The Chicago School of Professional Psychology, The Forensic Training Institute

ICAN Coroner Suicide Guidelines

Pilot form evaluation

This project investigated the effectiveness of the ICAN Coroner suicide guidelines form for child and adolescent suicide. This form was developed, implemented and utilized by the Inter-Agency Council on Child Abuse and Neglect and Los Angeles County Coroner Investigators to structure and assist suicide related data collection.

Introduction

Suicide is the third leading cause of death in youth ages 15 to 24. The total number of child and adolescent suicides in Los Angeles County has decreased in the past decade when compared to the number in the preceding decade (ICAN, 2011). However, the rates remain alarming (ICAN 2011). While risk factors have been identified, more information is needed to gain insight into the complexities and nuances of child and adolescent suicide. In an effort to identify suicide risk and protective factors by coroner investigators, a form was created which could be used during case investigation. Understanding the risk and protective factors for this population is necessary for the following three reasons (1) to reduce instances of potential child and adolescent suicide (2) increase awareness of the human cost of child and adolescent suicide (3) increase the awareness of collaborative efforts and referral efforts. This research project investigated the effectiveness of the ICAN Coroner suicide guidelines form for child and adolescent suicide. This form was developed, implemented and utilized by the Inter-Agency Council on Child Abuse and Neglect and Los Angeles County Coroner Investigators to structure and assist suicide related data collection. Findings indicated an increase in relevant information collected and reported after form implementation. Coroner investigators, administrators and collaborative partners may benefit from including the form as an investigative tool.

Investigative Guidelines

The need for investigative guidelines for death investigations has been established at the highest level. The U. S. Department of Justice, Office of Justice Programs research report (1999),

provides specific Medicolegal Death Investigation Guidelines beginning with a section including a comprehensive list of investigative tools and equipment and ending with section detailing the completion of the scene investigation. The justification for the guidelines can be found in the statement from then Attorney General Janet Reno, "The sudden or unexplained death of an individual has a profound impact on families and friends of the deceased and places significant responsibilities on the agencies tasked with determining the cause of death. Increasingly, science and technology play a key role in death investigations. One of the hallmarks of science is adherence to clear and well-grounded protocols." While the report has since been updated and investigators currently use the 2011 edition, this statement remains relevant particularly when seeking to justify updates to protocols. While many deaths referred to the coroner are natural deaths, those that are not may provide vital information useful for prevention. Information collection related to death helps to provide families, friends, scientist, researchers, advocates and others answers to a number of questions. The difficulty arises when investigators, who have a unique opportunity to collect information which may help to answer these questions, are unaware that specific information is needed. Additionally, some investigators may feel that it is beyond the scope of their duties to collect such information because it would seem intrusive to do so. In the case of suicide, questions beyond determining the cause and manner of death may seem beyond the scope of the investigator's duties. However, Section E: Establishing and Recording, 4 Documenting decedent mental health history, and 5 Documenting social history, provide rationale and justification for collecting such information, specifically that such information "will aid in establishing the cause, manner and, circumstances of the death." (U. S. Department of Justice p. 42-43). Thus it is essential to help investigators understand how gathering information in these areas is not only important but considered part of the established U. S. Department of Justice protocol.

Locally, the County of Los Angeles requires that investigators utilize guidelines for investigations. These investigative guidelines also require that specific protocol be followed. Emphasis is placed on

accurately documenting the facts related to the case which help to demonstrate the cause, manner and circumstances of death. With regard to suicide reports, the guidelines suggest consideration of information that can be collected and may be helpful in determining events that lead to the death (Los Angeles County Coroner, n.d.). It should be noted that there is no requirement that this information be collected therefore investigators may or may not inquire about it.

ICAN Coroner Suicide Guidelines Form

The rational for the creation of the ICAN Coroner Suicide Guidelines form was that while coroner investigator reports of child and adolescent suicide generally provided information that met the requirement of determining cause, manner and circumstance of death, at times there was little more provided. Specifically, Los Angeles County Child and Adolescent Suicide Review Teams (CASRT) members felt that additional information was needed. As a result of missing information, CASRT members were unable to determine what may have led to a child's death by suicide. Team members felt this limited future prevention and intervention. This was expressed by a CASRT member,

> *"In the meeting it is sad when there is no sense of the child, we feel like we know nothing about them. It is frustrating when we walk away with not a clue about the child. This is not helpful because we need to be able to identify preventative factors and risk factors."*

It is also important to note that CASRT members related the detail and depth of the reports appeared to vary widely. That is, some reports provided rich details about the child and other reports provided minimal details. Thus, it was determined that providing a guideline form could help to prompt investigators to collect specific information necessary for prevention.

Additionally, without reviewing the coroner narratives, CASRT members reported that there was difficulty quantifying data. For example, there was no way to know if specific questions about mental health or medical history were asked by the investigators during.

Based on the need for consistency in collecting and reporting data related to child and adolescent suicide, the ICAN Coroner Suicide Guidelines Form was developed. The form provided a format by which investigators could indicate if questions were asked, not asked, were not applicable and provided a space for additional comments in each section. This structured format would provide a means for coroner investigators to easily capture and relay case information for their reports and other stakeholders. Thus, the goals of the form were determined to serve as a method for 1) data collection and 2) provide a concise format for coroner investigators to collect and convey information that was being captured and conveyed inconsistently.

The ICAN Coroner Suicide Guidelines Form was beta tested in the field by Los Angeles County coroner investigators from January 1, 2012 – July 31, 2012. The domains of data collection on the form included Mental Health, Suicide Exposure and Behavior, Medical, Education/Occupation, and Support Systems and Other Involvement. The domains were consistent with data collected by the Center for Disease Control and Prevention's National Violent Death Reporting System (n.d.) and current bio-psycho-social trends. The form also included a section for investigator comments regarding full disclosure and additional comments.

Los Angeles coroner child and adolescent suicide cases reports from January 1, 2011 – July 31, 2011 were reviewed using the form to provide baseline data. As was previously mentioned, report details varied widely and it was important to determine how much information in the domains was already being collected prior to form implementation and where improvement was needed.

Researchers reviewed the coroner investigation reports to determine if information on the form could be ascertained by reading the narrative sections. It was determined from the baseline data that 6/6 questions in the mental health domain were able to be to answered, 2/3 questions in the suicide exposure and behavior domain were able to be answered, 1/3 questions in the medical domain was able

to be answered, 1/2 of the questions in education and occupation was able to be answered and 3/5 questions in the support system and other involvement were able to be answered (see charts 1-5). These results were promising in that while not all questions in each domain were being answered, at least some were. At best, all questions in the mental health domain were able to be answered and areas for improvement were in the medical and education/occupation domains were one question in each area was able to be answered. Therefore, it was determined that the form could help investigators expand their information collection in the areas they were already familiar with. Furthermore, a review of the reports determined that the information collected and relayed in the reports was within the scope of investigative protocols previously detailed.

The form was piloted in the field by Los Angeles County coroner investigators from January 1, 2012 – July 31, 2012. In each of the cases reported, the forms were completed by the investigators. While the form was used by all investigators, it appeared that the ways in which the form was used varied. The investigators checked the YES/NO/NA/Not Asked boxes and provided some comments but the extent of the comments ranged from no words to writing words beyond the space provided and into the margins of the paper. It is not known when and how the form was used. For example, the investigator may have used the form during their interviews and asked questions directly from the form or they may have conducted their interviews and completed the form afterwards. However, it should be noted that when taken together the form and the narratives did provide answers to the questions on the form (see charts 6-10).

The following charts reflect whether or not questions on the form could be answered from the narrative before (baseline data) and after from implementation (*1= Yes/0=No).

Chart 1: Mental Health questions 1-6 Baseline.
6/6 questions were answered by reading the narratives of the baseline data.

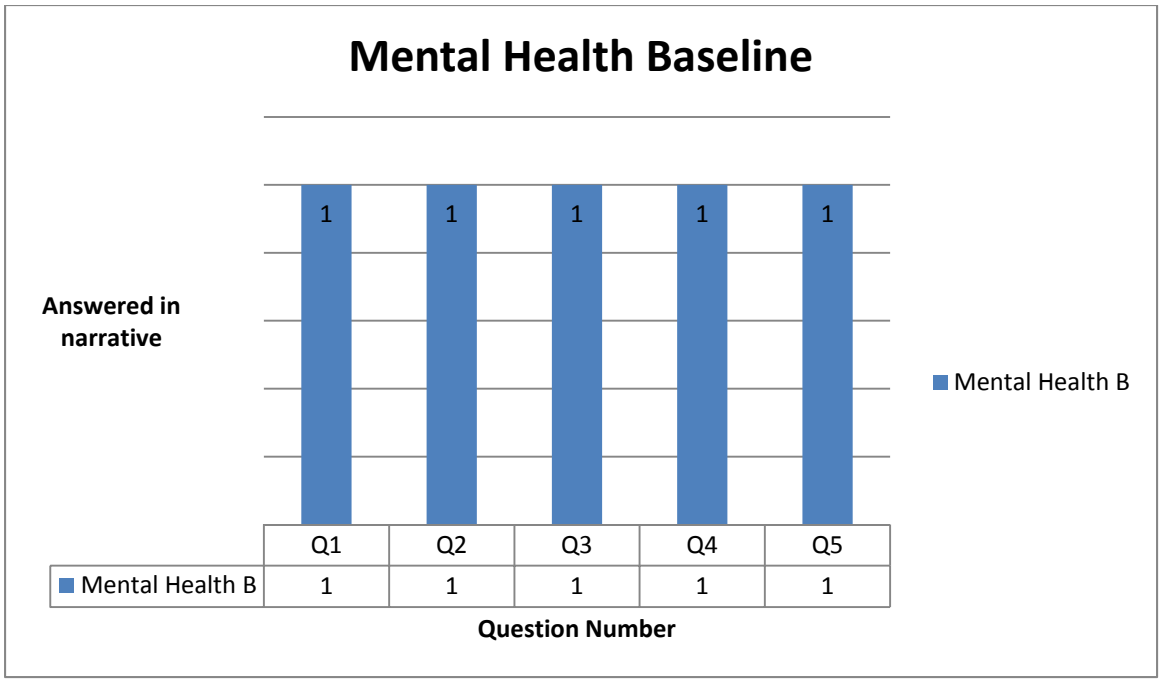
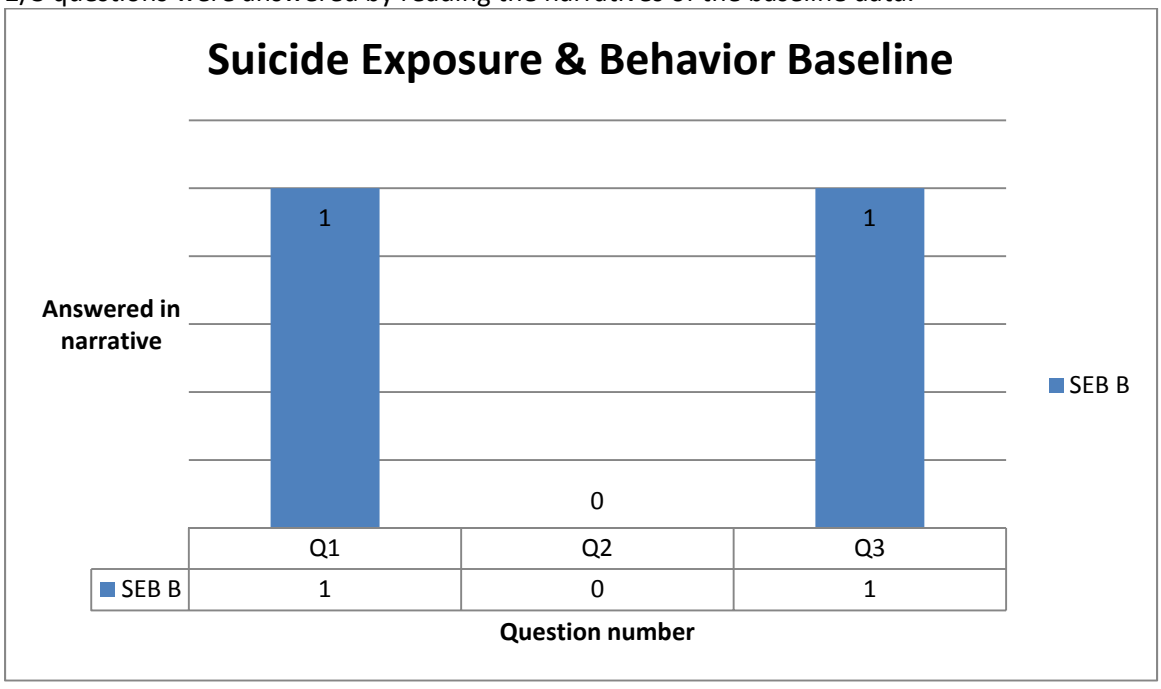


Chart 2: Suicide Exposure & Behavior questions 1-3 Baseline
2/3 questions were answered by reading the narratives of the baseline data.



Cart 3: Medical questions 1-3 Baseline.
1/3 questions were answered by reading the narratives of the baseline data.

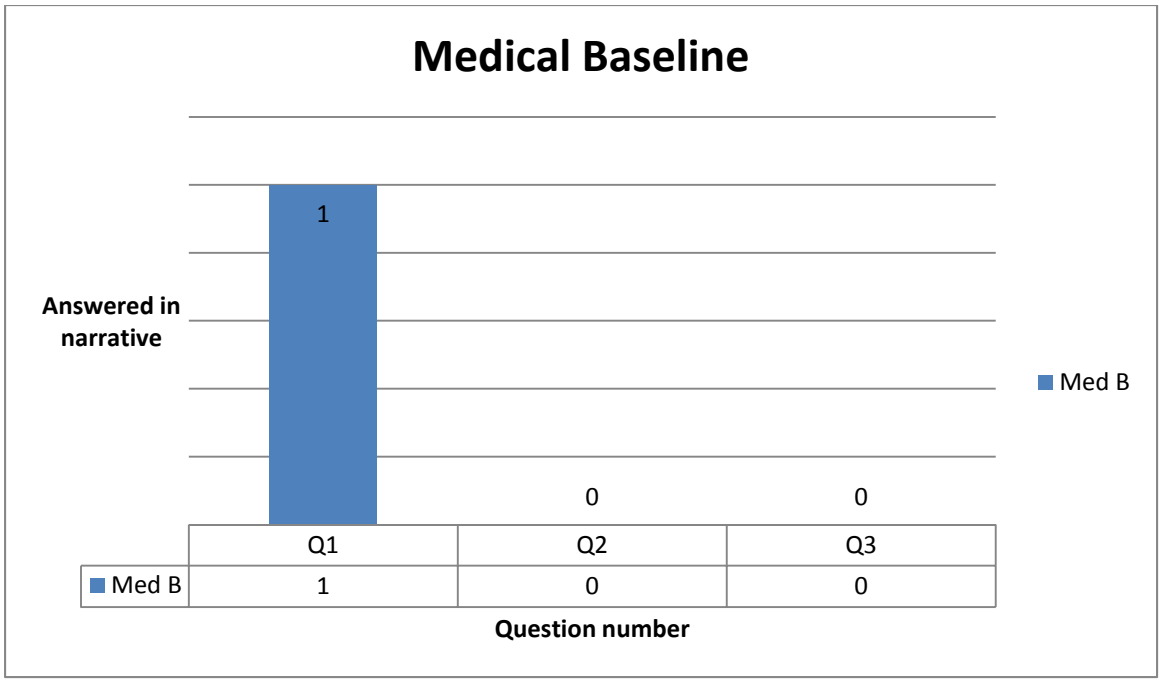


Chart 4: Education/Occupation questions 1-2 Baseline.
1/2 questions were answered by reading the narratives of the baseline data.

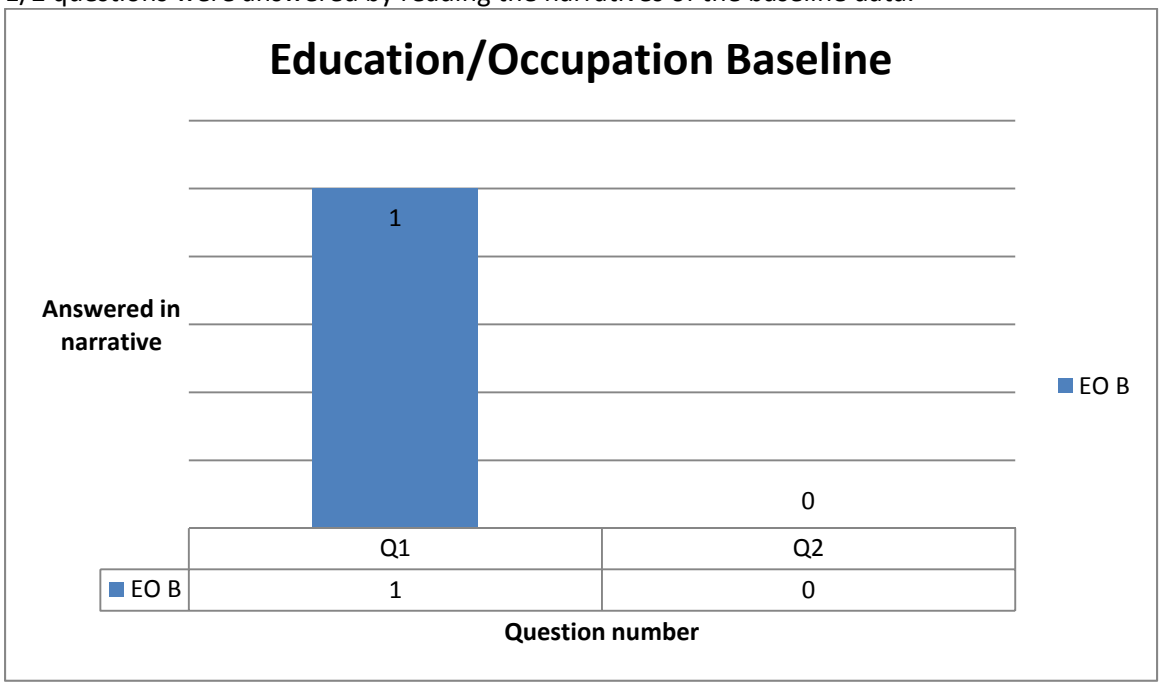


Chart 5: Support Systems and Other Involvement questions 1-5 Baseline.
3/5 questions were answered by reading the narratives of the baseline data.

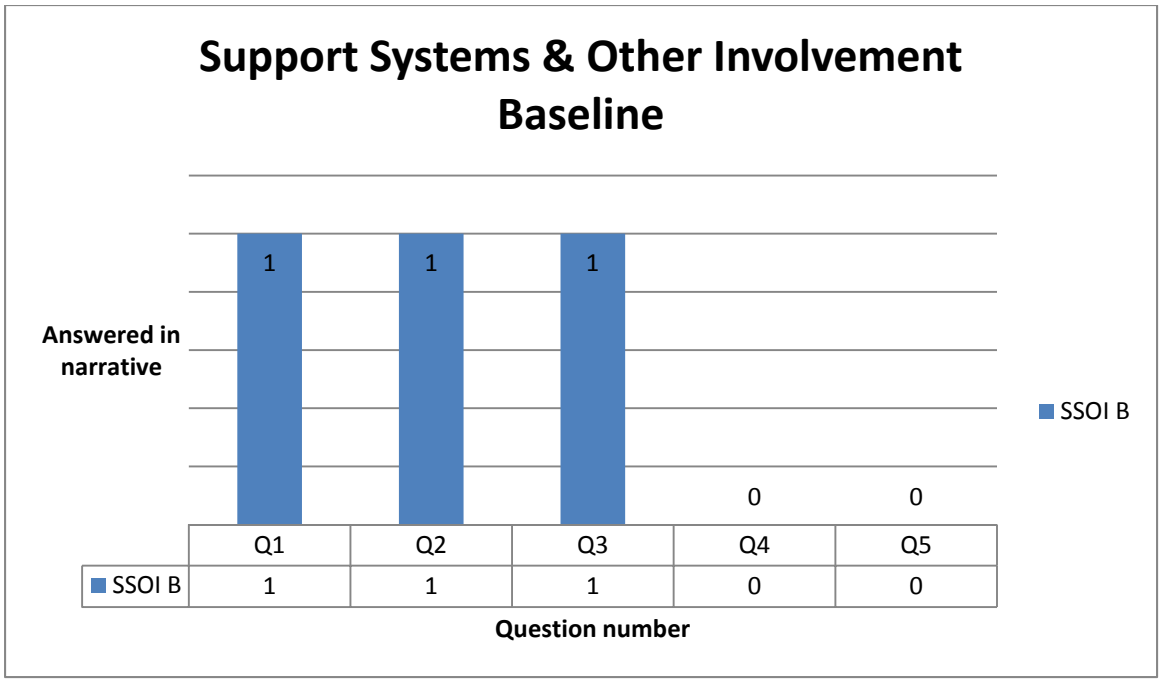


Chart 6: Mental Health questions 1-6.
6/6 questions were answered by reading the narratives before and after form implementation.

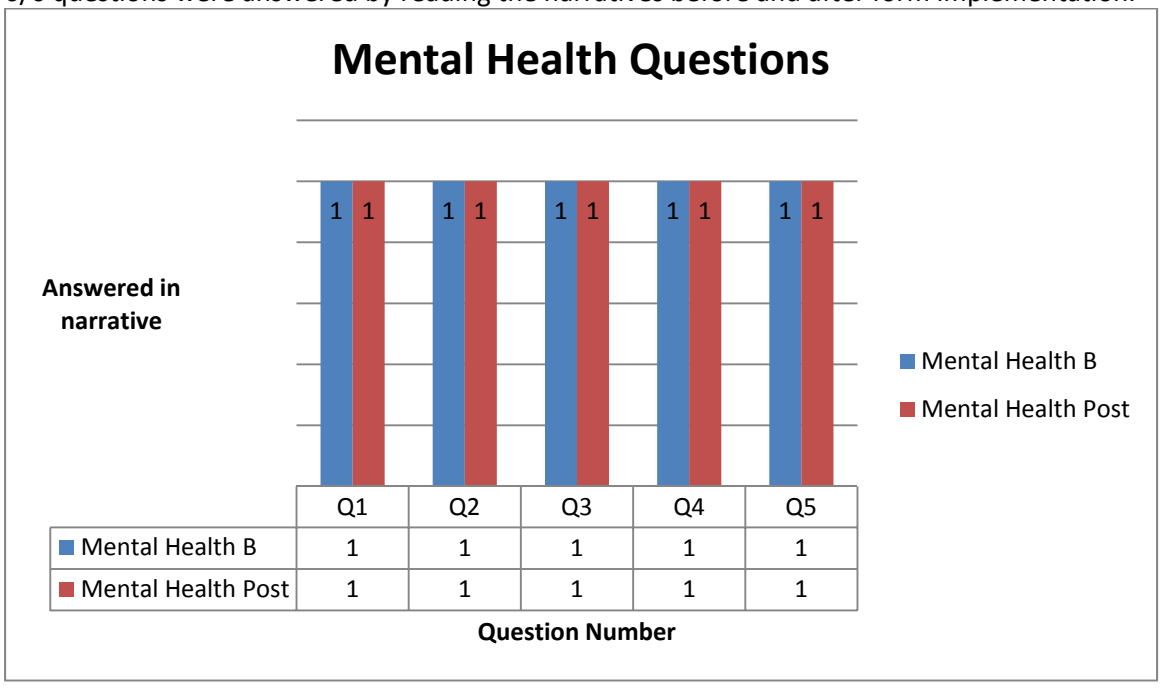


Chart 7: Suicide Exposure & Behavior questions 1-3.
2/3 question were answered by reading the narratives before form implementation and 3/3 questions were answered after from implementation.

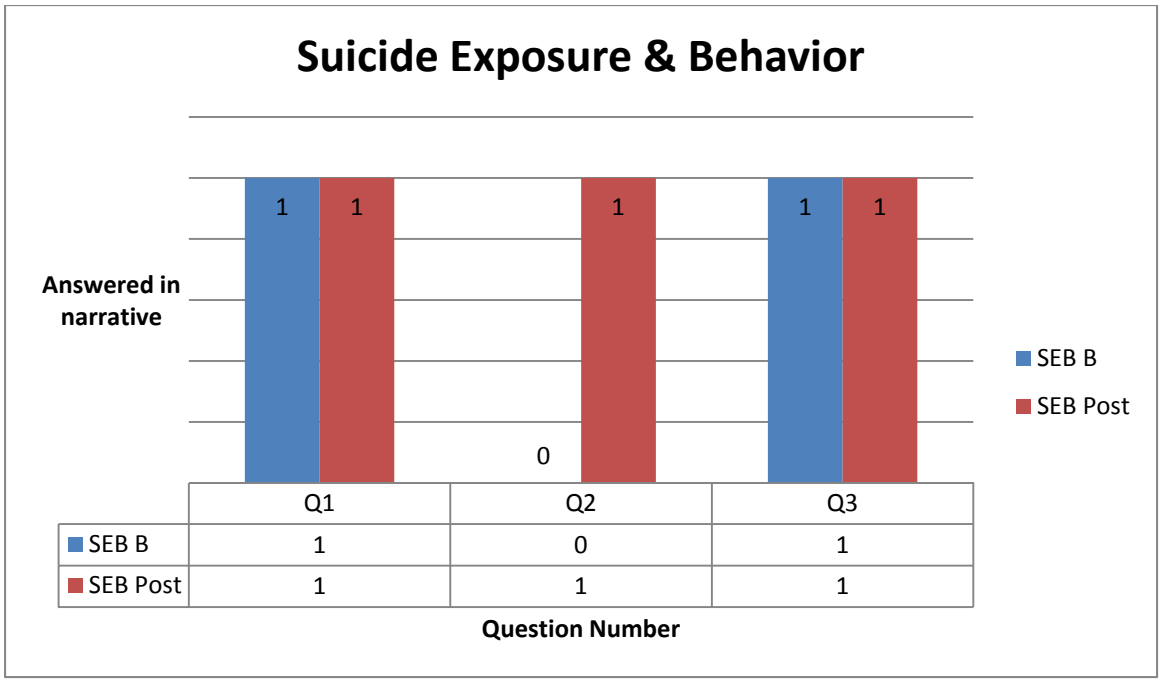


Chart 8: Medical questions 1-3.
1/3 question were answered by reading the narratives before form implementation and 3/3 questions were answered after from implementation.

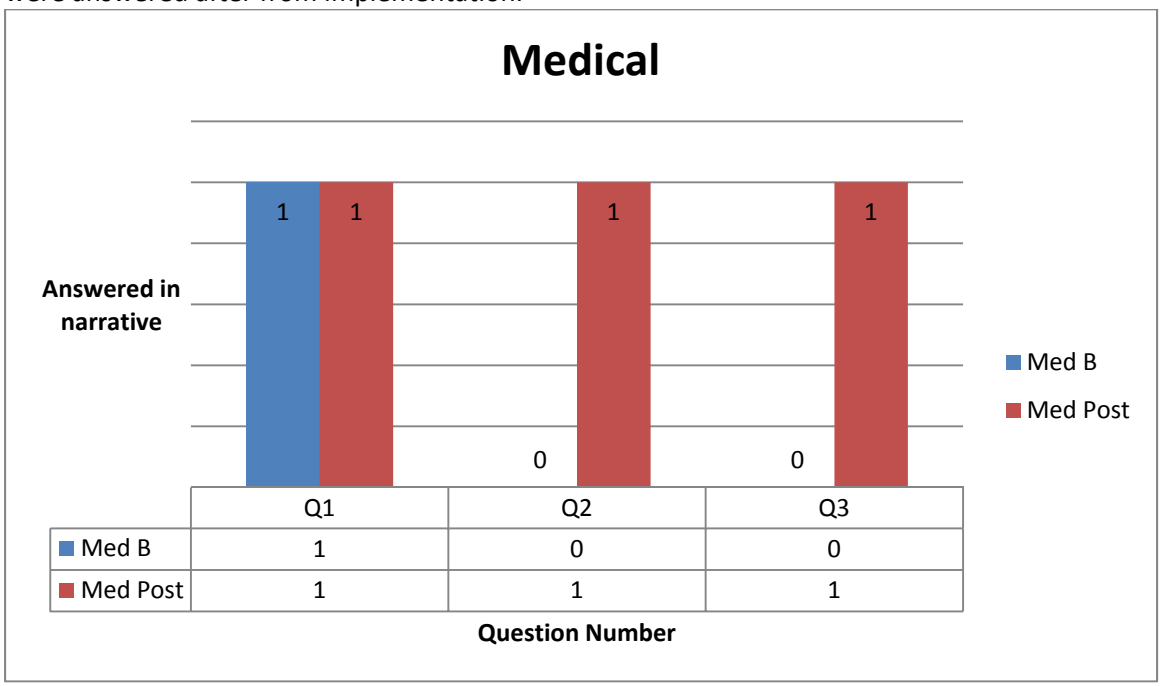


Chart 9: Education/Occupation questions 1-2.
1/2 question were answered by reading the narratives before form implementation and 2/2 questions were answered after from implementation.

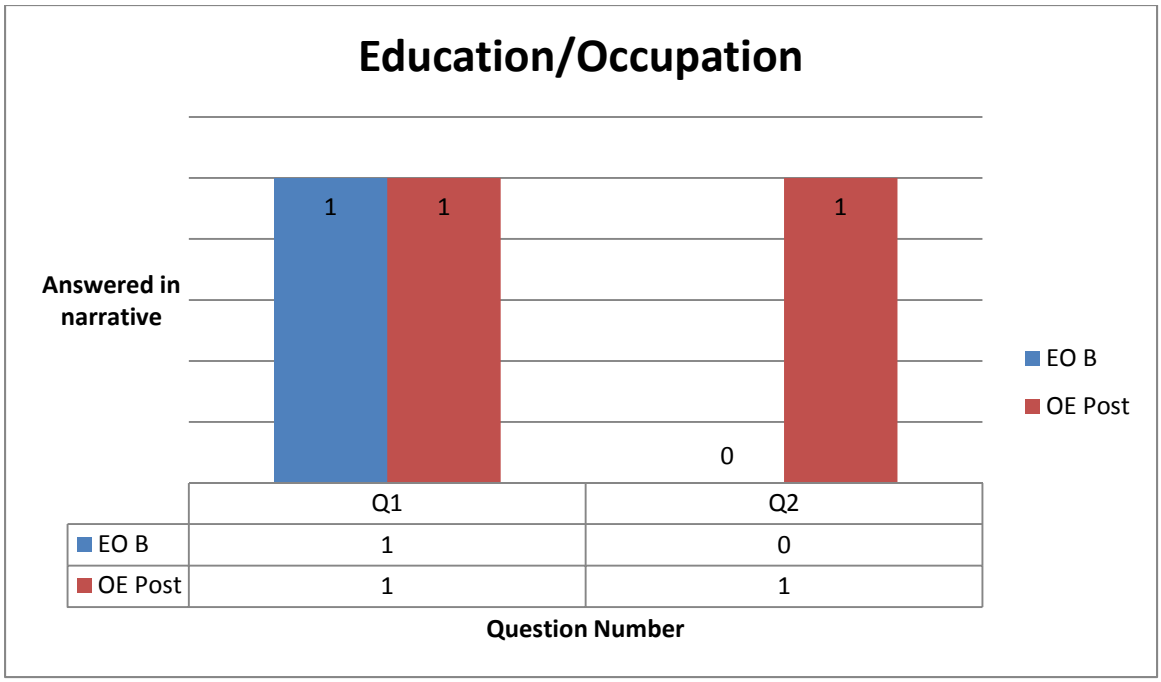
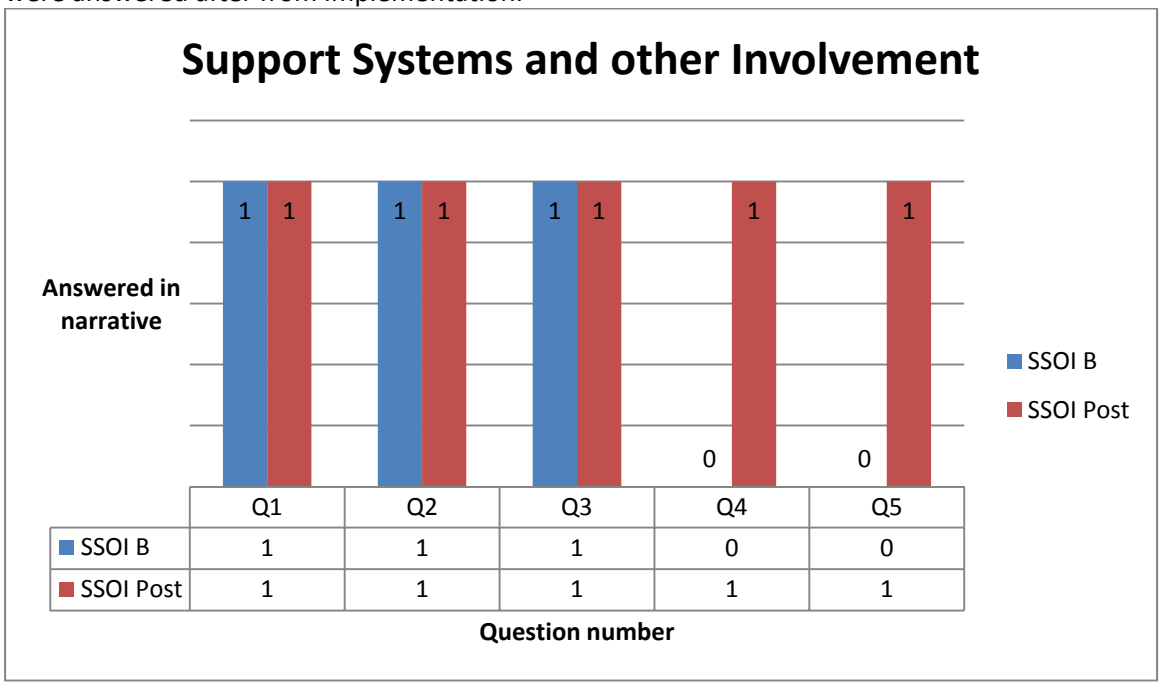


Chart 10: Support Systems and Other Involvement questions 1-5.
3/5 question were answered by reading the narratives before form implementation and 3/5 questions were answered after from implementation.



Next Steps

Training

With regards to the ICAN Coroner Suicide Guidelines form, training should include the rationale for the form. That is, why the form was created, including an overview of the review teams and the need for more information, need for data for prevention and intervention efforts and other relevant information. There was feedback that there was considerable confusion about which boxes were supposed to be checked and compliance varied widely among investigators. Investigators who used the form and found it helpful suggested training include more details about the form and how to use it,

> *"Training about why we are using it is important… training on interpretation of the form so they understand why these questions are necessary."*

The current focus of the investigators may be on getting the case in and on to the medical examiner. If the investigator received training which informed them that individuals beyond the medical examiner will possibly review the reports, they may be able to broaden the scope of their information collection.

It is also important to convey when the form should be used. That is, should it be used during the interview or after the interview? As mentioned previously, it was difficult to determine when the investigators used the form. It may be helpful for investigators to know the importance of using the form during their interviews as opportunities for collecting the information may be available at a later time.

When investigators are asked to collect information there should be a clear rationale provided. One way to provide this rationale is to articulate the need during training and relay the protocol from the highest level, the U. S. Department of Justice. Helping the investigator understand the importance of the information for prevention and intervention may help to provide a link from why they are being asked to do a task that appears to be beyond the scope of their duties to what is considered best practice can be beneficial.

Another approach may be to help investigators reframe their information collection methodology. This was illustrated in a statement from one of a seasoned investigator,

> *"Investigators are taught to deal with the facts and psycho-social aspects are more about opinion, which are viewed as not necessarily helpful. A new way of thinking would be that opinion is just as important as fact. The standpoint does not have to be fact vs. opinion."*

If investigators are trained in a way that they are able to incorporate their opinion and the facts, a more detailed picture of the person could be established. Furthermore, qualitative remarks received from those that provided extensive comments in this section indicated a very high level of satisfaction in having a place to enter additional comments and subjective impressions. Inasmuch as only empirical data was generally written in the narrative report, many investigators appreciated the opportunity to communicate subjective impressions to health prevention team members.

Although this form was created specifically for use in child and adolescent suicide investigations, early feedback during form creation was that it would be useful across age groups. An unexpected result of pilot form was that investigators who were not present during the form creation reported that it is a helpful tool in investigation of suicide death in adults,

> *"I found it useful and shared it with other investigators and they are using it with adults."*

Using the form across the lifespan could help to standardize information collections. It may be easier to implement one protocol rather than multiple ones.

Availability of the Study Form

It was noted previously that support for the study varied widely between supervisors, An ample supply of the forms were supplied by some supervisors while investigators in some of the work units did

not know that the study was taking place. In addition to training investigators should have immediate and continuous access to the form. One investigator reported that while they were trained on the form, the location was not widely known to other investigators and that it was not part of their standard tool kit. This can be problematic if an investigator is not usually assigned a child or adolescent case because they may not have the form with them as it is not used with adult investigations.

Form revisions

Overall the form is sound. Although investigators reported the form as easy to understand, slight revisions should be considered. The recommendations are as follow:

1. The dual purpose of the form: a) data collection and b) investigation tool created confusion. After extensive discussion with the investigators who used the form most, it was determined that the second purpose was most important and the form was revised to delete confusions fields. Instructions and examples are currently prepared and they will be used for training and will be available for use in the field.
2. Change numbering sequence by add numbering to the questions. Currently there are no corresponding identifiers for questions on the form. The numbers should correspond to the domain. For example, Mental Health question 1 should be labeled MH1. This would allow consistent data tracking.
3. Questions in the Education/Occupation domain were restructured with the Yes/No questions moved above School and Worksite as the presentation of the questions seems confusing.
4. The full disclosure comment section on the front of the form was moved to the back of the form in the area with Additional Comments by Investigator. This could be revised to read

"Additional case notes/comments" and elaboration of this section could be provided during training.

Conclusions

The ICAN Coroner Suicide Guidelines form was developed with the aim of helping coroner investigators collect information that only they have access to. This information can help others with prevention and intervention efforts. The form was piloted tested during the first six months of 2012. Results of the pilot indicate the form increased information collection by the investigators. However, because questions arose as to the use of the form, it was determined that form revisions and more targeted training is needed. While investigators did have input in the form development, it is essential that they remain part of the revision and training efforts as they are the ones most able to effectively communicate the necessity of this tool to their colleagues.

References

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