Fairfax County
Youth Suicide Review Team

Annual Report of Findings and Recommendations

September 2016

Executive Summary

The Fairfax County Youth Suicide Review Team (YSRT) is a multi-disciplinary team that reviews incidents of youth suicide. The team 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. Since it first began meeting in March 2015, the YSRT has reviewed 15 incidents of youth who died by suicide

Among the most common risk factors were those associated with mental health conditions and diagnoses. While other illnesses were present among many of the youth, depression was by far the most common, occurring in 80% of the reviewed cases. Most of the youth had, at least at some point, received treatment for their mental illness. The incidents 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. Lack of adherence to treatment recommendations was also consistently indicated. Other common risk factors included social isolation, change in learning environment (e.g., enrollment in a new school, switch to home schooling), family conflict, and substance use.

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. The recommendations are applicable to multiple sectors and domains:

Things Families Can Do:

- Learn about youth suicide warning signs, what effective treatments look like, and how to most effectively support children in treatment. This includes understanding the importance of adhering to the treatment protocol once therapy or treatment has begun. It also includes understanding the dangers of substance use for individuals with mental illness and how to keep their homes safe.
- Always immediately seek a mental health evaluation and follow provider recommendations when a child displays any suicide warning signs, regardless of circumstances.
- Learn about the availability of emergency behavioral health services and how to access them.
- Monitor children's internet and social media use.

Things Schools Can Do:

- Help families understand what to look for in a service provider and the importance of adhering to recommendations. Work with families to develop a coordinated treatment plan with the private practitioner so schools can provide appropriate school-based services.
- Support the appropriate diagnosis and treatment of ADHD and other mental health conditions, such as anxiety and depression.
- Educate students on warning signs and risk factors of depression and suicide and teach help-seeking skills for themselves and others.
- Implement intentional plans to welcome and engage new students when they move into a school.
- Promote an environment that prevents and effectively intervenes in cases of bullying or cyberbullying.

- Provide ongoing outreach and support to students with mental health problems who are receiving homebound education services.

Things Communities Can Do:

- Ensure behavioral health care providers use evidence-based risk assessments, safety plans, and treatments for youth with suicidal behavior.
- Promote access to treatment and services at the point of contact with Emergency Medical Services.
- Help families understand what to look for in a service provider and the importance of adhering to recommendations.
- Promote the appropriate diagnosis and evidence-based treatment of mental health disorders that underlie suicidal behavior, including mood, anxiety (including trauma), attention deficit/hyperactivity, eating, and substance use disorders.
- Ensure providers are aware of emergency services and how to access them, and include such services as a component of safety planning.

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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 VDH 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. Hence, this is the YSRT's first 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 are 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 members reading 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 one to two hours. They conclude with members identifying key risk factors and 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.

Findings

The findings and recommendations presented here are based on the 15 cases reviewed by the YSRT 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.)

Table 1 highlights the risk factors most often associated with the cases reviewed by the YSRT.

Among the most common risk factors were those associated with mental health conditions and diagnoses. While other illnesses were present among many of the youth, depression was by far the most common, occurring in 80% of the reviewed deaths. Nonetheless, in multiple instances, family members, friends, others involved in the youths' lives, and the youth themselves may have not recognized the signs and symptoms of depression or fully understand its potential impacts.

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 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.

Table 1. Risk factors present in 5 or more of the 15 cases reviewed by the YSRT, March 2015 – May 2016.

Risk Factor	*# of cases*	*% of cases*
Expressed thoughts of suicide or discussed death	12	80%
Diagnosis of depression	12	80%
Private provider treatment	10	67%
Untreated (or potentially harmful treatment of) mental illness	10	67%
Marijuana use	8	53%
Change in learning environment	7	47%
Past non-suicidal self-injury (e.g., cutting)	7	47%
Family history of mental illness	7	47%
ADHD diagnosis	7	47%
Past suicide attempts	7	47%
Conflict with parents/guardians	7	47%
Social isolation	7	47%
High cognitive functioning/academic performance	7	47%
Exposure to other recent suicides	6	40%
Impulsivity	6	40%
Victim of bullying	6	40%
Academic performance (i.e., grades) problems	6	40%
School attendance problems	6	40%
Non-adherence to provider recommendations	5	33%
Researched or had otherwise been exposed to details on methods of suicide	5	33%
Alcohol use	5	33%
Divorce	5	33%
Unmonitored social media use	5	33%
Legal issues/court involvement	5	33%

Social relationships and settings also featured prominently among the risk factors. Social isolation, whether actual and physical or perceived by the youth, was associated with nearly half of the cases. Many had also experienced a recent change in their learning environment; this includes moving to a new school, transitioning to home schooling, transferring to an alternative school, and other similar situations. Regular conflicts with parents are common to most teens, but when combined with other risk factors like those mentioned here, can be a prominent risk factor for suicide. Similarly, actual or perceived lack of parental acceptance and/or excessive parental academic or social pressure also emerged among the risk factors that could have heightened suicide risk amidst other stressors and mental health difficulties.

Substance use was another common element across many cases, with over half of the youth engaged in documented marijuana use. It is important to recognize the dangers of substance use, especially when combined with mental illness, medication use, impulsive tendencies, and life stressors. Most youth were not drunk or high at the time of their deaths, but the use of substances makes coping with and treating mental illness that much more difficult.

Recommendations

Recommendations are based on the thorough review of the 15 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, and the Northern Virginia Suicide Prevention Plan.

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.

The recommendations are divided into two categories. *Primary recommendations* should be considered as priorities for implementation, based on YSRT findings. *Points of continuing emphasis* acknowledge many of the great initiatives already underway or in place in Fairfax County that address critical areas identified by the YSRT; they may have been primary recommendations themselves if they weren't already happening. Potential resources for implementing the recommendations are listed in Appendix B.

Primary Recommendations

1. **Promote the use of evidence-based risk assessments, safety plans, and treatments for youth with suicidal ideation and behavior.** 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. This recommendation aligns with Goal 9, Strategy E in the SOC Blueprint.
    a. Promote and provide trainings in evidence-based risk assessment and treatment of youth suicidal ideation and behavior.
    b. Make available tools and resources (e.g., safety plan templates, treatment manuals) to providers.
    c. Work with the Virginia Department of Health Professions (the licensing boards) and state associations to advocate for the inclusion of training into licensing and graduate degree requirements as well as demonstrated maintenance of training over time (e.g., via continuing education credits).
    d. Work with state associations to promote provider consent form templates that require disclosure of the research evidence-base for particular treatments implemented by providers.

2. **Promote access to treatment and services at the point of contact with Emergency Medical Services (EMS).** Almost none of the youth and families had had contact with the CSB or other public services. While few had prior suicide attempts that resulted in EMS services, discussion with Fire and Rescue Department (FRD) staff highlighted this interaction as a key opportunity for intervention. For many families, a suicide attempt is the first time they have recognized the problem; several YSRT-reviewed cases illustrated this point. The initial contact by families with a trusted first responder can represent an important chance to provide information. This effort should be coordinated with SOC Blueprint strategies related to System of Care navigation and education/awareness.

a. Develop informational packets – with information on the Community Services Board (CSB), FCPS, the National Alliance on Mental Illness (NAMI Northern Virginia), PRS CrisisLink services, and school-based staff – for EMS personnel to distribute on calls.
b. Explore opportunities to immediately link families to CSB or the Children's Regional Crisis Response program (CR2) to ensure follow-up.
c. Explore opportunities to gain immediate parental consent allowing for notification to the school.

3. **Educate parents and youth on youth suicide warning signs, effective evidence-based treatment, and how to support their children in treatment.** The signs and symptoms of suicidality, and of mental illness, are complex and varied. And many are common to "typical" teens. But even when youth are identified as in need of treatment, families often are unaware of what to look for in a provider, what effective treatment looks like, and how important it is to adhere to the provider's recommendations. This effort should be coordinated with SOC Blueprint strategies related to System of Care navigation and education/awareness, and the component dealing with transition plans should be coordinated with FCPS's Return to Learn protocol for students returning to school after an extended absence (including those due to mental health problems).
    a. Develop and/or direct parents to existing materials that have been reviewed for accuracy and appropriateness that explain:
        i. Evidence-based youth suicide warning signs;
        ii. The importance of seeking an immediate mental health evaluation when suicide warning signs are observed, regardless of circumstances;
        iii. The impacts of substance use (including non-medical use of prescription or over-the-counter drugs), and how it interacts with mental illness;
        iv. What evidence-based treatments are and how they work for youth suicidal behavior as well as mental health and substance use disorders;
        v. The importance of connecting private providers with school-based mental health providers for coordinated care;
        vi. The importance of coordinated transition plans that involve the school and all youth providers (i.e., pediatricians, psychiatrists, therapists) when transitioning out of hospitalization or residential treatment to non-residential care;
        vii. How to develop and closely monitor an evidence-based safety plan;
        viii. What common medications are, how they work, and associated risks/benefits;
        ix. The importance of monitoring and adhering to treatment recommendations, including medications and therapy; and
        x. The importance of parental involvement in youth therapy (e.g., monitor safety plan, maintain a safe home, promote use of skills learned in treatment, consider changing providers and/or accessing higher level of care when needed).
    b. Encourage referring agents (e.g., primary care providers, schools, CSB) to review these materials with parents when making referrals, and for providers to review them with parents at the onset of treatment.
    c. Educate youth on suicide warning signs and how to access help for themselves or peers.

4. **Promote the appropriate diagnosis and treatment of ADHD.** Nearly half of the youth had been diagnosed with or treated for ADHD. ADHD often precedes and increases the likelihood of other types of mental illnesses if not diagnosed and *continuously* treated. ADHD also often co-occurs with other types of mental illnesses such as depression and anxiety. Given "symptom overlap"

(e.g., concentration problems, memory difficulties, academic/social impairment), ADHD can "mask" the symptoms of the other mental illness so that treatment is focused exclusively on the ADHD. At other times, the signs and symptoms of a mental illness can be misdiagnosed as ADHD. In all cases, the result may be that a young person's mental illness is not adequately treated.

   a. Provide pediatricians, other primary care providers, and behavioral health care providers with the ADHD Clinical Practice Guidelines and other resources to ensure proper diagnoses and treatment for comorbidity with emotional and substance use disorders.

5. **Educate health (including behavioral health) care providers on the availability of emergency behavioral health services and how to access them.** Almost none of the youth and families had had contact with the CSB or other public services. In developing safety plans and otherwise consulting with families, providers should be familiar with available emergency services, including PRS CrisisLink, mobile crisis services, and CSB emergency services. This recommendation aligns with Goal 9, Strategy B in the SOC Blueprint.
   a. Provide primary care, behavioral health, emergency department, and other providers with a basic fact sheet and guidelines on how and when to use crisis services.

6. **Promote the implementation of intentional planning by schools to welcome and engage new students.** Many of the youth had recently changed educational settings. A sense of isolation or lack of belonging can be a key risk factor for suicidal thought and behavior.
   a. Develop, at the school level, a process for welcoming new students to school that includes peer interaction and exposure to opportunities for involvement based on the student's interests.

Points of Continuing Emphasis

1. Continue implementation of the FCPS and County discharge/transition planning initiative with Dominion Hospital, and expand it to other hospitals. Monitor implementation of that initiative, and of FCPS's Return to Learn protocol, for effectiveness and opportunities for improvement.

2. Continue to widely promote the CSB's Entry and Referral and 24/7 Emergency Services.

3. Continue to review supports and resources provided to homebound students and their families, to include available behavioral health screenings and referrals, and to ensure parents are aware of available resources and how to access them.

4. Continue to implement, and seek opportunities to expand, peer "gatekeeper trainings" for teens that educate them on warning signs and risk factors of depression and suicide, teach help-seeking skills for themselves and others, and address the stigma around mental illness and suicide.

5. Continue to implement, and seek opportunities to expand, "gatekeeper trainings" for parents that educate them on warning signs and risk factors of depression and suicide, teach help-seeking skills for their children and others, and address the stigma around mental illness and suicide. Ensure such trainings emphasize the different symptoms that teens with depression can exhibit.

6. Continue to educate the parents, teens, and the community on the linkages between substance use and suicide and between non-suicidal self-injury and suicide.

7. Continue to provide the local crisis hotline and crisis text line, and to explore the feasibility of a "warm line" for those not in crisis to connect to a caring adult.

8. Continue to implement comprehensive bullying prevention and intervention activities in schools and community-based settings.

9. Continue the work of the YSRT to identify additional risk factors or intervention opportunities that may emerge from further reviews.

Appendix A: YSRT Members

Members

Lyn Tomlinson, Fairfax-Falls Church Community Services Board, *YSRT Chair*
Dede Bailer, Fairfax County Public Schools
Constance DiAngelo, Virginia Department of Health, Office of the Chief Medical Examiner
Christianne Esposito-Smythers, George Mason University Psychology Department and Center for Psychological Services
Jill Forbes, Fairfax County Department of Family Services
Laura Mayer, PRS CrisisLink
Jamie McCarron, Fairfax County Juvenile and Domestic Relations District Court, Court Services Unit
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
Jerry Watts, Fairfax County Police Department

Staff

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
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 for the Implementation of Recommendations

Primary Recommendations

Recommendation 1. The following resources may be helpful in identifying 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/

Recommendation 3. The following resources are of particular help for parents:

- Youth Suicide Warning Signs: http://www.youthsuicidewarningsigns.org/
- Society of Clinical Child and Adolescent Psychology's *Effective Child Therapy* site: http://effectivechildtherapy.org/

Recommendation 4. The following resource should be available to all pediatricians and schools:

- American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents: http://pediatrics.aappublications.org/content/128/5/1007
- US Department of Education "Dear Colleague letter" and Resource Guide on Students with ADHD: http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201607-504-adhd.pdf

Recommendation 5. The following emergency services should be included in messaging:

- 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.)

Points of Continuing Emphasis

CSB 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)

PRS CrisisLink (24/7), 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.)

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/

Unified Prevention Coalition Programs on Substance Use:

- http://www.unifiedpreventioncoalition.org/what-we-do.html

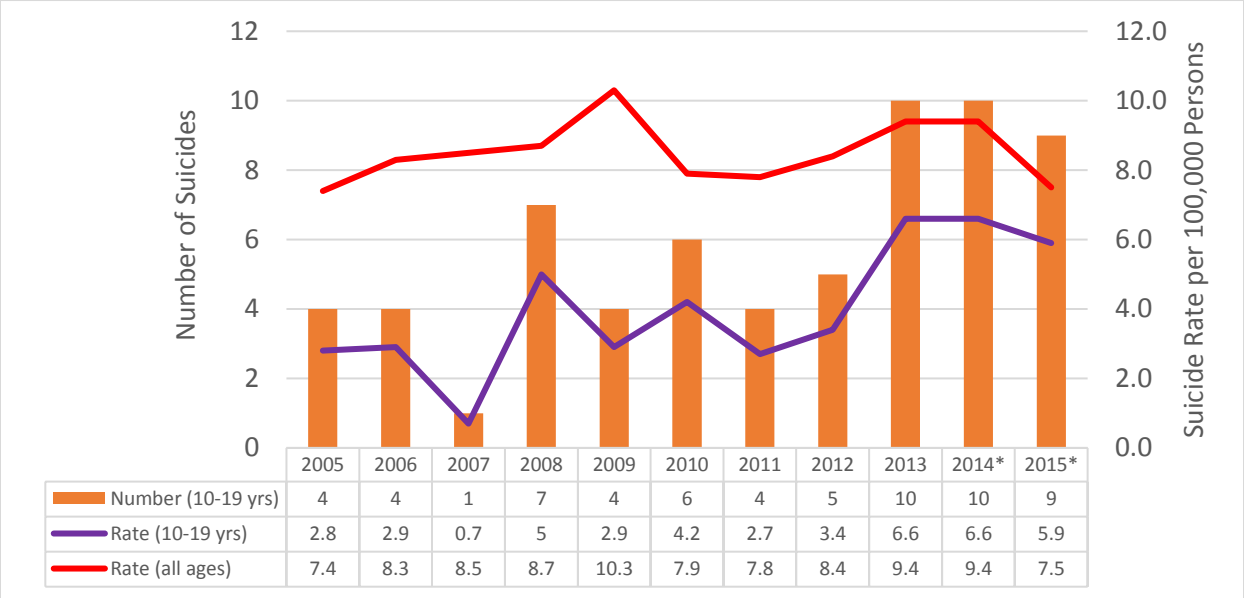
National Alliance on Mental Illness (NAMI) – Northern Virginia Chapter:

- http://www.nami-northernvirginia.org/

This graphic is on every FCPS school home page.

Appendix C: Local Suicide Data

Suicides in the Fairfax County Health District (Includes Fairfax County and the Cities of Fairfax and Falls Church), 2005-2015.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014*	2015*
Number (10-19 yrs)	4	4	1	7	4	6	4	5	10	10	9
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
Rate (all ages)	7.4	8.3	8.5	8.7	10.3	7.9	7.8	8.4	9.4	9.4	7.5

*The number of deaths for 2014 and 2015 are still preliminary and/or not finalized. Therefore, 2014 and 2015 data are subject to change.

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 *parent 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 doesn't 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.

David Winter of FRD and *Jennifer* Spears of FCPS. Our protocol and the nature of our team's work require a maximum level of participation from our members. But sometimes schedules simply do not allow people to attend all meetings. David and Jennifer were excellent and engaged alternates whose contributions to the team were incredibly important.

Finally, *Emily Womble* of the Virginia Department of Health, *Dr. Michael Pines* of the Los Angeles County Child and Adolescent Suicide Review Team, and *Sandy Bromley* of the Fairfax County Domestic Violence Fatality Review Team. Their support, knowledge, and advice were critical to getting the YSRT up and running.

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.