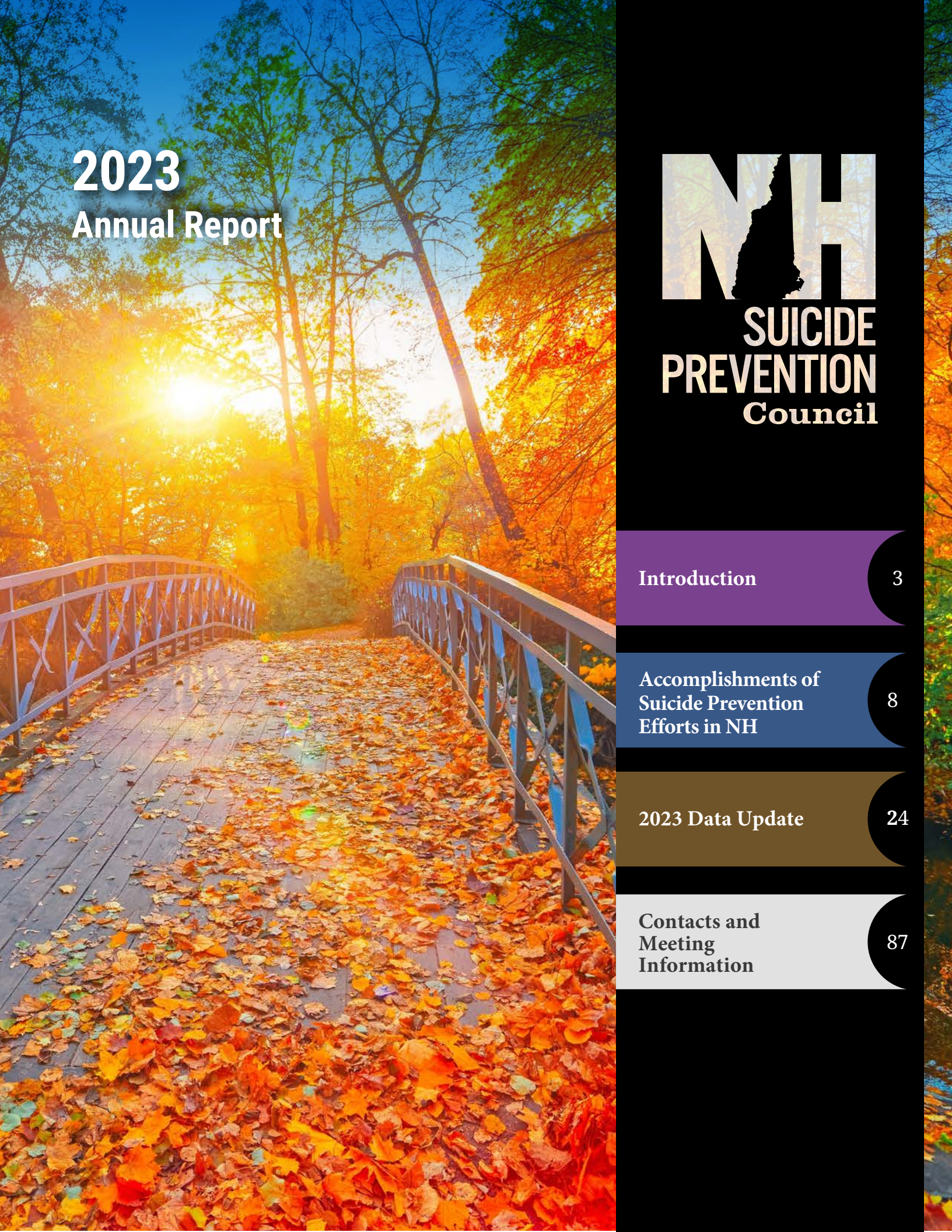

2023 Annual Report

NH SUICIDE PREVENTION Council

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INTRODUCTION

Introduction

The 2023 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 the NH Vital Records and the 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) is a grassroots organization working to improve the quality of life for all by providing support, education, and advocacy for people affected by mental illness and suicide.

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 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:

- Adam Burch, Section Administrator, NH-VDRS Co-Principal investigator, Risk Assessment and Data Analysis for Overdose Reduction Section, Division of Public Health Services, NH DHHS, Adam.S.Burch@dhhs.nh.gov.
- Djelloul Fourar-Laïdi, Lead Abstractor/NH-VDRS Co-Principal Investigator, Risk Assessment and Data Analysis for Overdose Reduction 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: Communications; Data Collection and Analysis; Law Enforcement; Military and Veterans; Public Policy; Suicide Fatality Review; and Survivors of Suicide Loss.

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, creating the original NH Suicide Prevention Plan, and involvement with the development of local suicide prevention programs.

ACCOMPLISHMENTS

Accomplishments of Suicide Prevention Efforts in NH

State Suicide Prevention Council

2023 marked the 15th 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 committees, and other stakeholders in the state began looking at ways of implementing the outlined goals. This work was aided by the first ever state funding for the SPC and the newly created State Suicide Prevention Coordinator position within NH DHHS.

Much of the work of the SPC is done at the committee level. Some of the committee activities occurring in 2023 to move forward the goals of the NH Suicide Prevention Plan included:

Communications Committee

- 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 2023 Annual NH Suicide Prevention Conference, in collaboration with a dedicated conference committee coordinator.
- Developed, posted, and released a new branding guide to be used by SPC subcommittees.
- Ongoing refinement of the content for the subcommittee pages and resource information section of the SPC website.

Data Collection and Analysis Committee

- Worked with multiple statewide partners to compile and analyze data for inclusion in the 2022 NH Suicide Prevention Annual Report.
- Distributed the 2022 NH Suicide Prevention Annual Report 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.

Military and Veterans Committee

- The Committee continued to align their efforts with, and actively participate, in the SAMHSA/VA Governor's Challenge to Prevention Suicide Among Service Members, Veterans, and their Families initiative. The NH Governor's Challenge Team/Military & Veterans Committee benefitted in various ways from this partnership including:

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

    - Committee Co-Chair/Team Lead attended three Academies in Washington, D.C. (February, April, September 2023). She attended multiple workshops and brought new ideas back to New Hampshire for consideration.
    - Facilitators were sent by SAMHSA/VA in March 2023 to guide the team through 1.5 days of workshops and planning related to reaching a diverse group of at-risk Veterans in New Hampshire.
    - Committee members participated virtually in a monthly national Community of Practice to learn about best practices around the country to address the suicide rate among Service Members, Veterans, and their Families (SMVF).
    - Co-chairs participated virtually in monthly Team Lead meetings with others from across the country to learn about strategies to improve the work of teams focusing on suicide prevention efforts.
    - Two committee members attended a summer conference to learn about innovative strategies for preventing suicide among SMVF.
- Committee members participated in planning for the Annual Suicide Prevention Conference where they ensured that the content presented at the conference represented the needs of providers serving military and veterans.
- Local Veterans Coalitions continued to be developed across New Hampshire in 2023. Members of those coalitions often attended SPC Military and Veterans Subcommittee meetings in order to align their efforts with statewide efforts.
- The Ask the Question (ATQ) Toolkit and Video series were completed at the end of 2022 and made available in 2023. Throughout the year, the toolkit and videos were promoted to organizations and providers looking to improve their practices around identifying SMVF. The Committee worked closely with the NH Department of Military Affairs and Veterans Services in 2023 to support the transition of ATQ responsibilities to the Department. The Committee continued to focus on promoting military culture training for providers and building capacity for delivery of such trainings. Work to develop an online Ask the Question training started in 2023.

Public Policy Committee

- Hosted a Suicide Prevention Advocacy Day at the Holiday Inn in Concord on May 4, 2023.
- Held several Community Outreach Presentations.
- Met bi-monthly with Public Policy Committee members.

Survivors of Suicide Loss Committee

- Continued holding two monthly virtual support groups, Coffee Chat on the 2nd Friday morning of the month and Tea Time on the 4th Tuesday late afternoon of the month. These sessions offer 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.
- Focusing on the theme of avoiding burnout and self-care, the subcommittee hosted a four-part workshop for SOSL support group facilitators.
- Hosted two evening presentations called "Survivor Stories." These presentations consisted of Survivors of Suicide Loss sharing their stories of loss, healing, and hope. All of the survivors who spoke were trained in the SurvivorVoices training provided by NAMI NH. Both events – one in Concord and one in Portsmouth – were well attended with 30-40 members of the public present.

- Provided support to NH Survivor of Suicide Loss support groups and promoted the American Foundation for Suicide Prevention (AFSP) International Survivors of Suicide Loss Day (ISOSLD), featuring several in-person NH sites in November 2023, 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 Subcommittee provided support and participated in many Loss Survivor events throughout NH, including AFSP Out of the Darkness Walks in designated towns and NAMIWalks NH, with Team SOS.

As the Council looks to continue its work, there is a desire to increase active membership of its committees. The Council also recognizes the role public health departments play in this work and the importance of their perspectives 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 advance 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 89 of this report. It can also be found at preventsuicidenh.org/get-involved/committees/.*

Suicide Fatality Review Committee (SFRC)

The SFRC reviews the suicide deaths of NH residents, across the lifespan. The committee membership is multidisciplinary, representing public and private agencies and programs. All fatality review meetings are confidential. The statute establishing the committee mandates the publishing of an annual report reflecting the work of the SFRC during the year of review. Highlights from the most recent committee report include:

Cases Reviewed in 2023
The SFRC reviewed cases with specific precipitating factors. Precipitating factors are stressful events that can trigger a suicidal crisis in a vulnerable individual. For 2023, the SFRC wanted to explore deaths that involved recent job loss or unexpected unemployment. Two cases were identified and reviewed in 2023.

Recommendations
- All offices of New Hampshire Employment Security prominently display the 988 Suicide & Crisis Lifeline information.
- Employees of the NH Employment Security receive training opportunities for suicide prevention.

Next Steps
The SFRC has identified the following next steps to improve and enhance the committee moving forward:

- Outreach with the agencies involved in procuring the records to improve the request and retrieval process. The goal is to improve the timeliness of obtaining critical information to promote discussion at the case review meetings.
- Improved communication with the NH Suicide Prevention Council Chair and Vice Chair to ensure information and recommendations are provided to the NH Suicide Prevention Council members.
- Offer suicide prevention trainings and presentations on key topics for the SFRC members.
- Improved access and reporting of suicide data from the NH Department of Health and Human Services and the NH Suicide Prevention Council Data Committee.
- Review current membership and consider expansion to key stakeholders in alignment with NH RSA 126-R:4.

The Youth Suicide Prevention Assembly (YSPA)

YSPA is a grassroots coalition comprised of individuals interested in learning more about how to prevent all suicides, but especially those that occur among individuals age twenty-four and younger. 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 attendees 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 beneficial. The Youth Suicide Prevention Assembly (YSPA) continues to meet the second Thursday of every month virtually, or in Concord, NH.

YSPA meetings continued with in-person meetings for the months of April through October (taking November off for the Suicide Prevention Conference). Virtual meetings were held in the winter months of January, February, March and December to avoid travel in potentially hazardous conditions.

Several presentations were made to YSPA attendees:

- "Young adult" mental health video
- YSPA participant Amanda Fontaine and her research presentation
- Magnify Voices Expressive Art Contest for NH students in grades 5-12
- A joint presentation about NH Rapid Response system and 988.
- Highlights of the YRBS results, presented by a YSPA participant, Lisa Hayward
- YSPA "Retreat"
- Data overview

- A meeting in Plymouth to try to accommodate northern YSPA participants (with full awareness that Plymouth is not as far north as Colebrook)
- A presentation on suicide and substance use presented by the NH Suicide Prevention Coordinator, Katherine Cox
- Conference feedback, planning for 2024 YSPA topics.

YSPA also faced the loss of a former Co-Chair and a key champion of suicide prevention with the September 2023 death of Elaine Frank. Elaine will be remembered for many things, including, but not limited to the following:

- Original member of the NH Firearms Safety Coalition in the 1990s (this relationship with the firearm community, most notably Ralph DiMicco, would prove to be invaluable in 2009 with the start of the Gun Shop Project)
- Helped to develop the Survivor of Suicide Loss packets
- Helped to develop the first Suicide Prevention Conferences
- Wrote the first State of NH Suicide Prevention Plan
- Developed the CALM (Counseling on Access to Lethal Means) training
- Facilitated the project with the current NH Firearms Safety Coalition and the American Academy of Pediatricians for a CALM-type training for pediatricians.

Elaine also left a lasting impact on issues outside of suicide prevention including: seatbelt and motorcycle helmet use, older adult fall prevention, support of the Traffic Safety and the Injury Prevention conferences, and poison prevention and overdose prevention for oxycontin and heroin. She helped launch the Safe Kids program, the trauma program at Dartmouth, and helped the Injury Prevention Center to coordinate with CHaD. Elaine was a tireless advocate for legislation for child safety. Everyone mattered, no matter what they did or who they were.

For more information on YSPA, including how to attend a meeting, please contact Katherine Cox: katherine.m.cox@dhhs.nh.gov or Susan Ward: sward@naminh.org

The NH Suicide Survivor Network

In 2023, Survivors of Suicide Loss (SOSL) continued their efforts to build capacity and establish 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 8 active groups, including two that meet over Zoom and are open to participants statewide.

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. An online survey is also provided to solicit feedback on the folder and provide additional avenues to connect loss survivors to help.

For 2023, SurvivorVoices speakers shared their stories of loss, healing, and hope for the American Foundation for Suicide Prevention (AFSP) International Survivors of Suicide Loss Day (ISOSLD or Survivor Day) events held at multiple sites throughout NH on the Saturday before Thanksgiving. Speakers participated at each in-person event and at the New England region virtual event.

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 Suicide 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.

New Hampshire Behavioral Health Crisis System Overview 2023

The New Hampshire Department of Health and Human Services has established a comprehensive framework to address the state's most pressing health and human services challenges through its Departmental Roadmap. The behavioral health crisis system is a critical component of this framework, directly supporting key roadmap goals, including Mission Zero, which aims to reduce the number of people seeking behavioral health services in emergency departments and improve access to behavioral health services statewide.

Strategic Alignment
Multiple drivers for change have aligned to support transformation of the state's behavioral health crisis system:

- 10-Year Mental Health Plan
- Children's System of Care
- Governor's Commission on Alcohol and Other Drugs Action Plan
- Statewide Suicide Prevention Strategic Plan

These multi-stakeholder committees include representation from various state agencies and members of the legislature working collaboratively to develop solutions for New Hampshire residents.

Crisis Now Model Implementation
New Hampshire has adopted the Crisis Now Model, which includes three essential pillars of crisis care:

- **Someone to Talk To**: Crisis communication services through:
    - Primary 988 Suicide and Crisis Lifeline operated by Headrest
        - In calendar year 2023 (January 1 - December 31), the primary lifeline center answered 9,066 contacts
        - Less than 1% of calls required an active rescue intervention
    - New Hampshire Rapid Response Access Point, which serves as the secondary 988 Suicide and Crisis Lifeline and answers calls to the state's dedicated 10-digit number (833-710-6477)
- In calendar year 2023 (January - December), the Access Point received 34,627 contacts
    - Served 10,566 unique individuals
- Someone to Respond: Mobile crisis response services
    - In calendar year 2023, 6,685 mobile crisis response dispatches were coordinated through the Rapid Response Access Point
- Somewhere to Go: Crisis Centers
    - In 2023, planning was underway to launch this third pillar of the crisis system
    - The state looks forward to the planning for the launch of these crisis centers in 2024

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:

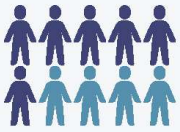
Someone to call, text or chat

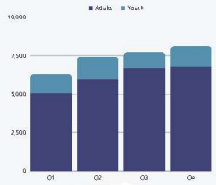
Someone to respond

Somewhere to go

22,200 CONTACTS

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





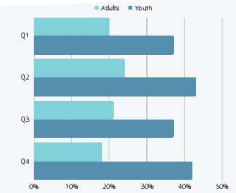
YOUTH & ADULTS

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

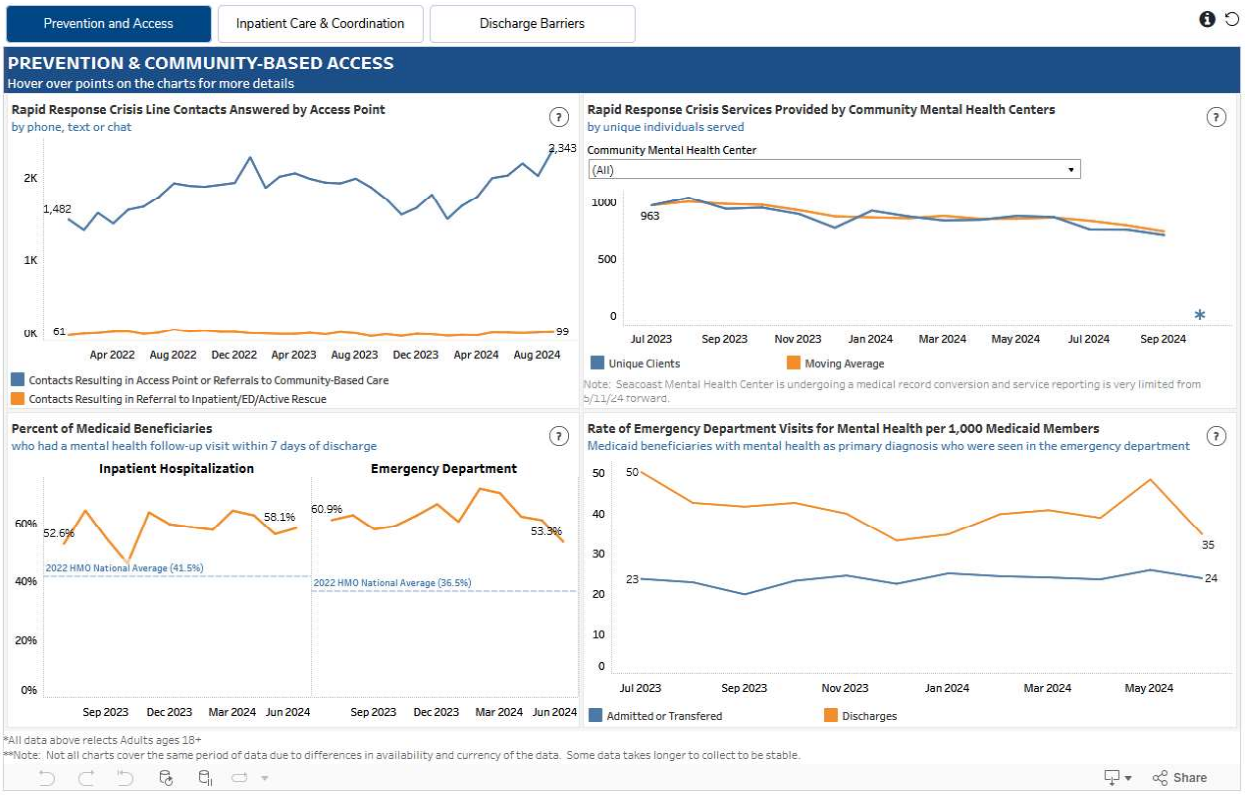
NH Rapid Response created an opportunity to strengthen the community-based crisis response system designed to care for NH children, youth, adults, and families experiencing a mental health and or substance use crisis. Many dedicated professionals who work in NH's behavioral health system are dedicated 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

There is now a public facing dashboard included on the NH DHHS Data Portal with access to recent NH Rapid Response data. Individuals interested in this updated data can access the interactive dashboard by going to:
https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=mental-health&subtopic=mission-zero-adult-mental-health&indicator=mission-zero-prevention-and-community-based-access



Other Statewide Initiatives

AFSP (American Foundation for Suicide Prevention)

The NH Chapter continued its efforts to increase support for Survivors of Suicide Loss in 2023. AFSP NH hosted a State Capitol Day in May of 2023. 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 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 is a nonprofit in New Hampshire. Its mission is to provide suicide prevention education to youth and trusted adults in New Hampshire and its bordering communities. CCF also aims to end the stigma around mental health. In 2023, the foundation more than doubled the number of trainings provided in 2022 with 73 suicide prevention trainings and events across the state with 4,778 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 76 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 2023. This event raised over $47,000 with 365 participants and 28 sponsors. Connor's Climb continues to expand and welcome opportunities to provide suicide prevention training to communities and nonprofits in addition to schools in the state of NH and the surrounding areas. Connor's Climb remains committed to advocating for RSA 193-J, an act relative to suicide prevention education that 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 15- to 34-year- olds[2] here in New Hampshire and among the top three leading causes of death 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 6/6/2024.

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 October 2023 and trained five individuals in the campus, social services, and school suicide prevention module. The two people trained in the college campus version are counselors from the NHTI college partners. The other three trainers include one care liaison from Riverbend, and two counselors who work with youth. Another TTT was held in a GLS region in October 2023, with 10 individuals from Governor Wentworth School District.

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. The GLS Connect Youth Leader training was held in April 2023. There were 33 youth & 15 adults at Concord High School in the Capital Region who 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. The CALM Training was provided for nine participants, of which five became trainers. This included the two care liaisons from Riverbend and Northern Human Services. The Carroll County RPHN coordinator for the GLS Implementation Team also became a trainer.

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 who 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 14 students and was held in January 2024 at NHTI in the Capital Region. A version of the Connect Young Adult training was provided to seven students at the Carroll County Young Adult Learning Center.

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. Although the GLS Care Liaison positions have seen turnover and vacancies, both positions are currently filled.

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 four 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 find ways to create connection and community for their students. The college is offering Wellness Wednesdays as time to connect with students around wellness topics. Faculty and staff completed the Connect eLearning Suicide Prevention training.

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.

NAMI In Our Own Voice Training: Participants are trained to effectively and safely share their story with the public. By speaking about their own experiences, presenters are able to educate communities and organizations about mental illness and help reduce the stigma surrounding it. In May, seven young adults completed the In Our Own Voice training and some have gone on to speak at various events.

Connect™ Online Suicide Prevention Training (eLearning Seats): The Connect Online Training Program is a self-paced course that takes approximately 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 503 Connect eLearning seats that included gatekeeper, school, healthcare, and mental health modules.

NH National Education Association Conference: The GLS Project Coordinator and a NAMI NH colleague presented a workshop in October 2023 at the NEA-NH Conference. The workshop was titled "Mental Health and Suicide Prevention Among LGBTQ+ Youth." There were two sessions with approximately 30 attendees.

NH Behavioral Health Summit: The GLS Project Coordinator presented with the GLS partner from NHTI at the NH Behavioral Health Summit. The workshop presented was titled "Empowering Young Voices to Present Suicide." The workshop included a young adult speaker who was also a former Connect young adult leader.

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

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 2023, the outcomes from this initiative included:

The Foundation for Healthy Communities' Behavioral Health Clinical Learning Collaborative

The Behavioral Health Clinical Learning Collaborative ("the Collaborative") at the Foundation for Healthy Communities is a grant-funded statewide program dedicated to improving the care and treatment of patients experiencing behavioral health crises in emergency departments. Funded by the Endowment for Health and the New Hampshire Charitable Foundation, the Collaborative focuses on enhancing the quality and accessibility of behavioral health crisis services. The Collaborative has been instrumental in advancing Mission Zero, an initiative to end psychiatric boarding in hospital emergency departments, and implementing Care Traffic Control, a system designed to streamline the coordination and management of emergency psychiatric care.

Since its inception in 2019, the Collaborative has grown to include over 300 members representing hospitals, community mental health centers, insurance plans, advocacy groups, peer support agencies, and individuals and families with lived experience in emergency rooms. Monthly meetings provide a platform for members to share learning, address challenges, and develop innovative solutions, reinforcing the Collaborative's commitment to strengthening the behavioral health system.

Annual NH Suicide Prevention Conference

The Annual NH Suicide Prevention Conference was held in-person on November 2, 2023 in Concord. The theme for 2023 was Empowering Everyday Helpers. This one day conference began with welcoming remarks and recognition of key community partners and stakeholders... The opening plenary, *Journey Towards Recovery*, featured Dennis Gillan. Dennis shared about his grief journey after losing two brothers to suicide and what he has learned along the way. Dennis is a returning keynote speaker and presented five years ago at the 15th Annual Suicide Prevention Conference.

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, offering evidence-based strategies in responding to individuals at risk for suicide, promoting healing, and reducing risk after a suicide death.

In addition to providing in-person and live virtual Connect suicide prevention and postvention trainings, the Connect eLearning training was well utilized, particularly by schools and health care providers. A total of over 800 seats for Connect eLearning were distributed in 2023, which expanded access to suicide prevention training in NH and other states around the U.S. In NH in 2023, there were 1,088 participants trained in Connect Prevention trainings and 292 in Connect Postvention trainings. Over 300 trainers were trained to help sustain suicide prevention and postvention efforts in their respective organizations.

At the NH Police Academy, more than 200 new recruits received training from NAMI NH 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.

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.

In addition to their work in New Hampshire in 2023, Connect Program staff provided training and consultation in-person and virtually in Arizona, Florida, Massachusetts, Minnesota, Montana, Nebraska, New York, Ohio, Oregon, Virgina, Wisconsin, and the Northern Mariana Islands.

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 around the United States as an in-person workshop, live and self-paced virtual trainings, and a Train the Trainer program.

In 2023, the CALM America website grew as a national resource to promote the CALM training. A version for general audiences, referred to as CALM Conversations, was launched in 2023.

The NH Firearm Safety Coalition

The NH Firearm Safety Coalition (NHFSC) experienced a transition in leadership in 2023 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. The NHFSC is organizing an updated list of firearm dealers in NH for outreach in 2024 to share resources and determine which dealers would be willing to store firearms for a gun owner voluntarily. A rack card providing information on safety with firearms was designed by members of the NHFSC and ready to be produced and offered to gun shops to include with new firearm sales.

2023 DATA UPDATE

2023 Data Update

SPC/YSPA Data Subcommittee
Membership Representation 2023-2024

Injury Prevention Center at Dartmouth Health
NAMI New Hampshire (National Alliance on Mental Illness)
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)[3] 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[4] 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. 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-VDRS data included in this report are limited to NH residents who died in NH. NH-VDRS abstracted data comes from Assistant Deputy Medical Examiner (ADME) investigation reports,

[3] Additional information and national findings from the National Violent Death Reporting System (NVDRS) are available from https://www.cdc.gov/mmwr/volumes/72/ss/ss7205a1.htm.
[4] Disclosure: NH-VDRS funding is from the Centers for Disease Control and Prevention Cooperative Agreement NU17CE010125-02-00.

toxicology, and autopsies reports, all of which are located in the Medical 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, hospital data, and YRBS and BRFSS survey data in this report. Some of this mental health data can also be viewed on the DHHS Data Portal at: https://wisdom.dhhs.nh.gov/wisdom/topics.html?topic=mental-health. The NH DHHS Data Portal hosts information on a broad number of public health topics.

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 over 1.4 million residents (US Census Bureau, 2023). 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[5] and the 23rd highest rate for marijuana use in the past month (National Survey on Drug Use and Health, 2022).

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

Table 1

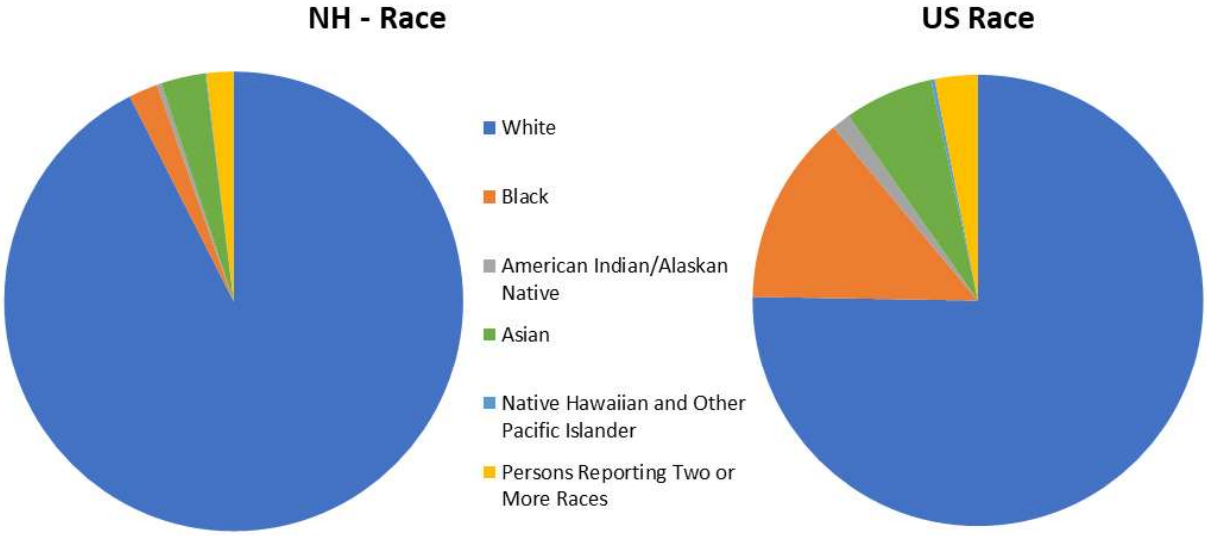
Race/Ethnicity.

	New Hampshire	United States
Race		
White	92.5%	75.3%
Black	2.1%	13.7%
American Indian/Alaskan Native	0.3%	1.3%
Asian	3.1%	6.4%
Native Hawaiian and Other Pacific Islander	0.1%	0.3%
Persons Reporting Two or More Races	1.9%	3.1%
Ethnicity		
Persons of Hispanic or Latino Origin	4.8%	19.5%

Data Source: US Census Bureau 2023

Figure 1

NH and US Race/Ethnicity.



Data Source: US Census Bureau 2023

Table 2

Age.

	New Hampshire	United States
Under 18	17.98%	21.75%
18 to 24	8.55%	9.12%
25 to 44	25.33%	26.85%
45 to 64	27.35%	24.59%
65 to 74	12.51%	10.36%
75 and Up	8.28%	7.33%

Data Source: US Census Bureau 2023

Table 3

Economic Factors.

	New Hampshire	United States
Unemployed Residents	2.4%	3.7%
Persons Below Poverty Level	8.5%	12.5%
Persons Without Health Insurance (under age 65)	5.8%	8.7%
Per Capita Income (Yearly)	$48,250	$41,261
Median Household Income	$90,845	$75,149
Median Home Value (Owner Occupied)	$384,700	$320,900

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	6.2%	10.9%
High School Graduate or Associates Degree	57.2%	57.4%
Bachelor's Degree or Higher	39.0%	34.3%

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	14.42%	14.11%
Alcohol Use – Past Month	58.73%	48.05%
Tobacco Use – Past Month	16.48%	19.07%

Data Source: National Survey on Drug Use and Health, 2021-2022

Table 6

Mental Health Indicators – Individuals Age 18 and Older.

	New Hampshire	United States
Serious Mental Illness – Past Year	5.87%	5.86%
Major Depressive Episode – Past Year	8.76%	8.63%
Had Serious Thoughts of Suicide – Past Year	4.87%	5.04%
Made Any Suicide Plans – Past Year	1.42%	1.45%
Attempted Suicide – Past Year	0.55%	0.67%
Received Mental Health Services – Past Year	26.57%	21.79%

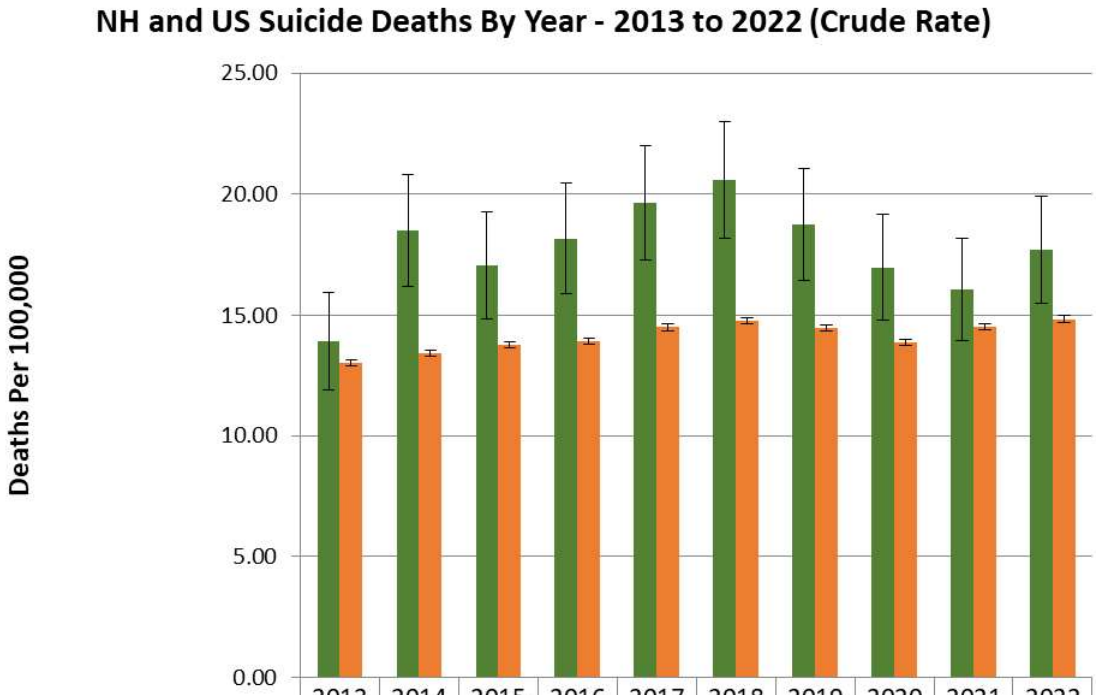
Data Source: National Survey on Drug Use and Health, 2021-2022

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 (below) presents the crude suicide rate in NH and the US for a ten-year period. NH's crude rate of suicide deaths has been higher than that of the US for that period. While NH's crude suicide rate fluctuates from year to year, due to low incidence of suicide deaths, 2014 marked the first time since at least the year 2000 that there had been statistically significant differences in crude rates for one year to the next.. In 2014 there was a spike in the NH rate that brought it significantly above the rate for 2013. 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. Again, none of these were statistically significant changes from the immediately preceding years. This decreased rate in 2019 and 2020 was also present in the rates for the US as a whole.

Figure 2

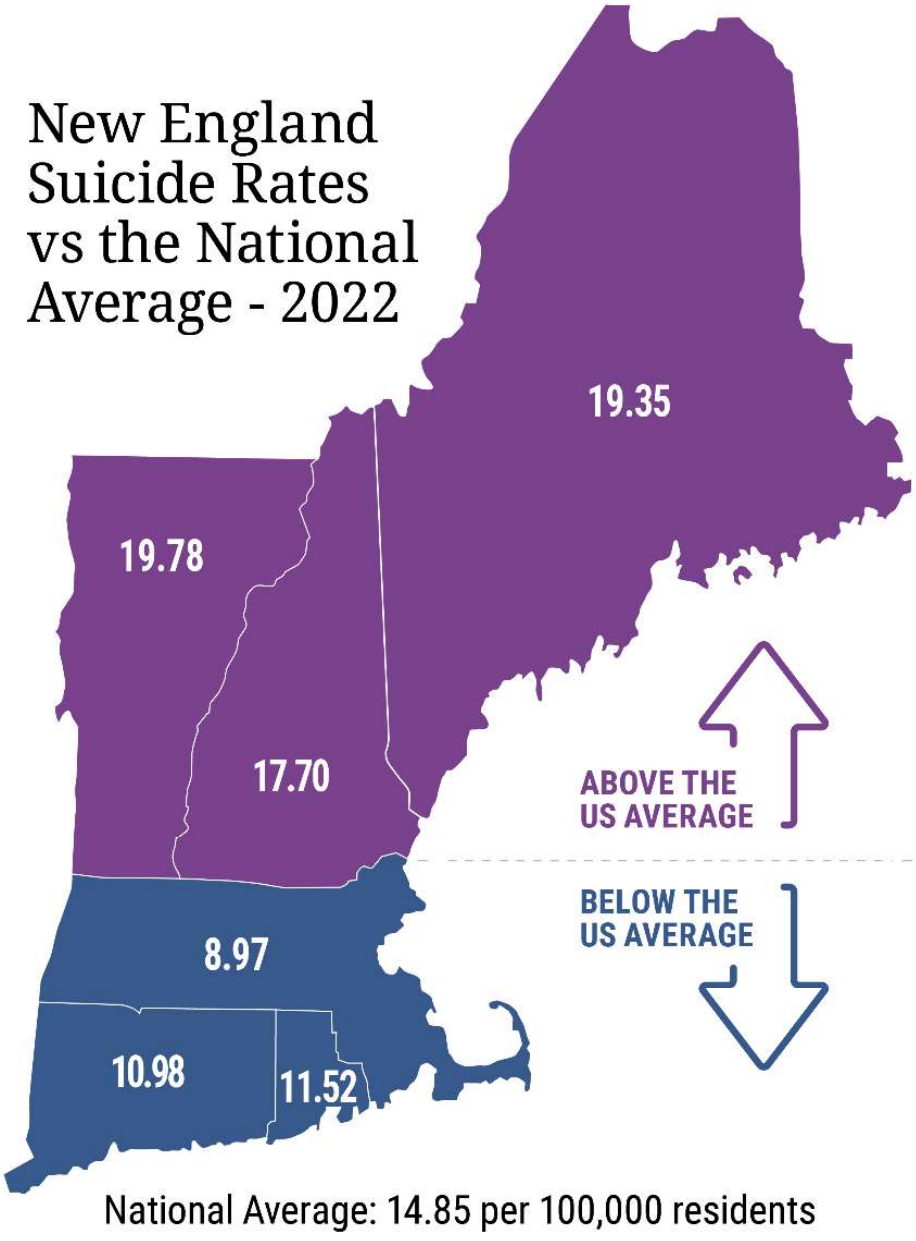


	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
NH Suicide Death Rate	13.94	18.51	17.05	18.16	19.62	20.59	18.74	16.98	16.05	17.70
US Suicide Death Rate	13.02	13.45	13.78	13.92	14.51	14.79	14.47	13.87	14.52	14.84

Data Source: CDC WISQARS

Having a suicide rate above the national average is not isolated to NH. As seen in **Figure 3** (pg. 30), all of the Northern New England states have rates above the national average, while the rates for Southern New England states are below the national average.

Figure 3



Data Source: CDC WISQARS

Table 7 (below) presents NH and US suicide death rates by age group. Adults age 40 to 59 had the highest suicide rates of all age groups identified above (23.64 NH, 18.83 US) from 2018-2022 in NH and the 2nd highest in the US. There is a substantial difference 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.

Table 7

Crude Suicide Death Rates per 100,000 in NH & US, by age group, 2018-2022.

Age Group	New Hampshire	United States
All Ages	18.38	14.43
Youth 10 to 17	5.01	5.00
Young Adults 18 to 24	18.56	16.30
Youth & Young Adults 10 to 24	11.79	10.39
Ages 25 to 39	22.93	18.37
Ages 40 to 59	23.64	18.83
Ages 60 to 74	18.55	16.25
Ages 75 and Over	22.01	19.70

Data Source: CDC WISQARS

Table 8 (below) displays the 10 leading causes of death for people of different age groups in NH. From 2013-2022, suicide was the second leading cause of death for people age 10-34 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 8

10 Leading Causes of Death, New Hampshire, by Age Group, 2013 – 2022.

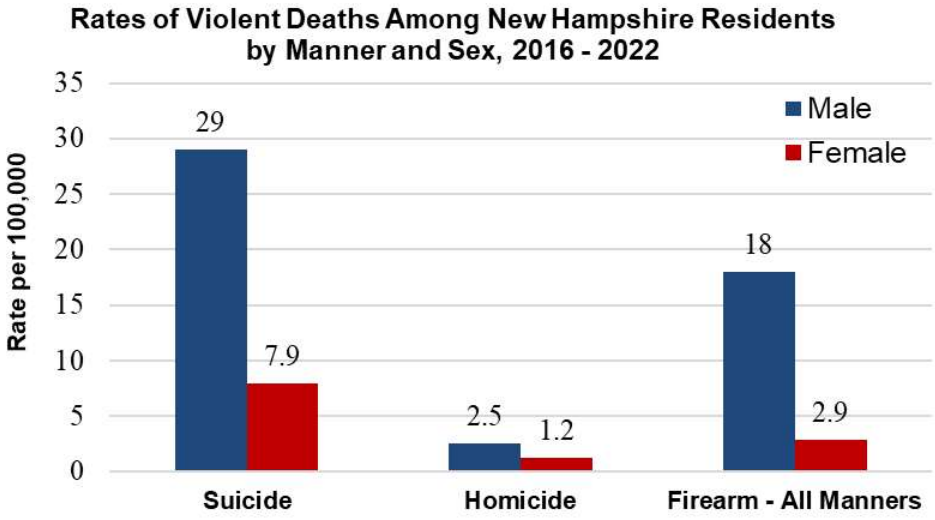
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 80	Unintentional Injury 23	Malignant Neoplasms 14**	Malignant Neoplasms 23	Unintentional Injury 550	Unintentional Injury 1,421	Unintentional Injury 1,242	Malignant Neoplasms 1,675	Malignant Neoplasms 5,177	Heart Disease 22,562	Malignant Neoplasms 27,785
2	Short Gestation 65	Congenital Anomalies 14**	Unintentional Injury 12**	Suicide 19**	Suicide 274	Suicide 383	Malignant Neoplasms 393	Unintentional Injury 1,148	Heart Disease 2,824	Malignant Neoplasms 20,329	Heart Disease 26,924
3	Maternal Pregnancy Comp. 38	Homicide 10**	Homicide --	Unintentional Injury 12**	Heart Disease 39	Malignant Neoplasms 125	Suicide 359	Heart Disease 1,131	Unintentional Injury 998	Chronic Low. Respiratory Disease 6,091	Unintentional Injury 8,661
4	Placenta Cord Membranes 32	Malignant Neoplasms --	Benign Neoplasms --	Congenital Anomalies --	Malignant Neoplasms 38	Heart Disease 102	Heart Disease 250	Suicide 509	Chronic Low. Respiratory Disease 780	Cerebrovascular 4,562	Chronic Low. Respiratory Disease 7,077
5	Sids 29	Heart Disease Influenza & Pneumonia --	Congenital Anomalies --	Benign Neoplasms --	Homicide 29	Liver Disease 39	Liver Disease 140	Liver Disease 385	Liver Disease 622	Alzheimer's Disease 4,347	Cerebrovascular 5,107
6	Respiratory Distress 17**		Heart Disease --	Influenza & Pneumonia --	Congenital Anomalies 10**	Homicide 27	Diabetes Mellitus 54	Diabetes Mellitus 211	Diabetes Mellitus 565	Unintentional Injury 3,245	Alzheimer's Disease 4,418
7	Circulatory System Disease 15**	Benign Neoplasms Covid-19 Diabetes Mellitus Septicemia --	Acute Bronchititis Cerebrovascular Diseases Of Appendix Influenza & Pneumonia --	Chronic Low. Respiratory Disease Heart Disease Nephritis Perinatal Period Pneumonitis --	Cerebrovascular Chronic Low. Respiratory Disease --	Cerebrovascular Diabetes Mellitus 19**	Cerebrovascular 38	Chronic Low. Respiratory Disease 146	Suicide 422	Diabetes Mellitus 2,809	Diabetes Mellitus 3,467
8	Intrauterine Hypoxia 14**						Homicide 35	Cerebrovascular 144	Cerebrovascular 329	Covid-19 2,129	Covid-19 2,506
9	Unintentional Injury 12**				Diabetes Mellitus --	Congenital Anomalies 18**	Covid-19 34	Covid-19 87	Covid-19 238	Influenza & Pneumonia 1,855	Suicide 2,407
10	Bacterial Sepsis 11**				Influenza & Pneumonia --	Chronic Low. Respiratory Disease 17**	Chronic Low. Respiratory Disease 32	Septicemia 62	Septicemia 177	Nephritis 1,618	Influenza & Pneumonia 2,054

** indicates unstable value (<20 deaths);
-- indicates suppressed value; (between one to nine deaths or nonfatal injury counts based on <20 unweighted count, <1,200 weighted count, or coefficient of variation of the estimate >30%);
--* 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

Violent deaths include deaths from suicide, homicide, and firearm-related deaths, regardless of intent. The vast majority of violent deaths in NH are suicides. For every homicide in NH, there are approximately 11 suicide deaths. This ratio is in sharp contrast to national statistics, which show approximately 2 suicide deaths for every homicide. (CDC WISQARS, 2018-2022). The breakdown of violent deaths in NH by sex is presented below in **Figure 4**. This shows that males die of violent deaths of all manners at rates greater than those for females.

Figure 4



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

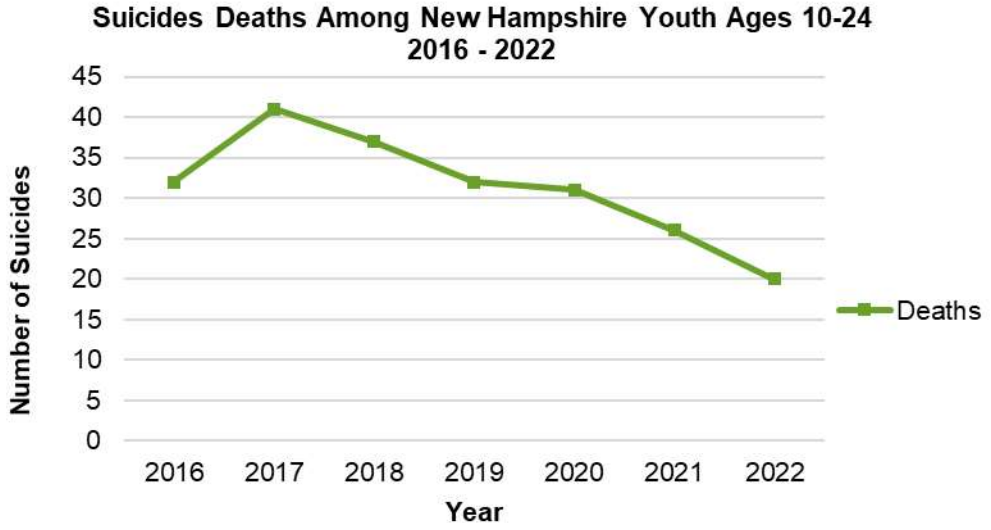
Youth and Young Adult Suicide in NH

Between 2018 and 2022, 219 NH youth and young adults aged 10-24 lost their lives to suicide. Males in this age group are much more likely to die by suicide in NH (77% of all suicide deaths among individuals aged 10-24 were male) and nationwide (79% of all suicide deaths among individuals aged 10-24 were male)[6]. Firearms were the most frequently used method in NH and nationally among youth and young adults who died by suicide during this period. The next most frequently used method among this age group was hanging[7].

Table 9 (pg. 36) presents the number of suicide deaths by year. This year-by-year data has been plotted in **Figures 5 and 6** (pg. 34). 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.

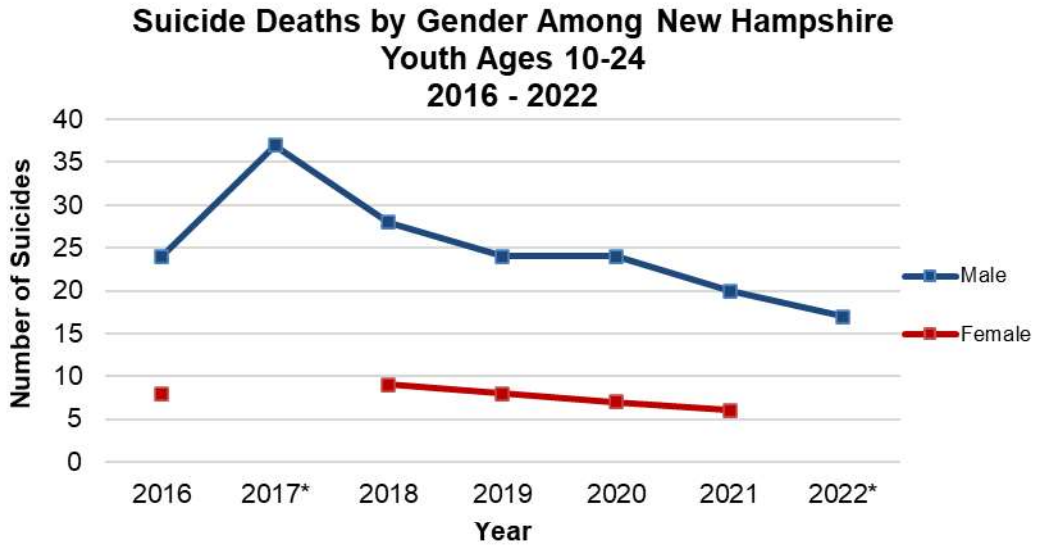
[6] CDC WISQARS
[7] CDC WISQARS

Figure 5



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

Figure 6



* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.

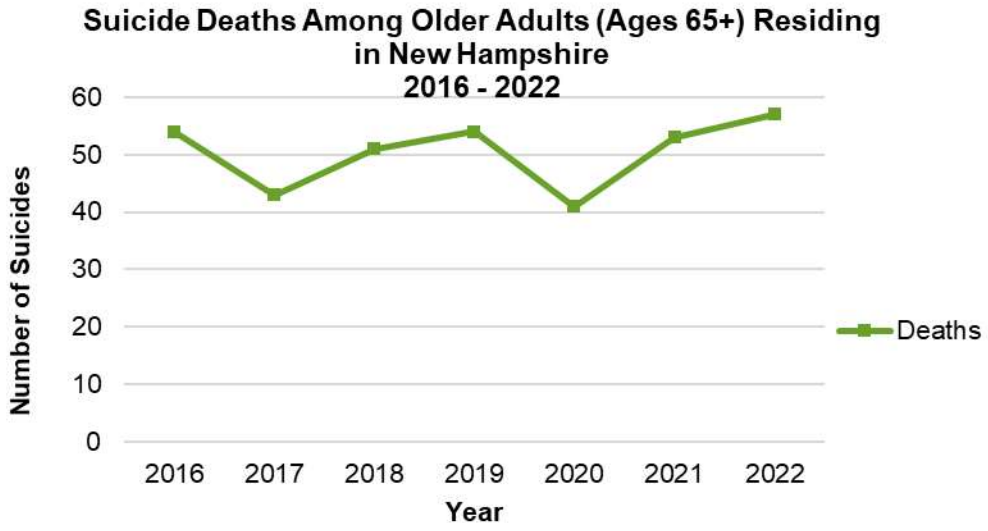
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

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 use disorders. Untreated mental illness such as depression is a significant risk factor for suicide at 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 driver of suicide deaths among older adults is lethality rate, which is markedly higher for people over 65 years of age 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 factor 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).[8]

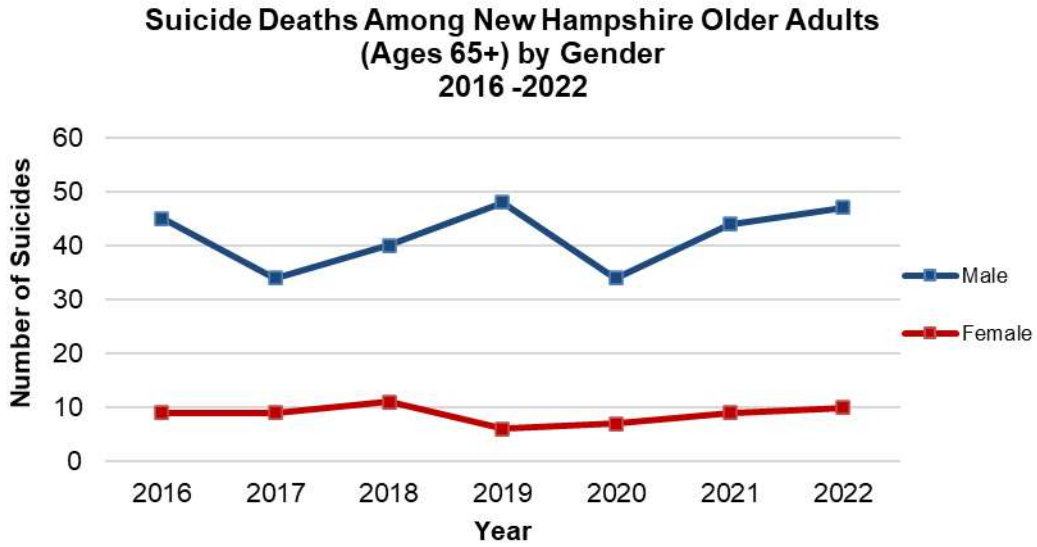
Figure 7



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

[8] 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 8



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 2016 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 9** (pg. 37) and **Figure 10** (pg. 37).

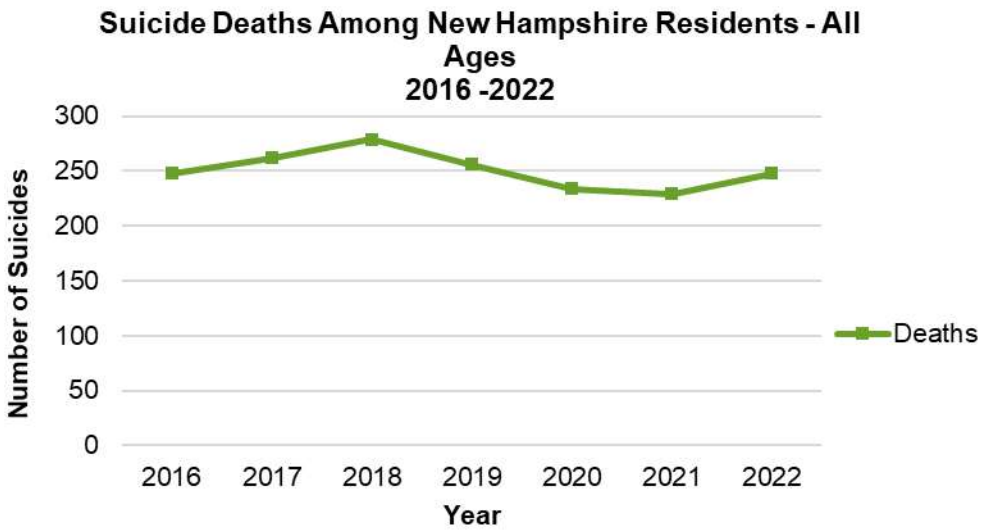
Table 9

NH All Ages Suicide Death Trend, by Sex, Age Group and Method, 2016-2022.

Year	Total	Male	Female	10-24	25-64	65+
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
2022	248	195	53	20	171	57
Total	1756	1374	382	219	1184	353
Percent of Total	100%	78%	22%	12%	67%	20%

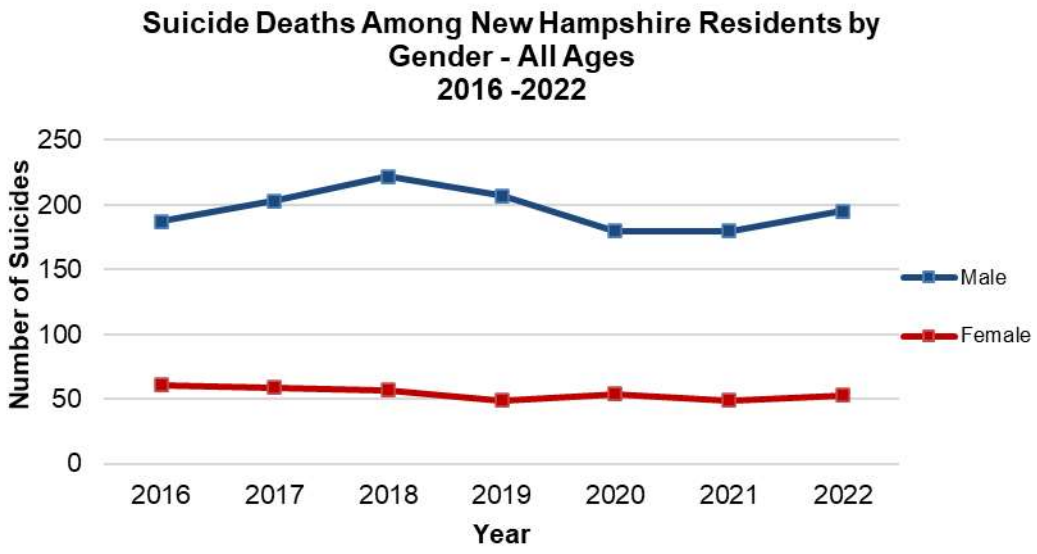
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 9



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

Figure 10

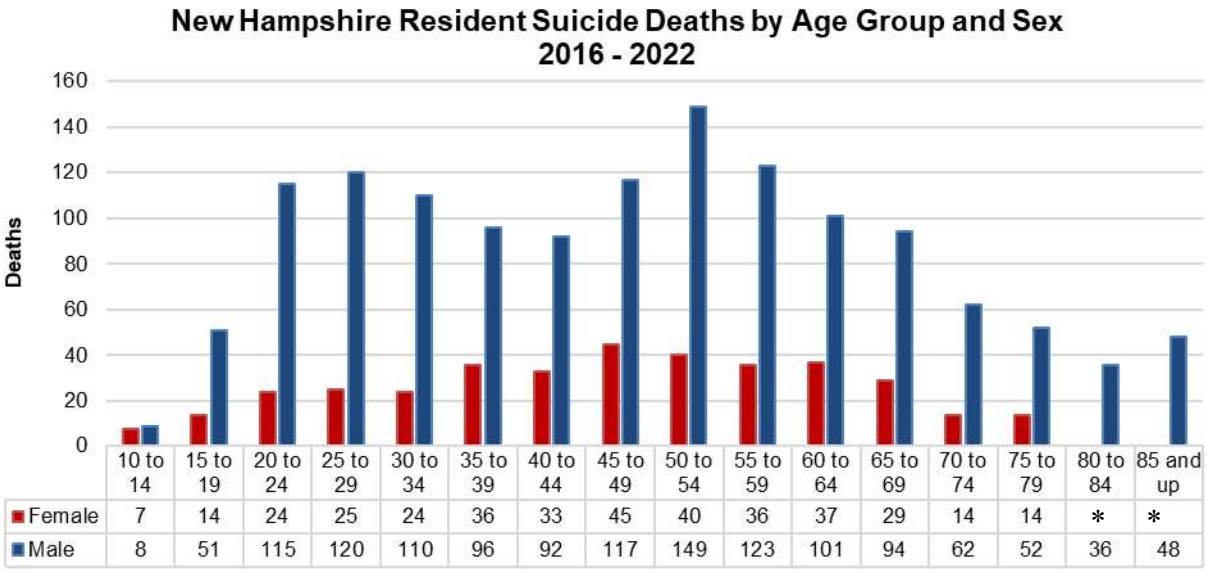


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 11 (pg. 39) and **Figure 12** (pg. 39), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and sex from 2016-2022. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal how death rates adjust for differences in the number of people in each age group. While the highest number of suicide deaths occur in the 55 to 59 year-old age groups, the highest rates, are males over the age of 80, making each individual male in this age group at greater risk. The age group at second highest risk is 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.

Suicide death rates are 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.

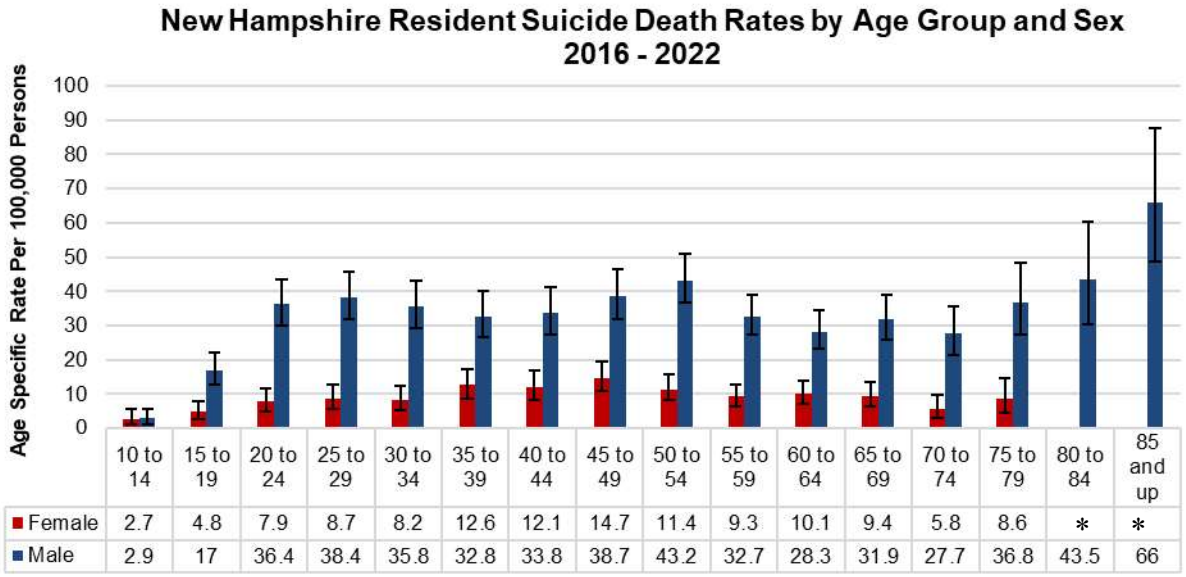
Figure 11



	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	7	14	24	25	24	36	33	45	40	36	37	29	14	14	*	*
Male	8	51	115	120	110	96	92	117	149	123	101	94	62	52	36	48

* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 12



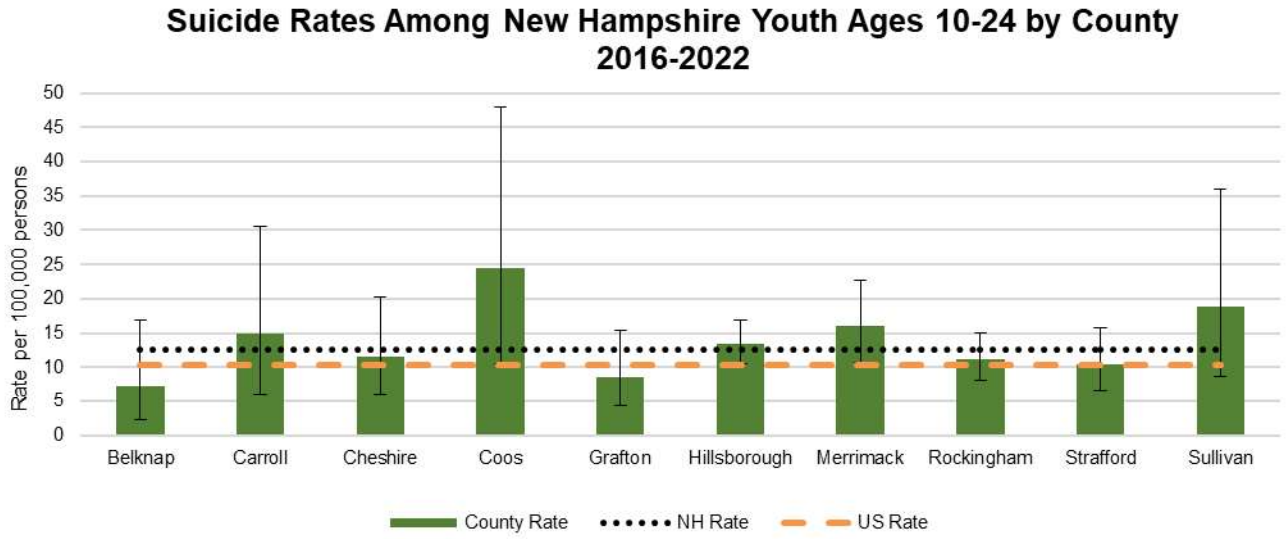
	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 and up
Female	2.7	4.8	7.9	8.7	8.2	12.6	12.1	14.7	11.4	9.3	10.1	9.4	5.8	8.6	*	*
Male	2.9	17	36.4	38.4	35.8	32.8	33.8	38.7	43.2	32.7	28.3	31.9	27.7	36.8	43.5	66

* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Geographic Distribution of Suicide in NH

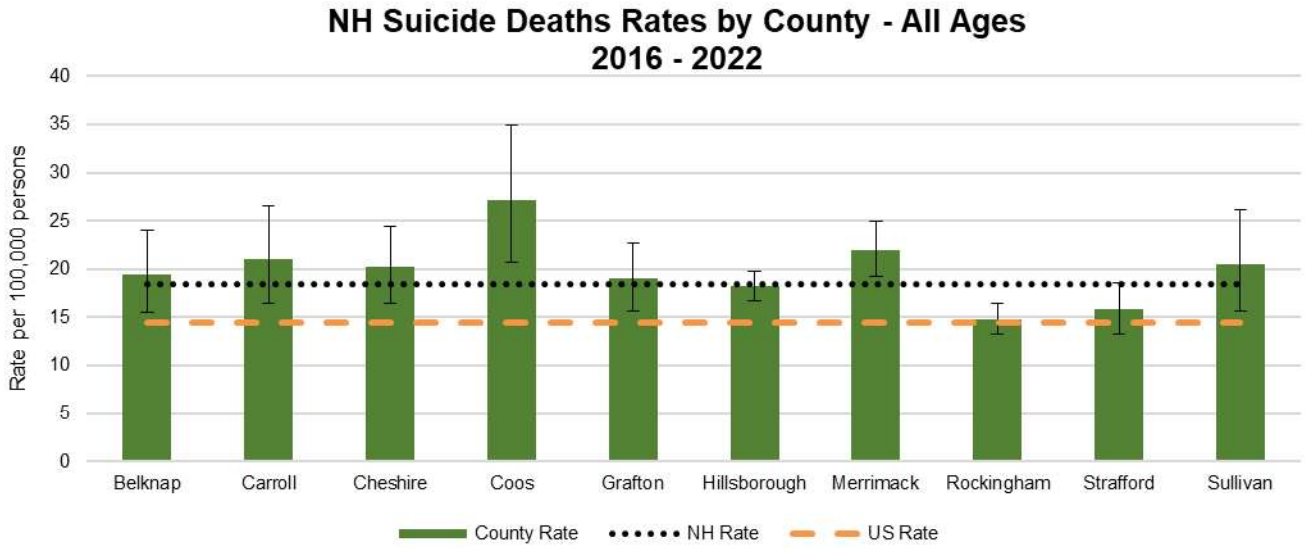
The numbers and rates of suicide in NH are not evenly distributed throughout the state. **Figure 13** (pg. 41) shows youth and young adult suicide rates by county in NH. **Figure 14** (pg. 41) presents this data for NH residents of all ages. The county suicide death rate chart indicates geographical 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 14 –** pg. 41) for Rockingham County (all-ages rate: 14.8 per 100,000) and Strafford County (all-ages rate: 15.8 per 100,000) are significantly lower than the all-ages suicide rates for Coos County (all-ages rate: 27.2 per 100,000) and Merrimack County (all-ages rate: 22.0 per 100,000). County limits are not absolute. A suicide death that occurs in one county can have a strong effect on neighboring counties or across the state, due to the mobility of residents. **Figure 15** (pg. 42) presents the suicide rates for all-ages from 2016 to 2022 as a NH map broken down by county.

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



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 15
Map of NH suicide death rates

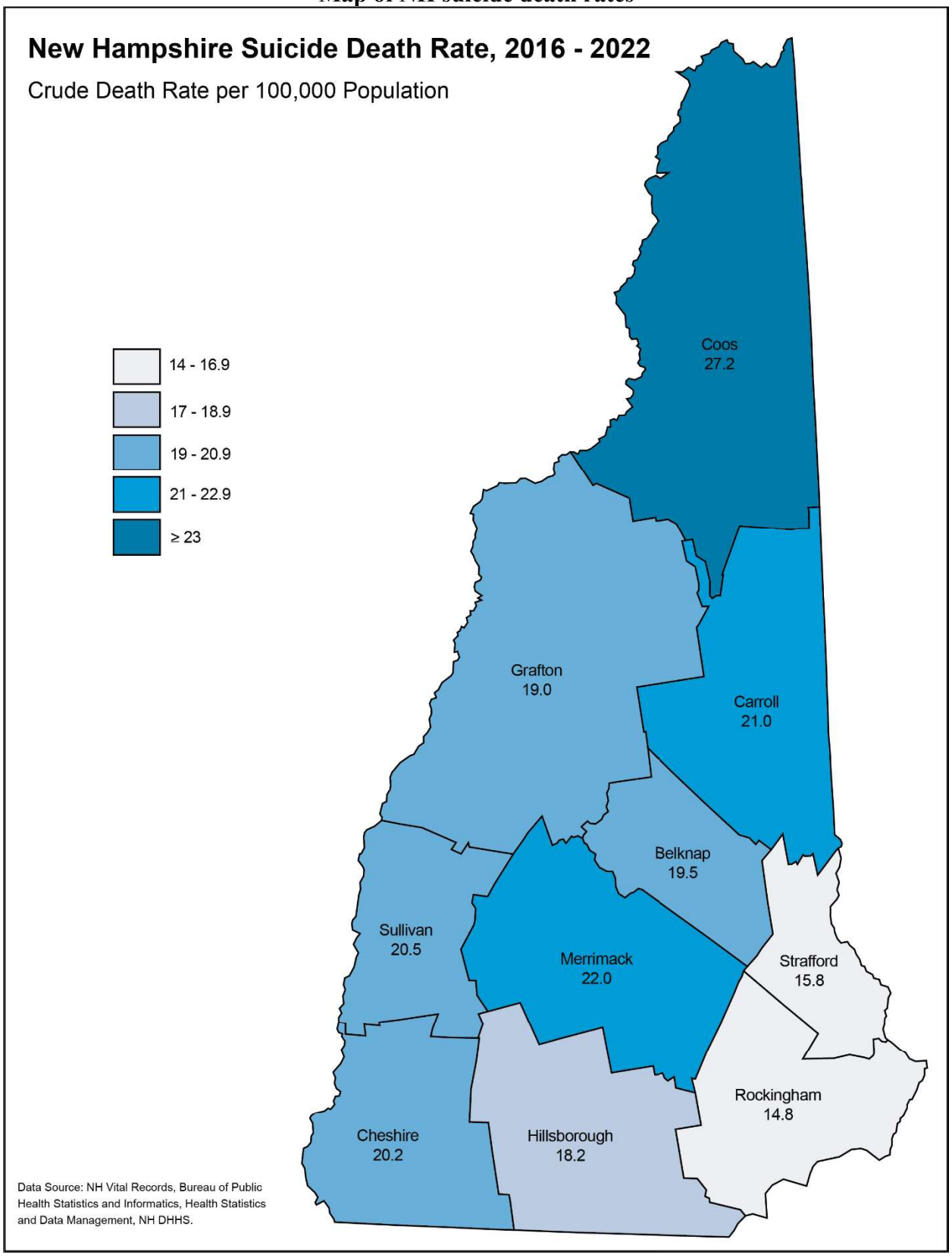


Table 10 (below) further expands upon this county breakdown by presenting the rates of suicide deaths in each county by sex. In the majority of counties, the ratio is three to four male deaths for every one female death. The exceptions to this include Coos County and Sullivan County where the ratios are 5 (Coos County) and 6 (Sullivan County) 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
2016 – 2022
Suicide Death Rates by Sex in NH Counties

County	Female Rates per 100,000	Male Rates per 100,000	Rate Ratio	Male to Female Suicide Death Ratio in County
Belknap	9.1	30.1	3.3	3:1
Carroll	8.6	33.7	3.9	4:1
Cheshire	9.2	31.6	3.4	3:1
Coos	8.6	43.9	5.1	5:1
Grafton	8.8	29.4	3.3	3:1
Hillsborough	8.9	27.5	3.1	3:1
Merrimack	9.3	35	3.8	4:1
Rockingham	5.6	24	4.3	4:1
Strafford	6.9	25	3.6	4:1
Sullivan	5.9	35.2	6	6:1

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

Gender Differences in NH[9] – Suicide Attempts, Deaths, and Risk Factors

Youth and Gender

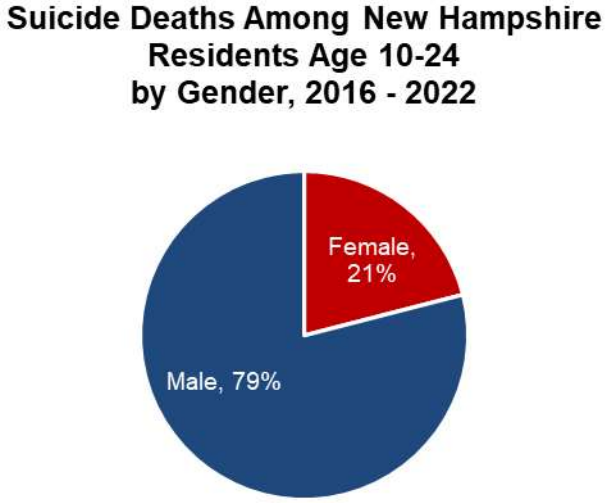
The fact that males represent 79% of the youth and young adult suicide deaths from 2016-2022, may largely be due to males using more lethal means. See **Figures 16** (pg. 44) and **17** (pg. 44). In fact, females *attempt* suicide at a higher rate than males – 1.4-2.1 times as often (**Figure 18 –** pg. 45**, Figure 19 and Figure 20 –** pg. 46). When examining how many NH youth and young adults ages 10-24 were hospitalized and then discharged for self-inflicted injuries in 2018-2022, data shows that females account for 68% of inpatient discharges (**Figure 18 –** pg. 45). Likewise, the 2023 NH Youth Risk Behavior Survey (YRBS) reports approximately twice as many female youth attempt suicide as males each year (10.3% of females and 6.5% of males). Emergency department (ED/ambulatory) data reveals a similar gender ratio, based on self-inflicted injury rates.[10]

[9] 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.

[10] 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.

Figure 16

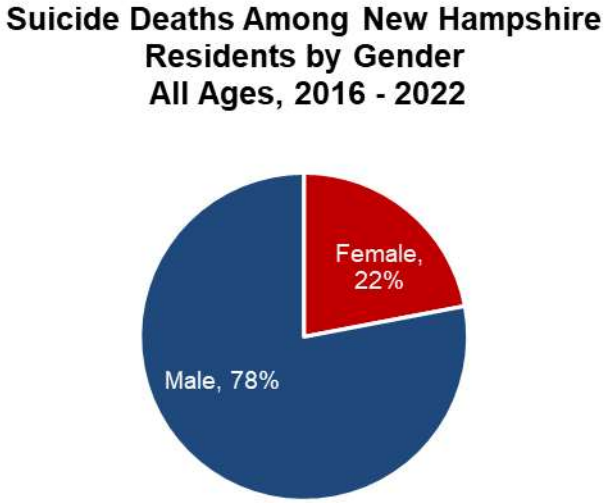
Four times as many male NH residents ages 10-24 died by suicide 2016-2022.



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

Figure 17

Three times as many male NH residents died by suicide than females during 2016-2022.



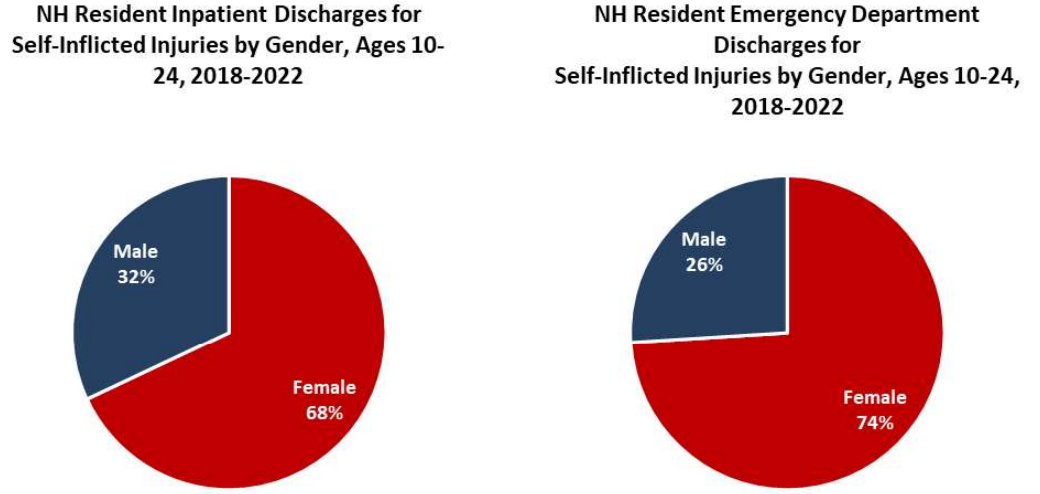
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

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.

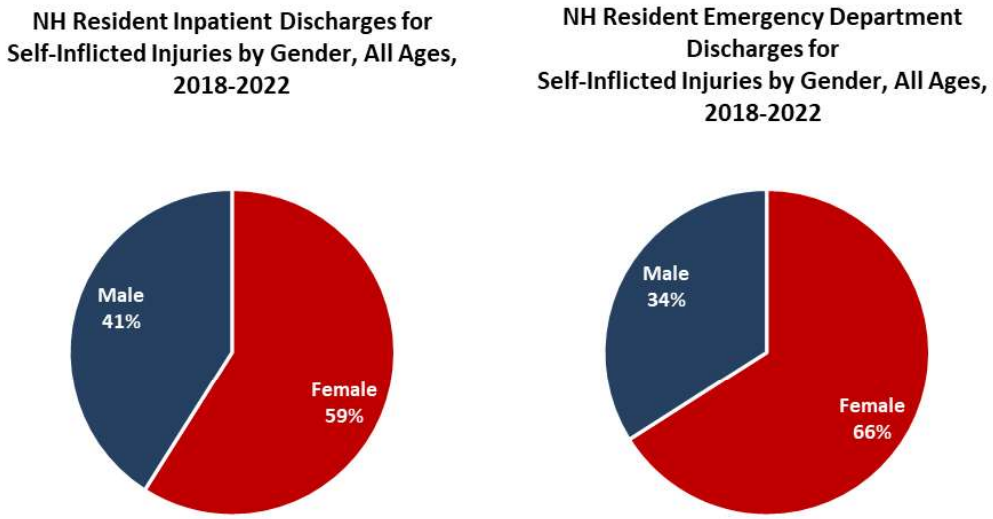
Figure 18

A greater percentage of female than male NH residents attempted suicide, as seen in inpatient and emergency department discharges related to self-inflicted injuries 2018-2022.



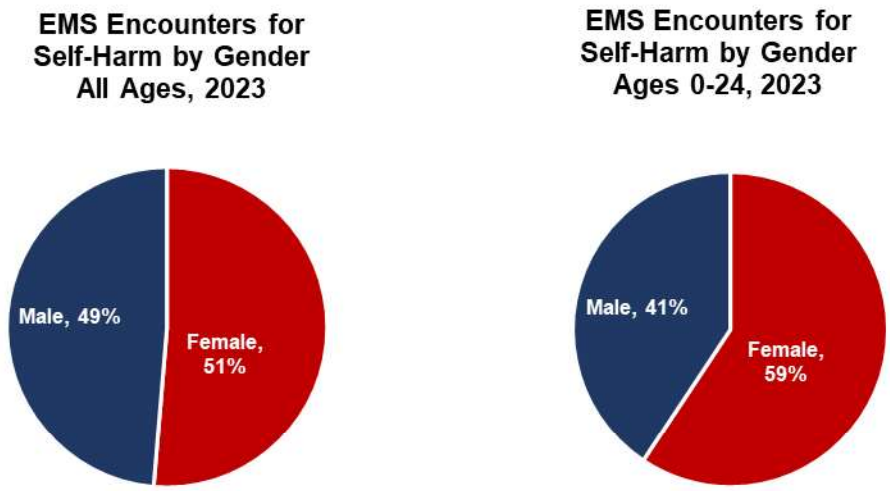
Data Source: NH Uniform Healthcare Facility Discharge Data Set (UHFDDS), Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 19



Data Source: NH Uniform Healthcare Facility Discharge Data Set (UHFDDS), Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 20



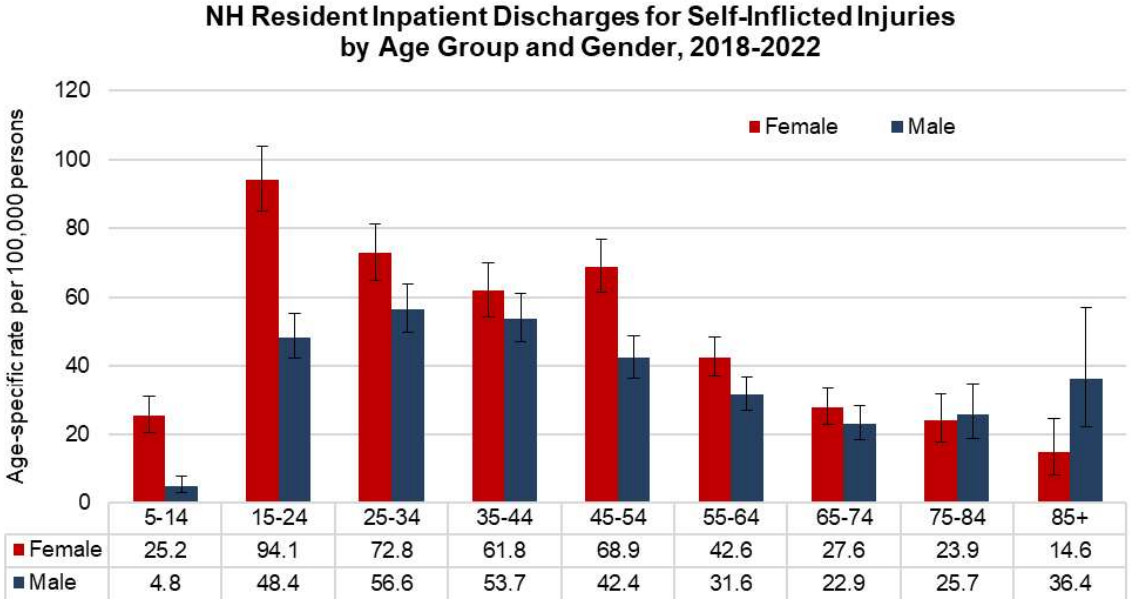
Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

Age, Gender and Self-inflicted Injury

When the rates for NH resident inpatient hospitalizations/discharges and emergency department use for self-inflicted injuries from 2018-2022 are examined by gender and age group, the variability can be seen (**Figure 21 –** below, **Figure 22 –** pg. 48). 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 21 –** below) is 94.1/100,000, 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 22** (pg. 48), 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 545.2/100,000, about 89 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 222.5/100,000. Although male rates peak around this age group, their rates are much lower than those for females. 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 23 –** pg. 48), 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 are equal to or exceed the rates for females in the EMS data.

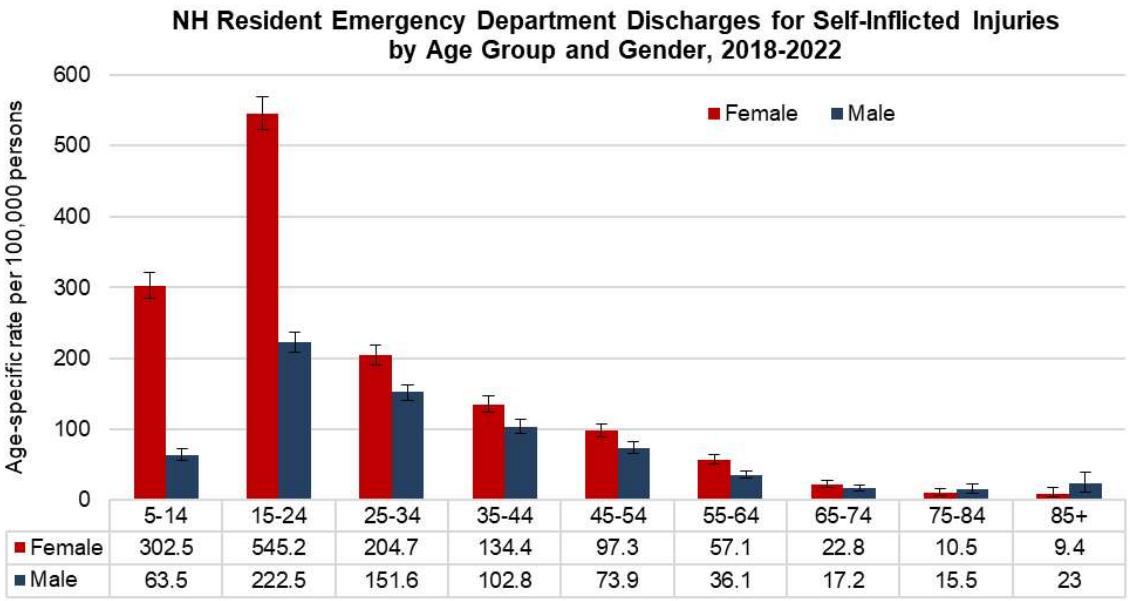
Figure 21



	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	25.2	94.1	72.8	61.8	68.9	42.6	27.6	23.9	14.6
Male	4.8	48.4	56.6	53.7	42.4	31.6	22.9	25.7	36.4

Data Source: NH Uniform Healthcare Facility Discharge Data Set (UHFDDS), Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

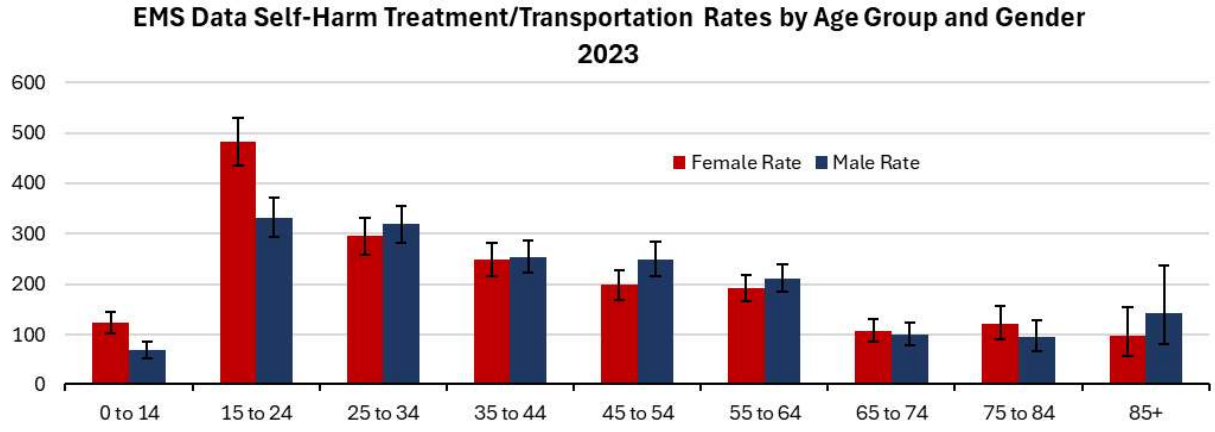
Figure 22



	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	302.5	545.2	204.7	134.4	97.3	57.1	22.8	10.5	9.4
Male	63.5	222.5	151.6	102.8	73.9	36.1	17.2	15.5	23

Data Source: NH Uniform Healthcare Facility Discharge Data Set (UHFDDS), Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 23



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

Comparing rates of inpatient and emergency department (ED) discharges with rates of death by suicide for all ages in NH, there are approximately 9 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 exhibit an even greater ratio of suicide attempts to deaths with nearly 36 attempts per death among individuals aged 10-24, and 28 attempts per death among females of all ages.

In contrast to the above data, which are based on cases where medical intervention is required, the results of the Youth Risk Behavior Survey (YRBS) presents data collected from high school aged youth by self-report (**Figure 59 –** pg. 77). In 2023, 8.5 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 2023 NH high school enrollment figures[11], this is equivalent to over 4,400 high school age youth in NH who may attempt suicide each year. Unlike the inpatient and ED discharge data, the YRBS reports may also include 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 majority of self-inflicted injuries[12] are not fatal, a significant indicator of risk for suicide is a previous attempt. A recently published meta-analysis of the existing literature found that one in five individuals who survive a suicide attempt are at risk for making a subsequent attempt (de la Torre-Luque et al, 2023)[13]. Therefore, any suicide attempt, regardless of 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.

[11] October 2023 NH grades 9-12 total enrollments – 52,241. Source: NH DOE iPlatform Public Reports - https://my.doe.nh.gov/iPlatform/Report/DataReportsSubCategory?reportSubCategoryId=10

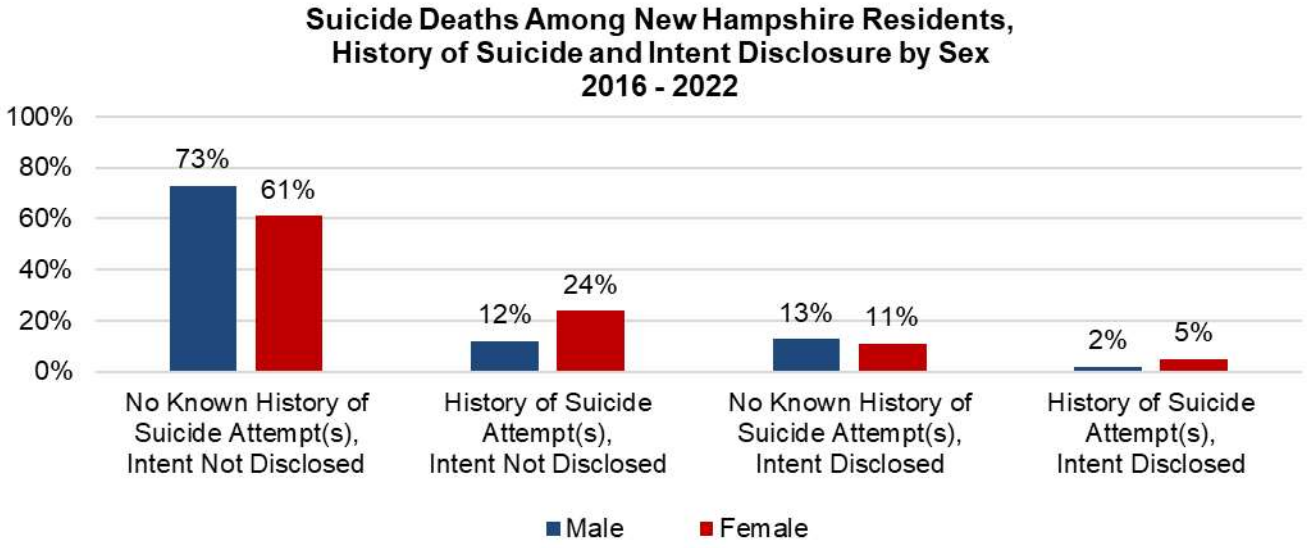
[12] Classifying an injury as self-inflicted is another way of stating that the injury was an instance of deliberate self-harm. Not all self-inflicted injuries necessarily represent suicide attempts. Analysis of these injuries, however, is the best currently available proxy for approximating suicide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

[13] de la Torre-Luque, A., Pemau, A., Ayad-Ahmed, W., Borges, G., Fernandez-Sevillano, J., Garrido-Torres, N., Garrido-Sanchez, L., Garriga, M., Gonzalez-Ortega, I., Gonzalez-Pinto, A., Grande, I., Guinovart, M., Hernandez-Calle, D., Jimenez-Treviño, L., Lopez-Sola, C., Mediavilla, R., Perez-Aranda, A., Ruiz-Veguilla, M., Seijo-Zazo, E., … Ayuso-Mateos, J. L. (2023). Risk of suicide attempt repetition after an index attempt: A systematic review and meta-analysis. General Hospital Psychiatry, 81, 51–56. https://doi.org/10.1016/j.genhosppsych.2023.01.007

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 24 –** below).

Figure 24



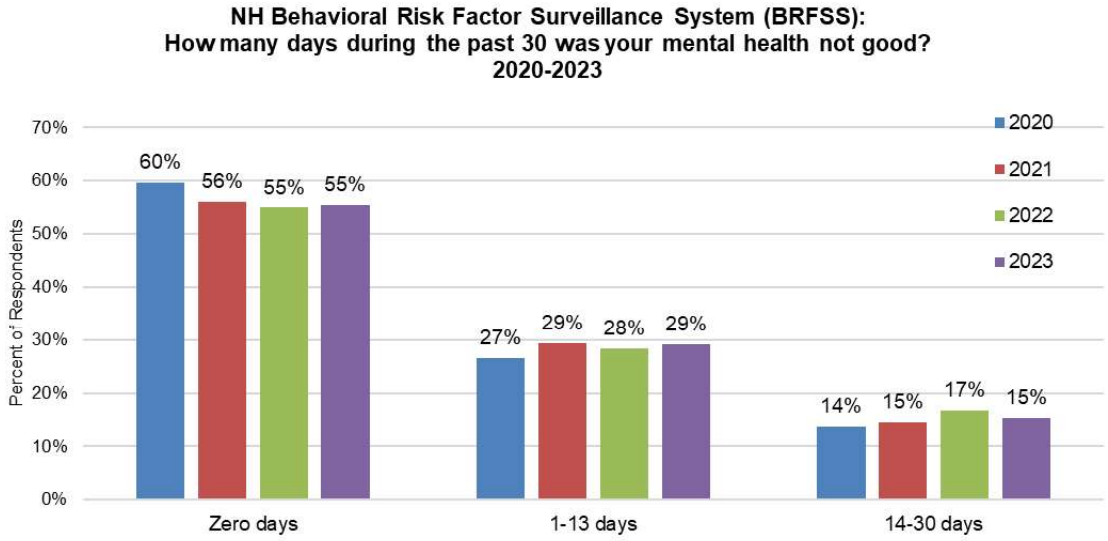
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

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 visit 988Lifeline.org to chat. **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 non-institutionalized state residents age 18 years and older. 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 25** (below).

Figure 25



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

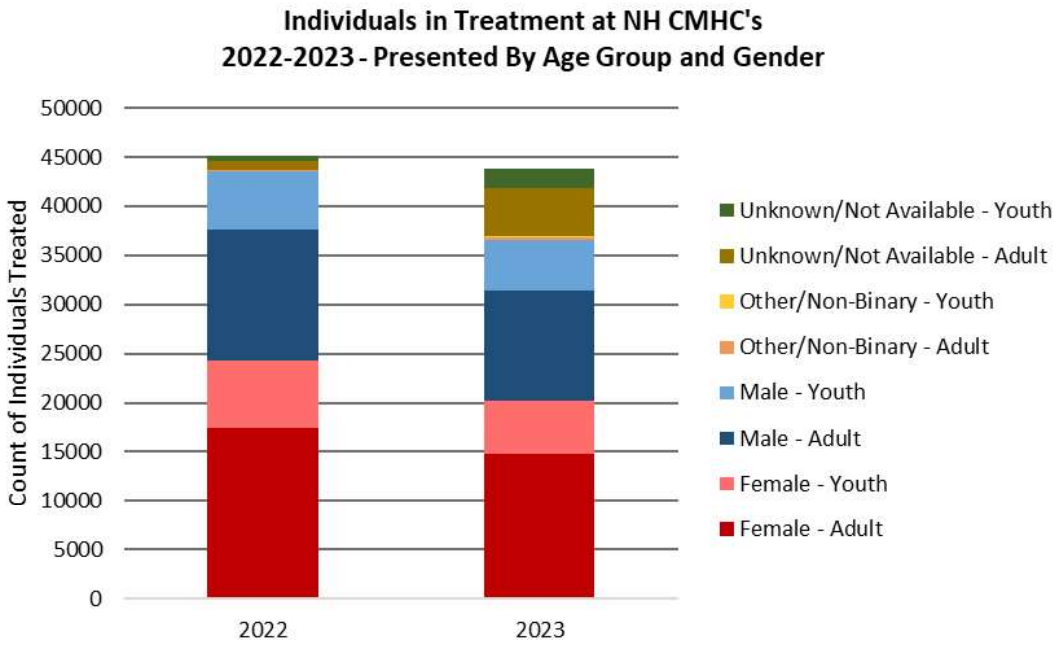
A 2018 CDC report indicated that approximately half of individuals who take their own life had a mental health diagnosis, the most common diagnoses being depression, anxiety, and substance use disorders. Yet a much smaller percentage (35.8%) had ever received treatment[14]. As shown in **Figure 26** (pg. 52), in 2023, over 43,500 people received treatment at one of the state's ten Community Mental Health Centers (CMHC)[15]. This works out to approximately 1 out of every 32 residents in the state. Of those individuals in treatment, approximately 46% of them were female and 37% were male, 1% identified as other/non-binary, and 15% of individuals chose not to

[14] 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.

[15] 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 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

disclose or the information was otherwise unavailable[16]. 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 26
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 people involuntarily admitted due to potential suicide risk, will generally be admitted to New Hampshire Hospital, NH's state psychiatric hospital, or another Designated Receiving Facility. **Figure 27** (pg. 53) presents data from a new Mission Zero adult mental health dashboard addressing inpatient care and coordination. This includes the number of individuals waiting in NH emergency departments for an involuntary acute psychiatric bed, and the average number of days those individuals waited before being accepted at one of the Designated Receiving Facilities. The public facing dashboard featured in **Figure 27** is regularly updated and can be accessed on the NH DHHS Data Portal.[17]

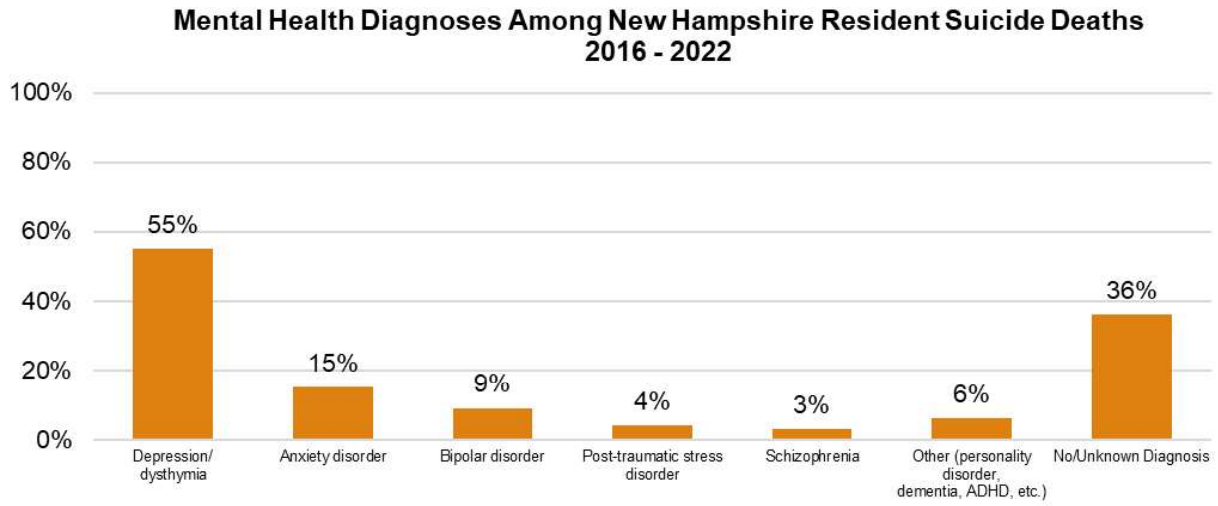
[16] Individuals identifying as transgender have been counted within the category for their reported gender identity (i.e., transgender males are counted within the male categories and transgender females within the female categories).
[17] Live dashboard access: https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=mental-health&subtopic=mission-zero-adult-mental-health&indicator=mission-zero-inpatient-care-and-coordination

Figure 27
NH Mission Zero Data Dashboard – Inpatient Care & Coordination

Data Source: NH DHHS Data Portal

Figure 28 (pg. 54) 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 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 28

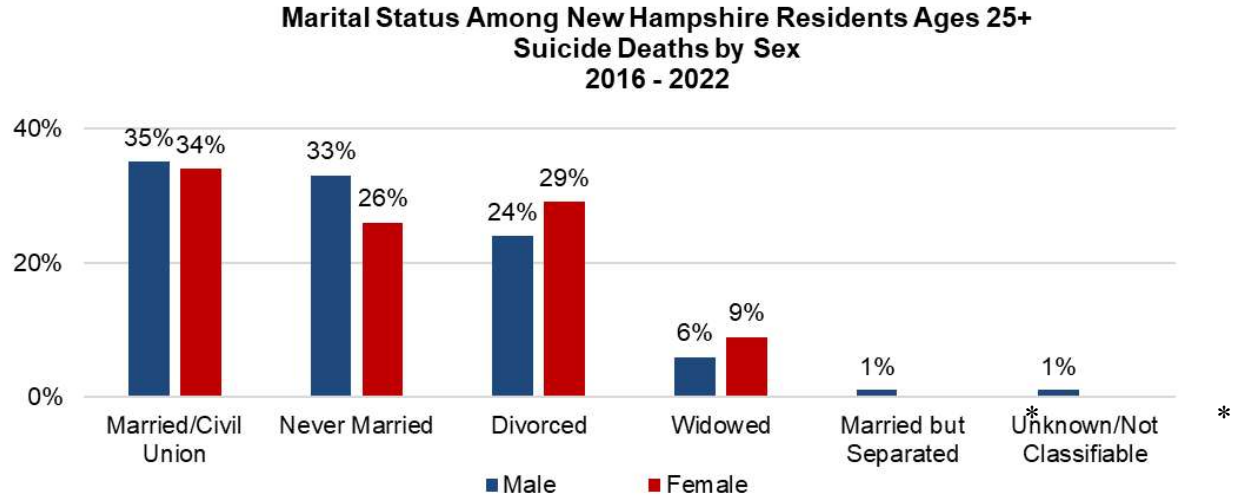


Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Additional Demographic Characteristics of Individuals in NH Who Died by Suicide

Additional demographic factors are correlated with suicide. **Figure 29** (below) presents the marital status of individuals who died by suicide in NH between 2016 and 2022. While approximately 51% of individuals in NH are married and 12% are divorced[18], only 36% of individuals who died by suicide in NH were married and 25% were divorced.

Figure 29

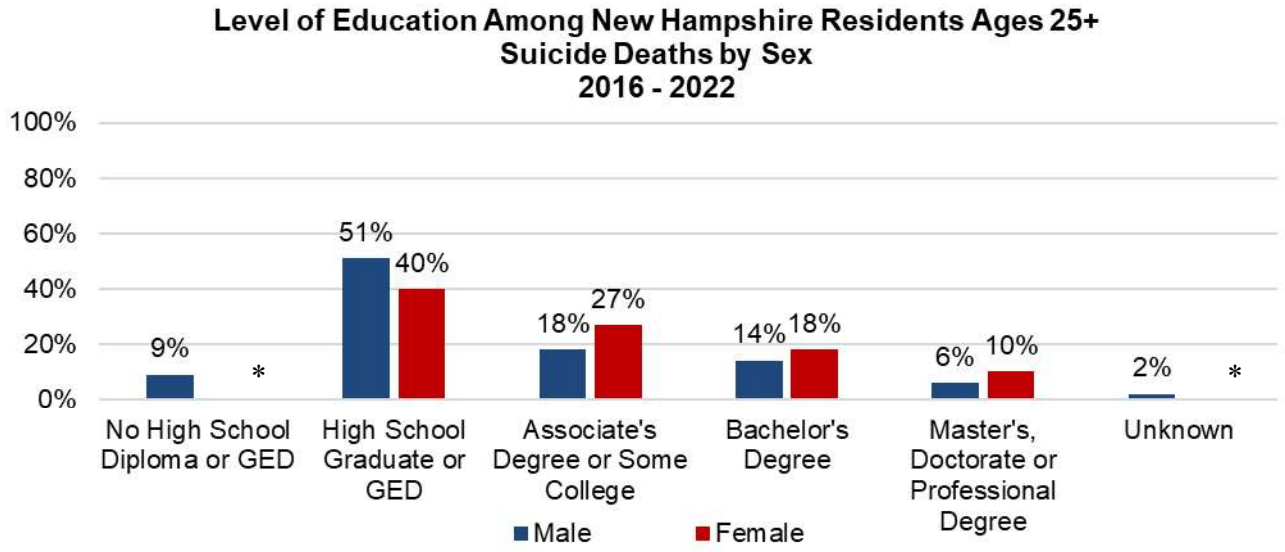


* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

[18] 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. 28), while only 20% of male and 28% 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 male suicide deaths[19]. Nationally, higher levels of education are generally correlated with higher income and lower levels of unemployment[20]. 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



* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS

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

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. In 2023 the SPC Data Subcommittee initiated the process to repeat the survey again in 2024 through the UNH Survey Center. This process was completed in May 2024.

The results from the survey are presented below in **Figures 31 – 36** (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[21]. Due to the shift in methodology the survey included data from approximately 930 respondents in 2022 and approximately 1,180 respondents in 2024 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.

While the results for 2022 and 2024 are similar, they differ from what was found in prior years with fewer individuals selecting the "Strongly Agree" category and more selecting the "Somewhat Agree" category (**Figures 32, 34, and 35 -** pgs. 57-59). 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 and 2024, these results still show the majority of respondents agreeing with the statements in **Figures 32, 34, and 35** (pgs. 57-59).

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

Figure 31

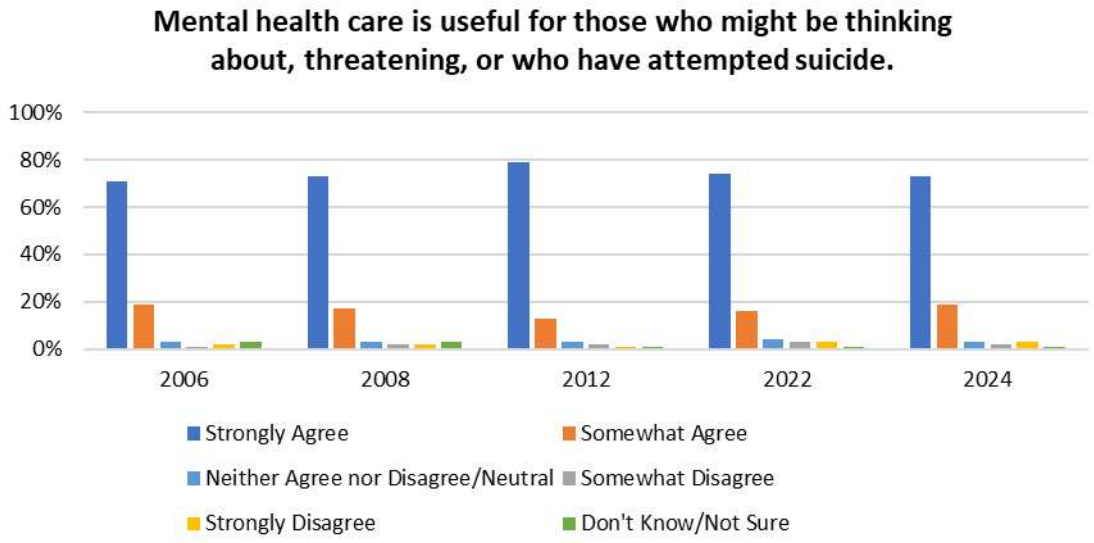
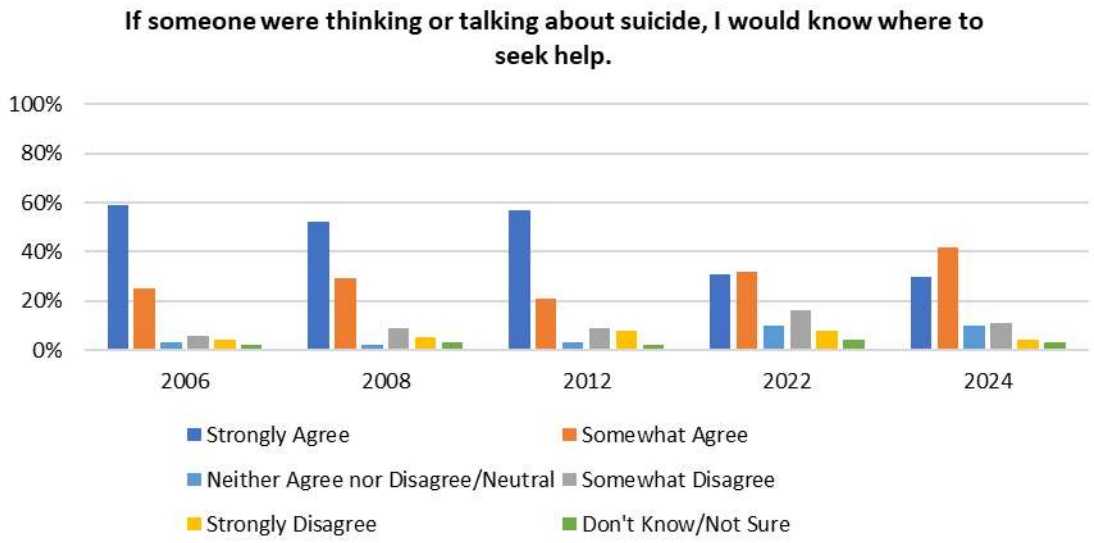


Figure 32



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

Figure 33

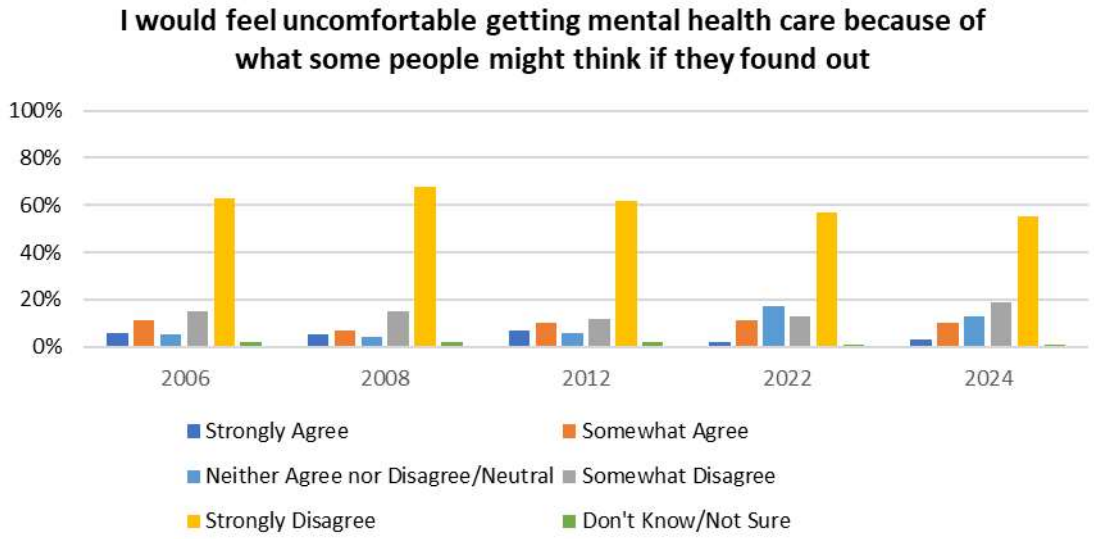


Figure 34

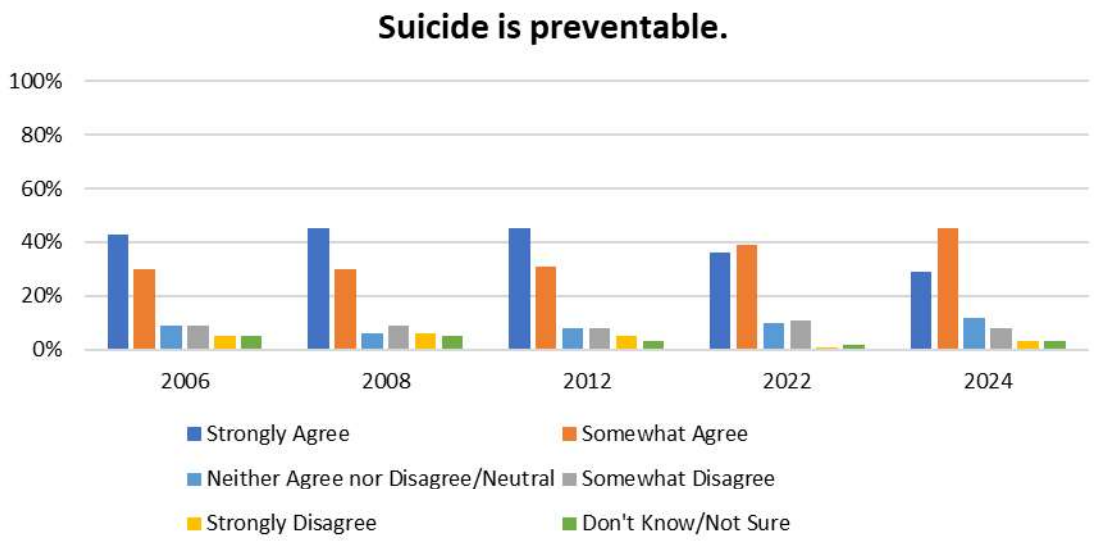
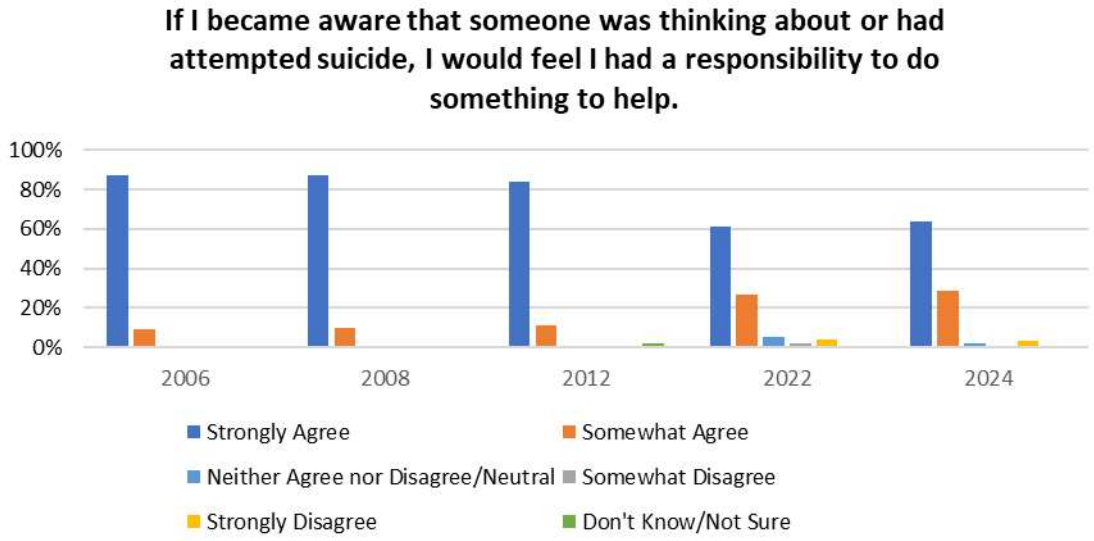
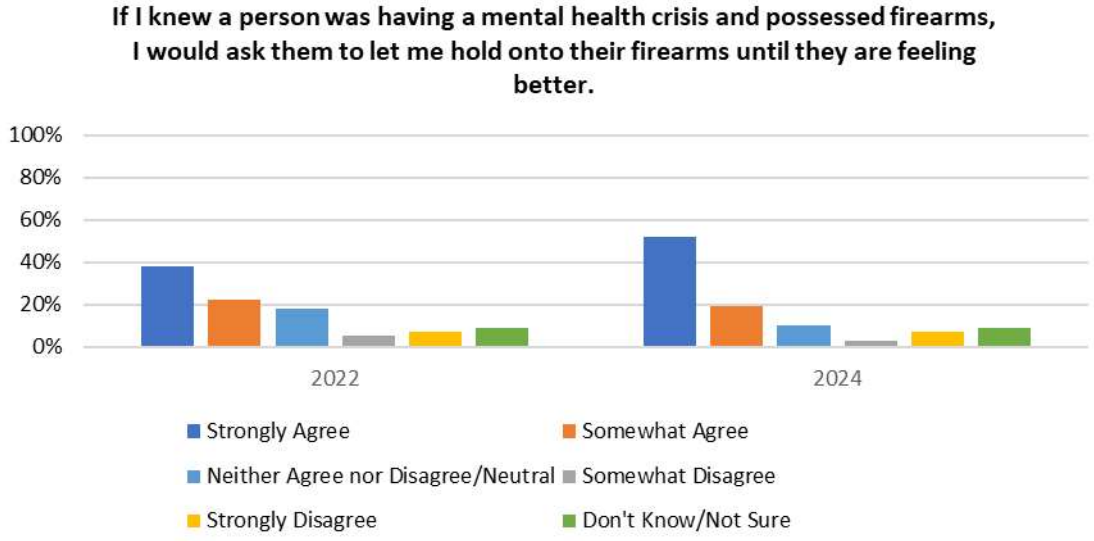


Figure 35



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 36



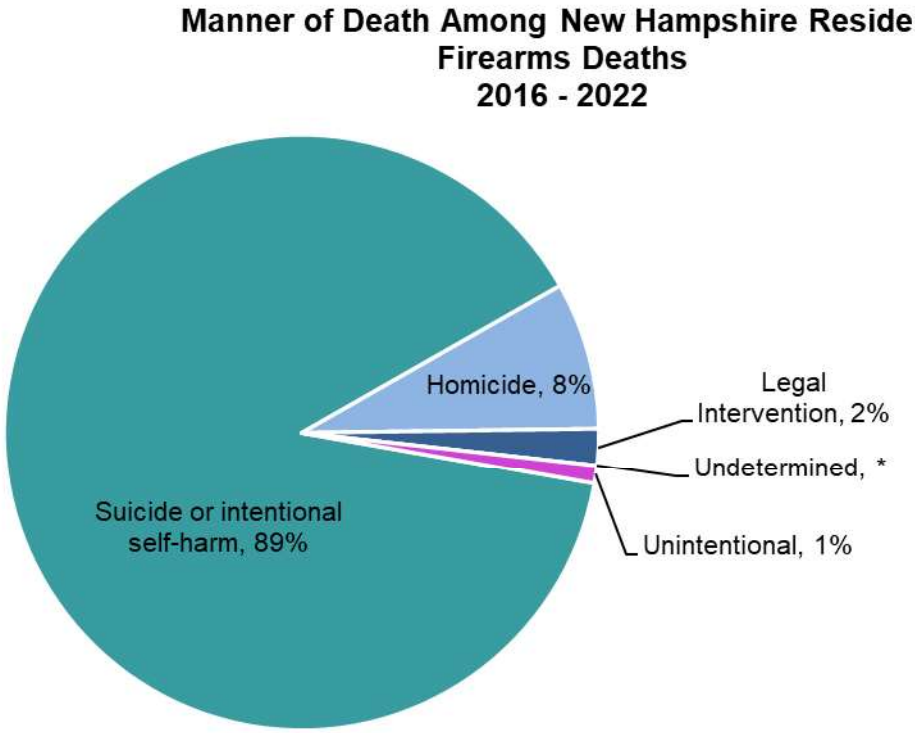
2006-2012 question wording: Not applicable – This question was first included in 2022.

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 (ages 10-24) who died by suicide between 2016 and 2022, 56% used firearms compared to 18% of females (**Figure 39 –** pg. 61). This gender disparity in firearm use decreases between the ages of 25 and 64 with 52% of males and 31% of females using firearms. The proportion of firearm deaths increases sharply after age 65 for males, with 70% of the suicide deaths in that age group involving a firearm. In NH, the vast majority of deaths involving a firearm are suicide. This can be seen in **Figure 37** (below).

Figure 37

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



* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

Suicide attempt methods have varying lethality. **Figures 40 and 41** (pg. 62) compare 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. 63) 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 (**Figures 38** and **39 –** below).

Figure 38

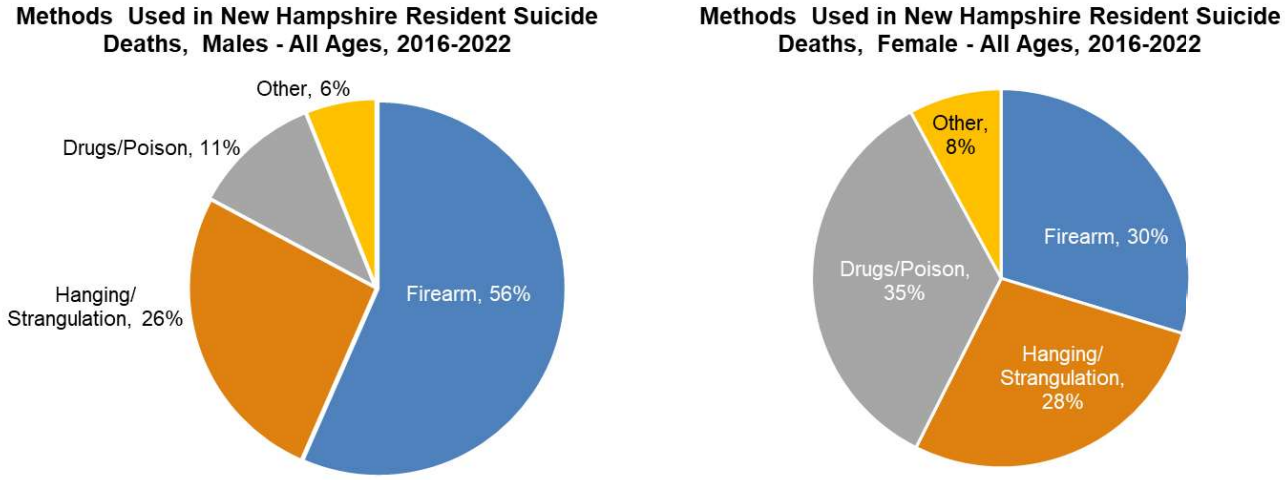
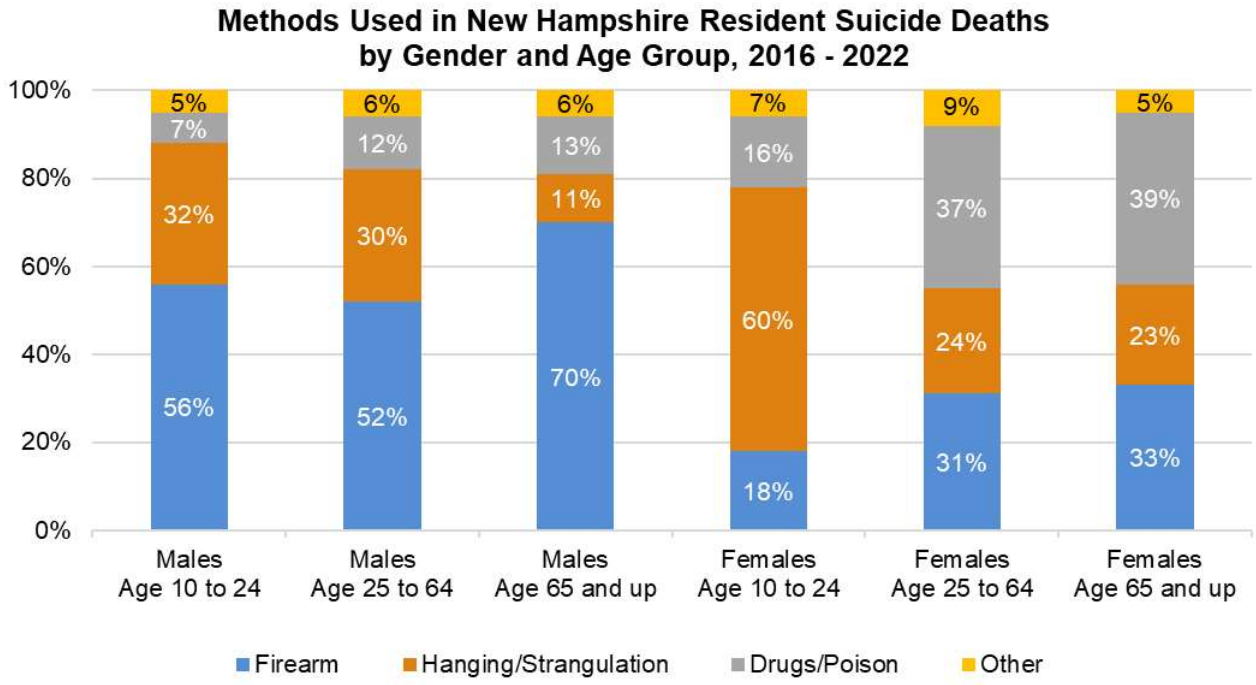
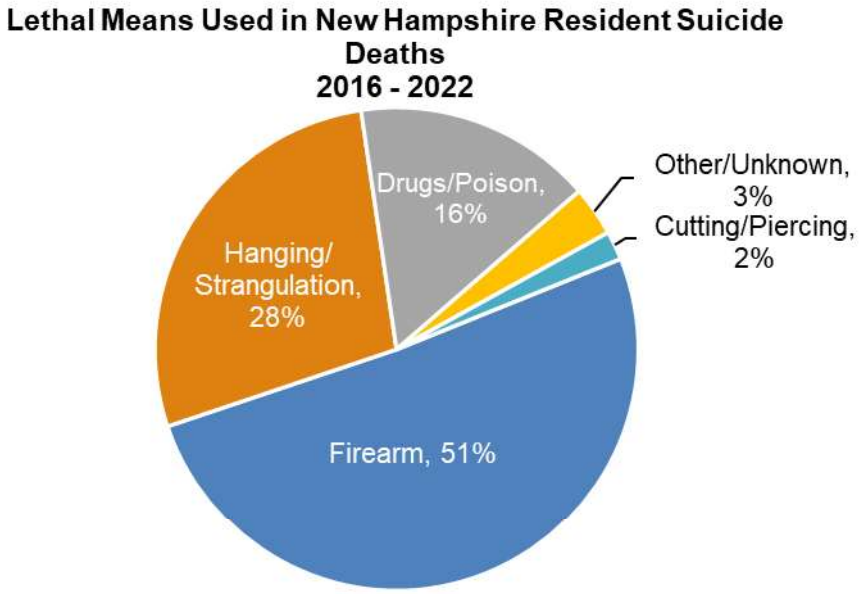


Figure 39



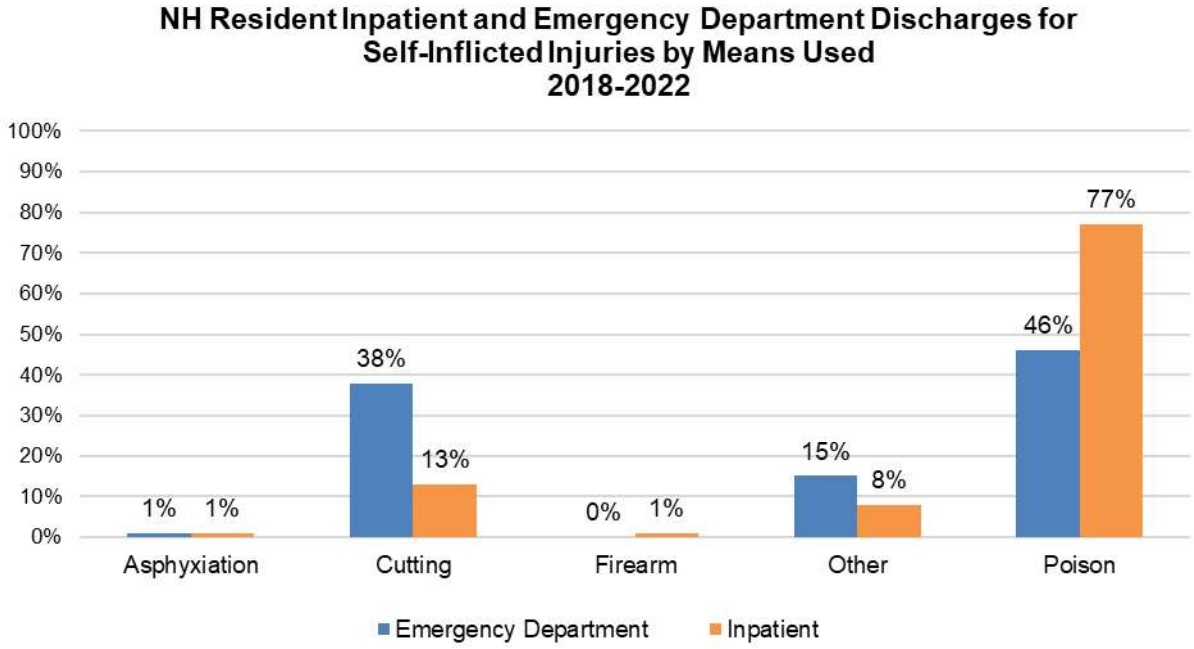
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Figure 40



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

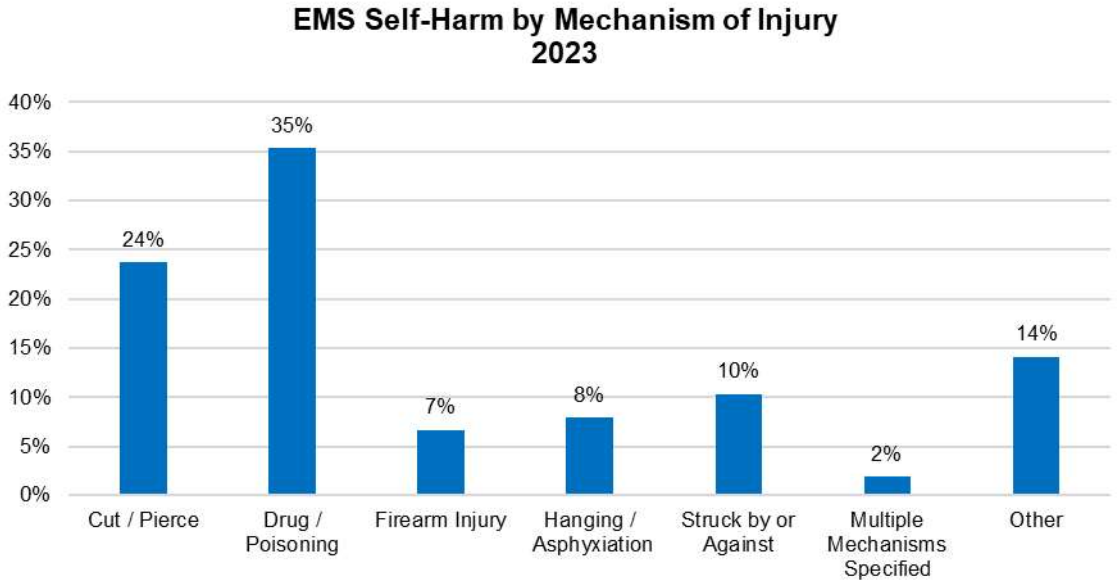
Figure 41



Data Source: NH Uniform Healthcare Facility Discharge Data Set (UHFDDS), Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 42[22]

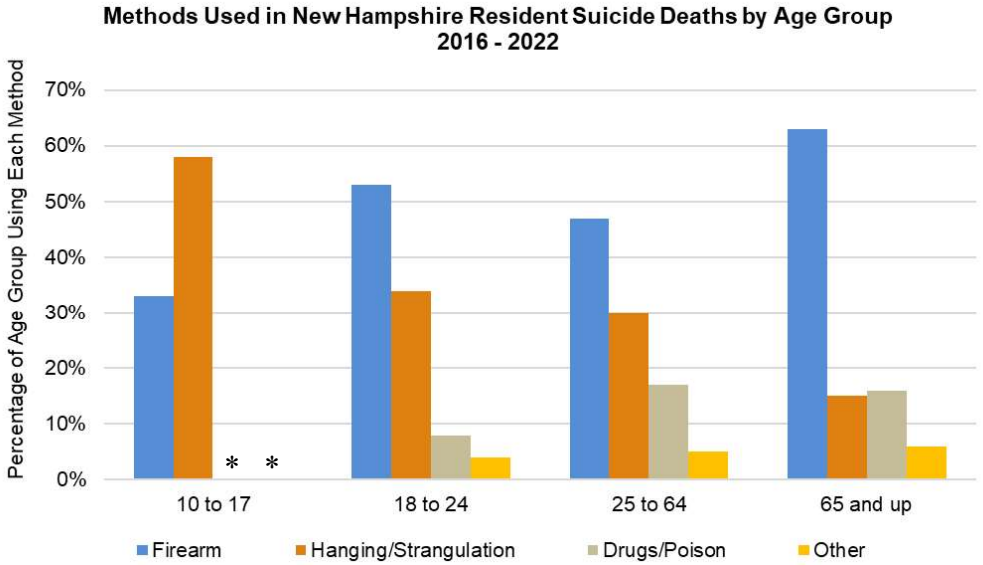
Percent of method of self-inflicted injuries treated/transported by EMS from 2023.



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

Figure 43

Suicide methods used in NH vary by age group, as seen in 2016-2022.



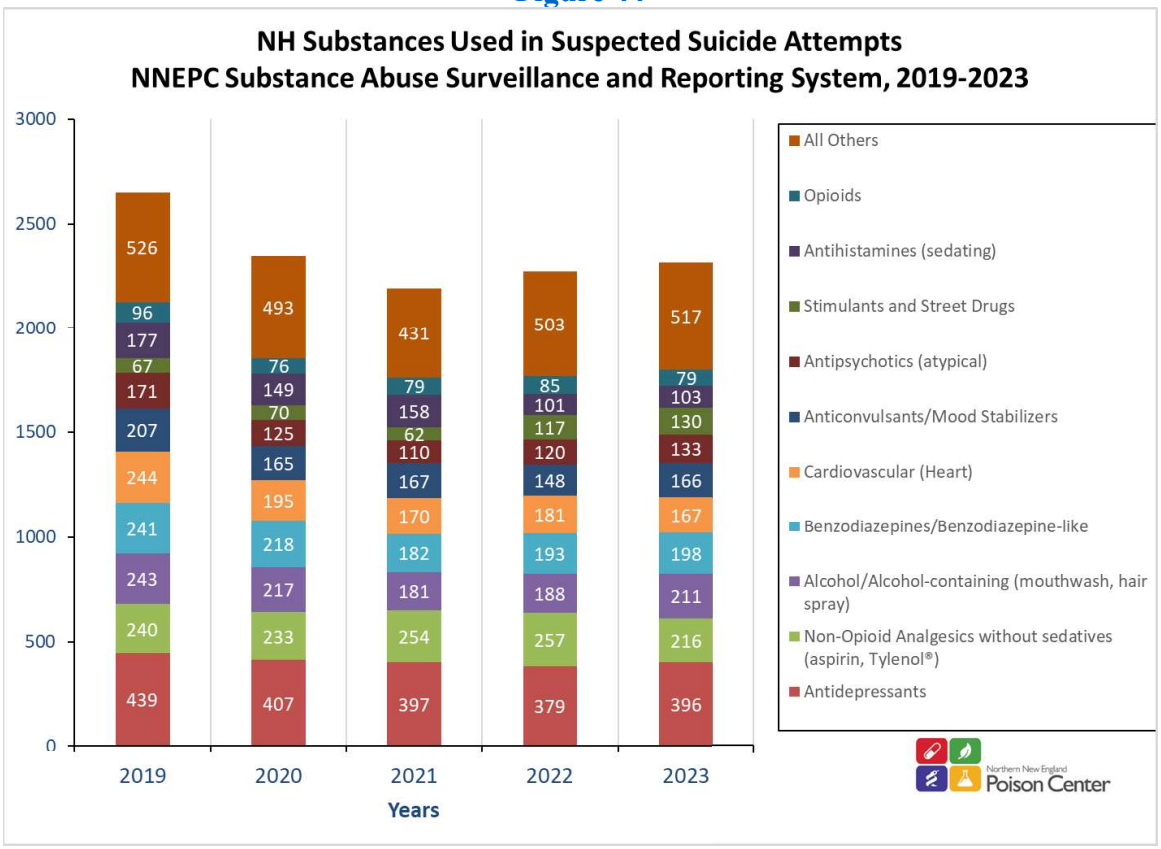
* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.

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

[22] This figure 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 38% of all incidents in 2023).

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 2023 were again antidepressants and non-opioid analgesics without sedatives (e.g., aspirin or Tylenol®/acetaminophen).[23]

Figure 44

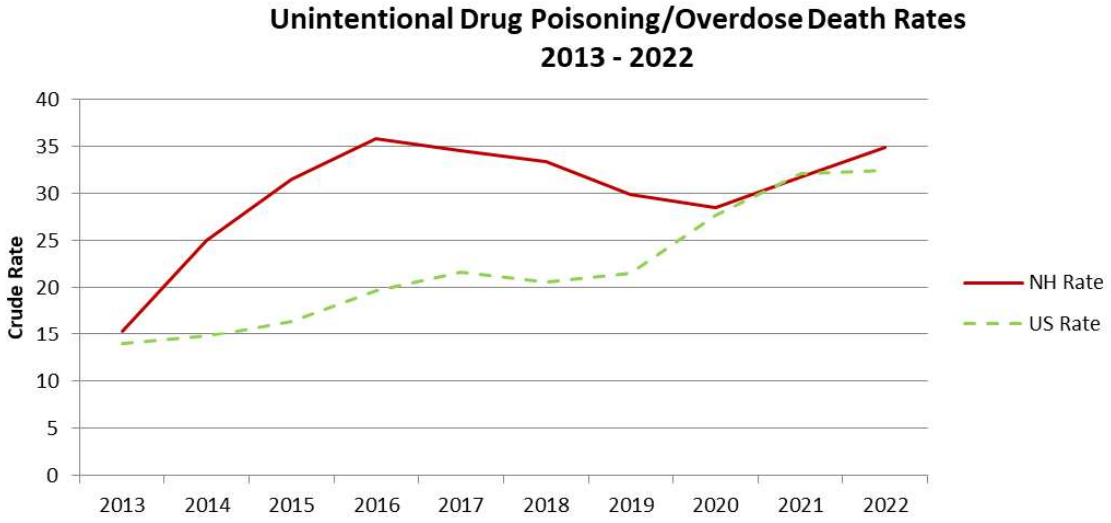


Data Source: Northern New England Poison Center

[23] 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 2013 to 2022. During this time the US and NH rates have increased by approximately 130%. 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.

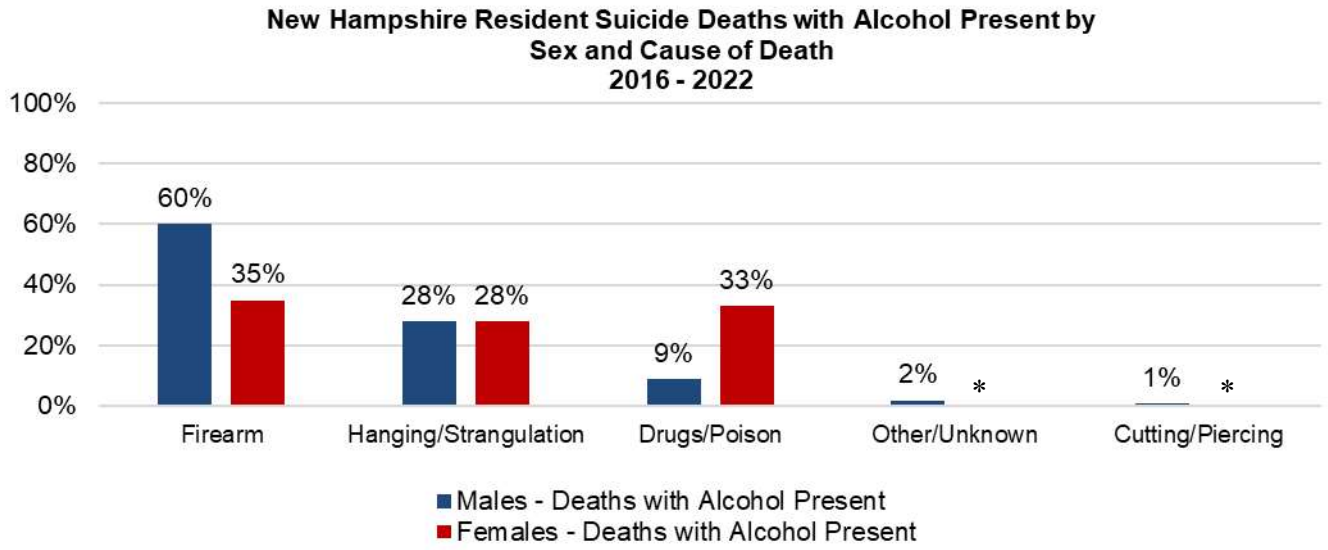
Figure 45
Poisoning/Drug-related death rates in NH increase by more than 140% from 2013 to 2022.



Data Source: CDC WISQARS

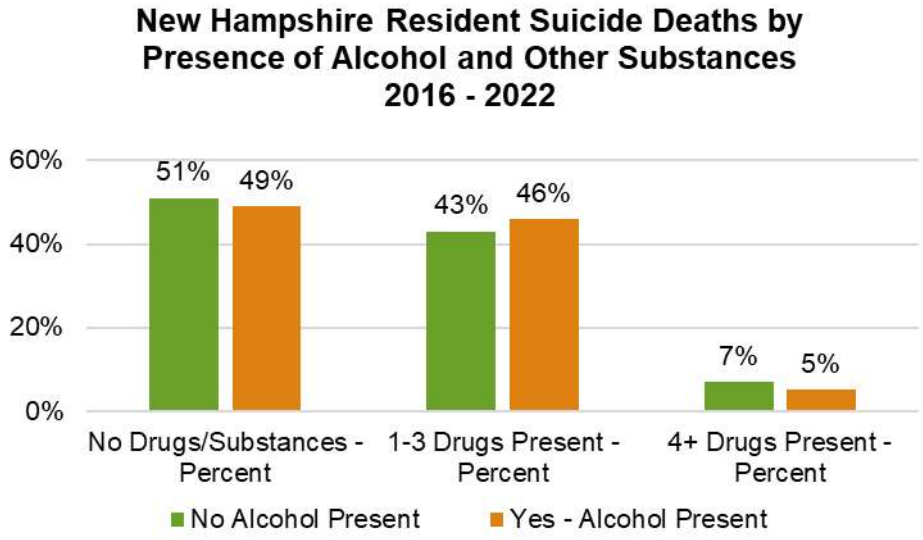
Alcohol and Drug Use and Suicide
Alcohol was found to be present in 30% of all NH suicide deaths from 2016 to 2022. Alcohol was found in a greater percentage of male deaths (32% of deaths) than female deaths (25% of deaths). When looking at the presence of alcohol by cause of death (**Figure 46 –** pg. 66), it was found to most often be present in firearm deaths for males (60% of male firearm deaths) and drug/poisoning deaths for females (33% 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 was present, approximately 51% also had one or more other drugs/substances present (**Figure 47 –** pg. 66**)**.

Figure 46



* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

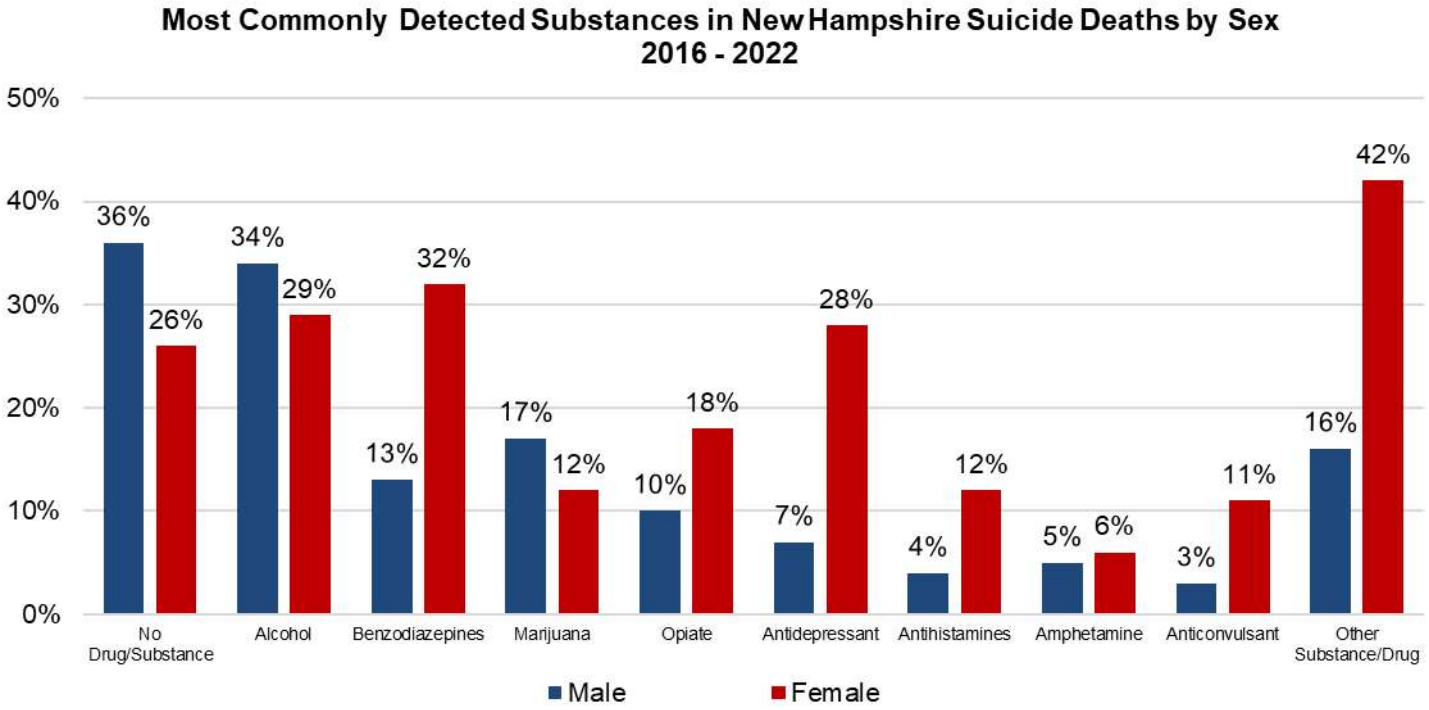
Figure 47



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. 62).

Figure 48

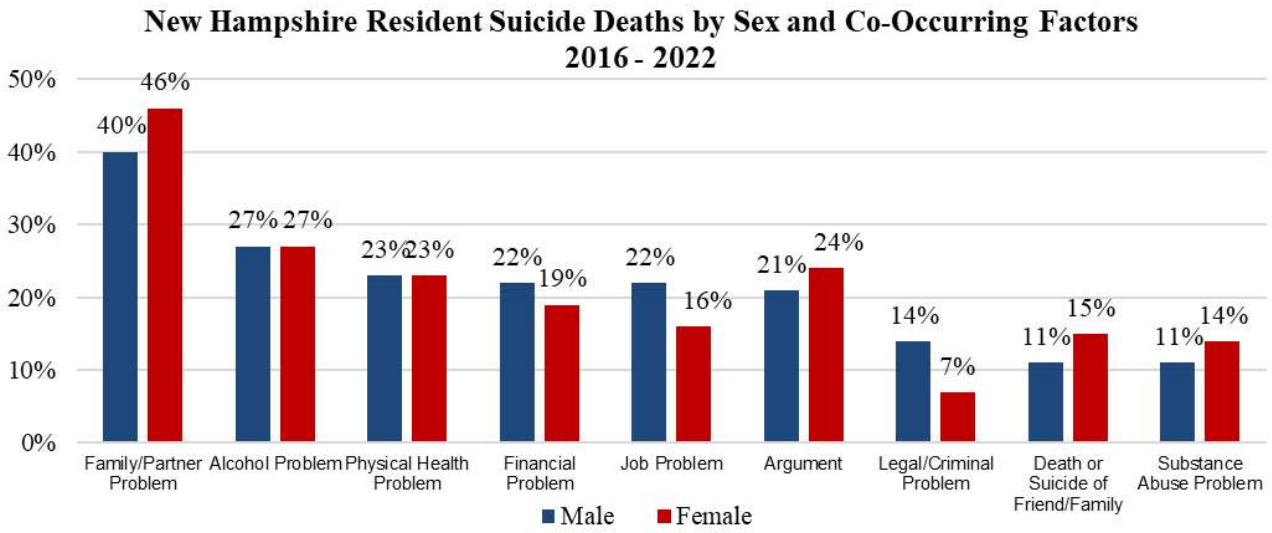


Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

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

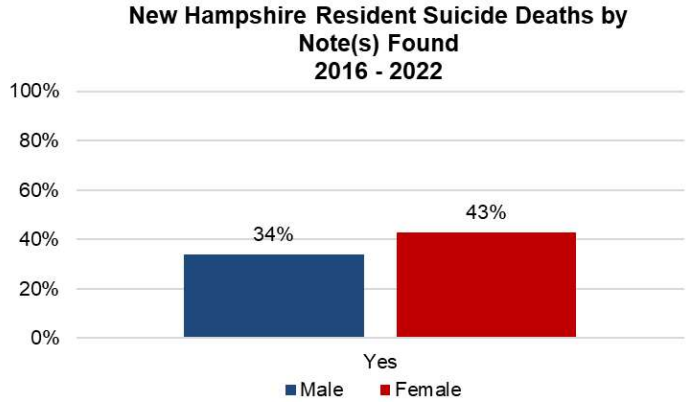


Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS.

Suicide Notes

In just over 35% of NH suicide deaths from 2016 to 2022, individuals left some form of note behind (**Figure 50 –** below). Females being more likely to have left a note (43% 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[24] are vital to suicide prevention efforts in NH and nationally. From its launch in July 2022 through December 31, 2023, 988 received approximately 8.1 million calls. In 2023, nearly 12,000 of those calls, or roughly 992 per month, were answered 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 2023 with over 22,700 contacts[25] being made through that system. More information about NHRR can be found in the infographic on page 15.

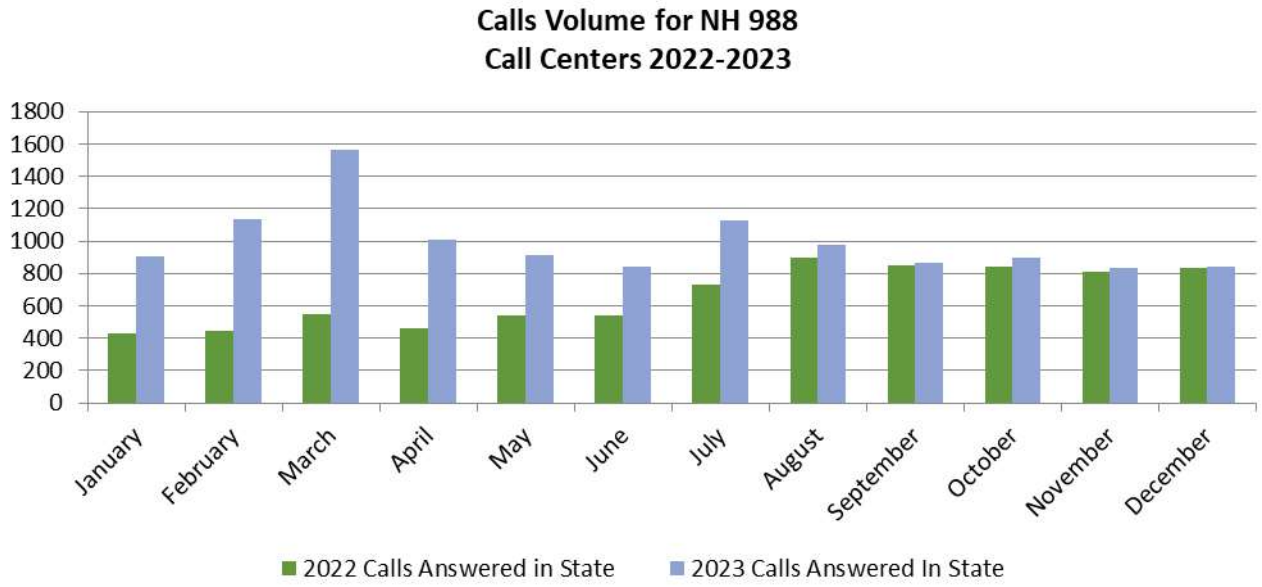
In addition to traditional crisis lines, individuals are increasingly turning to text message-based crisis services (see **Figure 52 –** pg. 70). Contacts from NH individuals[26] to Crisis Text Line average 394 conversations per month. From 2018 to 2023, Crisis Counselors at Crisis Text Line deescalated 336 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, 180 active rescues were called for New Hampshire-based texters in crisis.

Among the subset of texters who disclosed their demographics through an optional post-conversation survey, 69% of the texters who reached out to Crisis Text Line from NH were age 24 or under, 71% self-identified as female, and over half (52%) self-identified as LGBTQ[27].

[24] 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).
[25] Data Source: Mission Zero adult mental health dashboard - https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=mental-health&subtopic=mission-zero-adult-mental-health&indicator=mission-zero-prevention-and-community-based-access
[26]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 in individuals physically located in NH not being counted if they are using a device with an out-of-state area code.
[27]Surveys are completed by texters following approximately 20% of Crisis Text Line conversations.

Figure 51

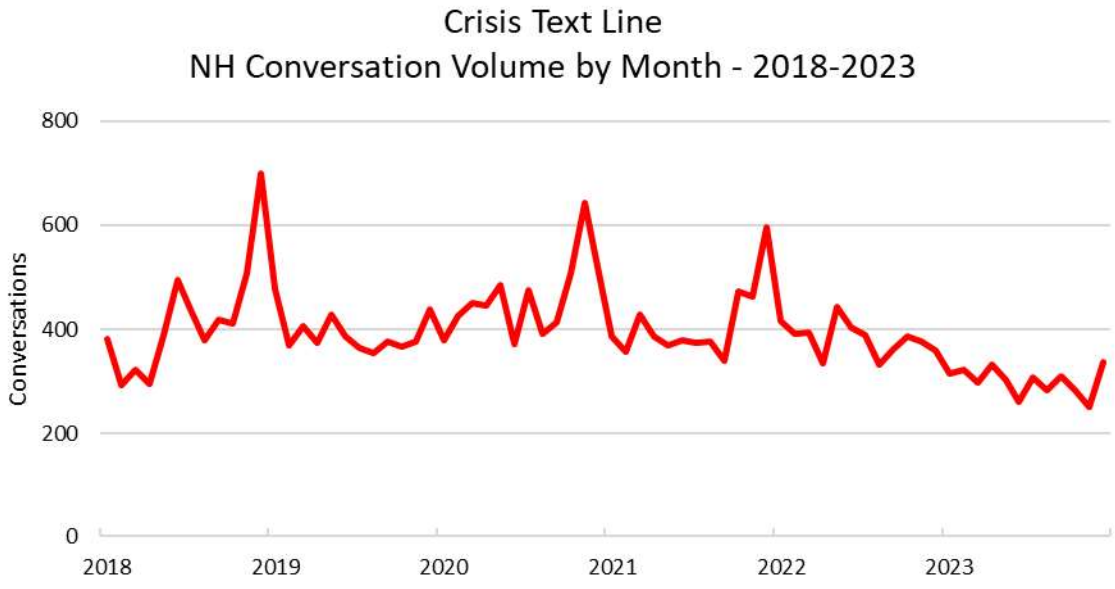
NH 988 call center responded to an average of 992 calls per month in 2023.



Data Source: 988 Suicide and Crisis Lifeline

Figure 52

The Crisis Text Line engaged in 3,604 text conversations with NH texters in 2023.



Data Source: Crisis Text Line

Costs of Suicide and Suicidal Behavior

There were between 34,107 and 45,864 years of potential life lost[28] to suicide from 2018-2022 in NH (CDC WISQARS, 2024). 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 $14.2 billion in health care costs in 2022. This does not include the costs associated with mental health services on an inpatient or outpatient basis (CDC WISQARS, 2024). In NH, suicide deaths where the individual received treatment in a hospital or emergency department and subsequently died resulted in an estimated $1.37 million in medical expenses in 2022 (CDC WISQARS, 2024).

Military and Veterans

The NH National Guard

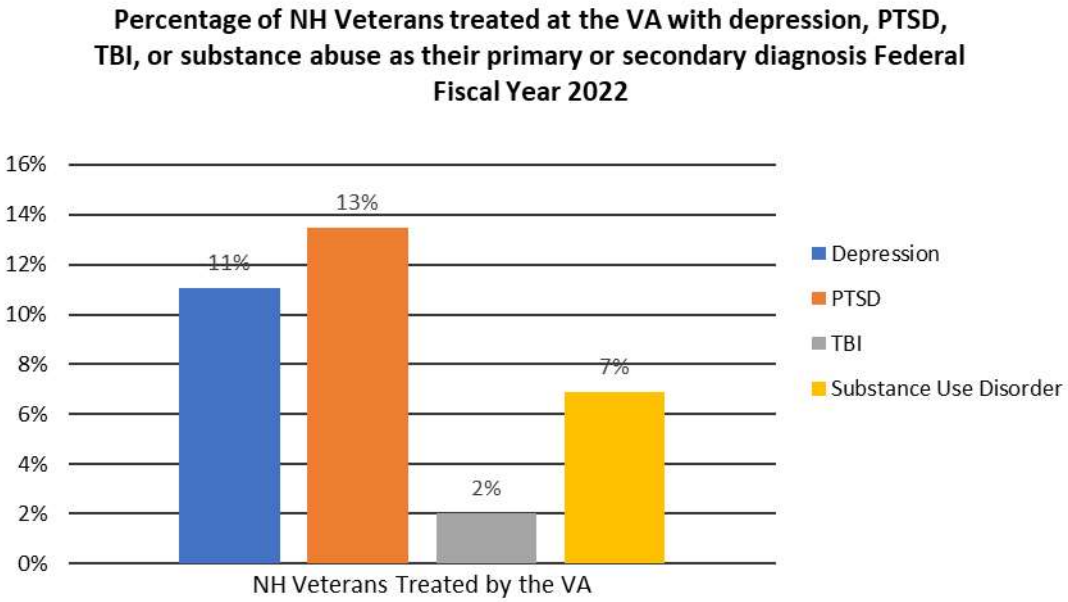
From 2018 through 2022 the NH Army National Guard recorded a total of 47 suicide related incidents of varying levels of severity (ideation, plan in place, attempt, or death), with the majority being ideation or having a plan in place. Of these incidents, 15% were from individuals under the age of 22, 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** (pg. 72).

[28] 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.

Figure 53

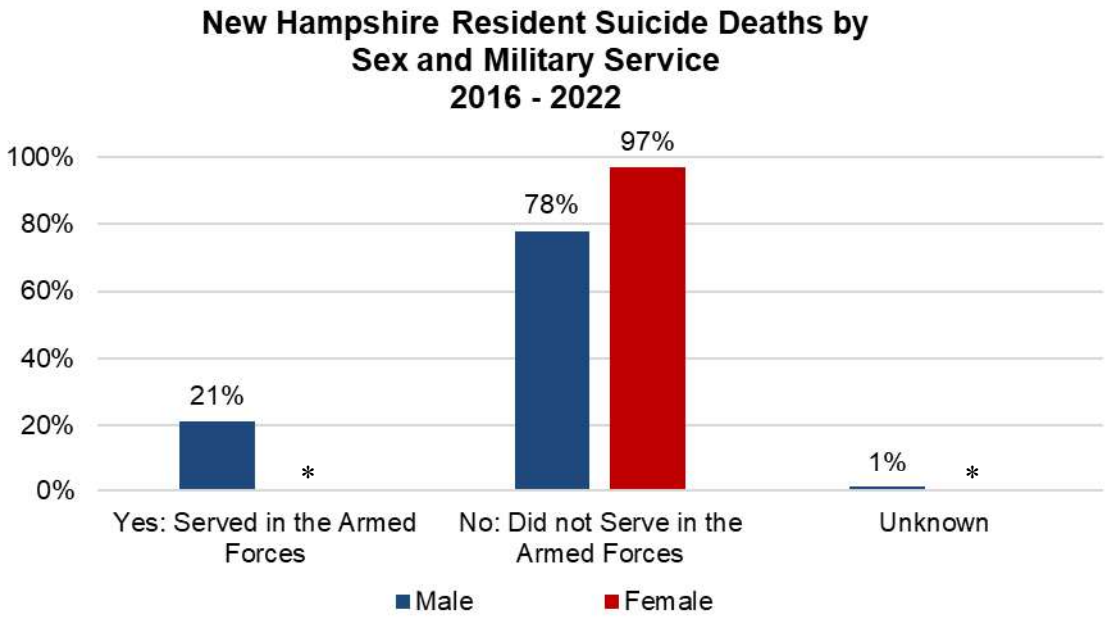


Data Source: Veterans Administration

Suicide Among Veterans in New Hampshire:[29]

Of the individuals who died by suicide in NH from 2016 to 2022, 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 2023[30]. 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



* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.

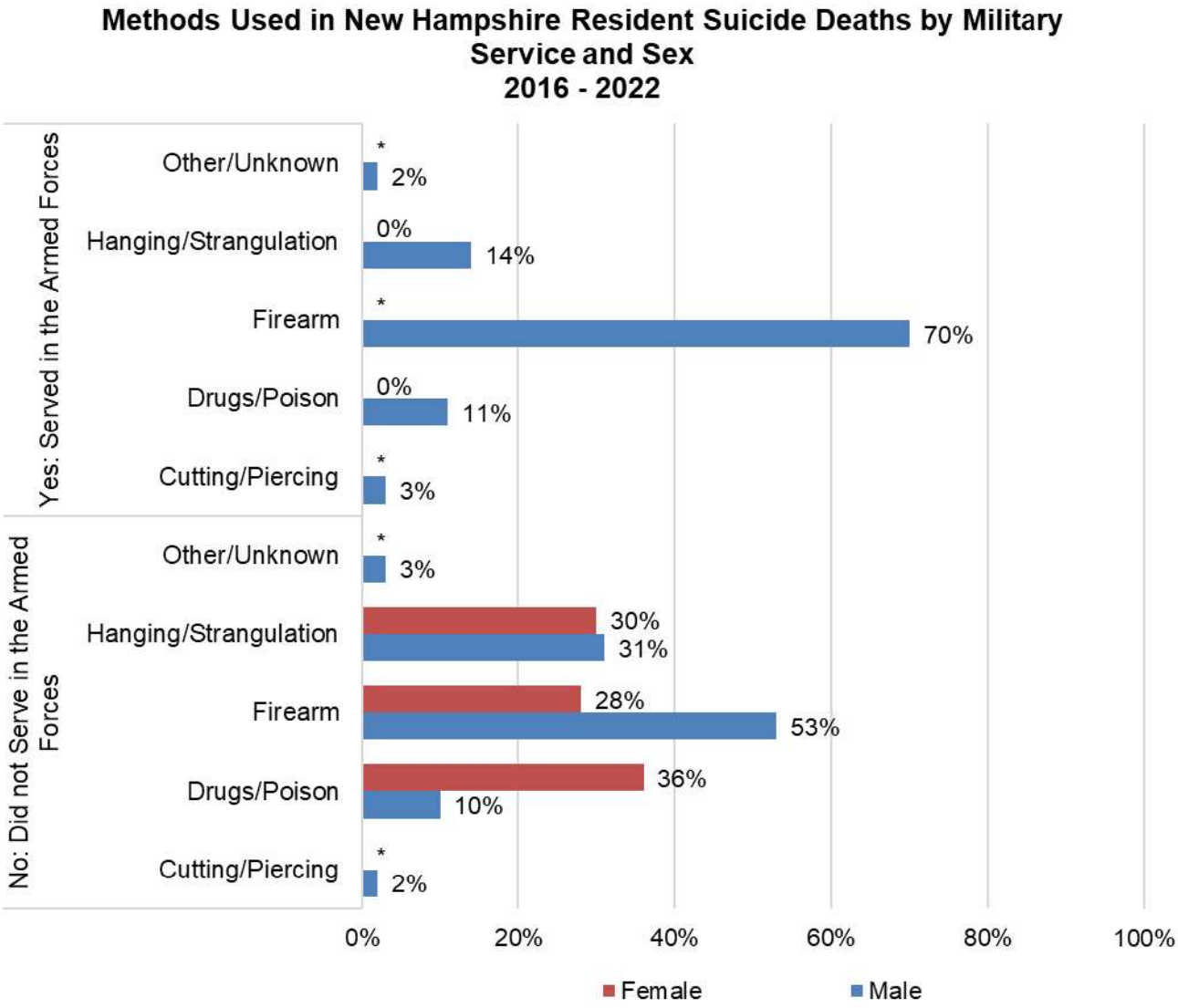
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

[29]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.

[30] Veteran population tables from https://www.va.gov/vetdata/veteran_population.asp

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 –** below). 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.

Figure 55

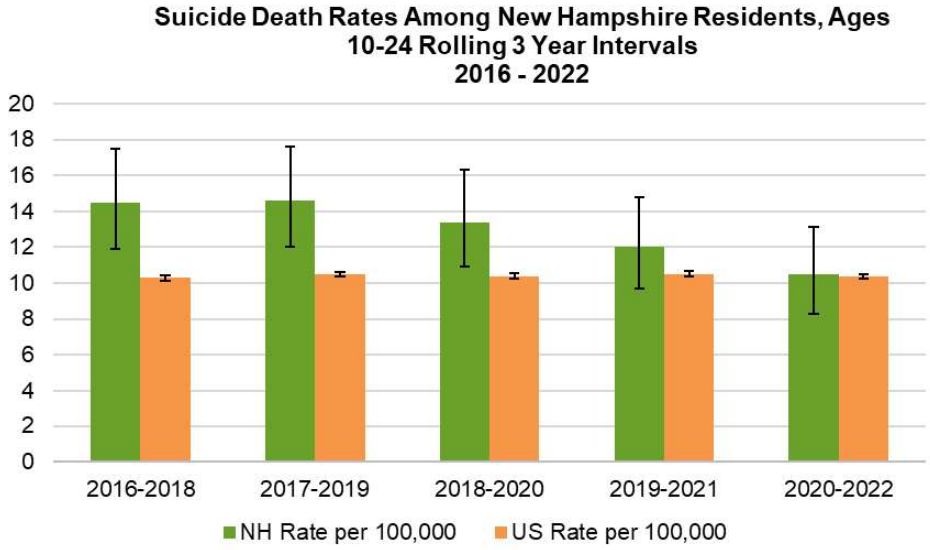


* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH National Violent Death Report System (NVDRS), Maternal & Child Health, NH DHHS

Suicide Rates in NH

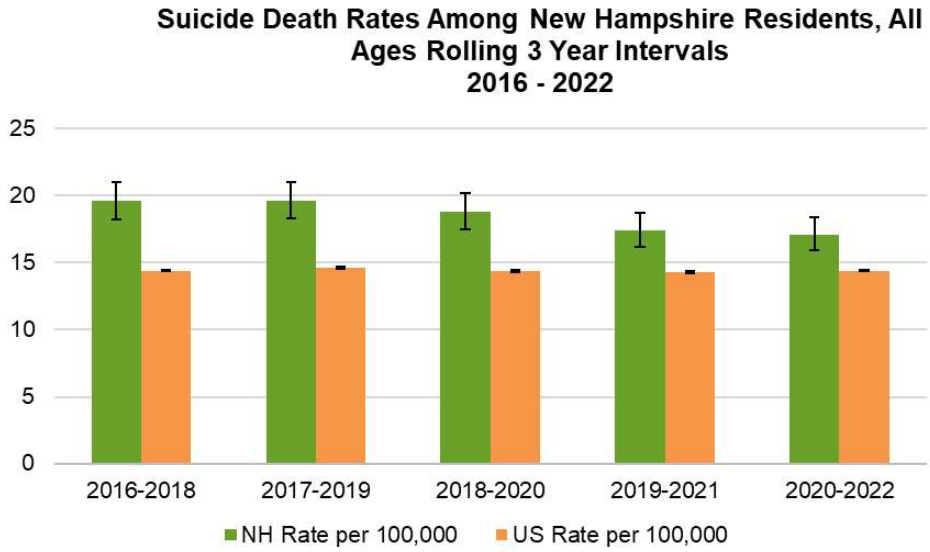
Figure 56 (below) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2016 to 2022 and **Figure 57** (below) presents the same information for individuals of all ages. The rolling intervals help to smooth out minor year-to-year variations that may be due to small numbers.

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

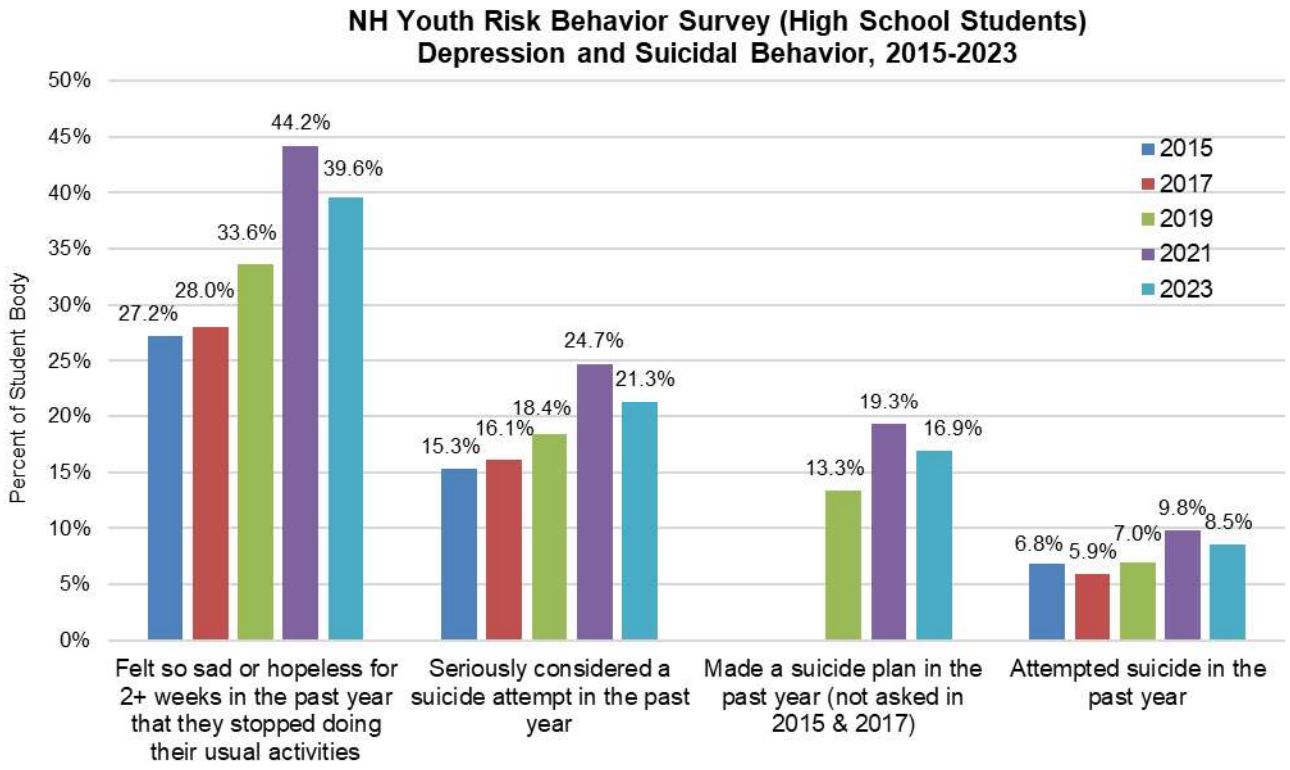


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.
US Rates: CDC WISQARS

Figure 58 (below) presents the results of the NH YRBS from 2015, 2017, 2019, 2021 and 2023. In 2023, 1 in 5 youth surveyed reported having seriously considered attempting suicide in the past year, while 1 in 12 reported having made an attempt. All of the items included in **Figure 58** (below) demonstrated significant increases in the percentage of youth self-reporting these thoughts/behaviors through 2021, and significant decreases from 2021 to 2023 ($p < 0.05$)[31]. While the percentage of your reporting these behaviors did decrease in 2023, the measures have not returned to the levels reported prior to the COVID-19 pandemic.

Figure 58

Self-reported depression and suicidal ideation among high school youth increased from 2015 to 2023.

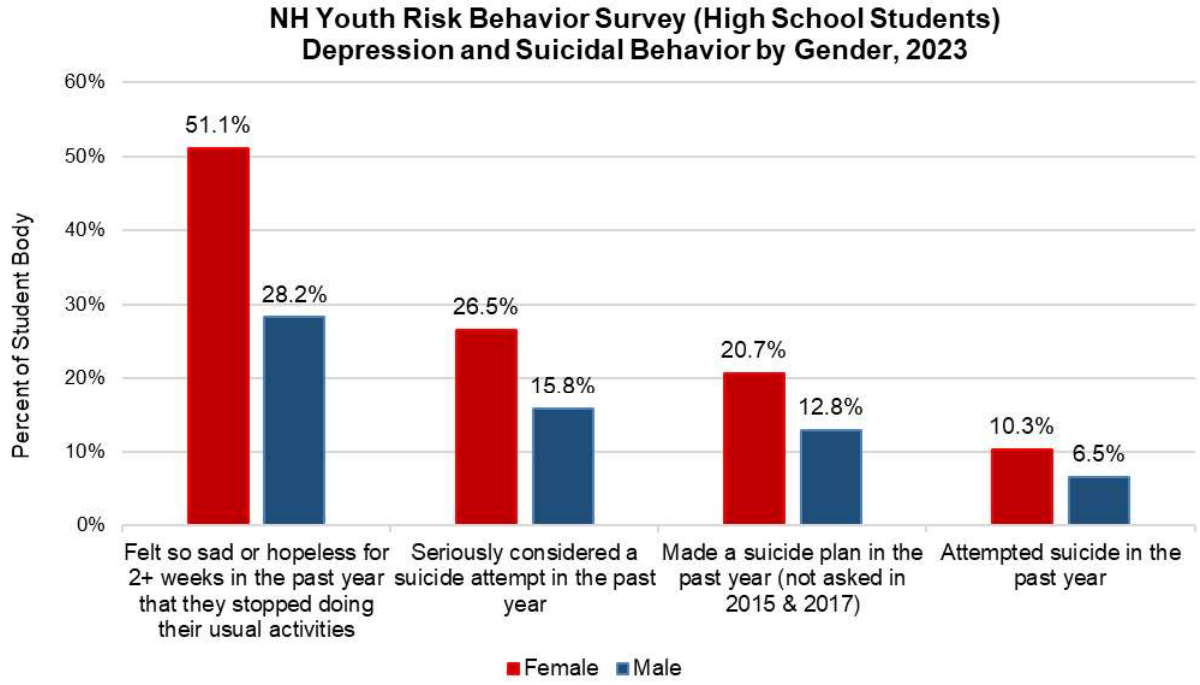


Data Source: NH YRBS, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH, DHHS.

[31] Detailed tables and analyses of the NH YRBS data are available from https://wisdom.dhhs.nh.gov/wisdom/topics.html?topic=youth-risk-behavior-survey-(yrbs)

Substantial variations are found within the 2023 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 three 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[32] and NH Department of Health and Human Services[33] websites.

Figure 59

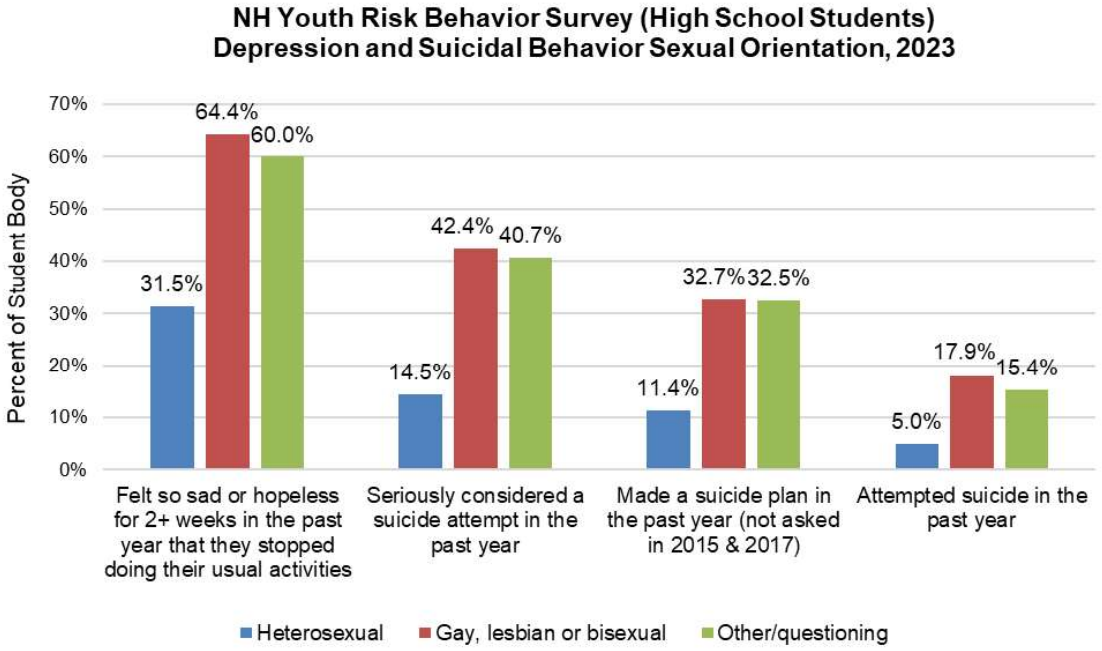


Data Source: NH YRBS, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH, DHHS.

[32] 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

[33] 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

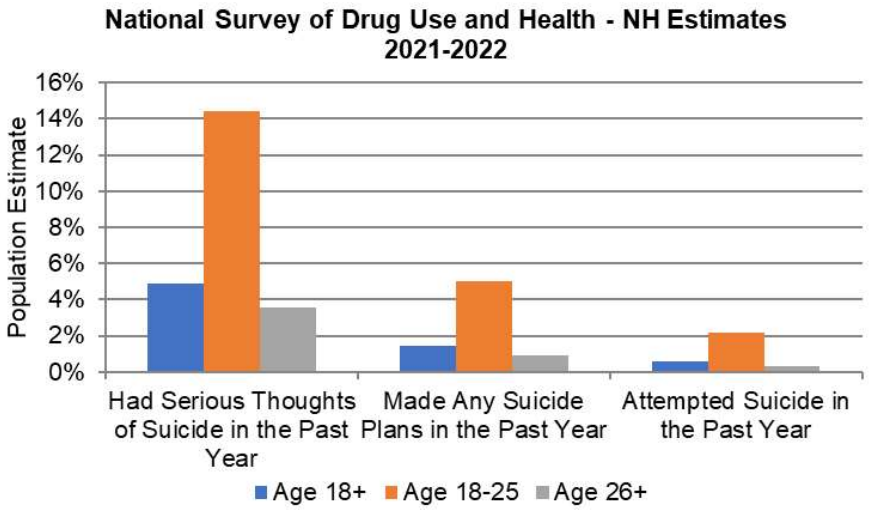
Figure 60



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

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 21 adults surveyed reported having serious thoughts of suicide in the past year, while 1 in 182 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 7 reporting serious thoughts of suicide in the past year and 1 in 28 reporting having made a suicide attempt during that time period.

Figure 61



Data Source: National Survey on Drug Use and Health, 2021-2022

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 5** 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 16**) of this report shows the percent of male and female youths and young adults in NH that died by suicide from 2016 to 2022.
- **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 11** and **12**) in this report show the number of suicide deaths by age group in NH from 2016 to 2022 and the rate of suicide deaths by age group in NH from 2016 to 2022.

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 5**, 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 2016 to 2022. 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 14**). 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

- **Count:** 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.

NH DHHS collaborates with the NH DOJ on implementation of the NH-VDRS under the auspices of the OCME. 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. NH-VDRS abstracted data comes from death certificates recorded by NH Division of Vital Records Administration, Assistant Deputy Medical Examiner (ADME) investigation reports, toxicology and autopsies reports, and law enforcement reports.

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.

In New Hampshire, YRBS is jointly administered by the Departments of Health & Human Services and Education. High schools are given the opportunity to participate in either the random state survey, a comprehensive school level census survey, or both. The survey is usually administered in New Hampshire schools during the early winter[34].

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 into groups large enough to prevent constructive identification of individuals who were discharged from 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.

[34] https://www.dhhs.nh.gov/programs-services/population-health/health-statistics-informatics/youth-risk-behavior-survey

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?**

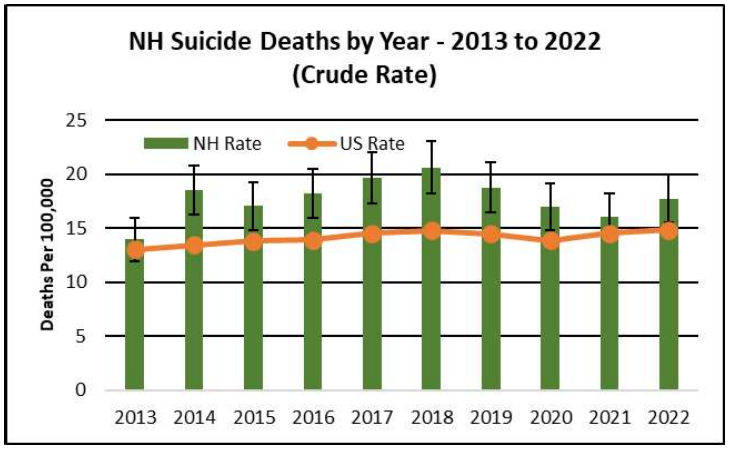
A: It is best to focus on data from a full year or multiple years rather than periods of just a few months. Over brief periods these numbers are too volatile to draw accurate conclusions from them.

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 – 2013-2022

Change in Rate per 100,000 from Year to Year	
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%)
2021-2022	16.05 to 17.70 (**Up** 10%)

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"* 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, 2013 – 2022

	<1	1–4	5–9	10–14	15–24	25–34	35–44	45–54	55–64	65+	All Ages
1	Congenital Anomalies 80	Unintentional Injury 23	Malignant Neoplasms 14**	Malignant Neoplasms 23	Unintentional Injury 550	Unintentional Injury 1,421	Unintentional Injury 1,242	Malignant Neoplasms 1,675	Malignant Neoplasms 5,177	Heart Disease 22,562	Malignant Neoplasms 27,785
2	Short Gestation 65	Congenital Anomalies 14**	Unintentional Injury 12**	Suicide 19**	Suicide 274	Suicide 383	Malignant Neoplasms 393	Unintentional Injury 1,146	Heart Disease 2,824	Malignant Neoplasms 20,329	Heart Disease 26,924
3	Maternal Pregnancy Comp. 38	Homicide 10**	Homicide --	Unintentional Injury 12**	Heart Disease 39	Malignant Neoplasms 125	Suicide 359	Heart Disease 1,131	Unintentional Injury 998	Chronic Low. Respiratory Disease 6,091	Unintentional Injury 8,661
4	Placenta Cord Membranes 32	Malignant Neoplasms --	Benign Neoplasms --	Congenital Anomalies --	Malignant Neoplasms 38	Heart Disease 102	Heart Disease 250	Suicide 509	Chronic Low. Respiratory Disease 780	Cerebrovascular 4,562	Chronic Low. Respiratory Disease 7,077
5	Sids 29	Heart Disease	Congenital Anomalies --	Benign Neoplasms --	Homicide 29	Liver Disease 39	Liver Disease 140	Liver Disease 385	Liver Disease 622	Alzheimer's Disease 4,347	Cerebrovascular 5,107
6	Respiratory Distress 17**	Influenza & Pneumonia --	Heart Disease --	Influenza & Pneumonia --	Congenital Anomalies 10**	Homicide 27	Diabetes Mellitus 54	Diabetes Mellitus 211	Diabetes Mellitus 565	Unintentional Injury 3,245	Alzheimer's Disease 4,418
7	Circulatory System Disease 15**	Benign Neoplasms	Acute Bronchitis	Chronic Low. Respiratory Disease	Cerebrovascular	Cerebrovascular	Cerebrovascular 38	Chronic Low. Respiratory Disease 148	Suicide 422	Diabetes Mellitus 2,609	Diabetes Mellitus 3,467
8	Intrauterine Hypoxia 14**	Covid-19	Cerebrovascular	Heart Disease	Chronic Low. Respiratory Disease --	Diabetes Mellitus 19**	Homicide 35	Cerebrovascular 144	Cerebrovascular 329	Covid-19 2,129	Covid-19 2,506
9	Unintentional Injury 12**	Diabetes Mellitus	Diseases Of Appendix	Nephritis	Diabetes Mellitus --	Congenital Anomalies 18**	Covid-19 34	Covid-19 87	Covid-19 238	Influenza & Pneumonia 1,855	Suicide 2,407
10	Bacterial Sepsis 11**	Septicemia --	Influenza & Pneumonia --	Perinatal Period Pneumonitis --	Influenza & Pneumonia --	Chronic Low. Respiratory Disease 17**	Chronic Low. Respiratory Disease 32	Septicemia 62	Septicemia 177	Nephritis 1,618	Influenza & Pneumonia 2,054

Data Source: CDC WISQARS, 2013-2022

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 Committees

Communications

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

Public Policy

Co-Chairs: Holly Stevens – hstevens@naminh.org
Emma Sevigny- esevigny@new-futures.org
Meets 3rd Wednesday of the Month

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 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:
   - Call/text 988 Suicide and Crisis Lifeline (24/7) **(when calling, press "1" for Veterans; "2" for a Spanish-speaking; "3" for LGBTQ+ Youth Support)**
   - 988 also offers text-based chat through their website: 988lifeline.org.
   - For an emergency, **dial 911**.

Mental Health and Suicide Prevention 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
LGBT National Help Center: 1-888-843-4564 lgbthotline.org
Youth Talkline: 1-800-246-PRIDE (7743)
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: www.naminh.org/SuicideAndAging
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)
Treatment Provider Locator: findtreatment.gov
A searchable list of mental health and substance use disorder providers.

Survivors of Suicide Loss / Individuals Bereaved by Suicide

Alliance of Hope for Suicide Survivors: www.allianceofhope.org
American Foundation for Suicide Prevention: afsp.org
Compassionate Friends: 1-877-696-0010 - www.compassionatefriends.org
Friends for Survival: 1-800-646-7322 - www.friendsforsurvival.org
Heartbeat: www.heartbeatsurvivorsaftersuicide.org
NAMI New Hampshire: https://www.naminh.org/sosl/
SAVE (Suicide Awareness Voices of Education): www.save.org