



# REVIEWING SUICIDES: Best Practices, Success Stories, and Resources

Tuesday, December 1, 2020





# KEY FUNDING PARTNER

## FEDERAL ACKNOWLEDGEMENT

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# HOUSEKEEPING

Before we get started

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- This webinar is being recorded and will be available on the National Center's webpage (URL: [www.ncfrp.org](http://www.ncfrp.org)).
- Participants are muted. Use the question and answer box to ask questions.
- Due to the large number of participants, the speakers may be unable to answer all questions. Unanswered questions will be answered and posted with the recording.
- Contact the National Center (email: [info@ncfrp.org](mailto:info@ncfrp.org)) for any tech problems.







# EVALUATION

<https://www.surveymonkey.com/r/32BRMMX>

# Diane Pilkey, RN, MPH

Welcome and Introductions

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**Senior Nurse Consultant,**

Emergency Medical Services for Children and

Injury Prevention Branch

Maternal and Child Health Bureau

Health Resources and Service Administration





## HRSA'S VISION FOR THE NATIONAL CENTER

# IMPROVING SYSTEMS OF CARE AND OUTCOMES FOR MOTHERS, INFANTS, CHILDREN, AND FAMILIES

Assist state and community programs in:

- Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
- Improving the quality and effectiveness of CDR/FIMR processes
- Increasing the availability and use of data to inform prevention efforts and for national dissemination



# PRESENTATION GOALS



Share a new resource from the National Center to support suicide fatality reviews.



Encourage fatality review teams to improve investigations, multi-agency collaborations, inclusion of family voices, and data collection in these reviews.



Share innovations from the field focusing on reviews, data collection, and prevention.



# Teri Covington, MPH

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**Consultant and Founding Director,**  
National Center for Fatality Review and Prevention





# Kelly Cunningham, MPH

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**Fatality Specialist,**

Child Fatality Review and Prevention Program

Indiana State Department of Health



# Lauren Savitskas, MPH

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**Program Manager,**

Overdose Fatality Program

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# Theresa Paulus, RN

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**Co-Chair, Child Death Review Team,**  
Winnebago County, Wisconsin





# Rachel Heitmann, MPH

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**Section Chief,**

Injury Prevention, Infant Mortality Reduction,  
and Death Review

Tennessee Department of Health





# Context and Resources

Data from the National Fatality Review-Case Reporting System  
&

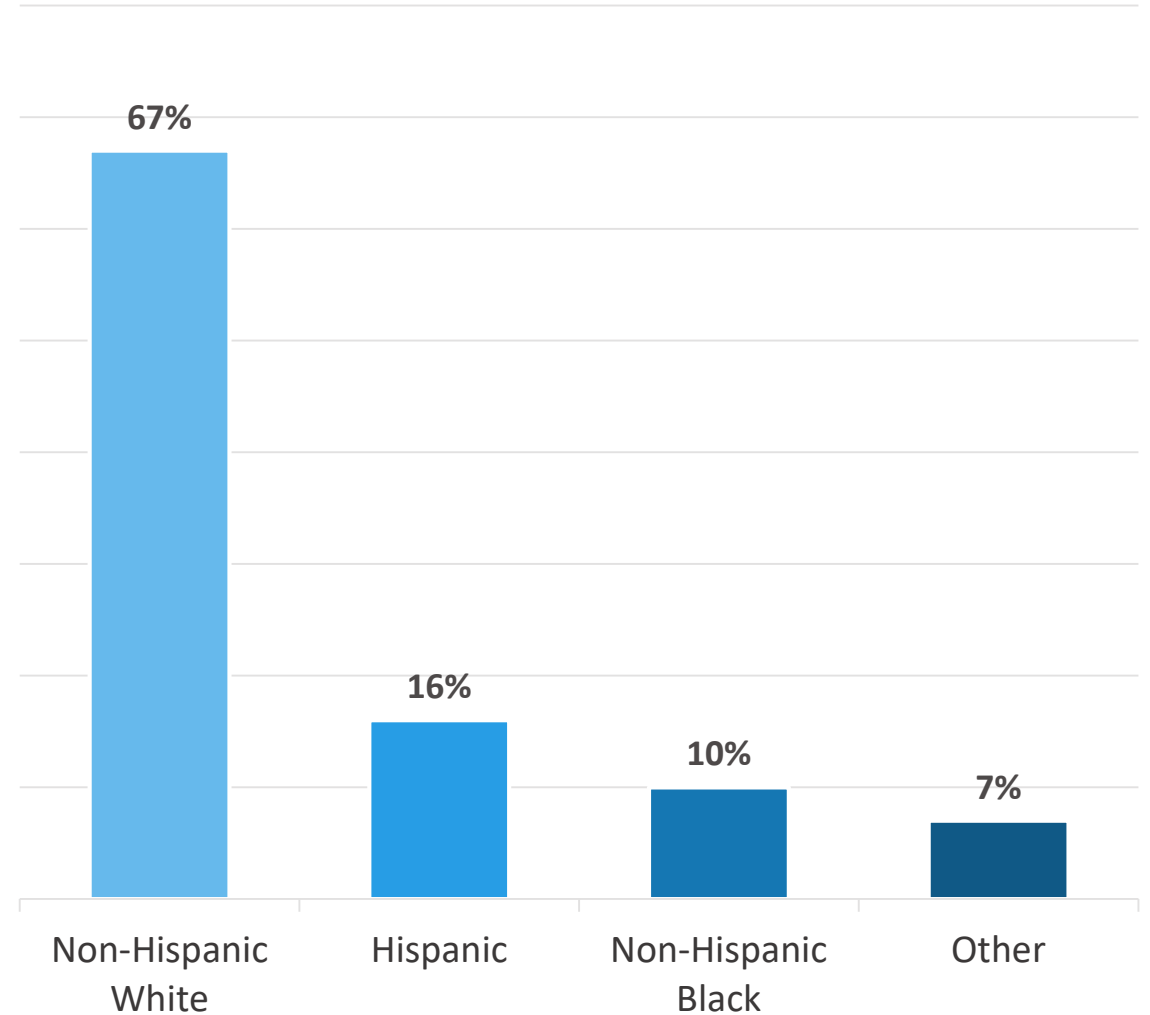
*Suicide Best Practices: National Center Guidance Report*

# Data Overview

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- Data from the National Fatality Review-Case Reporting System (NFR-CRS) between 2004 and 2017.
- Cases contributed by 40 states.
- Children aged 10-18 years old
- **Analysis of 8,196 cases**

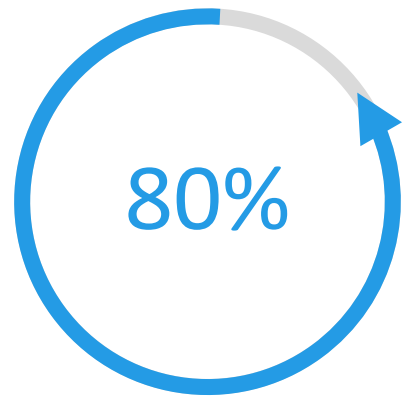
Suicides by race, NFR-CRS, 2004-2017





# Quick Facts: Suicide Deaths, NFR-CRS, 2004-2017

These data reflect the analysis of cases with Missing and Unknown responses removed.



## Means

Over 80% of the suicides were due to intentional asphyxia and firearms.



## Mental Health Services

Almost 6 in 10 children who died by suicide had previously received mental health services.

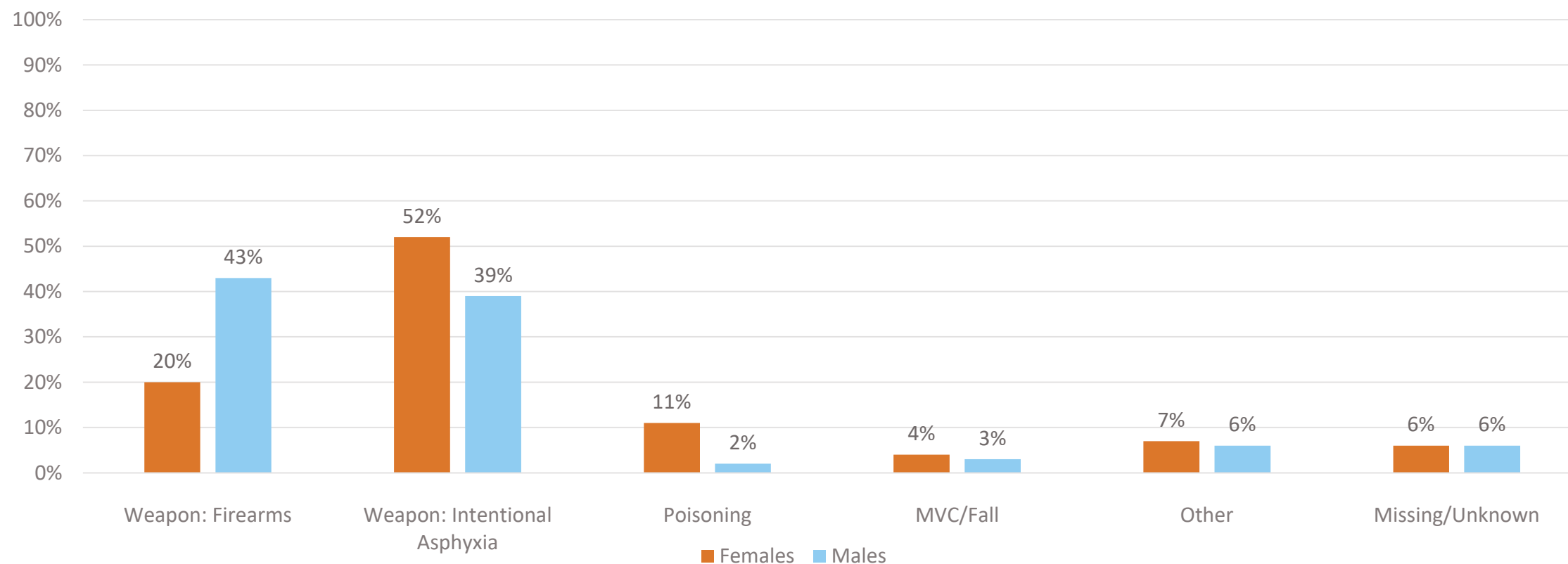


## Disability/Chronic Illness

One-third of the children who died by suicide had a noted disability or chronic illness

# Cause of death differs by sex.

Percent of children ages 10-18 who died by suicide, based on sex and cause of death, NFR-CRS, 2004-2017





## Key Questions to Ask

Key questions to consider both during the investigation and during the case review meeting, as well as potential data sources to identify the answers.



## Documenting in the NFR-CRS

Information on sections especially relevant to suicide fatalities, including the *Suicide* risk factors (section I6) and *Life Stressors* (section I&).



## Opportunities for Prevention

Compilation of relevant prevention resources, including from the Suicide Prevention Resource Center.



## Self-Care Considerations

Resources to support team representatives for whom these types of deaths are especially challenging to review.



## Healthy Equity Considerations

Suggestions to address disparities, including fully and equitably engaging the community, structuring the reviews to make room for equity considerations, and training staff and team members.



## Suicide Best Practices

*National Center Guidance Report*

November 2020





# Methods

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The Statewide Committee used the following data sources for this retrospective study:

- Death certificates
- Autopsy reports
- Coroner investigations
- LEA investigations
- Department of Child Services records
- CMHC treatment records
- Indiana National Violent Death Reporting System

# Selection Criteria

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**69**  
**total deaths**  
**were**  
**reviewed**

- To garner a large enough sample size for analysis, deaths occurring in 2015 and 2016 were identified.
- Deaths where the manner of death was suicide were included for review.
- Vital Records identified 67 cases for review and INVDRS identified two additional deaths of out-of-state residents where the death occurred in Indiana.

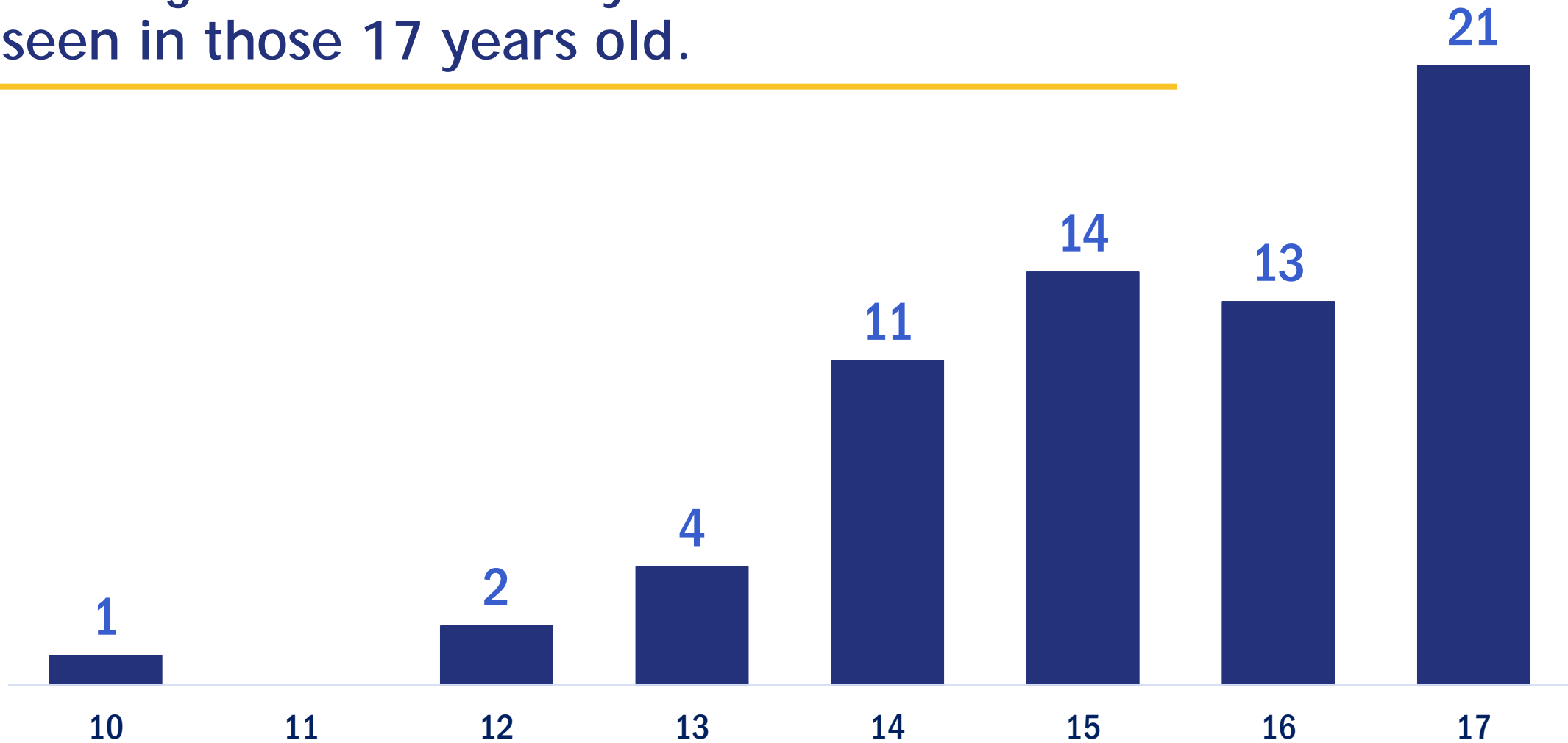
## The highest causes of death in youth suicide cases involved asphyxia and firearms.



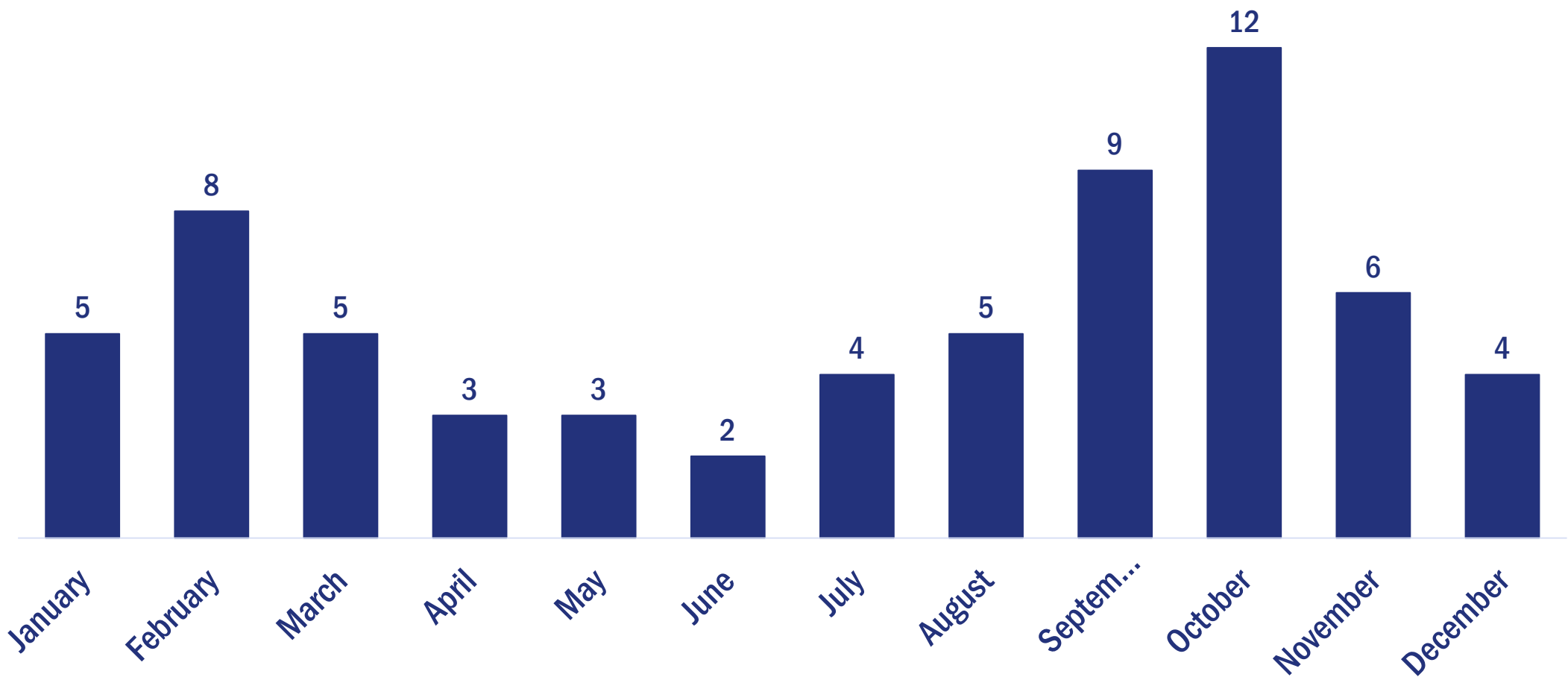


The highest number of youth suicide deaths were seen in those 17 years old.

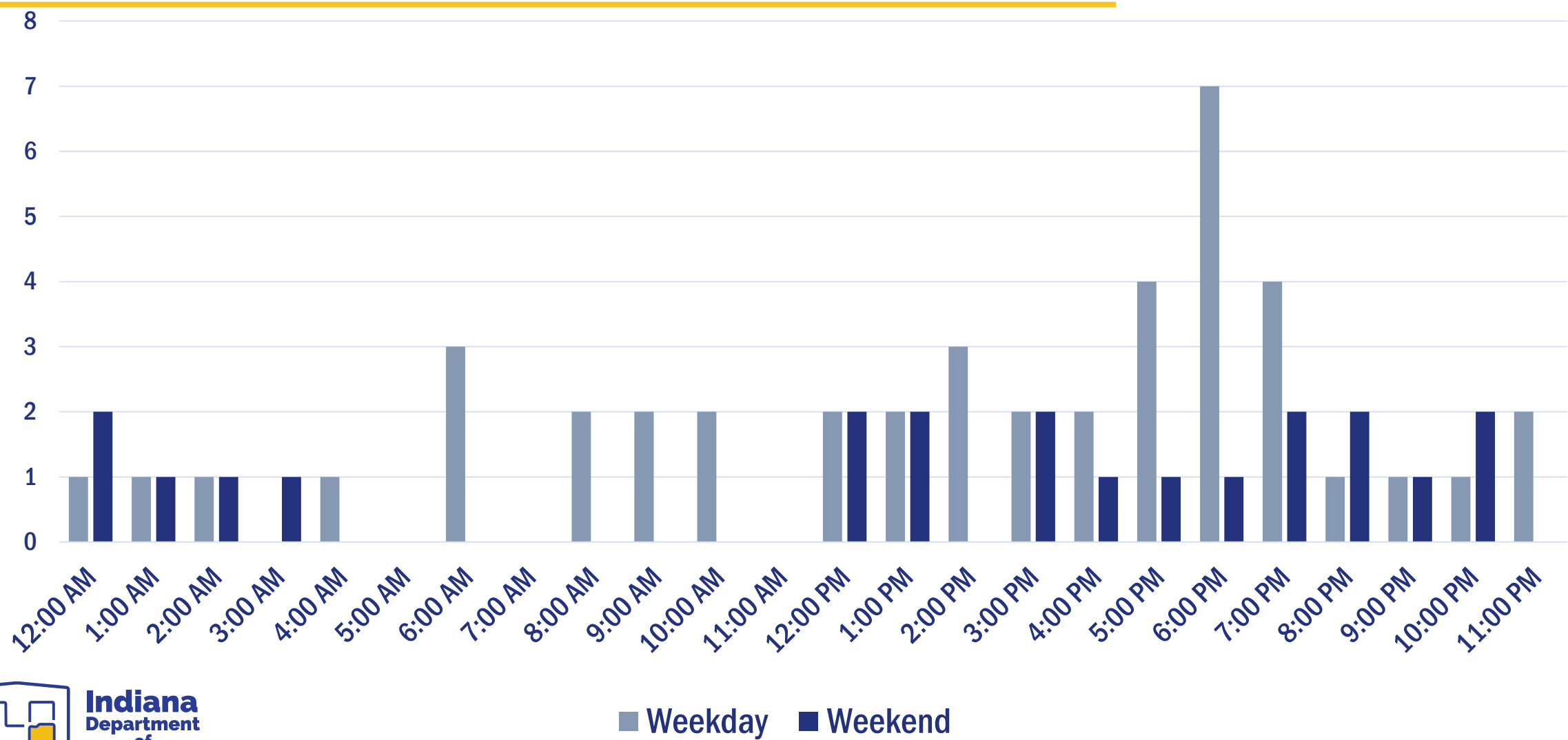
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The highest number of suicide completions were found to be in the months of October, September and February.



The highest number of suicide completions occurred between the hours of 5-7pm during the week.



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# Recommendations





# Prevention Recommendation:

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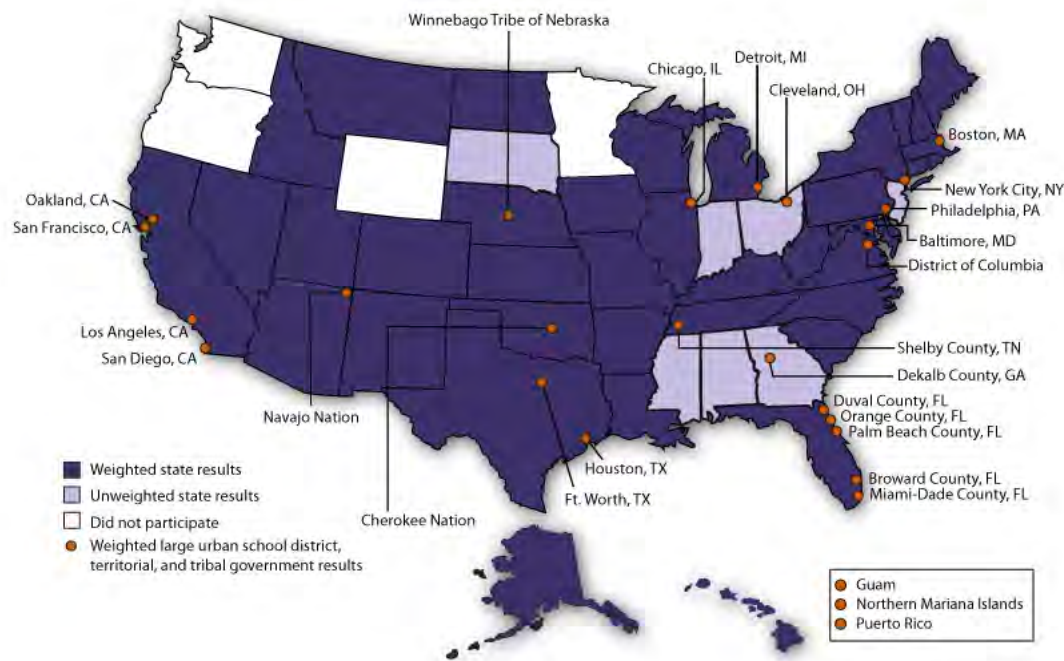
## Facilitate the adoption of the Handle with Care program across Indiana communities



If a law enforcement officer/first responder/DCS encounters a child during a call, that child's name and three words, "Handle with Care," are forwarded to the school/childcare agency before the school bell rings the next day. The school implements individual, class and whole school trauma-sensitive curricula so that traumatized children are "Handled With Care."

# Prevention Recommendation:

## Increase participation of Indiana schools in the Youth Risk Behavioral Survey



# Intervention Recommendation

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## Create a “Medical Home” concept for behavioral and mental health care coordination



Clinicians, therapists, social workers and other care providers should intentionally share a youth’s history of suicide attempts, suicidal ideations, and mental health diagnoses with the child’s other caregivers and their school, in order to ensure a consistent, informed continuum of care. Schools and family practice physicians can then be informed of potential triggers for each child at risk, and thus be involved in safety planning with care providers and families.

# Post-vention Recommendation

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All pediatric suicide deaths should be completely investigated, including a review of social, medical and educational histories, and a Suicide Investigation Checklist completed.



Key steps for a suicide death investigation should include:

- Obtaining background information (medical and social)
- Asking about any warning signs, including previous expressions of suicidal ideation
- Finding out about risk factors, including recent deaths in the family, social stressors or a family history of suicide
- Seeking suicide notes, including social media activity
- Determining if victim had previous suicide attempts



# Suicide Learning Collaborative



## Critical Partnerships

- Local Suicide Prevention Coalitions
- Indiana Dept of Health
- Division of Mental Health & Addiction
- Department of Education
- Department of Child Services
- Mental Health America
- Indiana Youth Services Bureau
- INVDRS
- Department of Homeland Services
- Commission on Improving the Status of Children
- Indiana HIDTA
- Prevent Child Abuse Indiana
- Indiana Hospital Association
- LCCs
- Local school and prevention professionals



# Questions?



**Indiana**  
Department  
of  
**Health**

# Suicide Prevention Death Investigation Tool

## A Community Collaboration

**Teresa Paulus**, RN, Co-chair Winnebago Co. Child Death Review Team

**Nicholas Keator**, Chief Deputy Coroner

**Sarah Bassing-Sutton**, Community Suicide Prevention Coordinator



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# Suicide Death Investigation Form: WHY?

Suicides leading cause of death in youth

Suicide data limited, incomplete and cumbersome to collect

Current professional data resources lag behind by years and may not adequately capture risk factors for specific populations.

**Develop a standardized Suicide Report Form** to record information that would be relevant to identifying risk factors with ultimate goal of effective prevention efforts



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# Suicide Death Investigation Form: Benefits

“Prevention is only as good as the data which is only as good as the questions asked.”

- Guide investigators to ask relevant comprehensive questions in a sensitive manner.
- Provides a ready to use tool that is consistent and captures risk factors relevant for prevention

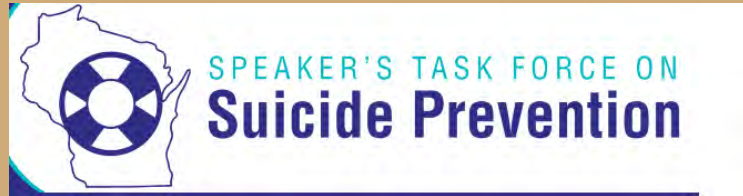
Produces information that can be used to develop recommendations/strategies for a specific population.





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# Supporters




**Suicide Prevention Resource Center**  
About Suicide Effective Prevention Resources & Programs Training News & Highlights Organizations


**8 2 5 5  
1 (800) 273 TALK**

**New from the Weekly Spark**

**Veterinarians Work to Prevent Suicide as Study Finds Increased Risk: "There Is Absolutely Nothing Weak about Asking for Help"**  
March 01, 2019

**KANSAS: Task Force Recommends Adding State Coordinator for Youth Suicide Prevention**  
March 01, 2019

**CALIFORNIA: California Chef Aims to Help Restaurant Workers Prevent Suicide**  
March 01, 2019

**Prescription Opioid or Benzodiazepine Abuse and Suicidal Ideation in Older Adults**  
February 22, 2019

**The Corps' Suicide Rate Is at a 10-Year High. This Is How the Marines Plan to Address It.**

## WISCONSIN: Suicide prevention group creates action plan

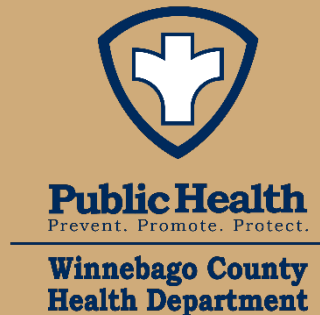
March 18, 2016

**News Type:** Weekly Spark, Weekly Spark News  
**State:** Wisconsin

The Northwestern.com

The Winnebago County Child Death Review Team recently released 11 recommendations for ways that Wisconsin communities can help prevent suicides. The overall goal is to identify and reduce risk factors and increase available support. The recommendations address key groups in the community including educators, community organizations, and others who work with youth; parents; youth; and the media. Recommendations include creating a standardized suicide report form to help identify risk factors, with the goal of developing effective prevention strategies; educating educators, parents, and youth about risk factors, how to address them, and available resources; and developing interventions and safe messaging for dealing with the aftermath of a suicide. The recommendations were discussed at a town hall meeting, which was one of 10 forums held across northeast and central Wisconsin in February and March. Input from these 10 town halls will be used to help develop a statewide call to action to be held in Madison on May 5.

**Spark Extra!** Learn about the use of state-level Child Death Review Teams as a source of information for suicide prevention efforts.



# Suicide Death Investigation Form



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The purpose of the form is to collect information about contributing factors that lead to suicide. Nonidentifying data will be compiled and analyzed by a qualified team to develop robust prevention strategies that are relevant to specific populations. This form can also serve as a template for Suicide Death Review Teams.

DECEDENT INFORMATION	
Last name:	Date of birth (MM/DD/YYYY):
First name:	Date of Death (MM/DD/YYYY):
Middle name:	Age at death:
Type of Residence: <input type="checkbox"/> Own home/townhouse <input type="checkbox"/> Nursing home/assisted living <input type="checkbox"/> School Dorm <input type="checkbox"/> Treatment facility	<input type="checkbox"/> Foster Care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Apt. <input type="checkbox"/> Group Home <input type="checkbox"/> Homeless shelter
Recent/Pending Eviction: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Recent/Pending Foreclosure: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Eviction/Loss of home: <input type="checkbox"/> Last 12 months <input type="checkbox"/> Last 2 weeks
Race: <input type="checkbox"/> Concerns with racial discrimination? <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian, specify: <input type="checkbox"/> American Indian, Tribe if known:	<input type="checkbox"/> Alaskan Native, Tribe if known: <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other, specify: <input type="checkbox"/> Unspecified



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<b>Sexual Orientation:</b> <input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian/gay <input type="checkbox"/> Questioning <input type="checkbox"/> Unknown/Other	<b>Sexual Orientation Struggle:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Last 12 months <input type="checkbox"/> Last 2 weeks															
<b>Gender identity:</b> <input type="checkbox"/> Cisgender male <input type="checkbox"/> Cisgender female <input type="checkbox"/> Transgender/Transfeminine (male to female) <input type="checkbox"/> Transgender/Transmasculine (female to male) <input type="checkbox"/> Gender non-conforming/non-binary	<b>CISGENDER:</b> identifies as their sex assigned at birth. <b>TRANSGENDER:</b> encompassing term of many gender identities of those who do not identify with their sex assigned at birth. <b>GENDER NON-CONFORMING:</b> umbrella term for all genders other than female/male or woman/man															
<b>Gender Identity Struggle:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Last 12 months <input type="checkbox"/> Last 2 weeks	<b>Relationship status:</b> <input type="checkbox"/> In a Relationship <input type="checkbox"/> Not in a Relationship <input type="checkbox"/> Unknown															
<b>Intimate Partner Problems:</b> <input type="checkbox"/> Last 12 months <input type="checkbox"/> Last 2 weeks <input type="checkbox"/> None  <input type="checkbox"/> Argument <input type="checkbox"/> Breakup <input type="checkbox"/> Other	<b>Intimate Partner Violence:</b> <input type="checkbox"/> Last 12 months <input type="checkbox"/> Last 2 weeks <input type="checkbox"/> None  <table> <tr> <td><b>Type:</b></td> <td><b>Victim:</b></td> <td><b>Perpetrator:</b></td> </tr> <tr> <td><input type="checkbox"/> Verbal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Sexual</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Emotional</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Physical</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<b>Type:</b>	<b>Victim:</b>	<b>Perpetrator:</b>	<input type="checkbox"/> Verbal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> Verbal	<input type="checkbox"/>	<input type="checkbox"/>														
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<input type="checkbox"/> Physical	<input type="checkbox"/>	<input type="checkbox"/>														



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## Sections:

- \* Relationship problems; intimate and familial

- \* Social Isolation

- \* Issues with friends

- \* Religious Affiliation and participation

- \* Education and School Concerns

- \* Harassment/ Bullying

- \* Employment information and Concerns

- \* Insurance and Financial concerns

- \* Military Status

- \* Chronic Medical conditions or life changing diagnosis

- \* TBI

- \* Mental Health diagnosis

- \* Last healthcare appointment

- \* Mental Health Medication and history of commitments

- \* ACES

- \* Addiction Issues

- \* Legal Involvement

- \* Primary Means of Injury

- \* Suicide Note

- \* Firearm information

- \* Signs prior to death



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**Additional Comments:**

**Known crisis of any kind in last 2 weeks?**

**Person(s) Interviewed:**

**Form Completed by and date:**

The form was compiled by a group dedicated to suicide and other death prevention. Please contact the lead for questions and comments.  
Improvements always welcome

Lead: Sarah Bassing-Sutton, N.E.W. Mental Health Connection; [sarah@newmentalhealthconnection.org](mailto:sarah@newmentalhealthconnection.org) 920-420-4903

Teresa Paulus, RN, Winnebago County Health Dept. [tpaulus@co.winnebago.wi.us](mailto:tpaulus@co.winnebago.wi.us) 920-642-3479

John Wallschlaeger, Community Liaison Specialist, City of Menasha Police Department

Heidi Keating, MPH, Community Health Educator, Outagamie County Public Health

Kim Maki and Nick Keator, Deputy Coroners and Barry Busby, Coroner, Winnebago County

Amy Parry, MPH, Data Project Manager, Children's Health Alliance of Wisconsin

Dan Hinton, Prevention Specialist, Winnebago County Human Services

Debbie Peters, Executive Director, Community for Hope of Winnebago County

Beth Clay, Executive Director, N.E.W. Mental Health Connection

Cindy Reffke, Chair, Prevent Suicide Fox Cities



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## How is Form Used?

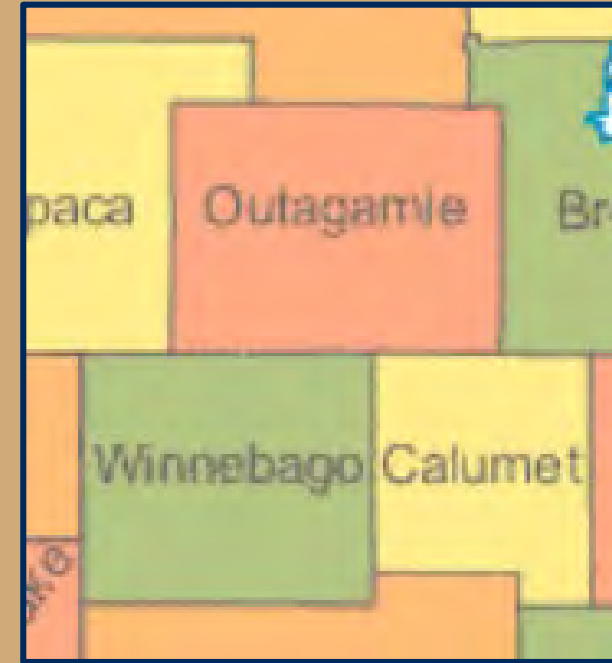
- Implementation of the form at the request of our coroner.
- Interviews can be done in any fashion, anywhere. (Over the phone, in person etc.)
- A casual conversations versus an interview.
- Families may or may not be receptive.
- Use your own judgement on time elapsed since event.



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# Targeted Suicide Prevention through the use of Data



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## Data Summary 2017-2019

- **Men** died at over 2x the rate of women
- Average age 34
- Only 30% left a **suicide note**
- **Firearm** was used in 60% of deaths
- Some college **education** or less had higher number of suicides
- 70% were employed
- Almost 50% had a **physical health issue**
- 70% had a history of **problematic alcohol use**

## VISION

Standardize use of the form across the Tri-County

Inform Adult Death Review Team

Inform Child Death Review Team

Intentional suicide prevention



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**Prevention is only as good as the data  
which is only as good as the questions  
asked**



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# THANK YOU!



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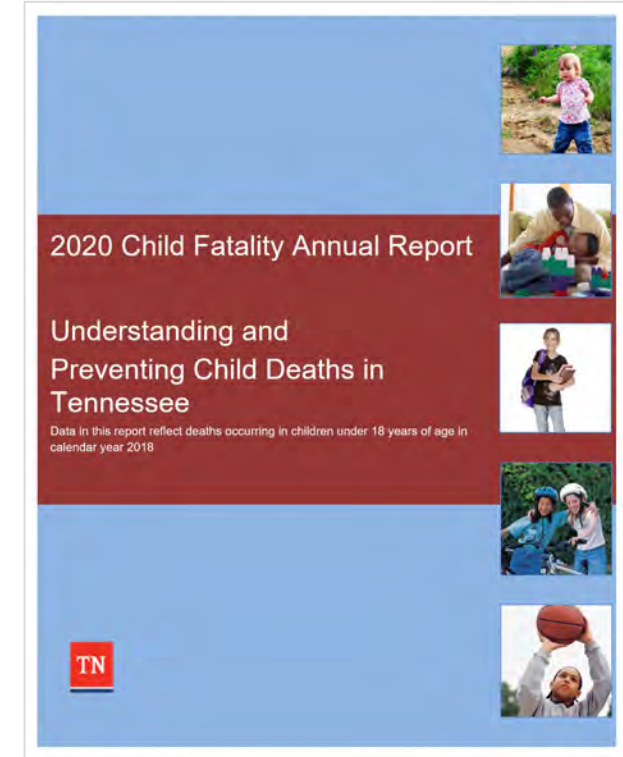


# Suicide Prevention in Tennessee

# Child Fatality Review Recommendation

State CFR team 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. 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).



# Suicide-Related ESSENCE Surveillance

- ESSENCE tracks:
  - Patient chief complaints
  - Discharge diagnoses
  - Demographics
  - Hospital name
  - Location
  - Date of visit
- 96 emergency departments report (83% of hospitals)
- Hospitals report within 24 hours.
- Monitoring for suicide attempts, suicidal ideation, and intentional self-harm visits in children  $\leq 18$  years of age.

**Electronic  
Surveillance  
System for the  
Early  
Notification of  
Community-based  
Epidemics**



# ESSENCE: Example of Weekly Data Report

Region/ Metro of Residence	Date of ED Visits	Number of ED Visits	Age Groups	Gender	Race/ Ethnicity	Chief Complaint/ Diagnosis	Hospitals Reporting
<b>East Region</b> <u>Counties</u> Crane (n=1) Smallville (n=1) Boxx (n=3)	5/5/2019	5	10-14 (n=3) 15-17 (n=2)	Male (n=2) Female (n=3)	White (n=5)	Suicidal ideations (n=4)  Psychiatric problems (n=1)	Grey Sloan Memorial Hospital(n=3)  Sacred Heart Hospital (n=1)  All Saints Hospital (n=1)
<b>South Central Region</b> <u>Counties</u> Cogg(n=1) Hamm (n=1) North Park (n=1)	5/7/19	3	10-14 (n=1) 15-17 (n=2)	Male (n=3)	White (n=1) Other (n=2)	Suicidal ideations (n=2)  Psychiatric problems (n=1)	County General Hospital (n=1)  Mercy Hospital (n=1)  Kingdom Hospital (n=1)
<b>Upper Cumberland Region</b> <u>Counties</u> Desatur(n=1) Lyles(n=1)	5/8/19	2	15-17 (n=2)	Male (n=1) Female (n=1)	White (n=2)	Suicidal ideations (n=2)	St. Mungo's Hospital (n=1)  St. Ambrose's Hospital (n=1)
<b>Northeast Region</b> <u>Counties</u> Flint (n=2) Sawkins (n=2)	5/9/19	4	10-14 (n=2) 15-17 (n=2)	Male (n=1) Female (n=3)	White (n=4)	Suicidal ideations (n=4)	St. Vincent's Hospital (n=3)  Lennox Hill Hospital (n=1)

# ESSENCE Rapid Prevention Response Plan

- Key stakeholders: Coordinated School Health Coordinators, TSPN Regional Directors, TN Department of Mental Health and Substance Abuse Services, Youth Villages, HCA Healthcare, and Centerstone staff
- Notified weekly of areas with alerts
- Stakeholders offer suicide prevention support, guidelines, resources and gatekeeper training



# QUESTIONS

WHAT ADDITIONAL INFORMATION WOULD BE HELPFUL?



## USE THE QUESTION AND ANSWER BOX

The box is located at the bottom of the screen



## UNANSWERED QUESTIONS

All unanswered questions will be answered and posted on the National Center's website (URL: [www.ncfrp.org](http://www.ncfrp.org)).



# EVALUATION

<https://www.surveymonkey.com/r/32BRMMX>





## CONTACT INFORMATION



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