HOMICIDES

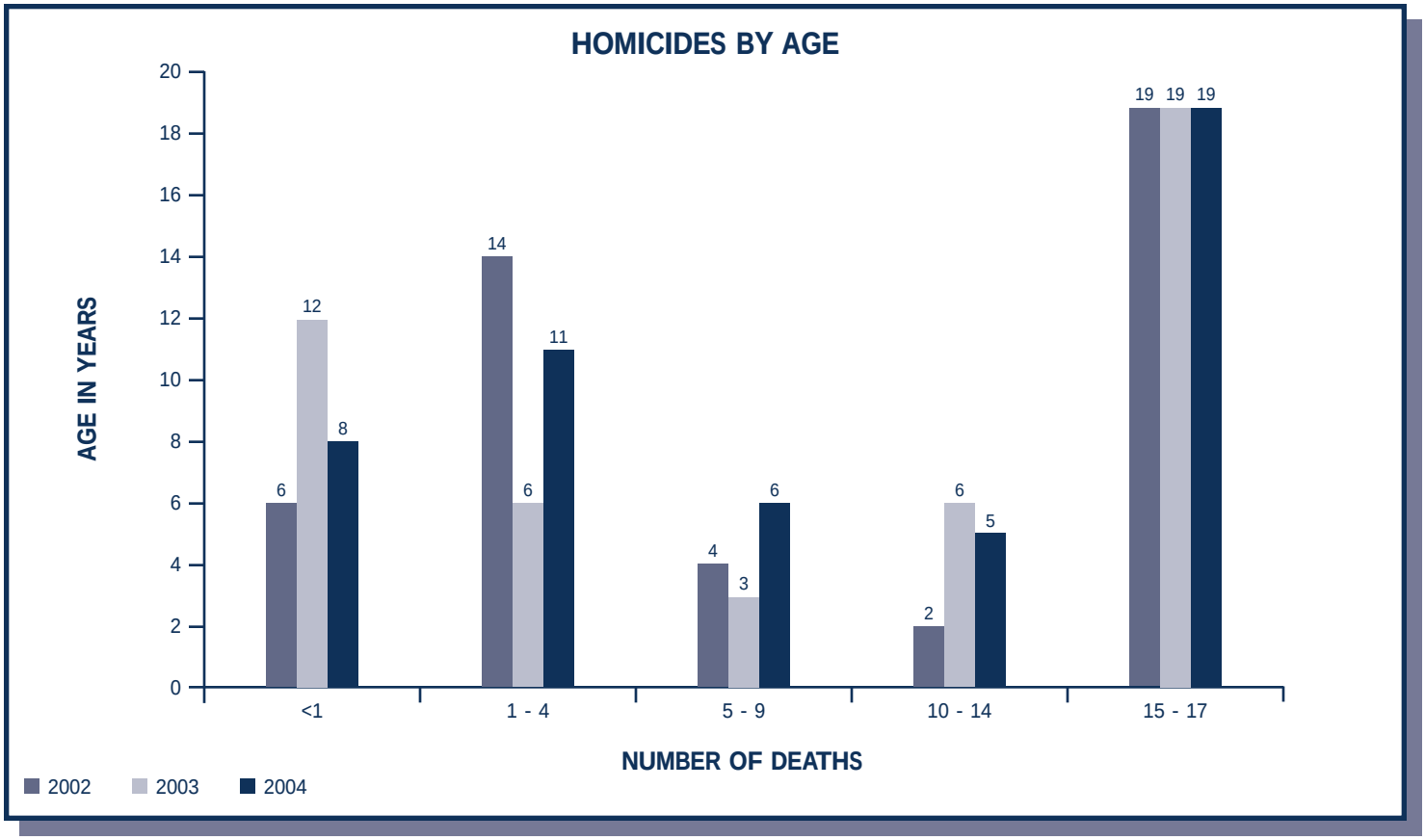
Homicide was listed as the death certificate manner of death for 49 Missouri children in 2004.

Homicide occurs when death results from a volatile act committed by another person to cause fear, harm, or death. Intent to kill is a common element, but is not required for classification as homicide. For the purpose of analysis of child deaths and their prevention, homicides are divided into three categories, based on the relationship of the perpetrator to the victim:

1. **Fatal Child Abuse and Neglect: Child death resulting directly from inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent.** This includes, but is not limited to, children whose deaths were reported as *homicide* by death certificate. In 2004, **70** Missouri children were victims of Fatal Child Abuse and Neglect; of those, **26** were reported by death certificate as homicide.

2. **Death of a child in which the perpetrator was not in charge of the child.** This most often includes youth homicides, such as gang-related or drug-related shootings and child abductions that culminate in murder. There were **23** such fatalities among Missouri children in 2004.

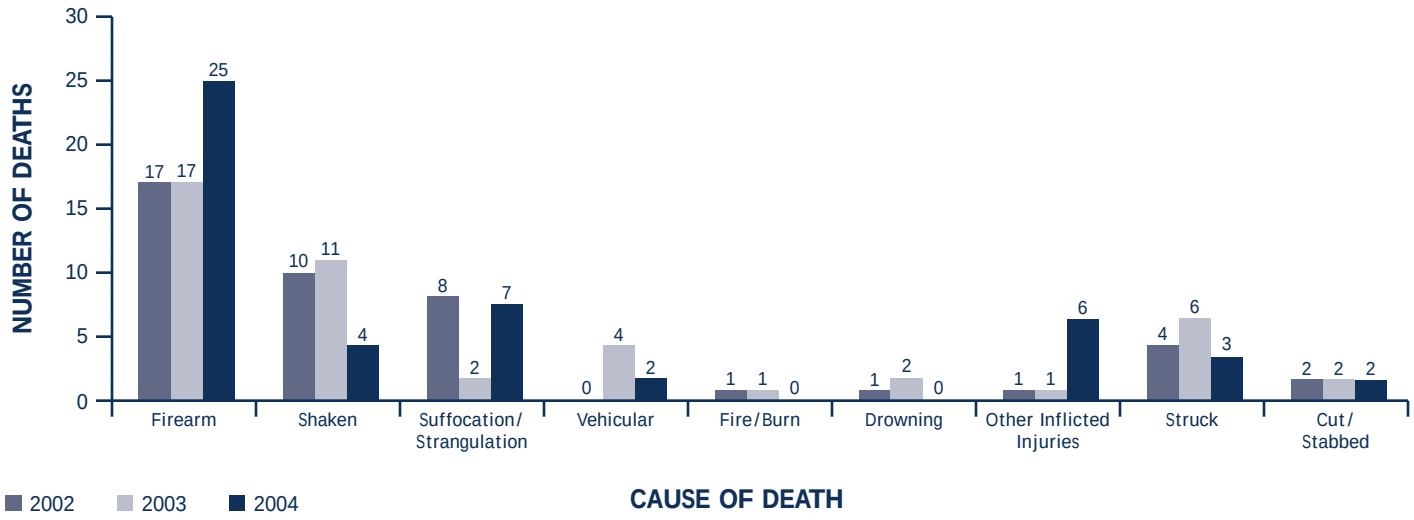
3. **Deaths of children in which the perpetrator, not in charge of the child, or negligent behavior and the child was not an intended victim.** Examples most often include motor vehicle-related deaths involving drugs, alcohol and other criminal behavior. In 2004, there were **no** homicide deaths of this type among Missouri children.



HOMICIDES BY SEX AND RACE

SEX	2002	2003	2004	RACE	2002	2003	2004
FEMALE	19	13	19	WHITE	24	25	20
MALE	26	33	30	BLACK	20	21	29
				OTHER	1		
	45	46	49		45	46	49

HOMICIDES BY CAUSE



Fatal Child Abuse and Neglect

In 2004, 70 Missouri children were victims of Fatal Child Abuse and Neglect. Of those, 26 were reported as homicide by death certificate.

Representative Cases:

- **Young children are more likely to die from abuse and neglect.**

  A one-year-old child with a history of asthma was coughing and wheezing. His mother put him in a stroller in the bathroom, turned on the hot water and left for 15 minutes. When she returned, the child was face down in the water with the stroller on top of him. It was determined that the account, in way, explained the child's injuries and the death was determined to be asphyxia/homicide.

  A 4-month-old infant was found unresponsive by his babysitter, who called 911 and claimed that she could not awaken him from a nap. Her suspicious behavior toward the 911 operator and investigators, along with suspicious finding at autopsy, prompted law enforcement to question her further. She eventually admitted to smothering the child with a pillow.

- **Multidisciplinary teams should be developed, supported and trained on the local level to investigate serious offenses against children.**

  An 11-year-old child was under hospice care for an acute illness, when she was found unresponsive. This initially appeared to be a natural death, but an active case with the Children's Division based on withholding medications, lack of supervision and giving inappropriate drugs prompted further investigation. Autopsy revealed acute intoxication with morphine and chlorahydrate.

  The family of a one-year-old child has several prior contacts with the Children's Division and a history of family violence. She was left in the care of a teenage boyfriend of an aunt, who lived in the home. The child was found dead and autopsy revealed that she had died of blunt force head trauma. The teen confessed to shaking and slamming her head against the arm of a couch.

- **Parents and caretakers must be educated about the dangers of shaking and ways to cope with crying infants.**

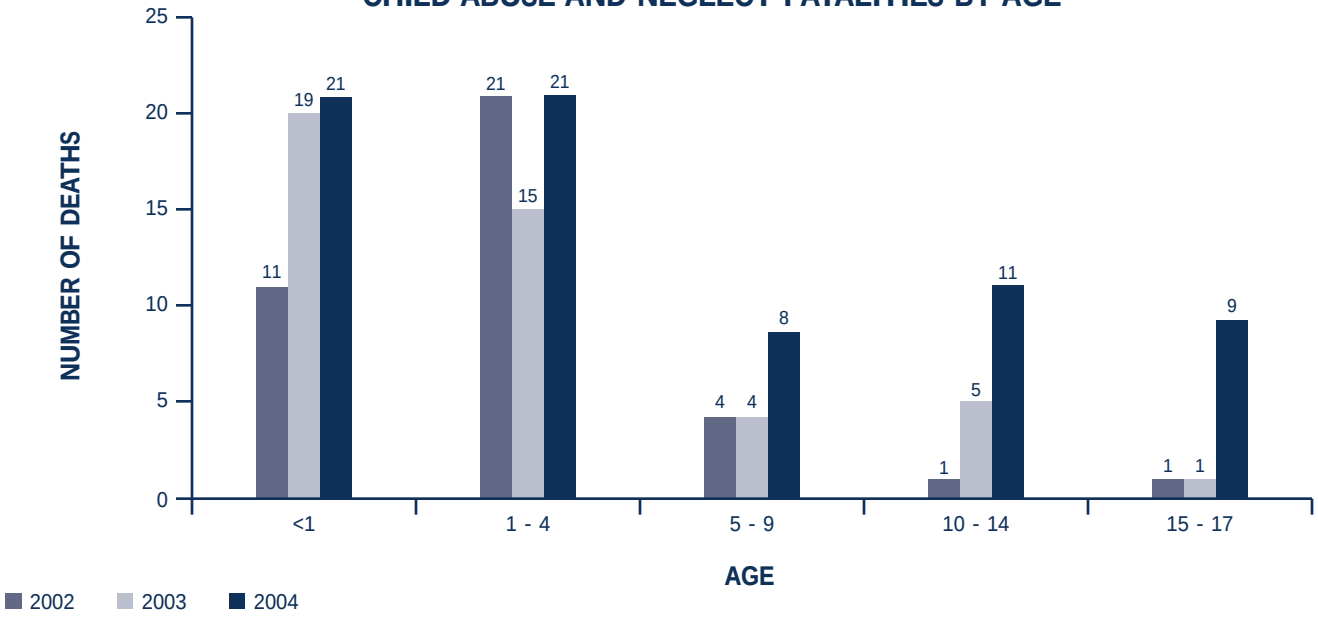
  The stepmother of a three-year-old child apparently became enraged with the child and began banging the child's head on the floor. She later admitted grabbing the child by the shoulders and shaking her violently, striking her head on the floor three times, in the process. Within a short time, the child began having seizures, lost consciousness, and developed breathing problems. There were several prior Hotline reports.

  A seven-month-old infant was in the care of her mother's boyfriend while the mother slept. When the mother awoke, the baby was unresponsive. She was rushed to the emergency room, where she was DOA. Bruising was beginning to appear around the ears, face and buttocks. The boyfriend claimed that he went to get a diaper and the baby fell off the couch. Autopsy revealed skull fracture and massive hemorrhage, consistent with Shaken Baby Syndrome.

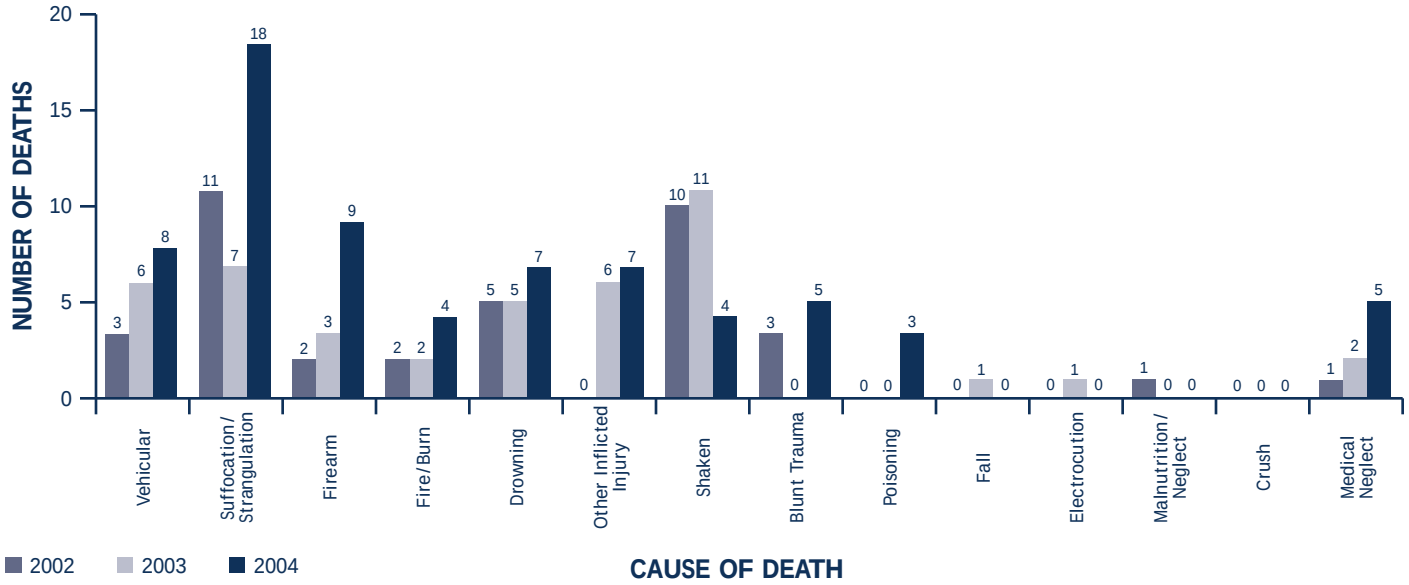
CHILD ABUSE AND NEGLECT FATALITIES BY AGE AND SEX

SEX	2002	2003	2004	RACE	2002	2003	2004
FEMALE	16	16	32	WHITE	27	32	48
MALE	22	28	38	BLACK	10	12	22
				OTHER	1		
	38	44	70		38	44	70

CHILD ABUSE AND NEGLECT FATALITIES BY AGE



CHILD ABUSE AND NEGLECT DEATHS BY CAUSE



Child fatalities are the most tragic consequence of child abuse and neglect. In the United States, approximately 1,200 children die of abuse or neglect each year, according to vital records (NCAN-DS). However, it is well documented that child abuse and neglect fatalities are under-reported and that, nationally, at least 2000 children die each year at the hands of their parents or caretakers. Some estimates are as high as 3-5,000. (Ewigman et al., 1993; Herman-Giddens et al., 1999) There are a number of reasons for the discrepancies and some of the fundamental problems are highlighted in this section. The Centers for Disease Control has funded an effort to develop a standardized national surveillance system capable of accurately reported child abuse and neglect families. On a state level, properly organized and functioning child fatality review systems have improved the accuracy of child death reporting.

In Missouri, there are three entities within state government responsible for child fatality information: **Department of Health and Senior Services' Bureau of Vital Statistics, Department of Social Services, Children's Division** and **Child Fatality Review Program.** All three exchange and match child fatality data in order to ensure accuracy throughout the system. However, the Bureau of Vital Statistics, Children's Division and the Child Fatality Review Program serve very different functions and, therefore, different classifications and timing periods apply when child fatality data is reported.

Vital Statistics and Death Certificate Information

The death certificate is issued for two major purposes. One is to serve as legal documentation that a specific individual has died. In general, the death certificate serves as legal proof that death has occurred, but not as legal proof of the cause of death. The second major purpose of the death certificate is to provide information for mortality statistics that may be used to assess the nation's health, causes of morbidity and mortality, and developing priorities for funding and programs that involve public health and safety issues.

Death certificate information is widely recognized as inadequate as a single source for identification of child abuse and neglect deaths. Misidentification of deaths may occur, because of inadequate scene investigation or autopsy procedure, inadequate investigation by law enforcement or child protection, or misdiagnosis by a physician or coroner. Child abuse and neglect fatalities often mimic illness and accidents. Neglect deaths are particularly difficult to identify, because negligent treatment often results in illness and infection that can be attributed to natural causes.

Children's Division: Child Abuse/Neglect Fatalities

In Missouri, the Children's Division is the hub of the child protection community. Since August 2000, all child deaths are reported to the Children's Division Central Registry. Any child not dying from natural causes, while under medical care for an established natural disease, is brought to the attention of the division by the coroner or medical examiner. A fatality report is taken and, when appropriate, the report is accepted for investigation of child abuse and neglect by the division. The Child Fatality Review Program is immediately notified of all fatality reports. The division is also responsible, if ordered by a judge, for protecting any other children in the household, until the investigation is complete and their safety can be assured.

After a report of child abuse or neglect has been made, investigations that return sufficient evidence supporting the report are classified as *probable cause child abuse and neglect.* When there is probable cause to believe that a child who has died was abused or neglected, or when this finding is court-adjudicated, that death is considered by the division to be a *probable cause child abuse and neglect fatality.* Thus, reports classified by the division as *probably cause child abuse and neglect fatalities* include deceased children whose deaths may or may not have been a direct result of the abuse or neglect. An example would be an unsupervised toddler who was run over in the driveway of her home. That death would be included as a pedestrian fatality in this CFRP Annual Report, with Inadequate Care as a contributing factor. In a case such as this, Children's Division would determine that there was *probable cause* to believe that this child was a victim of *neglect*, specifically, lack of supervision.

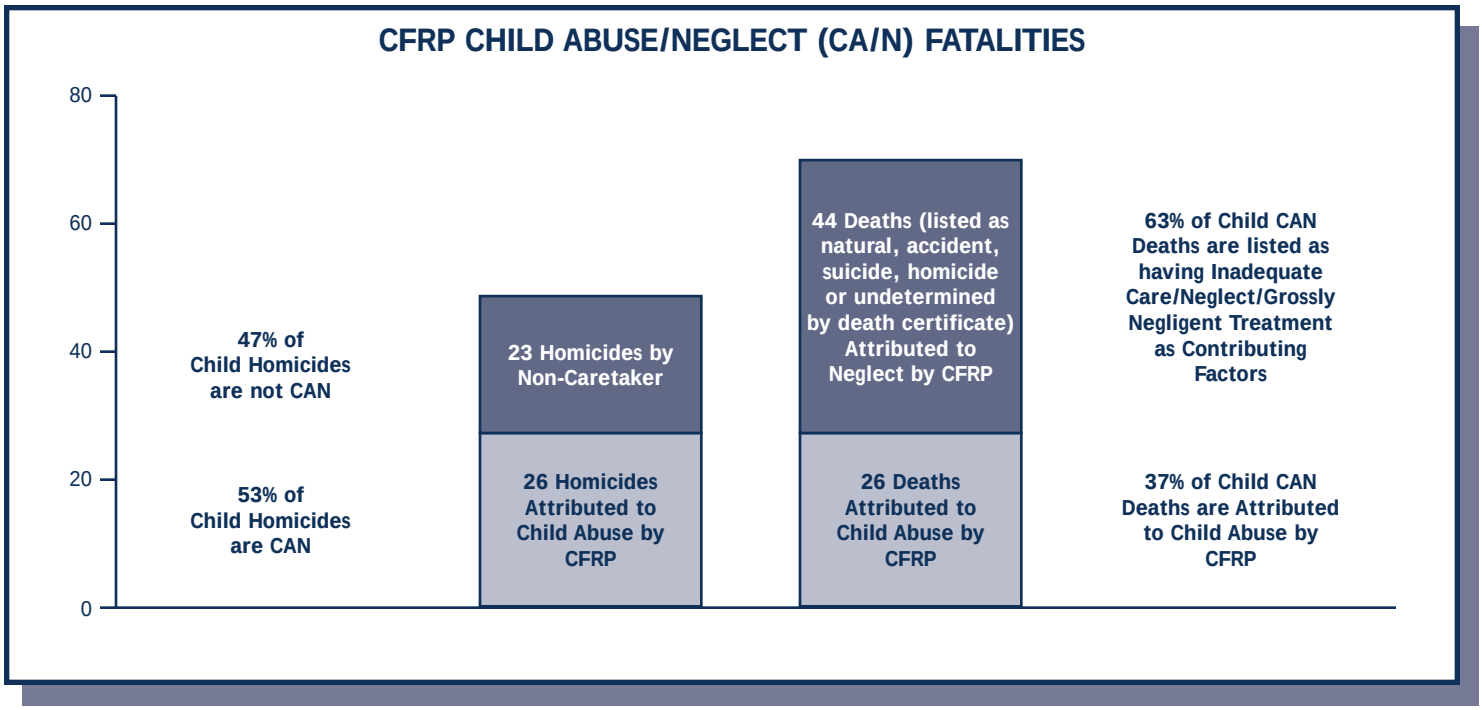
The Missouri Child Fatality Review Program: Fatal Child Abuse and Neglect

Child fatalities represent the extreme of all issues that have a negative impact on children. Despite an increasing awareness of severe violence against children, very little was known in the past about fatal child abuse and neglect. In the late-1980's, Missouri researchers discovered that many fatal child injury cases were inadequately investigated and that many children were dying from common household hazards with inadequate supervision. Many cases of fatal abuse and neglect went undetected, misclassified as natural deaths, accidents or suicides. The information necessary for a thorough investigation of a child death was distributed among agencies, which could not share records. In 1992, Missouri initiated a comprehensive, statewide child fatality review system. The CFRP review process has resulted in better investigations, more timely communication, improved training and technical assistance, and standardized data collection that allows us to understand much more about how our children die, the circumstances in which they die and who may be responsible.

Beginning in 1999, the Child Fatality Review Program Annual Reports refined the reporting and analysis of CFRP data in many ways, including an examination of data concerning "Fatal Child Abuse and Neglect." Those numbers represented a subset of child fatalities reported as *homicide* by death certificate. These changes allowed us to begin to understand much more about how Missouri children die, the circumstances in which they die and who may be responsible.

The Child Fatality Review Program defines *Fatal Child Abuse and Neglect* as child deaths resulting directly from inflicted physical injury and/or grossly negligent treatment by a parent or caretaker, regardless of motive or intent. This number includes, but is no longer limited to, children whose deaths were reported as homicide by death certificate; their death certificate manners of death may include natural, accident or undetermined. See Appendices 6 and 7 for additional information.

"Murder is no less a crime because a child, rather than an adult, is the victim."
-Unknown



Fatal Child Abuse: Inflicted Injury

In 2004, 26 Missouri children died from inflicted injury at the hands of a parent or caretakers. Of those, 18 (69%) were age 4 years or younger.

In the United States, the majority of fatal inflicted injury deaths among children result from abusive head trauma, commonly known as Shaken Baby Syndrome. In 2004, **four** of the 26 children who died from inflicted injury at the hands of a parent or caretaker were victims of abusive head trauma. This represents a dramatic reduction in the number of SBS fatalities in Missouri and may well be attributable to an aggressive statewide campaign designed to educate parents and caretakers about the dangers of shaking.

In the United States, the next most common type of physical abuse deaths involves punching or kicking the abdomen, resulting in massive internal injuries and bleeding. Infants and young children are especially vulnerable because vital organs are in close proximity to each other; the ribs are small and cannot protect vital internal organs. In 2004, **five** Missouri children died of blunt trauma injuries to the abdomen or head, when they were struck, punched, kicked or thrown.

Another common type of physical abuse death among young children, but often more difficult to detect is suffocation/strangulation. These injuries occur when hands or materials are used to block or cover external airways (suffocation) or used to exert pressure on the neck and interfere with breathing (strangulation), or pressure is exerted on the chest in order to interfere with breathing. In 2004, **six** Missouri children died of suffocation/strangulation at the hands of a parent or caretaker.

Fatal Abuse: Inflicted Injury

FATAL ABUSE INFLICTED INJURIES BY AGE	
<1 year	7
1-4 years	11
4-9 years	4
10-14 years	3
15-17 years	1

FATAL ABUSE INFLICTED INJURIES BY SEX	
Females	13
Males	13

FATAL ABUSE INFLICTED INJURIES BY RACE	
White	13
Black	13

FATAL ABUSE INFLICTED INJURIES BY CAUSE			
Shaken Baby Syndrome	4	Other - Drug Overdose	2
Blunt Trauma	5	Other - Cut/Stab	2
Suffocation/Strangulation	6	Other Inflicted Injuries	2
Firearm	5		

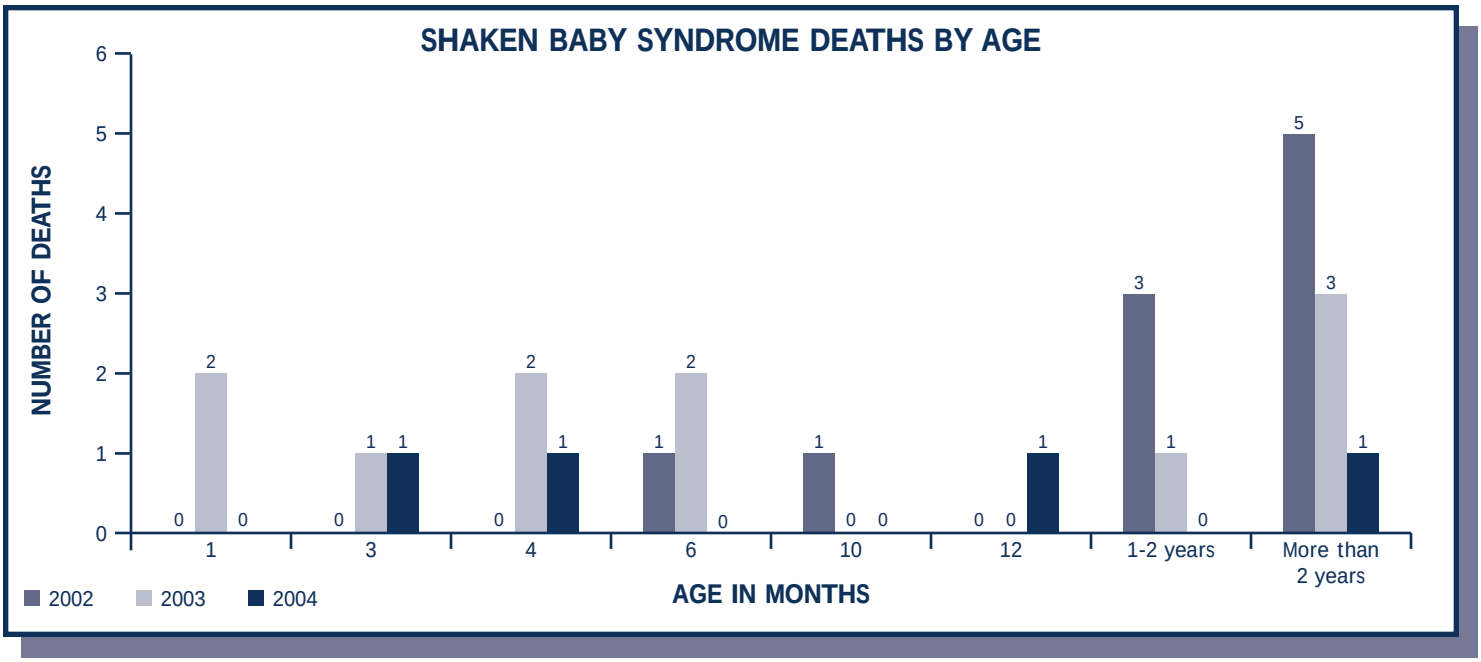
Shaken Baby Syndrome

The most common mechanism of child abuse fatalities in the United States, is abusive head trauma or Shaken Baby Syndrome (SBS), which involves the violent shaking of an infant or young child, usually under the age of 4 years. Babies' heads are large and heavy in proportion to their total body weight and their neck muscles are too weak to support such a disproportionately large head. Because a baby's brain is immature, it is more easily injured. When an infant or young child is violently shaken, the head rotates wildly on the axis of the neck, resulting in rotation of the brain within the skull. Brain tissue is bruised or destroyed.

Shaken Baby Syndrome involves an *extremely violent* act. Age-appropriate play, gentle shaking to awaken an unconscious child and CPR do not cause the massive destruction seen in Shaken Baby Syndrome. Short falls from sofas, beds and changing tables, and falls associated with the caretaker falling while carrying the child, do not produce the severe brain injuries of Shaken Baby Syndrome.

Immediate consequences include a decreased level of consciousness and seizures; breathing may stop; the heart may stop and the baby may die. Shaken Baby Syndrome is so lethal that 20-25% of SBS victims die of their injuries. Long term consequences for survivors may include physical disabilities, blindness, speech disabilities, seizures, learning disabilities and death. For survivors, research has established that a significant number of SBS cases are unrecognized and under-reported.

Of the **26** Missouri children who died of fatal inflicted injury in 2004, **four** (15%) were victims of Shaken Baby Syndrome.



SHAKEN BABY SYNDROME DEATHS BY SEX AND RACE

SEX	2002	2003	2004	RACE	2002	2003	2004
FEMALE	7	1	3	WHITE	7	9	2
MALE	3	10	1	BLACK	3	2	2
	10	11	4		10	11	4

Deliberate shaking of an infant or young child is usually the result of frustration or anger. This occurs most often when the baby won't stop crying. Other triggering events include toilet training difficulties and feeding problems.

SHAKEN BABY DEATHS BY APPARENT TRIGGERING EVENT

Cause	Number of Deaths
Crying	2
Other - Parent on Drugs	1
Not Answered	1

Perpetrators of Shaken Baby Syndrome can be anyone. Most individuals who shake infants do not fall into a specific category, yet research shows that certain characteristics make a person more at risk of being a perpetrator. For example, research has established that fathers and other male caretakers are the most frequent perpetrators of SBS. **Three** (75%) perpetrators of fatal SBS in 2004, were fathers and other male caretakers.

Perpetrator	Number of Deaths
Father	1
Mom's Paramour	2
Dad's Paramour	1

Fatal Child Neglect: Inadequate Care and Grossly Negligent Treatment

The majority of unintentional fatalities and serious injuries among young children are the result of a temporary lack of supervision or inattention at a critical moment. This is often the case when infants and toddlers drown in bathtubs and swimming pools, or young children dart in front of moving vehicles. Parent and other caretakers often underestimate the degree of supervision required by young children. This is complicated by the mistaken idea that young children have some sort of innate fear of dangerous situations.

Negligent treatment of a child is an act of omission, which is often fatal when due to grossly inadequate physical protection, withholding nutrition or health care necessary to preserve life. Child deaths resulting from grossly negligent treatment are frequently difficult to identify, because neglect often results in illnesses and infections that can be attributed to natural causes, or exposure to hostile environments or circumstances that result in fatal "accidents."

Definitions of negligent treatment vary depending on whether one takes a legal, medical, psychological, social service or lay perspective. There are broad, widely recognized categories of neglect that include: *physical neglect, emotional neglect, medical neglect, neglect of mental health, and educational neglect.* Within those definitions, there are subsets, as well as variations in severity that often include *severe* or *"nearly-fatal"* and *fatal.* Negligent treatment may or may not be intentional; however, the end result for the child is the same whether the parent is willingly neglectful (e.g., out of hostility) or neglectful due to factors such as ignorance, depression or overwhelming stress and inadequate support.

Grossly negligent treatment by a parent or caretaker generally involves failure to protect from harm and withholding or otherwise failing to provide food, shelter, or medical care necessary to meet the child's basic needs. This level of negligence is egregious and surpasses momentary inattention or a temporary condition; it is often part of a pattern of negligent treatment. Child deaths often result when a parent or caretaker fails to adequately supervise the child, usually for extended periods of time.

In some cases, "failure to protect from harm" or failure to meet basic needs, involves exposure to a hostile environment or a hazardous situation with potential for serious injury or death. An example would be a 3-year-old who was riding unrestrained, while his intoxicated parents were "playing chicken" with another vehicle. The child was ejected in the crash and died instantly. Another example is a toddler, put outside to play alone, who wandered out of the yard and drowned in a pond.

Medical neglect, as a form of grossly negligent treatment, refers to failure to provide prescribed medical treatment or emergency medical care for a known illness or injury with potential for a serious or fatal outcome. Examples include untreated diabetes or asthma.

In 2004, with the revision of the Data Form 2, CFRP panels were asked to consider and indicate all child fatalities in which Inadequate Care and/or Grossly Negligent Treatment contributed to the death of a child. For 2004, CFRP panels identified **44** Missouri children as victims of Inadequate Care and/or Grossly Negligent Treatment that resulted in death.

It should be noted that two of these 44 deaths were designated as homicide by death certificate. In both cases, the perpetrators were not caretakers of the children. All of the 44 deaths are included in the appropriate data sections Illness/Natural Cause, Unintentional Injury, Homicide or Suicide, according to cause and circumstances.

Total Deaths	Cause of Death	*Circumstances of Gross Negligence that Contributed to Death					Examples
		Lack of Supervision	Medical Neglect	Exposure to Hazardous Situation	Unrestrained Children	Other	
3	Illness/ Natural Cause	1	3	1	0	0	Prenatal cocaine use by mother. Untreated asthma.
8	Vehicular	2	0	3	3	3	Three children, riding unrestrained with their mother, who was under the influence of drugs. Two-year-old riding ATV with older sibling. Two children riding unrestrained with drivers impaired by alcohol.
12	Suffo-cation	6	1	2	0	5	Nine sudden, unexpected infant deaths involving unsafe sleep arrangements. Two suicides by hanging in children at high risk, left alone for extensive time period, with access to lethal means.
1	Poisoning	0	0	0	0	1	Overdose of cold medicine by multiple persons in household.
4	Firearm	1	0	3	0	1	Two suicides involved alcohol and/or drugs, access to lethal means and lack of response to known risks on the part of parents. Two homicides by non-caretakers. In both cases, perpetrators were in the household and known to be dangerous.
4	Fire/ Burn	2	0	0	0	2	In two cases, poor and dangerous living conditions contributed to the risk of fire and the inability to escape. One case involved lack of adult supervision.
7	Drowning	4	0	0	0	4	All involved lack of supervision of young children (ages 5 and under); infants left in the bathtub; toddlers entering swimming pools or ponds and lakes; and a 4-year-old who drowned in a lake, slipping from an inflatable toy and his mother couldn't swim.
3	Other	1	1	0	0	1	A teen in residential care died from an untreated spider bite. An 8-year-old had been exercising and going to a sauna with his father before football weigh-ins. Food and fluids had been withheld. A three-year-old was kicked by a horse.
TOTAL:		17	5	9	3	15	

*It should be noted that, in some cases, more than one neglect category was applied to a single child death.

Something We Can Do: Preventing Shaken Baby Syndrome

The majority of fatal inflicted injury deaths among children involve abusive head trauma, commonly known as Shaken Baby Syndrome (SBS). Research has demonstrated that prevention programs targeting all new parents and caregivers with education about the dangers of shaking and ways to cope with crying infants, results in a measurable reduction in the number of serious and fatal injuries.

Children's Trust Fund, Missouri's Foundation for Child Abuse Prevention, provides SBS Prevention materials, including brochures and "Preventing Shaken Baby Syndrome" videotapes for parent and for child care providers.

For additional information, or to order education materials, contact CTF at 573-751-5147 or visit the website at www.ctfkids.org.

Prevention Recommendations:

For parents:

- Report child abuse and neglect.
- Seek crisis help through the Parent Helpline (800-367-2543) or ParentLink (800-552-8522).

For community leaders and policy makers:

- *Support and fund home-visitation child abuse prevention programs that assist parents.*
- *Enact and enforce laws that punish those who harm children.*

For professionals:

- Support and facilitate public education programs that target male caretakers and child care provider.
- Expand training on recognition and reporting of child abuse and neglect.
- Support development and training for multidisciplinary teams to investigate child abuse.

For Child Fatality Review Panels:

- The role of CFRP panel is critical in identifying fatal child abuse, protecting surviving children, and ensuring that the family receives appropriate services. CFRP panels provide important data that enhances our ability to identify those children who are most likely to be abused and intervene before they are harmed.

Resources and Links:

National Committee to Prevent Child Abuse . . . . . www.childabuse.org
American Academy of Pediatrics . . . . . www.aap.org
Harborview Injury Prevention and Research Center . . . . . http://depts.washington.edu/hiprc
Missouri Children's Trust Fund
(Missouri's Foundation for Child Abuse Prevention) www.ctf4kids.com
The National Center on Shaken Baby Syndrome . . . . . www.dontshake.com
U.S. Department of Justice
Office of Juvenile Justice and Delinquency Prevention. . . . . www.ojjdp.ncjrs.org
ChildAbuse.com . . . . . .www.childabuse.com

"In the little world in which children have their existence, whosoever brings them up, there is nothing so finely preserved and so finely felt as injustice."
-Charles Dickens, from Great Expectations

Other Homicides

Of the 49 child homicides in Missouri in 2004, 23 involved perpetrators who were not in charge of the child; of those, 20 (89%) involved firearms.

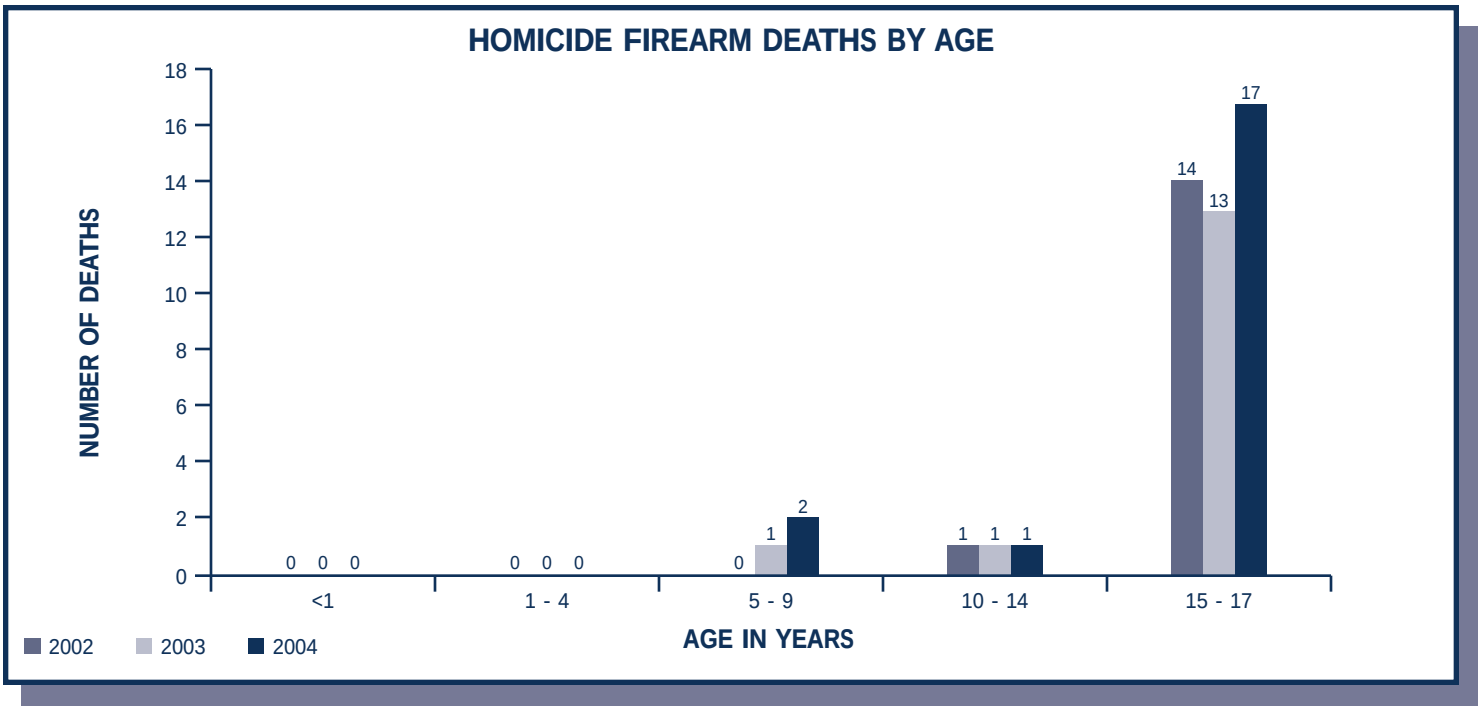
Representative Cases:

- **The increased availability of guns and drugs contributes to violence.**

  A 16-year-old male and several other household members were sitting on their front porch and argued with someone walking by. Later, someone shot several bullets into the group on the porch.

  A 17-year-old male had a long history of drug dealing. He was involved in gang activity and associated with chronic drug users. He was shot by a member of the gang because he was suspected of being a police informant.

  A 16-year-old female was standing in front of the home of a friend who has having a party. Another party goer, who had earlier been evicted for causing trouble, returned with an assault rifle and fired into the crowd. The teen victim was struck in the head and died at the scene.



HOMICIDE FIREARM FATALITIES BY SEX AND RACE

SEX	2002	2003	2004	RACE	2002	2003	2004
FEMALE	2	3	5	WHITE	3	2	7
MALE	13	12	15	BLACK	12	13	13
	15	15	20		15	15	20

In 2004, **23** Missouri children were murdered by non-caretakers. The vast majority of victims were adolescents. Most youth homicides involve juvenile crime and violence, or abductions by adults or other adolescents that culminated in murder.

Youth Violence		Homicides, Other	
Firearm	14	Firearm	6
		Suffocation	1
		Vehicular	2

YOUTH HOMICIDE:

The most common mechanism of juvenile homicide is firearms, particularly inexpensive, readily available handguns. **Twenty** Missouri youths died of intentional firearm injuries in 2004. Youth homicides are a serious problem in large urban areas, especially among black males. The majority of gun homicides occur in the metropolitan areas of St. Louis and Kansas City. The number of firearm homicides among Missouri adolescents has risen sharply in the last three years, particularly when drug and gang activity is a factor. Other factors known to contribute to youth homicide include poverty, easy access to firearms, family disruption and school failure.

Nationally, the rate of juvenile arrest for violent crime has risen sharply since the mid-1980's. Over the next 10 years (1985-1994), juvenile arrests for murder, robbery, motor vehicle theft and weapons violations far surpassed the growth in adult arrests for these crimes. The growth in juvenile

homicides has been particularly disturbing. The rapid rise of gun homicides of youth coincided with the growth of crack cocaine markets in the inner city. The increased availability of guns to youth has been matched by an increased willingness to use violence to achieve one's goals. Violent confrontations are common in adolescence. If both parties are armed, the one who acts first usually gains a decided advantage. The realization that many youth on the street are carrying a weapon, increases the potential for an immediate and exaggerated response to real or perceived threats. Young males commit the majority of juvenile crime and violence. With the exception of rape and domestic violence, males are also more likely to be victims of violence than females. By age 17, the risk of homicide among males is five times that of females.

"It is important to keep the problem of youth violence in perspective...The current portrait of youth presented by the media is not grounded in statistical reality. The vast majority of young people do not carry weapons, do not deal drugs, do not join gangs and do not victimize their friends or neighborhoods...Most young people, like most adults, want nothing more than to lead their lives in peace."

"The causes of violence are many. The multi-faceted nature of violence almost invariably frustrates simplistic approaches to the problem. Youth violence can be prevented, but efforts must start at an early age and be sustained over time. Early childhood experiences, the nature of a child's family, the influence of peers, the neighborhood and society are keys to solving the puzzle."
-Harborview Injury Prevention and Research Center

PROMISING APPROACHES:

Individuals and organization working to prevent firearm violence, choose and develop strategies that are specifically appropriate for them to use, depending on what aspect of the problem they would like to address. Interventions can be categorized into three basic types: educational, legal and technological/environmental.

- *Educational programs* are often carried out in the schools, and community-based organizations. They emphasize prevention of weapon misuse, the risks involved with possession of a firearm, and the need for conflict resolution and anger management skills.

- *Legal measures* strive to limit access to firearms-the number and type of people eligible to own or possess firearms, as well as the types of firearms that can be manufactured, owned and carried.

- *Technological/environmental interventions:* Firearm design requirements are both a technological and a legal intervention. Environmental and technological measures are based on the premise that automatic protections are more effective than those requiring specific action by individuals.

Violence Prevention Recommendations:

For parents:

- Provide supervision, support and constructive activity for children and adolescents in your household.
- Access family therapy and parenting assistance, as necessary, for help with anger management skills, self-esteem and school problems.

For community leaders and policy makers:

- Support the implementation of violence prevention initiatives.
- Encourage programs that provide support, education and activities for youth.
- Support legislation that restricts access to guns by children and adolescents.

For professionals:

- Support and implement crisis interventions and conflict resolution programs within the schools.

For Child Fatality Review Panels:

- Ensure that support for victims and survivors of youth violence is available.
- Support proactive approaches to crime control, especially those programs that include efforts to confiscate illegally carried firearms.

Resources and Links:

National Center for Injury Prevention and Control . . . . . .www.cdc.gov/ncipc

Harborview Injury Prevention and Research Center . . . . . http://depts.washington.edu/hiprc

US Department of Justice

Office of Juvenile Justice and Delinquency Prevention. . . . . www.ojjdp.ncjrs.org

The National Youth Violence Prevention Resource Center . . . . . www.safeyouth.org

Missouri Juvenile Justice Association . . . . . www.mjja.org

SUICIDES

"Suicide is not chosen; it happens when pain exceeds resources for coping with pain."

Suicide was the manner of death of 31 Missouri children in 2004.

Representative Cases:

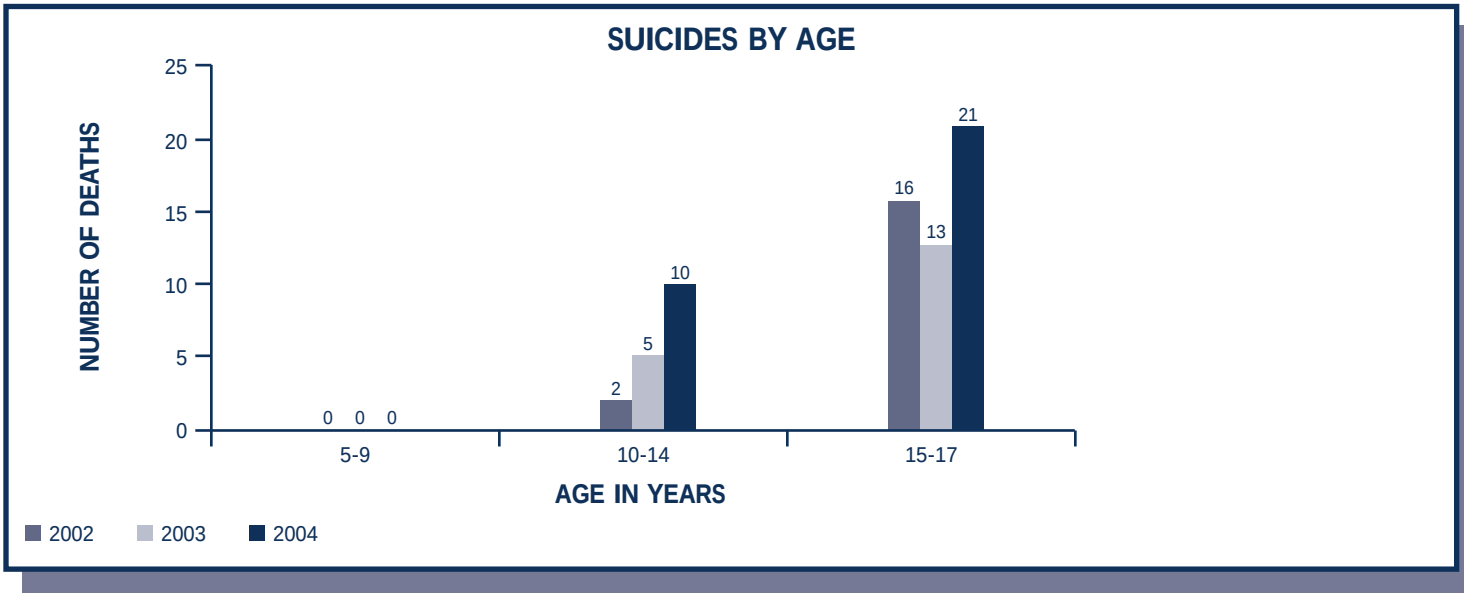
- **Parents and professionals are responsible for children must be educated to recognize and respond to risk factors for suicide.**

  A 13-year-old male with a history of mental health problems, got into trouble at school, on the bus and, later, at home. After arguing with his parents, he went upstairs and shot himself.

  A 17-year-old shot himself after a night of drinking; his blood alcohol was .14%. Law enforcement later learned that the mother had allowed her son and a group of teens to drink in her home. The victim had an extensive juvenile history and the mother had appeared in the Juvenile Office intoxicated.

  A 15-year-old had a history of depression and was being treated with an anti-depressant. He committed suicide by carbon monoxide vehicle exhaust. There were no medications found in his system.

In Missouri and the United States, suicide is the third leading cause of injury-related deaths for young people following unintentional injuries and homicides. The suicide rate among young teens and young adults increased by more than 300% in the last three decades and rates continue to remain high. In Missouri in 2004, **31** children died of self-inflicted injury; **21** were age 15-17; the remaining **10** were children age 10-14.

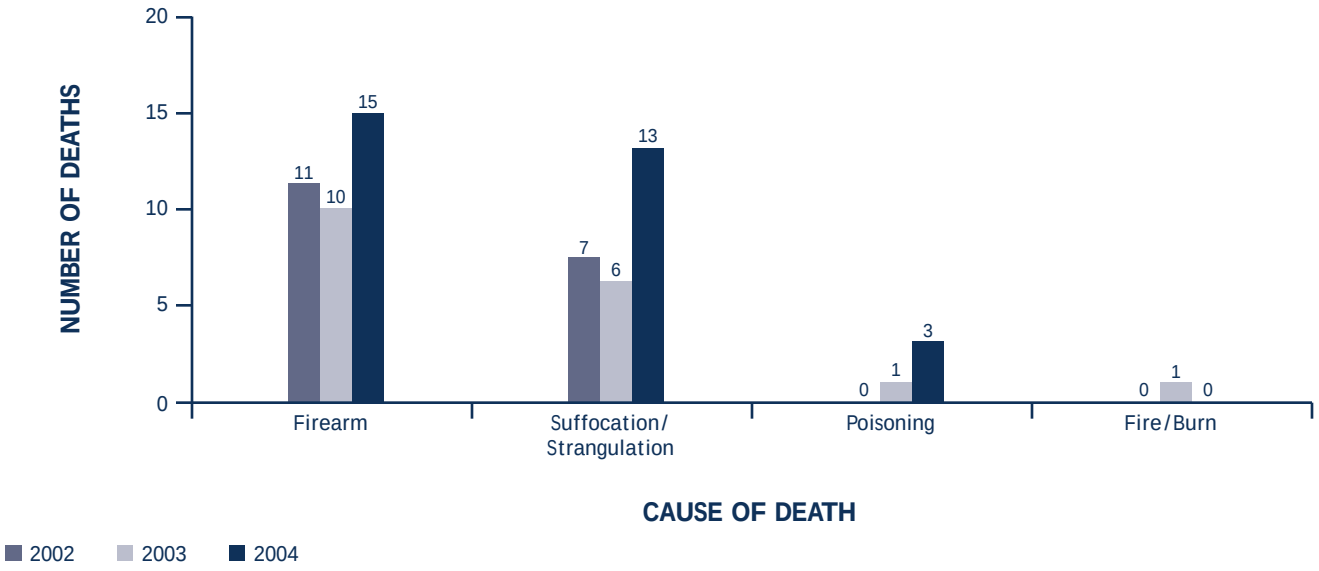


White males comprise the majority of adolescent suicide victims in Missouri. Although more females attempt suicide than males, males are approximately three times more likely to die from suicide.

SUICIDES BY SEX AND RACE

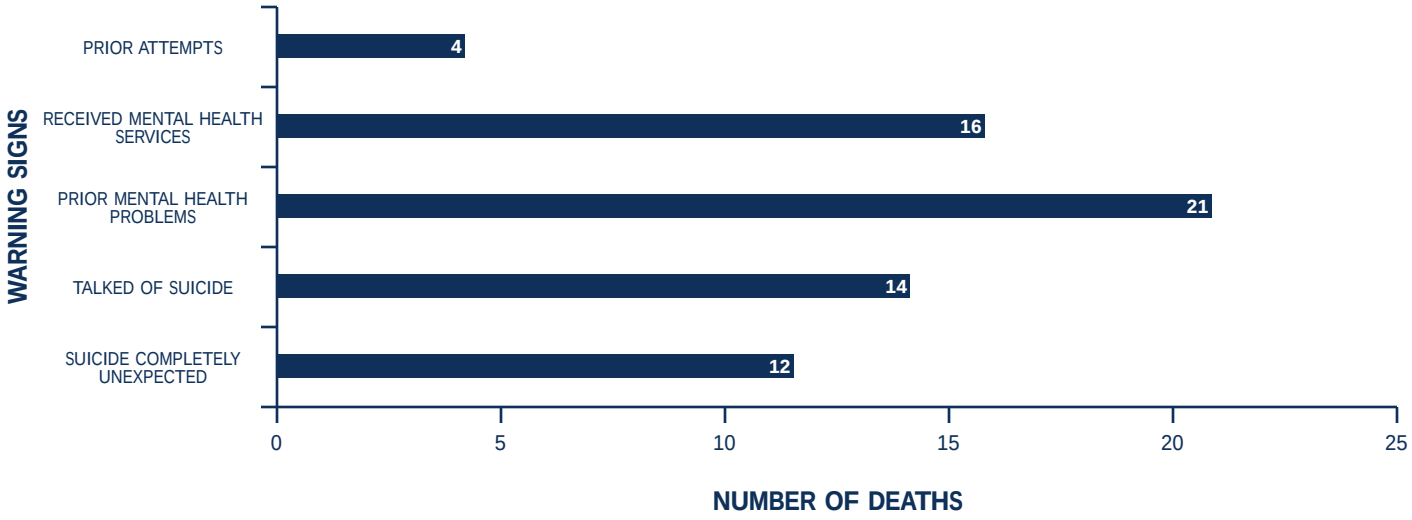
SEX	2002	2003	2004	RACE	2002	2003	2004
FEMALE	1	4	9	WHITE	17	15	28
MALE	17	14	22	BLACK	1	3	1
				OTHER			2
	18	18	31		18	18	31

SUICIDES BY MECHANISM



Firearms and suffocation/strangulation are the most common mechanisms of suicide among Missouri children.

WARNING SIGNS OF SUICIDE



Of the **31** suicide victims age 17 and under in 2004, **22** (71%) had displayed one or more warning signs.

"The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion of devastation that is, for the most part, beyond description."
-Kay Redfield Jamison

Preventing Youth Suicide:

Suicidal behaviors in young people are usually the result of a process that involves multiple social, economic, familial and individual risk factors, with mental health problems playing an important part in its development. Identified risk factors for suicide and attempted suicide for young people include: mood disorders, substance abuse, certain personality disorders, low socioeconomic status, childhood maltreatment, parental separation or divorce, inappropriate access to firearms and interpersonal conflicts or losses. Only a few studies have examined protective factors among youth for suicidal behavior. Both parent-family connectedness and perceived school connectedness have been shown to be protective against suicidal behavior.

Missouri's Response:

In 1999, the U.S. Surgeon General, Dr. David Satcher, issued a "Call to Action to Prevent Suicide," introducing an initial blueprint for reducing suicide in the United States, summarized as "AIM" (awareness, intervention and methodology.) In response, a conference was convened that same year in Kansas City titled: "Creating Community Action for Suicide Prevention: Bringing a National Dialogue to the Community." Missouri delegates met and began to outline strategies to address suicide prevention in our state. Subsequently a small writing group convened to develop a draft of Missouri's State Plan for Suicide Prevention, which includes specific Missouri statistics, prevention resources within state government, risk/protective factors applicable to Missouri, and specific strategies based on the AIM blueprint.

Prevention resources in Missouri government include the Department of Health and Senior Services, the Department of Mental Health, Department of Elementary and Secondary Education, Department of Social Services, Department of Corrections and Caring Communities. The Department of Elementary and Secondary Education was mandated to develop a suicide prevention plan for schools by SB 994, which was passed in 2000.

Within the Department of Social Services, the child abuse and neglect hotline is a source available to address suicide prevention intervention for the Children's Division. Foster parents are trained to identify and respond to suicidal behaviors. Each time a child is placed in a new foster home, the suicide risk is addressed. In-home Intervention Service workers attend annual training on suicide prevention and intervention.

The final version of the Missouri Suicide Prevention Plan and links to suicide prevention resources are available online at the Missouri Department of Mental Health website, www.dmh.mo.gov/cps/issues/suicide.htm.

Prevention Recommendations:

For parents:

- Seek early treatment for children with behavioral problems, possible mental disorders (particularly depression and impulse-control disorders) and substance abuse problems.
- Limit young people's access to lethal means of suicide, particularly firearms.

For community leaders and policy makers:

- Encourage health insurance plans to cover mental health and substance abuse on the level physical illnesses are covered.
- Support and implement school and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse and aggressive behaviors.
- Enact and enforce laws and policies that limit young people's access to firearms and encourages responsible firearm ownership.

For professionals:

- Children who have attempted suicide or displayed other warning signs should receive aggressive treatment attention.

For Child Fatality Review Panels:

- Support or facilitate evidence-based suicide prevention programs in your community.
- In reviewing a possible suicide, consider carefully the warning signs and history of the victim. Consider, also, points of early intervention that can be enhanced in your community to prevent other suicides and suicidal behaviors.

Resources and Links:

Missouri Department of Mental Health . . . . . www.dmh.mo.gov/cps/issues/suicide.htm

National Strategy for Suicide Prevention . . . . . www.mentalhealth.org/suicideprevention

American Association of Suicidology . . . . . www.suicidology.org

Kids Under Twenty-One (KUTO) . . . . . www.kuto.org

National Hopeline Network 1-800-SUICIDE (1-800-784-2433)