2022 Annual Report

NH SUICIDE PREVENTION Council

Table of Contents

INTRODUCTION

Introduction

The 2022 Annual Suicide Prevention Report, which includes a summary of accomplishments and data, is the result of the collaborative work of many groups, committees, and organizations in NH who have dedicated time and resources to study the issue of suicide and to look at prevention and postvention across the lifespan.

The work of these groups in suicide prevention and postvention is reaching across the state and into communities, schools, organizations, and individual lives.

Many achievements will be described further throughout this report. It is critical to NH that we continue to build on the momentum and collective knowledge that has been gained in suicide prevention to strengthen capacity and sustainability in order to reduce risk of suicide for all NH residents and promote healing for all of those affected by suicide.

Knowing that it takes all of us working together with common passion and goals, we wish to express our appreciation to everyone who has been involved in suicide prevention and postvention efforts in New Hampshire.

What's New in this Year's Report?

Some of the new highlights this year include:

- Data highlights from NH Rapid Response and 988
- Updated data from NH Vital Records and NH Violent Death Reporting System
- Expanded data from the NH Youth Risk Behavior Survey.
- Highlights of activities that took place across the state.

This report was produced by NAMI New Hampshire, the State Suicide Prevention Council (SPC) and Youth Suicide Prevention Assembly (YSPA).

Primary Partners

NAMI New Hampshire and The Connect™ Suicide Prevention Program

NAMI New Hampshire (National Alliance on Mental Illness), a grassroots organization of families, individuals living with mental illness, professionals, and other members, is dedicated to improving the quality of life of persons of all ages affected by mental illness and suicide through education, support, and advocacy.

NAMI NH's Connect Suicide Prevention Program has been recognized as a best practice and model for a comprehensive, systemic approach. The community-based approach of the Connect Program focuses on education about early recognition (prevention); skills for responding to attempts, thoughts, and threats of suicide (intervention); and reducing risk and promoting healing after a suicide (postvention). NAMI NH and The Connect Program assist the State Suicide Prevention Council and the Youth Suicide Prevention Assembly with implementation of the NH Suicide Prevention Plan. Connect provides consultation, training, technical assistance, information, and resources regarding suicide prevention throughout the state. NH-specific data, news and events, information and resources, and supports to survivors are available on the Connect website at www.TheConnectProgram.org.

New Hampshire Office of the Chief Medical Examiner

The New Hampshire Office of the Chief Medical Examiner (OCME) is responsible for determining the cause and manner of all sudden, unexpected or unnatural deaths falling under its jurisdiction (RSA 611-B:11). This includes all suicide deaths occurring within the state of NH. As the central authority making these determinations, the OCME is in an ideal position to provide timely data on NH suicide deaths. For more than 20 years the OCME has partnered with YSPA, and more recently the SPC, to provide data and insight into the deaths affecting the state.

New Hampshire Violent Death Reporting System

In 2015, the NH Department of Health and Human Services (DHHS) partnered with the Centers for Disease Control and Prevention (CDC) Injury Prevention Division and began a joint surveillance program, also known as the National Violent Death Reporting System (NVDRS), which is now applied in all fifty US states, the District of Columbia, and Puerto Rico. The surveillance program in NH is known as the NH Violent Death Reporting System (NH-VDRS), which is supported by CDC NVDRS grant funding. The NH DHHS Injury Prevention Program is the grant holder and provides administrative oversight for the program. The case abstraction staff are employed by the NH DHHS with support from staff at the OCME. The NH-VDRS program is tasked with compiling case level data on all violent deaths in NH, including suicides, homicides, all deaths involving firearms, and deaths resulting from legal intervention (such as law enforcement or war). The NH-VDRS program's work also entails disseminating information within NH and to the CDC Injury Prevention Division and other affiliates. Since its inception, NH-VDRS has engaged entities focusing on suicide in NH, including local suicide prevention service providers, suicide prevention advocates, law enforcement, lawmakers and other interested groups.

These groups are making use of aggregate data reported by NH-VDRS to enhance prevention efforts in the state. The NH-VDRS data in this report is made possible under Grant Award # 5 NU17CE010125-02-00.

For information regarding NH-VDRS or to request data, contact:

- JoAnne Miles-Holmes, Injury Prevention Program Administrator, NH-VDRS Co-Principal Investigator, Maternal and Child Health Section, Division of Public Health Services, NH Department of Health and Human Services, JoAnne.E.MilesHolmes@dhhs.nh.gov.
- Djelloul Fourar-Laïdi, Lead Abstractor/NH-VDRS Planning Analyst-Data Systems, Co-Principal Investigator, Maternal and Child Health Section, Division of Public Health Services, NH Department of Health and Human Services, Djelloul.A.Fourar-Laidi@dhhs.nh.gov.

State Suicide Prevention Council

The mission of the State Suicide Prevention Council (SPC) is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the NH Suicide Prevention Plan:

* Raise public and professional awareness of suicide prevention;
* Address the mental health and substance misuse needs of all residents;
* Address the needs of those affected by suicide; and
* Promote policy change.

The success and strength of the Council is a direct result of the collaboration that takes place within its membership and with other agencies/organizations, including public, private, local, state, federal, military, and civilian. Strong leadership and active participation come from the Council's subcommittees: Communication and Public Education; Data Collection and Analysis; Law Enforcement; Military and Veterans; Public Policy; Suicide Fatality Review; and the Survivors of Suicide Loss subcommittee.

As part of NH RSA 126-R, which legislatively established the Suicide Prevention Council, the Council is required to report on its progress annually, to both the Governor and the legislature. This report serves that purpose, as well as providing an annual update on the accomplishments of our collective achievements and data regarding suicide deaths and suicidal behavior in NH.

Youth Suicide Prevention Assembly

The Youth Suicide Prevention Assembly (YSPA) is dedicated to reducing the occurrence of suicide and suicidal behaviors among New Hampshire's youth and young adults up to the age of 24. This is accomplished through a coordinated approach to providing communities with current information regarding best practices in prevention, intervention, and postvention strategies and by promoting hope and safety in our communities and organizations.

YSPA is an ad hoc committee of individuals and organizations that meets monthly to review the most recent youth suicide deaths and attempts in order to develop strategies for preventing them. Over the years, YSPA and its partners have been involved with a wide range of suicide prevention

efforts in the state. These efforts include, but are not limited to, collecting and analyzing timely data on suicide deaths and attempts, collaborating on an annual educational conference, and creating the original NH Suicide Prevention Plan. The development of both The Connect™ Program and CALM (Counseling on Access to Lethal Means) suicide prevention trainings occurred because of YSPA participation and/or case reviews. The Survivor of Suicide Loss packets sent to the next of kin of anyone who dies by suicide in New Hampshire began in YSPA before expanding to all ages.

ACCOMPLISHMENTS

Accomplishments of Suicide Prevention Efforts in NH

State Suicide Prevention Council

2022 marked the 14th anniversary of NH's Suicide Prevention Council (SPC) since its legislative inception in 2008. In 2021, the SPC released an updated version of the NH State Suicide Prevention Plan[1]. With the release of the updated plan, the SPC, its subcommittees, and other stakeholders in the state have looked at ways of implementing the outlined goals. This work was aided by the first ever state funding for the SPC and newly created State Suicide Prevention Coordinator position within NH DHHS.

Much of the work of the SPC is done at the subcommittee level. Some of the subcommittee activities occurring in 2022 to move forward the goals of the NH Suicide Prevention Plan included:

Communication and Public Education Subcommittee

- Coordinated a press conference in September in support of Suicide Prevention Awareness, highlighting 988 and NH Rapid Response Access Point.
- Led the development of the 2022 Annual NH Suicide Prevention Conference, in collaboration with a dedicated conference committee coordinator.
- Led the development of a new Suicide Prevention Council logo.
- Began initial development of a branding guide for the Council.

Data Collection and Analysis Subcommittee

- Worked with multiple statewide partners to compile and analyze data covering calendar year 2021. The data were then included in the 2021 NH Suicide Prevention Annual Report and distributed statewide.
- Collaborated with the Analyst for the NH Violent Death Reporting System (NH-VDRS) to expand the use of NH-VDRS data in the NH Annual Suicide Prevention Report.
- Collaborated with the NH DHHS Health Statistics and Data Management Section to include Vital Records demographic data on suicide deaths and self-harm hospitalizations.
- Continued to partner with the Crisis Text Line for access to a dashboard summarizing NH contacts.
- Multiple subcommittee members and other stakeholders participated in a Suicide Prevention Resource Center (SPRC) community of practice focused on strengthening suicide prevention data infrastructure.
- Hosted multiple speakers at subcommittee meetings, including:
    - UNH MSW students presenting their research project involving NH YRBS data.
    - Jana French from the Crisis Text Line speaking about the Crisis Text Line data collection and reporting process.

[1] https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents/2021-11/2021-suicide-prevention-plan.pdf

Military and Veterans Subcommittee

- The Committee welcomed a new co-chair in 2022 after the VA Medical Center in Manchester, NH filled the position of Community Engagement and Partnerships Coordinator. The addition of the Community Engagement and Partnerships Coordinator to the committee is anticipated to result in greater collaboration among Veteran-focused groups in the state as well as an increase in committee membership in 2023.
- The Committee continues to be actively involved with the Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Families (SMVF) which is funded through the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Veterans Administration (VA). This initiative continues to provide members of the Committee with a variety of technical assistance and free training related to best practices to reduce the rate of suicide in the military-connected community.
- Ask the Question funding was used in 2022 for a contract through NH DMAVS with Granite River Studios to produce an Ask the Question video series that was made publicly available to providers seeking information and guidance on how to identify SMVF in their practices in an effective and sustainable way. These videos will be used in the coming year to support promotion of Ask the Question.
- The Committee continues to support the efforts of the Lakes Region Veterans Coalition (LRVC), which is a group formed as a result of the committee efforts to bring federal resources into the state aimed at reducing the Veteran suicide rate in rural areas. Together With Veterans (TWV) is a community-based suicide prevention program for rural Veterans. TWV involves partnering with rural Veterans and their communities to implement community-based suicide prevention. TWV is funded by the Veterans Administration Office of Rural Health. The Governor's Challenge Team first brought TWV to New Hampshire in 2018-2019 and then re-launched the effort in the Lakes Region in 2020 to form the group that is now known as Lakes Region Veterans Coalition. In 2022, LRVC obtained a 501(c)(3) designation so it can sustain efforts after the third and final year of funding and support through TWV. 2022 was the 2nd of a 3-year program. The SPC Military & Veterans Committee continues to actively collaborate with and support the efforts of the LRVC. In 2022, LRVC forged a collaboration with Lakes Region Community College and provided two trainings to EMT students at the college. This will be an ongoing partnership so trainings for first responder students at this college will continue in 2023. In 2023 they hope to establish a similar partnership with police and fire academies in New Hampshire.
- The promotion and provision of military cultural competency and suicide prevention trainings for community providers and employers continues to be a priority area for the committee. Between June and December 2022, 871.37 hours of training was made available to providers and businesses as a result of committee efforts. The Committee purchased 52 ASIST registrations that were provided to community providers interested in suicide prevention training. The Committee worked with PsychArmor and the VA to customize two online training portals for use in New Hampshire. One is for social service providers working with Veterans and the other is for employers and businesses employing Veterans and their family members. Both portals are free to use and contain a variety of high-quality training products related to serving or employing those with military

experience. Members and member organizations of the committee supported a monthly Lunch & Learn webinar series coordinated by the NH Department of Military Affairs and Veterans Services by presenting information and topics for the webinars that related to the issues Veteran families face or the resources available to them. In November 2022, the committee supported the coordination and implementation of an Annual Symposium for NH Veteran-Friendly Businesses that featured workshops on supporting the mental wellness of Veterans at work and how to effectively recruit and retain Veterans and their family members.

- The committee provided input to NH DMAVS to help design a Welcome Home Letter that includes community resources for, and is sent to, Veterans who recently separated from the military and moved home to New Hampshire. Information about where they or their family can access resources related to mental health and wellness are included in the letter. In 2022, 1,557 Welcome Home Letters with resources related to mental health and wellness were sent to individuals in New Hampshire who served in the US Armed Forces.
- Committee members continued to be actively involved in the development process of the state's closed loop referral system throughout 2022 to ensure that the system meets the needs of SVMF in New Hampshire as well as the needs of the Department of Military Affairs and Veterans Services (DMAVS) and the committee to access data demonstrating trends related to the needs of SMVF. As a result of this work, NH DMAVS contributed state funding to the project.
- The committee collaborated with the NH DMAVS to write a Request for Proposal in 2022 to allocate $750,000 for services that increase access to mental health services and reduce social isolation for Veterans in New Hampshire. Two contracts for this RFP were granted in 2022—Easterseals NH and Partnership for Public Health—and the services will be funded through the end of the state's fiscal year (June 2023). As part of the state contracts, the agencies receiving funding will be required to have representation on the SPC Military & Veterans Committee so their work can be shared with members of the committee and additional collaborations can be forged.
- The Committee's efforts are described and meeting minutes are publicly available at: https://www.dmavs.nh.gov/about-us/councils-and-committees/suicide-prevention-efforts

Public Policy Subcommittee

- Advocacy to Mental Health and Allied Health licensing boards to discuss suicide prevention CEUs requirement.
- Hosted a Suicide Prevention Advocacy Day at the Holiday Inn in Concord on May 4, 2022.
- Hosted an SPC Policy Partners meeting at PATH in Concord on March 16, 2022.
- Met monthly with Public Policy Committee members.

Survivor of Suicide Loss Subcommittee

- Began a monthly one-hour Coffee Chat over Zoom in December of 2020 that continued through 2022. The coffee chat offers Survivors of Suicide Loss (SOSL) access to a variety of resources as well as an opportunity to support fellow survivors through their loss and healing journeys.
- The Coffee Chats were going so well for 2020 with increased loss survivor attendance that the sub-committee, not only continued into 2022 but also added in an evening monthly one-hour Tea Time Chat as well. The SOSL sub-committee provides access to a variety of resources and materials as well as an opportunity to support fellow survivors through their loss and healing journeys.
    - Many comments of how these Coffee and Tea Chats have helped many Loss Survivors through their healing journeys and "it gives us, Hope!"
- Provided support and technical assistance to NH Survivor of Suicide Loss support groups and promoted the American Foundation for Suicide Prevention (AFSP) International Loss Survivor Day (ISOSLD) to several hosted sites in NH in November 2022, that were conducted in person with one virtual event for NH, VT, and ME. Over 100 were in attendance.
- Ensured Loss Survivor participation in community events through targeted outreach.
- The SOSL sub-committee provided support and participation for many Loss Survivor events throughout NH, including Out of Darkness Walks for the AFSP, in designated towns, and the NAMIWalks NH, with Team SOS.

As the council looks to continue its work, there is a desire to increase active membership of its subcommittees. The council also recognizes the role public health departments play in this work and the importance of their perspective for future collaborations. The public private partnerships developed in subcommittees should continue to expand and enhance the impact of the work being done by the council. Contact* any of the committee chairs if you have an initiative you would like to put forward related to suicide prevention efforts throughout the state.

The council continues to collaborate with the NH Department of Health and Human Services (DHHS) for statewide leadership and support as it looks to continue its work in promoting evidence-informed initiatives and refining and expanding the state plan to ensure the very best outcomes for NH citizens.

**If you would like to join any of the Suicide Prevention Council Subcommittees, please contact the designated committee chair. The committee meeting schedule has been included on page 87 of this report.*

The Youth Suicide Prevention Assembly (YSPA)

YSPA is a grassroots organization comprised of individuals interested in learning more about how to prevent all suicides, but especially those that occur among individuals age twenty-four and under. YSPA supports the State Suicide Prevention Plan by promoting a greater awareness of youth/young adult suicide risk factors, protective factors, and warning signs. YSPA encourages the development and maintenance of professional networks, and the use of natural supports to lessen the risk of suicide and promote support and postvention activities in the event of a suicide death.

YSPA membership continues to be diverse with regular membership representing behavioral health, substance use, all levels of education, law enforcement, LGBTQ+ groups, public health, social service agencies and persons with lived experience. Virtual meetings have allowed for attendees from all parts of the state to attend, which has been one benefit. The Youth Suicide Prevention Assembly (YSPA) continues to meet the second Thursday of every month virtually, or in Concord, NH.

YSPA resumed in-person meetings in June 2022. This allowed for the resumption of case reviews. YSPA is a grassroots organization, meaning that it does not fall under the umbrella of legislated fatality review committees. Virtual case reviews had been allowed under the Governor's Covid Emergency Order, but when the order ended, the ability to conduct virtual reviews ended. YSPA met in person for the rest of the year with the exception of November (no meeting due to the Suicide Prevention Conference) and December. The "Assembly" of YSPA decided to hold virtual meetings in the winter months (December through March) to avoid travel for attendees.

Several presentations were made to YSPA attendees:

- Overview of nation-wide 988 and NH Rapid Response Access Point
- Participant Bio
- Video, Ups and Downs
- SurvivorVoices speaker
- YSPA as my school assignment (presentation by a graduate student)
- YSPA "Retreat"
- Data overview
- NH Rapid Response and 988 use by youth
- GLS Grant Care Transitions work
- Conference feedback, planning for 2023 YSPA topics

For more information on YSPA, including how to attend a meeting, please contact Elizabeth Fenner-Lukaitis: Elizabeth.V.Fenner-Lukaitis@dhhs.nh.gov or Elaine de Mello: edemello@naminh.org.

The NH Suicide Survivor Network

In 2022 Survivors of Suicide Loss (SOSL) continued in their efforts of building capacity and establishing groups throughout NH. Loss survivors are finding comforting support in their healing journey and continue to mentor each other in facilitating and co-facilitating these groups by providing a safe environment to share their experience of suicide loss. The year began with 15 groups already in motion and attendees growing in numbers. As a result of COVID-19 some SOSL support groups decided to go virtual, and others decided to wait until they could return to meeting in person. All SOSL support groups are now back to being held in person with some groups still offering a virtual or hybrid option. NAMI New Hampshire continues to provide a Zoom account for SOSL groups to use.

Positive Outcomes and Testimonials

Both Sides of the Door - Law Enforcement Investing in Loss Survivors!

Several Loss Survivors have experienced an extremely difficult situation at the scene of a suicide death in their home. Loss Survivors are in complete shock and disbelief upon finding out about this tragedy – accompanied by feelings of grief, sadness, and devastation. The last thing they want is to be separated from their family and their loved one they just lost to suicide.

Through the chaos of a suicide death, most often Loss Survivors aren't given any information during the investigation and Loss Survivors are led to feel like a suspect in their own home and loved one's death.

Goffstown's law enforcement is one step ahead of this for Loss Survivors. Their goal is to "invest" in Loss Survivors, recognizing the importance of treating Loss Survivors with the utmost respect and compassion at the scene of a suicide death and thereafter. With their police department chaplain, they work together to make this unimaginably tragic situation run as smoothly as it can.

Many law enforcement departments in NH also have something like this in place – through the Laconia Police and the Partnership for Public Health in this region a protocol for unattended death/death notification has been put together for all law enforcement to help remind them of what can be done and said to Loss Survivors at the time of a suicide death and an unattended death as well. These two examples help to make a tragic situation such as a suicide death go a little more smoothly – Loss Survivors are better understood, and law enforcement recognizes the importance of compassionate approach.

An ever-growing number of NAMI New Hampshire SurvivorVoices speakers continued to share their personal stories and experiences of suicide loss to help educate the public and provide healing and support, within their communities and throughout the state. The NH Survivors of Suicide Loss Resource Packet was updated and is disseminated through the NH Office of the Chief Medical Examiner to the next of kin of all those who died by suicide. The book "Healing the Hurt Spirit: Daily affirmations for people who have lost a loved one to suicide," authored by a NH survivor, continues to be available to new loss survivors. An online survey is also provided to solicit feedback on the folder and provide additional avenues to connect loss survivors to help.

The American Foundation for Suicide Prevention (AFSP) International Survivors of Suicide Loss Day (ISOSLD or Survivor Day) are normally held each year at multiple sites throughout NH on the Saturday before Thanksgiving. For 2022, SurvivorVoices speakers shared their stories of loss, healing, and hope at each in person event and at the New England region virtual survivor day event held the Sunday before Thanksgiving.

The annual NH Survivor of Suicide Loss Newsletter, produced by NAMI NH, was distributed throughout the state, with some hard copies made available at trainings, loss survivor speaking presentations, health fairs, libraries, hospitals, healthcare facilities, mental health centers, funeral homes, churches and faith-based organizations, and in the NH Survivors of Suicide Loss Resource Packet. The newsletter was also distributed electronically to many email lists.

More and more loss survivors in NH are becoming involved in advocacy and fundraising efforts for various local and national suicide prevention organizations and initiatives. NH loss survivors volunteered over 1,000 hours of time by hosting support groups, sharing loss survivor resources at community events, speaking publicly about their loss, or displaying the quilts that were lovingly crafted by NH Survivors of Suicide Loss in memory of their loved ones lost to suicide.

The NH State Suicide Prevention Council continues to include the Survivors of Suicide Loss Subcommittee on the council, and to include loss survivors on the membership of the Council and its other subcommittees. Feedback from the NH loss survivor network clearly indicates great interest by loss survivors in expressing their voice, building capacity of support groups, expanding the International Survivors of Suicide Loss Day, and being involved in more advocacy and public speaking events. This committee encourages new members to join.

Positive Outcomes and Testimonials

"The resources for survivors are critical and every effort must be made to keep and improve their availability. Many survivors would not be functioning, healing or grieving if it were not for these programs. For a situation which is not understood by a large percentage of society, support and education still remain a priority."

A New Hampshire Survivor of Suicide Loss

Attempt Survivor Initiative:

An Attempt Survivor Committee was formed to look at resources and support for individuals in NH who have attempted suicide. The committee had representation from persons with lived experience (loss and attempt survivors), staff from New Hampshire Hospital (NHH), NAMI NH, the Office of Consumer Affairs, and Peer Support Centers in NH. In the course of the committee's work, models for attempt survivor support groups were researched and the committee developed a manual to provide guidance around leading support groups. Currently there are attempt survivor groups in Keene and Berlin.

Other Statewide Initiatives

AFSP (American Foundation for Suicide Prevention)

The NH Chapter continued its efforts to increase support for Survivors of Suicide Loss in 2022. Following on the success of its first State Advocacy Day in 2020, AFSP NH hosted a virtual State Capitol Day in March of 2022. The program encouraged the state to make an investment into state crisis service systems, including support for call centers. The chapter continues to offer Healing Conversations to survivors across the state. In the past, the chapter has consistently received 4-6 requests per month, with each visit completed within 10 days. Following each visit, a debriefing is conducted with the volunteers so that the chapter can support all involved in the visit in the best way possible.

Connor's Climb Foundation

Connor's Climb Foundation (CCF) is a New Hampshire based nonprofit on a mission to provide suicide prevention education to the youth and trusted adults in New Hampshire and bordering communities. CCF also works to end the stigma around mental health. In 2022, the foundation hosted 33 suicide prevention trainings and events across the state with 2,554 participants. Connor's Climb provided funding to implement the SOS Signs of Suicide Program (a nationally recognized, evidence-based school suicide prevention program) with students, faculty, and parents to 27 schools throughout the year. The foundation's largest awareness event, the Connor's Climb Annual 5K and Family Walk, was once again held in person in September of 2022. This event raised over $50,000 with 317 participants and 28 sponsors. Connor's Climb remains committed to advocating for RSA 193-J, an act relative to suicide prevention education which went into effect in July of 2020, and other legislation at the state level by continued involvement with the NH Suicide Prevention Council.

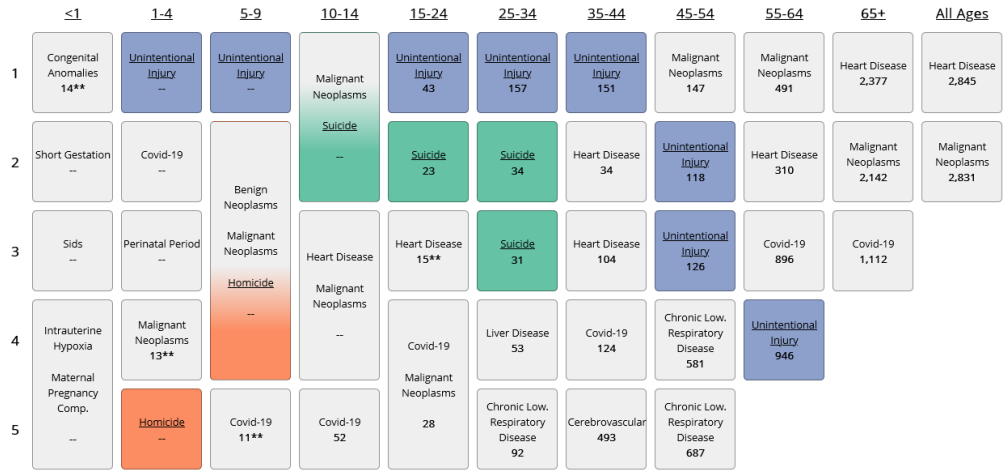
New Hampshire Nexus Project 2.0 – Garret Lee Smith (GLS) Grant Funding

Suicide remains the second leading cause of death for 10- to 34-year- olds[2] here in New Hampshire and nationwide. The GLS New Hampshire Nexus Project 2.0 (GLS NHNP 2.0) is a cross-systems, collaborative approach to reducing suicide incidents among youth by improving pathways to care and offering comprehensive training to provide youth serving organizations with the resources to identify, screen, refer, and treat at-risk youth.

GLS NHNP 2.0 is focused on youth/young adults ages 10-24 in the Capital Region, Carroll County, and North Country Regional Public Health Network (RPHN) of New Hampshire. Over the course of the five-year project period, project staff and key partners are working in collaboration to enhance care coordination infrastructure, suicide risk recognition and response, and statewide capacity for suicide prevention and postvention response.

[2] CDC WISQARS, https://wisqars.cdc.gov/, accessed on 2/12/2024.

5 Leading Causes of Death, New Hampshire 2021, All Races, Both Sexes



	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 14**	Unintentional Injury --	Unintentional Injury --	Malignant Neoplasms	Unintentional Injury 43	Unintentional Injury 157	Unintentional Injury 151	Malignant Neoplasms 147	Malignant Neoplasms 491	Heart Disease 2,377	Heart Disease 2,845
2	Short Gestation --	Covid-19 --	Benign Neoplasms	Suicide --	Suicide 23	Suicide 34	Heart Disease 34	Unintentional Injury 118	Heart Disease 310	Malignant Neoplasms 2,142	Malignant Neoplasms 2,831
3	Sids --	Perinatal Period --	Malignant Neoplasms	Heart Disease	Heart Disease 15**	Suicide 31	Heart Disease 104	Unintentional Injury 126	Covid-19 896	Covid-19 1,112	
4	Intrauterine Hypoxia	Malignant Neoplasms 13**	Homicide --	Malignant Neoplasms --	Covid-19	Liver Disease 53	Covid-19 124	Chronic Low. Respiratory Disease 581	Unintentional Injury 946		
5	Maternal Pregnancy Comp. --	Homicide --	Covid-19 11**	Covid-19 52	Malignant Neoplasms 28	Chronic Low. Respiratory Disease 92	Cerebrovascular 493	Chronic Low. Respiratory Disease 687			

5 Leading Causes of Death, United States 2021, All Races, Both Sexes

	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 3,963	Unintentional Injury 1,299	Unintentional Injury 827	Unintentional Injury 915	Unintentional Injury 15,792	Unintentional Injury 34,452	Unintentional Injury 36,444	Covid-19 36,881	Malignant Neoplasms 108,023	Heart Disease 553,214	Heart Disease 695,547
2	Short Gestation 2,946	Congenital Anomalies 412	Malignant Neoplasms 347	Suicide 598	Homicide 6,635	Suicide 8,862	Covid-19 16,006	Heart Disease 34,535	Heart Disease 89,342	Malignant Neoplasms 446,354	Malignant Neoplasms 605,213
3	Sids 1,459	Homicide 309	Homicide 188	Malignant Neoplasms 449	Suicide 6,528	Homicide 7,571	Heart Disease 12,754	Malignant Neoplasms 33,567	Covid-19 73,725	Covid-19 282,457	Covid-19 416,893
4	Unintentional Injury 1,306	Malignant Neoplasms 282	Congenital Anomalies 171	Homicide 298	Covid-19 1,401	Covid-19 6,133	Malignant Neoplasms 11,194	Unintentional Injury 31,407	Unintentional Injury 33,471	Cerebrovascular 139,257	Unintentional Injury 224,935
5	Maternal Pregnancy Comp. 1,113	Heart Disease 116	Heart Disease 66	Congenital Anomalies 179	Malignant Neoplasms 1,323	Heart Disease 4,155	Suicide 7,862	Liver Disease 10,501	Diabetes Mellitus 18,603	Chronic Low. Respiratory Disease 120,152	Cerebrovascular 162,890

Project partners include NAMI NH, the Behavioral Health Improvement Institute (BHII), Headrest, Northern Human Services, Riverbend Community Mental Health, Granite United Way, North Country Health Consortium, NHTI, and White Mountains Community College. Additionally, regional implementation teams established early in the project are comprised of key stakeholders across multiple community sectors working together to build and sustain capacity and infrastructure around implementation of best practices for suicide prevention and postvention for high-risk youth – and addressing overall access to care issues at a local and systemic level.

Connect Suicide Prevention Train the Trainer (TTT): Designated a National Best Practice program, Connect Prevention/Intervention Training incorporates key aspects of the National Suicide Prevention Strategy in a comprehensive training model which promotes an integrated community response to suicide prevention. TTT helps to sustain suicide prevention efforts beyond the GLS Grant and ensures communities in the three GLS regions are well equipped and supported to train stakeholders and community members to recognize and respond to individuals at risk,

strengthening the community safety net. The GLS Connect Suicide Prevention TTT was held in May 2022 and trained nine individuals from the North Country and Carroll County in the school suicide prevention module. Another TTT was held in October 2022 that trained six individuals from the Capital Region and other areas of the state in the mental health suicide prevention module and five individuals from the state in the social services module.

Connect Suicide Postvention Train the Trainer (TTT): The Connect Suicide Postvention Training helps sustain suicide postvention efforts and ensures communities in the three GLS regions and the state are well equipped and supported to train stakeholders and community members to respond effectively to a suicide death in order to prevent additional suicides and promote healing for survivors of suicide loss. The Connect™ Program developed specific best practice protocols for social services, mental health and substance abuse, education, law enforcement, emergency medicine, faith leaders, and others. The GLS Connect Suicide Postvention TTT was completed on January 20th, 23rd and 27th 2023, technically in Year 4 of the GLS Grant due to scheduling conflicts in Year 3 with five people becoming Connect trainers in postvention.

GLS Annual Partner Meeting: The 3rd Annual GLS Partner Meeting was held in April 2022. This meeting provided all GLS contracted partners, stakeholders, and supporters with an opportunity to learn about the work completed in each year of the project. During the meeting, the evaluators from BHII provided a comprehensive data update, making relevant connections to all attendees.

Connect Youth Leader Training: Connect Youth Leader training provides high school youth and key staff with opportunities to support one another and enhance suicide prevention efforts on campus. Youth take an active role in educating and empowering their peers to engage in prevention and create a school culture conducive to normalizing conversations about mental health, and specifically, suicide. We were unable to hold this training in year 1. The GLS Connect Youth Leader training was held in May 2022. There were 23 youth & staff at Moultonborough Academy in Carroll County that became trained in Connect Youth Leader.

Regional CALM Training: Reducing access to lethal means, such as firearms and medication, is an evidence-based strategy for reducing suicide risk. This training focuses on how to reduce access to the methods people use in suicide attempts. Second generation CALM trainers from Capital, Carroll County & the North Country Regional Public Health Networks (RPHNs) that were trained in year one of the project provided the training to approximately 10 individuals in the three GLS regions and statewide in September 2022.

Connect Young Adult Leader Training: This training is provided to young adults (18-24) by young adult leaders. Training focuses on suicide risk warnings, identifying substance misuse issues, and recognizing stigma. This training is for young adults that have a passion for this public health issue and may be role models to peers in college or in the workforce. The GLS Connect Young Adult Leader training trained 64 students and was held in August 2022 at New England College in the Capital Region.

Connect Young Adult Leader NH National Guard Training: This training is provided to young adults in the NH National Guard as a train-the-trainer model. Training focuses on suicide risk warnings, identifying substance misuse issues, and recognizing stigma. A total of five service members were trained in the NH National Guard Young Adult Leader training. Service members will train new recruits in the National Guard before they transition to basic training.

GLS Care Liaisons: Care Liaisons based at Riverbend Community Mental Health and Northern Human Services are working with youth and young adults 10 to 24 identified as high risk for suicide in their respective regions. Their services include implementation of a suicide care pathway to reduce risk, as well as facilitating stabilization and recovery following a high-risk incident or period utilizing evidence-based approaches for up to 90 days. This brief intervention provides an opportunity for education, as well as to strengthen the individual's paid and natural support system. Care Liaisons and their supervisors attend the GLS Community of Practice to provide guidance and education to support their work. The GLS Community of Practice is provided by the GLS Project Coordinator.

There has been some turnover in this position. Due to workforce shortage, the Care Liaison position at Northern Human Services has been unfilled after the former Care Liaison moved out of state. Northern Human Services has changed some facets of the position, offering two part-time positions and flexible hours to open the pool of possible candidates. An offer has been made to a candidate for this position.

NHTI: The GLS Coordinator hosted community campus events that included monthly mental health discussions. Both on-campus and off-campus students attended. Peer counselors trained the students in the nursing program in Connect Suicide Prevention. The peer counselors created a page on the college website as a student resource. NHTI continues to provide a community connection for students, offering suicide prevention training, support and opportunities for discussions around mental health and reducing stigma.

White Mountains Community College: WMCC created a team of three coordinators to fulfill the duties of the GLS grant. WMCC does not have residence halls and their students commute to the school or take online classes. The coordinators have begun collaborating with NHTI and other GLS partners to find ways to create connection and community for their students. The college is offering Wellness Wednesdays as a time to connect with students around wellness topics.

GLS RPHN Implementation Team Meetings: Each Regional Public Health Network in the Capital Region, North Country and Carroll County provides a monthly meeting that includes community sectors such as first responders, faith leaders, schools, community mental health centers and healthcare. These meetings allow cross-systems collaboration around mental health, suicide prevention, supports, education, training, and resources.

Connect Online Suicide Prevention Training (eLearning Seats): The Connect Online Training Program is a self-paced course that takes about two hours to complete and provides informational and interactive slides that teach participants about risk and protective factors, warning signs, and how to respond to a person at risk for suicide. The three GLS regions provided a total of 434 Connect eLearning seats that included gatekeeper, school, healthcare, and mental health modules.

May Mental Health Training for Adolescents: This mental health training was provided to 13 students at Second Start, an alternative school in the Capital Region for students that need an alternative high school setting due to learning and emotional differences. A college student from GLS partner, NHTI, accompanied this training and provided a discussion about overcoming challenges and her mental health journey.

ConcordTV: The GLS Project Coordinator, NAMI NH's Executive Director, the NHTI GLS Coordinator, and an NHTI student participated in a 30-minute interview including information about the GLS Grant and suicide prevention efforts at NHTI and across the GLS Regions of New Hampshire.

Teen Institute Leadership Camp Visit: The GLS Project Coordinator visited the Teen Institute Leadership Camp in August 2022. Teens from the GLS Regions and the state collaborated in regional teams to meet community members and discuss positive attributes about their community and a wish list for change. Discussion included ways to take their information back to their communities as leaders and promote change.

For more information on the GLS NHNP 2.0 contact Susan Ward at sward@naminh.org

New Hampshire Rapid Response

New Hampshire Rapid Response

New Hampshire's Rapid Response crisis system officially launched on January 1st, 2022. The below data spans **January through December 2022.** This data is preliminary but being shared to illustrate that the system is up and running and available statewide and across the lifespan.

WHAT IS IT?

The New Hampshire Rapid Response system is comprised of three components: Centralized Access Point, Mobile Crisis Response Teams, and location-based services. These services, in the most simple of terms, are meant to provide people in NH with:

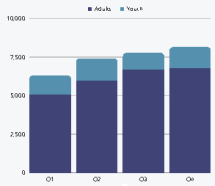
Someone to call, text or chat

Someone to respond

Somewhere to go

22,200 CONTACTS

Jan-Dec 2022 the access point assisted individuals 22,200 times via phone, text, and/or chat.

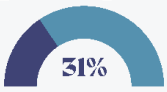


YOUTH & ADULTS

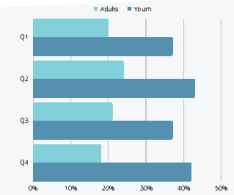
On average, **17%** of contacts with the access point were under 18 years old and **83%** were over 18

7,084

MOBILE DISPATCHES



On average, 31% of access point interactions state-wide resulted in mobile dispatches



Youth & Adults

On average, **42%** of contacts resulted in mobile dispatches for youth and **18%** of contacts resulted in mobile dispatches for adults

NH Rapid Response created an opportunity to strengthen the community-based crisis response system designed to care for NH children, youth, adults, and families experiencing a mental health and or substance use crisis. Many dedicated professionals who work in NH's behavioral health system are dedicated to successfully implementing this new model. While Rapid Response is now live and partners have worked hard to get to this point, system improvement continues to ensure each communities' unique needs are being met. Please reach out, engage early and often.

General NH Rapid Response questions can be sent to: DBHCrisisTransformation@dhhs.nh.gov

Get Help Now
Call/Text **833-710-6477**
Chat by visiting **www.nh988.com**

Updated January 2023

Zero Suicide – The Mental Health Center of Greater Manchester

The Mental Health Center of Greater Manchester (MHCGM) has been working with the Veterans Administration and Catholic Medical Center under a SAMHSA funded Zero Suicide grant with the goal of creating a suicide safer community.

In 2022, the outcomes from this initiative included:

The Foundation for Healthy Communities' Behavioral Health Clinical Learning Collaborative

The Foundation for Healthy Communities' Behavioral Health Clinical Learning Collaborative is a grant funded program designed to address the care and treatment of patients experiencing behavioral health crises in the emergency department (ED) setting. The Collaborative is funded by the Endowment for Health (endowmentforhealth.org) and New Hampshire Charitable Foundation (www.nhcf.org).

Members of the Collaborative are from all of New Hampshire's acute care hospitals, in-patient psychiatric hospitals, community mental health centers, health insurance plans and various community partners. The statewide group meets remotely each month. Programming during the year focused on services, resources and care management opportunities for emergency room clinicians, staff, patients, and families.

Previous topics have included:

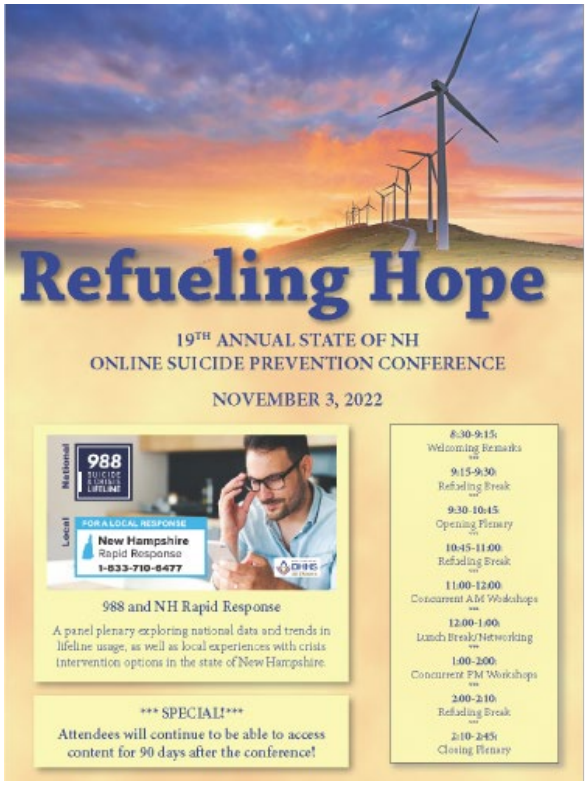
- A Boston Children's Hospital emergency room physician provided an overview of caring for pediatric patients while in the emergency room. Resources included a self-care, no-cost packet with age-appropriate activities that can be used in the ED setting for pediatric

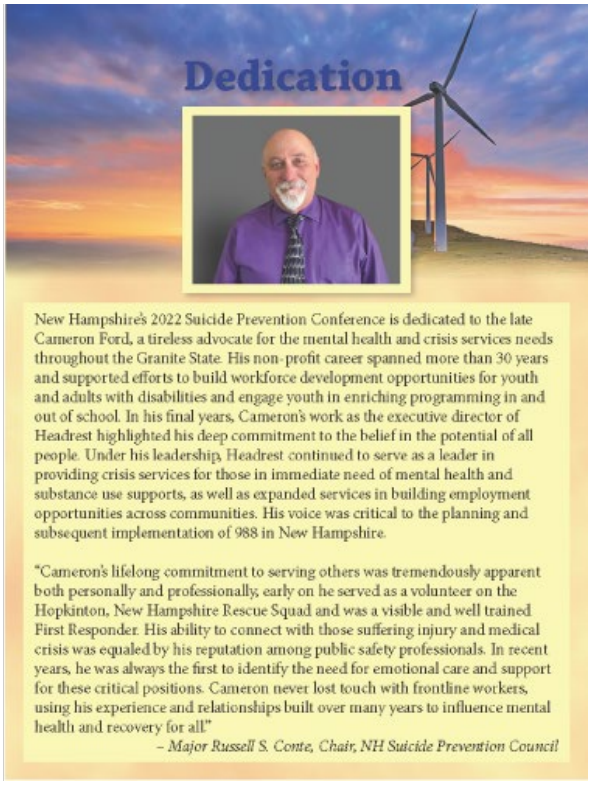
patients with behavioral health conditions. Several hospitals also joined an ECHO project sponsored by Yale University on Pediatric Behavioral Health.

- The Collaborative held a panel discussion where valuable perspectives and experiences were shared on care considerations for members of the LGBTQIA+ community in the emergency room settings. Requests for healthcare staff included: Wear pronoun and/or ally pins; use inclusive language; and understand and respect patient sexual orientation and gender identity.
- The Collaborative worked with the Veterans Administration Medical Center in Manchester to create an overview of support services and care coordination options for veterans who present in emergency rooms.
- Following the Collaborative's production of the Suicide Screening & Intervention Strategy for New Hampshire Emergency Departments in 2020, Littleton Regional Healthcare was able to train over 70 hospital staff on the Connect Suicide Prevention Training. Funding for the initiative was supported by NAMI NH's Garrett Lee Smith (GLS) New Hampshire Nexus Project 2.0.

Annual NH Suicide Prevention Conference

The NH Annual Suicide Prevention Conference was held virtually on November 3, 2022. The theme for 2022 was Refueling Hope. This one day virtual conference featured ways that communities at the national, state, and local levels have come together to prevent suicide, build resiliency, and generate hope. Attendees learned about efforts to create positive community change across the lifespan. The opening plenary, *Answering the Call: 988 and NH Rapid Response*, highlighted the launch of 988 and NH Rapid Response to support callers and texters in times of crisis.





NH Grown National Initiatives

The Connect™ Program

NAMI NH's Connect Suicide Prevention and Postvention Program continued to provide training and consultation to organizations, schools, and communities across NH and around the U.S, providing evidence-based strategies in responding to individuals at risk for suicide and promoting healing and reducing risk after a suicide death.

In addition to providing live virtual Connect suicide prevention and postvention trainings, the Connect E-Learning training was well utilized, particularly by schools and health care providers. A total of over 1,450 seats for Connect E-Learning were distributed in 2022, which expanded access to suicide prevention training in NH and other states around the U.S. In NH in 2022, there were 1,504 participants trained in Connect Prevention trainings and 337 in Connect Postvention trainings. 152 trainers were trained to help sustain suicide prevention efforts in their respective organizations.

At the NH Police Academy, nearly 200 new recruits also received training from Connect staff in suicide prevention and postvention as a standard part of their training curriculum, and the NH Department of Corrections also continued implementing mental health and suicide prevention training for new recruits through NAMI NH.

Positive Outcomes and Testimonials

"I feel more confident if a clinic patient is suicidal, I now know the steps to take to keep a suicidal patient safe. Thank you."

"I thoroughly enjoyed this training as it is a topic that hits close to home and makes me more acutely aware of ways to help and share resources for friends, family, staff, patients, etc."

"I am a triage nurse and some of the most stressful calls for me are the calls from individuals expressing thoughts of self-harm. This information will be a huge help to me! I will also pass it on to others!"

"I really liked that we addressed the 'elephant in the room' and that suicide is more complicated and it takes a village to save someone's life."

Feedback shared by Connect Suicide Prevention Training participants.

Several schools in NH also implemented the Connect Youth Leader program, training 195 high school youth to partner with adults to lead this program for peers and teachers in their schools and communities as a strong and vibrant protective factor. A new program called Connect Real Talk was developed as an extension of the Connect Youth Leader to address the mental health needs of young people post-pandemic.

Staff in the Connect Program assisted individuals, schools, and communities to help with their healing after a suicide with over 100 hours of postvention support and technical assistance to communities and organizations in NH.

The Connect Program staff also provided training and consultation in person and virtually in 2022 in numerous states and territories, including New Hampshire, Alaska, California, Ohio, Virginia, Georgia, South Carolina, Oregon, and the Northern Mariana Islands.

Under a grant through SAMHSA, the Connect Program began the process of reviewing the suicide prevention curriculum and design for greater accessibility and adaptability for diverse groups. This project will continue into 2023 to update parts of the program for other languages and cultures such as Deaf and Hard of Hearing and translation into Spanish.

Counseling on Access to Lethal Means - CALM

Counseling on Access to Lethal Means - CALM is a national best practice that was developed in NH in 2006. Since then, it has been offered as an in-person workshop and Train the Trainer program, several online versions and, since COVID-19, as a virtual training around the United States.

In 2022, the CALM America website grew as a national resource to promote the CALM training. The development of a version for general audiences, referred to as CALM Convo, was underway for launch in 2023. In NH, CALM trainers offered CALM training virtually through the GLS grant and other CALM trainings were offered in person throughout the state.

Positive Outcomes and Testimonials

"I feel [the CALM training] was very valuable. I feel that this training will help improve my skills."

"The data helped me to challenge many of my false perceptions."

"Excellent and helpful for staff to educate patients and families on prevention and actions to take."

Feedback shared by 2018 CALM training participants.

The NH Firearm Safety Coalition

The NHFSC returned to in-person meetings in 2022 and resumed the plan to reach out to gun shops and firing ranges in NH to offer suicide prevention materials for display in business settings. An internal review of materials and dialogue about strategies for reaching out was a primary focus for the NHFSC

Have you found this report to be useful?

Please share your feedback through the survey linked below so that this report can be even better in the future.

https://www.surveymonkey.com/r/PPJL25W

2022 DATA UPDATE

2022 Data Update

SPC/YSPA Data Subcommittee
Membership Representation 2022-2023

Injury Prevention Center at Dartmouth Health
NAMI New Hampshire (National Alliance on Mental Illness)
New Hampshire Army National Guard
State of New Hampshire Department of Health and Human Services
State of New Hampshire Office of the Chief Medical Examiner

Introduction

The data presented in this report are the result of collaboration among a variety of organizations and people. Key areas of interest and concern for suicidal behavior in NH are included in this report. A data interpretation and chart reading section is available at the end of the report to assist readers when needed.

While each suicide is a separate act, only aggregate data is presented in this report. Aggregate data helps inform which populations and age groups are most at risk, reveals points of particular vulnerability, and thus helps guide prevention and intervention efforts, and identify where to direct program funding. It also protects the privacy of individuals and their families. We respectfully acknowledge that the numbers referred to in this report represent lives tragically lost, leaving many behind who are profoundly affected by these deaths.

In previous years, this report included death data from two primary sources; Vital Records data (official death records for NH residents) for the State of NH obtained from Health Statistics and Data Management (HSDM), Division of Public Health Services, NH DHHS; and Office of the Chief Medical Examiner (OCME) for the State of NH. As of the 2019 NH Suicide Prevention Annual Report, data from NH's implementation of the National Violence Death Reporting System (NH-VDRS) has been included to provide greater detail around the circumstances surrounding suicide deaths in NH.

NH DHHS collaborates with the NH Department of Justice (DOJ) on implementation of the NH-VDRS[3] under the auspices of the OCME. The CDC currently includes all fifty states, the District of Columbia, and Puerto Rico in the NVDRS project. NVDRS is a de-identified secure database system used by all US states. NH-VDRS utilizes the system to collect data on violent deaths in NH. Violent deaths include suicides, homicides, firearms accidents, and other violent deaths.

Suicide death demographic data is collected from the NH Division of Vital Records Administration death certificate database on all suicide victims who died in the state of New Hampshire. NH residents who died in other states are included in the NVDRS statistics in the state where they died. NH-VDRS abstracted data comes from Assistant Deputy Medical Examiner (ADME) investigation reports, toxicology, and autopsies reports, all of which are located in the Medical

[3] Disclosure: NH-VDRS funding is from the Centers for Disease Control and Prevention Cooperative Agreement NU17CE010125-02-00.

Examiner's office. Another abstracted data resource is law enforcement reports, which include state, local, and sheriff departments.

The NH DHHS Health Statistics and Data Management Section provided a data quality assurance check on the outputs for the vital records, NH-VDRDS, and hospital data in this report.

NH-VDRS reports the outcomes of the data on violent deaths as defined by CDC grant requirements. The analysis as provided is focused on direct outcomes and does not engage in policy analysis. Any policy analysis based on the NH-VDRS provided data included in this report was done by the NH Suicide Prevention Council Data Subcommittee.

Additional data sources were used for specific purposes throughout this report that may have varying methods of collection. All of the Tables and Figures in this report include a citation for the data source to prevent confusion. Different data sources also vary regarding how quickly the information is made available, how often it is collected/reported, and which years of data may be combined. The time periods reported for each source are indicated with the corresponding Table or Figure.

Demographic Profile of New Hampshire

Comparing New Hampshire to the US

Tables 1 through **6** below present NH and US demographic characteristics, as well as indicators of substance use and mental health. NH is a small state, with just under 1.4 million residents (US Census Bureau, 2022). While NH is still relatively homogeneous in terms of race and ethnicity, it is becoming more diverse over time. The state has above average ratings for economic factors and education. NH is also above the US average for alcohol and illegal drug use, with the 2nd highest rate in the US for alcohol use in the past month[4] and the 23rd highest rate for marijuana use in the past month (National Survey on Drug Use and Health, 2021).

Table 1

Race/Ethnicity.

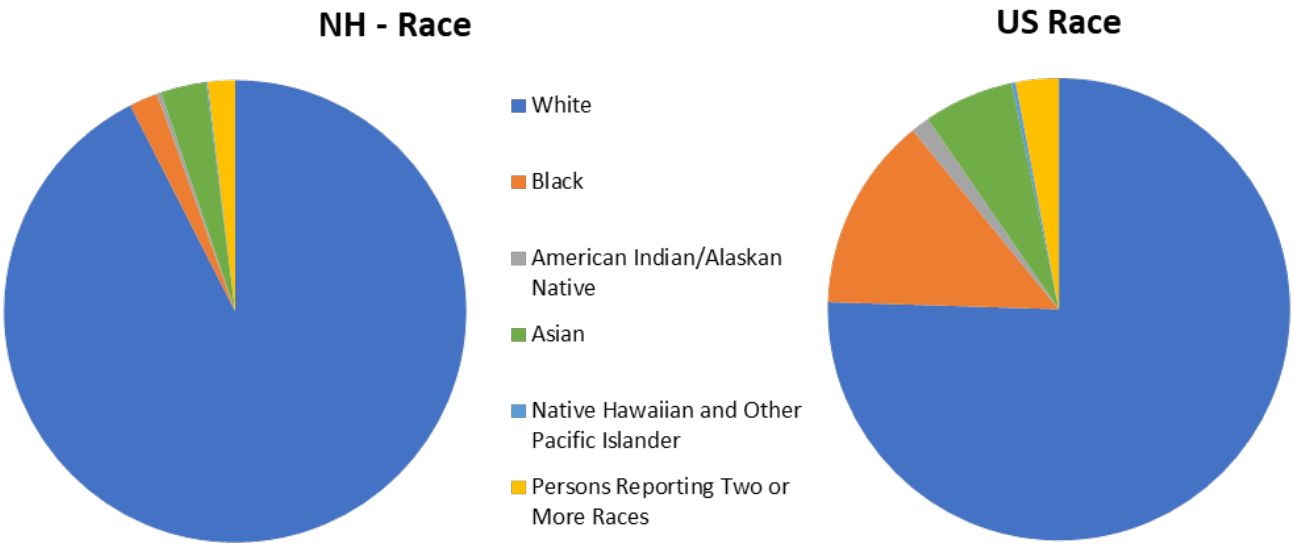
	New Hampshire	United States
Race		
White	92.6%	75.5%
Black	2.0%	13.6%
American Indian/Alaskan Native	0.3%	1.3%
Asian	3.2%	6.3%
Native Hawaiian and Other Pacific Islander	0.1%	0.3%
Persons Reporting Two or More Races	1.9%	3.0%
Ethnicity		
Persons of Hispanic or Latino Origin	4.6%	19.1%

Data Source: US Census Bureau 2022

[4] "Past month" refers to the 30 days prior to the administration of the National Survey on Drug Use and Health.

Figure 1

NH and US Race/Ethnicity.



Data Source: US Census Bureau 2022

Table 2

Age.

	New Hampshire	United States
Under 18	18.13%	22.74%
18 to 24	8.65%	9.40%
25 to 44	25.18%	26.76%
45 to 64	27.86%	24.76%
65 to 74	12.13%	10.14%
75 and Up	8.04%	7.20%

Data Source: US Census Bureau 2022

Table 3

Economic Factors.

	New Hampshire	United States
Unemployed Residents	2.5%	4.3%
Persons Below Poverty Level	7.2%	12.6%
Persons Without Health Insurance (under age 65)	6.0%	9.3%
Per Capita Income (Yearly)	$48,250	$41,261
Median Household Income	$90,845	$75,149
Median Home Value (Owner Occupied)	$337,100	$281,900

Data Source: US Census Bureau American Community Survey 2022

Table 4

Education – Individuals Age 25 and Older.

	New Hampshire	United States
Less Than High School Graduate	5.5%	10.4%
High School Graduate or Associates Degree	53.2%	54.0%
Bachelor's Degree or Higher	41.3%	35.7%

Data Source: US Census Bureau American Community Survey 2022

Table 5

Substance Use – Individuals Age 12 and Older.

	New Hampshire	United States
Marijuana Use – Past Month	12.43%	12.99%
Alcohol Use – Past Month	58.44%	47.55%
Tobacco Use – Past Month	18.41%	19.55%

Data Source: National Survey on Drug Use and Health, 2021

Table 6

Mental Health Indicators – Individuals Age 18 and Older.

	New Hampshire	United States
Serious Mental Illness – Past Year	5.17%	5.55%
Major Depressive Episode – Past Year	8.38%	8.29%
Had Serous Thoughts of Suicide – Past Year	4.56%	4.85%
Made Any Suicide Plans – Past Year	1.20%	1.39%
Attempted Suicide – Past Year	0.31%	0.69%
Received Mental Health Services – Past Year	21.47%	16.85%

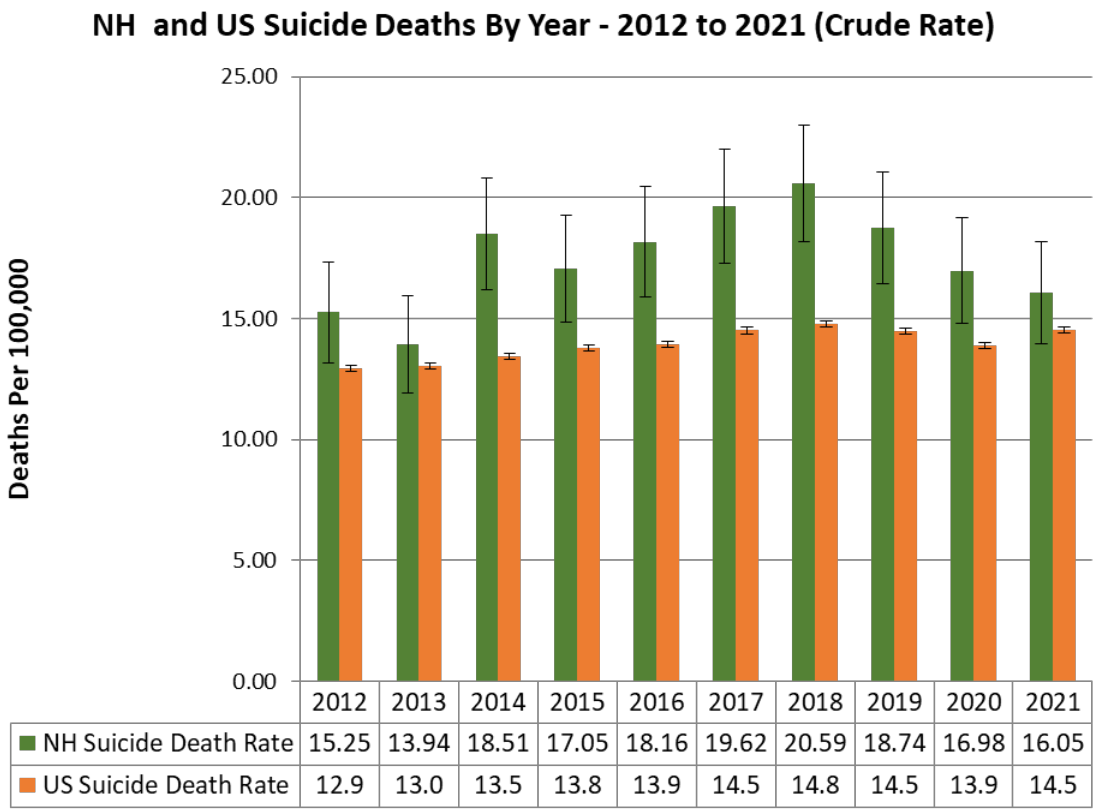
Data Source: National Survey on Drug Use and Health, 2021

The Big Picture: Suicide in NH and Nationally

The Tables and Figures below depict various suicide related data. Some are specific to NH while others compare NH and national statistics.

Figure 2 (pg. 31) presents the suicide rate in NH and the US for the past ten years. The rate in NH has varied from year to year, due to its small size, while the US rate has remained more consistent year to year. Even though the NH rate has varied, until 2014 there had been no statistically significant differences from one year to the next since at least the year 2000. 2010 was the first year in recent history where there was a statistically significant difference compared to any other recent year. The 2010-2012 suicide rates are significantly greater than the rates for 2000, 2002, and 2004. This appears to be consistent with changes in the rates of suicide nationally. In 2014 there was a spike in the NH rate that brought it significantly above the rate for 2013, and the rates prior to 2010. This increase was not seen in other states or for the US as a whole in 2014. The increase starting in 2014 continued through 2018, though not statistically significant from year to year. The rate decreased in 2019, 2020, and 2021, though none of these were statistically significant changes from the immediately preceding years. This decreased rate in 2019 and 2020 matched a national trend.

Figure 2



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NH Suicide Death Rate	15.25	13.94	18.51	17.05	18.16	19.62	20.59	18.74	16.98	16.05
US Suicide Death Rate	12.9	13.0	13.5	13.8	13.9	14.5	14.8	14.5	13.9	14.5

Data Source: CDC WISQARS

Table 7 (pg. 32) displays the 10 leading causes of death for people of different age groups in NH. From 2017-2021, suicide among those aged 15-34 was the second leading cause of death in NH and nationally, behind only deaths due to unintentional injury. Within that age group, a substantial number of unintentional injuries in NH include motor vehicle crashes and unintentional overdose deaths.

Table 7

10 Leading Causes of Death, New Hampshire, by Age Group, 2017 – 2021.

	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 43	Unintentional Injury 14**	Unintentional Injury --	Suicide 14**	Unintentional Injury 256	Unintentional Injury 756	Unintentional Injury 666	Malignant Neoplasms 766	Malignant Neoplasms 2,529	Heart Disease 11,576	Malignant Neoplasms 13,947
2	Short Gestation 35	Congenital Anomalies --	Malignant Neoplasms --	Malignant Neoplasms 10**	Suicide 154	Suicide 202	Malignant Neoplasms 185	Unintentional Injury 607	Heart Disease 1,491	Malignant Neoplasms 10,369	Heart Disease 13,873
3	Placenta Cord Membranes Sids 17**	Malignant Neoplasms Homicide --	Benign Neoplasms Homicide --	Unintentional Injury --	Malignant Neoplasms 20**	Malignant Neoplasms 59	Suicide 173	Heart Disease 594	Unintentional Injury 540	Chronic Low. Respiratory Disease 3,072	Unintentional Injury 4,548
4				Congenital Anomalies --	Heart Disease Homicide 19**	Heart Disease 57	Heart Disease 131	Suicide 259	Chronic Low. Respiratory Disease 425	Cerebrovascular 2,372	Chronic Low. Respiratory Disease 3,595
5	Maternal Pregnancy Comp. 14**	Covid-19 Diabetes Mellitus Heart Disease Influenza & Pneumonia Septicemia --	Congenital Anomalies --	Benign Neoplasms Chronic Low. Respiratory Disease Heart Disease Influenza & Pneumonia Perinatal Period Pneumonitis --		Liver Disease 22	Liver Disease 77	Liver Disease 205	Liver Disease 321	Alzheimer's Disease 2,310	Cerebrovascular 2,645
6	Respiratory Distress 11**		Acute Bronchititis Diseases Of Appendix --		Cerebrovascular Congenital Anomalies --	Homicide 14**	Covid-19 Diabetes Mellitus 31	Diabetes Mellitus 112	Diabetes Mellitus 280	Unintentional Injury 1,688	Alzheimer's Disease 2,347
7	Intrauterine Hypoxia --					Covid-19 12**		Chronic Low. Respiratory Disease 72	Suicide 217	Covid-19 1,626	Covid-19 1,891
8	Unintentional Injury --		Chronic Low. Respiratory Disease --		Cerebrovascular 11**	Cerebrovascular 25	Cerebrovascular 70	Cerebrovascular 161	Diabetes Mellitus 1,346	Diabetes Mellitus 1,779	
9	Bacterial Sepsis --		Aortic Aneurysm Covid-19 Influenza & Pneumonia Pneumonitis Septicemia --		Diabetes Mellitus --	Homicide 21	Covid-19 63	Covid-19 157	Influenza & Pneumonia 904	Suicide 1,256	
10	Circulatory System Disease Neonatal Hemorrhage --	Septicemia --			Chronic Low. Respiratory Disease 16**	Septicemia 40	Septicemia 89	Parkinson's Disease 870	Liver Disease 1,030		

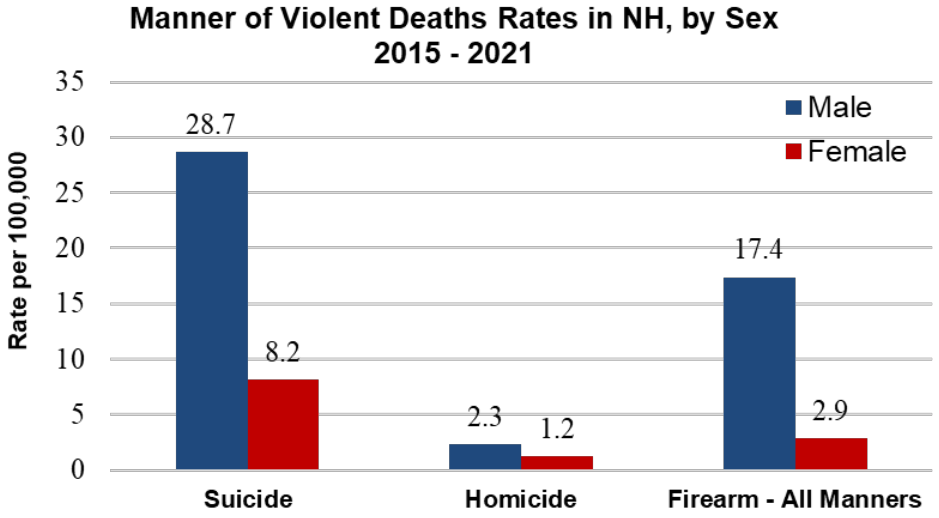
** indicates Unstable values, -- indicates Suppressed values, --* indicates Secondary Suppression

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics, National Vital Statistics System
---Note: Beginning with 2008 data, the CDC has suppressed state-level counts for categories with fewer than ten deaths

The vast majority of violent deaths in NH are suicides. For every homicide in NH, there are approximately 12 suicides. This ratio is in sharp contrast to national statistics, which show approximately 2 suicides for every homicide. For every suicide death in NH and nationally, there are approximately 4 deaths classified as unintentional injuries (CDC WISQARS, 2017-2021). Overall, suicide constitutes a larger proportion of all violent deaths in NH than in the US as a whole. The breakdown of violent deaths[5] in NH by sex is presented below in **Figure 3**.

Figure 3

Males die of violent deaths of all manners at rates greater than those for females.



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS

The most effective way to compare NH to the US is to look at suicide death rates. **Table 8** (below) presents NH and US suicide death rates by age group.

Table 8

Crude Suicide Death Rates per 100,000 in NH & US, by age group, 2017-2021.

	ALL AGES	YOUTH 10 TO 17	YOUNG ADULTS 18 TO 24	YOUTH AND YOUNG ADULTS 10 TO 24
NH	18.38	5.27	21.65	13.45
US	14.43	5.11	16.64	10.56

	AGES 25 TO 39	AGES 40 TO 59	AGES 60 TO 74	AGES 75 AND OVER
NH	22.69	24.95	17.68	21.52
US	18.06	18.81	16.14	19.44

Data Source: CDC WISQARS

[5] Violent deaths include suicide, homicide, and any firearm related death regardless of intent.

Adults age 40 to 59 had the highest suicide rates of all age groups identified above (24.95 NH, 118.81 US) from 2017-2021 in NH and the 2nd highest in the US. There is a substantial increase in the rates from youth (ages 10-17) to young adults (ages 18-24) revealing the transition from middle/late adolescence to late adolescence/early adulthood as a particularly vulnerable time for death by suicide.

Youth and Young Adult Suicide in NH

Between 2015 and 2021, 219 NH youth and young adults aged 10-24 have lost their lives to suicide. Males in this age group are much more likely to die by suicide in NH (80%) and nationwide (79%). Hanging and firearms were the most frequently used methods in NH among youth and young adults during this period, with firearms being used with a slightly higher frequency. Nationally, a greater proportion of youth and young adults who die by suicide use firearms.

Table 9 (pg. 37) presents the number of youth and young adult deaths by year. This year-by-year data has been plotted in **Figures 4 and 5** (pg. 35). There are a relatively small number of deaths in this age group that can fluctuate from year to year. The rates presented on the chart of deaths over rolling three-year intervals shown in **Figure 56** (pg. 75) helps to smooth out small year to year fluctuations, and also addresses population increases by presenting rates per 100,000.

Positive Outcomes and Testimonials

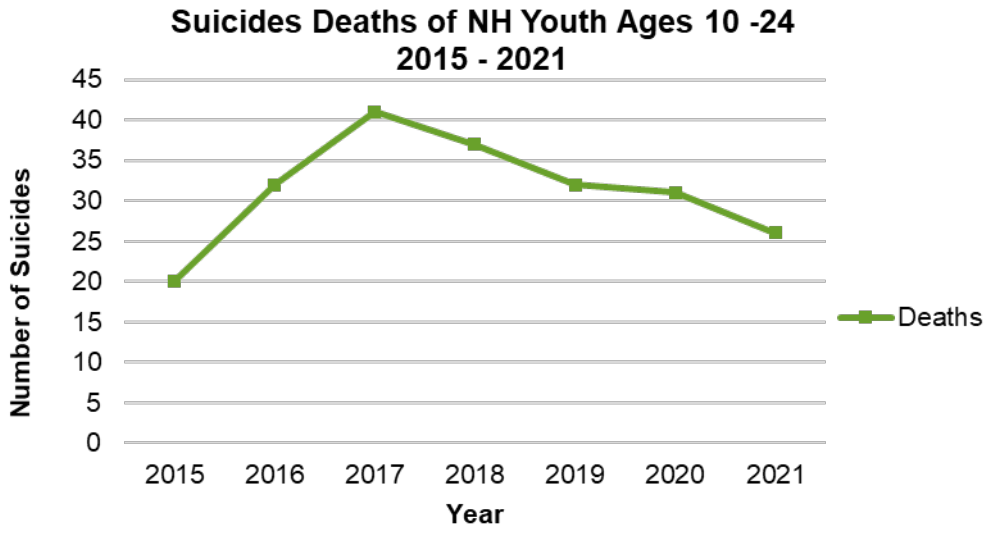
A student and his mother were sent to a NH emergency department one spring morning for an emergency suicide assessment based on requirements of the School District Suicide Intervention Protocol. The student had expressed suicidal warning signs. The School Resource Officer and a member of the Response Team, both known by the family, joined them at the hospital.

During the process the student's mother shared that her son had been asking for permission to take his father's rifle and go out into the woods near their home. The mother had denied his request and explained her safety concerns to him.

"There was a simultaneous shiver that went through each of us when we registered the great relief of intervening with an emergency assessment before a suicide attempt...especially with such a potentially lethal plan."

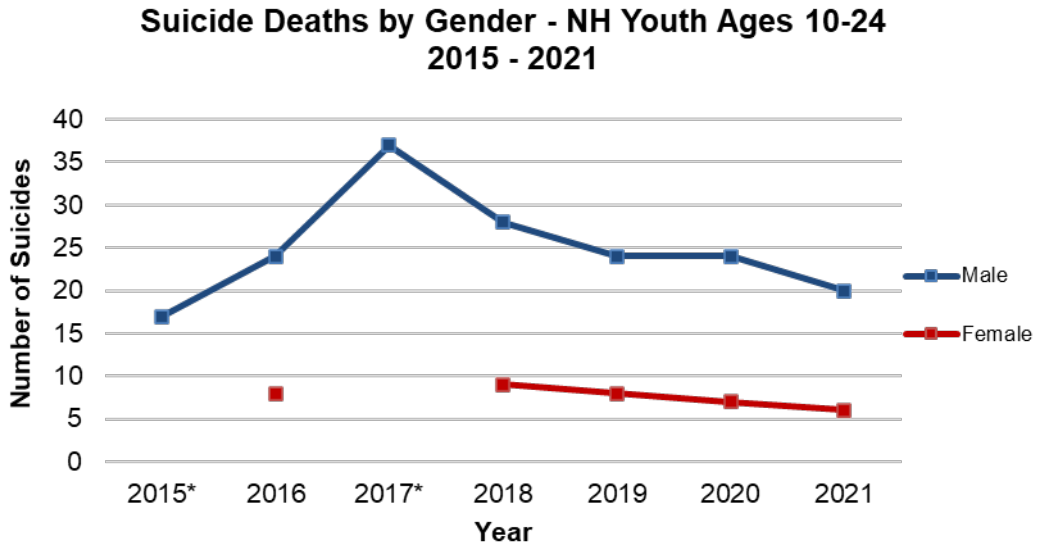
The student was able to share his feelings and a comprehensive follow up plan was created. The student and his mother learned about the resources available to help them both.

Figure 4



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 5



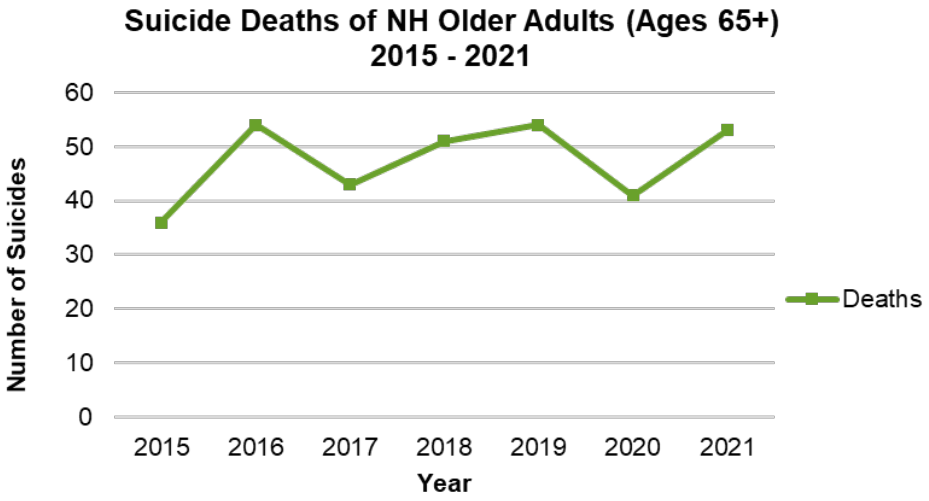
*Counts less than five are not disclosed for privacy purposes.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Older Adult Suicide in NH

In light of the rapidly expanding number and proportion of older adults in New Hampshire's population, suicide in older adults is a growing public health concern. Added to the changing demographics is the rising prevalence of mental illness and substance disorders. Untreated mental illness such as depression is a significant risk factor for suicide among all ages, but it is particularly of concern in later life as older adults with depression or other mental health conditions receive treatment at markedly lower rates than the rest of the population.

Another concern is the rate of attempts to suicides deaths for older adults. The lethality rate in people over 65 years of age is markedly higher in comparison to other age groups. While there is one death for every 36 attempts in the general population, there is one death for every four attempts in individuals over 65. One related factor is that aged individuals may be physically frailer than younger individuals and are therefore less likely to survive self-injurious acts. A second is that older adults tend to be more isolated than younger people, making detection or timely intervention less likely. A third factor is the lethality of means; compared to other age groups, adults over 65 are more likely to use firearms as a means of suicide (**Figure 39** – pg. 61).[6]

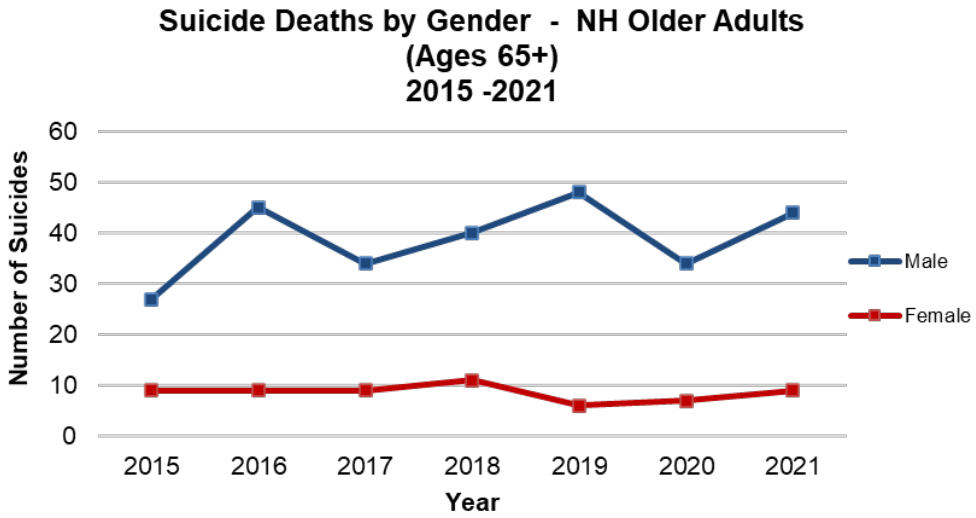
Figure 6



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

[6] Conwell Y. Suicide and suicide prevention in later life. Focus 2013; 11(1): 39–47. https://acl.gov/sites/default/files/programs/2016-11/Suicide%20Prevention%20Webinar%20Presentation%20Slides2.pdf

Figure 7



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Suicide Across the Lifespan in NH

Table 9 below presents the number of suicide deaths in NH by year, by sex, and selected age groups. These counts include both NH residents and out-of-state residents who died by suicide in NH. When comparing year to year, there is a noticeable increase in the number deaths from 2015 to 2018, followed by a decrease from 2018 to 2021. The proportion of deaths by sex and age group remained relatively consistent from one period to the next. The number of deaths by year have been plotted in **Figure 8** (pg. 38) and **Figure 9** (pg. 38).

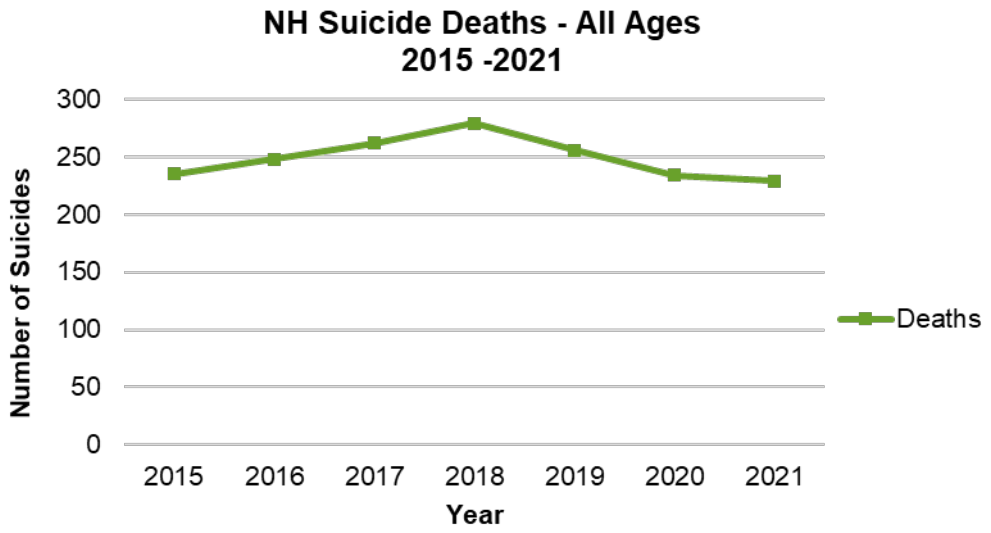
Table 9

NH All Ages Suicide Death Trend, by Sex, Age Group and Method, 2015-2021.

Year	Total	Male	Female	10-24	25-64	65+
2015	235	172	63	20	179	36
2016	248	187	61	32	162	54
2017	262	203	59	41	178	43
2018	279	222	57	37	191	51
2019	256	207	49	32	170	54
2020	234	180	54	31	162	41
2021	229	180	49	26	150	53
Total	1743	1351	392	219	1192	332
Percent of Total	100%	78%	22%	13%	68%	19%

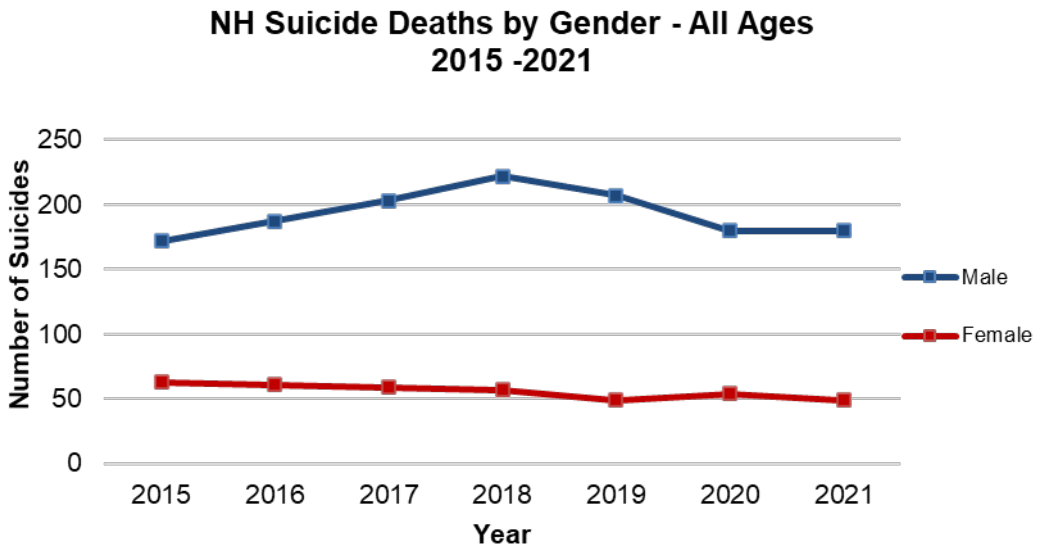
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 8



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 9

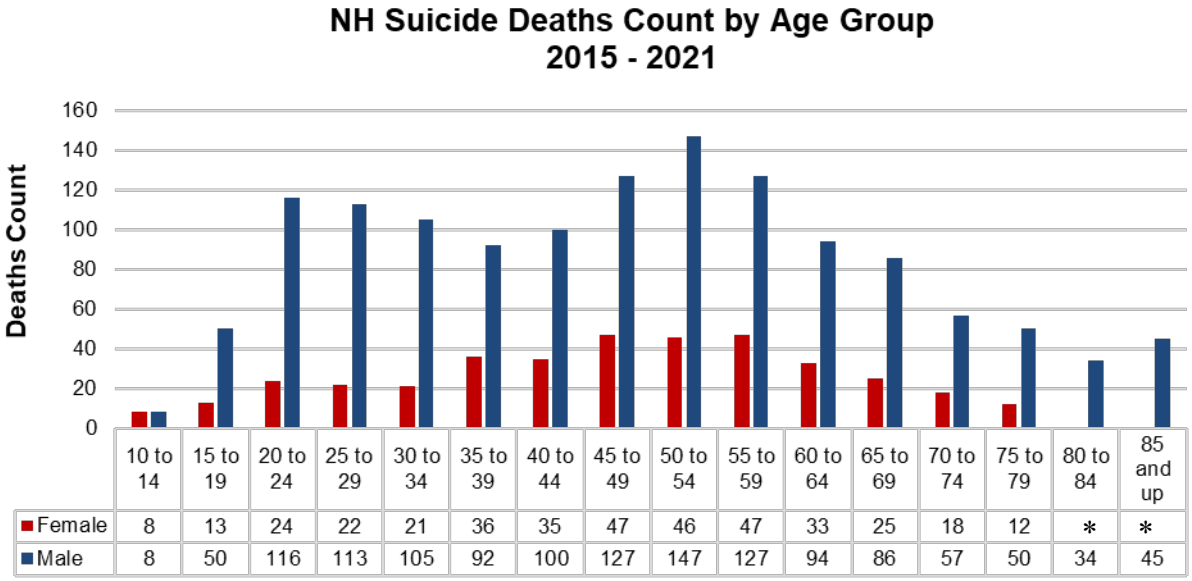


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 10 (below) and **Figure 11** (pg. 40), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and sex from 2015-2021. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal how death rates correct for differences in the size of each age group. While the highest number of suicide deaths occur in the 45 to 59 year-old age groups, the highest rates, or those potentially at the greatest risk, are males over the age of 80. This is followed by males between the ages of 45 and 54. This second high-risk group is younger than has been seen in past years, where individuals in their 70's generally exhibited higher rates of suicide than individuals in their 40's and 50's.

Figure 10

The highest numbers of suicides deaths are seen in males and females in the 40 and 50-year-old age groups.

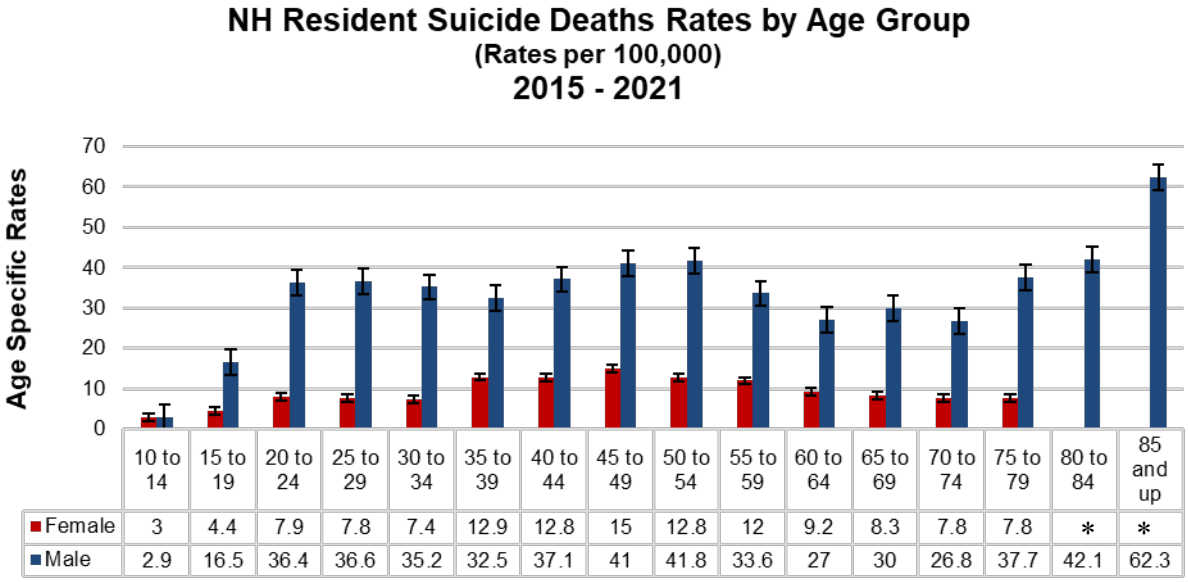


	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 and up
Female	8	13	24	22	21	36	35	47	46	47	33	25	18	12	*	*
Male	8	50	116	113	105	92	100	127	147	127	94	86	57	50	34	45

* Counts less than five are not disclosed for privacy purposes.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Suicide death rates are also important in determining vulnerable age groups and age-related transitions. The suicide death rate in males rises rapidly from ages 10-14 to 15-19 and then again from ages 15-19 to 20-24, pointing to a rise in vulnerability during the transitions from early adolescence to middle adolescence and then middle adolescence to late adolescence/early adulthood. Similarly, suicide rates among elderly males increase substantially at 85 years compared to the younger age groups, indicating another vulnerable time of life for men.

Figure 11



	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 and up
Female	3	4.4	7.9	7.8	7.4	12.9	12.8	15	12.8	12	9.2	8.3	7.8	7.8	*	*
Male	2.9	16.5	36.4	36.6	35.2	32.5	37.1	41	41.8	33.6	27	30	26.8	37.7	42.1	62.3

* Counts less than five are not disclosed for privacy purposes.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

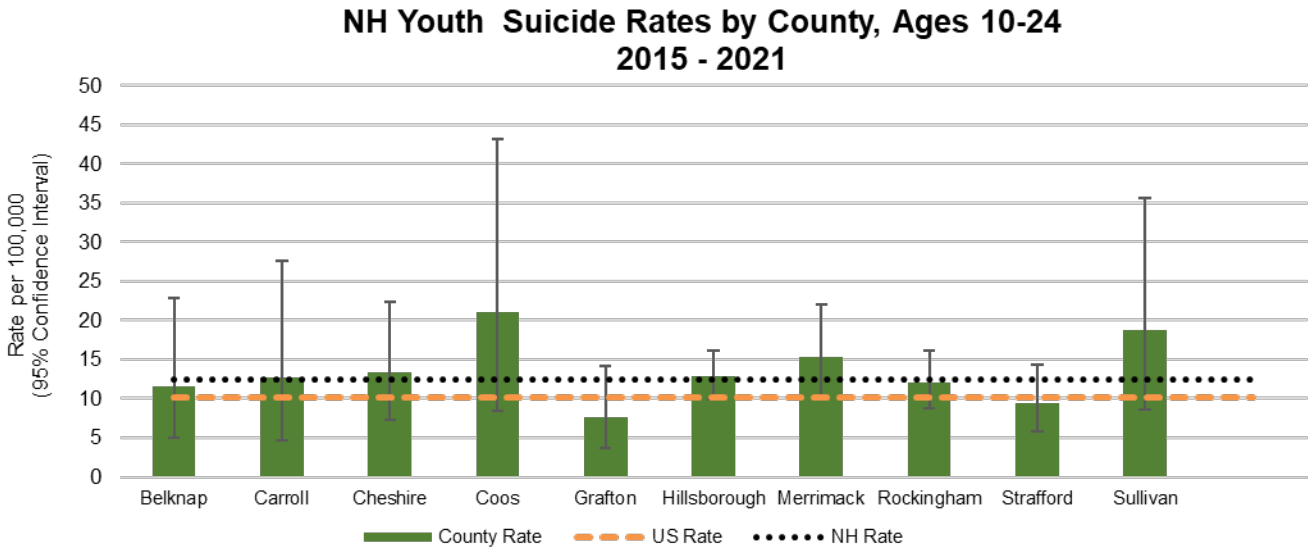
Quick Facts/Talking Points

- Males in NH die by suicide at a rate that is over three times the rate for females (CDC WISQARS, 2023).
- Although males are more likely than females to die by suicide, females report attempting suicide at more than twice the rate of males (NH YRBS, 2021)
- Suicides are preventable (WHO. Suicide prevention: a global imperative. Geneva, Switzerland: WHO Press; 2014).

Geographic Distribution of Suicide in NH

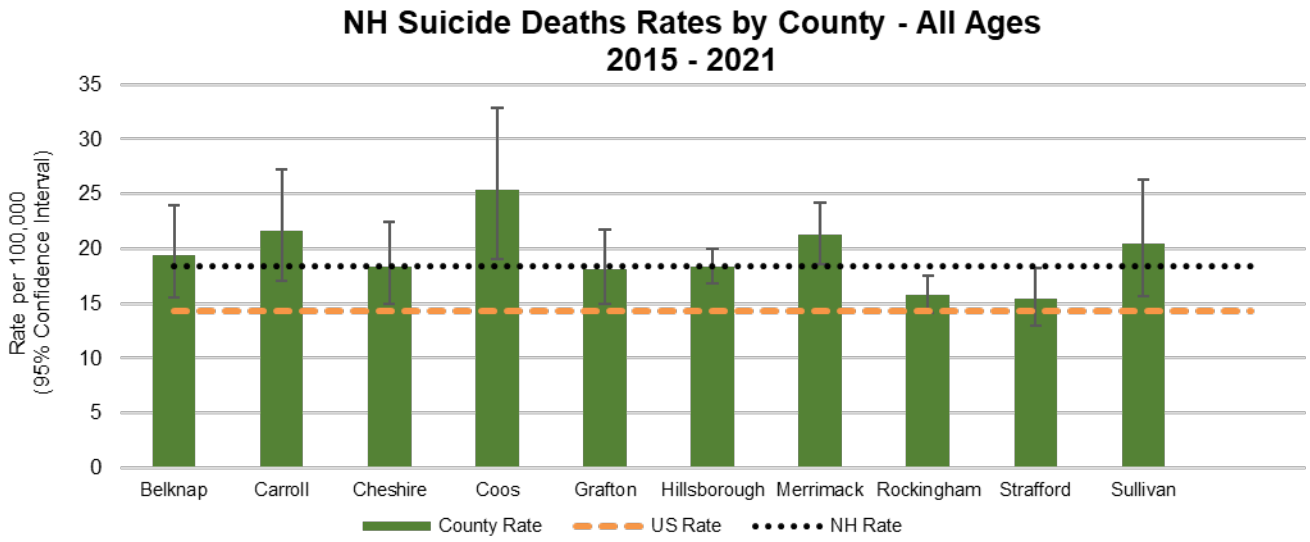
The numbers and rates of suicide in NH are not evenly distributed throughout the state. **Figure 12** (pg. 41) shows youth and young adult suicide rates by county in NH. **Figure 13** (pg. 41) presents this data for NH residents of all ages. The county suicide death rate chart indicates geographical locations that may be particularly vulnerable to suicide (youth and young adult and/or all ages). Due to small numbers, most of these differences are not statistically significant. However, the all-ages rates (**Figure 13** – pg. 41) for Rockingham County (all-ages rate: 14.1 per 100,000) and Strafford County (all-ages rate: 15.4 per 100,000) are significantly lower than the all-ages suicide rates for Coos County (all-ages rate: 25.3 per 100,000) and Merrimack County (all-ages rate: 21.3 per 100,000). County limits are neither soundproof nor absolute. A suicide that occurs in one county can have a strong effect on neighboring counties or across the state, due to the mobility of residents. **Figure 14** (pg. 42) presents the suicide rates for all-ages from 2015 to 2021 as a NH map broken down by county.

Figure 12



NH Rate Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS
US Rate Data Source: CDC WISQARS

Figure 13



NH Rate Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.
US Rate Data Source: CDC WISQARS

Figure 14
Map of NH suicide death rates

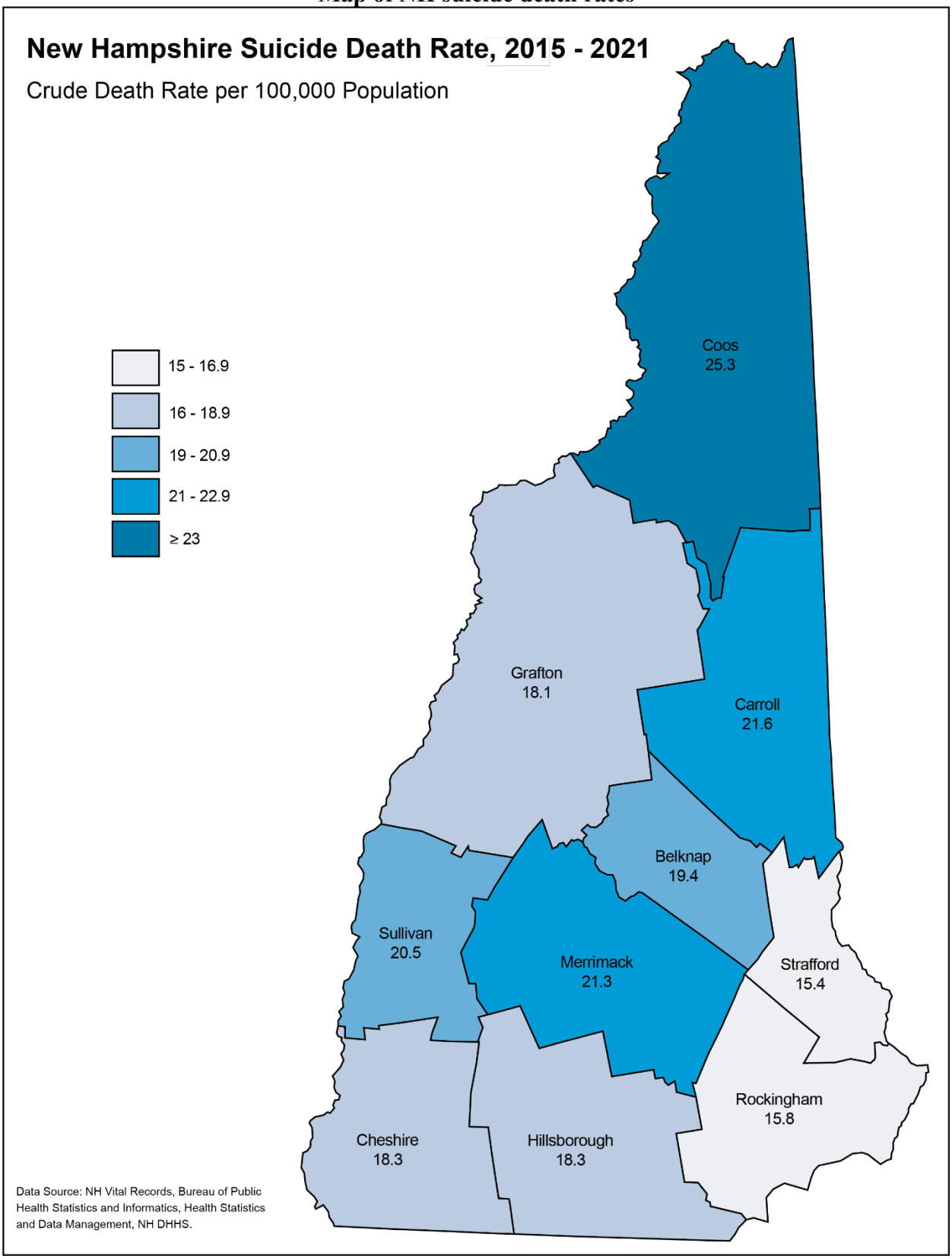


Table 10 (below) further expands upon this county breakdown by presenting the rates of suicide deaths in each county by Sex. In the majority of counties, the ratio is four male deaths for every one female death. The exceptions to this include Belknap County and Hillsborough County where the ratio is approximately three male deaths for every one female death. The ratio of males and females residing in each county is approximately one-to-one statewide.

Table 10
2015 – 2021
Suicide Death Rates by Sex in NH Counties
(Rates per 100,000 population)

County	Female Rates	Male Rates	Rate Ratio	Male to Female Suicide Death Ratio in County
Belknap	9.6	29.5	3.1	3:1
Carroll	8.7	34.8	4	4:1
Cheshire	7.3	29.8	4.1	4:1
Coos	9.5	39.3	4.1	4:1
Grafton	7.5	28.9	3.9	4:1
Hillsborough	9.3	27.4	2.9	3:1
Merrimack	9.1	33.7	3.7	4:1
Rockingham	6.9	24.8	3.6	4:1
Strafford	6.5	24.8	3.8	4:1
Sullivan	7.9	33.4	4.2	4:1

Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH, DHHS.

Suicide Behavior in NH: Gender Differences[7] – Attempts, Deaths, and Risk Factors

Youth and Gender

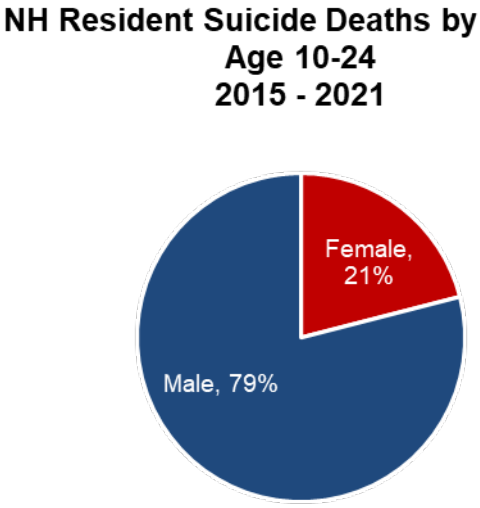
While males represent 79% of the youth and young adult suicides from 2015-2021, the fact that males *die* by suicide at a higher rate than females may largely be due to males using more lethal means. See **Figures 15** (pg. 44) and **16** (pg. 44). In fact, females *attempt* suicide at a higher rate than males. When examining how many NH youth and young adults ages 10-24 were hospitalized and then discharged for self-inflicted injuries in 2017-2021, it is shown that 67.99% of the 931 inpatient discharges represent females, while only 32.01% represent males. Likewise, the 2021 NH Youth Risk Behavior Survey (YRBS) reports approximately twice as many female youth attempt

[7] Gender data included in this report is in most cases only reported as female or male due to limitations in the source data. With most data sources, gender equates to sex assigned at birth. This report will expand beyond those binary options as data collection/reporting in these sources evolves over time.

suicide as males each year (13% of females and 6.3% of males). Emergency department (ED/ambulatory) data reveals a similar gender ratio, based on self-inflicted injury rates.[8]

Figure 15

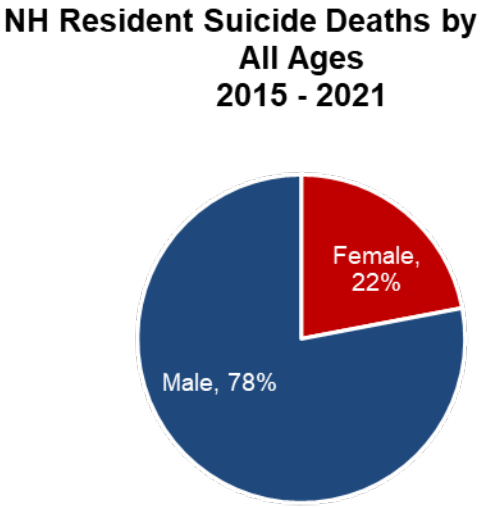
Four times as many male NH residents ages 10-24 died by suicide 2015-2021.



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 16

Three times as many male NH residents died by suicide than females during 2015-2021.



Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

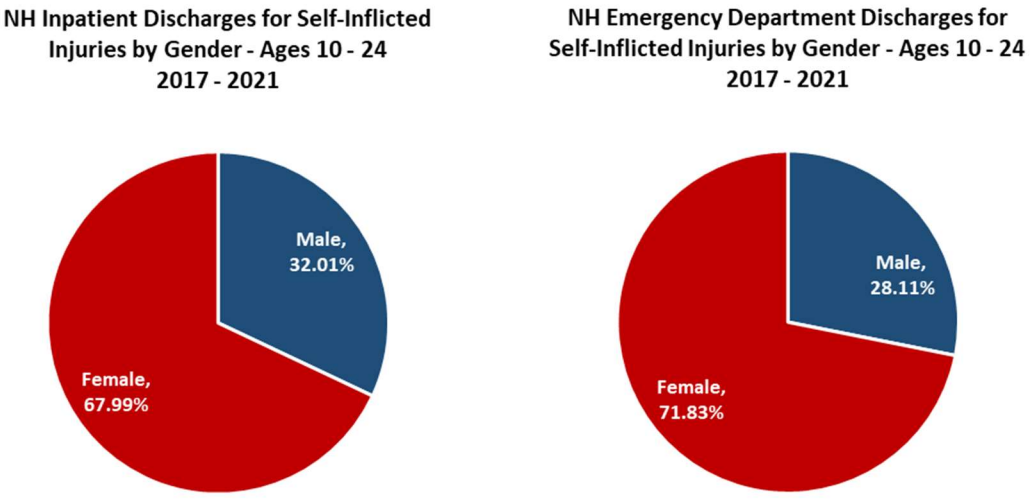
[8] Classifying an injury as self-inflicted is another way of stating that the injury was an instance of deliberate self-harm. Not all self-inflicted injuries necessarily represent suicide attempts. However, analysis of these injuries is the best currently available proxy for estimating suicide attempts.

Female youth are less likely to die by suicide, possibly resulting from less severe injuries during suicide attempts (self-inflicted injuries). However, female youth do attempt suicide more frequently than males – 1.3-2.6 times as often (**Figure 17** - below**, Figure 18 and Figure 19** – pg. 46). This report includes three sources of self-inflicted injury data; Emergency Department Discharges, Inpatient Discharges, and individuals treated/transported by Emergency Medical Services (EMS). Emergency Department (ED) data includes patients who came to the ED and stayed at the hospital for less than 24 hours (also called Ambulatory Discharges). Inpatient data refers to patients who were admitted to the hospital for more than 24 hours. If a patient goes to an ED and is admitted for inpatient services, they are removed from the count in the ED data and listed as inpatients. The hospital discharge data records the number of hospital visits, not the number of individual persons who went to the hospital for care. For example, if one patient went to the hospital three different times over the course of a year it would be counted as the same number of visits as three different patients who went to the hospital one time each over the course of a calendar year.

The EMS data presents the number of times individuals were treated and/or transported by an EMS provider where the individual had some type of self-inflicted injury. As with the hospital data, the EMS data looks at the number of visits/incidents, not unique individuals. The EMS data comes from a different source than the hospital data. Therefore, the cases are not de-duplicated between the two datasets (i.e., an individual may be counted in the hospital and EMS datasets for the same incident if they were transported by EMS to an Emergency Department). The cases included in the EMS dataset are ones where the intent of the injury was listed as "self-inflicted". This does not include incidents where an injury was deemed to be accidental.

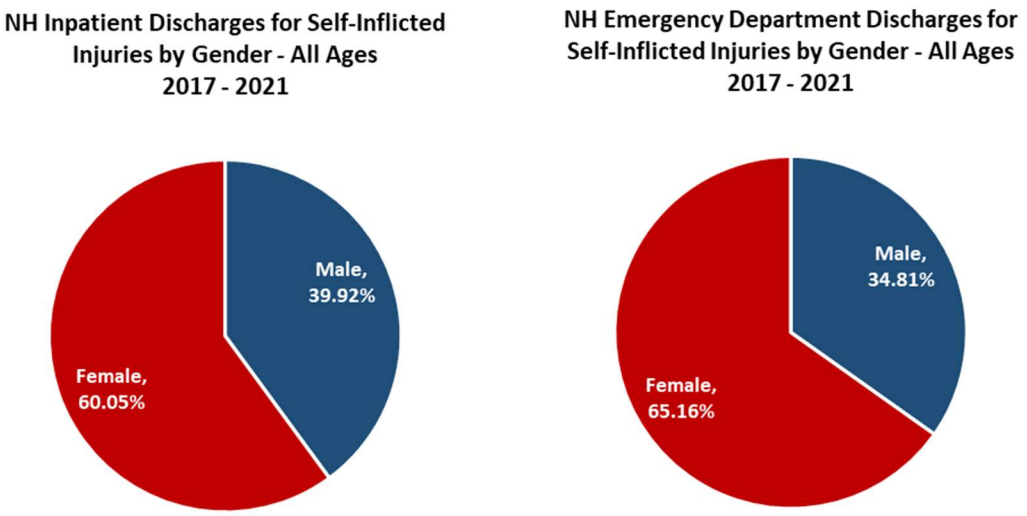
Figure 17

A greater percentage of female than male NH residents attempted suicide, as seen in inpatient and emergency department discharges related to self-inflicted injuries 2017-2021.



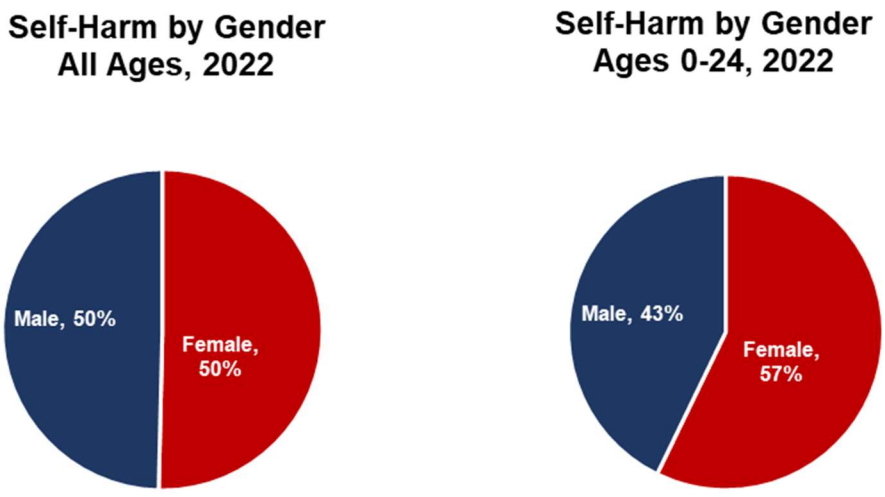
Data Source: NH Hospital Discharge Data by the NH DHHS Injury Prevention Program

Figure 18



Data Source: NH Hospital Discharge Data by the NH DHHS Injury Prevention Program

Figure 19

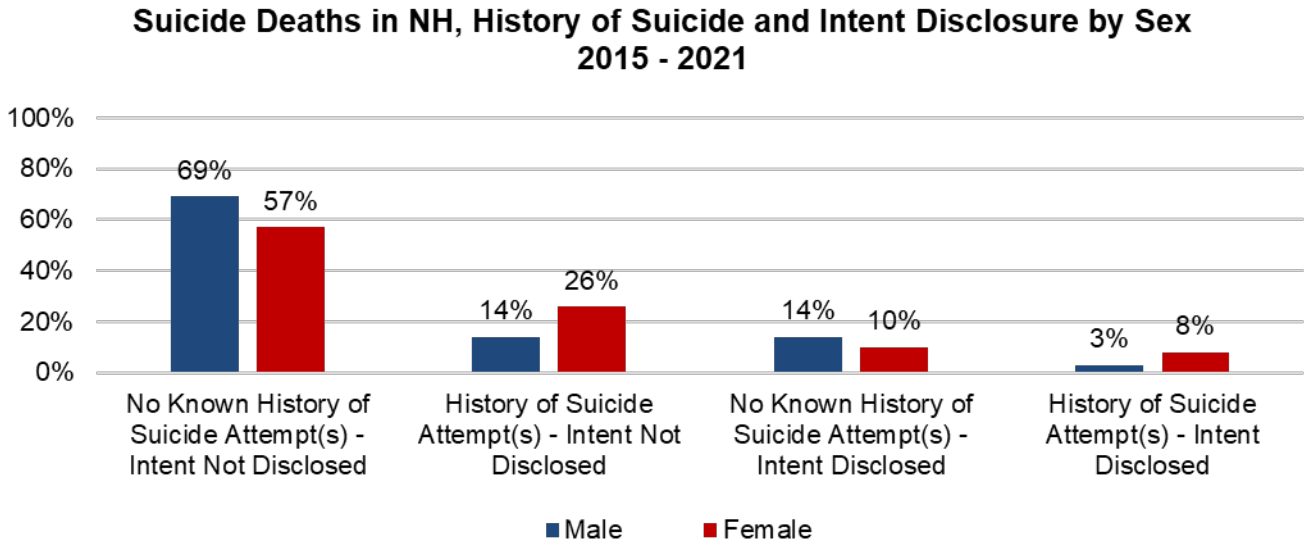


Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

History of Suicide Attempts and Intent Disclosure

The vast majority of individuals who died by suicide in NH have no reported history of prior suicide attempts or disclosure of suicidal intent. Females who died by suicide in NH were approximately twice as likely as males to be known to have a prior history of suicide attempts. Females who died by suicide in NH were more than twice as likely as males to have previously disclosed their suicidal intent (**Figure 20** – below).

Figure 20



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

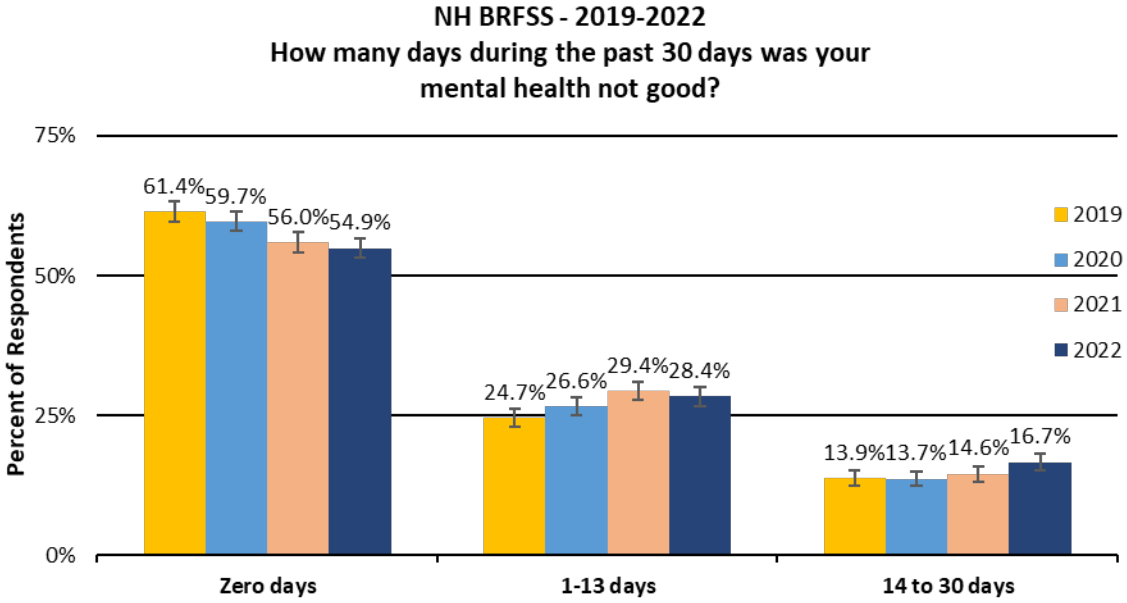
Disclosure of suicidal intent and prior suicide attempt(s) are significant risk factors for suicide. If you are concerned about an individual with these or other risk factors, connect them with appropriate resources such as the 988 Suicide and Crisis Lifeline – Call/Text 988 or a local mental health professional. **If you are concerned that there is imminent risk, call 911.**

NH Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is a survey conducted with a representative sample of state residents. The survey includes the question "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Although this is not a perfect proxy measure for depression, it gives one a general sense of the percentage of NH residents that may be experiencing a depressed mood. The results from this item are included in **Figure 21** (below).

Figure 21

NH BRFSS – Number of Days Mental Health Was Not Good – NH Residents Age 18 and Over.



Data Source: BRFSS data prepared by NH DHHS Bureau of Health Statistics and Informatics (BPHSI)

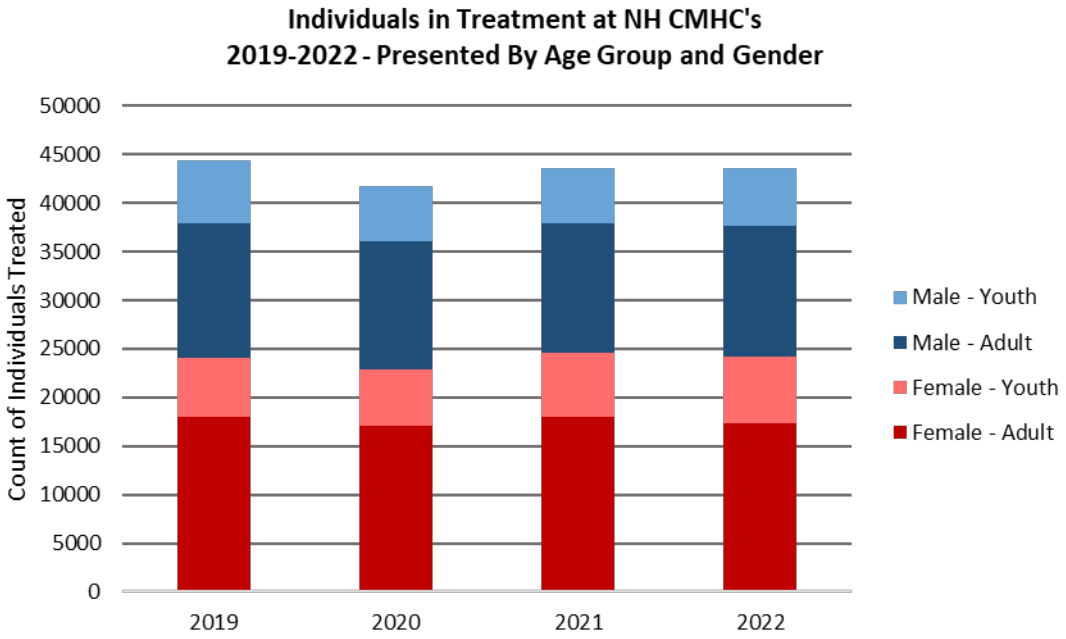
Gender differences exist not only for suicide attempts and deaths, but also for help-seeking behavior. A 2018 CDC report indicated that approximately half of individuals who take their own life had a mental health condition; the most common diagnoses being depression, anxiety, and substance use disorders[9]. Yet a much smaller percentage were receiving treatment. In 2022, over 43,500 people received treatment at one of the state's ten Community Mental Health Centers (CMHC)[10]. This works out to approximately 1 out of every 32 residents in the state. Of those

[9] Stone DM, Simon TR, Fowler KA, et al. Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morbidity Mortality Weekly Report 2018; 67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1.

[10] Community Mental Health Centers are private not-for-profit agencies that have contracted with the NH Department of Health and Human Services, Bureau of Behavioral Health, to provide publicly funded mental health

individuals in treatment, approximately 56% of them were female and 44% were male. This is illustrated in **Figure 22** (below). Without additional data it is not possible to say how these numbers relate to the connection between these treatment figures and the greater number of suicide deaths among males and/or the greater number of suicide attempts reported among females.

Figure 22
Individuals receiving treatment at NH Community Mental Health Centers presented by age and gender.



Data Source: NH Bureau of Behavioral Health

Patients that cannot be treated in an outpatient setting, such as involuntary admissions due to potential suicide risk, will generally be admitted to New Hampshire Hospital, NH's state psychiatric hospital, or another Designated Receiving Facility. In an average year there are approximately 1,101 admissions to New Hampshire Hospital (estimates based on New Hampshire Hospital admissions for fiscal years 2018 – 2022[11]).

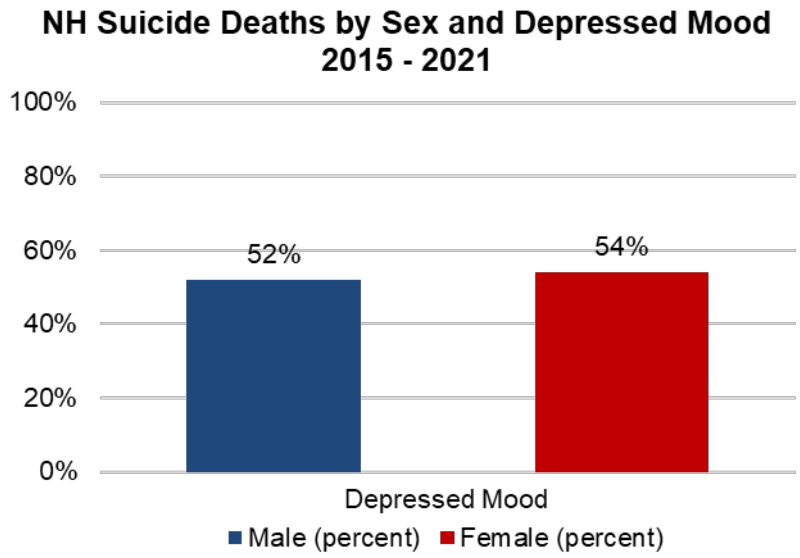
services to individuals and families who meet certain criteria for services. More information on the centers is available from http://www.dhhs.state.nh.us/dcbcs/bbh/centers.htm

[11] The NH State Fiscal Year runs from July 1st of one calendar year through June 30th of the following calendar year (e.g., fiscal year 2022 ran from July 1st 2021 through June 30th 2022).

Mental Health and Suicides in NH

Among the various risk factors for suicide in NH, depression and depressed mood[12] figure prominently. From 2015 to 2021, over half of all individuals who died by suicide in NH were reported to have a depressed mood around the time of death. A slightly greater proportion of females than males were reported to have been experiencing a depressed mood (**Figure 24** – below).

Figure 24



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Positive Outcomes and Testimonials

Suicide is preventable with the understanding we all must embrace: "treatment works".

Support and early intervention is everyone's job, as saving a life makes a world of difference for so many.

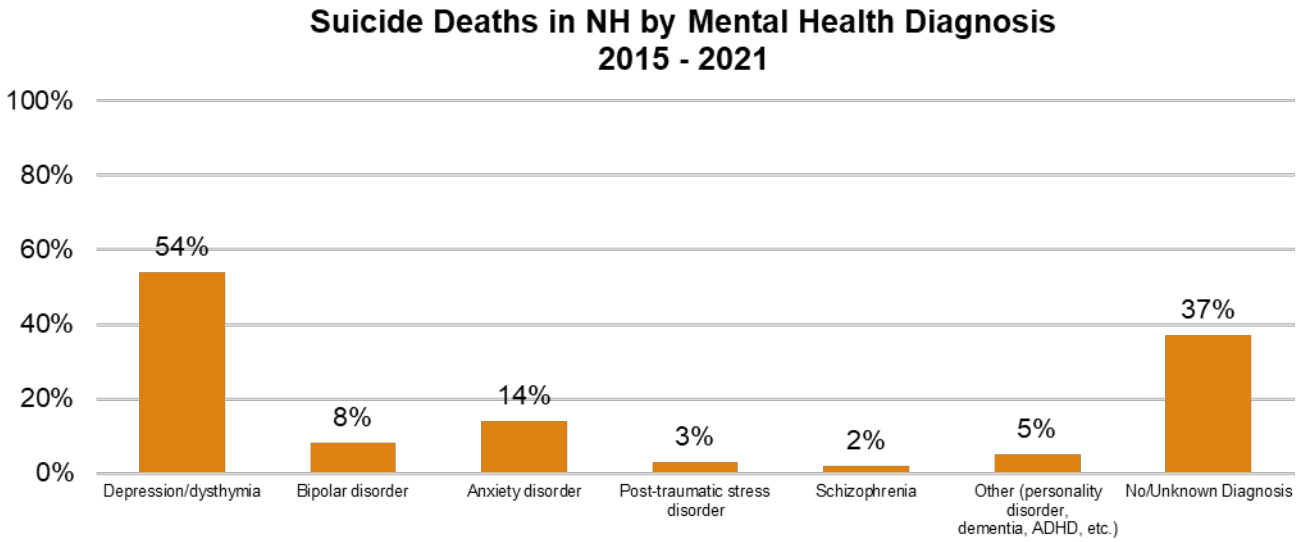
Maggie Pritchard
Executive Director, Lakes Region Mental Health
Former Vice-Chair, NH Suicide Prevention Council

Figure 25 (pg. 51) addresses mental health diagnoses of individuals who died by suicide, where this information was available. The mental health diagnoses are based on evidence at the scene such as medications prescribed to the deceased, information confirming that the individual had a mental health provider (psychiatrist, mental health counselor, etc.), and reports from next of kin. A challenge with reports from next of kin is that they may not have up-to-date knowledge on their loved one's mental health treatment and condition. As a result, there are many suicide deaths where there is no data available related to mental health diagnosis. The availability of mental health diagnosis information in the NH-VDRS continues to improve as death

[12] Depressed mood is a field tracked in the NH-VDRS. Based on CDC criteria, depressed mood does not require a clinical diagnosis, and does not need to have been identified as a factor directly contributing to the death.

scene investigators expand their documentation of mental health issues. Some decedents may have had more than one mental health diagnosis and are therefore counted in more than one category.

Figure 25



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Age, Gender and Self-inflicted Injury

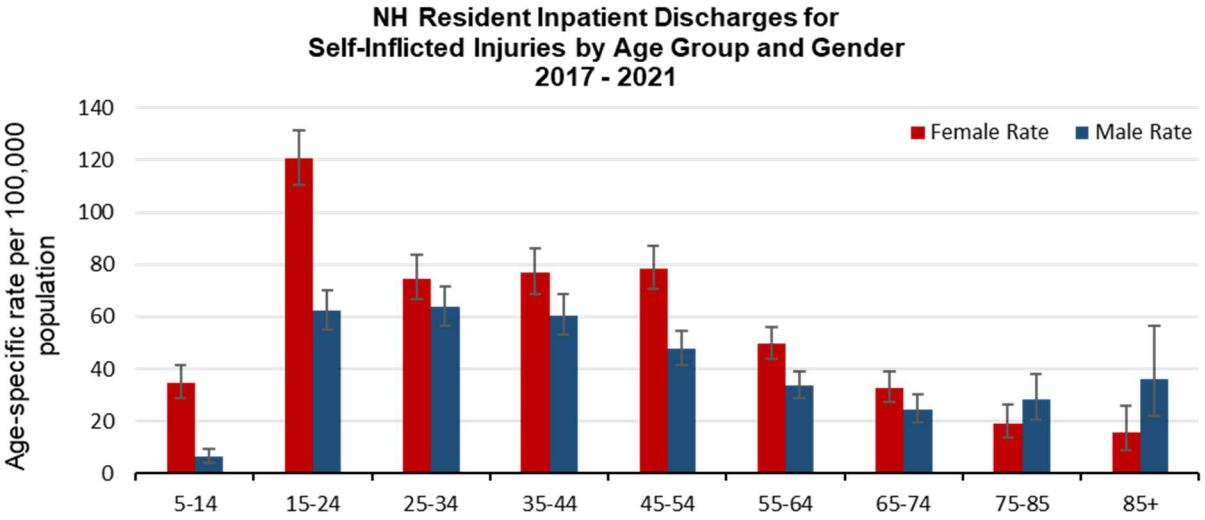
When the rates for NH resident inpatient hospitalizations/discharges and emergency department use for self-inflicted injuries from 2017-2021 are examined by gender and age group, the variability can be seen (**Figures 26** and **27 –** pg. 52). As above, these data refer to number of visits; therefore, individuals may be counted multiple times if they were admitted or seen more than once during the year.

Female NH residents have a higher overall rate of inpatient hospitalizations/discharges for self-inflicted injuries until the ages 75+ where the male rate exceeds the rate for females. For females aged 15-24, the rate of those being discharged from inpatient care (**Figure 26 –** pg. 52) is 120.6/100,000, nearly twice the rate for males of the same age. The peak age for males is between 25 and 34 for self-inflicted injuries requiring an inpatient admission. Again, ED usage rates, depicted in **Figure 27** (pg. 52), point to females aged 15-24 as a population particularly vulnerable to self-injury and/or suicide attempts, with females in this group exhibiting a rate over 568.6/100,000, about 90 times the suicide death rate for this population. Males also peak in self-injury around this age group with the male rates for ages 15 to 24 being 253.7/100,000. Although male rates peak around this age group, their rates are much lower than those for females. Also of note, the total number of youth and young adult (ages 15-24) ED visits (3,528) is nearly 4.5 times greater than the number of inpatient discharges for this population. This data reinforces that the transition from middle adolescence to late adolescence/ early adulthood is a time of great risk for suicidal thinking, self-harm and suicide attempts. EMS data (**Figure 28 –** pg. 53), which includes individuals treated and/or transported by Emergency Medical Services for a self-inflicted injury,

presents a similar picture to the hospital data in terms of high-risk age groups. Females aged 15 to 24 present the highest rates of self-inflicted injuries. In most other age groups, male rates exceed the rates for females in the EMS data.

Figure 26

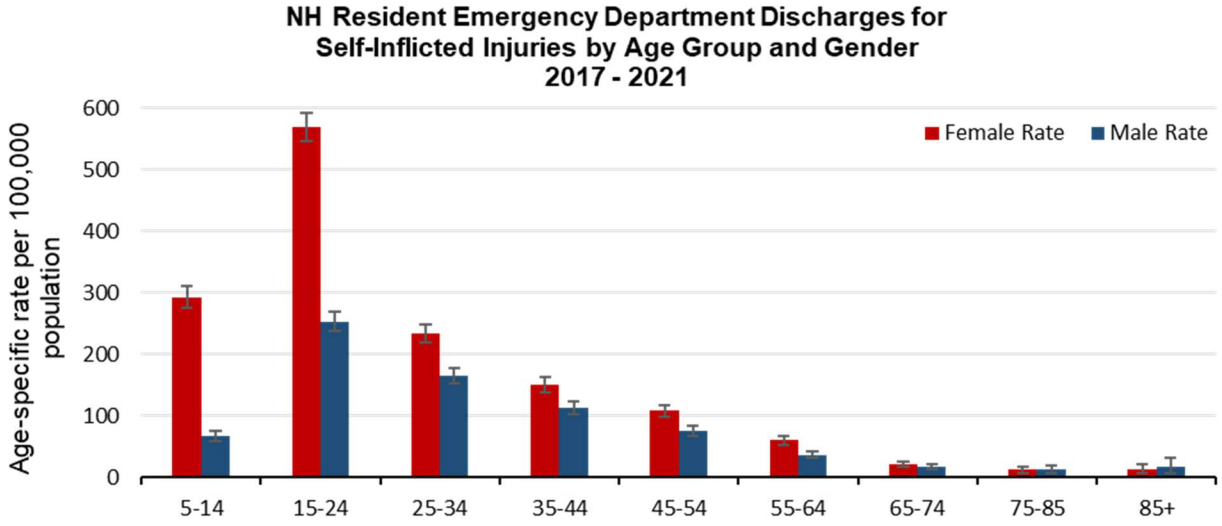
NH female residents ages 15-24 show the highest rates of suicide attempts, higher than males of any age group.



Data Source: NH Hospital Discharge Data prepared by the NH DHHS Injury Prevention Program

Figure 27

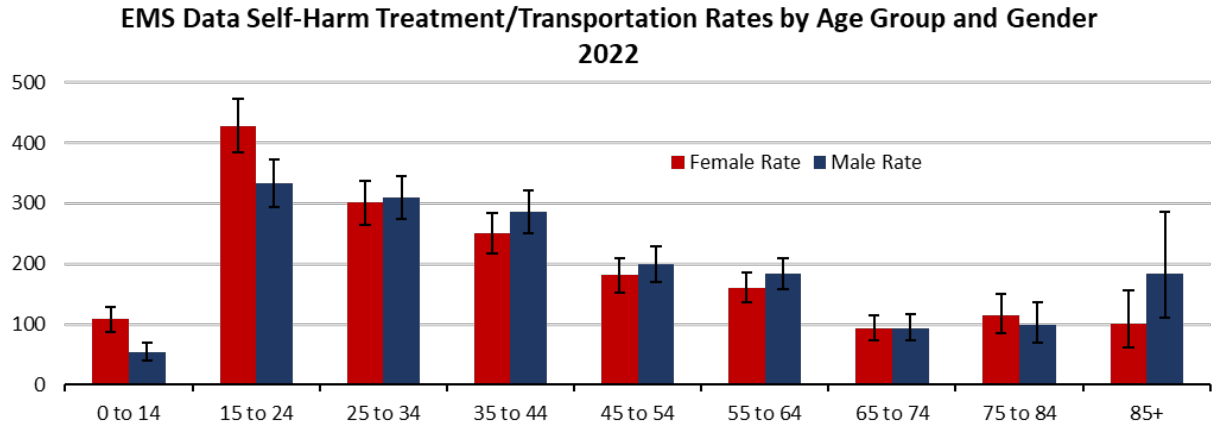
NH female residents ages 15-24 show the highest rates of suicide attempts, with male rates also peaking at this age.



Data Source: NH Hospital Discharge Data prepared by the NH DHHS Injury Prevention Program

Figure 28

NH female residents ages 15-24 show the highest rates of suicide attempts followed by males in the same age group.



Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

Based on inpatient and emergency department (ED) discharge data across all ages in NH, there are approximately 10 suicide attempts for every suicide death. This number does not include attempts that go unreported, unrecognized, or without a hospital or ED visit which required medical intervention. Further, the rates of attempts for young people and females create an even greater ratio of suicide attempts to deaths.

In contrast to the above data, which are based on cases where medical intervention is required, the results of the YRBS presents data collected from high school aged youth by self-report. In 2021, nearly 10 percent of high school students completing the YRBS reported having attempted suicide at least one time over the previous year. Based on the YRBS and 2021 NH high school enrollment figures[13], this works out to over 5,300 high school age youth in NH who may attempt suicide each year. The YRBS reports may account for attempts not included in hospital self-injury data. This could be the case for any attempts with relatively non-lethal means where medical assistance was not sought. Of particular concern for this data is the likelihood that in many of these cases, the youth have never sought help or disclosed the attempt to an adult. It is also possible that self-reports exaggerate the incidence of suicide attempts among high school age youth.

While the great majority of self-inflicted injuries[14] are not fatal, because of the larger incidence they may directly and indirectly affect a greater number of people than fatalities. A significant risk factor for suicide is a previous attempt: in one study 21-33% of people who die by suicide have made a previous attempt (Shaffer & Gould, 1987). Therefore, any suicide attempt, regardless of

[13] October 2021 NH grades 9-12 total enrollments – 52,224. Source: NH DOE iPlatform Public Reports - https://my.doe.nh.gov/iPlatform/Report/DataReportsSubCategory?reportSubCategoryId=10

[14] Classifying an injury as self-inflicted is another way of stating that the injury was an instance of deliberate self-harm. Not all self-inflicted injuries necessarily represent suicide attempts. Analysis of these injuries, however, is the best currently available proxy for approximating suicide attempts.

its lethality, must be taken seriously. If not addressed, it could be followed by additional attempts. Therefore, once an individual has made an attempt, secondary prevention is necessary.

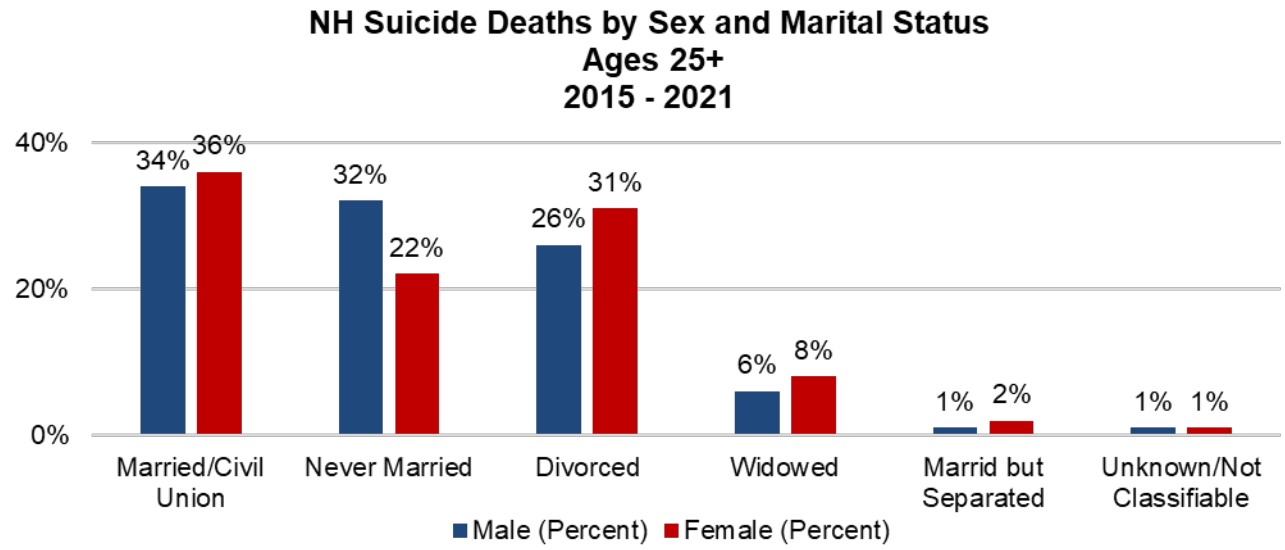
Additional Demographic Characteristics of Individuals in NH Who Died by Suicide

Additional demographic factors may play a role in suicide. **Figure 29** (below) presents the marital status of individuals who died by suicide in NH between 2015 and 2021. The data in **Figure 29** differs substantially from the overall breakdown by marital status for NH with fewer married individuals and more divorced individuals dying by suicide. In the NH population, approximately 51% of individuals are married and 12% are divorced[15], while only 36% of individuals who died by suicide in NH were married and 27% were divorced.

Positive Outcomes and Testimonials

Beginning with a SAMHSA grant awarded in 2018, the NH State Police have been implementing the Crisis Intervention Team (CIT) Program coordinated by NAMI NH. This training has resulted in Troopers being able to identify individuals experiencing a mental health crisis and/or individuals at risk for suicide, defuse situations, and direct individuals to mental health services where they might have otherwise been arrested.

Figure 29

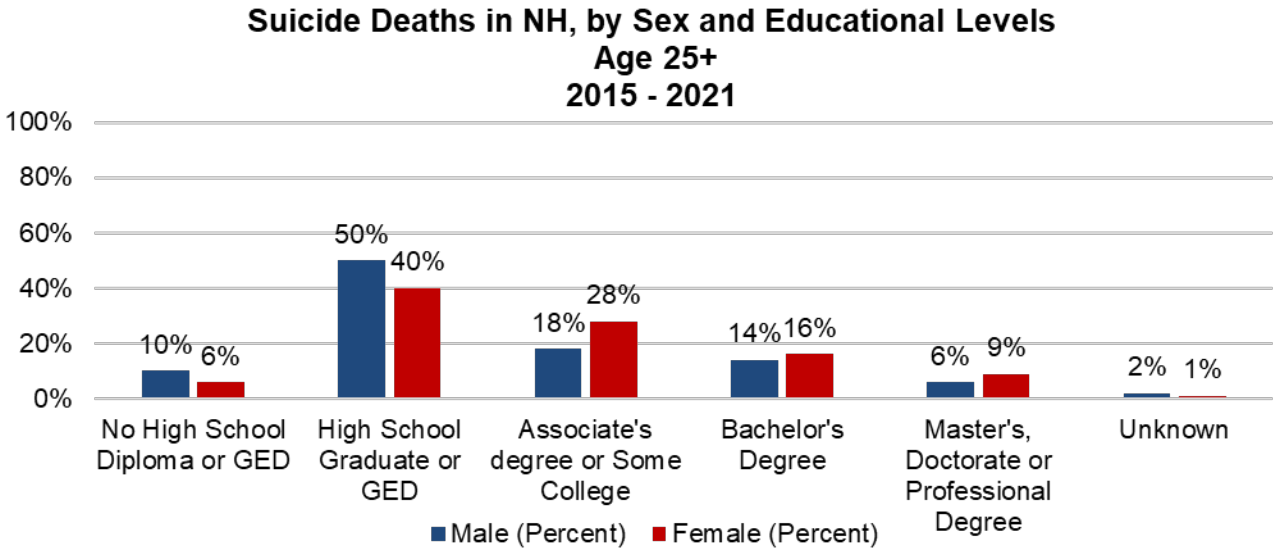


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

[15] US Census Bureau American Community Survey 2022

Educational attainment may also play a role in suicide. The prevalence of suicides in NH is greatest among individuals who had educational levels of high school or GED (**Figure 30 –** below) and substantially lower among individuals with college degrees. Among adults in NH, over 38% have a bachelor's degree or higher (**Table 4 –** pg. 30), while only 20% of male and 25% of female adult suicide deaths in NH are by individuals with an equivalent educational level. Additionally, adults in NH with no high school diploma or GED make up approximately 6% of the population while accounting for over 9% of adult suicide deaths[16]. Nationally, higher levels of education are generally correlated with higher income and lower levels of unemployment[17]. The larger number of suicide deaths among individuals with education levels of high school or less could indicate a greater prevalence of employment or financial stressors among this group. Job and financial stressors were frequently identified among individuals in NH who died by suicide (**Figure 49** – pg. 68).

Figure 30

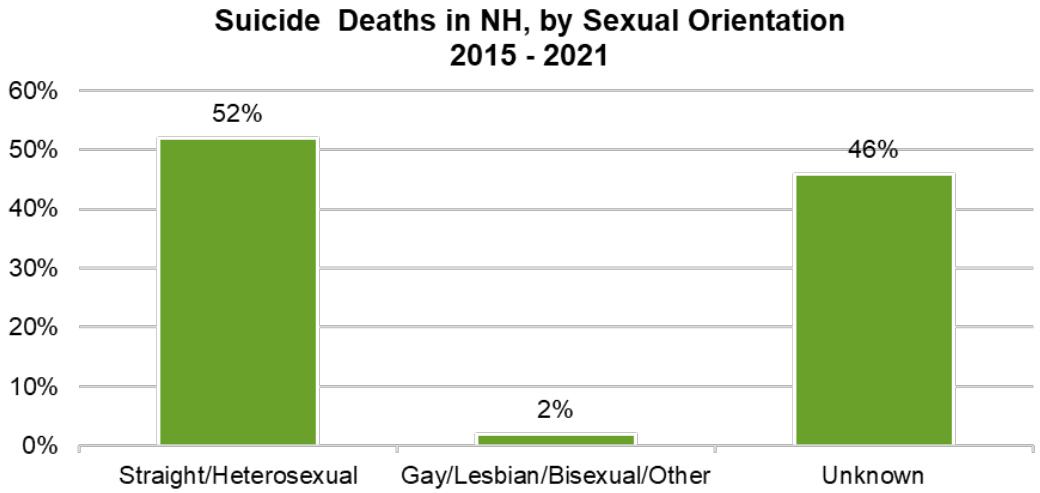


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS

Prior to the implementation of NH-VDRS, data on the sexual orientation of individuals who died in NH was not readily available. As seen in **Figure 31** (pg. 56), the data related to this is still limited for individuals who died by suicide, with sexual orientation being unknown in 46% of cases. The large number of cases where this information is unknown may be due to a number of factors, including the stringent NH-VDRS requirements for reporting sexual orientation, and stigma around revealing sexual orientation.

[16] US Census Bureau American Community Survey 2022
[17] https://www.bls.gov/careeroutlook/2021/data-on-display/education-pays.htm

Figure 31



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Attitudes Related to Suicide in NH

In 2006, as part of NH's First SAMHSA suicide prevention grant, NAMI NH, the SPC, and YSPA collaborated with the UNH Survey Center on a survey of NH residents about their attitudes toward suicide prevention and mental illness. The survey included 500 NH households representative of the state as a whole. The survey was repeated in 2008, and again in 2012 to determine if there had been any change in public perception. In 2021 the SPC Data Subcommittee began the process to repeat the survey and determine if attitudes in NH had shifted over the past decade. The survey was completed by the UNH Survey Center in May 2022. The SPC Data Subcommittee is working with the UNH Survey Center to repeat the survey again in 2024.

The results from the survey are presented below in **Figures 32 – 37** (pgs. 57-59). When the survey was conducted in 2006, 2008, and 2012 it was done as a phone interview. The survey methodology has changed since then and is now conducted via an online survey. Survey participants are recruited from randomly selected landline and cell phone numbers across NH. Individuals who agree to participate will then take part in the UNH Survey Center Granite State Panel[18]. Due to the shift in methodology the 2022 survey includes data from 930 respondents rather than the 500 respondents in prior years. Additionally, the wording of some questions has changed over time. In these cases, the change has been noted below the figure.

The 2022 results shown in **Figures 33, 35, and 36** (pgs. 57-59) differ from what was found in prior years in with fewer individuals selecting the "Strongly Agree" category and more selecting the "Somewhat Agree" category. This shift may be a result of changes in statewide attitudes, the changes made to the survey items, the change in survey format, or a combination of these and other factors. Even though fewer individuals selected the "Strongly Agree" option in 2022, these results still show the majority of respondents agreeing with the statements in **Figures 33, 35, and 36** (pgs. 57-59).

[18] https://cola.unh.edu/unh-survey-center/projects/granite-state-panel

Figure 32

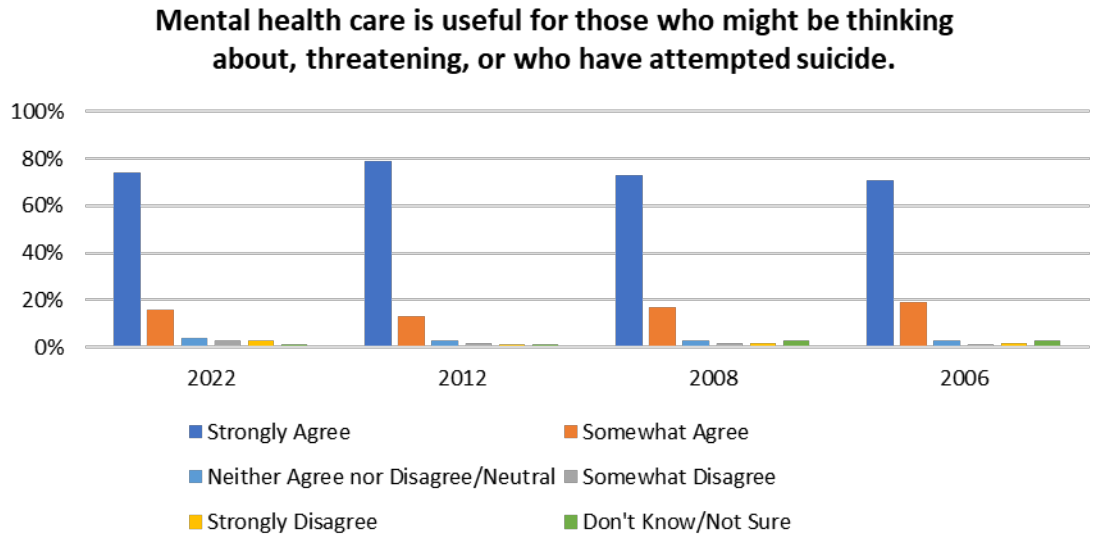
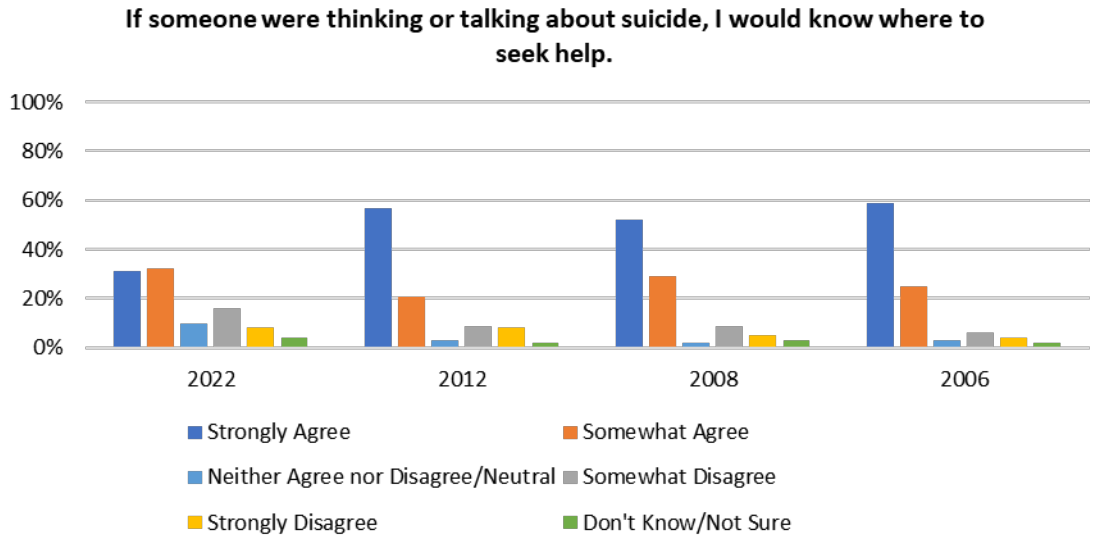


Figure 33



2006 & 2008 question wording: “If someone were thinking about, threatening, or had attempted suicide, I would know how to find help”

Figure 34

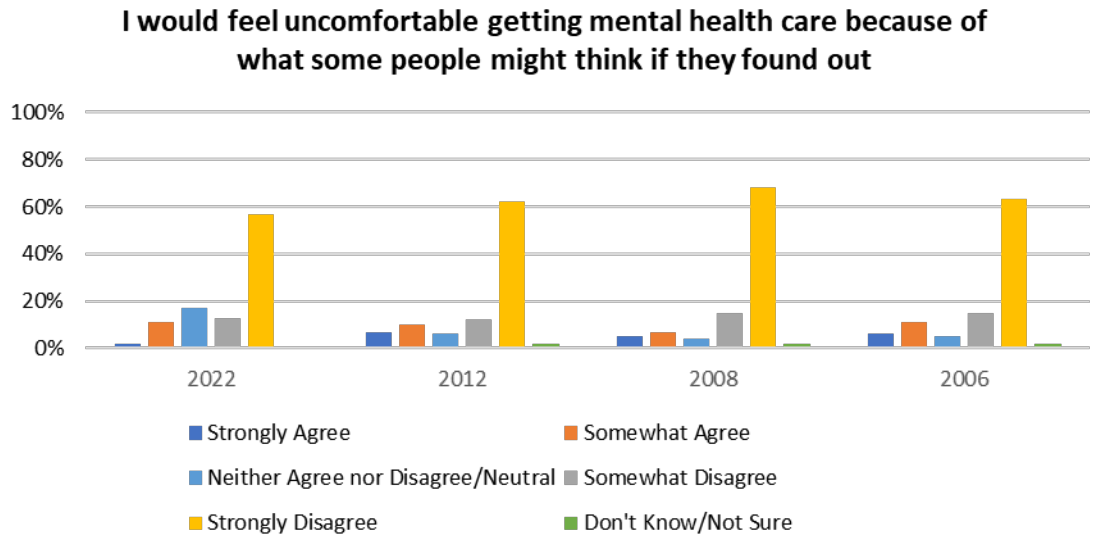


Figure 35

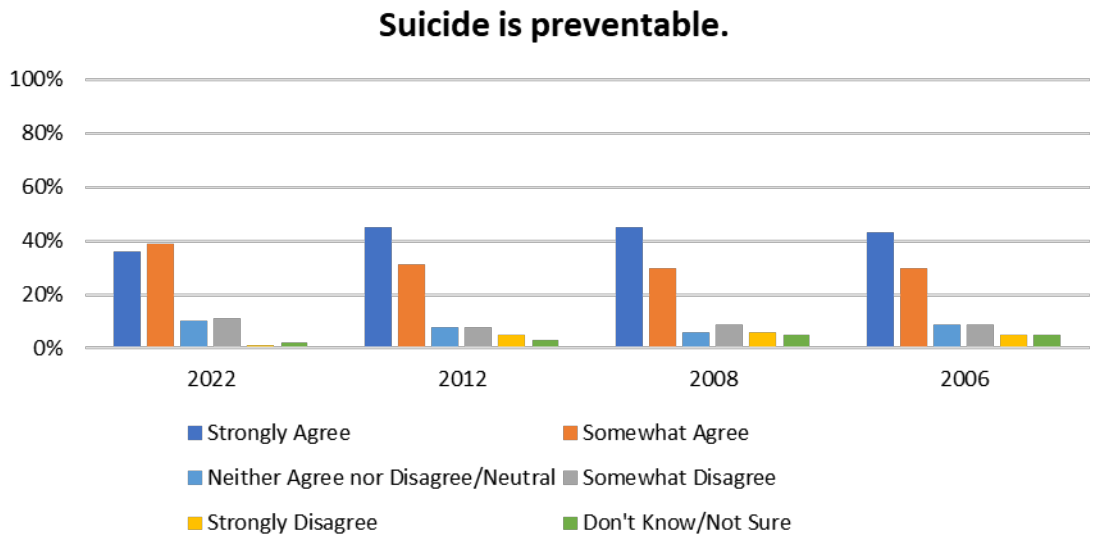
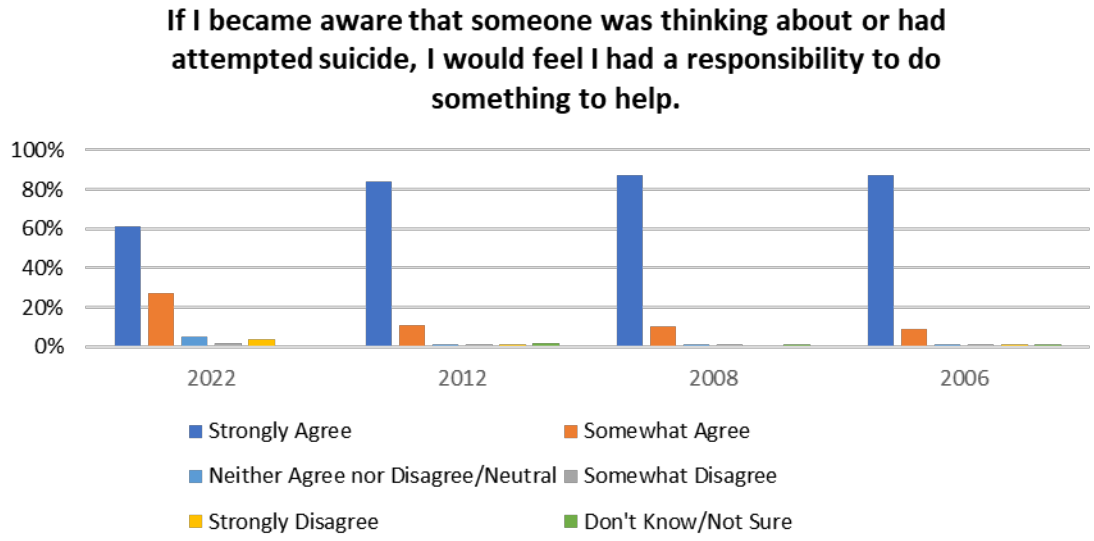
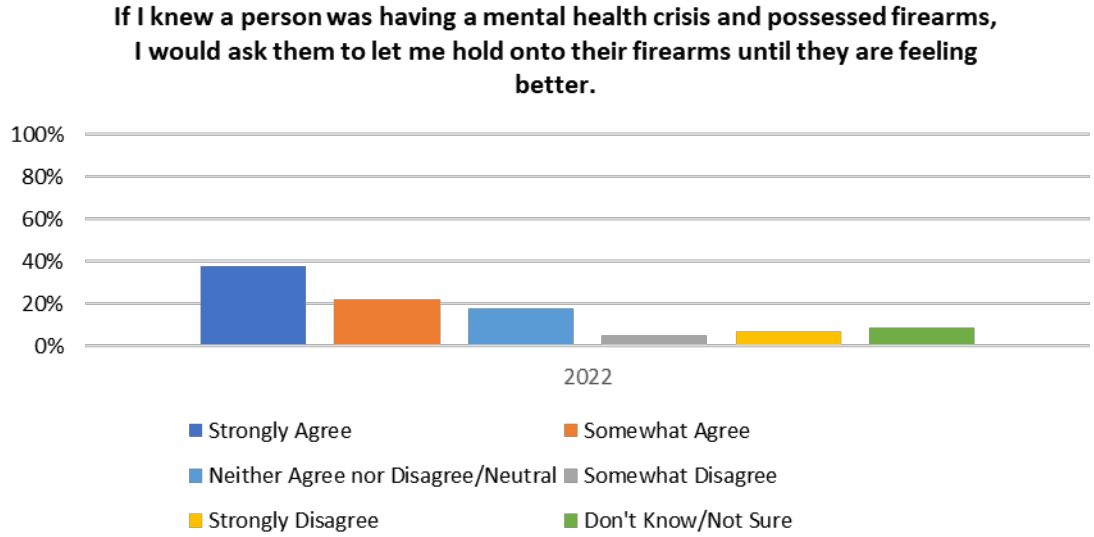


Figure 36



2006-2012 question wording: "If I became aware that a young person was thinking about or had attempted suicide, I would feel I had a responsibility to do something to help."

Figure 37



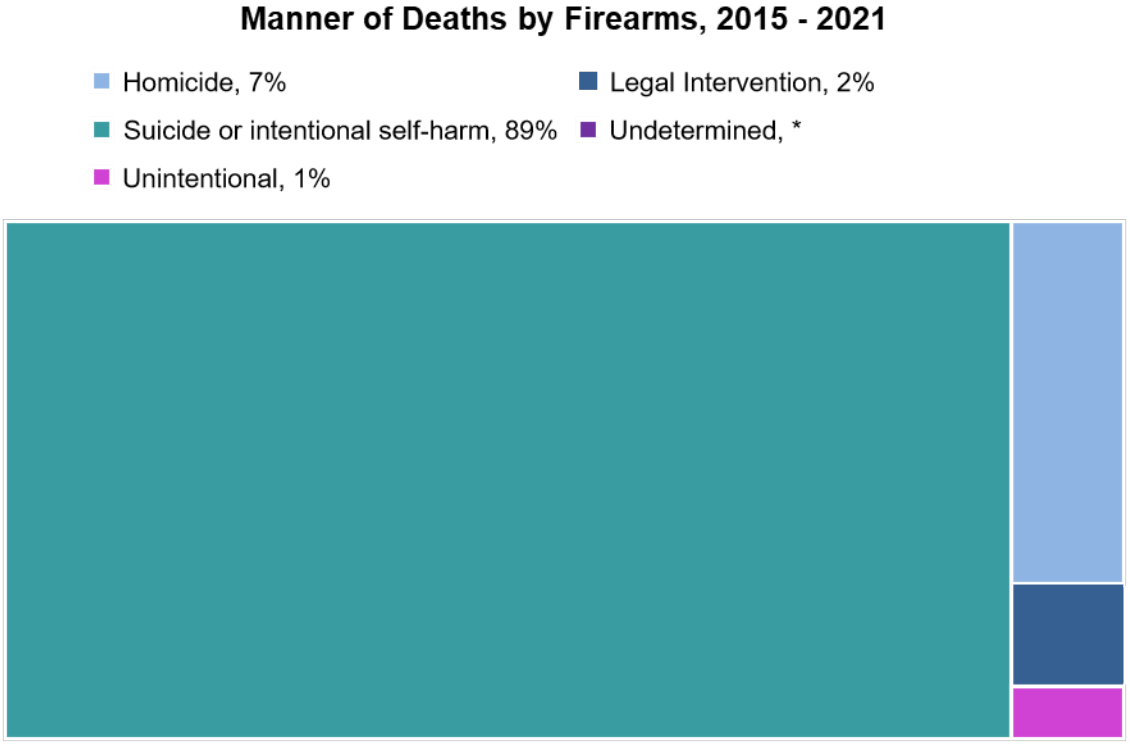
2006-2012 question wording: Not applicable – This question was first included in 2022.

Suicide in NH: Methods

The gender difference in suicide deaths/attempts may be explained in part by the fact that males, in general, use more lethal means. Of NH male youth and young adults who died by suicide between 2015 and 2021, 57% used firearms compared to 15% of females (**Figure 39** – pg. 61). This gender disparity in firearm use decreases between the ages of 25 and 64 with 53% of males and 29% of females using firearms. The proportion of firearm deaths increases sharply after age 65 for males, with 68% of the suicide deaths in that age group involving a firearm. In NH, the vast majority of all deaths involving a firearm are suicide. This can be seen in **Figure 38** (below).

Figure 38

From 2015-2021, approximately 89% of all NH deaths involving a firearm were suicides.

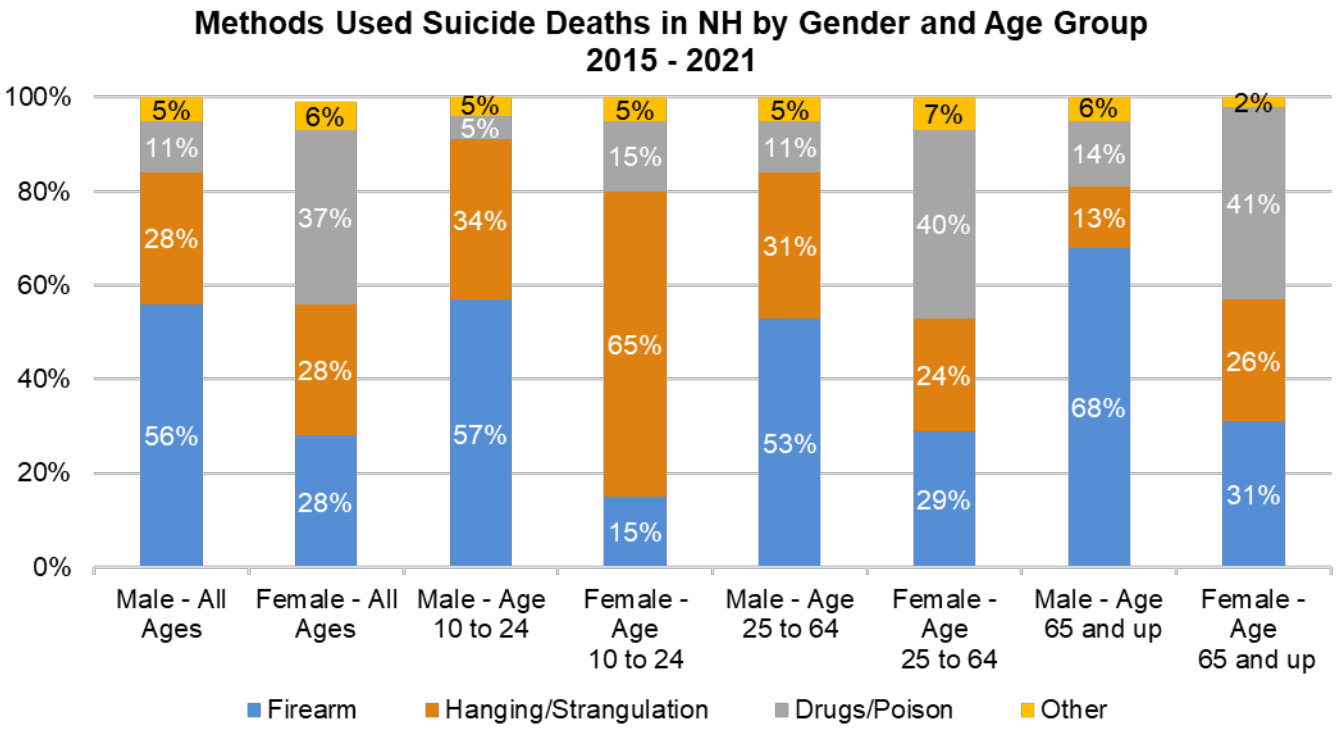


* Counts less than five are not disclosed for privacy purposes.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

Suicide attempt methods have varying lethality. **Figures 40 and 41** (pgs. 61-62) compares firearms, hanging, poisoning, and cutting/piercing in terms of the percentage of various outcomes (emergency department visit, inpatient admission, or death) for each method. Suicide deaths account for 89% of the firearm-related deaths. Among youth and young adults, suicide is often a highly impulsive act and poor impulse control is one of the risk factors for suicide. Therefore, intervention efforts that reduce access to firearms and other highly lethal means may be effective to reduce suicide among those at risk for suicide, particularly for those who are more likely to be impulsive. Firearms remain the most used method of suicide throughout the lifespan in NH. **Figure 42** (pg. 62) indicates that self-inflicted drug overdoses/poisonings are treated/transported by EMS

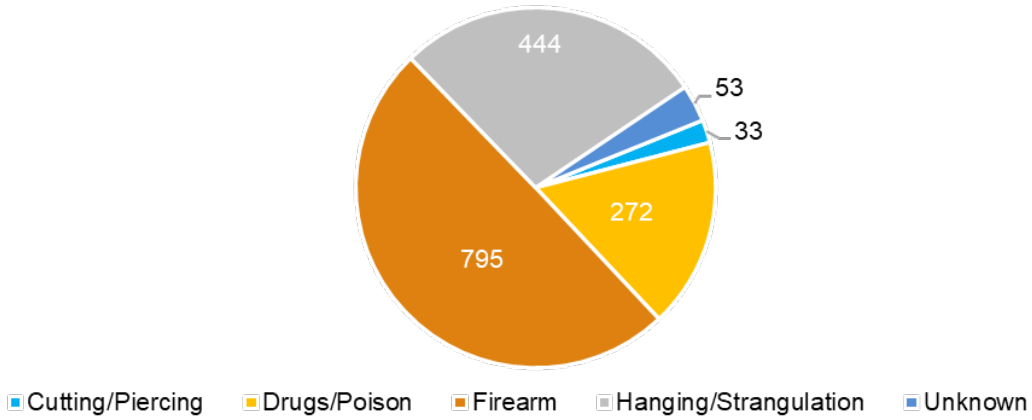
at several times the rate of most other mechanisms, followed by self-inflicted cutting/piercing injuries which were also treated/transported at a substantially higher rate than other mechanisms. The use of hanging/strangulation as a suicide method peaks in early adolescence and decreases steadily throughout the lifespan (**Figure 39** – below).

Figure 39



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

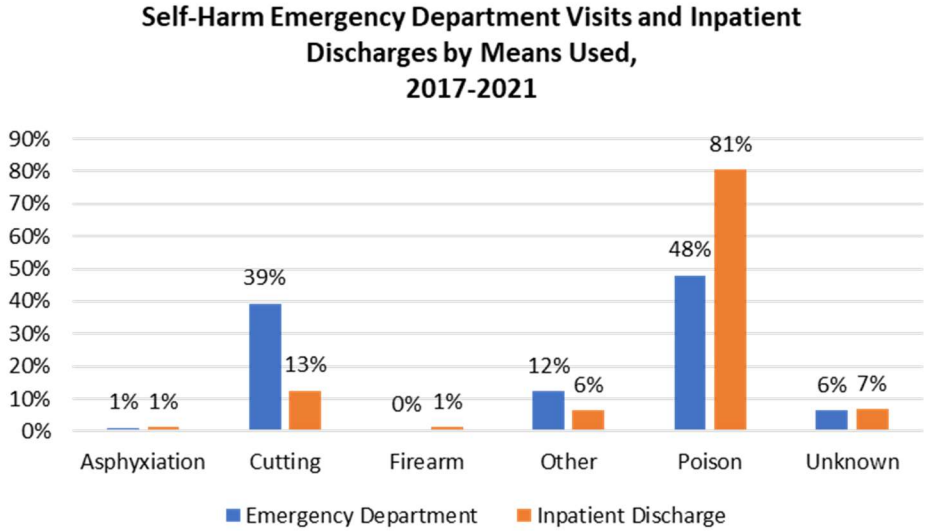
Figure 40



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Figure 41

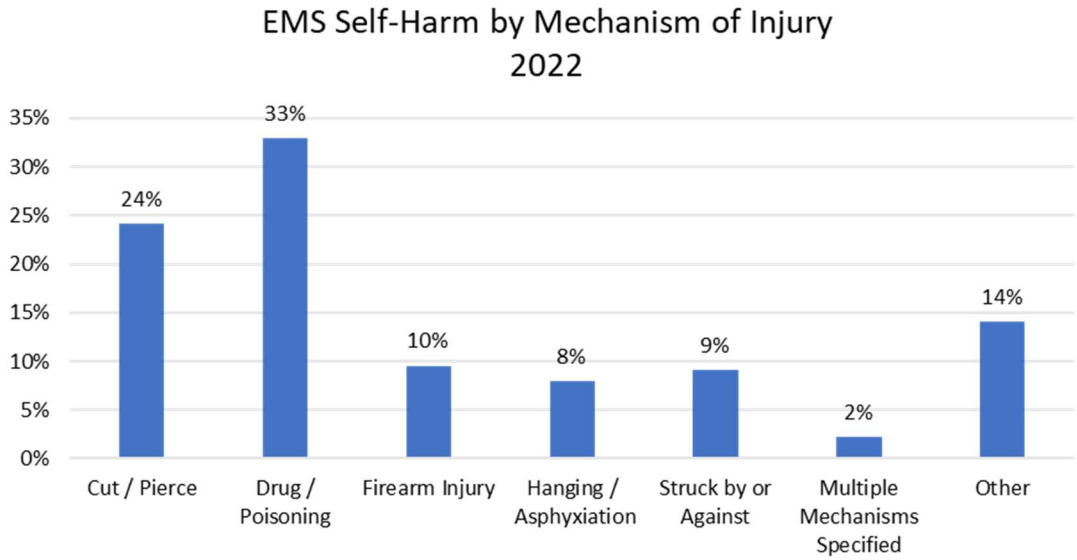
Count of Lethality of Means Used for Suicidal Behavior in NH, 2017-2021



*Means categories are not mutually exclusive and one visit/discharge may be counted in more than one category.
Data Source: NH Hospital Discharge Data prepared by the NH DHHS Injury Prevention Program

Figure 42[19]

Percent of method of self-inflicted injuries treated/transported by EMS from 2022.

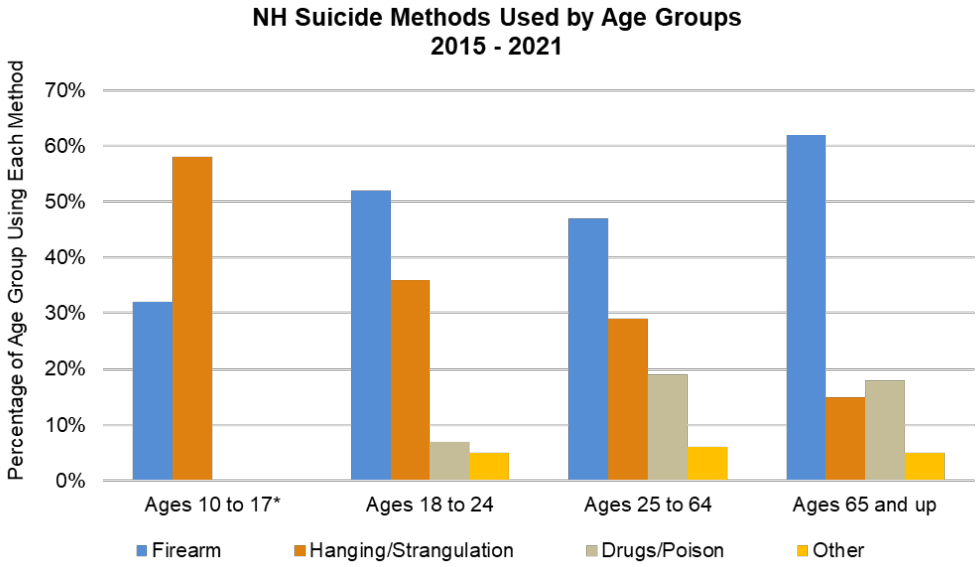


Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

[19] This chart is based on the field "Trauma Mechanism of Injury". This field is not available for all incidents. The field may also include a response of "Not Recorded" or "Not Applicable". For the purpose of this report, only incidents with a reported mechanism of injury were included above (approximately 36% of all incidents in 2022).

Figure 43

Suicide methods used in NH vary by age group, as seen in 2015-2021.

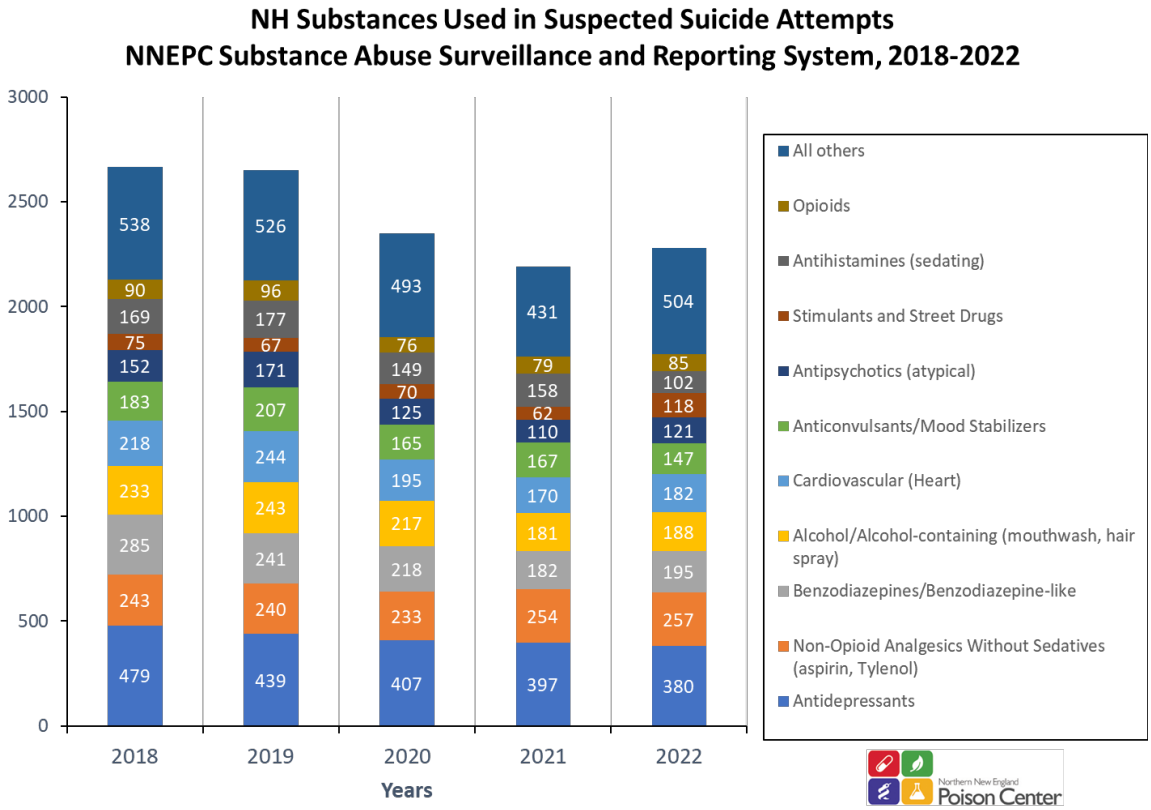


* Counts less than five are not disclosed for privacy purposes.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

Although suicide attempts employing poison do not account for as many deaths in NH as firearms or hangings, intentional poisonings account for the overwhelming majority of inpatient and ED admissions for suicide attempts (**Figure 41** – pg. 62). **Figure 44** (below) depicts the prevalence of the most common substances used in suspected suicide attempts and self-harm-related exposures in NH as collected by the NNEPC. The top two substances in 2022 were again antidepressants and non-opioid analgesics without sedatives (e.g., aspirin or Tylenol).[20]

Figure 44

Antidepressants have been the top substance used in suspected NH suicide attempts from 2018-2022.

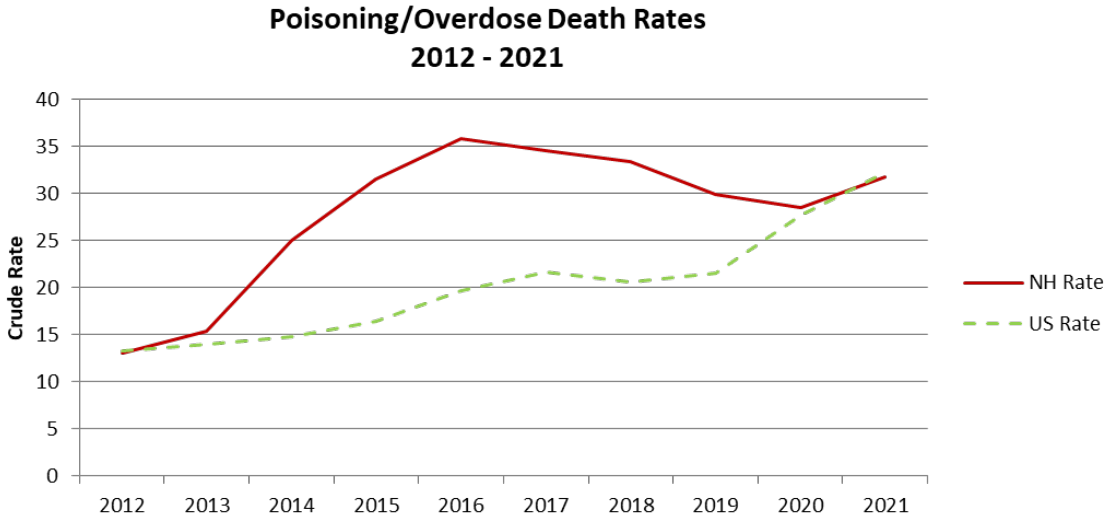


Data Source: Northern New England Poison Center

[20] The suspected suicide attempt cases presented were determined by self-report or the report of an individual acting on behalf of the patient (e.g., a health care professional), or a NNEPC staff assessment. For more information on the NNEPC Annual Report, contact Colin Smith - SMITHC12@mmc.org.

Increasing Accidental Poisoning and Drug-Related Death Rates – Cause for Concern
As seen in **Figure 45** (below), the accidental poisoning and drug-related death rates in NH and the US as a whole have steadily increased from 2012 to 2021. During this time the US and NH rates have increased by over 140%. Although it is not possible to determine an exact number, it is likely that these accidental poisoning and drug-related deaths include suicide deaths where there was not enough evidence for the Medical Examiner to classify them as such. This trend is a cause for concern as both an increase in poisoning and drug-related suicide deaths, and as a potential indicator of increased risk-taking behavior.

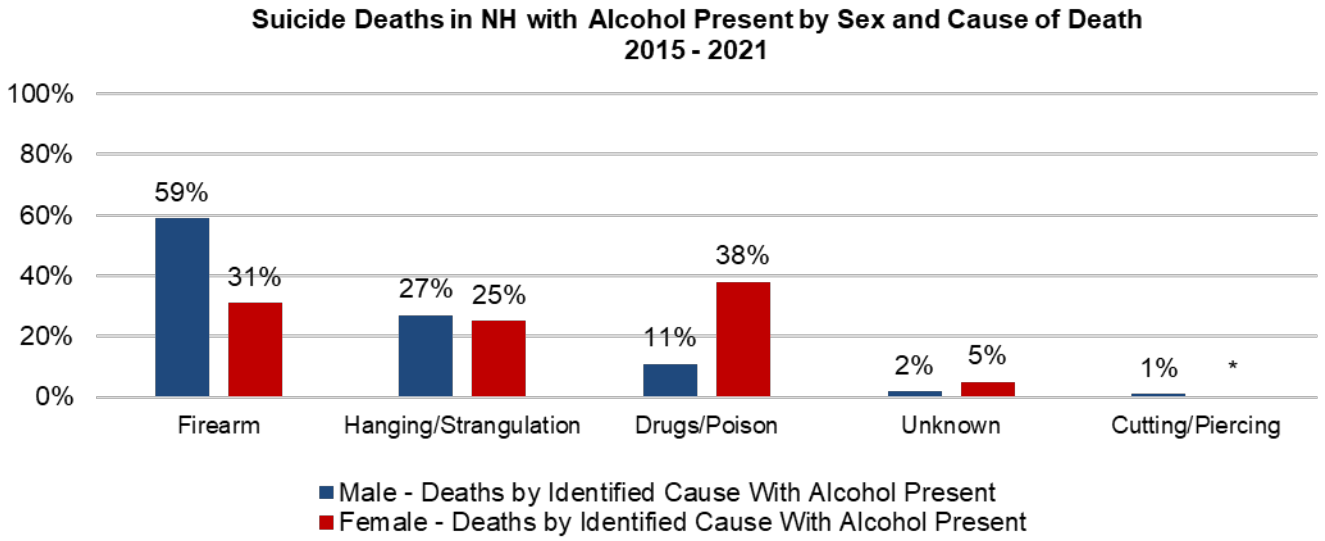
Figure 45
Poisoning/Drug-related death rates in NH increase by more than 140% from 2012 to 2021.



Data Source: CDC WISQARS

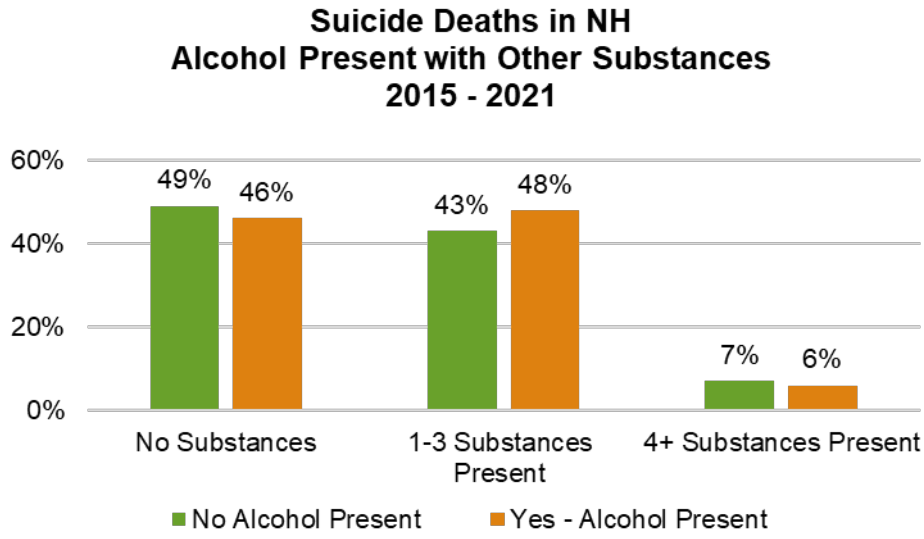
Alcohol and Drug Use and Suicide
Alcohol was found to be present in 33% of all NH suicide deaths from 2015 to 2021. Alcohol was found in a greater percentage of male deaths (35% of deaths) than female deaths (29% of deaths). When looking at the presence of alcohol by cause of death (**Figure 46** – pg. 66), it was found to most often be present in firearm deaths for males (59% of male firearm deaths) and drug/poisoning deaths for females (38% of female drug/poisoning deaths). Alcohol is often not the only substance used by individuals who die by suicide in NH. In cases where alcohol and/or substances were detected, approximately 54% of cases had both alcohol and one or more substance present (**Figure 47** – pg. 66**)**.

Figure 46



* Counts less than five are not disclosed for privacy purposes.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

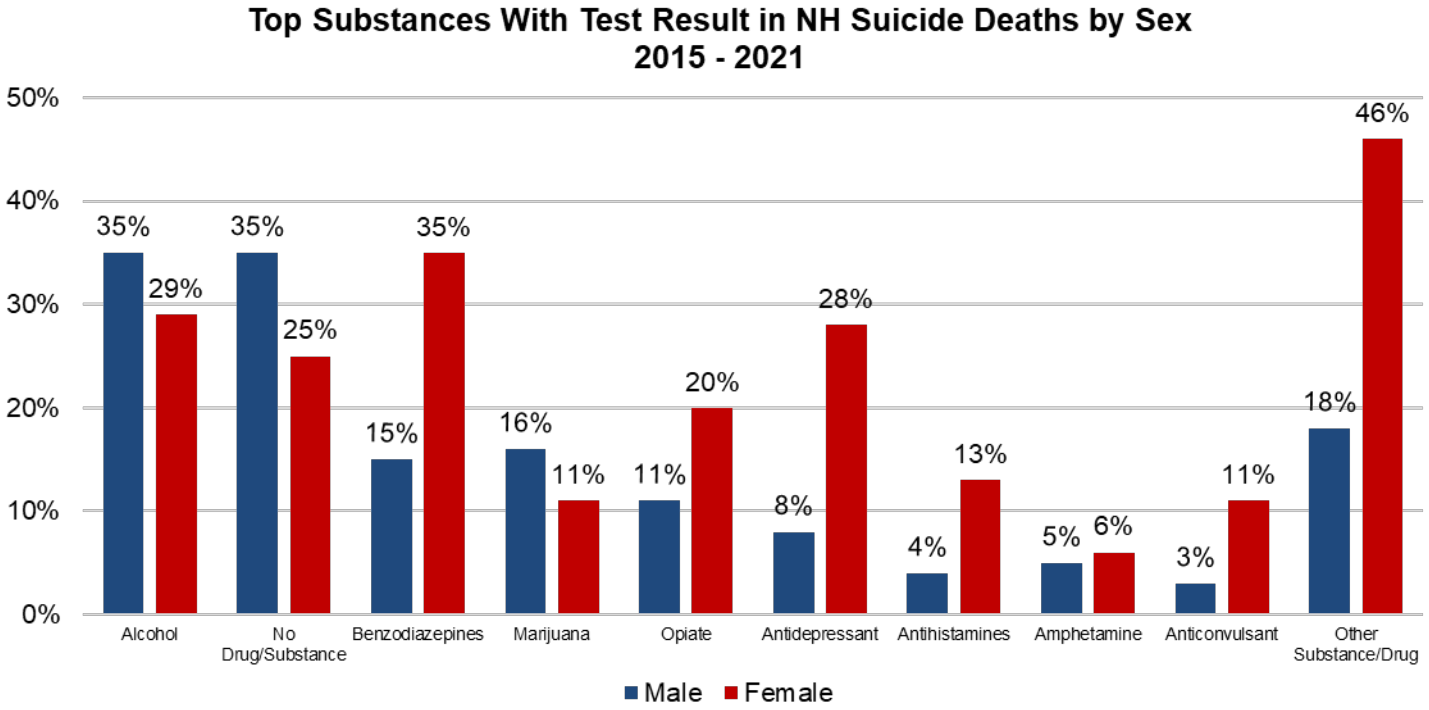
Figure 47



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

The results of toxicological reports include testing various specimens from suicide victims, at various points of the investigation or autopsy. **Figure 48** (below) depicts the categories of the most commonly found substances from toxicology reports. The most frequently detected substances were benzodiazepines, alcohol, and antidepressants among females, and alcohol, marijuana, and benzodiazepines among males. The figure is based on a total count of the number of times a substance was found in a positive test. Some decedents tested positive for multiple substances and are therefore counted in multiple categories. Individuals who tested positive in this compilation of substance(s) used may or may not have died of such substance(s). Cause of death is presented in **Figure 40** (pg. 61).

Figure 48

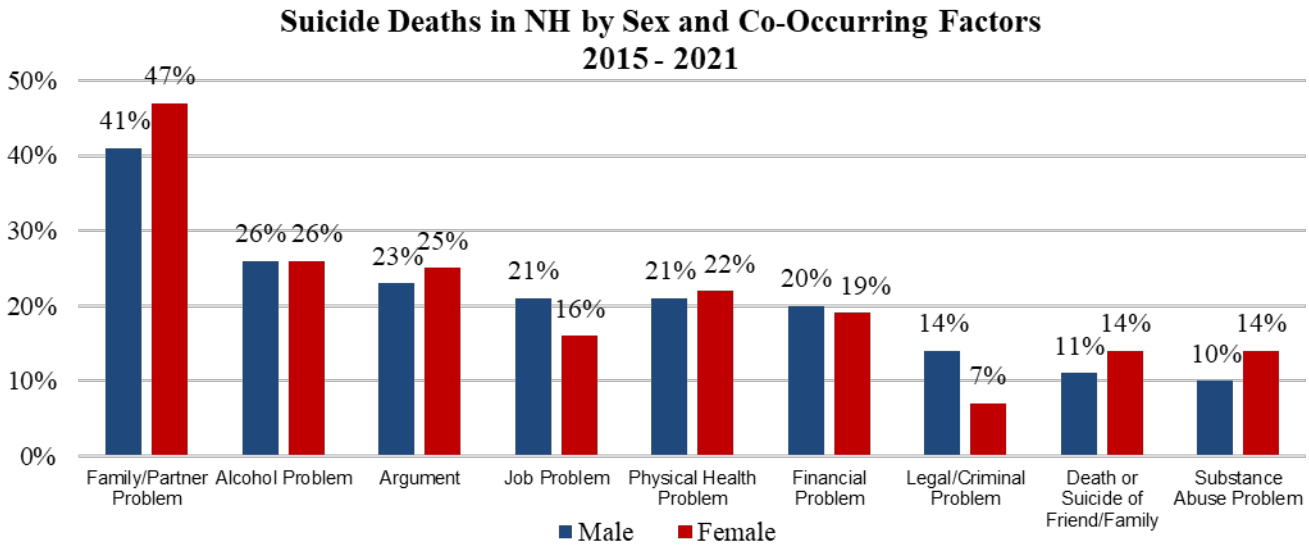


Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

Co-Occurring Factors and Suicide

Suicide is most often the result of a number of co-occurring risk factors. **Figure 49** (below) identifies the most commonly reported risk factors that are tracked in the NH-VDRS. The most frequently reported factor among both males and females was family/partner problems.

Figure 49

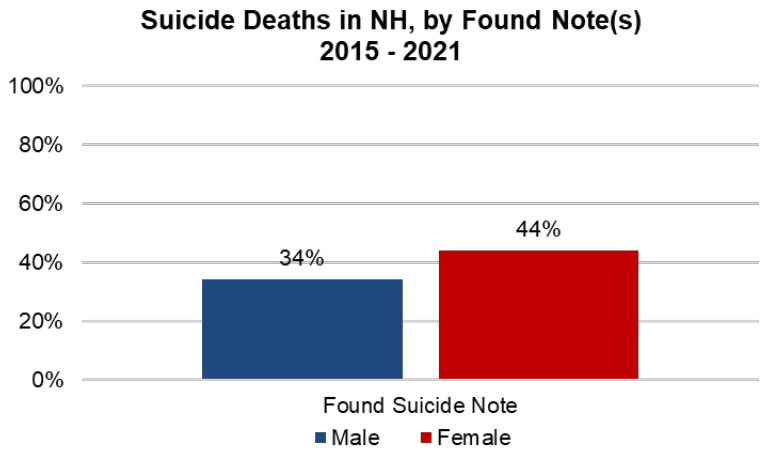


Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

Suicide Notes

In just over 36% of NH suicide deaths from 2015 to 2021, individuals left some form of note behind (**Figure 50** – pg. 69). Females being more likely to have left a note (44% of female deaths) than males (34% of male deaths). These notes vary in format, content, and intent. Individuals may leave instructions for their loved ones on how to resolve financial, estate, burial, and other affairs; complaints/obstacles that they faced; or planning/details that the deceased went through leading up to the death. For the individuals left behind after a suicide death, a note will rarely ever give a satisfactory answer to why their loved one died by suicide.

Figure 50



Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Linking At-Risk Individuals with Help

Crisis lines, such as the 988 Suicide and Crisis Lifeline[21] are vital to suicide prevention efforts in NH and nationally. Nationally, 988 receives approximately 2 million calls per year. In 2022, over 4,500 of those calls, or roughly 377 per month, were received by the NH 988 call center (see **Figure 51** – pg. 70). These calls indicate that individuals in the state who are at risk for suicide are reaching out for help. The large volume of calls may also indicate decreased stigma around help seeking for mental health and/or suicide. The NH Rapid Response (NHRR) system was also active during 2022 with over 22,200 contacts being made through that system. More information about NHRR can be found in the infographic on page 21.

In addition to traditional crisis lines, individuals are increasingly turning to text message-based crisis services (see **Figure 52** – pg. 71). Contacts from NH individuals[22] to Crisis Text Line average 418 conversations per month. From 2018 to 2022, Crisis Counselors at Crisis Text Line deescalated 311 conversations that were deemed to be at imminent risk for suicide by helping texters come up with a safety plan. To protect texters at imminent risk in instances where texters were unable to come up with a safety plan, 164 active rescues were called for New Hampshire-based texters in crisis.

CRISIS TEXT LINE

Text HOME to 741741 to connect with a volunteer Crisis Counselor

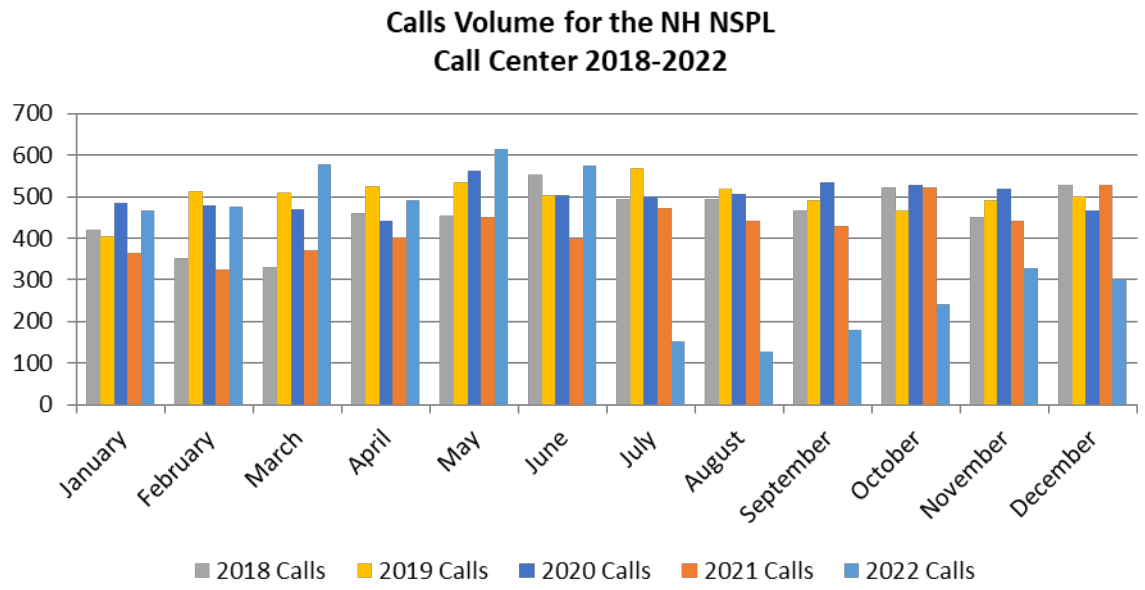
[21] The 988 Suicide and Crisis Lifeline was formerly known as the National Suicide Prevention Lifeline (NSPL) and used the advertised phone number of 1-800-273-TALK (8255).

[22]Crisis Text Line estimates location based on area code from the first 3 digits of the texter's phone number. This may result in some texters being counted who were not physically in NH at the time they communicated with the Crisis Text Line. It may also result individuals physically located in NH not being counted if they are using a device with an out-of-state area code.

Among the subset of texters who disclosed their demographics through an optional post-conversation survey, 71% of the texters who reached out to Crisis Text Line from NH were age 24 or under, 75% self-identified as female, and over half self-identified as LGBTQ[23].

Figure 51

NH NSPL call center responded to an average of 377 calls per month in 2022.



Data Source: 988 Suicide and Crisis Lifeline

Positive Outcomes and Testimonials

We received a call on our general mailbox from a woman that was directed to our Hotline Manager. The woman stated that she had been calling the Hotline for a long time whenever she is feeling down and everyone has been so great and supportive. "They make me feel better. I have just gotten to the point where I can't even reach out to my church pastor. I called tonight and was feeling very low and I don't remember who I talked to, but she was wonderful. Keep doing what you're doing, you train your people well. You people do good work. Thank you for what you do."

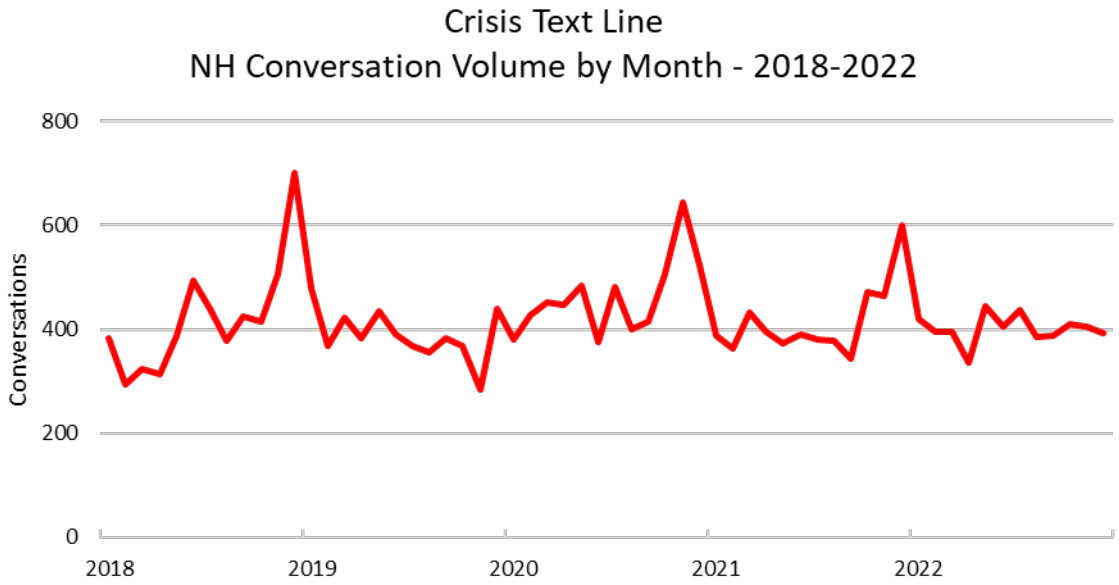
We also recently received a call from a gentleman who had just gotten off the phone with one of our hotline counselors who wanted to share his experience. He said he had called that morning because he was contemplating taking his life and that the Hotline counselor he spoke to had a "very calming and caring voice and listened to me for several minutes, with no judgement whatsoever. He then gave me some places I could call to get further help." He stated that our counselor gave him hope for the day.

Two examples of the feedback received by Headrest, the only accredited hotline in NH that receives calls placed to the 988 Suicide & Crisis Lifeline. Headrest receives the majority of calls originating from individuals in NH.

[23]Surveys are completed by texters following approximately 20% of Crisis Text Line conversations.

Figure 52

The Crisis Text Line engaged in 4,808 text conversations with NH texters in 2022.



Data Source: Crisis Text Line

Costs of Suicide and Suicidal Behavior

There were between 35,452 and 47,388 years of potential life lost[24] to suicide from 2017-2021 in NH (CDC WISQARS, 2023). The most obvious cost of suicide is the loss of individuals and their potential contribution to their loved ones and to society. For each suicide death, there are many survivors of suicide loss (the family and close friends of someone who died by suicide) who are then at higher risk for depression and suicide themselves. In addition, many others are affected, including those who provide emergency care to the victims and others who feel they should have seen the warning signs and prevented the death.

Nationally, suicide attempts treated in emergency departments and hospitals represented an estimated $13.2 billion in health care costs in 2021. This does not include the costs associated with mental health services on an inpatient or outpatient basis (CDC WISQARS, 2023). In NH, suicide deaths where the individual received treatment in a hospital or emergency department and subsequently died resulted in an estimated $1.63 million in medical expenses in 2021 (CDC WISQARS, 2023).

[24] Years of potential life lost (YPLL) is a measure of the extent of premature mortality in a population. This estimate is based on the approximate age at death as well as the number of people who died in that age group in a given year.

Military and Veterans

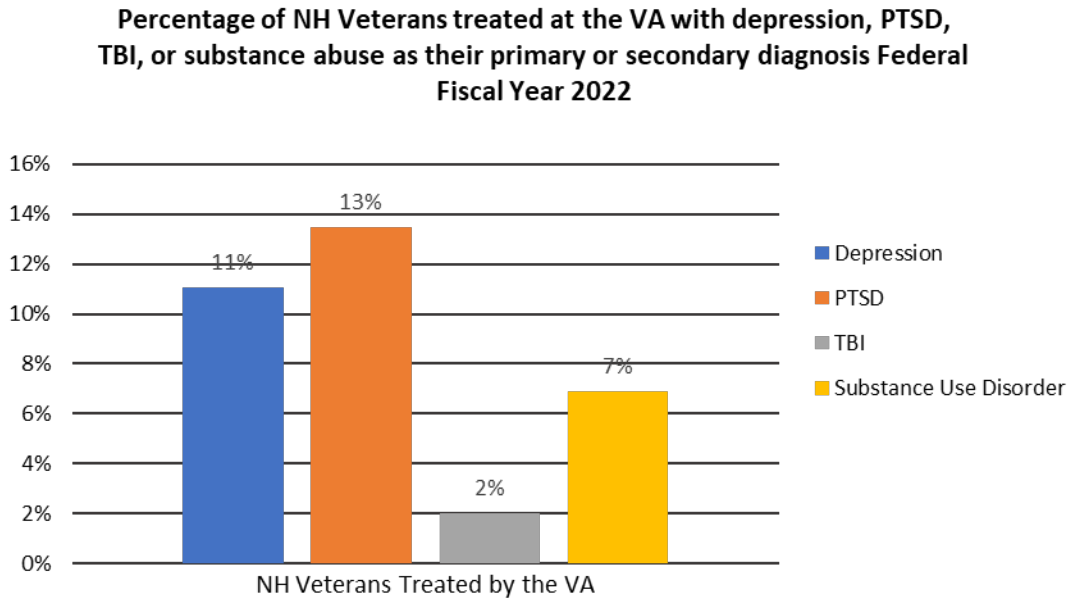
The NH National Guard

From 2018 through 2022 the NH Army National Guard recorded a total of 47 suicide related incidents of varying levels of severity (ideation, plan in place, attempt, or death), with the majority being ideation or having a plan in place. Of these incidents, 15% were from individuals under the age of 22, 34% were age 22-26, 21% were age 27-31, 6% were age 32-36, 6% were age 37-41, and 9% were ages 42-46. The remaining 9% were age 47 and above (total percentage may not equal 100% due to rounding). Fifty-one percent of the incidents were by non-deployed personnel, veterans, or dependents of National Guard personnel. Of the incidents recorded, 91% were by males and 9% were by females (males may be disproportionally represented among the NH National Guard compared with the general population).

NH Veterans Served by the Veterans Administration (VA)

The VA provides care to many of the Veterans in the State of NH. During the 2022 Federal Fiscal Year (October 1, 2021 – September 30, 2022), the VA provided care to 27,348 individuals in NH. The percentage of these individuals treated for depression, post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI), and substance use disorder is presented in **Figure 53** (below).

Figure 53

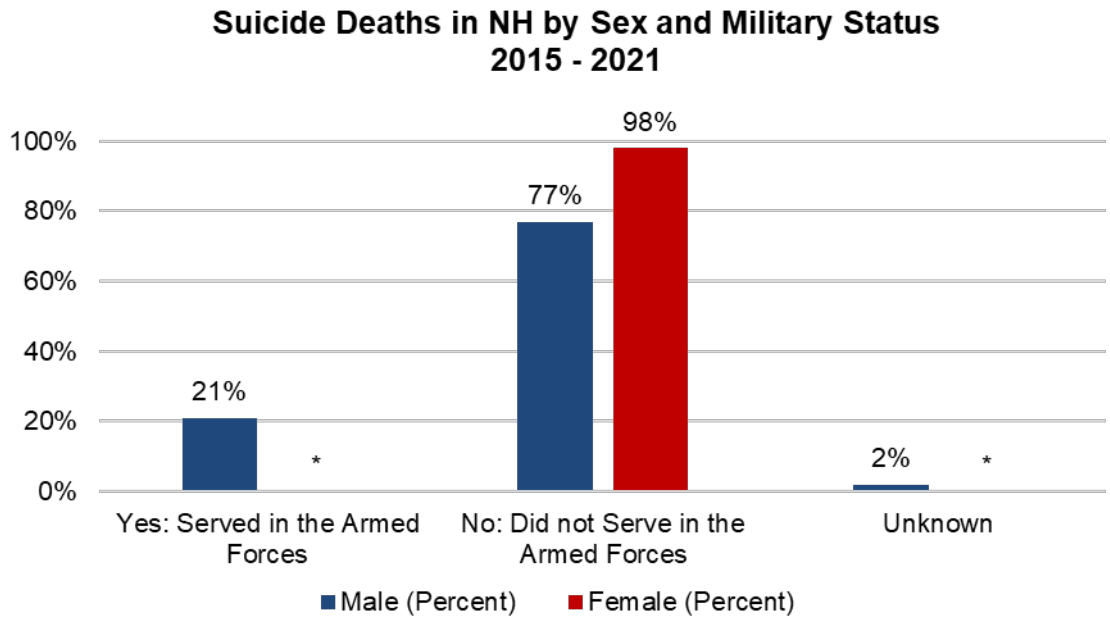


Data Source: Veterans Administration

Suicide Among Veterans in New Hampshire:[25]

Of the individuals who died by suicide in NH from 2015 to 2021, 17% were identified as having current or prior military service (**Figure 54** - below). The use of the term military service is for all those who served in the armed services of the United States or are still serving. The data sources available to NH-VDRS do not distinguish between individuals who are currently active and those who have been discharged. Veterans made up approximately 7% of the NH population as of 2020[26]. With veterans accounting for 17% of the individuals who died by suicide in the state, this may indicate a high-risk group dying at a greater than expected rate.

Figure 54



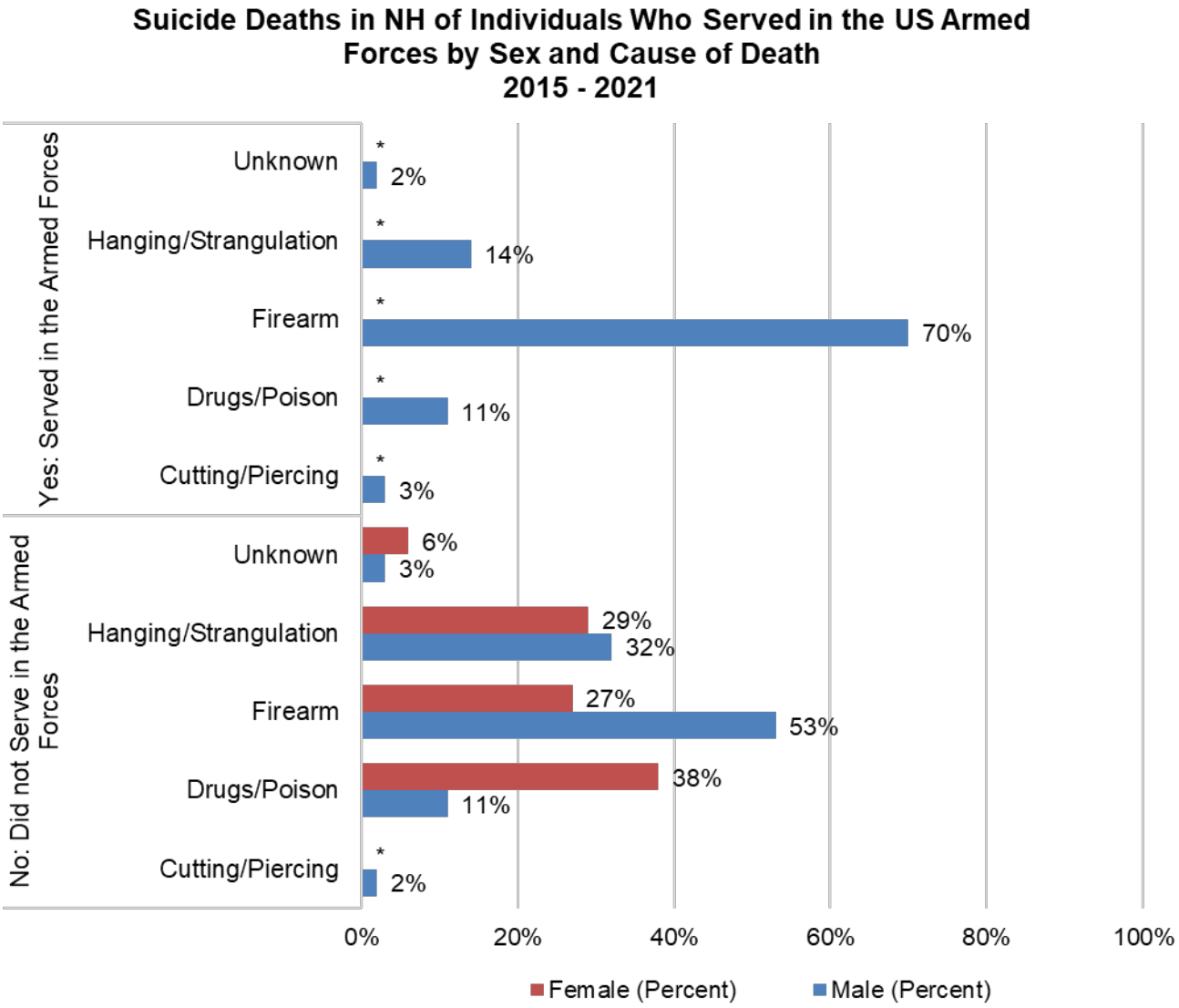
* Counts of less than five are not disclosed for privacy purposes.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Military Service and Cause of Death:

Individuals in NH who die by suicide that have served in the military are substantially more likely to use a firearm than civilians (**Figure 55** – pg. 74). This difference is evident in males with 53% of individuals with no military service using firearm compared with 70% of males with military service using a firearm.

[25]NH-VDRS collects data on veterans only from standard surveillance data sources. The data collection is based on medical examiner data, death certificates, and law enforcement reports. There is no data used that is sourced from any branch of the military.
[26] Veteran population data by state available from https://www.va.gov/vetdata/veteran_population.asp

Figure 55



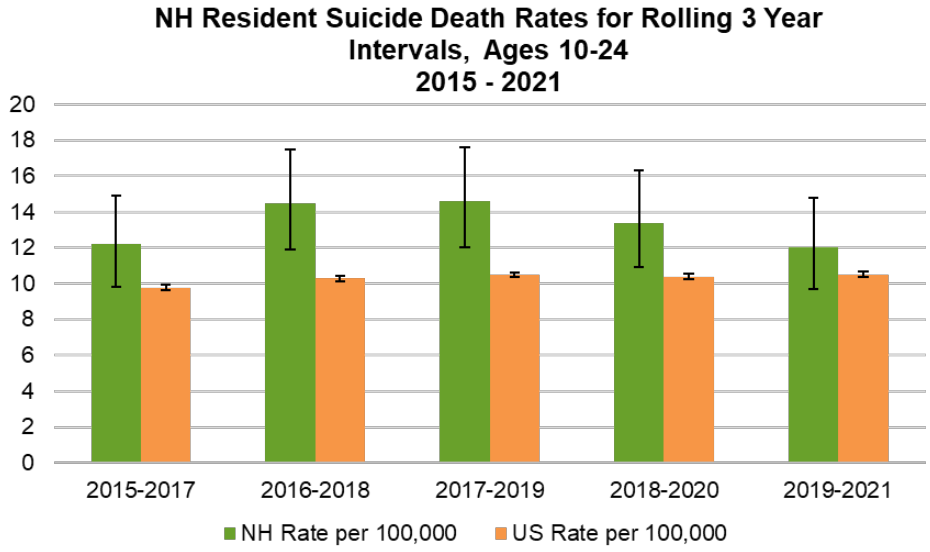
* Counts less than five are not disclosed for privacy purposes.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Suicide Rates in NH

Until 2010, data had indicated that rates of youth and young adult suicide and suicidality overall in NH were flat or on a downward trend. It is nearly impossible to firmly establish causality for such trends. Statewide collaborative prevention efforts, including the work of the SPC and other groups, implementation of NH's Suicide Prevention Plan, GLS funding through SAMHSA, suicide prevention programs implemented in the state, and the work of many community partners likely played a role in that downward trend. Even though rates have recently increased, the value of prevention efforts should not be discounted. Without the continued work of these and other individuals and organizations, a greater increase in NH suicide rates may have occurred.

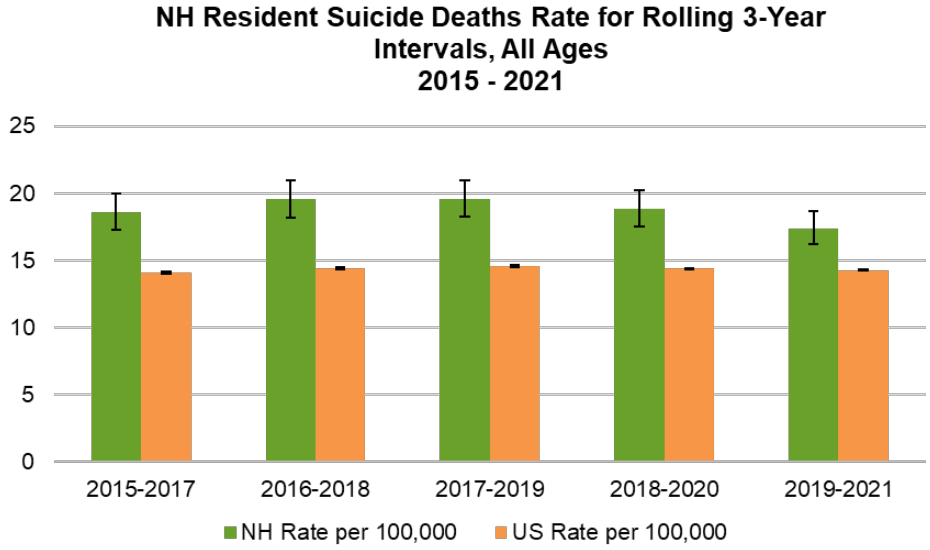
Figure 56 (below) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2015 to 2021 and **Figure 57** (below) presents the same information for individuals of all ages. NH-VDRS data is currently limited to 2015-2021. As new data becomes available these figures will be expanded and used to identify trends in NH rates over time and compare them with national trends.

Figure 56



Data Sources: NH Rates: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.
US Rates: CDC WISQARS

Figure 57

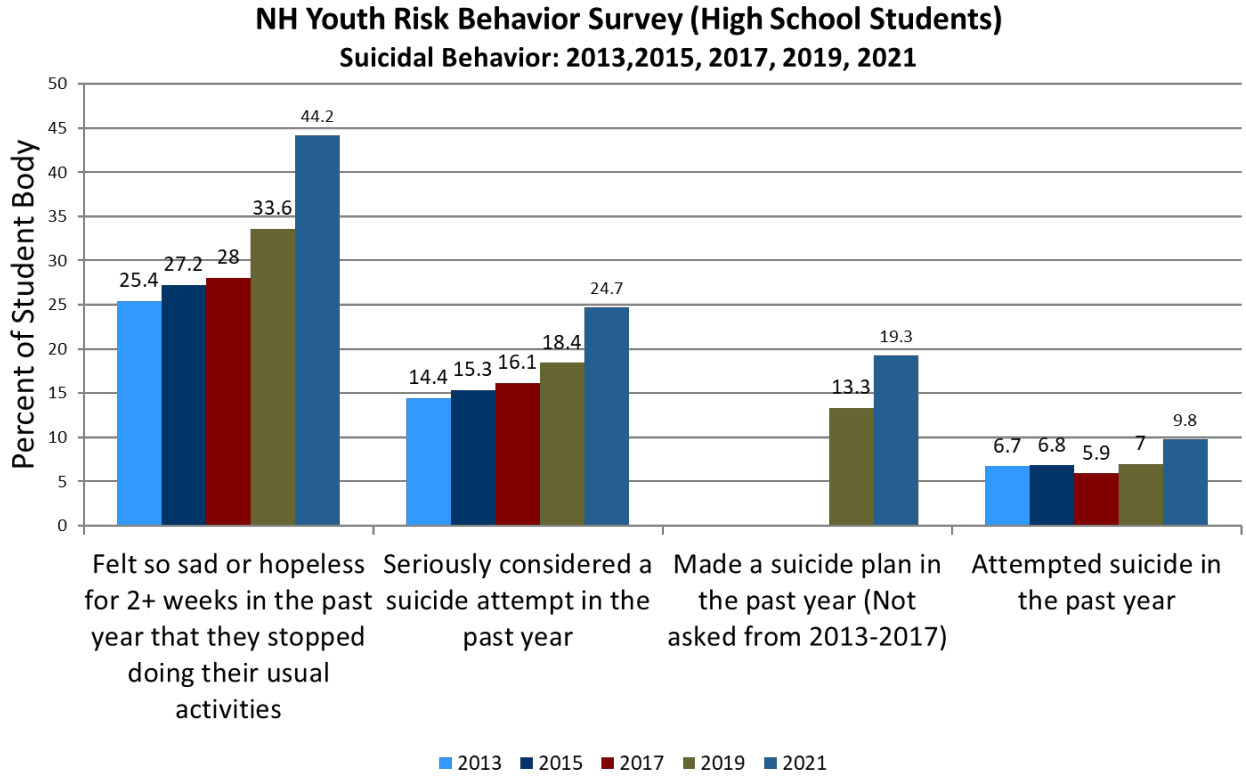


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.
US Rates: CDC WISQARS

Figure 58 (below) presents the results of the NH YRBS from 2013, 2015, 2017, 2019, and 2021. All of the items included in **Figure 58** (below) demonstrated significant increases in the percentage of youth self-reporting these thoughts/behaviors ($p < 0.05$)[27]. In 2021, 1 in 4 youth surveyed reported having seriously considered attempting suicide in the past year, while 1 in 10 reported having made an attempt.

Figure 58

Self-reported depression and suicidal ideation among high school youth increased from 2013 to 2021.



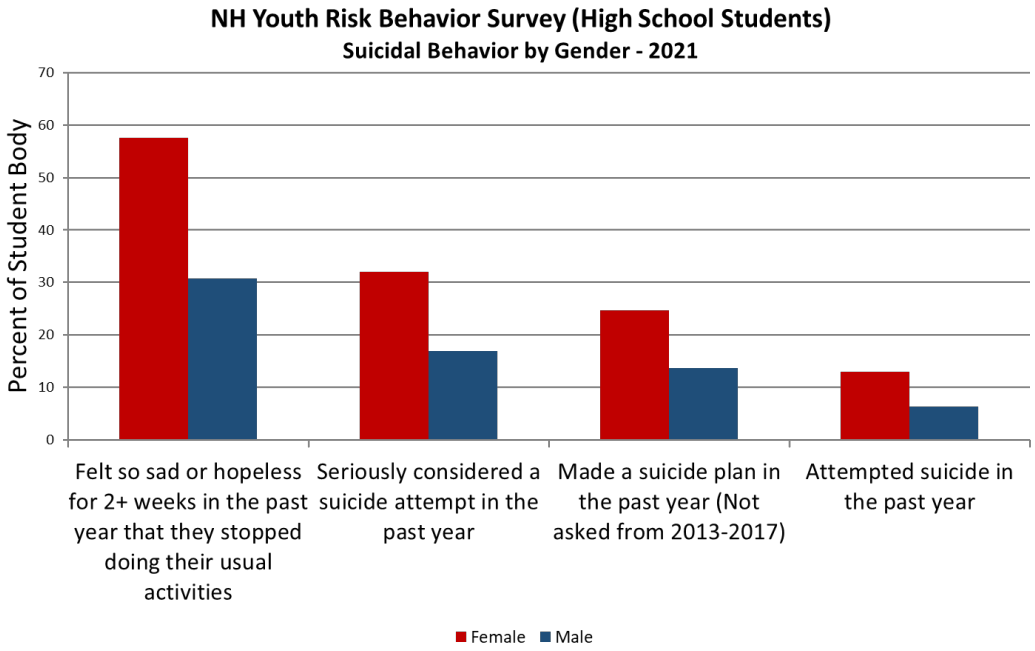
Data Source: NH YRBS Results, NH Department of Education

The NH YRBS item addressing whether students have made a suicide plan in the past year was not asked from 2013-2017. This was removed due to the similarity to the question asking whether youth had seriously considered a suicide attempt during the past year. Beginning in 2019 the question was again included in the survey.

[27] Detailed tables and analyses of the NH YRBS data are available from https://www.education.nh.gov/who-we-are/division-of-educator-and-analytic-resources/bureau-of-education-statistics/youth-risk-behavior-survey

Substantial variations are found within the 2021 YRBS results when broken down by gender and sexual orientation. Among the items included in **Figure 58** (pg. 76), females reported experiencing those thoughts, feelings, and behaviors at nearly twice the rate of males. Similarly, students identifying as gay, lesbian, or bisexual reported those thoughts, feelings, and behaviors at two to four times the rate for students identifying as heterosexual. Students identifying as other or questioning reported those thoughts, feelings, and behaviors at a rate slightly below that of students identifying as gay, lesbian, or bisexual. The breakdown by gender and sexual orientation is presented below in **Figures 59** (below) **and 60** (pg. 78). Additional details on these and other YRBS items are available from the NH Department of Education[28] and NH Department of Health and Human Services[29] websites.

Figure 59

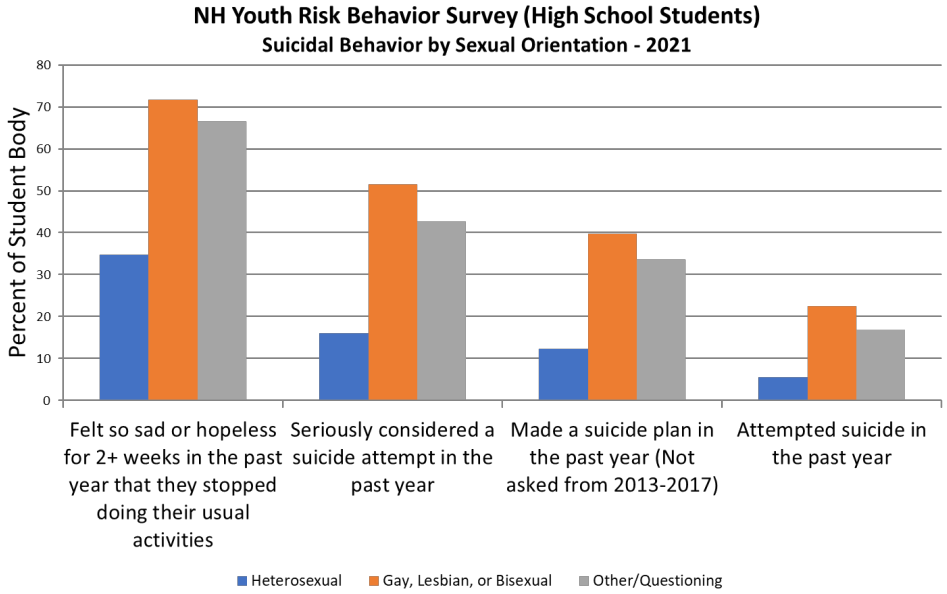


Data Source: NH YRBS Results, NH Department of Education

[28] NH Department of Education YRBS page: https://www.education.nh.gov/who-we-are/division-of-educator-and-analytic-resources/bureau-of-education-statistics/youth-risk-behavior-survey

[29] NH Department of Health and Human Services YRBS page: https://www.dhhs.nh.gov/programs-services/population-health/health-statistics-informatics/youth-risk-behavior-survey

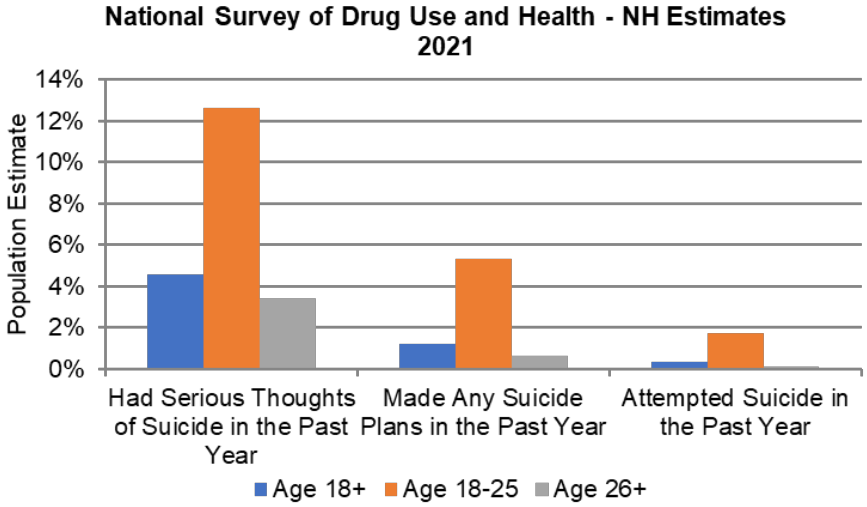
Figure 60



Data Source: NH YRBS Results, NH Department of Education

Figure 61 (below) presents the results of the National Survey of Drug Use and Health (NSDUH) for questions that are similar to those asked on the YRBS. The included NSDUH data focused on individuals age 18+ and shows that 1 in 22 adults surveyed reported having serious thoughts of suicide in the past year, while 1 in 322 reported having made a suicide attempt in the past year. These numbers are substantially higher for individuals between the ages of 18 and 25, with 1 in 8 reporting serious thoughts of suicide in the past year and 1 in 58 reporting having made a suicide attempt during that time period.

Figure 61



Data Source: National Survey on Drug Use and Health, 2021

Reading Tables and Figures

This section is intended to assist the reader in interpreting the various charts included in the report. The four topics covered in this section include types of charts; common parts of a chart; frequently used scales in charts; and interpreting the information presented in a chart. These topics contain information that applies primarily to the charts included in this report, but much of the information can also be applied elsewhere.

Types of Charts

- **Line Chart:** A line chart presents a series of connected observations in order. For example, the line chart in **Figure 4** of this report shows the number of youth and young adult suicides over a 5-year span in NH.
- **Pie Chart:** A pie chart gives the percent values for the individual parts of a whole using a circle that is divided into wedges. For example, a pie chart (**Figure 15**) of this report shows the percent of male and female youths and young adults in NH that died by suicide from 2015 to 2021.
- **Bar Chart:** A bar chart shows the values for one or more categories using rectangular boxes with height representing the value (greater height being a larger value and lesser height being a smaller value). For example, two bar charts (**Figures 10** and **11**) in this report show the number of suicide deaths by age group in NH from 2015 to 2021 and the rate of suicide deaths by age group in NH from 2015 to 2021.

Common Parts of a Chart

- **Title:** The title will generally be found at the top of the chart and should describe the data that are being presented. Depending on the chart this may list the variables and/or the time period. Also, all charts in this report list the data source used.
- **Scales/Labels:** The scales/labels are generally found on the bottom and left side of the chart. The scale/label on the bottom shows what is being measured on the x-axis (horizontal axis) and the scale/label on the left side shows what is being measured on the y-axis (vertical axis). For example, in **Figure 4**, the line chart of youth suicides in NH over the past four years has a different scale on each axis. On the x-axis (the bottom) are years which range from 2015 to 2021. On the y-axis (the side) the scale is the number of youth suicides, which ranges from 0 to 45.
- **Legend/Key:** Some charts include a legend/key to explain what different colors, shapes, dotted/solid lines mean. The location of this may vary depending on the type of chart and where space is available on the page.
- **Error Bars/Confidence Intervals:** Error bars/confidence intervals represent the range that the actual value may fall within. There is some degree of uncertainty when calculating values such as rates due to statistical error (captured by the confidence intervals) and data quality issues (which there is no real way to estimate). The width of the error bar/confidence interval indicates the level of uncertainty. A wider bar denotes more uncertainty and may indicate more data is needed. A smaller bar indicates a greater level of confidence in the results. When error bars/confidence intervals overlap in a chart, one cannot state with certainty whether there is a significant difference between the values.

Error bars can be seen on several of the charts in this document, including the NH crude death rate chart (**Figure 13**). In that chart you can see that the error bar for Merrimack County does not overlap the bar for Rockingham County. From this we are able to determine that the rate of suicide in Merrimack County is significantly different from the rate in Rockingham County.

Frequently Used Scales

- **Standard:** What is being referred to here as standard is a numbered scale that gives the actual value of the variable(s) being presented in the chart (e.g., the number of youth and young adult suicides in a given year).
- **Rate:** A scale using a rate is saying how common something is in relation to a standard value. This report uses rates per 100,000. Therefore, a youth and young adult suicide rate of 10 would mean that there are likely to be 10 suicides by youth or young adults for every 100,000 youths or young adults in the population. Rates are approximations based on past data and do not guarantee the same trend will or will not continue.
- **Percent:** A scale using percent is expressing a certain proportion of the variable falls into one category (i.e., 25% of youth is equivalent to 25 out of 100 youth).

Interpreting Information from Charts

- Can different charts be compared? Yes, but only under certain circumstances. Different charts should only be directly compared if they were generated using the same dataset and related variables. Depending on the charts there may be other factors that prevent you from directly comparing them. When in doubt, attempt to contact the person who made the chart or someone with access to the data used to generate the chart.
- Data is generated in a variety of ways and therefore it is not always consistent. For example, in NH the OCME is charged with keeping records of all deaths that occur in the state, regardless of where the person lived. Thus, a Vermont resident who dies in a NH hospital would be included in data addressing NH occurrences. On the other hand, the Bureau of Vital Records collects data on the deaths of NH residents regardless of where the death occurs. So, a NH resident who dies in Massachusetts would be included in Vital Records statistics and part of any data reporting on NH residents. Therefore, these two data sets will have small differences. Neither is wrong. They simply measure different things.

Glossary of Terms

Acronyms

American Foundation for Suicide Prevention	AFSP
Army National Guard	ARNG
Behavioral Risk Factor Surveillance System	BRFSS
Centers for Disease Control and Prevention	CDC
Crisis Intervention Team	CIT
Community Mental Health Center	CMHC
Counseling on Access to Lethal Means	CALM
Department of Health and Human Services	DHHS
Electronic Data Warehouse	EDW
Emergency Departments	ED
Garrett Lee Smith	GLS
Health Insurance Portability and Accountability Act	HIPAA
Health Statistics and Data Management	HSDM
International Classification of Diseases 10th Revision	ICD-10
National Alliance on Mental Illness New Hampshire	NAMI NH
National Violent Death Reporting System	NVDRS
New Hampshire Violent Death Reporting System	NH-VDRS
Northern New England Poison Center	NNEPC
Office of Economic Planning	OEP
Office of the Chief Medical Examiner	OCME
Post-Traumatic Stress Disorder	PTSD
Substance Abuse and Mental Health Services Administration	SAMHSA
Suicide Prevention Council	SPC
Suicide Prevention Program	SPP
Suicide Prevention Resource Center	SPRC
Survivor of Suicide Loss	SOSL
Traumatic Brain Injury	TBI
Veterans Administration	VA
Web-based Injury Statistics Query and Reporting System	WISQARS
Youth Risk Behavior Survey	YRBS
Youth Suicide Prevention Assembly	YSPA

Age Adjustment and Rates

When possible, rates in this document are age-adjusted to the 2010 US standard population. This allows the comparison of rates among populations having different age distributions by standardizing the age-specific rates in each population to one standard population. Age-adjusted rates refer to the number of events that would be expected per 100,000 persons in a selected population if that population had the same age distribution as a standard population. Age-adjusted rates were calculated using the direct method as follows:

$$\hat{R} = \sum_{i-1}^{m} s_i(d_i/p_i) = \sum_{i-1}^{m} w_i d_i$$

Where,
- m = number of age groups
- di= number of events in age group i
- Pi= population in age group i
- Si= proportion of the standard population in age group i

This is a weighted sum of Poisson random variables, with the weights being (Si /pi).

Age Specific Rate/Crude Rates

The age-specific rate or crude rate is the number of individuals with the same health issue per year within a specific age group, divided by the estimated number of individuals of that age living in the same geographic area at the midpoint of the year.

Confidence Intervals (Ci)

The standard error can be used to evaluate statistically significant differences between two rates by calculating the confidence interval. If the interval produced for one rate does not overlap the interval for another, the probability that the rates are statistically different is 95% or higher.

The formula used is:

$$R + z\,(SE)$$

Where,
- R=age-adjusted rate of one population
- z = 1.96 for 95% confidence limits
- SE= standard error as calculated below

A confidence interval is a range of values within which the true rate is expected to fall. If the confidence intervals of two groups (such as NH and the US) overlap, then any difference between the two rates is not statistically significant. All rates in this report are calculated at a 95% confidence level.

Data Collection

The BRFSS is a telephone survey conducted annually by the health departments of all 50 states, including NH. The survey is conducted with assistance from the federal CDC. The BRFSS is the largest continuously conducted telephone health survey in the world and is the primary source of information for states and the nation on the health-related behaviors of adults. The BRFSS has been conducted in NH since 1987. HSDM develops the annual questionnaire, plans survey protocol, locates financial support, and monitors data collection progress and quality with the

assistance of CDC. HSDM employs a contractor for telephone data collection. Survey data are submitted monthly to CDC by the contractor for cleaning and processing and then returned to HSDM for analysis and reporting.

Death Certificate Data is collected by the Department of Vital Records in NH and provided to the HSDM through a Memorandum of Understanding. Death Certificate Data is available to the HSDM through the state Electronic Data Warehouse (EDW), a secure data server.

Hospital Discharge Data for inpatient and emergency department care is complied, and de-identified at the Maine Health Information Center, delivered to the Office of Medicaid Business and Policy for further cleaning, then available to the HSDM through the state EDW.

State and county population estimates for NH data are provided by HSDM, Bureau of Disease Control and Health Statistics, Division of Public Health Services, and NH DHHS. Population data are based on US Census data apportioned to towns using NH Office of Economic Planning (OEP) estimates and projections, and further apportioned to age groups and gender using Claritas Corporation estimates and projections to the town, age group, and gender levels. Data add up to US Census data at the county level between 1990 and 2005 but do not add to OEP or Claritas data at smaller geographic levels.

Data Confidentiality

The data provided in this report adheres to the NH DHHS "Guidelines for Release of Public Health Data" and the Health Insurance Portability and Accountability Act (HIPAA). Data are aggregated in-to groups large enough to prevent constructive identification of individuals who were discharged for hospitals or who are deceased.

Graphs

Graphs have varying scales depending on the range of the data displayed. Therefore, caution should be exercised when comparing such graphs.

Incidence

Incidence refers to the number or rate of new cases in a population. Incidence rate is the probability of developing a particular disease or injury occurring during a given period of time; the numerator is the number of new cases during the specified time period and the denominator is the population at risk during the period. Rates are age-adjusted to 2010 US standard population. Some of the rates also include age-specific rates. Rates based on 10 or fewer cases are not calculated, as they are not reliable.

Death Rate

Death rate is the number of deaths per 100,000 in a certain region in a certain time period and is based on International Classification of Diseases 10th Revision (ICD-10). Cause of death before 1999 was coded according to ICD-9; beginning with deaths in 1999, ICD-10 was used.

Reliability of Rates

Several important notes should be kept in mind when examining rates. Rates based on small numbers of events (e.g., less than 10 events) can show considerable variation. This limits the usefulness of these rates in comparisons and estimations of future occurrences. Unadjusted rates (age-specific or crude rates) are not reliable for drawing definitive conclusions when making comparisons because they do not take factors such as age distribution among populations into account. Age-adjusted rates offer a more refined measurement when comparing events over geographic areas or time periods. When a difference in rates appears to be significant, care should be exercised in attributing the difference to any particular factor or set of factors. Many variables may influence rate differences. Interpretation of a rate difference requires substantial data and exacting analysis.

Small Numbers

With very small counts, it is often difficult to distinguish between random fluctuation and meaningful change. According to the National Center for Health Statistics, considerable caution must be observed in interpreting the data when the number of events is small (perhaps less than 100) and the probability of such an event is small (such as being diagnosed with a rare disease). The limited number of years of data in the registry and the small population of the state require policies and procedures to prevent the unintentional identification of individuals. Data on rare events, and other variables that could potentially identify individuals, are not published.

Standard Errors

The standard errors of the rates were calculated using the following formula:

Where,

w *j* = fraction of the standard population in age category
n *j* = number of cases in that age category
p = person-years denominator

$$S.E. = \sqrt{\frac{w_j^2 n_j}{p_j^2}}$$

Frequently Asked Questions about NH Suicide Data

Q: **Statistical significance of suicide deaths vs. significance in the community.**

A: Statistical significance, which this document focuses on, is used to look at whether the change in the number of suicide deaths from one time period to another has truly increased/decreased, or whether the difference is potentially due to chance. In general, in NH a small number of additional deaths are unlikely to result in a statistically significant change. However, the significance of even a single death in a family or a community is tremendous. When discussing "significance" it is best to be clear about whether the focus is on measurable changes or the practical impact on a family or community.

Q: **Have there been more suicide deaths in NH during *"X"* months of this year compared with previous years?**

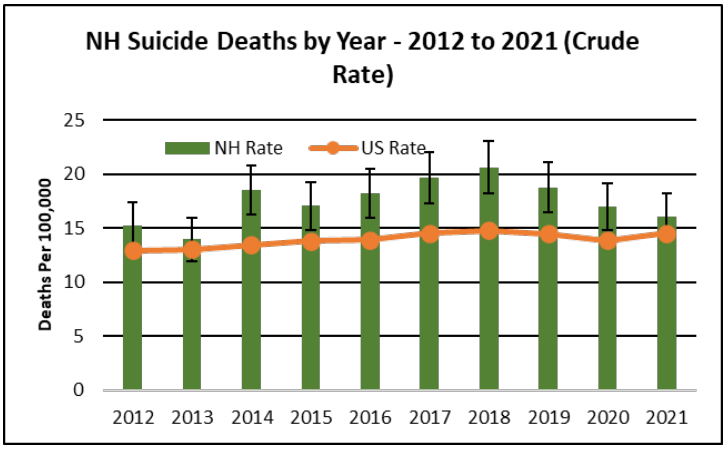
A: It is best to focus on data from a full year or multiple years rather than periods of just a few months. Over brief periods these numbers are too volatile to draw accurate conclusions from them.

Q: **If there is an increase during part of a year does this mean that there will be a greater number of suicide deaths during the remainder of the year when compared with previous years?**

A: Not necessarily. Even though there may have been a greater number of deaths during part of a given year, this does not indicate that there will be a greater number of deaths for the remainder of the year. Until the end of the year, it is not possible to say whether the overall number of suicide deaths will be higher or lower than previous years.

Q: **Has NH ever had a large change in suicide deaths from one year to the next?**

A: As a small state, NH has a substantial degree of variability in the suicide deaths in a given year. It is not at all uncommon for the number (and rate) of suicide deaths in NH to vary by as much as 33% (up or down) from the previous year – see chart and table below. Significant differences are indicated by non-overlapping confidence intervals (the brackets overlaid on the bars in the chart). For example, the confidence intervals for 2013 do not overlap with the 2014 or 2017-2019 confidence intervals, meaning that the rates for 2014 and 2017-2019 were significantly higher than the rate for 2013.



Data Source: CDC WISQARS – 2012-2021

Change in Rate per 100,000 from Year to Year	
2012-2013	15.25 to 13.94 (**Down** 9%)
2013-2014	13.94 to 18.51 (**Up** 33%)
2014-2015	18.51 to 17.05 (**Down** 8%)
2015-2016	17.05 to 18.16 (**Up** 7%)
2016-2017	18.16 to 19.62 (**Up** 8%)
2017-2018	19.62 to 20.59 (**Up** 5%)
2018-2019	20.59 to 18.74 (**Down** 9%)
2019-2020	18.74 to 16.98 (**Down** 9%)
2020-2021	16.98 to 16.05 (**Down** 5%)

Q: **What is the difference between a rate and a count?**

A: A count simply shows the number of incidents that have taken place during a given period of time (e.g., 100 deaths in a one-year period). A rate is a way of showing the prevalence of something among the population. For example, saying that there are 10 deaths resulting from "x" per 100,000 means that in a given population approximately 10 out of every 100,000 individuals have been found to die as a result of "x".

Q: **Has *"X"* (e.g., the recession) caused the increase/decrease in the number of suicide deaths in a specific year?**

A: Suicide is a complex issue, and it is not possible to say that a single factor is the direct cause of these deaths. For instance, from 2013 to 2014, the number of deaths were up over 33% followed by an 8% decrease from 2014 to 2015; we are still unable to identify the underlying cause of these fluctuations and whether any of those deaths are attributable to the same cause.

Q: **How do the number of suicide deaths compare to other causes of death in the state?**

A: 10 Leading Causes of Death, New Hampshire, by Age Group, 2017 – 2021

Data Source: CDC WISQARS, 2017-2021

---Note: Beginning with 2008 data, the CDC has suppressed state-level counts for categories with fewer than ten deaths

CONTACTS & MEETING INFORMATION

SPC Contacts and Meeting Information

Please note that meeting schedules may change. Contact the identified individual(s) below to confirm the meeting details if you would like to attend.

Committee information is also available from preventsuicidenh.org/get-involved/committees/

State Suicide Prevention Council

Chair: Amy Cook – acook@naminh.org
Vice Chair: Shamera Simpson – ssimpson@afsp.org
Meets 4th Monday – Every **other** month 10:00 am – 12:00 pm

Suicide Prevention Council Subcommittees

Communications & Public Education

Chair: Mary Forsythe-Taber – mft@mih4u.org
Meets 2nd Wednesday of the Month

Data Collection & Analysis

Chair: Patrick Roberts – proberts@naminh.org
Meets 4th Wednesday of Feb., May, Aug., and Oct.

Law Enforcement

Chair: Trooper Seth Gahr - Seth.L.Gahr@DOS.NH.GOV
Meeting schedule to be determined

Military & Veterans

Co-Chair: Amy Cook – acook@naminh.org
J. Justin Moeling - John.Moeling@va.gov
Meets 1st Wednesday of the Month

Public Policy

Check preventsuicidenh.org/get-involved/committees/ for current contact/meeting information.

Suicide Fatality Review

Chair: Dr. Paul Brown
Attendance is by invitation only

Survivors of Suicide Loss

Co-Chairs: Steve Boczenowski – boczeno@gmail.com
Megan Melanson - Megan.S.Melanson@centene.com
Meets 4th Monday of the Month

Recognize the Warning Signs for Suicide to Save Lives!

Sometimes it can be difficult to tell warning signs from "normal" behavior especially in adolescents. Ask yourself, *is the behavior I am seeing very different for this particular person?* Also, recognize that sometimes those who are depressed can appear angry, irritable, and/or hostile in addition to withdrawn and quiet.

Warning signs:

- Talking about or threatening to hurt or kill oneself
- Seeking firearms, drugs, or other lethal means for killing oneself
- Talking or writing about death, dying, or suicide
- Direct Statements or Less Direct Statements of Suicidal Intent: (Examples: "I'm just going to end it all" or "Everything would be easier if I wasn't around.")
- Feeling hopeless
- Feeling rage or uncontrollable anger or seeking revenge
- Feeling trapped - like there's no way out
- Dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life
- Acting reckless or engaging in risky activities
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious or agitated
- Being unable to sleep, or sleeping all the time

For a more complete list of warning signs and more information on suicide prevention, please consult the *Connect* website at www.theconnectprogram.org and click on Resources.

If you see warning signs and/or are otherwise worried about this person:

Connect with Your Loved One, Connect Them to Help

1) Ask directly about their suicidal feelings. Talking about suicide is the first step to preventing suicide!
2) Let them know you care.
3) Keep them away from anything that may cause harm such as guns, pills, ropes, knives, vehicles.
4) Stay with them until a parent or professional is involved.
5) Offer a message of hope - Let them know you will assist them in getting help.
6) Connect them with help:
   - 988 Suicide and Crisis Lifeline (24/7) Call or Text 988 **(press "1" for veterans)**
   - 988 also offers text-based chat through their website: 988lifeline.org
   - Headrest – For teens and adults (24/7) **1-800-639-6095** or your local mental health center
   - For an emergency, **dial 911**.

Mental Health and Suicide Prevention Resources

General Resources:

Local Resources

Community Mental Health Centers: nhcbha.org
Peer Support Agencies: dhhs.nh.gov/programs-services/mental-health/peer-support-agencies
Disaster Behavioral Health Response Teams: www.dhhs.nh.gov/disaster-behavioral-health
NAMI New Hampshire: www.NAMINH.org, 603-225-5359

LGBTQIA+ Resources

Trevor Helpline (24/7): 1-866-4u-TREVOR (488-7386) www.thetrevorproject.org
Fenway Peer Listening Line: 1-800-399-PEER www.fenwayhealth.org
GLBT National Hotline (M-F 4-12 pm; Sat. 12-5 pm): 1-888-843-4564 www.glnh.org
GLBT National Youth Talkline (M-F 8-12 pm): 1-800-246-PRIDE (7743)
Email: youth@GLBTNationalHelpCenter.org
SPRC Library: sprc.org/online-library/

Military Resources

Military One Source: www.militaryonesource.mil
Tragedy Assistance Program for Survivors (TAPS): www.taps.org
US Department of Veterans Affairs: www.va.gov
Veterans Crisis Line: 988 (press 1 after connecting)

National Organizations

American Association of Suicidology: www.suicidology.org
American Foundation for Suicide Prevention: www.afsp.org
National Action Alliance for Suicide Prevention: theactionalliance.org
National Alliance on Mental Illness: www.nami.org
Suicide Prevention Resource Center: www.sprc.org

Older Adults

NH Fact Sheet on Suicide and Aging: bit.ly/2nuLd5O
SPRC Older Adult Suicide Prevention Resources: www.sprc.org/populations/older-adults

Substance Abuse and Mental Health Services Administration (SAMHSA)

Obtaining Prevention Materials:
Visit their website: store.samhsa.gov (includes downloadable materials)
Call: 1-877-SAMHSA-7 (1-877-726-4727) or Email: samhsainfo@samhsa.hhs.gov
Treatment Provider Locator:
SAMHSA maintains a searchable list of mental health and substance use disorder providers. You can use it to find a local provider by going to www.samhsa.gov/find-treatment

Resources for Survivors of Suicide Loss / Individuals Bereaved by Suicide:

National Helplines

Compassionate Friends: 1-877-696-0010
Friends for Survival: 1-800-646-7322

Websites

Alliance of Hope for Suicide Survivors: www.allianceofhope.org
American Foundation for Suicide Prevention: afsp.org
Compassionate Friends: www.compassionatefriends.org
The Connect Program: https://theconnectprogram.org/find-support/coping-with-suicide-loss
Friends for Survival: www.friendsforsurvival.org
Heartbeat: www.heartbeatsurvivorsaftersuicide.org
Parents, Family and Friends of Suicide Loss: www.pos-ffos.com
SAVE (Suicide Awareness Voices of Education): www.save.org

Have you found this report to be useful?

Please share your feedback through the survey linked below so that this report can be even better in the future.

https://www.surveymonkey.com/r/PPJL25W