



**INDIANA STATE**

**SUICIDE**

**PREVENTION**

**PLAN**

***JOURNEY FROM  
HOPELESSNESS  
TO HEALTH***

# INDIANA STATE SUICIDE PREVENTION PLAN

Presented by the Indiana State Department of Health and  
the Indiana Family and Social Services Administration,  
Division of Mental Health and Addiction.

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*We would like to thank the courageous individuals who shared their heart-breaking stories with us. We commend their continued efforts in suicide prevention in Indiana. Our wish, like theirs, is a state working together to prevent the tragic loss of life by suicide.*



**For more information about suicide in Indiana, visit:**

[www.IN.gov/isdh/20627.htm](http://www.IN.gov/isdh/20627.htm) (youth mental health and suicide attempt)

[www.IN.gov/isdh/25194.htm](http://www.IN.gov/isdh/25194.htm) (adult mental health)

[www.IN.gov/isdh/reports/mortality/2009/table09/tbl09\\_00.htm](http://www.IN.gov/isdh/reports/mortality/2009/table09/tbl09_00.htm) (suicide among all ages)

# The Personal and Public Tragedy of Suicide in Indiana

## Burden of Suicide in the United States

The facts on suicide are staggering. More Americans die from suicide every year than from homicide. In 2009, nearly 37,000 suicides occurred, an average of one life lost every 14.2 minutes. In 2009, suicide was the 10<sup>th</sup> leading cause of death overall and 3<sup>rd</sup> for those ages 15–24 years. It is estimated that more than 900,000 Americans need emergency care annually due to a nonfatal suicide attempt. This translates to one attempt every 34 seconds and 25 attempts for every death by suicide.<sup>1</sup>

In 2009 in the U.S., one life was lost to suicide every 14.2 minutes.<sup>1</sup>

In addition to the emotional impact on families and friends, suicide also places an enormous financial burden on our society. The Centers for Disease Control and Prevention (CDC) estimated the cost to society of \$26.7 billion in combined medical and work loss costs in 2005.<sup>2</sup> For each suicide prevented, the United States could save an average of \$1,182,559 in medical expenses and lost productivity.<sup>3</sup>

## Burden of Suicide in Indiana

In 2009, 826 suicides occurred in Indiana, making suicide the 11<sup>th</sup> leading cause of death among Hoosiers. The majority of these deaths occurred among those ages 25–64 years (72%).<sup>4</sup>

826 Hoosiers died by suicide in 2009, making it the 11<sup>th</sup> leading cause of death.<sup>4</sup>

Suicide was the 2<sup>nd</sup> leading cause of death among those ages 15–34 years, the 3<sup>rd</sup> leading cause of death among those ages 10–14 years, and the 4<sup>th</sup> leading cause of death among those ages 35–54 years.<sup>4</sup>

In 2009, Hoosiers between the ages 25–34 had the highest rate of hospitalization (72.7 per 100,000) due to self-inflicted injury or suicide attempt, while those ages 15–24 years had the highest rate of emergency department visits (182.0 per 100,000).<sup>5</sup>

Suicide is a complex problem, resulting from one or more biological, psychological, environmental, social and/or cultural factors. Several factors can put a person at risk for suicide. But, having these risk factors does not always mean that suicide will occur.

### Known risk factors include:

- Previous suicide attempt(s)
- History of depression or other mental illness
- Alcohol or drug abuse
- Family history of suicide or violence
- Financial or relationship losses
- Lack of social support
- Barriers to care
- Physical illness
- Feeling alone

There are also factors that help protect people from suicide. Certain protective factors, such as problem-solving and conflict resolution skills, strong family and community connections, and access to effective clinical care for mental, physical and substance abuse disorders, can help counter these risks and challenges.

## Did you know that in Indiana: <sup>4,5</sup>

- More than 800 people a year die by suicide-- an average of 2 Hoosiers a day.
- Suicide is the 11<sup>th</sup> leading cause of death among Hoosiers of all ages; it is the 2<sup>nd</sup> leading cause of death among Hoosiers ages 15–34 years.
- More Hoosiers die by suicide than homicide.
- It is estimated that more than 4,000 Hoosiers will seek emergency care this year for injuries related to suicide attempt.

## Voices of Suicide Survivors

The designation of a “suicide survivor” refers to the family and friends who are directly affected and impacted by the suicide death of their loved one. This definition does not represent all the people affected by the suicide, such as those affected by a suicide death in a school, faith community or other community setting, but refers to those who were closest to the victim.<sup>1,6</sup> Survivors of suicide are themselves at an increased risk for suicide. Experts have estimated that each suicide intimately affects at least six other people.<sup>1</sup> Based on this estimate, there are about 5,000 new people affected by the tragedy of suicide in Indiana each year.<sup>4</sup>

## Suicide among Teenagers and Young Adults

Young people with mental health problems, such as anxiety, depression, bipolar disorder, or insomnia, are at higher risk for suicidal thoughts, as are teens experiencing major life changes, such as the divorce of parents, moving, or change in financial security. Victims of bullying are also more likely to think about suicide.<sup>7</sup> The Youth Risk Behavior Survey (YRBS) monitors health risks and behaviors among Indiana high school students. The results below from the 2011 YRBS show that nearly three out of ten high school students felt so depressed that they stopped doing their usual activities, and more than one out of ten actually attempted suicide.<sup>8</sup>

## Depression and Suicide among Indiana Students, Grades 9-12

During the past year:

**29%** felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing their usual activities.

**19%** seriously considered suicide.

**14%** made a plan about how they would attempt suicide.

**11%** actually attempted suicide.

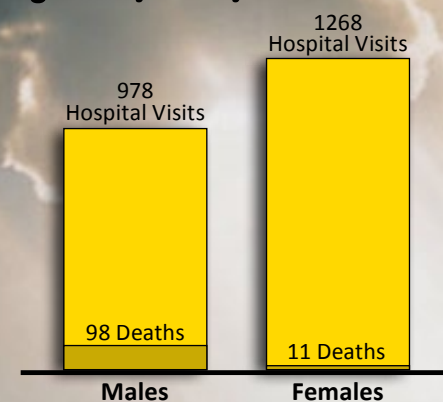
**4%** made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated medically.

**29:** the average annual number of suicide-related deaths among Indiana 14-18 year olds during 2004-2008.

Source: Indiana Youth Risk Behavior Survey, Indiana State Department of Health

## E.R. Visits/Hospitalizations and Deaths from Suicide Attempts

Ages 15-24, Indiana, 2009<sup>4,5</sup>



For teenagers and young adults ages 15–24 years, suicide is the 2<sup>nd</sup> leading cause of death.<sup>4</sup> But deaths from youth suicide are only part of the problem. For every suicide death, there are about 15 emergency department visits due to suicide attempts. Although girls are more likely to attempt suicide, boys are much more likely than girls to die by suicide.<sup>7</sup>

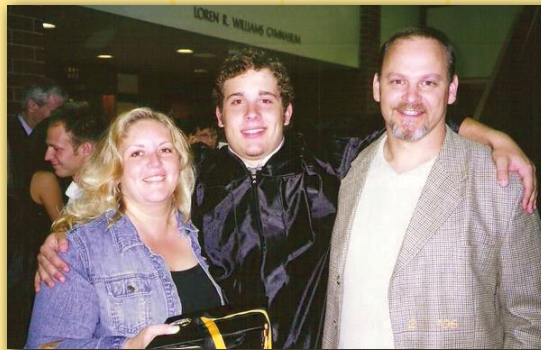
### In 2009:

- 109 Hoosiers ages 15–24 took their lives.<sup>4</sup>
- More than 1,600 Hoosiers ages 15–24 visited the emergency department due to self-inflicted injuries.<sup>5</sup>

## LOSS OF A SON

*“His heart, his laughter, comedy and smile are with me all the time...that precious young man that I am blessed to call SON.”* –Lisa B., Noblesville

“There is no way to accurately explain what it is like to have lost a loved one to a disease that so many do not recognize, understand, or care to acknowledge. There is no way to convey the hole in our hearts to individuals that cannot get past what shame it is because ‘we did not outlive our children.’ They are right we should not outlive our children, so let’s do something about it rather than just say what a shame it is. Let’s talk about the fact that my son was a handsome young man, strong in his love for children and animals, hilariously funny, and artistically creative, but suffered daily with a depressive disorder. Let’s talk about the stigma linked to anything labeled as a ‘mental illness’ and the reluctance to admit to anyone that such a problem might exist. Let’s talk about the never ending pain that will forever reside in a father that misses his son every day. The pain never goes away, we simply build up enough tolerance that we can mask it so we can continue to function...”



Lisa and Doug B. with son, Kurt

–Doug B., Noblesville

To view Kurt’s story visit:

<http://archive.constantcontact.com/fs063/1102603478461/archive/1106398954803.html>

## Child Maltreatment and Suicide

The long-term consequences of child maltreatment can be profound and may endure long after the abuse and neglect occurs. Effects can appear in childhood, adolescence, or adulthood, and experiencing one abusive event during childhood more than doubles the chance that a person will attempt suicide at some time.<sup>9,10</sup> As the amount of abuse increases, so does the likelihood of attempting suicide.<sup>10</sup>

### LOSS OF A MOTHER

*“I am so proud of being the first born of Nancy [C.]. My mom is the strongest person I have ever met. Her story could be a New York Times best seller. She will forever be my inspiration and hero.”* –Elisabeth C., Carmel

“The root of my mom’s struggles her entire life was her sexual abuse. It intertwined and infected itself in every angle imaginable. Depression, anxiety, and every other known mental health diagnoses in a college psychology textbook were the direct result of her abuse. My mom would want to let the world know to listen when children speak, be attentive and proactive when a child starts to act out, or behave differently, pay attention, open your eyes, and act on your gut and never stay silent. A child’s life depends on it.”



Nancy C.

– Elisabeth C., Carmel

To view Nancy’s story visit:

<http://archive.constantcontact.com/fs063/1102603478461/archive/1108037698739.html>

## Suicide in the Lesbian, Gay, Bisexual, and Transgender Population

More than nine out of ten people who kill themselves have a diagnosable and treatable mental illness, like depression. Mental illness is the greatest risk factor for suicide.<sup>11</sup> Rates of depression are higher in people who identify themselves as lesbian, gay, bisexual or transgender (LGBT). Researchers believe this is, at least partly, due to the social stigma, rejection, and bullying associated with having a minority sexual orientation. But suicide attempts in the LGBT population are not entirely explained by depression. People who identify themselves as LGBT are two to three times more likely to attempt suicide, even if they are not depressed.<sup>12</sup>

### LOSS OF A FRIEND

*“He was so depressed that the Jim I knew had vanished. The last picture taken of him was horrific. His eyes were dead. His sparkle was gone. I ... was devastated.” –Lisa D., Noblesville*

“Jim P., my then peer to turn boss and I were the best of friends the moment we met in 1999. We were inseparable and everyone thought we should be dating. Well, we were both gay so that wasn’t gonna happen! ...Driving down the 405 South in Los Angeles on July 17, 2007 my life took a change that I had never anticipated. I was told that my Jim had hanged himself on July 14, 2007 (just 2 days after my birthday and 2 days before his partners’ birthday).... I immediately went to OH MY GOD how could he do this to ME??? How DARE he do this to me! I was so upset that I called his cell phone number and vented, cried, vented, cried and pleaded with him to have not done this. While at work that day his partner Jamie called me after he heard my phone message. He told me that Jim had been deteriorating for a year. He had been hospitalized and they tried everything they could to save him. He was diagnosed with Bipolar and in one year, he lost his job, his house and his dignity.”



Jim P.

– Lisa D., Noblesville

To view Jim’s story visit:

<http://archive.constantcontact.com/fs063/1102603478461/archive/1109930688572.html>



## Suicide in the Older Adult Population

Depression is a true and treatable medical condition, and not a normal part of aging. However, older adults are at an increased risk for experiencing depression. Unfortunately, symptoms of depression are often overlooked and untreated when they occur with or as a result of other medical problems, such as stroke, heart disease or autoimmune diseases. They may also be ignored when they are a result of life events, such as death of a spouse, retirement, or loss of friends. In fact, the risk for suicide is increased for those who have lost a loved one, especially for older adult white males, who die from suicide more than any other age or ethnic group. Depression is a serious medical illness that should be treated at any age.<sup>13</sup>

### LOSS OF A FATHER

*“Dad had not been acting right these past few weeks, months, and if we thought hard enough, we would have realized he had not really smiled in years. He had slowly changed, but the problem was we did not know what we were seeing. We missed it.” –Britta N., Valparaiso*

“On December 10, 2005, suicide happened. It was a Saturday and I was getting ready for the holidays. In the hurry of the season, I had forgotten my cell phone. By the time I returned home, I discovered my mom had called several times but I was not available. When I finally returned her call, I could hear it in her voice. There was something terribly wrong. She proceeded to give me the news that she found my dad in the yard. He had taken his life.”



**Britta's father**

“Each of us handles grief differently. As a way of healing, I became more involved in suicide prevention and intervention efforts. I have learned about the warning signs and risk factors of suicide and now train others. It is my way of trying to make a difference, to reach out to others who encounter suicide, and hopefully save a life. I was not able to save my dad but it is my way of easing the pain. If I can help just one person, it also helps me!!!”

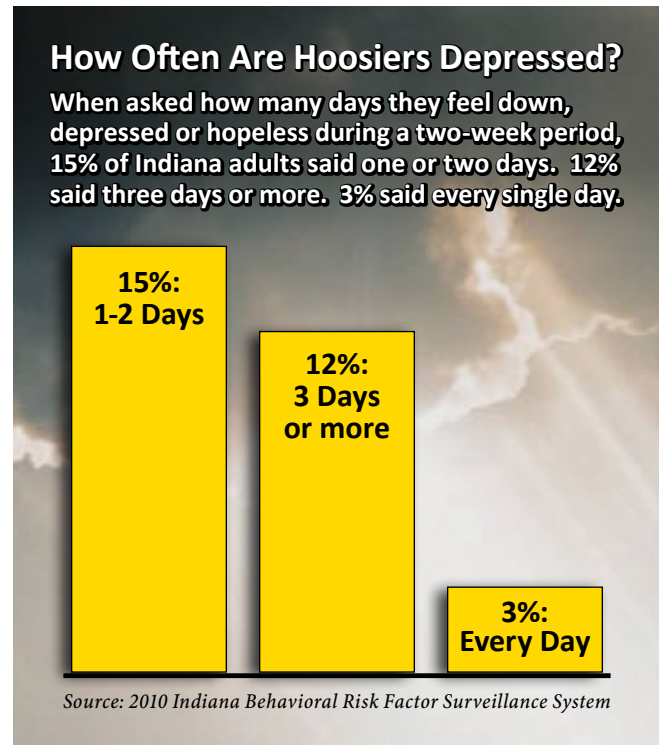
–Britta N., Valparaiso

To view Britta's father's story visit:

<http://archive.constantcontact.com/fs063/1102603478461/archive/1104017901994.html>

# The Behavioral Risk Factor Surveillance System

The **Behavioral Risk Factor Surveillance System (BRFSS)** is the world's largest on-going telephone health survey system, tracking health conditions and risk behaviors among U.S. adults. Results from the 2010 Indiana BRFSS Anxiety and Depression Module indicated that nearly 1.7 million adults reported poor mental health; meaning they identified themselves as having stress, depression, and problems with emotions for at least one day during the past 30 days.<sup>14</sup>



## Suicide in Ethnic and Racial Minority Groups

Suicide rates in the African American population have more than doubled over the past 20 years, with most of the deaths occurring among the young black male population.<sup>14</sup> Despite this increase, the topic of suicide is considered “taboo.” Most African Americans do not consider depression a mental illness, but see it as a character flaw or sign of weakness.<sup>15</sup>

Suicide rates are also increasing among Asian Americans and Pacific Islanders.<sup>15</sup> Asian American and Pacific Islander high school students are just as likely to attempt suicide as their classmates, and elderly Asian American and Pacific Islander women are much more likely to kill themselves than white or black elderly women.<sup>17</sup> Asian Americans and Pacific Islanders are unlikely to talk about their mental health problems to friends or medical care providers. Like African Americans, many view emotional problems as shameful and upsetting.

Hispanics of all ages are less likely to die from suicide than non-Hispanics, although Hispanic high school students report feeling depressed more often than their non-Hispanic classmates. The strength of family relationships may be a protective factor in Hispanic communities.<sup>18</sup>

Mental illness and suicide among refugee populations, such as the Burmese population in Indiana, are issues of growing concern. Many refugees suffer from post-traumatic stress disorder and depression, but cultural stigma prevents them from seeking out mental health services. Mental health care providers may lack understanding of cultural barriers and may not have translators available to help them care for refugees who do seek help.<sup>19</sup>

## SURVIVAL OF A SUICIDE ATTEMPT

*“No one is ‘exempt’ from experiencing the act of suicide. Depression has no name, color, shape, size, or religious belief attached to it; it can be anyone who has reached a breaking point in their lives.” -Clarissa T., Gary*

“In the midst of everything else, I had so many things that nagged and picked at my mind but I held so much in because I was the person that other people would come to be uplifted and to release smiles of joy into their lives, but it seemed like no one was there for me when I needed to be listened to and encouraged. The funny thing is that people act shocked and surprised when they see a ‘so-called’ strong person crying, when the truth is, **EVEN THE STRONG CAN BECOME WEAK AND NEED TO BE UPLIFTED!** I made my way to the medicine cabinet and I swallowed an overdose of pills that could have stopped my heart because I wanted to be numb to the negative side of life and all of the lacks, setbacks, and attacks!”



Clarissa T.

“Since then, I have lost much but I have also gained a whole lot as well. I went on to write a book that poetically speaks about my journey in the form of biographical poems, take part in what I love to do, (speak) to a crowd of people about my testimony, and live my dreams of being an Entrepreneur.”

-Clarissa T., Gary

To view Clarissa's story visit:

<http://archive.constantcontact.com/fs063/1102603478461/archive/1109011653586.html>

## Suicide in the Military

Military life, including the stress of deployments or mobilizations, traumatic brain injury, and post-traumatic stress disorder resulting from service, can present challenges to military members and their families that are both unique and difficult. The stigma associated with mental distress and the fear of appearing weak are thought to keep many military members from seeking help. Recent reports for 2012 indicate there is an average of one suicide a day among American troops, the fastest upswing in suicide deaths in the past decade of war. According to the Pentagon, from January to early June 2012, the 154 suicides among active-duty troops in the first 155 days of the year is an 18 percent increase from the same period in 2011.<sup>20</sup> And the higher rates of suicide remain even in the veteran population. Military veterans are twice as likely to die from suicide as people who have never served in the military.<sup>21</sup>

### LOSS OF A SOLDIER

*“Chancellor’s death was both senseless and preventable. We are determined to wrest purpose and meaning from our profound tragedy by bringing the issue of military suicide and all suicides to the forefront of national attention.”* –Gregg K., Indianapolis

“There was great shock among his commander and immediate superiors to learn that he was under suicide watch in 2007. No one knew, and the only way they could have known was if Chance told them.”

“General Casey wrote in late 2009 that it was Chance’s responsibility to tell his new unit of any mental health problems. We believe that is an especially tough burden to place on soldiers. Chance told us it was impossible to do that because he would not be believed and that it would appear as just trying to get out of being deployed. We encouraged him to talk with the Chaplain, but I believe that is very hard to do too, as it shows weakness and above all else, our son wanted to be strong!”



Chancellor K. and father, Gregg

–Gregg K., Indianapolis

To view Chancellor’s story visit:

<http://archive.constantcontact.com/fs063/1102603478461/archive/1103584066831.html>

## State of Suicide Survey

In early 2010, the Indiana Division of Mental Health and Addiction (DMHA), in conjunction with the Indiana State Department of Health (ISDH) collected data using 1) An electronic survey of providers and key stakeholders; 2) A review of current ISDH statistics regarding suicide; 3) A key stakeholder summit; and, 4) Additional research, to create a snapshot of current prevention, intervention, and postvention services in place within the state.

Analysis of this data identified several barriers to effective suicide prevention programming. The data confirmed that the areas of central and northwest Indiana with the largest cities in the state also had the highest concentration of services. Counties with the highest incidence of suicide were in areas of the state with shortages of health care provider that lacked suicide prevention activities. It was suggested that increased collaboration between the prevention, intervention and postvention programs that existed would increase the overall ability to meet the needs of Indiana's citizens.

Another barrier to effective suicide prevention programming identified was the stigma associated with mental health issues and suicide. The participants emphasized the importance of including all demographic, ethnic, and ability groups in evidence-based suicide-related efforts. Additional training needs were identified for key partners in suicide prevention and intervention efforts within medical, school, and criminal justice settings. Gaps in data were also identified which prevented effective identification and intervention for some at-risk individuals. Finally, insufficient funding for prevention efforts continues to be a challenge state-wide.

To respond to these barriers and challenges, the DMHA and the ISDH have convened mental health and public health providers and leaders from throughout the state to participate on the Indiana State Suicide Prevention Advisory Group. These leaders are the primary architects of the Indiana State Suicide Prevention Plan. They will continue to meet to assess the burden of suicide in Indiana and recommend effective strategies to optimize access to suicide prevention, intervention, and postvention services, for a safer and healthier Indiana.

### Note from a Suicide Survivor

*“Even if we had made the connection between suicide and depression, we most likely would not have had enough information to get beyond the ‘that would never happen to us’ syndrome.”*

*-Lisa*

# Indiana Suicide Prevention Action Areas

Preventing suicide is everyone's responsibility. With that premise in mind, the Indiana Suicide Prevention Plan is a tool you can use to help make your community healthier. The plan is organized into five suicide prevention action areas: Awareness, Prevention, Intervention, Postvention, and Evaluation. Each action area identifies goals and suggested activities for individuals, the state, and community groups in an effort to move the action area forward. Informed action saves lives. This document with accompanying resources is a map leading Indiana toward the ultimate goal of no loss of life due to suicide.

## I. AWARENESS

### Goals

1. Increase the knowledge base among Indiana's citizens regarding suicide risk and prevention.
2. Support factors that enhance personal wellness and reduce barriers to help-seeking behaviors.
3. Eradicate the stigma associated with suicide.
4. Enhance individual and public safety by reducing access to means of harm.
5. Support Indiana communities in the development of protective factors and resiliency across the entire life span.

### Rationale

When communities understand that suicide and suicidal behavior can be prevented and lives saved, they are more willing to learn how to prevent suicide. By increasing understanding and knowledge through varied educational efforts that replace myths with facts, communities can take specific actions that will make a difference. Specific actions can include but are not limited to, the implementation of prevention, intervention and postvention evidence based programs. Just as there are many factors that contribute to suicide, so there are many approaches to preventing suicide: mental, emotional, biological, social, cultural, spiritual. With broad-based support, all groups (schools, health care providers, faith-based organizations, youth groups, senior citizens centers, veterans' hospitals, etc.) will recognize the roles they can play and the ways in which they can collaborate. This can lead to additional public and private funding for prevention and treatment programs and for research and evaluation.

There are numerous research links between suicide, mental illness and substance use/abuse. Appropriate and effective treatments (therapies and/or medication) often result in lessening the impact of disorders in the patient's daily life. However, the stigma of shame, guilt and/or fear of discrimination prevents some people from seeking treatment which leads to the disorder becoming worse. Misinformation and stigma can be reduced through comprehensive public information and education campaigns

Resilience is the natural ability to "bounce-back" from hardships and become stronger. Resilient people understand that life is full of challenges, joys, losses, disappointments, and unexpected events. They learn from their mistakes, get support from others, and keep a broader perspective. This makes them less likely to succumb to the feelings of hopelessness and helplessness associated with suicidal behavior. Building resiliency is vital to creating opportunities for people to succeed through exercising judgment, discretion and imagination. Resilience is reinforced and sustained when people feel connected to each other and their community and feel that their life has meaning.

## **Call to Action**

### **Everyone**

1. Advocate for bullying prevention.
2. Uphold, honor and respect cultural traditions and diversity.

### **State of Indiana**

1. Provide data reports to the public and legislature, upon request.
2. Make suicide prevention information available in a wide variety of settings.

### **Individuals & Communities**

1. Support community efforts to provide adequate health care, positive educational outcomes, and efficient communication systems.
2. Where appropriate, honor and celebrate those who are successfully moving forward in recovery.
3. Utilize Web resources and social networks (Facebook, Twitter) to promote suicide awareness.
4. Create environments in schools, faith communities, and other structured settings, where people feel welcome and accepted.

### **Schools**

1. Make awareness training available in schools, for teachers and staff.
2. Provide support groups and peer mentors.
3. Make mental health education with age appropriate suicide prevention a component of health education starting in elementary school.
4. Make suicide prevention information available in a wide variety of settings.

### **Community Partnerships & Task Forces**

1. Collaborate with mental health and substance abuse agencies to implement public information campaigns that present mental health and substance abuse treatment as part of basic health care.
2. Develop a speaker's bureau on mental health, substance abuse and suicide prevention and include consumers of treatment services, as well as treatment providers and researchers.
3. Develop public service announcements that feature those who have recovered from mental illness, substance abuse or suicidality after treatment.
4. Provide information to the media that educates about safe, responsible reporting and portrayal of suicide, mental illness and substance abuse.
5. Provide support groups and peer mentors.
6. Work with injury prevention practitioners to develop appropriate materials to educate community members on the prevention of substance abuse and access to means of harm.
7. Hold ongoing clergy/clinician forums for mutual education and to promote closer working relationships.
8. Make suicide prevention information available in a wide variety of settings.

## Employers

1. Make suicide prevention information available in a wide variety of settings.
2. Support employee participation in suicide awareness, training, and community action events.
3. Sponsor suicide prevention training activities in your workplace.

## Health Care Providers

1. Provide information to the media about safe, responsible reporting and portrayal of suicide, mental illness and substance abuse.
2. Work with injury prevention practitioners to develop appropriate materials to educate community members on the prevention of substance abuse and access to means of harm.
3. Support the integration of mental health and addiction treatment with primary care.
4. Make suicide prevention information available in a wide variety of settings.

## Markers of Success

- Hoosiers, including those in high-risk groups, will know basic information about suicide, depression, warning signs, how to offer help, and where to go for help.
- More community members, treatment providers, and consumers will view mental disorders as illnesses that respond to specific treatment as well as see mental health as equal in importance to physical health in overall well-being.
- Hoosiers will be able to recognize and respond to suicide risk and access appropriate services as a result of the outreach efforts, education, and awareness campaigns.
- Hoosiers will embrace a culture which decreases the stigma of mental illness and encourages people to seek help.

## Note from a Suicide Survivor

*“I had a chance to think long and hard that the person who commits suicide may end their suffering, but the horrible pain they put their family through never ends.”*

*-Heather*

## II. PREVENTION

### Goals

1. Identify warning signs of suicide and respond proactively to suicide risk.
2. Recognize risk factors and vulnerabilities increasing an individual’s risk for suicide.
3. Understand community resources available to support individual wellness.
4. Assess and strengthen community capacity to meet the needs of those identified at high risk for suicide.



## **Rationale**

Many people are unprepared and lack confidence in recognizing and responding to suicide risk. Many professionals are unprepared to recognize and respond to suicide risk and lack the resources and training to prevent it. Communities need to be organized, have the necessary resources, and have effective mental health systems in order to be successful at preventing suicide. Many organizations are not adequately prepared and are not aware of key resources they could use to help prevent suicide among those at risk.

## **Call to Action**

### **Everyone**

1. Share suicide prevention resources via a website or social media and include a link to this state plan, specifically the resource section.
2. Create a supportive, inclusive community which decreases the stigma of suicide and encourages help-seeking behaviors.

### **State of Indiana**

1. Provide resources and support to communities for preventing suicide.
2. Present at professional conferences on suicide related topics.
3. Inventory existing suicide prevention organizations in the state.
4. Encourage and support the development of community partnerships and task forces for suicide prevention in areas where none exist.
5. Assess the impact of suicide prevention activities in the state.

### **Individuals & Communities**

1. Encourage and support the development of community partnerships and task forces for suicide prevention in areas where none exist.

### **Schools**

1. Work to incorporate evidence-based training on the recognition and response to suicide risk.
2. Update policies and protocols to ensure your organization is equipped to recognize and respond to suicide risk and suicidal behaviors.

### **Community Partnerships & Task Forces**

1. Provide resources and support to communities for preventing suicide.
2. Encourage professional training/graduate programs to include suicide prevention, intervention, and postvention training in their curricula as well as certification and/or licensure.
3. Present at professional conferences on suicide related topics.
4. Provide evidence-based training on the recognition of and response to suicide risk.
5. Hold open forums to address questions about stigma and myths pertaining to individuals who show signs of depression and suicidal ideation.
6. Train clergy to effectively refer individuals who are reluctant to seek professional mental health services for cultural or spiritual reasons.

## Employers

1. Work with appropriate community and state partners to provide evidence-based training on the recognition of and response to suicide risk.
2. Encourage and support the development of community partnerships and task forces for suicide prevention in areas where none exist.
3. Update policies and protocols in order to ensure your organization is equipped to recognize and can appropriately respond to suicide risk and suicidal behaviors.

## Health Care Providers

1. Present at professional conferences on suicide related topics.
2. Encourage professional training/graduate programs to include suicide prevention, intervention, and postvention training in their curricula as well as certification and/or licensure.
3. Work with appropriate partners to incorporate evidence-based training on the recognition of and response to suicide risk.
4. Hold open forums to address questions about stigma and myths pertaining to individuals who show signs of depression and suicidal ideation.
5. Encourage and support the development of community partnerships and task forces for suicide prevention in areas where none exist.
6. Update policies and protocols in order to ensure your organization is equipped to recognize and can appropriately respond to suicide risk and suicidal behaviors.

## Markers of Success

- More organizations will include suicide prevention training in their programs.
- More communities will be actively involved in suicide prevention activities.
- More communities will actively consider and implement ways to reduce access to lethal means of self-harm within their community.
- All professional staff will have received evidence-based professional development ensuring that they are able to recognize and effectively respond to suicide risk and suicidal behaviors
- Individuals affiliated with at-risk populations will receive training to recognize suicide warning signs and seek appropriate help.
- Communities will promote protective factors such as resiliency, communication skills, mental wellness, connectedness, and positive self-esteem.

## Note from a Suicide Survivor

*“We do not forget or try and hide our circumstance. Our focus is to raise awareness and help others so they do not have to live with the torment of waking up every morning and remembering their loved one is no longer with them.”*

*-Tammy*

## III. INTERVENTION

### Goals

1. Improve access to behavioral health programs to promote mental health and prevent substance abuse and relevant social services.
2. Promote the use of appropriate evidence-based practice guidelines.
3. Identify an appropriate ongoing continuum of supportive services for suicidal individuals from identification through treatment.
4. Employ culturally sensitive and trauma-informed practices that maintain individual autonomy and respect.

### Rationale

The State of Indiana Division of Mental Health and Addiction supports the recovery model of care fostering the integrated assessment and treatment for mental health, addiction, and physical health. Enhanced accessibility to mental health and substance abuse providers will translate to enhanced assessment for suicide risk. Indiana currently lacks a statewide system of crisis phone lines offering in-state resources for caller referral. This limits Indiana citizens' access to immediate support. Increasing the number of communities with Crisis Intervention Teams will assure skilled and thoughtful police intervention at times of psychological crisis. Training for those who may be the first responder to someone in crisis is an essential element in the creation of a safe and caring community.

The need for culturally competent, effective and evidence-based intervention programs (separately and incorporated into other mental health and/or substance abuse assessments) becomes critical as the population in Indiana becomes more diverse.

Suicide is not a disease. Rather it is a tragic ending, the result of a complex and varied mixture of biology, illness, feelings, thoughts, beliefs, behaviors, relationships, cultural history, community attitudes, and life events. Comprehensive treatment helps a suicidal individual address all of these areas. It provides support along the entire journey from hopelessness to health.

### Note from a Suicide Survivor

*“Why or how did I (his best friend) not see any signs of depression or anxiety? What did I do wrong? Was it my fault? It has been 3 years since [his] death - I still find myself asking these questions...”*

*-Amy*

## **Call to Action**

### **Everyone**

1. Adopt evidence-based programs.
2. Be aware of Lifeline services and promote Lifeline in your communities.

### **State of Indiana**

1. Support the integration of mental health services into primary health care.
2. Support the expansion of Lifeline services providers in the state.

### **Individuals & Communities**

1. Support the expansion of Lifeline services providers in your community.
2. Attend trainings in your community to learn how to identify someone who is suicidal and how to intervene effectively.

### **Schools**

1. Obtain buy-in from school administrators, mental health professionals, school personnel, families and others to increase receptiveness to school-based suicide prevention programs and screenings.
2. Ensure that staff are trained to recognize risk factors, warning signs and symptoms of suicide and intervene effectively.
3. Provide onsite student assistance services.
4. Provide referrals to community mental health services.
5. Work with families and peers of suicidal students to develop a protective school environment.

### **Community Partnerships & Task Forces**

1. Support the expansion of Lifeline services providers in your community.

### **Employers**

1. Support the expansion of Lifeline services providers in your community.
2. Ensure employees are aware of parity for mental health in health insurance coverage.

### **Health Care Providers**

1. Train staff to recognize risk factors, warning signs and symptoms of suicide and to intervene effectively.
2. Integrate ongoing mental health services and primary care services in your clinic setting.
3. Link patients without insurance to community mental health services providers.
4. Work with families of suicidal individuals to ensure access to services.

## Markers of Success

- Increased numbers of suicide prevention programs and trainings will be offered in underserved areas.
- More primary care providers, community health aides, emergency room staff and public safety officers will routinely ask about the presence of lethal means of self-harm including firearms, drugs and poisons in the home, and will provide education about actions to reduce associated risks.
- More Hoosiers will seek and access professional help for depression, substance abuse, and suicidal ideation.
- More Hoosiers will have access to culturally relevant and age-appropriate resources.

## IV. POSTVENTION

### Goals

1. Report suicide attempts and deaths responsibly in order to educate the public about risk factors and prevent additional suicide deaths in the community.
2. Provide appropriate support mechanisms to communities affected by suicide.
3. Increase awareness of available services for suicide survivors.

### Rationale

Suicide needs to be seen as a major public health issue in all Indiana communities. For too many years, communities hid the fact that suicides occurred. All segments of the community need to be aware of these issues. Communities can learn how to respond to a suicide in ways that reduce the risk for other suicides and help promote healing. Communities can learn how to embrace someone who has attempted suicide and welcome them back into the community. Treatment centers can help those who have attempted suicide understand how to talk with family and friends about the attempt and the treatment. Recovery programs and local suicide prevention organizations/community partnerships can provide needed information and training in how to respond to a suicide and how to help a suicide attempter.

### Call to Action

#### Everyone

1. Be aware of recommendations for responsible media reporting of suicide deaths.

#### State of Indiana

1. List available postvention resources on the state suicide prevention website.
2. Make training available to media on the responsible reporting of suicide deaths.
3. Strengthen partnerships with community organizations focused on postvention activities.

#### Individuals & Communities

1. Develop a crisis response plan for postvention.

2. Implement the crisis response plan when a suicide occurs.
3. Encourage those affected by suicide to help with and support peer groups in the community.
4. Assure responsible media reporting of suicide events.
5. Attend training to learn safe, responsible ways to help survivors go through the grieving process, come to terms with the loss and heal.

### **Schools**

1. Develop a crisis response plan for postvention.
2. Implement the crisis response plan when a suicide occurs.
3. Encourage youth survivors to help with and promote peer groups in schools.
4. Encourage postvention training to learn how to address the trauma issues associated with suicide.

### **Community Partnerships & Task Forces**

1. Sponsor and train counselors and professionals in postvention to address the trauma issues associated with suicide.
2. Distribute protocols and other information addressing a suicide survivor's needs immediately following a suicide.

### **Employers**

1. Identify community resources to help employees who are survivors of suicide.
2. Identify community resources to support a colleague who has experienced a suicide.

### **Health Care Providers**

1. Attend postvention training to learn how to address the trauma issues associated with suicide.
2. Link survivors of suicide to appropriate professional and community resources, including support groups.

## **Note from a Suicide Survivor**

*“I believe the future is ours and we can make it a better place for those suffering from depression and other mental disorders if we bring suicide out of the darkness and into the light.”*

*-Lisa*

## **Markers of Success**

- Communities and media will respond to and report suicides responsibly.
- Communities will encourage the development of mental health/suicide survivor support and peer groups.

## V. EVALUATION

### Goal

1. Use research and program evaluation to guide suicide awareness, prevention, intervention and postvention activities to ultimately reduce the suicide rate to zero.

### Rationale

Research and evaluation tell us what programs are most effective. It can be risky to recommend and implement programs that are not evidence-based. These programs may be ineffective, consuming scarce resources on activities that do not benefit the population. At worst, programs without evidence to support their effectiveness may actually have unintended consequences, such as increasing suicide rates in the population. Suicide prevention resources are scarce, so it is important to use them where they will have the largest impact.

### Call to Action

#### Everyone

1. Expect suicide prevention, intervention, and postvention activities in your communities to be based on evidence and effectiveness.

#### State of Indiana

1. Create the expectation that programs are based on evidence and effectiveness.
2. Require that evaluation be incorporated into all program activities.
3. Maintain a state registry of evidence-based programs.
4. Review program evaluations for effectiveness.

#### Individuals & Communities

1. Incorporate evaluation into all program activities.
2. Review program evaluations for effectiveness.
3. Review media coverage of suicide deaths for responsible content and follow-up with media when appropriate.

#### Schools

1. Incorporate evaluation into all program activities.
2. Review program evaluations for effectiveness.

## Note from a Suicide Survivor

*“I believe with all my heart that depression is why my son took his life, not because he was good or bad, but simply because he had a illness; an illness that took his life.”*

*-Doris*

3. Review school coverage of suicide deaths for responsible content and follow-up with media when appropriate.
4. Conduct after-action assessments to evaluate response to suicide deaths.

### **Community Partnerships & Task Forces**

1. Make training available to suicide prevention partners and organizations about how to build evaluation into all program activities.
2. Incorporate evaluation into all program activities.
3. Review program evaluations for effectiveness.
4. Review media coverage of suicide deaths for responsible content and follow-up with media when appropriate.

### **Employers**

1. Create the expectation that programs are based on evidence and effectiveness.
2. Require that evaluation be incorporated into all program activities.
3. Review employer coverage of suicide deaths for responsible content and follow-up with media when appropriate.
4. Conduct an after-action assessment to evaluate response to suicide deaths.

### **Health Care Providers**

1. Regularly review best-practices registries to ensure your interventions are current and evidence-based.
2. Evaluate staff training needs at least annually.
3. Regularly evaluate your referral and follow-up procedures for timeliness and effectiveness.

### **Markers of Success**

- Suicide prevention, intervention, treatment, and research programs will reduce the number of suicides and suicide attempts.
- Policies and protocols will be reviewed and updated, and will be guided by best practices in suicide prevention.



# Legislation

## Teacher training

### **Indiana House Bill 1019 & Indiana Senate Bill 4**

Synopsis: Training for child suicide prevention. Requires the division of mental health and addiction to consider evidence based programs and develop programs for teacher training on the prevention of child suicide and the recognition of signs that a student may be considering suicide. Allows a governing body to adjourn its schools to allow teachers to participate in a basic or in-service course of education and training on suicide prevention and the recognition of signs that a student may be considering suicide. Provides that after June 30, 2013, an individual may not receive an initial teaching license unless the individual has completed training on suicide prevention and the recognition of signs that a student may be considering suicide. (The introduced version of this bill was prepared by the Commission on Mental Health.)

Effective: July 1, 2011.

## Bully Legislation

### **Law Enforcement, School Policing, and Youth Work Group**

**§5-2-6.9-10 Duties of work group:** The Law Enforcement, School Policing, and Youth Work Group must, among other duties, make recommendations regarding the review of school safety policies and study the use of zero tolerance policies and their impact on youth involvement in the juvenile justice system. Recommendations may include training concerning law enforcement interaction with youth in schools, relationship building, cultural competency, and alternative to referral, arrest, and detention, among others. The work group expires 6/30/15.

### **Indiana Safe Schools Fund**

**§5-2-10.1 Purpose-Source of money-Grants:** Establishes the Indiana Safe Schools Fund to promote school safety, combat truancy, provide matching grants for safe haven programs, provide grants for school safety and safety plans, and to provide educational outreach and training to school personnel in identifying, preventing, and intervening in bullying.

**§5-2-10.1-9 School safety specialists-Duties:** Each school must designate an individual to serve as a school safety specialist who will serve on the county school safety commission, participate in school safety training, develop and coordinate school safety plans, and act as a resource on issues related to school discipline, safety, and security.

**§5-2-10.1-10 County school safety commissions-Membership-Duties:** A county may establish a school safety commission; specifies the members of that commission. The commission, if established, must perform a cumulative analysis of school safety needs within the county and make recommendations regarding the prevention of juvenile offenses, improving the reporting of those offenses, identifying and assessing children at high risk of becoming offenders, and meeting the educational needs of children who have been detained as juvenile offenders, among others. The commission must also assist school safety specialists in developing and requesting grants for safety plans and assist schools in carrying out those plans.

**§5-2-10.1-11 School safety specialist training and certification program:** Establishes school safety specialist training and certification program, which provides annual training sessions, best practice and resource information. The department of education must assemble an advisory group of school safety specialists to recommend training curriculum and standards, and must develop an appropriate curriculum/standards for training that include training in identifying, preventing, and intervening in bullying.

**§5-2-10.1-12 Safe school committees to be established:** Each school must establish a safe school committee, and the department of education must provide materials to assist that committee in developing a plan for the school that addresses unsafe conditions, crime prevention, school violence, bullying, and other issues that prevent the maintenance of a safe school. Encourages community and student involvement, the development of relationships between students and school personnel, and use of problem solving teams.

### Department of Education

**§20-19-3-4 Duties:** The Department of Education must, among other duties, categorize suspensions and expulsions by cause, including those due to destruction of property, fighting, battery, intimidation, verbal aggression or profanity, and defiance, among others.

**§20-19-3-10 Model dating violence educational materials and model dating violence response policies and reporting:** The Department of Education must collaborate with organizations that have expertise in dating violence, domestic violence, and sexual abuse to identify or develop model dating violence educational materials and a model for dating violence response policies and reporting. These policies must be made available to schools by 7/1/11.

## Note from a Suicide Survivor

*“[My son] didn’t want to seek counseling or take medication for his depression, because people ‘would think he was crazy.’ No matter how hard I tried to convince [him] this was not the case, he did not believe me.”*

*-Jessica*

### Internet Safety

**§20-30-5.5-3 Guidelines and rules must cover certain subjects:** Guidelines and rules adopted under section 2[IC 20-30-5.5-2] of the Internet Safety chapter must cover safe online communication, privacy protection, cyberbullying, viewing inappropriate material, file sharing, the importance of open communication with responsible adults. Bullying through the use of computer software that is accessed through a school computer, computer system, or computer network is prohibited.

### Student Discipline

**§20-33-8-0.2 “Bullying” defined:** Defines bullying as overt, repeated acts or gestures, including verbal or written communications transmitted, physical acts committed, or any other behaviors committed by a student/group of students against another student with the intent to harass, ridicule, humiliate, intimidate, or harm the other student.

**§20-33-8-8 Responsibilities of school corporation and students-Rights of school corporation personnel:** Among other responsibilities, school personnel “have the right to take any disciplinary action necessary to promote student conduct that conforms with an orderly and effective education system,” and are immune with respect to a disciplinary action taken to promote student conduct if taken in good faith and reasonable. Students must follow responsible directions of school personnel and refrain from behavior that disrupts the educational environment.

**§20-33-8-12 Discipline rules required-Publicity requirement-Regulations-Delegation:** School governing bodies must establish written discipline rules, including a graduated system of discipline, and publicize those rules within a school where the rules apply.

**§20-33-8-13.5 Disciplinary rule requirements-Section does not give rise to cause of action:** Requires discipline rules to prohibit bullying, including bullying through the use of data or computer software that is accessed through a computer, computer system, or computer network of a school corporation, and include provisions concerning education, parental involvement, reporting, investigation, and intervention. These rules apply when a student is on school grounds immediately before or during school hours, immediately after school hours, or at any other time when the school is being used by a school group; off school grounds at a school activity, function, or event; traveling to or from school or a school activity, function, or event; or using property or equipment provided by the school. This section may not be construed to give rise to a cause of action against a person or school based on an allegation of noncompliance with this section. Noncompliance may not be used as evidence against a school in a cause of action.

## Reporting Requirements

**§20-3-9-1.5 “Harassment” defined:** defines harassment as (under §35-45-2-2) the intent to harass, annoy, or alarm another person by, with no intent of legitimate communication, making a telephone call, communicating in written form, transmitting an obscene message or indecent or profane words on a radio channel, or using a computer network or other form of electronic communication to communicate or transmit an obscene message or indecent or profane words. Harassment is a Class B misdemeanor.

**§20-33-9-2 “Intimidation” defined:** defines intimidation as (under §35-45-2-1) communicating a threat to another person with the intent that the other person engage in conduct against their will, that the other person be placed in fear of retaliation, or with the intent to cause the evacuation of a building or vehicle. Intimidation is a Class A misdemeanor, unless the threat is communicated to a school employee or made using electronic equipment of a school, then which it becomes a Class D felony.

## Note from a Suicide Survivor

*“My attempt will always be a part of who I am; I will always have scars on my body from the cutting. However it’s a reminder. It’s a reminder of where I was before and where I am now.”*

*-Ashley*

**§20-33-9-4 “Threat” defined:** defined within the section on intimidation; defines “threat” as “an expression, by words or action, with the intent to (1) unlawfully injure the person threatened or another person, or damage property; (2) unlawfully subject a person to physical confinement or restraint; (3) commit a crime; (4) unlawfully withhold official action, or cause such withholding; (5) unlawfully withhold testimony or information with the respect to another person’s legal claim or defense, except for a reasonable claim for witness fees or expenses; (6) expose the person threatened to hatred, contempt, disgrace, or ridicule; (7) falsely harm the credit or business reputation of the person threatened; or (8) cause the evacuation of a dwelling, a building, another structure or a vehicle.”

**§20-33-9-10 Duty to report threat or intimidation:** An individual who has reason to believe that a school employee has received a threat or is the victim of intimidation, battery, or harassment must report that information as required.

**§20-33-9-11 Reports by staff members-Duty of recipient of report:** If an individual who is required to make a report is a school staff member, they must make the report by immediately notifying the principal that a school employee may have received a threat or may be the victim of intimidation, battery or harassment. The individual who receives this report must immediately make a report to law enforcement.

**§20-33-9-12:** This chapter does not relieve an individual of the obligation to report a threat, intimidation, battery, or harassment on their own behalf, unless a report has already been made.

**§20-33-9-13 Duty to make report to law enforcement:** An individual who has a duty under §§20-33-9-10 through 20-33-9-12 must immediately make an oral report to the local law enforcement agency.

# Resources

## Crisis Line

- Lifeline, 1-800-273-TALK [[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)]

## Organizations

- Active Minds [[www.activeminds.org](http://www.activeminds.org)]
- American Association of Suicidology [[www.suicidology.org](http://www.suicidology.org)]
- American Foundation for Suicide Prevention [[www.afsp.org](http://www.afsp.org)]
- Boys & Girls Club of America [[bgca.org](http://bgca.org)]
- Boys Scouts of America [[scouting.org](http://scouting.org)]
- Brighter Tomorrow for Teens [[jirwine@brightertomorrowforteens.com](mailto:jirwine@brightertomorrowforteens.com)]
- Center for Disease Control [[www.cdc.gov/DataStatistics](http://www.cdc.gov/DataStatistics)]
- Girl Scouts of USA [[www.girlscouts.org](http://www.girlscouts.org)]
- 4-H Youth Development Organization [[www.4-h.org](http://www.4-h.org)]
- Jason Foundation [[www.jasonfoundation.com](http://www.jasonfoundation.com)]
- Jed Foundation [[www.jedfoundation.org](http://www.jedfoundation.org)]
- Indiana Community Mental Health Centers & State Operated Facilities [[www.IN.gov/fssa/dmha/4521.htm](http://www.IN.gov/fssa/dmha/4521.htm)]
- Indiana Department of Education [[www.doe.IN.gov](http://www.doe.IN.gov)]
- Indiana Division of Mental Health and Addiction [[www.fssa.IN.gov/dmha](http://www.fssa.IN.gov/dmha)]
- Indiana Local Health Departments [[www.IN.gov/isdh/24822.htm](http://www.IN.gov/isdh/24822.htm)]
- Indiana Office of Faith-Based & Community Initiatives [[www.IN.gov/ofbci](http://www.IN.gov/ofbci)]
- IPFW Behavioral Studies & Family Institute [[new.ipfw.edu/departments/chhs/centers/bhi](http://new.ipfw.edu/departments/chhs/centers/bhi)]
- Indiana State Department of Health [[www.IN.gov/isdh](http://www.IN.gov/isdh)]
- Indiana State Police [[www.IN.gov/isp](http://www.IN.gov/isp)]
- Mental Health America of Indiana [[www.mhai.net](http://www.mhai.net)]
- Mental Health America of Greater Indianapolis [[www.mhaindy.net](http://www.mhaindy.net)]
- NAMI, the National Alliance on Mental Illness [[www.nami.org](http://www.nami.org)]
- NAMI Indiana [[www.namiindiana.org](http://www.namiindiana.org)]
- National Centers for Injury and Violence Prevention and Control [[www.cdc.gov/injury/index.html](http://www.cdc.gov/injury/index.html)]
- National Organization for People of Color Against Suicide [[nopcas.com](http://nopcas.com)]
- National Organization of State Mental Health Program Directors [[www.nasmhpd.org](http://www.nasmhpd.org)]
- SAVE - Suicide Awareness/Voices of Education [[www.save.org](http://www.save.org)]
- Stop a Suicide Today [[www.stopasuicide.org](http://www.stopasuicide.org)]
- Substance Abuse and Mental Health Services Administration [[www.samhsa.gov](http://www.samhsa.gov)]
- Suicide Prevention Action Network USA [[www.spanusa.org](http://www.spanusa.org)]
- Suicide Prevention Resource Center [[www.sprc.org](http://www.sprc.org)]
- The Trevor Project [[www.thetrevorproject.org](http://www.thetrevorproject.org)]
- US Department of Veterans Affairs [[www.va.gov](http://www.va.gov)]
- Yellow Ribbon [[www.yellowribbon.org](http://www.yellowribbon.org)]

## Peer Support

- Active Minds [[www.activeminds.org/](http://www.activeminds.org/)]
- American Foundation for Suicide Prevention - Indiana Support Groups [[www.afsp.org/index.cfm?fuseaction=home.viewPage&page\\_id=9DA567C3-918C-589E-74AE34A3B0484E2D](http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=9DA567C3-918C-589E-74AE34A3B0484E2D)]
- Depression & Bipolar Support Alliance [[www.dbsalliance.org](http://www.dbsalliance.org)]
- The National Mental Health Consumers' Self-Help Clearinghouse [[www.mhselfhelp.org](http://www.mhselfhelp.org)]
- The National Empowerment Center [[www.power2u.org](http://www.power2u.org)]
- Directory of Consumer-Run State-Wide Organizations [[www.power2u.org/consumerrun-statewide.html](http://www.power2u.org/consumerrun-statewide.html)]
- NAMI Indiana [[www.namiindiana.org](http://www.namiindiana.org)]
- National Consumer Supporter Technical Assistance Center [[www.ncstac.org](http://www.ncstac.org)]
- National Coalition of Mental Health Consumer/Survivor Organizations [[ncmhr.org](http://ncmhr.org)]
- STAR Center [[www.consumerstar.org](http://www.consumerstar.org)]
- To Write Love on Her Arms [[www.twloha.com/index.php](http://www.twloha.com/index.php)]

## Programs, Training and Related Material

- Affiliated Service Providers of Indiana, Inc. (ASPIN) [[www.aspin.org](http://www.aspin.org)]
- American Foundation for Suicide Prevention [[www.afsp.org](http://www.afsp.org)]
- Applied Suicide Intervention Skills Training (ASIST) [[www.livingworks.net/page/Applied%20Suicide%20Intervention%20Skills%20Training%20\(ASIST\)](http://www.livingworks.net/page/Applied%20Suicide%20Intervention%20Skills%20Training%20(ASIST))]
- Suicide Prevention Resource Center Training (free Web training!) [[training.sprc.org](http://training.sprc.org)]
- QPR Institute [[www.qprinstitute.com](http://www.qprinstitute.com)]
- School-Based Youth Suicide Prevention Guide [[theguide.fmhi.usf.edu](http://theguide.fmhi.usf.edu)]
- SOS High School Suicide Prevention Program [[www.mentalhealthscreening.org/highschool/sos](http://www.mentalhealthscreening.org/highschool/sos)]
- SAMHSA National Registry [[www.nrepp.samhsa.gov](http://www.nrepp.samhsa.gov)]
- Suicide Prevention Resource Center Registry [[www.sprc.org/bpr](http://www.sprc.org/bpr)]

## Available Sources of Data

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- Indiana State Department of Health, Behavior Risk Factor Surveillance System Report, 2010. [[www.IN.gov/isdh/reports/brfss/2010](http://www.IN.gov/isdh/reports/brfss/2010)]
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, 2011. Learn about the Costs of Violent Deaths. [[www.cdc.gov/Features/dsWISQARScost](http://www.cdc.gov/Features/dsWISQARScost)]
- Additional suicide and suicide attempt data can be requested from the Indiana State Department of Health. For contact information visit the Division of Trauma and Injury Prevention website. [[www.IN.gov/isdh/25397.htm](http://www.IN.gov/isdh/25397.htm)]

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<sup>18</sup> American Association of Suicidology (n.d.). Hispanic Suicide Fact Sheet. Available from URL: [http://www.suicidology.org/c/document\\_library/get\\_file?folderId=232&name=DLFE-243.pdf](http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-243.pdf)

<sup>19</sup> Centre for Suicide Prevention, 2010. Suicide and Self-Harm Among Refugees and Asylum Seekers. Available from URL: [http://suicideinfo.ca/LinkClick.aspx?fileticket=UH\\_9zd558Rg%3D&tabid=538](http://suicideinfo.ca/LinkClick.aspx?fileticket=UH_9zd558Rg%3D&tabid=538)

<sup>20</sup> Williams, T. (2012). Suicides outpacing war deaths for troops. Veterans for Common Sense, Retrieved from <http://veteransforcommonsense.org/>

<sup>21</sup> United States Department of Veterans Affairs: Mental Illness Research, Education and Clinical Centers (MIRECC), (n.d.). Providing Support for Suicide Survivors: Understanding Pertinent Military/Veteran Issues. Available from URL: [http://www.mirecc.va.gov/visn19/docs/Suicide\\_Support\\_Group.pdf](http://www.mirecc.va.gov/visn19/docs/Suicide_Support_Group.pdf)



# **Suicide Advisory Committee**

Chairman Sandy Appleby, Geminus Corp.  
Chairman Jack E. Hess, District Chaplain, Indiana State Police  
Joanne Abbott, NAMI Indiana  
Matthias Beier, Christian Theological Seminary  
Elizabeth Boyle, Mental Health America of Greater Indianapolis  
Lisa Brattain, American Foundation for Suicide Prevention (Indiana Chapter)  
Colleen Carpenter, Indiana Suicide Prevention Coalition  
Daniel Coffey, Department Chaplain, Indiana State Police  
Kathy Cook, Affiliated Service Providers of Indiana, Inc.  
Joan Duwve, Indiana State Department of Health  
Gina Eckart, former Director, Division of Mental Health & Addiction  
Gary Green, Indiana Department of Education  
Joni Irwin, Brighter Tomorrow for Teens  
Alice Jordan-Miles, Indiana University–Purdue University Fort Wayne  
Deirdre Kempson, Indiana Department of Education  
Andrew Klatter, Division of Mental Health & Addiction  
Martha Levey, Affiliated Service Providers of Indiana, Inc.  
Stephen McCaffrey, Mental Health America of Indiana  
Pam McConey, NAMI Indiana  
Kevin Moore, Division of Mental Health & Addiction  
Tiffany Peek, Mental Health America of Indiana  
Calvin Roberson, Indiana Minority Health Coalition  
Josh Sprunger, NAMI Indiana  
Stephanie Stscherban, Division of Mental Health & Addiction  
Kelsi Testa-Avila, student, Indiana University–Purdue University Indianapolis  
Bruce Vandusen, Division of Mental Health & Addiction  
Audrey Wilcox, Indiana Minority Health Coalition  
Julie Wirthwein, Indiana State Department of Health  
Stephanie Woodcox, Division of Mental Health & Addiction

## **Indiana State Suicide Prevention Plan Writing Committee**

Elizabeth Boyle, Mental Health America of Greater Indianapolis  
Lisa Brattain, American Foundation for Suicide Prevention (Indiana Chapter)  
Joan Duwve, Indiana State Department of Health  
Andrew Klatter, Division of Mental Health and Addiction  
Martha Levey, Affiliated Service Providers of Indiana, Inc.  
Julie Wirthwein, Indiana State Department of Health  
Stephanie Stscherban, Division of Mental Health and Addiction

**NATIONAL**

**SUICIDE**

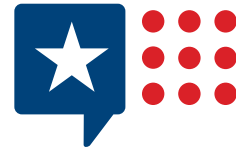
**PREVENTION**

**LIFELINE**

1-800-273-TALK (8255)<sup>TM</sup>

[suicidepreventionlifeline.org](http://suicidepreventionlifeline.org)

**Veterans  
Crisis Line**



1-800-273-8255  
**PRESS 1**

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**PREVENCIÓN**  
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**SUICIDIO**

1-888-628-9454

[prevenciondelsuicidio.org](http://prevenciondelsuicidio.org)



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SUICIDE  
PREVENTION**

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