Special Edition: Children’s Mental Health Month

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May 2020

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Visit our website
Fatality review colleagues,
In fatality review, we understand better than most the emotional wellbeing of children requires attention and investment just like their physical health. Robust mental health allows children and young people to develop the resilience to cope with life.

Beginning in 2005, the Substance Abuse and Mental Health Services Administration, organized the first Children’s Mental Health Awareness day to recognize the importance of positive mental health in the growth and development of children. Thursday, May 7th, 2020 is Children’s Mental Health Awareness Day, illuminating the importance of caring for every child’s mental health, regardless of diagnosis or severity of concern. In this special edition of the National Center’s newsletter, we want to draw your attention to three aspects of children’s mental health: infant and early childhood mental health; youth suicide; and the mental health needs of pregnant and parenting teens.

The unique charge of fatality review teams is to dig into life events, events that society often asks us to look away from. Reviewing a death gives the community the opportunity to peel back layers of risk factors to identify opportunities for systems
change. As fatality review professionals, we are acutely aware of how an individual’s mental health can impact all aspects of their life. The importance of total health, including mental health, is often at the forefront of many prevention discussions.

We recognize that current life events have impacted everyone’s life, particularly children. The American Academy of Pediatrics has a collection of resources for navigating the novel coronavirus pandemic; you can find them here: https://healthychildren.org/English/health-issues/conditions/chest-lungs/Pages/2019-Novel-Coronavirus.aspx.

The National Center has also compiled a list of resources for fatality review teams as we navigate these uncharted waters. You can find it here, under COVID Resources: https://www.ncfrp.org/tools_and_resources/products-and-publications/.

Thank you for all you are continuing to do to help make your communities healthy and safe. As always, please let us know if we can support your work in any way.

Toward a bright future,
Abby

**Upcoming Events**
WEBINAR

National Fatality Review-Case Reporting System
(NFR-CRS) Version 5.1

Wednesday, May 6th, 2:00-3:00 PM EST

National Center staff will highlight version 5.1 of the National Fatality Review-Case Reporting System (NFR-CRS), launched on April 27th. Key changes include:

- Expanded child’s mental health and substance use/abuse questions in Section A2 (CDR only)
- Expanded and revised suicide questions (CDR only)
- New section on life stressors
- Revision of Section L (Prevention) to focus on case findings
- All variable data download
- Health equity standardized report (FIMR only)
WEBINAR

Reviewing Drowning Deaths: Key Questions and Prevention Resources

Tuesday, May 19th, 2:00-3:00 PM EST

National experts and advocates will join the National Center to discuss drowning fatalities, focusing on preschool-age children. Building off the personal story of a bereaved mother and available fatality review data, speakers will highlight gaps in the research, opportunities of prevention based on better data collection, and valuable resources from prevention partners. Speakers include:

- Nicole Hughes, Founding Director, Levi's Legacy
- Todd Porter, MD, MSPH, FAAP
- Morag McKay, PhD, Director of Research, Safe Kids Worldwide

Join us as we discuss the burden of these types of deaths, and how to best address them.
Impact

Brain development in the critical first years of life lays the foundation for future health, learning, and behavior[1]. When effective bonding and attachment is challenged in infancy, children are at increased risk for mental illness. Somewhere between 10% and 20% of children younger than six years old experience mental illness, with similar rates to older children and youth; moreover, youth who have entered mental health treatment and their families report that often their first challenges began in their preschool years[2],[3]. Infant and early childhood mental health (IECMH) services support optimal social, emotional, and cognitive wellbeing of children ages 0 to 3 years. Clinicians provide home-based IECMH parent/infant support and intervention services to families when the child’s characteristics or parent’s condition and life circumstances challenge optimal attachment and the resulting development of the child. The specialist partners with families to address the needs of the infant, any other young children in the family, and the mental health needs of the caregivers. Professionals support families by facilitating secure and stable attachment-based relationships with nurturing caregivers. They typically provide weekly home visits to families who are enrolled during pregnancy, around the time of birth, or during the infant’s first year; these services are typically available till the child turns three. Community mental health services programs can provide infant mental health services as part of Medicaid 1915 (b)(3) services[4], as can
other state-led home-based programs.
Conditions that increase risk for insecure attachment and development include adolescent parents, low-income or single parents, first-born infants, low birth weight infants, and parents who have had diagnoses of developmental disability, substance use, or mental illness themselves. Families with multiple risk factors are the typical population served by these services.

Practitioners of IECMH services have unique insights into the underlying risk in families and the types of interventions that best support families with children in this age group. **They are excellent additions to fatality review teams both in case review contexts and in crafting relevant systems-level prevention recommendations.** Fatality review programs who have IECMH membership benefit from their insights and experiences. In case review contexts that do not include family interviews, like most child death review (CDR) programs, IECMH professionals are well-positioned to ensure a family-focused perspective is at the table. To find out what state-based IECMH resources are available in your state, click here:

https://www.zerotothree.org/resources/states.

Fatality Review Data

The National Fatality Review-Case Reporting System (NFR-CRS) collects information about decedents and parents in fatality cases. Some of the variables the NFR-CRS collects are relevant to populations served by IECMH services. The following data are taken from a larger subset and represent infants older than 27 days through the age of 4 years for whom it was indicated that the child had a known disability or chronic illness. The NFR-CRS contains 12,822 such cases, entered between 2004 and 2017. Of these:

- 11,900 (93%) had a noted physical or orthopedic disability
- 1290 (10%) had a cognitive or intellectual disability
- 406 (3%) had a noted sensory disability

Examining data related to biological mothers of these same children identified above, 3550 (27.7%) of them were known to have received social services in the 12 months prior to the child’s death. The known services mothers received included:
• 2682 (76%) who received Medicaid
• 1825 (51%) who received Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) benefits
• 424 (12%) who received Temporary Assistance for Needy Families (TANF)

When considering these data, it is helpful to remember that the data are limited by teams’ ability to identify the information from partners and records. Recently, the NFR-CRS began asking if, among social services, mothers were receiving home visiting services. This variable will yield valuable information to inform prevention in the future, as these populations may benefit from effective, evidence-based IECMH services in the home visiting context. These data can help teams consider available, and perhaps underutilized, prevention interventions. Of these same cases, a public health representative was present for 8664, or 68%, of the reviews; child welfare was present for 7910, or 62%, of the reviews; and mental health professionals were present for 3541, or 28%, of the reviews. These partners are well-positioned to share available community programs that include IECMH services.
The Substance Exposed Newborn (SEN) Task Force affiliated with the Flagler and Volusia County, Florida Healthy Start and Fetal and Infant Mortality Review (FIMR) program collaborated with hospitals, substance use treatment centers, state agencies, private physicians and infant mental health experts to improve outcomes for infants affected by maternal drug use. Together, they designed a “fast track” system for linkage to Healthy Start home visiting services, drug treatment, and immediate referral to pediatric services. The Women’s Intervention Specialist and the Neonatal Outreach Specialist work together to ensure appropriate and expedited enrollment and service delivery to the parent/infant dyad. The Task Force also provides a specialized training for caregivers of infants experiencing neonatal abstinence syndrome (NAS). For more information, click here: https://www.news-journalonline.com/assets/pdf/news-journalonline/LK1631320.PDF.
Prevention

The potential of IECMH services to reduce risk for child abuse and neglect is promising [1]. Preschool-age children and children with special needs that may increase the caregiving burden, including mental health issues, are at higher risk for experiencing child abuse and neglect (CAN) [2]. Conversely, supportive family environments, nurturing parenting skills, and stable family environments decrease risk. Infant and early childhood mental health services help families mitigate risk for CAN by increasing their capacity and resiliency in parenting. When prevalent risk factors among fatality cases indicate a need, fatality review teams should consider supporting the integration of IECMH services into existing programs to support optimal development and minimize risk.

IECMH Resources

- **The Basics of Infant and Early Childhood Mental Health: A Briefing Paper:**

- Summary of state-based IECMH resources from Zero to Three:
  https://www.zerotothree.org/resources/states (Each page includes articles highlighting state policies and initiatives that support infants, toddlers, and their families. They also include the State of Babies Yearbook: 2019 State Profile, where you can learn how your state measures up on indicators related to Good Health, Strong Families, and Positive Early Learning Experiences.)

- Think Babies™ **Infant and Early Childhood Mental Health Resource List:**

- Early Childhood Training and Technical Assistance System, U.S. Department of Health and Human Services:
Impact

Between 2009-2018, more than 11,500 children younger than age 18 died by suicide.[1] Youth suicide continues to be a public health crisis with few innovative strategies for reducing the burden. Suicide is now the second leading cause of death for people ages 10-34 years old. [2] More than 17 percent of young people responding to the Youth Risk Behavior Survey in a nationally-representative sample reported seriously considering a suicide attempt in the 12 months before the survey and almost 14 percent reported making a suicide plan in the 12 months before the survey. [3]

There are many disparities in youth suicide. According to Children’s Safety Network, males have a higher suicide rate than females and American Indian/Alaska Native youth are 3.6 times more likely to die by suicide than any other race. High school students who identified as bisexual, gay or lesbian had significantly higher rates of suicide. Lastly, young people living in rural areas were more likely to die by suicide than their peers living in urban areas. View the CSN infographic.

https://www.childrenssafetynetwork.org/infographics/suicide-disparities
Fatality Review Data

Thirty-nine states report reviewing suicides in CDR. Child death review teams play an important role in understanding the risk factors and circumstances surrounding a suicide. Given there is no single cause of suicide, it is vital these complex deaths be examined fully.

Data from the National Fatality Review-Case Reporting System (NFR-CRS) show that 7,903 suicides were reviewed by CDR teams and entered into NFR-CRS between 2004-2017. More than 70% of these deaths were to children ages 15-17. Additionally, more than 70% of children were male, and 65% were non-Hispanic White.

Out of the 7,903 deaths, mental health history was known on 33% percent (n=4,374) of children. Of these 4,374 children, 33% had a documented mental health history and 20% were receiving mental health services at the time of their death. Seventeen percent of these children were taking at least one medication for mental health needs. Furthermore, in 19% of deaths the child had a history of substance use. Nineteen percent were the victim of child maltreatment, and 8% were placed outside of the home prior to their death.

- 37% of suicides involved a firearm
- 44% involved asphyxia
- 5% were poisoning

The most common situational stressors noted were: history of family discord (16%), argument with parents (14%), argument with significant other (11%) and history of drug/alcohol use (10%).
Stories from the Field

CDR teams are a critical part of understanding how and why children die by suicide. In Montana, data used from fatality review helped to identify a systems gap in proving guidance and resources for working with the American Indian population. Read how Montana worked to address this issue.

**Prevention**

Given the complex nature of suicide, it is critical that prevention recommendations be data-driven, systematic, and address underlying issues of equity. The Suicide Prevention Resource Center has a step by step guide for developing a comprehensive approach to prevent suicide. [https://www.sprc.org/effective-suicide-prevention](https://www.sprc.org/effective-suicide-prevention). CDR teams should collaborate with suicide prevention partners before writing prevention recommendations.
Suicide Prevention Resources

- The Suicide Prevention Resource Center information on adolescent suicide
  [https://www.sprc.org/populations/adolescents](https://www.sprc.org/populations/adolescents)
- Centers for Disease Control and Prevention injury information
- Zero Suicide program [https://zerosuicide.edc.org/](https://zerosuicide.edc.org/)
- Suicide prevention resources from the Substance Abuse and Mental Health Services Administration
  [https://www.samhsa.gov/suicide/resources](https://www.samhsa.gov/suicide/resources)

The National Action Alliance for Suicide Prevention [https://theactionalliance.org/](https://theactionalliance.org/)

Pregnant and Parenting Teens
Impact

Becoming pregnant while a teenager and parenting as a teen, on top of navigating the usual developmental tasks of adolescence, can contribute to a wide range of mental health problems. In the United States, there are approximately 750,000 teen pregnancies and 400,000 teen births every year. While teen pregnancy rates are declining in recent decades, still, nearly 3 in 10 girls get pregnant at least once before age 20, and higher rates are reported among youth of color. Subsequent births among teens aged 15-19 represent 18.7% of teen births. [1]

Add NFR-CRS data here

Young mothers experience significantly higher rates of depression and anxiety, both prenatally and postpartum, than adult mothers and their nonpregnant peers[2]. There is much less information on the effects of becoming a dad as a teenager, but one study has demonstrated that fathers, in the setting of teenage pregnancy, have unrecognized symptoms of anxiety and depression and may require services along with teenage mothers.[3] Early childbearing is also associated with an elevated risk of substance abuse, compared to non-pregnant teens[2]. Boys and girls who become pregnant during adolescence are far more likely to have experimented with a variety of licit and illicit substances over the previous 12-months, most frequently, marijuana and
alcohol. Teens parents may underreport their drug use to providers because of stigma. Teen parents are also at risk for developing symptoms of post-traumatic stress disorder[2]. Teen parents are more likely to be poor and disproportionately African American and Latina, live in low-income communities, be born to parents with low educational and employment attainment, have a history of child abuse, reside in chaotic home environments characterized by poor interpersonal relationships, and have limited social support networks. More research is needed in this area, as it is unclear whether the stressors and experiences of early childbearing lead to mental health problems or whether the mental health outcomes among teens are a result of the adverse life circumstances that often precede and predict teen pregnancy.

Children born to teen parents often face challenges. They are more likely to have poorer educational, behavioral, and health outcomes throughout their lives, compared with children born to older parents [4]. Other effects to a child of teen parent may include:

- greater risk for lower birth weight and infant mortality
- less prepared to enter kindergarten
- rely more heavily on publicly funded health care
- are more likely to be incarcerated at some time during adolescence
- are more likely to drop out of high school
- are more likely to be unemployed or underemployed as a young adult

These effects can create a perpetual cycle for teenage parents, their children, and their children’s children.

Stacy Hodgkinson, Lee Beers, Cathy Southammakosane, Amy Lewin
Fatality Review Data

Between 2004 and 2017, 2810 biological mothers of decedents in the NFR-CRS were identified as being between the ages of 13 and 17 years old. Among this group, the most frequent manners of death among the deceased children were those due to natural causes, with 1812 (65%) of the deaths; deaths of undetermined cause with 502 (18%); and accidents with 309 (11%). The most common causes of death among these children were prematurity, with 917 (33%) deaths; undetermined if the cases were due to a medical cause or external injury, with 366 (13%); congenital anomalies, with 332 (12%) deaths; and unintentional asphyxia, with 249 (9%) deaths.

Among these mothers, 1511, or 54% of the infants were identified as White, while 993, or 35.3% of the infants were identified as Black. Infants were considered multiracial in 82, or 3% of cases, and 57, or 2%, of infants were American Indian/Alaska Native.
One FIMR program reviewed cases of very young teen mothers who experienced an infant loss. They wanted to know how this fit into the overall community profile. By looking at cases over time, it came to light that 46% of women in this FIMR community had their first birth as a teen. These findings spurred the community to create a special subcommittee of their Community Action Team to address teen pregnancy issues. A few of the actions implemented included implementing an evidence-based home visiting program for first-time low-income parents, expanding access to Medicaid family planning services, and utilizing mass media campaigns to promote safe sex.

Prevention

The primary prevention goal is straightforward: to reduce teen pregnancy, especially unplanned and unwanted pregnancies. The Center for Assessment and Policy
Development[1] suggests that a comprehensive program for pregnant and parenting teens should work toward achieving the following outcomes:

- **Self-Sufficiency Outcomes for Pregnant and Parenting Teens**
  - Increase high school graduation/GED completion
  - Increase completion of post-secondary education, vocational training, and/or employment at a livable wage
  - Increase self-reliance and transition to independent living (housing security)
  - Reduce/delay subsequent pregnancies
  - Reduce Sexually Transmitted Infections/HIV

- **Developmental Outcomes for Children of Teen Mothers and Teen Fathers**
  - Increase healthy births by providing adequate prenatal care and strong support networks during pregnancy
  - Increase age-appropriate physical, emotional, cognitive, and social development (and readiness for school success)
  - Increase appropriate discipline, nurturing behavior, and children who are well cared for

- **Relationship Outcomes for Pregnant and Parenting Teens**
  - Increase healthy relationships between partner(s), peers, and family

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Resources to Support Pregnant and Parenting Teens

- **National Campaign to Prevent Teen and Unplanned Pregnancies**, Child Welfare League of America: [National Campaign to Prevent Teen and Unplanned Pregnancies](https://www.cwla.org/may-is-national-teen-pregnancy-prevention-month)