who have died in Virginia. Includes underlying cause of death and additional cause of death statements.	Virginia Department of Health, Office of Information Management, Vital Event Statistics Program	Near real-time (updated weekly), but up to 9 month delay for certified death certificates	Data can be delayed (particularly if they are sudden deaths or deaths due to drug overdoses, etc.); does not include underlying health conditions unless it directly contributed to the death; does not have toxicology reports for drug overdose deaths
Population health survey data on adults	Behavioral Risk Factor Surveillance System (BRFSS)/ Virginia Adult Health Survey (VAHS)	Telephone-based survey for randomly selected adults aged 18 years and older; administered every year to collect data on health behaviors of adults, with a goal of at least 5,000 interviews; includes questions about depression (will include suicide questions in 2021 assessment)	Virginia Department of Health, Division of Population Health Data	Approx. one year behind	Not longitudinal; does not include more detailed questions about self-harm or suicidal thoughts (until 2021)
Population health survey data on middle and high school youth	Youth Risk Behavioral Surveillance System (YRBSS)/ Virginia Youth Survey (VYS)	Voluntary school-based survey administered every odd year to randomly selected middle and high schools in Virginia; approximately 10,000 students each cycle; includes questions about suicidal thoughts and suicide attempts	Virginia Department of Health, Division of Population Health Data		Conducted every other year; is not longitudinal; not every school participates, and only public schools participate
Population health survey data on pregnant and newly postpartum persons	Pregnancy Risk Assessment Monitoring System (PRAMS)	Annual survey of persons who recently birthed/ delivered a baby in Virginia; questions about a person's experience before, during, and after a pregnancy resulting in a live birth; approximately 1,200 pre- and post-natal participants each cycle; includes questions about postpartum depression	Virginia Department of Health, Division of Population Health Data	Approx. one year behind	Not longitudinal; does not include more detailed questions about self-harm or suicidal thoughts (until 2021)

Data collected:	Data source:	Brief description of data:	Where data is located (agency, office, etc.):	Estimated data lag timeframe:	Data limitations:
OCME: Forensic death data	Virginia Medical Examiner Data System (VMEDS)	Internal coding schema that collects data on deaths under OCME's jurisdiction; Data include deaths that occurred in Virginia - can be Virginia residents or out-of-state residents that occurred in Virginia	Virginia Department of Health, Office of the Chief Medical Examiner	Near real-time (no real lag)	Does collect data on risk factors in analyzable form
OCME: Violent death data	Virginia Violent Death Reporting System (VVDRS)	Virginia's version of the National Violent Death Reporting System, a CDC-based data system; collects detailed data on six types of violent deaths: homicides, suicides, accidental firearm deaths, legal interventions, deaths due to acts of terrorism, undetermined deaths, likely related to violence; comprehensive case review where case abstractors enter data	Virginia Department of Health, Office of the Chief Medical Examiner	At least two years	VERY significant delay of data; outside of accidental firearm deaths, no other accidental deaths included; more information on NVDRS can be found here: https://www.cdc.gov/violenceprevention/datasources/nvdrs/index.html

APPENDIX F: INTERVENTION TOOLS

SCREENING

NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen)*.
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Place:** _____ **4. Place:** _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Name:** _____ **Contact:** _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

2. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

3. **Local Emergency Department:** _____

Emergency Department Address: _____

Emergency Department Phone : _____

4. **Suicide Prevention Lifeline Phone:** 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

APPENDIX G: ACKNOWLEDGMENTS

The 2021 Suicide Prevention Across the Lifespan: A Plan for the Commonwealth of Virginia resulted from many collaborative efforts and was made possible by funding from the Substance Abuse and Mental Health Services Administration through the Garrett Lee Smith Grant. Staff from the Division of Prevention and Health Promotion and Division of Population Health Data within the Virginia Department of Health along with the Office of Behavioral Health Wellness within the Department of Behavioral Health and Developmental Services contributed to the vision, development, research, and writing of this document.

We would specifically like to thank members of the Suicide Prevention Interagency Advisory Group (SPIAG) for their review and contributions as well.

Finally, we would like to acknowledge each member of the state planning work group for their extraordinary efforts and dedication to improving the health and well-being of all Virginians.

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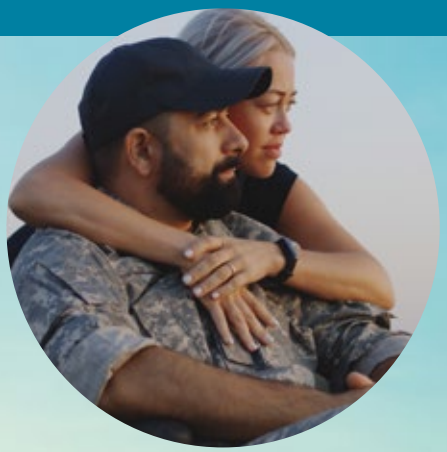
Design by the Virginia Office of Graphic Communications,
DGS: Division of Purchases and Supply



SUICIDE IN THE MILITARY AND VIRGINIA

"It's important to talk about military and veteran suicide because we know that group can be at higher risk but remembering that suicide is a concern for every citizen. It's not just a military and veteran conversation; it's a Virginian conversation."

Brandi Jancaitis, Director, Virginia Veteran and Family Support

If you or someone you know needs support, there is help.
Please dial 988 to speak with a trained crisis counselor
or text TALK to 741741.

VDH VIRGINIA DEPARTMENT OF HEALTH

Virginia Department of Behavioral Health & Developmental Services

Questions or Concerns?

The Virginia Department of Health Suicide Prevention Program is not an emergency crisis line.
Submissions are monitored Monday through Friday during regular business hours.
If you need immediate assistance please contact 911
or call the National Suicide Prevention Lifeline at 988.