Indiana State Department of Health INJURY ANA

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HIGHLIGHTS

In 2000, Indiana's census notes a population of 6,080,485. Population estimates by race were predominant for Whites who represented 87.5% of the population followed by Blacks/African Americans representing 8.4% of the population. Suicide rates in Indiana were consistent with that of the United States in that White and Blacks/African American males commit suicide more often than other groups. For census data for Indiana and the United States go to http://www.census.gov/.

♦In 2001, 706 Hoosiers committed suicide. Suicide ranked as one of the five leading causes of death for all persons age 15-54. For Hoosiers age 10-24, suicide ranked as the 3rd leading cause of death and accounted for 13% of all injury deaths in this age group.

♦From 1999-2000, suicide was the 2nd leading cause of INJURY deaths in Indiana, accounting for 20% of all injuries.

♦Compared to the national average, suicide rates in Indiana are higher for all age groups, except for senior citizens.

♦Hoosiers age 10-24 commit suicide more often when compared to 10-24 year olds in the United States and all regions in the U.S.

♦During the period 1999-2000, male Hoosiers had suicide rates 4-6 times those of females.

♦Black male Hoosiers age 20-24 have a higher rate of suicide compared to all other age groups.

♦Suicide rates are considerably lower for female Hoosiers. From 1999-2000, females age 40-49 committed suicide at a rate of 8.13 per 100,000 population, the highest rates for females regardless of age.

♦The use of firearms accounted for 60% of all suicides in Indiana.

♦According to the 2001 Youth Risk Behavioral Survey results for Indiana's 9th through 12 graders, 22.6% of females and 13.3% of males seriously considered attempting suicide during the past twelve months; 18.6% of females and 13.5% of males had a plan and 11.2% of females and 5.2% of males actually attempted suicide one or more times.

♦From January 2002 to June 2002, 913 Hoosiers age 12-91 were hospitalized as a result of self-inflicted injuries specified as intentional, (i. e., attempting to commit suicide). Eighty-four percent of these hospital admissions involved white males and females.

♦Ninety-two percent of people hospitalized for a suicide attempt in the first 6 months of 2002 involved self-inflicted poisoning by solid or liquid substances. The most frequent poisoning diagnoses requiring hospitalization resulted from ingestion of tranquilizers (34%) followed by the category of analgesics, antipyretics, and antirheumatics (23%).

SUICIDE IN INDIANA

INTRODUCTION

The newly established Injury Prevention Program at the Indiana State Department of Health (ISDH) presents this data on suicide as a preliminary report, based on the most recent mortality and morbidity data available. The objective of the report is to provide an overview of suicide in the United States and in Indiana. Prior to 1998, suicide ranked in the top ten leading causes of death when considering all Americans. Progress has been made in that it now ranks as the 11th cause of death in both the U.S and in Indiana. There have been minimal changes in its ranking when considering specific age groups.

Many suicides go unreported making the magnitude of the problem far greater than what current statistics demonstrate. To counteract this problem and to better identify populations at risk as well as trends in incidence and prevalence, we seek to improve the quality of data collection at local, state, and national levels. Injury surveillance and the use of descriptive epidemiology can provide detailed assessments on the impact of injuries, thus leading to the development of program strategies for decreasing morbidity and mortality rates. This will also help eliminate racial and ethnic disparities. The statistics presented in this report predominately cover mortality data from years 1999 through 2001, although some data for 2001 is not yet available at publication. Indiana hospital discharge data for 2002 (the first 6 months) has recently become available to ISDH. This report provides a brief summary of suicide-related hospitalizations from this data source. Future reports will use hospital discharge data to analyze and present morbidity statistics relating to suicide in Indiana.

OVERVIEW

Suicide in the United States

Suicide is the 11th leading cause of death for all Americans, the second leading cause of death for young adults age 25-34 years and the third leading cause of death for those 10-24 years of age. In 2000, suicide accounted for 29,350 deaths at a rate of 10.7 per 100,000-population (1). Mortality due to suicide is generally higher than the national average in the western states and lower in the eastern and mid-western states (2). Suicide rates increase with age and are highest among Americans 65 years and older, especially those who are divorced or widowed. CDC reports that **on average**, **an older adult commits suicide every 90 minutes in the United States**. Men in this age group have the highest rate. Risk factors associated with this higher incidence of suicide include but are not limited to depression, mental illness, and chronic disease. It is believed that men are less likely to ask for help, especially help for emotional concerns. This factor may contribute to the increased risk of suicide death in this category. In nearly all cases, men 65 and older who commit suicide suffer from depression and become more socially isolated and vulnerable to suicide (3).

Males are four times more likely to die from suicide than females, however females are more likely to attempt suicide than males. White males and white females are known to attempt suicide at higher rates than other races; together they accounted for over 90% of all suicides in 1999 (2). Males attempting suicide are also more likely to use lethal means, such as guns, which makes them at least four times more likely than females to die from suicide (3).

Nearly 3 of every 5 suicides were committed with a firearm. From 1999-2000, there was a total of 92,960 violence-related injury deaths. Over a third of these (39.4%) resulted from males who committed suicide with the use of a firearm – the number one mechanism regardless of age. In addition, suicide deaths by firearm were the leading cause of violence related injury deaths for males 35 years of age and older, the second leading cause for males 15-34 and the third leading cause for males 10-14 (1).

Persons under age 25 accounted for 14% of all suicides. Teens and young adults are involved in violence more often than any other age group. At this developmental stage, they may act impulsively and frequently engage in risk-taking behavior. Peer pressure in this group also increases the likelihood for involvement with substance abuse, delinquent peers and attempting personal violence, contributing factors for suicide and suicidal behavior in this age group. (3) **In 1999, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined** (2).

Suicide is the second leading cause of death for American Indians and Alaskan Natives ages 15 to 34. Risk in this age groups results from several factors, including limited employment and educational opportunities, alcohol use, and loss of traditional spiritual practices and indigenous languages (3).

Suicide in Indiana

From 1999-2000, 6,689 Hoosiers died from injuries, an average of 9 people each day. While 67% of the injury deaths were unintentional (accidental), 20% of these deaths were from suicide and 11% from homicide (Figure 1). Results from the 2001 Adolescent and School Health report ranked suicide as the 3rd leading cause of death for Hoosiers age 10-24 years of age, accounting for 13% of all deaths in Indiana.

When reviewing suicide deaths among Hoosiers by race, gender and age, there are more suicide deaths among white males in all categories, particularly in the 35-44 age group (Figures 2,3,4). *Note reference table for Figure 3 in Appendix A.* However, **black male Hoosiers, age 20-24 have a higher rate of suicide when compared to all other age groups.** The rate of suicide deaths for female Hoosiers is considerably lower than that of males (Figure 5). From 1999-2000, females age 40-49 committed suicide at a rate of 8.13 per 100,000 population, the highest rate for females regardless of age (1).

According to the 2001 Indiana Mortality Report, suicide ranked as one of the five leading causes of death for the Hoosiers age 15-54. During this same period, mortality due to suicide took the lives of 706 Hoosiers at a rate of 11.66 per 100,000 population. Males accounted for 80% (565)

of all suicides, of which 94% (533) were white men. Overall, females committed suicide less often than males, and white females who represented 20% (141) of all suicides, did so more often than black females.

DATA ON SUICIDE IN INDIANA

This section of the report consists of a number of charts and graphs to provide a better understanding of the demographic characteristics and dimensions of suicide. The majority of this data comes from years 1999 to 2000. The model used for presentation of suicide-related data is from "Suicide in Indiana, 1996-1999", a report published by Dr. Charlene Graves, Medical Director for Injury Prevention at the Indiana State Dept of Health (ISDH) and Dr. Xun Shen, Epidemiologist for ISDH and the Indiana Partnership to Prevent Firearm Violence.

Table 1: Comparison of Suicide Rates During 1999-2000.

	Indiana		Unites States		Northeast		South		West		Midwest	
Age in years	Deaths	Crude Rate	Deaths	Crude Rate	Deaths	Crude Rate	Deaths	Crude Rate	Deaths	Crude Rate	Deaths	Crude Rate
10-24	215	8.4	8,437	7.3	1,121	5.54	3,155	7.68	2,068	7.68	2,093	7.66
25-64	882	14.2	39,285	13.77	5,819	10.55	15,231	15.06	9,703	15.25	8,532	13.03
65+	214	14.39	10,818	15.61	1,452	9.9	4,225	17.34	2,908	20.97	2,233	13.61

Rates are per 100,000 Population.
(Source: CDC, WISQUARS)

Compared to the national average, suicide rates in Indiana are higher for all age groups, except for Senior citizens. Hoosiers age 10-24 commit suicide more often when compared to10-24 year olds in the United States and all regions of the U.S. (Table 1).

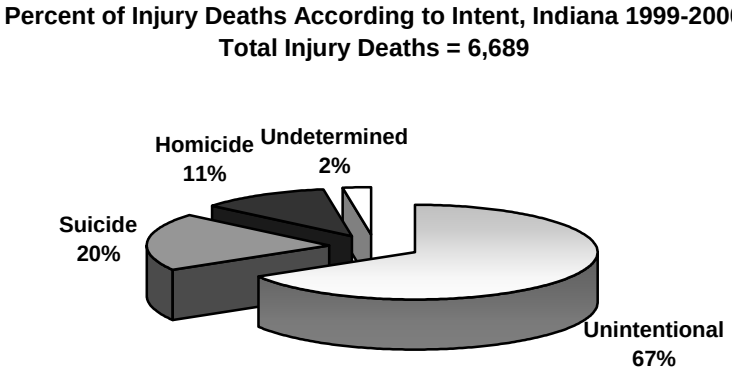


Figure 1: From 1999-2000, suicide ranked as the 2nd leading cause of injury death among Hoosiers.
(Source: CDC, WISQARS)

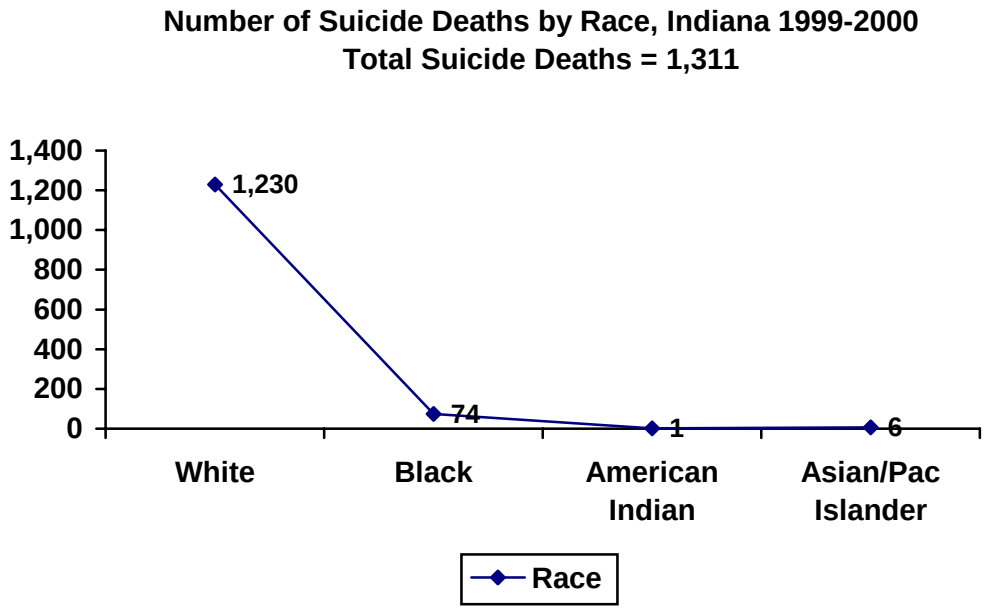


Figure 2: From 1999-2000, there is a 16.6 ratio of Whites to Blacks.
(Source: CDC, WISQARS)

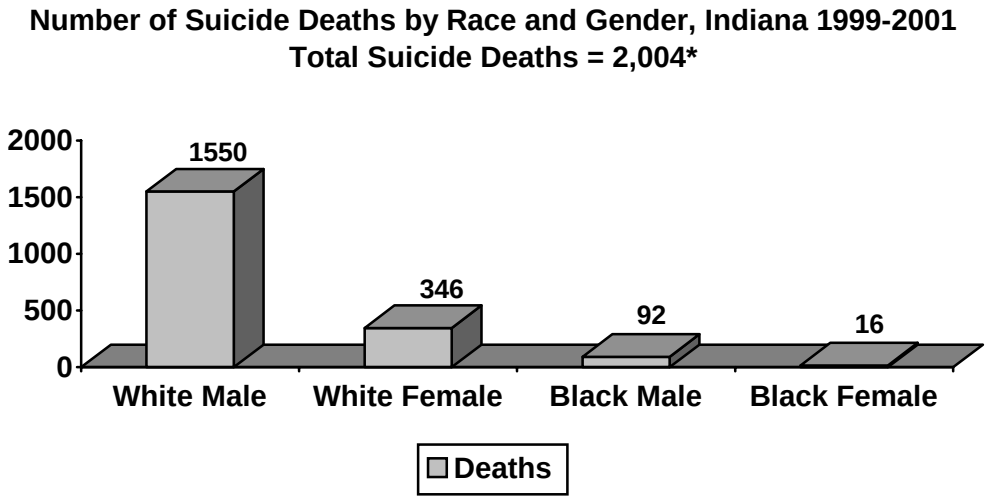


Figure 3: From 1999-2001, there is a 16.8 ratio of White males to Black males.
(Source: CDC, WISQUARS and 2001 Indiana Mortality Report)
***Data includes number of deaths from 1999-2000 (WISQARS) and the 2001 Indiana Mortality Report. See Appendix A for reference table.**

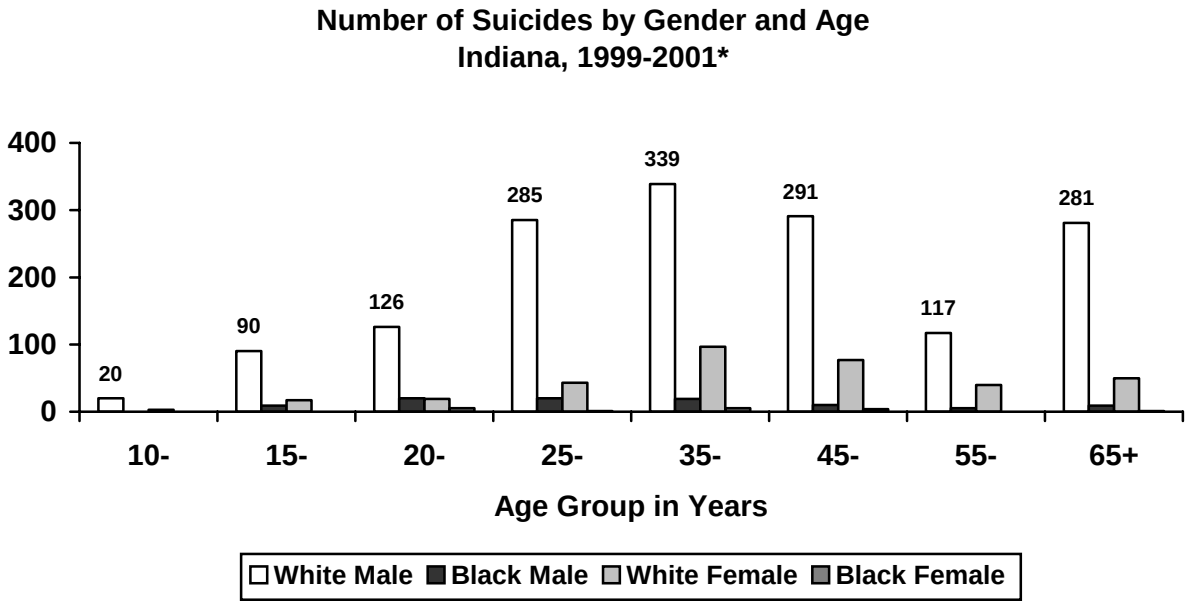


Figure 4: From 1999-2001, there are a greater number of suicides among White males.
(Source: CDC, WISQARS and 2001 Indiana Mortality Report)
***Data includes number of deaths from 1999-2000 (WISQARS) and the 2001 Indiana Mortality Report. See Appendix A for reference table.**

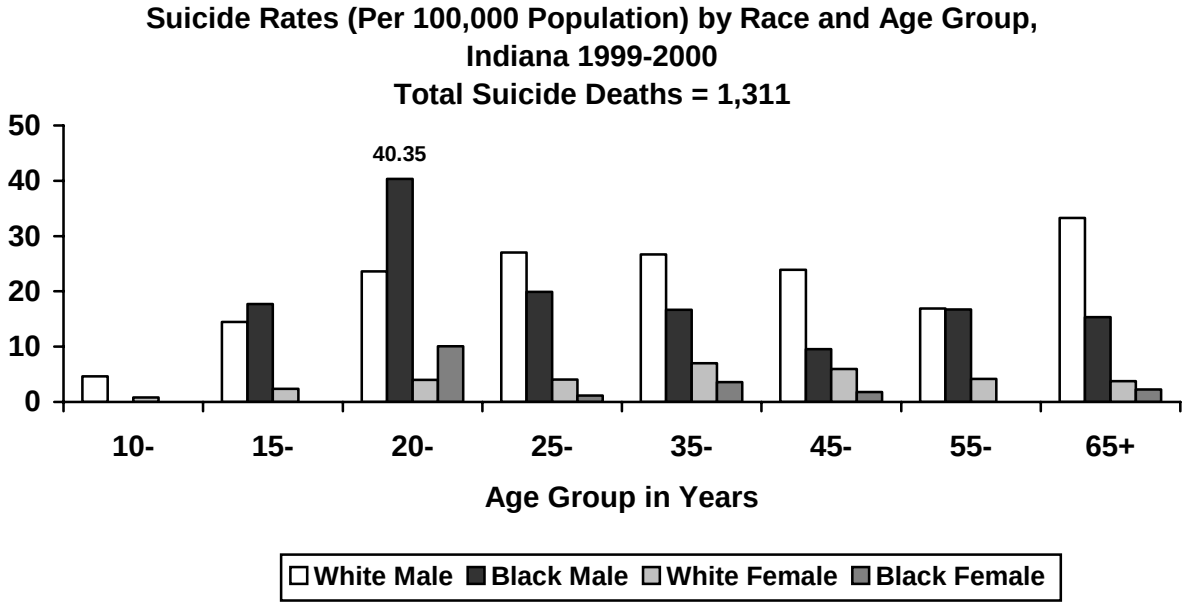
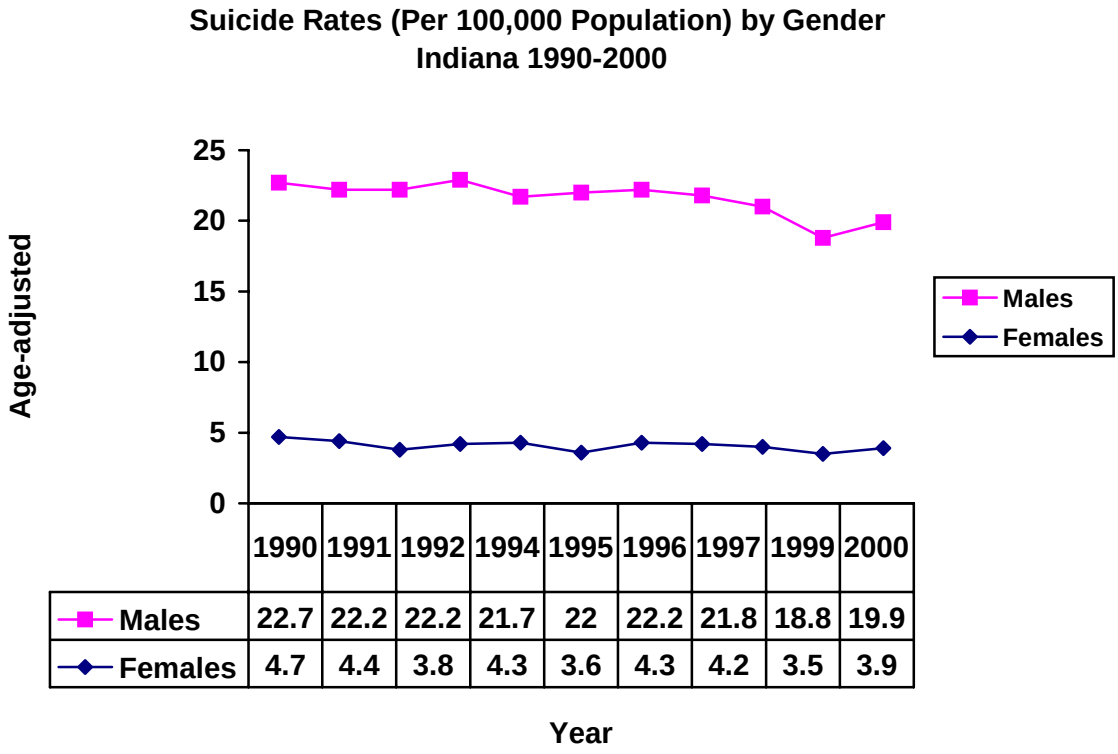


Figure 5: From 1999-2000, there is a higher rate of suicides among Black males age 20-24 years.
(Source: CDC, WISQARS)

In 2000, Indiana's census population was 6,080,485, forty-nine percent (2,982,474) males and 51% (3,098,011) females. Population estimates by race were predominant for Whites who represented 87.5% of the population followed by Blacks/African Americans representing 8.4% of the population. Suicide rates in Indiana were consistent with that of the United States.

From the period of 1990-2000, suicide death rates for male Hoosiers are approximately four to six times higher than that for females. Beginning in 1999, there has been a slight decrease in the number of suicide-related deaths (Figure 6).



	1990	1991	1992	1994	1995	1996	1997	1999	2000
Males	22.7	22.2	22.2	21.7	22	22.2	21.8	18.8	19.9
Females	4.7	4.4	3.8	4.3	3.6	4.3	4.2	3.5	3.9

Figure 6: Higher mortality rates for males versus females are demonstrated.
(Source: CDC, WISQARS)

White males commit suicide using a firearm at a rate of 12.3 per 100,000 population followed by black males at a rate of 9.25 per 100,000 population. **From 1999-2000, sixty percent of suicides were committed using a firearm** (Figure 7).

Percent of Suicide Deaths by Mechanism, Indiana 1999-2000 Total Suicide Deaths = 1,311

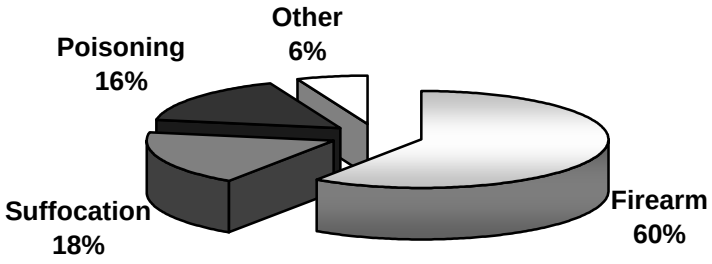


Figure 7: Sixty percent of suicides were committed using a firearm.
(Source: CDC, WISQARS)

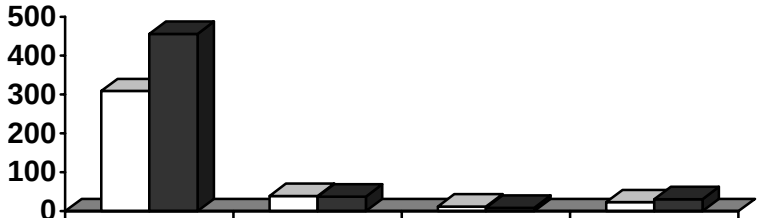
YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM DATA

The Youth Risk Behavior Surveillance System (YRBSS), established by the Centers for Disease Control, monitors the prevalence of youth behaviors impacting health. Its focus is on risky behaviors that would have an adverse effect both physically and socially among youths and young adults. The result of the 2001 national school-based Youth Risk Behavior Survey for Indiana (unweighted data) indicates that 18.4% of 9th through 12th grade Hoosiers (22.6% of males, 13.3% of females) seriously considered attempting suicide during the past twelve months. Sixteen percent (13.5% of males, 18.6% of females) of the students had a plan for how they would attempt suicide and 8.6% (5.2% of males, 11.2% of females) of the students actually attempted suicide one or more times during the past twelve months. Because data presented in the YRBSS report for the United States is weighted, comparisons cannot be made with Indiana.

INDIANA SUICIDE MORBIDITY (HOSPITAL DISCHARGE DATA)

This section of the report gives an overview of self-inflicted injuries among Hoosiers during January 2002 through June 2002, as based on data received from the Indiana Hospital and Health Association.

Self-Inflicted Injuries Specified as Intentional by Race
Indiana, Jan 2002 to June 2002
(Total Suicide Attempts = 913)



	White	Black	Minority	Other
Male	309	39	12	23
Female	456	37	9	31

Figure 8: January to June 2002, there is a 10.0 ratio for self-inflicted injuries of White to Black Hoosiers. (Source: Indiana State Department of Health, Injury Prevention Program)

The first two quarters of the Indiana 2002 hospital discharge dataset totaled 361,823 records. Of these, 14,902 had a principle diagnosis for injury and poisoning (ICD-9-CM codes 800-999). Then a query was done for suicide related ECODES (E950-E959), yielding 6% (913) patients with self-inflicted injuries specified as intentional. The average age was 35 (range: 12 to 91). Eighty-four percent of the attempts were made by persons of the white race, involving 60% females and 40% males. The majority (227 or 25%) of the injuries were among white females age 25-44 years (Figures 8,9).

Although detailed analysis by cost is unavailable, 48% of the patients identified Medicare, Medicaid and Managed Care Organizations as their primary source of payment (Table 2).

Table 3 shows the five most frequently reported ICD-9-CM codes (primary diagnosis) and Table 4 shows a listing of all Supplementary Classification of External Causes of Injury and Poisoning Codes (ECODES) for all categories of suicide attempts. Table 4 provides a detailed analysis of the various suicide attempt descriptors (ECODES) from the hospital discharge database. *Note that the ECODES are not mutually exclusive since one patient can have multiple ECODES listed as part of their diagnosis*.

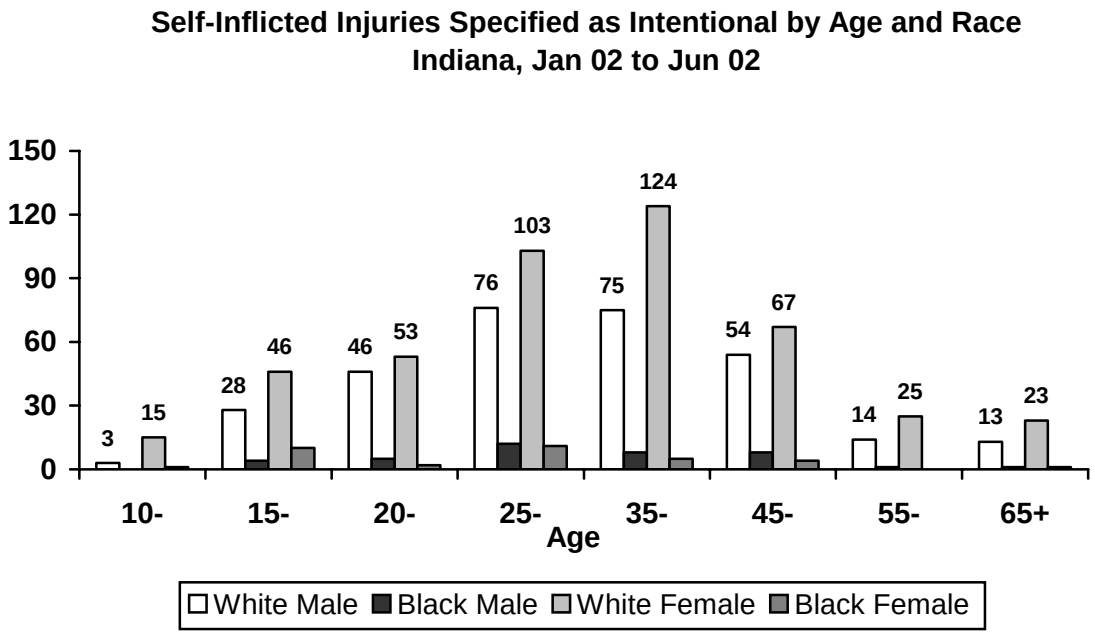


Figure 9: From January 2002 to June 2002, a higher number of self-inflicted injuries among white females. (Source: Indiana State Department of Health, Injury Prevention Program)

The overwhelming majority of hospital admissions for attempted suicide involved self-inflicted poisoning by solid or liquid substances (92%). Other methods of attempting suicide included cutting or piercing (41 or 3.2%), and use of firearms or explosives (26 or 2.1%). Suicide attempts by self-inflicted poisoning from gases such as carbon monoxide, hanging or strangulation, jumping from high places, or other unspecified means each involved less than 1% of hospital admissions for suicide attempts (Table 4).

The most frequent means of attempting suicide was by poisoning and involved the use of tranquilizers and other psychotropic agents (34%) followed by the category of analgesics, antipyretics, and antirheumatics (23%). The most frequently occurring primary diagnosis requiring hospitalization resulted from poisoning by **benzodiazepine-based tranquilizers** - *Chlordiazepoxide, Diazepam, Flurazepam, Lorazepam, Medazepam and Nitrazepam* (19%), **Antidepressants** - *Amitriptyline, Imipramine and Monoamine oxidase [MAO] inhibitors*, (14%) and **Aromatic Analgesics** - *Acetanilid, Paracetamol [acetaminophen] and Phenacetin [acetophenetidin]*, (14%).

Seventy-nine percent of the patients were admitted from emergency departments/outpatient centers. Other sources for admittance include routine (15%), transfer (4%) and other (2%). The types of admission for the majority of the patients was emergency (68%) followed by urgent (21%). Fifty-seven percent of the patients were hospitalized for one day (mean=2; median=1; range=0 to 44). Critical Care days during hospitalization ranged from 0 to 44 days with 52% of the patients requiring one day of critical care.

Regarding youth suicide attempts, there were 24% (219) Hoosiers age 12-21 who were hospitalized for injury during the first six months of 2002. When reviewing the means by which they attempted suicide, there were minimal differences compared to the overall total age group. The category of analgesics, antipyretics and antirheumatics (38%) was the leading mechanism for suicide attempts in this age group while in the overall age group this was the second leading mechanism (23%).

Table 2. Primary Payor of Hospitalization, Indiana Hospital Discharge Data, 2002 (Quarter 1 and 2)

PRIMARY PAYOR	FREQUENCY	PERCENT
Commercial Insurance	215	23.55
Medicaid	183	20.04
Self Pay	178	19.50
Managed Care	141	15.44
Medicare	118	12.92
Unknown	46	5.04
Other Government	32	3.50

(Source: Indiana State Department of Health, Injury Prevention Program)

Table 3: Five Most Frequently Reported ICD-9-CM Classification Codes Among Persons Who Attempted Suicide, Indiana Hospital Discharge Data, 2002 (Quarter 1 and 2)

ICD-9-CM CODE	DESCRIPTION	FREQUENCY	PERCENT
969.4	Benzodiazepine-Based Tranquilizers (Chlordiazepoxide, Diazepam, Flurazepam, Lorazepam, Medazepam, Nitrazepam)	172	18.84
965.4	Aromatic Analgesics, Not Elsewhere Classified (Acetanilid, Paracetamol [acetaminophen], Phenacetin [acetophenetidin])	132	14.46
969.0	Antidepressants (Amitriptyline, Imipramine, Monoamine oxidase [MAO] inhibitors)	132	14.46
965.1	Salicylates (Acetylsalicylic acid [aspirin], Salicylic acid salts	33	3.61
966.3	Other and Unspecified Anticonvulsants (Primidone) *Note: Excludes Barbiturates (967.0), Sulfonamides (961.0)*	25	2.74

(Source: Indiana State Department of Health, Injury Prevention Program)
(ICD-9-CM CODE Description Source: 2003 Annual Hospital Version: The Educational Annotation of ICD-9-CM (See Reference section for complete citation)

Table 4: Summary of ECODE Distribution for Suicide (E950-E959), Indiana Hospital Discharge Data, 2002 (Quarter 1 and 2)

ECODE	DESCRIPTION	FREQUENCY	PERCENT
E950	**Suicide and self-inflicted poisoning by solid or liquid substances**	**1169**	**92.40**
E950.3	Tranquilizers and other psychotropic agents	430	33.99
E950.0	Analgesics, antipyretics, and antirheumatics	291	23.00
E950.4	Other specified drugs and medicinal substances	261	20.63
E950.9	Other and unspecified solid and liquid substances	102	8.06
E950.2	Other sedatives and hypnotics	43	3.40
E950.5	Unspecified drug or medicinal substance	23	1.82
E950.1	Barbiturates	10	0.79
E950.7	Corrosive and caustic substances *(Suicide and self-inflicted poisoning by substances classifiable to E846)*	7	0.55
E950.6	Agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers	2	0.16
E950.8	Arsenic and its compounds	0	0
E951	**Suicide and self-inflicted poisoning by gases in domestic use**	**1**	**0.08**
E951.0	Gas distributed by pipeline	0	0
E951.1	Liquefied petroleum gas distributed in mobile containers	0	0
E951.8	Other utility gas	1	0.08
E952	**Suicide and self-inflicted poisoning by other gases and vapors**	**9**	**0.71**
E952.0	Motor vehicle exhaust gas	9	0.71
E952.1	Other carbon monoxide	0	0
E952.8	Other specified gases and vapors	0	0
E952.9	Unspecified gases and vapors	0	0
E953	**Suicide and self-inflicted injury by hanging, strangulation, and suffocation**	**5**	**0.40**
E953.0	Hanging	4	0.32
E953.1	Suffocation by plastic bag	0	0
E953.8	Other specified means	1	0.08
E953.9	Unspecified means	0	0
E954	**Suicide and self-inflicted injury by submersion [drowning]**	0	0
E955	**Suicide and self-inflicted injury by firearms, air guns, and explosives**	**26**	**2.06**
E955.0	Handgun	12	0.95
E955.1	Shotgun	4	0.32
E955.2	Hunting rifle	3	0.24
E955.3	Military firearm	0	0
E955.4	Other and unspecified firearm *(Gunshot, not otherwise specified; Shot, not otherwise specified)*	6	0.47
E955.5	Explosives	0	0
E955.6	Air gun (BB gun, Pellet gun)	0	0
E955.7	Paintball gun	0	0
E955.9	Unspecified	1	0.08

ECODE	DESCRIPTION	FREQUENCY	PERCENT
E956	**Suicide and self-inflicted injury by cutting and piercing instrument**	**41**	**3.24**
E957	**Suicide and self-inflicted injury by jumping from high place**	**1**	**0.08**
E957.0	Residential premises	1	0.08
E957.1	Other man-made structures	0	0
E957.2	Natural sites	0	0
E957.9	Unspecified	0	0
E958	**Suicide and self-inflicted injury by other and unspecified means**	**12**	**0.96**
E958.0	Jumping or lying before moving object	2	0.16
E958.1	Barns, fire	3	0.24
E958.2	Scald	0	0
E958.3	Extremes of cold	0	0
E958.4	Electrocution	0	0
E958.5	Crashing of motor vehicle	4	0.32
E958.6	Crashing of aircraft	0	0
E958.7	Caustic substances, except poisoning *(Excludes poisoning by caustic substance [E950.7])*	0	0
E958.8	Other specified means	2	0.16
E958.9	Unspecified means	1	0.08
E959	**Late effects of self-inflicted injury***	**1**	**0.08**

(Data Source: Indiana State Department of Health, Injury Prevention Program)
(ECODE Description Source: 2003 Annual Hospital Version: The Educational Annotation of ICD-9-CM (See Reference section for complete citation)
Note: ECODES are not mutually exclusive.
*Indicate circumstances classifiable to E950-E958 as the cause of death or disability from late effects, which are themselves classifiable elsewhere. The "late effects" include conditions reported as such, or as sequelae, which may occur at any time after the attempted suicide or self-inflicted injury.

The Need for Prevention

Mortality due to suicide accounts for approximately 30,000 lives in the United States each year. More than 264,000 Americans were treated in U.S. hospital emergency departments after attempting to take their own lives. Still, many suicides or suicide attempts go unreported. **Eighty-four people commit suicide each day in the United States.**

Risk factors associated with suicide include depression, alcoholism, a recent move, an upsetting end to a relationship, exposure to a non-suicide death or recent loss, and demographic characteristics as previously described.

Prevention Strategies

This report demonstrates that suicide is a problem at both the local and national level. However, limited information is available on how morbidity due to suicides has impacted our society. Prevention strategies can be developed when populations at risk are identified. We see in this report that male Hoosiers are the primary victims of suicide, while females may suffer suicide-related injuries as a result of their attempts. Intervention strategies should be prioritized in order to address the specific behavioral risk factors associated with suicide. For example, males are less likely to seek assistance for emotional concerns, thus making them more vulnerable and susceptible to suicide attempts. In addition, adolescents may show signs and symptoms of depression, which are often overlooked by family members, school personnel and health care providers. Research shows that suicide rates in males age 65 year and older are increasing because of the development of chronic disease and increasing isolation related to the deaths of family members and friends.

- In 1999, the Surgeon General's Call to Action to Prevent Suicide outlined suicide prevention strategies grouped under the "umbrella" term **AIM (Awareness, Intervention and Methodology).**
- **Awareness** seeks to appropriately broaden the public's awareness of suicide and its risk factors.
- **Intervention** refers to the enhancement of necessary services and programs.
- **Methodology** refers to advancing the science of suicide prevention. Suicide has been identified as a major public health issue and the Surgeon General has called for a public health approach to address it.

One of the goals of the Indiana Suicide Prevention Coalition and the Indiana Partnership to Prevent Firearm Violence is to assist in the development of a State Suicide Prevention Plan for Indiana. Work has been done on addressing suicide prevention within schools through the publication "Suicide: Students at Risk-A Suicide Prevention Resource Guide for Schools". The Indiana State Dept of Health published this document in 1995, through the efforts of a broad-based Youth Suicide Prevention Advisory Committee. The Indiana State Department of Education has agreed to form a working group to review this excellent guide for any necessary updating. Schools have frequently been in the forefront of suicide prevention efforts.

There are a number of tools that can be used to assess depression and the potential for suicide, such as questionnaires that are readily available to mental health professionals, counselors and health care providers. The availability of crisis intervention services, hotlines, and easy access to mental health providers can impact the problem of suicide in Indiana. All communities should become aware of what can be accomplished to prevent suicide in their locale.

The newly established Injury Prevention Program at ISDH will disseminate statistical descriptive information to entities throughout the state having an interest in suicide. The dissemination of information will increase awareness and can assist in implementing preventative and/or control program strategies. The goal of the ISDH Injury Prevention Program is to develop a functional surveillance system for all injuries and maintain a core injury team for the state. This program is currently supported by funding through a cooperative agreement with the Centers for Disease Control and Prevention (CDC), specifically the National Center for Injury Prevention and Control (NCIPC).

For more information on the Indiana Suicide Prevention Coalition, please contact one of the Co-Chairs, Kathleen O'Connell (oconnell@ipfw.edu) or Charlene Graves (e-mail listed below). For information on the Injury Prevention Program at the Indiana State Dept of Health, please contact Dr. Charlene Graves, Principle Investigator for the CDC - funded Core Injury Surveillance and Program Development Cooperative Agreement (# U17/CCU522371) by email: cgraves@isdh.state.in.us.

Suicide Prevention Organizations / Websites

Indiana Organizations

Indiana State Dept of Health
Injury Prevention Program
2 North Meridian Street
Indianapolis, IN 46226
(317) 233-7415 (317) 233-7805 (fax)
Newly established injury prevention program that will disseminate descriptive statistical information to those entities throughout the state having an interest in suicide and preventive control strategies. The program's goal is to develop a functional surveillance system for all injuries and establish a core injury team for the state.

Marion County Mental Health Association
Crisis and Suicide Intervention Services
2506 Willowbrook Pkwy, Suite 100
Indianapolis, IN 46205
(317) 251-7575 (24-hour Crisis Line) (317) 251-0005 (317) 254-2800 (fax)
A 24-hour telephone information and referral service for suicide prevention, family violence, depression, and a wide range of other issues. Services provided are confidential and free of charge. The Crisis and Suicide Intervention Service also offers training for community agencies, educational presentations to schools, churches, and civic groups, and phone consultation with concerned family member and friends.

Mental Health Association www.nmha.org
55 Monument Circle, Suite 455
Indianapolis, IN 46204
(317) 638-3501 (317) 638-3540 (fax)
Works for Indiana's mental health and victory over mental illness through education, advocacy, and direct services such as support groups.

Survivors of Suicide Support Groups www.afsp.org/survivor/group
Various Locations throughout Indiana: Check website for nearest location
Survivors of Suicide Support Groups were established to help friends and family members who have survived the suicide of a loved to cope with the grief and bewilderment of the issue. The Support Groups also advocate for education and prevention of suicide.

National Organizations

The American Academy of Child and Adolescent Psychiatry (AACAP) www.aacap.org
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
(202) 966-7300 (202) 966-2891 (fax)
This site provides information to aid in the understanding and treatment of the developmental, behavioral, and mental disorders affecting children and youth.

American Academy of Pediatrics (AAP) www.aap.org
141 Northwest Point Boulevard
Elk Grove Village, Illinois 60007-1098
(847) 434-4000 (847) 434-8000
This organization comprises 55,000 primary care pediatricians, pediatric medial specialist, and pediatrical surgical specialists. Provides information on child health, advocacy, and safety. Includes family-oriented publication, including one on adolescent development and suicide, and an on-line bookstore.

The American Association of Suicidology (AAS) www.suicidology.org
4201 Connecticut Avenue, NW Suite 408
Washington, DC 20008
(202) 237-2280 (202) 237-2282 (fax)
Dedicated to the understanding and prevention of suicide. Promotes research, public awareness programs, education and training, and serves as a national clearinghouse for information on suicide.

The American Foundation for Suicide Prevention (AFSP) www.afsp.org
120 Wall Street, 22nd Floor
New York, NY 10005 (212) 363-3500
(212) 363-6237 (fax) (888) 333-AFSP (toll free)
Funds research, education and treatment aimed at the prevention of suicide. Maintains a national directory of survivor support groups.

American Psychiatric Association www.psych.org
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-3901
(707) 907-7300 Email: apa@psych.org
This is the world's largest psychiatric organization representing over 38,000 psychiatric physicians from the U.S. and around the globe. Has links to legislative issues affecting psychiatrists and patients, information on how to prepare for and respond to disasters and trauma, and links to psychiatric-related literature. APA also offers grants and fellowships.

American Psychological Association (APA) www.apa.org
750 First Street, NE
Washington, DC 20002
(202) 336-5500
Provides information on psychology and its applications. Has many informative documents, including the online edition of the APA Monitor, the association newspaper. APA also publishes scholarly journals in all the specialty areas of psychology. PsycINFO is an electronic database of abstracts on more than 1,350 scholarly journals.

The Brady Center to Prevent Handgun Violence www.cphv.org
1225 Eye Street, NW, Suite 1100
Washington, DC 20005
(202) 898-0792 (202) 371-9615 (fax)
The Center to Prevent Handgun Violence is the education, legal advocacy, and research affiliate of Handgun Control, Inc. CPHV's national initiatives include prevention programs for parents and youth on the risks associated with guns, legal representation for gun violence victims, and outreach to the entertainment community to encourage the deglamorization of guns in the media.

Center for School Mental Health Assistance
University of Maryland at Baltimore
680 West Lexington St., 10 Floor
Baltimore, MD 21201-1570
(888) 706-0980 (410) 706-0984 (fax)
Provides leadership and technical assistance to advance effective interdisciplinary school-based mental health programs. The center offers a forum for training, the exchange of ideas, and promotion of coordinated systems of care that provide a full continuum of services to enhance mental health, development and learning in youth.

Centers for Disease Control and Prevention (CDC) www.cdc.gov/ncipc
National Center for Injury Prevention and Control (NCIPC)
Division of Violence Prevention
Mailstop K60
4470 Buford Highway NE
Atlanta, GA 30341-3724
(770) 488-4362 (770) 488-4349 (fax) Email: *DVPINFO@cdc.gov*
NCIPC works closely with other federal agencies, national, state and local agencies; state and local health departments; and research institutions to raise awareness of suicide as a public health problem. It has four priority areas for violence prevention; youth violence, family and intimate violence, suicide, and firearm injuries. It also functions as an information center on suicide, including statistics, researches findings, and research programs.

Children's Safety Network (CSN) www.edc.org/HHD/csn
55 Chapel Street
Newton, MA 02458-1060
(617) 969-7100, ext. 2207 (617) 244-3436 (fax) Email: *csn@edc.org*
This organization assists states, communities, and others to prevent child and adolescent injuries. CSN's provides information, training, and technical assistance to facilitate the development of new injury and violence prevention programs and enhance and support existing efforts.

The Gay, Lesbian and Straight Education Network www.glsen.org
121 West 27th Street #804
New York, NY 10001
(212) 727-0135 (212) 727-0245 (fax)
GLSEN strives to assure that each member of every school community is valued and respected, regardless of sexual orientation, by teaching the lesson of respect for all in public, private, and parochial K-12 schools. Founded as a small volunteer group in Boston in 1990, GLSEN led the fight that made Massachusetts the first state to ban discrimination against gay and lesbian students in public school in 1993.

Light for Life Foundation International www.yellowribbon.org
Yellow Ribbon Suicide Prevention Program
P. O. Box 644
Westminister, CO 80036-0644
(303) 429-3530 (303) 426-4496 (fax)
Provides information on suicide, survivors support groups, and task forces and coalitions around the country. Provide seminars and presentation that teach awareness and suicide prevention skills with chapters around the country to provide support and services to prevent suicide.

Mental Help Net www.mentalhelp.net
570 Metro Place North
Dublin, OH 43017
(614) 764-0143 (614) 764-0362 (fax)
Provides a comprehensive source of outline mental health information, news and resources.

National Depressive and Manic-Depressive Association www.ndmda.org
730 N. Franklin Street, Suite 501
Chicago, IL 60610-3526
(800) 826-3632 (312) 642-7243 (fax)
Seeks to educate patients, families, professionals, and the public on the nature of depressive and manic-depressive illness as treatable medical diseases; to foster self-help for patients and families; to eliminate discrimination and stigma; to improve access to care; and to advocate for research toward the elimination of these illnesses.

National Institute on Mental Health (NIMH) www.nimh.nih.gov
NIMH Public Inquiries
5600 Fishers Lane, Room 7C-02, MSC 8030
Bethesda, MD 20892-8030
Provides funds for research and suicide information; stimulates and monitors extramural research on suicide, keeps abreast of developments in suicidology and public policy issues related to suicide surveillance, prevention and treatment, and disseminates science-based information on suicidology.

The National Organization for People of Color Against Suicide
Dr. Donna Barnes, Founder and President
P.O. Box 125
San Marcos, TX 78667
(830) 625-3576 Email: *db31@swt.edu*
This small organization focuses on giving suicide survivors a way to heal and to reach into communities with suicide rates.

Office of the Surgeon General www.surgeongeneral.gov
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201
(202) 205-1463 (fax)
The Surgeon General's Office has issued The Surgeon General's Call to Action to Prevent Suicide and accompanying fact sheets. Additional information on the Healthy People 2000 and 2010 Objectives are available from the Office and through the website.

Pierre@virtualctiy.com www.virtualcity.com/youthsuicide
(403) 245-8827
Email: *Pierre@virtualcity.com*
Provides an extensive collection of information related to Gay/Bisexual Males suicide, Internet Resource Links, and bibliography with Links to Abstracts.

SA / VE www.save.org
PO Box 24507
Minneapolis, MN 55425-0507
(612) 946-7998
SA / VE is dedicated to education about brain disease that, if untreated medically and psychologically, can result in suicide death, to make statements through participation in the Annual Awareness Day and letter writing, to honor the memory of people who died by suicide and to eliminate the stigma of suicide.

Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov
105 Parklawn Building
Fisher's Lane
Rockville, MD 20857
(301) 443-4795 (301) 443-0284 (fax)
SAMHSA is a Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Suicide Information & Education Center (SIEC) www.siec.ca
201-1615 10TH Ave. SE
Calgary, Alberta, CANADA T3C 0J7
(403) 245-3900 (403) 245-0299 (fax) Email: siec@siec.ca
SIEC is the largest English-language suicide information resource center and library in the world. It holds more than 26,000 print and audiovisual material on all aspects of suicide behaviors. It provides information useful for developing successful suicide prevention, intervention, and postvention programs.

Suicide Prevention Advocacy Network (SPAN) www.spanusa.org
5034 Odin's Way
Marietta, GA 30068
(888) 649-1366 (770) 642-1419 (fax)
SPAN, a nonprofit organization is dedicated to the creation of an national suicide prevention strategy. SPAN links the energy of those bereaved by suicide with the expertise of leaders in science, business, government, and public service to achieve the goal of significantly reducing the national rate of suicide by the year 2010.

Suicide Prevention Resource Center
G. Thomas Shires, MD
Director, University of Nevada School of Medicine
Trauma Institute
2040 W. Charleston, Suite 501
Las Vegas, NV 84102
(702) 671-2276 (702) 385-2701 (fax)

Survivors of Suicide Support Groups www.survivorsofsuicide.com
Survivors of Suicide Support Groups were established to help friends and family members who have survived the suicide of a loved to cope with the grief and bewilderment of the issue. The Support Groups also advocate for education and prevention of suicide.

The organization list was adapted and modified from the summary produced by the Injury Prevention and Control Program of Massachusetts Department of Public Health and Children's Safety Network National Injury and Violence Prevention Resource Center's list of national organizations.

APPENDIX A

Number of Suicide Deaths, Indiana 1999-2001 (Reference Table for Figure 3 and Figure 4)

	WISQARS (1999-2000)				2001 Indiana Mortality				Totals
Age	Males		Females		Males		Females		Both Sexes
	White	Black	White	Black	White	Black	White	Black	Both Races
10-14	18	0	3	0	2	0	0	0	23
15-19	58	8	9	0	32	1	8	0	116
20-24	85	15	14	4	41	5	5	1	170
25-34	195	14	30	1	90	6	13	0	349
35-44	232	12	61	3	107	7	36	2	460
45-54	173	5	44	1	118	5	33	3	382
55-64	79	5	21	0	38	0	19	0	162
65+ (plus unknown)	177	5	31	1	105	4	19	0	342
All Ages	1017	64	213	10	533	28	133	6	2004

(Source: CDC, WISQARS and 2001 Indiana Mortality Report)

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