THE SUICIDE FATALITY REVIEW PROCESS

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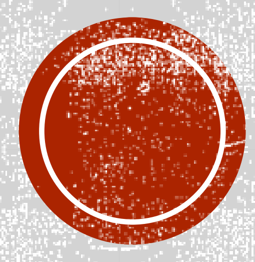
BUT FIRST, A THANK YOU!

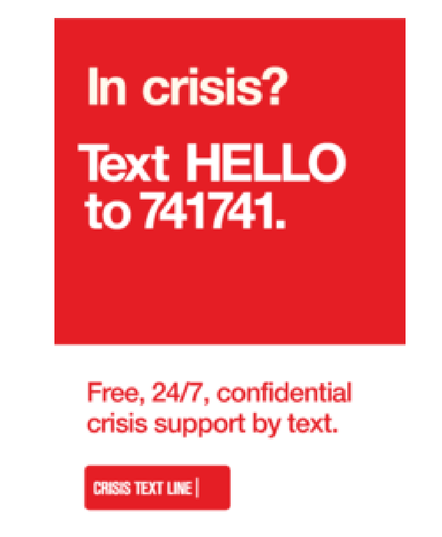


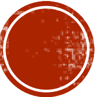
CONTENT WARNING

Suicide is a challenging topic for everyone.

If you need to talk to someone, please reach out to a trusted provider, family member or friend.

If you're in ever in crisis or if you'd simply prefer to speak to someone anonymously, put these numbers in your phone.





VA'S PUBLIC HEALTH APPROACH TO SUICIDE

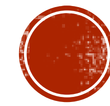
Step 1: Define the problem. This involves collecting data to determine the "who," "what," "where," "when," and "how" of suicide deaths.

Step 2: Identify risk and protective factors. Scientific research methods are used to explore the factors that increase risk for suicide, as well as the protective factors that serve as buffers against suicide risk.

Step 3: Develop and test prevention strategies. Suicide prevention strategies are developed and tested to see if they succeed in preventing suicide and/or suicidal behaviors.

Step 4: Assure widespread adoption. Strategies shown to be successful in Step 3 are broadly disseminated and implemented by a variety of stakeholders who play a role in preventing Veteran suicide.

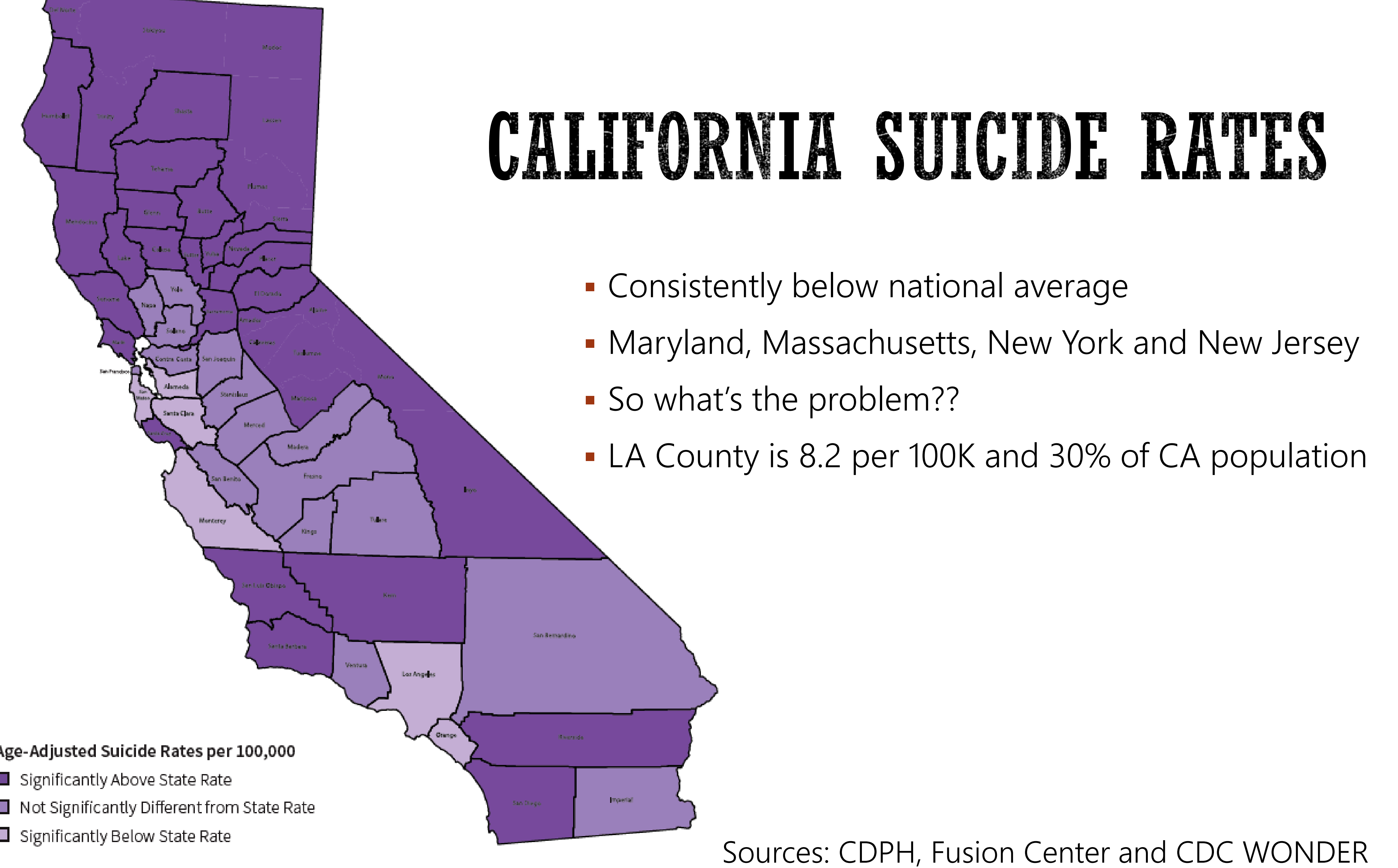
Veterans Affairs: https://www.va.gov/PREVENTS/docs/PRE-002-PREVENTS-Placemat_508.pdf



STEP 1: DEFINE THE PROBLEM

CALIFORNIA SUICIDE RATES

- Consistently below national average
- Maryland, Massachusetts, New York and New Jersey
- So what's the problem??
- LA County is 8.2 per 100K and 30% of CA population



Sources: CDPH, Fusion Center and CDC WONDER

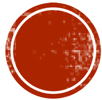
MASKING THIS BURDEN

Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Lake
Colusa
Sutter
Yuba
Nevada
Placer
Yolo
Sonoma
Napa
El Dorado
Alpine

STEP 2: IDENTIFY RISK AND PROTECTIVE FACTORS

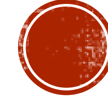
"In God we trust. All others bring data"

- W. Edwards Deming



RISK FACTOR DATA CONSIDERATIONS

- Level
  - population, individual, system
- Timeliness
  - Multiple years, a year, months, days
- Accuracy
- Actionability

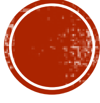


National surveillance data

Local death investigation data

Suicide Fatality Reviews

Individual psychological autopsies



NATIONAL VIOLENT DEATH REPORTING SYSTEM (NVDRS)

What KIND of Data Does NVDRS Collect?

NVDRS covers all types of violent deaths, in all settings, for all age groups. Over 600 data elements are captured, including:

- Location of injury
- Characteristics of victim
- Relationship of victim to suspect
- Weapons used
- Toxicology reports
- Alcohol or substance abuse

- Mental health problems and treatment
- Intimate partner violence
- Physical health problems
- Relationship problems
- Problems with job or finances

https://www.cdc.gov/violenceprevention/communicationresources/infographics/nvdrs-infographic.html

2018 CA-VDRS

Youth aged 10-17 years

- 17% intimate partner problem
- 17% school problem
- 17% recent or imminent crisis of any kind
- 15% other relationship problem (family or friend, but not an intimate partner)
- 11% argument or conflict
- 10% alcohol and/or substance abuse problem

Young adults aged 18-24 years

- 22% alcohol and/or substance abuse problem
- 19% intimate partner problem
- 15% recent or imminent crisis
- 8% financial and/or job problem

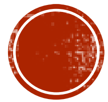
Adults aged 25-64 years

- 32% alcohol and/or substance abuse problem
- 21% intimate partner problem
- 16% recent or imminent crisis of any kind
- 14% financial and/or job problem
- 11% physical health problem

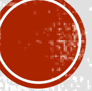
Older adults aged 65 years and older

- 48% physical health problem
- 12% alcohol and/or substance abuse problem
- 11% recent or imminent crisis of any kind
- 10% death of family member or friend (suicide or other)
- 5% eviction or loss of home

https://www.pacesconnection.com/fileSendAction/fcType/0/fcOid/521917012976202127/filePointer/521917012976202153/fodoid/521776275349232154/CalVDRS%20Factsheet_SuicideInCalifornia_2018_ADA.pdf



FOLLOW THE DATA TRAIL

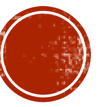


Kimberly Repp, PhD, MPH 1/26/2022

OUR SYSTEM IS BORN

Epidemiologists at an outbreak scene

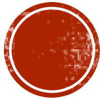
Investigators at a death scene



SUICIDE RISK FACTOR SURVEILLANCE SYSTEM (SRFSS)

Please indicate if any of the follow circumstances were present in the **months or years** prior to death and you believe they may have **contributed to the death**. If you would mention it in your report it's considered contributory. Point event crises will be collected later.

	Y	?	N
Social isolation	☐	☐	☐
Addiction other than alcohol or substance abuse	☐	☐	☐
Physical health problem	☐	☐	☐
Intimate partner problem	☐	☐	☐
Family relationship stress	☐	☐	☐



attempt to

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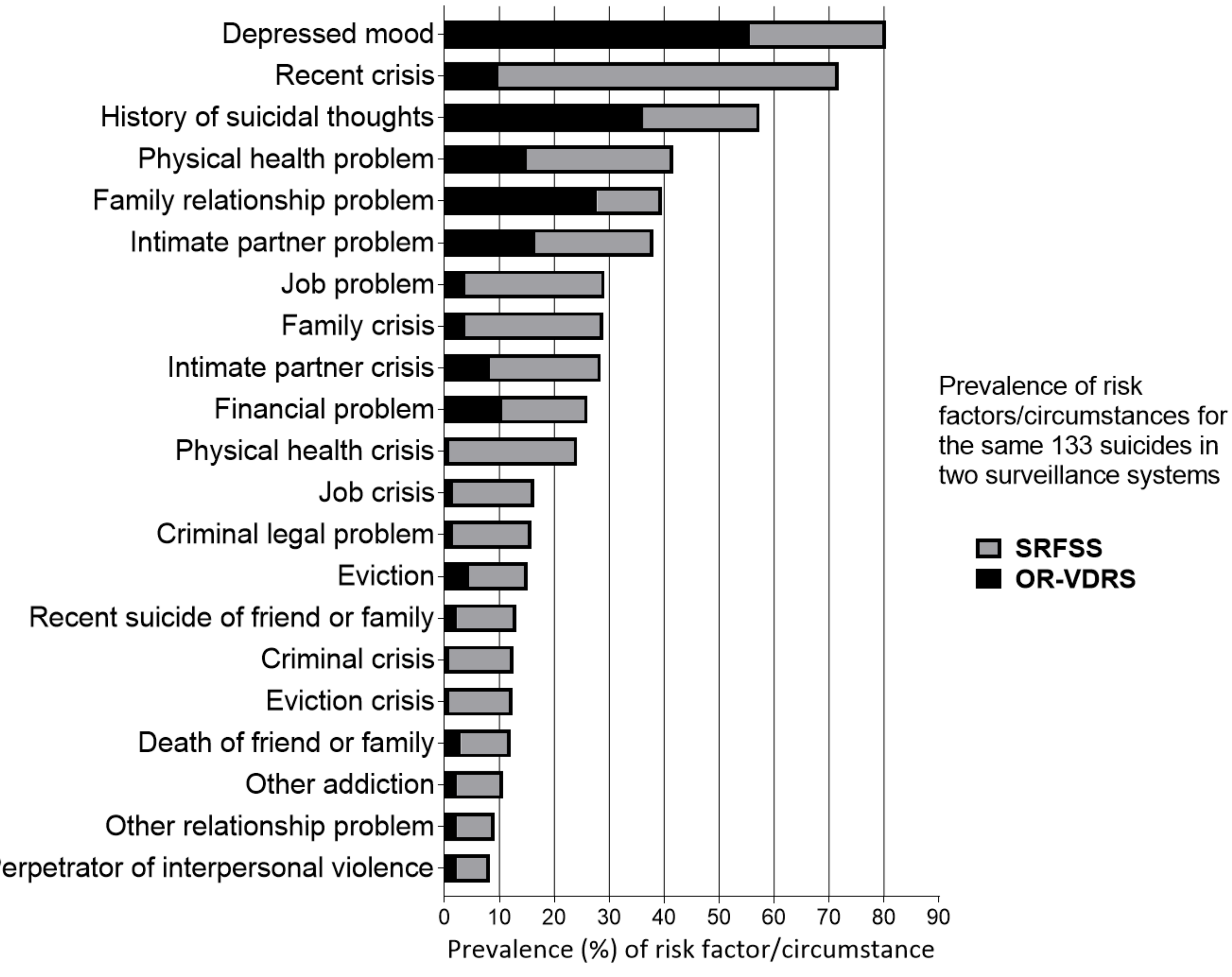
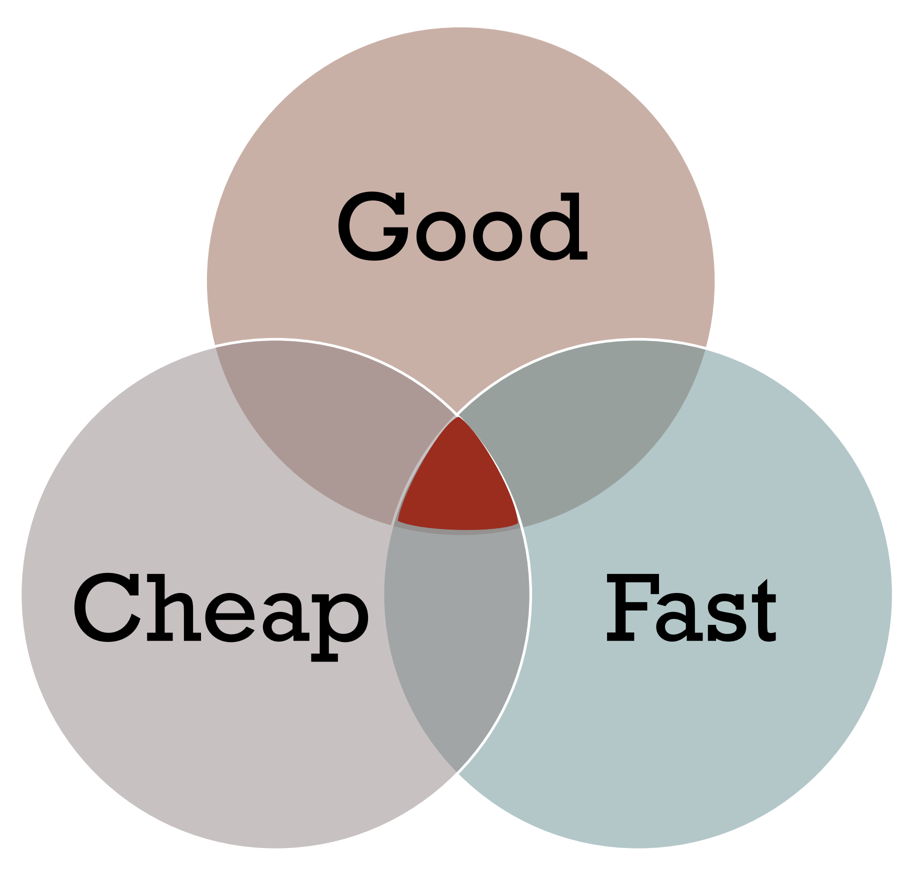


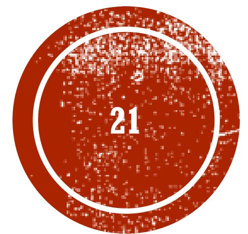
Prevalence of risk factors/circumstances for the same 133 suicides in two surveillance systems

- SRFSS
- OR-VDRS

Repp, Kimberly K. PhD, MPH*; Hawes, Eva MPH, CHES*; Rees, Kathleen J. MSPH*; Lovato, Charles AAS*; Knapp, Adam BA*; Stauffenberg, Michele MD† Evaluation of a Novel Medicolegal Death Investigator–Based Suicide Surveillance System to the National Violent Death Reporting System, The American Journal of Forensic Medicine and Pathology: September 2019 - Volume 40 - Issue 3 - p 227-231 doi: 10.1097/PAF.0000000000000491

WHY USE DEATH INVESTIGATOR DATA FOR RISK FACTORS AND CIRCUMSTANCES?





SUICIDE FATALITY REVIEW

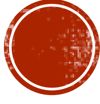
System level risk factors

National surveillance data (NVDRS)

Local death investigation data

Suicide Fatality Reviews

Individual psychological autopsies



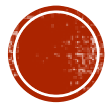
WHAT IS A SUICIDE FATALITY REVIEW?

SFR

- Multidisciplinary sources of information
- Requires consent
- Systematic method
- Does not include family/friends of decedent
- One meeting
- *How* do we prevent a death like this from happening again?

Psychological Autopsy

- Single certified professional trained in psychological autopsies
- Requires consent
- Systematic method
- Extensive interviews with many informants
- Months or a year
- *Why* did this death happen?



VALUABLE MEMBERS OF SFR

Government Programs

- Medical Examiners/Coroner
- Epidemiology
- Disability, Aging and Veteran Services
- Developmental Disabilities
- Emergency Medical Services
- Mental Health
- Commitment Team
- Sheriff's Office Crisis Team
- District Attorney's Office

Community members

- Portland Veteran's Association
- Lines for Life (crisis line)
- Local Chaplin (reports to death scenes)
- FBI
- National Alliance on Mental Illness
- Faith community leaders
- All major healthcare systems
- Substance use treatment centers
- Inpatient psych nurse leads

SFR STEPS AND PAPERWORK

Death occurs

- Forensic investigation
- Narrative and evidence

Death investigator work

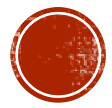
- Next of kin consent for information release
- Prepare SFR packets

Committee work pre-SFR

- Charter
- Confidentiality statement
- Roles and expectations

SFR meeting

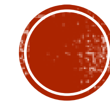
- Matrix



THE SUICIDE FATALITY REVIEW MEETING
Kimberly Repp, PhD, MPH 1/26/2022

MEETING PROCEDURE

- Meet 4-5 times yearly for two hours
  - 5 cases max
- Confidentiality and release form reviewed
- MDI reviews case file
- Committee members share their own case-specific information
  - Clarifying questions
  - Epidemiologist captures this information
- Protective and Risk Factors Modular Approach for each case
- Suicide Prevention Coordinator records all recommendations from matrix



THE SFR MATRIX APPROACH

	PROTECTIVE FACTORS							
RISK FACTORS	Effective clinical care for mental, physical, and substance use disorders	Easy access to a variety of clinical interventions and support for help-seeking	Restricted access to highly lethal means of suicide	Strong connections to family and community support	Support through ongoing medical and mental health care relationships	Skills in problem solving, conflict resolution & nonviolent handling of disputes	Cultural and religious	Other

Adapted from: http://www2.isu.edu/irh/projects/ysp/CommunitySuicidePrevention/4PreventionPlanning/PreventionPlanning.pdf

SFR FOCUSING QUESTION

What changes in behaviors, technologies, agency systems and or/laws could minimize the risk factors or increase the protective factors and prevent another suicide?

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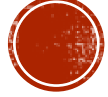
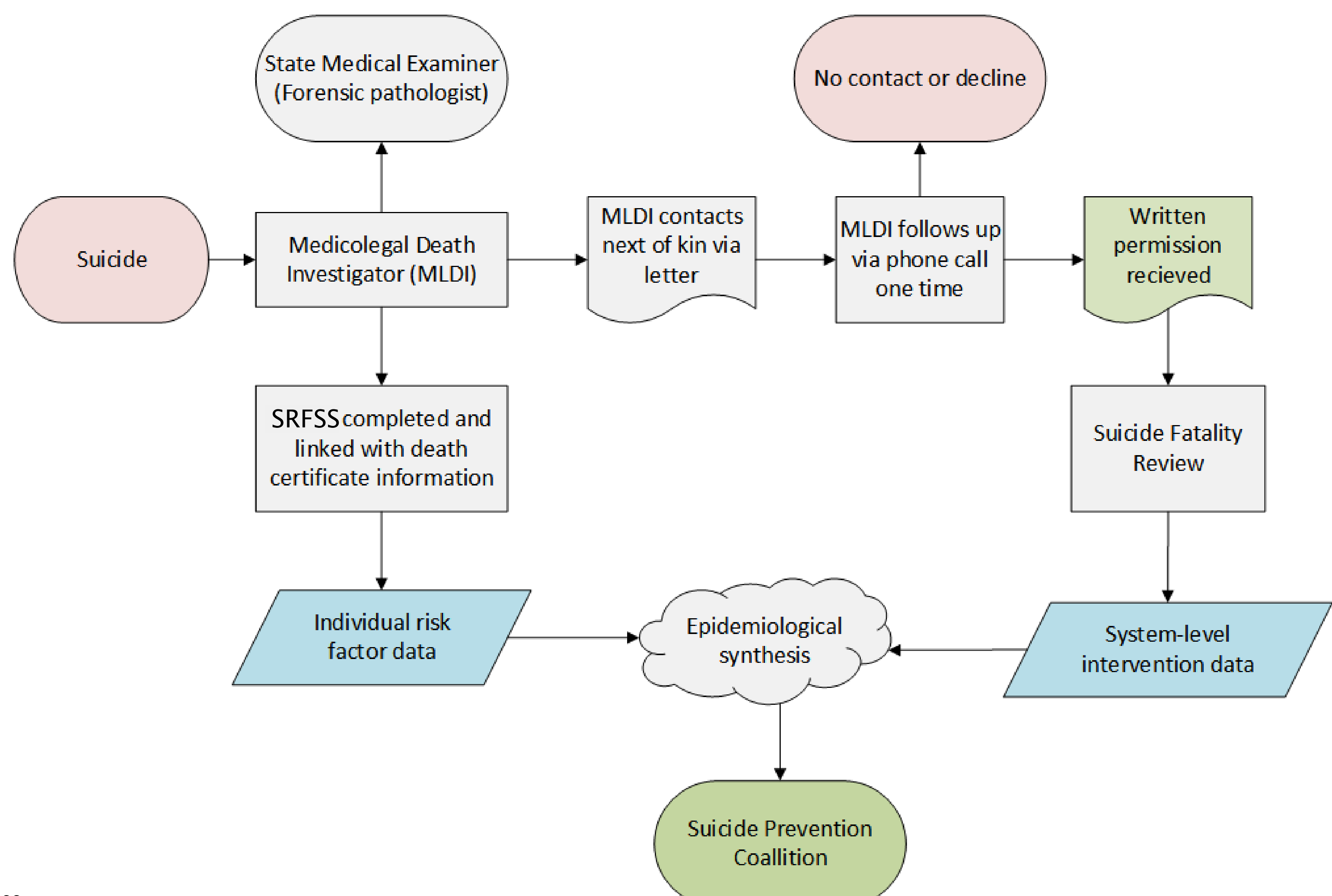
	PROTECTIVE FACTORS		
	Effective clinical care for mental, physical, and substance abuse disorders	Strong connections to family and community support	Reduce access to highly lethal means of suicide
RISK FACTORS: **Social isolation**	Suicide prevention training for vision practitioners Peer support connection resources through hospital	QPR training for neighborhood watch groups Enhance veteran support groups within county	Training on culturally competent means reduction Engage veteran support groups in education/training
Alcohol problem	Screening and interventions for alcohol abuse at hospital	Connect with AA and similar programs to provide awareness and education	Patient, community, and provider education on link of alcohol use and suicide attempt
Eviction crisis		List crisis line on eviction notices	

Adapted from: http://www2.isu.edu/irh/projects/ysp/CommunitySuicidePrevention/4PreventionPlanning/PreventionPlanning.pdf



THE FULL SYSTEM



STEP 3: DEVELOP AND TEST PREVENTION STRATEGIES

MOTEL

EVICTION NOTICE

To:

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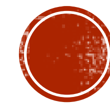
LESSONS LEARNED AND CHALLENGES

TWO YEARS OF SFR IN NEW YORK

- Align with legal on consent form
- Voluntarily engaged Coroner/ME office
  - Robust death investigations
  - Investigators *must* fill out SRFSS
  - Ability to support them administratively
- Existing Suicide Prevention group to implement recommendations
  - Policy/decision makers

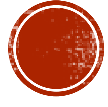


TIME COST

- SRFSS
  - Five minutes of MLDI time
  - Epi analysis time: 2h month
    - Software: Qualtrics, Stata
- Fatality review
  - Upfront legal time
  - 3-5h month for MLDI
  - 3h month for Prevention coordinator
  - 2h month for epi

BENEFITS

- Administration and community will see the value of death investigations
- Investigators learn how critical they are to public health
  - Investigating death to saving lives
- Grant funding for additional suicide prevention activities
- Stronger relationships



STEP 4: ENSURE WIDESPREAD ADOPTION

“NEVER GROW A WISHBONE, WHERE YOUR BACKBONE OUGHT TO BE.”

- CLEMENTINE PADDLEFORD

HUMBOLDT COUNTY, CA, SFR CORE TEAM

Kristen Smith – Senior Health Education Specialist	• Lessons learned
Ron Largusa – Epidemiologist	• Data
Dana Murguía – Senior Program Manager	• Purpose and intention