Fairfax County
Youth Suicide Review Team

Annual Report of Findings and Recommendations

October 2017

Executive Summary

The Fairfax County Youth Suicide Review Team (YSRT) has two primary goals: (1) to identify systems, policy, and practice changes to inform suicide prevention efforts; and (2) to identify trends in suicide and common risk factors for youth suicide in Fairfax County that can inform and improve efforts related to suicide prevention. The YSRT's first report, released in September 2016, was based on the 15 deaths reviewed by the team in its first year. During the past year, the YSRT reviewed 8 more cases; findings from those reviews are captured in this report.

It is important to note that the team is not intended to identify "causes" of suicides, nor should its findings be interpreted as assumptions that, had the recommendations been in place, the suicide(s) would not have occurred. For each youth, there were multiple risk factors present, but how they were revealed and understood vary significantly. It is neither correct nor appropriate to assign "blame" in any death.

Key findings highlighted in the 2016 report continue to be relevant to the deaths reviewed over the past year. Major risk factors identified include past suicide attempts, expressed thoughts of suicide, self-harm, and exposure to suicide and suicide methods. Most of the young people who died by suicide had a history and/or diagnosis of mental illness and had sought treatment. Most also had a family history of mental illness. Alcohol and marijuana use were frequently indicated, although few tested positive for illicit substances at the time of their death. Most of the youth had a high level of academic/cognitive functioning. Clinical notes indicated many behavioral health care providers are not providing evidence-based treatment for suicidal youth. And many of the youth experienced a lack of continuous care, did not adhere to provider recommendations, and/or did not adhere to medication directions.

Among the deaths reviewed over the past year, the YSRT identified more evidence of traumatic experiences in the youths' lives. These include family loss, divorce, family instability, parental neglect, parental substance abuse, domestic violence, bullying, verbal/emotional abuse, and dating abuse. This finding is consistent with that from the CDC "Epi-Aid" study, which determined that Fairfax County youth who had traumatic experiences (especially related to violence) were more likely to have considered and attempted suicide.

Four key recommendations emerged from this year's reviews:

1. We must continue our emphasis on evidence-based suicide prevention practices (EBPs) in health care. Providers must be educated on and trained in EBPs, and policies must be implemented to incentivize the use of EBPs. Additionally, families and caregivers must be educated about the benefits of EBPs, what to expect from treatment, and how to maintain adherence to providers' recommendations.

2. We must enhance substance use prevention efforts. Substance abuse can exacerbate mental health problems and makes coping with and treating mental illness that much more difficult.

3. We must continue to educate youth, families, and others on recognizing warning signs. The more people in someone's life aware of the warning signs, the more likely they will be recognized as such.

4. We must expand our efforts to recognize and respond to traumatic events from a behavioral health perspective. Trauma screenings should be commonplace throughout our systems. Appropriate responses should include referrals to grief counseling, trauma-informed therapies and other practices, and support and monitoring for kids who are victims of or otherwise exposed to violence.

Last year's recommendations also remain relevant. And while there has been significant progress on implementing them, they should still be included as areas of emphasis.

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History and Background

In September 2013, Fairfax County staff presented to the Board of Supervisors a report on suicide in Fairfax County. The report featured findings on the prevalence of suicide and the key risk factors for and circumstances surrounding suicide in the county. Among the recommendations in the report was the development of a Youth Suicide Review Team (YSRT):

> *Direct staff from relevant agencies, including the Police Department, CSB, FCPS, and the Health Department, to form a Youth Suicide Review Team, modeled on the County's Domestic Violence Fatality Review Team. This team would meet regularly to review incidences of suicide among youth in the county, analyze trends, work with [the Virginia Department of Health] to ensure timely access to data and information regarding youth suicides, and recommend to the Board programmatic and policy solutions to prevent future suicides.*

From late 2013 to the end of 2014, staff representing multiple agencies worked to develop the YSRT. To learn best practices and identify potential challenges, they met with coordinators and members of the Fairfax County Domestic Violence Fatality Review Team, the Northern Virginia Child Fatality Review Team, and the Los Angeles County Child and Adolescent Suicide Review Team. (To the best of staff's knowledge, the LA County team was, at the time, the only functioning fatality review team in the country focused exclusively on youth suicide deaths.) The Office of the County Attorney and the Virginia Department of Health (VDH) provided guidance and insight on team structure, governance, and processes.[1]

By late 2014, relevant County agencies and Fairfax County Public Schools (FCPS) had appointed representatives to participate on the YSRT. Additional community-based members were identified, VDH provided a training to the members, and the team's protocol/charter was adopted at the first official YSRT meeting in February 2015. A list of team members can be found in Appendix A, and the protocol/charter can be found on the YSRT website at www.fairfaxcounty.gov/ncs/prevention/ysrt.htm.

The team began reviewing cases in March 2015. Typically, the team will meet throughout the school year, and present its report of findings and recommendations in the summer or early fall. Since the first case reviews occurred late in the 2014-2015 school year, those cases were combined with those reviewed during the 2015-2016 school year. The YSRT's first report, released in September 2016, was based on the 15 cases reviewed that first year. During the 2016-2017 school year, the YSRT reviewed 8 more cases; findings from those reviews are captured in this report.

[1] VDH provides oversight to the state's child fatality review teams. Code of Virginia §32.1-283.2 provides for the establishment of local and regional child fatality review teams upon the initiative of local officials. Teams "may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region." Agencies are permitted to share information regarding cases. Such information is to be held confidential; violations are punishable as a Class 3 misdemeanor.

YSRT Process

Goals

The YSRT has two primary goals: (1) to identify systems, policy, and practice changes to inform suicide prevention efforts; and (2) to identify trends in suicide and common risk factors for youth suicide in Fairfax County that can inform and improve efforts related to suicide prevention.

It is important to note that the team's work is not intended to identify "causes" of suicides, nor should its findings be interpreted as assumptions that, had the recommendations been in place, the suicide(s) would not have occurred. Research has shown, and the incidents reviewed by the YSRT confirm, that the contexts and circumstances surrounding suicides are complex. For each youth, there were multiple risk factors present, but how they were revealed and understood vary significantly. **It is neither correct nor appropriate to assign "blame" in any death.**

The YSRT looked for and identified evidence that improved training, access, system coordination, or other improvements that could strengthen our system of care.

Process

The YSRT aims to review all suicides of Fairfax County residents under the age of 18. Reviews cannot begin prior to the completion of any police investigations connected with the death. Incidents for review are identified from records provided by Fairfax County Police Department (FCPD), FCPS, and VDH. Generally, one or two cases are reviewed each month.

For each review, agencies or systems the decedent had contact with prior to death are asked to complete case review forms and obtain all pertinent reports and case information that can be shared. Generally, health care (including behavioral health care) and police records can be shared under current privacy laws. However, even within the context of fatality review, the sharing of education and juvenile justice records requires parental consent. Parents/guardians are contacted prior to each review to explain the process, obtain consent for the release of information, and to have the opportunity to provide information and insight into the incident.[2]

Additionally, available media reports or other relevant information sources (e.g., social media posts) regarding the death or prior incidents are reviewed. Prior to the meeting, the information collected is compiled into the team's case review form and developed into a case summary/narrative.

Each meeting begins with the committee entering into closed session (in accordance with state code). Once in closed session, materials are distributed and members read the review form and narrative. In most cases, the FCPD detective who investigated the case is at the meeting to answer questions and provide insight. Members who provided information or have access to records share details and answer questions from the team. At the meetings, each review typically lasts approximately two hours. The last step in the review process is the identification of risk and protective factors present, and the identification of opportunities for intervention or other recommendations.

[2] The richest and most detailed information is available for the cases in which parents consent to information sharing and provide their insight. The YSRT's findings and recommendations would be fewer and infinitely less robust without parental cooperation.

Throughout the year, the team continually discusses emerging themes and revises potential recommendations. At its June meeting, the team finalizes the primary recommendations to be included in the annual report.

Meetings, including all discussions and materials related to individuals, are kept confidential. Meetings are closed, and all participants sign acknowledgements that they are not to share any information from the meeting; violations are punishable as a Class 3 misdemeanor. All notes, including those of each team member, are collected and maintained in a locked area between meetings.

Key Risk Factors

The findings and recommendations presented here are based on the eight cases reviewed by the YSRT between September 2016 and May 2017, in addition to the 15 cases reviewed between March 2015 and May 2016. To ensure a maximum level of privacy for the surviving family members, the specific time frame during which the deaths occurred will not be shared. It was, however, within the past several years.

For each case, the YSRT identified risk factors that were present in the individual's life. Risk factors should not be interpreted as causes of suicide, but are nonetheless helpful in identifying the life events, conditions, contexts, and circumstances that could result in suicide. Risk factors were noted only when there was sufficient evidence that they actually existed. Even when circumstantial evidence was abundant, a lack of direct evidence of a risk factor's presence would lead the YSRT to not indicate it as a risk factor for that case. (For example, it is likely that a higher percentage of individuals had a history of alcohol use.)

It is also important to note that, for each youth, the YSRT noted the presence of protective factors as well. Protective factors are critical to prevention. National and local data demonstrate time and again that youth who have caring adults in their lives, are engaged in meaningful activities, and have other "assets," are less likely to engage in suicidal behaviors. But they only help to reduce the risk. The youths whose deaths were reviewed by the YSRT had caring, loving families and friends. Many were engaged in sports, arts, and other activities. And these assets certainly provided some protection. But individuals with mental illness or who are otherwise suicidal need treatment, and need effective treatment. Treatment can work.

The YSRT considers its findings from its past year of reviews as building on those of the previous year. Information gathered from the eight deaths reviewed in 2016-17 provided further evidence of the most common and critical risk factors facing youth, and expanded the context for considering the initial 15 deaths that were reviewed in 2015-16. During the second year of reviews, some risk factors emerged as more prevalent, and some new recommendations were developed. However, the YSRT does not believe they constitute a time-defined trend. (In other words, just because X was more prevalent in the cases reviewed this year, the YSRT does not believe there is an increase in X as a cause of suicide.) In fact, it is likely that, as the YSRT gained more experience reviewing deaths, the team was more proactive in looking for key risk factors, affecting the questions the team asked of individuals such as parents, school staff, and police detectives. Key findings highlighted in the 2016 YSRT report continue to be relevant to the deaths reviewed over the past year. In particular:

- Major risk factors identified include past suicide attempts, expressed thoughts of suicide, self-harm (e.g., cutting), exploration of methods (e.g., Google searches), and exposure to other suicides (e.g., among friends or celebrities).
- Most of the young people who died by suicide had a history and/or diagnosis of mental illness (especially depression and anxiety) and had sought treatment. Most had a family history of mental illness, as well. Nonetheless, in multiple instances, it was not evident that family members, friends,

others involved in the youths' lives, or the youth themselves recognized the signs and symptoms of depression or fully understood its potential impacts.
- Reported marijuana and alcohol use were frequently indicated, although few of the decedents tested positive for illicit substances at the time of their death.
- Most of the youth had a high level of academic/cognitive functioning, based on standardized assessments or academic performance.
- Clinical notes indicated many behavioral health care providers are not providing evidence-based treatment for suicidal youth. There is evidence in the research base that some practices reportedly used – especially when implemented in the absence of evidence-based therapies and safety planning – may, in fact, be harmful.
- Many of the youth experienced a lack of continuous care, did not adhere to provider recommendations, and/or did not adhere to medication directions.

Among the deaths reviewed over the past year, the YSRT identified more evidence of traumatic experiences in the lives of the youth who died. These include family loss, divorce, family crisis or instability, parental neglect, parental substance abuse, domestic violence, bullying, verbal/emotional abuse, and dating abuse. This finding is consistent with that from the CDC "Epi-Aid" study, which analyzed Fairfax County Youth Survey data and determined that youth who had traumatic experiences (especially related to violence) were more likely to have considered and attempted suicide.

These findings are all consistent with national data and research identifying key risk factors for suicide and issues with treatment.

As mentioned above, most of the youth had, at least at some point, received treatment for their mental illness. The deaths reviewed by the YSRT highlight some of the reasons that, despite involvement in treatment, youth still died by suicide. Behavioral and medical health providers may not always have the training and skills necessary to treat clients who are suicidal. In addition, some families reported difficulty accessing care from a mental health provider who accepted their insurance. When they were able to access care, the available provider may not have had the skills required to provide the necessary level of care or type of evidence-based care shown to be most successful in the treatment of the presenting mental health condition. In the YSRT's review of parent/guardian reports and forensic review of clinicians' notes regarding treatments provided to youth and their families, in some cases the treatment did not match what the standard practice model would recommend for the diagnosed condition. Additionally, information indicated the treatment plan was not always followed. Many youth and families did not follow up on providers' recommendations, stopped taking medications without consulting their providers, or did not seek additional help when referred. When treatment and/or medication result in improvements, people sometimes believe that the individual is "better" or "cured." It is important to understand that ongoing treatment is likely necessary to maintain improvements, and any decisions to alter the course of treatment should be made in consultation with the provider.

Table 1 lists the key risk factors identified in at least one-third of the cases reviewed over the past two years.

Table 1: Risk Factors Present in at Least 33% of Reviewed Cases

Risk Factors	**2016 YRST Report** (15 cases total; "X" indicates presence in 5+ cases)	**2017 YSRT Report** (8 cases total; "X" indicates presence in 3+ cases)	**All Cases Combined** (23 cases total; "X" indicates presence in 8+ cases)
Attempts, Ideation, Exposure			
Past suicide attempt(s)	X	X	X
Expressed thoughts of suicide/discussed death	X	X	X
Details on method (e.g., Google searches)	X	X	X
Exposure to other suicides	X		X
Behavioral Health			
AD(H)D	X		
Depression	X	X	X
Anxiety		X	X
Family history of mental illness	X	X	X
Self-injury	X	X	X
Marijuana use	X		X
Alcohol use	X		
Impulsivity	X		
Behavioral Health Care/Treatment			
Non-adherence to medication directions		X	
Non-adherence to provider recommendations	X	X	X
Private provider therapy	X	X	X
Untreated mental illness*	X		X
Education			
School problems: grades	X		X
School problems: attendance	X	X	X
Recent change in learning environment (e.g., new school, change to home schooling)	X	X	X
Extended absence		X	
Family			
Conflict with parents	X	X	X
Divorce	X	X	X
Unmonitored social media	X		
Parental military involvement		X	
Social			
Social loss (e.g., death of a friend, friend moves away)		X	X
Social isolation	X		X
Other			
Trauma**	X	X	X
High cognitive/academic functioning	X	X	X
Legal/court issues	X		

*"Untreated mental illness" includes instances of significant lapses in treatment, or discontinued treatment, in addition to complete lack of treatment.

**"Trauma" was not a specific risk factor identified by the YSRT. However, there were multiple experiences that youth had that could be considered traumatic. This table reflects youth that had at least two of the following risk factors: family loss, divorce, family crisis/instability, parental neglect, problematic parental alcohol use, domestic violence (within the family), runaway, social loss, bullying (victim or aggressor), verbal/emotional abuse (victim), and dating abuse (victim). About half of the youth had at least two of those risk factors; one-sixth had four or more. Being a victim of bullying was the most common risk factor; it appeared in more than one-third of the cases reviewed for the 2016 report (but less than one-third of the second year's reviews). Trauma was slightly more present in the cases reviewed in 2016-17, but it was not reflected in last year's findings because the YSRT only began to review these factors together this year.

Recommendations

Recommendations are based on the thorough review of the cases studied by the YSRT. They should not be considered to be a complete set of recommendations to prevent suicide, and should be considered within the context of the Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint (SOC Blueprint), along with recommendations from other reports such as the 2013 Suicide in Fairfax County report, the 2015 CDC Epi-Aid report, the Northern Virginia Suicide Prevention Plan, and the 2016 Youth Suicide Review Team report.

In the course of reviewing the deaths, the YSRT generated many recommendations. Those included here were selected because of their potential impact, based on the number of reviewed situations for which they were relevant or based on their potential to increase protective factors, reduce risk factors, and decrease suicidal behaviors.

There are four key recommendations that emerged from this year's reviews:

1. **We must continue our emphasis on evidence-based suicide prevention practices in behavioral, primary, and emergency care.** We know that treatment is not perfect; sadly, a cure for mental illness and suicide does not exist. However, we also know that evidence-based practices (EBPs; practices that have demonstrated effectiveness, through rigorous research and evaluation, in the prevention of suicidal behaviors and key risk factors for suicide) are more effective than no treatment, and that certain practices can even elevate risk. Providers must be educated on and trained in EBPs, and policies must be implemented to incentivize the use of EBPs. Additionally, families and caregivers must be educated about the benefits of EBPs, what to expect from treatment, and how to maintain adherence to providers' recommendations. When parents are given the right information, they are better able to make sound decisions and select the most appropriate care for their children.

   It is also important to note that protective factors are critical to prevention. National and local data demonstrate time and again that youth who have caring adults in their lives, are engaged in meaningful activities, and have other "assets," are less likely to engage in suicidal behaviors. But they only help to reduce the risk. The youths whose deaths were reviewed by the YSRT had caring, loving families and friends. Many were engaged in sports, arts, and other activities. And these assets certainly provided some protection. But individuals with mental illness or who are otherwise suicidal need treatment, and need effective treatment. Treatment can work.

   Provider training and parent resources are each key elements of the Behavioral Health System of Care Blueprint; the implementation of these strategies is underway.

2. **We must enhance our substance use prevention efforts.** Marijuana, alcohol, and other substance abuse can exacerbate mental health problems. Even with the relatively low (and, in many cases, falling) rates of substance use among Fairfax County youth, the dangers of use among youth – especially for individuals with mental health problems – remains poorly understood by the public. Early intervention and awareness building activities must remain priorities. It is important to recognize the dangers of substance use, especially when combined with mental illness, medication use, impulsive tendencies, and life stressors. The use of substances makes coping with and treating mental illness that much more difficult.

   The Blueprint includes strategies to address substance use, as well. While a proposed school-based pilot initiative was not funded in Fiscal Year 2018, prevention programs throughout the county continue to be implemented and expanded, and FCPS staff are being trained in Screening, Brief

Intervention, and Referral to Treatment (SBIRT; an evidence-based practice) through a partnership with George Mason University.

3. **We must continue efforts to educate youth, families, and others on the recognition of warning signs.** The signs and symptoms of suicidality, and of mental illness, are complex and varied. And many are common to "typical" teens. The more people in someone's life aware of the warning signs, the more likely they will be recognized as such.

   Fairfax County and Fairfax County Public Schools have invested a lot of money and effort into "gatekeeper trainings" and other initiatives designed to educate people on the warning signs and how to connect someone to help. The online Kognito trainings, Mental Health First Aid, and Signs of Suicide are among the most common and popular programs. Additionally, there will be a new campaign to increase awareness of "Three to Succeed," messaging from the Fairfax County Youth Survey that emphasizes the role of protective factors in preventing negative outcomes. Furthermore, a new "Healthy Minds Post" blog feature on fcps.edu will target parents with health promotion messages. The prioritization of and publicity surrounding these programs should not be allowed to wane.

4. **We must expand our efforts to recognize and respond to traumatic events from a behavioral health perspective.** Trauma screenings should be commonplace throughout our systems. Appropriate responses should include referrals to grief counseling, trauma-informed therapies and other practices, and support and monitoring for kids who are victims of or otherwise exposed to violence.

   Multiple and multi-faceted efforts to ensure our system is trauma-informed are being implemented through the Blueprint, the Trauma-Informed Community Network, and individual agencies and organizations. These efforts must continue, and practices must be brought to scale.

As mentioned above, this year's findings very much echoed last year's. Therefore, last year's recommendations remain relevant, and it is important to recap them here (Table 2, below) and briefly highlight progress towards implementing them. They should be included in any listing of recommendations from this report.

Table 2: Progress on Recommendations from the 2016 YSRT Report

Recommendation	*Progress*
1. Promote the use of evidence-based risk assessments, safety plans, and treatments for youth with suicidal ideation and behavior.	This is a key component of a standard training for local behavioral health providers that is being developed through the Healthy Minds Fairfax Training Collaborative, as identified in the Behavioral Health System of Care Blueprint.
2. Promote access to treatment and services at the point of contact with Emergency Medical Services (EMS).	The CSB developed a packet of information for EMS to distribute to families when responding to suicide attempts. The County is also working with Inova on facilitating access to treatment for individuals treated in the Emergency Department.
3. Educate parents and youth on youth suicide warning signs, effective evidence-based treatment, and how to support their children in treatment.	Multiple Blueprint strategies address this recommendation. Planning is in place for various parent education/support initiatives, including navigation support and a resource website. And gatekeeper trainings such as the Kognito trainings, Mental Health First Aid, and Signs of Suicide continue to be offered.

4. Promote the appropriate diagnosis and treatment of ADHD.	Healthy Minds Fairfax is partnering with Inova to offer a training to pediatricians on identifying and treating a number of behavioral health issues, including ADHD.
5. Educate health (including behavioral health) care providers on the availability of emergency behavioral health services and how to access them.	This strategy is also in the Blueprint, and the CSB is developing a resource for providers and others on accessing emergency services.
6. Promote the implementation of intentional planning by schools to welcome and engage new students.	Several high schools and at least one middle school are currently using materials developed to welcome newly enrolled students. FCPS is currently developing a system-wide student ambassador program. They are partnering with the School Liaison Officers from Fort Belvoir to generalize a model used by the services for military connected youth to be used with all students. The model will be piloted with select high schools, revised as necessary, and rolled out more broadly next year.

Appendix A: YSRT Members

Members

Christianne Esposito-Smythers, George Mason University Psychology Department and Center for Psychological Services, *YSRT Chair*
Dede Bailer, Fairfax County Public Schools
Bob Bermingham, Fairfax County Juvenile and Domestic Relations District Court, Court Services Unit
Bryan Holland, Fairfax County Police Department
Melissa Holt, Mt. Pleasant Baptist Church and Fairfax County Chaplain Corps
Meghan Kessler, Virginia Department of Health, Office of the Chief Medical Examiner
Allison Lowry, Fairfax County Department of Family Services
Laura Mayer, PRS CrisisLink
Jocelyn Posthumus, Virginia Department of Health, Office of the Chief Medical Examiner
Raja'a Satouri, Fairfax County Health Department
David Schwartzmann, Fairfax County Fire and Rescue Department
Lyn Tomlinson, Fairfax-Falls Church Community Services Board
David Winter, Fairfax County Fire and Rescue Department

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Jesse Ellis, Fairfax County Department of Neighborhood and Community Services, *YSRT Coordinator*
Gloria Addo-Ayensu, Fairfax County Health Department
Jonathan Melendez, Fairfax County Department of Neighborhood and Community Services
May Shallal, Fairfax County Office of the County Attorney
Chris Sigler, Fairfax County Office of the County Attorney

If you have questions about the YSRT, please contact Jesse Ellis at jesse.ellis@fairfaxcounty.gov or 703-324-5626.

Appendix B: Resources

Evidence-Based Practices

- Suicide Prevention Resource Center's *Programs and Practices Database* (be sure to check the "Display only Programs with Evidence of Effectiveness" box): http://www.sprc.org/resources-programs
- US Substance Abuse and Mental Health Services Administration's *National Registry of Evidence-Based Programs and Practices (NREPP)*: http://www.samhsa.gov/nrepp
- Society of Clinical Child and Adolescent Psychology's *Effective Child Therapy* site: http://effectivechildtherapy.org/
- Safety Planning: http://www.suicidesafetyplan.com/

Warning Signs

- Youth Suicide Warning Signs: http://www.youthsuicidewarningsigns.org/

Emergency Services

- Community Services Board Emergency Services: 703-573-5679, TTY 711, http://www.fairfaxcounty.gov/csb/
- Children's Regional Crisis Response (CR2): 844-N-Crisis (844-627-4747) or 571-364-7390, http://cr2crisis.com/
- PRS CrisisLink, http://prsinc.org/crisislink/:
  - Phone: 703-527-4077, TTY 711
  - Text: Text CONNECT to 85511 (FCPS advertises "Text NEEDHELP to 85511." Both keywords access the same service.)

Community Services Board Access

- http://www.fairfaxcounty.gov/csb/
- Entry and Referral: 703-383-8500, TTY 711 (M - F, 9 am - 5 pm)
- Emergency Services: 703-573-5679, TTY 711 (24/7)

Gatekeeper Trainings for Teens

- Online Kognito Friend 2 Friend Training: http://www.fairfaxcounty.gov/csb/at-risk/
- Many schools and community organizations implement additional gatekeeper trainings such as Signs of Suicide (SOS) or Lifelines. Contact ncs-prevention@fairfaxcounty.gov for more information.

Gatekeeper Trainings for Adults

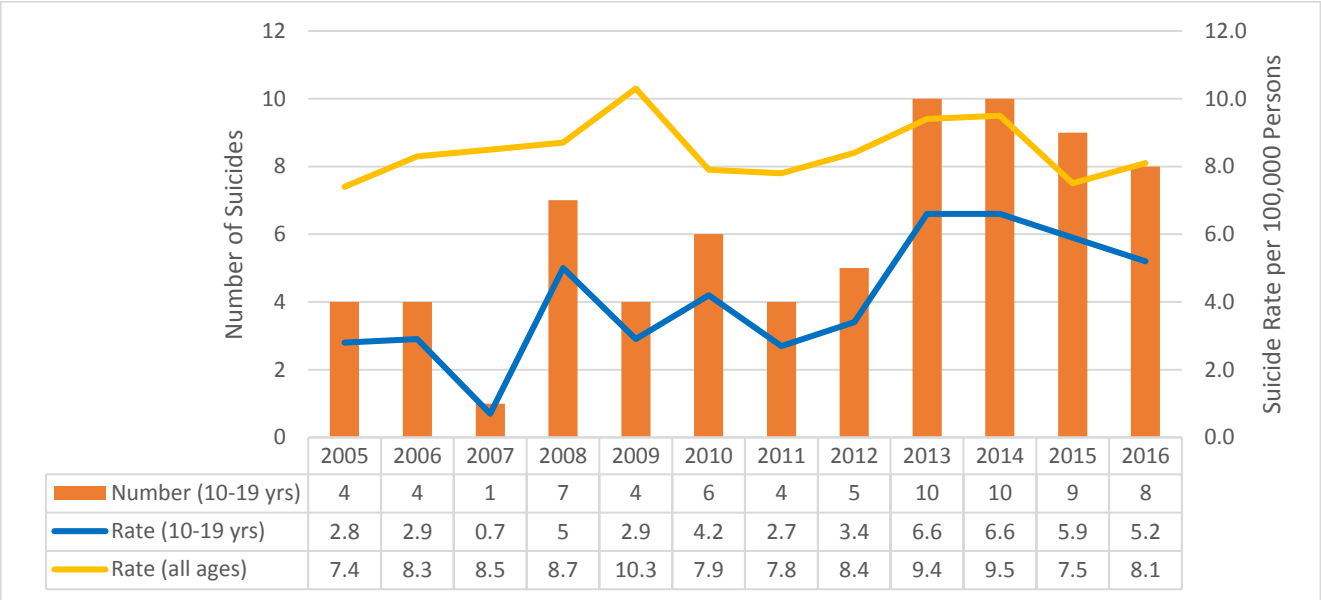
- Mental Health First Aid: http://www.fairfaxcounty.gov/csb/mental-health-first-aid/
- Online Kognito Trainings: http://www.fairfaxcounty.gov/csb/at-risk/
- Online Kognito Trainings for Medical Professionals: http://www.fairfaxcounty.gov/csb/bhmedical/

Unified Prevention Coalition Programs on Substance Use

- https://unifiedpreventioncoalition.org/projects/

Appendix C: Local Suicide Data

Suicides in the Fairfax County Health District (Includes Fairfax County and the Cities of Fairfax and Falls Church), 2005-2016.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number (10-19 yrs)	4	4	1	7	4	6	4	5	10	10	9	8
Rate (10-19 yrs)	2.8	2.9	0.7	5	2.9	4.2	2.7	3.4	6.6	6.6	5.9	5.2
Rate (all ages)	7.4	8.3	8.5	8.7	10.3	7.9	7.8	8.4	9.4	9.5	7.5	8.1

Sources: Fairfax County Health Department
Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health
U.S. Census Bureau, Population Division

Acknowledgements

The members of the YSRT would like to thank the following individuals for their contributions to the team and this report:

First and foremost, the *parents and guardians of young people who lost their lives to suicide*. We recognize the deep and never-ending grief and sense of loss you struggle with every day. Your courage and willingness to allow the team access to your children's records have been critical to increasing our understanding of youth suicide. We cannot thank you enough.

The *FCPD detectives and other police officers* who joined the team to discuss the cases they investigated. Even the most detailed written reports and case files only provide a glimpse into the story behind a death. Thank you for taking the time to spend with us, answer the most basic of questions, and help improve our understanding of what happened.

Dede Bailer of FCPS. Dede is a member of the team, but deserves a special acknowledgement of thanks for the many hours she spent contacting families, obtaining their consent to share information, and listening to them. While nothing can approach the difficulty of losing your child, there is still quite a significant emotional toll to the work Dede performed with such grace, compassion, and dedication. It does not go unnoticed.

Unnamed staff from FCPS, County agencies, PRS CrisisLink, VDH, and other organizations who supported this team tremendously by helping to track down information, answering questions, and otherwise contributing to our work.

If you or someone you know is in emotional distress or suicidal crisis, call CSB Emergency Services at 703-573-5679, call PRS CrisisLink at 703-527-4077, or text CONNECT to 855-11.