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

09/17/2021
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
WELCOME, BRIAN BUSCHING!

INTERIM DIVISION OF TRAUMA AND INJURY PREVENTION DIRECTOR
Division Vacancies

• Injury Prevention Epidemiologist
• Drug Overdose Prevention Epidemiologist
• INVDRS Records Consultant (Abstractor)
Division Fall Interns

INVDRS
  ◦ Chantal Lompo

Trauma
  ◦ Jocelyn Grider

Drug Overdose Prevention
  ◦ Sara Rivera

Naloxone Program
  ◦ Jada Burton
Resource Guide App

Regularly Updated
• Free download for iOS & Android
Phone & tablet capabilities
• Available in Apple & Google Play stores
Upcoming Events

September
• Nation Suicide Prevention Month
• National Recovery Month
• Infant Mortality Awareness Month

October
• National Domestic Violence Awareness Month
• Eye Injury Prevention Month
• National Substance Abuse Prevention Month
• National Crime Prevention Month

**September 17:** National Concussion Awareness Day

**September 19-25:** Child Passenger Safety Week

**October 10:** World Mental Health Day

**October 17-23:** Teen Driver Safety Week
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana State Trauma Care Committee, 10 am EST</td>
<td>September 20th</td>
</tr>
<tr>
<td></td>
<td>November 19th</td>
</tr>
<tr>
<td>Indiana Trauma Network, 12:30 pm EST</td>
<td>September 20th</td>
</tr>
<tr>
<td></td>
<td>November 19th</td>
</tr>
</tbody>
</table>
INTENTIONAL INJURY PRESENTATION:

INDIANA CENTER FOR PREVENTION OF YOUTH ABUSE & SUICIDE

Maggie Owens
Director of Education and Community Relations
501(c)(3) not-for-profit that opened its doors on April 30, 2001 as a child advocacy center.

We currently serve nine Central Indiana counties: Hamilton, Boone, Hancock, Marion, Hendricks, Tipton, Owen, Delaware, and Madison.

Programs:
- Child Lures/Teen Lures Prevention
- Stewards of Children®
- Lifelines and QPR
1 in 4 children have experienced at least one form of abuse or neglect.*

Since 2012, the number of child abuse and neglect reports made to the Indiana Department of Child Services has increased 30%.

The direct lifetime cost of child maltreatment in one year is estimated at $124 billion.*

*Source: Centers for Disease Control
Child Abuse Prevention Programs

We’ve adopted evidence-based Child Lures and Teen Lures programs to meet the legislative requirements. Through our newly expanded program, we still provide child sexual abuse prevention education, but now our program also works to prevent all forms of child abuse, neglect, and bullying.
Requires all students in grades K-12 receive YEARLY child abuse prevention education.

Legislation includes all forms of child abuse, neglect, and bullying.

Education must be Evidence-Based.

Requires the Indiana Department of Education to supply programming resources.

Mandate is UNFUNDED by the state.
ICPYAS has also developed, piloted, and implemented a curriculum for students with special needs that includes auditory, visual, and kinesthetic materials to meet the unique needs of this vulnerable population.
In 2017, 25,711 Students in grades K, 2, and 4 participated in our Smart Steps program.
In the 2018-2019 school year, 105,450 Students in grades K-12 have received our newly expanded child abuse, neglect, and bullying prevention program.
Middle and High School Program

ICPYAS has implemented Teen Lures Prevention in 27 middle and high schools throughout Central Indiana in the 2018-2019 school year reaching over 42,000 teens.
Stewards of Children is a child sexual abuse prevention program that educates adults to prevent, recognize and react appropriately to child sexual abuse.

This training program is designed for parents and any adults who work with children or adolescents. Stewards of Children is the only nationally available program scientifically proven to increase knowledge, improve attitudes and change child-protective behaviors.
One in 10 children will experience sexual abuse by their 18\textsuperscript{th} birthday.

90\% of victims know their abuser.

Only about 38\% of child victims disclose abuse.

As many as 40\% of abuse occurs at the hand of older, more powerful children.

81\% of child sexual abuse occurs in one-on-one situations.
Stewards of Children Participants

- Carmel Clay Parks and Recreation
- Fishers Parks and Recreation
- Northview Church
- Our Lady of Mount Carmel School
- The O’Connor House
- Noblesville Schools
- Deveau’s Gymnastics
Requires all teachers working with students in grades 5 - 12 receive suicide awareness and prevention education every TWO years.

May require other staff working with students in grades 5-12 receive this education.

Education must be Evidence-Based.

Requires the Indiana Department of Education to supply programming resources.

Mandate is UNFUNDED by the state.
➢ Indiana has the highest rate of suicidal ideation (19%) and the 2\textsuperscript{nd} highest rate (11%) of suicide attempts for teens in the United States.\textsuperscript{1}

➢ Indiana’s suicide rate increased more than 30% from 1996 to 2016.\textsuperscript{2}

➢ Children who are abused are at significantly greater risk for later posttraumatic stress, anxiety, depression, and suicide attempts.

➢ 58% of suicide attempts by women were connected to Adverse Childhood Experiences (ACES)\textsuperscript{2}

\textsuperscript{1}Indiana Youth Institute: Kids Count Data Book, 2015.
\textsuperscript{2}Centers for Disease Control and Prevention.
Suicide Prevention Programs

Began offering Lifelines Youth Suicide Prevention Program in schools and youth-serving organizations in 2012.

2017

Began offering QPR Gatekeeper training in 2017.

Question. Persuade. Refer.
Lifelines is a comprehensive *youth suicide prevention program* that targets the entire school community. It has four sequential components for administration, school faculty/staff, parents, and students.

- Administrative Crisis Plan Review
- Faculty/Staff Training
- Parent Workshop
- Student Curriculum

Typically this process takes six to twelve months to complete in addition to ongoing student curriculum.
Participating Schools and Organizations

- Shenandoah Schools
- Westfield Washington Schools
- Hamilton Heights Schools
- Logansport Schools
- North Montgomery Schools
- Hamilton Southeastern Schools
- Lawrence Township Schools
- Brooke’s Place
- Christ the Savior Lutheran Church
- Crosspoint Church
- Hamilton County Juvenile Services
Question. Persuade. Refer.

QPR is a one- or two-hour stand alone training designed to give participants the tools to:

• Recognize the risk factors, warning signs and protective factors of suicide
• Know how to offer hope
• Know how to get help and save a life
Participating Schools and Organizations

- Westfield Washington Schools
- Lebanon Schools
- Zionsville Schools
- Western Boone Schools
- Heritage Christian Schools
- Irvington Preparatory Academy
- The O’Connor House
- Riverview Hospital
UNINTENTIONAL INJURY PRESENTATION:

FATALITY REVIEW AND PREVENTION TEAM

Kelly Cunningham, MPH
Maternal Mortality Review Coordinator
Equity Statements

• Some families lose infants, children, youth, and adults to the types of deaths reviewed by our teams not as the result of the actions or behaviors of those who died, or their parents or caregivers.

• Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds are also contributing factors in many deaths.

• It’s important to acknowledge that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one’s ability to access health care.

• Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Hoosiers.
A prevention process that examines the preventability of the circumstances and risk factors involved in a death.

The goal is to improve the health and safety of children and families by identifying the factors that place them at risk for illness or injury and acting upon those factors.
Every Fatality Review is...

1. A comprehensive review of death cases conducted by multi-disciplinary teams, analyzing the death response and investigation

2. A presentation of pertinent records including:
   - Death Certificate
   - DCS records
   - LEA records
   - Coroner report and Autopsy
   - Medical Records
   - School Records
   - Mental Health
   - Social Services Records

3. A discussion of:
   - delivery of services
   - data sharing
   - stakeholder-led recommendations and system improvements
   - next steps to implement through community action
Fatality Review is NOT...

- A peer review
- Designed to examine individual performance or place blame
- An opportunity to second guess agency policy or practice
- An opportunity to vilify the individuals involved in the fatality
The Burden of Fatal and Nonfatal Injuries

- Deaths
- Hospitalizations
- Emergency department visits
- Outpatient facility visits
- Medically unattended
Maternal Mortality Review (MMR) IC 16-50

Review all pregnancy-associated deaths and provide recommendations that may eliminate preventable maternal deaths, reduce maternal morbidity, and improve the population health for women of reproductive age in Indiana.

- Identifying health issues causing maternal deaths
- Reduction in maternal mortality and morbidity
- Improvement in Indiana’s population health for women of reproductive age
- Elimination of preventable maternal deaths
Suicide and Overdose Fatality Review (SOFR)
IC 16-49-5

- Model reflects other mortality review teams (child fatality review, fetal-infant mortality review, etc.)
- **Multi-agency/multi-disciplinary team assembled to conduct confidential case reviews of overdose deaths**
- Team members bring information from respective agencies to inform review

**Preliminary Outcomes**
- Increased communication amongst agencies that work together to care for the same individuals
- Recognition of responder fatigue in communities challenged by substance use disorders and mental health challenges
- Naloxone for DCS workers in homes where there might be substance use
- Establishing Handle with Care program, trauma informed care or evidenced based programs
- **Bereavement care for loved ones/survivors**
1. Indiana’s infant mortality rate is among the highest in the country
2. Identify contributing factors to the premature loss of a fetus or infant
3. Reviews and analyzes de-identified fetal and infant deaths
4. Obtain data through interviews with the mother/family, medical records, WIC, social service agencies, and birth and death certificates

Outcomes:
- Early detection of increased STI rates
- Reduction of unsafe sleep deaths through coordinated community messaging
- Greater understanding of limitations to accessing care and services, including transportation, isolation, insurance status
- Majority of negative outcomes are related to poor pre-conception health
Child Fatality Review (CFR)
IC 16-49

1. Injury is the number one cause of death for children in Indiana
2. Nearly 1,300 Indiana children died from injury-related causes in the last five years
3. An average of 260 preventable deaths per year
4. Every two minutes a child is treated for an injury in an ER

Local CFR
• Safe sleep education in school system
• Ladder lock legislation for above-ground swimming pools
• Improved collaboration between DCS and local drug task force
• Local distribution programs for car seats and bicycle helmets
• Addressing needs of parents with SUD
• Water safety programs and warning signs near open bodies of water
Reducing Child Fatalities and Recurring Child Injuries Caused by Crime Victimization/Child Safety Forward Grant

Aims to develop multidisciplinary strategies and responses to address fatalities or near-death injuries as a result of child abuse or neglect

• Five-Year Local CFR Retrospective in Clark, Grant, Madison, and Delaware Counties
• State CFR Committee Retrospective in Howard, Kosciusko, Lake, Bartholomew, and St. Joseph Counties
• Evaluation and analysis will be completed by the IU School of Social Work
Community Coordinators

The state has been divided into three regions, and each region is supported by a Community Coordinator.

Community Coordinators develop and support Community Action Teams throughout the state. The focus of these teams is prevention.
Health Equity and Inclusion in Fatality Review

Social and environmental factors that significantly impact disease and injury risk

• Living situation
• Income and education
• Treatment based on race/ethnicity
• Residential segregation impacts:
  ◦ access to high-quality education
  ◦ employment opportunities
  ◦ healthy foods
  ◦ healthcare
<table>
<thead>
<tr>
<th>High Risk Behavior that the Team Identifies</th>
<th>Victim Blaming</th>
<th>What Factors Contributed to the High-Risk Behavior? WHY Did the High-Risk Behavior Occur?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Use Disorder</td>
<td>“Mother was told that she should stop taking drugs once she found out she was pregnant.”</td>
<td>➢ Medicaid issues, childbearing years, SUD treatment availability</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>“Mother should have left the father in earlier instances of abuse. If it was that bad, why didn’t she leave?”</td>
<td>➢ Manipulation &amp; control, wage inequality, isolation/segregation</td>
</tr>
<tr>
<td>Inconsistent prenatal care appointments</td>
<td>“Mother was told it was a high-risk pregnancy and needed to return for doctor’s appointments every week until delivery. She was non-compliant.”</td>
<td>➢ Lack of transportation, childcare, and flexible work schedule</td>
</tr>
<tr>
<td>Baby was placed to sleep in an adult bed at a motel</td>
<td>“Dad did not provide a safe sleep environment for the baby.”</td>
<td>➢ Eviction due to Covid-19, no space, no access</td>
</tr>
</tbody>
</table>
Why Collect Data?

- Capture the risk factors and circumstances contributing to the death
- Provide ability to track trends at county, regional, state, and national levels
- Allow prevention to be targeted to specific groups or risk factors
- Data give us the evidence to accurately target prevention efforts!
Trend Data

Annual Fatality Review Data

Total Number of Cases: 60

<table>
<thead>
<tr>
<th>Race</th>
<th>F</th>
<th>Count</th>
<th>Share of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>39</td>
<td>65%</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>11</td>
<td>18%</td>
<td></td>
</tr>
<tr>
<td>Latino</td>
<td>3</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Not entered</td>
<td>3</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Multi-racial</td>
<td>2</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>3%</td>
<td></td>
</tr>
</tbody>
</table>

Include/exclude specific causes

(Checking on a race will display information specific to that race. Clicking again will return the display to full view)

Cause

- Medical: 22 (37%)
- Sleep-related: 11 (18%)
- Homicide: 9 (15%)
- Motor vehicle: 8 (13%)
- Other cause: 6 (10%)
- Suicide: 3 (5%)
- Drowning: 1 (2%)

Number of times team disagreed with official cause or manner of death: 0

CPS referral involving parents and/or child any time prior to death?

- No/unknown: 55 (92%)
- Yes: 5 (8%)
Local CFR Successes/Outcomes

- Safe sleep education in school system
- Improved collaboration between DCS and local drug task force
- Local distribution programs for car seats and bicycle helmets
- Addressing needs of parents with SUD
- Educational material created explaining hazards of low-head dams and retention ponds
- Local law enforcement participating in PSAs and Roll Call Videos about teen driver safety
- Reports to Consumer Product Safety Commission when children are injured by products
- Filmed a Safe Sleep Training module that reached 1,401 police officers from 58 departments and 30 counties
- Implemented ACEs screenings
- Partnered with jails to ensure pregnant individuals received prenatal care
St Joseph OFR data

- Reviewed and entered 60 cases into the OFR National Database
- Average age of decedents was 40.6 years old (range from 15-66)
- 95% lived in Indiana (three out of state that recently moved)
- 66.7 % male (40 cases); 33.3% female (20 cases)
- 46 cases were white 14 were black
- 4 served in the armed forces
- 38 individuals were employed
- 39 lived in South bend, 10 lived in Mishawaka
Criminal Justice Data

- 28 individuals were on probation during their life
  - 11 individuals on probation at time of death
- 38 individuals had been arrested
  - Age of first arrest: 13 to 59
    - 17 in their 20s
- 28 individuals had been incarcerated
- 6 individuals were on specialty courts

![Bar chart showing the distribution of criminal justice data](chart.png)
Criminal Justice Recommendations

- Connect individuals on probation that are having difficulty getting medication, to Oaklawn
- Connect individuals to resources before release and immediately upon release from DOC
- Increase quality of treatment in criminal justice involved individuals
- Create standard level of care for criminal justice systems
- Improve discharge planning from the DOC
- Develop a system of care for returning citizens from incarceration
<table>
<thead>
<tr>
<th>Cause</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overdose, accidental and undetermined intent</td>
<td>41</td>
</tr>
<tr>
<td>Motor vehicle collision</td>
<td>13</td>
</tr>
<tr>
<td>Homicide</td>
<td>10</td>
</tr>
<tr>
<td>Cancer</td>
<td>9</td>
</tr>
<tr>
<td>Suicide</td>
<td>7</td>
</tr>
<tr>
<td>Sepsis/infection</td>
<td>7</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>5</td>
</tr>
<tr>
<td>Lobar pneumonia</td>
<td>3</td>
</tr>
</tbody>
</table>
Prenatal Care by Insurance Status

Percentage of maternal deaths where women entered prenatal care in the first trimester of pregnancy, by insurance status:

- Medicaid: 50%
- Private: 69%

Average number of prenatal care appointments kept among maternal deaths, by insurance status:

- Medicaid: 9.0
- Private: 11.6
Substance use disorder was the most common contributing factor identified, likely contributing to over half of all pregnancy-associated deaths in 2018.
Indiana Successes

INDIANA SUICIDE PREVENTION NETWORK

4 TIPS FOR PARENTS AND CAREGIVERS TO HELP BABY SLEEP SAFELY
Play for Kate – Indiana’s Helmet Law
UNINTENTIONAL INJURY DATA PRESENTATION:

DRUG POISONINGS

Veronica Daye, MPH
Injury Prevention Epidemiologist
Drug Poisoning Deaths

Drug overdose deaths, more specifically opioid-involved deaths, have continued to rise in Indiana and impact people of all races, sexes, ages and locations.
**Drug Poisonings by Underlying Cause of Death**

- Accidental poisoning by drugs
  - ICD-10 codes: X40-X44
- Intentional self-poisoning by drugs
  - ICD-10 codes: X60-X64
- Assault by drug poisoning*
  - ICD-10 codes: X85
- Drug poisoning of undetermined intent
  - ICD-10 codes: Y10-Y14

*suppressed due to low count
Drug Poisonings by Age

- Number of deaths by age group and year:
  - 2017
  - 2018
  - 2019

Age groups:
- <1
- 1-4
- 5-14
- 15-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85+

Graph shows the number of drug poisonings by age group for 2017, 2018, and 2019.
Drug Poisonings by Month

# of deaths

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

2017 2018 2019 2020
Drug Poisonings by Location

# of deaths

District 1  District 2  District 3  District 4  District 5  District 6  District 7  District 8  District 9  District 10

2017  2018  2019  2020
Top counties with highest poisoning deaths

2017
- Marion: 365
- Lake: 164
- Allen: 92
- St. Joseph: 71
- Vanderburgh: 66
- Wayne: 66
- Delaware: 51
- Madison: 51
- Hamilton: 49
- Porter: 46

2018
- Marion: 335
- Lake: 130
- Allen: 85
- St. Joseph: 62
- Clark: 51
- Tippecanoe: 42
- Wayne: 42
- Delaware: 41
- Vanderburgh: 41
- Hamilton: 40

2019
- Marion: 377
- Lake: 151
- Allen: 112
- Madison: 53
- Wayne: 48
- Delaware: 43
- Tippecanoe: 43
- Clark: 42
- Porter: 40
- Floyd: 38

2020
- Marion: 584
- Lake: 166
- Allen: 116
- St. Joseph: 83
- Clark: 63
- Johnson: 61
- Delaware: 60
- Hendricks: 51
- Madison: 51
- Vanderburgh: 48

The top 3 counties accounted for an average of 35.5% of poisoning deaths.
2017 Age-Adjusted Death Rate per 100,000

Counties in gray = rates based on counts less than 20; considered unstable/unreliable and should be interpreted with caution.
2018 Age-Adjusted Death Rate per 100,000

Counties in gray = rates based on counts less than 20; considered unstable/unreliable and should be interpreted with caution.
2019 Age-Adjusted Death Rate per 100,000

Counties in gray = rates based on counts less than 20; considered unstable/unreliable and should be interpreted with caution
Visit our website for more information!

https://www.in.gov/health/overdose-prevention/data/indiana/

Indiana Drug Overdose Dashboard
County Response

<table>
<thead>
<tr>
<th>County Response</th>
<th>Opioid Prescriptions</th>
<th>Hospital Discharges</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>-</td>
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</tr>
</tbody>
</table>

Programs

- All Programs
- Overdose Response Project
- Opioid Fatality Review Team
- LEAD Recovery County
- First Responder Malleable County
- Non-Syringe Harm Reduction Program
- Syringe Exchange
- INCAR (EOD)

County Participation
77 of 92 counties

Program Contact Information

For more information and to report overdose events, please contact indianaoverdose@health.in.gov.

For more information and to report overdose events, please contact indianaoverdose@health.in.gov.

Drugs that are available on the Indianas Toll Free number 1-800-274-7282.

https://www.in.gov/health/overdose-prevention/data/indiana/
INTENTIONAL INJURY DATA PRESENTATION:
COVID19 AND MENTAL HEALTH IN INDIANA

Morgan Sprecher, MPH
Indiana Violent Death Reporting System (INVDRS) Epidemiologist
COVID-19 and Mental Health in Indiana
Examining How Hoosiers are Adjusting to the New Normal

Coming September 2021

Can be accessed on the Trauma website:
During the pandemic, 3 in 10 adults in the United States reported symptoms of anxiety or depressive disorder.

**FACTORS CONTRIBUTING TO INCREASED MENTAL HEALTH PROBLEMS DURING THE PANDEMIC**

- Isolation
- Fear of Infection
- Economic Hardship
- Decreased access to mental health services
- School closures
- Loss of family member or friend
Emergency Department Visits - Overdoses

3 out of 4 counties report an increase in ED visits for overdoses.
Emergency Department Visits - Suicides

<table>
<thead>
<tr>
<th></th>
<th>Rural 2019</th>
<th>Rural 2020</th>
<th>Urban 2019</th>
<th>Urban 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits per 100,000</td>
<td>43.6</td>
<td>35.9</td>
<td>35.7</td>
<td>31.8</td>
</tr>
</tbody>
</table>

- Rural ED Visits per 100,000 in 2019: 43.6
- Rural ED Visits per 100,000 in 2020: 35.9
- Urban ED Visits per 100,000 in 2019: 35.7
- Urban ED Visits per 100,000 in 2020: 31.8
Overdose Deaths

62% of counties report an increase in overdose deaths from 2019-2020
Overdose Deaths
40% of counties report an increase in suicide deaths from 2019-2020.
Is there a correlation between COVID-19 Case Counts and Overdose Deaths?
Conclusions and Interpretations

COVID-19 Pandemic → Fear of Infection → Decreased Access to Mental Health Care → Poor Mental Health Outcomes
2021 Meeting Dates

November 19
THANKS!

<table>
<thead>
<tr>
<th>Presenter</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morgan Sprecher</td>
<td>812-929-3069</td>
<td><a href="mailto:msprecher@isdh.in.gov">msprecher@isdh.in.gov</a></td>
</tr>
<tr>
<td>Veronica Daye</td>
<td>317-234-4943</td>
<td><a href="mailto:vdaye@isdh.in.gov">vdaye@isdh.in.gov</a></td>
</tr>
<tr>
<td>Maggie Owens</td>
<td>317-759-8008</td>
<td><a href="mailto:maggie@indianaprevention.org">maggie@indianaprevention.org</a></td>
</tr>
<tr>
<td>Kelly Cunningham</td>
<td>317-652-4643</td>
<td><a href="mailto:kcunningham2@isdh.in.gov">kcunningham2@isdh.in.gov</a></td>
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