

# Teen Suicide Prevention Report & Recommendations For the Commission on Improving the Status of Children

Infant & Child Mortality and Child Health Task Force  
Substance Abuse & Child Safety Task Force



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## Executive Summary

The Infant and Child Mortality and Child Health Task Force (ICMCH) and the Substance Abuse and Child Safety Task Force (SACS) of the Commission on Improving the Status of Children have both examined the issue of child and teen suicide in the state of Indiana. The Commission was given a legislative charge, requested by State Senator Jean Breaux, to study the issue during the 2015 Interim Study Committee session. The ICMCH task force was assigned the topic and asked to make recommendations for consideration by the Commission.

Both the ICMCH and SACS task forces held a joint meeting on October 19, 2015 and adopted the following key recommendations for consideration by the Commission:

**In order to prevent suicides, we need the 3 legged stool:**

### OUTREACH & EDUCATION IN SCHOOLS

Leadership, policies, awareness & training of youth, families, and educators (Intervene as early as possible and connect to crisis or treatment services)

- Expand SEA4 Suicide Prevention (2011) to require all teachers be trained in evidence-based suicide prevention and awareness, including a role-playing, skill-based component to demonstrate skill development.
- Incentivize training and education for more youth-serving professionals including child psychiatrists, psychologists, social workers, school counselors, and others and expand the workforce in rural areas.
- Ensure that all schools have a written policy and procedures covering suicide prevention, non-suicidal self-injury, suicide attempts, and suicide postvention (intervention/support after a suicide occurs).

### CRISIS RESPONSE DEMONSTRATION PROJECT

Access to comprehensive psychiatric crisis response and stabilization services (System ready to help when awareness increases)

- Build more comprehensive psychiatric response and stabilization services, similar to recommendation in SB485 Psychiatric Crisis Intervention (2015).

### TREATMENT & WORKFORCE EXPANSION

Access to robust, evidence-based mental health and substance use disorder services staffed with qualified workforce (System ready to help with early intervention and post-crisis follow-up as awareness increases. *Note: There is a severe shortage of mental health therapists and other members of the treatment team – See Appendix G for maps illustrating shortages.*)

- Improve access to both inpatient and outpatient behavioral health programs to promote mental health, relevant social services, and prevent substance abuse, and suicide.
- Expand the mental health and substance use disorder workforce to address the severe shortage.
- Ensure that all professionals serving children are trained in evidence-based suicide prevention, intervention, and postvention (intervention/support after a suicide occurs).

Suicide is the second leading cause of death among youth ages 15-24 in Indiana and the state has the nation's highest rate of high school students contemplating suicide (19%) in the United States. Suicide is a highly

complex problem with many contributing factors including depression, alcohol or drug abuse, family history of suicide, lack of social support and barriers to the access of treatment.

The current statutes relating to suicide prevention include the Suicide Prevention law (SEA4) authored by State Senator Patricia Miller in 2011 and the Mental Health Matters law (HEA1269) authored by State Representative Ed Clere in 2015. SEA4 requires that all new teachers who apply for a license after July 1, 2013 be required to receive training in suicide prevention and awareness and HEA1269 requires that the State Department of Health's (ISDH) Division of Mental Health and Addiction (DMHA) create a Mental Health Matters training for teachers and other professionals and that schools may enter into Memoranda of Understanding (MOU) with local mental health providers or centers as treatment referral options for students. School corporations also have school safety specialists, school counselors and school social workers who can all be trained in suicide prevention, awareness, and postvention support for schools.

Both task forces understand that a comprehensive approach to suicide prevention is needed and that there are many challenges to doing so, but with the public and private sectors joining forces as well as legislative and administrative changes, we can make significant strides to reduce and prevent suicides in youth.

## Introduction

According to *2011 Indiana State Suicide Prevention Plan*<sup>i</sup>, suicide is a complex problem with many factors including biological, psychological, environmental, social and/or cultural at its root. Known risk factors for suicide 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 health and mental health care
- Physical illness
- Feeling alone
- Access to lethal suicide attempt methods

Protective factors also exist to help prevent a person from considering suicide including:

- Problem-solving & conflict resolution skills
- Strong family and community connections
- Access to effective clinical care for mental, physical, and substance use disorders
- Lack of access to lethal suicide attempt methods

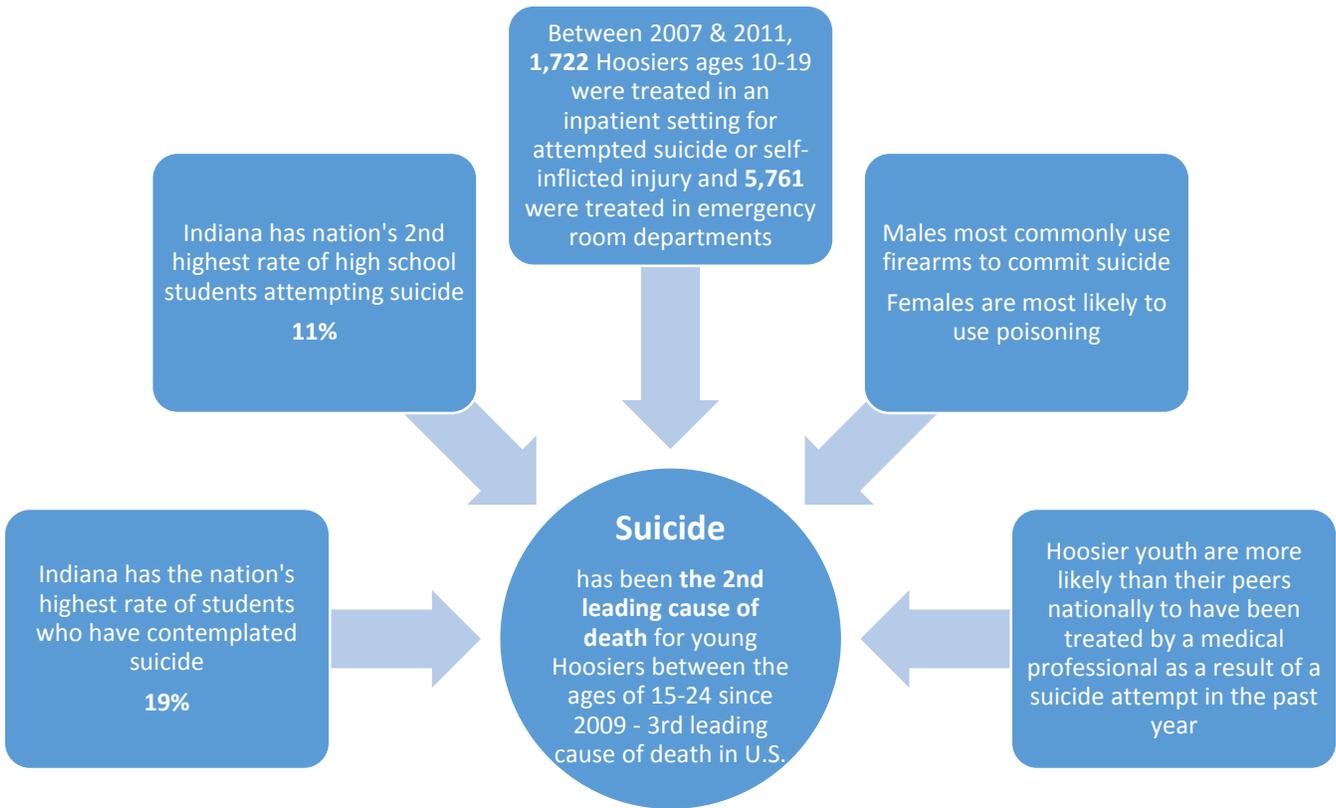
For teenagers and young adults, thoughts of suicide may be precipitated by mental health problems such as anxiety or depression, or by life changes such as parental divorce or moving. Youth who are targets of bullying or who are struggling with understanding their sexual orientation or gender identity may also be at higher risk for considering suicide especially when these youth are concurrently feeling sad or hopeless. A child who is the victim of physical, sexual, or emotional abuse may also be at greater risk of attempting suicide.

Several barriers exist that can hinder effective suicide prevention methods. Barriers include stigma associated with mental illness, geographic barriers, insufficient numbers of qualified professionals, and a lack of awareness of community suicide prevention methods or how to provide help to individuals at risk. It is important to also consider that persons who need treatment for mental health issues may not be willing to seek treatment due to the perceived stigma from family and friends. Additionally, they may be unable to afford mental health treatment due to a lack of insurance coverage and/or because they may not live close enough to a mental health professional or facility.

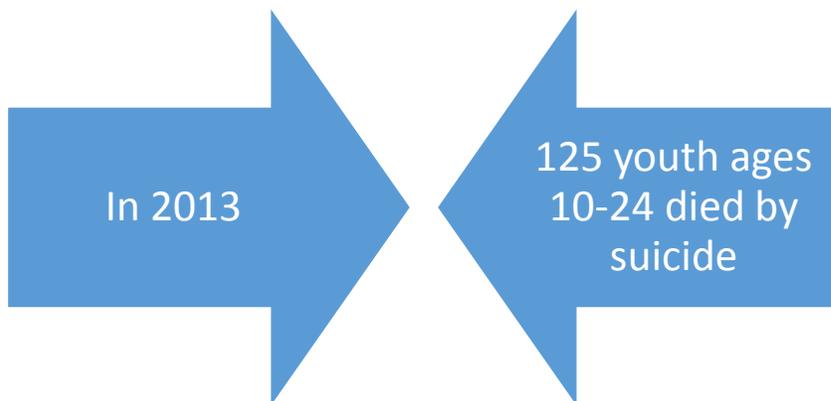
In Indiana, there are several data collection reference points to understand the scope of the problem of teen suicide – The *KIDS COUNT in Indiana Data Book* compiled annually by the Indiana Youth Institute (IYI), the annual mortality report compiled by the Indiana State Department of Health (ISDH) and the *Youth Risk Behavior Survey* compiled nationally by the Centers for Disease Control and Prevention (CDC).

The *KIDS COUNT in Indiana Data Book*<sup>ii</sup> is part of a national network of state-level projects coordinated and supported by the Annie E. Casey Foundation ([www.aecf.org](http://www.aecf.org)). The KIDS COUNT project provides national and state-by-state information about the well-being of children, youth, and their families.

A review of recent data finds:



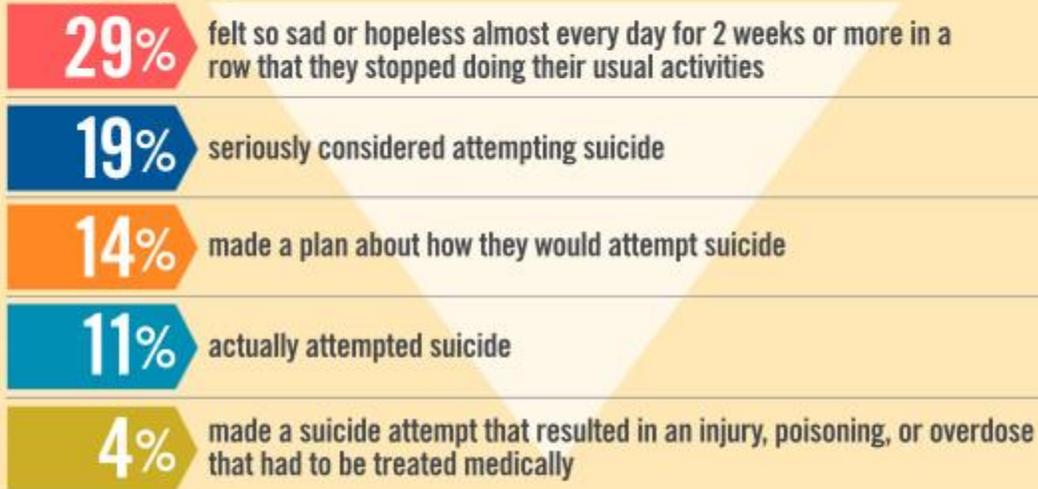
Source: 2015 KIDS COUNT in Indiana Data Book, IYI



Source: 2013 Mortality Report, Indiana State Department of Health (ISDH)

# DEPRESSION *and* SUICIDE

During the past year:



**29** | the average annual number of suicide-related deaths among Indiana 14–18 year olds during 2004–2008 80% were among males

The Indiana YRBS is part of a nationwide surveying effort led by the Centers for Disease Control and Prevention (CDC) to monitor students' health risks and behaviors in six categories. The YRBS is conducted every two years among a representative group of Indiana students in grades 9-12.

Source: 2011 Indiana Youth Risk Behavior Survey, Indiana State Department of Health & Centers for Disease Control and Prevention

Data from the Indiana State Department of Health's *Indiana Youth & Young Adult Self-inflicted Injury & Suicide Data* fact sheet<sup>iii</sup> shows an increasing trend in the rate of suicides among Indiana's youth between 2006 and 2013. The number of suicides, broken down by age group, per year are:

Year	10-14 Years	15-19 Years	20-24 Years	Total 10-24 Years
2006	6	34	57	97
2007	6	36	61	103
2008	6	44	43	93
2009	5	40	69	114
2010	5	38	65	108
2011	<5	45	46	U
2012	7	51	68	126
2013	10	43	72	125

\*Counts under 5 suppressed, total suppressed (U)

The same report also breaks down the suicide deaths from 2011-2013 according to mechanism and age group:

Mechanism	10-14 Years	15-19 Years	20-24 Years	Total
Firearm	7	63	93	163
Suffocation	12	57	73	142
Poisoning	0	9	8	17
Unspecified	<5	<5	6	7
Other Specified, Classifiable	<5	<5	<5	<5
Transport, Other Land	<5	<5	<5	<5
Other Specified, Not Elsewhere Classifiable	<5	<5	<5	<5
Drowning	<5	<5	<5	<5
Fall	<5	<5	<5	<5
Fire/Flame or Hot Object/Scald	<5	<5	<5	<5
Cut/Pierce	<5	<5	<5	<5
<b>Total</b>	<b>20</b>	<b>139</b>	<b>186</b>	<b>345</b>

A research-based estimate from American Association of Suicidology suggests that for each death by suicide 115 people are exposed (14,375 new loss survivors in 2013), and among those, 25 experience a major life disruption (3125 new loss survivors in 2013).<sup>iv</sup>

Additionally, the American Foundation for Suicide Prevention (AFSP), estimates that suicide cost Indiana a total of \$1,023,791,000 of combined lifetime medical and work loss cost in 2010, or an average of \$1,184,944 per suicide death.<sup>v</sup> For further examination of county-level risk or protective factors, including the counties with highest adult suicide death rates in 2013, see Appendix F.

## Enacted Indiana Laws

The following are a summary of laws passed in the past five legislative sessions pertaining to mental health and suicide:

**HEA1269 Health matters (Rep. Clere, 2015)** Requires the division of mental health and addiction to develop a mental health first aid training program. Includes a mental health first aid training program in the: (1) continuing education programs promoted by the emergency medical services commission; and (2) basic or inservice course of education and training for teaching professionals beginning in the 2016-2017 school year. Establishes the mental health counselor licenses for school counselors grant. Authorizes a school corporation to enter into a memorandum of understanding with a mental health care provider or a community mental health center to establish conditions or terms for referring students of the school corporation for services. Requires the school corporation to obtain written parental consent before referring a student to mental health services and limits mental health information that may be included in the student's cumulative record. Prohibits a school counselor or other school corporation employee from diagnosing a student as having a mental health condition unless the diagnosis is within the individual's scope of practice.

**SEA343 Law enforcement training and emergency services (Sen. Lanane, 2014)** Requires the Indiana Emergency Medical Services Commission to establish protocols for persons who provide emergency medical services to notify law enforcement when services have been provided to an individual who has attempted suicide and who has indicated that the attempt was due in part to bullying.

**HEA1423 Antibullying (Porter, 2013)** Requires the department of education, in consultation with school safety specialists and school counselors, to develop guidelines to assist school corporations and safe school committees in establishing bullying prevention programs, investigation and reporting procedures, and discipline rules. Requires each school corporation to include the number and categories of bullying incidents that occur within the school corporation on the school corporation's annual performance report. Requires each school corporation to provide training to school employees and volunteers concerning the school corporation's bullying prevention program, and to provide annual bullying prevention education to students. Modifies the definition of "bullying". Requires each school corporation to include detailed procedures for investigation and reporting of bullying behaviors in the school corporation's discipline rules. Requires each school corporation to include detailed procedures outlining the use of follow-up services for support services for the victim and bullying education for the bully in the school corporation's discipline rules. Sets out a bullying reporting requirement for each school corporation. Requires that if a board of trustees of a state educational institution elects to govern, by regulation or another means, the conduct of students, faculty, employees, and others on the property owned, used, or occupied by the state educational institution, the regulation must include a policy prohibiting bullying.

**SEA4 Suicide prevention (Sen. Pat Miller, 2011)** Allows a governing body to adjourn its schools to allow teachers to participate in a basic or inservice course of education and training on suicide prevention and the recognition of signs that a student may be considering suicide. Requires the division of mental health and addiction to provide information and guidance to local school corporations on evidence based programs for teacher training on the prevention of child suicide 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.)

**HEA1083 Various criminal law matters (Rep. Crouch, 2011)** Provides defenses to the crimes of disseminating matter that is harmful to minors, child exploitation, and possession of child pornography if a cellular telephone was used and the defendant and recipient of the matter are certain ages and meet other requirements. Provides that a school corporation may offer classes, instruction, or programs regarding the risks and consequences of creating and sharing sexually suggestive or explicit materials. Provides that discipline rules adopted by a school corporation must prohibit bullying through the use of computers, computer systems, or computer networks of a school corporation. Provides a defense to child exploitation and possession of child pornography if the acts constituting the offense were performed by a school employee in the course of the person's employment. Requires the criminal code evaluation commission to study certain sex crimes against children during the 2011 interim.

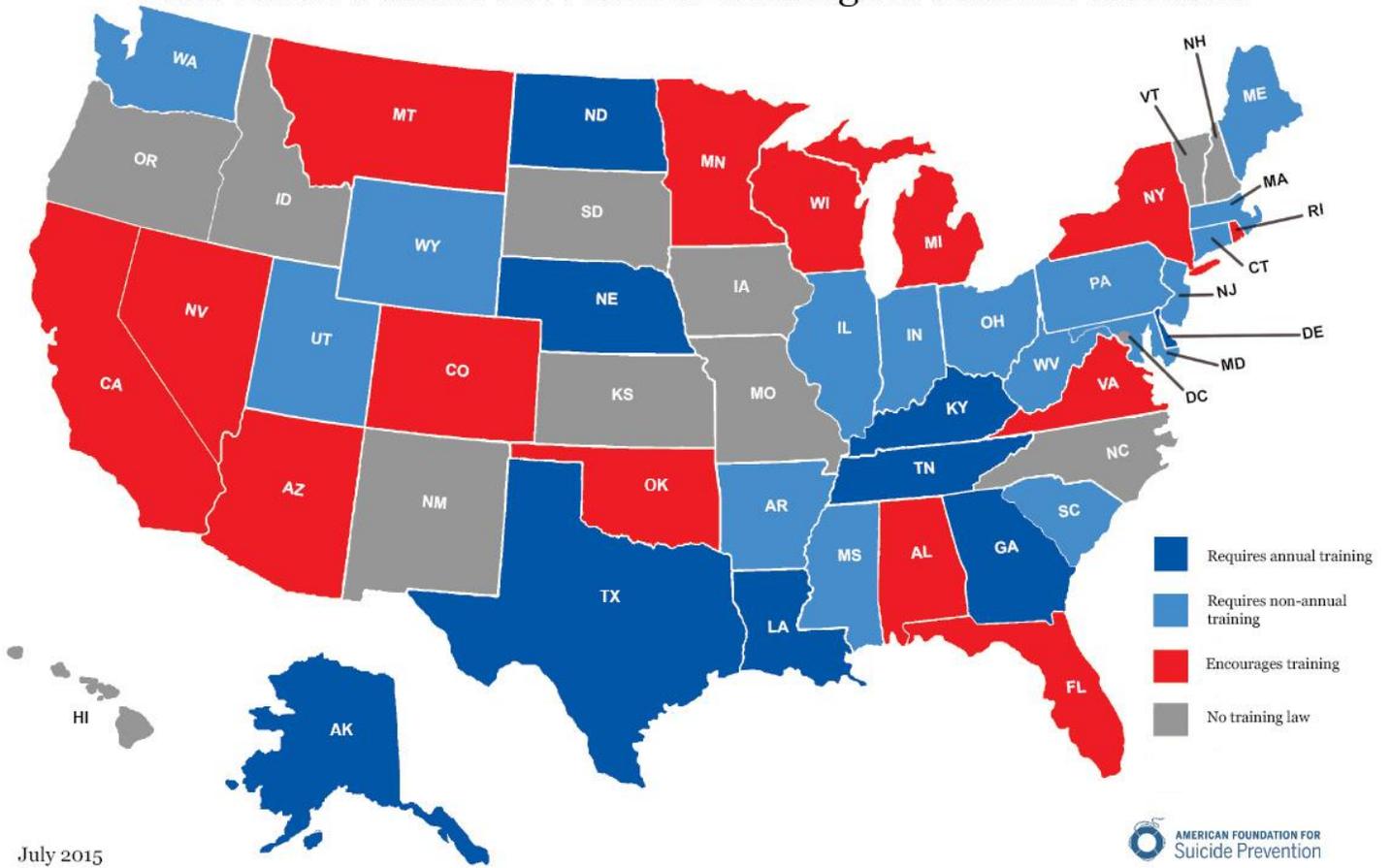
**SEA316 Dating violence (Sen. Rogers, 2010)** Requires the department of education, in collaboration with organizations that have expertise in dating violence, domestic violence, and sexual abuse, to develop or identify model dating violence educational materials and a model for dating violence response policies and reporting. Requires the department to make the model dating violence educational materials and model for dating violence response policies developed or identified available to assist schools with the implementation of dating violence education programs for grades 6 through 12 and dating violence response policies by July 1, 2011.

#### *How Does Indiana Compare?*

It is important to note that while Indiana does require one-time training for all new teachers applying for their teaching license after July 1, 2013, it does not require on-going continuing education for those teachers and it does not require training for teachers licensed prior to July 1, 2013. This constitutes a large gap in the number of teachers trained in suicide prevention and awareness and does not include a comprehensive school-wide approach to prevention and intervention to help identify students potentially considering suicide.

Currently, Indiana does not require schools to have policies or plans in place to address potentially suicidal students or how to respond post-suicide and does not require any awareness education for students.

# State Laws: Suicide Prevention Training for School Personnel





## Indiana Code Pertaining to Safe Schools

### *Indiana Safe Schools Fund (IC 5-2-10.1)*

The Indiana safe schools fund was created to do the following:

- Promote school safety through the use of dogs trained to detect drugs and illegal substances and purchase of other equipment and materials used to enhance the safety of schools.
- Combat truancy.
- Provide matching grants to schools for school safe haven programs.
- Provide grants for school safety and safety plans.
- Provide educational outreach and training to school personnel concerning the identification of, prevention of, and intervention in bullying.
- Provide educational outreach to school personnel and training to school safety specialists and school resource officers concerning the identification of, prevention of, and intervention in criminal gang activities.
- Provide grants for school wide programs to improve school climate and professional development and training for school personnel concerning alternatives to suspension and expulsion and evidence based practices that contribute to a positive school environment, including classroom management skills, positive behavioral intervention and support, restorative practices, and social emotional learning.

### *School Safety Specialists (IC 5-2-10.1-9)*

Each school corporation has a school safety specialist, chosen by the superintendent, who does the following:

- Serves on the county school safety commission, if a county school safety commission is established.
- Participates each year in a number of days of school safety training that the council determines.
- With the assistance of the county school safety commission, develops a safety plan for each school in the school corporation.
- Coordinates the safety plans of each school in the school corporation as required under rules adopted by the Indiana state board of education.
- Acts as a resource for other individuals in the school corporation on issues related to school discipline, safety, and security.

### *School Safety Specialist Training and Certification Program (IC 5-2-10.1-11)*

The school safety specialist training program provides annual training sessions and information concerning best practices and available resources for school safety specialists and county school safety commissions. The department of education is responsible for assembling an advisory group of school safety specialists from around the state to make recommendations concerning the curriculum and standards for school safety specialist training and developing an appropriate curriculum and the standards for the school safety specialist training and certification program. The curriculum developed must include training in identifying, preventing, and intervening in bullying and criminal gang activity. School safety specialists are eligible for a school safety specialist certificate as determined by the Department of Education.

### *Safe school committees (IC 5-2-10.1-12)*

Every school corporation is required to establish a safe school committee. The Department of Education, the school corporation's school safety specialist, and, upon request, a school resource officer provide materials

and guidelines to assist a safe school committee in developing a plan and policy for the school that addresses issues related to:

- Unsafe conditions, crime prevention, school violence, bullying, criminal gang activity, and other issues that prevent the maintenance of a safe school.
- Professional development needs for faculty and staff to implement methods that decrease those problems identified as identified in the schools.
- Methods to encourage involvement by the community and students, development of relationships between students and school faculty and staff, and use of problem solving teams.
- The guidelines developed must include age appropriate, research based information that assists school corporations and safe school committees in:
  - Developing and implementing bullying prevention programs
  - Establishing investigation and reporting procedures related to bullying
  - Adopting discipline rules that comply with the state anti-bullying statute

## Previous Relevant Legislation

***SB485 Psychiatric crisis intervention (Sen. Crider, 2015)*** Changes the date by which the office of the secretary of family and social services must provide a report concerning comprehensive psychiatric crisis intervention services. Requires the division of mental health and addiction to establish a psychiatric crisis intervention pilot program. Makes an appropriation.

***HB1453 Anti-hazing policies (Candelaria Reardon, 2013)*** Requires school corporations and accredited nonpublic schools to establish anti-hazing disciplinary rules. Defines "hazing". Requires approved postsecondary educational institutions to establish an anti-hazing policy.

## Policy Recommendations

Below is a summary of the recommendations put forth by the two task forces of the Commission on Improving the Status of Children – the Substance Abuse & Child Safety Task Force and the Infant Mortality & Child Health Task Force.

**In order to prevent suicides, we need the 3 legged stool:**

### OUTREACH & EDUCATION IN SCHOOLS

Leadership, policies, awareness & training of youth, families, and educators (Intervene as early as possible and connect to crisis or treatment services)

- Expand SEA4 Suicide Prevention (2011) to require all teachers be trained in evidence-based suicide prevention and awareness, including a role-playing, skill-based component to demonstrate skill development.
- Incentivize training and education for more youth-serving professionals including child psychiatrists, psychologists, social workers, school counselors, and others and expand the workforce in rural areas.
- Ensure that all schools have a written policy and procedures covering suicide prevention, non-suicidal self-injury, suicide attempts, and suicide postvention (intervention/support after a suicide occurs).

### CRISIS RESPONSE DEMONSTRATION PROJECT

Access to comprehensive psychiatric crisis response and stabilization services (System ready to help when awareness increases)

- Build more comprehensive psychiatric response and stabilization services, similar to recommendation in SB485 Psychiatric Crisis Intervention (2015).

### TREATMENT & WORKFORCE EXPANSION

Access to robust, evidence-based mental health and substance use disorder services staffed with qualified workforce (System ready to help with early intervention and post-crisis follow-up as awareness increases. *Note: There is a severe shortage of mental health therapists and other members of the treatment team – See Appendix G for maps illustrating shortages.*)

- Improve access to both inpatient and outpatient behavioral health programs to promote mental health, relevant social services, and prevent substance abuse, and suicide.
- Expand the mental health and substance use disorder workforce to address the severe shortage.
- Ensure that all professionals serving children are trained in evidence-based suicide prevention, intervention, and postvention (intervention/support after a suicide occurs).

## Substance Abuse & Child Safety Task Force Recommendations

The full report is attached; below are the key recommendations:

### Suicide Prevention

- Workforce Development
  - Improve suicide screening and assessment tools at the six Department of Mental Health and Addictions State Operated Facilities
  - Mandate evidence-based suicide prevention training for mental health providers
  - Ensure that all teachers are trained in mental health awareness (i.e. mental health first aid) and receive two hours of evidence-based youth suicide awareness and prevention training (expand SEA4 Suicide Prevention)
    - Ensure that funding is available for training teachers
  - Explore ways to create incentives for professional education/training in child psychiatry
  - Increase funding to expand substance abuse and mental health treatment services, particularly in rural areas
  - Work with the American Academy of Pediatrics, IN chapter to increase awareness about mental health, suicide risk, and substance abuse screening for all pediatricians
  - The state shall build a comprehensive psychiatric crisis response and stabilization services
  - The state shall expand the mental health and substance use disorder workforce
- Schools
  - Each school corporation shall enter into a memorandum of understanding with a community mental health center established under IC 12-29-2 or a provider certified or licensed by the division of mental health and addiction to establish conditions or terms for referring students of the school corporation to an appropriate mental health care provider or community mental health center for services.
  - Each school district shall establish a written policy and procedures covering suicide prevention, suicide attempts, and suicide postvention
- State shall provide support and resources to help schools and community agencies identify and implement evidence-base prevention programs that reduce suicide risk factors and build resiliency and other protective factors in youth and families

### Privacy

- Provide guidance on how to avoid the HIPAA/42CFR issues as schools want information that behavioral health providers cannot provide without patient/parental consent
- Modify release of information laws/policies regarding at-risk youth

### Education, Awareness Campaigns & Reduction of Stigma

- Conduct major efforts for stigma reduction across the state
- Enact supportive and inclusive legislation that reduces discrimination
- Make a program like Question, Persuade and Respond (QPR) part of public policy as a periodic local campaign. "Multiple strategies across multiple domains" This would be one strategy & would reach multiple domains, sectors, age groups, etc.
- Work with the American Academy of Pediatrics, IN chapter to increase awareness about mental health and substance abuse screening for all pediatricians

## **Infant Mortality & Child Health Task Force Recommendations**

Overall Recommendation – Revise *2011 Indiana State Suicide Prevention Plan* to include timelines for implementation and accountability. Key recommendations from the plan include:

### **Awareness**

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

### **Prevention**

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

### **Intervention**

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

### **Postvention**

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

### **Evaluation**

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

## Potential Challenges

- In the 2015 legislative session, SEA500 Education deregulation was introduced, the end result of two dozen school corporations hiring a law firm to comb through the state's education statute and remove provisions deemed too burdensome, obsolete or duplicative. One provision that was slated for removal was the training requirement for all new teachers applying for a license to have suicide prevention training, which was passed in SEA4 in 2011.
- Due to the multiple requirements for teacher training but lack of funding for schools to do so, school administrators are not in favor of passing additional unfunded mandates.
- Current training requirements for teachers do not specify that the training must be evidence or research based, although the Indiana Department of Education's list of resources does utilize recommended best-practice programs.
- Schools often lack support service personnel (school counselors, school social workers, and school psychologists) to help with the identification and referral of students for services. Teachers are not equipped to handle mental health issues. Funding is not available for schools to have a support service professional in each school.
- Indiana has gaps in access to mental health treatment including:
  - High ratio of individuals per mental health professionals – 750:1<sup>vi</sup> (Mental Health America, 2015)
  - 71.1% of youth with a serious major depressive episode (MDE) did not receive treatment in 2012-2013<sup>vii</sup>

# Appendices

## Appendix A - Resources

### Indiana Department of Education – Suicide Prevention Resources

Resource Website: <http://www.doe.in.gov/student-services/suicide-prevention-and-response>

#### **Recommended Training for Teachers**

- Society for the Prevention of Teen Suicide – SPTS University <http://sptsuniversity.org/>
- Mental Health First Aid - <http://www.mentalhealthfirstaid.org/cs/about/community-impact/>

#### **Prevention Resources**

- Substance Abuse and Mental Health Administration’s (SAMHSA) *Preventing Suicide: A Toolkit for High Schools* [http://store.samhsa.gov/product/preventing-suicide-a-toolkit-for-high-schools/sma12-4669?wt.ac=eb\\_20130318\\_sma12-4669](http://store.samhsa.gov/product/preventing-suicide-a-toolkit-for-high-schools/sma12-4669?wt.ac=eb_20130318_sma12-4669)
- Suicide Prevention Resource Center (SPRC) <http://www.sprc.org/stateinformation/index.asp>

#### **Response Resources**

- American Foundation for Suicide Prevention (AFSP)
  - *After a Suicide: A Toolkit for Schools* <http://www.doe.in.gov/sites/default/files/student-assistance/afsp.after-suicide.toolkit-schools.pdf>
  - *Talking to Children About Suicide* <http://www.doe.in.gov/sites/default/files/student-assistance/afsp.talking-children-about-suicide.pdf>
  - *Surviving a Suicide Loss: A Resource and Healing Guide* <http://www.doe.in.gov/sites/default/files/student-assistance/afsp.resource-healing-guide.pdf>
- Suicide Prevention Resource Center (SPRC)
  - *Suicide Prevention Resources for Survivors of Suicide Loss* <http://www.doe.in.gov/sites/default/files/student-assistance/sprc.survivors-suicide-loss.pdf>
  - *Sudden death-suicide-critical incident: Crisis response for principals and student services staff* [http://www.sprc.org/library\\_resources/items/sudden-death-suicide-critical-incident-crisis-response-principals-and-studen](http://www.sprc.org/library_resources/items/sudden-death-suicide-critical-incident-crisis-response-principals-and-studen)
- Families for Depression Awareness *Coping After A Suicide* <http://www.doe.in.gov/sites/default/files/student-assistance/families-depression.coping-after-suicide-brochure.pdf>
- U.S. Department of Education *Lessons Learned from School Crises and Emergencies: Responding to a Suicide Cluster* [http://rems.ed.gov/docs/ll\\_vol5issue2.pdf](http://rems.ed.gov/docs/ll_vol5issue2.pdf)

### Other Resources & Programs

- Indiana State Suicide Prevention Task Force - <http://www.in.gov/issp/index.htm>
  - Training Resource List [http://www.in.gov/issp/files/2015\\_updated\\_12\\_19\\_SB4\\_TeacherTrainingPrograms.pdf](http://www.in.gov/issp/files/2015_updated_12_19_SB4_TeacherTrainingPrograms.pdf)
- Suicide Prevention Resource Center Best Practices Registry - <http://www.sprc.org/bpr>
- U.S. Surgeon General & National Alliance for Suicide Prevention: *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, [http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full\\_report-rev.pdf](http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf)

## Appendix B – Key Stakeholders

### Legislative

- *Senator Jean Breaux* – made request for an interim study committee topic which was assigned to Commission on Improving the Status of Children, Infant Mortality & Child Health Task Force
- *Senator Pat Miller* – authored SEA4 (2011) which made suicide prevention training mandatory for all new teachers after July 1, 2013
- *Senator Jim Merritt* – interested in issues related to suicide prevention and substance abuse prevention in teens/young adults
- *Senator Randy Head* – Chair of the Substance Abuse and Child Safety Task Force of the Commission on Improving the Status of Children

### Commission on Improving the Status of Children

*Infant Mortality & Child Health Task Force* – co-chaired by Jane Bisbee (Department of Child Services) & Dr. Jennifer Walthall (Indiana State Department of Health)

- Assigned the legislative study topic

*Substance Abuse & Child Safety Task Force* – chaired by State Senator Randy Head. Studying suicide prevention as it pertains to the intersection of substance use and mental health issues.

- Key Members include – Mindi Goodpaster (Marion County Commission on Youth), Suzanne Clifford & Cathy Boggs (Community Health Network), Sirilla Blackmon (Department of Mental Health and Addictions), and Lisa Rich (Department of Child Services)

### State Suicide Advisory Committee

Statewide network of state agencies, non-profits, organizations and individuals working to coordinate suicide prevention efforts. Key stakeholders include:

- Amy Lentz, Family and Social Services Administration, Coordinator
- Department of Mental Health and Addictions
- Steve McCaffrey, Mental Health America Indiana
- Josh Sprunger, National Alliance on Mental Illness, Indiana Chapter
- Alice Jordan-Miles, Assistant Director, Behavioral Health and Family Studies
- Institute, Indiana University Purdue University - Fort Wayne (IPFW)
- Indiana State Department of Health
- Lisa Brattain, American Foundation for Suicide Prevention, Indiana Chapter
- Community Health Network
- Indiana Youth Group
- Janet Schnell, American Association of Suicidology, Survivor Division Director

### Community Health Network

Received federal grant for Zero Suicides Initiative – led by Suzanne Clifford & Cathy Boggs

- Working with schools and providers on suicide prevention trainings
- Increasing in-patient and out-patient treatment services
- Coordinating suicide prevention text crisis line with Mental Health America Indiana
- Hosting website [www.havehope.com](http://www.havehope.com)

## **Public Policy Statement and Recommendations**

**The Child Safety and Substance Abuse Task Force examined issues related to caretaker substance use disorder, child substance use disorder, child mental health and suicide, child safety related to abuse or neglect in the home and other critical issues. This report includes public policy recommendations to address these issues. The most critical recommendations are highlighted in yellow.**

### **Youth Suicide Prevention**

**Statement:** Youth deaths by suicide and suicide attempts are an alarming public health problem in Indiana. In the U.S., a life is lost to suicide on average every 16 minutes. In Indiana, more Hoosiers died from suicide than homicide, and suicide is the 2nd leading cause of death among 15 – 34 year olds in Indiana. According to the *2011 Indiana Youth Risk Behavior Survey*:

- 29% of Indiana high school students felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing their usual activities
- 19% of Indiana high school students reported that they seriously considered suicide (16.3% males and 21.5% females)
- 11% of Indiana high school students reported that they actually attempted suicide
- One out of 25 Indiana high school students surveyed who reported making an attempt (4%), made a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated medically
- During 2004 – 2008, the average annual number of suicide-related deaths among Indiana 14-18 year olds was 29

Youth suicide is preventable, and schools and educators are one key to the prevention of youth suicide.

**Proposal:** Support legislation and state policy to maintain safe school environments, provide evidence-based training for those in the school setting coming in contact with youth, and connect youth with a continuum of prevention and treatment.

- Require all teachers and certain school personnel to complete two hours of youth suicide awareness and prevention training in order to maintain or renew their licensing credentials.
- Each school corporation shall enter into a memorandum of understanding with a community mental health center established under IC 12-29-2 or a provider certified or licensed by the division of mental health and addiction to establish conditions or terms for referring students of the school corporation to an appropriate mental health care provider or community mental health center for services.
- Each school district shall establish a written policy and procedures covering suicide prevention, suicide attempts, and suicide postvention.
- State shall provide support and resources to help schools and community agencies identify and implement evidence-base prevention programs that reduce suicide risk factors and build resiliency and other protective factors in youth and families.
- The state shall build a comprehensive psychiatric crisis response and stabilization services. *(Please see the next section: Comprehensive psychiatric crisis response and stabilization services)*
- The state shall expand the mental health and substance use disorder workforce. *(Please see the section: Mental Health and Addiction Workforce)*

## **Comprehensive psychiatric crisis response and stabilization services**

**Statement:** Comprehensive psychiatric crisis response and stabilization services are an essential component of a public mental health system. Crisis services work to stabilize a person in crisis. They can eliminate or reduce inpatient hospital stays and costs, provide linkage to necessary services and supports, and improve outcomes for the client.

The demand for psychiatric crisis services continues to climb in Indiana. One central Indiana provider reported an 11% increase in number of clients seeking crisis care at their 24/7 Crisis Center and a 13% increase in call volume to their Crisis Hotline. This increase was from calendar year 2013 to calendar year 2014.

**Proposal:** Support legislation and state policy to allow for the funding of pilot programs, and specifically support Senate Bill 485 (Psychiatric Crisis Intervention) was introduced in the 2015 Session which requires the Division of Mental Health and Addiction to establish a psychiatric crisis intervention pilot program and makes an appropriation for the program.

The language introduced specific to the pilot program reads:

(d) The division of mental health and addiction shall establish a psychiatric crisis intervention pilot program in at least three (3) locations. The pilot programs must be established in rural and urban areas.

(e) The psychiatric crisis intervention pilot programs established under subsection (d) must be selected and evaluated based on the psychiatric crisis services identified in subsection (b) and policies and procedures determined by the division of mental health and addiction. The psychiatric crisis may include services listed in subsection (c)(1) through (c)(11) and any other services determined by the division of mental health and addiction.

(f) The division of mental health and addiction shall evaluate the pilot programs based on criteria determined by the division and the following:

- (1) Recidivism.
- (2) Sustainability.
- (3) Resources investment.
- (4) Cost effectiveness.
- (5) Clinical outcomes.
- (6) Ability to provide twenty-four (24) hour walk-in crisis 9 services.
- (7) Ability to provide mental health and substance use disorder inpatient services.

(g) There is appropriated from the state general fund to the division of mental health and addiction the following:

- (1) Five million dollars (\$5,000,000) to implement psychiatric crisis intervention pilot programs under subsection (d).
- (2) Seventy-five thousand dollars (\$75,000) to study comprehensive psychiatric crisis intervention services and prepare the report required by subsection (b).

## **Mental Health and Addiction Workforce**

**Statement:** Mental health and addiction workforce issues continue to be a concern throughout the country. With the Affordable Care Act requiring all insurers to cover the treatment of drug and alcohol addiction and with the expansion of Medicaid in Indiana through the HIP 2.0 program, the number of Hoosiers seeking addiction treatment is anticipated to increase. The 2013 Substance Abuse and Mental Health Services Administration (SAMHSA) report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues states:

An adequate supply of a well-trained workforce is the foundation for an effective service delivery system. Workforce issues, which have been of concern for decades, have taken on a greater sense of urgency with the passage of recent parity and health reform legislation.

SAMHSA also recognizes that increasing the size of the workforce, recruiting a more diverse, younger workforce, and retaining trained and qualified staff are necessary to provide for the behavioral health needs of the nation's population.

DMHA received a three year Cooperative Agreement Grant in 2012 Substance Abuse Enhancement Dissemination Grant (SAT-ED). From this project the following educational opportunities are being developed:

- On line Certificate Program in conjunction with Indiana University focusing on adolescent substance use.
- ICAADA Certification Specialty focusing on Adolescent Substance Abuse
- IVY Tech offering a minor course in Adolescent Addictions

**Proposal:** Support legislation and state policy to build capacity in the provider network.

- Provide tuition reimbursement and other incentives for professional education/training in child psychiatry, psychiatric nurse practitioners and for Licensed Clinical Social Workers (LCSWs).
- Engage in a state-wide effort to educate and inspire future mental health and addiction practitioners by engaging high school populations and other populations to consider working in the helping profession.
- Encourage addiction providers to become Medicaid providers by providing technical assistance on licensing and certification, how to create a business infrastructure to perform Medicaid billing, pass audits, etc.
- Pursue federal programs and funding for designated shortage areas.

### **Effective Substance Abuse Prevention and Treatment for Substance Use Disorder**

**Statement:** All too often funding for substance use disorder care is restricted or insufficient for treatment needs. With the prescription drug abuse epidemic, heroin use on the rise, and the troubling prevalence of alcohol and marijuana use among teens, increased investment in treatment programs is essential.

The same is true for the prevention of substance abuse, which is often neglected and woefully underfunded. SAMHSA's National Registry of Evidence-based Programs and Practices offers schools and communities a menu of universal, selective, and indicated strategies to prevent substance abuse and related risky behaviors. Every Indiana school and community would also benefit from utilizing SAMHSA's Strategic Prevention Framework, which is an effective way to guide prevention planning, implementation, evaluation, and improvements.

Using the SAT-ED grant, this summer training was provided to all of the school social workers and counselors in Indianapolis Public Schools (IPS) on Screening Brief Intervention and Referral (SBIRT). Depending on the success and linkage with mental health teams in the schools, this training and process could be replicated in other school systems in the state.

**Proposal:** Support legislation and state policy to:

- Fund a demonstration project for treatment for mental health and substance use disorder for transitioned age youth requiring evidence based practices or promising practices be utilized.
- Fund two demonstration projects for prevention of Neonatal Abstinences Syndrome (NAS). A task force was formed by ISDH as a result of SEA 408 from the 2014 Session which calls for the study of neonatal abstinence syndrome (NAS) and implementation of one or more pilots. The task force has developed a protocol for screening pregnant women for addictive substances. If a pregnant woman has a positive screen, treatment would then be provided so that she can successfully address addiction issues

and have a better chance of delivering a baby without NAS. Ensure that funding for treatment and care coordination is funded.

- Provide and build capacity for a continuum of treatment options that focus on adolescent substance abuse as the primary.
- Provide and build capacity for a continuum of evidence-based prevention strategies for schools and communities that reduce risk factors and increase protective factors in youth and families.

## **Other Public Policy Suggestions**

### **Prevention**

- Improve suicide screening and assessment tools at the six DMHA State Operated Facilities

### **Treatment**

- Provide access to naloxone and link to treatment
- Increase funding for youth mental health services
- Provide more substance abuse treatment options. Increase access, increase funding, increase Medication Assisted Treatment)
- Build capacity to deliver intensive substance use disorder treatment (such as the START program) for families to improve child safety and treatment outcomes

### **Workforce Development**

- Mandate evidence based suicide prevention training for mental health providers
- Ensure that all teachers are trained in mental health awareness and suicide prevention
- Ensure that funding is available for training teachers

### **Suicide Prevention**

- Ensure that all teachers are trained in mental health awareness (i.e. mental health first aid) and suicide prevention
- Ensure that funding is available for training teachers
- Explore ways to create incentives for professional education/training in child psychiatry
- Increase funding to expand substance abuse and mental health treatment services, particularly in rural areas
- Work with the American Academy of Pediatrics, IN chapter to increase awareness about mental health and substance abuse screening for all pediatricians

### **Privacy**

- Provide guidance on how to avoid the HIPAA/42CFR issues as schools want information that behavioral health providers cannot provide without patient/parental consent
- Modify release of information laws/policies regarding at-risk youth

### **Education, Awareness Campaigns & Reduction of Stigma**

- Conduct major efforts for stigma reduction across the state
- Enact supportive and inclusive legislation that reduces discrimination
- Make a program like Question, Persuade and Respond (QPR) part of public policy as a periodic local campaign. “Multiple strategies across multiple domains” This would be one strategy & would reach multiple domains, sectors, age groups, etc.

- Work with the American Academy of Pediatrics, IN chapter to increase awareness about mental health and substance abuse screening for all pediatricians
- Increase Medication Assisted Treatment (MAT) education to combat the perception that using MAT is trading one drug for another

## Appendix D – Indiana State Suicide Prevention Plan

*See separate document attached.*

## American Foundation for Suicide Prevention

### **AFSP Model Legislation: Suicide Prevention in Schools**

(1) Beginning in the 2016-2017 school year, the State *Board/Department* of Education shall adopt rules to require that all public school personnel receive at least 2 hours of suicide awareness and prevention training each year\*. This training shall be provided within the framework of existing in-service training programs offered by the State *Board/Department* of Education or as part of required professional development activities.

(2) The State *Board/Department* of Education shall, in consultation with *state agency/coalition charged with coordinating state suicide prevention activities, other stakeholders, and suicide prevention experts*, develop a list of approved training materials to fulfill the requirements of this Section.

(a) Approved materials shall include training on how to identify appropriate mental health services both within the school and also within the larger community, and when and how to refer youth and their families to those services.

(b) Approved materials may include programs that can be completed through self-review of suitable suicide prevention materials.

(3)

(a) Each public school district shall adopt a policy on student suicide prevention. Such policies shall be developed in consultation with school and community stakeholders, school employed mental health professionals, and suicide prevention experts, and shall, at a minimum, address procedures relating to suicide prevention, intervention, and postvention.

(b) To assist school districts in developing policies for student suicide prevention, the Department of Education shall develop and maintain a model policy to serve as a guide for school districts in accordance with this section.

(4)

(a) No person shall have a cause of action for any loss or damage caused by any act or omission resulting from the implementation of the provisions of this Section or resulting from any training, or lack thereof, required by this Section.

(b) The training, or lack thereof, required by the provisions of this Section shall not be construed to impose any specific duty of care.

\*In those states where the legislature must amend section (1) to require training less often, for example, once every 5 years, or that remove a frequency requirement entirely, a new section will be added that states: The State *Board/Department* of Education shall adopt rules to require that all newly employed public school personnel receive at least 2 hours of suicide awareness and prevention training within 12 months of their date of hire.

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

## MODEL LEGISLATION – WORKFORCE/LOAN FORGIVENESS

### DEFINITIONS

“Child Psychiatrist” means a physician who specializes in the prevention, diagnosis and treatment of mental illness with additional training in child psychiatry.

“Department” means the Department of Health of the State.

“Program” means the Child Psychiatrist Loan Forgiveness Program.

### LOAN FORGIVENESS PROGRAM

The Program will be administered by the Department.

1. Applications – The Department shall promulgate guidelines for the selection of candidates to the program based upon the following criteria:
  - a. Demonstrated need.
  - b. Willingness to continue practicing as a child psychiatrist in the state after completing the program.
2. Eligibility – A program applicant must be:
  - a. A citizen of the United States
  - b. Licensed to practice medicine in the state.
3. Verification – The department shall monitor and verify a physician’s fulfillment of all requirements of the program.
4. Amount of Loan Forgiveness – A physician accepted into the program may be reimbursed an amount up to \$50,000 per year for each year of specialty training in child psychiatry based upon the following repayment assistance schedule:
  - a. First year of service, 20%.
  - b. Second year of service, 20%.
  - c. Third year of service, 20%.
  - d. Fourth year of service, 20%.
  - e. Fifth year of service, 20%.
5. Contract – Physician receiving loan forgiveness shall enter into a contract with the department. The contract shall include, but not be limited to, the following terms and conditions:
  - a. The physician shall agree to practice not fewer than the five full consecutive years in the state immediately following completion of specialty training pursuant to the schedule provided in this section.
  - b. The physician shall agree to practice on a full time basis.
  - c. The physician shall permit the department to monitor compliance with the work requirement.
  - d. The contract shall be renewable on an annual basis upon certification by the department that the physician has complied with the terms of the contract.

- e. The contract shall terminate if the physician dies, is not able to perform the duties of a child psychiatrist or is not able to maintain the physician's license to practice medicine due to physical or mental disability.
- f. If the physician's license to practice is suspended or revoked, the department shall have the authority to terminate the physician's participation in the program and demand repayment of all loan forgiveness payments rendered to date.
- g. A physician who fails to begin or complete the obligations contracted for shall reimburse the state all amounts received under this act and interest thereon as determined by the department. Both the physician and the department shall make every effort to resolve conflicts in order to prevent a breach of contract.
  - i. Contract enforcement – the department shall have the authority to seek garnishment of wages for the collection of damages provided for in subsection (5)(g).
6. Disqualification – Any person who knowingly or intentionally procures, obtains or aids another to procure or obtain loan forgiveness under this act through fraudulent means shall be disqualified from participation and shall be liable to the department for an amount equal to three times the amount obtained.
7. Tax Consequences -- Loan forgiveness payments received by a physician shall not be considered taxable income.
8. Limitation – Participation in the program is limited to no more than four physicians a year unless sufficient funding is available to reimburse more than four physicians a year in accordance with this act.
9. Regulations – The department may adopt regulations and procedures necessary to carry out the purposes of this act.
10. Funding – Loan forgiveness repayments shall be made to the extent that funds are appropriated to the Child Psychiatrist Loan Forgiveness Program by the State Legislature.

## Appendix F – Indiana Counties with Highest and Lowest Adult Suicide Death Rates and Certain Risk & Protective Factors - 2013

Source: Indiana Mortality Report, 2013 <http://www.in.gov/isdh/reports/mortality/2013/index.htm>

### County Rankings According to Total Number over 20 and Age-Adjusted Death Rate

County	# of Deaths	Age-Adjusted Death Rate	% Persons Below Poverty Level †	% Unemployment Rate ††	Health Outcomes Rank (among 92 IN counties; 50 states + DC) †††	Family & Social Support System Rank †††	Access to Health Care Rank (2014) †††	Ratio – Mental Health Providers to Population (2013) †††	Status of Indiana Syringe Access Program (SAP) (10/21/15) †††
1. Vigo	23	22.52	20.0	9.5	59	78	22	861:1	Community members working toward potential
2. Vanderburgh	33	18.04	15.9	7.2	76	86	6	719:1	Community members working toward potential
3. Johnson	25	17.26	10.6	6.3	13	44	5	2020:1	
4. LaPorte	20	17.08	16.5	9.4	65	82	48	1456:1	
5. Porter	28	16.05	10.4	7.2	18	40	9	885:1	
6. Tippecanoe	25	15.89	21.6	6.7	20	33	37	960:1	Community members working toward potential
7. Marion	150 (22 ages 15-24)	15.63	20.4	8.4	82	90	24	535:1	
8. Madison	20	14.60	17.3	9.3	75	84	33	1240:1	State approved SAP
9. St. Joseph	36	13.40	17.7	8.8	43	77	25	609:1	Community members working toward potential
10. Lake	59 (13 ages 15-24)	12.37	17.8	9.2	84	89	45	758:1	
11. Allen	42	11.53	15.3	7.5	35	57	35	812:1	County health director declares Hepatitis C or HIV epidemic related to injection drug use
12. Elkhart	22	10.83	16.7	7.3	19	67	86	1155:1	Community members working toward potential
13. Hamilton	29	9.70	5.1	5.1	1	3	1	924:1	

†Source: United States Census Bureau

†† Source: Bureau of Labor Statistics, 2013 <http://www.bls.gov/lau/#cntyaa>

††† Source: Indiana Prevention Resource Center, <http://www.drugs.indiana.edu/prev-stat/county-profiles-data>

### County Rankings According to <1 Total Suicides

County	# of Deaths	% Persons Below Poverty Level	% Unemployment Rate ††	Health Outcomes Rank (among 92 IN counties; 50 states + DC) †††	Family & Social Support System Rank †††	Access to Health Care Rank (2014) †††	Ratio – Mental Health Providers to Population (IN rate 916:1) (2013) †††	Status of Indiana Syringe Access Program (SAP) (10/21/15) †††
Adams	0	18.1	6.2	13	28	80	6957:1	
Blackford	0	16.0	9.9	90	91	57	12665:1	
Ripley	0	9.4	8.7	29	53	53	2639:1	

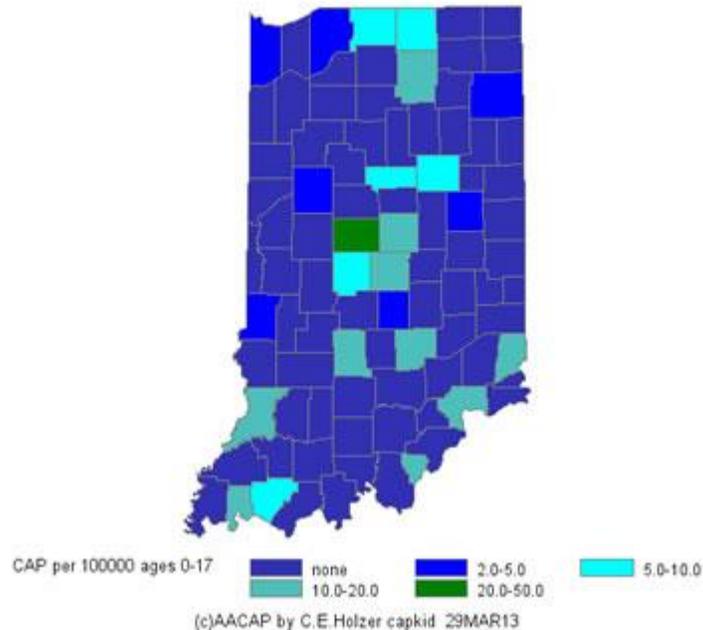
County	# of Deaths	% Persons Below Poverty Level	% Unemployment Rate ††	Health Outcomes Rank (among 92 IN counties; 50 states + DC) †††	Family & Social Support System Rank †††	Access to Health Care Rank (2014) †††	Ratio – Mental Health Providers to Population (IN rate 916:1) (2013) †††	Status of Indiana Syringe Access Program (SAP) (10/21/15) †††
Crawford	1	19.6	10.0	89	82	67	2681:1	
Ohio	1	8.3	8.2	43	39	39	6131:1	
Pike	1	12.7	6.9	67	68	66	2595:1	
Vermillion	1	15.8	10.8	80	60	52	2708:1	

## Appendix G – Mental Health Professional Estimated Shortages

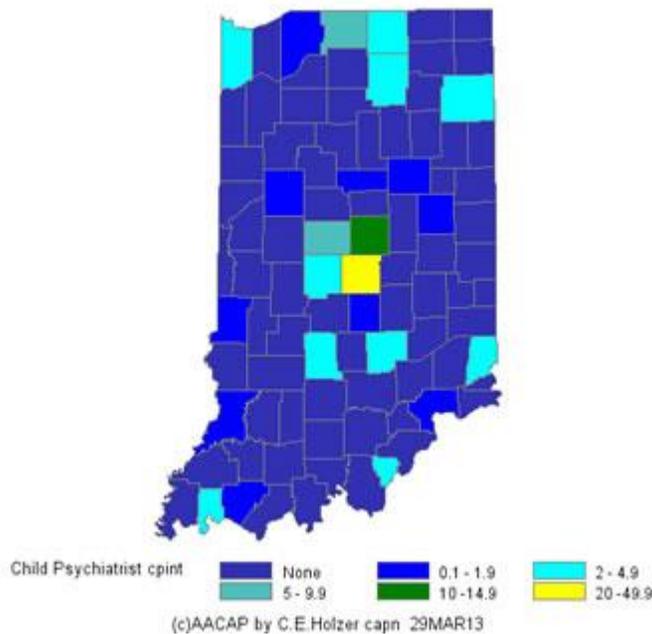
This information is presented to be used as a guide on understanding the possible gaps in mental health services in Indiana, but due to limitations in data collection and interpretation, should not be used exclusively to determine the actual needs in regions and communities.

### Indiana: Practicing Child and Adolescent Psychiatrists – American Academy of Child & Adolescent Psychiatry

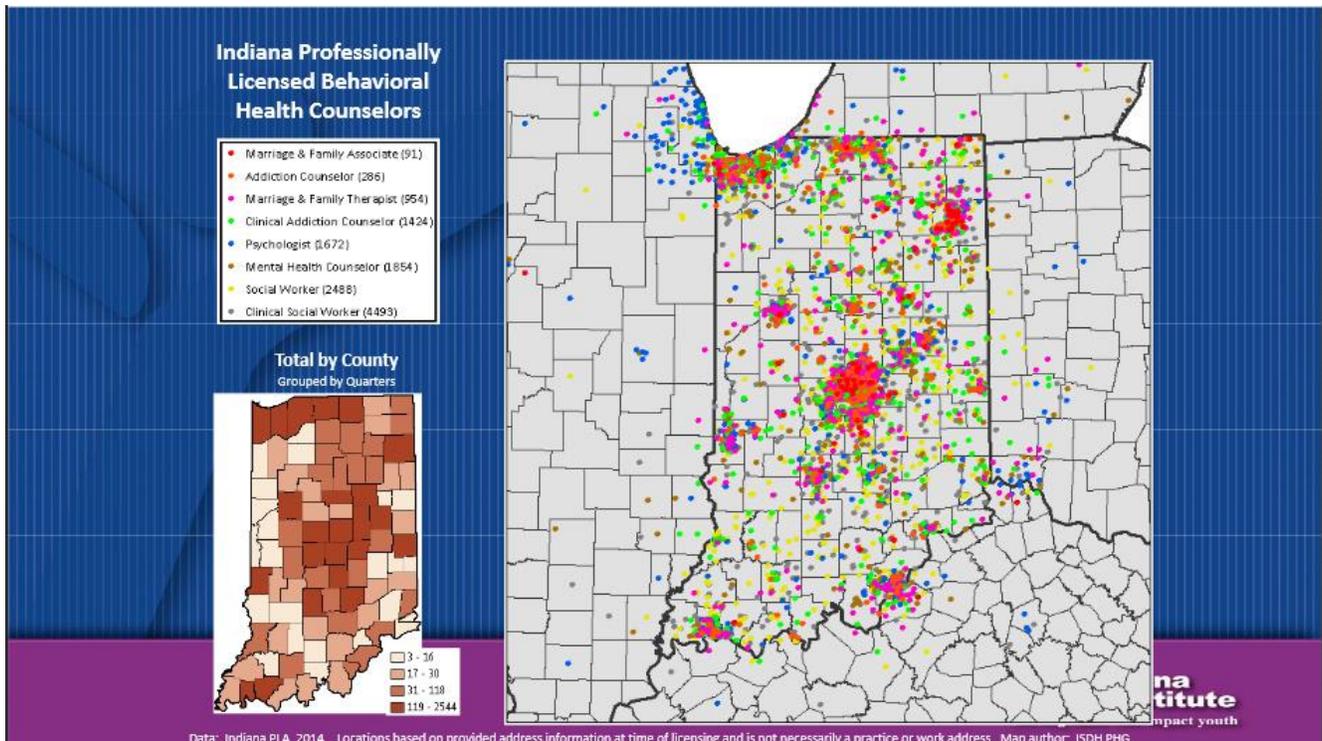
**Indiana: Practicing Child and Adolescent Psychiatrists 2012**  
Rate per 100,000 children age 0-17



**Indiana: Practicing Child and Adolescent Psychiatrists 2012**  
Number per county



[http://mobile.aacap.org/AACAP/Advocacy/Federal and State Initiatives/Workforce Maps/Indiana.aspx](http://mobile.aacap.org/AACAP/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Indiana.aspx)



Data: Indiana PLA, 2014. Locations based on provided address information at time of licensing and is not necessarily a practice or work address. Map author: ISDH PHG.

Source: Data Mapping Task Force presentation to Commission on Improving the Status of Children, February 18, 2015

<sup>i</sup> 2011 Indiana State Suicide Prevention Plan, [https://secure.in.gov/isdh/files/SuicidePrevPlan\\_Final.pdf](https://secure.in.gov/isdh/files/SuicidePrevPlan_Final.pdf)

<sup>ii</sup> 2015 KIDS COUNT in Indiana Data Book, <http://www.iyi.org/resources//pdf/KC-DATA-BOOK-IYI-2015.pdf>

<sup>iii</sup> Indiana State Department of Health, *Indiana Youth & Young Adult Self-inflicted Injury & Suicide Data*, [http://www.in.gov/isdh/files/suicide\\_prevention\\_data.pdf](http://www.in.gov/isdh/files/suicide_prevention_data.pdf)

<sup>iv</sup> Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2015) and Washington, DC: American Association of Suicidology, dated April 24, 2015, downloaded from <http://www.suicidology.org>.

<sup>v</sup> SUICIDE: INDIANA 2015 FACTS & FIGURES, <http://www.afsp.org>

<sup>vi</sup> Mental Health America 2015 Mental Health Workforce Availability Ranking, <http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data#Workforce>

<sup>vii</sup> Mental Health America, <http://www.mentalhealthamerica.net/issues/mental-health-america-access-care-data#Youth%20No%20Tx>