CENTER FOR HEALTH POLICY

INDIANA UNIVERSITY

RICHARD M. FAIRBANKS SCHOOL OF PUBLIC HEALTH

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Suicide Trends in Indiana: Recommendations for Prevention

Executive Summary

The purpose of this report is to provide an overview of suicide risks, trends, and current interventions in Indiana. To accomplish this, we (1) reviewed the literature and existing data, (2) conducted key informant interviews with state experts, and (3) synthesized the information to provide recommendations for suicide prevention.

Suicide, or intentional self-harm, is one of the leading causes of death in the United States. Suicide rates among Hoosiers have increased from 12.6 per 100,000 in 2008 to 16.3 per 100,000 in 2017, a nearly 30% increase over the 10-year period. In Indiana, the most common method was death by firearms, followed by suffocation.

Nearly one-third of Indiana high school students reported feeling sad or hopeless in the past year, one in five students seriously considered attempting suicide, and one in ten students attempted and survived suicide. High school students who identified as gay, lesbian, or bisexual had significantly higher rates of suicide-related thoughts and behaviors compared to students who identified as heterosexual.

A variety of factors contribute to a person's likelihood to engage in suicidal thoughts and behaviors. Some of these circumstances can increase a person's risk to attempt or die by suicide (risk factors), while other circumstances can reduce the risk (protective factors). Though anyone can be affected by suicide, there are some groups within the population that are at a particularly high risk due to the stresses they experience. We identified the following high-risk groups:

- Veterans
- Sexual and gender minorities / LGBTQ individuals
- Incarcerated and released prisoners
- First responders
- Individuals with lower socioeconomic status

We conducted key informant interviews with state experts in suicide prevention to get a better understanding of the magnitude and impact of suicide in Indiana; the resources and interventions necessary to effectively address the issue; and how the State is currently responding to the situation. For this study, 11 experts were interviewed, and key themes were summarized in the following categories:

- Magnitude of the problem
- Vulnerable populations and risk factors
- Suicide trends
- Stigma and resilience
- Indiana's response
- Gaps
- Recommendations

Traditionally, suicide has been addressed after people showed signs of suicidal behaviors, by providing immediate care or mental health services. Although these services are crucial and need to be part of a comprehensive prevention framework, they do not stop suicidal thoughts and behaviors from occurring in the first place. A broader public health approach including primary, secondary, and tertiary prevention can be useful to address suicidality at all stages of the continuum.

Findings from our key informant interviews and a review of the literature indicate the importance of addressing the entire spectrum of suicide. We provide the following recommendations:

- Make suicide prevention a statewide priority and coordinate across state agencies
- Provide adequate and sustained funding
- Reduce stigma and promote resilience
- Encourage consistent data collection
- Improve access to timely, affordable, and quality mental health care
- Support mental health integration
- Implement evidence-based programs, strategies, and resources

Introduction

Suicide, or intentional self-harm, is one of the leading causes of death in the United States. From 1999 through 2016, suicide rates rose significantly in 44 states; 25 states reported an increase in suicide rates of over 30% [1].

Suicide is the 10th leading cause of death among all age groups combined. In 2017, it accounted for 47,173 fatalities and contributed to nearly 2% of all U.S. deaths. Among young people, however, suicide was the 2nd leading cause of death, resulting in 19% of deaths in 10- to 24-year-olds and 11% of deaths in those aged 25 to 44 [2].

In its *Healthy People 2020* initiative, the federal government identified suicide as a leading mental health indicator. Prevention efforts aim to reduce the overall suicide rate by 10%, from a baseline of 11.3 suicide deaths per 100,000 population in 2007 to 10.2 deaths per 100,000 population by 2020. However, in 2017 the rate had actually increased to 14.0 deaths per 100,000 [3]. A second goal of the initiative was to reduce suicide attempts among adolescents by 10%, from a baseline of 1.9 suicide attempts per 100 population in 2009 to 1.7 attempts per 100 population by 2020. In 2017, however, the rate had risen to 2.4 per 100 population [3].

Though the emotional costs associated with suicide can be difficult to assess, the impact it has on family and friends can be substantial. Individuals exposed to suicide (i.e., knowing or identifying with someone who died by suicide) are more likely to engage in suicidal behaviors themselves, develop post-traumatic stress disorder (PTSD), and experience extended periods of grief and depression [4 5]. Individuals who are most at risk include those who personally knew the deceased (such as family, friends, or associates), those who learned about the death, those who witnessed the death, or those who found the deceased [6].

In addition to the emotional toll, suicide and attempted suicide also have an economic impact. The domestic cost of suicide deaths and attempts in 2013, based on reported numbers, was $58.4 billion. When adjusted for under-reporting, the estimate rose to $93.5 billion ($298 per capita) [7]. In 2014, the Centers for Disease Control and Prevention (CDC) estimated that suicide cost the state of Indiana $1.2 billion ($183 per capita) in lifetime medical and work–loss costs [8].

The purpose of this report is to provide an overview of suicide risks, trends, and current interventions in Indiana. To accomplish this, we have divided the report into three parts:

1. Review of the literature and data (Part I)
2. Key informant interviews with state experts (Part II)
3. Recommendations for suicide prevention (Part III)

Furthermore, a short list of suicide prevention resources is provided in Appendix I.

Part I: Review of the Literature and Data

Risk and Protective Factors

A variety of factors contribute to a person's likelihood to engage in suicidal thoughts and behaviors. Some of these circumstances can increase a person's risk to attempt or die by suicide (risk factors), while other circumstances can reduce the risk (protective factors).

Major risk factors for suicide include [9]:

- Having a mental disorder
- Misusing alcohol or other drugs
- Having experienced childhood trauma (adverse childhood experiences or ACEs)
- Having had prior suicide attempt(s)
- Knowing someone who died by suicide, particularly a family member
- Experiencing social isolation, feeling cut off from other people
- Having a chronic disease and/or disability
- Having access to lethal means (e.g., firearms)

Major protective factors for suicide include [9]:

- Having access to effective behavioral health care
- Feeling connected to family and friends, the community, and social institutions
- Having the necessary life skills, including problem solving and coping skills, and ability to adapt to change
- Being surrounded by cultural, religious, and personal beliefs that discourage suicide

THE GENDER PARADOX IN SUICIDE

Gender differences in suicidal behavior have shown to be significant. Women report higher rates of suicidal thoughts and non-fatal attempts, while men die by suicide at higher rates; a phenomenon known as the gender paradox in suicide [10]. This, in part, is due to the tendency of males to attempt suicide using more lethal methods, such as firearms. Additionally, females may be more easily deterred from attempting suicide [11]. Recent mortality data indicate this gender gap may be narrowing. Among young people, rates of suicide remain higher among male youth than female youth, but there has been a disproportionate increase in suicide rates among female youth [12].

MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Mental illness is strongly linked to suicidal behaviors. About 90% of people who die by suicide have at least one psychiatric disorder [13]. Suicide risk is highest for individuals with mood disorders (major depression, bipolar disorder), as well as those with personality and psychotic disorders [13 14].

Substance misuse is a risk factor for suicidality, as suicide attempts and deaths often occur by means of intentional overdose. Alcohol use disorder has been significantly associated with suicidal ideation, attempts, and completion [15-17]. Individuals with alcohol dependence and individuals who use drugs have a 10 to 14 times higher risk of dying by suicide compared to the general population [18].

The risk of suicide further increases for individuals with a co-occurring disorder; i.e., those who suffer from both substance use and mental health disorders [17 19].

ADVERSE CHILDHOOD EXPERIENCES

Adverse childhood experiences (ACEs) can contribute to psychiatric problems. In Indiana, about 52% of children reported experiencing at least one ACE. These children are at a higher risk of experiencing depression and other mental health disorders. The full consequences of trauma are often not apparent until long after the initial traumatization. Adults who experienced trauma at a young age often adopt risk behaviors while attempting to cope with stress. These risk behaviors can lead to illness and early death [20].

Childhood trauma changes the way an individual's brain processes stress and makes it more difficult to develop healthy coping skills [21]. Those with a history of childhood trauma tend to display greater impulsivity and aggression [22]. These traits make an individual more vulnerable to suicidal action.

Exposure to multiple and/or more severe ACEs increases a person's likelihood to engage in suicidal behavior. For example, the odds of suicide attempts were 2 to 4 times higher in women who had been sexually abused as children, compared to women who had not experienced sexual abuse. The impact was even greater in men. The odds of attempting suicide were 4 to 11 times higher in male sexual abuse victims, compared to those who did not experience sexual abuse during childhood [23].

Women are more likely to report ACEs than men. This could be part of the reason that women experience higher rates of depression and more suicide attempts [24].

PAST ATTEMPTS AND SUICIDE EXPOSURE

Both prior suicide attempts, as well as knowing someone who attempted or died by suicide, can increase the likelihood that a person will engage in suicidal behaviors. Studies have shown that a history of suicidal ideation and past suicide attempts are prominent risk factors, often resulting in death by suicide [25].

Exposure to suicide ('suicide contagion') increases the risk of suicide attempts among people "exposed"; this can mean family, friends, community members, or people who had a strong connection with the deceased [6 26].

Recent studies show that when the media widely report on celebrity suicides, the rate of suicide briefly increases [27]. In addition to traditional media coverage of celebrity deaths by suicide, social media has emerged as a powerful tool for possibly influencing suicidal behaviors [28]. Conversely, it may also be a powerful tool in identifying concerning behaviors and implementing interventions aimed at preventing suicide attempts [29].

ACCESS TO LETHAL MEANS

The relationship between access to firearms and death by suicide is very strong; i.e., firearms have a higher case fatality rate than other means of death by suicide [30]. Furthermore, firearms play a larger role in suicide deaths than homicides. In 2016, nearly 23,000 people used a firearm to die by suicide, accounting for more than half of all suicides that year. In the same year, a total of 14,415 people died in gun homicides [31]. States with higher prevalence of gun ownership had higher rates of overall suicide and firearm-specific suicide [32]. Previous gun control measures, such as the firearm buyback program in Australia, and the Israeli Defense Force initiative to prohibit soldiers from bringing firearms home, reduced firearm suicides by 74% and 40%, respectively [33 34]. Domestically, states with policies that require mental health or criminal background checks have lower rates of firearm suicides [35].

Specific High-Risk Groups

Though anyone can be affected by suicide, there are some groups within the population that are at a particularly high risk for suicidality due to the stresses they experience. Reviewing the literature, we identified the following high-risk groups:

- Veterans
- Sexual and gender minorities
- Incarcerated and released prisoners
- First responders
- Individuals with lower socioeconomic status

VETERANS

Individuals with a history of military service are at an elevated risk of suicide. Members of the military are often subjected to high stress situations that can leave lasting trauma. Veterans and active duty military account for 20% of all suicides in the U.S. Many veterans have easy access to firearms, which causes them to be at a higher risk of dying from a suicide attempt [36].

Within the military, individuals are frequently encouraged to use suppression and avoidance techniques in order to cope with the extreme demands placed on them. In the short term these can help one function during a traumatic event. However, in the long term this can create psychological distress, and if not processed adequately, can lead to mental health and substance use disorders [37].

Another aspect of military culture that fosters suicide risk is the desensitization to death and violence. While this is often necessary to perform duties, it can also lead one to become less inhibited when engaging in acts of self-harm. Individuals who are habituated to physical pain and violence are more likely to complete a suicide attempt [38]. Furthermore, depression and PTSD can lead veterans to perceive themselves as a burden to those in their life. Even though this belief is irrational, it can lead at-risk individuals to take suicidal actions [37].

After military service ends, many veterans still bear deep physical and psychological scars. Often, they struggle to reassimilate into the social structures they left behind when they went into service. This leaves them without a clear sense of purpose and control in their lives. Veterans are at the highest risk of suicide within the first two years of returning from combat. However, those who are supported by their friends and family are less likely to engage in suicidal behaviors [39].

Many veterans are hesitant to seek mental health services because of stigma and other barriers. Normalizing mental health care is critical to reducing these barriers and providing veterans with the support they need. Veterans tend to internalize stigma-based ideas about mental health problems. This leads them to attempt to stifle their symptoms, often by concealing them with maladaptive coping behaviors [40].

SEXUAL AND GENDER MINORITIES

According to the National Institutes of Health, *"sexual and gender minority (SGM) populations include but are not limited to, individuals who identify as lesbian, gay, bisexual, asexual, transgender, two-spirit, queer, and/or intersex. Individuals with same-sex or -gender attractions or behaviors and those with a difference in sex development are also included. These populations also encompass those who do not self-identify with one of these terms but whose sexual orientation, gender identity or expression, or reproductive development is characterized by non-binary constructs of sexual orientation, gender, and/or sex."* The term "SGM" is similar to, but more inclusive than the frequently used abbreviation "LGBTQ" (lesbian, gay, bisexual, transgender, queer/questioning) [41].

SGM individuals are at an elevated risk for suicidal behavior. Lifetime suicide attempts are three times as high in gay and bisexual men, and twice as high in lesbian and bisexual women when compared to heterosexual individuals [42]. LGB youth contemplate suicide at three times the rate of heterosexual youth, and were nearly five times more likely to require medical treatment [43]. Transgender individuals are also at higher risk of suicidality- one study reported that 40% of transgender adults reported making a suicide attempt [44].

Poorer mental health among SGM individuals contributes to elevated suicide rates.

When compared to others with mental health disorders, members of the SGM community are at a higher risk of suicide [45]. Furthermore, this higher prevalence of mental health disorders alone does not explain the significantly increased rates of suicidality among this population; SGM individuals also experience high rates of social stigma, prejudice, discrimination, and victimization [46].

Young people are particularly vulnerable. Loss of familial belonging can cause a sense of instability, leaving youths feeling hopeless. SGM youths who experience familial rejection are at a much higher risk of suicidal behavior [47].

SGM individuals living in hostile communities are also at greater risk for suicidality. One report showed that LGB adults in states that passed amendments banning same-sex marriage displayed a 37% rise in mood disorders, a 40% increase in alcohol use disorders, and a 250% rise in generalized anxiety disorders [48].

INCARCERATED/RELEASED PRISONERS

Current and former prisoners are also at an elevated risk of suicide. According to a 2015 report by the Bureau of Justice, the number of inmates who have died by suicide in U.S. correctional facilities increased each year from 2010 to 2014, and increased 30% from 2013 to 2014 [49]. The transition into and out of prison can be extremely destabilizing and make it difficult for individuals to connect to meaningful social networks. In addition, individuals with severe mental illness often end up in prison instead of treatment. By some estimates, about 54% of all released prisoners have been diagnosed with a psychiatric disorder at some point [50]. The stressors of prison life can worsen symptoms and drive inmates to suicidal action [51].

Those who are incarcerated face many challenges in coping with prison life. Imprisonment can exacerbate mental disorders because prisoners are frequently cut off from family members and close social connections. Loneliness is a persistent stressor within the prison population. Individuals who reported lower social support and more loneliness were at a higher risk for all forms of self-harm [51].

Prisons often lack effective resources for treating those suffering from mental disorders. Instead of receiving treatment, many mentally ill prisoners are placed in solitary confinement. Research shows that any length of time spent in solitary confinement raises the risk of self-harm. When compared to inmates who had never experienced solitary confinement, inmates who had experienced solitary confinement were significantly more likely to commit acts of self-harm [52].

Individuals who have recently been released from prison are also at an elevated risk of suicide. The highest risk occurs during the first

year after release [50]. This can be attributed to the difficulty of transition out of prison and the struggle of re-integration into society. Released offenders often face stigma from others in their community. Those who do not feel accepted by their community typically have more trouble adjusting. Experiencing stigma can result in unhealthy coping mechanisms such as social withdrawal and substance abuse [53].

FIRST RESPONDERS

First responders such as firefighters, police officers, and emergency medical service (EMS) workers endure countless high-stress situations over the course of their careers. There is evidence to suggest that this repeated exposure to stressors can worsen existing mental health problems and result in the development of new conditions. One study indicated that 37% of fire and EMS professionals have contemplated suicide; a rate nearly 10 times higher than the national average [54]. More first responders die by suicide than in the line of duty [55]. Addressing first responder suicides is critical to ensuring that these individuals perform their jobs effectively without sacrificing their mental health.

The stigma of seeking mental health treatment leads many first responders to neglect their own well-being. First responders often worry that seeking help will make them appear "weak" or harm their career. A third of first responders report experiencing stigma around mental health treatment. Often this stigma comes from a fear that services will not be kept confidential and will cause one's coworkers to view them as less dependable. First responders often try to hide symptoms and push through instead of seeking help with mental health conditions. This can lead to more severe symptoms of PTSD, depression, and alcohol abuse [56]. Only about 3-5% of U.S. law enforcement agencies have suicide prevention programs [55]. This means that mental health problems are less likely to be identified early and are more likely to result in suicide or chronic poor mental health.

The long, stressful hours of first responder work can result in burnout. Exhaustion and a lack of cohesion among a first responder workforce can contribute to burnout, and first responders who experience burnout are more prone to mental health problems. For example, police officers who reported burnout showed a 117% higher rate of suicidal thoughts [54]. First responders who lack training and resources to manage mental health problems as they arise are more likely to develop burnout. However, the strong sense of community and self-efficacy among first responders can function as a protective factor. Many first responders find profound meaning and purpose in their jobs which can protect them from developing mental health conditions [57]. However, first responders who express frustration and dissatisfaction with supervisors are more likely to develop PTSD.

Unity within first responder communities is critical to sheltering these groups from suicide risk [54].

INDIVIDUALS WITH LOWER SOCIOECONOMIC STATUS

Lower socioeconomic status (SES) is associated with a higher rate of mental illness, which results in a greater risk of suicidal behavior. Mental illness can be a contributing factor to low socioeconomic status; i.e., individuals suffering from serious mental illness can struggle to hold down a job or advance in the workplace. Economic downturns and increases in income inequality can lead to rising suicide rates within vulnerable communities. Broader feelings of frustration and dissatisfaction can cause individuals to experience suicidal behavior [58]. Geographic areas with lower poverty, unemployment, and family disruption typically experience lower suicide rates. The community in which a person lives provides important context about their suicide risk. Community-level social disruption leads to an increase in suicidal behavior. However, individuals who have strong social ties and those who experience purpose and a sense of responsibility to others are less likely to display suicidal behavior [59].

Some research suggests that perceived SES may be a more important risk factor than objective SES. Lower perceived social status has been connected to the worsening of several important biomarkers of health. The long-term impact of stress about one's social position can contribute to higher rates of suicide. Multiple studies indicate that income is a better predictor of suicide for men than women. Women's educational attainment is a better predictor of their suicide risk. Income may be a more important symbol of social status for men, and men who are unsatisfied with their income have worsened mental health and struggle to find their place in society [60].

The unemployed are a group of low SES individuals who are at an especially high risk of suicide. Part of this increase in risk can be attributed to the higher rates of mental health disorders present among the unemployed. In addition, unemployment can cause individuals to feel a lack of purpose and a loss of identity, leading to an increase in suicidal behavior. Additionally, individuals of lower SES are more likely to face obstacles, such as financial barriers, lack of transportation, and stigma, when accessing mental healthcare [61].

Suicide-Related Statistics in Indiana

INDIANA'S GENERAL ADULT POPULATION

Data from the 2017-2018 National Survey on Drug Use and Health (NSDUH) indicated that 5% of Indiana residents ages 18 or older had serious thoughts of suicide within the past year. The rate was higher for 18- to 25-year-olds (12%), compared to those ages 26 and older (4%) [62].

INDIANA'S HIGH SCHOOL STUDENTS

According to data from the 2015 Youth Risk Behavior Surveillance System (YRBSS), the most recent year available for Indiana, 29% of Hoosier high school students reported feeling sad or hopeless in the past year. Furthermore, about one in five Indiana students engaged in suicidal behaviors in the past year, specifically:

- 20% seriously considered attempting suicide,
- 17% made a plan about how they would attempt suicide,
- 10% attempted suicide, and
- 4% of suicide attempts were serious enough to result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse.

2015 YRBSS data indicate that Indiana ranked 3rd out of 37 states in the percentage of students who reported they seriously considered attempting suicide, and 2nd out of 34 states in the percentage of students who made a suicide plan. Notable differences in suicide-related prevalence rates were found to exist between genders, sexual orientation, and sexual contact [63].

Gender: More female than male high school students indicated that they felt sad and hopeless or engaged in suicidal thoughts and behaviors in the past year [63].

Sexual Orientation: High school students who identified as gay, lesbian, or bisexual had significantly higher rates of suicide-related thoughts and behaviors compared to students who identified as heterosexual [63].

Sexual Contact: For all measures, students with no sexual contact had lower reported rates than those who reported any type of sexual contact. In almost all reported measures, students who indicated sexual contact with both sexes reported the highest rates of suicidal ideation and attempts [63].

For details on differences in suicide-related thoughts and behaviors in high school students, see Appendix II, A through D.

SUICIDE MORTALITY

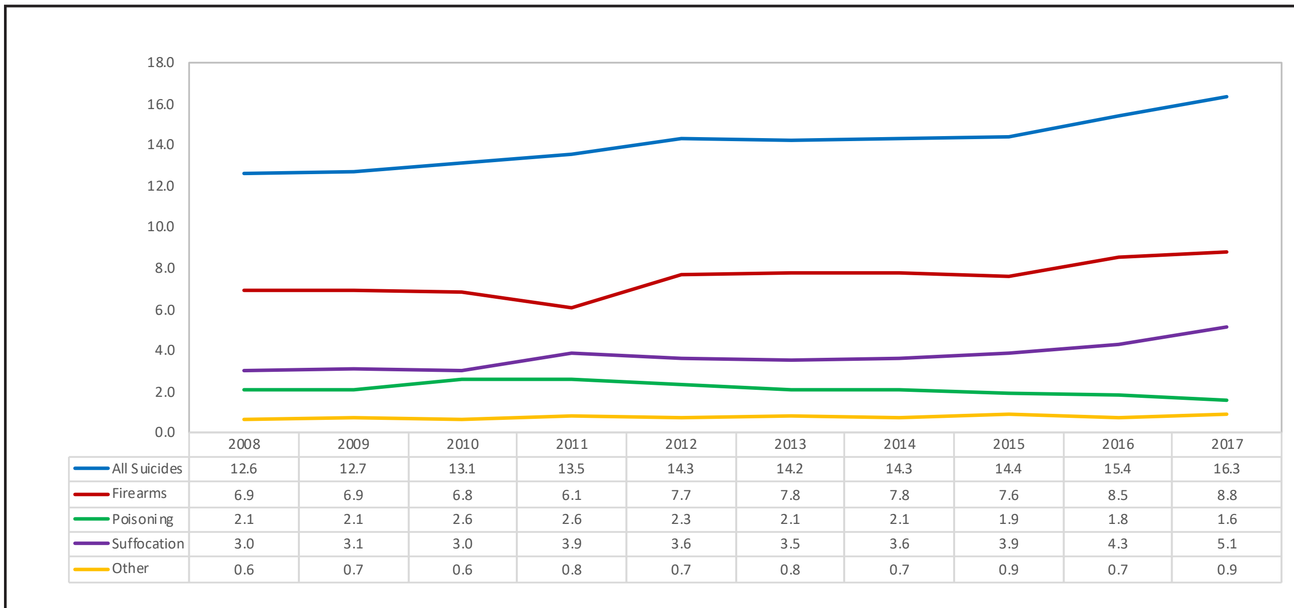
Suicide rates among Hoosiers have increased from 12.6 per 100,000 in 2008 to 16.3 per 100,000 in 2017, a nearly 30% increase over the 10-year period (see Figure 1). In Indiana, the most common method was death by firearms, followed by suffocation [64].

See Appendix III for a map of Indiana showing each county's suicide mortality rate for 2008 - 2017 combined.

VETERANS IN INDIANA

The U.S. Department of Veterans Affairs (VA) collects and analyzes veteran suicide data at

Figure 1: Age-Adjusted Suicide Rates per 100,000 Population in Indiana, 2008-2017[1]



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
All Suicides	12.6	12.7	13.1	13.5	14.3	14.2	14.3	14.4	15.4	16.3
Firearms	6.9	6.9	6.8	6.1	7.7	7.8	7.8	7.6	8.5	8.8
Poisoning	2.1	2.1	2.6	2.6	2.3	2.1	2.1	1.9	1.8	1.6
Suffocation	3.0	3.1	3.0	3.9	3.6	3.5	3.6	3.9	4.3	5.1
Other	0.6	0.7	0.6	0.8	0.7	0.8	0.7	0.9	0.7	0.9

Source: CDC WONDER, 2019

the national and state level. In 2017, the suicide rate for Indiana veterans was 28.0 per 100,000 (U.S.: 31.0 per 100,000) (see Figure 2). This rate was significantly higher than Indiana's suicide mortality rate for the general population (16.3 per 100,000; see Figure 1).

Among veterans, the age group most frequently dying by suicide in Indiana were those between the ages of 35-54 years. Nationally, however, veterans most at risk of death by suicide were somewhat younger, i.e., between the ages of 18-34 years.

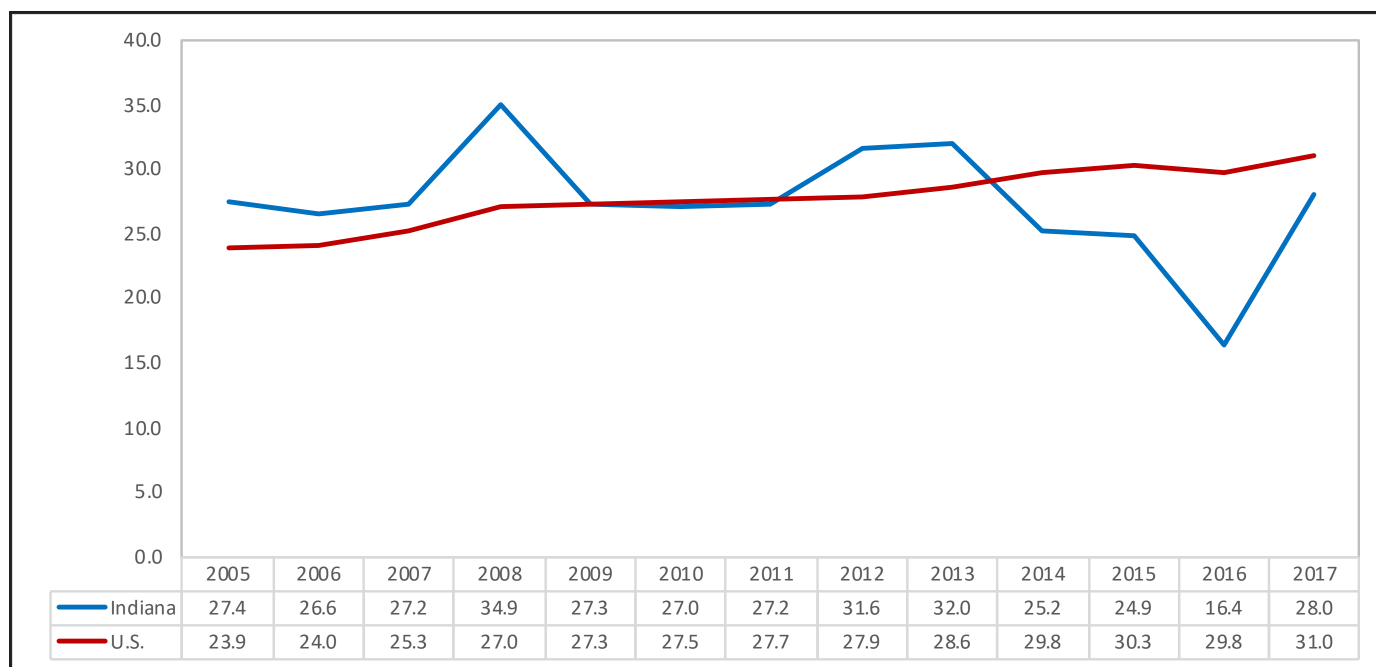
The majority of Hoosier veteran deaths occurred via firearm (73.0%), followed by suffocation (17.4%). For additional details, see Appendix IV [65].

THE INCARCERATED

The Deaths in Custody Reporting Program (DCRP), now called the Mortality in Correctional Institutions (MCI) program, collects inmate death records on a quarterly basis from all state prisons and juvenile correctional authorities, as well as 3,095 local jails. Between 2000 and 2013, there were 805 state prisoner deaths in Indiana, 51 of which were reported as suicide (6.3%) [66].

[1]For this analysis, we included only mortality in which the underlying cause of death was attributable to intentional self-harm or injury in the CDC WONDER database. ICD-10 codes were grouped as follows: X60-84 (labeled as 'Total'), X72-X74 (labeled as 'Firearms'), X60-X69 (labeled as 'Poisoning), X70 (labeled as 'Suffocation'), X71 & X75-X84 (labeled as 'Other')

Figure 2: Veteran Suicide Rates per 100,000 Population, 2005-2017



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Indiana	27.4	26.6	27.2	34.9	27.3	27.0	27.2	31.6	32.0	25.2	24.9	16.4	28.0
U.S.	23.9	24.0	25.3	27.0	27.3	27.5	27.7	27.9	28.6	29.8	30.3	29.8	31.0

Source: U.S. Department of Veterans Affairs, 2019

Suicide Prevention Framework

The Indiana Suicide Prevention Network (ISPN) has developed a suicide prevention framework, with support from the Indiana Family and Social Services Administration (FSSA)'s Division of Mental Health and Addiction (DMHA). ISPN is comprised of stakeholders from both the public and private sectors, and various state agencies [67]. The prevention framework was adapted from the Zero Suicide Initiative, which contains seven essential elements for health and behavioral health systems to adopt [68]. The goal of this framework is to approach suicide as a public health issue and to reduce the number of deaths by suicide in Indiana to zero, using a combination of efforts in addition to the promotion of intervention, resilience, postvention and social change [67]. The prevention framework distinguishes between three levels of prevention effort- primary, secondary, and tertiary prevention.

The Indiana State Suicide Prevention Framework identifies five goals with the aim of decreasing suicide among Hoosiers:

1. Develop an interactive suicide prevention website.
2. Increase participation with suicide prevention coalitions by 20%.
3. Submit suicide prevention budget recommendation.

4. Provide quarterly suicide prevention awareness training opportunities to reduce stigma.
5. Increase the number of national suicide prevention lifeline crisis centers.

Each of these goals has multiple objectives, which are tied to at least one of the following concepts adapted from the Zero Suicide Initiative – Lead, Train, Identify, Engage, Treat, Coordinate and Improve[2] [68].

Indiana Policies

Legislative action is an effective tool for drawing attention and resources toward suicide prevention. Indiana has passed several pieces of legislation to promote mental health and reduce suicide deaths. The Indiana Safe Schools Fund supplies grants to help schools develop effective anti-bullying policies to create a more supportive school environment [69]. Zero tolerance policies are intended to ensure that bullying is taken seriously, and victims are provided with appropriate support. Schools have a "Duty to Report" threats and intimidation [70]. Beginning in 2011, Indiana House Bill 1019 and Indiana Senate Bill 4 required programs to be developed that help prepare educators in identifying and assisting students who appear to be at-risk [71]. In 2017, Indiana House Bill 1430 required teachers and other appropriate school employees who work with students in grades 5-12 to attend and participate in evidence-based youth suicide awareness and prevention programs every 3 years. It also required DMHA to develop a statewide suicide prevention program and employ a statewide suicide prevention coordinator [72].

Part II: Key Informant Interviews with State Experts

Methodology

We conducted key informant interviews[3] with state experts in suicide prevention to get a better understanding of the magnitude and impact of suicide in Indiana; the resources and interventions necessary to effectively address the issue; and how the State is currently responding to the situation. Between October and November of 2019, a total of 11 experts were interviewed. (See Appendix V for introductory message and interview questions.)

[2]The original Zero Suicide Framework lists the following 7 elements: (1) Lead system-wide culture change committed to reducing suicides, (2) Train a competent, confident, and caring workforce, (3) Identify individuals with suicide risk via comprehensive screening and assessment, (4) Engage all individuals at-risk of suicide using a suicide care management plan, (5) Treat suicidal thoughts and behaviors using evidence-based treatments, (6) Transition individuals through care with warm hand-offs and supportive contacts, and (7) Improve policies and procedures through continuous quality improvement [68].

[3]Study proposal was submitted to Indiana University's Internal Review Board (IRB) and qualified as "exempt" (study protocol #1908571459).

Key themes were identified and summarized for the following categories:

- Magnitude of the problem
- Vulnerable populations and risk factors
- Suicide trends
- Stigma and resilience
- Indiana's response
- Gaps
- Recommendations

Results

MAGNITUDE OF THE PROBLEM

"Every year the numbers go up, and I think that's the most important statistic…we're not decreasing, every single year, it's going up."

All key informants stated that suicide is a significant problem in Indiana, citing that suicide is one of the leading causes of death across many age groups. Most key informants were concerned about the rising rates of suicide attempts and deaths.

Furthermore, the coroners' systems for reporting suicides are inconsistent across Indiana counties. Many of our experts believed that the number of suicide deaths may be underreported because of stigmatization and/or misattributing suicides as accidental deaths with undetermined intent.

"I haven't met with a school district that hasn't been touched by a suicide. It seems to be everywhere, there's something, whether it's a staff member or it's one of their students."

VULNERABLE POPULATIONS AND RISK FACTORS

Population groups that were consistently identified by our experts as vulnerable included:

- Individuals with mental health problems and/or substance use disorders; especially those who experience both (co-occurring disorder)
- Individuals who identify as LGBTQ / sexual and gender minorities
- Youth and young adults
- Military (both veterans and active duty members)
- Members of law enforcement, first responders
- Middle-aged men

"Men tend to die more violently by suicide versus women, who tend to choose drug overdose as their means, and then someone finds them, resuscitates them, and gets them into treatment."

Most key informants also mentioned one or more of the following risk factors for suicide:

- Social isolation
- Access to lethal means (e.g., firearms)
- Lack of access to mental health care
- Exposure to trauma, including adverse childhood experiences (ACEs)
- Exposure to suicide (e.g., suicide by family members, friends, community members, or celebrities)

TRENDS

Key informants generally stated that many suicide trends in Indiana are similar to those in the U.S.; however, they also expressed that Indiana exhibited higher rates of suicide.

Emergency departments in Indiana have seen increases in youth with suicide ideation.

Some key informants reported that hanging (asphyxiation) as a means of dying by suicide was more frequently seen than expected, especially among youth. Furthermore, more and more schools have been reaching out for help in creating suicide crisis plans.

Less access to mental health treatment in Indiana compared to other states was also mentioned as a potential reason for the state's high suicide rates. Indiana has a low ratio of mental health providers to the population they serve, as well as low treatment rates for behavioral health services, especially for the youth population.

> *"Younger and younger students, as young as 8, are coming forward and saying they're having suicidal ideations."*

STIGMA AND RESILIENCE

> *"Mental health is just as important as your physical health."*

Our key informants felt that mental health and suicide are highly stigmatized topics. This stigmatization creates barriers for individuals to seek the help they need. Being more resilient is an important protective factor for individuals with suicidal ideation.

Key informants were asked how to reduce stigma and promote resilience in Hoosiers. The three major themes that emerged involved programming, pro-social attitudes, and mental health integration.

Programming

Our experts stated the need to identify and implement evidence-based programs and strategies to reduce stigma and boost resilience. Many key informants suggested campaigns to raise awareness about mental health and suicide within the general public, but also targeting groups who work with or come in

contact with youth; e.g., parents, teachers and other school staff, and physicians and other healthcare professionals.

Peer support programs were also mentioned as effective ways to "elevate the youth voice". Many key informants talked about the need for training and support to overcome stigma and normalize help-seeking behaviors.

> *"We need to equip our parents and educate them about overcoming the taboos and stigmas of help-seeking behaviors."*

Pro-Social Attitudes

Promoting pro-social behaviors in general and encouraging community engagement was also frequently mentioned by our key informants. Many pointed out that by focusing solely on negative outcomes (such as deaths), the "culture of stigma" is perpetuated. Suggestions included using less stigmatizing language and promoting messages of hope, resilience, and connectedness. In addition, fostering social connections reduces social isolation, which is a significant risk factor for suicidal behaviors.

> *"Talk about suicide not only in terms of deaths, but stick to messages of hope, messages of resilience, messages of connectedness."*

Many key informants mentioned that such a change in social attitudes may be generational and require a shift in the overall culture. Having champions for mental health issues from various sectors of the community (e.g., law enforcement, education, medicine, business, etc.) could prove to be beneficial in reducing stigma.

Mental Health Integration

Multiple key informants strongly felt that mental health should be well-integrated into overall healthcare and other community sectors. Integration into medical care could include training of healthcare professionals to make them more aware of mental health and suicide issues, and reduce the stigma they may harbor; it could also include routine screenings of mental health and suicidality during medical exams.

Education is another sector that, according to many of our respondents, could benefit from mental health integration. This could include incorporating mental health education into the curriculum; providing training in QPR and trauma-informed care to all school staff who interact with students (e.g., teachers, nurses, counselors, cafeteria workers, bus drivers); having social workers in every school; and conducting mental health screenings within the school system similar to vision and hearing tests.

INDIANA'S RESPONSE

When asked what the state is currently doing in terms of suicide prevention/intervention, key informants indicated the following efforts:

Legislative Efforts

Compared to previous years, there has been increased legislative attention on suicide. In 2017, House Bill 1430 was passed by the Indiana General Assembly, which (1) mandated that teachers and other employees who work with students in grades 5-12 complete a suicide prevention training program every three years, and (2) required the Division of Mental Health and Addiction (DMHA) to create a statewide suicide prevention program and a position for a state suicide prevention coordinator. In addition, the 2019 state budget had designated funds specifically for suicide prevention efforts.

Committees

There are a number of committees whose objective is to review deaths by suicide and work on suicide prevention efforts. These include the following:

- The Commission on Improving the Status of Children
- DMHA Review Committee
- ISDH Child Mortality Review Group
- Suicide Learning Collaborative
- ISPN/ISPNAC as dedicated task forces

Programs/Trainings

There has been an increase in trainings offered throughout the state, including: Zero Suicide Initiative, QPR trainings, and Social Emotional Learning (in schools). ISDH has trained 14 individuals in psychological autopsies, and overall, there has been an increase in peer-to-peer support groups.

Other State Efforts

- Statewide coalitions have used their limited funding to host conferences, provide trainings, and offer support at the community level
- Increased access to mental health care via less traditional methods (e.g., mobile van)
- Agencies/groups are becoming more collaborative
- Some private funding for prevention efforts has been secured (e.g., grants)

"Lately, we have more collaboration and more people vested in suicide prevention, working at agencies that either serve broad areas of the state or are supposed to serve the whole state, so that is a new phenomenon."

GAPS

Key informants were also asked what gaps they observed in current suicide prevention efforts. The following major themes were identified:

Lack of Funding

Many of our experts indicated that suicide prevention efforts in Indiana have suffered due to lack of or limited funding.

Data

Multiple key informants indicated that Indiana lacks in-depth data on suicidal behaviors and the way suicides are reported by coroners is inconsistent. Indiana has had low response rates for surveys such as the Youth Risk Behavioral Surveillance System (YRBSS), which provides estimates on health and risk behaviors (including suicidal behaviors) among high school students. Also, data are not necessarily shared between state agencies.

Access to Care

All our key informants raised concerns about access to mental health care. Access to these services remains a barrier in Indiana, and treatment rates continue to be low. Receiving mental health services is stigmatized, so many people do not seek the treatment they need. For those individuals who decide to get treatment, there is a long wait time for providers. The ratio of mental health care providers to the population who seek treatment is very low, exacerbating these wait times.

Programs may not be implemented throughout the state, leading to coverage gaps. Care may be too expensive, and low-cost care may not always be good quality care, furthering health disparities. There is a lack of continuity of care, especially after individuals are discharged from emergency departments. Mental health is not integrated well into other settings, such as primary care or in school settings.

There are 24 community mental health centers (CMHCs) in Indiana. Some key informants indicated that CMHCs had gaps in their services, indicating concerns such as a lack of a triage system, lack of thorough assessments, and lack of efficiency and responsiveness. More guidance from the state may be helpful.

"We need to improve...the quality of services that are available. We still have emergency rooms that send people out without plans for help. We still have people that wait 4 to 6 weeks for an appointment with their psychiatrist. We still have correctional facilities that stick people in isolation, when they need assistance. We have people that have been put in jail on a suicide watch call and released 24 hours later with no assessment. There's lots of missed opportunities."

Workforce

Indiana's workforce is not properly equipped to handle the growing problem of suicide. There is only one prevention coordinator for the entire state of Indiana, and the workforce overall is under-resourced. Trainings throughout the state

are limited and key people, especially in rural areas, often do not have access to the trainings.

Other

Indiana does not have an official state suicide prevention plan and many respondents felt that our legislators do not make suicide prevention a priority. Generally, there seems to be a lack of awareness or acceptance that suicide is a public health issue. Furthermore, some of our key informants talked about a "silo-ing" of efforts, i.e., efforts and funding are not as collaborative as they should be.

RECOMMENDATIONS

Our experts recommended comprehensive and diverse systems changes, including evidence-based programming at multiple levels (primary, secondary, and tertiary preventive measures). Many key informants felt that there needs to be increasing focus on true primary or upstream prevention efforts. In addition, all levels of prevention and intervention should be done concurrently. Many of our experts mentioned the need for support from multiple sources, including employer policies designed to support mental health (e.g., mental health days and family care policies), as well as more legislative efforts to provide support (e.g., universal childcare). Key informants advocated for a broad public health approach to enact change, rather than just focusing on mental health services.

Virtually all of our experts emphasized the need for increased access to care, including support services such as providing transportation to mental health providers. One key informant also suggested that mental health providers should be closely located to (or co-located with) other health care providers, for ease of access and stigma reduction. Finally, workforce development should be supported to increase the number of mental health providers in Indiana.

Overall, all our experts mentioned needing more mental health treatment and prevention efforts. Many key informants stated that more focus was needed on upstream prevention to address risk factors, such as ACEs, and start primary prevention in individuals at a young age. Mental health resources must be accessible and comprehensive, as effective treatment can lower or even prevent suicide risks. In addition, key informants felt that there should be more awareness in general, by offering more trainings including gatekeeper training, the Zero Suicide Initiative, and postvention efforts such as loss survivor teams. More guidance or information about current suicide prevention efforts from the state might also prove helpful in order for organizations to understand the current state of prevention efforts across the state.

All our key informants felt having additional resources and programs would be valuable, and they expressed the need for increased funding

for prevention/intervention efforts and trainings such as psychological autopsies. Ideally, funding streams could be blended to better help current efforts. Furthermore, if tools and resources used could be standardized across multiple sectors this would lead to more efficient communication and better data collection. Standardizing procedures for coroners to report suicides would provide more accurate estimates on suicide deaths.

Ideally, there would also be structured suicide prevention efforts across all local health departments.

There must be comprehensive support of prevention efforts from multiple industries and sectors, such as engaging with firearm communities in regard to gun safety, or engagement with the faith community. There need to be more culturally competent efforts, with diverse providers.

Part III: Recommendations for Suicide Prevention

Traditionally, suicide has been addressed after people showed signs of suicidal behaviors, by providing immediate care or mental health services. Although these services are crucial and need to be part of a comprehensive prevention framework, they do not stop suicidal thoughts and behaviors from occurring in the first place. A broader public health approach including primary, secondary, and tertiary prevention can be useful to address suicidality at all stages of the continuum.

Primary prevention (also known as ‘upstream’ prevention) focuses on preventing the onset of a condition or behavior. Primary prevention aims to reduce the number of new cases in the general population [73] and can raise awareness of how an individual’s risk and protective factors may influence his or her propensity to engage in harmful behaviors [67].

Examples: Promoting pro-social activities and community engagement; educational campaigns (e.g., anti-stigma or anti-bullying campaigns); school-based programs (e.g., life skills training); parent-child classes; ACEs prevention; screening programs, such as the use of questionnaires to identify individuals at higher risk of suicidal ideation or behaviors.

Secondary prevention aims to treat people who display signs of the condition or risk behaviors associated with the condition [67]. Secondary prevention aims to recognize and assess a person’s suicide risk as early as possible and refer them to treatment before a suicide attempt occurs.

Examples: QPR (Question, Persuade, Refer) training; gatekeeper training; mental health integration (e.g., routine screenings during primary care visit or for students in school);

timely and adequate access to mental health services; use of antidepressant medications and/or behavioral therapies.

Tertiary prevention (also known as 'postvention') treats individuals who are already afflicted with the condition or behavior, and seeks to reduce any further impact [67]. This includes providing care and mental health services to survivors of suicide and individuals who have lost a loved one to suicide.

Examples: Timely and adequate access to mental health services; suicide loss support groups / increased monitoring of suicide loss survivors, who are at an increased risk of suicidal behaviors; improving data collection on suicide attempts and deaths.

Findings from our key informant interviews and a review of the literature indicate the importance of addressing the entire spectrum of suicide. We provide the following recommendations:

- *Make suicide prevention a statewide priority and coordinate across state agencies*
  Preventing suicide takes a coordinated effort—from government to organizations to local communities. The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends for states to build "an infrastructure to support stable, comprehensive, and coordinated suicide prevention efforts," across multiple sectors and settings [74].
- *Provide adequate and sustained funding*
  To build and maintain a statewide suicide prevention infrastructure requires substantial resources. Federal grants as well as state and local funding could contribute to these efforts. Ideally, states include a line item for suicide prevention in their state budget.
- *Reduce stigma and promote resilience*
  Specific programs and campaigns can assist in promoting pro-social behaviors and fostering community engagement.
- *Encourage consistent data collection*
  Standardize coroners systems for reporting suicide deaths to provide more accurate and reliable estimates. Furthermore, encourage schools to participate in the biennial YRBSS survey, which provides important estimates on suicide and other risk behaviors among high school students.
- *Improve access to timely, affordable, and quality mental health care*
  Adequate access to mental health services is crucial, especially during crisis. Workforce development initiatives can support the need for more mental health providers.
- *Support mental health integration*
  Integrating mental health into medical settings (e.g., primary care) as well as other sectors (e.g., education, justice system) can help catch at-risk individuals who otherwise may not get the help they need.
- *Implement evidence-based programs, strategies, and resources*

Evidence-based practices (EBPs) are those that have been shown, through research, to be effective. They allow professionals to make the most efficient use of the resources available to them. Examples of EBPs include:

- Zero Suicide - a framework to improve the quality and continuity of care in health and behavioral health care systems.
- Dialectical behavior therapy (DBT) - cognitive behavioral therapy designed to treat suicidal behaviors.
- Sources of Strength - a suicide prevention program that uses peer leaders to increase protective factors at the school level.
- Applied Suicide Intervention Skills Training (ASIST) for all mental health providers- trains participants to utilize a suicide intervention model.
- Crisis Intervention Team (CIT) training - for law enforcement officials, educates participants about types of mental illnesses and available resources in the community, and trains them in active listening and de-escalation of crisis situations.
- Mental Health First Aid - trains participants to identify, understand, and respond to signs of mental health problems.
- Question Persuade Refer (QPR) - trains participants to respond to individuals in crisis.
- Wellness Recovery Action Plan (WRAP) for Life - a self-designed prevention and wellness process/tool.
- Columbia Suicide Severity Rating Scale (C-SSRS) - a questionnaire designed to assess the severity of suicidal ideation and behaviors.

In conclusion, suicide is an issue that affects all of us. Many concerted efforts are currently underway in Indiana, trying to prevent the rising number of deaths, but more needs to be done. The intention of this report is to provide an overview of the risks and trends, together with recommendations to guide Indiana's suicide prevention efforts. This is not meant to be an exhaustive report, but a stepping stone that could serve as the foundation for a state strategic plan.

Appendix I - Suicide Prevention Resources

INDIANA

Call 211 or (866) 211-9966, or visit https://in211.communityos.org/ to connect with a navigator who can help connect you with local resources.

Visit https://www.in.gov/issp/ for help locating suicide prevention resources throughout Indiana.

Visit www.lookupindiana.org (also available as a hotline, text line, or online chat) to learn about suicide prevention resources in your area.

Visit https://www.in.gov/issp/files/regional_map_support_group.pdf for suicide prevention coalition and postvention support groups in your region.

Visit https://www.in.gov/isdh/files/Suicide%20Resrouce%20Guide%20Jan%202019.pdf for an Indiana resource guide, including resources for vulnerable populations and a guide to mobile applications.

Families First Indiana Hotline: (317) 251-7575 or Text CSIS to 839863.

Mental Health America Hotline: 1-765-742-0244 or 1-877-419-1632.

UNITED STATES

National Suicide Prevention Lifeline: 1-800-273-8255

In Spanish: 1-888-628-9454

For Deaf & Hard of Hearing: 1-800-799-4889

Appendix II – Past-year Prevalence Rates of Suicide-Related Risk Behaviors Among High School Students

Appendix II.A: By Gender

Measure	Gender	Indiana (95% CI)	U.S. (95% CI)
Felt sad or hopeless	Female	39.2% (33.6–45.0)	39.8% (36.5–43.2)
	Male	19.8% (17.5–22.3)	20.3% (18.9–21.8)
Seriously considered attempting suicide	Female	26.0% (22.2–30.1)	23.4% (21.5–25.4)
	Male	13.7% (10.5-17.6)	12.2% (11.2-13.3)
Made a plan	Female	20.6% (18.5-22.8)	19.4% (17.5-21.5)
	Male	13.6% (10.7-17.2)	9.8% (8.8-11.0)
Attempted suicide	Female	10.9% (8.3–14.1)	11.6% (9.7-13.7)
	Male	5.5% (4.7-6.4)	8.7% (6.0-12.5)
Attempt warranted care by doctor or nurse	Female	4.4% (2.7–7.0)	3.7% (2.9-4.7)
	Male	1.9% (1.3-2.8)	3.3% (1.9-5.6)

Source: Youth Risk Behavior Surveillance System, YRBSS, 2015

Appendix II.B: By Sexual Orientation

Measure	Sexual Orientation	Indiana (95% CI)	U.S. (95% CI)
Felt sad or hopeless	Heterosexual	25.2% (22.5–28.0)	26.4% (24.6–28.4)
	Gay, Lesbian or Bisexual	57.8% (44.8–69.8)	60.4% (55.1–65.4)
	Not sure	44.6% (28.6–61.9)	46.5% (41.2–51.8)
Seriously considered attempting suicide	Heterosexual	15.2% (13.6–16.8)	14.8% (13.7–15.9)
	Gay, Lesbian or Bisexual	46.4% (34.9–58.4)	42.8% (38.4–47.3)
	Not sure	39.1% (29.0–50.2)	31.9% (27.1–37.1)
Made a plan	Heterosexual	13.0% (11.7–14.4)	11.9% (10.8–13.1)
	Gay, Lesbian or Bisexual	42.8% (34.8–51.1)	38.2% (34.0–42.6)
	Not sure	31.9% (21.3–44.9)	27.9% (21.3–44.9)
Attempted suicide	Heterosexual	6.8% (5.0–9.2)	6.4% (5.6–7.3)
	Gay, Lesbian or Bisexual	34.2% (27.5–41.5)	29.4% (25.7–33.3)
	Not sure	17.6% (7.5–35.9)	13.7% (10.0–18.5)
Attempt warranted care by doctor or nurse	Heterosexual	3.0% (1.7–5.4)	2.0% (1.5–2.7)
	Gay, Lesbian or Bisexual	11.1% (7.1–17.1)	9.4% (7.3–12.1)
	Not sure	7.8% (2.7–20.7)	4.7% (2.7–8.1)

Source: Youth Risk Behavior Surveillance System, YRBSS, 2015

Appendix II.C: By Race/Ethnicity

Measure	Race/Ethnicity	Indiana (95% CI)	U.S. (95% CI)
Felt sad or hopeless	American Indian/Alaskan Native (Non-Hispanic)	N/A	34.9% (25.2–46.0)
	Asian (non-Hispanic)	N/A	22.9% (18.0–28.7)
	Black (non-Hispanic)	31.2% (22.2–41.8)	25.2% (21.7–29.1)
	Hispanic	36.8% (27.8–46.8)	35.3% (32.3–38.4)
	Native Hawaiian or Other Pacific Islande (non-Hispanic)	N/A	33.7% (19.4–51.7)
	White (non-Hispanic)	28.4% (25.8–31.1)	28.6% (25.8–31.5)
	Multiple Race (Non- Hispanic)	31.6% (24.2–40.0)	38.8% (34.8–43.0)
Seriously considered attempting suicide	American Indian/Alaskan Native (Non-Hispanic)	N/A	20.9% (13.2–31.4)
	Asian (non-Hispanic)	N/A	17.7% (13.1–23.5)
	Black (non-Hispanic)	22.2% (14.1–33.1)	14.5% (12.3–17.1)
	Hispanic	23.8% (16.4–33.2)	18.8% (17.1–20.7)
	Native Hawaiian or Other Pacific Islander (non-Hispanic)	N/A	N/A
	White (non-Hispanic)	18.9% (17.1–20.8)	17.2% (15.4–19.2)
	Multiple Race (Non- Hispanic)	25.9% (17.5–36.6)	26.6% (21.0–33.0)
Made a plan	American Indian/Alaskan Native (Non-Hispanic)	N/A	17.4% (12.2–24.4)
	Asian (non-Hispanic)	N/A	13.8% (8.5–21.6)
	Black (non-Hispanic)	19.1% (14.6–24.6)	13.7% (10.8–17.2)
	Hispanic	20.9% (13.8–30.4)	15.7% (14.2–17.4)
	Native Hawaiian or Other Pacific Islander (non-Hispanic)	N/A	N/A

Appendix II.C (continued from previous page)

Measure	Race/Ethnicity	Indiana (95% CI)	U.S. (95% CI)
	White (non-Hispanic)	15.8% (14.2–17.6)	13.9% (12.1–15.9)
	Multiple Race (Non- Hispanic)	23.5% (15.4–34.3)	19.6% (15.8–24.1)
Attempted suicide	American Indian/Alaskan Native (Non-Hispanic)	N/A	15.0% (8.9–24.1)
	Asian (non-Hispanic)	N/A	7.8% (4.9–12.2)
	Black (non-Hispanic)	14.5% (8.8–23.1)	8.9% (6.7–11.9)
	Hispanic	15.5% (8.9–25.8)	11.3% (9.9–13.0)
	Native Hawaiian or Other Pacific Islande (non-Hispanic)	N/A	N/A
	White (non-Hispanic)	8.7% (6.5–11.5)	6.8% (5.5–8.4)
	Multiple Race (Non- Hispanic)	10.5% (5.7–18.4)	15.2% (11.5–19.8)
Attempt warranted care by doctor or nurse	American Indian/Alaskan Native (Non-Hispanic)	N/A	4.0% (1.7–9.0)
	Asian (non-Hispanic)	N/A	1.5% (0.6–3.6)
	Black (non-Hispanic)	9.2% (5.0–16.4)	3.8% (2.2–6.3)
	Hispanic	6.7% (2.0–20.5)	3.7% (2.7–5.1)
	Native Hawaiian or Other Pacific Islander (non-Hispanic)	N/A	N/A
	White (non-Hispanic)	2.8% (1.6–4.8)	2.1% (1.5–2.9)
	Multiple Race (Non- Hispanic)	5.3% (2.1–12.7)	2.8% (1.6–4.8)

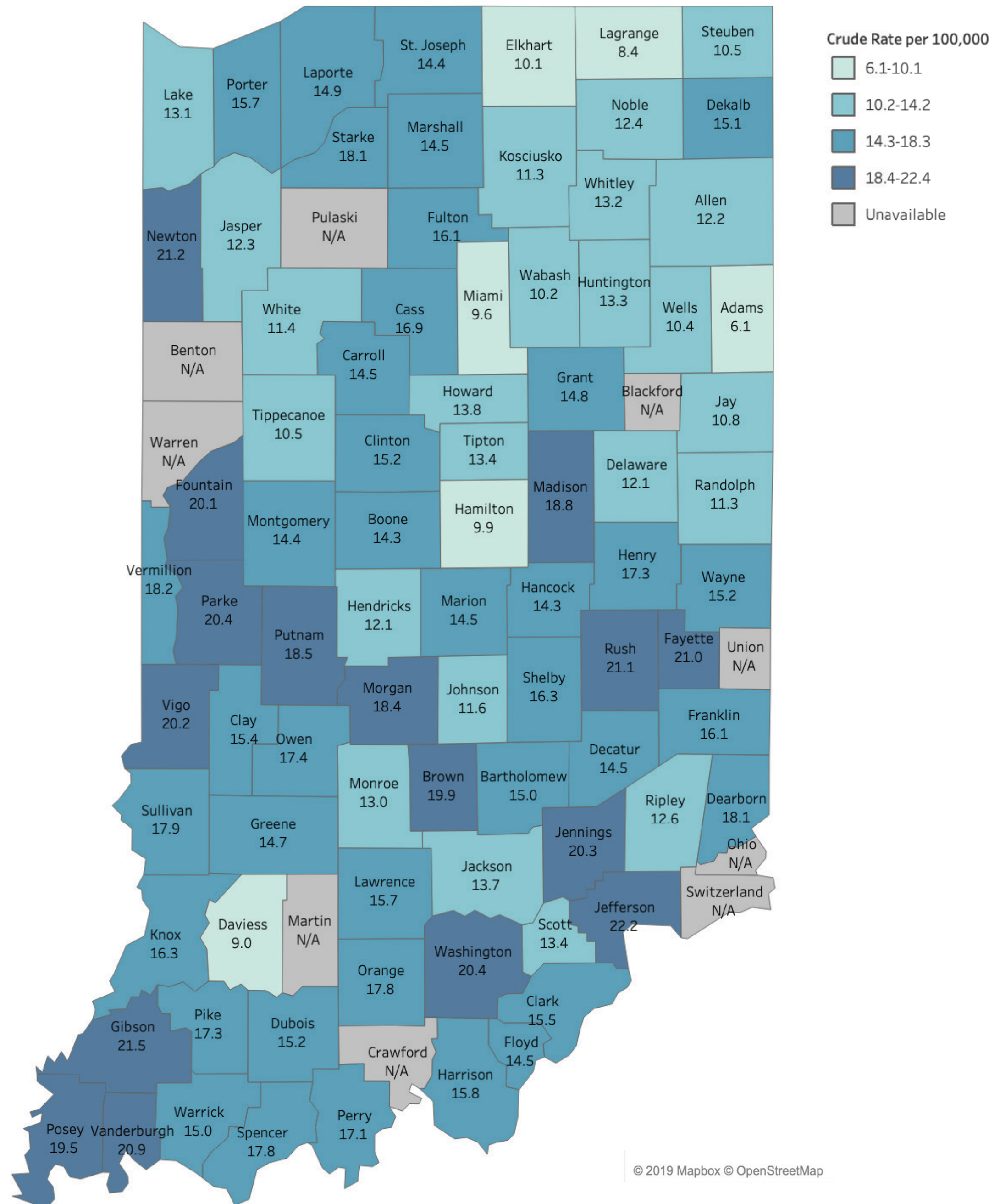
Source: Youth Risk Behavior Surveillance System, YRBSS, 2015

Appendix II.D: By Type of Sexual Contact

Measure	Sexual Contact With	Indiana (95% CI)	U.S. (95% CI)
Felt sad or hopeless	Opposite sex only	31.4% (27.1–36.0)	32.9% (30.9–35.0)
	Same sex only	41.4% (22.4–63.4)	48.7% (39.2–58.2)
	Both sexes	77.0% (67.2–84.5)	67.7% (61.8–73.0)
	No sexual contact	20.8% (17.7–24.2)	22.3% (20.4–24.3)
Seriously considered attempting suicide	Opposite sex only	21.7% (18.6–25.1)	19.7% (18.4–20.9)
	Same sex only	28.3% (17.1–43.2)	38.5% (29.2–48.8)
	Both sexes	63.5% (51.8–73.7)	46.6% (41.2–52.1)
	No sexual contact	11.3% (8.9–14.3)	12.0% (10.6–13.6)
Made a plan	Opposite sex only	18.4% (15.5–21.5)	15.6% (14.2–17.0)
	Same sex only	20.6% (10.1–37.4)	28.1% (19.4–38.9)
	Both sexes	59.6% (48.7–69.6)	43.6% (38.4–49.1)
	No sexual contact	10.0% (7.2–13.7)	10.1% (9.0–11.3)
Attempted suicide	Opposite sex only	11.0% (8.2–14.7)	9.7% (8.6–10.9)
	Same sex only	23.9% (12.6–40.6)	20.6% (12.9–31.3)
	Both sexes	37.1% (29.0–46.1)	29.9% (25.5–34.7)
	No sexual contact	4.4% (2.6–7.5)	4.2% (3.3–5.3)
Attempt warranted care by doctor or nurse	Opposite sex only	4.0% (2.5–6.4)	3.4% (2.6–4.3)
	Same sex only	17.0% (7.5–34.2)	8.5% (4.1–16.8)
	Both sexes	14.6% (8.2–24.7)	11.8% (8.9–15.5)
	No sexual contact	1.4% (0.5–3.9)	0.9% (0.6–1.4)

Source: Youth Risk Behavior Surveillance System, YRBSS, 2015

Appendix III. Average Annual Crude Suicide Mortality Rates per 100,000 in Indiana



Source: CDC WONDER, 2019

Note: Pooled averages from 2008-2017

Appendix IV. Veteran Suicide by Age Group in 2017

Age Group	Indiana Veteran Suicides (Rate per 100,000)	Midwestern Veteran Suicides (Rate per 100,000)	National Veteran Suicides (Rate per 100,000)
Total	115 (28.0)	1,284 (30.7)	6,139 (31.0)
18-34	13 (32.5)	189 (49.3)	864 (44.5)
35-54	36 (36.0)	359 (37.4)	1,708 (35.1)
55-74	43 (23.5)	477 (25.7)	2,319 (27.1)
75+	23 (26.1)	257 (26.0)	1,242 (27.9)

Source: U.S. Department of Veterans Affairs, Indiana Veteran Suicide Data Sheet, 2019

Appendix V. Key Informant Interview Questions

Dear [Name of Potential Key Informant],

The Center for Health Policy at the Indiana University Richard M. Fairbanks School of Public Health is conducting a study on suicide prevention in Indiana. As part of this project, we are interviewing experts in the field to help us get a deeper understanding of the problem; what interventions are necessary; and how the State of Indiana is addressing the situation.

We would greatly appreciate, if we could schedule a time for an interview. The interview will take about 30 to 45 minutes and include questions such as:

1. How much of a problem is suicide in Indiana?
2. Which groups are particularly vulnerable; i.e., are at a high risk of attempting suicide or dying by suicide?
3. Have you noticed any trends in suicide behaviors or outcomes in Indiana that are different from those in the nation?
4. What has been Indiana's response to the rising suicide rates?
   a. What has the state done well?
   b. What could be improved upon and how?
5. How can we reduce the stigma associated with suicide, and promote resilience in those at risk?
6. In a perfect world (if we had all the necessary resources available to us), what would the ideal prevention / intervention model look like?
7. Is there anything else we should have asked you, but didn't / anything you would like to add?

Participation in this study is completely voluntary and can be terminated at any point of time without negative consequences.

If you have any questions or concerns about this study, please contact me at [Contact Information]. We are looking forward to your response.

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