Indiana Department of Health

INJURY PREVENTION ADVISORY COUNCIL (IPAC) & INDIANA VIOLENT DEATH REPORTING SYSTEM (INVDRS) MEETING

11/20/2020

OUR MISSION:

To develop, implement and provide oversight of a statewide comprehensive trauma care system that:

- Prevents injuries.
- Saves lives.
- Improves the care and outcomes of trauma patients

OUR VISION:

Prevent injuries in Indiana.

Round Robin and Introductions

1. Name
2. Position
3. Organization/ Association
4. Updates
5. Current Projects and Programs
6. Upcoming events

Resource Guide App

Constantly Updated

- Free download for iOS & Android

phone & tablet capabilities

- Available in Apple & Google Play stores

Grant Activities

Students Teachers and Officers Preventing (STOP) School Violence

- Not funded

Upcoming Events

December

- Safe Toys and Gifts Month

Nov 1-8: Drowsy Driving Prevention Week

Nov 18: National Injury Prevention Day

Nov 21: International Survivors of Suicide Loss Day

Dec 23-31: Drive Sober or Get Pulled Over Week

ISTCC/ITN Meeting Dates

Indiana State Trauma Care Committee, 10 am EST

December 11th

Indiana Trauma Network, 12:30 pm EST

December 11th

Indiana Department of Health

2019 CDC SITE VISIT EVALUATION

Tia Rogers, PhD, MPH

Epidemic Intelligence Service (EIS) Officer

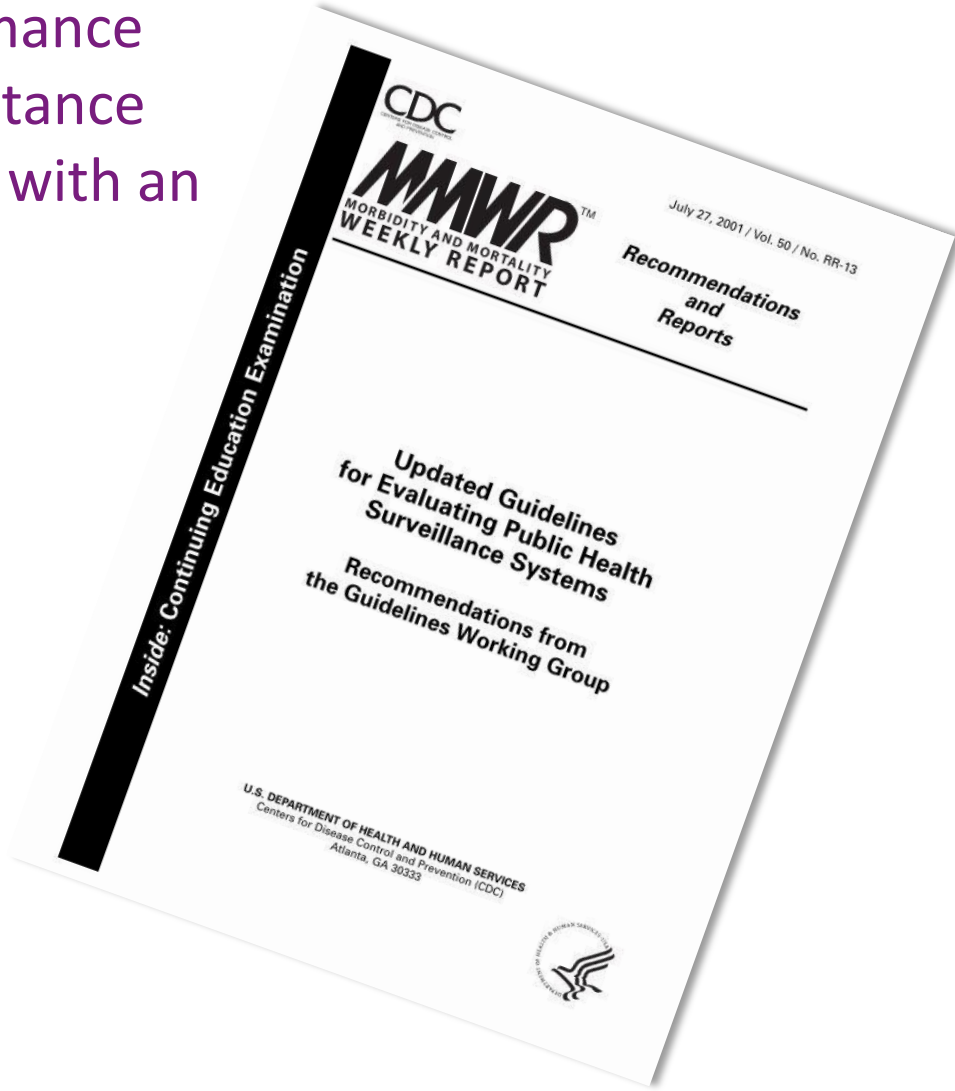
Lieutenant, United States Public Health Service

Division of Violence Prevention

Purpose of Evaluation

The purpose of this evaluation was to assess the performance of INVDRS as a surveillance system for capturing circumstance information on fatalities due to violent death in general, with an emphasis on suicide.

- Utility
- Simplicity
- Flexibility
- Data Quality
- Acceptability
- Sensitivity and Predictive Value Positive
- Representativeness
- Timeliness
- Stability
- Informatics



Evaluation Methods

INVDRS Documents

- Annual performance reports
- Budgets
- Work plans
- Police Reports
- Coroner/Medical Examiner Reports

Key Stakeholder Interviews

- INVDRS staff
- Law Enforcement (Retired)
- Coroner’s Office
- CDC Project Staff

INVDRS Utility

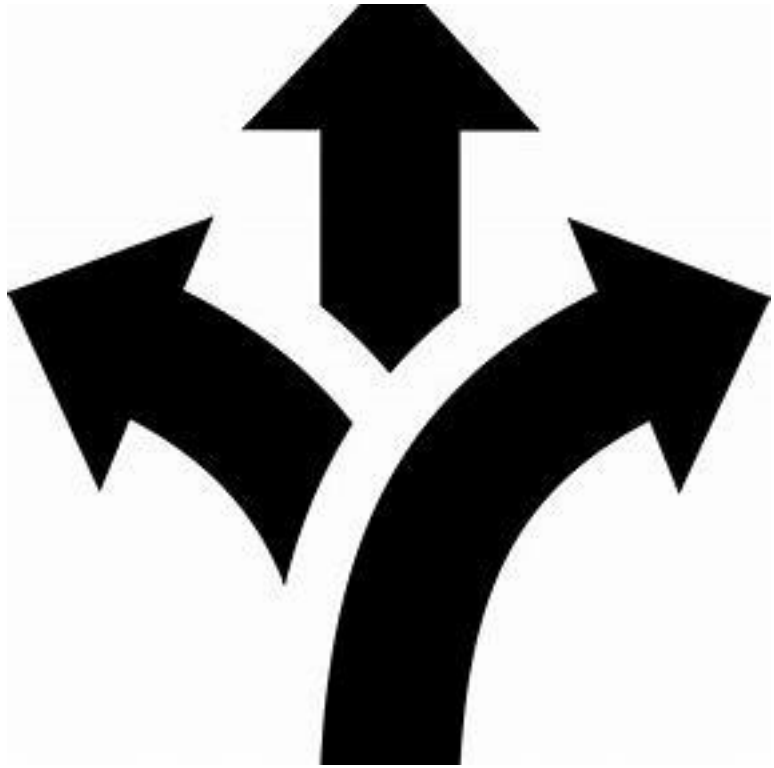
- **Highly useful**
- **Used for public health action**
- **INVDRS data disseminated in multiple ways**
  - Conference presentations, journal articles
- **Enduring support for INVDRS data**
  - Challenges in obtaining coroner/medical examiner reports
  - Challenges in obtaining circumstance information from coroner/medical examiner and law enforcement reports.

INVDRS Simplicity

- **Moderately complex**
  - Data abstractors must review multiple documents
  - Time consuming
  - Requires thorough reading/interpretation of reports
  - Knowledge of case definitions for >600 NVDRS variables

INVDRS Flexibility

- **Moderately flexible**
  - INVDRS uses the NVDRS web-based portal
  - All variables INVDRS collects already exist in the NVDRS
  - Changes in case definition or collection of new information can easily be implemented at the National level



INVDRS Data Quality

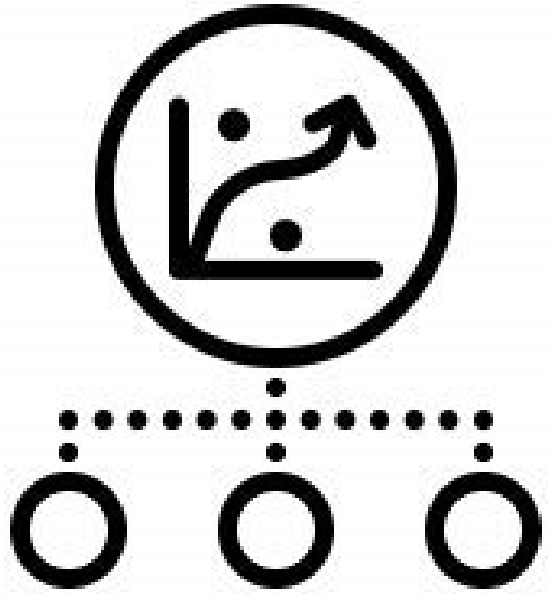
- **High quality data**
  - Centralized OCME ensures consistency in assigning medical examiners manner of death
  - Electronic files transfers minimizes errors in transcribing data from paper
- **Variability in completeness of circumstance data by source**

INVDRS Acceptability

- **INVDRS data is highly acceptable by its stakeholders**
- **Strong relationship exists between INVDRS and data providers**
- **INVDRS has data sharing agreements with multiple data users**
- **Advisory Board**
  - Advisory board meets regularly

INVDRS Sensitivity and Predictive Value Positive (PVP)

- **Death certificates used to initiate a case in INVDRS**
  - “Gold standard” for mortality data
  - Not possible to calculate PVP and sensitivity

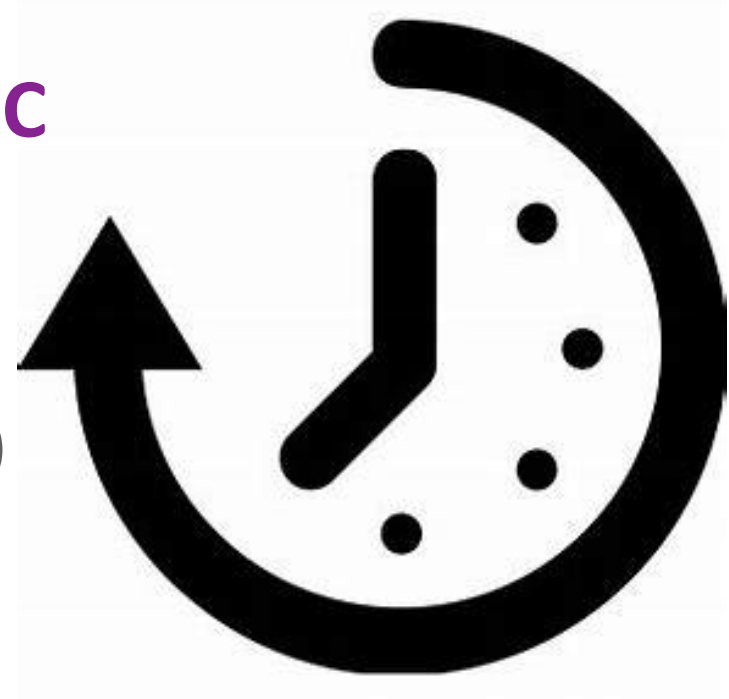


INVDRS Representativeness

- **The NVDRS**
  - 50 states, the District of Columbia, and Puerto Rico submit data to NVDRS.
  - Web-Based Injury Statistics Query and Reporting System (WISQARS) and the NVDRS Restricted Access Database (RAD)
- **The INVDRS**
  - Law enforcement agencies from all 92 counties
  - Only 83 of 92 counties provide coroner report or medical examiner data

INVDRS Timeliness

- **INVDRS receives timely data from data providers**
- **NVDRS states must submit information to CDC 18 months after the last day of calendar year**
- **INVDRS timeliness for 2017**
  - Cases must be initiated within 6 months (180 days) from date of death
  - 92% of cases initiated within 180 days
  - Median number of days to case initiation was 129 days



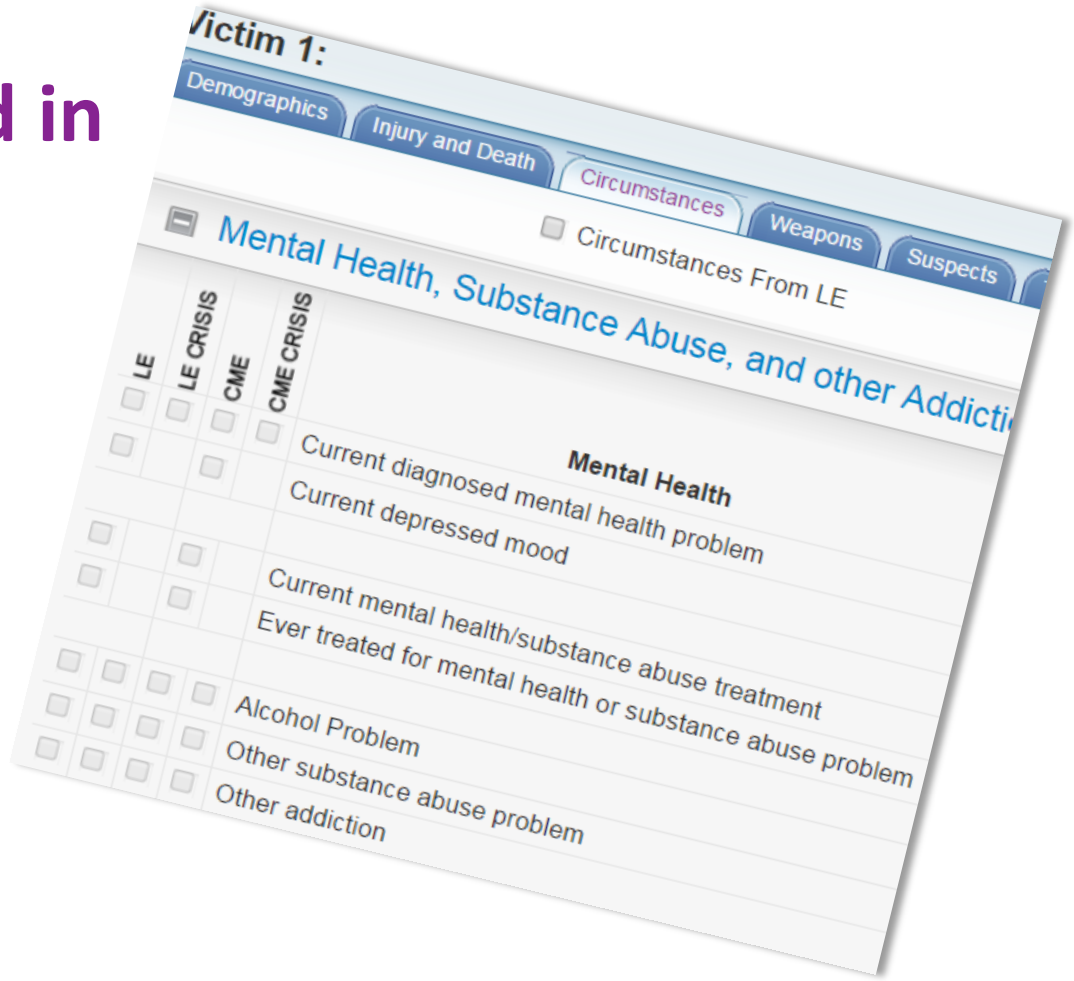
INVDRS Stability

- **NVDRS is a stable system with a 17 year history**

- **INVDRS is a moderately stable system with a 5 year history**
  - Coroner term limits negatively impact data collection and availability of data to the system
    - Constant on-boarding
    - Inconsistent data flow
    - Inconsistent policies and procedures

INVDRS Informatics

- Web-based software implemented in 2013
- Improvement in user experience

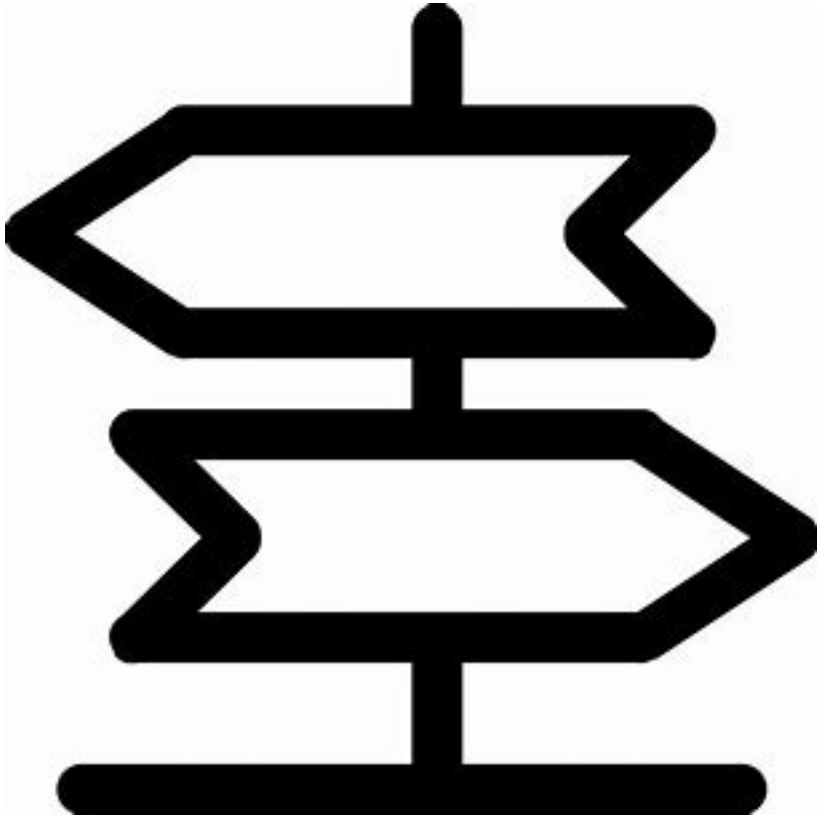


INVDRS Challenges

- Procuring timely and complete coroner reports
- Obtaining detailed information on circumstances for suicide deaths

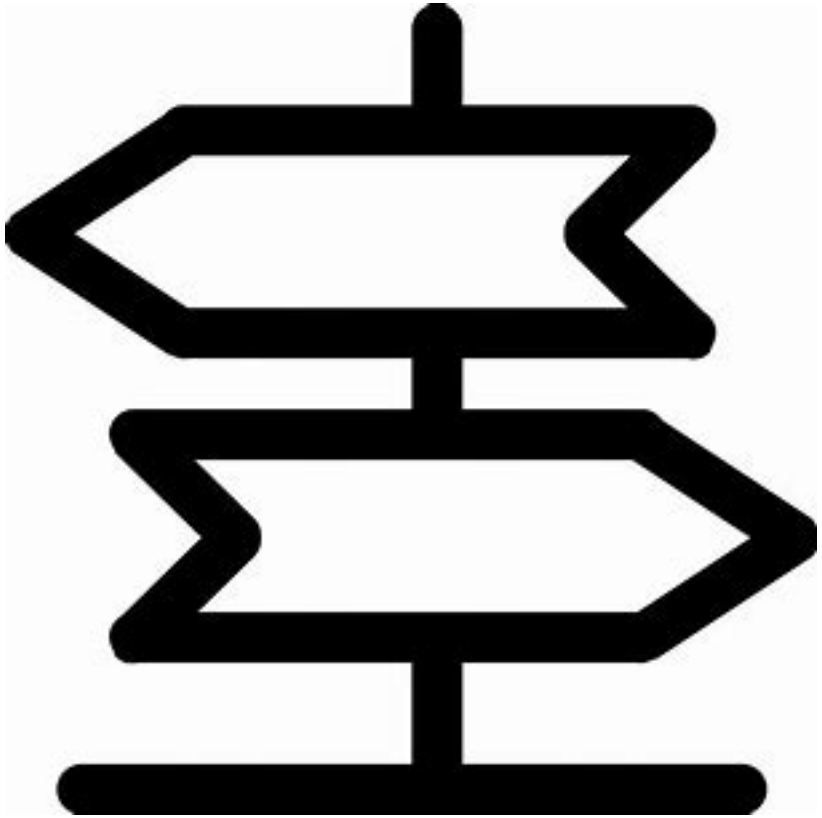
Recommendations

- To improve buy-in from law enforcement and Coroner stakeholders
  - Increase engagement with law enforcement through the advisory board meetings.
  - Endorsements from participating law enforcement agencies.
- To address the lack of bandwidth among Coroners
  - Implement an intern-based program to assist coroners with the timely sharing of complete reports.



Recommendations

- To improve the level of detail regarding circumstance data
  - Explore using psychological autopsy as a method to help clarify cause of death, particularly where precise mode of death is unclear.
  - The inclusion of data from a psychological autopsy can help in the process of establishing whether an equivocal death was the result of natural causes, suicide, accident or murder.
  - Provides evidence of the decedent's mental state.
  - Useful in providing more specific information around circumstance of death.



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INTENTIONAL INJURY PRESENTATION:

SUICIDE PREVENTION RESOURCES TOOLKIT

Madeline Tatum

Indiana Department of Health

Toolkit Overview

The Indiana Suicide Prevention Resources Toolkit is designed to address the need for **practical** and **profession-specific** suicide prevention tools. The toolkit includes the following:

- Suicide data report (based on 2018 data)
- Profession-specific sections: healthcare, first responders, government, stakeholder groups, justice, employers, faith-based, media, coroners, family, education, and at-risk populations.

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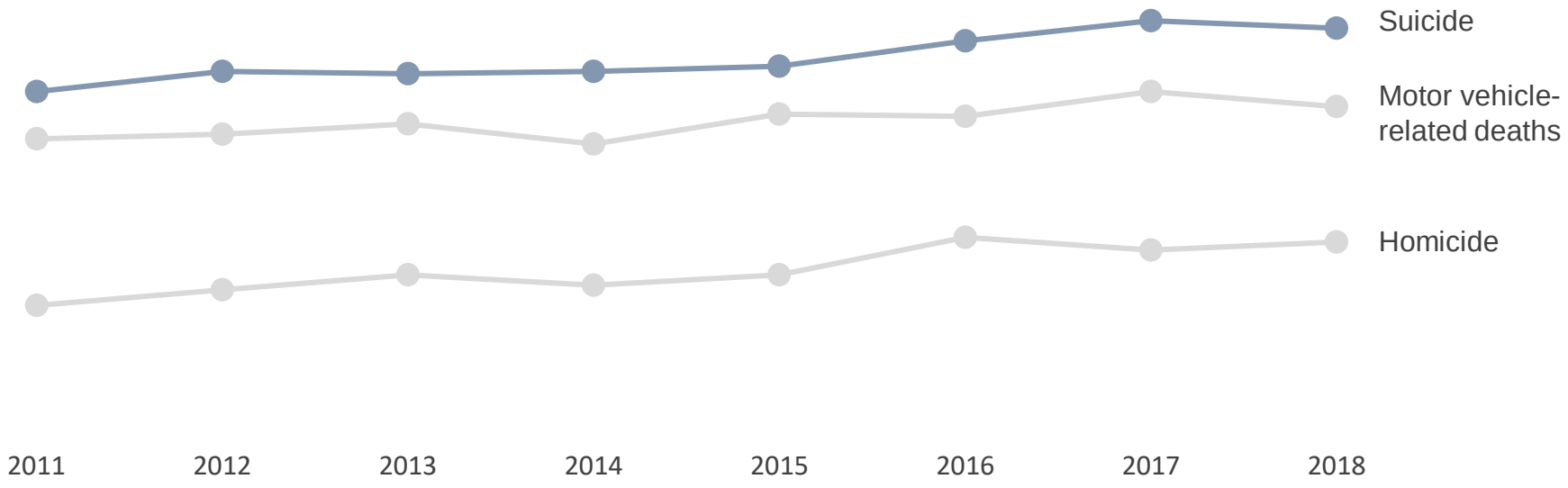
Data

Suicide deaths have continued to surpass both motor vehicle-related and homicide deaths in Indiana.

ISDH, Vital Records, 2011-2018.



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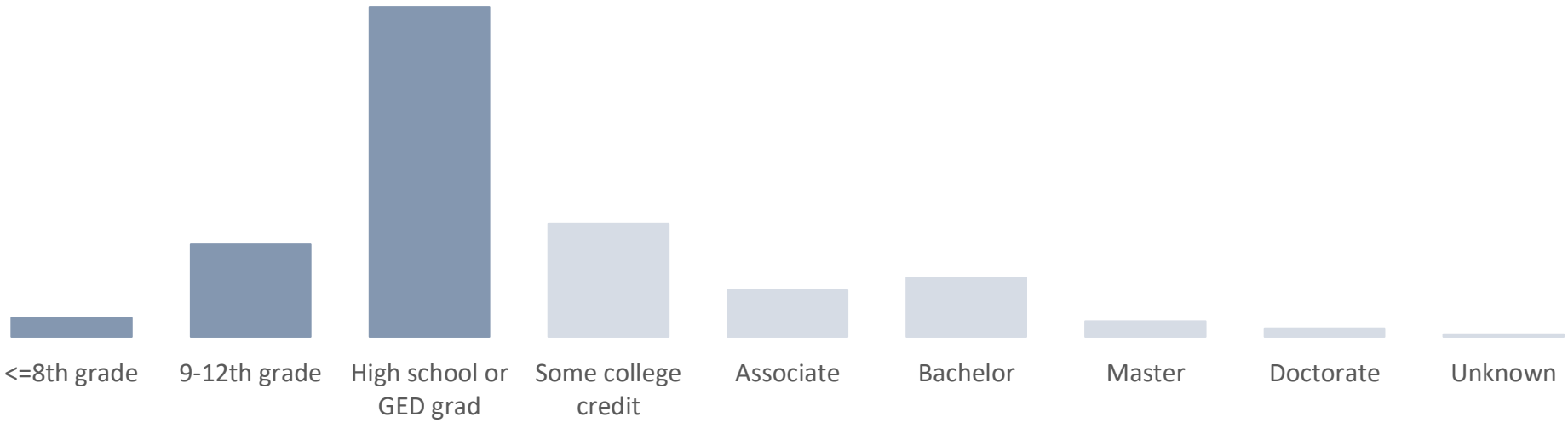
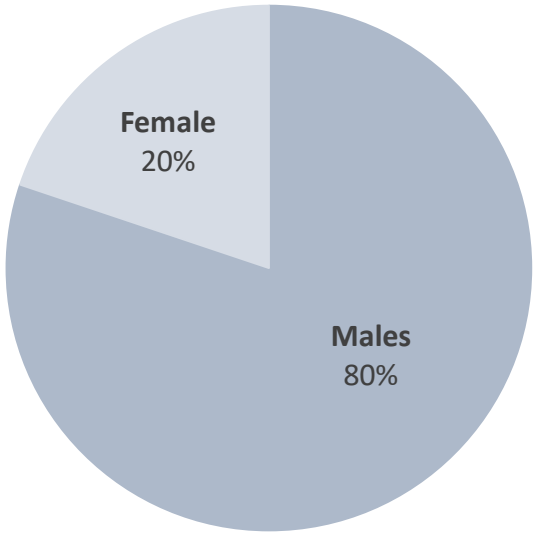
Of Individuals who died by suicide in Indiana, from 2015-2018, 64% had a high school diploma or less.

Number of suicides, 2015-2018 (National Violent Death Reporting System).



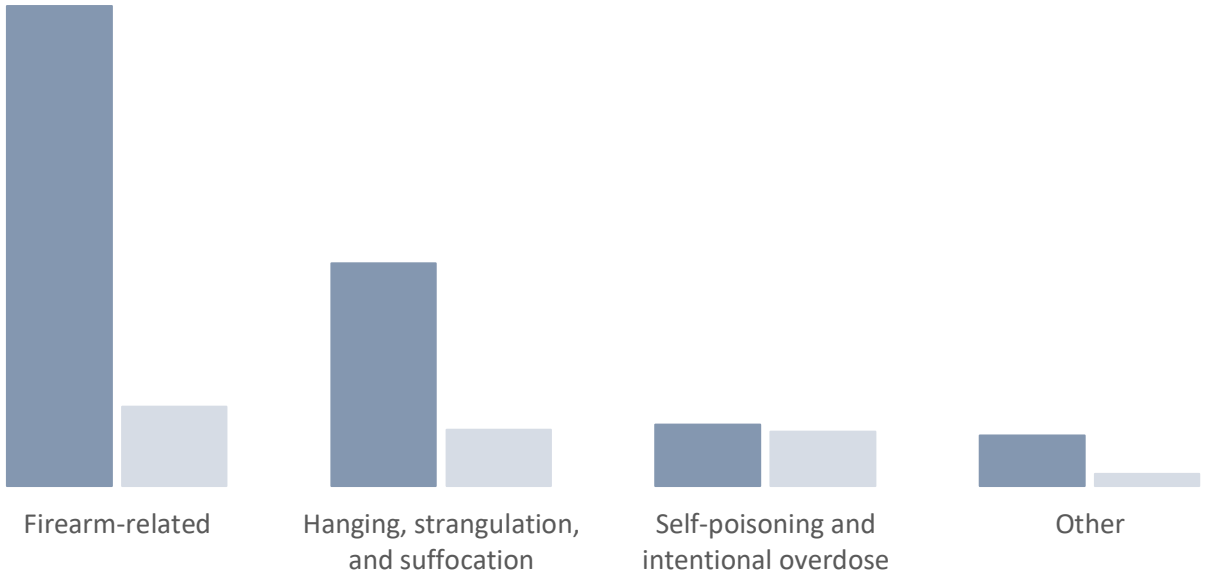
Males in Indiana experienced 4x as many deaths to suicide in Indiana compared to females.

ISDH, Vital Records, 2015-2018.



Males in Indiana had higher numbers of suicide deaths due to all means when compared to females. The disparity was largest among firearm-related and hanging-related deaths.

ISDH, Vital Records, 2015-2018.



Profession-Specific Sections

Profession-Specific Sections


First Responders


Employers


Healthcare


Populations of Special Consideration


Family


Faith-based


Media


Education


Government


Justice


Stakeholder Groups


Coroners

Healthcare

Introduction

Healthcare professionals work every day to improve the health and wellness of their patients. As such, healthcare professionals should be prepared to treat a patient experiencing suicidal ideation or following a suicide attempt. Being prepared can simply mean screening every patient and having the policies and protocols in place to address patients presenting with suicide risk. On an individual-level, this can be having a protocol in place after a patient discloses they are experiencing suicidal ideation. On a population-level, this can be evaluating the current hospital screening and discharge protocol.

As far as data, there is a clear trend showing need for greater healthcare engagement. For example, after patients leave inpatient psychiatric care, their suicide death rate is 300 times higher in the first week and 200 times higher in the first month when compared with the general population's.[2] The individual's suicide risk remains high for up to three months after discharge and for some, their elevated risk persists longer.[3-5] Additionally, a recent study found that individuals who presented in emergency departments (EDs) with deliberative self-harm had a suicide rate of 56.8 times higher than demographically similar individuals the year after their visit.[19] Those with suicidal ideation had a 31.4 times higher rate.[19] In fact, one out of seven people in the United States who died by suicide had contact with inpatient mental health services in the year before their death.[6] Of individuals who later died by suicide, 46% had a mental health diagnosis and 90% had shown symptoms of a known mental health condition.[7]

Healthcare Resources:

- Warning Signs of Suicide
- Screening Tools Guide
- Safety Planning Guide
- Suicide Safety Planning Template
- Discharge Protocol
- After a Suicide Attempt: What Family Members Need to Know
- After a Suicide Attempt: What Family Members Need to Know
    - *Also included in the Family and First Responder sections of the toolkit
- Provider Self-Care Checklist
- Suicide Training: Healthcare (p. 200-203)

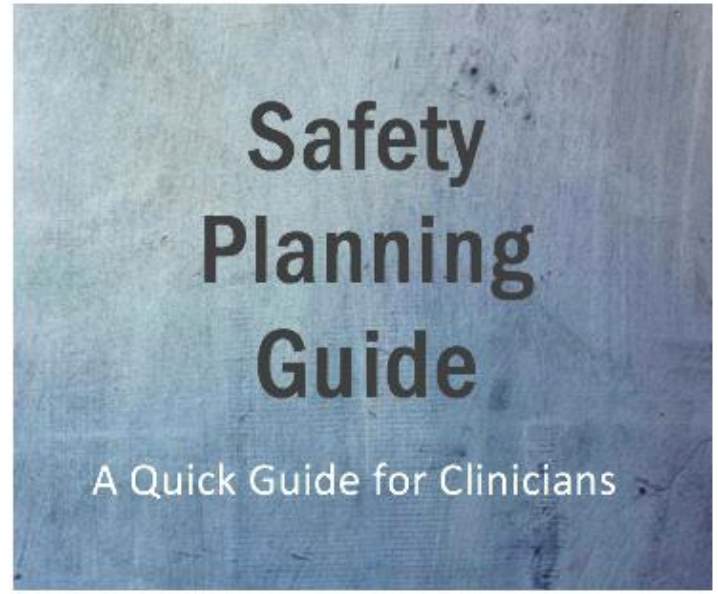
What are the steps after the plan is developed?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances. Consider if there should be any social media element protection included, if this is a sensitive point for the patient.

REVIEW the plan periodically when patient's circumstances or needs change.



WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicide crisis. The plan is brief, is in the patient's own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicide crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use. While this is a clinical process, anyone can create safety plan as this is a vital step in suicide prevention. Individuals do not need to be mental health professionals.

DEVELOPING AND IMPLEMENTING THE SAFETY PLAN

The following section outlines the six steps in building and putting into action a safety plan.

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Developing and Implementing the Safety Plan: A Six Step Process

Warning Signs

*Ask: **"How will you know when the safety plan should be used?"**
*Ask: **"What do you experience when you start to think about suicide or feel extremely depressed?"**
*List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patient's own words.

Internal Coping Strategies

*Ask: **"What can you do, on your own, if you experience suicidal ideation again, to help yourself not to act on your thoughts?"**
*Assess likelihood of use: Ask: **"How likely do you think you would be able to do this step during a time of crisis?"**
*If doubt about use is expressed, ask: **"What might stand in the way of you thinking of these activities or doing them?"**
*Use a collaborative, problem solving approach to address potential roadblocks and identify alternative coping strategies.

Social Contacts Who May Distract from the Crisis

*Instruct patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
*Ask: **"Who or what social settings help you take your mind off your problems at least for a little while?" "Who helps you feel better when you socialize with them?"**
*Ask for safe places they can go to be around people (i.e. coffee shop).
*Ask patient to list several people and social settings in case the first option is unavailable. Keep in mind the potential for online supports.
*Remember, in this step, the goal is distraction from suicidal ideation.
*Assess likelihood that patient will engage in this step; identify potential obstacles, and problem solve, as appropriate.

Family Members or Friends Who May Offer Help

*Instruct patients to use Step 4 if Step 3 does not resolve crisis
*Ask: **"Among your family or friends, who do you think you could contact for help during a crisis?"** or **"Who is supportive of you and who do you feel that you can talk with when you're under stress?"**
*Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
*Assess likelihood patient will engage in this step; identify potential obstacles, and problem solve.
Role play and rehearsal can be very useful in this step.

Professionals and Agencies to Contact for Help

*Instruct the patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
*Ask: **"Who are the mental health professionals that we should identify to be on your safety plan?"** and **"Are there other health care providers?"**
*List names, numbers of clinicians and urgent care services.
*Assess likelihood patient will engage in this step; identify potential obstacles, and problem solve.
*Role play and rehearsal can be very useful in this step.

Making the Environment Safe

*Ask patients which means they would consider using during a suicidal crisis.
*Ask: **"Do you own a firearm, such as a gun or rifle?"** and **"What other means do you have access to and may use to attempt to kill yourself?"**
*Collaboratively identify ways to secure or limit access to lethal means: Ask: "How can we go about developing a plan to limit your access to these means?"
*For low lethality methods, clinicians may ask patients to remove or limit their access to these methods.
*Restricting the patient's access to a **highly lethal method**.

PROVIDER SELF-CARE CHECKLIST

Each provider may have a different way of coping with work-related stress. Below is a checklist of some warning signs of immediate stress responses and long-term effects. If you or someone you know is displaying some of these symptoms, seek professional help or follow the listed self-care strategies.

Warning Signs Checklist

Physical reactions

- ☐ Fatigue
- ☐ Sleep disturbances
- ☐ Changes in appetite
- ☐ Headaches
- ☐ Upset stomach
- ☐ Chronic muscle tension
- ☐ Sexual dysfunction

Emotional Reactions

- ☐ Feeling overwhelmed/ emotionally spent
- ☐ Feeling helpless
- ☐ Feeling inadequate
- ☐ Sense of vulnerability
- ☐ Increased mood swings
- ☐ Irritability
- ☐ Crying more easily or frequently
- ☐ Suicidal or violent thoughts or urges

Behavioral Reactions

- ☐ Isolation, withdrawal
- ☐ Restlessness
- ☐ Changes in alcohol or drug consumption
- ☐ Changes in relationships with others, personally & professionally

Cognitive Reactions

- ☐ Disbelief, sense of numbing
- ☐ Replaying events in one's mind over & over
- ☐ Decreased concentration
- ☐ Confusion or Impaired memory
- ☐ Difficulty making decisions or problem-solving
- ☐ Distressing dreams or fantasies

This was adapted the Healthcare Toolbox's page "Self-Care for Providers," which can be found here: https://healthcaretoolbox.org/self-care-for-providers.html

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RESOURCE "TUCK" CARDS TEMPLATE

If first responders are responding to a scene, but are not providing any additional transportation, it can be helpful to provide a resource list to affected individuals. Not a multi-page resource list that is difficult to read, instead a "tuck" card where the handout is small enough to fit inside the individual's pocket. Below is a sample template that communities can use to create their own "tuck" cards (the grey portions indicate customizable sections).

(Front of card)

Help is available if you or someone that someone you care about it at risk of suicide.

[Lead organization name]

State and Local Resources

In case of Emergency:
- Call 911 or visit the emergency room

Local Resource
- *Phone number*

Local Resource
- *Phone number*

Remedy Live Text Line (mental health line):
- Text "REMEDY" to 494949

Indiana 211/Be Well Crisis Line (Indiana-specific resources and mental health line):
- Call 211
- Press 3 for the Be Well Crisis Line

(Back of card)

You are not alone.

National Resources

National Suicide Prevention Hotline:
- Call 1-800-273-8255
- Text "IN" to 741741

Veterans Crisis Line
- Call (800)273-TALK (8255)
- Text anything to 838255

Trevor Project (LGBTQ+ youth line)
- Call (866)488-7386
- Text "TREVOR" to (202)304-1200

Trans Lifeline
- Call (877)565-8860

Crisis Line for Individuals Deaf and Hard of Hearing
- Call (800) 273-8255, video relay service or voice/caption phone
- Call (800)799-4889, TTY

Ayuda En Español
- Llama al número (888)628-9454

National Teen Dating Abuse Helpline
- Call (866)331-9474

RAINN National Sexual Assault Hotline
- Call (800)656-HOPE (4673)

INTERNAL NOTIFICATION MEMO TEMPLATE

When companies experience a suicide death, it is vital to communicate with employees. Below are two templates that can be used, depending on whether the cause of death was revealed. The first can be used when the cause of death is revealed and the second when the cause of death is not revealed.

SAMPLE INTERNAL NOTIFICATION MEMO - **WHEN CAUSE OF DEATH REVEALED**

Date:
To: Staff
From: [Name of CEO]
Re: Death of [name of employee]

[Our workplace] is saddened to learn of the reported suicide of [employee]. The tragic and sudden circumstances of [employee's] death may cause a range of reactions among our workplace, so with the family's permission we are sharing the facts as we know them and are offering support for those who might need it.

[Employee] worked for [workplace] for the last [number] years. On [Saturday night] [s/he] died around [11:00PM] [DO NOT MENTION PLACE OR METHOD USED FOR SUICIDE]. We may never know all the factors leading to this tragedy; however, experts agree that in nearly all suicides there is no single cause or simple explanation.

[Employee's] memorial service will be held on [January 7 at 11:00AM], and all employees who wish to attend may be excused. The family would like to welcome all of [his/her] friends and colleagues who wish to share in the celebration of [his/her] life.

Some of you may be having difficulty coping with the sudden loss of one of our workplace family. We have arranged for the Employee Assistance Program (EAP) professionals to facilitate a debriefing on [January 8th at 5:00PM]. During this group meeting, counselors will be on hand to support us and answer any questions we may have. Others may prefer individual support at this time. If so, please contact our EAP program by calling [1-800-123-4567].

The family has requested that instead of flowers, those who wish to do so may donate to [a local suicide prevention center or other charity as shared by the family] in [employee's] memory.

For those who would like to talk about what has happened, our HR team is available to you.

Sincerely,
[Name of CEO]

This was adapted from the Workplace Postvention Task Force of the American Association of Suicidology and the Workplace Task Force of the National Action Alliance for Suicide Prevention's "A Manager's Guide to Suicide Postvention in the Workplace," which can be found here: https://theactionalliance.org/sites/default/files/managers-guidebook-to-suicide-postvention-web.pdf.

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Risk Factors

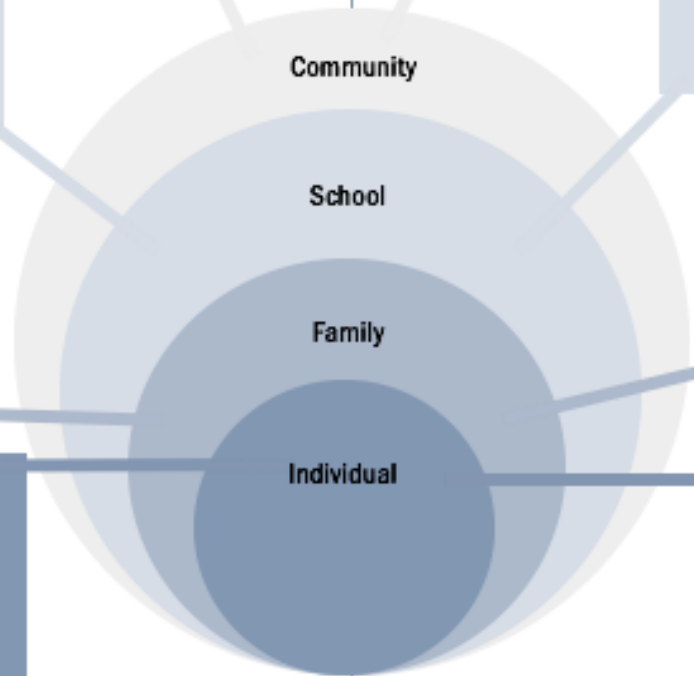
Characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

- Low community attachment and organization
- Community/personal transitions and mobility
- Laws and norms favorable to drug use
- Perceived availability of drugs
- Economic disadvantage

- Academic failure or low academic achievement
- Low commitment to school
- Bullying

- Poor family management and discipline
- Family conflict
- Family history of antisocial behavior
- Favorable parental attitudes toward problem behavior

- Rebelliousness
- Early initiation of problem behavior ; impulsiveness
- Antisocial behavior
- Favorable attitudes toward problem behavior
- Interaction with friends involved in problem behavior
- Sensation seeking
- Rewards for antisocial involvement



Protective Factors

Characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact.

- Opportunities for prosocial involvement in the community
- Recognition of prosocial involvement
- Exposure to evidence-based programs and strategies

- Opportunities for prosocial involvement in school
- Recognition of prosocial involvement

- Attachment and bonding to family
- Opportunities for prosocial involvement in family
- Recognition of prosocial involvement

- Social skills
- Belief in moral order
- Emotional control
- Interaction with prosocial peers

This plan has been developed using information from Montgomery County Alcohol Drug Addiction and Mental Health Services document, "Utilizing the Entire Spectrum of Prevention Strategies," which can be found here: https://csw.osu.edu/wp-content/uploads/2019/03/Hoff-Andrea-Handouts.pdf

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First Responder Mental Health Resources

Safe Call Now – 1(206)459-3020
A 24/7 help line staffed by first responders for first responders and their family members. They can assist with treatment options for responders who are suffering from mental health, substance use disorder, and other personal issues.

Fire/EMS Helpline – 1(888)731-3473
A 24/7 confidential hotline specifically for Firefighters, EMS professionals, and their families. This helpline is designed to address behavioral health issues, including stress, depression, PTSD, substance use disorder, and more.

Copline (Law Enforcement Only) – 1(800)267-5463
A 24/7 confidential helpline staffed by retired trained officers. This Law Enforcement-specific helpline can assist with various stressors Law Enforcement careers encounter both on and off the job.

Frontline Helpline – 1(866)676-7500
A 24/7 confidential helpline is staffed by first responders. This helpline can help with the following issues: substance use disorder, anger management, depression, anxiety, sleep deprivation, PTSD, psychological stress, divorce & family issues.

You are not alone.

This was adapted from Code Green's Help and Resources page, which can be found here: https://codegreencampaign.org/resources/.

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Organization Partners

Allen County Drug & Alcohol Consortium, Inc.

Indiana Department of Health

UNINTENTIONAL INJURY DATA PRESENTATION:

INJURY IN INDIANA

Veronica Daye, MPH
Injury Prevention Epidemiologist

Injuries in Indiana

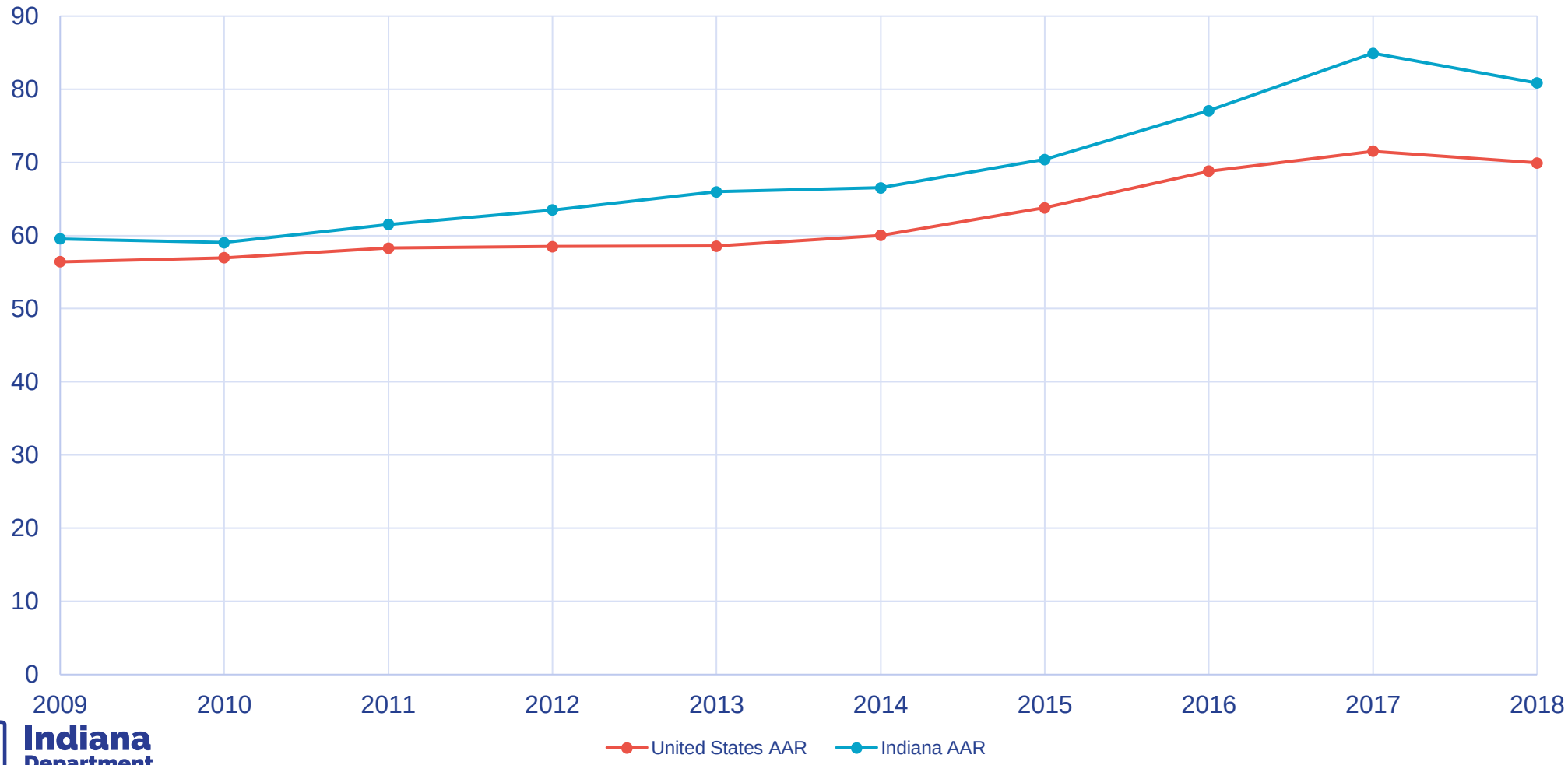
5,487 died from injuries in 2018.

~69% of these deaths were unintentional.

There were 569,653 ED visits that were injury-related in 2018.

The injury death rate has increased by 35% in Indiana and is almost 12% higher that the national age-adjusted rate

Age-Adjusted Rate per 100,000



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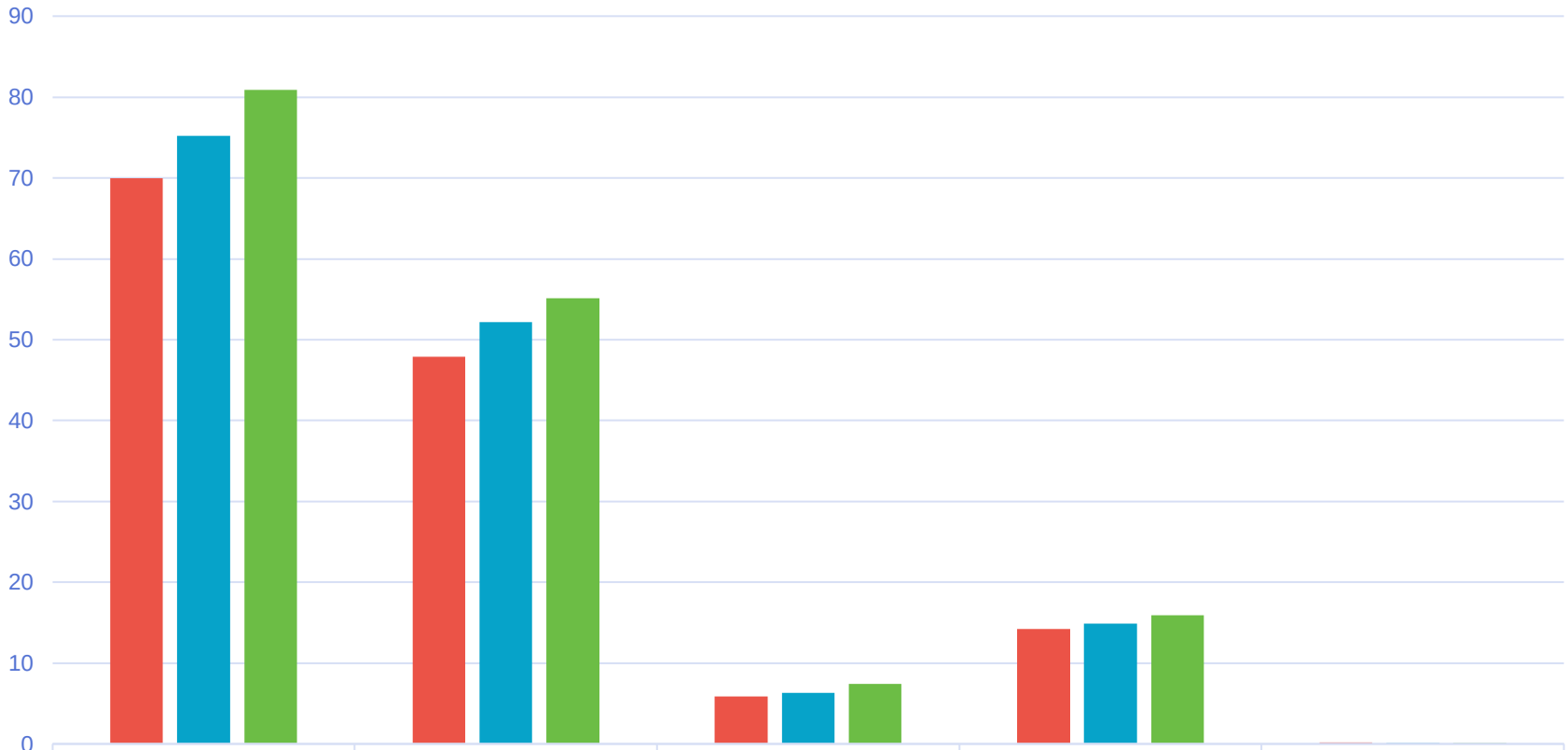
Source:
1. National Center for Injury Prevention and Control, National Center for Health Statistics Vital Statistics System, WISQARS
2. Indiana State Department of Health, Division of Trauma and Injury Prevention

Injury Death Rate, United States, Midwest, and Indiana Comparison, 2018

Age-Adjusted Rate per 100,000



	All Intents	Unintentional	Homicide	Suicide	Legal Intervention
United States	69.93	47.91	5.9	14.21	0.2
Midwest	75.21	52.15	6.37	14.93	0.14
Indiana	80.86	55.14	7.42	15.96	0.14 *

*Rate based on 20 or fewer deaths

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

10 Leading Causes of Death, Indiana
2009, All Races, Both Sexes

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 147	Unintentional Injury 32	Unintentional Injury 18	Unintentional Injury 28	Unintentional Injury 277	Unintentional Injury 296	Unintentional Injury 359	Malignant Neoplasms 1,197	Malignant Neoplasms 2,531	Heart Disease 10,619	Heart Disease 13,509
2	Short Gestation 130	Homicide 15	Malignant Neoplasms 12	Malignant Neoplasms ---	Suicide 110	Suicide 115	Heart Disease 315	Heart Disease 891	Heart Disease 1,562	Malignant Neoplasms 8,928	Malignant Neoplasms 13,093
3	SIDS 62	Congenital Anomalies ---	Congenital Anomalies ---	Influenza & Pneumonia ---	Homicide 75	Homicide 107	Malignant Neoplasms 294	Unintentional Injury 461	Chronic Low. Respiratory Disease 376	Chronic Low. Respiratory Disease 3,179	Chronic Low. Respiratory Disease 3,745
4	Unintentional Injury 47	Malignant Neoplasms ---	Benign Neoplasms ---	Suicide ---	Malignant Neoplasms 36	Heart Disease 82	Suicide 171	Suicide 194	Unintentional Injury 267	Cerebro-vascular 2,579	Cerebro-vascular 3,004
5	Maternal Pregnancy Comp. 41	Influenza & Pneumonia ---	Chronic Low. Respiratory Disease ---	Cerebro-vascular ---	Heart Disease 24	Malignant Neoplasms 76	Homicide 53	Liver Disease 157	Diabetes Mellitus 254	Alzheimer's Disease 1,865	Unintentional Injury 2,577
6	Bacterial Sepsis 18	Chronic Low. Respiratory Disease ---	Homicide ---	Congenital Anomalies ---	Chronic Low. Respiratory Disease ---	Influenza & Pneumonia 17	Diabetes Mellitus 47	Diabetes Mellitus 145	Cerebro-vascular 226	Nephritis 1,206	Alzheimer's Disease 1,884
7	Circulatory System Disease 16	Heart Disease ---	Five Tied ---	Chronic Low. Respiratory Disease ---	Influenza & Pneumonia ---	HIV 16	Cerebro-vascular 42	Cerebro-vascular 137	Liver Disease 175	Diabetes Mellitus 1,188	Diabetes Mellitus 1,646
8	Placenta Cord Membranes 15	Septicemia ---	Five Tied ---	Heart Disease ---	Complicated Pregnancy ---	Chronic Low. Respiratory Disease 11	Liver Disease 35	Chronic Low. Respiratory Disease 136	Nephritis 134	Influenza & Pneumonia 965	Nephritis 1,442
9	Respiratory Distress 15	Three Tied ---	Five Tied ---	Homicide ---	Congenital Anomalies ---	Complicated Pregnancy 11	HIV 30	Septicemia 70	Suicide 119	Unintentional Injury 791	Influenza & Pneumonia 1,191
10	Two Tied 14	Three Tied ---	Five Tied ---	Meningo-coccal Infection ---	Two Tied ---	Diabetes Mellitus 10	Two Tied 25	Nephritis 66	Septicemia 117	Septicemia 607	Septicemia 832

Indiana Department of Health

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

10 Leading Causes of Death, Indiana

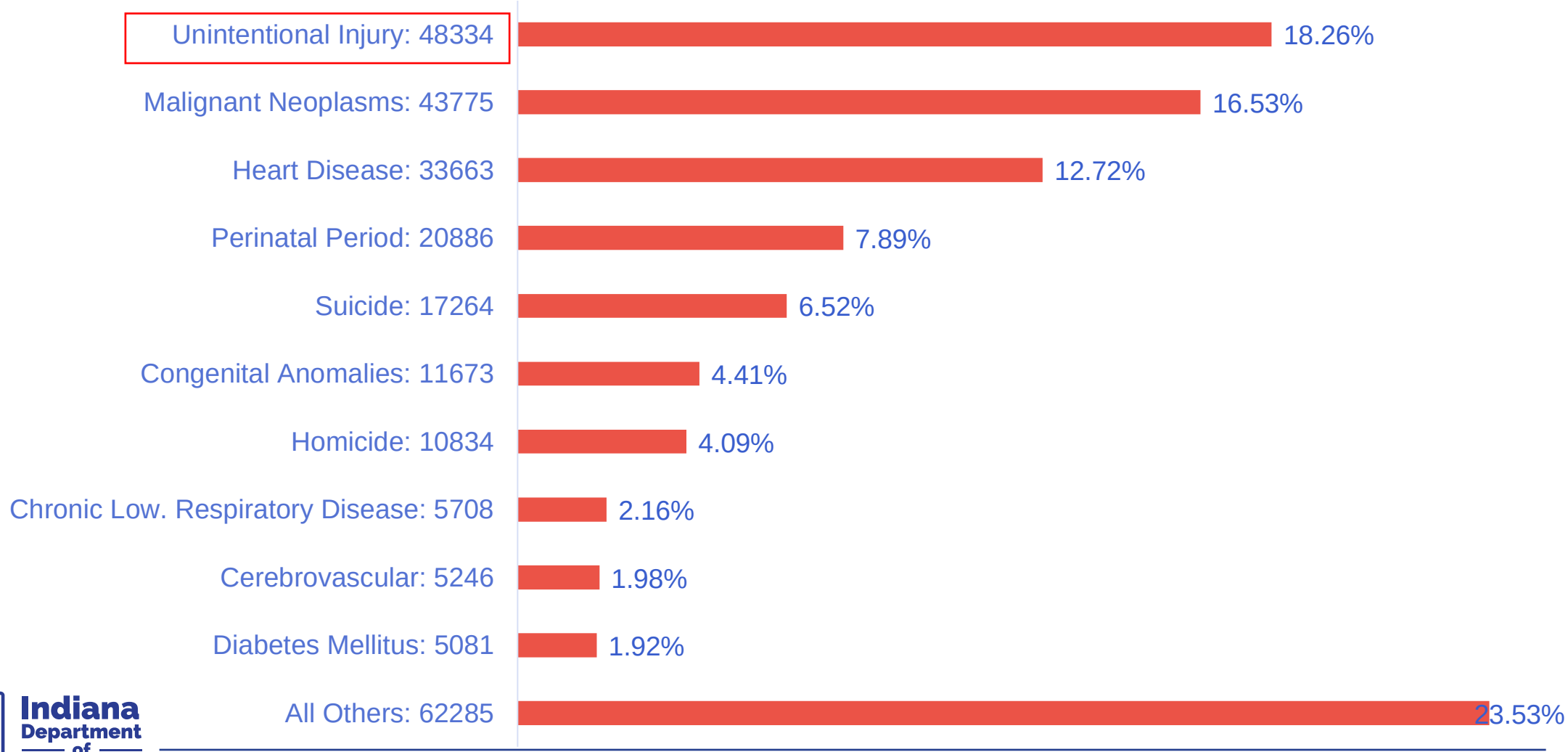
2018, All Races, Both Sexes

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 127	Unintentional Injury 33	Unintentional Injury 18	Unintentional Injury 19	Unintentional Injury 309	Unintentional Injury 603	Unintentional Injury 602	Malignant Neoplasms 827	Malignant Neoplasms 2,698	Heart Disease 11,417	Heart Disease 14,532
2	Short Gestation 109	Congenital Anomalies 13	Malignant Neoplasms ---	Suicide 11	Suicide 168	Suicide 182	Heart Disease 270	Heart Disease 799	Heart Disease 1,937	Malignant Neoplasms 9,601	Malignant Neoplasms 13,479
3	SIDS 48	Homicide 11	Congenital Anomalies ---	Homicide ---	Homicide 121	Homicide 119	Malignant Neoplasms 232	Unintentional Injury 552	Chronic Low. Respiratory Disease 605	Chronic Low. Respiratory Disease 3,844	Chronic Low. Respiratory Disease 4,618
4	Unintentional Injury 36	Malignant Neoplasms ---	Homicide ---	Malignant Neoplasms ---	Malignant Neoplasms 25	Heart Disease 79	Suicide 187	Liver Disease 196	Unintentional Injury 486	Cerebro-vascular 2,710	Unintentional Injury 3,782
5	Maternal Pregnancy Comp. 28	Influenza & Pneumonia ---	Influenza & Pneumonia ---	Congenital Anomalies ---	Heart Disease 22	Malignant Neoplasms 75	Homicide 98	Suicide 188	Diabetes Mellitus 379	Alzheimer's Disease 2,644	Cerebro-vascular 3,151
6	Bacterial Sepsis 20	Benign Neoplasms ---	Cerebro-vascular ---	Chronic Low. Respiratory Disease ---	Congenital Anomalies 13	Liver Disease 22	Liver Disease 71	Diabetes Mellitus 147	Liver Disease 303	Diabetes Mellitus 1,499	Alzheimer's Disease 2,668
7	Placenta Cord Membranes 14	Cerebro-vascular ---	Chronic Low. Respiratory Disease ---	Diseases Of Appendix ---	Complicated Pregnancy ---	Diabetes Mellitus 17	Diabetes Mellitus 46	Chronic Low. Respiratory Disease 133	Cerebro-vascular 266	Nephritis 1,171	Diabetes Mellitus 2,093
8	Respiratory Distress 14	Chronic Low. Respiratory Disease ---	Heart Disease ---	Heart Disease ---	Chronic Low. Respiratory Disease ---	Four Tied 10	Cerebro-vascular 38	Cerebro-vascular 119	Suicide 191	Unintentional Injury 1,124	Nephritis 1,412
9	Neonatal Hemorrhage 12	Heart Disease ---	Septicemia ---	Liver Disease ---	Diabetes Mellitus ---	Four Tied 10	Septicemia 24	Septicemia 74	Septicemia 188	Influenza & Pneumonia 895	Septicemia 1,182
10	Two Tied 11	Nephritis ---	Benign Neoplasms ---	Septicemia ---	Influenza & Pneumonia ---	Four Tied 10	Two Tied 19	Nephritis 59	Nephritis 159	Septicemia 879	Influenza & Pneumonia 1,118

Indiana Department of Health

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

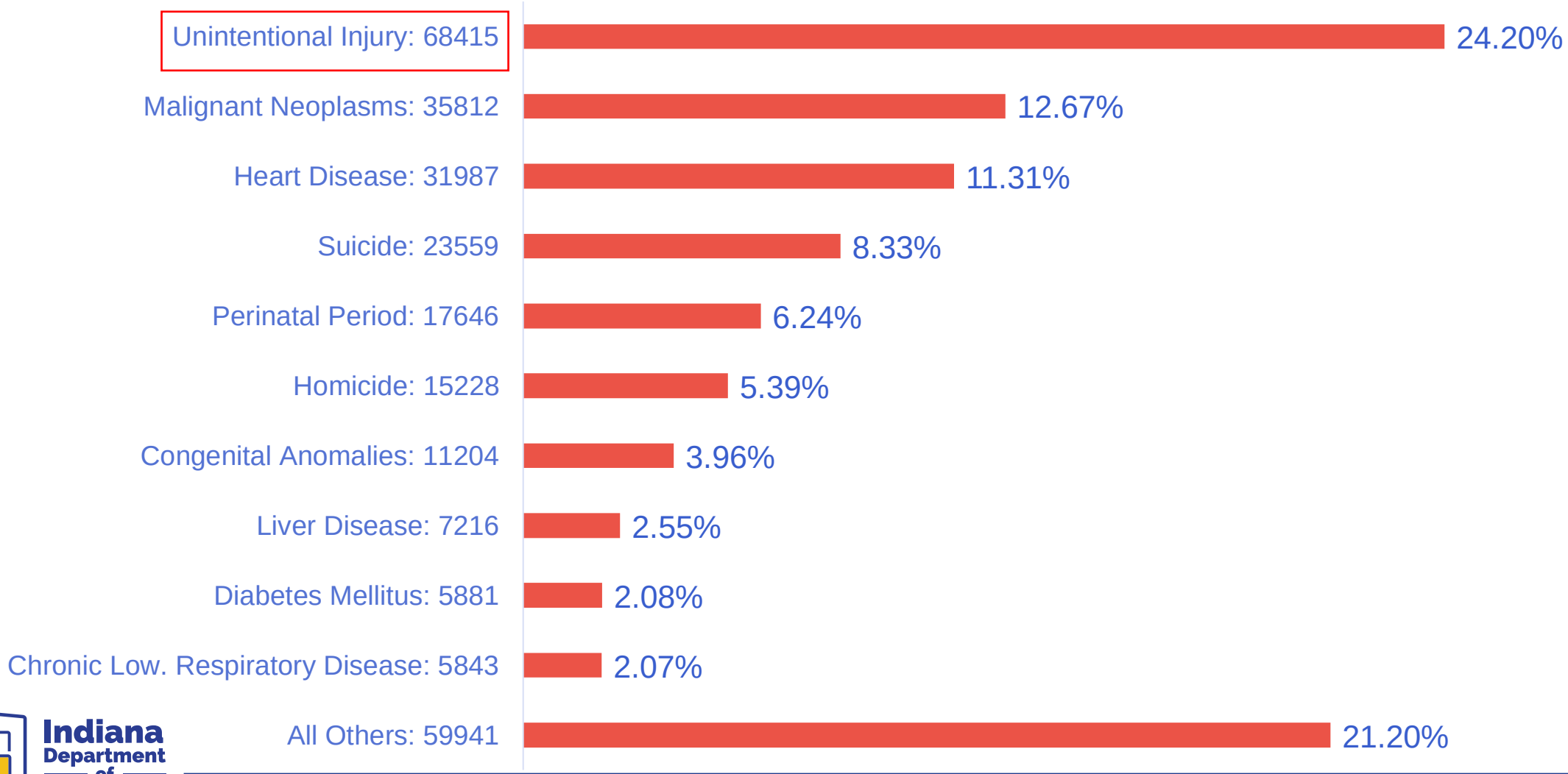
Years Potential Life Lost Before Age 65, Indiana, 2009



Indiana Department of Health

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

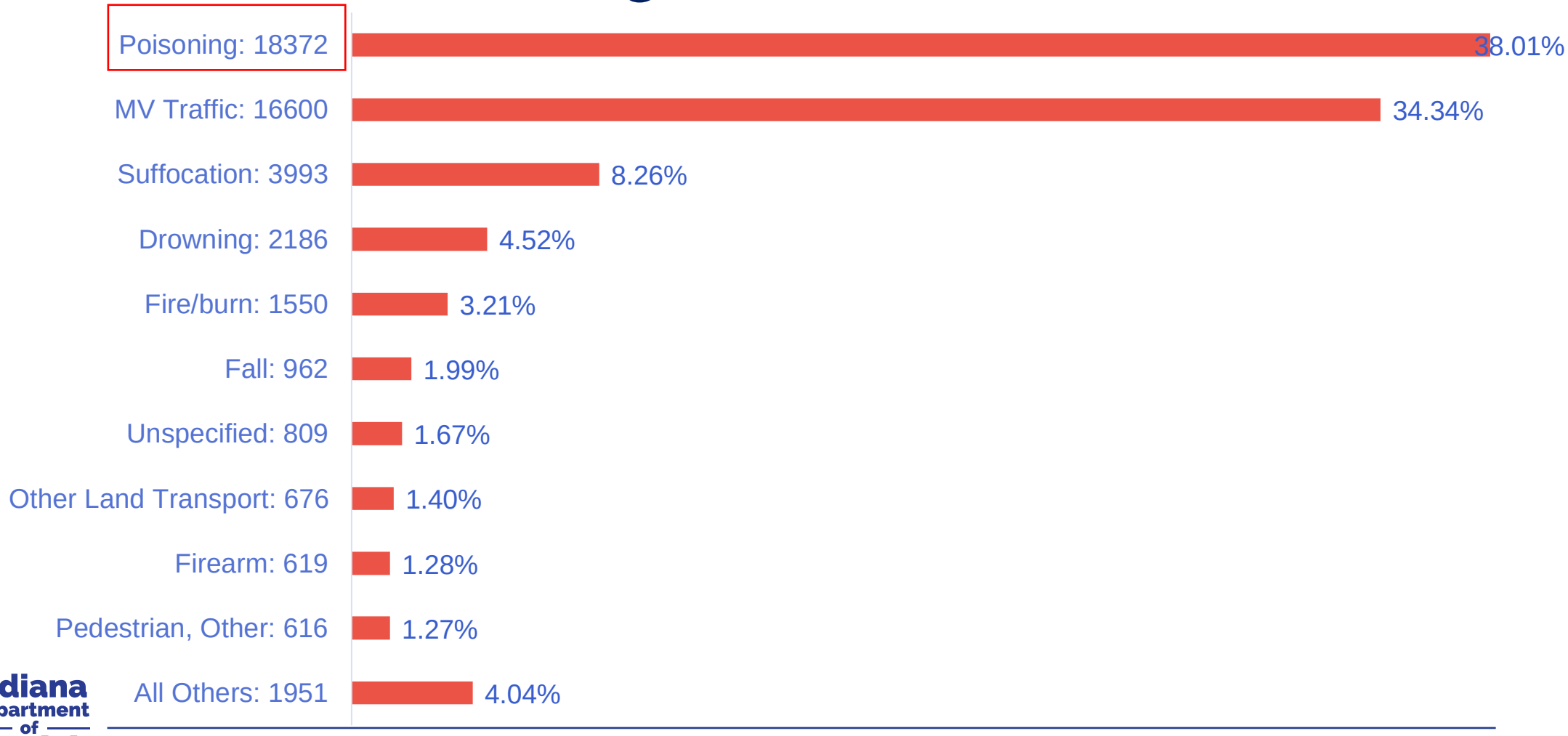
Years Potential Life Lost Before Age 65, Indiana, 2018



Indiana Department of Health

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

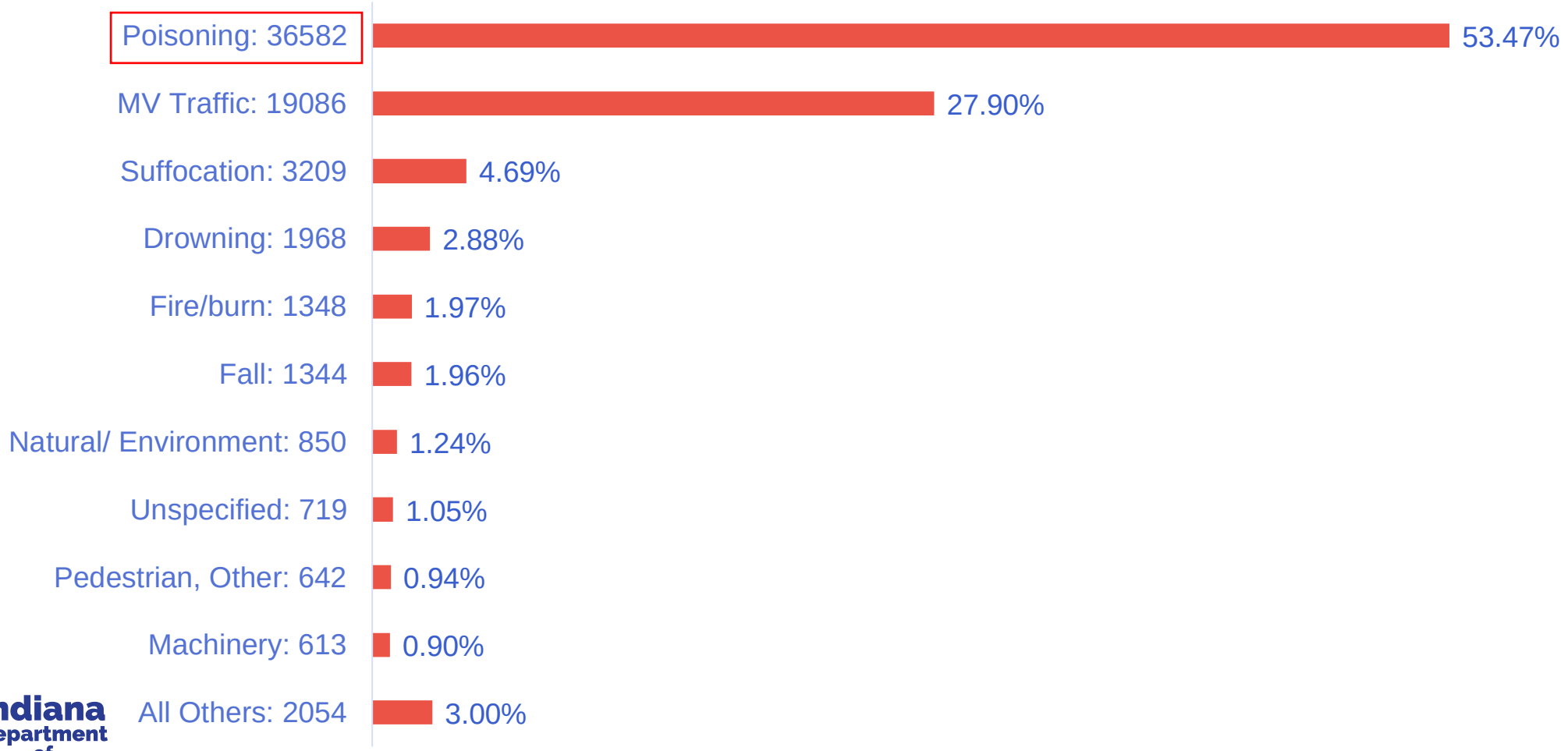
Unintentional Injury Causes of Years Potential Life Lost Before Age 65, Indiana, 2009



Indiana Department of Health

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

Unintentional Injury Causes of Years Potential Life Lost Before Age 65, Indiana, 2018



Indiana Department of Health

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

Indiana Department of Health

INTENTIONAL INJURY DATA PRESENTATION:

REVIEW OF 2020 DATA REQUESTS

Morgan Sprecher, MPH

Indiana Violent Death Reporting System (INVDRS) Epidemiologist

Purpose of Request

Research Project: 4

Analysis: 3

Grant Writing: 3

Presentation: 2

2/19/2020 - Research

Request

- Drug abuse in Indiana (Muncie if available)
  - 2016-2019
- Sex, race, age
- Specifically want deaths with ICD codes:
  - T40.0-5
  - X40-44
  - T42.4
  - T43.6

Results

2016 Overdose Deaths	
Count	1355
Rate (per 100,000 persons)	20.4
Sex	
Male	878
Female	477
Age	
18-25	157
26-35	419
36-45	302
46-55	307
56-65	146
Race	
White	1198
Black	143
Asian	*
American Indian	*
Pacidic Islander	*
Other	0

2017 Overdose Deaths	
Count	1747
Rate (per 100,000 persons)	26.2
Sex	
Male	1143
Female	604
Age	
18-25	200
26-35	484
36-45	458
46-55	368
56-65	195
Race	
White	1515
Black	213
Asian	*
American Indian	*
Pacidic Islander	0
Other	0

2018 Overdose Deaths	
Count	1581
Rate (per 100,000 persons)	23.6
Sex	
Male	1038
Female	543
Age	
18-25	154
26-35	435
36-45	409
46-55	294
56-65	208
Race	
White	1384
Black	177
Asian	*
American Indian	*
Pacidic Islander	0
Other	0

Indiana Department of Health

3/3/2020 – Analysis & Grant Writing

Request

- Suicide deaths at Indiana colleges/universities
  - 2019
  - By county
- Race and sex
- Ages 18-23
- ICD-10 code X83.8

Results

Ages 18-23	Count
Sex	
Male	20
Female	5
Race	
White	17
Black	6
Other	*

* did not do by county due to low count

4/28/2020 – Analysis, Grant, Presentation

Request

- Suicide rates for Hamilton Co & Fishers, IN
  - 2010 – 2020
- All demographics

Results

HAMILTON COUNTY		
Year	Count	Rate per 100,000 persons
2010	19	6.92
2011	13	4.73
2012	29	10.56
2013	26	9.47
2014	24	8.74
2015	34	12.38
2016	38	13.84
2017	36	13.11
2018	40	12.12
2019	35	10.60

FISHERS		
Year	Count	Rate per 100,000 persons
2015	9	11.72
2016	12	15.63
2017	7	9.12
2018	13	13.92
2019	11	11.78

HAMILTON COUNTY 2010-2019		
Age	Count	Rate per 100,000 persons
School Age (5-17)	*	0.74
College Age (18-24)	18	8.86
Young Adult (25-44)	86	12.19
Older Adult (45-64)	101	14.59
Seniors (65 and Older)	27	8.26

Indiana Department of Health

6/9/2020 – Analysis & Grant Writing

Request

- Suicide deaths and attempts in Johnson Co (2016-2019, by year)
- Age and sex

Results

2015 Suicide Deaths	
Count	22
Rate (per 100,000 persons)	14.77
Sex	
Male	18
Female	*
Age	
0-18	0
19-29	5
30-39	*
40-49	5
50-59	*
60-69	*
70-79	4
80+	0

2016 Suicide Deaths	
Count	14
Rate (per 100,000 persons)	9.24
Sex	
Male	12
Female	*
Age	
0-18	0
19-29	*
30-39	0
40-49	6
50-59	*
60-69	*
70-79	0
80+	*

2017 Suicide Deaths	
Count	21
Rate (per 100,000 persons)	13.65
Sex	
Male	15
Female	6
Age	
0-18	*
19-29	5
30-39	5
40-49	*
50-59	*
60-69	*
70-79	*
80+	0

2018 Suicide Deaths	
Count	23
Rate (per 100,000 persons)	14.73
Sex	
Male	19
Female	*
Age	
0-18	*
19-29	*
30-39	*
40-49	*
50-59	*
60-69	*
70-79	0
80+	*

2019 Suicide Deaths	
Count	22
Rate (per 100,000 persons)	13.91
Sex	
Male	17
Female	5
Age	
0-18	0
19-29	*
30-39	*
40-49	*
50-59	7
60-69	*
70-79	*
80+	*

7/31/2020 - Research

Request

- Gun deaths (homicide and suicide) in Vanderburgh Co
  - 2018-2020
- Race, sex, age

Results

2018	
Suicide	23
Homicide	17

Race

White	33
Black	7
Asian	0
American Indian	0
Pacific Islander	0

Sex

Male	35
Female	5

Age

0-14	0
15-24	7
25-34	7
35-44	7
45-54	8
55-64	5
65-74	5
75-84	0
85+	1

8/5/2020 – Grant, Presentation, Research

Request

- Gun-related violence with domestic violence
  - Statewide, 2019-2020
- All age and races

Results

2018	
Suicide	576
Homicide	362

Location (Suicide)

House/Apartment	452
Motor Vehicle	42
Natural Area	26
Street/Road/Alley	13
Park/playground	6

Location (Homicide)

House/Apartment	156
Street/Road/Alley	73
Motor Vehicle	48
Parking lot/garage	21
Commercial establishment	12
Service station	10
Bar/nightclub	7

Age (Suicide)

0-14	*
15-24	91
25-34	75
35-44	90
45-54	105
55-64	109
65-74	60
75-84	36
85+	8

Age (Homicide)

0-14	9
15-24	108
25-34	96
35-44	87
45-54	28
55-64	26
65-74	7
75-84	*
85+	0

2019	
Suicide	87
Homicide	60

Location (Suicide)

House/Apartment	75

Location (Homicide)

House/Apartment	19
Street/Road/Alley	16
Motor Vehicle	14

Age (Suicide)

0-14	*
15-24	11
25-34	16
35-44	13
45-54	5
55-64	14
65-74	13
75-84	9
85+	5

Age (Homicide)

0-14	*
15-24	22
25-34	17
35-44	8
45-54	7
55-64	*
65-74	*
75-84	0
85+	0

8/28/2020 – Grant Writing

Request

- Suicide rates in Indiana
  - 2014-2018
- 10-19 years old

Results

10-14 year olds		
Year	Count	RATE per 100,000 persons
2014	10	2.26
2015	8	1.80
2016	10	2.26
2017	10	2.26
2018	11	2.48

15-19 year olds		
Year	Count	RATE per 100,000 persons
2014	44	9.70
2015	49	10.81
2016	49	10.81
2017	64	14.11
2018	75	16.54

10-19 year olds		
Year	Count	RATE per 100,000 persons
2014	54	6.02
2015	57	6.36
2016	59	6.58
2017	74	8.25
2018	86	9.59

9/18/2020 - Research

Request

- Suicide deaths with previous attempts vs suicide decedents without previous attempt
  - 2008-2019
- Specified age groups & sexes

Results

2016

	Number of Suicides with Attempt History	Number of Suicides with NO Attempt History
Sex		
Female	36	144
Male	56	708
Age		
0-14	*	8
15-24	19	118
25-34	13	135
35-44	13	136
45-54	20	167
55-64	15	133
65-74	8	88
75-84	*	46
85+	*	21

*missing 98 responses

2017

	Number of Suicides with Attempt History	Number of Suicides with NO Attempt History
Sex		
Female	29	142
Male	67	663
Age		
0-14	0	10
15-24	11	109
25-34	35	144
35-44	17	142
45-54	16	162
55-64	11	119
65-74	*	66
75-84	*	34
85+	0	19

*missing 192 responses

2018

	Number of Suicides with Attempt History	Number of Suicides with NO Attempt History
Sex		
Female	54	94
Male	79	358
Age		
0-14	0	5
15-24	23	70
25-34	30	74
35-44	24	73
45-54	28	70
55-64	20	89
65-74	6	42
75-84	*	21
85+	*	8

*missing 506 responses

10/15/2020 - Presentation

Request

- Suicide deaths by occupation
  - 2017-2019
- All demographics

Results

- Over 1,000 line by line items of occupations pulled
  - Requestor sorted out by larger categories

2021 Meeting Dates

January 15
March 19
May 14
July 16
September 17
November 19

THANKS!

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