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Using Child Death Review to Inform Title V Programs on Adolescent Mental Health

National Center Guidance Report

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Using Child Death Review to Inform Title V Programs on Adolescent Mental Health

Introduction

This document is intended to advise Title V programs on using the data and findings from Child Death Review (CDR) to inform interventions to reduce the risks of mental health and self-harm for our nation's children and adolescents.

Among high school-aged youth 14–18 years, suicide is the second leading cause of death after unintentional injuries.[1] CDR is an essential means to help communities understand and address mental health's role in children's deaths, including how community, racial, ethnic, and socioeconomic factors impact youth. Title V programs are engaged with state and local CDR teams in a variety of ways. Forty-eight state CDR programs report coordinating with their state Title V programs to some degree.[2]

Current Title V Engagement

In addition to the engagement described above, Title V programs serve as the administrative home for CDR programs, collaborate on prevention at the state or local level, and provide funding to CDR programs at the state or local level.

1 Ivey-Stephenson, A, et al, (2019), Suicidal Ideation and Behaviors Among High School Students-Youth Risk Behavior Survey, United States, 2019, MMWR August 2020, https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901a6-H.pdf.

2 The National Center for Fatality Review and Prevention. Keeping Kids Alive: Child Death Review in the United States, 2018. Michigan Public Health Institute, 2020.

According to the 2018 Summary of CDR programs:[3]

- ☐ *29 CDR programs are led by state health departments*
- ☐ *48 state CDR programs reported coordinating with the state Title V program*
- ☐ *41 states fund CDR at the state level*
- ☐ *11 states allow for Title V funds to be used to fund CDR at the local level*

As noted above, CDR is not always funded or led by Title V. States that have a joint home for CDR and Title V do not always have the most robust collaboration. Regardless of how the state health department is structured, meaningful, authentic collaboration between CDR and Title V can occur.

For example:

- In states where CDR is based outside of state health departments, in child welfare agencies, or the state government's judicial arm, the collaboration can focus on resources, including funding, staff participates in reviews or shared prevention activities.
- Some CDR programs have an administrative home outside of state government. CDR data, findings, and recommendations are shared to inform programs and prevention.
- Depending on the timeline for case review, CDR teams can provide more timely access to data on child deaths. This allows for the early identification of systems challenges and trends.

Title V programs are well-positioned to act on findings and recommendations generated from CDR. See page 20 for a detailed description of how CDR can add value to Title V.

3 The National Center for Fatality Review and Prevention. Keeping Kids Alive: Child Death Review in the United States, 2018. Michigan Public Health Institute, 2020.

Title V Testimonial

"The ability to explore the details of youth suicide through the child fatality review provides New Mexico with the opportunity to examine how our systems work together to serve adolescents and families, and how those systems could be improved. Although very challenging, this work provides important data on the impact of adolescent mental health on how and why New Mexico's children are dying. This information is used to inform programs throughout the New Mexico Department of Health, including Title V activities, assessments, and planning."

Janis Gonzales MD, MPH, FAAP, Family Health Bureau Chief/
Title V Director, New Mexico Department of Health

Child Death Review

Overview

CDR enables states and communities to identify underlying risk and protective factors related to child deaths and to use that information to create meaningful change and safer communities. **This generates a deeper understanding of how the child lived and why the child died.** There are more than 1,350 CDR teams in all 50 states, the District of Columbia, Guam, and within some Tribes. Although they sometimes go by different names, review different types of deaths, or operate out of different agencies, CDR programs share their commitment to learning from the tragedies they face and help protect children in the future. CDR teams operate at the state, regional, county, or city level. Each state has an identified CDR coordinator that supports CDR in a variety of ways. That support varies by state depending on funding and structure. Find your state's coordinator (URL: https://www.ncfrp.org/cdr-map/).

CDR teams are comprised of members from multiple disciplines, agencies, and organizations, including law enforcement, child protective services, the judicial system (e.g., prosecutor), the medical examiner/coroner, public health, first responders, and medicine (e.g., pediatricians, hospital staff). Teams may choose to include additional members depending on the review type, community, and legislation. Team members must be willing to have open, honest, and cooperative relationships and dialogue. Team members must also be willing to advocate for change to prevent future deaths.

During the review process, CDR teams collect extensive data on the child, the family, the incident, the death investigation, cause-specific risk, protective factors, and systems issues and barriers. The team also documents findings and prevention recommendations.

The purpose of CDR is to provide a comprehensive and multidisciplinary review of the circumstances of child deaths to better understand how and why children die. These findings are used to catalyze action to prevent other injuries and deaths and ultimately improve the health and safety of communities, families, and children across the life course, to demonstrate to providers and the community the critical importance of being explicitly anti-racist in their work.

The graphic below provides an overview of four steps in the CDR process:

Learn more about CDR by reviewing the National Center's CDR 101 module: Child Death Review 101 and chapter 1 of the CDR Program Manual (URL: https://bit.ly/2Le7G3o).

About the National Center

The National Center for Fatality Review and Prevention (National Center) is the technical support and data center serving CDR and Fetal and Infant Mortality Review (FIMR) programs across the country. The National Center offers a wide variety of available services via site visits, email, and telephone.

The National Center offers virtual and on-site technical assistance to states.

- ☐ *Technical assistance, training, and support with strategic planning to help support teams to develop, implement, and sustain prevention-focused CDR processes.*
- ☐ *Maintenance of the National Fatality Review-Case Reporting System (NFR-CRS), a database into which fatality review teams enter the circumstances of the individual deaths they review.*
- ☐ *Consultation to coordinate with other reviews related to domestic violence, serious injury, maternal mortality, elder/vulnerable adult fatality reviews, Citizen Review Panels, and others, as well as a collaboration between FIMR and CDR.*
- ☐ *Support for the network of state CDR coordinators.*
- ☐ *Resources such as a listserv, website, written review guidances, webinars, and training modules.*

Data Collection

The NFR-CRS is a free, web-based data system available to CDR teams. Teams can easily access and download their data and run standardized reports. Forty-six states currently use the NFR-CRS for CDR; a data use agreement must be completed to participate. Additionally, data are owned by the state, which allows the state to retain control over how the data are used at a national level and for research. As a result, not all states allow their data to be included in publications.

Given all this information, NFR-CRS data can help in the following ways:

1. *State and local teams have access to their data to identify trends and significant risk factors that inform prevention. These data can be shared with Title V programs for real-time monitoring of Title V activities.*

2. *State teams review local findings (when available) to identify trends and significant risk factors and develop recommendations and action plans for state policy and practice improvements.*

3. *State teams match review findings with vital records and other mortality data sources to identify gaps in the reporting of deaths.*

4. *State and local teams use the findings as a quality assurance tool for their review processes.*

5. *Local teams and states use the reports to demonstrate the effectiveness of their reviews and advocate for funding and support for their program.*

6. *National groups use state and local findings for national policy and practice changes*

Learn more about NFR-CRS (URL: https://www.ncfrp.org/data/).

Overview of the Problem

National Data

Mental and behavioral disorders among children, such as anxiety, depression, and attention deficit hyperactivity disorder, are described as serious changes in the way children typically learn, behave, or handle their emotions, causing distress and problems getting through the day.[4] Among the more common mental disorders diagnosed in childhood are attention-deficit/hyperactivity disorder (ADHD), anxiety, and behavior disorders.[5] According to the National Institute of Mental Health (NIMH),[6] one in 10 children and adolescents has mental illness severe enough to impact their growth and daily life. **Fifty percent of all mental illness is identified by age 14.**[7]

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4 Perou R, Bitsko RH, Blumberg SJ, Pastor P, Ghandour RM, Gfroerer JC, Hedden SL, Crosby AE, Visser SN, Schieve LA, Parks SE, Hall JE, Brody D, Simile CM, Thompson WW, Baio J, Avenevoli S, Kogan MD, Huang LN. Mental health surveillance among children – United States, 2005—2011. MMWR 2013;62(Suppl; May 16, 2013):1-35. [Read summary].

5 Centers for Disease Control and Prevention [Online]. Data and Statistics on Children's Mental Health. Available at URL: https://www.cdc.gov/childrensmentalhealth/data.html#ref.

6 Ivey-Stephenson, A, et al, (2019), Suicidal Ideation and Behaviors Among High School Students-Youth Risk Behavior Survey, United States, 2019, MMWR August 2021, https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901a6-H.pdf.

7 Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication.

Between 2014-2018, 4.7 percent of youth ages 10-17 died by suicide.[8] **Approximately one out of every 15 high school students reports attempting suicide each year.**[9] Certain youth, including those who identify as a part of the LGBTQ community and American/Indian Alaska Native, are at greater risk of suicide due to homophobia, transphobia, racism, and historical trauma.[10] Additional risk factors for suicide include a history of mental health treatment or substance use treatment, a family history of suicide, bullying as both a victim and perpetrator and easy access to lethal methods.[11] In the 2019 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.[12]

Additionally, 13% of youth ages 12-17 report at least one major depressive episode (MDE) in the past year, which increased 99,000 youth from the previous year.[13] Furthermore, 9% of youth in the same age range report severe major depression, which frequently co-occurs with other disorders such as anxiety, disorderly behavior, or substance use. It is important to note that this is an increase of 121,000 youth experiencing a severe MDE from the previous year.[11] Barriers to mental health treatment for youth continue to be a significant problem, with 59% of youth who reported MDE unable to receive treatment.[11]

While national data provide a basic picture of youth's mental health needs, they do not address the circumstances of the child's life, such as a full medical history, experiences in school, and peer relationships. Data from fatality review teams can provide the context in which the child lived and died.

8 Centers for Disease Control WISQARS Fatal Injury Data Visualization Tool https://wisqars-viz.cdc.gov:8006/explore-data/home [Online] Accessed November 5, 2020.

9 Youth.GOV [Online]. Available from URL: https://youth.gov/youth-topics/youth-suicide-prevention. [2020 October 7].

10 Ivey-Stephenson, A, et al, (2019), Suicidal Ideation and Behaviors Among High School Students-Youth Risk Behavior Survey, United States, 2019, MMWR August 2020, https://www.cdc.gov/mmwr/volumes/69/su/pdfs/su6901a6-H.pdf.

11 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-for-Suicide.aspx [2020 September 15].

12 CDC YBRS Data Summary & Trends Report: 2007-2019, [Online], Available from URL: https://www.cdc.gov/healthyyouth/data/yrbs/pdf/trendsreport.pdf.

13 Mental Health American [Online] Available from URL: https://www.mhanational.org/issues/2020/mental-health-america-youth-data [2020 October 7].

Data from the National Fatality Review-Case Reporting System

CDR teams in 40 states reviewed and entered data from 31,003 deaths of children ages 10-17 into NFR-CRS between 2008-2017. Given that states retain ownership of their data, not all states allow for data to be used in analyses like this one. The data presented below excludes missing and unknown data. Although CDR data provides rich, detailed context, there are limitations to the data. It is not population-based, deaths reviewed and entered into NFR-CRS can differ between states. The data may have high rates of missing and unknown responses.[14]

For this report, the youth were divided into three categories:

1. *Youth whose manner of death was listed as accident or homicide on death certificates AND had no documented mental health history. There were 3,224 youth in this category.*[15]

2. *Youth whose manner of death was listed as accident or homicide on death certificates AND had a documented mental health history. There were 1,375 youth in this category.*

3. *Youth whose manner of death on death certificates was listed as a suicide. There were 6,732 youth in this category.*

According to the American Academy of Pediatrics stages of adolescence, the three existing groups were further divided into two subcategories: early adolescence (ages 10-13) and middle adolescence (ages 14-17).[16]

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

15 As defined in A30-A32 in NFR-CRS URL: https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/CDR_CRS_v5-1.pdf.

16 American Academy of Pediatrics [Online]. Stages of Adolescence https://www.healthychildren.org/English/ages-stages/teen/Pages/Stages-of-Adolescence.aspx [2020 September 15].

Characteristics of the Child

A total of 10,006 deaths from these three groups of children were analyzed.

- ☐ *The age, race, and ethnicity breakdowns were consistent between all three groups, with males representing three-quarters of the deaths.*
- ☐ *Non-Hispanic White children represented the highest percentage of deaths across all groups, accounting for more than 50% of each group's total deaths.*
- ☐ *Non-Hispanic Black children and children of other races accounted for the smallest percentage of suicide deaths (10% and 8%, respectively).*
- ☐ *Youth in middle adolescence had a higher percentage of substance use history and history of criminal or delinquent activities than youth in early adolescence.*

Children ages 10-17 with a documented mental health history were reported to have been the victim of maltreatment more frequently (60%) than their peers who died of suicide (34%) or did not have a mental health history (21%). Additionally, children ages 10-17 with a documented mental health history were more likely to have ever received mental health treatment, be receiving mental health treatment at the time of death, and to be taking medications for mental health reasons than their peers who died of suicide.

Cause and Manner of Death Stratified by Age and Mental Health History can be found in Table 1, Figure 1, and Figure 2.

Table 1. *Cause and Manner of Death Stratified by Age and Mental Health History*

	Manner of Death was Accident or Homicide AND No Mental Health History Documented		Manner of Death was Accident or Homicide AND Mental Health History Documented		Manner of Death was Suicide	
	Early Adolescence Ages 10-13	Middle Adolescence Ages 14-17	Early Adolescence Ages 10-13	Middle Adolescence Ages 14-17	Early Adolescence Ages 10-13	Middle Adolescence Ages 14-17
Accident	79%	71%	77%	66%	0%	0%
Homocide	21%	29%	23%	34%	0%	0%
Suicide	0%	0%	0%	0%	100%	100%

Figure 1. *Cause of Death for Youth Ages 10-17 Where Manner of Death was Accident or Homicide AND No Mental Health History Documented*

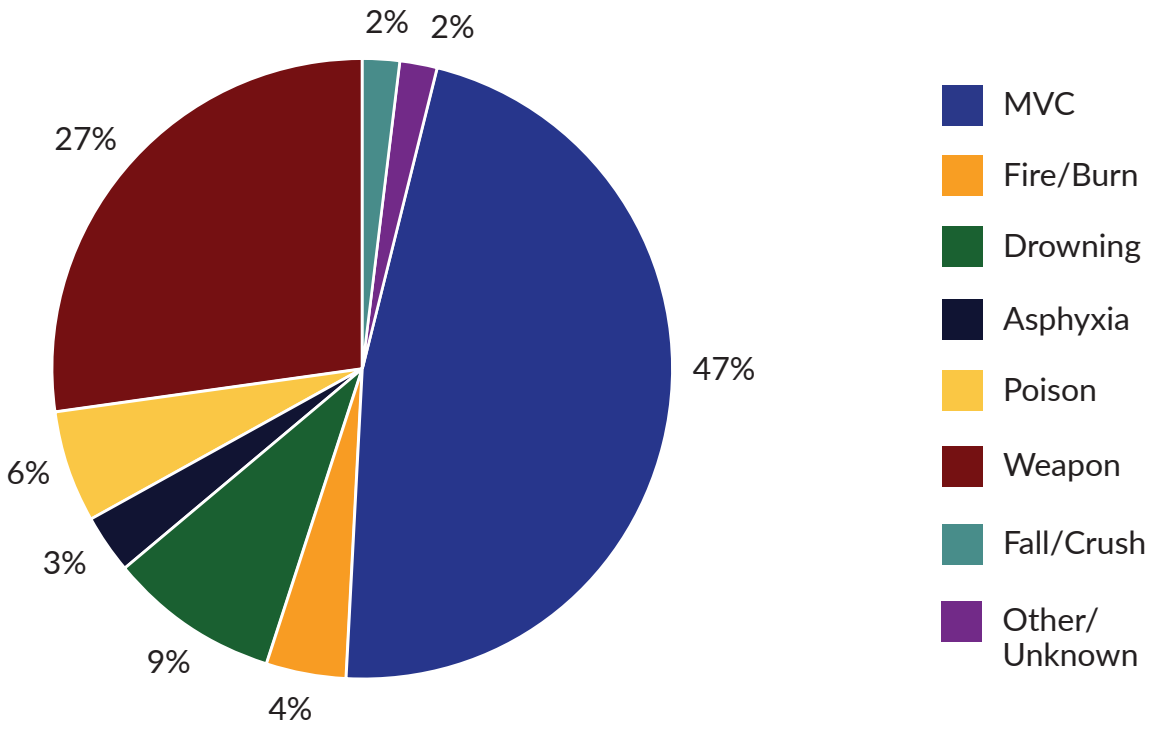


Figure 2. *Cause of Death for Youth Ages 10-17 Where Manner of Death was Accident or Homicide AND Mental Health History Documented*

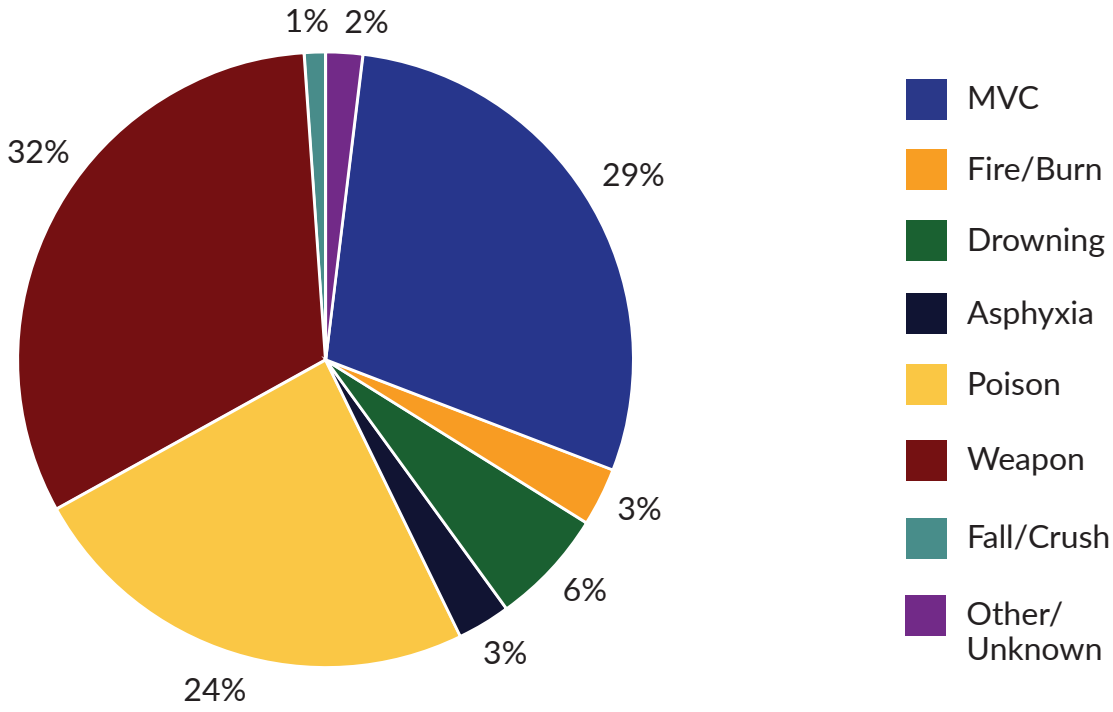
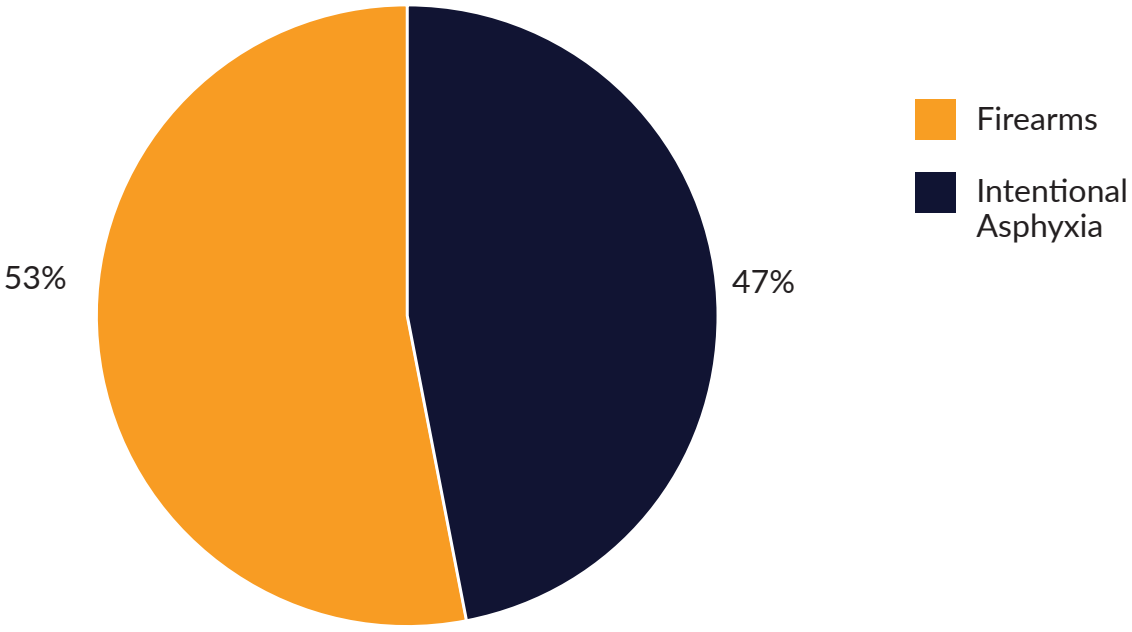


Figure 3. *Cause of Death for Youth Ages 10-17 Where Manner of Death was Suicide*



Key Characteristics of Youth Fatalities Stratified by Age and Mental Health History provides an overview of data findings from the NFR-CRS (Table 2). These data demonstrate that youth who died by accident or homicide and had a documented mental health history were more likely to be placed outside of their home before death than children in the other two groups. Additionally, youth who died by accident or homicide and had a documented mental health history were more likely to have "abuse, neglect, poor supervisor or exposure to hazards" listed as contributing factors.

Table 2. *Key Characteristics of Youth Fatalities Stratified by Age and Mental Health Needs*

	Manner of Death was Accident or Homicide AND No Mental Health History Documented		Manner of Death was Accident or Homicide AND Mental Health History Documented		Manner of Death was Suicide	
	Early Adolescence Ages 10-13	Middle Adolescence Ages 14-17	Early Adolescence Ages 10-13	Middle Adolescence Ages 14-17	Early Adolescence Ages 10-13	Middle Adolescence Ages 14-17
Ethnicity/Race						
Hispanic	17%	18%	13%	15%	15%	16%
Non-Hispanic White	52%	49%	54%	48%	60%	68%
Non-Hispanic Black	25%	27%	27%	32%	18%	9%
Other Race	6%	5%	5%	4%	7%	8%
Sex						
Female	38%	29%	24%	28%	35%	28%
Male	62%	71%	77%	72%	65%	72%
Maltreatment						
History as a Victim of Maltreatment	23%	21%	63%	59%	35%	34%
Family had Open CPS Case at Time of Death	4%	3%	19%	16%	7%	6%
Child Placed Outside of Home Prior to Death	6%	6%	33%	35%	12%	13%
CPS Record Check Conducted as a Result of the Death	60%	50%	66%	58%	67%	54%
Abuse, Neglect, Poor Supervision, or Exposure to Hazards Contributed to Death	41%	19%	47%	32%	17%	15%
School						
Child Had History of Problems in School	10%	23%	73%	84%	60%	57%
Mental Health and Substance Use History						
History as a Victim of Maltreatment	23%	21%	63%	59%	35%	34%
Family had Open CPS Case at Time of Death	4%	3%	19%	16%	7%	6%
Child Placed Outside of Home Prior to Death	6%	6%	33%	35%	12%	13%
CPS Record Check Conducted as a Result of the Death	60%	50%	66%	58%	67%	54%
Abuse, Neglect, Poor Supervision, or Exposure to Hazards Contributed to Death	41%	19%	47%	32%	17%	15%
Criminal or Delinquent History						
History of criminal and/or delinquent activities	3%	19%	12%	61%	8%	23%

How CDR Adds Value to the Understanding of Risk Factors Associated with Adolescent Mental Health

CDR teams seek to clarify how adolescent mental health issues impact adolescent mortality. Below are examples of how information from CDR can add to that understanding.

Provide Context through Review and Data Collection

Death certificates provide information on how children die but do not provide information on the potential stressors contributing to the child's death. For example, CDR teams gather information on community risk and protective factors surrounding the child. **Furthermore, CDR teams discuss how systems worked together and expose structural barriers and systems gaps.** This information is vital for improving service delivery to help keep other children alive.

CDR teams collect extensive data on the child, the family, the incident and investigation, risk and protective factors, systems gaps and barriers, and cause of death specific risk factors.

Specific to adolescent mental health, CDR teams collect data on:

- ☐ *History of mental health and substance use services, including if they were being provided at the time of death*
- ☐ *History of maltreatment*
- ☐ *Family history of mental health and substance use services*
- ☐ *Risk factors related to suicide, including crisis information, behavior changes, and history of impulsive behavior*
- ☐ *Life stressors that may have impacted the child or family, including things like racism, food insecurity, disagreement with family or friends, and the pressure to succeed*
- ☐ *Systems gaps, including the availability of records, agency policy/procedure, and agency participation in the review*

In addition to case-specific data, CDR teams have access to 30 standardized reports, which allow teams to produce a summary of their NFR-CRS data efficiently.

The following standardized reports from NFR-CRS are available from the state CDR coordinator can help understand how adolescent mental health is related to these deaths:

- ☐ *Manner and Cause of Death by Age Group*
- ☐ *Suicide Information: A history of mental health treatment, social and academic behaviors, involvement in activities, crises in the 30 days before the death, and life stressors that may have contributed to the death.*
- ☐ *Findings from the Review: These risk and protective factors inform programs and policies at all levels.*

Prevention

Findings and prevention strategies are discussed and documented for each case reviewed. These can form the basis for recommendations to Title V programs, other state agencies, and community partners. **Not only does the broad group of stakeholders engaged in CDR add value to prevention work, the unique data collected provides an additional layer of understanding of how and why children die.** CDR teams can be leveraged to understand how systems work together, common risk factors related to death, and current agency practices related to mental health. While this information could be gathered by approaching each agency/team member, using the CDR team can expedite the process.

CDR teams are not expected to do prevention work. They are expected to share what is learned during the review and catalyze prevention. Title V is a natural partner in efforts to use CDR findings to prevent child fatalities.

Community Engagement & Partnerships

CDR, at its core, leads to community engagement by bringing together a wide array of partners. Although caregivers and community members rarely participate in the review of the death, they play a vital role in prevention. Additionally, the professionals who participate in CDR bring their community connections to the review table.

One of the unique components of CDR is that it brings together a broad, diverse group of stakeholders committed to improving the community's health and safety; the process itself is community engagement. As a result, agencies who do not typically work together begin to build or enhance relationships, which translates to systems working together more effectively. Tapping into CDR teams also provides a broad audience who can help disseminate messages, identify challenges and problem-solving solutions.

Health Disparities

CDR teams can play a role in illuminating disparities and identifying populations at the most significant risk for a poor outcome. **However, case review should never become a context in which to blame community agencies and individual providers, and teams should not blame families or parents for the loss of their children.** CDR teams look at cases from a systems-level to identify opportunities to improve systems, reducing or eliminating systematic and structural oppression. Lastly, CDR teams are a venue for providing training on health equity, social determinants of health, and implicit bias. This allows for a broad reach of training materials.

Fatality review teams provide a unique look into the social-environmental context of how communities function. CDR teams, with their in-depth analysis of systems issues, gaps in care, impacts of Adverse Childhood Experiences, and social determinants of health, are uniquely situated to understand factors that influence risk and can help inform interventions. These data can be captured in the National Fatality Review-Case Reporting System.

Many of resources are available on the National Center website (URL: http://ncfrp.org/center-resources).

Success Stories

SUICIDE PREVENTION IN TENNESSEE

In 2014, Tennessee was below the national average for youth suicide deaths. From 2014 – 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 the 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 a 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.** TDH will monitor hospital Emergency Department (ED) visits through ESSENCE to target coordinated, timely outreach and direct evidence-based prevention programs such as Question, Persuade, Refer (QPR) (URL: https://qprinstitute.com/).

To address this recommendation from the state CFR team, TDH staff developed an algorithm to identify ED visits 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 seeing an increase in youth ED visits for suicide-related behavior by creating an alert. TDH staff created a rapid response plan to notify the suicide prevention network and coordinate regional school health staff to identify an alert 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.

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

CONNECTICUT SUICIDE ADVISORY BOARD

The Connecticut Suicide Advisory Board developed this Postvention Protocol to ensure a timely, evidence-based response to youth suicide death to provide support to and reduce risk to the surviving family, school, and community. This work is accomplished by a multiagency collaboration initiated by the **Office of the Chief Medical Examiner (OCME)** in partnership with the Office of the Child Advocate (OCA) and the Connecticut Suicide Advisory Board. Upon the identification of a youth suicide death, the OCME notifies the OCA, who then informs members of the Suicide Advisory Board through a group email, mobilizing their systems and resources.

- ☐ ***Department of Children and Families (DCF), Central Office*** *contacts the local youth mobile crisis provider to inform them of the death. Additionally, the mobile crisis provider prepares for potential activation upon the request of the surviving family, school system, or community.*

- ☐ ***Department of Mental Health and Addiction Services (DMHAS), Office of the Commissioner*** *contacts the Regional Behavioral Health Action Organization (RBHAO) to inform them of the death, and to have them notify the Local Prevention Council (LPC) and/or town Youth and Family Services. The RBHAO promotes the evidence-based After a Suicide: A Toolkit for Schools (URL: https://bit.ly/2LwPqlJ), and encourages local promotion of the practices in the toolkit. Use of mobile crisis services and the Toolkit are strongly encouraged.*

- ☐ ***State Department of Education (SDE), Commissioner's Office*** *contacts the local school where the deceased youth attended. Use of mobile crisis services and the Toolkit are strongly encouraged. Staff share any pertinent knowledge of the surviving family, school, and/or community with the response group.*

- ☐ ***Connecticut Chapter of the American Foundation for Suicide Prevention (AFSP)*** *shares available resources with the group, and any pertinent knowledge of the surviving family, school, and/or community. They prepare for response upon request of the family and community. Use of mobile crisis services and the Toolkit are strongly encouraged, as well as the Survivor Outreach Program (URL: https://bit.ly/3nxll2I) that provides trained peer support to survivors.*

- ☐ ***Jordan Porco Foundation (JPF)*** *shares available resources with the group, and any pertinent knowledge of the surviving family, school, and/or community.*

Through this comprehensive, multiagency postvention response, grief support is available to the entire community including the family, school, and professionals. Each of the above agencies offer and provide additional guidance and support as requested. Following a suicide, all primary suicide prevention activities are postponed for at least three months to allow the community the opportunity to receive needed grief support. Suicide prevention efforts occur within the context of larger grief support efforts in order to reduce risk of contagion and to connect survivors to available resources.

Summary

Fatality Review can offer valuable tools and information to enhance and inform state Title V needs assessments, action planning, data collection, and analysis.

CDR benefits Title V programs by:

- ☐ *Examining social, cultural, safety, and health systems factors that are associated with child and adolescent mortality through review of individual cases*
- ☐ *Identifying system barriers and problems that need improvement through interdisciplinary case reviews*
- ☐ *Improving service systems and community resources to reduce future deaths*
- ☐ *Providing valuable qualitative data to use with the state's quantitative infant and child mortality data*
- ☐ *Informing a state's broader needs assessment and state action plan*

For specific inquiries on how fatality reviews can support Title V maternal child health programs' work, contact the National Center at info@ncfrp.org.

Prevention Resources

- Association of Maternal Child Health Programs (URL: http://www.amchp.org/programsandtopics/AdolescentHealth/Pages/default.aspx) works with MCH professionals to achieve the following adolescent health goals: 1) Improve the health of women, children, youth, families and children and youth with special health care needs; 2) Promote the health of adolescents by strengthening the state-level capacity; 3) Pursue the elimination of health disparities and inequities; 4) Advance leadership practices for MCH at the national, state and local levels.

- Children's Safety Network (URL: https://www.childrenssafetynetwork.org/) works with state and jurisdiction MCH and Injury & Violence prevention programs to create an environment in which all infants, children, and youth are safe and healthy. Their goal is to equip states and jurisdictions to strengthen their capacity, utilize data, and implement effective strategies to reduce injury-related deaths, hospitalizations, and emergency department visits.

- Health Resources and Services Administration, Maternal Child Health Bureau (URL: https://www.hrsa.gov/library/child-and-adolescent-health) works to increase comprehensive, coordinated, confidential health care. This includes supporting strength-based models of care, screening for behavioral health issues, including thoughts of suicide, promoting school-based services, and disseminating bullying prevention resources.

- Substance Abuse and Mental Health Services Administration (URL: https://www.samhsa.gov/) (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

- Suicide Prevention Resource Center (URL: https://www.sprc.org/) is the only federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention (URL: https://store.samhsa.gov/product/National-Strategy-for-Suicide-Prevention-2012-Goals-and-Objectives-for-Action/PEP12-NSSPGOALS).

www.ncfrp.org