STATE CHILD FATALITY TEAM REPORT PREVIEW

Office of the Chief Medical Examiner January, 2000

Suicide Fatalities Among Children & Adolescents in Virginia 1994-95

From 1980 to 1996, the rate of suicide among persons aged 10-14 increased by 100% and has become the 3rd leading cause of death for children in the Commonwealth. The State Child Fatality Review Team, in recognition of the significance of this public health problem, has spent the past two years reviewing the suicides of children and youth in Virginia. This review has convinced us that the majority of these deaths can be prevented. What is needed is the commitment and will to address the problem.

Addressing the problem requires recognition of the variable signs and symptoms of depression in children and understanding the risk factors for suicide. Suicide is not an inevitable death. Depression can be treated and children can be helped in times of crisis. What is needed is greater awareness and response to children in need. All of us, parents, educators, health care professionals, mental health professionals, clergy, and children themselves need to realize that indeed we are our brother's keeper. When a child says I am going to kill myself, we need to take such expressions seriously and to seek help for them. We need societal awareness about suicide that is on the scale of the successful "Friends don't let friends drive drunk" campaign. Over 40 percent of the children in this review told someone, a friend, a parent, a teacher, a sibling, a counselor, about their intent to die. The opportunity to intervene was lost for a variety of reasons, the signs of childhood depression were not recognized, the magnitude of the problem not understood, firearms were not removed from the home, medications were not secured, peers and families thought they could handle it themselves, or they did not know where to turn for help, or when help was sought it was not available. When a child's behavior is a cry for help, each of us needs to respond and families and other adults need to know where to seek help. Resources must be available that are affordable, accessible, and appropriate. When a child has been traumatized by sexual abuse or other violence, when a child is suffering from depression or other psychological conditions, we must give them and their families support. Treatment must be available and our response should have the same intensity and urgency as when a child has leukemia or head trauma.

The Team has taken a first step by closely reviewing these tragic deaths. The Team asks elected officials, faith communities, schools, health care professionals, mental health care providers, parents and the Departments of Social Services, Mental Health, Mental Retardation and Substance Abuse Services and Juvenile Justice to learn, as we have, and to take action to raise awareness and improve services for children at risk for suicide.

Marcella F. Fierro, MD
Chair

FINDINGS

The Virginia State Child Fatality Review Team was established by the General Assembly in 1995. The purpose of the Team, as outlined in Code Section §32.1-283.1, is to review child deaths in Virginia of children less than 18 years old to ensure a systematic analysis of their deaths. Deaths to be reviewed include: violent and unnatural deaths, sudden child deaths in the first 18 months of life, and deaths where the manner was not determined with reasonable medical certainty.

The State Child Fatality Review Team reviewed suicides of children and adolescents to gain a broader understanding of the circumstances surrounding child and adolescent suicide, to obtain a profile of the children who commit suicide, and to generate recommendations for prevention, intervention, education, and investigation of child death due to suicide.

The Team examined 58 records of children less than 18 years old who died as a result of a suicide in 1994 and 1995.

DEMOGRAPHICS

• Seventy-four percent of all the suicides reviewed were committed by males, with 62% committed by white males.

• The average annual suicide incident rate among males was 3.67 per hundred thousand as compared to 1.36 for females.

• Sixty-two percent of the deaths occurred in the 15 to 17 year age group, 34% occurred in the 10 to 14 year age group, and less than 4% were under 10 years old.

• There was little variation in the suicide incidence rate by health service area with the exception of the Northwest area. The average annual incident rate in the Central, Eastern and Northern areas were 2.04, 2.10 and 2.11 respectively. The rate for the Southwest area was 2.54, and the Northwest area had a rate of 4.59.

KEY FINDINGS

• More than half of the cases were deemed preventable by the Team.

• In more than half of the cases, the child had threatened to commit suicide or had previously attempted suicide.

• In 23 cases or 40%, the children had told either a friend, parent, counselor, or school employee of their intent to commit suicide.

• Eighty-two percent of all the suicides were committed in the home.

• In one third of the cases a precipitating event had occurred within 24 hours of the suicide. These included relationship breakups, arguments with parents or friends, or interactions with the juvenile justice system.

• In 36 cases or 62%, a firearm was utilized, with both poisoning and hanging each accounting for 17% or 10 cases each.

• Of the 36 cases where a firearm was used, 27 or 75% were household weapons.

• Males were 1.75 times more likely to utilize a firearm to commit suicide than the females, 70% versus 40%.

• Twenty-two or 38% of the children had a psychological or behavioral disorder diagnosis and 28% were taking medications.

• Twelve or 21% were involved in custody disputes.

• Twenty of the children or 34% had been subjected to physical abuse, sexual abuse or neglect, or had witnessed domestic violence at some point in their lives.

• One third, or 19 of the children were involved with the juvenile justice system or law enforcement. Of those 90% were male.

• In reviewing school records almost half (47%) performed below average to poor for their ability. A drop in grades and attendance was seen for the majority of the cases.

• Seventeen percent (10/58) had involvement with Child Protective Services, a quarter (14/58) were involved with the Juvenile Justice System, and a quarter (14/58) received services from a Community Services Board.

• Twenty-three of the children had received mental health services.

• Females were 1.8 times more likely to have received mental health services than males, 60% versus 33%.

RECOMMENDATIONS

The State Child Fatality Review Team's review of child and adolescent suicides in 1994 and 1995 identified serious gaps in programs, services, and responses to children at risk for depression and suicide. We believe that a majority of suicides can be prevented, but this requires the willingness to acknowledge the problem and the creation and funding of programs and services to address it. The consensus recommendations that follow are based on an in depth review of the circumstances and events that culminated in a child taking his or her own life. The State Child Fatality Review Team believes that we can improve the outcomes of children in crisis and makes the following recommendations as a first step towards that end.

PREVENTION AND INTERVENTION

We recommend that the Department of Mental Health, Mental Retardation and Substance Abuse Services identify children with mental health needs as a priority population and fund appropriate community mental health services for them, including assessments.

We recommend that the agencies that provide services to children and families, including the Department of Social Services, Department of Juvenile Justice, Department of Education and local school boards, Community Services Boards, and Courts improve identification, assessment, treatment, and follow-up of children at risk for depression and suicide.

We recommend that the Courts appoint *guardians ad litum* for children who are the objects of custody disputes and that the Courts insure that the emotional and psychological needs of children are addressed by requiring risk assessments, evaluations, and counseling for children and families.

We recommend that the Commonwealth provide funding to support and enforce the recommended school nurse to student ratio, in all school divisions.

We recommend that parents secure all firearms and that they remove firearms when at risk children are in the home.

We recommend that parents secure all medications when at risk children are in the home.

We recommend that prevention strategies address gender and cultural differences.

We recommend that prevention strategies address peer resistance to reporting threats made by others.

LEGISLATION

We recommend that the General Assembly adopt legislation that would provide immunity from liability for school personnel who identify or assess children for suicide risk.

EDUCATION

We recommend that the Department of Health, the Department of Education, and the Department of Mental Health, Mental Retardation and Substance Abuse Services conduct a major public awareness campaign regarding signs and symptoms of depression and risks for suicide among children and youth.

We recommend that the Medical Society of Virginia, the Pediatric Society of Virginia and the Virginia Chapter of the American College of Emergency Physicians include risk assessment for depression and suicide and safety planning for children and youth at risk as an on-going component of continuing medical education.

TRAINING

We recommend that the Department of Education provide training for all school personnel to implement the suicide protocol recently developed by the Department.

We recommend that the Department of Mental Health, Mental Retardation and Substance Abuse Services initiate and support training for clinical staff of Community Service Boards to improve identification, treatment, and follow-up of children who have been traumatized by physical, emotional and sexual abuse or who have been witnesses to domestic violence.

DEATH INVESTIGATIONS

We recommend that the Office of the Chief Medical Examiner request and that the Division of Forensic Sciences conduct full toxicology screens on all suicides to assess the impact of substance abuse or prescription drugs on the suicide event.

We recommend that the Office of the Chief Medical Examiner develop a protocol for child suicide investigations to obtain more complete information on the circumstances and precipitating events of the suicide.

We recommend that in all child suicides by firearms that law enforcement personnel conduct an investigation to support prosecution under §18.2-56.2 regarding access to firearms by children.

1999 State Child Fatality Review Team

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