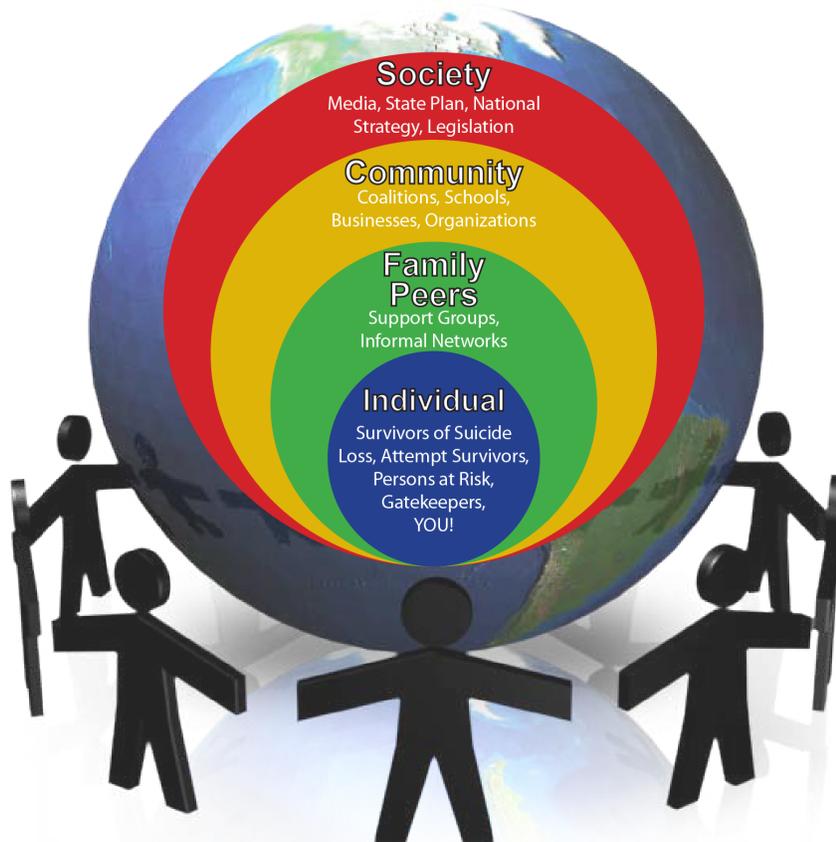


New Hampshire Suicide Prevention



Annual Report 2021

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

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Introduction

The 2021 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:

- A summary of the results from a statewide survey on attitudes towards mental health and suicide prevention.
- Data on NH contacts to the Crisis Text Line.
- Expanded data from the National Survey on Drug Use and Health.
- Highlights of activities that took place across the state.

Primary Partners

NAMI New Hampshire and The Connect Suicide Prevention Program

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

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

New Hampshire Office of the Chief Medical Examiner

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

New Hampshire Violent Deaths 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 and Puerto Rico. The surveillance program in NH is known as the NH Violent Death Reporting System (NH-VDRS), which is supported by CDC NVDRS grant funding. The NH DHHS Injury Prevention Program is the grant holder and provides administrative oversight for the program. The case abstraction staff are employed by the 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 # 5NU17CE924939-02-00.

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

- JoAnne Miles-Holmes, Injury Prevention Program Administrator, NH-VDRS Principal Investigator, Maternal and Child Health Section, Division of Public Health Services, NH Department of Health and Human Services, JoAnne.E.MilesHolmes@dhhs.nh.gov.
- Djelloul Fourar-Laïdi, Lead Abstractor/NH-VDRS Planning Analyst-Data Systems, Office of the Chief Medical Examiner, NH Department of Justice, djelloul.fourar-laid@doj.nh.gov.
- Kim Fallon, Chief Forensic Investigator, Office of the Chief Medical Examiner, kim.fallon@doj.nh.gov.

State Suicide Prevention Council

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

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

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

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

Youth Suicide Prevention Assembly

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

YSPA is an ad hoc committee of individuals and organizations that meet 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. The development of both The Connect Program and CALM (Counseling on Access to Lethal Means) suicide prevention trainings occurred because of YSPA participation and/or case reviews. The Survivor of Suicide Loss packets sent to the next of kin of anyone who dies by suicide in New Hampshire began in YSPA before expanding to all ages.

Accomplishments of Suicide Prevention Efforts in NH

State Suicide Prevention Council

This year marked the 13th 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 Plan¹. With the release of the updated plan, the SPC, its subcommittees, and other stakeholders in the state have looked at ways of implementing the outlined goals. This work was aided by the first ever state funding for the SPC and newly created State Suicide Prevention Coordinator position within NH DHHS.

Much of the work of the SPC is done at the subcommittee level. Some of the subcommittee activities occurring in 2021 to move forward the goals of the NH Suicide Prevention Plan included:

Communications Subcommittee

- Coordinated a press event in September for Suicide Prevention Awareness Week.
- Worked with the Public News Service on writing and publishing stories around prevention efforts in the state. The stories take into account the media recommendations for reporting on suicide (<http://reportingonsuicide.org/>) as well as the National Action Alliance's Framework for Successful Messaging: <http://suicidepreventionmessaging.org/>.

Data Collection and Analysis Subcommittee

- Worked with multiple statewide partners to compile and analyze data covering calendar year 2020. The data were then included in the 2020 NH Suicide Prevention Annual Report and distributed statewide.
- Collaborated with the Analyst for the NH Violent Death Reporting System (NH-VDRS) to expand the use of NH-VDRS data in the NH Annual Suicide Prevention Report.
- Partnered with the Crisis Text line for access to a dashboard summarizing NH contacts.
- Conducted a statewide survey through the University of New Hampshire (UNH) Survey Center addressing attitudes towards mental health and suicide prevention.

Military and Veterans Subcommittee

- The Committee continues to be actively involved with the Governor's Challenge to Prevent Suicide among Service Members, Veterans and their Families which is funded through the Substance Abuse and Mental Health Services Administration (SAMHSA). This initiative continues to provide members of the Committee with a variety of technical assistance and free training related to best practices to reduce the rate of suicide in the military-connected community. The Service Members, Veterans and their Families (SMVF) Technical Assistance Center, contracted by SAMHSA, will be providing

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

facilitation services to the committee in early 2022 to help re-focus the efforts of the group and identify priority areas.

- The Committee continues to support the efforts of the Lakes Region Veterans Coalition (LRVC), which is a group formed as a result of the committee bringing federal resources into the state aimed at reducing the Veteran suicide rate in rural areas. Together With Veterans (TWV) is a community-based suicide prevention program for rural Veterans. TWV involves partnering with rural Veterans and their communities to implement community-based suicide prevention. TWV is funded by the Veterans Administration Office of Rural Health. In 2021, LRVC developed a Board, sent Board members to multi-day academies hosted by Together With Veterans, engaged community partners in meetings and projects, provided support to local Veterans and began the process to obtain a 501(c)(3) designation.
- Committee members continue to promote military cultural competency and suicide prevention trainings for community providers and have extended promotion to employers in the state as they have unique access to SMVF who are employed. Star Behavioral Health Providers continues to provide free clinical training to providers in the state. The committee worked with PsychArmor in 2021 to develop the NH Online Training Portal—an online training resource providing free military culture and suicide prevention trainings for providers. A portal specifically for employers and military culture and suicide prevention trainings was also created by PsychArmor for New Hampshire and will be promoted by the committee to that audience in 2022.
- Committee members have been actively involved in the development process of the state's closed loop referral system throughout 2021 to ensure that the system meets the needs of SVMF in New Hampshire as well as the needs of the Department of Military Affairs and Veterans Services (DMAVS) and the committee to access data demonstrating trends related to the needs of SMVF.
- The Committee's efforts are described and meeting minutes are publicly available at: <https://www.dmavs.nh.gov/about-us/councils-and-committees/suicide-prevention-efforts>

Public Policy Subcommittee

- Reestablished the Public Policy Subcommittee, created work plan and funding request.
- Welcomed NH House of Representative member Erica Layon to the Council and oriented her to subcommittee's work.

Survivor of Suicide Loss Subcommittee

- Began a monthly one-hour Coffee Chat over Zoom in December of 2020 that continued through 2021. The coffee chat offers Survivors of Suicide Loss (SOSL) access to a variety of resources as well as an opportunity to support fellow survivors through their loss and healing journeys.
- The Coffee Chats were going so well for 2020 with increased loss survivor attendance that the sub-committee, not only continued into 2021 but also added in an evening monthly one-hour Tea Time Chat as well. The SOSL sub-committee provides access to a variety of resources and materials as well as an opportunity to support fellow survivors through their loss and healing journeys.

- Many comments of how these Coffee and Tea Chats have helped many Loss Survivors through their healing journeys and "it gives us, Hope!"
- Provided support and technical assistance to NH Survivor of Suicide Loss Support groups and promoted the American Foundation for Suicide Prevention (AFSP) International Loss Survivor Day (ISOSL) to several hosted sites in NH in November, that were conducted in person with one virtual event for NH, VT, and ME. Over 100 were in attendance.
- Ensured Loss Survivor participation in community events through targeted outreach.
- The SOSL sub-committee provided support and participation for many Loss Survivor events throughout NH, including Out of Darkness Walks for the AFSP, in designated towns, and the NAMI NH Annual Walk, with Team SOS.

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

The council continues to collaborate with the Department of Health and Human Services (DHHS) for statewide leadership and support as it looks to continue its work in promoting evidence-based 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 85 of this report.*

The Youth Suicide Prevention Assembly (YSPA)

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

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

COVID-19 continued to present challenges in running YSPA meetings. Given the nature of YSPA as a grassroots organization, it does not fall under the umbrella of legislated fatality review committees. The Emergency Order issued by the Governor was rescinded, which meant that virtual case reviews needed to stop in October 2021. YSPA meetings resumed in-person in April 2022.

YSPA continued to function in a virtual format with three “Participant Bio” presentations. Participant Bios are an opportunity for YSPA members to learn about other YSPA members and what “brought them to the table”. This was a suggestion made in an annual retreat many years ago and has continued to be a prominent aspect of YSPA.

Other presentations were made to YSPA attendees:

- Information about the Fast Forward program overseen by Children’s Behavioral Health
- The work of the NH Firearms Safety Coalition with the American Academy of Pediatricians for a CALM-like training (final version available here: <https://shop.aap.org/calm-for-pediatric-providers-counseling-on-access-to-lethal-means-to-prevent-youth-suicide/>)
- A presentation by the Chief Medical Examiner on how deaths are classified and the investigative process
- A presentation highlighting an initiative with Seacoast Mental Health Center staff and the Managed Care Organizations
- A summary of the data in NH for YSPA-age individuals.
- A presentation about an Attempt-Survivor group in the Keene area.

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

The NH Suicide Survivor Network

In 2021 Survivors of Suicide Loss (SOSL) continued in their efforts of building capacity and establishing groups throughout NH. More and more loss survivors are finding comforting support in their healing journey and continue to mentor each other in facilitating and co-facilitating these groups by providing a safe environment to share their experience of suicide loss. The year began with 15 groups already in motion and attendees growing in numbers. As a result of the COVID-19 pandemic, many of these groups were forced to temporarily halt in-person meetings. In order to continue to support loss survivors, many of the groups began holding virtual meetings. As COVID-19 rates decreased in NH, the number of groups resuming in-person meetings began to increase. Talk of teen (ages 14-18) and young adult (ages 18-25) Survivor of Suicide Loss peer support groups, while delayed by the pandemic, has continued to progress.

Positive Outcomes and Testimonials

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

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

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

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

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

An ever-growing number of Loss Survivor 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 disseminated through the NH Office of the Chief Medical Examiner to the next of kin of all those who died by suicide. The book "Healing the Hurt Spirit: Daily affirmations for people who have lost a loved one to suicide," authored by a NH survivor, continues to be available to new loss survivors. An online survey is also provided to solicit feedback on the folder and provide additional avenues to connect loss survivors to help.

Viewings of the American Foundation for Suicide Prevention (AFSP) International Survivors of Suicide Loss Day (ISOSLD or Survivor Day) are normally held at multiple sites throughout NH on the Saturday before Thanksgiving.

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

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

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

This committee encourages new members to join and attend their monthly conference calls.

Positive Outcomes and Testimonials

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

A New Hampshire Survivor of Suicide Loss

Attempt Survivor Initiative:

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

Other Statewide Initiatives

AFSP (American Foundation for Suicide Prevention)

The NH Chapter continued its efforts to increase support for Survivors of Suicide Loss in 2021.

Following on the success of its first State Advocacy Day in 2020, AFSP NH hosted a virtual State Capitol Day in March of 2021. The program encouraged the state to make an investment into state crisis service systems, including support for call centers.

The chapter continues to offer Healing Conversations to survivors across the state. In the past, the chapter has consistently received 4-6 requests per month, with each visit completed within 10 days. Following each visit, a debriefing is conducted with the volunteers so that the chapter is able to support all involved in the visit in the best way possible.

Connor's Climb Foundation

Connor's Climb Foundation is a New Hampshire based nonprofit on a mission to provide suicide prevention education to NH youth and communities and end the stigma around mental health. Despite the challenges once again of COVID-19, the foundation hosted 21 suicide prevention trainings and events across the state with 3,447 attendees. Thirteen of these events were focused on the SOS Signs of Suicide® Prevention Program, which is a nationally recognized, evidence-based school suicide prevention program. Connor's Climb provided funding to implement the SOS program with students, faculty, and parents to 45 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 2021 garnering its highest ever attendance and fundraising achievements: 492 participants and over \$60,000 raised. Connor's Climb remains committed to advocating for LS 193-J, an act relative to suicide prevention education which went into effect in July of 2020, and other legislation at the state level by continued involvement with the NH Suicide Prevention Council.

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

Suicide became the leading cause of death in children ages 10 to 14, and remains the second leading cause of death for 10- to 34-year-olds² here in New Hampshire in 2020. Nationwide, suicide is the second leading cause of death for ages 10 to 14 and 25 to 34, and the third leading cause of death in ages 15-24.

² CDC WISQARS, <https://wisqars.cdc.gov/>, accessed on 11/30/2022.

5 Leading Causes of Death, New Hampshire 2020, All Races, Both Sexes

		Age Groups									
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies ---	Unintentional Injury ---	Benign Neoplasms ---	Suicide ---	Unintentional Injury 44	Unintentional Injury 122	Unintentional Injury 133	Malignant Neoplasms 147	Malignant Neoplasms 482	Heart Disease 2,328	Malignant Neoplasms 2,826
2	Short Gestation ---	Congenital Anomalies ---	Congenital Anomalies ---	Heart Disease ---	Suicide 29	Suicide 43	Malignant Neoplasms 40	Heart Disease 128	Heart Disease 312	Malignant Neoplasms 2,139	Heart Disease 2,814
3	SIDS ---	Homicide ---	Malignant Neoplasms ---	Influenza & Pneumonia ---	Heart Disease ---	Heart Disease 13	Suicide 34	Unintentional Injury 110	Unintentional Injury 102	COVID-19 730	Unintentional Injury 872
4	Maternal Pregnancy Comp. ---	Malignant Neoplasms ---	Unintentional Injury ---	Malignant Neoplasms ---	Homicide ---	Malignant Neoplasms 12	Heart Disease 28	Suicide 46	Chronic Low. Respiratory Disease 81	Chronic Low. Respiratory Disease 556	COVID-19 779
5	Respiratory Distress ---	Septicemia ---		Unintentional Injury ---	Malignant Neoplasms ---	Liver Disease ---	Liver Disease 20	Liver Disease 43	Liver Disease 63	Cerebrovascular 506	Chronic Low. Respiratory Disease 656

5 Leading Causes of Death, United States 2020, All Races, Both Sexes

		Age Groups									
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 4,043	Unintentional Injury 1,153	Unintentional Injury 685	Unintentional Injury 881	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31,057	Malignant Neoplasms 34,589	Malignant Neoplasms 110,243	Heart Disease 556,665	Heart Disease 696,962
2	Short Gestation 3,141	Congenital Anomalies 382	Malignant Neoplasms 382	Suicide 581	Homicide 6,466	Suicide 8,454	Heart Disease 12,177	Heart Disease 34,169	Heart Disease 88,551	Malignant Neoplasms 440,753	Malignant Neoplasms 602,350
3	SIDS 1,389	Homicide 311	Congenital Anomalies 171	Malignant Neoplasms 410	Suicide 6,062	Homicide 7,125	Malignant Neoplasms 10,730	Unintentional Injury 27,819	COVID-19 42,090	COVID-19 282,836	COVID-19 350,831
4	Unintentional Injury 1,194	Malignant Neoplasms 307	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	Suicide 7,314	COVID-19 16,964	Unintentional Injury 28,915	Cerebrovascular 137,392	Unintentional Injury 200,955
5	Maternal Pregnancy Comp. 1,116	Heart Disease 112	Heart Disease 56	Congenital Anomalies 150	Heart Disease 870	Malignant Neoplasms 3,573	COVID-19 6,079	Liver Disease 9,503	Chronic Low. Respiratory Disease 18,816	Alzheimer's Disease 132,741	Cerebrovascular 160,264

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, Carroll County, and North Country Regional Public Health Networks (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.

Project partners include NAMI NH, the Behavioral Health Improvement Institute, 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): 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 TTT was held on March 22nd, 25th, & 30th 2021. We trained 13 individuals representing law enforcement, education, mental health/substance misuse, and public health.

Connect & C-SSRS Training with Jackson Police Department: The Jackson PD in Carroll County has been a consistent participant on the Carroll County Implementation Team since its formation in year one of the GLS project. Chief Perley indicated interest in a tool/training for officers to assess suicide risk in the field. The RPHN coordinator connected Chief to the GLS Project Coordinator (GLS PC) to explore options for training. The GLS PC and the Director of Suicide Prevention Services at NAMI NH worked together to develop a more comprehensive training process that included not only training on the C-SSRS, but foundational Connect Suicide Prevention training as well. This three-phase training plan included:

- Two hour Connect Suicide Prevention eLearning for all staff at the PD.
- Training for officers on the C-SSRS tool on the Columbia Lighthouse Project Website.
- Live virtual training tailored specifically for law enforcement including case scenarios and role-play opportunities.

The training was completed by May 6, 2021. This opportunity was made possible by leveraging the existing relationships within the regional IT to help identify individuals at risk in their respective communities and refer them to the appropriate level of care, instead of the standard drop off at the local emergency department (ED). Jackson PD is currently working with the Director of Suicide Prevention Services in engaging other local PDs in Carroll County in this initiative. This is significant, as it will likely lead to an increase in accessing community-based mental health supports and services and could decrease ED drop offs as the standard, and a decrease in stigma overall. Our evaluator at the Behavioral Health Improvement Institute (BHII) created a tool to measure outcomes associated with this work and we will continue to work together to track outcomes.

Capital Region Connect Suicide Prevention Training & Planning Session: The Capital Regional lacked the capacity to meet this deliverable in year 1, sighting the pandemic as a significant contributing factor in the inability to mobilize community stakeholders. Through technical assistance (TA)/support from the GLS PC and the Capital Regional Implementation Team, we were able to meet this deliverable early in year 2. This comprehensive community-based training and planning process was held on 1/21/2021 & 1/22/2021.

Special Olympics Suicide Prevention Presentation: The GLS PC provided training to the New Hampshire Special Olympics (SO) at their request. The presentation focused on warning signs and basic gatekeeper information regarding responding to young people at risk. Approximately 6 SO coaches were trained.

SOSL Coffee Chats: The GLS PC participates on the SOSL subcommittee of the NH SPC. Representation on this subcommittee ensures connectivity/support for youth and young adults as survivors of suicide loss here in New Hampshire. The GLS PC worked with committee members to create monthly opportunities for survivors of suicide loss to come together via Zoom and talk about healthy coping strategies and ways to process grief. We bring in guest speakers to share their experiences of loss and healing. The meetings are well attended, and the feedback has been very positive.

GLS Annual Partner Meeting: The 2nd Annual GLS Partner Meeting was held on May 3, 2021. This meeting provided all GLS contracted partners, stakeholders, and supporters with an opportunity to learn about the work completed in each year of the project. This year our evaluators from BHII provided a comprehensive data update, making relevant connections to all attendees.

Connect Youth Leader Training: Connect Youth Leader training provides high school youth and key staff with opportunities to support one another and enhance suicide prevention efforts on campus. Youth take an active role in educating and empowering their peers to engage in prevention and create a school culture conducive to normalizing conversations about mental health, and specifically, suicide. We were unable to hold this training in year 1. The GLS Connect Youth Leader training was held on May 13, 2021. We were able to train youth & staff in the North Country RPHNs at Berlin High School & White Mountains Regional High School.

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 to kill themselves. 2nd generation CALM trainers from Capital, Carroll County & the North Country RPHNs that were trained in year one of the project provided training to approximately 30 individuals in the three GLS regions and statewide on August 4, 2021.

Connect Suicide Postvention Training & Planning Session: Day One provides the six-hour training curriculum. Day Two applies Day One's training to develop a postvention response plan. The interactive planning process empowers a community to create a comprehensive plan based on 15 key postvention protocols and in the context of their culture and resources. The GLS Connect Postvention Training and Planning Sessions were held in each GLS region in October 2021.

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, recognizing stigma. This training is for young adults that have a passion for this public health issue and may be role models to peers in college or in the workforce. The GLS Connect Young Adult Leader training was held on December 2nd 2021 at NH Technical Institute (NHTI) and the Adult Learning Center in Conway, NH.

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.

NHTI: The GLS Coordinator at NHTI worked with campus safety to redevelop their suicide prevention policies and protocols. NHTI's GLS coordinator trained four peer counselors who provide regular support to identified students. The GLS Coordinator hosted other events to include a Mental Health Awareness Bonfire evening with 58 students and 2 faculty and staff in attendance to provide discussions to break the stigma regarding mental health issues. An "Ice Cream & Mental Health" event provided a space for a facilitated discussion about mental health and a game night was held to discuss stress management strategies among students.

Connect Online Suicide Prevention Training (eLearning Seats): The Connect Online Training Program is a self-paced course that takes about two hours to complete and provides informational and interactive slides that teach participants about risk and protective factors, warning signs, and how to respond to a person at risk for suicide. The three GLS regions provided a total of 1,774 Connect eLearning seats that included gatekeeper, school, healthcare, and mental health modules. For more information on the GLS NHNP 2.0 contact Susan Ward at sward@naminh.org

Manchester VA Zero Suicide Community of Practice

As not all Veterans receive their care through the Veterans Health Administration (VHA), implementing a comprehensive approach to suicide prevention that reaches all Veterans is only possible with community partner engagement. Manchester Veterans Administration Medical Center (VAMC), with the support of the NH State Suicide Prevention Council, engaged key community partner agencies across New Hampshire in a 9-month online community of practice (CoP). The Manchester VA Zero Suicide CoP provided opportunities for community partners to apply the organizing principles of Zero Suicide to their own suicide prevention practices. This CoP further facilitated stronger partnerships between VA and community agencies throughout the state.

Partners Engaged in the Community of Practice:

- Dartmouth Health
- Foundation for Healthy Communities
- Greater Nashua Mental Health Center
- Hampstead Hospital
- Jackson, Jackson & Wagner
- Lakes Region Veterans Coalition
- Makin' It Happen
- Mental Health Center of Greater Manchester
- New England College
- NH Department of Health and Human Services
- Northern Human Services
- Riverbend Community Mental Health Center
- White River Junction VAMC

The Foundation for Healthy Communities' Behavioral Health Clinical Learning Collaborative

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

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

Topics included:

- A Boston Children's Hospital emergency room physician provided an overview of caring for pediatric patients while in the emergency room. Resources included a self-care, no-cost packet with age-appropriate activities that can be used in the ED setting for pediatric patients with behavioral health conditions. Several hospitals also joined an ECHO project sponsored by Yale University on Pediatric Behavioral Health.
- The Collaborative held a panel discussion where valuable perspectives and experiences were shared on care considerations for members of the LGBTQIA+ community in the emergency room settings. Requests for healthcare staff included: Wear pronoun and/or ally pins; use inclusive language; and understand and respect patient sexual orientation and gender identity.
- The Collaborative worked with the Veterans Administration Medical Center in Manchester to create an overview of support services and care coordination options for veterans who present in emergency rooms.
- Following the Collaborative's production of the Suicide Screening & Intervention Strategy for New Hampshire Emergency Departments in 2020, Littleton Regional Healthcare was able to train over 70 hospital staff on the Connect Suicide Prevention Training. Funding for the initiative was supported by NAMI NH's Garret Lee Smith New Hampshire Nexus Project 2.0.

Annual NH Suicide Prevention Conference

The NH Annual Suicide Prevention Conference was held virtually on November 3-4, 2021. The theme for 2021 was Growth and Renewal. Leaders from multiple organizations, state agencies, and people with lived experience welcomed attendees in an earnest fashion that brought immediate engagement and trust that advocacy, resources, and support are growing, in spite of our second year of a worldwide pandemic. The conference offered more extensive tracks on November 3rd and a plenary and variety of workshops on November 4th.

Concepts of varying levels of mental wellness and mental health conditions were presented, in the context of lived experience and diversity. Voices of youth speaking about their mental health needs were featured as part of the plenary on November 4th.

NH Grown National Initiatives

Connect

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

In addition to providing live virtual Connect suicide prevention and postvention trainings, the Connect E-Learning training was well utilized, particularly by schools and health care providers. A total of 5,573 seats for Connect E-Learning were distributed in 2021, which expanded access to suicide prevention training in NH and other states around the U.S. In NH in 2021, there were 2,201 participants trained in Connect Prevention trainings and 1,125 in Connect Postvention trainings. 149 trainers were trained to help sustain their suicide prevention efforts in their respective organizations.

At the NH Police Academy, 209 new recruits also received training from Connect staff in suicide prevention and postvention as a standard part of their training curriculum, and the Department of Corrections also began implementing mental health and suicide prevention training for new recruits through NAMI NH.

Positive Outcomes and Testimonials

“This Conference saved my life”

Feedback from an attendee at the Annual NH Suicide Prevention Conference

Positive Outcomes and Testimonials

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

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

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

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

Feedback shared by Connect Suicide Prevention Training participants.

In collaboration with Jackson NH Police Department, the Connect Suicide Prevention training for law enforcement was modified to include the Columbia Suicide Severity Rating Scale for law enforcement. This brings a tool into broader knowledge about how to handle calls involving persons at risk. This Connect program was rolled out with two police departments in Carroll County.

Several schools in NH also implemented the Connect Youth Leader program, training 117 high school youth to partner with adults to lead this program for peers and teachers in their school and communities as a strong and vibrant protective factor. One young adult leader training was held during the pandemic. Both youth leader and young adult trainings were designed carefully to ensure safety and connectedness for these vulnerable populations.

NAMI NH's SurvivorVoices Speakers Bureau was also designed for a virtual delivery, after much careful research and development to assure a sensitive and safe environment to conduct this program.

Staff in the Connect program assisted individuals, schools, and communities to help with their healing after a suicide with over 130 hours of postvention support and technical assistance to communities and organizations in NH.

The Connect Program staff also provided virtual training and consultation throughout the country in 2021 in numerous states, including Alaska, Ohio, Oregon, Georgia, Colorado, and California.

Counseling on Access to Lethal Means - CALM

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

In 2021, CALM training continued to be in high demand both in NH and around the country. Master Trainers were added in Oregon, a partnership was established with PsychHub to develop an online version as part of their suite of evidence-based programs in suicide prevention, and work was completed with other groups to adapt CALM for several specific audiences. With the New York State Governors Challenge, a website geared towards friends and families of veterans was created to assist them in using CALM with their loved ones. Further, the NH Firearm Safety Coalition (NHFSC) is developing an online CALM training in collaboration with the American Academy of Pediatrics geared to those providing primary care for children and youth. CALM continues to be evaluated to demonstrate and improve its effectiveness.

Positive Outcomes and Testimonials

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

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

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

Feedback shared by 2018 CALM training participants.

The NH Firearm Safety Coalition

In 2021, the NHFSC continued to focus its work on the American Academy of Pediatrics (AAP) Project to develop an educational program for pediatricians and other child-focused primary care providers on why and how to provide lethal means counseling to their patients and their families. The NHFSC was selected for this project due to its experience in developing culturally appropriate training to effectively work with gun owning families. Due to the expansion of the project from a simple presentation format to an online, self-paced training module, the project will not be completed until 2022.

This year however, the bulk of the work has been completed. This includes developing the framework for the module, creating realistic scenarios, seeking and responding to feedback from AAP members and staff, geographically diverse pediatricians and other professionals as well as from gun-owning parents and teens to ensure that the finished product will be well-received.

The NHFSC hopes to return to in-person meetings and a fuller agenda in 2022.

Have you found this report to be useful?

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

<https://www.surveymonkey.com/r/RR3YM62>

2021 Data Update

SPC/YSPA Data Subcommittee Membership Representation 2021-2022

Injury Prevention Center at CHaD
NAMI New Hampshire (National Alliance on Mental Illness)
New Hampshire Army National Guard
State of New Hampshire Department of Corrections
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. The data were compiled by two major groups for suicide prevention in New Hampshire, the YSPA and the SPC. YSPA and SPC merged data efforts, combining historical expertise with emerging methods. YSPA has been collecting and analyzing data about youth and young adult suicide deaths and behavior over the last 20+ years and first created this report format in 2003. The SPC has been analyzing and planning for data capacity improvements since it was established in 2008. Key areas of interest and concern for suicidal behavior in NH are included in this report. A data interpretation and chart reading section has been included at the end of the report.

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, the primary source of death data has been changed to NH's implementation of the National Violence Death Reporting System (NH-VDRS).

NH DHHS collaborates with the NH Department of Justice (DOJ) on implementation of the NH-VDRS³ under the auspices of the OCME. The CDC currently includes all fifty states and Puerto Rico in the NVDRS project. NVDRS is a de-identified secure database system used by all US states. NH-VDRS utilizes the system to collect data on violent deaths in NH. Violent deaths include suicides, homicides, firearms accidents, and other violent deaths.

³ Disclosure: NH-NCDRS funding is from the Centers for Disease Control and Prevention Cooperative Agreement Number 6 NU17CE002610-04-02.

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

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 citation for the data source to prevent confusion. Different data sources also vary regarding how quickly the information is made available and how often it is collected/reported. 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 1.3 million residents (US Census Bureau, 2021). Overall, NH is relatively homogeneous in terms of race and ethnicity. It 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 month⁴ and the 13th highest rate for marijuana use in the past month (National Survey on Drug Use and Health, 2019-2020).

Table 1

Race/Ethnicity.

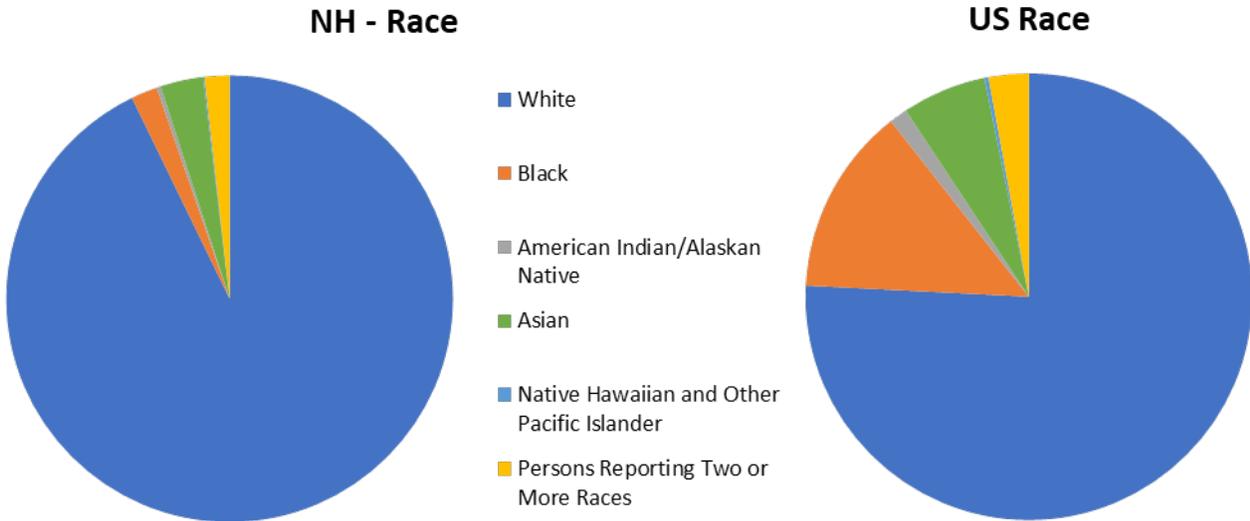
	New Hampshire	United States
Race		
White	92.8%	75.8%
Black	1.9%	13.6%
American Indian/Alaskan Native	0.3%	1.3%
Asian	3.1%	6.1%
Native Hawaiian and Other Pacific Islander	< 0.1%	0.3%
Persons Reporting Two or More Races	1.8%	2.9%
Ethnicity		
Persons of Hispanic or Latino Origin	4.4%	18.9%

Data Source: US Census Bureau 2021

⁴ “Past month” refers to the 30 days prior to the administration of the National Survey on Drug Use and Health.

Figure 1

NH and US Race/Ethnicity.



Data Source: US Census Bureau 2021

Table 2

Age.

	New Hampshire	United States
Under 18	18.46%	22.17%
18 to 24	8.85%	9.07%
25 to 44	24.94%	26.79%
45 to 64	28.49%	25.16%
65 to 74	12.00%	10.14%
75 and Up	7.26%	6.68%

Data Source: US Census Bureau 2021

Table 3

Economic Factors.

	New Hampshire	United States
Unemployed Residents	2.5%	3.4%
Persons Below Poverty Level	7.0%	11.4%
Persons Without Health Insurance (under age 65)	7.6%	10.2%
Per Capita Income (Yearly)	\$41,234	\$35,384
Median Household Income	\$77,923	\$64,994
Median Home Value (Owner Occupied)	\$272,300	\$229,800

Data Source: US Census Bureau American Community Survey 2020

Table 4

Education – Individuals Age 25 and Older.

	New Hampshire	United States
Less Than High School Graduate	6.7%	11.5%
High School Graduate or Associates Degree	55.7%	55.6%
Bachelor’s Degree or Higher	37.6%	32.9%

Data Source: US Census Bureau American Community Survey 2020

Table 5

Substance Use – Individuals Age 12 and Older.

	New Hampshire	United States
Marijuana Use – Past Month	14.33%	11.66%
Alcohol Use – Past Month	59.06%	50.40%
Tobacco Use – Past Month	19.25%	19.88%

Data Source: National Survey on Drug Use and Health, 2019-2020

Table 6

Mental Health Indicators – Individuals Age 18 and Older.

	New Hampshire	United States
Serious Mental Illness – Past Year	5.06%	5.44%
Major Depressive Episode – Past Year	9.12%	8.12%
Had Serous Thoughts of Suicide – Past Year	4.62%	4.84%
Made Any Suicide Plans - Past Year	1.39%	1.34%
Attempted Suicide - Past Year	0.57%	0.52%
Received Mental Health Services – Past Year	20.48%	16.54%

Data Source: National Survey on Drug Use and Health, 2019-2020

The Big Picture: Suicide in NH and Nationally

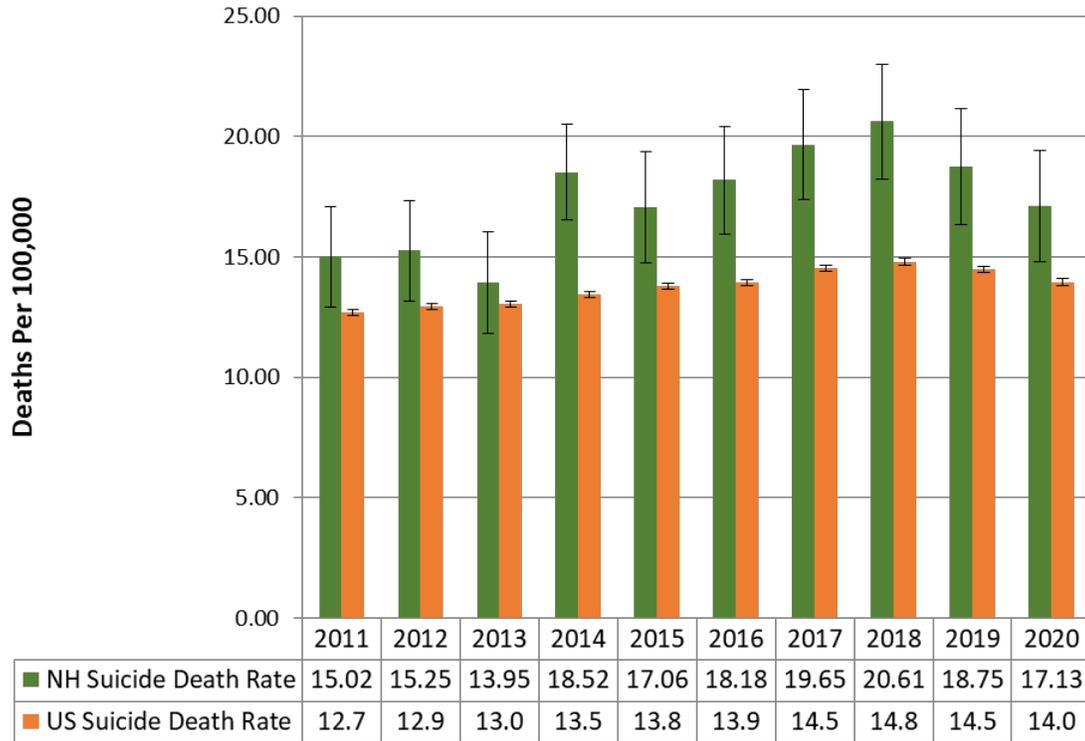
The Tables and Figures below depict various suicide related data. Some are specific to NH while others compare NH and national statistics.

Figure 2 (pg. 26) presents the suicide rate in NH and the US for the past ten years. The rate in NH has varied from year to year, due to its small size, while the US rate has remained more consistent year to year. Even though the NH rate has varied, until 2014 there had been no statistically significant differences from one year to the next since at least the year 2000. 2010 was the first year in recent history where there was a statistically significant difference compared to any other recent year. The 2010-2012 suicide rates are significantly greater than the rates for 2000, 2002, and 2004. This appears to be consistent with changes in the rates of suicide nationally. In 2014 there was a spike in the NH rate that brought it significantly above the rates prior to 2010. This increase was not seen in other states or for the US as a whole in 2014. The increase starting in 2014 continued through 2018, though not statistically significant from year to year. The rate decreased in 2019 and 2020, though neither were statistically significant changes from the immediately preceding years. This decreased rate in 2019 and 2020 matched a national trend.

Figure 2

Crude Suicide Death Rates per 100,000 in NH by Year 2011-2020.

NH and US Suicide Deaths By Year - 2011 to 2020 (Crude Rate)



Data Source: 2011-2020 – CDC WISQARS

Table 7 (pg. 27) displays the 10 leading causes of death for people of different age groups in NH. From 2016-2020, suicide among those aged 10-34 was the second leading cause of death in NH and nationally. Suicide rates for individuals age 15-34 during 2016-2020 were 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. Suicide among individuals of all ages was the 8th leading cause of death in NH, and the 10th leading cause of death nationally.

Table 7
10 Leading Causes of Death, New Hampshire, by Age Group, 2016 – 2020.

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Short Gestation 34	Unintentional Injury 12	Malignant Neoplasms ---	Malignant Neoplasms 12	Unintentional Injury 303	Unintentional Injury 784	Unintentional Injury 653	Malignant Neoplasms 823	Malignant Neoplasms 2,571	Heart Disease 11,383	Malignant Neoplasms 13,991
2	Congenital Anomalies 32	Congenital Anomalies ---	Unintentional Injury ---	Suicide 12	Suicide 162	Suicide 196	Malignant Neoplasms 206	Unintentional Injury 605	Heart Disease 1,469	Malignant Neoplasms 10,290	Heart Disease 13,659
3	Placenta Cord Membranes 16	Homicide ---	Benign Neoplasms ---	Unintentional Injury ---	Heart Disease 19	Malignant Neoplasms 59	Suicide 185	Heart Disease 599	Unintentional Injury 503	Chronic Low. Respiratory Disease 3,080	Unintentional Injury 4,526
4	Maternal Pregnancy Comp. 14	Malignant Neoplasms ---	Congenital Anomalies ---	Benign Neoplasms ---	Malignant Neoplasms 19	Heart Disease 56	Heart Disease 125	Suicide 259	Chronic Low. Respiratory Disease 409	Alzheimer's Disease 2,321	Chronic Low. Respiratory Disease 3,592
5	Respiratory Distress 12	Influenza & Pneumonia ---	Homicide ---	Congenital Anomalies ---	Homicide 17	Liver Disease 18	Liver Disease 80	Liver Disease 184	Liver Disease 287	Cerebrovascular 2,307	Cerebrovascular 2,587
6	SIDS 12	Diabetes Mellitus ---	Acute Bronchitis ---	Influenza & Pneumonia ---	Congenital Anomalies ---	Cerebrovascular 12	Diabetes Mellitus 29	Diabetes Mellitus 96	Diabetes Mellitus 267	Unintentional Injury 1,647	Alzheimer's Disease 2,355
7	Bacterial Sepsis ---	Heart Disease ---	Diseases Of Appendix ---	Chronic Low. Respiratory Disease ---	Chronic Low. Respiratory Disease ---	Homicide 11	Homicide 22	Chronic Low. Respiratory Disease 81	Suicide 222	Diabetes Mellitus 1,298	Diabetes Mellitus 1,702
8	Circulatory System Disease ---	Septicemia ---	Heart Disease ---	Heart Disease ---	Cerebrovascular ---	Diabetes Mellitus ---	Cerebrovascular 21	Cerebrovascular 71	Cerebrovascular 171	Influenza & Pneumonia 977	Suicide 1,277
9	Intrauterine Hypoxia ---	---	---	Nephritis ---	Diabetes Mellitus ---	Complicated Pregnancy ---	Chronic Low. Respiratory Disease 13	Septicemia 35	Septicemia 94	Parkinson's Disease 838	Influenza & Pneumonia 1,074
10	Unintentional Injury ---	---	---	Pneumonitis ---	Four Tied ---	Septicemia ---	Congenital Anomalies ---	Nephritis 27	Nephritis 82	Nephritis 787	Liver Disease 935

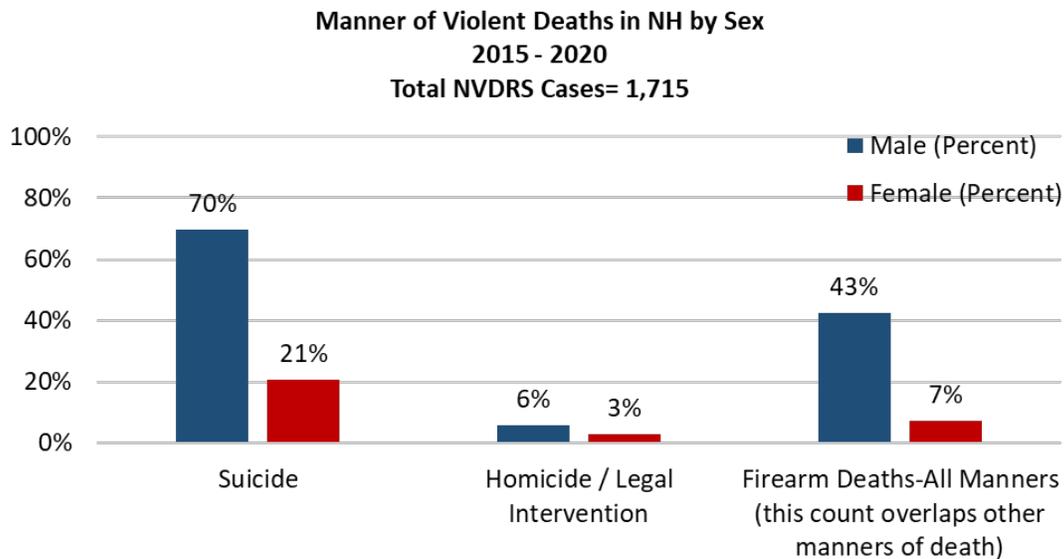
Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Data Source: National Center for Health Statistics, National Vital Statistics System

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

The vast majority of violent deaths in NH are suicides. For every homicide in NH, there are approximately 12 suicides. This ratio is in sharp contrast to national statistics, which show approximately 2 suicides for every homicide. For every suicide death in NH and nationally, there are approximately 4 deaths classified as unintentional injuries (CDC WISQARS, 2016-2020). Overall, suicide constitutes a larger proportion of all traumatic deaths in NH than in the US as a whole. The breakdown of violent deaths⁵ in NH by gender is presented below in **Figure 3**.

Figure 3
Males die of violent deaths of all manners at rates greater than those for females.



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

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

Table 8
Crude Suicide Death Rates per 100,000 in NH & US, by age group, 2016-2020.

	ALL AGES	YOUTH 10 TO 17	YOUNG ADULTS 18 TO 24	YOUTH AND YOUNG ADULTS 10 TO 24
NH	18.85	5.30	22.39	13.89
US	14.33	5.05	16.08	10.31

	AGES 25 TO 39	AGES 40 TO 59	AGES 60 TO 74	AGES 75 AND OVER
NH	23.45	25.26	18.60	21.50
US	17.59	19.27	16.28	18.84

Data Source: CDC WISQARS

⁵ Violence deaths include suicide, homicide, and any firearm related death regardless of intent.

Adults age 40 to 59 had the highest suicide rates of all age groups identified above (25.26 NH, 19.27 US) from 2016-2020 in both NH and the US. There is a substantial increase in the rates from youth (ages 10-17) to young adults (ages 18-24) revealing the transition from middle/late adolescence to late adolescence/early adulthood as a particularly vulnerable time for death by suicide.

Youth and Young Adult Suicide in NH

Between 2015 and 2020, 188 NH youth and young adults aged 10-24 have lost their lives to suicide. Males in this age group are much more likely to die by suicide in NH (80%) and nationwide (79%). Hanging and firearms were the most frequently used methods in NH among youth and young adults during this period, with firearms being used with a slightly higher frequency. Nationally, a greater proportion of youth and young adults who die by suicide use firearms.

Table 9 (pg. 32) presents the number of youth and young adult deaths by year. This year-by-year data has been plotted in **Figures 4 and 5** (pg. 30). 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. 73) helps to smooth out small year to year fluctuations, and also addresses population increases by presenting rates per 100,000.

Positive Outcomes and Testimonials

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

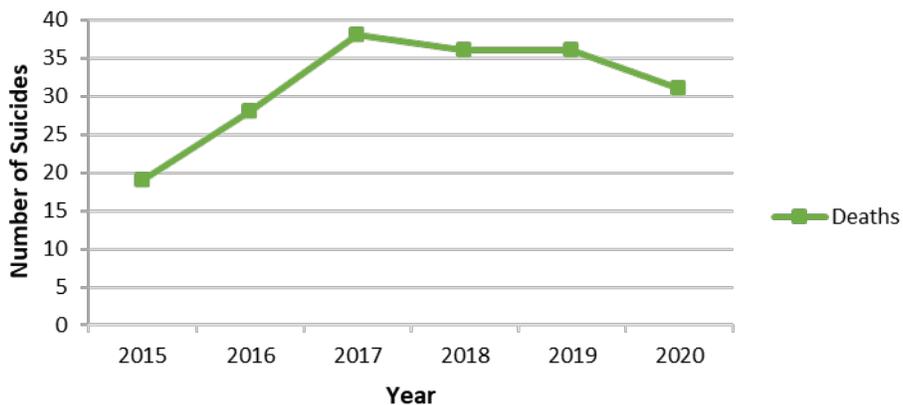
During the process the student's mother shared that her son had been asking for permission to take his father's rifle and go out into the woods near their home. The mother had denied his request and explained her safety concerns to him.

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

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

Figure 4

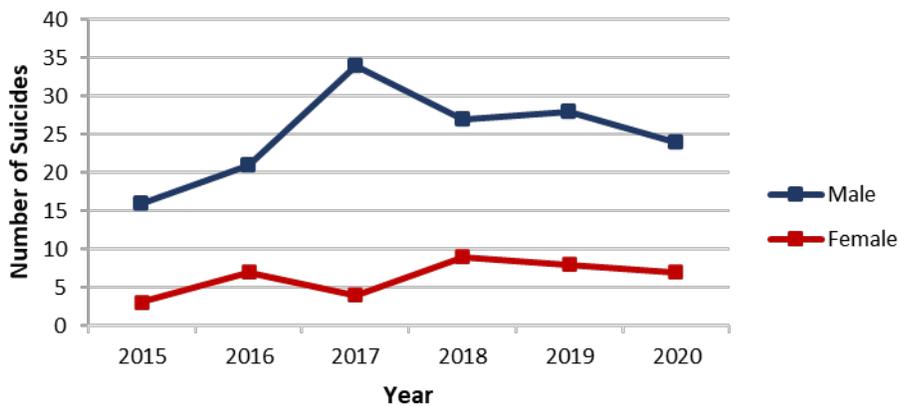
**Suicide Deaths of NH Youth Ages 10-24
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 5

**Suicide Deaths by Gender - NH Youth Ages 10-24
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

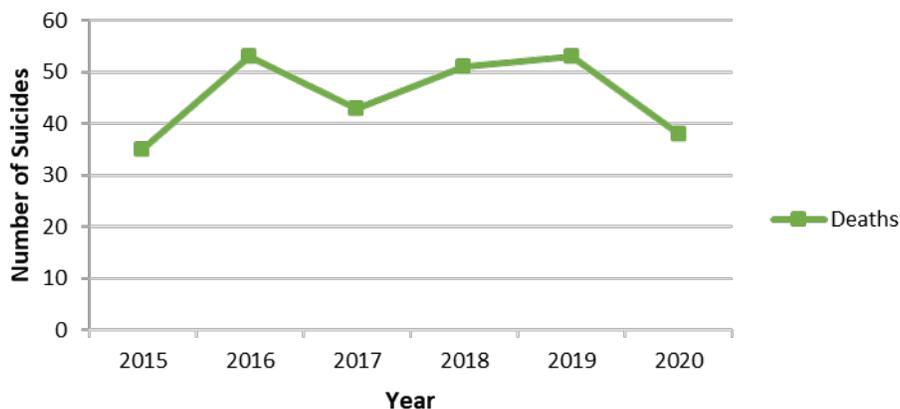
Older Adult Suicide in NH

In light of the rapidly expanding number and proportion of older adults in New Hampshire's population, suicide in older adults is a growing public health concern. Added to the changing demographics is the rising prevalence of mental illness and substance disorders. Untreated mental illness such as depression is a significant risk factor for suicide among all ages, but it is particularly of concern in later life as older adults with depression or other mental health conditions receive treatment at markedly lower rates than the rest of the population.⁶

Another concern is the rate of attempts to suicides deaths for older adults. The lethality rate in people over 65 years of age is markedly higher in comparison to other age groups. While there is one death for every 36 attempts in the general population, there is one death for every four attempts in individuals over 65. One related factor is that aged individuals may be physically frailer than younger individuals and are therefore less likely to survive self-injurious acts. A second is that older adults tend to be more isolated than younger people, making detection or timely intervention less likely. A third factor is the lethality of means; compared to other age groups, adults over 65 are more likely to use firearms as a means of suicide (**Figure 42** – pg. 59).

Figure 6

Suicide Deaths of NH Older Adults (Ages 65+) 2015 - 2020

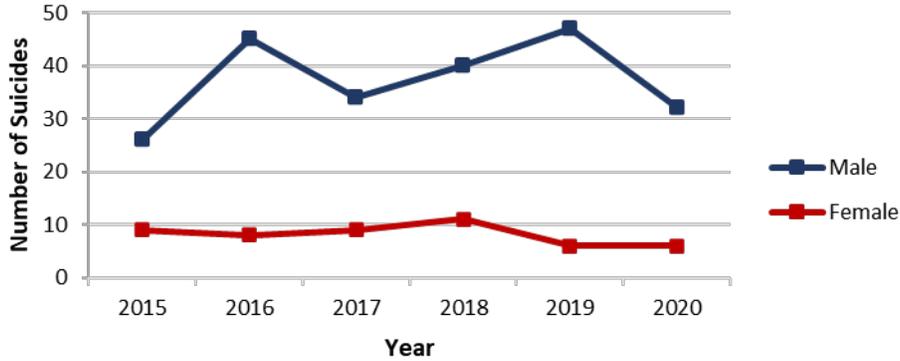


Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

⁶ Conwell Y. Suicide and suicide prevention in later life. *Focus* 2013; 11(1): 39–47.
http://www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Suicide%20Prevention%20Webinar%20Presentation%20Slides2.pdf#page=14

Figure 7

**Suicide Deaths by Gender - NH Older Adults
(Ages 65+)
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Suicide Across the Lifespan in NH

Table 9 presents the number of suicide deaths in NH by year, by gender, and selected age groups. These counts include both NH residents and out-of-state residents who died by suicide in NH. When comparing year to year, there is a noticeable increase in the number deaths from 2015 to 2020. The proportion of deaths by gender and age group remained relatively consistent from one period to the next. The number of deaths by year have been plotted in **Figure 8** (pg. 33) and **Figure 9** (pg. 33).

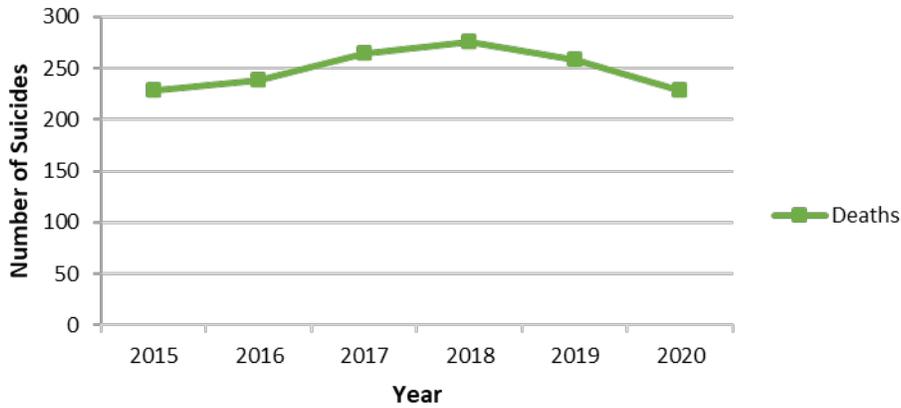
Table 9
NH All Ages Suicide Death Trend, by Gender, Age Group and Method, 2015-2020.

Year	Total	Male	Female	≤ 24	25-64	65+
2015	228	164	64	19	174	35
2016	238	180	58	28	157	53
2017	264	206	58	38	183	43
2018	276	219	57	36	189	51
2019	258	206	52	36	169	53
2020	229	176	53	31	160	38
Total	1493	1151	342	188	1032	273
Percent of Total	100 %	77%	23%	13%	69%	18%

Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 8

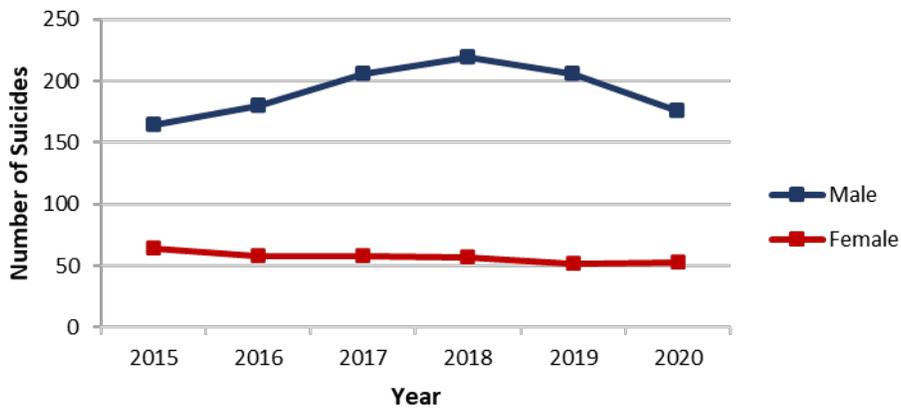
NH Suicide Deaths - All Ages
2015 - 2020



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 9

NH Suicide Deaths by Gender - All Ages
2015 - 2020



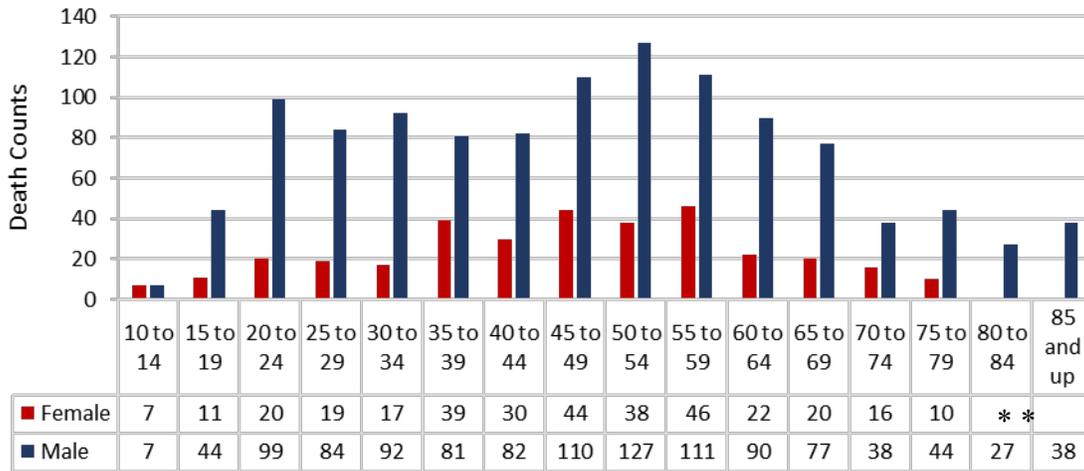
Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 10 (pg. 34) and Figure 11 (pg. 35), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and gender from 2015-2020. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal how death rates correct for differences in the size of each age group. While the highest number of suicide deaths occur in the 45 to 59 year-old age groups, the highest rates, or those at the greatest risk, are males over the age of 85. This is followed by males between the ages of 50 and 54. This second high-risk group is younger than has been seen in past years, where individuals in their 70's generally exhibited higher rates of suicide than individuals in their 40's and 50's.

Figure 10

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

**NH Resident Suicide Deaths Counts by Age Group
2015 - 2020**



*Note: Counts/Rates for categories with fewer than six deaths have been suppressed.

Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

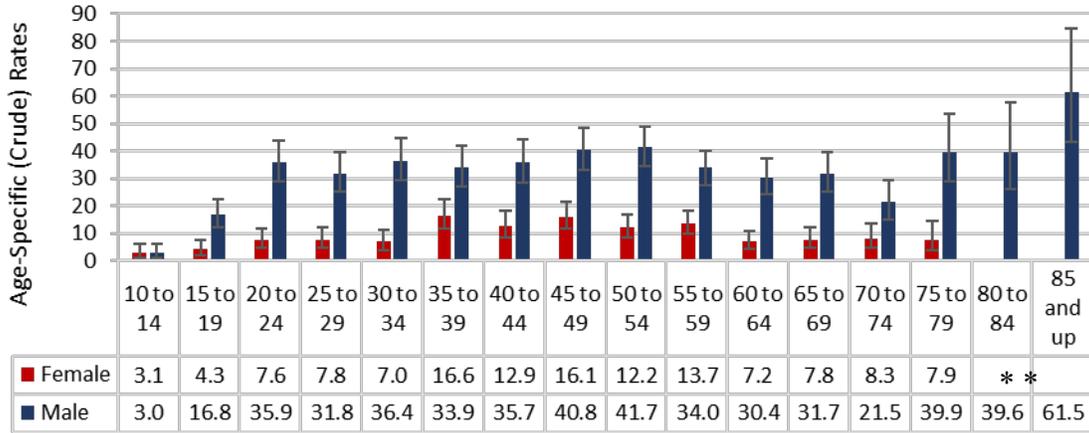
Suicide death rates are also important in determining vulnerable age groups and age-related transitions. The suicide death rate in males rises rapidly from ages 10-14 to 15-19 and then again from ages 15-19 to 20-24, pointing to a rise in vulnerability during the transitions from early adolescence to middle adolescence and then middle adolescence to late adolescence/early adulthood. Similarly, suicide rates among elderly males increase substantially at 85 years compared to the younger age groups, indicating another vulnerable time of life for men. As mentioned above, there has been a recent increase in the suicide rates among individuals between the ages of 45 and 59. This may indicate an additional transition period where individuals are vulnerable.

Quick Facts/Talking Points

- Males in NH die by suicide at a rate that is over three times the rate for females (CDC WISQARS, 2022).
- Although males are more likely than females to die by suicide, females report attempting suicide at nearly twice the rate of males (NH YRBS, 2019)
- Suicides are preventable (WHO. Suicide prevention: a global imperative. Geneva, Switzerland: WHO Press; 2014).

Figure 11

**NH Resident Suicide Deaths Rates by Age Group
(Rates per 100,000)
2015 - 2020**



*Note: Counts/Rates for categories with fewer than six deaths have been suppressed.

Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

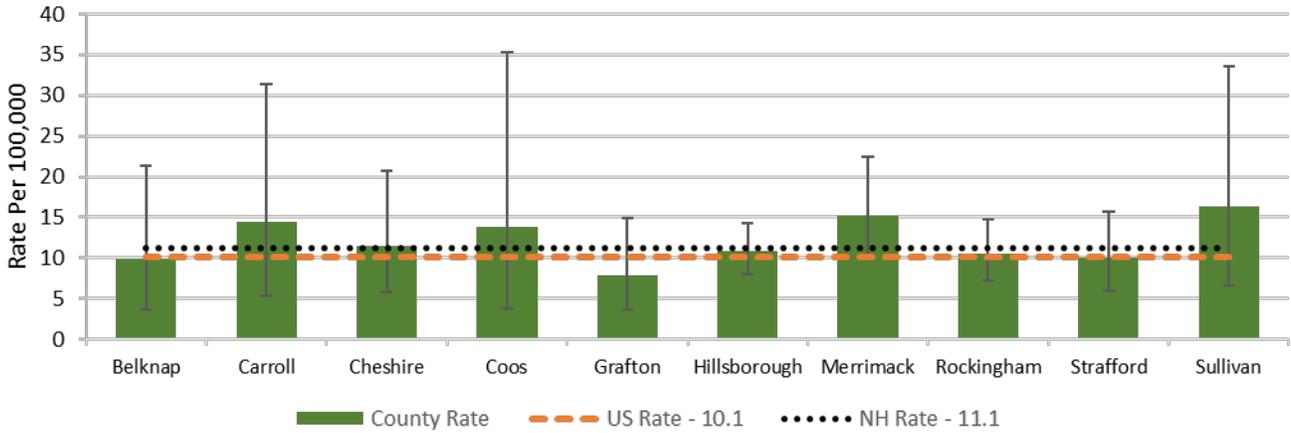
Geographic Distribution of Suicide in NH

The numbers and rates of suicide in NH are not evenly distributed throughout the state. **Figure 12** (pg. 36) shows youth and young adult suicide rates by county in NH. **Figure 13** (pg. 36) presents this data for NH residents of all ages⁷. 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 rate (**Figure 13** – pg. 36) for Rockingham County (all-ages rate: 14.6 per 100,000) is significantly lower than the all-ages suicide rates for Merrimack County (all-ages rate: 21.0 per 100,000). The rates for Belknap County (all-ages rate: 18.6), Carroll County (all-ages rate: 20.1 per 100,000), Coos County (all-ages rate: 22.5 per 100,000), Hillsborough County (all-ages rate: 17.3 per 100,000), Merrimack County (all-ages rate: 21.0 per 100,000), and Sullivan County (all-ages rate: 20.1 per 100,000) were significantly higher than the all-ages US rate (all-ages rate: 14.2 per 100,000). County limits are neither soundproof nor absolute. A suicide that occurs in one county can have a strong effect on neighboring counties, as well as across the state, due to the mobility of residents. **Figure 14** (pg. 37) presents the suicide rates for all-ages from 2015 to 2020 as a NH map broken down by county.

⁷ County level analyses exclude any cases where location data were unknown or otherwise not available. Eight cases were excluded due to missing data for 2015-2019.

Figure 12

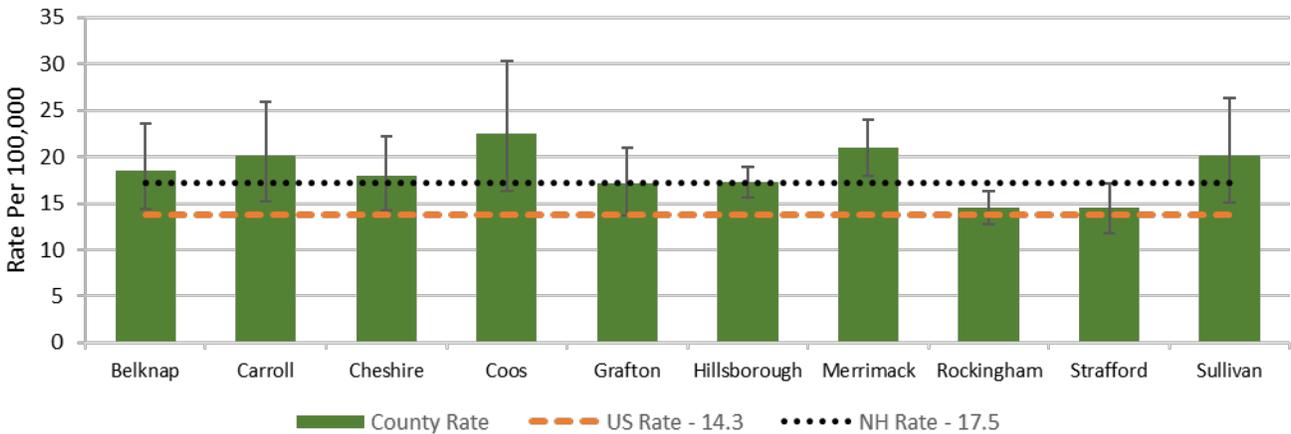
**NH Youth Suicide Crude Death Rates by County - Ages 10 - 24
2015 - 2020**



NH Rate Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program
US Rate Data Source: CDC WISQARS

Figure 13

**NH Resident Suicide Crude Death Rates by County - All Ages
2015 - 2020**



NH Rate Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program
US Rate Data Source: CDC WISQARS

Figure 14
Map of NH suicide death rates

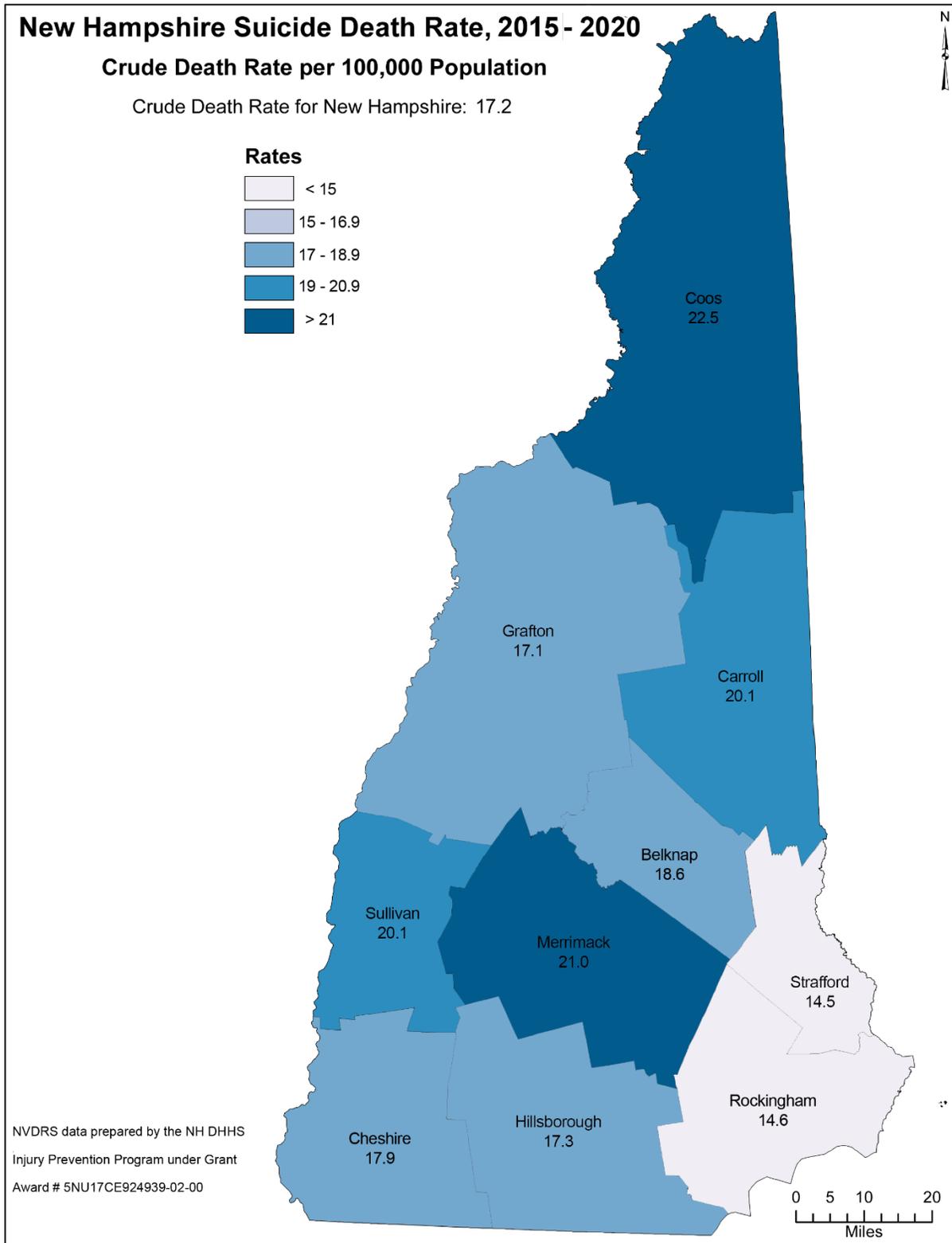


Table 10 (below) further expands upon this county breakdown by presenting the percent of suicide deaths in each county by gender. In the majority of counties, the ratio is four male deaths for every one female death. The exceptions to this include Belknap, Hillsborough, Merrimack, and Rockingham Counties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

Table 10
2015 - 2020

Percent of Suicide Death by Gender in NH Counties

	Percent of Female Deaths in County	Percent of Male Deaths in County	Male to Female Suicide Death Ratio in County	Percent of Female County Residents	Percent of Male County Residents	Male to Female Population Ratio
Belknap County	25%	75%	3:1	51%	49%	1:1
Carroll County	19%	81%	4:1	50%	50%	1:1
Cheshire County	18%	82%	4:1	51%	49%	1:1
Coos County	21%	79%	4:1	48%	52%	1:1
Grafton County	20%	80%	4:1	51%	49%	1:1
Hillsborough County	26%	74%	3:1	50%	50%	1:1
Merrimack County	23%	77%	3:1	51%	49%	1:1
Rockingham County	23%	77%	3:1	50%	50%	1:1
Strafford County	19%	81%	4:1	51%	49%	1:1
Sullivan County	21%	79%	4:1	51%	49%	1:1

Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

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

Youth and Gender

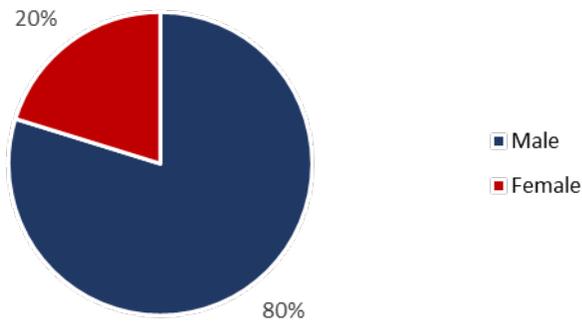
While males represent 80% of the youth and young adult suicides from 2015-2020, the fact that males *die* by suicide at a higher rate than females may largely be due to males using more lethal means. See **Figures 15** (pg. 39) and **16** (pg. 39). In fact, females *attempt* suicide at a higher rate than males. When examining how many NH youth and young adults ages 10-24 were hospitalized and then discharged for self-inflicted injuries in 2015-2020, it is shown that 68% of the 772 inpatient discharges represent females, while only 32% represent males. Likewise, the 2019 NH Youth Risk Behavior Survey (YRBS) reports approximately 1.6 times as many female youth attempt suicide as males each year (8.4 % of females and 5.3% of males). Emergency department (ED/ambulatory) data reveals a similar gender ratio, based on self-inflicted injury rates.⁸

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

Figure 15

Four times as many male NH residents ages 10-24 died by suicide 2015-2020.

**NH Resident Suicide Deaths by Gender
- Ages 10-24
2015 - 2020**

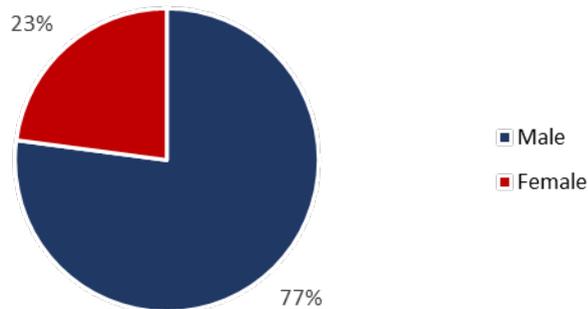


Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 16

For NH residents of all ages, three times as many males died by suicide than females during 2015-2020.

**NH Resident Suicide Deaths by Gender
- All Ages
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

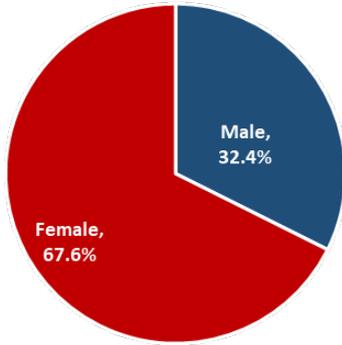
Female youth are less likely to die by suicide, possibly resulting from less severe injuries during suicide attempts (self-inflicted injuries). However, female youth do attempt suicide more frequently than males – 1.3-2.3 times as often (**Figure 17, Figure 18, and Figure 19** – pgs. 41-42). This report refers to three types of 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 one 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). 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. The NH Department of Safety, Division of Fire Standards and Training and Emergency Medical Services reports that pre-hospital care (EMS) was significantly impacted by COVID-19 in 2020. Self-harm/Suicide attempt calls were down approximately 8%, while the total number of incidents was down approximately 15%. In 2021 the number of calls returned to approximately the same level that was seen prior to COVID-19.

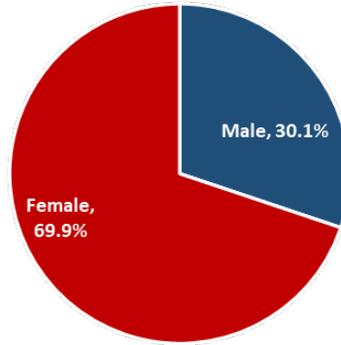
Figure 17

A greater percentage of female than male NH residents attempted suicide, as seen in inpatient and emergency department discharges related to self-inflicted injuries 2016-2020.

**NH Inpatient Discharges for Self-Inflicted Injuries by Gender - Ages 10 - 24
2016 - 2020**



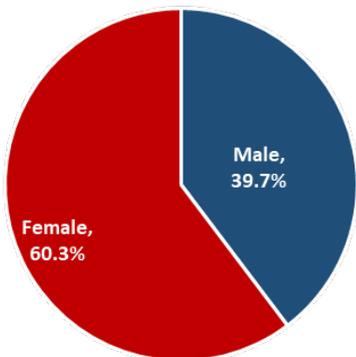
**NH Emergency Department Discharges for Self-Inflicted Injuries by Gender - Ages 10 - 24
2016 - 2020**



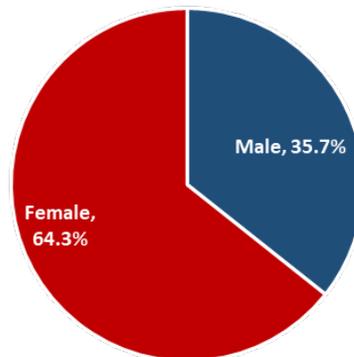
Data Source: NH Hospital Discharge Data by the NH DHHS Injury Prevention Program

Figure 18

**NH Inpatient Discharges for Self-Inflicted Injuries by Gender - All Ages
2016 - 2020**



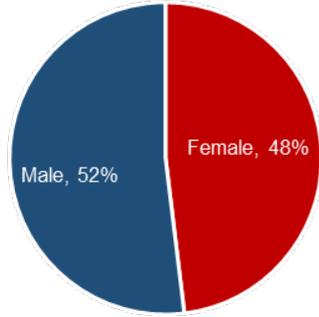
**NH Emergency Department Discharges for Self-Inflicted Injuries by Gender - All Ages
2016 - 2020**



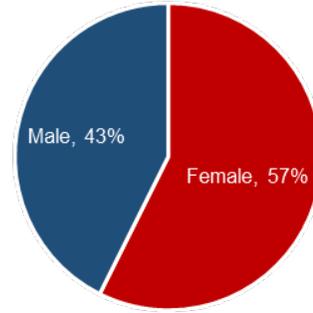
Data Source: NH Hospital Discharge Data by the NH DHHS Injury Prevention Program

Figure 19

Self-Harm by Gender
All Ages, 2021



Self-Harm by Gender
Ages 0-24, 2021



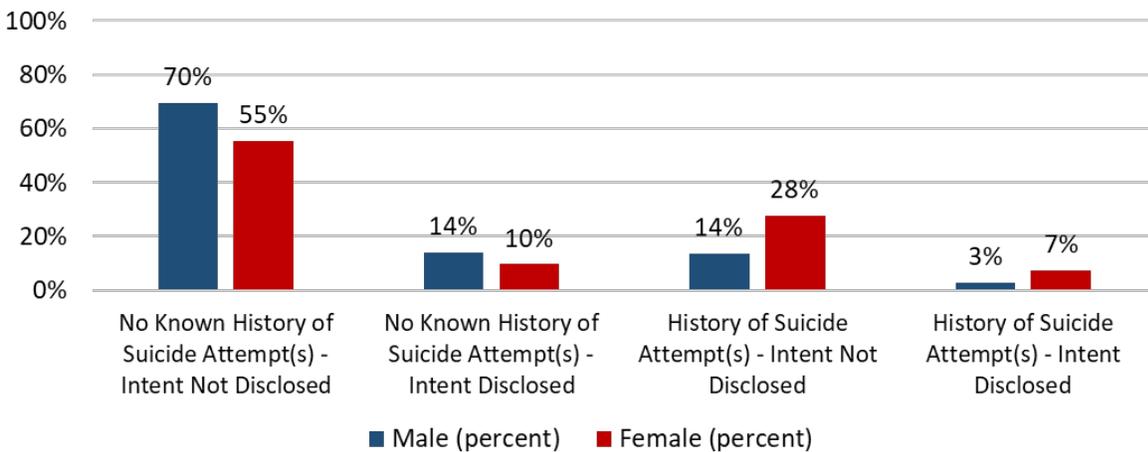
Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

History of Suicide Attempts and Intent Disclosure

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

Figure 20

Suicide Deaths in NH - History of Suicide and Suicide Intent Disclosure by Sex
2015 - 2020



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

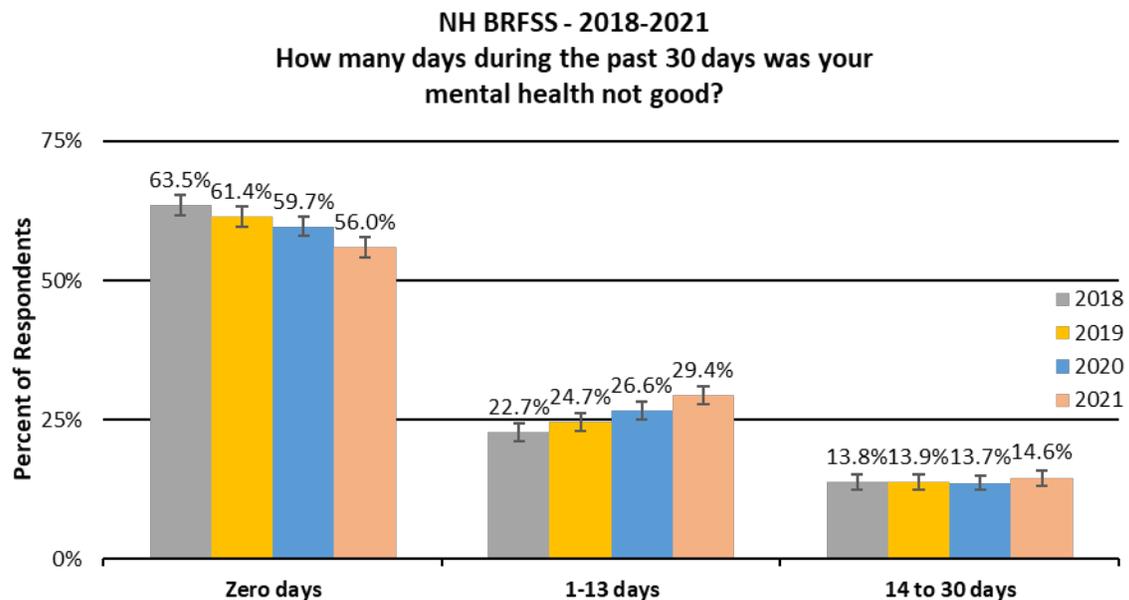
Disclosure of suicidal intent and prior suicide attempt(s) are significant risk factors for suicide. If you are concerned about an individual with these or other risk factors, connect them with appropriate resources such as the 988 Suicide and Crisis Lifeline – Call/Text 988 or a local mental health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

NH Behavioral Risk Factor Surveillance System (BRFSS)

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

Figure 21

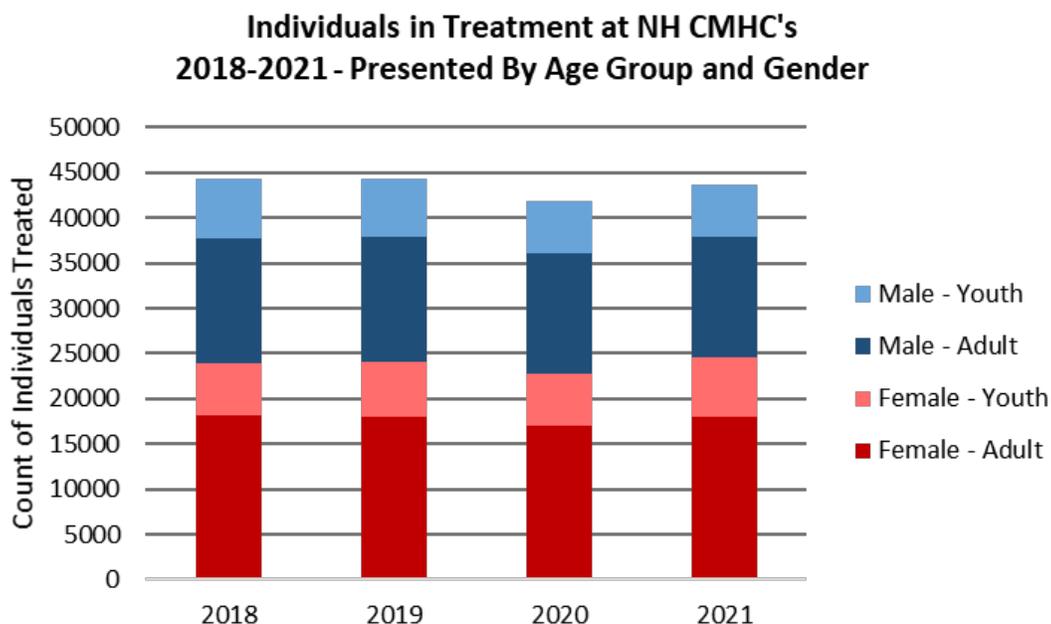
NH BRFSS – Number of Days Mental Health Was Not Good - NH Residents Age 18 and Over.



Data Source: BRFSS data prepared by NH DHHS BPHSI

Gender differences exist not only for suicide attempts and deaths, but also for help-seeking behavior. A 2018 CDC report indicated that approximately half of individuals who take their own life had a mental health condition; the most common diagnoses being depression, anxiety, and substance use disorders⁹. Yet a much smaller percentage were receiving treatment. In NH, over 43,500 people received treatment at one of the state’s ten Community Mental Health Centers (CMHC)¹⁰ each year. In 2021, this works out to approximately 1 out of every 32 residents in the state. Of those individuals in treatment, approximately 57% of them were female and 43% were male. This is illustrated in **Figure 22** (below). Without additional data it is not possible to say how these numbers relate to the connection between these treatment figures and the greater number of suicide deaths among males and/or the greater number of suicide attempts reported among females.

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



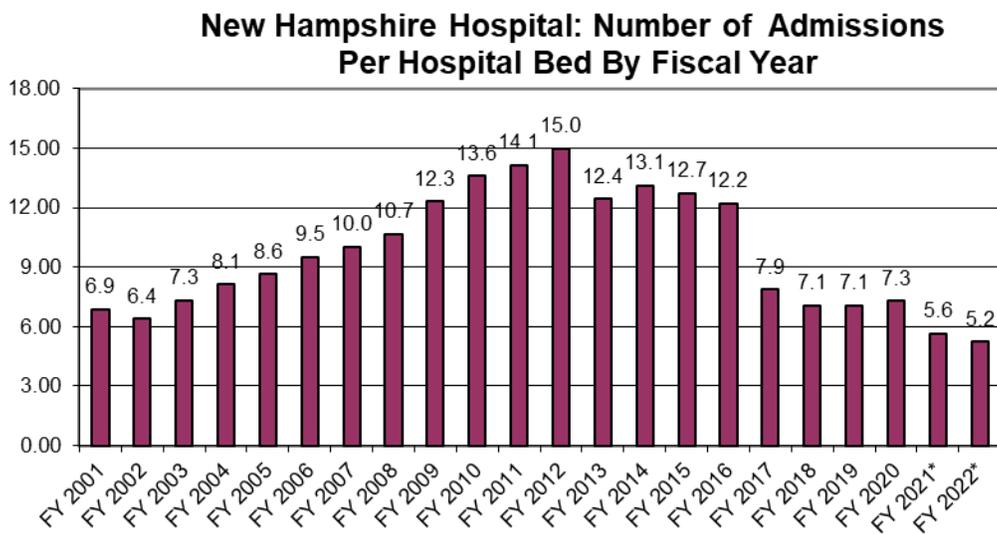
Data Source: NH Bureau of Behavioral Health

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

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

Patients that cannot be treated in an outpatient setting, such as involuntary admissions due to potential suicide risk, will generally be admitted to New Hampshire Hospital, the NH state psychiatric hospital. In an average year there are approximately 1,101 admissions to New Hampshire Hospital (estimates based on New Hampshire Hospital admissions for fiscal years 2018 - 2022¹¹). **Figure 23** (below) presents the total number of admissions per bed at New Hampshire Hospital. It is worth noting that at any given time, over 30 percent of the beds at New Hampshire Hospital are occupied by individuals who no longer require that level of care. These individuals are unable to be discharged due to a shortage of appropriate community based supports such as nursing home beds, community residence beds, and apartments with intensive outpatient supports.

Figure 23



Data Source: New Hampshire Hospital

*The number of admissions per bed were calculated based on the total number of beds in each fiscal year. In State Fiscal Years 2021 and 2022 there were substantial temporary decreases to the number of beds able to be used due to COVID-19 related quarantining and staffing shortages.

Positive Outcomes and Testimonials

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

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

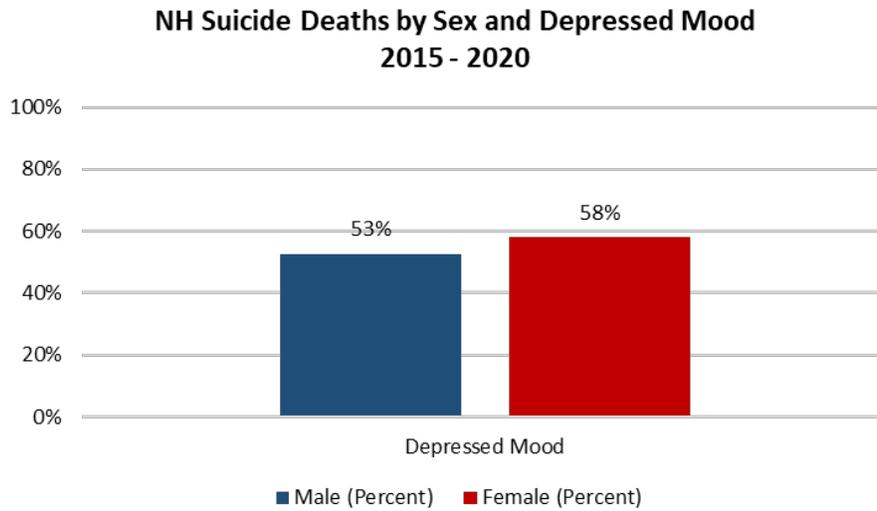
Maggie Pritchard
 Executive Director, Lakes Region Mental Health
 Former Vice-Chair, NH Suicide Prevention Council

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

Mental Health and Suicides in NH

Among the various risk factors for suicide in NH, depression and depressed mood¹² figure prominently. From 2015 to 2020, over half of all individuals who died by suicide in NH were reported to have a depressed mood around the time of death. A slightly greater proportion of females than males were reported to have been experiencing a depressed mood (**Figure 24** – below).

Figure 24



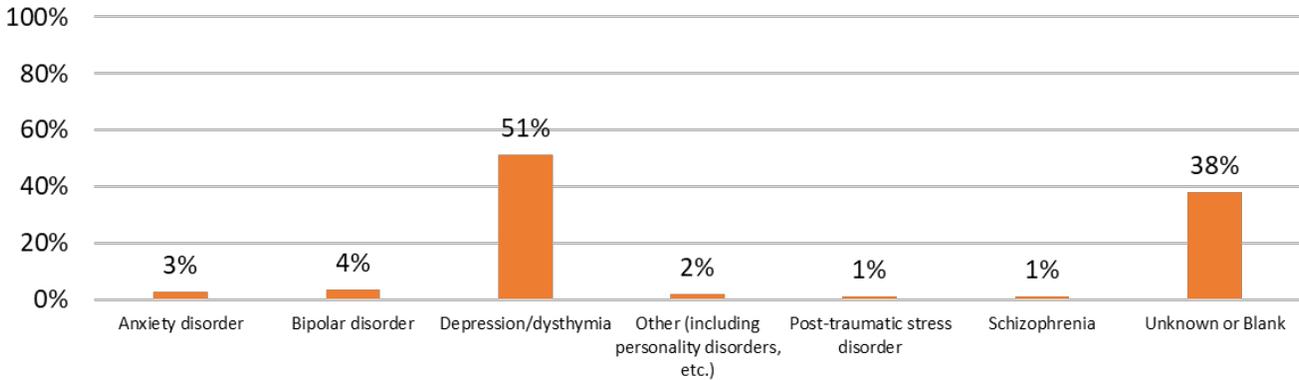
Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 25 (pg. 47) 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. The categories in the graph below are based on counts in a data field that represents the primary mental health diagnosis. Some decedents may have had more than one mental health diagnosis.

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

Figure 25

**Suicide Deaths in NH by Mental Health Diagnosis
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Age, Gender and Self-inflicted Injury

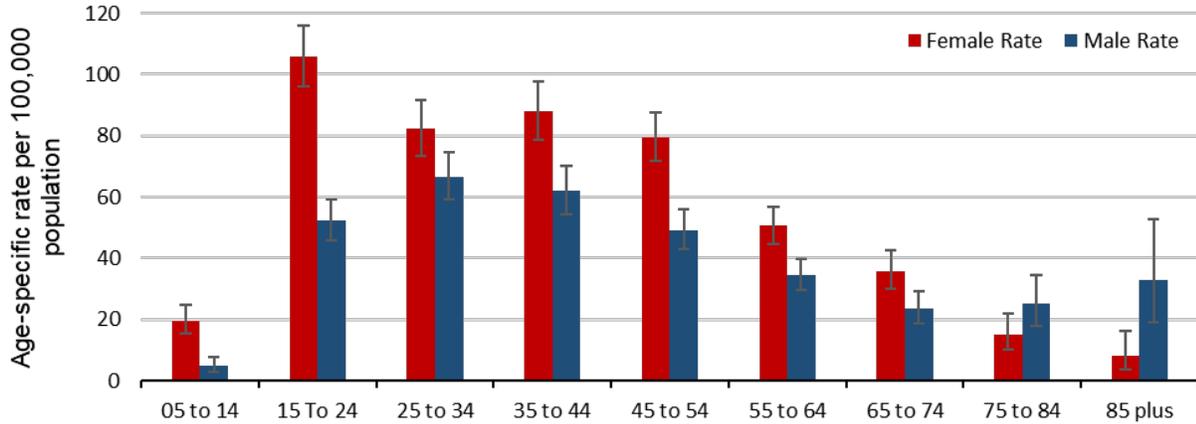
When the rates for NH resident inpatient hospitalizations/discharges and emergency department use for self-inflicted injuries from 2016-2020 are examined by gender and age group, the variability can be seen (**Figures 26 and 27** – pg. 48). As above, these data refer to number of visits; therefore, individuals 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 26** – pg. 48) is 105.6/100,000, more than twice the rate for males of the same age. The peak age for males is between 24 and 34 for self-inflicted injuries requiring an inpatient admission. Again, ED usage rates, depicted in **Figure 27** (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 541.8/100,000, about 90 times the suicide death rate for this population. Males also peak in self-injury around this age group with the male rates for ages 15 to 24 being 261.4/100,000. Although male rates peak around this age group, their rates are much lower than those for females. Also of note, the total number of youth and young adult (ages 15-24) ED visits (3,480) is 5 times greater than the number of inpatient discharges for this population. Because less severe injuries are more common among self-inflicted youth injuries, there are many more attempts than deaths. This data reinforces that the transition from middle adolescence to late adolescence/early adulthood is a time of great risk for suicidal thinking, self-harm and suicide attempts. EMS data (**Figure 28** – pg. 49), which includes individuals treated and/or transported by Emergency Medical Services for a self-inflicted injury, presents a similar picture to the hospital data in terms of high-risk age groups. Females aged 15 to 24 present the highest rates of self-inflicted injuries. In most other age groups, male rates exceed the rates for females in the EMS data.

Figure 26

NH female residents ages 15-24 and 35-44 show the highest rates of suicide attempts, higher than males of any age group.

NH Resident Inpatient Discharges for Self-Inflicted Injuries by Age Group and Gender 2016 - 2020

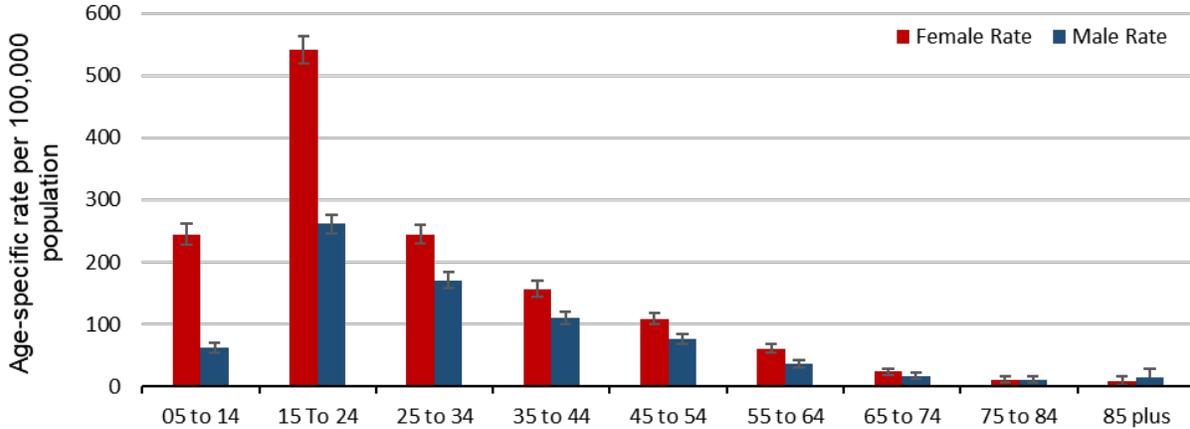


Data Source: NH Hospital Discharge Data prepared by the NH DHHS Injury Prevention Program

Figure 27

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

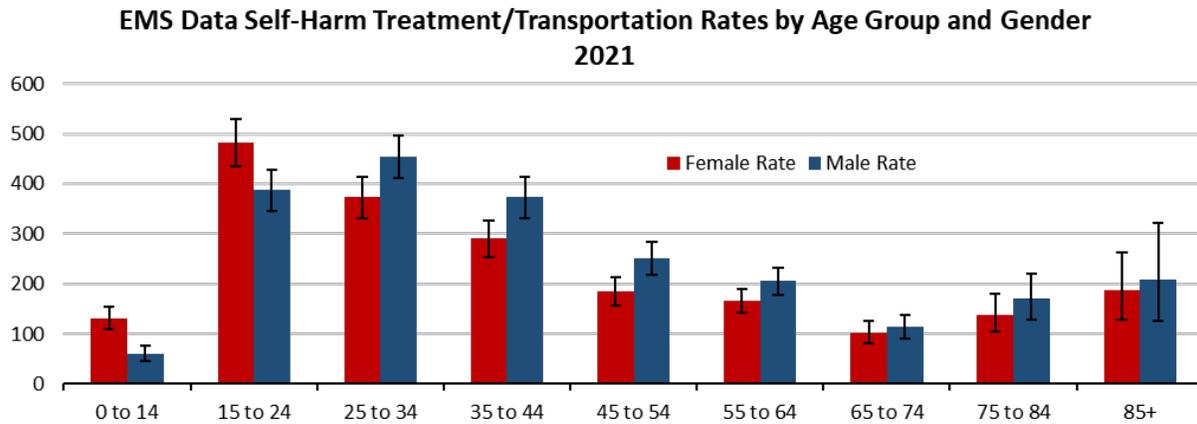
NH Resident Emergency Department Discharges for Self-Inflicted Injuries by Age Group and Gender 2016 - 2020



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

Figure 28

NH female residents ages 15-24 show the highest rates of suicide attempts followed closely by males in the 25-34 age group.



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

According to inpatient and emergency department (ED) discharge data across all ages in NH, there are approximately 10 suicide attempts for every suicide death. This number does not include attempts that go unreported, unrecognized, or without a hospital or ED visit which required medical intervention. Further, the rates of attempts for young people and females create an even greater ratio of suicide attempts to deaths. Based solely on hospital and emergency department self-injury data, it can be estimated that over 1,072 youth and young adults (age 24 and under) attempt suicide each year in NH.

Positive Outcomes and Testimonials

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

In contrast to the above data, which are based on cases where medical intervention is required, the results of the YRBS presents data collected from high school aged youth by self-report. In 2019, nearly 7 percent of high school students completing the YRBS reported having attempted suicide at least one time over the previous year. Based on the YRBS figures, this works out to over 3,800 high school age youth in NH who may attempt suicide each year. The YRBS reports may account for attempts not included in hospital self-injury data. This could be the case for any attempts with relatively non-lethal means where medical assistance was not sought. Of particular concern for this data is the likelihood that in many of these cases, the youth have never sought help or disclosed the attempt to any adult. It is also possible that self-reports exaggerate the incidence of suicide attempts among high school age youth.

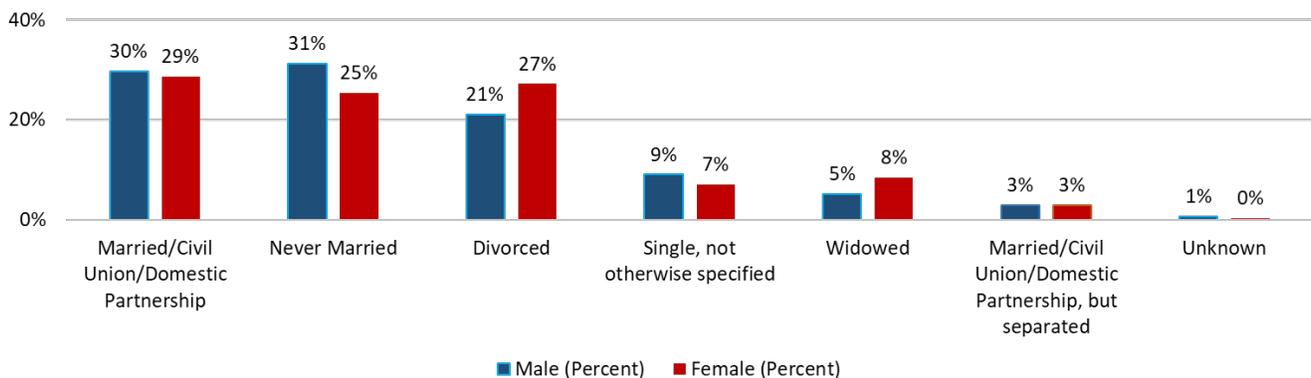
While the great majority of self-inflicted injuries¹³ are not fatal, because of the larger incidence they may directly and indirectly affect a greater number of people than fatalities. A significant risk factor for suicide is a previous attempt: in one study 21-33% of people who die by suicide have made a previous attempt (Shaffer & Gould, 1987). Therefore, any suicide attempt, regardless of its lethality, must be taken seriously. If not addressed, it could be followed by additional attempts. Therefore, once an individual has made an attempt, secondary prevention is necessary.

Additional Demographic Characteristics of Individuals in NH Who Died by Suicide

Additional demographic factors may play a role in suicide. **Figure 29** (below) presents the marital status of individuals who died by suicide in NH between 2015 and 2020. The data in **Figure 29** differs substantially from the overall breakdown by marital status for NH with fewer married individuals and more divorced individuals dying by suicide. In the NH population, approximately 50% of individuals are married and approximately 12% are divorced, while only 30% of individuals who died by suicide in NH were married and over 22% were divorced.

Figure 29

**Suicides in NH by Sex and Marital Status
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

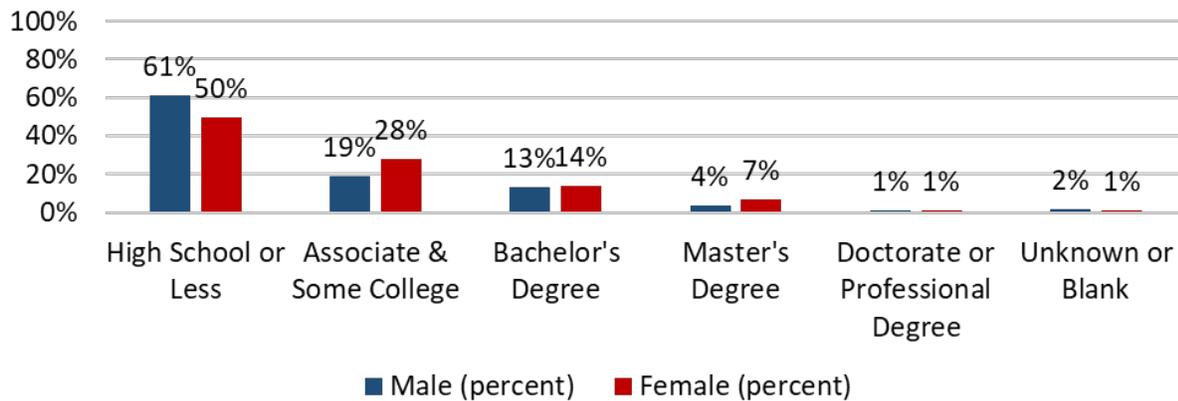
Educational attainment may also play a role in suicide. The prevalence of suicides in NH is greatest among individuals who had educational levels of high school or less than high school (**Figure 30** – pg. 51) and substantially lower among individuals with college degrees. Among adults in NH, over 37% have a bachelor’s degree or higher (**Table 4** – pg. 25), while only 18% of male and 22% of female suicide deaths in NH are by individuals with an equivalent educational level. Nationally, higher levels of education are generally correlated with higher

¹³ 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.

income and lower levels of unemployment¹⁴. 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. 64).

Figure 30

**Suicide Deaths in NH by Sex and Educational Levels
2015 - 2020**



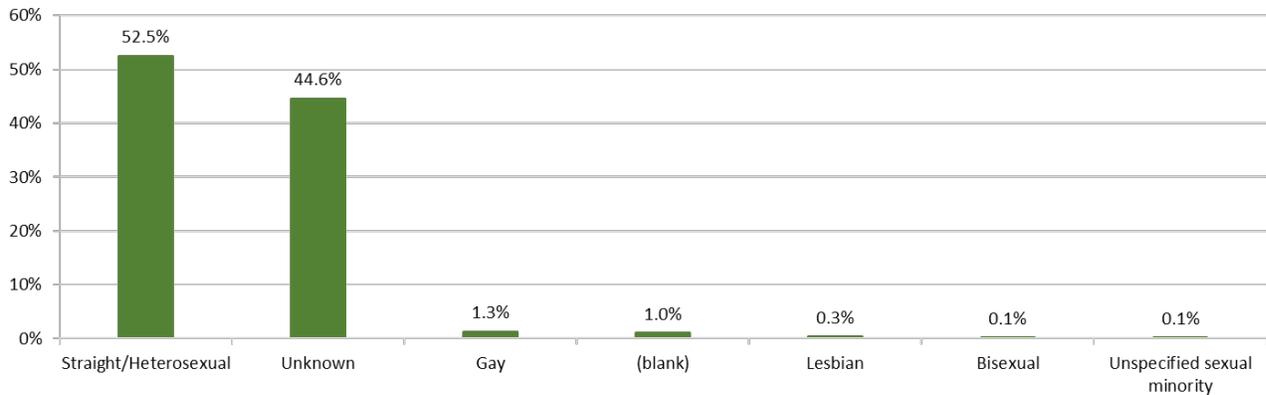
Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Prior to the implementation of NH-VDRS, data on the sexual orientation of individuals who died in NH was not readily available. As seen in **Figure 31** (pg. 52), the data related to this is still limited for individuals who died by suicide, with sexual orientation being unknown in over 40% of cases. The large number of cases where this information is unknown may be due to a number of factors, including the stringent NH-VDRS requirements for reporting sexual orientation, and stigma around revealing sexual orientation.

¹⁴ <https://www.bls.gov/careeroutlook/2021/data-on-display/education-pays.htm>

Figure 31

**Suicide Deaths in NH by Sexual Orientation
2015-2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Suicide Risk While Incarcerated - NH Department of Corrections

The New Hampshire Department of Corrections reported that there have been two deaths by suicide in their facilities during the past seven years. At any given time, there are approximately 2,000 residents (including all facilities), with approximately 900 individuals admitted to Department of Corrections facilities in 2021. Upon arrival, every resident (including new or returning) receives a comprehensive behavioral health screening which includes an assessment for risk of suicide. This screening is repeated as warranted, based on resident statements and behavior. Individuals assessed as being at risk for suicide are placed on a 24-hour observation level that includes continuing assessment by mental health professionals. After they are discharged from this level of care, they receive appropriate follow up services for a time-period based on their individual needs.

Ongoing training includes quarterly suicide prevention trainings conducted for the corrections officers on the Special Housing Unit (SHU), the Reception and Diagnostics Unit (R & D), and the Secure Psychiatric Unit. All new Department of Corrections employees, both uniformed and non-uniformed, receive four hours of suicide prevention and mental health training as part of the comprehensive orientation program and security officers newly employed at the Secure Psychiatric Unit receive an additional 16 hours of training on behavioral health issues.

Attitudes Related to Suicide in NH

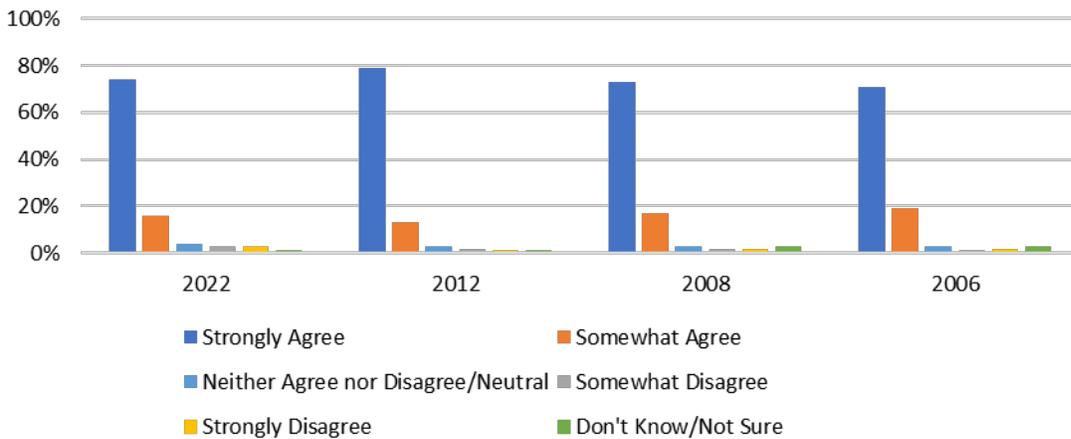
In 2006, as part of NH’s First SAMHSA suicide prevention grant, NAMI NH, the SPC, and YSPA collaborated with the UNH Survey Center on a survey of NH residents about their attitudes toward suicide prevention and mental illness. The survey included 500 NH households representative of the state as a whole.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

shifted over the past decade. The survey was completed by the UNH Survey Center in May 2022. The results from the survey are presented below in **Figures 32 – 37** (pgs. 53-56). 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 Panel¹⁵. Due to the shift in methodology the 2022 survey includes data from 930 respondents rather than the 500 respondents in prior years. Additionally, the wording of some questions has changed over time. In these cases, the change has been noted below the figure.

The 2022 results shown in **Figures 33, 35, and 36** (pgs. 54-55) differ from what was found in prior years in with fewer individuals selecting the “Strongly Agree” category and more selecting the “Somewhat Agree” category. This shift may be a result of changes in statewide attitudes, the changes made to the survey items, the change in survey format, or a combination of these and other factors. Even though fewer individuals selected the “Strongly Agree” option in 2022, these results still show the majority of respondents agreeing with the statements in **Figures 33, 35, and 36** (pgs. 54-55).

Figure 32

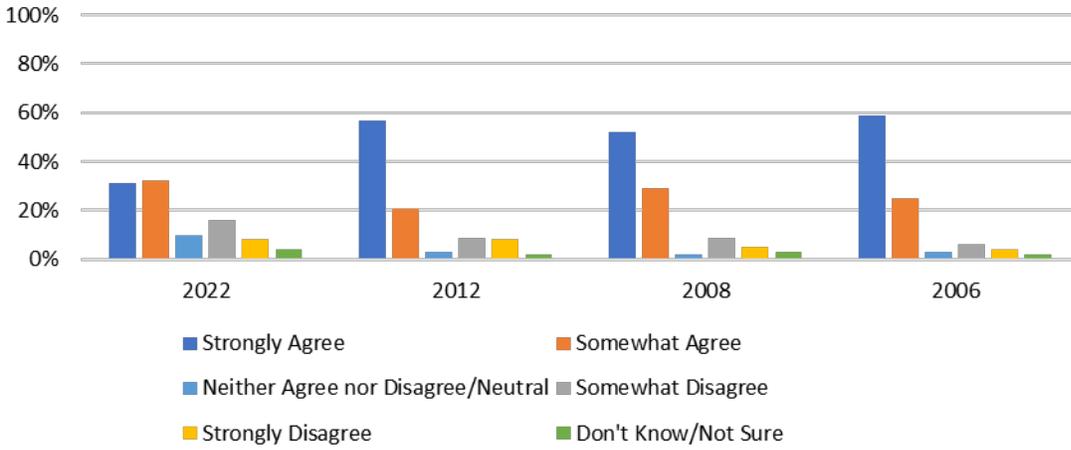
Mental health care is useful for those who might be thinking about, threatening, or who have attempted suicide.



¹⁵ <https://cola.unh.edu/unh-survey-center/projects/granite-state-panel>

Figure 33

If someone were thinking or talking about suicide, I would know where to seek help.



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

Figure 34

I would feel uncomfortable getting mental health care because of what some people might think if they found out

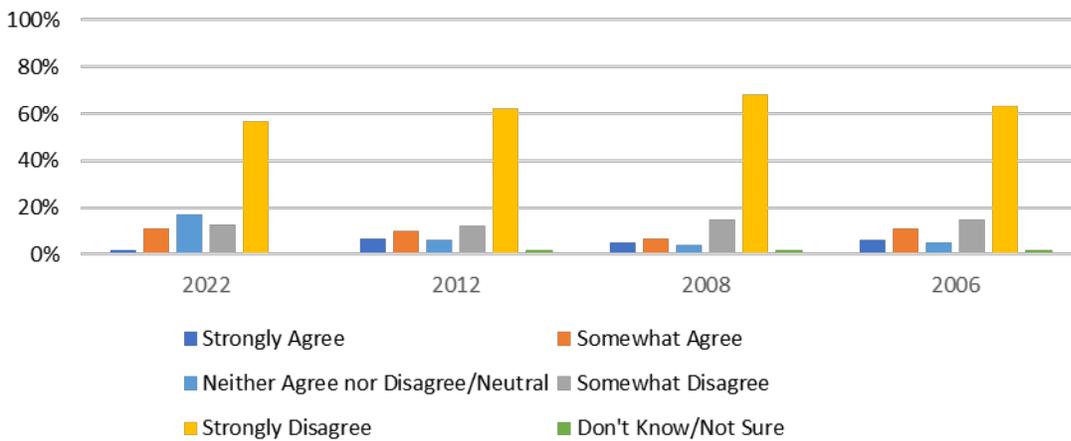


Figure 35

Suicide is preventable.

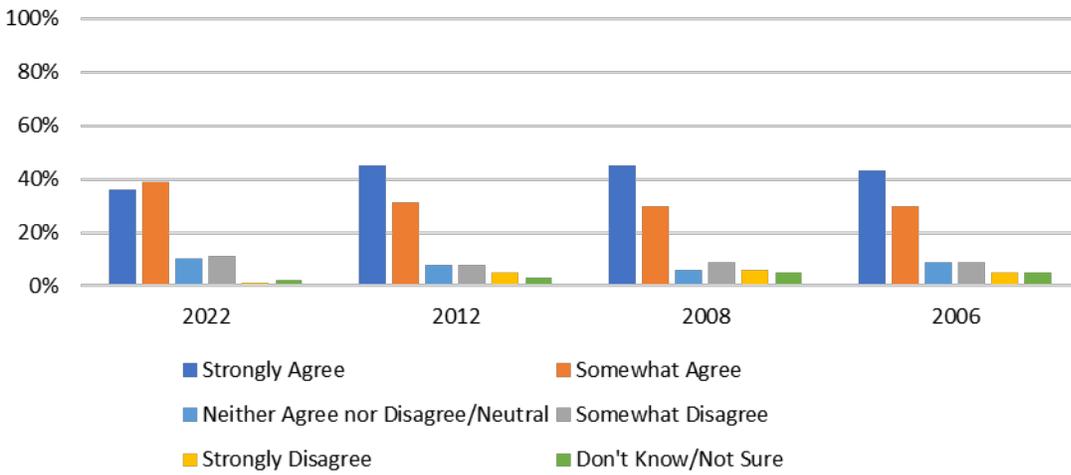
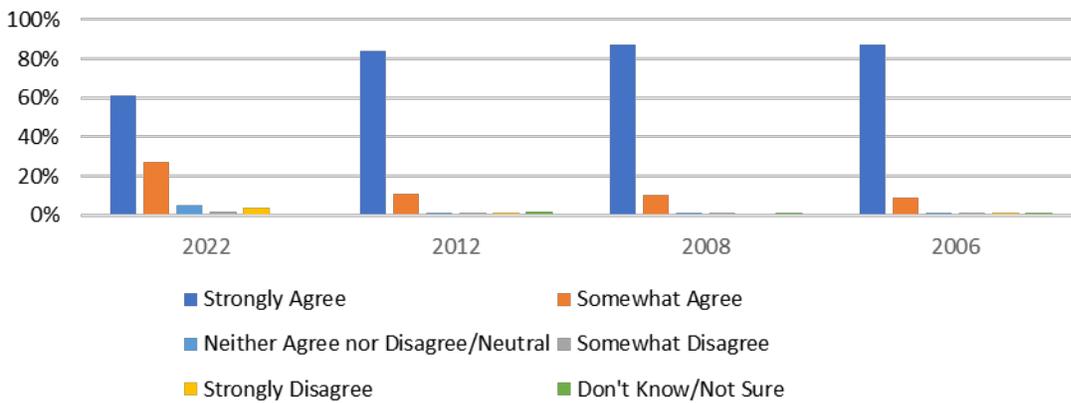


Figure 36

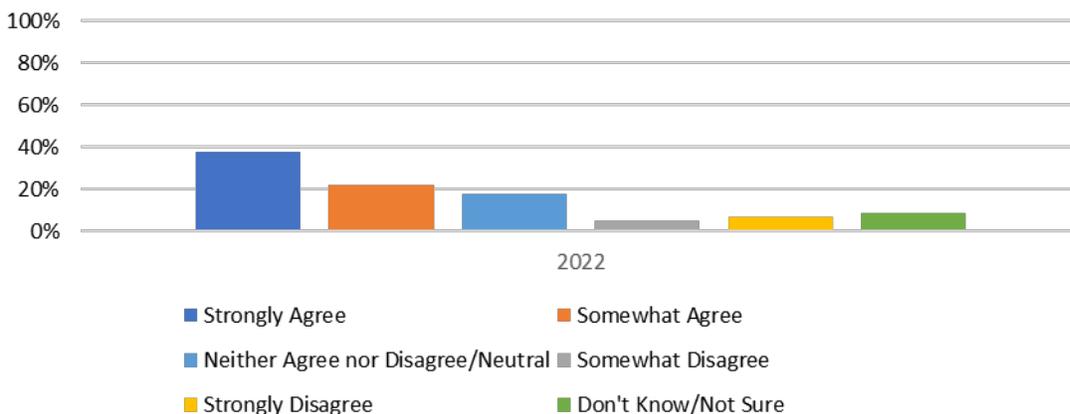
If I became aware that someone was thinking about or had attempted suicide, I would feel I had a responsibility to do something to help.



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

Figure 37

If I knew a person was having a mental health crisis and possessed firearms, I would ask them to let me hold onto their firearms until they are feeling better.



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

Suicide in NH: Methods

The gender difference in suicide deaths/attempts may be explained in part by the fact that males, in general, use more lethal means. Of NH male youth and young adults who died by suicide between 2015 and 2020, 56% used firearms compared to 13% of females (**Figure 39** – pg. 58). This gender disparity in firearm use decreases between the ages of 25 and 64 with 51% of males and 30% of females using firearms. The proportion of firearm deaths increases sharply after age 65 for males, with 68% of the suicide deaths in that age group involving a firearm. In NH, the vast majority of all deaths involving a firearm are suicide. This can be seen in **Figure 38** (pg. 57).

Figure 38

In 2020, approximately 89% of all NH deaths involving a firearm were suicides.

Manner of Death by Firearms, 2015-2020

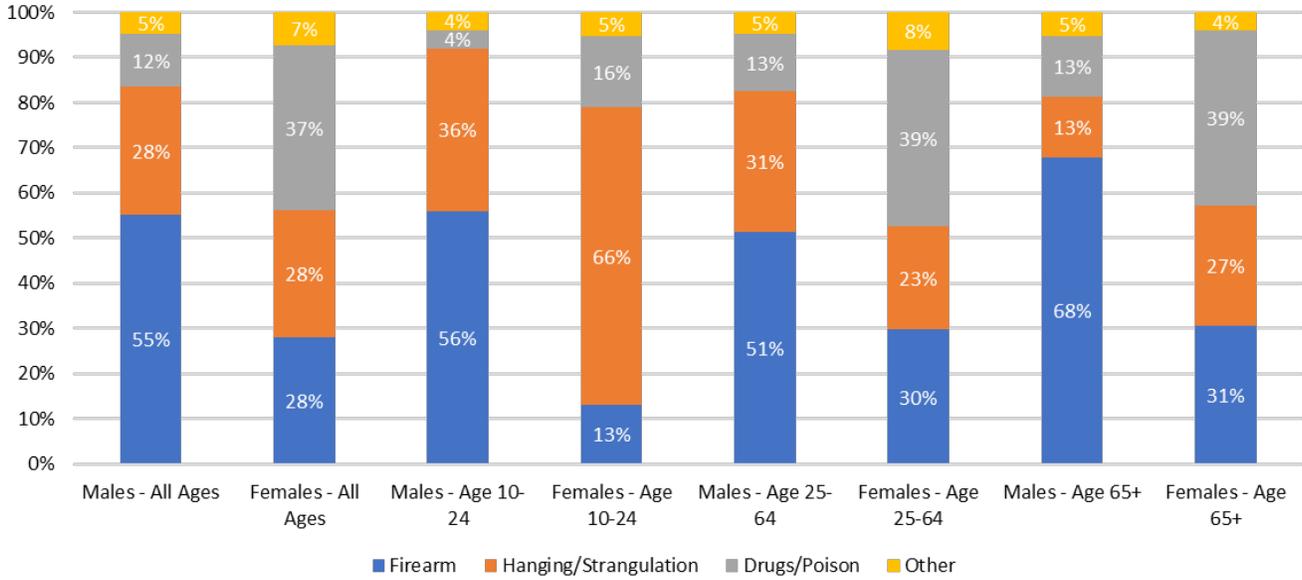


Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Suicide attempt methods have varying lethality. **Figure 40** (pg. 58) compares firearms, hanging, poisoning, and cutting/piercing in terms of the percentage of various outcomes (emergency department visit, inpatient admission, or death) for each method. Suicide deaths account for 88.6% 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 41** (pg. 59) indicates that self-inflicted drug overdoses/poisonings are treated/transported by EMS at several times the rate of most other mechanisms. The one exception being self-inflicted cutting/piercing injuries which were also treated/transported at a substantially higher rate than other mechanisms. Hospital data (**Figure 43** – pg. 60) does not show this same proportion of cut/pierce injuries indicating that EMS providers may treat self-inflicted cut/pierce injuries without the need to transport the individual to a hospital, or that individuals are more likely to contact EMS for a cut/pierce injury and be transported to a hospital by other means for things such as a poisoning. It may also indicate that EMS providers are more likely to report that a cut/pierce injury as being self-inflicted than they are with other injury types. The use of hanging/strangulation as a suicide method peaks in early adolescence and decreases steadily throughout the lifespan (**Figure 39** – pg. 58).

Figure 39

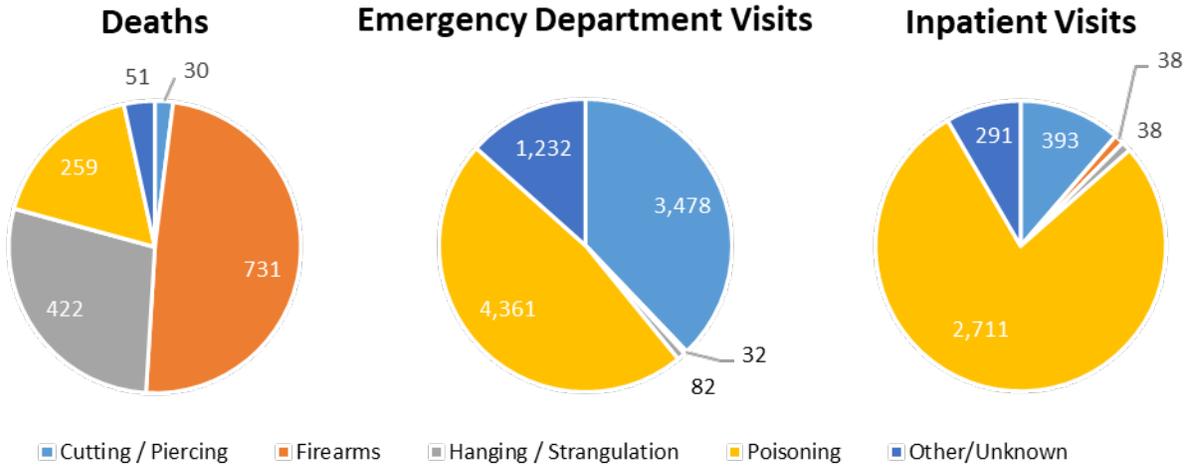
**Methods Used in Suicide Deaths by Gender and Age Group
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 40

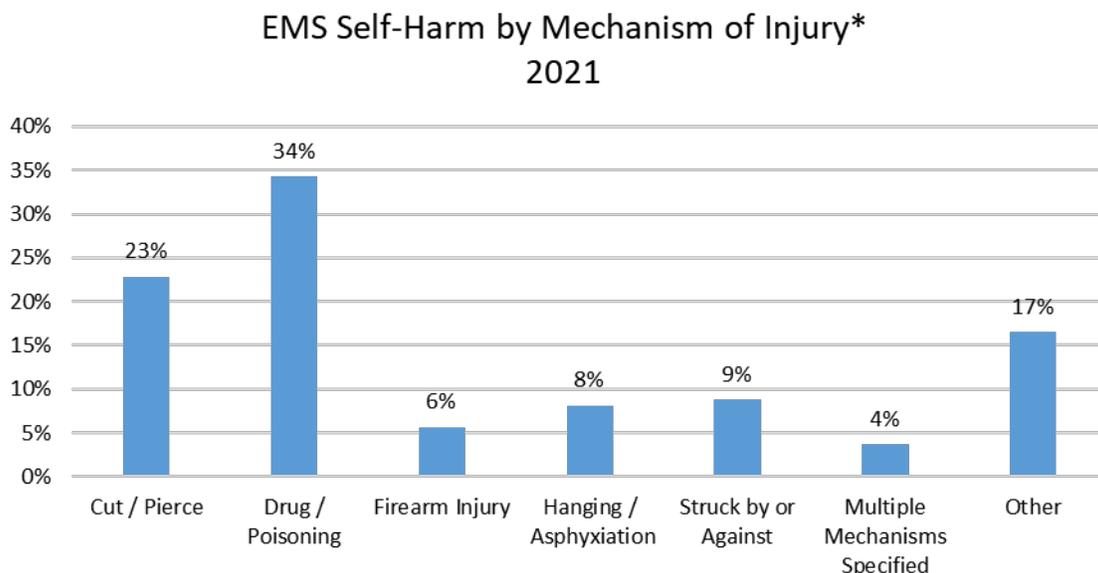
Count of Lethality of Means Used for Suicidal Behavior in NH, 2015-2020



Data Source: NH-VDRS (deaths) and NH Hospital Discharge (emergency and inpatient visits)
Data prepared by the NH DHHS Injury Prevention Program

Figure 41¹⁶

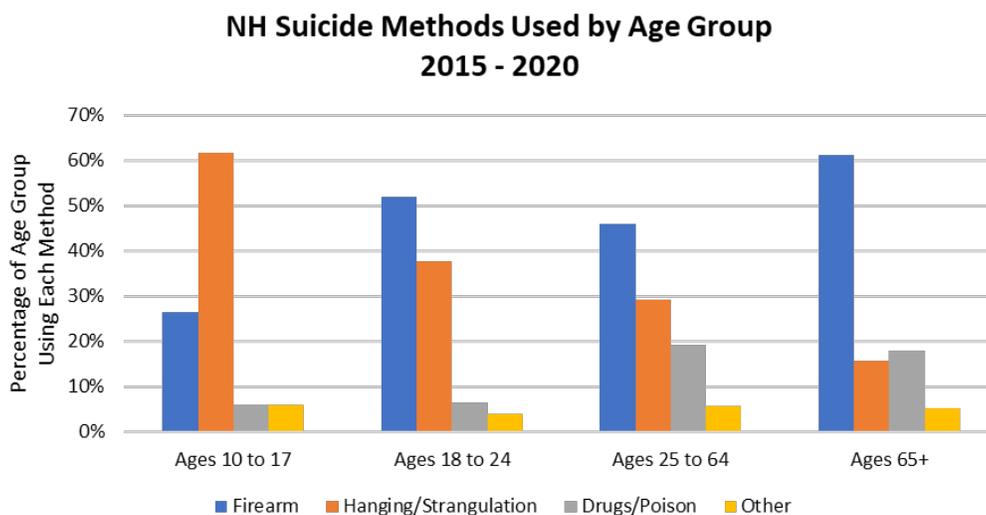
Percent of method of self-inflicted injuries treated/transported by EMS from 2021.



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

Figure 42

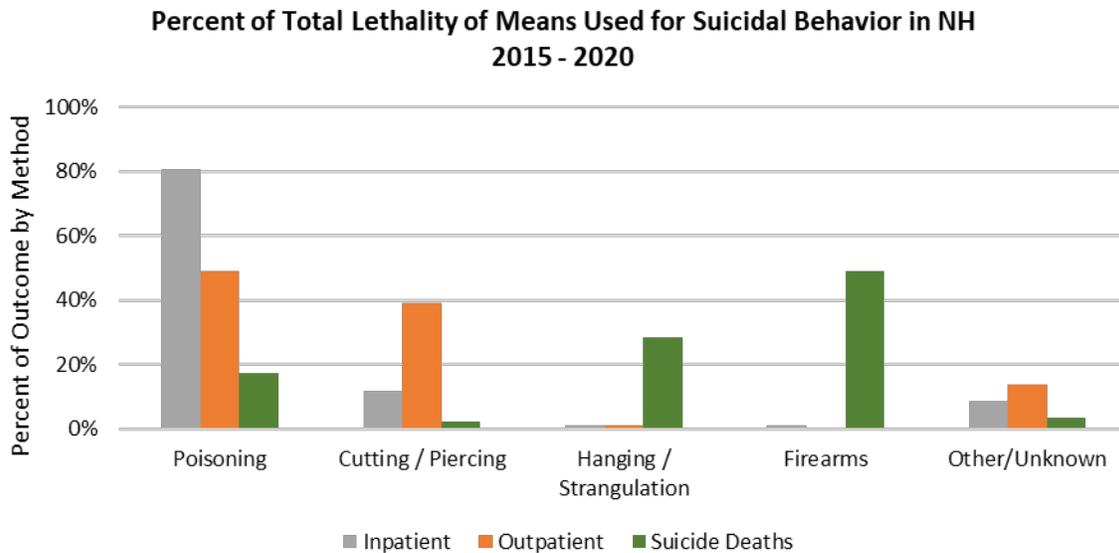
Suicide methods used in NH vary by age group, as seen in 2015-2020.



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

¹⁶ This chart is based on the field “Trauma Mechanism of Injury”. This field is not available for all incidents. The field may also include a response of “Not Recorded” or “Not Applicable”. For the purpose of this report, only incidents with a reported mechanism of injury were included above (approximately 36% of all incidents in 2021).

Figure 43
Poisoning is the most frequent method of suicide attempt,
as seen in hospital discharge data 2015-2020.



Data Source: NH-VDRS (deaths) and NH Hospital Discharge (emergency and inpatient visits)
 Data prepared by the NH DHHS Injury Prevention Program

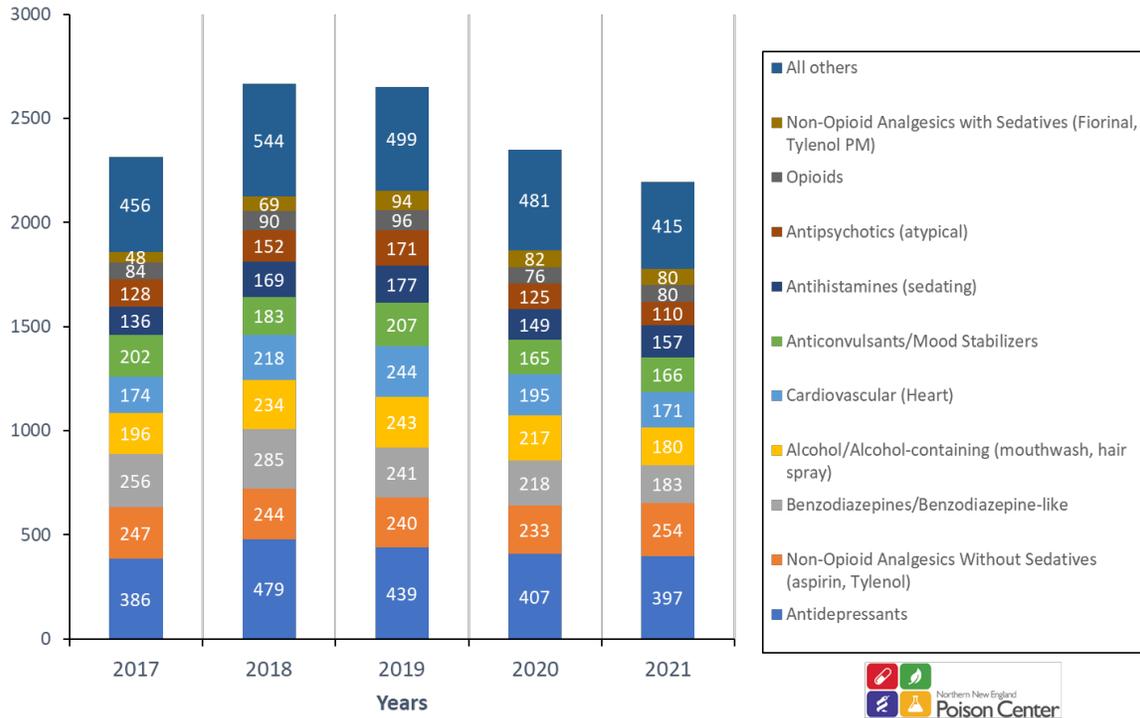
Although suicide attempts employing poison do not account for as many deaths in NH as firearms or hangings, intentional poisonings account for the overwhelming majority of inpatient and ED admissions for suicide attempts (**Figure 40** – pg. 58). **Figure 44** (pg. 61) depicts the prevalence of the most common substances used in suspected suicide attempts and self-harm-related exposures in NH as collected by the NNEPC. The top two substances in 2021 were again antidepressants and non-opioid analgesics without sedatives (e.g., aspirin or Tylenol).¹⁷

¹⁷ 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.

Figure 44

Antidepressants have been the top substance used in suspected NH suicide attempts from 2017-2021.

**NH Substances Used in Suspected Suicide Attempts
NNEPC Substance Abuse Surveillance and Reporting System, 2017-2021**



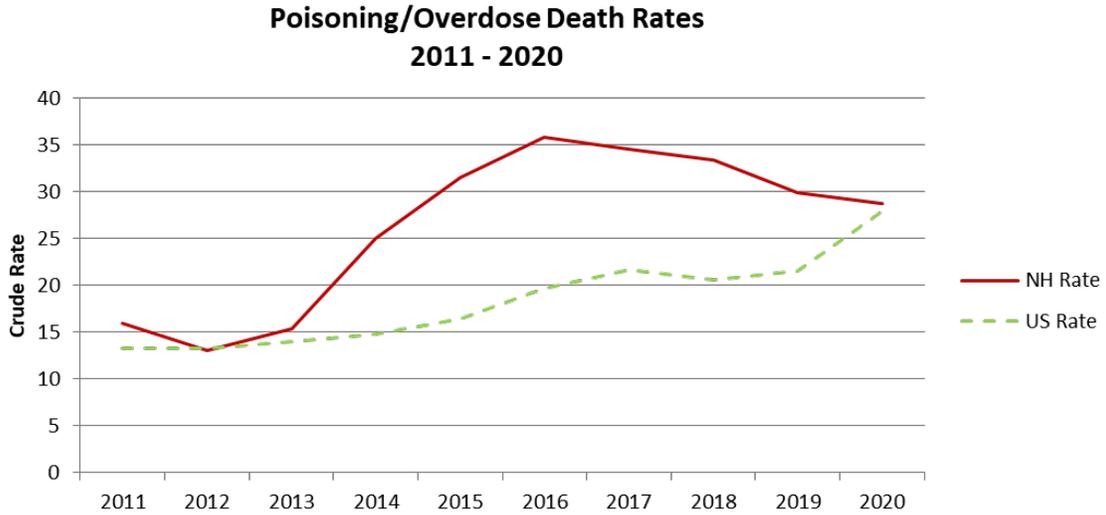
Data Source: Northern New England Poison Center

Increasing Accidental Poisoning and Drug-Related Death Rates – Cause for Concern

As seen in **Figure 45** (pg. 62), the accidental poisoning and drug-related death rates in NH and the US as a whole have steadily increased from 2011 to 2020. During this time the US rate has increased by approximately 110% while the NH rate has increased more than 80%. 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 a potential 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 80% from 2011 to 2020.



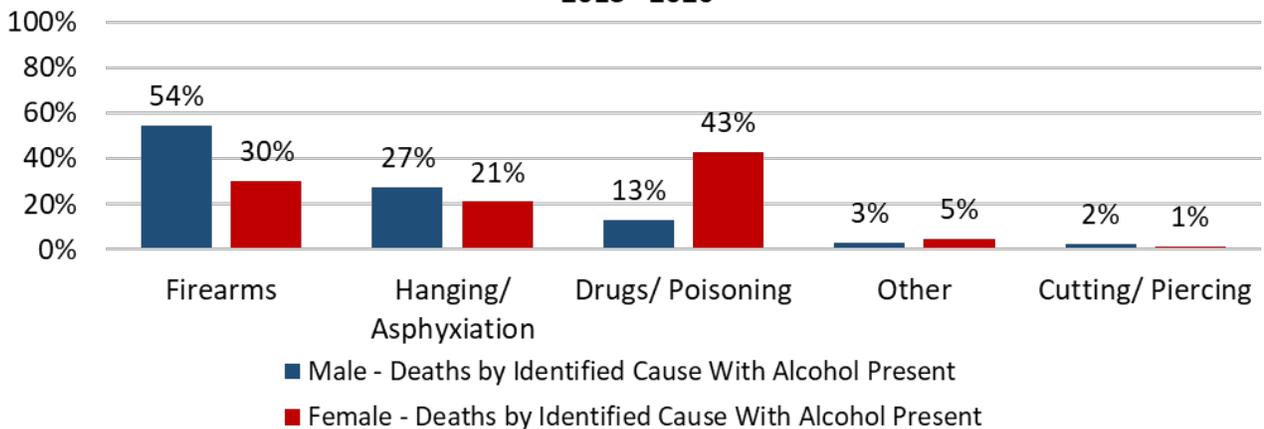
Data Source: CDC WISQARS

Alcohol and Drug Use and Suicide

Alcohol was found to be present in 33% of all NH suicide deaths from 2015 to 2020. Alcohol was found in a greater percentage of male deaths (33% of deaths) than female deaths (17% of deaths). When looking at the presence of alcohol by cause of death (**Figure 46** – below), it was found to most often be present in firearm deaths for males (54% of male firearm deaths) and drug/poisoning deaths for females (43% of female drug/poisoning deaths). Alcohol is often not the only substance used by individuals who die by suicide in NH. In cases where alcohol and/or drugs were detected, approximately 33% of cases had both alcohol and one or more drugs present (**Figure 47** – pg. 63).

Figure 46

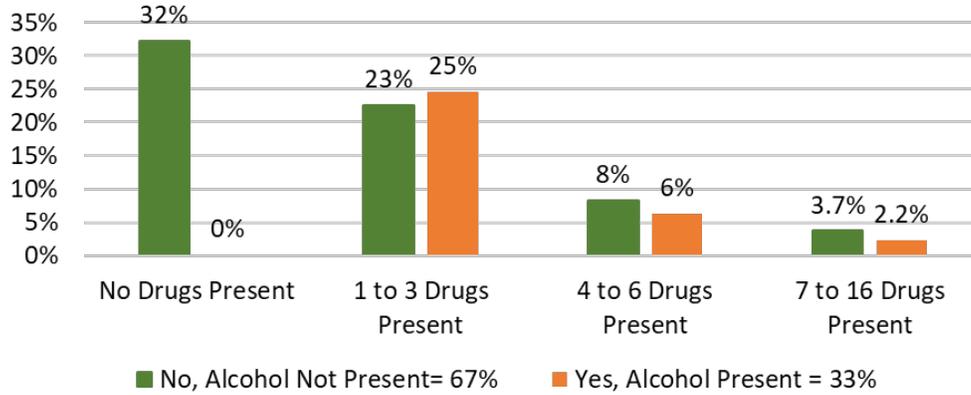
**Suicide Deaths in NH with Alcohol as a Risk Factor by Sex and Cause of Death
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 47

Suicide Deaths in NH
Alcohol Present with Drugs
2015-2020

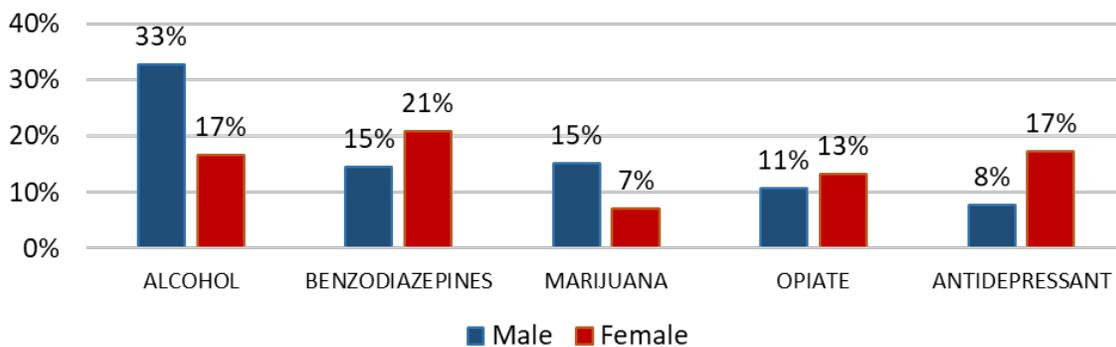


Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

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 and antidepressants among females, and alcohol and marijuana 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 39** (pg. 58).

Figure 48

Top Five Substances with a Positive Test Result
in NH Suicide Deaths by Sex
2015 - 2020



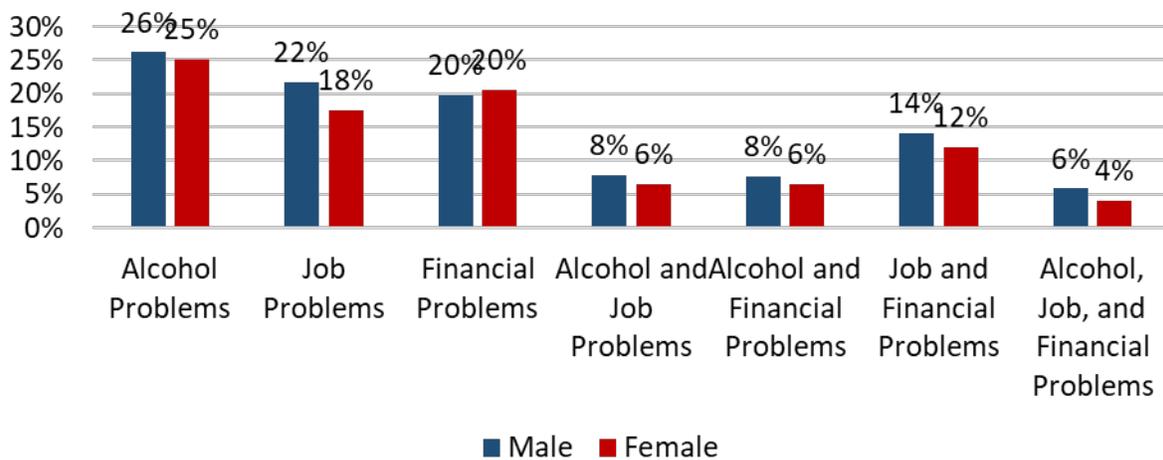
Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Co-Occurring Factors and Suicide

Suicide is most often the result of a number of co-occurring risk factors. **Figure 49** (below) identifies three risk factors that are tracked in the NH-VDRS – problems with alcohol, employment, and finances¹⁸. Approximately 66% of individuals who died by suicide from 2015 to 2020 experienced at least one of those three risk factors. When looking at the intersection of those risk factors, 66% of individuals who were experiencing job problems around the time of death were also experiencing financial problems. It is not surprising to find such a strong correlation between employment and finances as one can have a direct relationship on the other. However, as these risk factors compound, individuals may feel that they are under ever increasing levels of stress.

Figure 49

Suicide Deaths in NH by Sex and Co-Occurring Factors 2015 - 2020



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

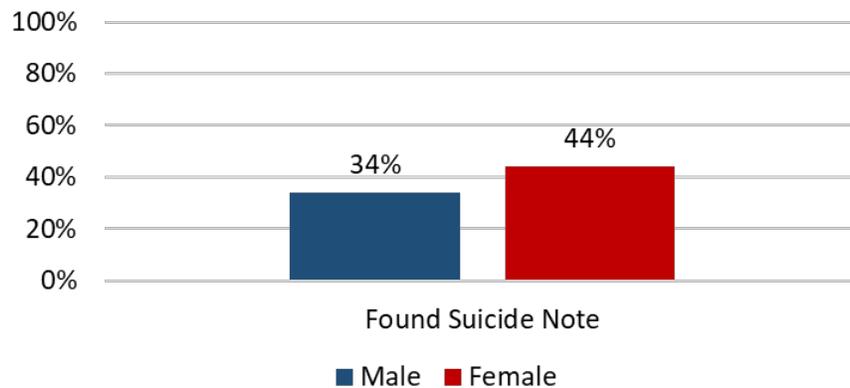
¹⁸ The NH-VDRS does not have access to detailed data on financial hardship or other such documents, only observations made during field investigations were compiled in ADME reports. Financial hardship may include any one of the following: loss of income, foreclosure on estate/business or, loss of business. NH-VDRS also does not have access to detailed employment data. Job troubles were documented based on OCME field investigations, death certificate statements, by funeral home directors, and declarations by next of kin.

Suicide Notes

In just over 36% of NH suicide deaths from 2015 to 2020, individuals left some form of note behind (**Figure 50** – below). Females being more likely to have left a note (44% of female deaths) than males (34% of male deaths). These notes vary in format, content, and intent. Individuals may leave instructions for their loved ones on how to resolve financial, estate, burial, and other affairs; complaints/obstacles that they faced; or planning/details that the deceased went through leading up to the death. For the individuals left behind after a suicide death, a note will rarely ever give a satisfactory answer to why their loved one died by suicide.

Figure 50

Suicide Deaths in NH, Found Note Left by Sex 2015 - 2020



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Linking At-Risk Individuals with Help

Crisis lines, such as the 988 Suicide and Crisis Lifeline¹⁹ are vital to suicide prevention efforts in NH and nationally. Nationally, 988 receives approximately 2 million calls per year. In 2021, over 5,000 of those calls, or roughly 429 per month, were received by the NH 988 call center (see **Figure 51** – pg. 66). 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.



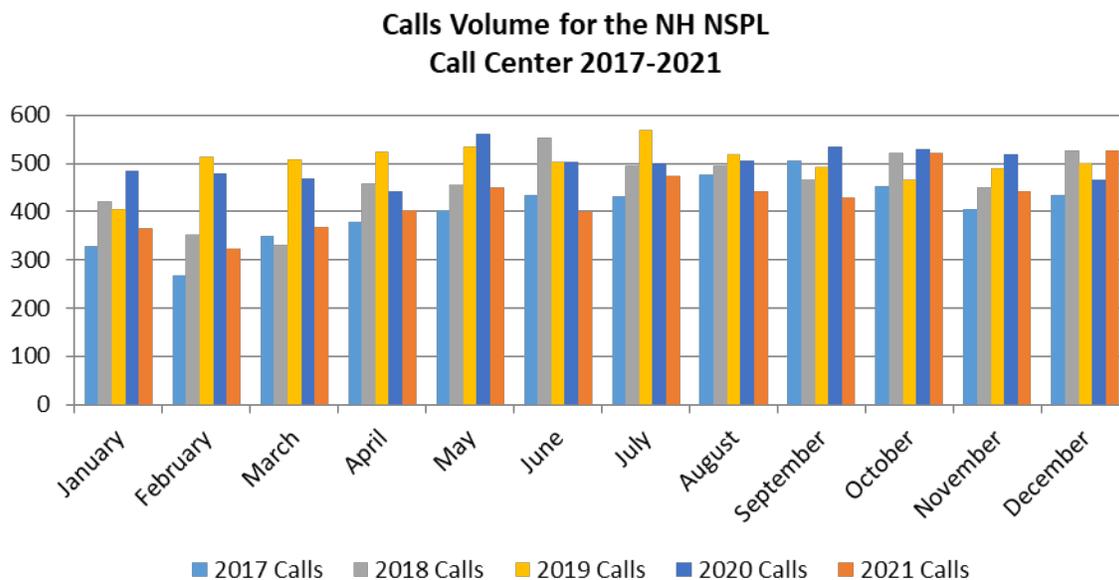
¹⁹ The 988 Suicide and Crisis Lifeline was formerly known as the National Suicide Prevention Lifeline (NSPL) and used the advertised phone number of 1-800-273-TALK (8255).

In addition to traditional crisis lines, individuals are increasingly turning to text message-based crisis services (see **Figure 52** – pg. 67). Contacts from NH individuals²⁰ to Crisis Text Line have increased from a monthly average of 339 in 2017 to 414 in 2021. From 2017 to 2021, Crisis Counselors at Crisis Text Line deescalated 252 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, 183 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, 72% of the texters who reached out to Crisis Text Line from NH were age 24 or under, 76% self-identified as female, and nearly half self-identified as LGBTQ²¹.

Figure 51
NH NSPL call center responded to an average of 429 calls per month in 2021.



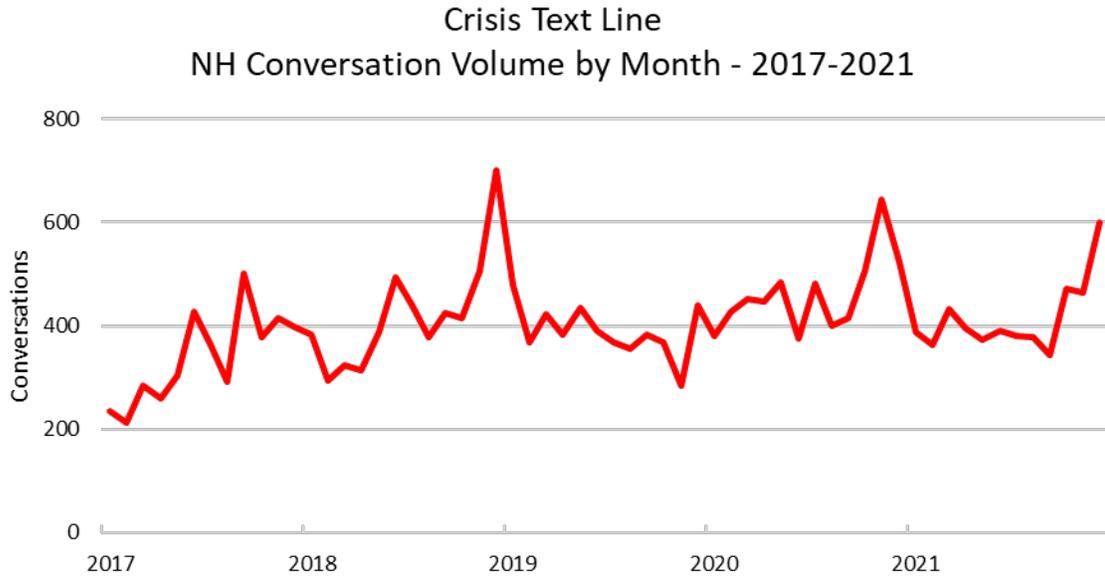
Data Source: 988 Suicide and Crisis Lifeline

²⁰Crisis Text Line estimates location based on area code from the first 3 digits of the texter’s phone number. This may result in some texters being counted who were not physically in NH at the time they communicated with the Crisis Text Line. It may also result individuals physically located in NH not being counted if they are using a device with an out-of-state area code.

²¹Surveys are completed by texters following approximately 20% of Crisis Text Line conversations.

Figure 52

The Crisis Text Line engaged in 4978 text conversations with NH texters in 2021.



Data Source: Crisis Text Line

Positive Outcomes and Testimonials

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

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

Two examples of the feedback received by Headrest, the only accredited hotline in NH that receives calls placed to the National Suicide Prevention Hotline. Headrest receives the majority of calls originating from individuals in NH.

Costs of Suicide and Suicidal Behavior

There were between 36,090 and 48,259 years of potential life lost²² to suicide from 2016-2020 in NH (CDC WISQARS, 2022). 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 \$12.98 billion in health care costs in 2020. This does not include the costs associated with mental health services on an inpatient or outpatient basis (CDC WISQARS, 2022). In NH, suicide deaths where the individual received treatment in a hospital or emergency department and subsequently died resulted in an estimated \$1.07 million in medical expenses in 2020 (CDC WISQARS, 2022).

Military and Veterans

The NH National Guard

From 2017 through 2021 the NH Army National Guard recorded a total of 48 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, 13% were from individuals under the age of 22, 33% were age 22-26, 13% were age 27-31, 8% were age 32-36, 13% were age 37-41, and 10% were ages 42-46. The remaining 10% were age 47 and above (total may not equal 100% due to rounding). Forty-two percent of the incidents were by non-deployed personnel, veterans, or dependents of National Guard personnel. Of the incidents recorded, 96% were by males and 4% were by females (males may be disproportionately represented among the NH National Guard compared with the general population).

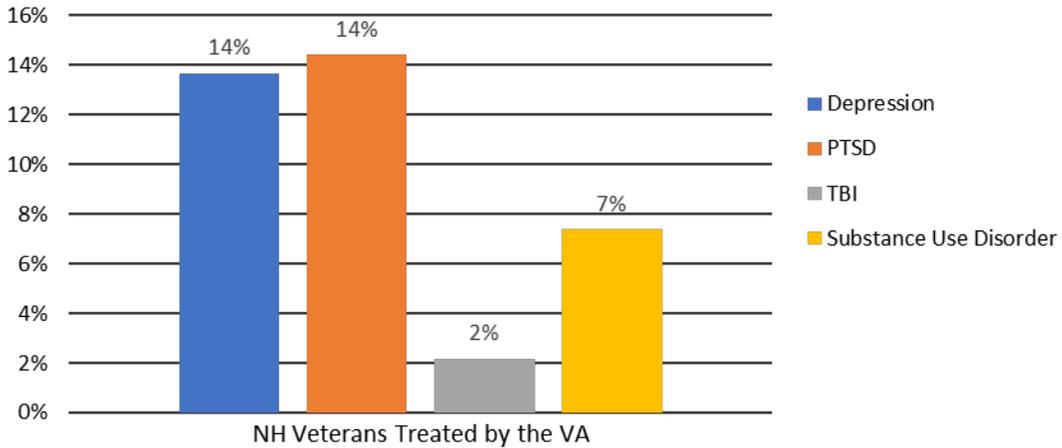
NH Veterans Served by the Veterans Administration (VA)

The VA provides care to many of the Veterans in the State of NH. During the 2020 Federal Fiscal Year (October 1, 2019 – September 30, 2020), the VA provided care to 24,776 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. 69).

²² 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

Percentage of NH Veterans treated at the VA with depression, PTSD, TBI, or substance abuse as their primary or secondary diagnosis Federal Fiscal Year 2020



Data Source: Veterans Administration

Suicide among Veterans in New Hampshire:²³

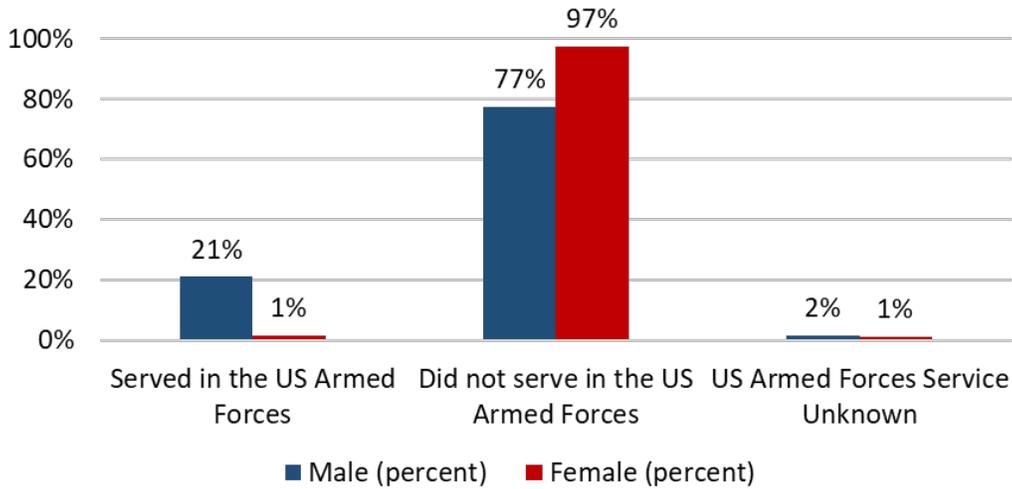
Of the individuals who died by suicide in NH from 2015 to 2020, 16% were identified as having current or prior military service (**Figure 54 and Table 11** – pg. 70). The use of the term military service is for all those who served in the armed services of the United States or are still serving. The 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 2020²⁴. With veterans accounting for 16% of the individuals who died by suicide in the state, this may indicate a high-risk group dying at a greater than expected rate.

²³NH-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.

²⁴ Veteran population data by state available from https://www.va.gov/vetdata/veteran_population.asp

Figure 54

**Suicide Deaths in NH by Sex and Military Status
2015 - 2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Table 11

**Suicide Deaths in NH by Sex and Military Status
2015 - 2020**

NH Suicides - Military Status	Male (Count)	Male (percent)	Female (Count)	Female (percent)
Served in the US Armed Forces	241	20.94%	*	1.46%
Did not serve in the US Armed Forces	892	77.50%	333	97.37%
US Armed Forces Service Unknown	18	1.56%	*	1.17%

Note:

*Counts/Rates for categories with fewer than six deaths have been suppressed.

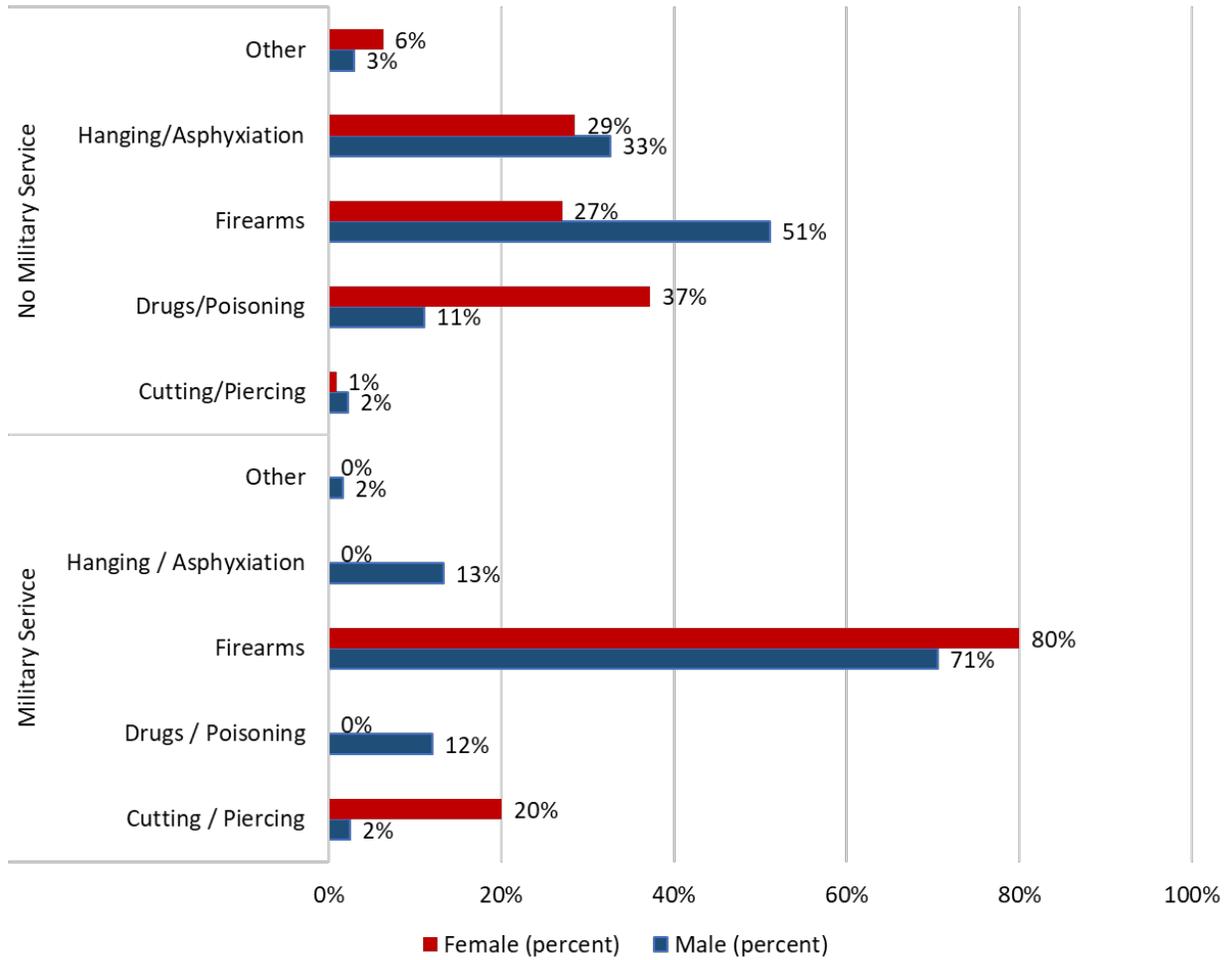
Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Military Service and Cause of Death:

Individuals in NH who die by suicide that have served in the military are substantially more likely to use a firearm than civilians (**Figure 55** – pg. 71, and **Table 12** – pg. 72). This difference is evident in males with 51% of individuals with no military service using firearm compared with 71% of males with military service using a firearm. The difference is even more significant among females with military service. Among females with no military service just 27% used firearms, while 80% of females with military service used a firearm. It should be noted that the percentage for females may be skewed due to the small number of suicide deaths by females with military service.

Figure 55

Suicide Deaths in NH of Individuals Who Served in the US Armed Forces by Sex and Cause of Death 2015 - 2020



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Table 12
Suicide Deaths in NH of Individuals Who
Served in the US Armed Forces by Sex and Cause of Death
2015 - 2020

NH Suicides of Individuals Who Served in the US Armed Forces - Cause of Death	Lethal Means	Male (Count)	Male (percent)	Female (Count)	Female (percent)
Military Service	Cutting / Piercing	6	2.49%	*	20.00%
	Drugs / Poisoning	29	12.03%	-	0.00%
	Firearms	170	70.54%	*	80.00%
	Hanging / Asphyxiation	32	13.28%	-	0.00%
	Other	*	1.66%	-	0.00%
No Military Service	Cutting/ Piercing	20	2.24%	*	0.90%
	Drugs/ Poisoning	99	11.10%	124	37.24%
	Firearms	456	51.12%	90	27.03%
	Hanging/ Asphyxiation	291	32.62%	95	25.83%
	Other	26	2.91%	21	6.31%

Note:

*Counts/Rates for categories with fewer than six deaths have been suppressed.

-Indicates a category with no cases to report.

Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Suicide Rates in NH

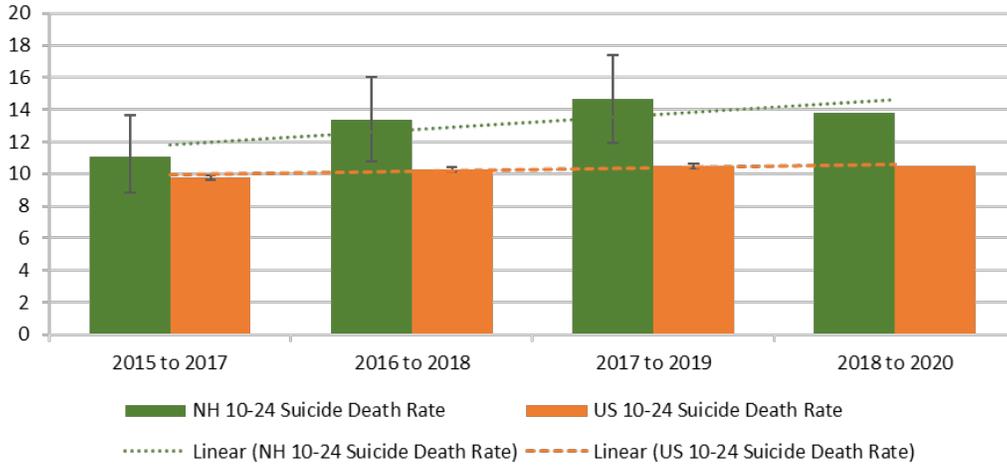
Until 2010, data had indicated that rates of youth and young adult suicide and suicidality overall in NH were flat or on a downward trend. It is nearly impossible to firmly establish causality for such trends. Statewide collaborative prevention efforts, including the work of YSPA, the SPC, implementation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

Figure 56 (pg. 73) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2015 to 2020 and **Figure 57** (pg. 73) presents the same information for individuals of all ages. NH-VDRS data is currently limited to 2015-2020. As new data becomes available these figures will be expanded and used to identify trends in NH rates over time and compare them with national trends.

Figure 56

Suicide rates among 10-24 year old NH residents have increased from 2015-2020.

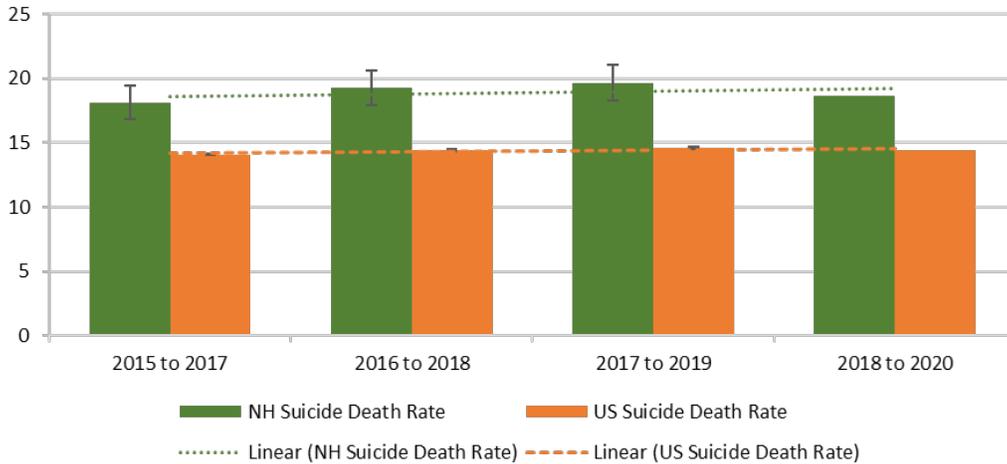
**NH Resident Suicide Death Rates for Rolling
3-Year Intervals - Ages 10-24
2015-2020**



Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 57

**NH Resident Suicide Death Rates for Rolling
3-Year Intervals - All Ages
2015-2020**

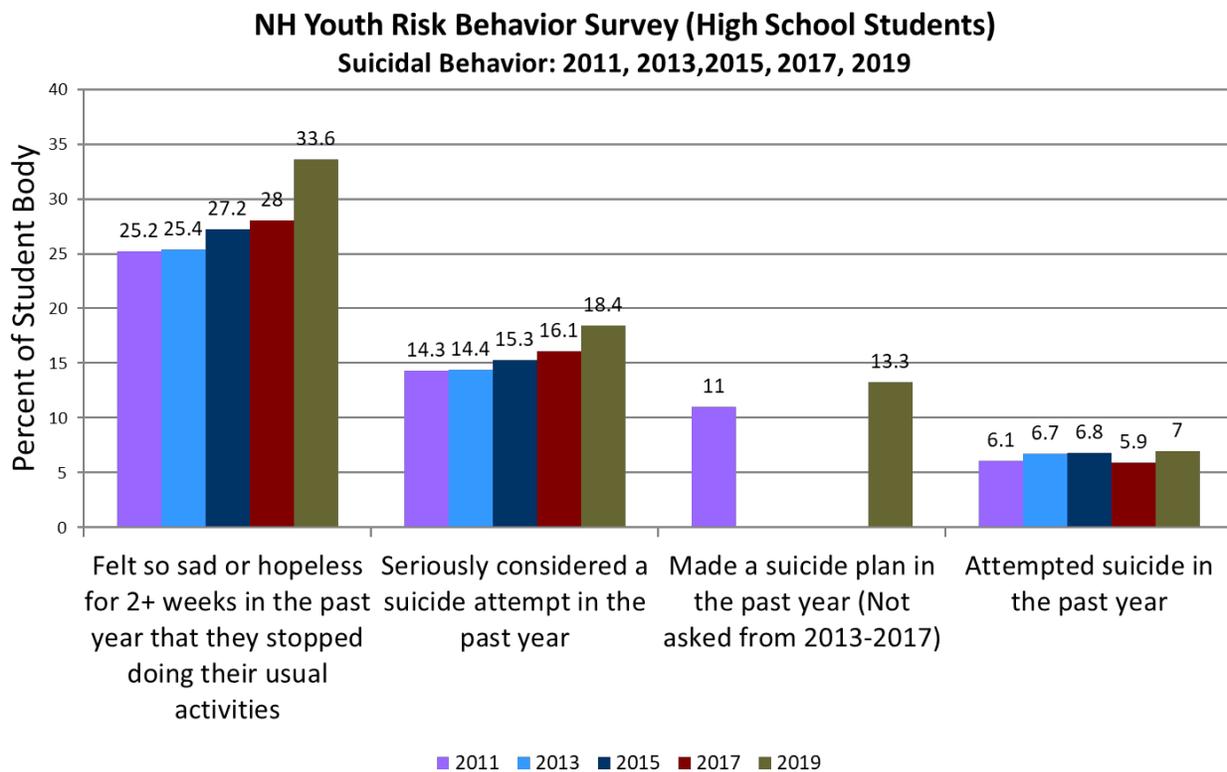


Data Source: NH-VDRS data prepared by the NH DHHS Injury Prevention Program

Figure 58 (below) presents the results of the NH YRBS from 2011, 2013, 2015, 2017, and 2019. The percentage of high school youth in NH who felt sad or hopeless for 2+ weeks in the past year and the percentage of youth who seriously considered a suicide attempt in the past year have both increased between 2011 and 2019. In 2019, 1 in 5 youth surveyed reported having seriously considered attempting suicide in the past year, while 1 in 14 reported having made an attempt.

Figure 58

Self-reported depression and suicidal ideation among high school youth increased from 2011 to 2019.

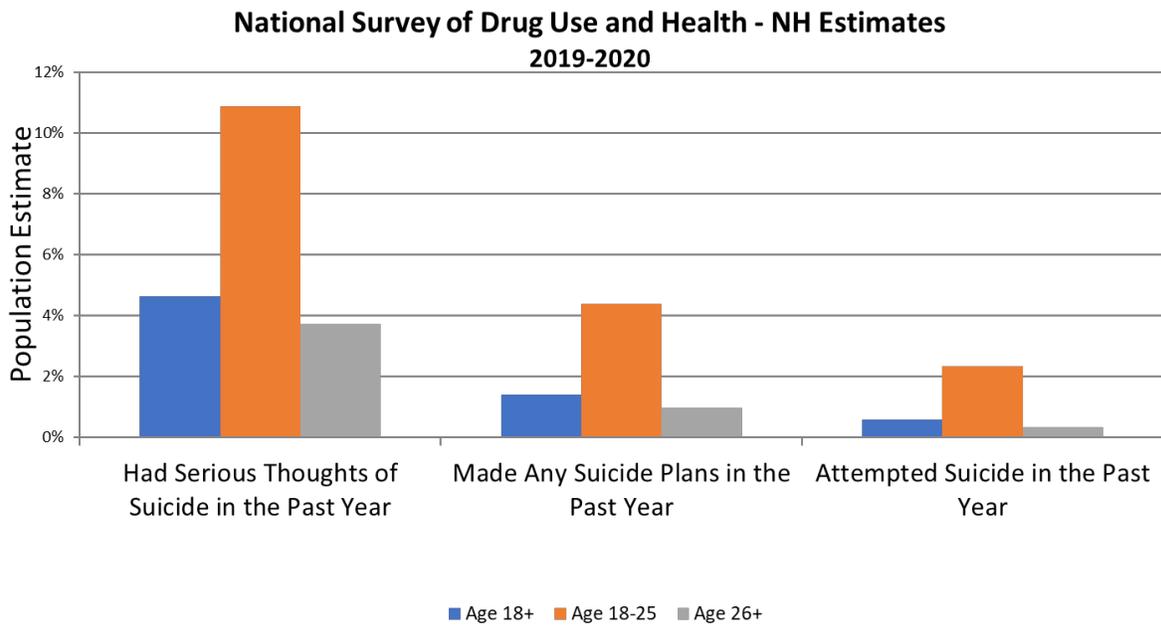


Data Source: NH YRBS Results, NH Department of Education

The NH YRBS item addressing whether students have made a suicide plan in the past year was not asked from 2013-2017. This was removed due to the similarity to the question asking whether youth had seriously considered a suicide attempt during the past year. At the time the removal of this question allowed for the addition of a question addressing non-suicidal self-inflicted injuries (e.g., cutting or burning oneself without the intent of dying). Beginning in 2019 the question was again included in the survey. The results of the question on self-inflicted injuries indicate that 19.8% of NH high school age youth (12.6% of males and 27.3% of females) report intentionally hurting themselves without the intent to die during the past year (NH YRBS, 2019).

Figure 59 (below) presents the results of the National Survey of Drug Use and Health (NSDUH) for questions that are similar to those asked on the YRBS. The included NSDUH data focused on individuals age 18+ and shows that 1 in 22 adults surveyed reported having serious thoughts of suicide in the past year, while 1 in 175 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 9 reporting serious thoughts of suicide in the past year and 1 in 43 reporting having made a suicide attempt during that time period.

Figure 59



Data Source: National Survey on Drug Use and Health, 2019-2020

Positive Outcomes and Testimonials

Safe Messaging and Media Guidelines:

Work has been done continuously across the state to educate the public and media about safe messaging, a national best practice standard (www.sprc.org/library/SafeMessagingfinal.pdf). Safe messaging has become part of the standard for statewide and regional meetings, part of suicide prevention trainings, a guide for health promotion materials, and essentially part of the culture in NH. Media Guidelines have been disseminated to media outlets across the state, and journalism students in several universities in NH have received training in the Media Guidelines and how to safely write about suicide. The Communications/Media Sub-Committee of the SPC provides feedback to media outlets and suicide prevention experts in the state to guide public information that is produced through consultation, media contributions and feedback. The results of these efforts became evident after the tragic death of Robin Williams. Rather than sensationalizing this highly publicized tragedy, many media outlets across NH interviewed local representatives in the mental health and suicide prevention field. “Not only did the media in our state reach out to partner with key stakeholders to create responsible follow up articles, but all of the people interviewed provided the same consistent messages of hope and help for those struggling with mental illness and resources for those in crisis. It was clear that everyone, independent of each other, was reading off of the same page.”

Elaine de Mello
Director of Suicide Prevention Services
NAMI New Hampshire

Reading Tables and Figures

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

Types of Charts

- **Line Chart:** A line chart presents a series of connected observations in order. For example, the line chart in **Figure 4** of this report shows the number of youth and young adult suicides over a 5-year span in NH.
- **Pie Chart:** A pie chart gives the percent values for the individual parts of a whole using a circle that is divided into wedges. For example, a pie chart (**Figure 15**) of this report shows the percent of male and female youths and young adults in NH that died by suicide from 2015 to 2020.
- **Bar Chart:** A bar chart shows the values for one or more categories using rectangular boxes with height representing the value (greater height being a larger value and lesser height being a smaller value). For example, two bar charts (**Figures 10 and 11**) in this report show the number of suicide deaths by age group in NH from 2015 to 2020 and the rate of suicide deaths by age group in NH from 2015 to 2020.

Common Parts of a Chart

- **Title:** The title will generally be found at the top of the chart and should describe the data that are being presented. Depending on the chart this may list the variables and/or the time period. Also, all charts in this report list the data source used.
- **Scales/Labels:** The scales/labels are generally found on the bottom and left side of the chart. The scale/label on the bottom shows what is being measured on the x-axis (horizontal axis) and the scale/label on the left side shows what is being measured on the y-axis (vertical axis). For example, in **Figure 4**, the line chart of youth suicides in NH over the past four years has a different scale on each axis. On the x-axis (the bottom) are years which range from 2015 to 2020. On the y-axis (the side) the scale is the number of youth suicides, which ranges from 0 to 40.
- **Legend/Key:** Some charts include a legend/key to explain what different colors, shapes, dotted/solid lines mean. The location of this may vary depending on the type of chart and where space is available on the page.
- **Error Bars/Confidence Intervals:** Error bars/confidence intervals represent the range that the actual value may fall within. There is some degree of uncertainty when calculating values such as rates due to statistical error (captured by the confidence intervals) and data quality issues (which there is no real way to estimate). The width of the error bar/confidence interval indicates the level of uncertainty. A wider bar denotes more uncertainty and may indicate more data is needed. A smaller bar indicates a greater level of confidence in the results. When error bars/confidence intervals overlap in a chart, one cannot state with certainty whether there is a significant difference between the

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

Frequently Used Scales

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

Interpreting Information from Charts

- Can different charts be compared? Yes, but only under certain circumstances. Different charts should only be 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 OCME data. 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. 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 10 th Revision	ICD-10
National Alliance on Mental Illness New Hampshire	NAMI NH
National Suicide Prevention Lifeline	NSPL
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:

Where,

m = number of age groups

d_i = number of events in age group i

P_i = population in age group i

S_i = proportion of the standard population in age group i

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

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

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:

Where,

R=age-adjusted rate of one population

z = 1.96 for 95% confidence limits

SE= standard error as calculated below

$$R + z (SE)$$

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 compiled, and de-identified at the Maine Health Information Center, delivered to the Office of Medicaid Business and Policy for further cleaning, then available to the HSDM through the state EDW.

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

Data Confidentiality

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

Graphs

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

Incidence

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

Death Rate

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

Reliability of Rates

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

Small Numbers

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

Standard Errors

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

Where,

w_j = fraction of the standard population in age category

n_j = number of cases in that age category

p = person-years denominator

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

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?

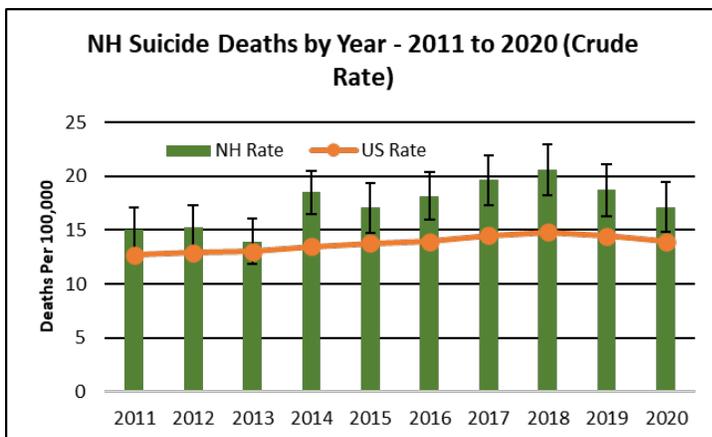
A: It is best to focus on data from a full year or multiple years rather than periods of just a few months. Over brief periods these numbers are too volatile to draw accurate conclusions from them.

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 – 2011-2020

Change in Rate per 100,000 from Year to Year	
2011-2012	15.02 to 15.25 (Up 2%)
2012-2013	15.25 to 13.95 (Down 9%)
2013-2014	13.95 to 18.52 (Up 33%)
2014-2015	18.52 to 17.06 (Down 8%)
2015-2016	17.06 to 18.18 (Up 7%)
2016-2017	18.18 to 19.65 (Up 8%)
2017-2018	19.65 to 20.61 (Up 5%)
2018-2019	20.61 to 18.75 (Down 10%)
2019-2020	18.75 to 17.13 (Down 9%)

Q: What are the differences between the Centers for Disease Control (CDC) data and NH data on suicide deaths?

A: The CDC data includes all deaths of NH residents regardless of whether they occurred in the state or elsewhere. The NH data comes directly from the Office of the Chief Medical Examiner (OCME) and includes all suicide deaths that have occurred in the state, even if the death was of a non-resident. Also, CDC data are often not released until 12-24 months after the end of a calendar year (e.g., 2020 data were released in early-2022). Preliminary NH data are available within months of a calendar year ending.

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

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

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

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

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

A: 10 Leading Causes of Death, New Hampshire, by Age Group, 2016 – 2020

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Short Gestation 34	Unintentional Injury 12	Malignant Neoplasms ---	Malignant Neoplasms 12	Unintentional Injury 303	Unintentional Injury 784	Unintentional Injury 653	Malignant Neoplasms 823	Malignant Neoplasms 2,571	Heart Disease 11,383	Malignant Neoplasms 13,991
2	Congenital Anomalies 32	Congenital Anomalies ---	Unintentional Injury ---	Suicide 12	Suicide 162	Suicide 196	Malignant Neoplasms 206	Unintentional Injury 605	Heart Disease 1,469	Malignant Neoplasms 10,290	Heart Disease 13,659
3	Placenta Cord Membranes 16	Homicide ---	Benign Neoplasms ---	Unintentional Injury ---	Heart Disease 19	Malignant Neoplasms 59	Suicide 185	Heart Disease 599	Unintentional Injury 503	Chronic Low Respiratory Disease 3,080	Unintentional Injury 4,526
4	Maternal Pregnancy Comp. 14	Malignant Neoplasms ---	Congenital Anomalies ---	Benign Neoplasms ---	Malignant Neoplasms 19	Heart Disease 56	Heart Disease 125	Suicide 259	Chronic Low Respiratory Disease 409	Alzheimer's Disease 2,321	Chronic Low Respiratory Disease 3,592
5	Respiratory Distress 12	Influenza & Pneumonia ---	Homicide ---	Congenital Anomalies ---	Homicide 17	Liver Disease 18	Liver Disease 80	Liver Disease 184	Liver Disease 287	Cerebrovascular 2,307	Cerebrovascular 2,587
6	SIDS 12	Diabetes Mellitus ---	Acute Bronchitis ---	Influenza & Pneumonia ---	Congenital Anomalies ---	Cerebrovascular 12	Diabetes Mellitus 29	Diabetes Mellitus 96	Diabetes Mellitus 267	Unintentional Injury 1,647	Alzheimer's Disease 2,355
7	Bacterial Sepsis ---	Heart Disease ---	Diseases Of Appendix ---	Chronic Low Respiratory Disease ---	Chronic Low Respiratory Disease ---	Homicide 11	Homicide 22	Chronic Low Respiratory Disease 81	Suicide 222	Diabetes Mellitus 1,298	Diabetes Mellitus 1,702
8	Circulatory System Disease ---	Septicemia ---	Heart Disease ---	Heart Disease ---	Cerebrovascular ---	Diabetes Mellitus ---	Cerebrovascular 21	Cerebrovascular 71	Cerebrovascular 171	Influenza & Pneumonia 977	Suicide 1,277
9	Intrauterine Hypoxia ---	---	---	Nephritis ---	Diabetes Mellitus ---	Complicated Pregnancy ---	Chronic Low Respiratory Disease 13	Septicemia 35	Septicemia 94	Parkinson's Disease 838	Influenza & Pneumonia 1,074
10	Unintentional Injury ---	---	---	Pneumonitis ---	Four Tied ---	Septicemia ---	Congenital Anomalies ---	Nephritis 27	Nephritis 82	Nephritis 787	Liver Disease 935

Data Source: CDC WISQARS, 2016-2020

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

Contacts and Meeting Information

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

State Suicide Prevention Council

Chair: Russell Conte – Russell.Conte@dos.nh.gov

Vice Chair: Mary Forsythe-Taber – mft@mih4u.org

Meets 4th Monday – Every **other** month 10:00 am – 12:00 pm

Youth Suicide Prevention Assembly

Primary Contact: Elaine de Mello – edemello@naminh.org

Meets 2nd Thursday of the month 10:00 am – 12:30 pm

Suicide Prevention Council Subcommittees

Communications & Public Education

Chair: Mary Forsythe-Taber – mft@mih4u.org

Contact Mary Forsythe-Taber for current meeting schedule

Data Collection & Analysis

Chair: Patrick Roberts – proberts@naminh.org

Meets 4th Wednesday of Feb., May, Aug., and Oct. 9:30 – 11:30 am

Law Enforcement

Chair: Trooper Seth Gahr

Meeting schedule to be determined

Military & Veterans

Chair: Amy Cook – Amy.Cook@nh.gov

Meets 1st Wednesday of the Month 2:00 – 3:30 pm

Public Policy

Chair: Debbie Robinson - deborah.a.robinson@dhhs.nh.gov

Meets 3rd Wednesday of Jan., Mar., May, July, Sept., and Nov. 1:00 pm – 2:00 pm

Suicide Fatality Review

Chair: Dr. Paul Brown

Attendance is by invitation only

Survivors of Suicide Loss

Co-Chairs: Deb Baird – dbaird0688@gmail.com

Steve Boczenowski – boczeno@gmail.com

Meets 4th Monday of the Month 1:00 pm – 2:00 pm

Recognize the Warning Signs for Suicide to Save Lives!

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

Warning signs:

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

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

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

Connect with Your Loved One, Connect Them to Help

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



Mental Health and Suicide Prevention Resources

General Resources:

Local Resources

Community Mental Health Centers: nhcbha.org

Disaster Behavioral Health Response Teams: www.dhhs.nh.gov/disaster-behavioral-health

NAMI New Hampshire: www.NAMINH.org, 603-225-5359

Gay, Lesbian Bisexual, and Transgender (GLBT) Resources

Fenway Peer Listening Line: 1-800-399-PEER www.fenwayhealth.org

GLBT National Hotline (M-F 4-12 pm; Sat. 12-5 pm): 1-888-843-4564 www.glnh.org

GLBT National Youth Talkline (M-F 8-12 pm): 1-800-246-PRIDE (7743)

Email: youth@GLBTNationalHelpCenter.org

SPRC Library: www.sprc.org/library_resources/sprc

Trevor Helpline (24/7): 1-866-4u-TREVOR (488-7386) www.thetrevorproject.org

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: 1-800-273-8255 (press 1 after connecting)

National Organizations

American Association of Suicidology: www.suicidology.org

American Foundation for Suicide Prevention: www.afsp.org

National Action Alliance for Suicide Prevention: theactionalliance.org

National Alliance on Mental Illness: www.nami.org

Suicide Prevention Resource Center: www.sprc.org

Older Adults

NH Fact Sheet on Suicide and Aging: bit.ly/2nuLd5O

SPRC Older Adult Suicide Prevention Resources: www.sprc.org/populations/older-adults

Substance Abuse and Mental Health Services Administration (SAMHSA)

Obtaining Prevention Materials:

Visit their website: store.samhsa.gov (includes downloadable materials)

Call: 1-877-SAMHSA-7 (1-877-726-4727) or Email: samhsainfo@samhsa.hhs.gov

Treatment Provider Locator:

SAMHSA maintains a searchable list of mental health and substance use disorder providers.

You can use it to find a local provider by going to www.samhsa.gov/find-treatment

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

National Helplines

Compassionate Friends: 1-877-696-0010

Friends for Survival: 1-800-646-7322

Websites

Alliance of Hope for Suicide Survivors: www.allianceofhope.org

American Foundation for Suicide Prevention: afsp.org

Compassionate Friends: www.compassionatefriends.org

The *Connect* Program: <https://theconnectprogram.org/find-support/coping-with-suicide-loss>

Friends for Survival: www.friendsforsurvival.org

Heartbeat: www.heartbeatsurvivorsaftersuicide.org

Parents, Family and Friends of Suicide Loss: www.pos-ffos.com

SAVE (Suicide Awareness Voices of Education): www.save.org/coping

Survivors of Suicide Loss: www.survivorsofsuicide.com

Discussion Forums

Help for People Left Behind: forums.grieving.com

Suicide's Survivors: bit.ly/legacy-suicidesurvivors

Booklets

Coping with the Loss of a Friend or Loved One: bit.ly/save-coping-withloss

Hope and Healing after Suicide: bit.ly/2n0cxsE

Resource and Healing Guide: bit.ly/2nyiEVg

Have you found this report to be useful?

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

<https://www.surveymonkey.com/r/RR3YM62>