NATIONAL CFRP

Center for Fatality Review & Prevention

Suicide Best Practices

National Center Guidance Report

November 2020

ACKNOWLEDGMENTS:

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Fatality review teams obtain information to provide context on the death of an infant, child, or adolescent. Social factors such as geography, access to education, experience with discrimination, trauma (including historical trauma), and access to physical and behavioral healthcare can contribute to premature mortality. Residential, educational, and occupational segregation impacts access to high-quality education, employment opportunities, healthy foods and physical and behavioral health care. Combined, these structural inequities have long lasting health impacts including adverse birth outcomes, infant mortality, as well as high rates of homicide, gun violence, and motor vehicle deaths.

Context and Cause for Concern

Suicide is the second leading cause of death for young people between 10 to 24 years old.[1]

Approximately one out of every 15 high school students reports attempting suicide each year.[2] Some youth, including those who are involved in the child welfare and juvenile justice systems; lesbian, gay, bisexual and transgender; American Indian/Alaska Native; and military service members are at a greater risk for suicidal thoughts and behavior.[3] In the 2017 Youth Risk Behavior Surveillance System findings, 32%, or 1 in 3 students, reported feeling persistently sad or helpless, which is a common sign of suicidality.[4]

The multidisciplinary nature of fatality review teams provides a unique opportunity to gain a deeper understanding of the risk factors and circumstances surrounding a suicide. This guidance provides comprehensive information about conducting high quality, multidisciplinary suicide fatality reviews, including key questions to ask during the death scene investigation and review meeting.

Prevention opportunities and success stories from the field are included as examples of action steps that communities can take to combat youth suicide. Special considerations for health equity are included to help fatality review teams conduct an effective review, document appropriate findings and ultimately impact prevention.

1   Centers for Disease Control and Prevention, Youth Behavioral Risk Survey Data Summary & Trends Report: 2007-2017 [Online]. Available from URL: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf [2020 September 15].

2   Youth.GOV [Online]. Available from URL: https://youth.gov/youth-topics/youth-sucide-prevention [2020 September 15].

3   Suicide Prevention Resource Center [Online]. Risk and Protective Factors. Available from URL: https://www.sprc.org/about-suicide/risk-protective-factors [2020 September 15].

4   CDC YBRS Data Summary & Trends Report: 2007-2017.

Fatality Review Data

The National Fatality Review-Case Reporting System (NFR-CRS) collects fatality case review data from child death review (CDR) teams. Forty-six states currently contribute data to the NFR-CRS. These data cannot be used to create population-level statistics, as different states have different case selection criteria for including cases in fatality review. Nonetheless, CDR data from interdisciplinary case reviews provides insights that would not otherwise be available through vital statistics or other reporting methods.[5]

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5   Covington TM. The U.S. National Child Death Review Case Reporting System. Injury Prevention 2011;17(S1): i34–i37.

A total of 8,196 deaths to children ages 10-18 who had a manner of death listed as suicide in NFR-CRS were analyzed. A total of 40 states[6] contributed to these data.

THIS ANALYSIS DEMONSTRATED:

☐ 67% of decedents were non-Hispanic White; followed by 16% Hispanic; 10% non-Hispanic Black; and 7% other.

☐ 46% of youth died by suicide from intentional asphyxia; 39% used a firearm; and 5% completed suicide by intentional poisoning.

☐ Intentional asphyxia and firearms account for 80% of all suicides. Youth ages 10-14 were likely to die from an intentional asphyxia whereas youth ages 15-18 were more likely to use a firearm.

☐ 46% of decedents ages 13-18 identified were identified as male and 19% as female. The numbers of decedents who reported their gender as transgender is too small to report. The missing and unknown rate for this variable is 35%.

☐ 34% of decedents ages 13-18 were identified as heterosexual, 2% as questioning, and less than 1% as bisexual, lesbian and gay. The missing and unknown rate for this question is 63%.

☐ Consistent with data from other sources,[7,8] the NFR-CRS data show that males are more likely to die by firearm suicide, whereas females are more likely to die from an intentional asphyxia and poisoning suicide.

☐ Compared to youth ages 10-14, youth ages 15-18 were more likely to leave a note (42% vs 35%), have a history of talking about suicide (57% vs 48%) and having previous attempts (35% vs 23%). These data exclude missing and unknown.

Understanding the unique equity considerations for each case reviewed by a CDR team
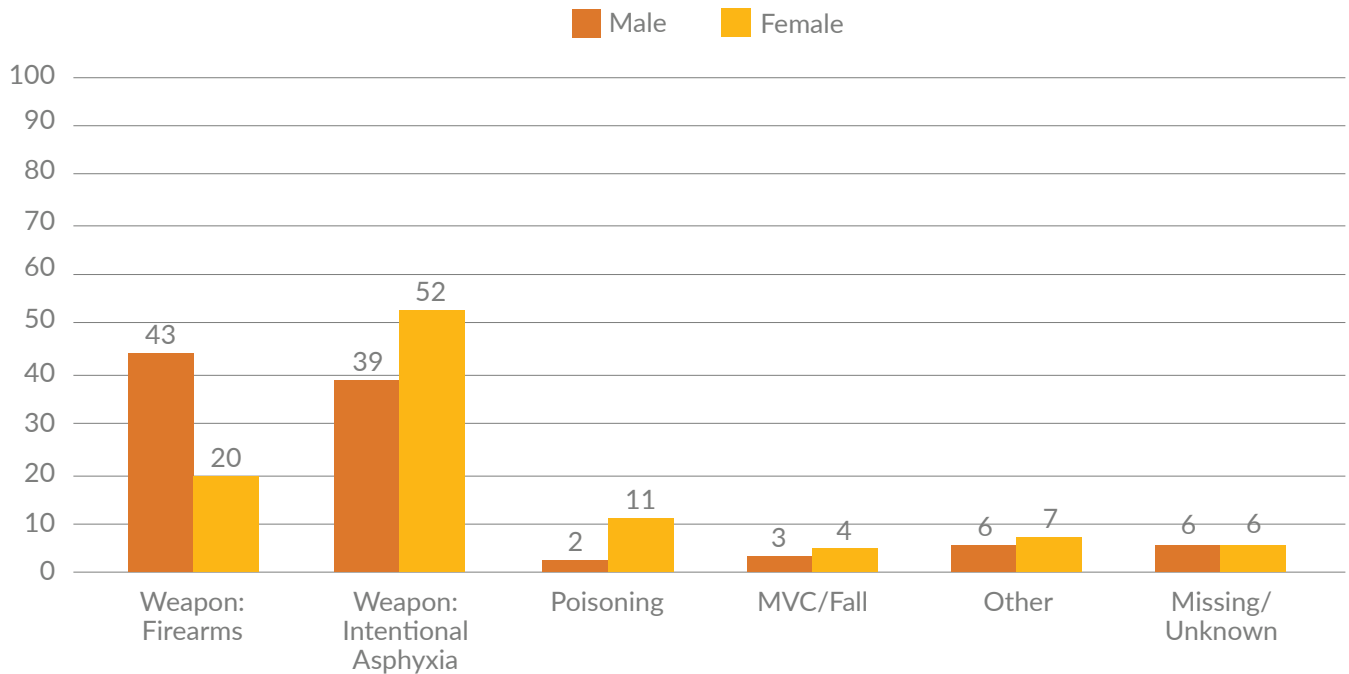
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6 States control utilization of their data and five states do not release NFR-CRS data for external use.

7 Centers for Disease Control and Prevention, Youth Behavioral Risk Survey Data Summary & Trends Report: 2007-2017 [Online]. Available from URL: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf [2020 September 15].

8 Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-Based Injury Statistics Query and Reporting System [Online]. Available from URL: https://www.cdc.gov/injury/wisqars/index.html [2020 September 15].

Differences Between Cause of Death and Sex

Percent of children ages 10-18, who die by suicide, based on sex and cause of death

■ Male ■ Female

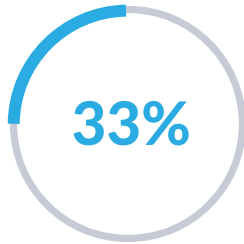|	Weapon: Firearms	Weapon: Intentional Asphyxia	Poisoning	MVC/Fall	Other	Missing/Unknown
Male	43	39	2	3	6	6
Female	20	52	11	4	7	6

Data Source: NFR-CRS January 2020 Research File

Characteristics of Children

Percent for children between the ages of 10-18 who died by suicide

33%

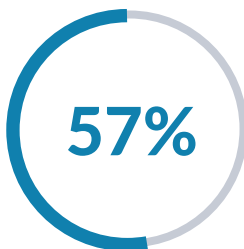## Disability/Illness

33 percent of children who died by suicide had a noted disability or chronic illness. Missing/unknown 34 percent excluded above.
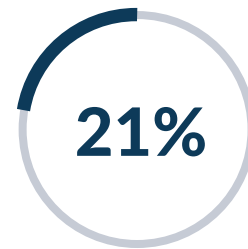
59%

Mental Health (MH) Services

59 percent of children who died by suicide had received mental health services. Missing/unknown 45 percent excluded above.
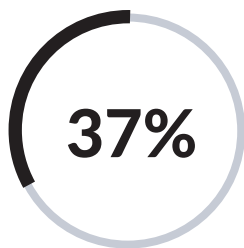
57%

Problems in School

57 percent of children who died by suicide had problems in school noted. Missing/unknown 51 percent excluded above.

21%

Criminal History

21 percent of children who died by suicide had a criminal history. Missing/unknown 41 percent excluded above.

37%

Substance Abuse

37 percent of children who died by suicide had a documented history of substance abuse. Missing/unknown 46 percent excluded above.

According to NFR-CRS data, youth ages 10-18 who died by suicide had a history of disability/illness, problems in school, and had accessed services more frequently than youth of the same age who died of other causes. The data presented on this page excludes missing and unknown.

Data Source: NFR-CRS January 2020 Research File

Characteristics of Children

Percent for children between the ages of 10-18 who died by suicide

40%
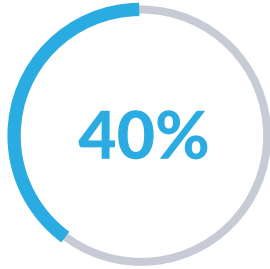
Receiving MH Services

40 percent of children who died by suicide were receiving mental health services at their time of death. Missing/unknown 49 percent excluded above.

11%

Barriers to MH Services

11 percent of children who died by suicide had barriers to access mental health care. Missing/unknown 61 percent excluded above.
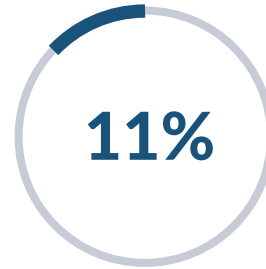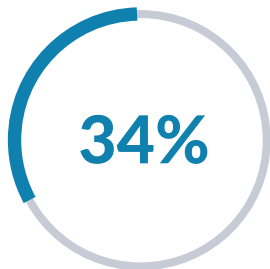
34%

Taking MH Medication

34 percent of children who died by suicide were taking medication at their time of death. Missing/unknown 49 percent excluded above.

According to NFR-CRS data youth ages 10-18 who died by suicide had a history of receiving mental health and substance abuse services, taking medication for mental health needs, and experienced barriers to accessing treatment more frequently than youth of the same age who died of other causes. Data presented on this page excludes missing and unknown.

Data Source: NFR-CRS January 2020 Research File

» **When the child's history of substance use was noted,** 65% reported a history of using marijuana/ THC, followed by 40% reporting using alcohol. These are not mutually exclusive.

Health Equity Considerations

is an important step in improving the quality of the review, data collection and most importantly, prevention recommendations. **Health equity means that everyone has a fair and just opportunity to be as healthy as possible.** This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[9] Certain youth, including those who identify as a part of the LGBTQ community and American/Indian Alaska Native youth, are at greater risk of suicide due to homophobia, transphobia, racism, and historical trauma. Additional risk factors for suicide include a history of mental health treatment and/or substance use treatment, a family history of suicide, bullying or easy access to lethal methods.[10]

Without understanding the equity implications in a death, CDR teams have an incomplete picture of the community and context the child lived in.

To build capacity to address health equity, teams should proactively provide team member training and facilitate team discussions on these topics. Addressing health equity requires a lifelong commitment to learning and changing thoughts, beliefs and actions. As such, teams should have frequent conversations about these topics.

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9   Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

10   American Academy of Pediatricians, Which Kids Are Highest Risk for Suicide [online]. Available at URL: https://www.healthychildren.org/English/health-issues/conditions/emotional-problems/Pages/Which-Kids-are-at-Highest-Risk-foSuicide.aspx [2020 September 15].

TEAMS MAY CONSIDER THE FOLLOWING:

Fully engage community members and elevate marginalized voices: To fully appreciate the unique context and challenges of a community, include a community member to represent the people most impacted by the types of deaths being reviewed as a valued and equal participant in a case review meeting. Community representatives have unique insights into what works in a community, what doesn't, and how community members are impacted by unjust policy. These participants are invaluable in both the case review context and in the crafting of prevention recommendations.

Structure the case review to make room for the equity-focused insights: Consider that existing team members may have similar unique insights into cases, and given the opportunity, may choose to provide helpful personal insights. While it is important to never pressure a team member to speak from a place of personal experience, providing an invitation to do so as a standing agenda item may change perspectives on a case. One way to do this is to pose a question like, "Does anyone around the table have a personal insight into this case or context, beyond the provided records, that they think could add to our understanding?" When participants share, listen and thank them for their contribution.

Train staff and team members: While there are many excellent health equity trainings, the National Center has created a training module for CDR teams, Using Health Equity in Fatality Review Video Module (URL: https://bit.ly/3ayWoPv). This half-hour video module introduces concepts of equity, oppression, and power and illustrates how these can play out in communities and organizations.

Key Questions to Ask

Key Questions to Ask During the Investigation:

Although the cause and manner of a youth suicide may be clear from the beginning, a thorough death scene investigation increases a community's understanding of the associated risk factors.

Consider using a standardized investigation form for suicides to ensure all relevant information is collected. Sample forms are available on the National Center's website (URL: http://www.ncfrp.org).

> **It is important to have a multi-agency review of a youth suicide which includes records from law enforcement, coroner/medical examiner, education, child welfare and a detailed medical history.** «

Together, all these pieces can create a picture of the events leading up to, during, and after a suicide.

POTENTIAL DATA SOURCES FOR ACCESSING THESE DETAILS INCLUDE:

- ☐ Medical records, including primary care and emergency treatment
- ☐ Mental health records
- ☐ Substance use treatment records
- ☐ Family and peer interviews
- ☐ Child welfare records
- ☐ School records
- ☐ Law enforcement records
- ☐ Job/occupational records
- ☐ Social connections, including social media records, email records, texts, and other personal correspondence

ALL AGENCIES INVESTIGATING THE DEATH SHOULD GATHER INFORMATION ON THE CHILD'S:

☐ Identity, including sexual orientation and gender identity[11]

☐ Medical history, including mental health history and treatment, substance use history and treatment, history of impulsive behaviors, history of trauma, medication history and current prescriptions

☐ Family and social relationships; including relationship(s) with a significant other

☐ Living environment, including members of the household and those present at the time of the suicide

☐ School experience, academic history, peer and teacher relationships, and challenges

☐ Job or occupational history

☐ Warning signs or behavior changes within the 30 days prior to the death[12]

DEATH SCENE INVESTIGATORS SHOULD GATHER INFORMATION ON THE INCIDENT, INCLUDING:

☐ Any communication from the decedent about suicidal ideation or evidence of suicidal behaviors including a suicide note, social media posts, or text messages

☐ Evidence of substance use leading up to the suicide, including alcohol and marijuana

☐ Detailed notes about how the body was found

☐ Location(s) of other individuals in the area where the body was found

☐ Description of how the decedent died as well as any information about the decedent accessed them

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11 Haas, A., Lane, A., Blosnich, J., Butcher, B., & Mortali, M. (2019, February). Collecting Sexual Orientation and Gender Identity Information at Death. Retrieved October 25, 2020, from https://www.ncbi.nlm.nih.gov/pubmed/30571294.

12 Youth Warning Signs [Online]. Available at URL: https://www.youthsuicidewarningsigns.org/ [2020 September 15].

All agencies investigating the death should collect information on life stressors that may have impacted the suicide. The National Center has created resources for completing the life stressors section (URL: https://www.ncfrp.org/wp-content/uploads/Completing-the-Life-Stressors-Section.pdf).

CONSIDER THE FOLLOWING LIFE STRESSORS CATEGORIES:

Social/economic: The decedent's/ family's experience of racism, discrimination, poverty, neighborhood discord, job problems, money problems, food insecurity, housing instability, witnessing violence, pregnancy or pregnancy scare

Relationships: Family discord, argument with parents/caregivers, parents' divorce/ separation, parents' incarceration, argument with significant other, breakup with significant other, social discord, argument with friends, bullying as a victim, bullying as a perpetrator, cyberbullying as a victim, cyberbullying as a perpetrator, peer violence as a victim, peer violence as perpetrator, isolation, stress due to sexual orientation or stress due to gender identity

School: Failure, pressure to succeed, extracurricular activities, or new school

Technology: Negative impacts due to electronic gaming, texting, restriction of technology or social media

Transitions: Release from hospital, transition from one level of mental health care to another (e.g., outpatient to inpatient), juvenile justice facility, end of school year/ graduation, school break, to/from child welfare system, or immigrant detention

Trauma: Rape/sexual assault, previous abuse (emotional/physical) or family/domestic violence, current or previous conversion therapy (intended to change sexual orientation or transgender identity)

Other: Any other factor that may have increased suicide risk that is not captured in these categories

These life stressors should be documented in Section I7 in the NFR-CRS.

Key Questions to Ask During the Review Meeting:

Some questions to consider including in your review discussion, although not necessarily included in the NFR-CRS tool, can help inform prevention work.

HOW DID THE CHILD ACCESS THE MEANS USED FOR SUICIDE?

Were the means stored safely, e.g., a gun stored in a locked cabinet, separate from the ammunition? Were there resources available for appropriate storage of potentially lethal items? Was the family provided with instruction to secure their firearm safely?

WAS THE CHILD WELL-CONNECTED WITH OTHERS?

Describe the child's social connections, including at school, extracurricular activities, faith community, community at large and family. Describe any other significant relationships including a romantic partner.

WERE THERE CRISIS SERVICES AVAILABLE TO THE YOUTH?

These could be in any mode such as texting or phone calls and occur at the local, state or national level. Did the child access services? Which ones? Did the child experience barriers to accessing crisis services?

WHEN DID THE CHILD AND FAMILY LAST ACCESS MEDICAL CARE?

Was this care provided by a primary care provider or in an emergency setting? Was the child screened or assessed for suicide risk or depression?

WHAT WAS THE CHILD'S MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT?

Describe the child's history of mental health and/or substance abuse treatment to include levels of care, medications, historical treatment, current treatment, barriers to care and progress in care.

WHAT SERVICES WERE AVAILABLE TO THE COMMUNITY FOLLOWING THE SUICIDE?

Were there appropriate postvention[13] services available, did first responders/ other professionals have access to critical incident debriefing, did the family have access to resources to assist with cleaning up the death scene.

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13   A Share Vision: U.S. National Guidelines [Online] Available at URL: https://www.sprc.org/comprehensive-approach/postvention [2020 September].

Documenting in the NFR-CRS

In 2020, the NFR-CRS section on suicide was revised to reflect current research on risk factors associated with youth suicide. While it can be challenging for CDR teams to gather the information in the NFR-CRS, it is critical for understanding how to prevent future deaths. These data points can be found on the National Center's website (URL: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/CDR_CRS_v5-1.pdf).

Effective with the Version 5.1 Release (May 2020) of the NFR-CRS, fatality review teams can now complete the suicide risk factor section (Section I6) for deaths where manner of death on the death certificate was not indicated as suicide but review teams felt the death may have been intentional on the part of the youth. The goal of answering these questions when there is a chance the child intended to hurt himself/herself is not to second guess the cause and manner of death as ruled by the death certifiers, but to identify potential risk factors related to the child's life, suicide, and community.

The narrative section allows teams to share summaries of salient points that inform prevention efforts.

In addition to the variables described in the NFR-CRS, it is helpful to include more detail in the narrative. Specifically, providing answers to the Key Questions to Ask During the Investigation outlined in the previous section can maximize the impact of the narrative. See example narratives below for guidance on writing NFR-CRS narratives.

A 16-year-old female died by a single gunshot wound to the right temple.
Autopsy and death scene investigation found everything to be consistent with a suicide. Toxicology was negative at autopsy. The decedent didn't leave a note or communicate her intent to die with anyone. The gun used to belong to the decedent's mother and was stored unlocked, with bullets. The decedent has a history of ADHD but was not currently taking medication or in therapy. There is no history of abuse or child welfare involvement. The decedent did "well" in school and had no problems. It is unclear if there was any triggering event within 30 days of her death.

A 12-year-old male died by intentional asphyxia from hanging from a tree.
The decedent used a belt that was tied around his neck. Autopsy and death scene investigation found everything to be consistent with a suicide. Toxicology was positive for Xanax at autopsy. It is unclear where the medication came from. It was not the child's, nor did it belong to any member of their family or household. The decedent didn't leave a note but communicated on social media that he wanted to "be released from his pain." The decedent did not have a formal medical diagnosis, but he was described by his friends and teachers as depressed. The decedent was a below-average student and was described as someone who kept to himself. It is unclear if there was any triggering event within 30 days of his death.

Note:

Do not include any personally identifiable information in the narrative, such as names, dates, or specific locations. This can be accomplished by using words like "the decedent" or "child" instead of the child's name or "hospital" instead of the hospital name.

Self-Care

Consider ahead of time how each of the team members may personally have been impacted by the suicide and create space for a variety of reactions to the suicide, including vicarious trauma.

Take time to acknowledge what went well. Consider providing an opportunity for participants to highlight one strength they saw in the community or in an agency in the face of the suicide and the associated challenges. If possible, focus on the strengths of the agencies and individuals in the room, acknowledging their important contributions. View the National Center's Guidance on Findings (URL: https://bit.ly/3maEIhS).

Allow team members to opt out of reviews if they experienced a close connection, either personal or professional, to the youth who died. Additionally, team members who have personal experience with suicide may want to opt out of review. These connections can be direct or indirect such as a child at the same school, a neighbor, etc. Other stressors may impact a team member's ability to participate. Coordinators may provide an opt-out option when they send out the case information for the upcoming meeting.

THE NATIONAL CENTER OFFERS THESE RESOURCES ON PROMOTING SELF-CARE:

☐ Guidance for CDR and FIMR Teams on Addressing Vicarious Trauma (URL: http://bit.ly/2PbaJc0)

☐ Webinar from November 2016, Recognizing and Responding to Vicarious Trauma in Fatality Review (URL: https://bit.ly/2KD66YI) - under Specific Review Strategies

☐ Death Scene Investigation Learning Series Module on Self-Care (URL: https://courses.mihealth.org/PUBLIC) - releasing in January 2021

Opportunities for Prevention

Many communities seek to implement a suicide prevention program following a youth suicide. It is important to evaluate current suicide prevention activities to reduce duplication, maximize resources, and align efforts with your state's existing strategies.

SUICIDE PREVENTION RESOURCES:

☐ Garratt Lee Smith Youth Suicide Prevention Program
(URL: https://www.sprc.org/grantees)

☐ Maternal Child Health Title V Programs (URL: https://mchb.hrsa.gov/maternal-child-health-initiatives/mental-behavioral-health)

☐ National Strategy for Suicide Prevention (URL: https://www.hhs.gov/surgeongeneral/reports-and-publications/suicide-prevention/index.html)

☐ National Suicide Prevention Lifeline Affiliates
(URL: https://suicidepreventionlifeline.org/our-network/)

☐ Recommendations for State Suicide Prevention Infrastructure
(URL: https://www.sprc.org/state-infrastructure)

☐ Zero Suicide for Health and Behavioral Health (URL: http://zerosuicide.edc.org/)

☐ Model School District Policy for Suicide Prevention (URL: https://www.thetrevorproject.org/wp-content/uploads/2019/09/Model_School_Policy_Booklet.pdf)

☐ The Trevor Project Suicide Prevention and Crisis Intervention Services
(URL: https://www.thetrevorproject.org/get-help-now/)

» Consider choosing strategies from the Suicide Prevention Resource Center's (SPRC) Comprehensive Approach to Suicide Prevention that complement existing strategies (URL: http://www.sprc.org/effective-prevention/comprehensive-approach).

Planning Approach to Prevention

The Suicide Prevention Resource Center recommends a six-step approach to planning suicide prevention activities (URL: https://www.sprc.org/effective-prevention/strategic-planning).

1. **Describe the problem and its context:** Use data and other sources to understand how suicide affects the community and to describe the problem and its context. *Fatality review data should be used to help understand the problem.*

2. **Choose long-term goals:** Identify a small set of realistic and achievable long-term goals (e.g., reduce the suicide rate).

3. **Identify key risk and protective factors:** Prioritize the key risk and protective factors on which to focus your prevention efforts.

4. **Select or develop interventions:** Begin planning the approach by deciding which activity or combination of activities best address key risk and protective factors.

5. **Plan the evaluation:** Develop an evaluation plan to track progress toward long-term goals, show the value of prevention efforts, and provide the information needed to refine, expand, or determine other next steps.

6. **Implement and evaluate activities,** and use the evaluation data to monitor implementation, solve problems, and enhance prevention.

This approach can be started at any time. Although the steps are listed in the order they should be taken, a community may move between steps in a fluid manner. SPRC offers a free web-based training (URL: https://training.sprc.org/enrol/index.php?id=31) on how to implement this course.

Success Stories From the Field

TENNESSEE

In 2014, Tennessee was below the national average for youth suicide deaths. Between 2014 and 2017, Tennessee saw an increase in youth suicide with 24 deaths in 2014 to 51 deaths in 2017 (an increase of 1.6 per 100,000 population to 3.4 per 100,000 population). By 2017, Tennessee was above the national average for rate of youth suicide.

To address this increase in deaths by suicide, the state Child Fatality Review (CFR) team prioritized youth suicide prevention as a state recommendation. The reviews found there were often warning signs before the death. This led the Tennessee Department of Health (TDH) to recommend tracking suicide attempts through a more real-time data source. Identifying individuals at-risk was key to preventing these child deaths.

The TDH state CFR team made the following recommendation: All hospitals should report into ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics) to better capture suicidal ideation and suicide attempts among youth. The TDH will monitor hospital emergency department (ED) visits through ESSENCE in order to target coordinated, timely outreach and to direct evidence-based prevention programs such as Question, Persuade, Refer (QPR).

To address this recommendation from the state CFR team, the TDH staff developed an algorithm to identify ED visits that are coded as suicide-related behavior, including suicide attempts, intentional self-harm, and suicidal thoughts and feelings. The algorithm assists in identifying areas of the state which are seeing an increase in youth ED visits for suicide-related behavior by creating an alert. The TDH staff created a rapid response plan to notify suicide prevention networks and coordinated school health regional staff that an alert was identified in their area. These staff then attempt to increase the training and education being provided in these areas.

During COVID, staff developed alternative methods for reaching parents and students while schools were not in session. Several schools disseminated suicide prevention information to parents while they were distributing breakfast and lunch to students. Several school districts also used social media platforms to spread information about suicide.

The TDH will continue to monitor and respond to these suicide-related behavior trends to reduce the number of deaths by suicide.

WINNEBAGO COUNTY, WI

"Prevention is only as good as the data which is only as good as the questions asked."

The Winnebago County, Wisconsin CDR team observed an increase in the number of youth who died by suicide. In order to develop prevention recommendations, a CDR subcommittee including public health, coroners, law enforcement and local suicide prevention supporters convened. Members realized that data collected on suicides varied in quantity and quality. Additionally, it was discovered there are not national standards for suicide death scene investigation (DSI). The subcommittee released a recommendation that a DSI form for suicides be created and implemented. This recommendation gathered the support of local, state, and national suicide prevention professionals.

The DSI form includes questions related to recent crisis, physical and mental health, life stressors, substance use, adverse childhood experiences, barriers to treatment, means of suicide and other relevant questions. With the support of the Winnebago County Coroner's Office (Coroner's Office), a pilot study was conducted. An in-person visit was conducted with the Coroner's Office who supplied community resources as well as collected information. Family and friends were receptive to the visit as they were able to speak about their loved one and felt good to know that they could contribute to prevention of other deaths.

This process has continued to be successful. A suicide prevention coordinator has been hired by the Winnebago County Health Department to assist with this project. This coordinator is trained in psychological autopsies and assists in interviews. Other options are being considered for additional staff to conduct interviews. Additionally, a plan is also being developed to start an adult suicide review team.

Winnebago County has received inquiries from other Wisconsin counties who are seeking to improve suicide prevention programs through comprehensive data collection when a child dies by suicide. View the suicide DSI form (URL: https://www.ncfrp.org/resource-tag/dsi-tools/).

INDIANA

Suicide has been the second-leading cause of death for Indiana residents between the ages of 15-24 since 2009 and for children ages 10-17 since 2013. To help improve capacity to address the burden of these deaths, the Indiana Department of Health, Division of Fatality Review and Prevention has begun work in several areas.

First, in an effort to establish accurate and baseline trend data, as well as ascertain the effectiveness of suicide death investigations and postvention work being undertaken in Indiana, the Statewide Child Fatality Review Committee conducted a retrospective case review of youth suicides which occurred in 2015 and 2016.

Key project partners and data sources included the Department of Child Services (DCS); local Child Fatality Review (CFR) data entered in the CDR-CRS; Community Mental Health Center treatment reports provided by the Department of Mental Health and Addiction; and records housed in the Indiana National Violent Death Reporting System. While some data is limited due to inconsistent death investigation protocols for pediatric suicide, the team was able to identify some striking preliminary findings. Analysis of this combined data led to the discovery of some seasonality associated with suicide completions in children, as well as consistent peer-to-peer disclosures of intent. From this and other data, key recommendations around prevention, intervention and postvention efforts were developed.

PREVENTION RECOMMENDATIONS INCLUDED:

☐ Improving the capacity for pediatric mental health care in Indiana by providing training on screening for suicidal risk, screening for ACEs, and implementing appropriate intervention practices in all pre-professional schooling programs

☐ Encouraging Indiana communities to adopt the Handle with Care program

☐ Increasing participation of Indiana schools in the Youth Risk Behavior Survey (YRBS)

The Division of Fatality Review and Prevention has also prioritized prevention of pediatric suicides through the development of the Children's Safety Network Learning Collaborative (CSLC) and expansion of local fatality review teams. The overarching aim of the CSLC in Indiana includes identifying both state level partners and local coalitions and providers to develop strategies and better understand the landscape and challenges in Indiana, associated with mental health care and suicide prevention. This group conducted a needs assessment in the gaps in information and data which was ultimately presented to the multi-branch Commission on Improving the Status of Children, to help inform policy and recommendations with the findings. Findings from the retrospective pediatric suicide review and assessment of local prevention needs have also led to the creation of a comprehensive community suicide prevention toolkit. Dissemination of this is expected in the fall of 2020.

To further efforts to address the burden of suicide, the IDOH FRP division utilized funding from the CDC Prevention for States grant to conduct an evaluation of the necessity of overdose fatality review (OFR) teams and the need for legislation to provide statutory authority and protection for local teams. The successes and barriers of three pilot sites were evaluated, as they reviewed opioid related deaths. This led to dedicated staff to coordinate the OFR teams and expand their activities into suicide reviews, as well as expand the network of local fatality review teams examining those types of deaths.

Local Suicide-Overdose Fatality Review (SOFR) teams recognize that these deaths of despair share risk and protective factors, and recommendations around improved mental health services and reduction of stigma would be beneficial to the prevention of suicide and deaths due to overdose. In 2020, the suicide and overdose fatality review program has grown to 16 counties, and the lessons learned from SOFR are critical to creating evidence-based prevention recommendations, particularly with regard to mental health care in Indiana.

Conclusion

As the second leading cause of death among youth 10-24,[14] and with 1 in 15 youth reporting suicide attempts in the last year,[15] suicide remains a significant threat to the lives of children and youth across the country. Communities often feel helpless in the face of these types of deaths. Multi-disciplinary, prevention-focused child death reviews provide a mechanism for communities to respond and proactively improve their community resources and responses to help reduce suicides in children and youth. By identifying and addressing health equity within the fatality review process, a complete picture of the child's life can be created to help drive prevention.

Fatality review teams are uniquely equipped to provide needed clarity and understanding about why youth die by suicide, inform suicide prevention programs, and partner to decrease suicide risk in their communities. Through in-depth review and data collection, and focusing on life stressors, suicide warning signs, and health equity, CDR teams can identify factors that increase risk and suicide vulnerability. Identifying these factors equips teams and their partners to implement meaningful, actionable prevention recommendations to help keep children and youth alive.

The National Center welcomes questions or inquiries about cause-specific fatality reviews and prevention. These can be forwarded to the National Center email address (Email: info@ncfrp.org).

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14 Centers for Disease Control and Prevention, Youth Behavioral Risk Survey Data Summary & Trends Report: 2007-2017 [Online]. Available from URL: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf [2020 September 15].

15 Youth.GOV [Online]. Available from URL: https://youth.gov/youth-topics/youth-suicide-prevention [2020 September 15].