SUICIDE IN FAIRFAX COUNTY

A REPORT TO THE FAIRFAX COUNTY BOARD OF SUPERVISORS

SEPTEMBER 2013

July 2014 update: See page 64 for corrected suicide rate data.

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

SUICIDE IN FAIRFAX COUNTY

EXECUTIVE SUMMARY

Fairfax County's suicide rate, 7.9 per 100,000 persons from 2003 to 2011, has been consistently lower than state and national rates, both overall and when broken down by age group. However, in a county as large as Fairfax, even relatively low rates result in immense impacts. Eighty-two county residents commit suicide in an average year. Most years, between four and seven youth take their own lives; the youth rate, despite also being below state and national rates, remains unacceptable. The impact of suicide on families, friends, and communities is immeasurable.

Suicide disproportionately affects certain demographics. Whites and males are most likely to commit suicide, nationally and in Fairfax. The elderly – especially older males – are also overrepresented among those who commit suicide.

A variety of circumstances may contribute to a suicide. The most common circumstances facing Fairfax County victims are mental health, substance abuse, and relationship problems. Youth are also likely to have school or legal problems. Physical health and mental health problems were the most common circumstances among older adults.

Fairfax County agencies, Fairfax County Public Schools, and community organizations are committed to reducing the incidence of mental illness and the prevalence of suicide in the county. A variety of programs, procedures, and services are in place across the county designed to prevent and respond to suicides. These range from 24/7 crisis response services to police training to mental health screenings to primary prevention programs. No single agency or organization is responsible for the breadth of services and programs; yet they all fit into a broad comprehensive approach to suicide prevention and response. Nonetheless, there is more that can be done, both to improve the coordination and functioning of the existing system, and to fill gaps in service and address unmet needs. Recommended short-term changes to improve our prevention and response interventions include the following:

1. Form a Youth Suicide Review Team to review incidences of suicide in the county, analyze trends, and recommend to the Board programmatic and policy solutions to prevent future suicides;
2. Develop a clear timetable for policy and funding decisions to improve the quality of the youth behavioral health services system and improve access to the system;
3. Commit to provide resources for primary prevention activities that provide the best opportunities to prevent suicide and the risk factors that accompany it;
4. Identify critical issues for elder suicide prevention that need to be addressed through the County's 50+ Action Plan, the Long Term Care Coordinating Council's Strategic Plan, or other initiatives;
5. Direct the reestablished countywide prevention coordination unit to incorporate specific suicide prevention strategies within their broader prevention plan, and to review population-level data, identify service gaps and other needs, and coordinate approaches among various stakeholders on a regular and ongoing basis; and
6. Promote guidelines on suicide reporting to the local press.

This report, including the attached resources and appendices, and its recommendations should provide the data and analysis necessary to form a foundation for strengthening the County's approach to suicide prevention.

CONTRIBUTORS

This report is the work of a cross-disciplinary team that was responsible for accessing and analyzing national, state, and local statistics; documenting existing services; and developing and reviewing recommendations. Team members included:

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INTRODUCTION

In a Board Matter presented to the Fairfax County Board of Supervisors on April 23, 2013, Supervisor John Cook noted that 86 people had committed suicide in Fairfax County in 2011, while another 293 had attempted suicide (see Appendix A). Local incidents involving teens have raised the public's awareness of this issue. Recognizing the serious nature of this issue, especially with regards to incidents involving youth, the Board directed staff to report on the incidence of suicide in the county and on efforts to prevent suicide.

Like all public health issues, suicide is caused by an array of factors at the individual, community, and societal level. Prevention efforts must be developed and implemented at all of those levels in order to be effective. This report will provide background on the incidence and prevalence of suicide in Fairfax County; highlight existing efforts, planned initiatives, and where gaps remain; and provide recommended strategies to further our efforts at preventing suicide.

SUICIDE IN FAIRFAX COUNTY

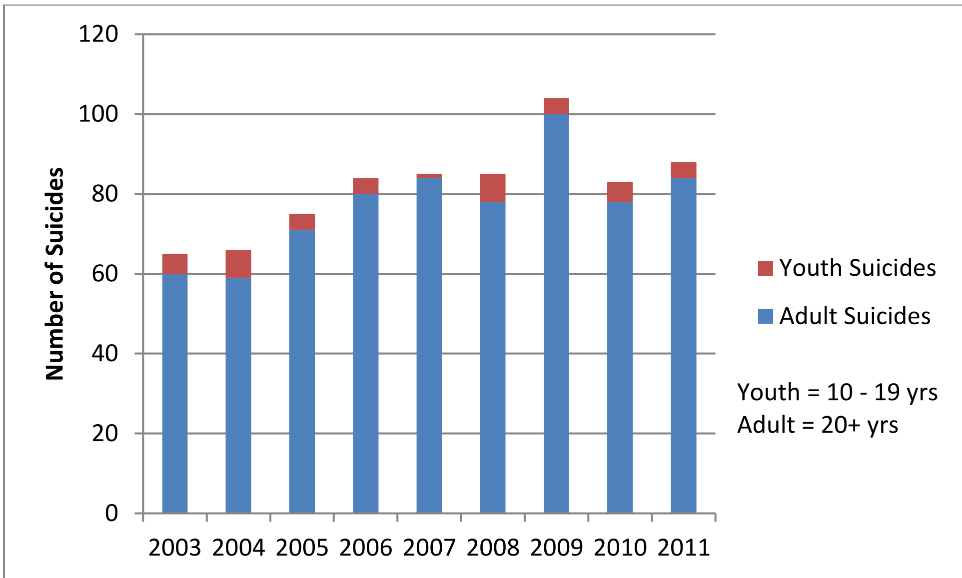
Nationally, suicide is one of the four most common causes of death among persons aged 15 to 44. While chronic diseases such as cancer, heart disease, and stroke become much more prevalent as people age, therefore reducing the relative impact of suicide overall (suicide was the county's 11th most common cause of death in 2011), suicide remains one of the primary killers for many Americans at several critical age groups. (See Appendix B for the most common causes of death by age.)

Consistently rated the Commonwealth's healthiest jurisdiction in the annual County Health Rankings (http://www.countyhealthrankings.org/app/#/virginia/2013/rankings/outcomes/overall/by-rank), mortality rates for all the major causes of death in Fairfax County are much lower than the Virginia statewide rates. Suicide is no exception; in 2011, Fairfax's suicide rate was 7.0 per 100,000 persons, compared to Virginia's 12.5.

Nonetheless, Fairfax County is a large jurisdiction. Even these relatively low rates translate to dozens of lives lost per year (an average of 82 per year between 2003 and 2011), as shown in Figure 1.

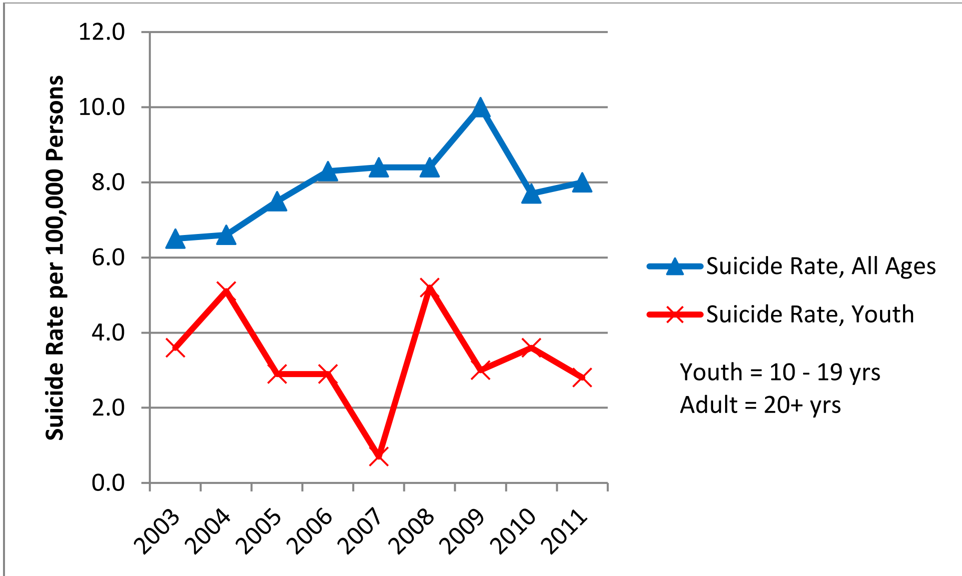
Because the number of suicides in the county can fluctuate from year-to year, examining any one year's data may not be productive. (For example, the 10.0 suicide rate in 2009, and the one youth suicide in 2007, both seem like aberrations that are not indicative of longer-term trends.) Therefore, this report will review the rate and range of suicides over time. Another important caveat is that the latest available data from the Virginia Department of Health is for 2011, so the most recent events to occur in Fairfax County are not included in this analysis. That said, the trend over the past decade seems to indicate a rising prevalence of suicide, at least among adults, even if it has leveled off or slightly declined since 2006, as illustrated in Figure 2. It is critical for the County, schools, and community to understand these data and to identify and implement best practices to prevent the tragedy of suicide in the future.

Figure 1. Annual Suicides in Fairfax County, 2003-2011.



Source: Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System. A National Violent Death Reporting System project. www.cdc.gov/ncipc/pubres/nvdrs-coding/VS2/default.htm

Figure 2. Annual Suicide Rates in Fairfax County, 2003-2011.



Source: Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System. A National Violent Death Reporting System project. www.cdc.gov/ncipc/pubres/nvdrs-coding/VS2/default.htm

Suicide Incidence and Rates

According to the Office of the Chief Medical Examiner (OCME) in the Virginia Department of Health, 735 people died in Fairfax County of suicide between 2003 and 2011, with annual totals ranging from 65 to 104. (See Appendix C for the full report.) The youngest victims (3 incidences) were 13 years old; 5.6 percent of the suicides were to youth ages 10 to 19, with a range of 1 to 7 suicides per year. Just over seven percent occurred among young adults ages 20 to 24, with an annual range of three to eight suicides.

These numbers translate to a suicide rate of 7.9 per 100,000 persons; the annual rate during these nine years ranged from 6.5 to 10.0. During the same time, Virginia's statewide suicide rate was a significantly higher 11.7. Put another way, if the county's suicide rate matched Virginia's, Fairfax would experience 40 additional suicide deaths every year, or 360 over the reporting period of nine years. The total rate, and rates by age group, were also below national averages, as shown in Table 1.

Table 1. Fairfax County Suicide Rate by Age Group, 2003-2011. (per 100,000 persons)

Age Group	Fairfax County Suicide Rate	Range of Annual Fairfax County Suicide Rate	National Suicide Rate (2003-2010)
Total (10+ years)	7.9	6.5 – 10.0	11.5
10 – 19 years	3.3	0.7 – 5.2	4.3
20 – 24 years	10.0	6.0 – 13.6	12.7
25+ years	10.3	8.2 – 13.5	15.3
60+ years (2003-10)	12.4	not available	15.6

Sources:
Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System. A National Violent Death Reporting System project.
www.cdc.gov/ncipc/pubres/nvdrs-coding/VS2/default.htm
CDC Web-based Injury Statistics Query and Reporting System.
www.cdc.gov/injury/wisqars/index.html
Virginia Department of Health, Office of the Chief Medical Examiner. Elder Suicide in Virginia.
http://www.vdh.virginia.gov/medExam/documents/2013/pdf/Elder%20Suicide%20in%20Virginia%202003%202010.pdf

A separate analysis by the OCME covered the same time period, but included suicides in the cities of Fairfax and Falls Church (thereby covering the Fairfax Health District; see Appendix D for the full report). It highlights youth suicide among 10 to 14 year-olds and 15 to 19 year-olds; rates for those age groups are shown in Table 2.

Elder suicide (among individuals ages 60 and older) has been noted as a critical issue in Virginia, where the elder suicide rate for 2003 to 2010 (15.6 per 100,000 persons) was 1.5 times greater than that of non-elders. A recent Virginia Department of Health (VDH) Report highlights the complex and unique issues regarding elder suicide and its prevention, issues addressed later in this report.

Table 2. Fairfax Health District Youth Suicide Rate by Age Group, 2003-2011.

Age Group	Total Suicides	Fairfax Health District Suicide Rate	Virginia Suicide Rate
10 – 14 years	6	0.9	1.1
15 – 19 years	36	5.8	7.3

Source: Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System. A National Violent Death Reporting System project. http://www.cdc.gov/ncipc/pub-res/nvdrs-coding/VS2/default.htm

Disparities by Gender, Race, and Ethnicity

Within Fairfax County, there are differences in suicide rates among certain populations. The most notable differences are by gender; males are more than twice as likely to commit suicide as females. The total rate for males is 11.2, while the female rate is 4.8. Similar disparities between males and females are observed among every age and race group.

There are smaller disparities by race and ethnicity; in general, though, whites have the highest suicide rates. The total rate for whites is 8.8, while it is 6.0 for Asians and 5.4 for blacks. These differences tend to persist across age groups, with one notable difference: the suicide rate for black individuals ages 20-24 is 12.9, higher than the white rate of 11.1 (although the small sample size – there were only 8 suicides among black individuals in this age group over the 8 year study period – likely means that this is an insignificant difference). The white-other disparity is more pronounced among males, but white females are also more likely to commit suicide than females of other races. Hispanics can be of any race; the suicide rate among Hispanics is 3.8, less than half of the 8.6 rate among non-Hispanics. The Hispanic-non-Hispanic disparity exists at every age group.

Among individuals age 60 and over, the gender and race gaps are much more stark. Statewide, from 2003 through 2010, 82 percent of the 1,539 elder suicide victims were men, a rate of 29.4. The female suicide rate was 4.9. The rate among whites was 17.9, compared to 5.3 for blacks and 9.0 for Asians.

Circumstances Surrounding Suicide

The Virginia Department of Health tracks the circumstances of individuals who commit suicide. Circumstances should not necessarily be interpreted as causes, but are nonetheless helpful in identifying the life events and conditions that could influence one's decision to attempt suicide. (As individuals may have more than one circumstance, percentages will not add to 100.)

The most common circumstance among those who committed suicide in Fairfax County between 2003 and 2011 was a current mental health problem; 65.6 percent had such a problem, a prevalence that was fairly consistent among youth (ages 10-19), young adults (20-24), and adults (25 and older). Among those with a mental health problem, 70 percent were receiving treatment at the time of the suicide. Among all people who had committed suicide, 8.6 percent had received mental health treatment in the past (but were not receiving treatment at the time). Also prevalent across all age groups was a current depressed mood, affecting 37.1 percent of individuals who committed suicide.

The next most common circumstances were those revolving around relationships. More than a quarter (27.2 percent) had problems with an intimate partner, and 11.1 percent had a non-intimate partner

relationship problem. Nearly half of youth ages 10 to 19 (46.3%) had a non-intimate partner relationship problem.

Substance abuse was also a common element in many suicides; 25.4 percent had substance abuse problems, and similar numbers were seen across age groups. Alcohol was the most commonly abused substance.

Other common circumstances included physical health problems (23.2 percent), job problems (17.5 percent), and financial problems (16.5 percent).

Because the vast majority of suicides (87 percent) occurred among the adult (25 and older) population, that demographic tends to skew the data around circumstances. Mental health, substance abuse, and relationship problems were common among all age groups. However, among youth (ages 10 to 19), 39 percent had a school problem and 14.6 percent had a recent criminal legal problem. Among young adults (ages 20 to 24), 13.7 percent had a recent criminal legal problem.

Past suicide attempts and disclosed intent to commit suicide were also common; 56.4 percent, including about 70% of 10-24 year olds, had disclosed intent or had a history of suicide attempts.

The VDH report on elder (i.e., age 60 and older) suicide cites circumstances statewide for 2003 through 2010 and demonstrates some differences between older adults and other age groups. Half of all elder suicides were among people with current mental health problems, although 67.5 percent of women had such problems, compared to 47.1 percent of men. Likewise, 50 percent of suicide victims faced physical health problems, although the gender disparity was reversed: 52.5 percent of men and 38.6 percent of women had physical health problems. About one-fifth of decedents had both mental and physical health problems at the time of their suicide. Among physical health problems, 38.9 were diagnosed with cancer, and 31.2 percent experienced pain, either alone or in conjunction with another disease or problem.

Substance abuse among older adults was less common than among younger populations, as it was a characteristic of 12.2 percent of suicide victims. Also less common were intimate partner problems (13.9 percent). And while elder suicide rates are much higher for people who were divorced, separated, or widowed than for married individuals, only 13.9 percent of the suicide victims had intimate partner problems and only 9.9 percent had experienced the death of a family member or friend in the past five years.

Older men, data indicate, often lack ambivalence, an attitude that offers hope for intervention in younger age groups. More so than any age group, older men are likely to commit suicide using firearms, offering few “second chances.” Additional, alcohol is often a minor factor in these deaths. That is, these men were so intent on ending their lives that they apparently didn’t require intoxication to loosen impulse control and summon courage to pull the trigger. Finally, 20 percent of elders who killed themselves believed they were suffering from a hopeless illness when autopsies showed they were not. Many of this group apparently didn’t believe their physicians or simply were not going to see a doctor at all.

Methods

Three methods account for 92 percent of all suicides in Fairfax County from 2003 to 2011. Firearms were used in 39.3 percent of suicides, hanging/suffocation in 29.8 percent, and poison in 22.2 percent. While firearms were the most prevalent overall, hanging/suffocation was most common among youth (61 percent) and young adults (45.3 percent).

Among elder suicides statewide, the same top three methods accounted for nearly 94 percent of suicides. Firearms were used in 72 percent of suicides, including in 79.7 percent of suicides among older men. Older women were as likely to use poison (37.1 percent) as a firearm (36.1 percent).

What the Youth Survey Tells Us

A joint initiative of Fairfax County Government and Fairfax County Public Schools (FCPS), the annual Fairfax County Youth Survey provides data on student behaviors and risk and protective factors. The 2011-12 school year survey taken by eighth, tenth, and twelfth graders included questions about mental health and suicide.[1] Full results can be found at www.fairfaxcounty.gov/youthsurvey. A presentation specific to results regarding depression and suicide is included in the Prevention Toolkit and can be found at www.fairfaxcounty.gov/ncs/prevention/toolkit_mental_health.htm.

Among eighth, tenth, and twelfth graders, 29.2 percent reported depressive symptoms. ("Depressive symptoms" is defined as answering "yes" to the following question on the survey: "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?") Females (35.1 percent) are much more likely to report depressive symptoms than males (23.0 percent). Furthermore, 37.6 percent of Hispanics report depressive symptoms, compared to between 25 and 29 percent for other races and ethnicities. Within all racial and ethnic categories, females are more likely to report depressive symptoms than males; nearly half of all Hispanic females (46.9 percent) report them, making them by far the demographic group most affected.

National data (that includes adults) indicates that most suicides are committed by white males, yet data regarding suicidal thoughts and behaviors among Fairfax County youth paint a different picture, one more in line with the local student data on depression. Females are more likely than males to have considered suicide in the past year (19.6 percent to 11.9 percent). White students (13.8 percent) were least likely to consider suicide, while Hispanic students (18.8 percent) were most likely. The percentage of students who reported actually attempting suicide in the past year, of course, is much lower (yet still alarming); the demographic differences, however, remain present. Females were more likely than males to attempt suicide (4.7 percent to 2.8 percent). Hispanic students (5.9 percent) were almost twice as likely as white students (3.0 percent) to attempt suicide.

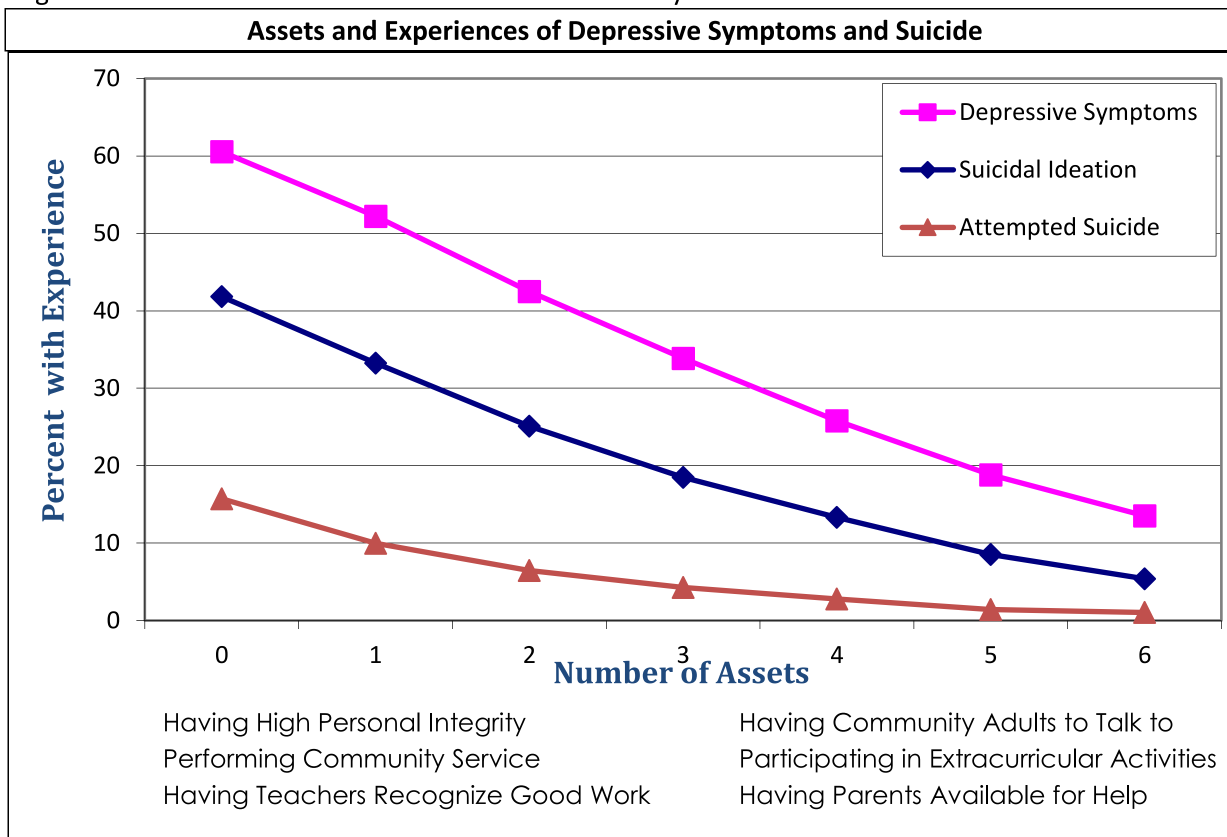
Even more dangerous than substance use or depression on their own is when they are co-occurring among youth. Given the impact of drugs and alcohol on decision-making and emotional regulation, a depressed teen who uses substances is at great risk for self-harm. Among students who reported not drinking alcohol within the past 30 days, 25.8 percent reported depressive symptoms; that number

[1] Results from the 2012-13 survey have recently been released and are available on the Youth Survey website. However, since questions about suicide attempts and thoughts were not included – they are asked only every other year – the 2011-12 results are presented here. The percentages of students reporting depressive symptoms are slightly higher in 2012-13; the disparities are still evident.

ranged from 39.1 percent to 50 percent among students who did drink. Similar numbers exist for teens who binge drink or smoke marijuana; in both cases, slightly more than a quarter of youth who did not engage in those activities experienced depressive symptoms, while more than 40 percent of those who did reported feelings of depression.

As it does with most (if not all) problem behaviors, the Youth Survey provides clues as to how programs and services should be designed to prevent youth suicide. *Three to Succeed* is a campaign designed to raise awareness of how youth with just three protective factors present in their lives are much more likely to avoid negative outcomes than those with zero. As indicated in Figure 3, youth with positive assets (protective factors), such as high personal integrity and the presence of adults in the community to talk to, are much less likely to experience depressive symptoms and thoughts of suicide and to have attempted suicide.

Figure 3. Three to Succeed: From the 2011 Youth Survey.



Addressing Suicide in Fairfax County

In 2012, the US Surgeon General published the National Strategy for Suicide Prevention, a compilation of goals and objectives, based on the best available research and evidence. The strategy includes actions at every level – national/federal, state, and local – and is organized by four strategic directions: healthy and empowered individuals, families, and communities; clinical and community preventive services; treatment and support services; and surveillance, research, and evaluation. Table 3 outlines the

strategic directions and goals of the strategy and highlights the current and proposed local actions that comprise Fairfax County's suicide prevention strategy.

There remain some gaps, particularly around the development and implementation of a fully coordinated approach. County staff and partners have been reviewing the Strategy (and will continue to review it) to identify gaps at the local level and propose opportunities to strengthen the system. However, this broad review identifies the much of the breadth of existing activities. The sections of this report that follow elaborate on the specific programs, services, and recommendations.

A noticeable omission from this table, and the remainder of this report, is an overview of the notable and critical services provided by community-based organizations, faith-based organizations, health care providers, advocacy groups, and other non-public entities serving Fairfax. Many organizations are engaged in prevention programming, training, counseling, crisis response, community education, systems planning, advocacy, and other strategies essential to suicide prevention. While this report primarily focuses on public agencies, Fairfax County and FCPS are committed to continuing strong relationships with community-based partners in suicide prevention efforts.

Table 3. Goals of the National Strategy for Suicide Prevention and Local Efforts and Recommendations

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities	
Goal 1. Integrate and coordinate suicide prevention activities across multiple sectors and settings.	There are several examples of how organizations within Fairfax County are integrating elements of suicide prevention and mental health promotion into service delivery and collaborating on suicide prevention. FCPS's *Resiliency Project*, for example, integrates multiple components (e.g., by focusing on bullying, depression, and coping skills) and multiple methods (e.g., by implementing programs, screenings, faculty training, and policies). The CSB collaborates with the Police Department to provide *Crisis Intervention Training* to officers, enabling them to better respond to mental health emergencies. A broader effort is necessary, however, to ensure a coordinated approach, reaching the entire community, is implemented. This need is reflected in Recommendation 5, countywide prevention coordination.
Goal 2. Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.	There are multiple initiatives aimed at messaging and communication around suicide prevention. The *Resiliency Project* and NCS's *Prevention Toolkit* provide information to the community, stakeholders, and families on effective ways to promote mental health and prevent suicide. *Mental Health First Aid*, a training offered by the CSB, reduces stigma and teaches people how to recognize signs of mental illness and refer people to help. A coordinated educational campaign to educate the public on mental health and suicide, is a key strategy listed in the Partnership for a Healthier Fairfax's upcoming *Community Health Improvement Plan,* but resources will need to be identified for its implementation.

Goal 3. Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.	Many programs, including those listed above, are being implemented throughout Fairfax County. CSB's *Emergency Services* are an additional component, recognizing when people are in crisis and quickly getting them to treatment and recovery services.
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.	Proper reporting of suicides, when they occur, can help educate the community and prevent additional suicides. Strengthening the press's response to suicides is included in Recommendation 6, the promotion of guidelines on suicide reporting to the local press.
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.	Many programs, including those listed above, are being implemented throughout Fairfax County. The *Partners in Prevention Fund* builds the non-profit community's capacity to deliver high quality prevention programming. And multiple efforts to integrate primary and behavioral health care will increase opportunities for people to get the help they need.
Goal 6. Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.	Counselors and others working with individuals with identified suicide risk routinely assess clients' access to lethal means. *Operation Medicine Cabinet Cleanout* is another example of an effective local effort aimed at reducing access to lethal means of suicide.
Goal 7. Provide training to community and clinical service providers on the prevention of suicide and related behaviors.	Several organizations are planning to expand existing efforts to train providers on suicide prevention. *Mental Health First Aid* and *Signs of Suicide* are two of the most common programs in use.
Strategic Direction 3: Treatment and Support Services	
Goal 8. Promote suicide prevention as a core component of health care services.	An existing emphasis on suicide prevention within behavioral health care services will be strengthened as a result of current efforts to better integrate primary and behavioral health care.
Goal 9. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.	While the Youth Behavioral Health Task Force will be recommending increasing the use of standardized screenings and assessments across service providers, and while the Partnership for a Healthier Fairfax will be developing strategies to increase the use of evidence-based screenings among primary care providers, most of the key stakeholders identified in this report are currently implementing effective assessment and treatment practices.

Goal 10. Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.	Local responses, such as the one initiated recently by Community of Solutions, have often supplemented formal, standardized FCPS responses that are based on national standards. The Police Department's partnership with CrisisLink also provides immediate care and support to families.
Strategic Direction 4: Surveillance, Research, and Evaluation	
Goal 11. Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use information for action.	While national surveillance is not within Fairfax County's scope, local data is available through the Virginia Department of Health and the Behavioral Risk Factor Surveillance System. The locally implemented Fairfax County Youth Survey is another source. The recommended Youth Suicide Review Team (Recommendation 1) would work with VDH to ensure timely access to data and information regarding youth suicides.
Goal 12. Promote and support research on suicide prevention.	While a national research agenda is not within Fairfax County's scope, County and FCPS staff consistently mine Youth Survey and other data for information that would lead to more effective prevention.
Goal 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.	Program and policy evaluation is strongly supported and encouraged in Fairfax County, and is routinely conducted. A better coordinated, resourced, and standardized approach to evaluation would be a key focus of a countywide prevention coordination unit, as described in Recommendation 5.

RESPONSES TO SUICIDE AND ACUTE SUICIDE RISK

Police

As the primary law enforcement agency, the Fairfax County Police Department (FCPD) is responsible for investigating calls for services involving suicide and attempted suicide cases within Fairfax County. Information collected through FCPD's Records Management system shows that, on average, officers respond to over 24 suicide threat/attempt calls for services per month, as shown in Table 4.

Table 4. Fairfax County Police Department Investigations*

	2011	2012	2013 (through May 31)
Total Suicides	83	91	35
Juvenile Suicides**	4	4	2
Total Suicide Attempts	305	299	134

Source: Fairfax County Police Department
* Data may change or differ from state data as a result of delay in official medical examiner's reports and other investigative factors (e.g., suspicious death ruled suicide).
**Ages of juveniles who committed suicide range from 12 to 17.

It is worth noting, though, that officers respond to an overwhelming number of additional calls that initially involve depression, domestic disputes, child abuse, and other issues that have a nexus to mental health-related concerns which may potentially escalate or lead to suicide incidents. In 2010, patrol officers responded to 2,311 such calls; in 2011, patrol officers responded to 2,182 such calls; and in 2012, patrol officers responded to 2,497 such calls. Through May 2013, patrol officers had responded to 1,374 such calls. Additionally, as the police data indicate, the vast majority of suicide attempts are unsuccessful. How police and others respond to attempted suicides and other circumstances that often accompany suicide attempts is critical.

As first responders, police officers respond to calls for services for individuals experiencing a crisis or emotional stress. *FCPD General Order 603.3* mandates that officers be trained to collaborate with and utilize the advanced expertise of the Fairfax-Falls Church Community Services Board (CSB) staff with Emergency Services and the Mobile Crisis Unit. The Mobile Crisis Unit, in partnership with the police officers, has been very effective in addressing calls involving emotionally disturbed individuals.

The FCPD, in conjunction with the Community Services Board and Sheriff's Office, has developed the *Jail Diversion Program* to provide an alternative to arresting individuals with mental illnesses. The program establishes community-based options for a coordinated response to individuals with mental illnesses who have committed minor, non-violent criminal offenses. The program's goal is to provide intense and on-going treatment in lieu of incarceration. Treatment is provided by the Community Services Board or its vendors. The Commonwealth's Attorney's Office has endorsed this program and the use of diversion in lieu of arrest.

In response to an initial report of a suspicious or accidental death, the FCPD's Victim Services Specialists are the first to be deployed to assist families and friends. The Office of the Chief Medical Examiner will determine the manner and cause of death (as a suicide). In the meantime, the Victim Services Specialists and CrisisLink staff work collaboratively to provide the following counseling and advocacy services to the decedent's family members:

- Crisis intervention services,
- Short and long term counseling,
- Access and referrals to self-help support groups,
- Group counseling,
- Updates on status of investigation, and
- Possible compensation claims (possible scene clean up and funeral costs) filing assistance.

Once the manner of death has been confirmed as suicide, CrisisLink serves as the primary focus group for the family members. Such support can help to minimize the impact of the trauma that may be experienced by those close to someone who commits suicide.

When a suicide involves a youth (either as victim or as a witness), FCPD officers will notify the appropriate School Resource Officer(s) and the School Liaison Commander. A Memorandum of Understanding between the Police Department and FCPS dictates how information is shared between

the two organizations after a youth commits suicide. The FCPD *School Liaison Commander*, assigned to the FCPS Office of Safety and Security, coordinates the process, helping to ensure that appropriate resources and information is provided to FCPS and shared, when appropriate, with school leadership, the Department of Special Services, and others. The School Liaison Commander also serves as a link to School Resource Officers and others in the Police Department to ensure critical information is shared in a timely manner.

Community Services Board

CSB *Emergency Services* serves adults, adolescents, and children experiencing psychiatric crisis, including in situations involving substance use. Through *Emergency Walk-In* sites and the *Mobile Crisis Unit (MCU)*, Emergency Services takes crisis intervention into the community, working closely with individuals, families, and public safety agencies. Recovery-oriented risk assessments, crisis intervention/crisis stabilization, psychiatric and medication evaluations, and case management are provided along with hospital pre-admission screenings, pre-detention evaluations, and admissions to regional Crisis Stabilization Units. Services are accessible, affordable and ensure community safety, and they promote wellness, compassion and respect. Individuals and families in crisis are helped through education, empowerment and support in the least restrictive setting. Woodburn Emergency Services is a 24-hour, 365-day walk-in service, which includes psychiatry medication capabilities. General services provided by the MCU are offered seven days per week from 8 a.m. to midnight.

The MCU also includes a 24 hour-per-day rapid deployment team that responds to hostage/barricade incidents with the Special Weapons and Tactics (SWAT) team and police negotiators, and partners with public safety agencies during disaster events. The MCU teaches the Crisis Intervention Training classes at the Police Academy and also teaches crisis assessment and response modules as part of periodic week-long hostage/barricade training at the Academy.

The Emergency Services cluster is able to admit adults in crisis to the *Woodburn Place Crisis Care* residential crisis stabilization facility for up to 21 days and adolescents to *Leland House* youth residential crisis stabilization facility for up to 45 days. These facilities are a diversion alternative to inpatient hospitalization and are used when this less restrictive but still intensive option may be safely chosen. Referrals may also be made to the CSB's *Adult Partial Hospitalization (APH)* program. APH is an intensive four- to eight-week non-residential crisis stabilization program that is another alternative to hospitalization, when appropriate. Individuals attend APH four full days each week and also have access to other acute care safety net services, such as walk-in emergency.

Below, Table 5 provides a summary of crisis services provided to youth and adults over a recent six month time span; Tables 6 and 7 provide data on youth and adult psychiatric hospital admissions. Hospitalization is employed only when safe, less-restrictive alternatives are not viable. The majority of hospitalizations – both voluntary and involuntary – involve suicide risk and, therefore, represent true "saves"; that is, in many cases, an actual suicide or serious attempt has been prevented. In the case of involuntary hospitalizations, magistrates will not issue a detention order unless the recommending clinician can make a strong case based upon behavioral evidence of suicide risk (i.e., actual actions and direct threats; a clinician's evaluation of risk potential, in the absence of supporting evidence, is not enough to secure an order).

Table 5. Crisis Services Provided by CSB Emergency Services, by Client Age, Dec. 2012 – May 2013

	Under 14 years	14 – 17 years	18 years and older	*Total*
Crisis Intervention/Risk Assessment (Face-to-face)	161	331	1,423	*1,915*
Crisis Intervention/Risk Assessment (Telephone)	222	479	3,003	*3,704*
Psychiatric Evaluation	5	8	229	*243*
Medication Evaluation	25	73	1,188	*286*
Psychiatric/Clinical Consultation	16	29	145	*190*
Case Coordination/Crisis Case Management	50	104	744	*898*
Total Service Units Provided	*479*	*1,024*	*6,732*	*8,235*
Individuals Served (Unduplicated)	*180*	*360*	*2,124*	*2,664*

Source: Fairfax-Falls Church Community Services Board

Table 6. Youth Hospital Admissions by CSB Emergency Services, by Client Age, Dec. 2012 – May 2013

		Under 14 years (n = 26)[1]	14 – 17 years (n = 82)[2]	*Combined (n = 108)*
Hospital Location	Northern Virginia (Regionally)	81%	58%	63%
	Out of Region	19%	42%	37%
Admission Type	Voluntary	86%	50%	57%
	Involuntary (Temporary Detention)	14%	50%	43%
Risk Issue(s)	Serious danger to Self	44%	52%	50%
	Serious danger to self and others	50%	28%	32%
	Serious danger to others	6%	12%	11%
	Serious deterioration in ability to care for self in a developmentally age appropriate manner	0%	8%	7%
Engaged in Treatment (at time of admission)	CSB Youth/Family	31%	16%	19%
	Private Sector	13%	5%	5%

Source: Fairfax-Falls Church Community Services Board

[1]Includes one voluntary admission for a Prince William County resident and one involuntary admission for a Loudoun county resident

[2]Includes voluntary admissions for one Prince William County resident and one Loudoun County resident, and one involuntary admission for a Stafford County resident

Table 7. Adult Hospital Admissions by CSB Emergency Services, by Facility Type, Dec. 2012 – May 2013

	Voluntary	Involuntary
Crisis Care	203	3
Northern Virginia Hospitals	135	374
Out of Region Hospitals	0	0
Total	*338*	*377*

Source: Fairfax-Falls Church Community Services Board

While the CSB has an excellent specialist-staffed 24-hour emergency service available for people at immediate risk of suicide or harm to others, there has been a need to deepen skill levels for clinicians doing ongoing, longer-term outpatient and residential work with individuals at risk for suicide across the entire CSB system. They enlisted Dr. David Jobes, a nationally recognized expert on suicide, to train line staff and supervisors on a system of assessment and intervention he developed. *Collaborative Assessment and Management of Suicide* (CAMS) is a model system, in use at military bases, Veterans Affairs facilities, and treatment centers including the Menninger and Mayo Clinics. Two years ago, Dr. Jobes provided an all-day CAMS training to 350 CSB line clinicians. This was followed up with advanced training sessions for 100 clinical supervisors and managers. Among the group with advanced training, the CSB established *CAMS suicide resource teams* at 24 CSB sites around the county, including outpatient centers, residential settings and the Adult Detention Center. These on-site suicide teams are now available daily for suicide consultations by line clinicians a short hallway walk away.

The CSB has held "Grand Rounds" case conference staffings for resource team members, co-facilitated by Dr. Jobes and CSB clinical staff. At these sessions, clinicians bring in challenging cases and staff them with their colleagues and the experts, applying CAMS concepts and providing deeper learning for all participants. Other methods are also used to further learning, such as bringing in an individual who had been suicidal – along with the clinician he worked with – to speak to the learning collaborative about which clinical practices had helped lower the risk and which did not. Clinicians reported that the perspective of an individual receiving services was unique and invaluable. The Grand Rounds sessions are also used to review analytic reports prepared by the Virginia Office of the Chief Medical Examiner, such as the recent analysis of elder suicides in Virginia.

CSB Youth and Family Services have developed an array of specific resources, practices, and protocols used specifically to prevent suicide and to treat suicide risk when it exists. This also involves a collaborative interface with other programs, agencies, and contractors. Youth who receive Intensive Care Coordination services via the Comprehensive Services Act and are most at risk for long-term out of home placement have *wraparound specialists* on call 24/7 to provide crisis intervention services. The *Leland House* youth crisis care facility (a public/private partnership) provides 24/7 short-term residential psychiatric stabilization services for up to 45 days per stay. It serves youth between the ages of 12 and 17 and can manage eight youth at any given time. *Walk-in emergency services* for youth are provided at Woodburn (24/7) and the Gartlan Center (40 hours per week). The MCU is available seven days per week, from 8 a.m. to midnight.

CSB Youth and Family Outpatient Services staff brings additional resources to its ongoing work with youngsters and their families. The CAMS array of interventions noted above is being implemented at all Youth and Family sites. The *CSB Risk Assessment Protocol Guidebook* is routinely used by clinicians in evaluating risk in children and adolescents. Among other features, the guidebook outlines risk factors associated with suicide and violence, provides examples of questions most likely to elicit critical risk-defining information from a youngster, and provides information about a range of clinical options, including hospitalization, when justified.

The CSB is in the process of further integrating youth services for mental health and substance use disorders, recognizing that evidence-based best practices dictate that such treatment should neither occur sequentially, nor in parallel using separate clinicians. In children, as in people of all ages, substance use and mental health disorders interact with and impact each other. A single clinician, proficient in both disorders, has clearly been demonstrated to provide the most effective care and, in the process, lower the risk of harm to self or others.

Fairfax County Public Schools

Fairfax County Public Schools (FCPS) employs school psychologists and school social workers who are available to all adolescents and children in psychiatric crisis. These clinicians provide a supervised, safe environment while working with parents/guardians to secure a level of care and placement which matches the mental health needs. In response to self-reported depression/suicidal ideation or a report by another individual, a school psychologist or school social worker conducts a suicide risk assessment with the student. The assessment follows the Virginia Department of Education Suicide Prevention Guidelines and includes notification of parents/guardians, interventions, referral to outside agencies or mental health facilities as necessary, and follow-up. A standard protocol, Guidelines for Suicide Assessment, has been developed which includes practice guidelines and resources to be used by all school psychology and school social work responders. Students for whom acute care is not determined to be necessary are monitored by the school mental health team. Individuals and families in crisis are linked to community services, with the clinician often accompanying the family to provide assistance in gaining care. In the 2012-12 school year, FCPS school psychologists and school social workers completed 1,389 formal suicide assessments.

FCPS also follows best practice models in its school crisis intervention work when a student suicide has occurred. Last year, 74 school social workers and school psychologists completed the PREPaRE certification training on school crisis intervention and recovery. PREPaRE is a nationally recognized crisis response model which helps crisis teams provide immediate psychological first aid to individuals and groups impacted by a crisis or a loss, as well as a framework for ongoing postvention supports and activities.

FCPS has 24 teams of 6 to 8 social workers and psychologists who respond when there is a death of a student or a staff member in a school, or when a community situation occurs which is likely to impact significant numbers of students or family members (e.g., shooting, arrest of a sex offender, death of someone who had close ties to the school community). Each team leader has completed the PREPaRE training. These teams are organized to mirror the school system's geographical Clusters. A team from each Cluster is "on call" each month, rotating to the next team from that Cluster as incidents occur.

When a crisis of some type occurs, the FCPS crisis manager consults with the principal to determine if one of these external teams is needed, or if the school-based team of psychologist, social worker, and counselors will respond. If an external team is requested, which is always the case in the event of a suicide, the team on call leaves their normally assigned schools and goes to the impacted school. The external team members work collaboratively with the school based team to provide direct support to students, teachers, and administrators. Depending on the situation, an evening meeting for parents may also be held. The external team fades support over two or three days as the situation stablizes and the school-based team assumes responsibility for longer term interventions and monitoring. Staff members needing ongoing support are referred to the Employee Assistance Program.

When a suicide has occurred, FCPS crisis teams adhere to current guidelines in sharing relevant information (confirming the loss); supporting affected peers, siblings, and staff members; and providing outreach to the affected family members. Further, crisis teams understand that suicide postvention activities provide an opportunity to identify and potentially refer others who are at risk for suicide. In the ensuing days after such a loss, crisis team members have the opportunity to talk with students and school staff members about risk factors; identify students and/or staff members of concern; promote and/or identify appropriate coping strategies; guide and potentially supervise memorial activities; and

publicize and utilize referral procedures. Priority is given to those at highest risk; a triage and screening process helps identity those who need immediate attention. Psychological and physical safety is critical, as is direct provision of psychological first aid to impacted individuals. Crisis team intervention plans and suicide postvention plans are evaluated, and next steps are identified. Long after the crisis occurs, local school crisis team members (school mental health professionals) continue their outreach to impacted students, family members, staff members, and surviving siblings who attend FCPS schools. Students identified through the postvention/assessment process receive follow-up by assigned team members. The school team may identify additional outreach opportunities for the school community through ongoing collaboration with administrators, students, faculty and parents, and develop education and awareness activities.

When multiple suicides occur within a school community, consultation is sought with national and community agency partners to discuss possible patterns and to work together to reduce the potential for further losses.

In 2012-2013, external crisis teams responded to 24 incidents, which include deaths of students from a variety of causes and deaths of teachers and other staff members.

CrisisLink

CrisisLink, a non-profit organization that receives some County funding, provides crisis hotlines and supportive listening services twenty-four hours per day, seven days per week, and 365 days per year. During FY 2013, they responded to 758 individuals referred via the National Suicide Hotline and an additional 1,358 callers in need of supportive listening services. CrisisLink also provides crisis response teams and community education services focused on suicide prevention.

PREVENTING SUICIDE

Of course, the best, most effective, and most efficient strategies to prevent suicide are implemented long before suicidal ideation occurs. These services, programs, policies, and environmental approaches are designed to provide the supports and opportunities that contribute to healthy, positive development, and are rarely classified as "suicide prevention." For example,

- Chronic Disease Self-Management programs help individuals learn to manage their illness, reducing their dependency on medical care and increasing their sense of control and actual control of their wellness;
- Senior centers, teen centers, community centers, after-school and sports programs, mentoring programs, and a whole host of other programs and facilities enhance individuals' attachment to their communities, peers, and caring adults, and reduce isolation, especially among seniors;
- Positive Behavioral Intervention and Supports is but one of several approaches being used in Fairfax County Public Schools classrooms and among other youth serving programs to take a proactive, strengths-based approach to behavior issues;
- Operation Medicine Cabinet Cleanout helps to reduce the availability of potentially lethal drugs that can often be found in households; and
- Trauma-informed care practices, implemented in a variety of mental health, child welfare, domestic violence, criminal and juvenile justice, and other settings, are designed to ensure programs and services fully support and avoid re-traumatization of the victims of trauma.

Nonetheless, more targeted prevention efforts are still necessary to intervene and keep those most at-risk from progressing to the point at which those persons are seriously considering suicide. Awareness of the signs of suicide, risk factors, helpful interventions, and available resources are keys that can help prevent suicide and suicide's lasting harmful effects on individuals, families, and communities. The causes of suicide are complex, yet the goal of suicide prevention is simple: reduce factors that increase risk and increase factors that promote resilience or coping. With a public health approach, prevention occurs at all levels of society—from the individual, family, school, population, and community levels to the broader social environment. Effective prevention strategies are needed to promote awareness of suicide while at the same time promoting prevention, resilience, and a commitment to social change. Community and prevention approaches are vital to building skills to better equip the community to respond and help. A variety of such approaches exist in Fairfax County.

Police

Since 2006, FCPD officers have received *Crisis Intervention Training* (CIT), a 40-hour course taught by the CSB. The training program's objective is to provide effective tools for officers to better respond to and handle the challenges of crisis situations. The training increases the effectiveness of law enforcement officers in managing mental health crises when they are first on scene in a sensitive, safe, and effective manner. The most common call of this kind involves suicide risk. To date, 391 FCPD officers, including all School Resource Officers (SROs), have attended CIT; this represents 43 percent of the patrol force. The department's goal is to train all patrol officers in CIT, even though the national recommendation is that 25 percent of a department's patrol force receive the training. The next class will take place in October 2013.

Fairfax County Public Schools

FCPS utilizes a comprehensive and research-based approach to student wellness, addressing concerns of depression in children and youth, preventing suicide through a variety of curriculum- and assessment-based approaches, and providing effective and immediate crisis response to restore equilibrium and prevent additional losses. The work connecting the mental and emotional wellness of students is integrated under the Resiliency Project.

The *Resiliency Project* is a framework for developing and implementing system-wide protocols to support students when school or life circumstances result in significant emotional distress. The project focuses on integrating school counselors, school psychologists, and school social workers in expert teams to systematically intervene in a manner which supports and empowers students to deal with the challenges of the moment and encourages growth in self-esteem and the ability to cope with future challenges. In collaboration with parents, community groups, and county agencies, the project developed parent workshops and a webpage of resources, located at http://www.fcps.edu/dss/ips/resiliency/resources/res-assets.shtml.

The project is a multi-year initiative and will include universal training for each counselor, psychologist, and social worker team on existing research-based protocols such as bullying, suicide risk assessment, and crisis intervention. During 2011-2012, this project focused on system-wide implementation of FCPS's comprehensive Bullying Prevention and Intervention program. During 2012-2013, the project focused on Depression Awareness and Suicide Prevention and Crisis Response. Additionally, the Bullying Prevention and Intervention initiative has expanded to include identification of interventions and

resources applicable to vulnerable subgroups, such as students with disabilities and students who identify as lesbian, gay, bisexual, or transgender.

To further guide the intervention and prevention work of individual school communities, the results from the Fairfax County Youth Survey were disaggregated by pyramid and shared with school teams. Using the pyramid-level data, schools identified areas of focus and worked to strengthen prevention and intervention efforts in identified areas.

Mental health services on depression and suicide awareness and other issues are addressed in the school setting by school psychologists and school social workers. Prevention efforts are targeted toward identifying strategies to proactively and explicitly help students and staff understand the connection between the development of resiliency and the ability to make safe and healthy life choices. The multi-disciplinary team supporting the resiliency project includes school-based clinicians, FCPS instructional staff, and outside agencies with a charge to integrate and connect the work of their office to the work of other offices.

All secondary students participating in health/physical education receive *universal prevention modules* on signs and symptoms of depression and suicidal thinking and where to turn for help, including school based resources, community supports and 24 hour crisis hotlines. All school social workers and school psychologists receive training on research-based prevention models and the process for completing a structured suicide assessment protocol. The protocol provides a plan of support/intervention when a student is referred for possible suicidal ideation. In addition, all school psychologists and school social workers attended an 8-hour workshop by Nan Henderson, a nationally recognized expert in resilience, learning evidence-based practices to build protective factors and reduce risk for depression, anxiety, and risky behaviors such as drug use. At the start of the 2013-2014 school year, all clinicians attended a 13-hour course by Dr. William Steele, founder of the National Institute for Trauma and Loss in Children and Adolescents, on trauma-informed care, using evidence-based practices developed for the school setting. Student and parent education, on topics including risk factors associated with suicide and how to elicit and respond to critical disclosures by students, was included in this course.

All high schools and the majority of (15) middle schools provide additional education outreach to faculty, parents, and students on how to identify and intervene when symptoms of depression or suicidal ideation may be present. Twenty-two secondary (i.e., middle and/or high) schools use comprehensive, evidence-based approaches to suicide prevention, including *Youth ACT – Signs of Suicide (SOS)* and *RESPONSE*. These psycho-educational approaches not only inform participants about the signs and symptoms, but also help teach and develop norms for seeking help for oneself or for others who may be exhibiting concerning symptoms. Eighteen secondary schools have adopted a wellness focus which also encourages healthy and positive relationships and mental wellness activities. Seventeen schools have also utilized a universal screening process to screen and identify students who may be struggling and need support. These screening activities involve the entire student services team who collaboratively instruct and assess large groups of students (often an entire grade or multiple grades). School wide screenings require extensive staff time and planning, in addition to collaboration with community providers as many students require additional assessment and referral. In 2012-2013, 16,526 students participated in group screening activities. Of those, 1357 were identified as needing additional screening and follow-up by school-based clinicians. In addition to school-based supports, 537 were referred to community providers (private therapists, CSB mental health centers, or Woodburn or other emergency rooms for immediate evaluation). Appendix E includes a chart that documents each

FCPS high school's depression and suicide-related prevention activities, including school-wide screening, educational outreach, special programs, and increased staff training.

Regardless of which approach is utilized, every school in FCPS has a *structured response protocol* for assessing and providing support to any referred student. In addition, partnerships with the Josh Anderson Foundation, Actively Caring for People, NEXXUS, Community of Solutions, the United Prevention Coalition, Fairfax Partnership for Youth, and other groups have provided funding, forums for youth leaders to meet share their insights with adults, and collaboratively planned prevention and wellness activities for school communities. Student-led wellness activities, including lunchtime learning, awareness raising projects, and stress reducing programs provide increased opportunities for de-stigmatizing anxiety, depression, and other common mental health issues in adolescents; they also actively engage and empower students as part of the larger community of caring within their school.

At every school site in FCPS, students with social, emotional, and behavioral needs are served by the school psychologist and school social worker assigned to the building. The mental health team responds to all crisis and urgent/acute needs, and is part of the prevention and intervention work on mental wellbeing.

For students identified as having significant emotional issues or a diagnosed mental illness, more intensive services are available in comprehensive special education settings. The intervention and therapeutic work provided to the students by school-based clinicians (school psychologists and school social workers) in these settings enables the students to continue to progress academically and reduces the need for more restrictive, community-based day schools or residential placements. Students in these programs are frequently also hospitalized or placed in short-term inpatient programs such as Leland House, and may have attended day treatment programs in the past. Protocols are in place for exchange of information as these students transition back to the school setting, as well as for ongoing counseling and acute care as needed to maintain the student in the school setting. Students who are referred to outside providers continue to also receive support while at school. These intensive services are provided across three public day schools, five comprehensive high school sites, five comprehensive middle school sites, and eight elementary school sites. Approximately 1,000 students are served in these specialized settings. In addition, students with significant intellectual, sensory, medical and/or behavioral disabilities are served at one of two public day schools, or at one of two career centers serving students between the ages of 18 and 22 with autism, intellectual disabilities, emotional disabilities, or multiple disabilities. These students have complex medical and behavioral health needs, and school psychologists and social workers provide both direct services and extensive case management to help parents access community services in addition to those provided at school. Approximately 400 students are served in these settings.

All school psychologists and school social workers have a senior supervisor available with whom they can conference regarding challenging cases. Clinicians also meet monthly for supervision with their senior practitioner and colleagues to discuss cases, crisis response, suicide assessments, and other issues.

Through a *Parent Clinic Program*, FCPS school psychologists and school social workers are available, by appointment, to meet with parents to discuss any issue about which the parent may be concerned. The program started during spring break in March of 2010 and has continued each summer through 2013. In the summer of 2013, Parent Clinic responded to 1,013 phone calls and had 325 appointments with parents.

Community Services Board

The CSB offers an array of suicide prevention strategies that employ nationally recognized community-based approaches. Programs such as Mental Health First-Aid educate the public about suicide risk and engage them as prevention partners. Additionally, the CSB offers high-level assessment and intervention services through acute care emergency services, as well as evidence-based and effective suicide assessment and treatment services for individuals in ongoing outpatient and residential services.

While CSB prevention services have been cut dramatically in the past five years, there are still several programs offered to the community. *Mental Health First Aid* (MHFA) is an eight hour certification course that teaches a 5-step action plan offering initial help to people with the signs and symptoms of a mental illness or in crisis, including suicide, and connecting them with the appropriate professional, peer, social, or self-help care. Attendees learn warning signs and risk factors for depression, anxiety disorders, trauma, psychotic disorders, substance use disorders and eating disorders. This course is taught to over 500 people per year. Anyone can take the Mental Health First Aid certification course; participants have included first responders, students, teachers, leaders of faith communities, human services staff, aides to Board of Supervisors members, human resources professionals, and caring residents, among others. The course is open to all members of the Fairfax-Falls Church community; a $25 fee covers materials. The CSB will soon offer the eight-hour Youth MHFA, course which targets adults who work with or interact with youth on a regular basis.

Youth ACT- Signs of Suicide (SOS) is a depression awareness and suicide prevention program. Its primary objectives are to educate teens that depression is a treatable illness and to equip them with techniques to respond to a potential suicide in a friend or family member. The program includes a depression/suicide screening component and is available for middle and high school aged youth. Booster sessions and training for gatekeeper adults are available, as well. The CSB has several certified "Trainer of Trainers" with the goal of building capacity for this program throughout the community; CSB has partnered with FCPS in the school system's implementation of SOS. The SOS program design is flexible and can be completed in as few as three sessions.

Neighborhood and Community Services

The *Prevention Toolkit* (http://www.fairfaxcounty.gov/ncs/prevention/toolkit.htm) is a collection of data and resources regarding youth behaviors and risk factors, including depression and suicide, in Fairfax County. The toolkit supports organizations, communities, and individuals in developing data-informed strategies to address identified needs. It includes links to and resources about developing programs, implementing policies, and accessing services.

Fairfax Partnership for Youth

The Fairfax Partnership for Youth (FPY), a local non-profit organization, established a Youth Suicide and Depression Task Force in 2006. This initiative is now referred to as Youth Mental Wellness Resources in FPY materials. FPY takes a "whole child, whole community" approach to teen suicide prevention and advocates for coordinated, systemic strategies to bolster the resilience of youth in the face of hardship, promote empathy, and provide effective supports and treatment when youth are overcome with emotional or environmental challenges.

FPY has held a variety of conferences, workshops, and symposia on trauma, suicide, depression, and bullying prevention over the past seven years. FPY hosted a session of the SOS program for facilitators that was instrumental in establishing implementation of SOS as a key FCPS strategy for suicide prevention and intervention.

The FPY bullying prevention team developed a community training program in partnership with FCPS and Northern Virginia Mediation Service, to reduce the number of youth adversely affected by interpersonal harassment and bullying. FPY is delivering a joint presentation with FCPS and NCS on community-school collaborations in bullying prevention at the national Conference on Advancing School Mental Health in October 2013.

FPY's handbook for teens, *Feeling Better from the Inside Out*, covers a variety of mental/behavioral health and self-care topics, to improve the self-awareness knowledge base of teens and arm them with strategies for coping or seeking help. This unique resource is used by teens and by direct service professionals to facilitate learning and enhance teen resilience throughout northern Virginia. The second edition will be released in fall of 2013. In May 2013, FPY debuted the Channel 16 educational program "The FPY Show: The 411 on Mental Health Resources," which thoughtfully introduces teens to the delicate topic of suicide, and suggests alternatives and ways to access help if needed.

PLANNED OR PROPOSED INITIATIVES

Despite youth and adult suicide rates well below state and national rates, nobody is willing to accept the status quo. Several new initiatives and programs are in various stages of planning, proposal, and implementation.

Virginia's Health Planning Region II (which includes Fairfax County) is receiving $900,000 in new state funding to staff and implement a *regional mobile crisis service specifically targeting and responding solely to youth at risk*. These services will include a mobile crisis service to provide youth crisis intervention services in the community, a provision for crisis stabilization beds, and additional child psychiatry services to the region. The service will include two teams, some contracted beds with the Grafton program in Berryville, a limited number of bed days with United Methodist Family Services (UMFS), and an additional 12 child psychiatry hours per week. These funds will make a significant – if not fully adequate – improvement in the region's capacity to serve youth in crisis.

In addition to recent budget cuts, the CSB's prevention services is losing $27,000 from its annual Substance Abuse Prevention and Treatment block grant funding due to sequestration. The CSB is developing funding alternatives to replace the loss with local funds and implement evidence-based web-based programming to provide education and intervention approaches to school personnel, educators in institutions of higher learning, military families, and people who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ).

Multiple county agencies and FCPS are working with community members and organizations in the Woodson High School community to develop a community-driven approach to responding to recent student suicides. As this initiative continues to grow, staff will review its successes and lessons learned to develop more coordinated community-driven approaches for additional communities.

In response to Board of Supervisors budget guidance, County, FCPS, and community members have formed a task force that is currently meeting to discuss and make recommendations to improve the local public system of behavioral health for youth. The task force is reviewing existing services from the CSB, FCPS, and other agencies; identifying gaps; and developing proposals for increasing service access and quality. The task force will be presenting its findings and recommendations to the Successful Children and Youth Policy Team and to the Board of Supervisors this fall.

The Partnership for a Healthier Fairfax is a multi-sectoral coalition with hundreds of members representing many agencies, organizations, businesses, and interest groups. The Partnership is currently developing a Community Health Improvement Plan (CHIP); implementation of some CHIP strategies will be funded through the County's Community Transformation Grant (CTG), awarded by the US Centers for Disease Control and Prevention. While the CHIP is still in development, and funding has yet to be allocated, some of the highest priority strategies will be around mental health. They are likely to include strategies to increase access to behavioral health services, to implement a comprehensive and community-wide suicide prevention strategy, and to implement services, policies, and systems and environmental changes designed to promote mental health, especially among youth. The CHIP, and the first year of CTG project implementation funding, is expected to be finalized this fall.

CONCLUSION AND RECOMMENDATIONS

What More Can Be Done

There are other efforts aimed at suicide prevention and response that are being implemented or planned by the County, FCPS, community-based organizations, faith-based organizations, foundations, groups of concerned citizens and parents, and others. Those listed above provide a snapshot of the broadest county-wide efforts.

While behavioral health systems cannot rest as long as any suicides occur, local statistics suggest that our community's combined approaches have made a difference, as reflected in local suicide rates that are consistently below those of the rest of the state and country. And while a goal of preventing all suicides is as unrealistic as a goal of preventing all deaths due to cancer or heart disease – suicide-generating disorders such as schizophrenia, major depression, organic brain disorders and related illnesses each have a demonstrable biological foundation and very real mortality and morbidity even with the very best state-of-the-art services provided – more can certainly be done. Recent federal and state actions have provided some exposure and momentum.

In the wake of the last year's shooting at a Newtown, Connecticut, elementary school, President Obama released a plan to reduce gun violence that includes some provisions focused on mental health. Among these is an emphasis on hiring more school counselors, and expanding coverage of mental health services, especially for youth. The Patient Protection and Affordable Care Act also includes a requirement that all new small group and individual market insurance plans cover mental health and substance use disorder services at parity with medical and surgical benefits.

Additional impetus has come as a result of recent state actions and legislation. The Department of Behavioral Health and Developmental Services (DBHDS) has convened a committee to update the *Suicide Prevention Across the Lifespan Plan for the Commonwealth of Virginia.* Further underscoring the Commonwealth's emphasis on suicide prevention, DBHDS has begun tracking local CSBs' suicide

prevention efforts as a part of existing system audits. Legislation signed by Governor McDonnell as a part of a broad school safety initiative includes items related to bullying, the implementation of school-based threat assessment teams, requiring relationships between community colleges and CSBs to expand behavioral health services access, increased MHFA training, and increased mental health services for children and youth.

Finally, as noted earlier, County staff and partners have been, and will continue to, reviewing the National Strategy for Suicide Prevention to identify gaps at the local level and propose opportunities to strengthen the system.

Recommendations

In the short term, the staff collaborating on this report are recommending the Board of Supervisors take the following actions:

1. 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.

2. Commit to a timetable to make policy and funding decisions to improve the quality of the youth behavioral health services system and improve access to the system based on the recommendations of the Successful Children and Youth Policy Team's review of the youth behavioral health services task force. These recommendations should be viewed within the context of the National Strategy for Suicide Prevention, to ensure that critical gaps in a comprehensive approach to suicide prevention are addressed.

3. Maintain a resource commitment to primary prevention activities that provide the best opportunities to prevent suicide and the risk factors that accompany it. Programs, services, and approaches designed to foster healthy and strong relationships among individuals and communities are necessary to maintaining low suicide rates. Activities should be developed and implemented in partnership with the community; specific programs designed to prevent suicide or address certain risk factors should be current, relevant, culturally competent and relevant, and – when appropriate – based on solid evidence and theory.

4. Direct staff from relevant agencies and partners to review the data around elder suicide in Fairfax County and identify critical issues for suicide prevention that need to be addressed through the 50+ Action Plan, the Long Term Care Coordinating Council's Strategic Plan, or other initiatives.

5. Direct the reestablished countywide prevention coordination unit to incorporate specific suicide prevention strategies within their broader prevention plan, and to review population-level data, identify service gaps and other needs, and coordinate approaches among various stakeholders on a regular and ongoing basis. Among the already-identified gaps in local efforts within the context of the National Strategy for Suicide Prevention are several related to coordination of effort.

6. Direct the Office of Public Affairs to work with the Police Department, CSB, and FCPS to develop or adapt guidelines on suicide reporting to be promoted to the local press, including high school newspaper staffs and journalism classes. According to the American Foundation for Suicide Prevention, “certain ways of reporting about suicide can unintentionally contribute to further suicides." Research-based recommendations for media coverage have been developed and should be shared and promoted extensively with the local press, County and FCPS spokespeople, and others writing or otherwise communicating about local suicides.

Resources

Suicide Information
Suicide Prevention, Virginia Department of Health:
http://www.vdh.state.va.us/ofhs/prevention/preventsuicideva/

Suicide Prevention, US Centers for Disease Control and Prevention:
http://www.cdc.gov/ViolencePrevention/suicide/index.html

Youth Suicide, US Centers for Disease Control and Prevention:
http://www.cdc.gov/violenceprevention/pub/youth_suicide.html

Reports
Fairfax County Youth Survey Presentation on Mental Health: Depression, Suicide and Unhealthy Weight Loss, September 2012: http://www.fairfaxcounty.gov/ncs/prevention/toolkit_mental_health.htm

"Elder Suicide in Virginia: A Report from the Virginia Violent Death Reporting System 2003-2010." Virginia Department of Health, March 2013:
http://www.vdh.virginia.gov/medExam/documents/2013/pdf/Elder%20Suicide%20in%20Virginia%2020 03%202010.pdf

Programs, Trainings, and Prevention Strategies
Resiliency Project, Fairfax County Public Schools: http://www.fcps.edu/dss/ips/resiliency/index.shtml

Youth ACT – Signs of Suicide: www.mentalhealthscreening.org/programs/youth-prevention-programs/sos

More Than Sad, American Foundation for Suicide Prevention: http://morethansad.org/

Mental Health First Aid: http://www.fairfaxcounty.gov/csb/events/mental-health-first-aid.htm and http://www.mentalhealthfirstaid.org/cs/

Family of Heroes: http://www.familyofheroes.com/virginia/

Kognito evidence-based programs: http://www.kognito.com/products/

"The FPY Show: The 411 on Mental Health Resources":
http://www.fairfaxcounty.gov/cable/channel16/the_fpy_show.htm

"Feeling Better from the Inside Out: A Handbook for Teens," Fairfax Partnership for Youth:
https://www.fairfaxyouth.org/upload/wysiwyg/FPY%20Handbook%20for%20Teens%202012.pdf

Virginia Department of Health trainings:
http://www.vdh.state.va.us/ofhs/prevention/preventsuicideva/training.htm

Suicide Prevention Resource Center online trainings: http://training.sprc.org/

Suicide Prevention Resource Center Best Practices Registry: http://www.sprc.org/bpr

National Registry of Evidence-Based Programs and Practices, US Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.nrepp.samhsa.gov/

"2012 National Strategy for Suicide Prevention," U.S. Surgeon General and National Action Alliance for Suicide Prevention,
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

"Preventing Suicide: A Toolkit for High Schools," SAMHSA: http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

"After a Suicide: A Toolkit for Schools," American Foundation for Suicide Prevention:
http://www.afsp.org/preventing-suicide/our-education-and-prevention-programs/programs-for-teens-and-young-adults/after-a-suicide-a-toolkit-for-schools

"Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities," SAMHSA: http://store.samhsa.gov/shin/content/SMA10-4515/SMA10-4515.ToolkitOverview.pdf

"Suicide Prevention Guidelines," Virginia Department of Education:
http://www.doe.virginia.gov/support/prevention/suicide/index.shtml

"Recommendations for Reporting on Suicide," SAMHSA:
http://www.samhsa.gov/samhsanewsletter/Volume_19_Number_2/MediaAndSuicides.aspx

Contacts

If you have questions or would like further information, please contact one of the following individuals.

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APPENDIX A: SUPERVISOR JOHN COOK'S BOARD MATTER

Request for Human Services Committee Briefing Regarding Suicides

April 30, 2013

Madame Chairman:

In 2012 we declared September 9 to September 15 "Suicide Prevention Week" in Fairfax County. But last year 86 people still committed suicide in this County, while another 293 people attempted to take their life. In 2011, the numbers were nearly identical. On average our police are responding to calls regarding suicide or an attempted suicide once a day. The numbers are equally disturbing across the U.S., with approximately one person committing suicide every 18 minutes. There is also an average of 18 suicides per day among veterans. We need to take a closer look at our mental health programs in general, and our suicide prevention efforts in particular, especially as they pertain to our children

Before we can adequately address the issues we face as a community, however, we must first understand them. Suicide is not a new issue to Fairfax County. This week, the Washington Examiner noted the tragic deaths over the last couple of years of three students attending W.T. Woodson High School. The article noted all three were suspected suicides. In fact, each year about five percent of all suicides in Fairfax County involve a teen. In a County that prides itself on its accomplishments; we are failing to address mental health issues adequately. Clearly, we need to be doing more to prevent these suicides.

Without objection, I ask that County staff, the Community Services Board and Fairfax County Public Schools provide the Board with a briefing at a future Human Services Community Meeting on the incidences of suicides in the County, especially those involving children, what we're already doing to prevent them, and what we need to do to stop more in the future.

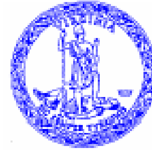
Accessed July 17, 2013, from
http://www.fairfaxcounty.gov/braddock/boardmatters/2013/mentalheath.htm

Appendix B: Leading Causes of Death by Age, Nationally

10 Leading Causes of Death by Age Group, United States – 2010

Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
	Age Groups										
1	Congenital Anomalies 5,107	Unintentional Injury 1,394	Unintentional Injury 758	Unintentional Injury 885	Unintentional Injury 12,341	Unintentional Injury 14,573	Unintentional Injury 14,792	Malignant Neoplasms 50,211	Malignant Neoplasms 109,501	Heart Disease 477,338	Heart Disease 597,689
2	Short Gestation 4,148	Congenital Anomalies 507	Malignant Neoplasms 439	Malignant Neoplasms 477	Homicide 4,678	Suicide 5,735	Malignant Neoplasms 11,809	Heart Disease 36,729	Heart Disease 68,077	Malignant Neoplasms 396,670	Malignant Neoplasms 574,743
3	SIDS 2,063	Homicide 385	Congenital Anomalies 163	Suicide 267	Suicide 4,600	Homicide 4,258	Heart Disease 10,594	Unintentional Injury 19,667	Chronic Low. Respiratory Disease 14,242	Chronic Low Respiratory Disease 118,031	Chronic Low. Respiratory Disease 138,080
4	Maternal Pregnancy Comp. 1,561	Malignant Neoplasms 346	Homicide 111	Homicide 150	Malignant Neoplasms 1,604	Malignant Neoplasms 3,619	Suicide 6,571	Suicide 8,799	Unintentional Injury 14,023	Cerebro-vascular 109,990	Cerebro-vascular 129,476
5	Unintentional Injury 1,110	Heart Disease 159	Heart Disease 68	Congenital Anomalies 135	Heart Disease 1,028	Heart Disease 3,222	Homicide 2,473	Liver Disease 8,651	Diabetes Mellitus 11,677	Alzheimer's Disease 82,616	Unintentional Injury 120,859
6	Placenta Cord. Membranes 1,030	Influenza & Pneumonia 91	Chronic Low Respiratory Disease 60	Heart Disease 117	Congenital Anomalies 412	HIV 741	Liver Disease 2,423	Cerebro-vascular 5,910	Cerebro-vascular 10,693	Diabetes Mellitus 49,191	Alzheimer's Disease 83,494
7	Bacterial Sepsis 583	Septicemia 62	Cerebro-vascular 47	Chronic Low Respiratory Disease 73	Cerebro-vascular 190	Diabetes Mellitus 606	Cerebro-vascular 1,904	Diabetes Mellitus 5,610	Liver Disease 9,764	Influenza & Pneumonia 42,846	Diabetes Mellitus 69,071
8	Respiratory Distress 514	Benign Neoplasms 59	Benign Neoplasms 37	Benign Neoplasms 45	Influenza & Pneumonia 181	Cerebro-vascular 517	HIV 1,898	Chronic Low. Respiratory Disease 4,452	Suicide 6,384	Nephritis 41,994	Nephritis 50,476
9	Circulatory System Disease 507	Perinatal Period 52	Influenza & Pneumonia 37	Cerebro-vascular 43	Diabetes Mellitus 165	Liver Disease 487	Diabetes Mellitus 1,789	HIV 3,123	Nephritis 5,082	Unintentional Injury 41,300	Influenza & Pneumonia 50,097
10	Necrotizing Enterocolitis 472	Chronic Low Respiratory Disease 51	Septicemia 32	Septicemia 35	Complicated Pregnancy 163	Congenital Anomalies 397	Influenza & Pneumonia 773	Viral Hepatitis 2,376	Septicemia 4,604	Septicemia 26,310	Suicide 38,364

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC using WISQARS™.



CENTRAL DISTRICT:
400 E. Jackson St.
Richmond, Virginia 23219-3694
(804) 786-3174
800-447-1708
FAX (804) 371-8595

WESTERN DISTRICT:
6600 Northside High School Road
Roanoke, Virginia 24019
(540) 561-6615
800-862-8312
FAX (540) 561-6619

COMMONWEALTH of VIRGINIA

Department of Health
Office of the Chief Medical Examiner
400 E. Jackson Street
Richmond, VA. 23219-3694

TIDEWATER DISTRICT:
830 Southampton Ave., Suite 100
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800-395-7030
FAX (757) 683-2589

NORTHERN VA. DISTRICT:
10850 Pyramid Place, Suite 121
Manassas, Virginia 22032-1700
(703) 530-9210
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Prepared for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Date: June 18, 2013
Prepared by: Marc Leslie, Virginia Violent Death Reporting System Coordinator
Phone number: (804) 205-3855
E-mail: marc.leslie@vdh.virginia.gov

Attached please find the data report you requested, which represents persons who died by suicide in Fairfax County, 2003-2011. The data you requested on college students will be sent at a later date. The data you requested with the geographic detail will be handled as a separate request.

Data were drawn from the National Violent Death Reporting System (NVDRS), which documents violent deaths that originate within a state's borders. It compiles all information sources involved in violent death investigation, and links victims to circumstances such as mental illness, intimate partner violence, and the other events leading up to and contributing to the violent death. The Virginia Violent Death Reporting System (VVDRS) is the operation and reporting system of the NVDRS within Virginia, and uses the methodology, definitions, coding schema, and software of the NVDRS.

A violent death results from the intentional use of force or power against oneself, another person, group, or community. The VVDRS surveils the following types of violent deaths within Virginia: suicide, homicide, legal intervention, unintentional firearm death, undetermined death, and terrorism-related death.

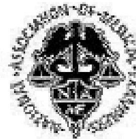
Data reports made up of relatively small numbers (20 or fewer cases) are considered statistically unreliable and should be interpreted and used with caution. Percentages based on small numbers of cases should be interpreted with care. Numbers and percentages based on 20 or fewer cases are presented in this report in the interest of complete reporting.

The research files for this report were created on May 30, 2013. Data may continue to be entered and updated in VVDRS after this date.

Complete descriptions of the data elements collected by VVDRS can be found in the NVDRS Coding Manual at: http://www.cdc.gov/ncipc/pub-res/nvdrs-coding/vs3/NVDRS_Coding_Manual_Version_3-a.pdf

Suggested citation for these tables:
Source: Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System. A National Violent Death Reporting System project. http://www.cdc.gov/ncipc/pub-res/nvdrs-coding/VS2/default.htm

Thank you for your interest in the VVDRS, and best wishes in your prevention work. Please let me know if I can be of any further assistance.



Accredited by the National Association of Medical Examiners

Suicide in Fairfax County by Age Group and Year, 2003-2011 [1,2]

	Ages 10-19			Ages 20-24			Ages 25 and Older			TOTAL		
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate
2003	5	12.2	3.6	3	5.7	6.0	57	8.9	8.5	**65**	**8.8**	**6.5**
2004	7	17.1	5.1	4	7.5	7.1	55	8.6	8.2	**66**	**9.0**	**6.6**
2005	4	9.8	2.9	5	9.4	8.8	66	10.3	9.8	**75**	**10.2**	**7.5**
2006	4	9.8	2.9	7	13.2	12.2	73	11.4	10.8	**84**	**11.4**	**8.3**
2007	1	2.4	0.7	7	13.2	11.4	77	12.0	11.3	**85**	**11.6**	**8.4**
2008	7	17.1	5.2	7	13.2	11.2	71	11.1	10.4	**85**	**11.6**	**8.4**
2009	4	9.8	3.0	7	13.2	10.8	93	14.5	13.5	**104**	**14.1**	**10.0**
2010	5	12.2	3.6	5	9.4	8.3	73	11.4	9.9	**83**	**11.3**	**7.7**
2011	4	9.8	2.8	8	15.1	13.6	76	11.9	10.1	**88**	**12.0**	**8.0**
TOTAL	**41**	**100.0**	**3.3**	**53**	**100.0**	**10.0**	**641**	**100.0**	**10.3**	**735**	**100.0**	**7.9**

[1] Rates reflect risk per 100,000 persons.

[2] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County
by Age, 2003-2011[1]

	#	%
13	3	0.4
14	3	0.4
15	2	0.3
16	5	0.7
17	10	1.4
18	11	1.5
19	7	1.0
20	14	1.9
21	13	1.8
22	11	1.5
23	7	1.0
24	8	1.1
25 and older	641	87.2
TOTAL	**735**	**100.0**

[1] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group and Gender, 2003-2011[1,2]

	Ages 10-19			Ages 20-24			Ages 25 and Older			TOTAL		
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate
Male	32	78.0	5.0	39	73.6	14.1	441	68.8	14.6	**512**	**69.7**	11.2
Female	9	22.0	1.5	14	26.4	5.5	200	31.2	6.2	**223**	**30.3**	**4.8**
TOTAL	**41**	**100.0**	**3.3**	**53**	**100.0**	**10.0**	**641**	**100.0**	**10.3**	**735**	**100.0**	**7.9**

[1] Rates reflect risk per 100,000 persons.

[2] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group and Race, 2003-2011 [1,2]

	Ages 10-19			Ages 20-24			Ages 25 and Older			TOTAL		
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate
White	31	75.6	3.5	42	79.2	11.1	517	80.7	11.3	590	80.3	8.8
Asian	6	14.6	3.0	3	5.7	3.6	86	13.4	8.1	95	12.9	6.0
Black	3	7.3	2.1	8	15.1	12.9	38	5.9	6.7	49	6.7	5.4
Native American	1	2.4	14.9	0	0.0	0.0	0	0.0	0.0	1	0.1	2.3
TOTAL	41	100.0	3.3	53	100.0	10.0	641	100.0	10.3	735	100.0	7.9

[1] Rates reflect risk per 100,000 persons.

[2] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group and Race/Gender, 2003-2011[1,2]

	Ages 10-19			Ages 20-24			Ages 25 and Older			TOTAL		
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate
White Male	24	58.5	5.2	31	58.5	15.4	360	56.2	16.0	**415**	**56.5**	**12.3**
Black Male	3	7.3	4.1	7	13.2	23.0	28	4.4	10.7	**38**	**5.2**	**8.7**
Asian Male	5	12.2	4.8	1	1.9	2.3	53	8.3	10.6	**59**	**8.0**	**7.7**
White Female	7	17.1	1.6	11	20.8	6.2	157	24.5	6.8	**175**	**23.8**	**5.2**
Native American Female	1	2.4	31.0	0	0.0	0.0	0	0.0	0.0	**1**	**0.1**	**4.8**
Asian Female	1	2.4	1.0	2	3.8	4.9	33	5.1	5.8	**36**	**4.9**	**4.4**
Black Female	0	0.0	0.0	1	1.9	3.1	10	1.6	3.3	**11**	**1.5**	**2.3**
Native American Male	0	0.0	0.0	0	0.0	0.0	0	0.0	0.0	**0**	**0.0**	**0.0**
TOTAL	**41**	**100.0**	**3.3**	**53**	**100.0**	**10.0**	**641**	**100.0**	**10.3**	**735**	**100.0**	**7.9**

[1] Rates reflect risk per 100,000 persons.

[2] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group and Ethnicity, 2003-2011[1,2,3]

	Ages 10-19			Ages 20-24			Ages 25 and Older			TOTAL		
	#	%	Rate	#	%	Rate	#	%	Rate	#	%	Rate
Non-Hispanic	36	87.8	3.4	44	83.0	10.4	606	94.5	11.1	**686**	**93.3**	**8.6**
Hispanic	5	12.2	2.8	9	17.0	8.5	35	5.5	4.7	**49**	**6.7**	**3.8**
TOTAL	**41**	**100.0**	**3.3**	**53**	**100.0**	**10.0**	**641**	**100.0**	**10.3**	**735**	**100.0**	**7.9**

[1] Rates reflect risk per 100,000 persons.

[2] There were no suicides to persons under age 13.

[3] Hispanic persons may be of any race.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group and Race/Ethnicity, 2003-2011 [1]

	Ages 10-19		Ages 20-24		Ages 25 and Older		TOTAL	
	#	%	#	%	#	%	#	%
Non-Hispanic White	26	63.4	34	64.2	482	75.2	**542**	**73.7**
Non-Hispanic Asian	6	14.6	2	3.8	86	13.4	**94**	**12.8**
Non-Hispanic Black	3	7.3	8	15.1	38	5.9	**49**	**6.7**
Hispanic White	5	12.2	8	15.1	35	5.5	**48**	**6.5**
Non-Hispanic Native American	1	2.4	0	0.0	0	0.0	1	**0.1**
Hispanic Asian	0	0.0	1	1.9	0	0.0	1	**0.1**
TOTAL	**41**	**100.0**	**53**	**100.0**	**641**	**100.0**	**735**	**100.0**

[1] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group, Race, and Place of Birth 2003-2011[1,2]

	Ages 10-19		Ages 20-24		Ages 25 and Older		TOTAL	
	#	%	#	%	#	%	#	%
White	31	75.6	42	79.2	517	80.7	590	80.3
U.S.-Born	*31*	*75.6*	*33*	*62.3*	*442*	*69.0*	***506***	***68.8***
Foreign-Born	*0*	*0.0*	*8*	*15.1*	*70*	*10.9*	***78***	***10.6***
Black	3	7.3	8	15.1	38	5.9	49	6.7
U.S.-Born	*3*	*7.3*	*8*	*15.1*	*27*	*4.2*	***38***	***5.2***
Foreign-Born	*0*	*0.0*	*0*	*0.0*	*11*	*1.7*	***11***	***1.5***
Asian	6	14.6	3	5.7	86	13.4	95	12.9
U.S.-Born	*3*	*7.3*	*2*	*3.8*	*7*	*1.1*	***12***	***1.6***
Foreign-Born	*3*	*7.3*	*1*	*1.9*	*79*	*12.3*	***83***	***11.3***
Native American	1	2.4	0	0.0	0	0.0	1	0.1
U.S.-Born	*1*	*2.4*	*0*	*0.0*	*0*	*0.0*	***1***	***0.1***
Foreign-Born	*0*	*0.0*	*0*	*0.0*	*0*	*0.0*	***0***	***0.0***
TOTAL	41	100.0	53	100.0	641	100.0	735	100.0

[1] There were no suicides to persons under age 13.

[2] For Whites, the birthplace of six persons was unknown.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Suicide in Fairfax County by Age Group and Method of Fatal Injury, 2003-2011[1,2]

	Ages 10-19		Ages 20-24		Ages 25 and Older		TOTAL	
	#	%	#	%	#	%	#	%
Firearm	11	26.8	18	34.0	260	40.6	**289**	**39.3**
Hanging/Suffocation	25	61.0	24	45.3	170	26.5	**219**	**29.8**
Poison	1	2.4	9	17.0	153	23.9	**163**	**22.2**
Fall	3	7.3	0	0.0	26	4.1	**29**	**3.9**
Sharp Instrument	0	0.0	1	1.9	28	4.4	**29**	**3.9**
Drowning	0	0.0	0	0.0	9	1.4	**9**	**1.2**
Motor Vehicle	1	2.4	0	0.0	4	0.6	**5**	**0.7**
Fire/Burns	0	0.0	0	0.0	4	0.6	**4**	**0.5**
Other Transport Vehicle	0	0.0	0	0.0	4	0.6	**4**	**0.5**
Other	0	0.0	1	1.9	3	0.5	**4**	**0.5**
TOTAL	**41**	**100.0**	**53**	**100.0**	**641**	**103.1**	**735**	**102.7**

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

[2] There were no suicides to persons under age 13.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

Selected Circumstances of Suicide in Fairfax County by Age Group, 2003-2011 [1,2,3,4,5,6]

Mental Health Characteristics	Ages 10-19 (*n* = 41) #	%	Ages 20-24 (*n* = 51) #	%	Ages 25 and Older (*n* = 628) #	%	TOTAL (*N* = 720) #	%
Current Mental Health Problem	25	61.0	34	66.7	413	65.8	**472**	**65.6**
Mental Health Treatment	25	61.0	30	58.8	338	53.8	**393**	**54.6**
Current Mental Health Treatment	*21*	*51.2*	*19*	*37.3*	*291*	*46.3*	***331***	***46.0***
Noncurrent Mental Health Treatment	*4*	*9.8*	11	21.6	*47*	*7.5*	***62***	***8.6***
Substance Use Characteristics								
Problem with Alcohol and/or Other Substances	8	19.5	10	19.6	165	26.3	**183**	**25.4**
Problem with Alcohol	1	*2.4*	*0*	*0.0*	*96*	*15.3*	***97***	***13.5***
Problem with Other Substances	*6*	*14.6*	*5*	*9.8*	*40*	*6.4*	***51***	***7.1***
Problem with Alcohol and Other Substances	1	*2.4*	*5*	*9.8*	*29*	*4.6*	***35***	***4.9***
Relationship Characteristics								
Intimate Partner Problem	8	19.5	21	41.2	167	26.6	**196**	**27.2**
Non-intimate Partner Relationship Problem	19	46.3	10	19.6	51	8.1	**80**	**11.1**
Suicide/Death of Family/Friend, Past 5 Years	2	4.9	1	2.0	36	5.7	**39**	**5.4**
Perpetrator of Interpersonal Violence, Past Month	1	2.4	1	2.0	21	3.3	**23**	**3.2**
Victim of Interpersonal Violence, Past Month	2	4.9	1	2.0	0	0.0	**3**	**0.4**
Life Stressor Characteristics								
Physical Health Problem	0	0.0	5	9.8	162	25.8	**167**	**23.2**
Job Problem	0	0.0	2	3.9	124	19.7	**126**	**17.5**
Financial Problem	1	2.4	3	5.9	115	18.3	**119**	**16.5**
Recent Criminal Legal Problem	6	14.6	7	13.7	58	9.2	**71**	**9.9**
School Problem	16	39.0	1	2.0	1	0.2	**18**	**2.5**
Noncriminal Legal Problem	1	2.4	0	0.0	14	2.2	**15**	**2.1**
Event Characteristics								
Disclosed Intent and/or History of Suicide Attempt	28	68.3	36	70.6	342	54.5	**406**	**56.4**
Disclosed Intent to Commit Suicide	24	58.5	21	41.2	268	42.7	**313**	**43.5**
Left a Suicide Note	13	31.7	14	27.5	246	39.2	**273**	**37.9**
Current Depressed Mood	13	31.7	14	27.5	240	38.2	**267**	**37.1**
Crisis within Two Weeks of the Suicide	24	58.5	27	52.9	180	28.7	**231**	**32.1**
History of Suicide Attempt	12	29.3	23	45.1	149	23.7	**184**	**25.6**

[1] More than one characteristic may be noted per person. Percentages are based on the number of suicides where characteristics are known.

[2] For complete descriptions of these characteristics, see section 7 of the NVDRS Coding Manual at: http://www.cdc.gov/ncipc/pub-res/nvdrs-coding/VS2/NVDRS%20Coding%20Manual%20Full.pdf.

[3] *Current Mental Health Treatment*: Treatment received within the two months preceding the suicide. *Noncurrent Mental Health Treatment*: Treatment received more than two months before the suicide.

[4] *Problem with Other Substances* automatically includes persons with a positive postmortem test for cocaine who did not die from cocaine poisoning.

[5] *Recent Criminal Legal Problem* automatically includes persons who were incarcerated or died by suicide to avoid an impending arrest.

[6] *Disclosed Intent to Commit Suicide* includes persons who reported suicidal ideation.

Data request for: Sophia Dutton, Fairfax Dept. of Neighborhood & Community Services
Data source: Virginia Violent Death Reporting System, Office of the Chief Medical Examiner, Virginia Department of Health

APPENDIX D: FAIRFAX HEALTH DISTRICT SUICIDE REPORT

CENTRAL DISTRICT:
400 E. Jackson St.
Richmond, Virginia 23219-3694
(804) 786-3174
800-447-1708
FAX (804) 371-8595

WESTERN DISTRICT:
6600 Northside High School Road
Roanoke, Virginia 24019
(540) 561-6615
800-862-8312
FAX (540) 561-6619

COMMONWEALTH of VIRGINIA

Department of Health

Office of the Chief Medical Examiner
400 E. Jackson Street
Richmond, VA. 23219-3694

TIDEWATER DISTRICT:
830 Southampton Ave., Suite 100
Norfolk, Virginia 23510
(757) 683-8366
800-395-7030
FAX (757) 683-2589

NORTHERN VA. DISTRICT:
10850 Pyramid Place, Suite 121
Manassas, Virginia 22032-1700
(703) 530-9210
FAX (703) 530-0510

Prepared for:	Laura Yager, Fairfax-Falls Church CSB
Date:	June 12, 2013
Prepared by:	Marc Leslie, Virginia Violent Death Reporting System Coordinator
Phone number:	(804) 205-3855
E-mail:	marc.leslie@vdh.virginia.gov

Attached please find the data report you requested, which represents persons who died by suicide in the Fairfax-Falls Church CSB coverage area, 2003-2011.

Data were drawn from the National Violent Death Reporting System (NVDRS), which documents violent deaths that originate within a state's borders. It compiles all information sources involved in violent death investigation, and links victims to circumstances such as mental illness, intimate partner violence, and the other events leading up to and contributing to the violent death. The Virginia Violent Death Reporting System (VVDRS) is the operation and reporting system of the NVDRS within Virginia, and uses the methodology, definitions, coding schema, and software of the NVDRS.

A violent death results from the intentional use of force or power against oneself, another person, group, or community. The VVDRS surveils the following types of violent deaths within Virginia: suicide, homicide, legal intervention, unintentional firearm death, undetermined death, and terrorism-related death.

Data reports made up of relatively small numbers (20 or fewer cases) are considered statistically unreliable and should be interpreted and used with caution. Percentages based on small numbers of cases should be interpreted with care. Numbers and percentages based on 20 or fewer cases are presented in this report in the interest of complete reporting.

The research files for this report were created on May 30, 2013. Data may continue to be entered and updated in VVDRS after this date.

Complete descriptions of the data elements collected by VVDRS can be found in the NVDRS Coding Manual at: http://www.cdc.gov/ncipc/pub-res/nvdrs-coding/vs3/NVDRS_Coding_Manual_Version_3-a.pdf

Suggested citation for these tables:
Source: Virginia Department of Health, Office of the Chief Medical Examiner, Virginia Violent Death Reporting System. A National Violent Death Reporting System project. http://www.cdc.gov/ncipc/pub-res/nvdrs-coding/VS2/default.htm

Thank you for your interest in the VVDRS, and best wishes in your prevention work. Please let me know if I can be of any further assistance.

Accredited by the National Association of Medical Examiners

Suicide in the Fairfax-Falls Church Community, 2003-2011

Marc E. Leslie
Coordinator, Virginia Violent Death Reporting System
Office of the Chief Medical Examiner, Virginia Department of Health

Prepared for the Fairfax-Falls Church Community Services Board
June 12, 2013

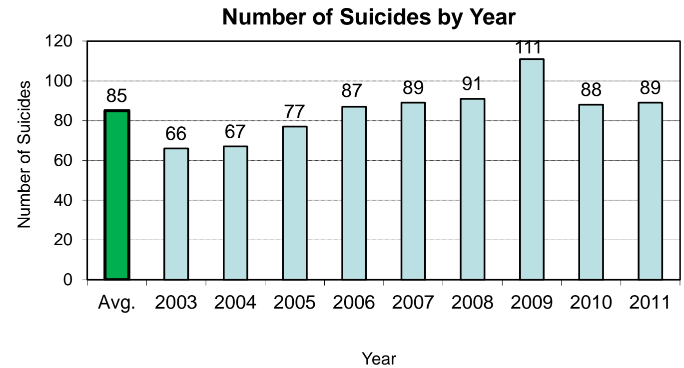
Suicide in the Fairfax-Falls Church Community,* 2003-2011

Overview of the Problem

*Report covers Fairfax County, Fairfax City, and Falls Church City

2

Suicide in the Fairfax-Falls Church Community, 2003-2011



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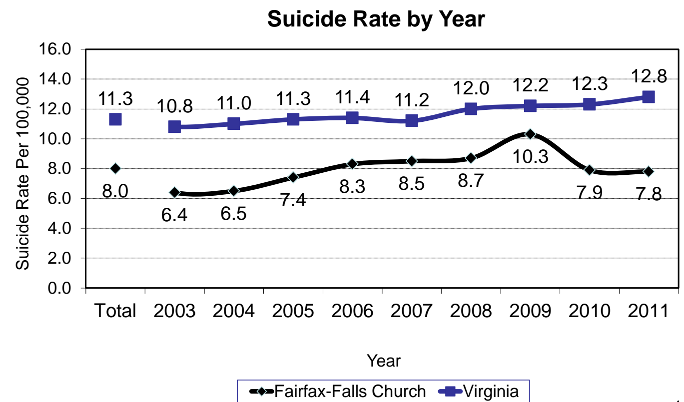
Suicide in the Fairfax-Falls Church Community, 2003-2011



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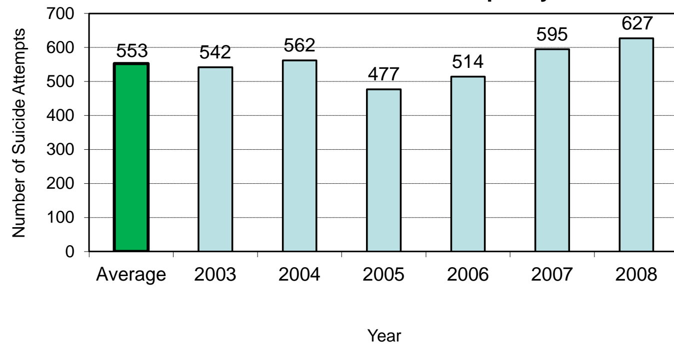
Suicide in the Fairfax-Falls Church Community, 2003-2011

Suicide vs. Homicide (2003-2011)

- 765 suicides; rate of 8.0 (Virginia rate is 11.7)
- 146 homicides; rate of 1.5 (Virginia rate is 5.0)
- Suicide about 5 times more common than homicide

5

Suicide in the Fairfax-Falls Church Community, 2003-2008



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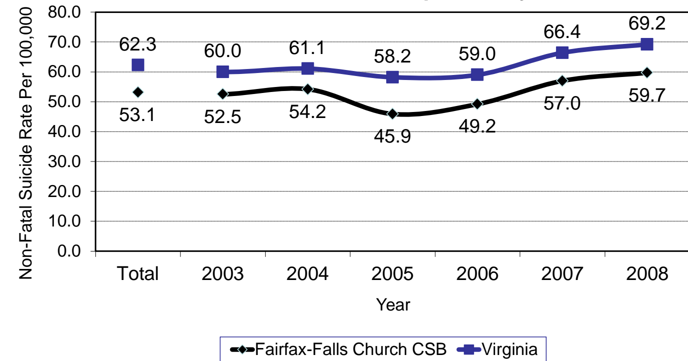
Suicide in the Fairfax-Falls Church Community, 2003-2008



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Suicide in the Fairfax-Falls Church Community, 2003-2011

Who is at Risk?

8

Suicide in the Fairfax-Falls Church Community, 2003-2011

Selected Demographic Elements

- ❖ Gender
- ❖ Race
- ❖ Age

9

Suicide in the Fairfax-Falls Church Community, 2003-2011

Race and Gender

- Male (69%, rate of 11.2)
- White (81%, rate of 8.9)
- White males (57%, rate of 12.5), Black males (5%, rate of 8.5), and Asian males (8%, rate of 7.5)

(remember, overall rate for Fairfax-Falls Church is 8.0)

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Age

- Median age is 47
- Ages 45-54 most common age group (24%)
- Highest rates for those ages 75-84 (18.5), ages 45-54 (11.5), and 85 and older (11.1)

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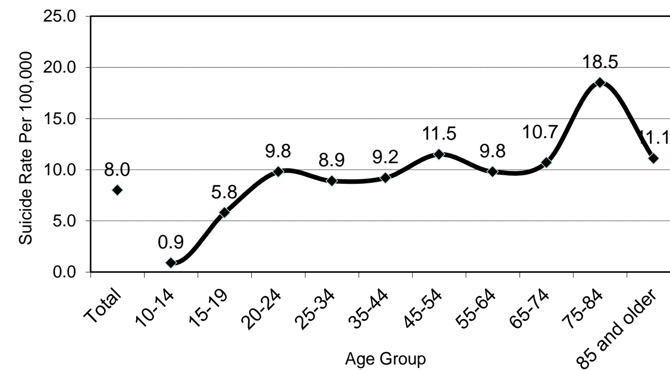
Suicide in the Fairfax-Falls Church Community, 2003-2011



12

Suicide in the Fairfax-Falls Church Community, 2003-2008

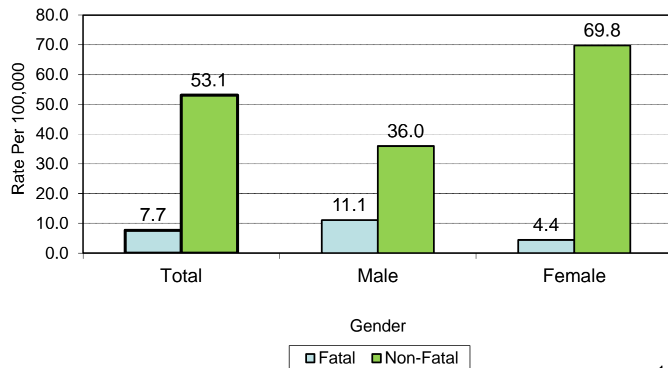
Race and Gender: Non-Fatal Attempts

- Most commonly by females (66%, rate of 69.8)
- Whites still most common and highest risk; risk levels rises for all races

13

Suicide in the Fairfax-Falls Church Community, 2003-2008

Fatal and Non-Fatal Suicide Rates by Gender



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Suicide in the Fairfax-Falls Church Community, 2003-2008

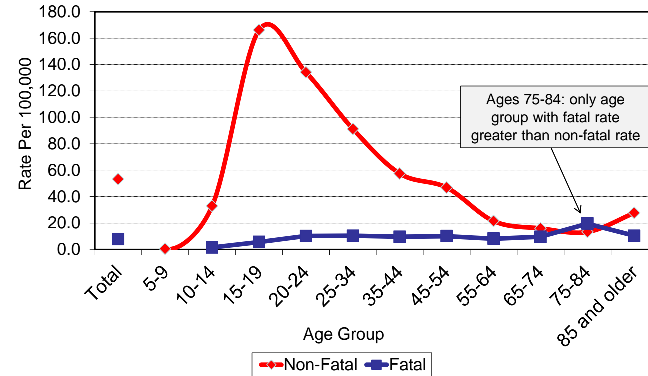
Age: Non-Fatal Attempts

- Non-fatal risk is greater than fatal suicide risk for all age groups, except ages 75-84
- 30 times rate increase for those ages 15-19 (from 5.6 to 166.1)
- In general, non-fatal attempt rate *decreases* with age

15

Suicide in the Fairfax-Falls Church Community, 2003-2008

Non-Fatal and Fatal Suicide Rate by Age Group



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Suicide in the Fairfax-Falls Church Community, 2003-2011

Veterans

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Veterans

- 17% of all suicides (18 years and older)
- 24% of males; 3% of females
- Unknown if veterans served in combat, but can generally tell if they are currently in the military

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Veterans

- Male veterans older than male non-veterans (median ages of 63 and 45, respectively)
- Median age suggests that those who are combat veterans generally not in the most recent conflicts
- 65% of males ages 65 and over are veterans compared to 15% of males ages 18-64

19

Suicide in the Fairfax-Falls Church Community, 2003-2011

Method of Fatal Injury

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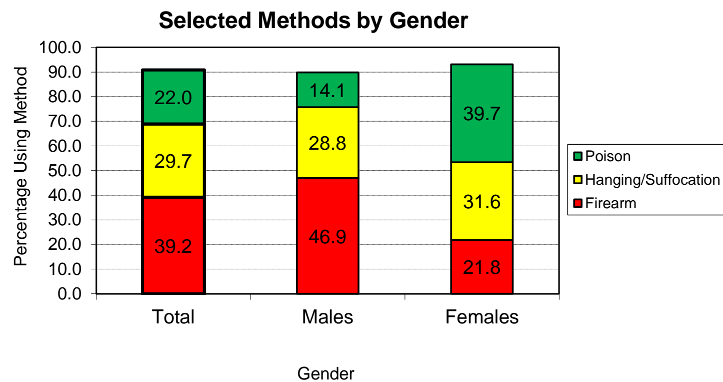
Suicide in the Fairfax-Falls Church Community, 2003-2011

Method of Fatal Injury

- More than one method of fatal injury can be used per suicide (e.g., combining poison and drowning)
- Firearm, poison, and/or hanging/suffocation are used in 90% of suicides
- Most poisons are prescribed medications, primarily mental health medications and pain medications

21

Suicide in the Fairfax-Falls Church Community, 2003-2011



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Suicide in the Fairfax-Falls Church Community, 2003-2008

Method of Fatal Injury: Non-Fatal Attempts

- Most common method for non-fatal attempts is poison (76%)
- Poison use is defining method difference between fatal and non-fatal attempts

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Geography

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Locality of Residence	#	Rate
Fairfax City	21	10.2
Falls Church	9	8.8
Fairfax County	735	7.9

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Selected Circumstances

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Most Common Circumstances

- Mental health problem (66%)*
- Crisis in past two weeks (33%)
- Intimate partner problem (27%)
- Problem with alcohol and/or other substances (26%)
- Physical health problem (23%)

* 19% of all persons had both a mental health and an alcohol/substance abuse problem

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Circumstances: Mental Health

- Females (76%) more than males (62%)
- Most prevalent in ages 55-64 (75%); nearly 50% or more of every age group except 10-14
- 83% treated in past two months and/or prior
- 72% known to take mental health medications currently or in the past*

* 2007-2011 data

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Suicide in the Fairfax-Falls Church Community, 2003-2011

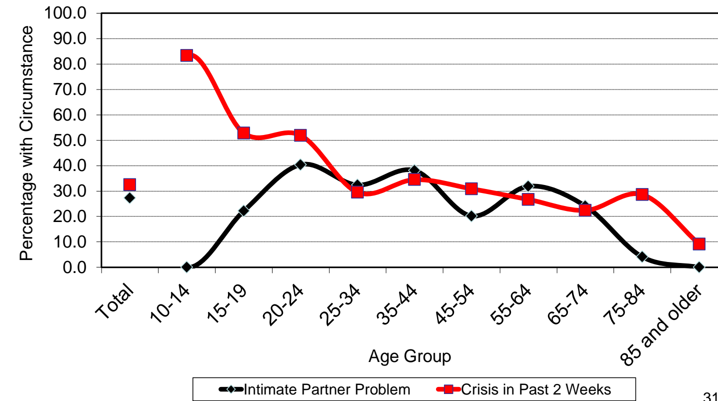
Circumstances: Crisis in Past 2 Weeks

- 33% of all persons; no real gender difference
- Most crises (69%) occurred in the past 24 hours*
- Indicator of reactive suicides
- 30% or more for all age groups up through 45-54

*2007-2011 data

29

Suicide in the Fairfax-Falls Church Community, 2003-2011



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Suicide in the Fairfax-Falls Church Community, 2003-2011

Circumstances: Intimate Partner Problems

- 27% having problems with current/former intimate partner at time of suicide
- 26% of males, 31% of females
- 52% also having a crisis in the past 2 weeks
- Shows volatility of intimate partner conflict

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Circumstances: Alcohol and Other Substance Problems

- 26% of all persons
- Peaks at 32% for ages 45-54
- 42% of those with alcohol problems had elevated levels of alcohol (≥ .08 BAC) in their system at death compared to 9% of those without alcohol problems

32

Suicide in the Fairfax-Falls Church Community, 2003-2011

Circumstances: Physical Health Problems

- 23% of all suicides; 22% of males, 25% of females
- Median age of 60 compared to 43 for those without a physical health problem
- 58% of those ages 65 and older

33

Suicide in the Fairfax-Falls Church Community, 2003-2011

Circumstances: Physical Health Problems

- Explains majority of elder suicides
- Problems range from treatable (diabetes, mild pain) to severe (loss of vision, amputations) to terminal diseases and conditions

34

Suicide in the Fairfax-Falls Church Community, 2003-2011

Circumstances: Warning Signs

- 56% disclosed intent and/or had prior attempts
- Most commonly disclosed to intimate partners (47%), family (36%), friends/acquaintances (19%), and mental health/medical professionals (19%)*
- Disclosing intent similar for males (42%) and females (46%)
- Prior attempts more common for females (39%) than for males (20%)
- *2007-2011 data

35

Suicide in the Fairfax-Falls Church Community, 2003-2011

Actions Taken to Prevent Suicide*

- Sought/encouraged mental health treatment (44%)
- Tried to persuade person to not attempt suicide (20%)
- Checked in on person (18%)
- Limited access to firearms/ammunition (18%)
- Called 911/law enforcement (16%)

*2007-2011 data (entire slide)

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Efforts to Limit Access to Firearms and/or Ammunition*

- 14 persons had friends or family members who restricted access to firearms or ammunition
- Includes persons not known to disclose intent, but loved ones acted out of concern
- Restriction including removing, hiding, and locking
- Of these persons, 13 (93%) used a firearm as method of fatal injury

*2007-2011 data (entire slide)

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Other Warning Signs of Suicide*

- Taking prescribed pain medication (20%)
- Sleeping too little (18%)
- Unusual behavior, past two weeks (6%)
- Family/friends expected suicide (4%)

*2007-2011 data (entire slide)

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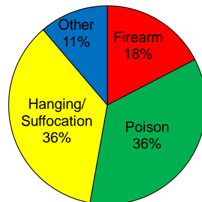
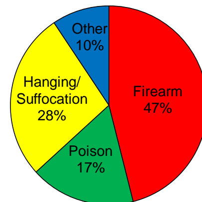
Suicide in the Fairfax-Falls Church Community, 2003-2011

In the fatal suicide, those with prior attempts
used less lethal methods than those without prior attempts

Prior Suicide Attempts



No Prior Suicide Attempts



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Suicide in the Fairfax-Falls Church Community, 2003-2011

Conclusions

- Suicide rates are highest among Whites, males, and older adults
- A firearm is the most common method of fatal injury
- The majority have a mental health problem, and most of these persons were being treated

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Conclusions

- 56% are *known* to talk about plans or desire to die by suicide and/or have a history of non-fatal suicide attempt(s)
- Fatal suicide and non-fatal suicide attempts present different pictures of risk and methods of fatal injury

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Questions, Data Requests, Further Information

Marc Leslie, VVDRS Coordinator

737 N. 5th Street, Suite 301
Richmond, VA 23219

804-205-3855

marc.leslie@vdh.virginia.gov

http://www.vdh.virginia.gov/medExam/NVDRS.htm

Our goal is to provide data and information that can be used for prevention and education; please let me know how I can help

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Appendix: Additional Information and Complete Tables

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Index: Fatal Suicide

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Suicide in the Fairfax-Falls Church Community, 2003-2008

Index: Non-Fatal Suicide

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Gender	49
Race	49
Ethnicity	49
Age Group	50
Method of Fatal Injury	
Complete List of Methods	56

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%	Rate
Selected Race/Gender			
White male	434	56.7	12.5
Black male	38	5.0	8.5
Asian male	59	7.7	7.5
White female	185	24.2	5.3
Asian female	36	4.7	4.3
Black female	11	1.4	2.3

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%	Rate
Gender			
Male	531	69.4	11.2
Female	234	30.6	4.8
Race			
White	619	80.9	8.9
Asian	95	12.4	5.8
Black	49	6.4	5.3
Native American	1	0.1	2.3
Other Race	1	0.1	-
Ethnicity			
Hispanic	51	6.7	3.9
TOTAL	**765**	**100.0**	**8.0**

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%	Rate
Age Group			
10-14	6	0.8	0.9
15-19	36	4.7	5.8
20-24	54	7.1	9.8
25-34	107	14.0	8.9
35-44	141	18.4	9.2
45-54	183	23.9	11.5
55-64	119	15.6	9.8
65-74	58	7.6	10.7
75-84	50	6.5	18.5
85 and older	11	1.4	11.1
TOTAL	**765**	**100.0**	**8.0**

Largest percentage: ages 45-54

Highest risk: ages 75-84

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Non-Fatal Suicide Attempts in the Fairfax-Falls Church Community, 2003-2008

	#	%	Rate
Gender			
Male	1,114	33.6	36.0
Female	2,202	66.4	69.8
Unknown	1	<0.1	-
Race			
White	2,348	70.8	50.9
Black	232	7.0	38.8
Asian	224	6.8	22.1
Native American	2	0.1	8.5
Other	26	0.8	-
Unknown	485	14.6	-
Ethnicity			
Hispanic	293	8.8	36.2
TOTAL	**3,317**	**100.0**	**53.1**

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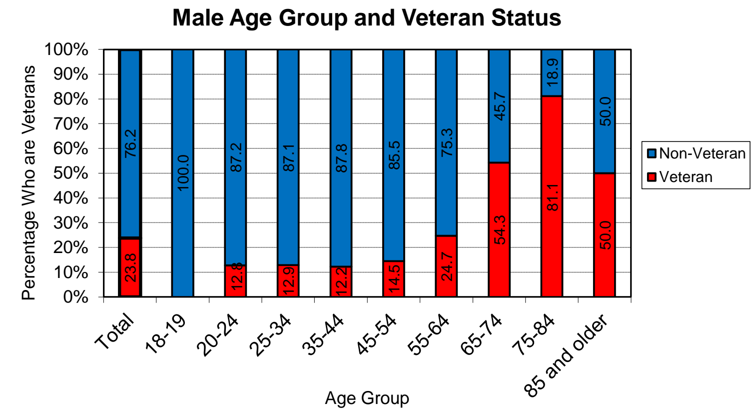
Suicide in the Fairfax-Falls Church Community, 2003-2011



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Non-Fatal Suicide Attempts in the Fairfax-Falls Church Community, 2003-2008

Greatest risk and largest percentage: ages 15-19

	#	%	Rate
Age Group			
5-9	2	0.1	0.5
10-14	142	4.3	32.8
15-19	681	20.5	166.1
20-24	479	14.4	134.1
25-34	661	19.9	91.2
35-44	589	17.8	57.4
45-54	494	14.9	46.8
55-64	172	5.2	21.4
65-74	55	1.7	15.9
75-84	23	0.7	13.2
85 and older	16	0.5	27.6
Unknown	3	<0.1	-
TOTAL	**3,317**	**100.0**	**53.1**

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Suicide in the Fairfax-Falls Church Community, 2003-2011

90% of all suicides (Firearm, Hanging/Suffocation, Poison)

Method of Fatal Injury	#	%
Firearm	300	39.2
Hanging/Suffocation	227	29.7
Poison	168	22.0
Sharp Instrument	31	4.1
Fall	31	4.1
Drowning	11	1.4
Motor Vehicle	6	0.8
Fire/Burn	4	0.5
Other Transport Vehicle	4	0.5
Other	4	0.5

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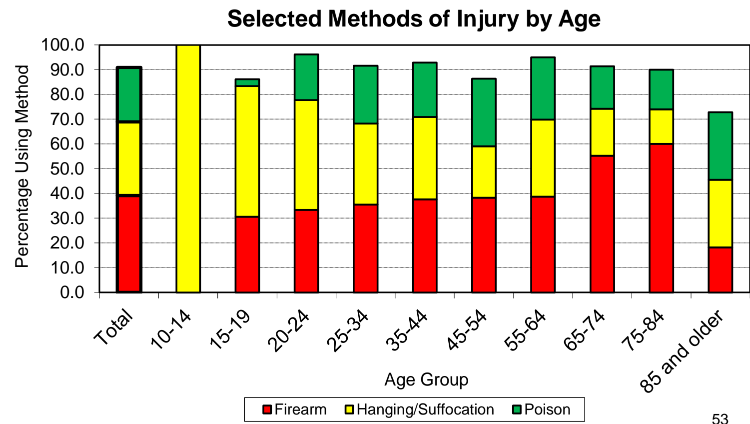
Suicide in the Fairfax-Falls Church Community, 2003-2011



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Suicide in the Fairfax-Falls Church Community, 2003-2011

General Category of Poison	#	%
Prescription Medication	122	72.6
Over-the-Counter Medication	46	27.4
Alcohol	38	22.6
Carbon Monoxide	18	10.7
Street Drugs	4	2.4

Percentages are based on the number of poisoning suicides (*n* = 168).

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Suicide in the Fairfax-Falls Church Community, 2003-2011

*Commonly prescribed for pain management

** Commonly prescribed for mental health treatment

Most Common Poisons (10 or more deaths)	#	%
Oxycodone*	28	16.7
Diphenhydramine	26	15.5
Methadone*	24	14.3
Alprazolam**	19	11.3
Acetaminophen	18	10.7
Hydrocodone*	17	10.1
Zolpidem	17	10.1
Fluoxetine**	16	9.5
Morphine*	16	9.5
Bupropion**	13	7.7
Citalopram**	13	7.7
Promethazine	12	7.1
Amitriptyline**	11	6.5
Diazepam	11	6.5

Percentages based on the number of poisoning suicides (*n* = 168).

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Non-Fatal Suicide Attempts in the Fairfax-Falls Church Community, 2003-2008

Method of Fatal Injury	#	%
Poison	2,532	76.3
Sharp Instrument	590	17.8
Fall	33	1.0
Hanging/Suffocation	29	0.9
Fire or Burn	16	0.5
Firearm	15	0.5
Motor Vehicle	4	0.1
Hot Object/Substance	3	0.1
Other	76	2.3
Unspecified	19	0.6

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%
Relationship Characteristics		
Intimate Partner Problem	205	27.3
Non-intimate Relationship Problem	82	10.9
Life Stressor Characteristics		
Crisis within Two Weeks of Suicide*	244	32.5
Physical Health Problem	173	23.1
Job Problem	130	17.3
Financial Problem	122	16.3
Recent Criminal Legal Problem	73	9.7
Death/Suicide of Family/Friend	41	5.5
Perpetrator of Interpersonal Violence	24	3.2

Percentages are based on the number of suicides with at least one known circumstance (*n* = 750).

* Of these, 69.3% had a crisis in past 24 hours (2007-2011 data)

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%
Substance Use Characteristics		
Problem with Alcohol/Other Substances	193	25.7
Problem with Alcohol	*99*	*13.2*
Problem with Other Substances	*56*	*7.5*
Problem with Alcohol and Other Substances	*38*	*5.1*

Percentages are based on the number of suicides with at least one known circumstance (*n* = 750).

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%
Mental Health Problems		
Current Mental Health Problem	496	66.1
Diagnosis: Depression	381	50.8
Diagnosis: Anxiety Disorder	85	11.3
Diagnosis: Bipolar	83	11.1
Diagnosis: ADD/ADHD	19	2.5
Diagnosis: Schizophrenia	17	2.3
Diagnosis: PTSD	16	2.1
Mental Health Treatment	411	54.8
Current Mental Health Treatment	*348*	*46.4*
Noncurrent Mental Health Treatment	*63*	*8.4*

Percentages are based on the number of suicides with at least one known circumstance (*n* = 750). Diagnoses are not exclusive, but represent the most common diagnoses.

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Suicide in the Fairfax-Falls Church Community, 2003-2011

	#	%
Use of Prescribed Mental Health Medications		
Used in Past 31 Days and/or Prior	226	71.7
Used in Past 31 Days	*186*	*59.0*
Used, But Not in Past 31 Days	*40*	*12.7*
Unknown/Never Used	89	28.3

Percentages are based on the number of persons with a mental health problem (*n* = 315). Data are from 2007-2011.

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Warning Signs of Suicide	#	%
Disclosed Intent/History of Attempts	419	55.9
Disclosed Intent to Commit Suicide	*321*	*42.8*
History of Suicide Attempts	*193*	*25.7*

Percentages are based on the number of suicides with at least one known circumstance (*n* = 750).

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Person to Whom Intent was Disclosed	#	%
Intimate Partner (Current/Former)	65	46.8
Family Members	50	36.0
Friends/Acquaintances	27	19.4
Mental Health/Medical Professional	26	18.7

Percentages are based on the number of suicides where intent was disclosed and where this information is known (*n* = 139). Data are from 2007-2011.

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Some persons had family, friends, or others who reacted to the disclosed intent and tried to prevent the suicide

Type of Action Taken to Prevent Suicide	#	%
Sought Mental Health Treatment	34	44.2
Tried to Persuade Person	15	9.5
Checked on Person	14	18.2
Limited Access to Firearms and/or Ammunition	14	18.2
Called 911/Law Enforcement	12	5.6
Monitored Person	4	5.2

Percentages are based on the number of suicides where someone took action to prevent the suicide (*n* = 77). Data are from 2007-2011.

63

Suicide in the Fairfax-Falls Church Community, 2003-2011

How Firearm Access was Restricted	#	%
Removed; all firearms	4	28.6
Removed; person purchased another firearm	2	14.3
Removed; all but one firearm	1	7.1
Removed; person had hidden firearm	1	7.1
Removed; later returned	1	7.1
Restricted; hidden	1	7.1
Restricted; locked	1	7.1
Restricted; tried to monitor access	1	7.1

Percentages are based on the number of suicides where it was known how firearm access was restricted (*n* = 14). Data are from 2007-2011.

64

Suicide in the Fairfax-Falls Church Community, 2003-2011

Number of Prior Suicide Attempts	#	%
One	64	50.4
Two	27	21.3
Three	9	7.1
Four	3	2.4
Five	3	2.4
Multiple, unspecified	21	16.5

Percentages are based on the number of persons with a known number of prior attempts (n = 127). Data are from 2007-2011.

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Suicide in the Fairfax-Falls Church Community, 2003-2011

Other Warning Signs	#	%
Took Prescribed Pain Medication, Past Two Months	90	20.2
Sleep Problems	85	19.1
Sleeping Too Little	*81*	*18.2*
Sleeping Too Much	*4*	*0.9*
Tired of Living	35	7.9
Did Not Want to be a Burden	14	3.1
Unusual Behavior, Past Two Weeks	26	5.8
Felt Alone	26	5.8
Family History of Suicide	16	3.6
Family/Friends Expected Suicide	13	2.9

Percentages are based on the number of suicides with at least one known circumstance (n = 445). Data are from 2007-2011.

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APPENDIX E: FCPS HIGH SCHOOL SUICIDE PREVENTION ACTIVITIES

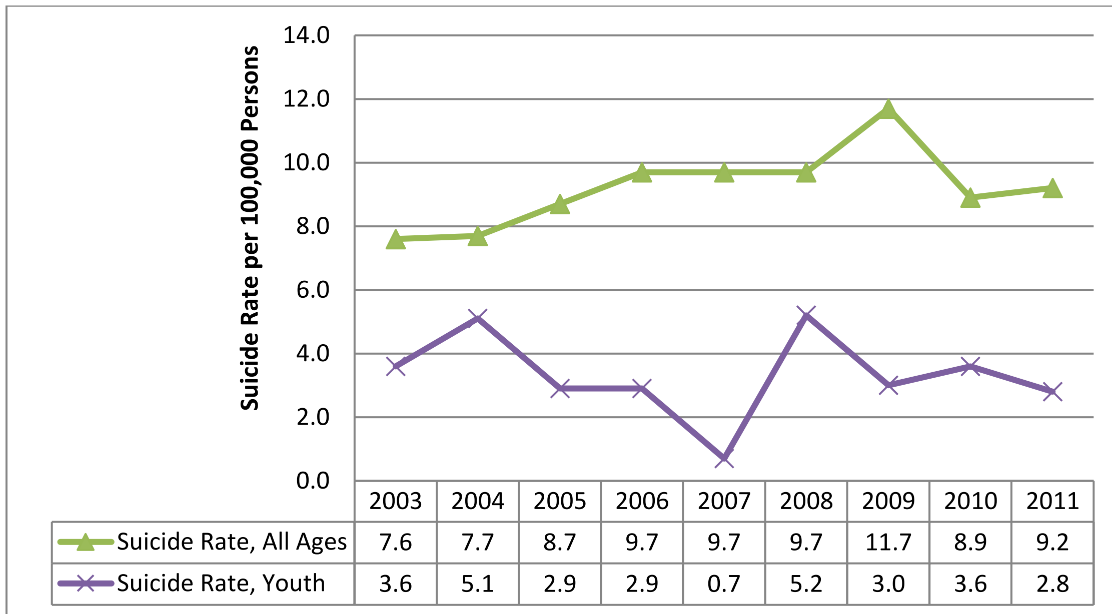
High School	Indiv. Screen → SW Screen	Indiv. Screen → Ed Focus	Educational materials used	SW Screen	Indiv. Screen with incr. staff training
Chantilly	X		SOS		
Fairfax	X		SOS		
Herndon	X		SOS		
Marshall	X		SOS, WW, Speaker		
McLean	X		SOS, WW, Speaker		
Robinson	X		SOS		
Stuart	X		SOS		
Thomas Jefferson	X		Speaker		
Westfield	X		SOS, Speaker		
Annandale		X	SOS		
Edison		X	More Than Sad		
Falls Church		X	SOS, WW, Speaker		
Lake Braddock		X	WW, Speaker		
Langley		X	WW, Speaker		
Mt. Vernon		X	More Than Sad		
West Potomac		X	WW, More Than Sad		
Woodson		X	SOS, Speaker		
Centreville			SOS	X	
Madison			WW, Speaker	X	
South County			SOS	X	
South Lakes			SOS, WW	X	
West Springfield			SOS	X	
Hayfield					X
Oakton					X
Lee					X and jointly presented with FLE lessons

Indiv. Screen → SW Screen: These schools screened students who were referred in 2011-12, but began more universal screenings in 2012-13.
Indiv. Screen → Ed Focus: These schools screened students who were referred in 2011-12, but used a broader educational focus in 2012-13.
Educational Materials Used: SOS is the Youth ACT – Signs of Suicide program. WW is a Wellness Week with a depression/suicide component. More Than Sad is American Foundation for Suicide Prevention program for teens.
SW Screen: These schools used universal screenings in 2011-12 and in 2012-13.
Indiv. Screen with incr. staff training: These schools screened referred students, and coupled that approach with an increased focus on staff training in 2012-13.

Please Note:

Due to an error in the calculations made by the Virginia Department of Health, the all-ages suicide rates for Fairfax County were incorrectly reported. The actual rates are higher, although they remain below state and national rates. Incorrect rates are reported on pages 2, 4, 5, 6, and 7 of this report, and in Appendix C, on the chart on page 35.

Figure 2, on page 6, should appear as follows:



	2003	2004	2005	2006	2007	2008	2009	2010	2011
Suicide Rate, All Ages	7.6	7.7	8.7	9.7	9.7	9.7	11.7	8.9	9.2
Suicide Rate, Youth	3.6	5.1	2.9	2.9	0.7	5.2	3.0	3.6	2.8

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

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To request this information in an alternate format, call Jesse Ellis, 703-324-5626, TTY 711.