

SUICIDE IN INDIANA REPORT 2011-2015

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 Epidemiology Resource Center and
Division of Trauma and Injury Prevention

SUICIDE IN INDIANA

Indiana State Department of Health

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Highlights in Indiana

Mortality, 2011–2015 ¹

- From 2011–2015, 4,696 Hoosiers died by suicide, making it the 11th-leading cause of death in Indiana.
- Males accounted for 79.4% (3,730) of all suicides; of those, 93.4% were white males.
- Males were approximately four times more likely to complete suicide compared to females.
- White males aged 45–54 years had the highest rate of suicide, followed by white males 65 years of age or older, and white males aged 35–44 years.
- Suicide was the second leading cause of death among 15- to 34-year-olds, the third-leading cause of death among 10- to 14-year-olds and the fourth-leading cause of death among 35- to 54-year-olds. ²
- The methods in which Hoosiers died by suicide included firearms (53%), suffocation including drowning (25.6%), poisoning (15.8%) and other means (5.6%).¹
- The most common method for male suicide was via firearms, while the most common method among females was poisoning.

Inpatient data—Self-inflicted injuries (suicide attempt), 2011-2014 ³

- 15,797 hospitalizations were due to self-inflicted injuries. The average age of these patients was 36 years.
- Females accounted for the majority (58%; 9,192) of suicide attempts resulting in hospitalizations.
- For suicide attempts resulting in hospitalization, an overwhelming majority involved poisoning by solid or liquid substances. The top three medications used in poisonings

included tranquilizers, pain relievers, and sedatives.

Emergency Department (ED) data—Self-inflicted injuries (suicide attempt), 2011–2014⁴

- ❑ 23,381 ED visits were due to self-inflicted injuries. The average age of these patients was 30 years.
- ❑ Females accounted for the majority (58%; 13,560) of suicide attempts seen in the ED.
- ❑ For suicide attempts seen in the ED, 75.3% involved poisonings, of which tranquilizers and pain relievers were used most often. Additionally, 25.7% of attempts involved cutting or piercing methods.

Suicide attempts among youth, 2011-2015⁵

- ❑ 29.3% of high school students reported feeling sad or hopeless almost every day for two weeks or more in a row resulting in changes in behavior during the past 12 months.
- ❑ 9.9% of Indiana high school students reported that they attempted suicide in the previous 12 months.
- ❑ 19.8% of Hoosiers in grades 9–12 seriously considered attempting suicide during the past 12 months.
- ❑ Among students who attempted suicide during the 12 months before the survey, 34.2% asked for help from someone before their suicide attempt, such as a doctor, counselor, or hotline.

Introduction

Suicide is a major preventable public health problem endemic throughout the U.S. Individuals who die by suicide cross all economic, racial/ethnic, age and social boundaries. Death by suicide accounted for 44,193 lives lost in the United States (U.S.) in 2015, which equates to 121.1 suicides per day, a 15% increase since 2010.² In 2014, 469,096 Americans were seen in hospital emergency departments (ED) for nonfatal, self-inflicted injuries, commonly termed suicide attempts.² However, many suicides or suicide attempts are unreported or misreported as accidents, causing the magnitude of the problem to be far greater than current statistics indicate.

According to the American Foundation for Suicide Prevention, some suicides occur without any warning, but the majority of suicidal individuals show warning signs. Warning signs include talking about a specific suicide plan, losing interest in things and activities and acting irritable or agitated.⁶ While each suicide or attempted suicide can be as unique as the person who experiences it, there are ways to address the multiple social, emotional, environmental and health factors involved. Suicide prevention efforts must involve different strategies, requiring a wide range of partners, and draw on a diverse set of resources and tools.⁶

Almost two decades have passed since Surgeon General David Satcher broke the silence surrounding suicide in the United States by issuing *The Surgeon General's Call to Action to Prevent Suicide*.⁷ Published in 1999, this landmark document introduced a blueprint for suicide prevention and guided the development of the National Strategy for Suicide Prevention. Released in 2001, the National Strategy set forth an ambitious national agenda for suicide prevention consisting of 11 goals and 68 objectives.⁸

In September 2012, the National Action Alliance for Suicide Prevention released a revised *National Strategy* reflecting substantial input from individuals and organizations nationwide with an interest in suicide prevention. The revised National Strategy is a call to action intended to guide suicide prevention strategies in the U.S. over the next decade.¹⁰ Major developments addressed in the revised version include:

- ❑ A better understanding of how suicide is related to mental illness, substance abuse, trauma, violence and other related issues;
- ❑ New information about groups that may be at an increased risk for suicidal behaviors;
- ❑ Increased knowledge of the types of interventions that may be most effective for suicide prevention; and
- ❑ An increased recognition of the importance of implementing suicide prevention efforts in a comprehensive and coordinated way.⁸

The 2012 National Strategy emphasizes the role every American can play in protecting friends, family members and colleagues from suicide. It also provides guidance for schools, businesses, health systems, clinicians and many other sectors about suicide prevention and takes into account nearly a decade of research and other advancements in the field since the last strategy was published.⁸

In an effort to describe the burden of suicide in Indiana, the Division of Trauma and Injury Prevention at the Indiana State Department of Health (ISDH) compiles and disseminates data based on the most recent mortality and morbidity data available at the state and national levels. This data helps identify populations at risk for suicide and reveal trends in suicide incidence and prevalence. The objective of this report is to define the problem, both in the U.S. and in Indiana, and provide an overview of risk factors, protective factors, prevention issues and local and national resources available.

Suicide in the United States

The most recent data ranks suicide as the 10th-leading cause of death for Americans (Table 1), with an average of one American dying by suicide every 12.6 minutes.² The incidence of suicide

was 13.7 per 100,000 in 2015, with an age-adjusted value of 13.3 per 100,000. Between 1999 and 2015, suicide rates in the U.S. have ranged from 10.5 and 13.3 per 100,000 (Figure 1).⁹ The suicide rate has steadily increased since 2006.

Nationally, suicide is the second-leading cause of death among those 15–34 years of age, and the third leading cause of death among youth aged 10–14 (Table 1).² Figure 2 displays a more detailed breakdown of suicide deaths by age group. In 2015, persons under age 25 years accounted for 12.4% of all suicides.^{9,11} Each year, there are about 10 youth suicides for every 100,000 youth, with an average of one person under 25 years of age dying by suicide every hour and a half.¹¹ Statistics indicate that youth and young adult suicide rates in the U.S. increased by more than 200% from the 1950s to the late 1970s, remained stable from the late 1970s to the mid-1990s, and slightly decreased in the early 2000s. However, between 2011 and 2015 the youth suicide rate increased from 11.0 to 12.5 per 100,000 youths.^{9,11} While suicide is a leading cause of death among youth, rates increase with age and are highest among Americans 45-54 years old (20.0 per 100,000).¹²

Figure 3 looks into the difference in the national suicide rates by sex and race. White males from 2011 to 2015 had higher suicide rates (22.9 per 100,000) than American Indian/Alaska Native males (17.4 per 100,000), African American males (9.5 per 100,000), Asian/Pacific Islander males (6.2 per 100,000) and all females. Among females, Whites had the highest suicide rate (6.4 per 100,000), followed by American Indian/Alaskan Natives, Asian/Pacific Islanders, and African Americans, respectively (Figure 3). Whites accounted for 90.1% of all suicides in 2015.⁹

When comparing sex differences from 2011-2015, males (20.5 per 100,000) were nearly four times more likely to die from suicide than females (5.6 per 100,000). Males accounted for 77.8% (161,945) of all suicide deaths, of whom 90.4% (146,356) were White.⁹ Overall, females died by suicide less often than males. Yet, White females accounted for 20.0% (41,650) of all suicides in the U.S from 2011-2015.⁹

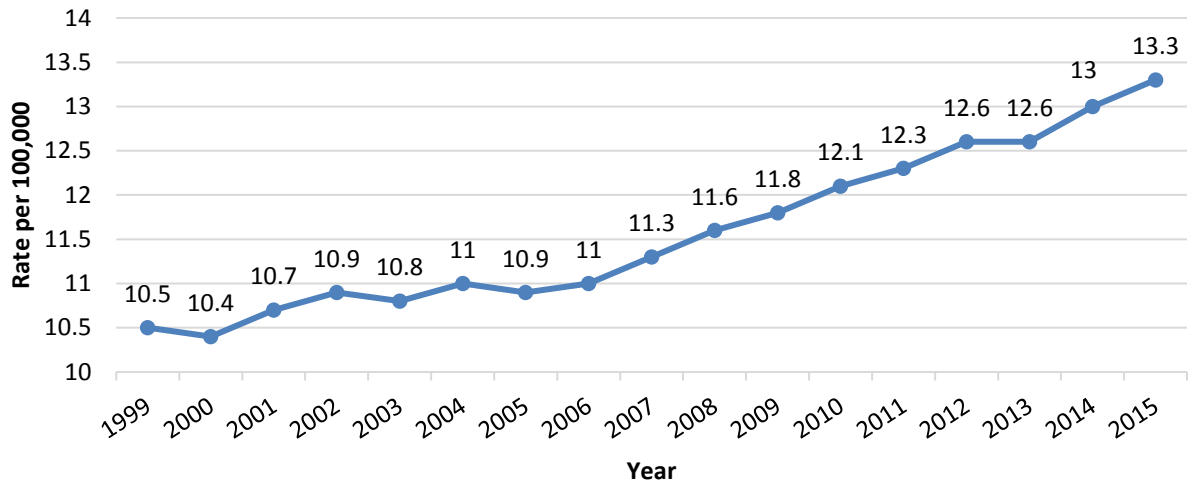
Firearms remain the most common method of suicide in the U.S., as intentional self-harm by discharge of firearms accounted for 105,183 deaths by suicide from 2011 to 2015. Of the 208,233 individuals who took their lives during this time period, about half (50.5%) used a firearm, 26% suffocated, 16% used poison and 8% used another method (Figure 4).⁹ Figure 5 show the differences in mechanism between the sexes. The most common method of suicide for males was firearms, with males using firearms six times more often than their female counterparts (11.4 versus 1.7 per 100,000). Suicide by poisoning accounted for 33,554 deaths from 2011-2015 at a rate of 2.1 per 100,000, although since 2001, poisoning has surpassed firearms as the most frequently used method for female suicides.⁹

Table 1: Ten leading causes of death by age group, all races, both sexes, U.S., 2011-2015

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 24,281	Unintentional Injury 6,497	Unintentional Injury 3,735	Unintentional Injury 3,969	Unintentional Injury 60,207	Unintentional Injury 84,730	Unintentional Injury 79,484	Malignant Neoplasms 230,998	Malignant Neoplasms 570,430	Heart Disease 2,437,953	Heart Disease 3,055,583
2	Short Gestation 20,767	Congenital Anomalies 2,304	Malignant Neoplasms 2,201	Malignant Neoplasms 2,183	Suicide 25,142	Suicide 32,180	Malignant Neoplasms 56,579	Heart Disease 175,571	Heart Disease 364,883	Malignant Neoplasms 2,041,435	Malignant Neoplasms 2,931,824
3	SIDS 8,265	Homicide 1,821	Congenital Anomalies 901	Suicide 1,808	Homicide 22,374	Homicide 21,785	Heart Disease 52,220	Unintentional Injury 103,609	Unintentional Injury 85,555	Chronic Low. Respiratory Disease 627,935	Chronic Low. Respiratory Disease 737,779
4	Maternal Pregnancy Comp. 7,789	Malignant Neoplasms 1,748	Homicide 655	Congenital Anomalies 809	Malignant Neoplasms 7,719	Malignant Neoplasms 18,174	Suicide 33,550	Liver Disease 44,027	Chronic Low. Respiratory Disease 80,147	Cerebrovascular 561,516	Unintentional Injury 667,411
5	Unintentional Injury 5,940	Heart Disease 784	Heart Disease 386	Homicide 793	Heart Disease 4,845	Heart Disease 16,653	Homicide 13,288	Suicide 43,859	Diabetes Mellitus 65,810	Alzheimer's Disease 452,607	Cerebrovascular 659,882
6	Placenta Cord Membranes 4,850	Influenza & Pneumonia 504	Chronic Low. Respiratory Disease 350	Heart Disease 566	Congenital Anomalies 1,980	Diabetes Mellitus 3,523	Liver Disease 12,852	Diabetes Mellitus 29,932	Liver Disease 60,000	Diabetes Mellitus 269,337	Alzheimer's Disease 457,480
7	Bacterial Sepsis 2,813	Septicemia 283	Influenza & Pneumonia 275	Chronic Low. Respiratory Disease 372	Influenza & Pneumonia 947	Liver Disease 3,347	Diabetes Mellitus 9,646	Cerebrovascular 27,440	Cerebrovascular 57,482	Unintentional Injury 233,588	Diabetes Mellitus 379,364
8	Respiratory Distress 2,461	Chronic Low. Respiratory Disease 261	Cerebrovascular 202	Influenza & Pneumonia 237	Diabetes Mellitus 933	HIV 3,061	Cerebrovascular 8,668	Chronic Low. Respiratory Disease 22,533	Suicide 35,851	Influenza & Pneumonia 230,382	Influenza & Pneumonia 273,730
9	Circulatory System Disease 2,322	Benign Neoplasms 219	Benign Neoplasms 196	Cerebrovascular 231	Cerebrovascular 865	Cerebrovascular 2,719	HIV 6,439	Septicemia 12,302	Septicemia 26,763	Nephritis 195,831	Nephritis 236,430
10	Neonatal Hemorrhage 2,114	Cerebrovascular 211	Septicemia 163	Benign Neoplasms 172	Complicated Pregnancy 848	Influenza & Pneumonia 2,266	Influenza & Pneumonia 4,258	HIV 12,002	Nephritis 24,981	Septicemia 142,524	Suicide 208,233

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WISQARS

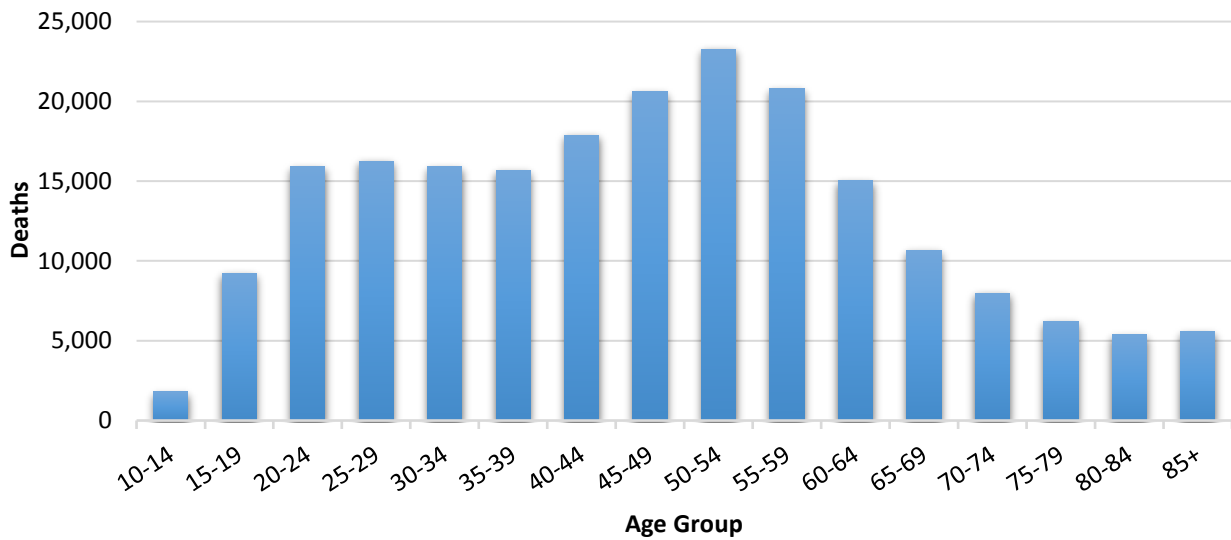
Figure 1. Suicide rates*, U.S., 1999–2015



*Age-adjusted rates per 100,000 population

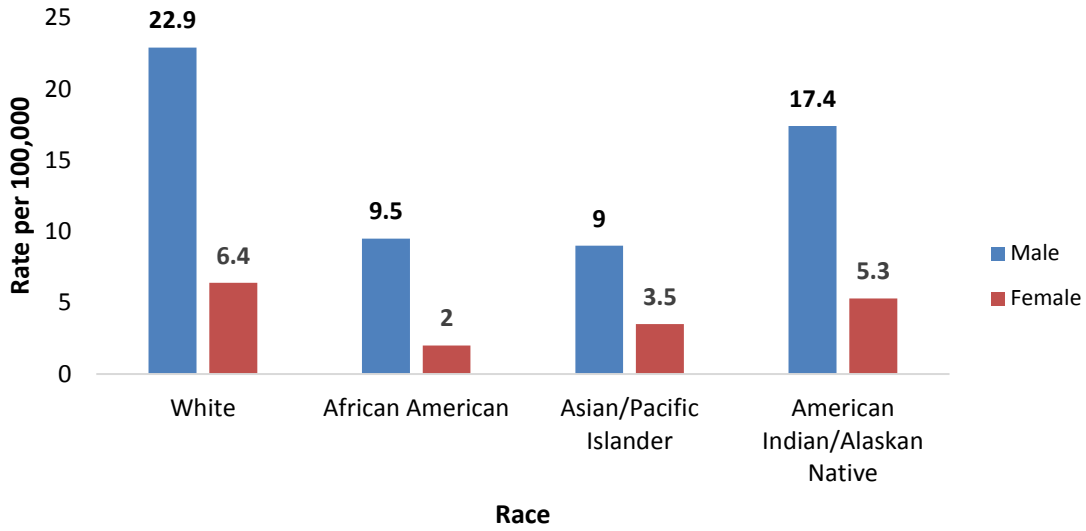
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 2. Suicides by age group, U.S., 2011-2015



Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

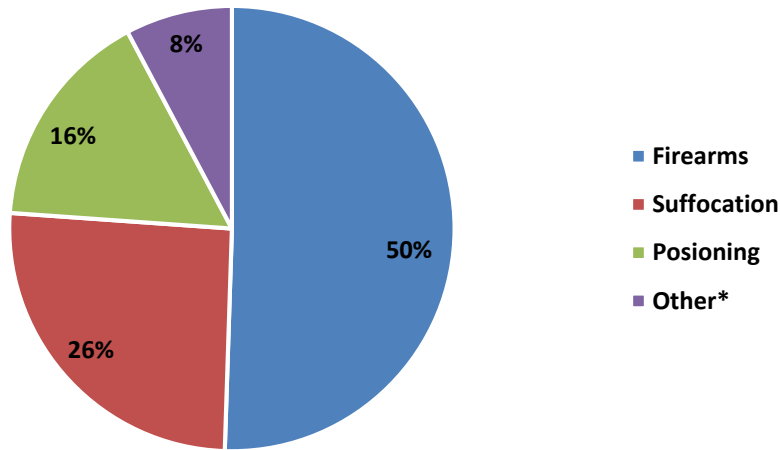
Figure 3. Suicide rate* by race and sex, U.S., 2011-2015



*Age-adjusted rates per 100,000 population

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

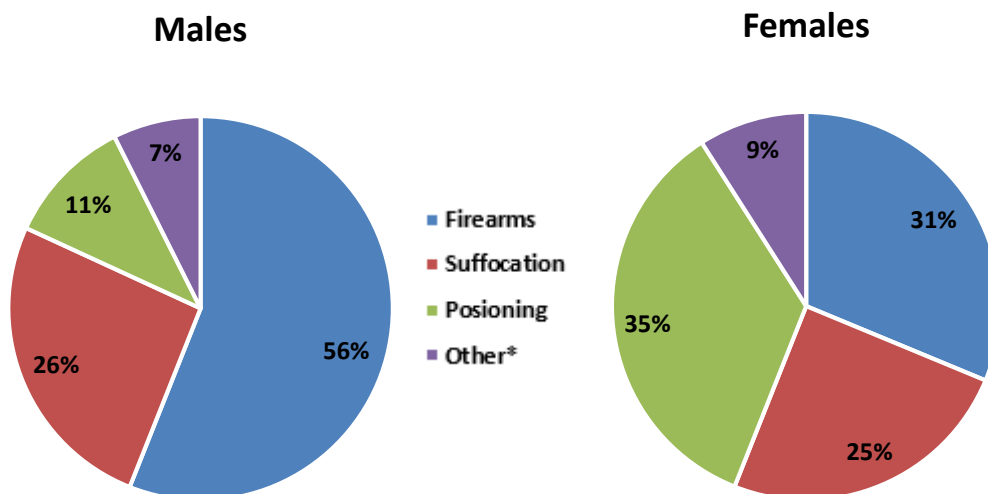
Figure 4. Suicide by mechanism, U.S., 2011-2015



*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figures 5. Suicide by mechanism and sex, U.S., 2011-2015



*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Suicide in Indiana

From 2011 to 2015, 21,837 Hoosiers died from injuries, averaging 12 deaths each day. During 2015 alone, 3,258 deaths from unintentional injuries occurred.¹ While 69% of the injury deaths were unintentional (accidental), 20% of the deaths resulted from suicide, 8% from homicide, and 3% were of undetermined intent (Figure 6).¹

From 2011-2015, 4,673 suicides were reported in Indiana, of which 962 occurred in 2015.¹ Suicide was the 11th-leading cause of death among Hoosiers during this time period (Table 2).² The suicide rate in Indiana has increased nearly every year since 1999 with a total increase of 72% from 1999-2015.¹ Though the rate has remained relatively stable since 2012, the trend line continued to slowly increase (Figure 7). The overall suicide rate in Indiana was also higher than the U.S. and Midwest rates. When comparing age groups, Indiana suicide death rates were slightly higher than the U.S. rates in all age categories except for those over 65 years of age. The Indiana suicide rates were higher than the Midwest rate in all age categories except 10-14 years of age (Table 3).^{1,9}

From 2011-2015, suicide was the second-leading cause of death in the 15–34 age group, the third leading cause of death among those 10–14 years of age, fourth among those 35–54 years of age and eighth for the 55-64 age group (Table 2).² The majority of the deaths by suicide

occurred in those aged 45–54 years (996 suicides), followed by those aged 35–44 years (841 suicides) and aged 25–34 years (826 suicides) (Figure 8).¹

National statistics indicate males die by suicide more frequently than females, and this is also true in Indiana (Figure 9).^{1, 2} In 2015, the overall suicide death rate for Hoosiers was 14.4 per 100,000, 23.8 per 100,000 among males and 5.6 per 100,000 among females.¹ The suicide rate among males increased from 2011 to 2015, while the female suicide rate decreased from a high of 6.0 per 100,000 in 2011 to 5.6 per 100,000 in 2015 (Figure 10). Male suicide rates over these years have been consistently around four times greater than female suicide rates.¹ When comparing age groups, males aged 45–54 years accounted for the most deaths (766), followed by males aged 25–34 (Figure 11)

From 2011 to 2015, 93.4% of suicide deaths in Indiana occurred among White Hoosiers. Whites (15.2 per 100,000) surpassed African Americans (6.4 per 100,000) and Asian/Pacific Islanders (6.4 per 100,000) in numbers of suicides during 2011–2015 (Figure 12). More suicide deaths were reported among White males compared to all other race/gender categories (Figure 13). When comparing rates, White male Hoosiers aged 45–54 years had the highest rate of suicide, followed by White males 35–44 years and White males aged 65 and older.¹

Of the 4,696 Indiana suicides reported from 2011 to 2015, 53% died by firearm, 25.6% by suffocation, 15.8% by poisoning, and 5.6% by other methods (Figure 14). Firearms were the leading mechanism of injury for males, while females more often died from poisoning (Figure 15).¹ White males died by suicide using firearms at a rate of 14.4 per 100,000, compared with African American males at a rate of 5.9 per 100,000. White females were more likely to die by suicide by poisoning (2.3 per 100,000) than by firearms (2.1 per 100,000) or suffocation (1.5 per 100,000) and have higher rates in all categories compared to African American females (Table 4).¹ Mechanism of injury also varies across age groups; 50% of those under 18 died of suffocation, while less than 10% of those 65 and older died from that mechanism. Firearms accounted for almost 80% of suicides from those 65 and older, 20% higher than any other age group (Figure 16).¹

Suicide death data comes from the ISDH mortality reports and differs slightly from the nationally based National Center for Health Statistics (NCHS). In addition, accuracy of mortality data is dependent upon how thoroughly the death certificate is completed, specifically with regards to intent. Another limitation is that race/ethnicity is reported at the discretion of the person completing the death certificate and may not reflect how an individual would define his or her own race.

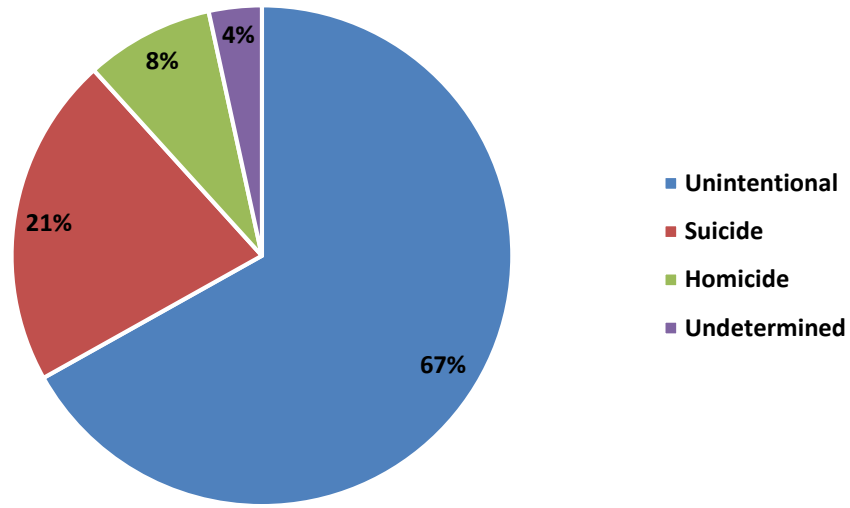
Table 2: Eleven leading causes of death by age group, all races, both sexes, Indiana, 2011-2015

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 688	Unintentional Injury 164	Unintentional Injury 88	Unintentional Injury 98	Unintentional Injury 1,504	Unintentional Injury 2,069	Unintentional Injury 1,871	Malignant Neoplasms 5,635	Malignant Neoplasms 13,360	Heart Disease 53,621	Heart Disease 68,532
2	Short Gestation 530	Congenital Anomalies 56	Malignant Neoplasms 59	Malignant Neoplasms 52	Suicide 577	Suicide 820	Malignant Neoplasms 1,316	Heart Disease 4,307	Heart Disease 8,668	Malignant Neoplasms 45,837	Malignant Neoplasms 66,836
3	SIDS 224	Homicide 44	Congenital Anomalies 25	Suicide 37	Homicide 524	Heart Disease 466	Heart Disease 1,272	Unintentional Injury 2,218	Chronic Low. Respiratory Disease 2,528	Chronic Low. Respiratory Disease 17,129	Chronic Low. Respiratory Disease 20,533
4	Unintentional Injury 214	Malignant Neoplasms 35	Homicide 16	Homicide 23	Malignant Neoplasms 143	Homicide 457	Suicide 842	Suicide 989	Unintentional Injury 1,740	Cerebro-vascular 12,988	Cerebro-vascular 15,262
5	Maternal Pregnancy Comp. 136	Septicemia 14	Heart Disease ---	Congenital Anomalies 20	Heart Disease 133	Malignant Neoplasms 389	Liver Disease 280	Liver Disease 879	Diabetes Mellitus 1,605	Alzheimer's Disease 10,820	Unintentional Injury 14,605
6	Placenta Cord Membranes 88	Heart Disease 10	Septicemia ---	Heart Disease 12	Congenital Anomalies 37	Liver Disease 88	Homicides 264	Chronic Low. Respiratory Disease 698	Cerebro-vascular 1,352	Diabetes Mellitus 6,816	Alzheimer's Disease 10,917
7	Bacterial Sepsis 81	Influenza & Pneumonia --	Chronic Low. Respiratory Disease ---	Chronic Low. Respiratory Disease 10	Complicated Pregnancy 24	Diabetes Mellitus 72	Diabetes Mellitus 245	Diabetes Mellitus 697	Liver Disease 1,269	Nephritis 5,651	Diabetes Mellitus 9,460
8	Respiratory Distress 72	Chronic Low. Respiratory Disease --	Benign Neoplasms ---	Influenza & Pneumonia --	Septicemia 21	Cerebro-vascular 61	Cerebro-vascular 204	Cerebro-vascular 612	Suicide 731	Unintentional Injury 4,639	Nephritis 6,782
9	Circulatory System Disease 55	Perinatal Period ---	Influenza & Pneumonia ---	Diabetes Mellitus ---	Diabetes Mellitus 20	Complicated Pregnancy 61	Influenza & Pneumonia 122	Septicemia 322	Nephritis 728	Influenza & Pneumonia 4,320	Influenza & Pneumonia 5,243
10	Homicide 49	Cerebro-vascular ---	Anemias ---	Cerebro-vascular ---	Chronic Low. Respiratory Disease 19	Influenza & Pneumonia 60	HIV 103	Nephritis 262	Septicemia 718	Septicemia 3,793	Septicemia 5,048
11	Neonatal Hemorrhage 46	Benign Neoplasms ---	Cerebro-vascular ---	Septicemia ---	Two Tied 18	Congenital Anomalies 51	Septicemia 99	Homicide 231	Influenza & Pneumonia 449	Parkinson's Disease 2,729	Suicide 4,673

Note: For leading cause categories, counts less than 10 deaths have been suppressed (---).

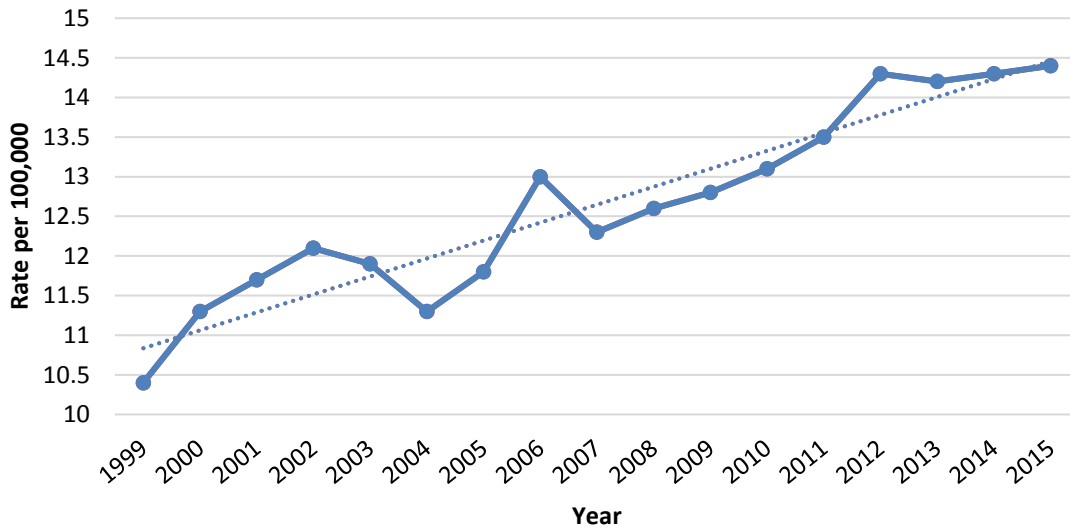
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WISQARS

Figure 6. Percent of injury deaths according to intent, Indiana, 2011-2015



Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 7. Suicide rate* and trend, Indiana, 1999-2015



*Age-adjusted rates per 100,000 population

**Dotted line represents data trend line

Source: Indiana State Department of Health, Epidemiology Resource Center

Table 3. Comparison of suicide rates*, 2011-2015

Age in Years	Indiana		United States		Midwest**	
	Number	Death Rate	Number	Death Rate	Number	Death Rate
10–24	614	8.9	26,950	8.3	6,426	9.3
25–64	3,382	19.9	145,440	17.4	31,336	17.7
65+	677	14.8	35,789	16.0	6,788	13.9
Total	4,673	14.1†	208,233	12.8†	44,555	12.9†

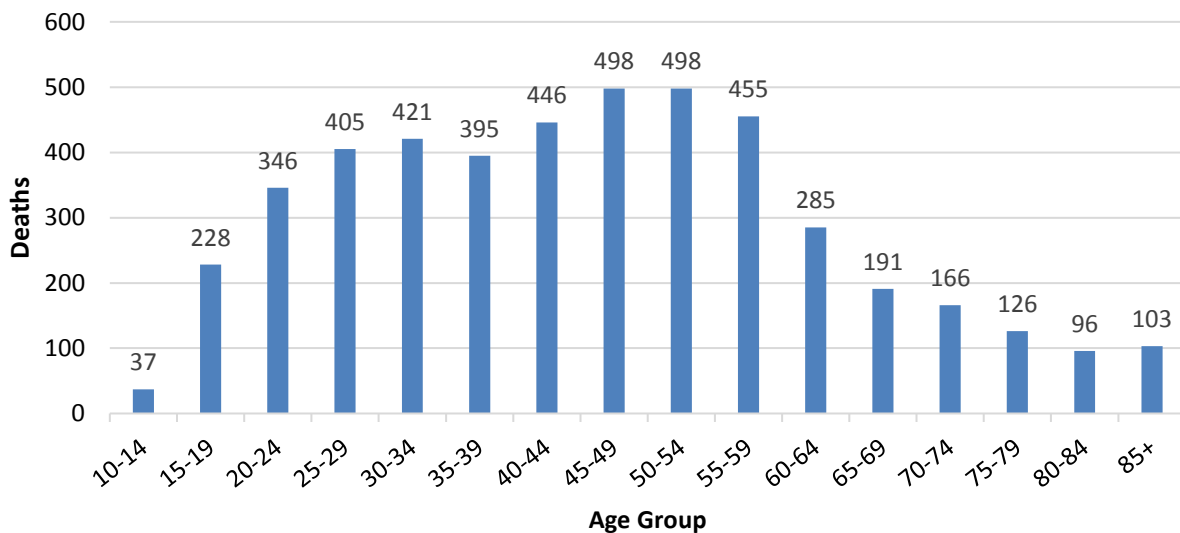
*Rates per 100,000 population

**Midwest includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin

†Age-adjusted rates

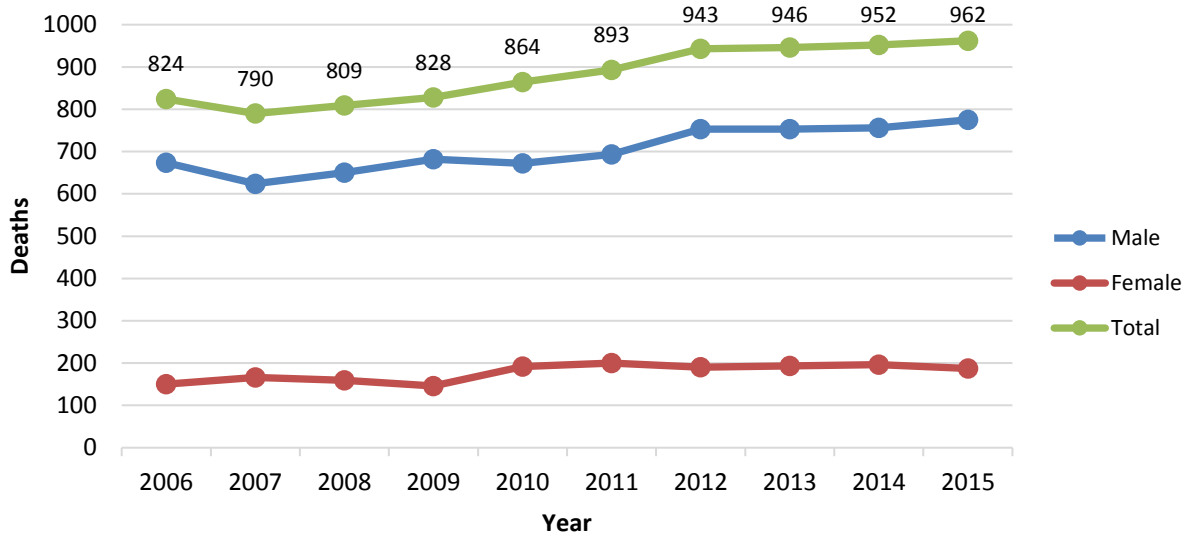
Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 8. Suicides by age group, Indiana, 2011-2015



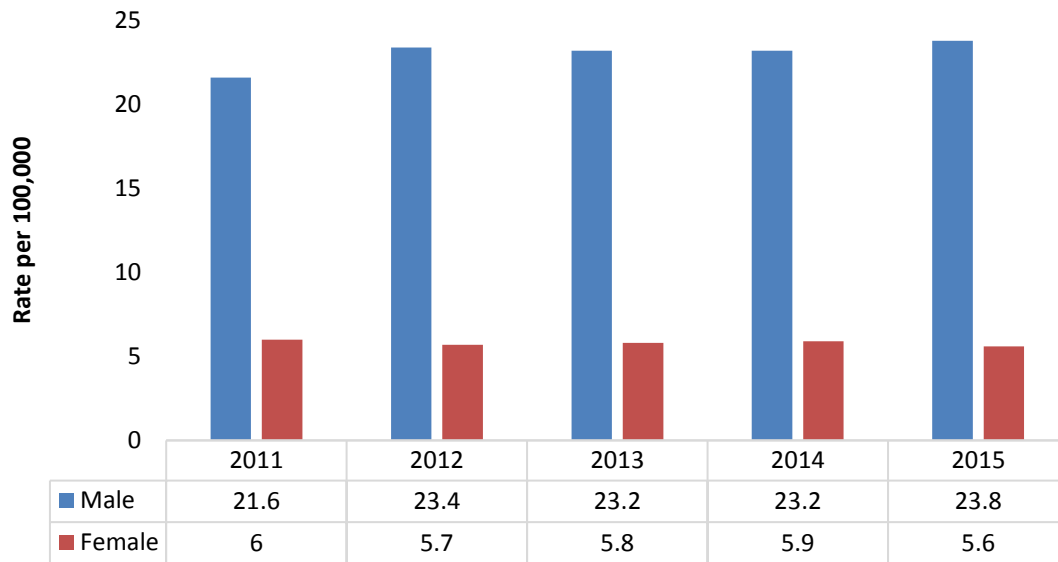
Source: Indiana State Department of Health, Epidemiology Resource Center

Figure 9. Suicides by sex, Indiana, 2011-2015



Source: Indiana State Department of Health, Epidemiology Resource Center

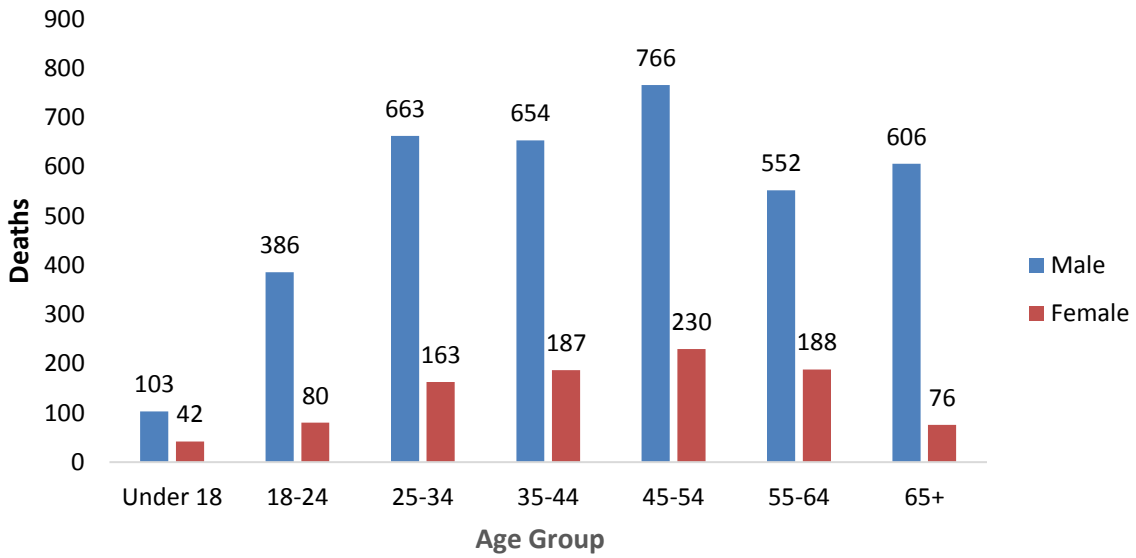
Figure 10. Suicide rates* by sex, Indiana, 2011-2015



*Age-adjusted rates per 100,000 population

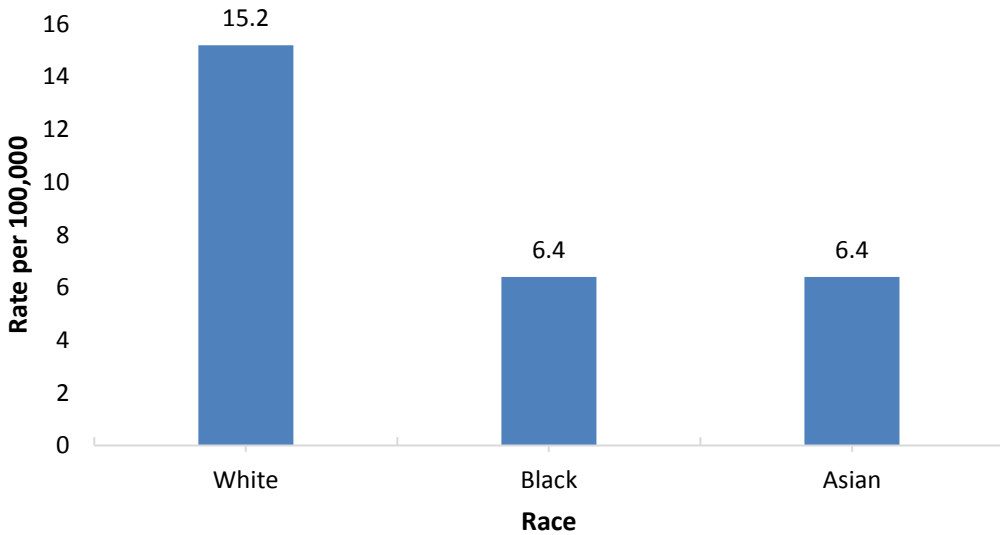
Source: Indiana State Department of Health, Epidemiology Resource Center

Figure 11. Suicide by sex and age, Indiana, 2011-2015



Source: Indiana State Department of Health, Epidemiology Resource Center

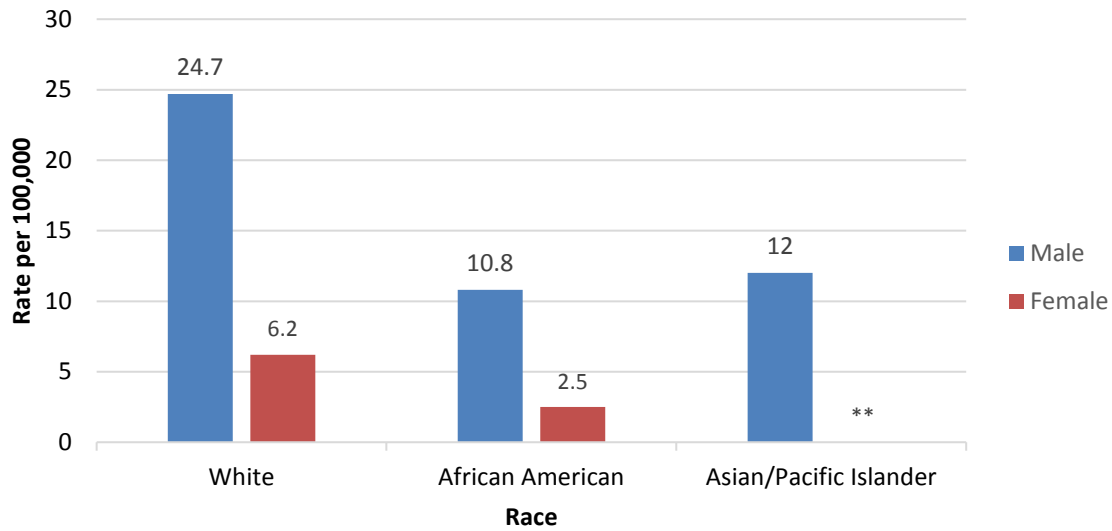
Figure 12. Suicide rates* by race, Indiana, 2011-2015



*Age-adjusted rates per 100,000 population

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

Figure 13. Suicide rates* by race and sex, Indiana, 2011-2015

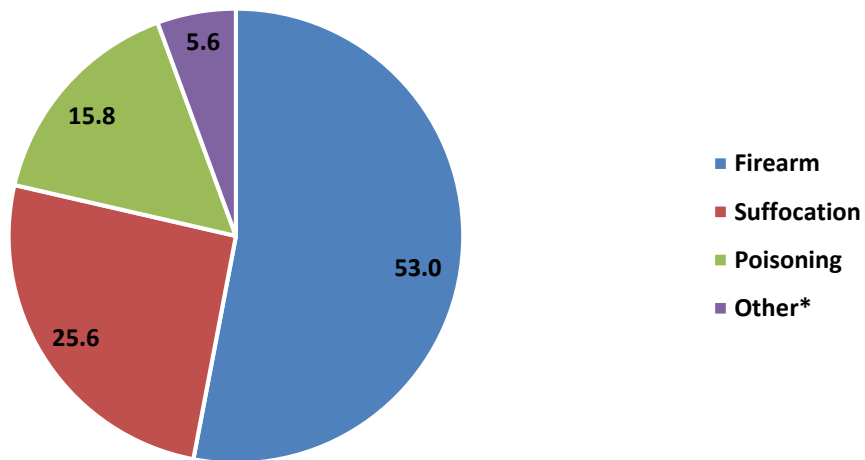


*Age-adjusted rates per 100,000 population

**Asian/Pacific Islander Female rate suppressed due to unstable rate.

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WONDER

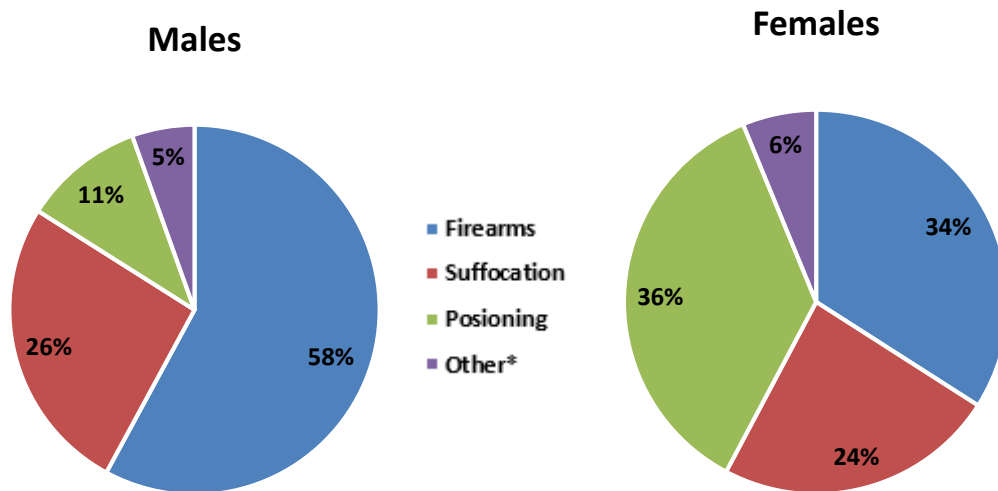
Figure 14. Suicide by mechanism, Indiana, 2011-2015



*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified

Source: Indiana State Department of Health, Epidemiology Resource Center

Figure 15. Suicide by mechanism and sex, Indiana, 2011-2015



*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified
 Source: Indiana State Department of Health, Epidemiology Resource Center

Table 4. Suicide rates* by mechanism, race, and sex, Indiana, 2011-2015

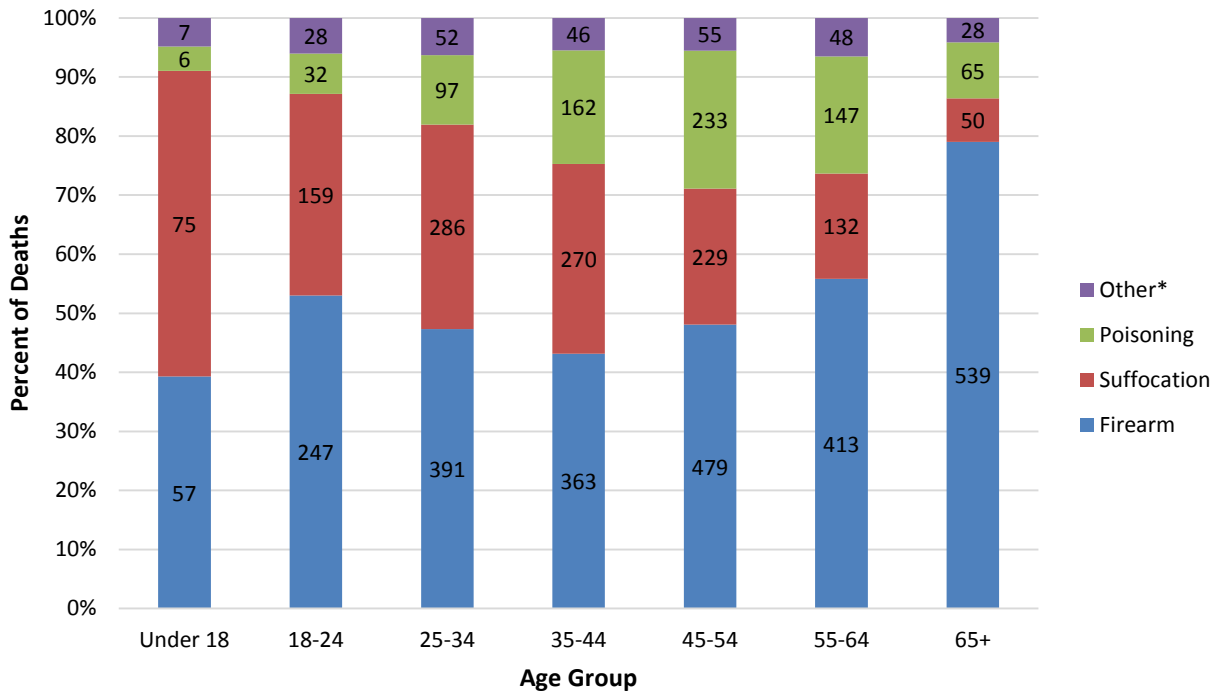
Mechanism	White Males	African American Males	White Females	African American Females
	Number	Number	Number	Number
	Death Rate	Death Rate	Death Rate	Death Rate
Firearms	2,072 14.4	86 5.9	308 2.1	†
Suffocation	888 6.4	50 3.1	203 1.5	†
Poisoning	367 2.6	†	335 2.3	†

*Age-adjusted rates per 100,000 population

†Suicide deaths 20 or fewer do not produce stable rates and therefore are not included.

Source: Indiana State Department of Health, Epidemiology Resource Center

Figure 16. Suicide by mechanism and age, Indiana, 2011-2015



Source: Indiana State Department of Health, Epidemiology Resource Center

Years of Potential Life Lost (YPLL)

Years of potential life lost indicates the number of years lost due to premature death, defined as death before age 65.¹² YPLL is used to quantify social and economic loss associated with premature death and has been promoted to emphasize specific causes of death affecting younger age groups. Table 5 presents this measure of the burden of suicide during 2011 to 2015 in Indiana. Table 6 provides a comparison of the YPLL of suicide to other causes of death in Indiana and the U.S and their contribution to the total YPLL. Suicide accounted for nearly 20,353 years of life lost in Indiana in 2010, and while suicide was the 11th-leading cause of death among Hoosiers, it was the fourth-leading cause of YPLL (Table 7). Suicide surpassed the perinatal period as the fourth-leading cause of YPLL in 2012. Suicide is a leading cause of death among youth and young adults, and contributes to substantial premature mortality, thus resulting in a high YPLL.

Table 5. Years of YPLL and YPLL rate* due to Suicide, Indiana, 2011-2015

	2011	2012	2013	2014	2015	2011-2015
YPLL	18,464	19,549	19,768	19,909	20,353	98,043
YPLL rate per 100,000	343	362	364	365	374	361

*Age-adjusted rates per 100,000 population

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WISQARS

Table 6. YPLL before age 65 by common causes of deaths, all races, Indiana and U.S., 2015

Cause	Indiana		United States	
	YPLL	YPLL %	YPLL	YPLL %
Unintentional Injury	58,326	20.9	2,401,254	20.9
Malignant Neoplasms	41,218	14.8	1,737,694	15.2
Heart Disease	32,718	11.7	1,347,979	11.8
Suicide	20,353	7.3	869,164	7.6
Perinatal Period	19,110	6.89	759,988	6.6
Homicide	13,181	4.7	557,474	4.9

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WISQARS

Table 7. Rate* of YPLL by common causes of death, Indiana, 2011-2015

Cause	2011	2012	2013	2014	2015	2011-2015
Unintentional Injury	904	938	1,001	990	1,071	981
Malignant neoplasms	697	709	682	663	673	685
Heart Disease	574	556	537	553	551	555
Perinatal Period	357	322	348	352	361	348
Suicide	343	362	364	365	374	361

*Age-adjusted rates per 100,000 population

Source: National Center for Injury Prevention and Control CDC, National Center for Health Statistics Vital Statistics System, WISQARS

Suicide Survivors

The designation of “survivor of suicide” refers to the family and friends who are directly affected and impacted by the suicide of their loved one. This definition does not represent all the people affected by the suicide (e.g., school, church, community, etc.), but those considered family and close friends.^{13, 14} Survivors represent “the largest mental health casualties related to suicide” because survivors themselves are at an increased risk of suicide. Numbers of survivors are difficult to determine; however, it is estimated that for every suicide, an average of six people suffer intense grief.¹⁴ Based on this estimate, in 2015, there were 5,772 suicide survivors in Indiana, and it is estimated during 2015, one out of every 63 Americans is a survivor of suicide, 5.1 million people in total.¹⁴

Suicide Attempts in the United States

Deaths by suicide represent only a fraction of the number of persons affected by suicidal thoughts and behaviors.⁶ However, there is no official source of national data on suicide attempts because not all attempts require medical attention, and those that do may not be identified or correctly coded as suicide attempts. It is generally estimated that there are 25 attempts for each suicide death.^{5, 11} Based on this estimate, approximately 1.1 million suicide attempts were made in 2015 in the U.S.¹¹ Females, youths, and older adults attempt suicide more often compared to other populations. The average of 25 attempts for each suicide death

varies by demographics. For every youth suicide death, there are an estimated 100 to 200 youth who attempt suicide, and in the elderly population, 4 attempts per elderly suicide death.^{5, 11} Whites attempt suicide at higher rates than other races, with white females attempting suicide three times more often than white males.⁵

Suicide Attempts in Indiana

The ISDH hospital discharge data set gives an indication of the number of attempted suicides in Indiana, although with some limitations. The International Classification of Disease Revision 9 Clinical Modification (ICD-9-CM) coding scheme includes external cause of injury codes, or E-codes, that indicate the source or cause of the injury, intentionality, and in some cases, location of occurrence. However, it is estimated that only 70% of hospital discharge records contain these codes.^{3, 4} Therefore, the total number of suicide attempts is an underestimation of the true amount.

E-codes specific to suicide or attempted suicide (self-inflicted injuries specified as intentional) include E950–E959. However, the data are not sensitive enough to distinguish which self-inflicted injuries are related to a self-mutilation disorder versus attempted suicide. Also, the ISDH hospital database does not contain a patient-specific unique identifier, meaning that it does not distinguish whether one person had five visits or whether five people visited once. Therefore, statistics only reflect visits and not specific numbers of people.

A final limitation of the hospital discharge data is that not all hospitals submit discharge data. Data submission compliance among hospitals varies by year, but typically a few acute and psychiatric/behavioral hospitals do not report. As a result, the total number of attempts for the inpatient and ED/outpatient data is an underestimation of the actual number of suicide attempts and should be used with caution.

Hospital Inpatient Data

The 2011 to 2014 Indiana inpatient hospital discharge data set totaled 3,178,533 records. A query was conducted for suicide-related E-codes, yielding 15,797 patients with self-inflicted injuries.³ The number of self-inflicted hospitalizations remained fairly stable over the four-year period, with a slight decrease in 2013 (Figure 17). The average age for suicide attempts was 36 years old. Fifty-eight percent (9,192/15,797) of the attempts were made by females, and 42% (6,605/15,797) of attempts were made by males. African American females had the highest rate of self-inflicted injury among ages 15-19 years, followed by the second-highest rate among African American females aged 20-24 years. White females had a higher rate of self-inflicted

injury compared to African American females in those 25 and older. African American males had the highest rate of hospitalizations in the 25-34 age group (Figure 18).³

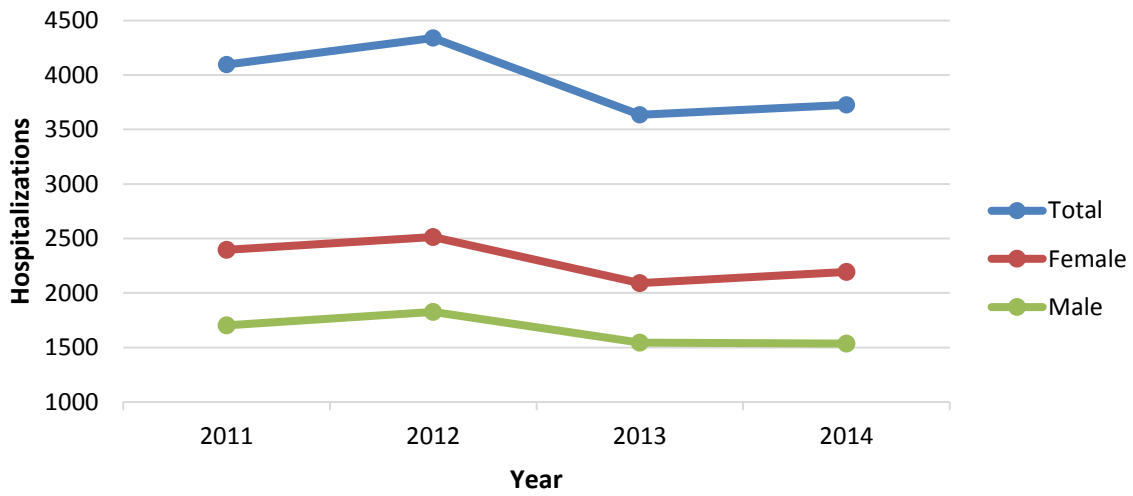
The majority of patients were admitted as an emergency (74.7%), followed by those classified as “urgent” (10.1%). Ten percent of patients admitted themselves to the hospital. Critical care days, meaning the number of days a patient spent in either an intensive care unit, critical care unit or other specialized intensive care unit of a facility during hospitalization, ranged from zero to 80 days, with 50% of the patients requiring at least one day of critical care.³

Although detailed analysis by cost is unavailable, 37.6% of patients who attempted suicide identified Medicare and/or Medicaid and 31.4% identified managed care organizations and/or commercial insurance as their primary source of payment (Table 8). The median total cost in Indiana for the 12,892 self-inflicted injuries was \$10,200 (Range \$34–\$2,792,227) for the four-year period.³ The total cost for all inpatient care related to self-inflicted injuries for 2011–2014 was nearly \$298 million.³

Table 9 lists the E-codes associated with suicide attempts, including the methods or cause of suicide attempt from 2011 to 2014. The vast majority of hospital admissions for attempted suicide involved self-inflicted poisoning by solid or liquid substances. The substances used most frequently in poisoning include benzodiazepine-based tranquilizers (chlordiazepoxide, diazepam, flurazepam, lorazepam, medazepam, and nitrazepam) (22%), analgesics (pain relievers) (13.6%), and other antipsychotics, neuroleptics, and major tranquilizers (6.2%) (Table 10).³

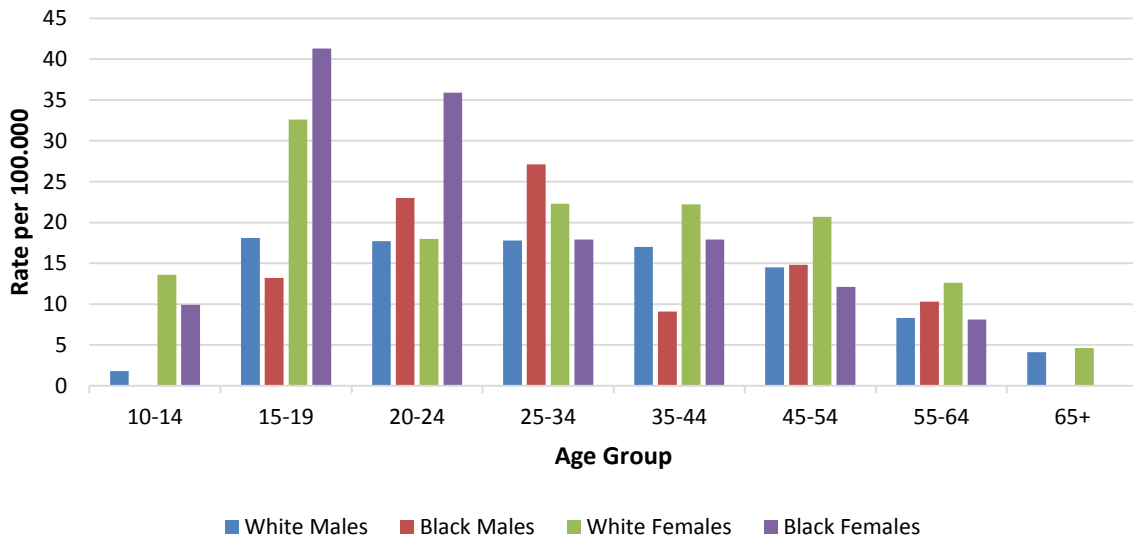
Other methods of attempting suicide included cutting or piercing (12.5% or 1,976 incidents) and use of firearms, air guns, or explosives (1.8% or 284 incidents). Hospitalizations resulting from suicide attempts by firearm are less common because these injuries are more likely to be fatal. Other suicide attempts, including poisoning via carbon monoxide, hanging or strangulation, jumping from high places and other unspecified means, involved less than 8.8% of hospital admissions for suicide attempts (Table 9).³

Figure 17. Self-inflicted injury hospitalizations, Indiana, 2011-2014



Source: Indiana Hospital Association, Hospital Discharge Data

Figure 18. Self-inflicted injury hospitalization rates by age and race, Indiana, 2011-2014



Source: Indiana Hospital Association, Hospital Discharge Data

Table 8. Primary payer of hospitalizations, Indiana, 2011-2014

Primary Payer	Frequency	Percent
Commercial Insurance (Includes Managed Care)	4,968	31.4
Medicaid	3,427	21.7
Self-Pay	3,254	20.6
Medicare	2,511	15.9
Other/Unknown	1,192	7.5
Other Government	445	2.8

Source: Indiana Hospital Association, Hospital Discharge Data

Table 9. E-code distribution for self-inflicted injury hospitalizations, Indiana, 2011-2014

ECODE	Description	Frequency	Percent
E950	Suicide and self-inflicted poisoning by solid or liquid substance	17,468	92.1
E950.0	Analgesics, antipyretics, and antirheumatics	4,480	
E950.1	Barbiturates	94	
E950.2	Other sedatives and hypnotics	873	
E950.3	Tranquilizers and other psychotropic agents	6,152	
E950.4	Other specified drugs and medicinal substances	4,038	
E950.5	Unspecified drug or medicinal substance	411	
E950.6	Agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers	49	
E950.7	Corrosive and caustic substances <i>(Suicide and self-inflicted poisoning by substances classifiable to E846)</i>	118	
E950.8	Arsenic and its compounds	0	
E950.9	Other and unspecified solid and liquid substances	1,253	
E951	Suicide and self-inflicted poisoning by gases in domestic use	11	<0.1
E951.0	Gas distributed by pipeline	4	
E951.1	Liquefied petroleum gas distributed in mobile containers	3	
E951.8	Other utility gas	4	

E952	Suicide and self-inflicted poisoning by other gases and vapors	145	0.9
E952.0	Motor vehicle exhaust gas	90	
E952.1	Other carbon monoxide	33	
E952.8	Other specified gases and vapors	20	
E952.9	Unspecified gases and vapors	2	
E953	Suicide and self-inflicted injury by hanging, strangulation, and suffocation	419	2.7
E953.0	Hanging	353	
E953.1	Suffocation by plastic bag	6	
E953.8	Other specified means	52	
E953.9	Unspecified means	8	
E954	Suicide and self-inflicted injury by submersion [drowning]	8	<0.1
E955	Suicide and self-inflicted injury by firearms, air guns, and explosives	284	1.8
E955.0	Handgun	105	
E955.1	Shotgun	17	
E955.2	Hunting rifle	10	
E955.3	Military firearm	0	
E955.4	Other and unspecified firearm (<i>Gunshot, not otherwise specified; Shot, not otherwise specified</i>)	98	
E955.5	Explosives	1	
E955.6	Air gun (BB gun, Pellet gun)	4	
E955.7	Paintball gun	0	
E955.9	Unspecified	49	
E956	Suicide and self-inflicted injury by cutting and piercing instrument	1,976	12.5
E957	Suicide and self-inflicted injury by jumping from high place	65	0.4
E957.0	Residential premises	19	
E957.1	Other man-made structure	32	
E957.2	Natural site	0	
E957.9	Unspecified	14	
E958	Suicide and self-inflicted injury by other and unspecified means	733	4.6
E958.0	Jumping or lying before moving object	33	
E958.1	Burns, fire	73	
E958.2	Scald	1	
E958.3	Extremes of cold	6	
E958.4	Electrocution	0	

E958.5	Crashing of motor vehicle	43	
E958.6	Crashing of aircraft	0	
E958.7	Caustic substances, except poisoning (Excludes poisoning by caustic substances [E950.7])	8	
E958.8	Other specified means	409	
E958.9	Unspecified means	160	
E959	Late effects of self-inflicted injury	154	1.0

Source: Indiana Hospital Association, Hospital Discharge Data

Table 10. Five most frequently reported ICD-9-CM classification codes among persons who attempted suicide, hospitalizations, Indiana, 2011-2014

ICD-9-CM Code	Description	Frequency	Percent*
969.4	Benzodiazepine-based tranquilizers (chlordiazepoxide, diazepam, flurazepam, lorazepam, medazepam, nitrazepam)	3,471	22.0
965.4	Aromatic Analgesics, Not Elsewhere Classified (acetanilid, paracetamol [acetaminophen], phenacetin [acetophenetidin])	2,151	13.6
969.3	Other antipsychotics, neuroleptics, and major tranquilizers	979	6.2
967.8	Other sedatives and hypnotics	705	4.5
965.1	Salicylates	467	3.0

*Percent is based off of the total number of suicide attempts.

Source: Indiana Hospital Association, Hospital Discharge Data

Emergency Department (ED) Data

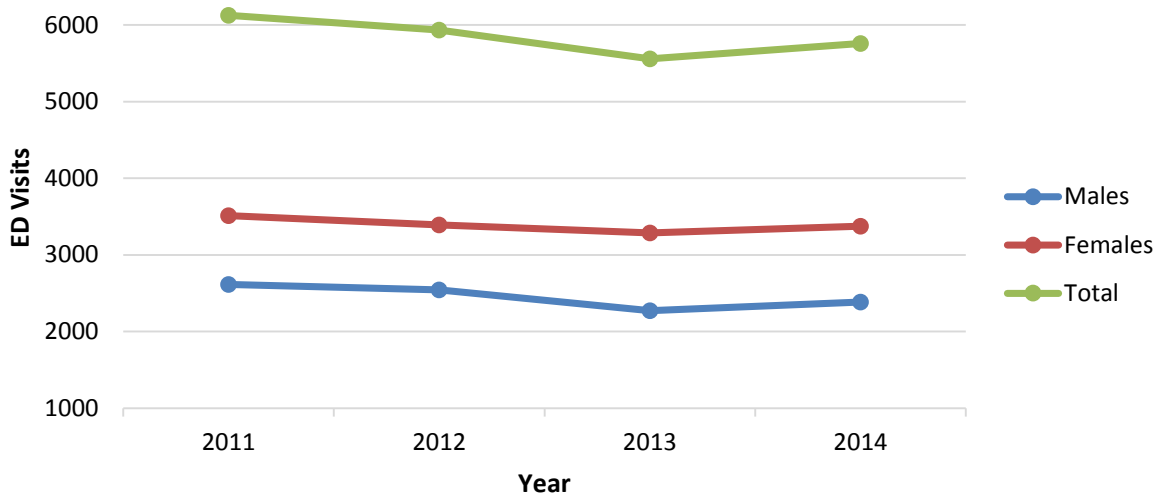
The 2011-2014 Indiana emergency department (ED)/outpatient discharge data set totaled 20,878,193 records. A query was done for suicide-related E-codes, yielding 23,381 patients with self-inflicted injuries specified as injuries in suicide or attempted suicide. The number of self-inflicted injury ED visits remained fairly stable during the four-year period, ranging from a low of 5,558 to a high of 6,127 (Figure 19).⁴ The average age of attempted suicide was 30 years. Fifty-eight percent (13,560/23,381) of the attempts were made by females and 42% (9,814/23,381) were made by males. The largest numbers of injuries (19.4% or 4,533 incidents) occurred among white females age 15–19 years and 25–34 years. White females had the highest total rate of injuries due to attempted suicide compared to all other race/sex categories, followed by African American females (Figure 20).⁴

Although detailed analysis by cost is unavailable, 36.8% of patients identified Medicare and/or Medicaid, and 30.6% identified managed care organizations and/or commercial insurance, as their primary source of payment (Table 11). The median total cost of Indiana residents with an E-code indicating suicide at an ED/outpatient center for the five-year period was \$3,083 (range \$13–106,993). The total charges for all ED care related to self-inflicted injuries during 2011-2014 was nearly \$91 million.⁴

Table 12 shows a listing of the E-codes associated with suicide attempts, including methods and means. The majority of hospital ED/outpatient visits for attempted suicide involved self-inflicted poisoning by solid or liquid substances (75.3% or 17,602 incidents). The substances used most frequently are controlled prescriptions for benzodiazepine-based tranquilizers (chlordiazepoxide, diazepam, flurazepam, lorazepam, medazepam, and nitrazepam) (13.4%) and analgesics (pain relievers) (7.3%). The second most frequent ICD-9-CM Code was for open wound of wrist (7.8) (Table 13).⁴

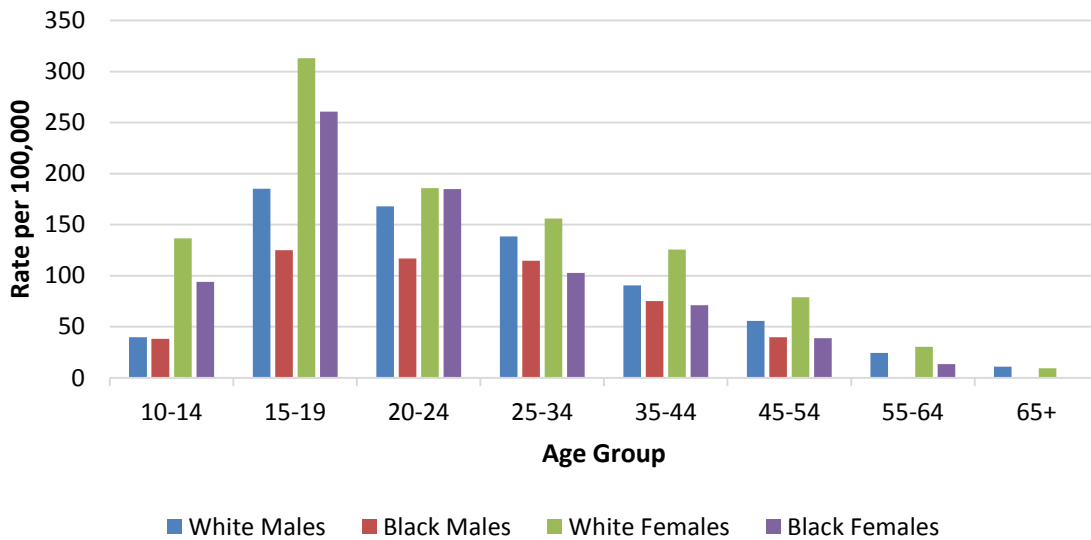
Other methods of attempting suicide included cutting or piercing (25.7%, or 6,018 incidents) and hanging, strangulation, and suffocation (2.7%, or 626 incidents). Suicide attempts for firearms and explosives accounted for 259 visits (1.1%). ED visits for suicide attempts by firearm are less common because these injuries are more likely to be fatal. Other suicide attempts, including poisoning via carbon monoxide, drowning, jumping from high places and other unspecified means, involved less than 11.1% of ED/outpatient visits for suicide attempts (Table 12).⁴

Figure 19. Self-inflicted injury emergency department (ED) visits, Indiana, 2011-2014



Source: Indiana Hospital Association, Hospital Discharge Data

Figure 20. Self-inflicted injury ED visit rates by age and race, Indiana, 2011-2014



Source: Indiana Hospital Association, Hospital Discharge Data

Table 11. Primary Payer of ED visits, Indiana, 2011-2014

Primary Payer	Frequency	Percent
Commercial Insurance (Includes Managed Care)	7,164	30.6
Medicaid	6,327	27.1
Self-Pay	5,076	21.7
Medicare	2,257	9.7
Other/Unknown	2,090	8.9
Other Government	467	2.0

Source: Indiana Hospital Association, Hospital Discharge Data

Table 12. Summary of E-code distribution for self-inflicted injury ED visits, Indiana, 2011-2014

ECODE	Description	Frequency	Percent
E950	Suicide and self-inflicted poisoning by solid or liquid substance	17,602	75.3
E950.0	Analgesics, antipyretics, and antirheumatics	4,641	
E950.1	Barbiturates	39	
E950.2	Other sedatives and hypnotics	797	
E950.3	Tranquilizers and other psychotropic agents	6,114	
E950.4	Other specified drugs and medicinal substances	3,986	
E950.5	Unspecified drug or medicinal substance	887	
E950.6	Agricultural and horticultural chemical and pharmaceutical preparations other than plant foods and fertilizers	43	
E950.7	Corrosive and caustic substances (Suicide and self-inflicted poisoning by substances classifiable to E846)	167	
E950.8	Arsenic and its compounds	3	
E950.9	Other and unspecified solid and liquid substances	925	
E951	Suicide and self-inflicted poisoning by gases in domestic use	8	<0.1
E951.0	Gas distributed by pipeline	0	
E951.1	Liquefied petroleum gas distributed in mobile containers	7	
E951.8	Other utility gas	1	

E952	Suicide and self-inflicted poisoning by other gases and vapors	169	0.7
E952.0	Motor vehicle exhaust gas	101	
E952.1	Other carbon monoxide	12	
E952.8	Other specified gases and vapors	50	
E952.9	Unspecified gases and vapors	6	
E953	Suicide and self-inflicted injury by hanging, strangulation, and suffocation	626	2.7
E953.0	Hanging	464	
E953.1	Suffocation by plastic bag	4	
E953.8	Other specified means	130	
E953.9	Unspecified means	28	
E954	Suicide and self-inflicted injury by submersion [drowning]	18	<0.1
E955	Suicide and self-inflicted injury by firearms, air guns, and explosives	259	1.1
E955.0	Handgun	76	
E955.1	Shotgun	25	
E955.2	Hunting rifle	5	
E955.3	Military firearm	1	
E955.4	Other and unspecified firearm (<i>Gunshot, not otherwise specified; Shot, not otherwise specified</i>)	81	
E955.5	Explosives	2	
E955.6	Air gun (BB gun, Pellet gun)	16	
E955.7	Paintball gun	0	
E955.9	Unspecified	53	
E956	Suicide and self-inflicted injury by cutting and piercing instrument	6,018	25.7
E957	Suicide and self-inflicted injury by jumping from high place	142	0.6
E957.0	Residential premises	24	
E957.1	Other man-made structure	106	
E957.2	Natural site	4	
E957.9	Unspecified	8	
E958	Suicide and self-inflicted injury by other and unspecified means	2,239	9.6
E958.0	Jumping or lying before moving object	46	
E958.1	Burns, fire	74	
E958.2	Scald	1	
E958.3	Extremes of cold	9	
E958.4	Electrocution	8	

E958.5	Crashing of motor vehicle	63	
E958.6	Crashing of aircraft	0	
E958.7	Caustic substances, except poisoning (Excludes poisoning by caustic substances [E950.7])	5	
E958.8	Other specified means	1,468	
E958.9	Unspecified means	565	
E959	Late effects of self-inflicted injury*	95	0.4

Source: Indiana Hospital Association, Hospital Discharge Data

Table 13. Five most frequently reported ICD-9-CM classification codes among persons who attempted suicide, ED visits, Indiana, 2011-2014

ICD-9-CM Code	Description	Frequency	Percent*
969.4	Benzodiazepine-based tranquilizers (chlordiazepoxide, diazepam, flurazepam, lorazepam, medazepam, nitrazepam)	3,136	13.4
881.02	Open wound of wrist without mention of complication	1,824	7.8
965.4	Aromatic Analgesics, Not Elsewhere Classified (acetanilid, paracetamol [acetaminophen], phenacetin [acetophenetidin])	1,702	7.3
881.00	Open wound of elbow, forearm, and wrist	1,546	6.6
969.3	Other antipsychotics, neuroleptics, and major tranquilizers	712	3.0

*Percent is based off of the total number of suicide attempts.

Source: Indiana Hospital Association, Hospital Discharge Data

Geographic Distribution

The number of suicide deaths and attempts in each Indiana county are displayed in Table 14 and are shown in map form in Figures 21-24.^{1, 3, 4} Average age-adjusted rates are shown in parentheses for suicide deaths. However, rates are not included for suicide attempts due to the limitations of this data previously discussed.

Table 14. Suicide deaths (2011-2015), hospitalizations and ED visits (2011-2014) by county of residence, Indiana

County ID	County Name	Suicides, (Rate) ‡	Hospitalizations*, (#)	ED Visits*, (#)
01	Adams	9 (U) §	34	74
02	Allen	221 (12.2)	845	959
03	Bartholomew	65(16.3)	230	368
04	Benton	11 (U) §	16	32
05	Blackford	9 (U) §	34	68
06	Boone	49 (16.2)	138	88
07	Brown	17(U) §	18	14
08	Carroll	16 (U) §	31	56
09	Cass	27 (14.0)	21	26
10	Clark	92 (16.3)	132	168
11	Clay	22 (16.5)	121	228
12	Clinton	19 (U) §	146	298
13	Crawford	8 (U) §	15	24
14	Daviess	17 (U) §	99	116
15	Dearborn	37 (14.9)	72	151
16	Decatur	20 (15.2)	70	163
17	Dekalb	33 (15.6)	34	31
18	Delaware	76 (13.0)	264	371
19	Dubois	34 (16.1)	87	43
20	Elkhart	105 (10.5)	532	900
21	Fayette	29 (24.4)	58	159
22	Floyd	56 (14.8)	115	178
23	Fountain	15 (U) §	43	100
24	Franklin	18 (U) §	11	48
25	Fulton	19 (U) §	28	104
26	Gibson	37 (22.0)	36	72
27	Grant	50 (14.5)	89	244
28	Greene	31 18.9)	92	132
29	Hamilton	147 (9.9)	550	887
30	Hancock	58 (16.2)	124	319
31	Harrison	29 (14.8)	41	115
32	Hendricks	94 (12.3)	321	549
33	Henry	44 (17.9)	128	216
34	Howard	49 (11.8)	248	476
35	Huntington	26 (14.1)	71	185
36	Jackson	31 (14.3)	87	56
37	Jasper	18 (U) §	44	38

38	Jay	10 (U) [§]	24	90
39	Jefferson	28 (17.3)	39	301
40	Jennings	26 (18.5)	105	242
41	Johnson	86 (11.8)	244	531
42	Knox	36 (18.9)	194	187
43	Kosciusko	48 (12.3)	145	350
44	LaGrange	15 (U) [§]	30	61
45	Lake	330 (13.4)	906	655
46	LaPorte	91 (16.4)	227	277
47	Lawrence	31 (13.5)	140	257
48	Madison	116 (17.8)	569	569
49	Marion	679 (14.7)	2,540	4,314
50	Marshall	31 (13.2)	75	198
51	Martin	10 (U) [§]	25	22
52	Miami	19 (U) [§]	71	231
53	Monroe	87 (12.2)	437	303
54	Montgomery	27 (14.1)	84	175
55	Morgan	55 (15.8)	167	230
56	Newton	14 (U) [§]	5	7
57	Noble	28 (11.8)	71	152
58	Ohio	†	14	19
59	Orange	14 (U) [§]	40	86
60	Owen	19 (U) [§]	83	52
61	Parke	16 (U) [§]	59	54
62	Perry	20 (20.6)	31	87
63	Pike	12 (U) [§]	34	20
64	Porter	133 (16.0)	407	472
65	Posey	24 (18.8)	12	9
66	Pulaski	8 (U) [§]	28	87
67	Putnam	39 (20.7)	90	194
68	Randolph	22 (17.2)	39	114
69	Ripley	16 (U) [§]	21	91
70	Rush	16 (U) [§]	41	87
71	St. Joseph	177 (13.3)	1,024	1,004
72	Scott	18 (U) [§]	27	32
73	Shelby	45 (20.2)	92	300
74	Spencer	15 (U) [§]	31	26
75	Starke	24 (20.8) [§]	50	148
76	Steuben	16 (U) [§]	39	162
77	Sullivan	22 (20.8)	58	117
78	Switzerland	11 (U) [§]	9	27
79	Tippecanoe	96 (10.7)	329	564

80	Tipton	6 (U) [§]	31	68
81	Union	†	†	6
82	Vanderburgh	195 (21.5)	263	286
83	Vermillion	12 (U) [§]	112	63
84	Vigo	121 (22.4)	653	570
85	Wabash	16 (U) [§]	41	143
86	Warren	6 (U) [§]	17	33
87	Warrick	44 (14.4)	66	58
88	Washington	25 (17.9)	32	119
89	Wayne	42 (12.4)	63	83
90	Wells	13 (U) [§]	58	94
91	White	15 (U) [§]	54	141
92	Whitley	26 (15.6)	56	90
99	Other¶	0	668	667
	Total	4,696	15,797	23,381

*Numbers based on hospital ED/outpatient center and inpatient data. Due to only 70% of hospital discharge records having E-codes, the numbers are a gross underestimation of the actual number of suicide attempts.

†The number of suicide deaths or hospitalizations was less than 5 and is suppressed to protect confidentiality.

‡Age-adjusted rates per 100,000 population

§ 'U' signifies that the age-adjusted rates are unstable due to less than 20 deaths for the county

¶ Attempts with incorrect zip codes or Out of State Residents

Age adjusted rates are not included for attempt data due to the gross underestimation of the number of attempts. Attempt data must be used with caution.

Source: Indiana State Department of Health, Epidemiology Resource Center and Indiana Hospital Association, Hospital Discharge Data

Youth Suicide Attempts

Hospital Inpatient Data

A reported 2,786 Hoosiers aged 10-19 years were treated in an inpatient setting for attempted suicide or self-inflicted injury during 2011 to 2014, accounting for 17.6% of the total number of patients seen for self-inflicted injury. Individuals ages 15 to 19 years comprised the majority (77.8%) of these attempts. Sixty-eight percent of patients aged 10-19 were female. More specifically, whites accounted for 71% of youth attempts, of which 48% were white females and 22.6% were white males. African Americans accounted for 9.5% of youth attempted suicides. Race was unknown for 17.6% of patients.³

Emergency Department Data

The 2011-2014 hospital discharge dataset was reviewed for youth suicide attempts. Based on a query completed in the ED/outpatient center database, 6,696 youth patients attempted suicide or had injuries consistent with self-inflicted intentional injuries, accounting for 28.3% of the total number of ED/outpatient center patients seen for self-inflicted injury. Individuals ages 15 to 19 years comprised the majority (75%) of these attempts. More specifically, whites accounted for 76% of youth attempts, of which 74.5% were white females and 25.5% were white males. African Americans accounted for 8% of youth-attempted suicide. Race was unknown for 14.2% of patients.⁴

Behavior Survey Data

The Youth Risk Behavior Survey (YRBS) was developed in 1990 to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems among youth in the U.S. The Indiana Youth Risk Behavior Survey is conducted every two years among students in grades 9-12. In 2015, 43 high schools and 1,912 students participated in the survey, allowing for appropriate conclusion to be drawn due to a statistically significant population size.¹⁵ According to the 2011 and 2015 Indiana YRBS, the percentage of youth who reported having attempted suicide one or more times during the past 12 months decreased from 11.0% to 9.9%. However, the percentage who reported having seriously considered attempting suicide or made a plan about how they would attempt suicide during the 12 months prior to the survey increased from 2011 to 2015. Thirty-four percent of students who had attempted suicide during the 12 months prior reported having asked for help from someone before their suicide attempt. This was a new question on the 2015 survey so no comparison can be made with the 2011 survey (Table 15).¹⁵

Table 15. Youth Risk Behavior Survey results, Grades 9-12, Indiana, 2011 & 2015

Health-risk Behavior	2011		2015	
	Total Percent	95% CI	Total Percent	95% CI
During the 12 months prior to the survey, students in grades 9-12:				
Felt sad or hopeless almost every day for 2 or more weeks in a row, so that they stopped doing some usual activities	29.1	(26.3–31.9)	29.3	(27.0–31.9)
Seriously considered attempting suicide	18.9	(15.8–22.5)	19.8	(17.9–21.7)
Made a plan about how they would attempt suicide	13.6	(11.9–15.5)	17.0	(15.3–19.0)
Attempted suicide one or more times	11.0	(8.9–13.4)	9.9	(7.7–12.7)
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	3.9	(3.2–4.9)	3.9	(2.5–6.0)
Asked for help from someone before their suicide attempt such as a doctor, counselor, or hotline (Among students who attempted suicide during the 12 months before the survey)	*	*	34.2	(28.4–40.6)

*New Question to 2015 YRBS Survey

Source: Indiana Youth Risk Behavior System Survey 2011 and 2015

Risk Factors and Special Populations

Risk and protective factors and their interactions form the empirical base for suicide prevention. Variations in suicide rates between age, sex, ethnicity, and culture provide opportunities to understand the different factors that affect these groups and indicate the need for different strategies to meet the needs of different populations.⁶ Risk factors involve neurobiological, psychological, social and cultural characteristics, genetic predisposition and environmental factors.^{6, 7, 16}

No single factor has gained acceptance as a universal cause of suicide. Some risk factors associated with a higher incidence of suicide include, but are not limited to, depression, mental illness, schizophrenia, drug and/or chemical dependency, conduct disorders (in adolescence) and chronic disease. Research findings indicate that individuals with mental health diagnoses are generally at greater risk for suicide. Psychological autopsy studies reflect that more than 90% of people who died by suicide had one or more mental health disorders, including substance abuse.¹⁶

Other risk factors can be present in different levels of a person’s life. Unhealthy relationships involving high conflict or violence and a family history of suicide can be influential. A community that offers few mental health resources or struggles with barriers to health care, such as lack of

access to providers or medications, can put individuals at greater risk. Additionally, availability of lethal means of suicide and sensationalized media portrayals of suicide are risk factors at the societal level.¹⁶

Adults

Major depression is the psychiatric diagnosis most commonly associated with suicide. Nationally, individuals suffering from major depression have a suicide rate 21 times the general population.¹⁶ Lifetime risk of suicide among patients with untreated depressive disorder is nearly 20%, and about two-thirds of people who die by suicide are depressed at the time of their death.¹⁷ The Behavioral Risk Factor Surveillance System (BRFSS) is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors for individuals 18 years and older in the U.S. The BRFSS has been conducted annually since 1984. While the general survey is conducted every year, the Anxiety and Depression module is only given periodically. The most recent year data was collected with the Anxiety and Depression module was 2010. The 2010 Indiana BRFSS Anxiety and Depression module showed that 14.9% of Hoosiers felt down, depressed or hopeless for one to three days in the past two weeks, 11.6% felt that way for three or more days, and 3.4% felt that way every day. However, the majority (70.1%) indicated that they did not feel down, depressed, or hopeless in the past two weeks.¹⁸

When asked "Over the last two weeks, how many days have you felt bad about yourself or that you were a failure or had let yourself or your family down?", 9.1% reported between one to three days, 7.2% reported three or more days, and 3.7% reported every day, while 80.0% reported they did not feel bad about themselves. Of the surveyed population, 13.5% indicated that a doctor/healthcare provider told them they had an anxiety disorder, which includes acute stress disorder, anxiety, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, phobia, post-traumatic stress disorder, or social anxiety disorder, and 18.2% had a doctor/healthcare provider tell them they had a depressive disorder, which includes depression (major or minor) and dysthymia.¹⁸

According to the 2010 Indiana BRFSS, 35.3% of individuals reported poor mental health, meaning they identified themselves as having stress, depression, and/or problems with emotions, for at least one day in the past 30 days.¹⁸ In the 2015 survey, that percentage increased to 37.1%.¹⁹ Females (43.9%) reported having more days of poor mental health than males (30.1%). Thirty-seven percent of Non-Hispanic white respondents said they experienced poor mental health, 36.3% of Non-Hispanic African American respondents reported as such, and 31.8% of Hispanic respondents reported poor mental health. Of respondents, 5.5% (4.8% of males and 6.2% of females) said they experienced poor mental health every day.¹⁹ Older adults are particularly vulnerable to depression. Of those surveyed, 44.5% aged 65 years and older reported having poor mental health at least one day in the past 30 days, and 7.4% reported having poor mental health every day.¹⁹ Poor mental health is a leading contributor to death by suicide among that population.⁶ When asked if one had ever been told they have a depressive

disorder (depression, major depression, dysthymia, or minor depression) 20.4% of respondents answered yes, including 29.3% of those aged 18-24 years old.¹⁹

Alcohol dependence is a risk factor for suicidal behavior and acute alcohol use is also associated with suicide. Alcohol intoxication can increase suicide risk up to 90 times compared to alcohol abstinence.²⁰ According to the 2015 Indiana BRFSS, 39.3% of males reported having five or more drinks on at least one occasion in the past 30 days, and 23.2% of females reported that they had four or more drinks in the same time period, which is known as binge drinking.¹⁹

Other risk factors for suicide include being socially isolated, divorced, separated, or widowed, or suffering from a physical illness.⁶ According to the 2010 Indiana BRFSS, most recent available, when asked how often respondents get the social and emotional support they need, 50.6% responded “always”, 30.6% responded “usually”, 11.4% responded “sometimes”, 3.2% responded “rarely” and 4.5% said “never.” Of those aged 75 and older, 10.9% reported “never” getting the social and emotional support they need.¹⁸

The elderly are especially susceptible to depression due to changes in physical health and loss of friends and/or spouse. Of those aged 65–74 years, 14.9% did not have good physical health one to seven days in the previous month, 11.5% did not have good physical health 8–29 days of the previous month, and 10.6% did not have good physical health every day. Statistics were slightly higher for those 75 years and older (18.5%, 12.5% and 12.3%, respectively). Of adults 65–74 years, 16.4% reported their general health as fair and 8.2% reported it as poor. Seventeen percent of adults over 75 years of age reported their general health as fair and 10.4% reported it as poor.^{18, 19}

Military Veterans

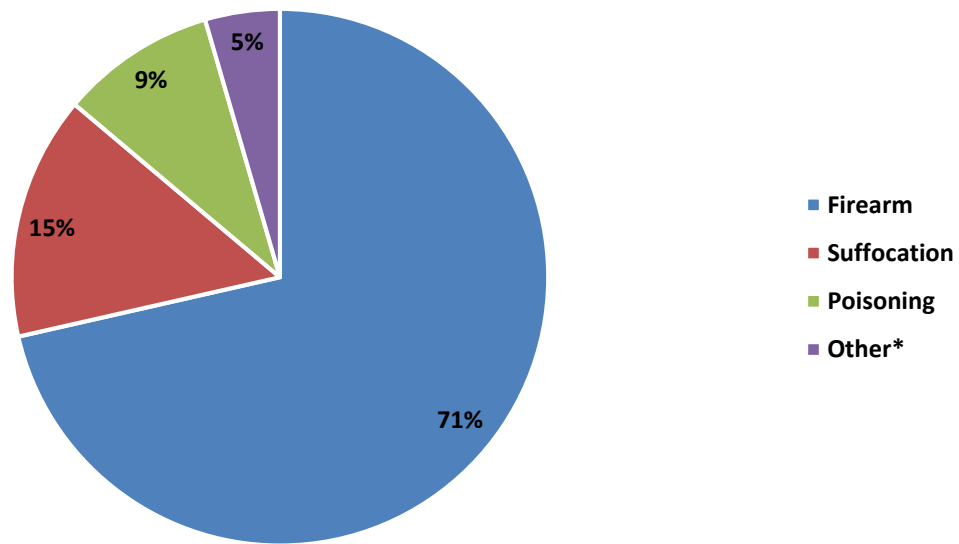
Military services members, especially those recently returned from combat, experience stress-related conditions that can present challenges to members and their families. Many are exposed for prolonged periods of time to combat-related stress or traumatic events. Indiana has a high number of deployed service members, and most are deployed to front lines. A comprehensive study conducted found that an estimated 18.5% of military service members who have returned from deployment report symptoms consistent with a diagnosis of post-traumatic stress disorder (PTSD) or depression.²¹ Recently, the U.S. Department of Veterans Affairs (VA) reported “in 2014, an average of 20 veterans died from suicide each day” nationwide. In response the VA has strengthened mental health services for veterans by establishing new resources and improving access to care for those dealing with post-war stressors.²²

From 2011 to 2015, 832 suicides were reported among Indiana veterans, of which 71% died by firearm, 15% by suffocation, 9% by poisoning, and 5% by other methods (Figure 25).¹ In this report, veteran status is determined through indication on the death certificate, which is self-reported by family members of the deceased. Males accounted for 97.0% (807) of veteran

suicides, and the largest number of suicides occurred among those age 50-54 years (Figure 26).¹ The number of veteran suicides per Indiana county of residence is displayed in Figure 27.¹

BRFSS results from 2010 reflect this increase in mental health needs among recently returned veterans.²³ Indiana was one of 12 states that participated in the optional BRFSS mental health and the military module. When asked, “Over the last two weeks, how many days have you felt down, depressed or hopeless,” 4.9% of respondents who were on active duty during the last 12 months, but not at the time of the survey, said “every day.” Of those who had never served in the military, 3.3% said they felt this way every day during the last two weeks. Of the surveyed population, 17.1% of those on active duty during the last 12 months, but not at the time of the survey, said that over the last two weeks they had trouble falling asleep or staying awake or sleeping too much every day, compared to 10.9% of those who had never served.²³

Figure 25. Veteran* suicide by mechanism, Indiana, 2011-2015

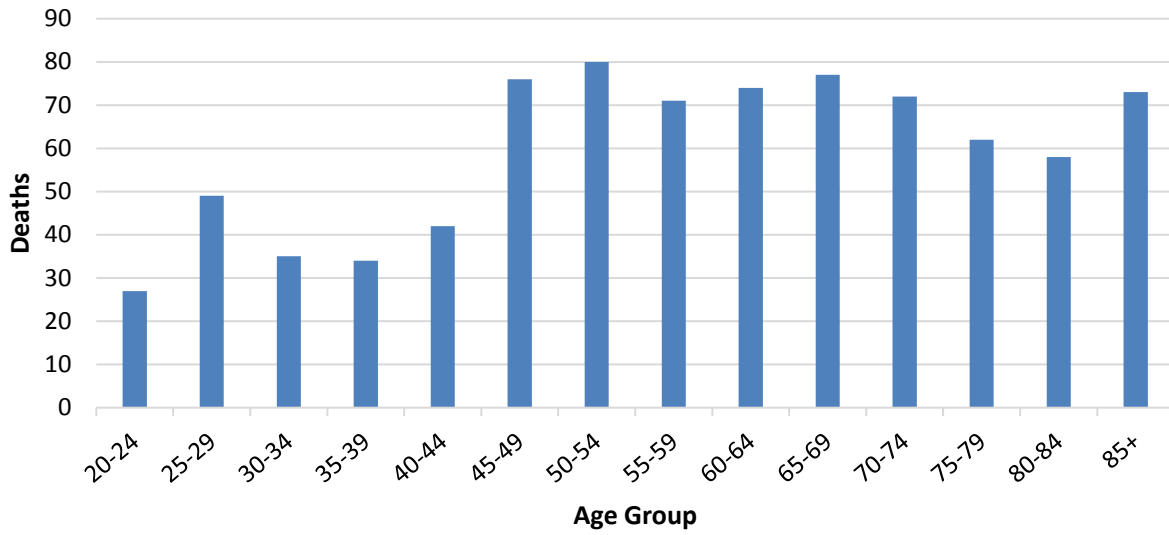


*Other mechanisms include: drowning, cutting/piercing, fall, motor-vehicle collisions, fire and unclassified/unspecified

*Veteran as reported on the death certificate

Source: Indiana State Department of Health, Epidemiology Resource Center

Figure 26. Veteran* suicide by age group, Indiana, 2011-2015



*Veteran as reported on the death certificate

Source: Indiana State Department of Health, Epidemiology Resource Center

Youth

Youth risk factors for suicide include family history of suicide, suicide attempt, or mental illness; male gender; history of physical or sexual abuse; personal mental health problems; and gay or bisexual orientation. Feelings of hopelessness are also found to be predictive of suicide.²⁴ The 2015 Indiana YRBS indicates that 29.3% of high school students reported feeling sad or hopeless almost every day for two or more consecutive weeks so that they stopped doing usual activities during the 12 months before the survey (Table 15).¹⁵ A prior suicide attempt is also a risk factor for eventual suicide completion.²⁴ According to the YRBS, 9.9% of Indiana high school students reported that they attempted suicide in the previous 12 months. Seventeen percent of Hoosiers in grades 9–12 had a plan for how they would attempt suicide during the past 12 months, and approximately 19.8% of students had seriously considered attempting suicide (Table 15).¹⁵

Protective Factors

Protective factors play an important role in understanding and preventing suicide. Protective factors include an individual's coping and problem solving skills, reasons for living (e.g., children in the home), and moral/religious objections to suicide. A person's relationships, such as connectedness to individuals, family, community and social institutions, and supportive relationships with health care providers contribute to mental health status. Safe and supportive school and community environments and sources of continued care after psychiatric hospitalization are community-level protective factors. Society plays a vital role in protecting individuals from suicide, including availability of physical and mental health care and restrictions to lethal means of suicide.⁶ Understanding the measures or factors that safeguard against suicide is essential to preventing suicide, yet may not entirely remove the risk.

Indiana Violent Death Reporting System (INVDRS)

In 2014, the ISDH submitted a successful application for the Centers for Disease Control and Prevention (CDC) grant funding opportunity to establish the Indiana Violent Death Reporting System (INVDRS). The purpose of the INVDRS is to collect, maintain, and disseminate complete and comprehensive surveillance data on violent deaths, including suicides, that occurred in Indiana beginning January 1, 2015. For every death, data is collected from the death certificate, coroner report, toxicology, law enforcement records, and autopsy. The system collects information on who died, where victims were killed, when they were killed and what factors were perceived to contribute or precipitate the death to better understand the circumstances surrounding violent death in Indiana to inform prevention efforts. The goal of the INVDRS is to translate research findings into prevention strategies by disseminating useful, actionable data to guide, support, and improve local, state, and national violence prevention policies, programs and practices. INVDRS data will be available starting in the fall of 2017.

Prevention Strategies

The public health approach (Figure 28) is an ideal method to address suicide prevention. The first two steps, defining the burden of suicide in Indiana and identifying risk and protective factors for suicide and suicide attempts, have been addressed in this report. The next steps include developing, implementing, and evaluating prevention strategies that are informed by data.

Figure 28. Public health approach to suicide prevention



Suicide Prevention Resource Center (SPRC) Best Practices Registry

The best practices registry can be utilized to identify, review and disseminate information about best practices for suicide prevention that address specific objectives of the National Strategy for Suicide Prevention. The three sections of the registry listed below provide different types of programs and practices reviewed according to specific criteria.

- ❑ Section I: Evidence-Based Programs: Programs are effective, although their effectiveness may not hold true for all audiences or settings.
- ❑ Section II: Expert and Consensus Statements
- ❑ Section III: Adherence to Standards

This registry can be accessed at: <http://www.sprc.org/bpr/section-i-evidence-based-programs#sec1listings>.

Conclusion

Suicide remains a serious public health issue for the nation and for Indiana. Suicide took the lives of 962 Hoosiers at a rate of 14.4 per 100,000 population in 2015, making suicide the 11th-leading cause of death.¹ Suicide was the second-leading cause of death in the 15–34 age group and the third-leading cause of death among those aged 10–14 years.¹ As with other public health issues, efforts to reduce suicide require multiple strategies at national, state, and community levels. The objective of this report was to take the initial step of the public health approach: to define the problem, both in the U.S. and in Indiana, and help community leaders begin to identify the causes of suicide, develop and implement interventions and ultimately evaluate the interventions.

Suicide Prevention Organizations and Websites

Many local, state and national organizations exist to help with suicide awareness and intervention. A number of tools can be used to assess the risk factors and protective factors in a community to determine the potential for suicide and opportunities for prevention. Such tools include 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. Training and sessions on suicide awareness are also effective. All communities should become aware of what can be accomplished to prevent suicide in their locales.

Indiana Organizations and Websites

American Foundation for Suicide Prevention (AFSP)—Indiana Chapter

<https://afsp.org/chapter/afsp-indiana/>

P.O. Box 1793

Noblesville, IN 46061

Contact: Lisa Brattain, Regional Director

Phone: (317) 517-5973

The American Foundation for Suicide Prevention (AFSP) is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. The Indiana Chapter is dedicated to serving the AFSP mission.

Community Health Network

Zero Suicide

<https://www.ecommunity.com/services/mental-behavioral-health/zero-suicide-initiative>

1500 North Ritter Avenue

Indianapolis, IN 46219

Phone: (317) 621-5700 or (800) 662-3445 toll free

Community Health Network hospitals in Indiana offer a Zero Suicide Initiative in order to provide mental health services to Indiana's youth. There are chat and text features that allow instant access to a mental health responder.

Family and Social Services Administration

Division of Mental Health and Addiction

<http://www.in.gov/fssa/dmha/index.htm>

The Division of Mental Health and Addiction in the Family Social Services Administration ensures that Hoosiers have quality addiction and mental health services that promote resilience and

recovery for multiple levels of the community by: setting standards for mental health and addiction treatment services, certifying mental health centers and addiction treatment service providers, providing funding for substance abuse prevention programs and etc.

**Families First
Crisis and Suicide Intervention Services**

<http://familiesfirstindiana.org/>

615 N. Alabama St. Suite 320

Indianapolis, IN 46204

Phone: (317) 634-6341

24-hour Crisis Line: (317) 251-7575

Fax: (317) 464-9575

Families First offers a 24-hour telephone information and referral service for suicide prevention, family violence, depression, and a wide range of other issues. Their services are confidential and free.

Indiana State Department of Health

<http://www.in.gov/isdh/19537.htm>

Division of Trauma and Injury Prevention

2 N. Meridian St.

Indianapolis, IN 46204

Program contact: Rachel Kenny (rkenny@isdh.in.gov)

Phone: (317) 233-8197

The Division of Trauma and Injury Prevention disseminates descriptive statistical information to those entities throughout the state having an interest in suicide and preventive control strategies. The Indiana Violent Death Reporting System is housed and managed by the division.

Indiana Youth Group

<http://indianayouthgroup.org/>

2943 E. 46th St.

Indianapolis, IN 46205

Phone: (317) 541-8726

Indiana Youth Group (IYG) provides safe places and confidential environments where self-identified lesbian, gay, bisexual, transgender, and questioning youth are empowered through programs, support services, social and leadership opportunities and community service. IYG advocates on their behalf in schools, in the community and through family support services.

Mental Health America of Indiana

www.mentalhealthassociation.com

1431 North Delaware Street

Indianapolis, IN 46202
Phone: (317) 638-3501 or (800) 555-MHAI (6424)
Fax: (317) 638-3540

The Mental Health Association focuses on mental health issues in Indiana and works for victory over mental illness through education, advocacy, and direct services such as support groups. As of September 2007, 52 counties have county-level mental health organizations.

National Organizations and Websites

Suicide-Specific Organizations

American Association of Suicidology (AAS)

www.suicidology.org
5221 Wisconsin Avenue, NW
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2282

The American Association of Suicidology is dedicated to understanding and preventing suicide. AAS promotes research, public awareness programs, education and training for professionals and volunteers, and serves as a national clearinghouse for information on suicide. Suicide grief support brochures: "Survivors of Suicide, Coping with the Suicide of a Loved One" are available.

American Foundation for Suicide Prevention (AFSP)

www.afsp.org
120 Wall Street, 29th Floor
New York, New York 10005
Phone: (888) 333-AFSP or (212) 363-3500
Fax: (212) 363-6237

The American Foundation for Suicide Prevention funds research, education, and treatment aimed at the prevention of suicide and the understanding of depression. AFSP maintains a national directory of survivor support groups. The website also has recommendations for the media about responsible reporting on suicide.

Centre for Suicide Information

<http://suicideinfo.ca/>
Suite 320, 105 12 Avenue S.E.
Calgary, AB T2G 1A1
Phone: (403) 245-3900
Fax: (403) 245-0299

Centre for Suicide Information is a Canadian organization that maintains a resource library with extensive information on: suicide prevention, post intervention, intervention efforts and trends, development of successful suicide prevention, intervention, and post intervention programs, statistics, resource people, computer literature searches, and document delivery.

**Light for Life Foundation International
Yellow Ribbon Suicide Prevention Program**

www.yellowribbon.org

P.O. Box 644

Westminster, CO 80036-0644

Phone: (303) 429-3530

The Yellow Ribbon Suicide Prevention Program provides information on suicide, survivors support groups, and task forces and coalitions around the country. They also provide seminars and presentation that teach awareness and suicide prevention skills with chapters around the country to provide support and services to prevent suicide.

Livingworks

<http://www.livingworks.net/>

P.O. Box 9607

Fayetteville, NC 28311

Phone: (910) 867-8822

Fax: (910) 867-8832

The Livingworks Program is a comprehensive, coordinated and integrated approach to preventing suicide that involves the entire community. Livingworks Program is best known for distributing the ASIST Training (Applied Suicide Intervention Skills Training). The ASIST Training has been refined for over 23 years with feedback from over 500,000 participants and 3,000 active trainers. Other programs offered include: suicideTALK, esuicideTALK, safeTALK, safeTALK T4T, and suicide to Hope.

National Alliance on Mental Illness (NAMI)

www.nami.org

3803 N. Fairfax Drive, Suite 100

Arlington, VA 22203

Phone: (703) 524-7600

The National Alliance on Mental Illness is the nation's largest grassroots mental health organization dedicated to improving the lives of people living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a national organization including NAMI organizations in every state and over 1,100 local communities

across the country who join together to meet the NAMI mission through advocacy, research, support, and education.

National Organization for People of Color Against Suicide

www.nopcas.org

P.O. Box 75571

Washington, D.C. 20013

Phone: (973) 204-8233

The National Organization for People of Color Against Suicide is an organization that focuses on helping minority suicide survivors through services such as training, grief recovery, and support.

National Suicide Prevention Lifeline

<http://www.suicidepreventionlifeline.org/>

Phone: (800) 273-TALK (8255)

The National Suicide Prevention Lifeline is a network of 24-hour crisis centers with a toll-free suicide prevention service available to anyone in suicidal crisis. Calls originating anywhere in the United States will be routed to the nearest available crisis centers. This call-routing is based on crisis center call capacity and availability. With over 160 crisis centers across the country, the national suicide prevention lifeline's mission is to provide immediate assistance to anyone seeking mental health services.

QPR Institute

www.qprinstitute.com

Phone: (888) 726-7926

QPR is a simple educational program that teaches citizens how to recognize a mental health emergency and how to get a person at risk the help they need. QPR stands for Question, Persuade, and Refer, which are the three simple steps that anyone can learn to prevent suicide.

Screening for Mental Health (SOS Suicide Prevention Program)

<https://mentalhealthscreening.org/programs/sos-signs-of-suicide>

One Washington Street, Suite 304

Wellesley Hills, MA 02481

Phone: (781) 239-0071

Fax: (781) 431-7447

Screening for Mental Health has a suicide prevention program called the SOS Signs of Suicide Prevention Program. The training is a nationally recognized program for secondary school students. It is the only school-based program to show a reduction in suicide attempts (by 40%) in a randomized controlled study (American Journal of Public Health, March, 2004).

Stop a Suicide Today

<http://www.stopasuicide.org/>

Stop a Suicide Today can teach how to recognize the warning signs of suicide in family, friends, co-workers, and patients, and why one needs to respond as with any medical emergency. The program emphasizes the relationship between suicide and mental illness and the notion that a key step in reducing suicide is to get those in need into mental health treatment.

Suicide Awareness Voice of Education (SAVE)

www.save.org

8120 Penn Ave. South Suite 470
Bloomington, MN 55431
952-946-7998

Suicide Awareness Voice of Education's mission is to educate the public about suicide prevention and to speak for suicide survivors. The resource focus areas include: public awareness, education, training and consulting, grief support, products & resources, and research and innovation.

Suicide Prevention Resource Center (SPRC)

www.sprc.org

Education Development Center, Inc.
43 Foundry Avenue
Waltham, MA 02453
Phone: (617) 964-5448 or (877) 438-7772

The Suicide Prevention Resource Center is a national resource center that provides technical assistance, training and information in order to strengthen suicide prevention networks and advance the National Strategy for Suicide Prevention. The center provides suicide prevention technical assistance to national, state, and local organizations, disseminates suicide prevention related information, identifies best practices in suicide prevention, develops and delivers training on suicide prevention topics, and conducts policy activities. SPRC maintains an on-line library with extensive information and a registry of best practices.

Youth Suicide Prevention School-based Guide

<http://theguide.fmhi.usf.edu/>

Contact: Stephen Roggenbaum
Louis de la Parte Florida Mental Health Institute (FMHI)
The University of South Florida
13301 Bruce B. Downs Blvd., MHC-2405
Tampa, FL 33612-3699
Phone: (813) 974-6149

The Guide is not a program but a tool that provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school administrators can use to enhance or add to their existing program.

Related Organizations

American Academy of Child and Adolescent Psychiatry (AACAP)

www.aacap.org

3615 Wisconsin Ave. NW

Washington D.C. 20016

Phone: (202) 966-7300

Fax: 202-464-0131

The American Academy of Child and Adolescent Psychiatry promotes an understanding of mental illnesses and removing the stigma associated with them, advancing efforts in prevention of mental illnesses, and assuring proper treatment and access to services for children and adolescents.

American Academy of Pediatrics (AAP)

www.aap.org

141 Northwest Point Blvd.

Elk Grove Village, Illinois 60007-1098

Phone: (847) 434-4000 or (800)433-9016 (toll-free)

Fax: (847) 434-8000

The American Academy of Pediatrics comprises 66,000 primary care pediatricians, pediatric medical specialists, and pediatric surgical specialists. AAP provides information on child health, advocacy, and safety and has a family-oriented publication, including one on adolescent development and suicide, and an on-line bookstore.

American Psychiatric Association

www.psych.org

1000 Wilson Blvd., Suite 1825

Arlington, VA 22209-3901

Phone: (707) 907-7300

Email: apa@psych.org

The American Psychiatric Association is the world's largest psychiatric organization, representing more than 37,000 psychiatric members in practice, research, and academia from around the globe. The website 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 St. NE

Washington, DC 20002

Phone: (202) 336-5500 or (800) 374-2721

The American Psychological Association is the largest scientific and professional organization representing psychology in the U.S., with more than 122,500 researcher, educators, clinicians, consultants and students as members. APA works to advance psychology as a science, as a profession, and as a means of promoting human welfare. PsychINFO is an electronic database of abstracts on nearly 2,500 journals.

Centers for Disease Control and Prevention (CDC)

National Center for Injury Prevention and Control (NCIPC)

www.cdc.gov/ncipc

Mailstop MS K-65

1600 Clifton Road

Atlanta, GA 30329-4027

Phone: (800) CDC-INFO (232-4636)

The National Center for Injury Prevention and Control is the lead federal agency for injury prevention. NCIPC works closely with other federal agencies, national, state, and local organizations, health departments, and research institutions and focuses on science-based prevention strategies to reduce injuries and deaths due to interpersonal violence and suicidal behavior.

Center for School Mental Health Assistance

<http://csmh.umaryland.edu/>

University of Maryland at Baltimore

Department of Psychiatry

737 West Lombard St., 4th Floor

Baltimore, MD. 21201-1570

Phone: (410) 706-0980

The Center for School Mental Health Assistance 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.

Children’s Safety Network (CSN)

<http://www.childrensafetynetwork.org/>

43 Foundry Avenue

Waltham, MA 02453-8313

Phone: (617) 618-2918

Email: csninfo@edc.org

The Children’s Safety Network assists states, communities, and others to prevent child and adolescent injuries. CSN provides information, training, and technical assistance to facilitate the development of new injury and violence prevention programs and enhance and support existing efforts.

Depression and Bipolar Support Alliance

<http://www.dbsalliance.org/>

55 E. Jackson Blvd, Suite 490

Chicago, Illinois 60604

Phone: (800) 826-3632

Fax: (312) 642-7243

The Depression and Bipolar Support Alliance provides hope, help, support, and education to improve the lives of people who have mood disorders. DBSA works to create the opportunity for meaningful lives by compassionately engaging with individuals and providing peer-led support groups, educational materials, and wellness tools that focus on resiliency, achievement, creativity and connection.

The Gay, Lesbian and Straight Education Network (GLSEN)

www.glsen.org

110 William Street, 30th Floor

New York, NY 10038

Phone: (212) 727-0135

The Gay, Lesbian, and Straight Education Network strives to ensure 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.

Mental Help Net

www.mentalhelp.net

900 Broadway, Suite 704

New York, NY 10003

The Mental Help Net provides a comprehensive source of on-line mental health information, news and resources.

The Partnership News Service

<http://www.drugfree.org/join-together>

352 Park Avenue South, 9th Floor

New York, NY 10010

Phone: 212-922-1560

Fax: 212-922-1570

The Partnership News Service, formerly Join Together, is a national resource for communities fighting substance abuse. The Partnership News Service provides news and information from sources such as: The New York Times, USA Today and The Wall Street Journal and produce original articles.

Mental Health America

www.nmha.org

500 Montgomery Street, Suite 820

Alexandria, VA 22314

Phone: (703) 684-7722 or (800) 969-6642

Fax: (703) 684-5968

Mental Health America (formerly known as the National Mental Health Association) provides referrals for mental health services to the public, local mental health associations, corporations and other mental health organizations. The Association's website has a link to depression screening tools for teens at www.depressionscreening.org. Please note that this depression screening is not intended to diagnose clinical depression but may help to identify symptoms for further evaluation.

National Association of School Psychologists

National Mental Health and Education Center

www.nasponline.org

4340 East West Highway Suite 402

Bethesda MD 20814

Phone: (301) 657-0270 or (866) 331-NASP

Fax: (301) 657-0275

The National Mental Health and Education Center promotes educationally and psychologically healthy environments for all children and youth by assisting school psychologists with effective practices that promote optimal learning, behavior, and mental health. Its website has resources on mental illness, including depression and suicide.

National Institute of Mental Health (NIMH)

<http://www.nimh.nih.gov/index.shtml>

6001 Executive Boulevard
Rm. 6200, MSC 9663
Bethesda, MD 20892-9663
Phone: (301) 443-8431 or (866) 615-6464
Fax: (301) 443-4279

The National Institute of Mental Health Suicide Research Consortium coordinates program development in suicide research across the Institute, identifies gaps in the scientific knowledge base on suicide across the life span, stimulates and monitors extramural research on suicide, keeps abreast of scientific developments in suicidology and public policy issues related to suicide surveillance, prevention and treatment, and disseminates science-based information on suicidology to the public, media, and policy makers .

National Mental Health Information Center

<https://health.gov/nhic/>

1101 Wootton Parkway, Suite LL100
Rockville, MD 20852
Fax: (240) 453-8282

The National Mental Health Information Center provides a user-friendly, "one stop" gateway to a wide range of mental health resources. The National Mental Health Information Center was developed for users of mental health services and their families, the general public, policy makers, providers, and the media. Information Center staff members are skilled at listening and responding to questions from the public and professionals. The staff quickly directs callers to federal, state, and local organizations dedicated to treating and preventing mental illness. The Information Center also has information on federal grants, conferences, and other events.

Office of the Surgeon General

www.surgeongeneral.gov

200 Independence Avenue S.W.
Washington DC 20201

The Surgeon General's Office has released a report, National Strategy for Suicide Prevention: Goals and Objectives for Action and accompanying fact sheets.

Striving to Reduce Youth Violence Everywhere (STRYVE)

<https://vetoviolence.cdc.gov/apps/stryve/>

1600 Clifton Road
Atlanta, GA 30329-4027
Phone: 800-232-4636

STRYVE, or Striving to Reduce Youth Violence Everywhere, is a national initiative led by the Centers for Disease Control and Prevention (CDC) to prevent youth violence before it starts among young people ages 10 to 24. **STRYVE's** vision is safe and healthy youth who can achieve their full potential as connected and contributing members of thriving, violence-free families, schools, and communities

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

5600 Fishers Lane

Rockville, MD 20857

Phone: (877) 726-4727

The Substance Abuse and Mental Health Services Administration 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.

Disclaimer: The sites listed here have been identified based on their relevance to intentional injury prevention. Views expressed on the web sites are not necessarily those of the Indiana State Department of Health.

The organizations list was partially adapted and modified from the summary produced by the Injury Prevention and Control Program of the Massachusetts Department of Public Health.

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