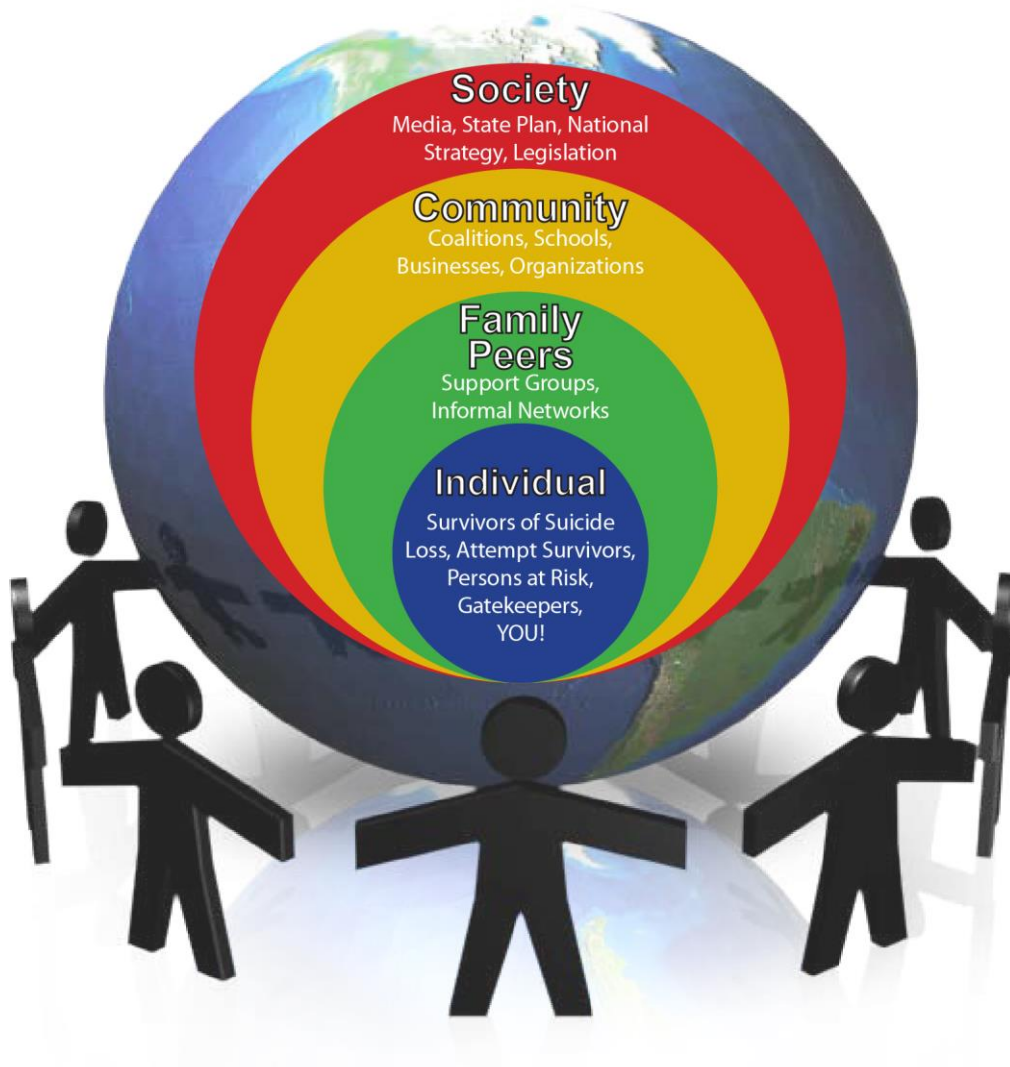


New Hampshire Suicide Prevention



Annual Report 2015

This report was produced by the National Alliance on Mental Illness – NH (NAMI NH), State Suicide Prevention Council (SPC) and Youth Suicide Prevention Assembly (YSPA).

Any individual or organization may freely copy and distribute this report. Electronic copies are available at www.TheConnectProgram.org/annual-reports.

Table of Contents

Introduction	2
What’s New in This Year’s Report?	2
Primary Partners	3
Accomplishments of Suicide Prevention Efforts in NH	4
State Suicide Prevention Council	4
Youth Suicide Prevention Assembly	5
The NH Suicide Survivor Network	6
State and Tribal Youth Suicide Prevention and Early Intervention Grant Program.....	7
Campus Youth Suicide Prevention and Early Intervention Grant Program	8
Annual NH Suicide Prevention Conference	9
Local Coalitions: Suicide Prevention at a Grassroots Level	9
State and National Attention on NH Initiatives	10
2015 Data	12
Introduction	12
Demographic Profile of New Hampshire	13
The Big Picture: Suicide in NH and Nationally	15
Youth and Young Adult Suicide in NH	18
Older Adult Suicide in NH	22
Suicide Across the Lifespan in NH	24
Suicide Behavior in NH: Gender Differences	30
Suicide in NH: Methods	38
Reducing Access to Lethal Means	43
Linking At-Risk Individuals with Help	44
Costs of Suicide and Suicidal Behavior	44
Additional Data Sources	45
NH Behavioral Risk Factor Surveillance System.....	46
NH National Guard	46
Veterans Health Administration.....	47
NH Department of Corrections	48
Suicide Rates in NH	48
Reading Tables and Figures	52
Glossary of Terms	54
Reliability of Rates	57
Frequently Asked Questions about NH Suicide Data	58
Contacts and Meeting Information	60
Recognize the Warning Signs of Suicide	62
Mental Health and Suicide Prevention Resources	63
Appendix A: New Hampshire Violent Death Reporting System	65
Appendix B: 2015 Suicide Fatality Review Committee Report	71

Introduction

The 2015 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.

Our work in suicide prevention and postvention is reaching across the state and systems as well as into communities, schools, organizations and individual lives.

Evidence of this includes some of the following accomplishments from calendar year 2015:

- The 2015 Suicide Prevention Conference was again a sold out event with close to 300 people participating.
- NH Senate Bill 33 (2015) requiring training in suicide prevention for mental health professionals was signed into law.
- In 2015 the work of NH's third federal Garrett Lee Smith (GLS) Suicide Prevention Grant was underway, and a new GLS Campus Grant began at UNH.

Many achievements will be described further throughout this report. It is critical to NH in the next few years that we build on the momentum and collective knowledge that has been gained in suicide prevention to strengthen capacity and sustainability to reduce risk of suicide for all NH citizens and promote healing for all of those affected by suicide. Despite significant challenges with a struggling economic environment, including budget cuts and reduced access to mental health and substance use treatment, NH continued to make progress in suicide prevention work in many diverse and systemic ways.

Knowing that it takes all of us working together with common passion and goals, we thank 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:

- Preliminary data from the NH Violent Death Reporting System (**Page 65**)
- New suicide death data from the Centers for Disease Control.
- New self-inflicted injury data emergency medical service providers.
- New examples of positive outcomes and testimonials related to suicide prevention work being done in NH. These examples are included as text boxes interspersed throughout the report.

Primary Partners

NAMI NH and the Connect Suicide Prevention Program

The National Alliance on Mental Illness (NAMI NH), a grassroots organization of families, consumers, professionals and other members, is dedicated to improving the quality of life of persons of all ages affected by mental illness and/or serious emotional disorders through education, support and advocacy.

NAMI NH's Connect Suicide Prevention Program is designated as a National Best Practice (www.sprc.org/bpr). 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). The Connect Program assists the Youth Suicide Prevention Assembly and the State Suicide Prevention Council with implementation and oversight 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.

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 abuse 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 comes from the Council's subcommittees: Communication and Public Education; Cross-Training and Professional 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 SB 390, which legislatively established the Suicide Prevention Council, the Council is required to annually report on its progress, 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 24 years old. 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 – including but not limited to: collecting and analyzing timely data on suicide deaths and attempts, collaborating on an annual educational conference, creating the original NH Suicide Prevention Plan and identifying the need for statewide protocols and training, which were developed through NAMI NH into the Connect Program.

Accomplishments of Suicide Prevention Efforts in NH

State Suicide Prevention Council

This year marked the seventh anniversary of NH's Suicide Prevention Council since its legislative inception.

The leadership transitions begun in 2014 with Dr. Dan Potenza, Medical Director of Forensic Services for the Department of Corrections, taking over as chair of the council continued with Deb Robinson, Administrator of SPU and RTU for the Department of Corrections, stepping down as the SPC Coordinator, and Patricia Tilley, Chief of the Bureau of Population Health and Community Services for the Department of Health and Human Services, taking on that role.

A great success for the council this year included legislation requiring training in suicide prevention for mental health professionals being signed into law. This initiative was led by the Public Policy subcommittee with other subcommittees providing support, in the form of outreach, as well as written and personal testimonies. Discussions continue about a similar requirement for groups such as staff members in schools and non- licensed clinicians. These efforts will also include alternatives to legislation, as was discussed with the NH School Administrators Association to bring suicide prevention training to school districts.

The council will continue to work on increasing collaboration between committees. The council's success on initiatives put forth by individual committees will be enhanced by its ability to join forces, as resources are limited and voices are stronger and louder together. It will mean further transitions and transformation for the council as it looks to potentially narrow its focus to ensure goals and objectives are met. The members of the council look forward to maximizing their effectiveness as a council

As the council looks to have the committees work together, there is also a desire to increase membership. This is particularly true for representatives from the field of substance abuse as the council looks at the relationship between substance misuse and suicide prevention. The council

also recognizes the role public health departments play in this work and their perspective is important 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 committee meeting schedule and contacts have been included on pages 60-61 of this report.

The council continues to collaborate with DHHS for statewide leadership and support as it transitions to another coordinator and 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 pages 60-61 of this report.

The Youth Suicide Prevention Assembly (YSPA)

The Youth Suicide Prevention Assembly (YSPA) meets monthly in Concord to review cases of youth suicides under the age of 25 in order to identify trends and insights into suicide prevention. YSPA also utilizes monthly meeting for networking, learning about resources, and having formal presentations on a wide variety of related topics. In 2015, some of the topic and resource areas of focus included: Dr. Thomas Andrew, Chief Medical Examiner, speaking on heroin deaths and suicide rulings; a presentation from an In Our Own Voice speaker sharing his lived experience with mental illness, and Dr. Sonya Lee Kelly presenting on the impact on clinicians who lose a client to suicide.

YSPA case reviews allowed for an in-depth look at some of the trends that were emerging in youth and young adult suicides. Noted in 2015 was the recurrence of young males over the age of 18, many not in college and minimally employed; several of whom had recent encounters with the law and/or issues with substance misuse; and a concerning pattern of young parents who took their lives, leaving very young children behind.

YSPA continues to meet monthly and in 2015 we welcomed Lt. Margaret Lougee from the Bow Police Department as a co-chair, replacing Pauline Laliberte, a long standing chair and YSPA member. Traci Belanger from SNHU also serves as a co-chair along with Elaine de Mello (NAMI NH) and Elizabeth Fenner-Lukaitis (DBH). As part of an annual retreat, the YSPA mission statement was reviewed and modified to shape future meetings. For more information on YSPA, please contact Elizabeth Fenner-Lukaitis: Elizabeth.Fenner-Lukaitis@dhhs.nh.gov or Elaine de Mello: edemello@naminh.org

The NH Suicide Survivor Network

In 2015 **Survivors of Suicide Loss (SOSL)** continued in their efforts of building capacity and established four new support groups throughout NH, with those groups already in motion and attendees growing in numbers as the groups are added. 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. These support groups continue to meet on a weekly, bi-weekly and monthly basis.

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. In 2015 there were over 35 presentations by loss survivors. Six new loss survivors were trained and are members of the Survivor Voices Speakers Bureau.

The NH **Survivors of Suicide Loss Resource Packet** was updated and disseminated through the NH Office of 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 (ISOS) Loss Day** were held in 11 sites on the last Saturday before Thanksgiving and gathered over 100 loss survivors together in healing, support and understanding.

Positive Outcomes and Testimonials

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

This became a workshop that was put together for the 2015 NH Suicide Prevention Conference.

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 of this tragedy and along with their grief, sadness, and devastation. The last thing they don't 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 lead to feel like a suspect in their own home and loved ones death.

The Goffstown law enforcement is one step ahead of this for Loss Survivors, their goal is to “invest” in Loss Survivors and recognize that it is most important to treat Loss Survivors with the utmost respect and compassion at the scene of a suicide death and on a longer term thereafter. With their police department chaplain they work together to make this unimaginable tragic situation run as smoothly as it can.

Since this workshop, it has been discovered that many law enforcement departments in NH do have something like this in place and 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 have on hand at the scene to help remind them of what can be done and said to Loss Survivors at the upon a suicide death and an unattended death as well. These two examples help to make a tragic situation such as a suicide death to go a little more smoothly for Loss Survivors to be understood and for law enforcement to make sure that they have that important compassionate part to achieve that goal.

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 too 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 1050 hours in 2015. This included displaying the 3 **Life Keeper Memory Quilts** lovingly put together by survivors of suicide loss in NH. The quilts were displayed along with loss survivor resources at many of these events such as the NAMI NH Walk, NH Seacoast and Nashua AFSP “Out of the Darkness Walk”, Nathan’s Ride, Paddle Power, and Compassionate Friends. These quilts were also displayed at all of the loss survivor speaker presentations and the State Suicide Prevention Conference.

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

The NH State Suicide Prevention Council continues to include survivors of suicide loss in their work by encouraging each existing sub-committee on the council to include

loss survivors on the membership. Continued surveys to the NH loss survivor network clearly indicate great interest so they may express their voice, build capacity of support groups, expand the International Survivors of Suicide Teleconference day, and be involved in more advocacy and state wide Loss Survivor events.

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

State and Tribal Youth Suicide Prevention and Early Intervention Grant Program (Garrett Lee Smith Grant)

The federal SAMHSA GLS suicide prevention grant awarded to NH in 2013 strengthened the work that has been established in NH over the years as described in this report, as well as to venture into new initiatives. Some of the highlights are described in the following sections:

NH Hospital:

One area of development included the establishment of an Aftercare Liaison at NH Hospital (NHH). The role of this staff person is to reach out to youth aged 24 and younger who are admitted to NHH and help to educate and support them and their families/natural supports for their transition back into the community. Engaging with and educating youth who are at high risk for suicide during their hospital stay can ensure continuity of care into the community to ease their transition during a high risk period (post discharge) and minimize the potential for relapse

and increased suicide risk. The project builds off of Project Red, a best practice implemented through NHH around post discharge follow-up. The Aftercare Liaison position, hired in 2014, began identifying, engaging with and following young people and their families at NH Hospital and helping them connect with resources in their communities, tapping into the knowledge and services of the regional public health coalitions, NAMI NH affiliates, and other community resources to build a strong safety net towards recovery and resilience.

The Aftercare Liaison saw 50 clients in 2015; none were re-hospitalized at NHH during that period. An increase in the use of safety plans and distribution of suicide prevention information and NAMI NH linkages resulted from this project. An improvement in communication, record transfer and continuity of care was also noted by mental health centers interfacing with the After Care Liaison. A suicide prevention task force was established at NHH and continues to meet and look at best practices across the facility, including institutionalizing the Connect Suicide Prevention Program as part of the orientation for all Mental Health Workers hired at NHH.

Campus Youth Suicide Prevention and Early Intervention Grant Program (Garrett Lee Smith Grant)

Plymouth State University (PSU):

PSU completed its third and final year of a GLS grant in 2015 with expansion on the foundation built for the university and a focus not just on prevention but also postvention and sustainability. The development of a loss survivor support group on campus brought additional resources to those impacted by suicide, and an International Survivors of Suicide Loss event was held on campus in November 2015.

Additional Connect Trainings of Trainers helped to build capacity and extend suicide prevention training out to students through training offered by professors and residential staff. Strengthening of protocols for referral of students at risk for suicide included incorporation of the CARE form into the Connect training and protocols. This resulted in a notable increase in CARE form submissions, most of which referenced some level of concern about a student at risk for suicide. Utilizing Connect's best practice postvention protocols and technical assistance were essential when the campus community responded to a tragedy late in 2015, with the support of Genesis Behavioral Health and NAMI NH.

University of NH (UNH):

UNH began the first year of a GLS grant in September of 2015. The pre-existing Campus Suicide Prevention Committee (CSPC) has focused on expanding the network of services to students through CSPC. Under the grant, they will continue enhancing in-person and online suicide prevention trainings, as well as offering more tailored and sustainable programs and educational materials to the campus focused on students particularly at high risk including LGBTQ+ identified students and student veterans.

Plans are in place to train a total of 2,000 students each year of the three year GLS grant on the three peer Kognito programs as well as 500 faculty and staff each year on the three faculty/staff programs, for a total of 7,500 campus members. In addition, up to 2,000 campus members, and up to ten additional trainers will be trained in Mental Health First Aid. Due to these efforts an

increase is anticipated in referrals to and consultations with the Counseling Center and the Behavioral Intervention Team, particularly from at-risk student groups.

Annual NH Suicide Prevention Conference

NH's 2015 Suicide Prevention Conference: "Partnering for Prevention-Everyone Has A Role" once again attracted a wide range of attendees from virtually every sector of the community. Hosted by YSPA, SPC, NAMI NH and Regional Coalitions, the conference exemplified the work being done across the state and national initiatives, and brought in keynote speakers on topics related to trauma and loss. A highlight for the day was the presentation by Hanover High School Youth Suicide Awareness Committee, who shared their student led video: End The Silence about Suicide Prevention: <http://bit.ly/2cQjGnU>, followed by a distribution throughout the audience of their End The Silence wristbands.

Positive Outcomes and Testimonials

"This Conference saved my life"

Feedback from an attendee at the Annual NH Suicide Prevention Conference

Local Coalitions: Suicide Prevention at a Grassroots Level

Public Health Networks (PHNs) in tandem with GLS/NAMI NH staff provided outreach and education in a variety of ways. In addition to coordinating Connect Train the Trainer sessions, CALM (Counseling on Access to Lethal Means) was offered for first responders in each of the three public health regions identified in the grant (Capital Region, Lakes Region, and Greater Manchester Region), bringing this important best practice to several dozen law enforcement officers and emergency medical personnel.

The PHNs were actively extending support and resources to communities and schools in the aftermath of tragic suicides and working with the media to ensure safe messaging wherever possible, PHNs partnered with regional stake holders to create suicide prevention messages through bus posters (Manchester) and a public service video (Laconia).

The PHNs were also involved in setting up International Survivor of Suicide loss Day sites and promoting a range of suicide prevention activities and information. Other regions, such as those in Carroll County and the Upper Valley, continued to expand on their suicide prevention work by conducting trainings in Connect and CALM and participating in regional and statewide initiatives.

State and National Attention on NH initiatives

NH Firearm Safety Coalition and the “Gun Shop Project”

The “Gun Shop Project”, a NH initiative born out of the NH Firearm Safety Coalition, developed informational materials on suicide prevention and lethal means reduction for gun shops and firing ranges in NH in 2011 and disseminated these materials to more than 65 gun shops across the state. Follow up surveys noted utilization of these materials in over half of these establishments. This unique partnership between the firearm community and suicide prevention advocates was recognized nationally. Numerous states have followed up to replicate this initiative and several media reports were produced about the project, including an article in U.S News and World Report and a five minute piece on CNN. This new coverage and all materials can be viewed at www.nhfsc.org.

The Firearm Safety Coalition continues to meet and work on extending awareness, education and opportunities for suicide prevention in NH. For more information, contact Elaine Frank at: Elaine.M.Frank@Dartmouth.edu

Attempt Survivor Initiative:

With a national movement bringing a voice to those who survived a suicide attempt, an event called Hope Beyond the Darkness of Suicide was sponsored by the Capital Area Public Health Network and NAMI NH which brought a panel of speakers with lived experience (attempt survivors) to a public venue in May of 2015. These speakers, with their powerful stories, shared their struggles and strengths to the general public and answered questions from the audience, offering hope and inspiration to many who shared their own experience with mental illness and suicide. During this year, the establishment of an Attempt Survivor Task Force was formed and has been meeting since to review models of support groups and other initiatives to extend to attempt survivors in NH,

Best Practice Programs Developed in NH:

CALM (Counseling on Access to Lethal Means) – A national best practice training that was developed in NH and has been utilized throughout the state and in dozens of states around the U.S. The method of lethal means reduction is cited as an effective suicide prevention practice in the National Strategy for Suicide Prevention and has been offered to first responders, medical providers, schools and families across NH and the U.S.

Connect – Approximately 100 individuals were trained as Connect Prevention or Postvention Trainers in 2015 throughout NH representing schools, campuses, law enforcement, social services, mental health and public health networks and homeless liaisons. In addition, specialized Connect Trainings of Trainers were conducted with leaders from the Deaf and Hard of Hearing community and the Bhutanese community so that the Connect training could be provided in other languages.

Positive Outcomes and Testimonials

“Before I had the [Connect] training, I wouldn’t have known what to do and would have probably done nothing. Because of the training, I got involved right away and I knew where to turn to get support and resources immediately.”

Tammy Levesque, Lakes Region Partnership for Public Health on responding to a suicide in her region

The Connect Suicide Prevention and Postvention program also continues to expand its geographical reach with trainings and workshops. As of the end of 2015, Connect Suicide Prevention training has had a presence in 41 US states, as well as the British Isles, Canada, and Guam.

Best Practice Programs Brought Into NH:

ASIST (Applied Suicide Intervention Skills Training) – Offered by the National Guard, the two day ASIST training has been made available to military members and civilians across NH, expanding the repertoire of tools and skills of citizens across the state to respond to persons at risk.

SOS (Signs of Suicide) – An evidence based secondary school-based suicide prevention program that includes screening and education, was introduced to a number of schools in NH in 2015, strengthening the safety net and awareness around youth suicide prevention in the school systems throughout the state.

2015 Data

SPC/YSPA Data Subcommittee Membership Representation 2015-2016

Injury Prevention Center at CHaD
National Alliance of Mental Illness New Hampshire
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 Chief Medical Examiner

Introduction

The data presented in this report is the result of collaboration among a variety of organizations and people. The data were compiled by the two major collaborative groups for suicide prevention in New Hampshire, the YSPA and the SPC. YSPA and SPC merged data efforts over the past several years, 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 18 years and first created this report format in 2003. The SPC has been analyzing and planning for data capacity improvements for the last 7 years. 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 leads to determinations of prevention and intervention efforts as well as 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 tragic lives lost, leaving many behind who are profoundly affected by these deaths.

When reading this report it is important to note that two primary sources of NH data were used. One main data source is 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. The other main data source is the Office of Chief Medical Examiner (OCME) for the State of NH. These two key data sources cover similar populations, but small differences in numbers and rates may occur due to differences in how the data is collected. The Vital Records data, as reported by the Centers for Disease Control (CDC), include suicide deaths of NH residents that occurred both inside and outside of the state. The OCME data includes all suicide deaths that occurred in NH regardless of where the individual resided and does not capture suicide deaths by NH residents that occurred outside of the state. Additional data sources were used for specific purposes that may have varying methods of collection. All of the charts and graphs in this report include citations of 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, 2015). Overall, NH is relatively homogeneous in terms of race and ethnicity, and has above average ratings for economic factors and education. NH is above the US average for alcohol and illegal drug use, with the 2nd highest rate in the US for alcohol use and the 10th highest rates for illegal drug use (National Survey on Drug Use and Health, 2013-2014).

Table 1

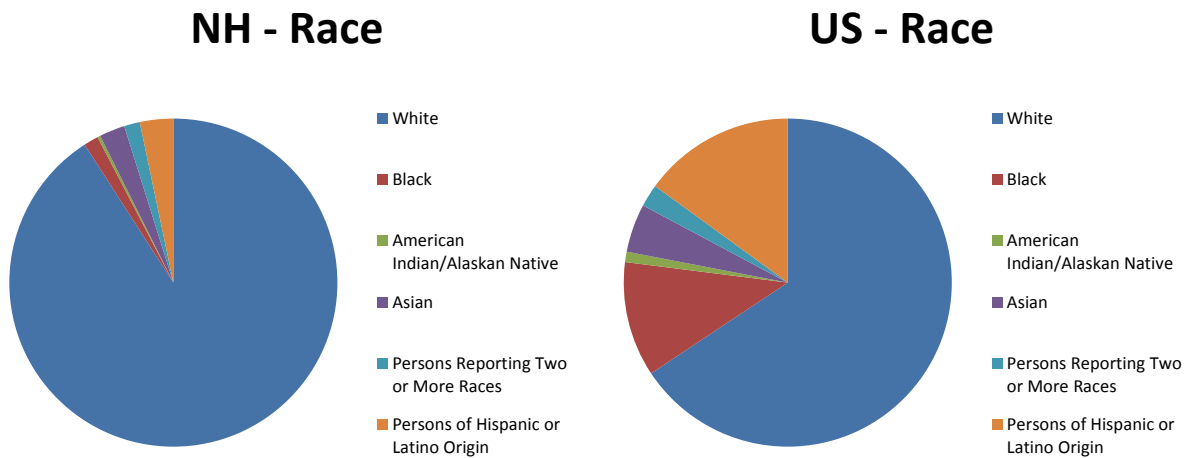
Race/Ethnicity.

	New Hampshire	United States
White	93.9%	77.1%
Black	1.5%	13.3%
American Indian/Alaskan Native	0.3%	1.2%
Asian	2.6%	5.6%
Persons Reporting Two or More Races	1.6%	2.6%
Persons of Hispanic or Latino Origin	3.4%	17.6%

Source: US Census Bureau 2015

Figure 1

NH and US Race/Ethnicity.



Source: US Census Bureau 2015

Table 2

Age.

	New Hampshire	United States
Under 18	19.86%	23.00%
18 to 24	9.68%	9.62%
25 to 44	23.33%	26.24%
45 to 64	30.64%	26.23%
65 to 74	9.75%	8.60%
75 and Up	6.73%	6.31%

Source: US Census Bureau 2015

Table 3

Economic Factors.

	New Hampshire	United States
Unemployed Residents	4.4%	5.8%
Persons Below Poverty Level	8.9%	15.6%
Persons Without Health Insurance	10.3%	14.2%
Per Capita Income (Yearly)	\$33,821	\$28,555
Median Household Income	\$65,986	\$53,482
Owner Occupied Homes	71.0%	64.4%
Median Home Value	\$237,400	\$175,700

Sources: US Census Bureau American Community Survey 2014

Table 4

Education – population age 25 and older.

	New Hampshire	United States
Less Than High School Graduate	8.0%	13.6%
High School Graduate or Associates Degree	57.6%	57.1%
Bachelor’s Degree or Higher	34.3%	29.3%

Source: US Census Bureau American Community Survey 2014

Table 5

Substance Use – Individuals Age 12 and Up.

	New Hampshire	United States
Illicit Drug Use – Past Month	11.28%	9.27%
Alcohol Use – Past Month	65.19%	52.13%
Tobacco Use – Past Month	25.54%	26.10%

Source: National Survey on Drug Use and Health, 2013-2014

Table 6

Mental Health Indicators – Individuals Age 18 and Up.

	New Hampshire	United States
Serious Mental Illness – Past Year	4.73%	4.15%
Major Depressive Episode – Past Year	7.90%	6.63%
Had Thoughts of Suicide – Past Year	4.12% ¹	3.94%

Source: National Survey on Drug Use and Health, 2013-2014

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 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. 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 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 is significantly above the rates prior to 2010. Such an extreme increase was not seen in other states or for the US as a whole in 2014.

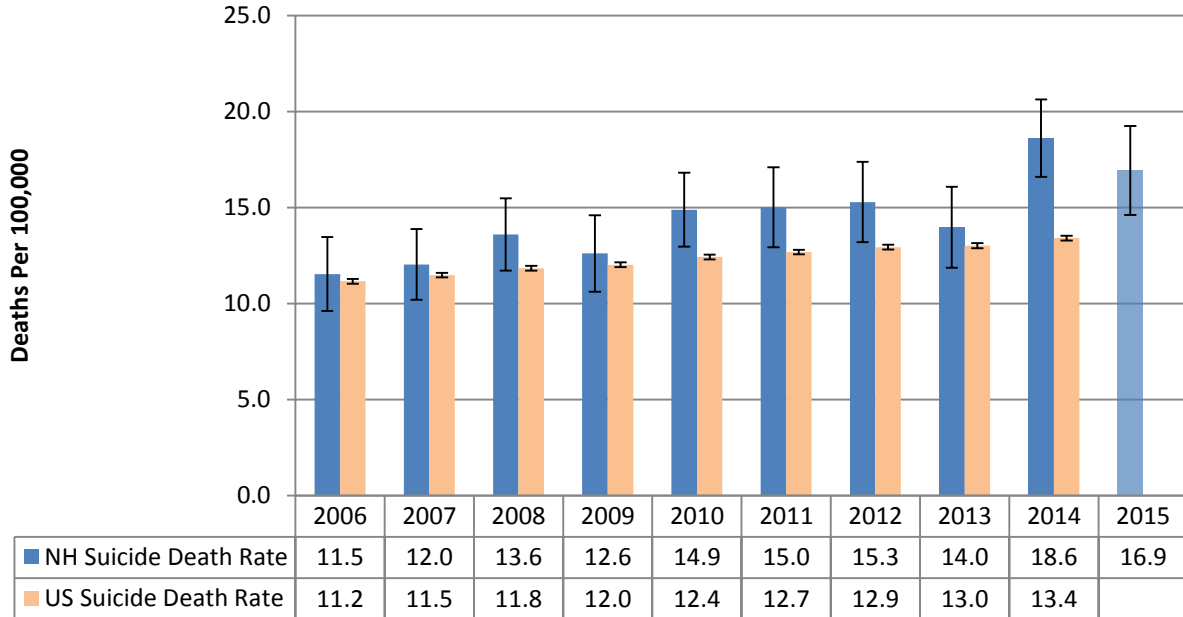
New Hampshire was recently awarded a grant from the CDC to contribute data to the National Violent Death Reporting System (NVDRS). 2015 is the first year that NVDRS data will be available for NH. A preliminary report on some of the available data from this system has been included in Appendix A on page 65. As more NH level data become available, the NH Department of Justice and NH Department of Health and Human Services will release additional reports based on the rich data that is part of the NVDRS. Future editions of this report will also incorporate NVDRS data when available.

¹ A 2016 report found an increase in reported thoughts of suicide from 2013-2014 among NH residents between the ages of 18 and 24 - http://www.samhsa.gov/data/sites/default/files/report_2387/ShortReport-2387.pdf.

Figure 2

Crude Suicide Death Rates per 100,000 in NH by Year 2006-2015.

NH and US Suicide Deaths By Year - 2006 to 2015 (Crude Rate)



Source: 2006-2014 – CDC Data; 2015 – NH OCME Data

Table 7 displays the 10 leading causes of death for people of different age groups in NH. From 2010-2014, suicide among those aged 15-34 was the second leading cause of death for NH and nationally. In prior years suicide was the third leading cause of death nationally for that age group. Suicide rates for individuals age 15-34 during 2010-2014 were behind only deaths due to unintentional injury; primarily motor vehicle crashes and unintentional overdose deaths in NH within this age group. Suicide among individuals of all ages was the 9th 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, 2010 – 2014.

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 48	Unintentional Injury 11	Malignant Neoplasms (*see note)	Malignant Neoplasms 12	Unintentional Injury 234	Unintentional Injury 370	Unintentional Injury 312	Malignant Neoplasms 1,020	Malignant Neoplasms 2,521	Heart Disease 9,914	Malignant Neoplasms 13,207
2	Short Gestation 38	Congenital Anomalies (*see note)	Unintentional Injury (*see note)	Suicide (*see note)	Suicide 111	Suicide 152	Malignant Neoplasms 206	Heart Disease 565	Heart Disease 1,177	Malignant Neoplasms 9,339	Heart Disease 11,845
3	Maternal Pregnancy Comp. 26	Homicide (*see note)	Cerebro-vascular (*see note)	Unintentional Injury (*see note)	Malignant Neoplasms 21	Malignant Neoplasms 73	Suicide 149	Unintentional Injury 416	Unintentional Injury 327	Chronic Low. Respiratory Disease 2,859	Chronic Low. Respiratory Disease 3,281
4	Placenta Cord Membranes 18	Malignant Neoplasms (*see note)	Chronic Low Respiratory Disease (*see note)	Heart Disease (*see note)	Homicide 15	Heart Disease 40	Heart Disease 126	Suicide 268	Chronic Low. Respiratory Disease 313	Cerebro-Vascular 2,133	Unintentional Injury 2,978
5	SIDS 16	Heart Disease (*see note)	Congenital Anomalies (*see note)	Benign Neoplasms (*see note)	Heart Disease 12	Homicide 13	Liver Disease 33	Liver Disease 160	Liver Disease 228	Alzheimer's Disease 1,888	Cerebro-vascular 2,362
6	Respiratory Distress 10	Influenza & Pneumonia (*see note)	Heart Disease (*see note)	Congenital Anomalies (*see note)	Cerebro-vascular (*see note)	Congenital Anomalies 12	Diabetes Mellitus 21	Diabetes Mellitus 92	Diabetes Mellitus 221	Unintentional Injury 1,289	Alzheimer's Disease 1,930
7	Circulatory System Disease (*see note)	Benign Neoplasms (*see note)	Homicide (*see note)	Homicide (*see note)	Congenital Anomalies (*see note)	Diabetes Mellitus 12	Homicide 16	Chronic Low. Respiratory Disease 86	Suicide 197	Diabetes Mellitus 1,051	Diabetes Mellitus 1,401
8	Neonatal Hemorrhage (*see note)	Nephritis (*see note)	Suicide (*see note)	Influenza & Pneumonia (*see note)	Chronic Low Respiratory Disease (*see note)	Chronic Low Respiratory Disease (*see note)	Cerebro-vascular 13	Cerebro-vascular 60	Cerebro-vascular 141	Influenza & Pneumonia 937	Influenza & Pneumonia 1,035
9	Unintentional Injury (*see note)				Diabetes Mellitus (*see note)	Complicated Pregnancy (*see note)	Chronic Low Respiratory Disease (*see note)	Viral Hepatitis 30	Septicemia 73	Nephritis 793	Suicide 1,028
10	Necrotizing Enterocolitis (*see note)				Three Tied (*see note)	Cerebro-vascular (*see note)	Septicemia (*see note)	Influenza & Pneumonia 27	Nephritis 61	Parkinson's Disease 550	Nephritis 881

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

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

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

The vast majority of violent deaths in NH are suicides. For every homicide in NH, there are approximately 10 suicides. This ratio is in sharp contrast to national statistics, which show fewer than 2 suicides for every homicide. For every suicide death in NH and nationally, there are approximately 3 deaths classified as unintentional injuries. Overall, suicide constitutes a larger proportion of all traumatic deaths in NH than in the US as a whole.

The most effective way to compare NH to the US is to look at suicide death rates. **Table 8** 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, 2009-2013.

	ALL AGES	YOUTH 10-17	YOUNG ADULTS 18-24	YOUTH AND YOUNG ADULTS 10-24
NH	15.56	4.01	14.76	9.21
US	12.89	3.52	12.84	8.03

	AGES 25 TO 39	AGES 40 TO 59	AGES 60 TO 74	OVER 75
NH	19.39	22.94	15.27	15.42
US	14.94	19.05	15.22	17.15

Source: CDC WISQARS

Adults age 40 to 59 had the highest suicide rates of all age groups identified above (22.94 NH, 19.05 US) from 2010-2014 in both NH and the US. There is a tremendous 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

In the 10 years from 2006-2015, 204 NH youth and young adults aged 10-24 have lost their lives to suicide. **Table 9** (pg. 20) depicts the most up-to-date information about these youth and young adults as reported by the OCME in NH and collected and aggregated by YSPA. Males are much more likely to die by suicide in NH (81%) and nationwide. Hanging and firearms were used with nearly the same frequency among youth and young adult deaths during this period. Nationally, a greater proportion of youth and young adults who die by suicide use firearms.

From 2004 to 2006 a decreasing trend among youth suicide deaths was noted. This trend reversed in 2007. This increase in youth suicide deaths is apparent when comparing the five year period from 2006-2010 to the following five year period from 2011-2015. From the first period to the second there was a 43% increase. When looking at this it is important to keep in mind that the total number of youth deaths are few in number, and a relatively small increase in the number of deaths will impact the percent increase. Additionally, looking solely at the number of deaths does not take into account increase in population size. The rates presented on the chart of deaths

over rolling three-year intervals shown on **pages 49-50** help to smooth out small year to year fluctuations, and also addresses population increases by presenting rates per 100,000.

Please note that **Table 9** is based on OCME data. “Hanging/Asphyxiation” refers to all forms of suffocation (e.g. hanging, object covering nose and mouth) and “Drugs/Poison” refers to all suicide cases of drug-related deaths or ingested poisons. Suicides where carbon monoxide poisoning was the cause of death are reported in the “Other” section. These categories are slightly different from those used by the Center for Disease Control and Prevention (CDC), which places suicides by carbon monoxide into the “Poison” category (e.g., **Figure 24**).

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.

Table 9
NH Youth (age 24 and under) Suicide Death Trend, by Gender, Age Group and Method, 2006-2015.

Year	Total	Male	Female	≤ 19	20-24	Firearms	Hanging/ Asphyxiation	Drugs/ Poison	Other
2006	12	10	2	1	11	6	3	1	2
2007	13	9	4	3	10	5	4	2	2
2008	15	10	5	8	7	5	9	1	0
2009	20	18	2	10	10	12	7	0	1
2010	24	22	2	11	13	11	11	2	0
2006- 2010 Sub Total	84	69	15	33	51	39	34	6	5
Percent of Sub- Total²	100%	82%	18%	39%	61%	46%	40%	7%	6%
2011	29	23	6	9	20	10	15	2	2
2012	18	15	3	8	10	10	7	0	1
2013	21	17	4	6	15	7	10	3	1
2014	33	26	7	8	25	23	8	0	2
2015	19	16	3	7	12	7	10	1	1
2010 - 2014 Sub Total	120	97	23	38	82	57	50	6	7
Percent of Sub- Total¹	100%	81%	19%	32%	68%	48%	42%	5%	6%
Total	204	166	38	71	133	96	84	12	12
Percent of Total¹	100%	81%	19%	35%	65%	47%	41%	6%	6%

Produced by: NAMI NH
Data Source: NH OCME

² Note: Rounding may cause percentages to not total to 100%

Figure 3

NH Youth, Ages 10-24, Suicide Deaths.

New Hampshire Youth Suicides from 2006 to 2015

Data Source: Office of the Chief Medical Examiner, NH

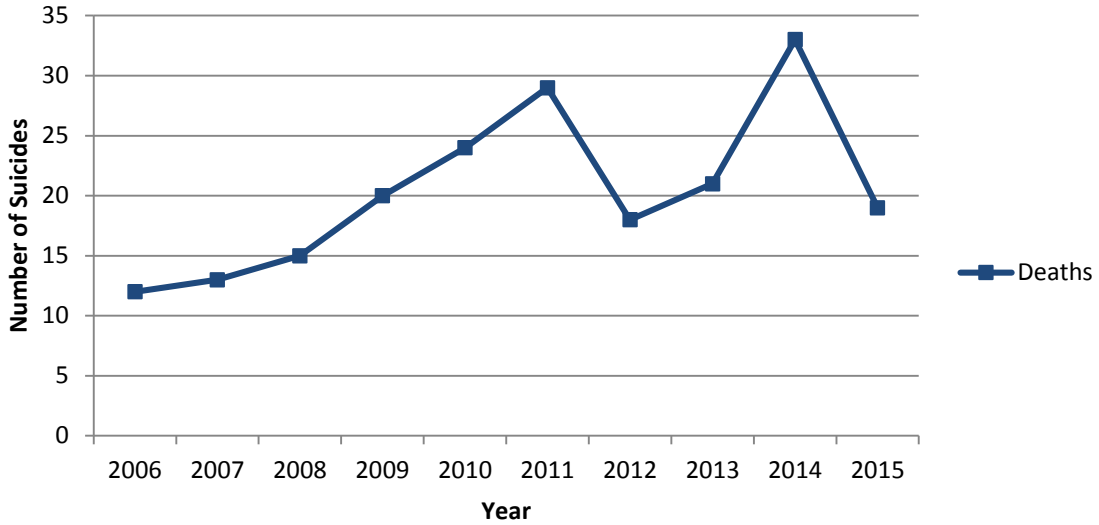
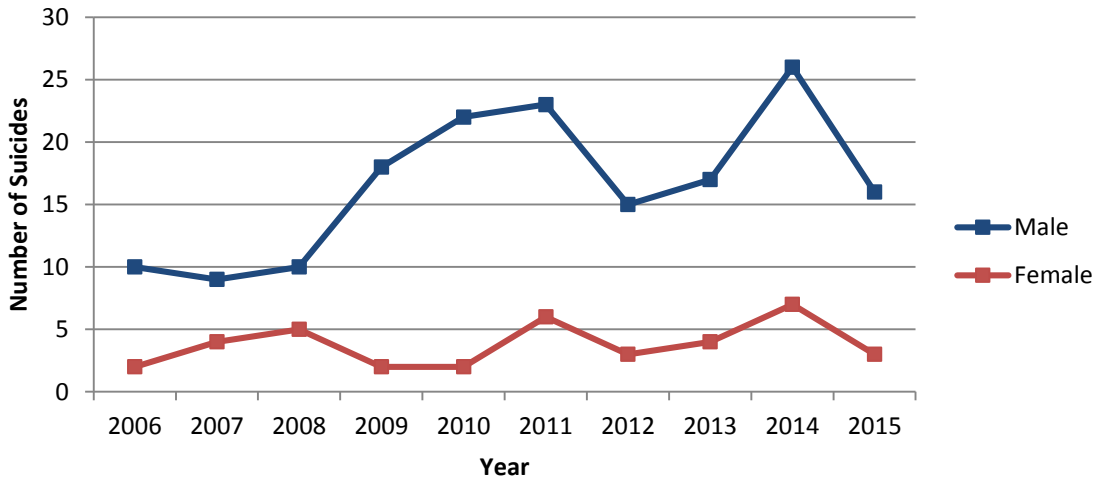


Figure 4

NH Male Youth Suicide Deaths Decrease then Increase 2006-2015, While Female Youth Rates have Remained Relatively Stable.

New Hampshire Youth Suicides from 2006 to 2015 by Gender

Data Source: Office of the Chief Medical Examiner, NH

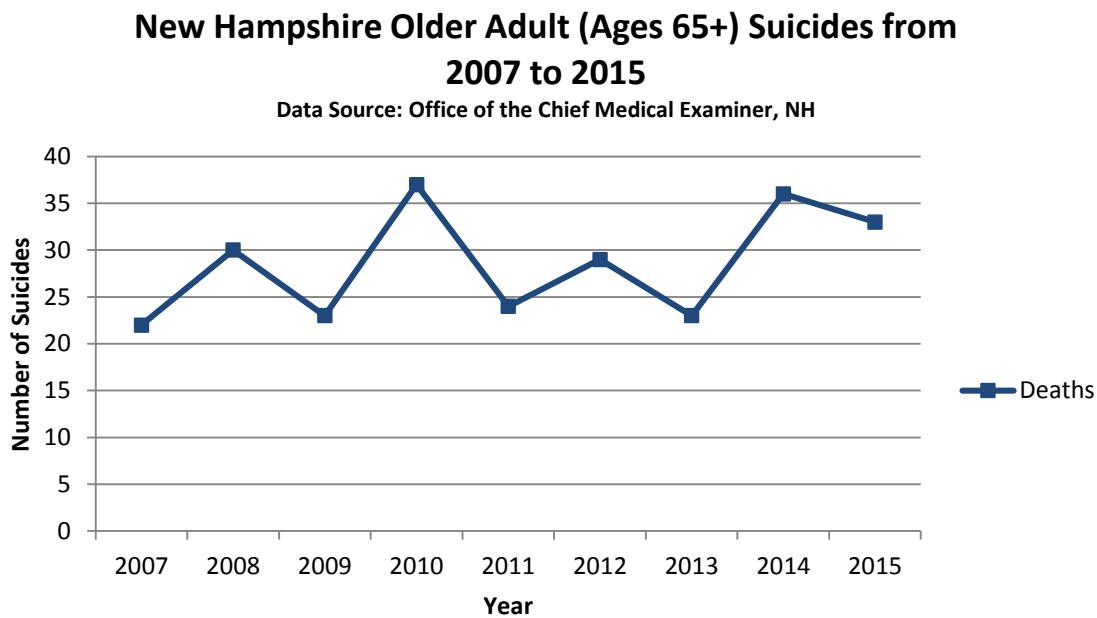


Older Adult Suicide in NH

In light of the rapidly expanding number and proportion of older adults in New Hampshire's population, suicide in older adults is on course to become a growing public health concern. Added to the changing demographics is the also rising prevalence of mental illness and substance use 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.³

Another concern is the rate of attempts to completed suicides 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 generally tend to be more physically frail 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 5
NH Older Adults, Ages 65+, Suicide Deaths.



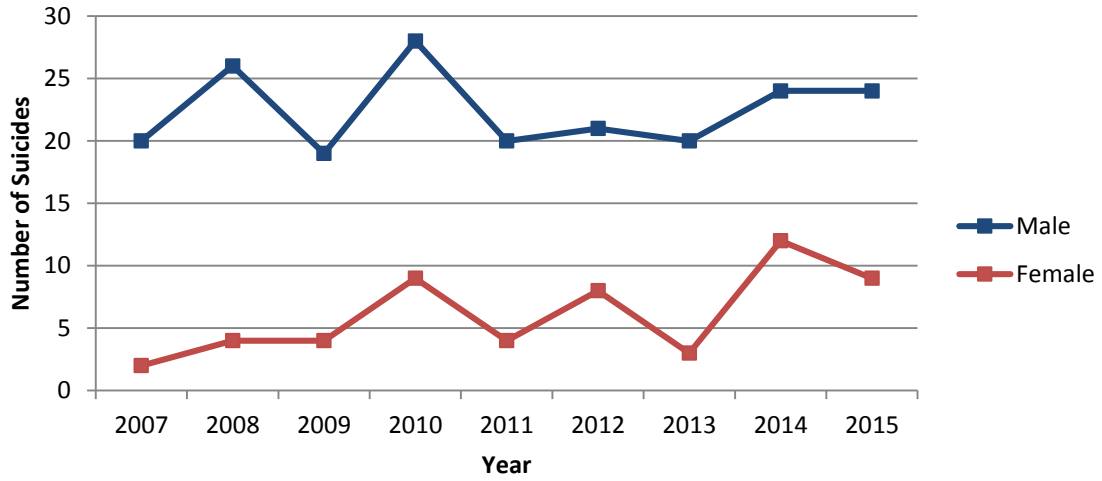
³ Conwell Y. Suicide and suicide prevention in later life. *Focus* 2013; 11(1): 39–47.
http://www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Suicide%20Prevention%20Webinar%20Presentation%20Slides2.pdf#page=14

Figure 6

The Number of Male and Femal Older Adult Deaths are Relatively Stable from Year to Year.

**New Hampshire Older Adult (Ages 65+) Suicides
2007 to 2015 by Gender**

Data Source: Office of the Chief Medical Examiner, NH



Suicide Across the Lifespan in NH

Table 10 presents the most up-to-date data on individuals of all ages in NH as reported by the OCME. This data covers shorter period of time than the data for youth because tracking all ages data through the OCME is a more recent state initiative. The number of deaths by year has been plotted in **Figure 7** (pg. 25) and **Figure 8** (pg. 25).

Table 10
NH All Ages Suicide Death Trend, by Gender, Age Group and Method, 2007-2015.

Year	Total	Male	Female	≤ 24	25-44	45-64	65+	Firearms	Hanging/ Asphyxiation	Drugs/ Poison	Other
2007	150	115	35	13	47	68	22	69	31	28	22
2008	175	135	40	15	64	66	30	86	42	20	27
2009	167	136	31	20	51	73	23	80	48	31	8
2010	206	159	47	24	56	89	37	103	49	40	14
2011	200	162	38	29	49	98	24	77	61	37	25
2012	203	160	43	18	60	96	29	97	56	29	21
2013	182	140	42	21	46	92	23	81	60	31	10
2014	252	192	60	33	83	100	36	112	70	42	28
2015	225	162	63	19	76	97	33	100	67	40	18
Total	1760	1361	399	192	532	779	257	805	484	298	171
Percent of Total⁴	100%	77%	23%	11%	30%	44%	15%	46%	28%	17%	10%

Produced by: NAMI NH
Data Source: NH OCME

⁴Note: Rounding may cause percentages to not total to 100%

Figure 7
NH Residents, All Ages, Suicide Deaths 2007 - 2015

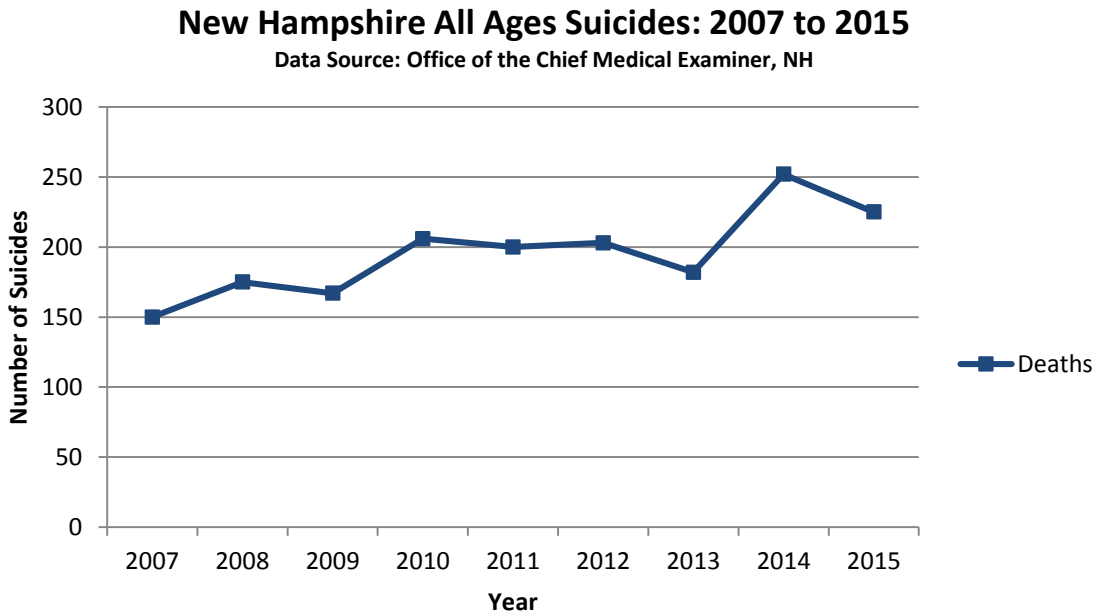


Figure 8
NH Male and Female Suicide Rates 2007 – 2015

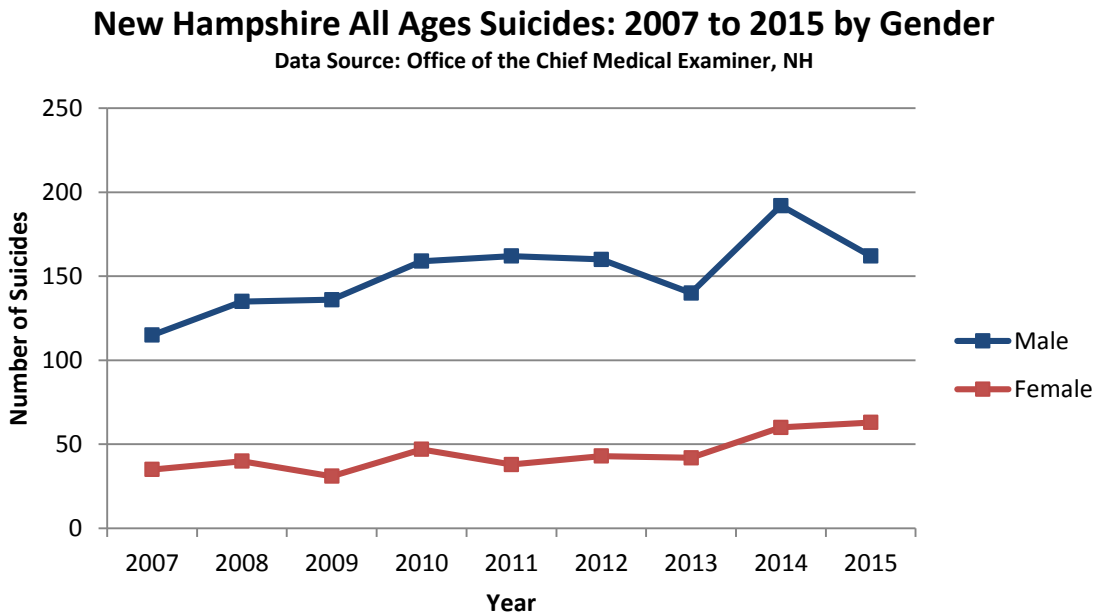


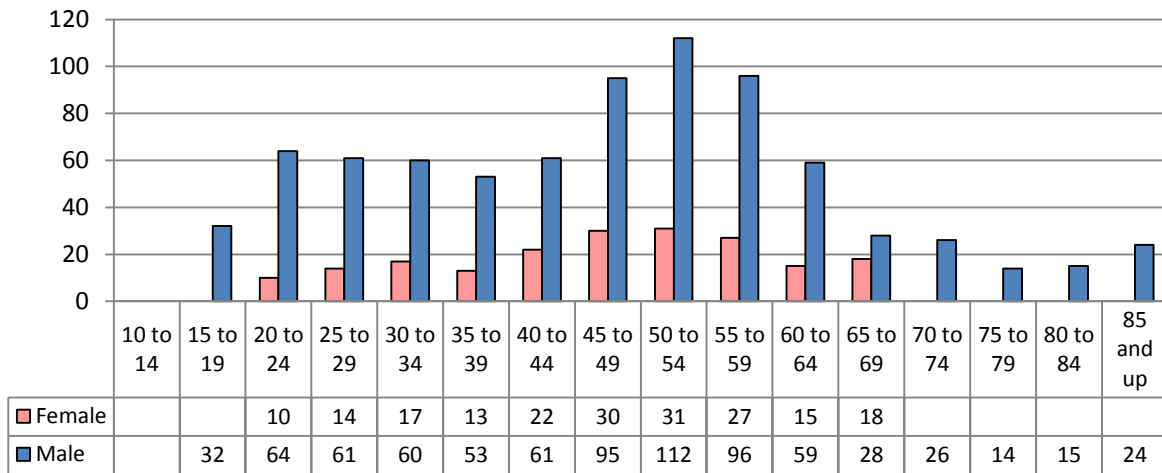
Figure 9 (below) and **Figure 10** (pg. 27), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and gender from 2010-2014. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal how death rates correct for differences in the size of each age group. While the highest number of suicide deaths occur in the 40 and 50 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 45 and 59. 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 9

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

**New Hampshire Resident Suicide Deaths by Age Group,
2010-2014**

Data Source: CDC WISQARS*



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

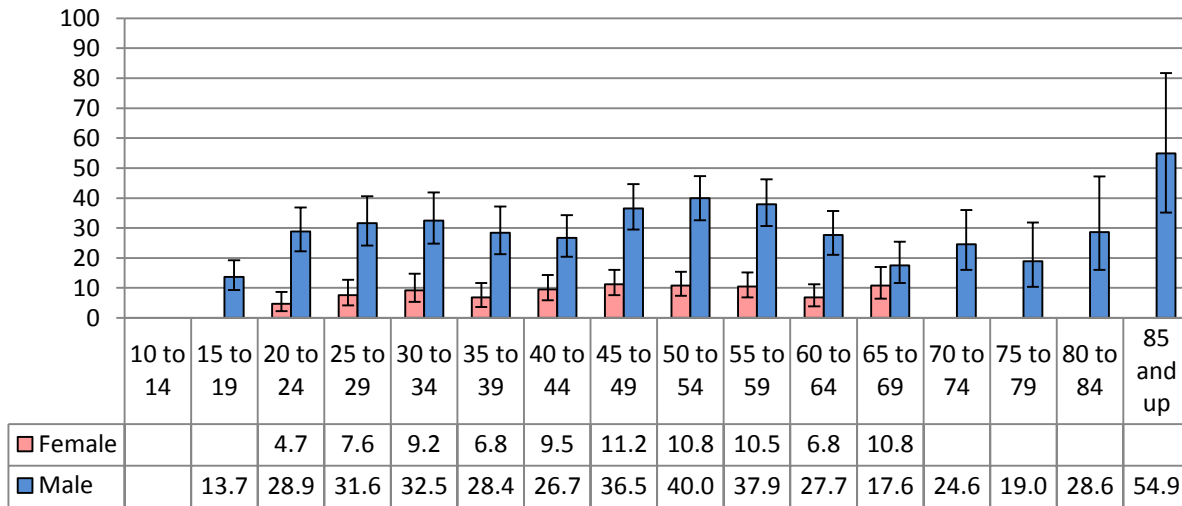
Suicide death rates are also important in determining vulnerable age groups and age-related transitions. The suicide death rate in males rises rapidly from ages 10-14 to 15-19 and then again from ages 15-19 to 20-24, pointing to a rise in vulnerability during the transitions from early adolescence to 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 more vulnerable.

Figure 10

Male NH residents over age 85 have the highest rate of suicide deaths, and male youth transition periods see the most significant changes in suicide rates, between ages 10-14 to 15-19.

**New Hampshire Resident Suicide Death Rates (per 100,000)
By Age Group, 2010-2014**

Data Source: CDC WISQARS*



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

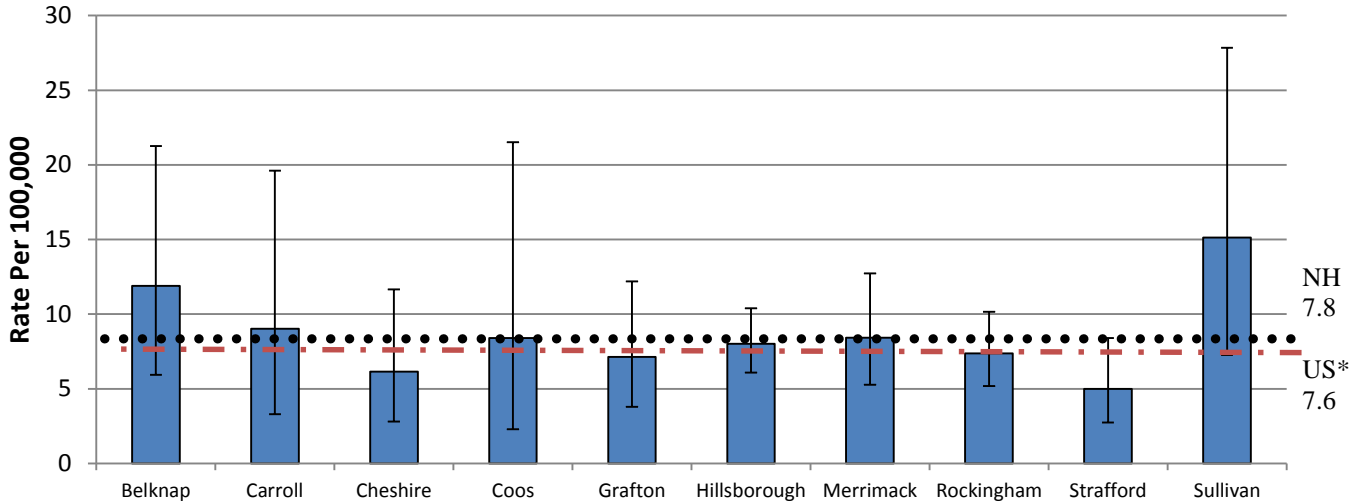
Geographic Distribution of Suicide in NH

The numbers and rates of suicide in NH are not evenly distributed throughout the state. **Figure 11** (pg. 28) shows youth and young adult suicide rates by county in NH. **Figure 12** (pg. 28) presents this data for NH residents of all ages. The county suicide death rate chart indicates geographical locations that may be particularly vulnerable to suicide (youth and young adult and/or all ages). Due to small numbers, most of these differences are not statistically significant. However, Carroll County (Carroll County all ages rate: 19.1 per 100,000) and Coos County (Coos County all ages rate: 18.1) did have significantly higher all ages suicide rates than Rockingham County (all ages rate: 11.9 per 100,000), as well as being significantly above the US rate (US all ages rate: 12.5 per 100,000). Additionally, the rate for Carroll County was significantly above the rates for Hillsboro and Strafford Counties (all ages rates: 13.9 per 100,000 and 12.9 per 100,000 respectively). For youth and young adults there were no statistically significant differences between counties or from the US rate of 7.6 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 13** (pg. 29) presents the suicide rates for all ages from 2007 to 2015 as a NH map broken down by county.

Figure 11

New Hampshire Youth Suicide Crude Death Rates by County
Ages 10-24 2007-2015

Data Source: Office of Chief Medical Examiner, NH



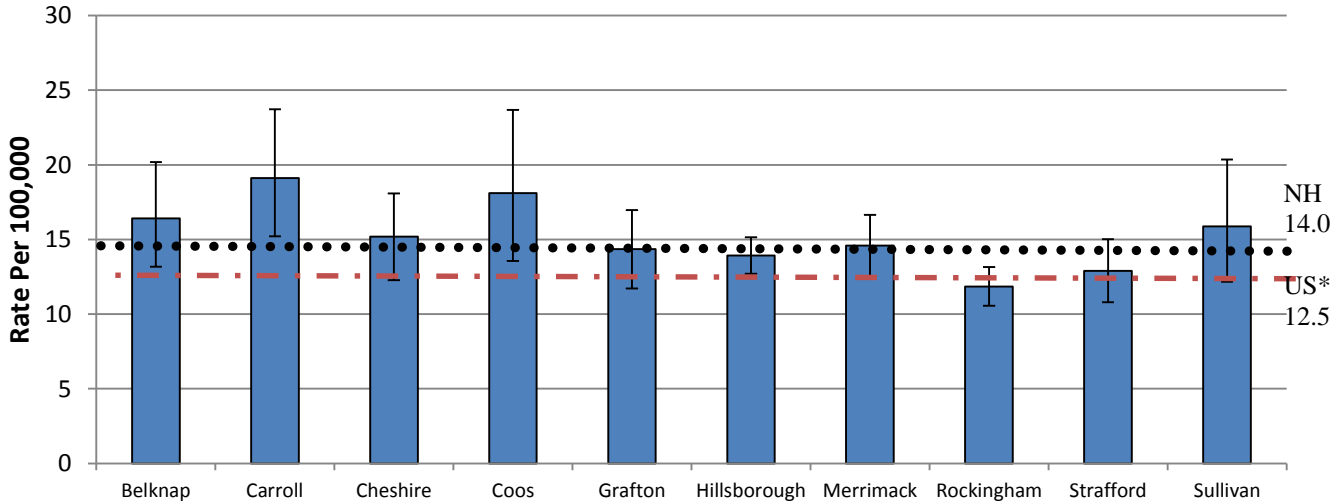
*US Rate is only through 2014

Source: CDC WISQARS

Figure 12

New Hampshire Resident Suicide Crude Death Rates by County
All Ages 2007-2015

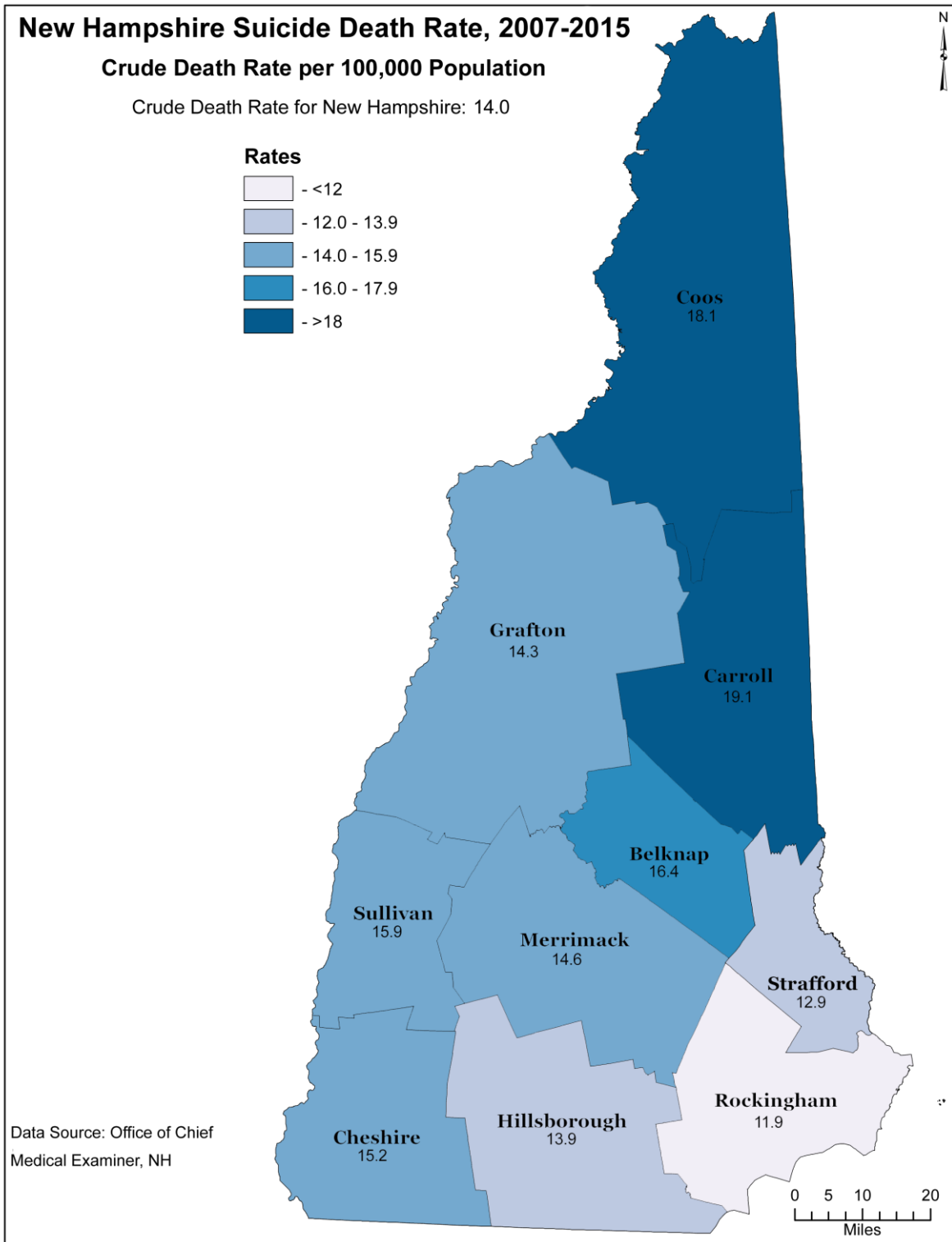
Data Source: Office of Chief Medical Examiner, NH



*US Rate is only through 2014

Source: CDC WISQARS

Figure 13
Map of NH suicide death rates



Suicide Behavior in NH: Gender Differences - Attempts and Deaths

Youth and Gender

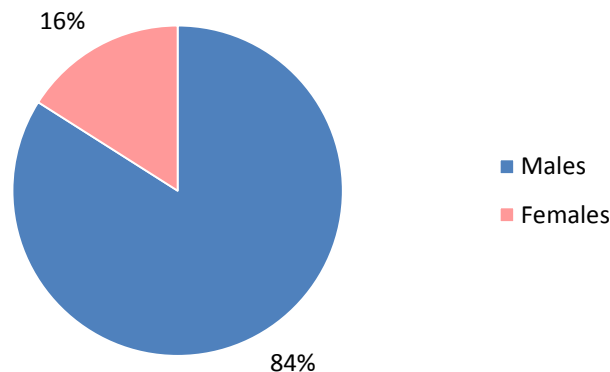
While males represent nearly 85% of the youth and young adult suicides from 2010-2014, the fact that males *die* by suicide at a higher rate than females may largely be due to males using more lethal means. See **Figures 14** (below) and **15** (pg. 31). In fact, females *attempt* suicide at a higher rate than males. When examining how many NH youth and young adults were hospitalized and then discharged for self-inflicted injuries in 2011, it is shown that 57% of the 781 inpatient discharges represent females, while only 43% represent males. Likewise, the 2015 NH Youth Risk Behavior Survey (YRBS) reports approximately 1.9 times as many female youth attempt suicide as males each year (8.9 % of females and 4.6% of males). Emergency department (ED/ambulatory) data reveals a similar gender ratio, based on self-inflicted injury rates.⁵

Figure 14

Over five times as many male NH residents ages 10-24 died by suicide 2010-2014.

NH Resident Suicide Deaths by Gender 2010-2014, Ages 10-24, N=120

Data Source: CDC WISQARS



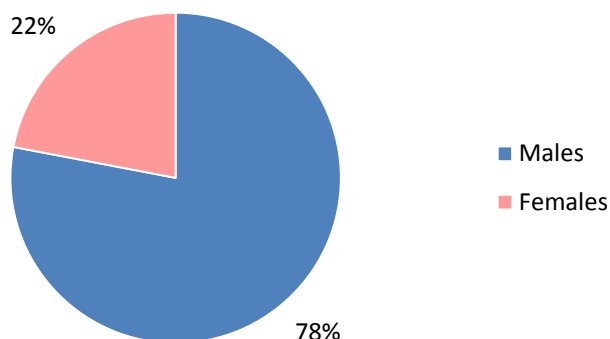
⁵ Classifying an injury as self-inflicted is another way of stating that the injury was an instance of deliberate self-harm. Not all self-inflicted injuries necessarily represent suicide attempts. However, analysis of these injuries is the best currently available proxy for estimating suicide attempts.

Figure 15

Three times more male than female NH residents of all ages died by suicide 2010-2014.

NH Resident Suicide Deaths by Gender 2010-2014, All Ages, N=1,028

Data Source: CDC WISQARS



Female youth are less likely to die by suicide, possibly resulting from less severe injuries during suicide attempts (self-inflicted injuries). However, females do make a greater number of attempts than males – 1.2-1.6 times as often (**Figure 16, Figure 17, and Figure 18** – pgs. 32-33). 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 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 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.

Quick Facts/Talking Points

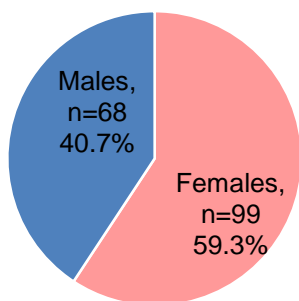
- Males in NH die by suicide at a rate that is nearly four times the rate for females (CDC WISQARS, 2015).
- Although males are more likely than females to die by suicide, females report attempting suicide at nearly twice the rate of males (NH YRBS, 2015)
- Over ¾ of NH adults report that they feel suicide is preventable (2012 Granite State Poll - UNH Survey Center)

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.

Figure 16

A greater percentage of female than male NH residents attempted suicide, as seen in inpatient self-inflicted injuries 2011.

NH Resident Inpatient Discharges for Self-Inflicted Injuries, by Gender, Ages 10-24 Years, 2011
Data Source: Injury Surveillance Program, NH DHHS



NH Resident Inpatient Discharges for Self-Inflicted Injuries, by Gender, All Ages, 2011
Data Source: Injury Surveillance Program, NH DHHS

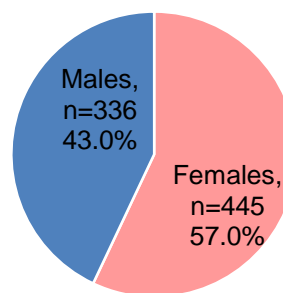
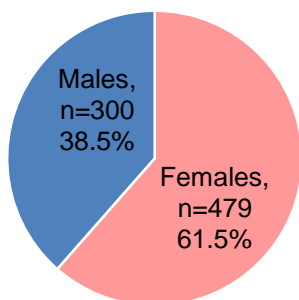


Figure 17

A greater percentage of female than male NH residents attempted suicide, as seen in ambulatory self-inflicted injuries 2011.

NH Resident Emergency Department Discharges for Self-Inflicted Injuries, by Gender, Ages 10-24 Years, 2011
Data Source: Injury Surveillance Program, NH DHHS



NH Resident Emergency Department Discharges for Self-Inflicted Injuries, by Gender, All Ages, 2011
Data Source: Injury Surveillance Program, NH DHHS

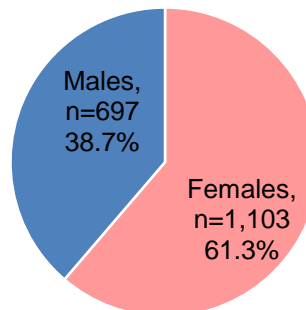
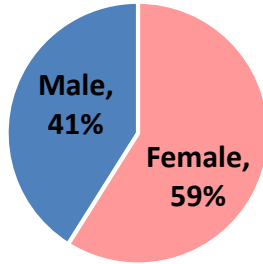


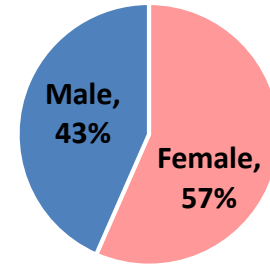
Figure 18

A greater percentage of female than male NH residents attempted suicide, as seen by self-inflicted injuries treated by Emergency Medical Services self-inflicted injuries 2006-2015.

**Self-Harm by Gender
Ages 10-24, 2006-2015**
New Hampshire Department of Safety, Division of Fire
Standards and Training and Emergency Medical Services



**Self-Harm by Gender
All Ages, 2006-2015**
New Hampshire Department of Safety, Division of Fire
Standards and Training and Emergency Medical Services



Data Note

Due to changes in how new (2010 on) Hospital Discharge Data were collected, they are not comparable to older data (i.e. 2000-2009). Because only 2 years of this newer data are available at this time, the graphs in this section present 2011 as a point in time. Trends will be prepared when 5 years or more of data are available. The 2011 inpatient data is complete. Quality assurance checks by NH DHHS revealed that the 2011 Emergency Department database may be incomplete. Future editions of this report will include the most complete data available at the time of publication. The NH Health WISDOM system provides online access to this and other data as they become available. The system can be accessed at: <http://wisdom.dhhs.nh.gov/wisdom/>

Gender differences exist not only for suicide attempts and deaths, but also for help-seeking behavior. It has been estimated that as many as 90% of individuals who take their own life had a diagnosable mental illness; the most common diagnoses being depression and substance abuse disorders⁶. Yet a much smaller percentage were receiving treatment. In NH, nearly 10,000 people received treatment at one of the state's ten Community Mental Health Centers (CMHC)⁷ for depression during 2014⁸. This works out to

⁶ Conwell Y, Brent D. Suicide and aging I: patterns of psychiatric diagnosis. *International Psychogeriatrics*, 1995; 7(2): 149-64.

⁷ 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>

⁸ The NH Bureau of Behavioral Health has implemented a new data system and is for the first time able to provide unduplicated case data. The system is still in a testing phase and these counts may change in the future when the system is more mature.

approximately 1 out of every 139 residents in the state. Of those individuals in treatment for depression, approximately 2/3 of them were female and 1/3 were male. This is illustrated in **Figure 19** (below). Without additional data it is not possible to say how these numbers relate to the comparative incidence of depression nor 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.

Positive Outcomes and Testimonials

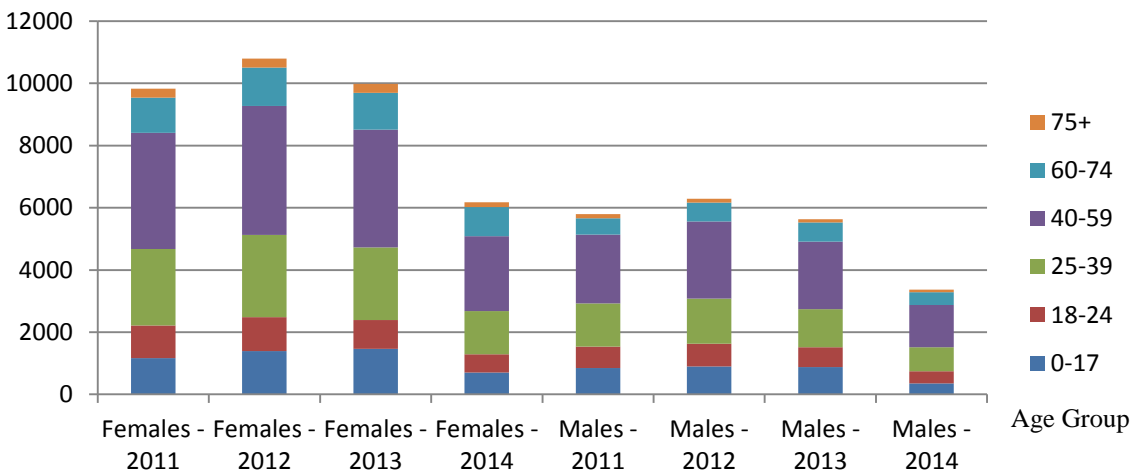
Suicide is preventable with the understanding we all must embrace: “treatment works”.

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

Maggie Pritchard
 Executive Director, Genesis Behavioral Health
 Vice-Chair, NH Suicide Prevention Council

Figure 19
Individuals receiving treatment for depression at NH Community Mental Health Centers presented by age and gender.⁹

Individuals in Treatment at NH CMHC's for Depression: 2012 - 2014 - Presented By Age and Gender
Data Source: NH Bureau of Behavioral Health



Patients that cannot be treated in an outpatient setting, such as involuntary admissions due to potential suicide risk, will generally be admitted to New Hampshire Hospital, the NH state psychiatric hospital. In an average year there are approximately 2,069 admissions to New Hampshire Hospital (estimates based on New Hampshire Hospital admissions for fiscal years 2012 - 2016¹⁰). The gender differences for individuals receiving treatment at New Hampshire Hospital are much smaller than for those receiving treatment for depression through the CMHCs. The admissions are approximately an even split between females and males. Although the number of admissions were comparable for males and females, this does not guarantee that severity of the cases were similar or that the lengths of stay were similar. **Figure 20** (pg. 35)

⁹ These numbers include all individuals with a primary or secondary diagnosis of depression.

¹⁰ 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 2016 ran from July 1st 2015 through June 30th 2016).

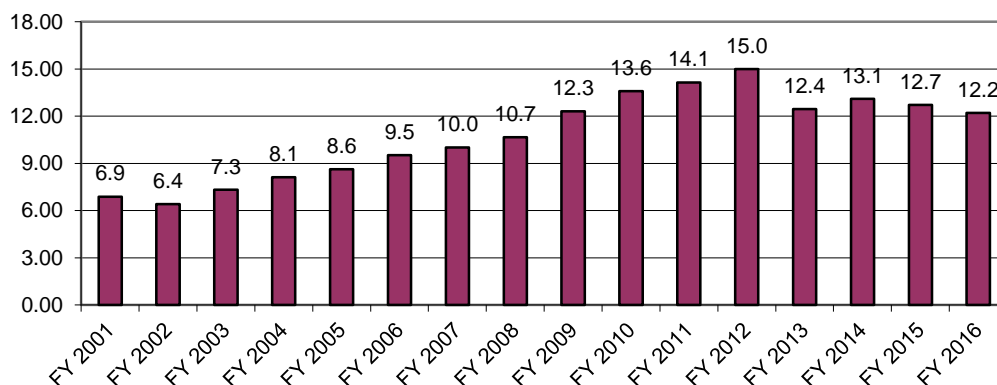
presents the number of admissions per bed at New Hampshire Hospital. The increase over time on this chart has been due to both an increase in the number of admissions at the hospital (from 1460 admissions in fiscal year 2001 to 1930 admissions in fiscal year 2016), and a decrease in the number of available beds (from 212 beds in fiscal year 2001 to 158 beds beginning in fiscal 2012).

Figure 20

The number of admissions per bed at New Hampshire Hospital have doubled since 2001.

New Hampshire Hospital: Number of Admissions Per Hospital Bed By Fiscal Year

Source: New Hampshire Hospital



Age, Gender and Self-inflicted Injury

When the rates from 2011 for NH resident inpatient hospitalizations/discharges and emergency department use for self-inflicted injuries are examined by gender and age group, the variability can be seen (**Figures 21 and 22** – pg. 36). As above, these data refer to number of visits; therefore, individuals may be counted more than once 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, yet for ages 80 and up, males may, with some uncertainty due to overlapping confidence intervals, have a greater rate of self-inflicted injuries. For those females aged 30-39, the rate of those being discharged from inpatient care (**Figure 21** pg. 36) is close to 136/100,000, more than two times the rate for males of the same age. The peak age for males is between 40 and 44 for self-inflicted injuries requiring hospitalizations. Again, ED usage rates, depicted in **Figure 22** (page 36), point to females aged as a population particularly vulnerable to self-injury and/or suicide attempts, with females age 15-19 exhibiting a rate over 544/100,000, about 170 times the suicide death rate for this population. Males also peak in self-injury around this age group with the male rates ages 15 to 19 being over 295/100,000. 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 ED visits (779) is 4.7 times greater than the number of inpatient discharges for this population. Since 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 23 pg. 37), which includes individuals treated and/or transported by Emergency Medical Services for a self-inflicted injury, presents a similar picture to the hospital data. Females age 15 to 24 present the highest rates of self-inflicted injuries, and female rates are generally higher for other age groups. A difference seen in this dataset is that males age 85 present the next highest rate. This high male rate is part of an overall increase seen for adults over the age of 65 in this dataset.

Figure 21
NH female residents ages 30-34 and 35-39 show the highest rates of suicide attempts, higher than males of any age group.

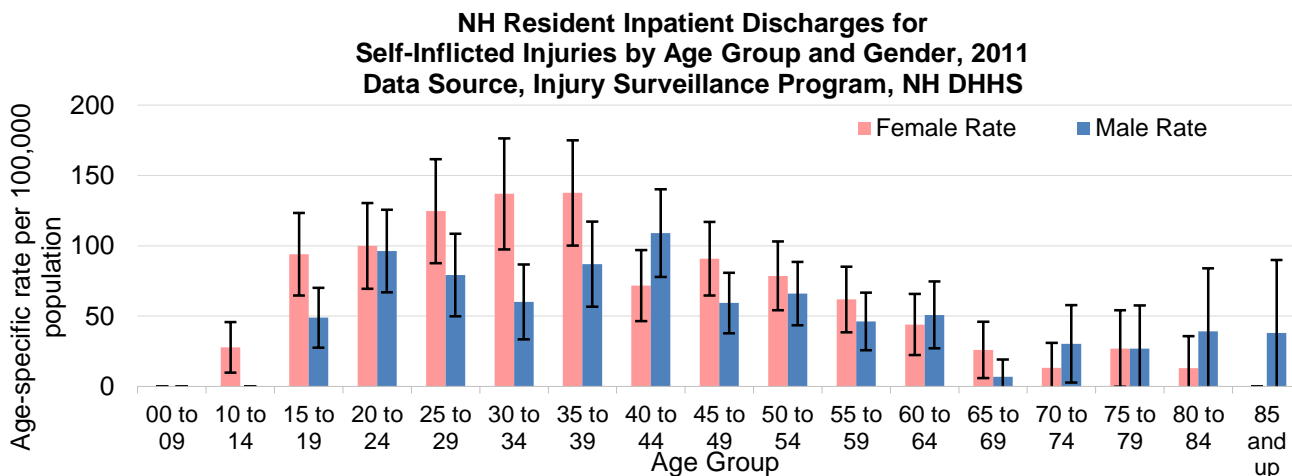


Figure 22
NH female residents ages 15-19 show the highest rates of suicide attempts, but male rates also peak at this age.

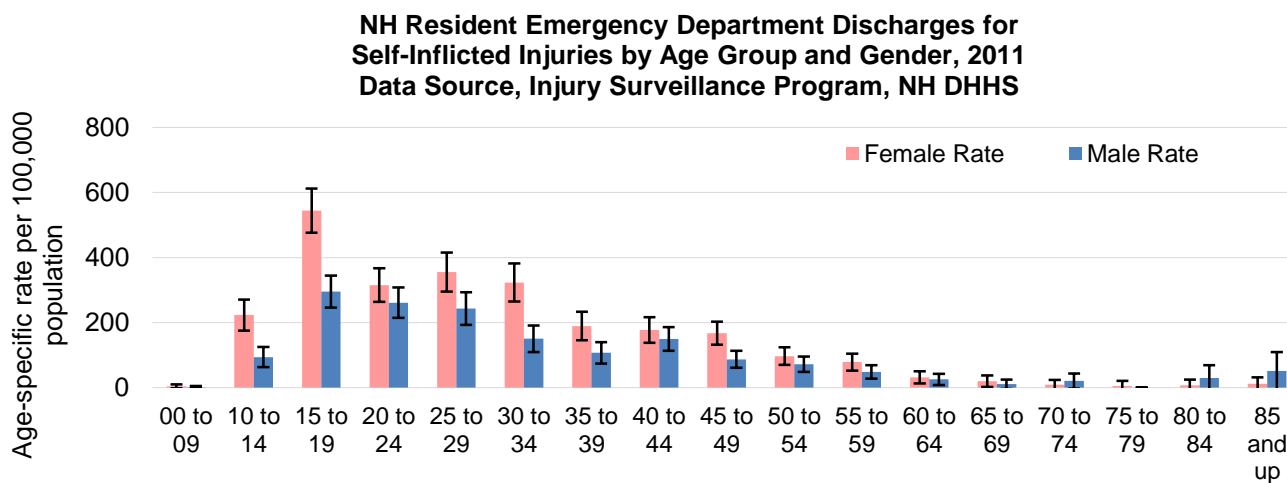
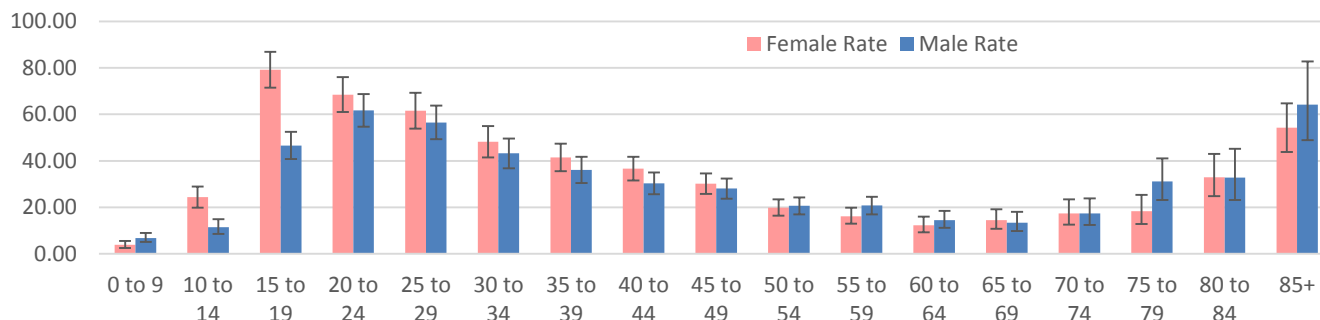


Figure 23

NH female residents ages 15-24 show the highest rates of suicide attempts followed closely by male rates for residents age 85 and over.

**EMS Data Self-Harm Treatment/Transportation Rates by Age Group and Gender
2006-2015**

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



According to inpatient admissions/discharges and ED/ambulatory use data across all ages in NH, there are approximately 13 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 is estimated that over 900 youth and young adults (age 24 and under) attempt suicide each year in NH.

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 2015, 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 3,900 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 injuries¹¹ are not fatal, because of the larger incidence they directly and indirectly affect a substantially greater number of people than do 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 lead to additional attempts; therefore, once an individual has made an attempt, secondary prevention is necessary.

¹¹ 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.

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 2010 and 2014, 57% used firearms compared to 21% of females (**Figure 24** – pg. 39). This gender disparity in firearm use persists as residents enter their late 20's, 30's, and 40's with the proportion of male and female deaths from firearms decreasing equally for both genders. The proportion of firearm deaths increases sharply at age 75 for males, with more than 80% of the suicide deaths in that age group involving a firearm.

Suicide attempt methods have varying lethality. **Figure 25** (pg. 39) 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. Approximately 80% of self-injuries using a firearm result in death (**Figure 25** pg. 39). 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 commonly used method of suicide throughout the lifespan in NH. **Figure 26** (pg. 40) indicates that self-inflicted cut/pierce injuries are treated/transported by EMS at more than twice the rate of any other mechanism. Hospital data (**Figure 25** pg. 39) does not show this same proportion of cut/pierce injuries indicating that EMS providers may treat self-inflicted cut/pierce injuries without 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 suffocation as a suicide method peaks in early adolescence, and decreases steadily throughout the lifespan (**Figure 27** – pg. 40).

Positive Outcomes and Testimonials

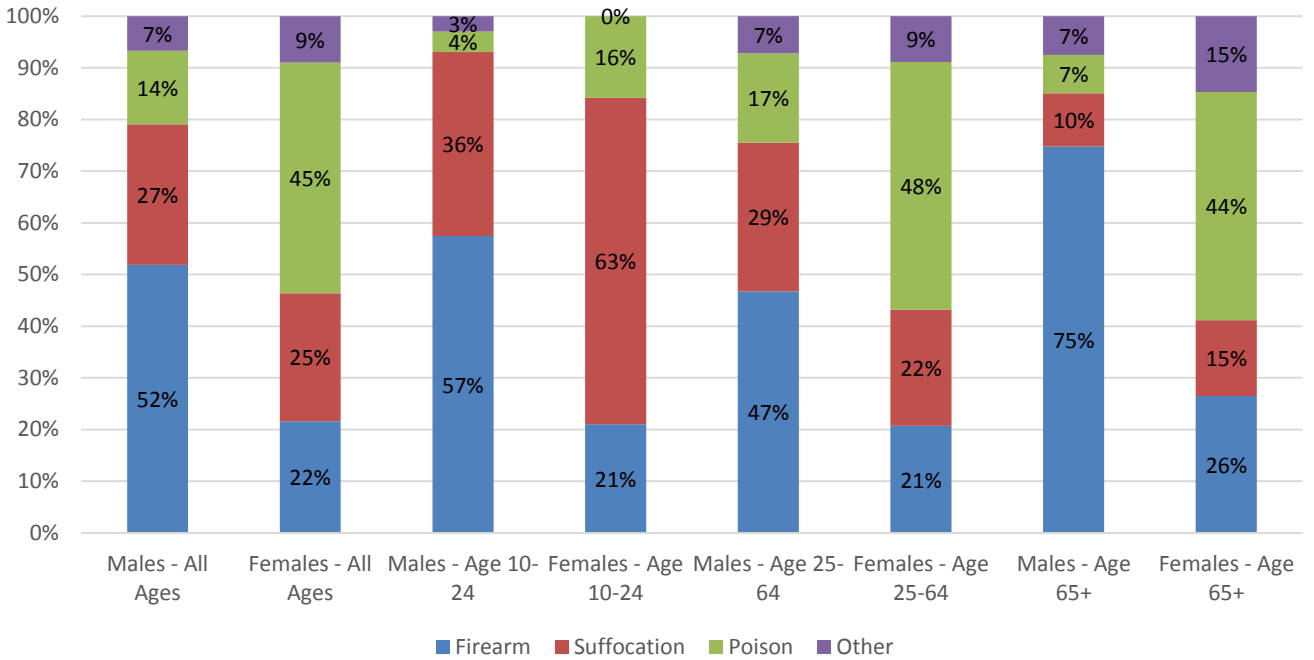
I am a business owner and mom who cares about people and the community where I live. I became a *Connect* Trainer to help people in my community know when someone needs help and know what to do. When I lead a *Connect* Suicide Prevention Seminar I have to make sure that I'm mentally prepared because I don't know who will be attending or what their experience is with suicide or mental illness. Afterwards, I feel pretty good. Seminar participants contact me and tell me about something that happened the next day that they might not have noticed or not known what to say, but now they did. Wow, maybe I did make a difference in someone's life!

Sharon Eng: Parent, Business Owner, and Rotary Member

Figure 24

Variation in Method of Completed Suicide Deaths by Gender and Age Group, 2010-2014.

Method Used in Completed Suicides, 2010-2014



Data Source: CDC WISQARS

Figure 25

Count of Lethality of Means Used for Suicidal Behavior in NH, 2011

Data Source: Injury Surveillance Program, NH DHHS

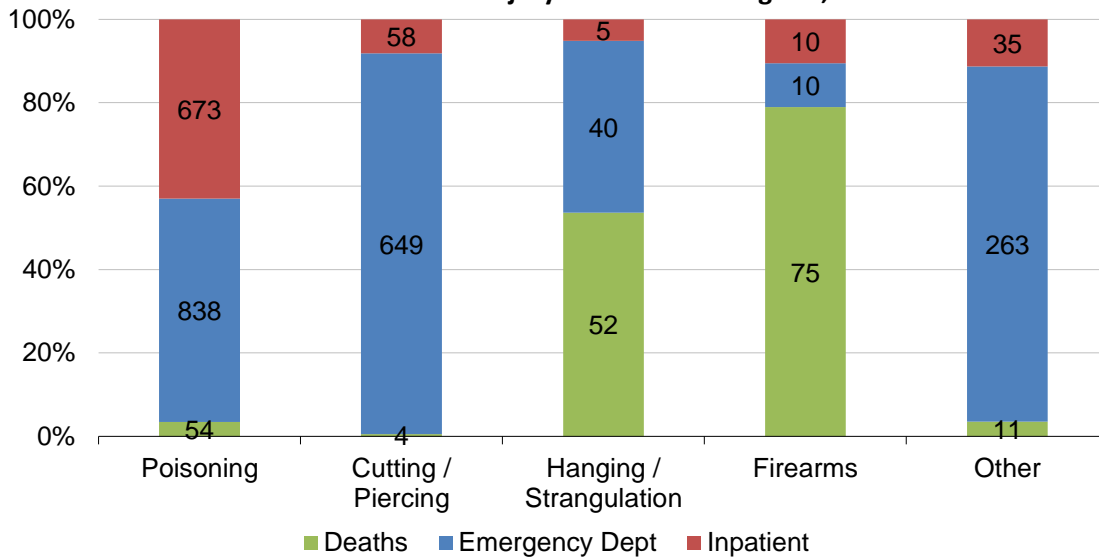


Figure 26

Percent of method of self-inflicted injuries treated/transported by EMS from 2006-2015.

**EMS Self-Harm Treatment/Transportation by Type
2006-2015**

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

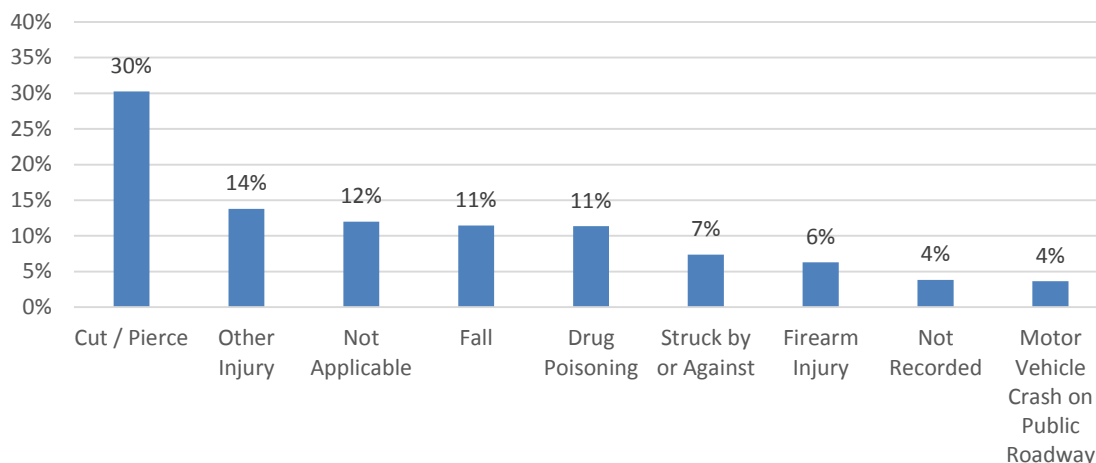


Figure 27

Suicide methods used in NH vary by age group, as seen in 2010-2014.

Suicide Methods Used by Age Group

NH Data, 2010-2014

Data Source: CDC WISQARS

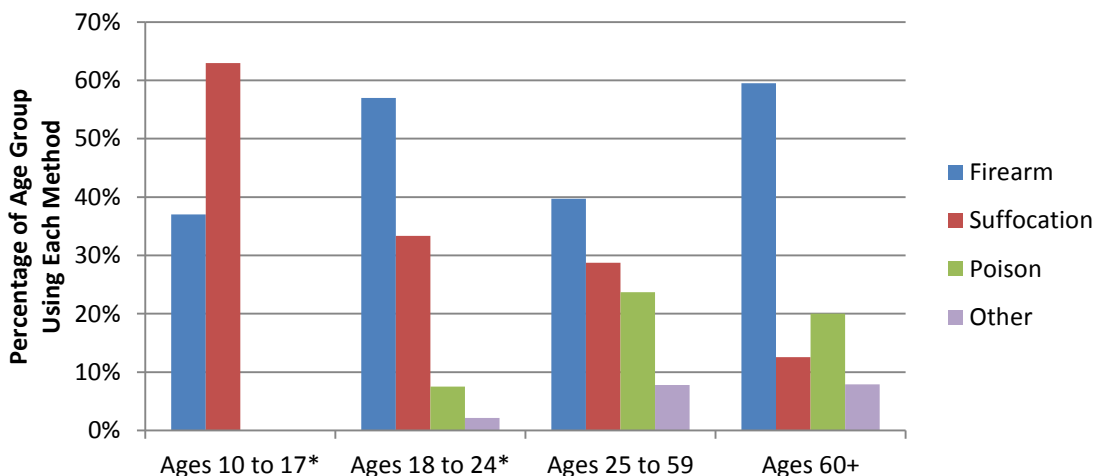
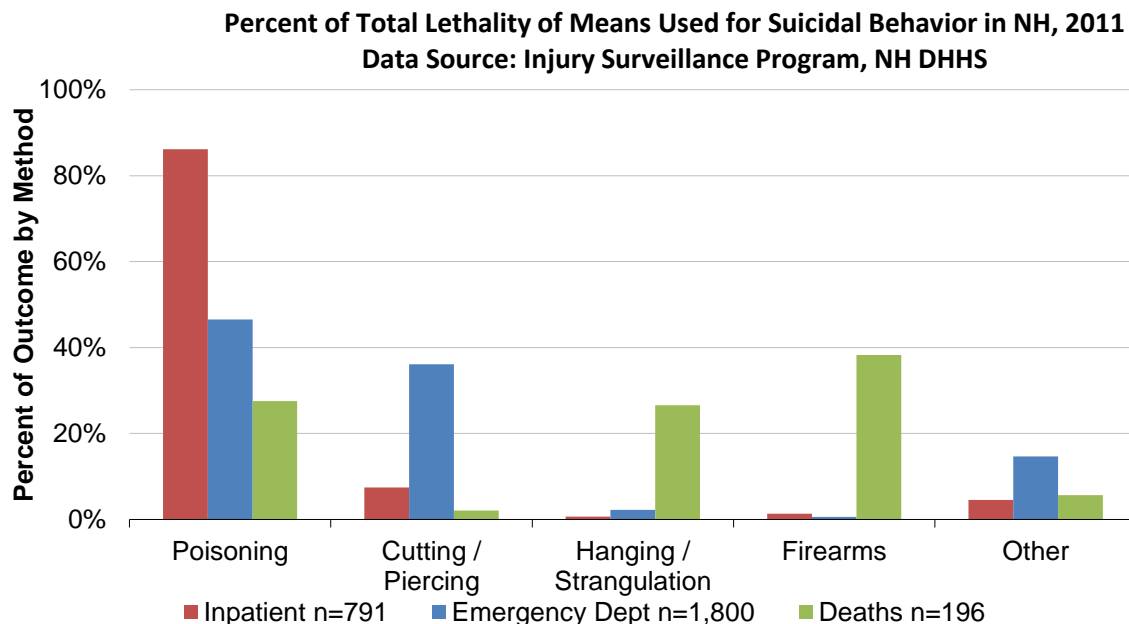


Figure 28

Poisoning is the most frequent method of suicide attempt, as seen in hospital discharge data 2011.

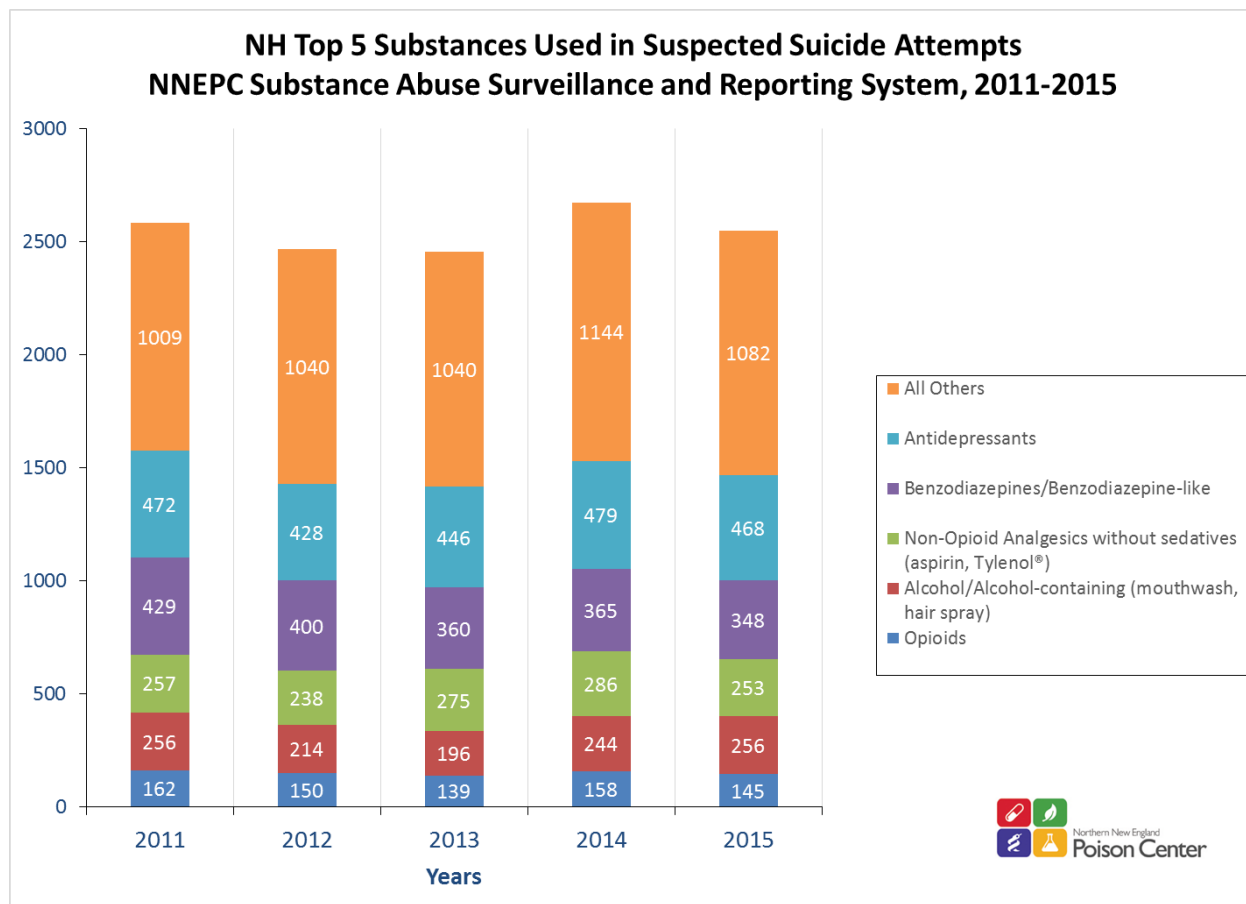


Although suicide attempts employing poison do not account for as many deaths in NH as firearms or hangings, intentional poisonings account for the overwhelming majority of inpatient and ED admissions for suicide attempts (**Figure 28** above). **Figure 29** (pg. 42) depicts the prevalence of the five most common substances used in suspected suicide attempts in NH as collected by the NNEPC. The top two from 2011 through 2015 have been Antidepressants and Benzodiazepines.¹²

¹² 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.

Figure 29

Antidepressants and Benzodiazepines have been the top substances used in suspected NH suicide attempts from 2011-2015.



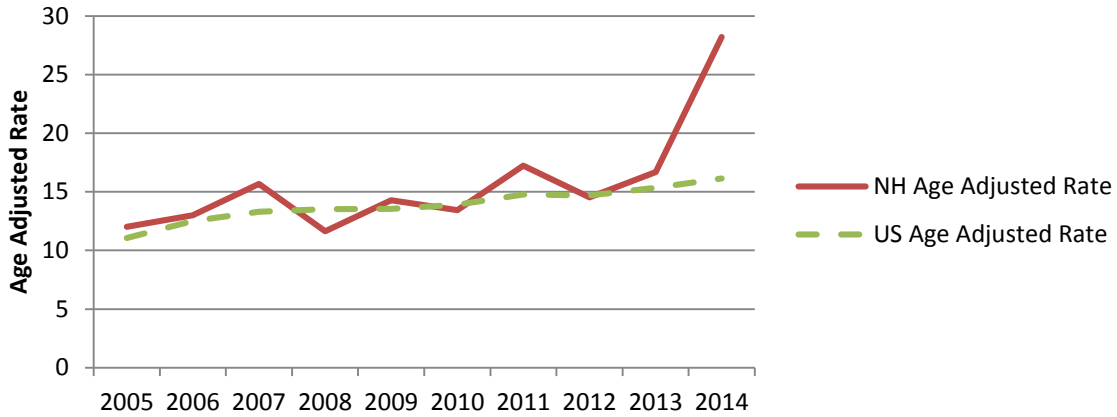
Increasing Accidental Poisoning and Drug-Related Death Rates – Cause for Concern

As seen in **Figure 30** (pg. 43), the accidental poisoning and drug-related death rates in NH and the US as a whole have steadily increased from 2005 to 2014. During this time the US rate has increased by nearly 60 percent while the NH rate has increased more than 130 percent. 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 30

Poisoning/Drug-related death rates in NH increase by more than 130% from 2005 to 2014.

Poisoning/Overdose Death Rates 2005 - 2014



Data Source: CDC WISQARS

Reducing Access to Lethal Means

Reducing access to lethal means is part of many suicide prevention goals and protocols, including the National Strategy for Suicide Prevention, NH’s Suicide Prevention Plan, the Gun Shop Project, *Connect* and CALM. While it has not been conclusively demonstrated that the

efforts being undertaken in NH and nationally to reduce access to lethal means are responsible for the reductions in suicides using firearms. These reductions suggest that when access to a highly lethal means is reduced, there is little “means substitution” (seeking a different method of suicide). Means reduction may be an effective part of a comprehensive suicide prevention strategy.

Positive Outcomes and Testimonials

"A number of lives have been undoubtedly saved since we integrated the CALM training into our structured interview. Now, not a day goes by in the Concord Hospital Emergency Department where we are not counseling patients and family members around the danger of access to firearms and other means of self-harm for people experiencing depression."

Karl Boisvert, LMHC
Director, Emergency Services
Riverbend Acute Care Services

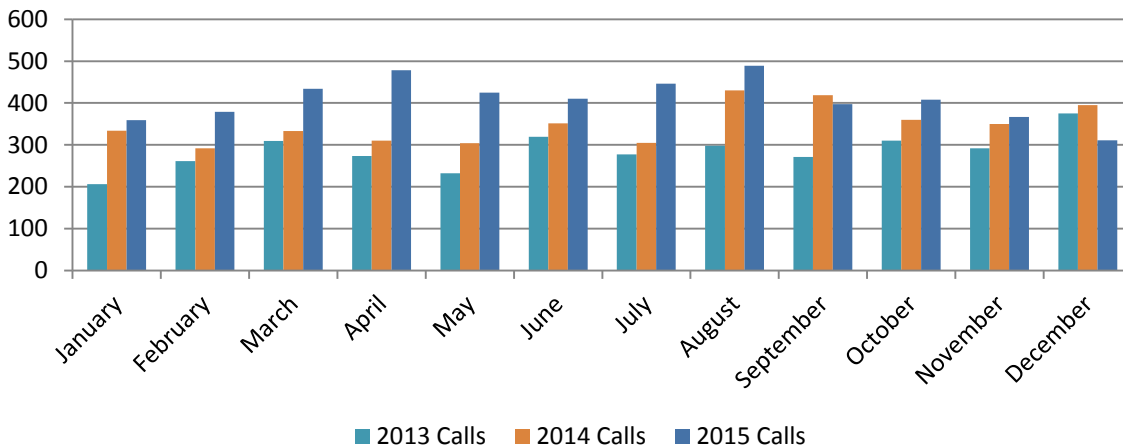
Linking At-Risk Individuals with Help

Crisis lines, such as the National Suicide Prevention Lifeline (NSPL) are vital to suicide prevention efforts in NH and nationally. In 2015, there were 2,171,231 calls made to the NSPL. 4,903 of these calls, or roughly 409 per month were received by the NH NSPL call center (see **Figure 31** below). 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.

Figure 31

NH NSPL call center responded to an average of 409 calls per month in 2015.

Calls Volume for the NH NSPL Call Center 2013-2015



Costs of Suicide and Suicidal Behavior

There were between 29,276 and 39,116 years of potential life lost to suicide from 2010-2014 in NH (CDC WISQARS). Suicide's most obvious cost 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 \$3.9 billion in health care costs in 2010. This does not include the costs associated with mental health services on an inpatient or outpatient basis (CDC WISQARS, 2015). In NH, suicide deaths where the individual received treatment in a hospital or emergency department and subsequently died resulted in an estimated \$500,000 in medical expenses in 2010 (CDC WISQARS, 2015). Harder to measure is the cost to employers of lower or lost productivity due to suicide attempts or deaths by employees or their loved ones. An estimate provided by the

CDC indicates that there is an average work loss cost of \$1.1 million for each suicide death in NH (CDC WISQARS, 2015).

Additional Data Sources

NH Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted with a representative sample of state residents, includes a core question on the number of days that poor physical or mental health kept individuals from doing their day-to-day activities. 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 depression. The results from this item are included in **Figure 33** (pg. 46).

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. (Instead of) 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
Supervisor of Training and Prevention Services
NAMI New Hampshire

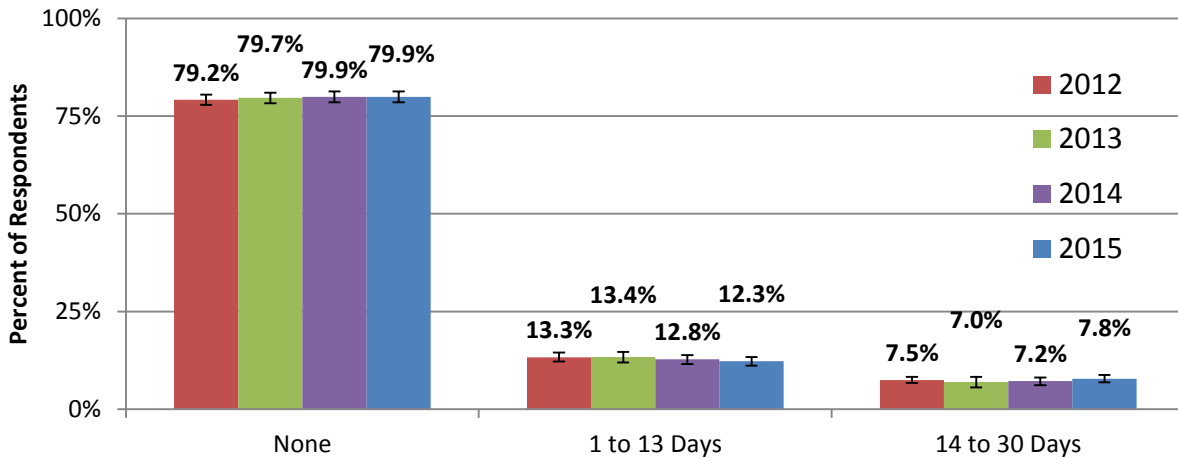
Figure 33

NH BRFSS – Number of Days Physical or Mental Health Impacted Daily Activities of NH Residents Age 18 and Over.

NH BRFSS - 2012-2015

How many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation

Data Source: NH DHHS BPHSI



Data from the NH National Guard

From 2011 through 2015 the NH National Guard recorded a total of 90 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, 28% were from individuals under the age of 22 and 40% were age 22-26, 10% were age 27-31, 6% were age 32-36, and 7% were age 37-41. The remaining 10% were age 42 and above. Forty-three percent of the incidents were by non-deployed personnel, veterans, or dependents of National Guard personnel. Of the incidents recorded, 86% were by males and 14% were by females (males may be disproportionately represented among NH National Guard compared with the general population).

Positive Outcomes and Testimonials

The NH Army National Guard Substance Abuse Program (NH ARNG SAP) has a mission to deliver prevention training, promote family and peer support through education, and provide treatment resources in an effort to increase military discipline, individual performance, and combat readiness and resilience. This work is done in collaboration with the work of the NH Army National Guard Suicide Prevention Program. The NH Army National Guard Suicide Prevention Program (NH ARNG SPP) has a mission to implement proactive and caring strategies to serve Soldiers, Family members, and Army civilians. The NH ARNG SPP works with a variety of civilian and NH ARNG supports who recognize imminent danger and take immediate action to save a life.

In Training Year 2013 the ARNG was able to hire Department of Defense Contractors to supplement the NH ARNG SAP and NH ARNG SPP positions in each state and territory to assist the ARNG's continued efforts of prevention and resilience training to reduce high risk behaviors for its Soldiers, Families and Army civilians.

Data on NH Veterans from the Veterans Administration (VA)

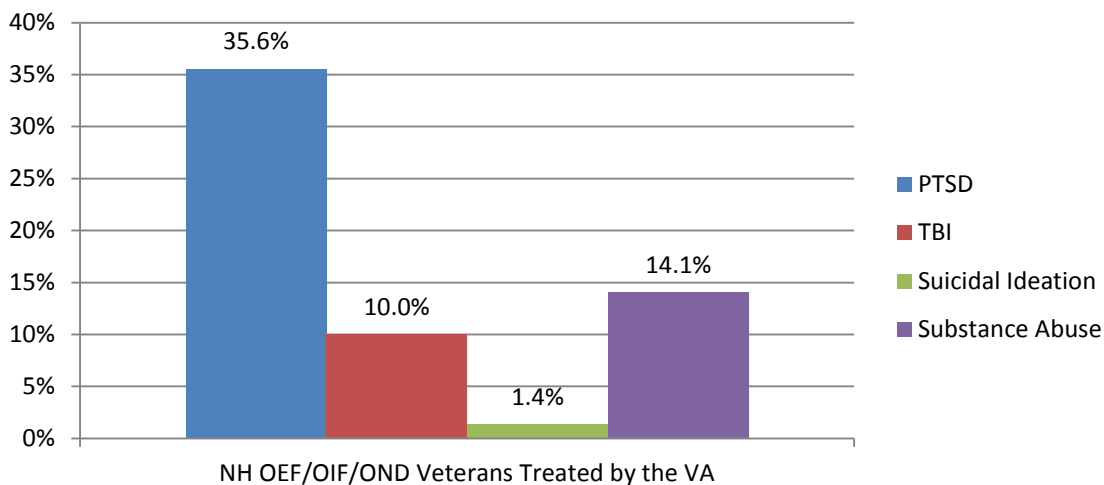
The VA provides care to many of the Veterans in the State of NH including those recently returned from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). Of the NH Veterans who served in OEF/OIF/OND, approximately 3,200 are treated at the VA each year. The percentage of these individuals treated for post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI), suicidal ideation, and substance abuse are presented in **Figure 34** below.

Figure 34

More than one in four NH OEF/OIF/OND Veterans treated at the VA have a primary or secondary diagnosis of PTSD.

Percentage of NH OEF/OIF/OND Veterans treated at the VA with PTSD, TBI, suicidal ideation, or substance abuse as their primary or secondary diagnosis Federal Fiscal Years 2013 - 2015

Data Source: Veterans Administration



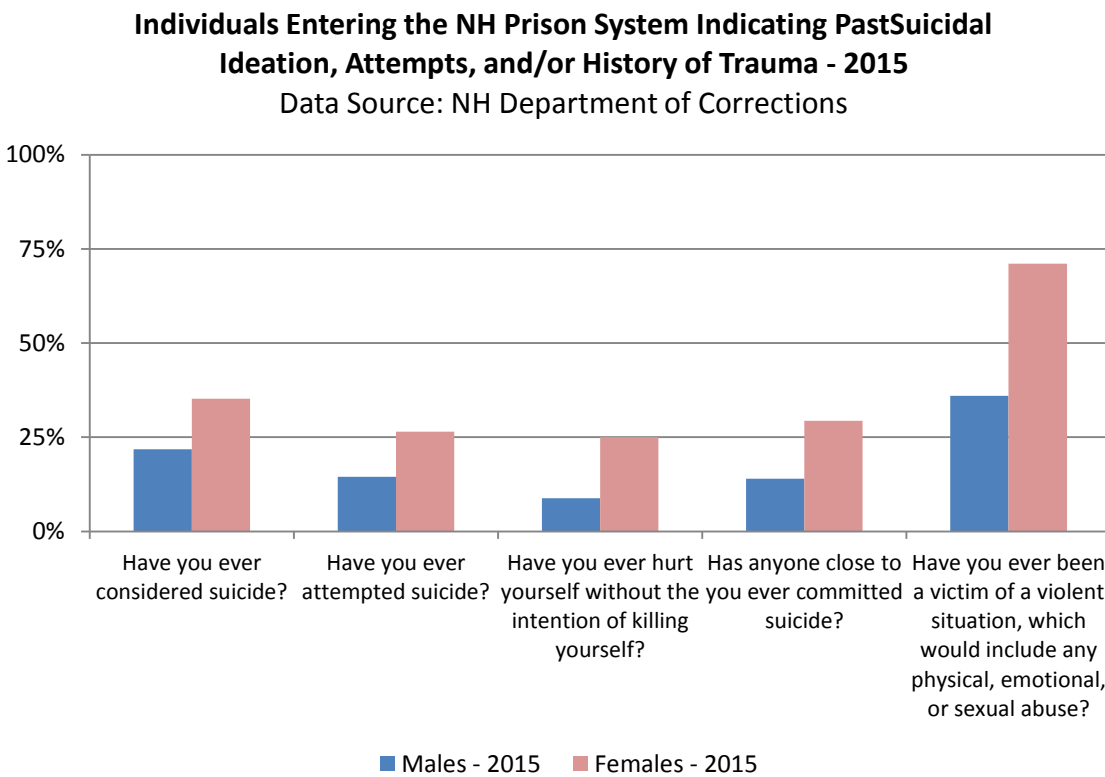
Data from the NH Department of Corrections

In 2015, the NH Department of Corrections had a total of 1,107 males and 204 females who were screened for suicidality and history of trauma upon their entry into the prison facilities. (**Note:** this does not reflect the populations in county or local facilities.) After an immediate screening by a correctional officer, mental health staff met with the individuals within 14 days of entry into the system to complete an individual in-depth mental health assessment. Data available from 2015 show that at intake nearly 22% of males and 35% of females indicated past suicidal ideation and approximately 15% of males and 27% of females indicated a past suicide attempt¹³. Although past suicidal ideation and attempts were relatively high for this group, fewer than 1%

¹³ This information should be interpreted cautiously for several reasons. The information is collected by self-report from inmates at a single point in time. Inmates may also have incentive to falsely report past suicidal ideation if it would result in desirable outcomes from the inmates' point of view (e.g., allowing them to avoid someone or something that they dislike).

of the individuals screened at intake answered yes to the question, “Are you currently thinking about killing yourself?”. **Figure 35** (below) displays the percentage of intakes indicating suicidal ideation and/or attempts by gender. In 2015 there was one completed suicides in the NH Prison System (facilities operated by the NH Department of Corrections).

Figure 35
Percentage of individuals entering NH prisons 2015 indicating past suicidal ideation, attempts, and/or history of trauma by gender.



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, the *Connect* Program, GLS funding through the SAMHSA, CALM 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 individuals and organizations, a greater increase in NH suicide rates may have occurred.

Figure 36 (below) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2005 to 2014. **Figure 36** shows a small dip for the 2005-2007 and 2006-2008 intervals. However, this decrease and the subsequent increase are not statistically significant from interval to interval. The rolling three-year intervals for NH residents of all ages combined does show a significant difference between the first two intervals (2005-2007 and 2006-2008) final three intervals (2010-2012, 2011-2013, and 2012-2014), with the first two intervals being significantly lower. Additionally, the 2007-2009 interval was significantly lower than the 2012-2014 interval (**Figure 37** – pg. 50).

Figure 36

Suicide rates among 10-24 year old NH residents have increased from 2005-2014.

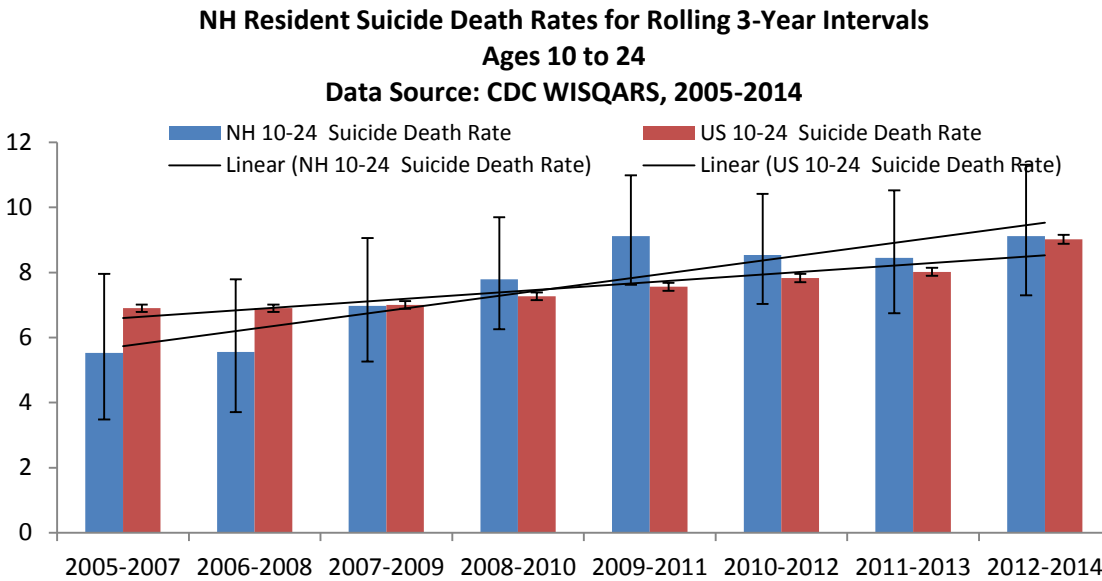


Figure 37

Figure 32 shows that the suicide death rate for people of all ages in NH has increased over the last 10 years.

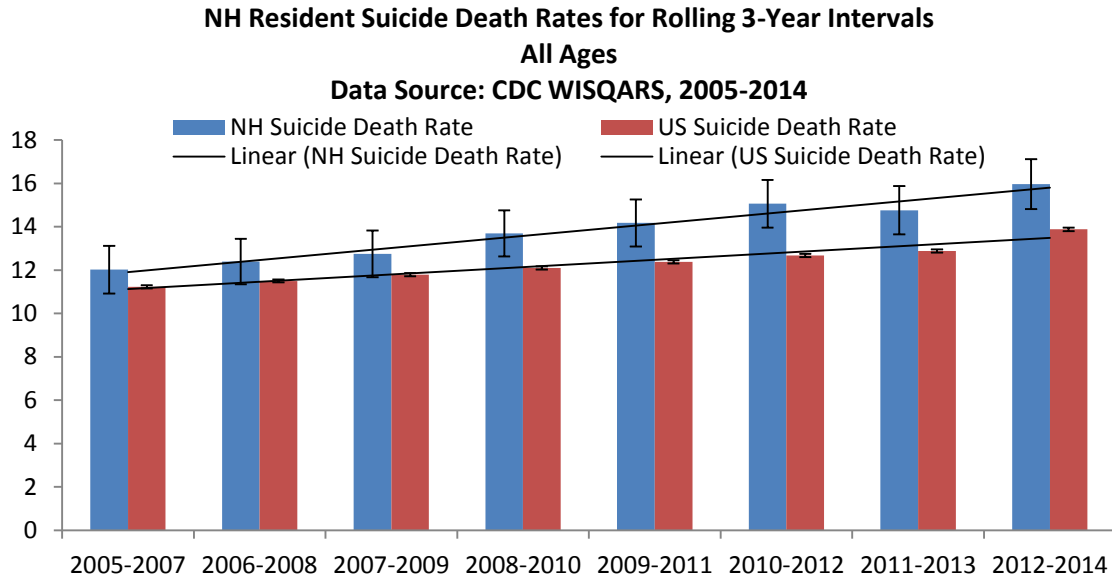
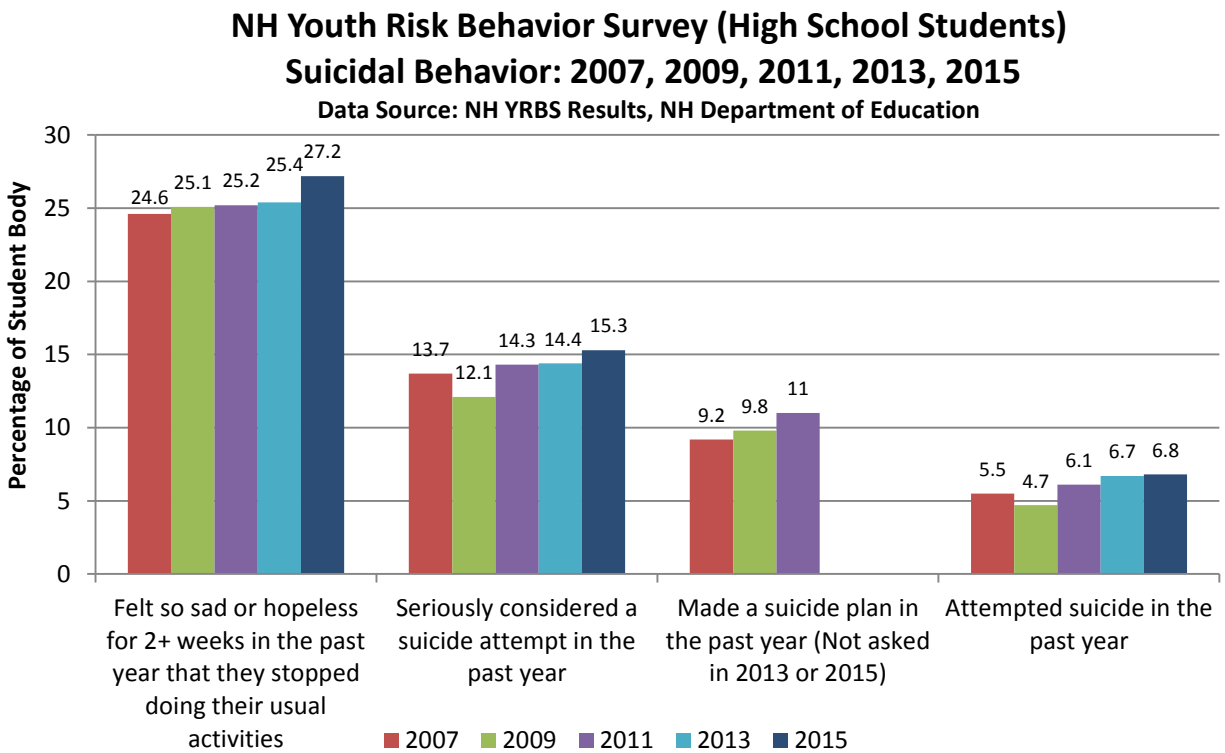


Figure 38 (below) indicates results of the NH YRBS from 2007, 2009, 2011, 2013, and 2015. The percentage of high school youth in NH who seriously considered a suicide attempt in the past year and the percentage of those who made a suicide plan in the past year have both increased slightly between 2007 and 2015. In 2015, 1 in 7 youth surveyed reported having seriously considered attempting suicide in the past year, while 1 in 15 reported actually having made an attempt.

Figure 38

Depression among high school youth remains at about one fourth of the population despite decreases in suicide attempts and suicidal ideation from 2007 to 2015.



The NH YRBS item addressing whether students have made a suicide plan in the past year was not asked in 2013 or 2015. This was done due to the similarity to the question asking whether youth had seriously considered a suicide attempt during the past year. 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). The results of that new question indicate that 18.5% of NH high school age youth (10.2% of males and 27% of females) report intentionally hurting themselves without the intent to die during the past year (NH YRBS, 2015).

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 3** of this report shows the number of youth and young adult suicides over a 10-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 14**) of this report shows the percent of male and female youths and young adults in NH that died by suicide from 2010 to 2014.
- **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 9 and 10**) in this report show the number of suicide deaths by age group in NH from 2010 to 2014 and the rate of suicide deaths by age group in NH from 2010 to 2014.

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 3**, the line chart of youth suicides in NH over the past ten years has a different scale on each axis. On the x-axis (the bottom) are years which range from 2006 to 2015. On the y-axis (the side) the scale is the number of youth suicides, which ranges from 0 to 35.
- **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 12**). In that chart you can see that the error bars for Carroll County and Coos County do not overlap the bar for Rockingham County. From this we are able to determine that the rates of suicide in Carroll County and Coos County are significantly different from those 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 (i.e., 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 percent 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
Assessing and Managing Suicide Risk	AMSR
Behavioral Risk Factor Surveillance System	BRFSS
Centers for Disease Control and Prevention	CDC
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
Northern New England Poison Center	NNEPC
Office of Economic Planning	OEP
Office of the Chief Medical Examiner	OCME
Operation Enduring Freedom	OEF
Operation Iraqi Freedom	OIF
Operation New Dawn	OND
Post-Traumatic Stress Disorder	PTSD
Substance Abuse and Mental Health Services Administration	SAMHSA
Substance Abuse Program	SAP
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

All 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

di= number of events in age group i

Pi= population in age group i

Si= proportion of the standard population in age group i

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

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

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

$$R \pm z (SE)$$

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

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

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 due to random 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?

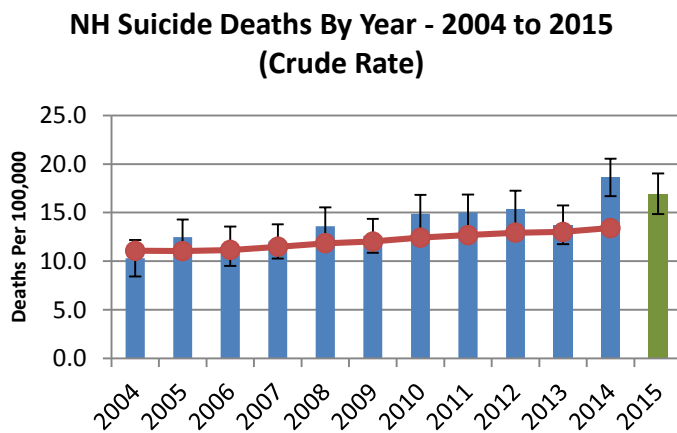
A: It is best to focus on data from a full year or multiple years rather than periods of just a few months. Over brief periods these numbers are too volatile to draw accurate conclusions from them.

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 20% (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 2004 do not overlap with the 2010 through 2012 and 2014 confidence intervals, meaning that the rate for 2010 - 2012 and 2014 was significantly higher than the rate for 2004.



Change in Rate per 100,000 from Year to Year	
2004-2005	10.31 to 12.48 (Up 21%)
2005-2006	12.48 to 11.54 (Down 8%)
2006-2007	11.54 to 12.04 (Up 4%)
2007-2008	12.04 to 13.60 (Up 13%)
2008-2009	13.60 to 12.61 (Down 7%)
2009-2010	12.61 to 14.89 (Up 18%)
2010-2011	14.89 to 15.02 (Up 1%)
2011-2012	15.02 to 15.37 (Up 2%)
2012-2013	15.37 to 13.75 (Down 11%)
2013-2014	13.75 to 18.62 (Up 35%)
2014-2015	18.62 to 16.93 (Down 9%)

2004-2014 = CDC Data, 2015 = NH Data

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 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., 2007 data were released in mid-2010). The 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 2004 to 2005, the number of deaths were up over 20% followed by an 8% decrease from 2005 to 2006; 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, 2010 – 2014

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 48	Unintentional Injury 11	Malignant Neoplasms ---	Malignant Neoplasms 12	Unintentional Injury 234	Unintentional Injury 370	Unintentional Injury 312	Malignant Neoplasms 1,020	Malignant Neoplasms 2,521	Heart Disease 9,914	Malignant Neoplasms 13,207
2	Short Gestation 38	Congenital Anomalies ---	Unintentional Injury ---	Suicide ---	Suicide 111	Suicide 152	Malignant Neoplasms 206	Heart Disease 565	Heart Disease 1,177	Malignant Neoplasms 9,339	Heart Disease 11,845
3	Maternal Pregnancy Comp. 26	Homicide ---	Cerebrovascular ---	Unintentional Injury ---	Malignant Neoplasms 21	Malignant Neoplasms 73	Suicide 149	Unintentional Injury 416	Unintentional Injury 327	Chronic Low Respiratory Disease 2,859	Chronic Low Respiratory Disease 3,281
4	Placenta Cord Membranes 18	Malignant Neoplasms ---	Chronic Low Respiratory Disease ---	Heart Disease ---	Homicide 15	Heart Disease 40	Heart Disease 126	Suicide 268	Chronic Low Respiratory Disease 313	Cerebrovascular 2,133	Unintentional Injury 2,978
5	SIDS 16	Heart Disease ---	Congenital Anomalies ---	Benign Neoplasms ---	Heart Disease 12	Homicide 13	Liver Disease 33	Liver Disease 160	Liver Disease 228	Alzheimer's Disease 1,888	Cerebrovascular 2,362
6	Respiratory Distress 10	Influenza & Pneumonia ---	Heart Disease ---	Congenital Anomalies ---	Cerebrovascular ---	Congenital Anomalies 12	Diabetes Mellitus 21	Diabetes Mellitus 92	Diabetes Mellitus 221	Unintentional Injury 1,289	Alzheimer's Disease 1,930
7	Circulatory System Disease ---	Benign Neoplasms ---	Homicide ---	Homicide ---	Congenital Anomalies ---	Diabetes Mellitus 12	Homicide 16	Chronic Low Respiratory Disease 86	Suicide 197	Diabetes Mellitus 1,051	Diabetes Mellitus 1,401
8	Neonatal Hemorrhage ---	Nephritis ---	Suicide ---	Influenza & Pneumonia ---	Chronic Low Respiratory Disease ---	Chronic Low Respiratory Disease ---	Cerebrovascular 13	Cerebrovascular 60	Cerebrovascular 141	Influenza & Pneumonia 937	Influenza & Pneumonia 1,035
9	Unintentional Injury ---	---	---	---	Diabetes Mellitus ---	Complicated Pregnancy ---	Chronic Low Respiratory Disease ---	Viral Hepatitis 30	Septicemia 73	Nephritis 793	Suicide 1,028
10	Necrotizing Enterocolitis ---	---	---	---	Three Tied ---	Cerebrovascular ---	Septicemia ---	Influenza & Pneumonia 27	Nephritis 61	Parkinson's Disease 550	Nephritis 881

Source: CDC WISQARS, 2010-2014

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

Contacts and Meeting Information

State Suicide Prevention Council

Primary Contact: Patricia Tilley – patricia.tilley@dhhs.nh.us

Meets 2nd Monday – Every **other** month 10:00 am – 12:00 pm
DHHS, 29 Hazen Drive, Concord

Youth Suicide Prevention Assembly

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

Meets 2nd Thursday of the month 10:00 – 12:30 am
Brown Building, DHHS, Concord

Connect Program of NAMI NH

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

NH Suicide Survivor Network

Primary Contact: Deb Baird – dbaird@naminh.org

Suicide Prevention Council Subcommittees

Communications & Public Education

Chair: Rhonda Siegel – rsiegel@dhhs.nh.us

Meets 1st Wednesday of the month 1:00 pm – 3:00 pm
DHHS, 29 Hazen Drive, Concord

Cross Training & Professional Education

Co-Chairs: Maggie Pritchard – mpritchard@genesisbh.org
Jennifer Schirmer – Jennifer.schirmer@dhhs.nh.us

Meets 1st Friday of the Month 8:30 am – 9:30 am
Room 433, Brown Building, DHHS, Concord

Data Collection & Analysis

Chair: Patrick Roberts – proberts@naminh.org

Meets 4th Friday of the Feb., May, Aug., and Oct. 9:30 – 11:30 am
NAMI NH, 85 North State Street, Concord

Military & Veterans

Co-Chairs: Dale Garrow – dale.garrow@accenturefederal.com
Loren Haberski – loren.haberski@va.gov

Meets 1st Wednesday of the Month 2:30 – 4:30 pm
VA Manchester Medical Center

Public Policy

Co-Chairs: James Mackay – james.mackay@mygait.com
Keith Pomkoski – kjpomkoski@comcast.net

Meets 3rd Friday of the month 10:00 am – 12:00 pm
New Futures, 10 Ferry Street, Suite 307, Concord

State Suicide Prevention Conference Meetings

Primary Contact: Mary Forsythe-Taber– mft@mih4u.org

Contact Mary Forsythe-Taber for current meeting schedule and location

Suicide Fatality Review

Chair: Alex deNesnera – adenesnera@dhhs.state.nh.us

Attendance is by invitation only

Survivors of Suicide Loss

Co-Chairs: Susan Morrison – SOSL4NHSPC@gmail.com
Deb Baird – dbaird@naminh.org

Meets 4th Wednesday of the Month 6:00 pm – 7:30 pm
All meetings held via conference call

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.

These warning signs can also be applied to adults:

- 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 <http://www.theconnectprogram.org> and click on Understanding Suicide.

If you see warning signs and/or are otherwise worried that 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:
 - * National Suicide Prevention Lifeline (24/7) **1-800-273-TALK (8255)** (press **“1” for veterans**)
 - * The Lifeline also offers text based chat through their website: <http://www.suicidepreventionlifeline.org/>
 - * Head rest – 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: <http://www.dhhs.state.nh.us/dcbcs/bbh/centers.htm>
Disaster Behavioral Health Response Teams: <http://www.dhhs.nh.gov/esu/dbhrtnh.htm>
NAMI New Hampshire: www.naminh.org, 603-225-5359

Gay, Lesbian Bisexual, and Transgender (GLBT) Resources

Family Acceptance Project www.familyproject.sfsu.edu/
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: actionallianceforsuicideprevention.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/1KqsBH3
SPRC Older Adult Suicide Prevention Resources: bit.ly/1Jod4n3

Substance Abuse and Mental Health Services Administration (SAMHSA)

Obtaining Prevention Materials:
Visit their website: store.samhsa.gov/home (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 abuse providers. You can use it to find a local provider by going to www.samhsa.gov/treatment/

Youth

www.Reachout.com

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: bit.ly/afsp-survivors

Compassionate Friends: www.compassionatefriends.org

The *Connect* Program: <http://www.theconnectprogram.org/survivors>

Friends for Survival: www.friendsforsurvival.org

Grief After Suicide: bit.ly/suicidegriefsupport

Heartbeat: 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

Suicide: Finding Hope: www.suicidefindinghope.com

Discussion Forums

Parents of Suicides and Friends & Families of Suicides: www.suicidegrief.com

Help for People Left Behind: bit.ly/grieving-suicidesurvivors

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

Booklets

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

Financial Guide: www.afsp.org/financialguide

Handbook for Survivors of Suicide: bit.ly/aas-store

Hope and Healing after Suicide: bit.ly/camh-hopehealing

Resource and Healing Guide: bit.ly/afsp-surviving-suicide

Appendix A

New Hampshire Violent Deaths Reporting System (NVDRS)

Violent Deaths Analysis, With a Focus on Suicide & its Primary Factors, in 2015

Author:
Djelloul Fourar-Laïdi,
Planning Analyst/Data Systems
603-271-1235

September 22, 2016
Office of Medical Examiner
Dept. of Justice

Summary: This is a brief analysis on violent deaths in NH in 2015. The data for 2015 is compiled from different primary sources which include, Vital Records of New Hampshire, NH State Forensic Laboratory Toxicology reports (as well as other labs for special cases), Medical Examiner (ME) extensive autopsy and field investigation reports based on field examination of the body by the Assistant Deputy Medical Examiners, and the various Law Enforcement (LE) reports. LE reports are also based on field investigation and follow up interviews and data from extra investigative time by detectives.

- ❖ New Hampshire Violent Death Reporting System (NHVDRS): Is the new system that is used by the State of New Hampshire to track down violent deaths, which is operated by the Office of Medical Examiner in collaborating with NH DHHS and CDC. CDC awarded the NVDRS to NH in 2014 and the program became operational only in December 2015.

The Definition of Violent Death: Accordingly CDC (and NVDRS grants) defines a violent death as a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community.

The data specifications: According to CDC & grant specifications, NVDRS (nationally) collects information about violent deaths, such as homicides, suicides, and deaths where individuals are killed by law enforcement in the line of duty. In addition, NVDRS gathers information about unintentional firearm injury deaths and on deaths where the intent cannot be determined, although these deaths are not considered violent deaths by the above definition. Also, in NH, we compile data on violent deaths that occurred in the geographical space of the State of New Hampshire on those victims who are not state residents. NHVDRS also reports on deaths which are undetermined or accidental in manner. Regardless, some of these deaths may not be deemed as violent.

- ❖ Although we do not have enough data to format a trend or make definite declarations, we are able to report on issues that are of interest to various stakeholders and organizations with special interest.

Suicide among veterans is a topic with contemporary prominence. Also, there is urgency nowadays and interest in tackling suicide among active military and non-active military personnel. In NHVDRS we track violent deaths that occurred in the territorial space of the State of New Hampshire where the victim of such violent death is a veteran (please see figure 1).

Figure 1

Victims of Violent Death (Suicides) by Status in Armed Forces				
Gender	No	Unk	Yes	
Female	61	-	-	
Male	125	-	36	
Total	186	-	36	227*
*(-) Categories with three or fewer cases are not reportable.				
Source: DFL_NHVDRS, OCME, NHDOJ				

The proportion of suicide deaths in NH in 2015 that is gathered from NHVDRS, shows a glimpse of the disparities which exist among victims of suicide depending on their level of educational attainment. We also introduce the timeline factor that we hope (as we collect more

data) would be able to shed some light on stressors that contributed to such violent acts of death. We need to look for compelling evidence that will be backed by data (please see figure 2). The educational attainment levels in figure 2 were grouped as follows:

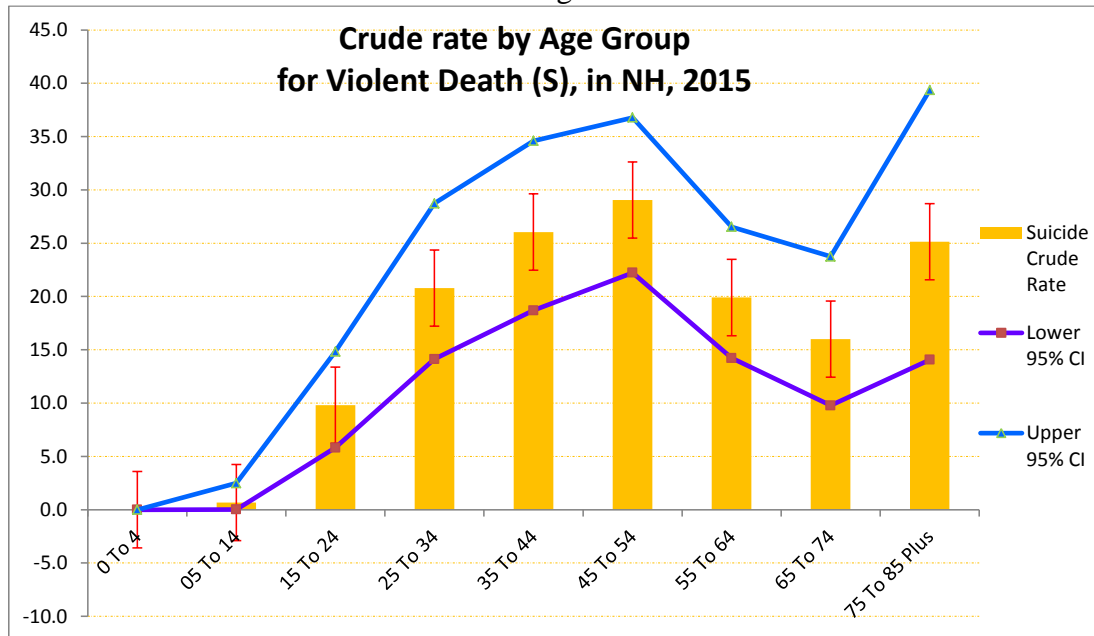
- * HS/GED or less (combined)
- * Some college, no degree
- * Associate Degree
- * Bachelor Degree
- * Higher Degree/Professional (not reportable)

Figure 2

NH Monthly Suicide Incidents, All Gender Rates by Educational Level, Year 2015* (Percentages)				
Educational Level	3: HS/GED or less (combined)	4: Some college, no degree	5: Associate Degree	6: Bachelor Degree
Jan	6.0%	*	*	1.3%
Feb	4.0%	2.2%	*	*
Mar	5.3%		*	1.8%
Apr	6.6%	1.3%	*	*
May	4.4%		*	1.8%
Jun	1.8%	1.3%	1.3%	1.8%
Jul	6.2%	*	*	*
Aug	4.0%	1.8%	1.3%	*
Sep	4.0%	*	*	2.2%
Oct	7.5%	*	*	*
Nov	6.6%	1.3%	*	1.3%
Dec	6.6%	1.3%	*	*

- ❖ The crude rate of suicide in New Hampshire for year 2015, for age groups was normalized to account for population distribution variations across these age groups. This indicates that there are three groups that are mostly vulnerable to suicide ideation.

Figure 3



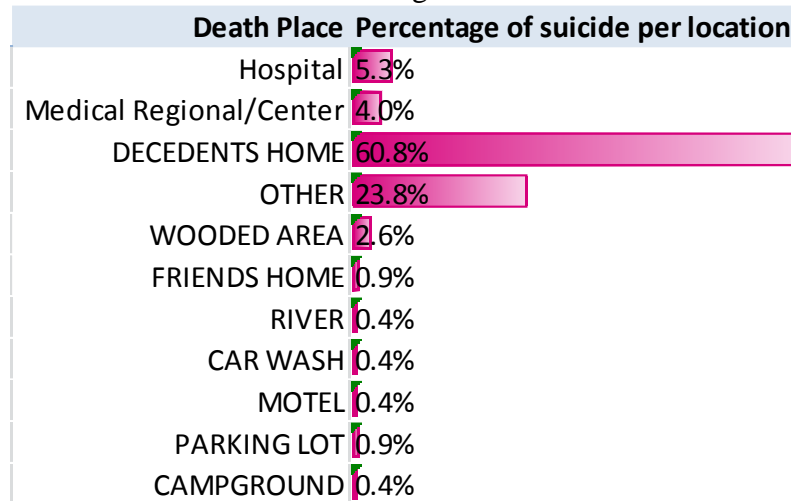
The first and second age groups that have seen high rates of suicides are victims of age 45 years old to 54 years old and those 35 years old to 44 years old, then followed (not closely) by victims in the age bracket 75 years old plus. The ramifications from these facts lend themselves for a closer scrutiny – (Please see figure 3).

- ❖ Some of the prominent topics of discussion surrounding suicide are how easy and frequently have victims of suicide had access to medical health services and mental health services. To capture the essence of this discussion, NHVDRS is collecting data on whether victims of suicide have a regular Primary Care Provider (PCP); that includes physician, Assistant Physician, Specialized Nurse at a hospital setting, medical center or community health center. Also, how often and easy do suicide victims access mental health service; again that includes psychologist, psychiatrist, mental health counselors and other specialized mental health providers at any of the above mentioned facility settings. Private practices' data are very difficult to access. According to field data from the Office of Medical Examiner, these are some of the statistics for suicide in 2015:

- 1- 54% of people who died by suicide had a PCP*.
- 2- 15% of people who died of suicide were 65 years or older. Of those 11% had a PCP*.
- 3- 3% of people who died of suicide were recently seen in the Emergency Department.

- ❖ 61 % of suicide deaths in NH in 2015 occurred in the victim's home. There the method of injury was very lethal and survivability was dim. However, there were 9.3 % of the suicide deaths where the condition of the victim who committed suicide was managed first at the scene. First responders were able to help victims survive initially, when they received emergency assistance at the scene. Victims of suicide who survived initially were transported and admitted to medical or regional health center (including hospital) for further interventions.

Figure 4



The remainder of suicide deaths occurred at various locations and under varied circumstances: i.e. wooded area, campground, parking lot etc... And they accounted for about 30% of the suicide deaths in the state in 2015. In this last category, the victim either had left notes to alert loved ones of their act of suicide or used social media. The notes were in various formats ranging from simple text messages to Facebooking. Some other victims had left no communication trace and ultimately were discovered accidentally by someone in the general public (please see figure 4).

- ❖ The most lethal methods of death for suicide varied by gender and by educational level. This distinction holds mostly true when we consider age as another factor. Cases of hanging are very comparable among same age group, for both sexes, when considering whether victims of suicide had high school/ GED or less in educational attainment.

Figure 5

	Percent of Male Suicide Deaths	Percent of Female Suicide Deaths
High School Grad / GED or less		
Poisoning	7%	22%
Suffocation/Hanging	16%	14%
Firearms	38%	11%
Other	2%	2%
Assoc/Bachelor degree, & some college		
Poisoning	5%	14%
Suffocation/Hanging	9%	6%
Firearms	15%	14%
Other	2%	5%
Advanced/Professional (Master & higher)		
Poisoning	1%	5%
Suffocation/Hanging	2%	3%
Firearms	1%	3%
Other	1%	-

Nonetheless, the cause of death by poisoning is three times more prominent among female suicide victims than male. However, the differences are minimal when comparing causes of death by gender for those who attained a higher level of education among all age groups of suicide victims.

Appendix B

2015 Suicide Fatality Review Committee Report

2015 Suicide Fatality Review Committee Report

ACKNOWLEDGMENTS

Sincere appreciation goes to the members of the Suicide Fatality Review Committee (SFRC), who have continued to work diligently and respectfully to study New Hampshire's suicide deaths, in an effort to prevent the tragedy of suicide in our state. These cases are difficult and painful to review. The SFRC has worked to honor the lives that have been lost, the impact it has on family, friends, and communities, and examine ways to help prevent future fatalities. The SFRC would like to recognize and thank all of the individuals who have made presentations at SFRC meetings and who have participated as guests in reviewing the cases. We are indebted to these individuals for assisting us in better understanding suicide and all of its implications.

BACKGROUND:

New Hampshire has long been recognized nationally as a leader in suicide prevention efforts and addressing suicide as a public health issue. Early efforts included a legislative study committee on youth suicide in 1991 that recommended the formation of a coalition to address youth suicide, which resulted in the formation of the Youth Suicide Prevention Assembly (YSPA). YSPA addressed the issue of suicide in youth up to age 18. Recognizing the importance of addressing the higher rates of suicide in transition age youth, in 2003 YSPA expanded its focus to age 24. Following the adoption of the National Strategy for Suicide Prevention in 2002, New Hampshire created a State Suicide Prevention Plan in 2004 that addressed suicide across the lifespan. A state Suicide Prevention Council was formed in 2006 and legislatively established in 2008.

New Hampshire has a successful history of using fatality review committees to inform prevention efforts. Multi-disciplinary committee members closely examine the antecedents to death with goals of identifying and making recommendations regarding trends, opportunities for improved training, and changing protocols, policy and practice.

New Hampshire's first fatality review committee (the Child Fatality Review Committee) was established by executive order in 1991. A Domestic Violence Fatality Review Committee was created by executive order in 1999. The Incapacitated Adult Fatality Review Committee was legislatively established in 2008.

Key components to a successful fatality review committee as established by New Hampshire's previous fatality review committees include:

- 1: Clear purpose and objectives.
- 2: Multidisciplinary membership.
- 3: Sharing of information and data.
4. Open and honest discussion.
5. Systems change instead of "blame and shame".
6. Educational opportunities.
7. Development of realistic recommendations that are able to be implemented.

While each of these fatality review committees occasionally chose to review suicide cases, the focus of each was narrow. The Child Fatality Review Committee only reviewed suicide up to age 18, the Domestic Violence Fatality Review Committee only addressed homicide-suicide cases and the Incapacitated Adult Fatality Review Committee focused on suicide deaths over age 65 or of individuals who were incapacitated. This left the whole adult population age 18 - 65 without any mechanism for reviewing suicide deaths as well as the potential for more thorough reviews of suicide deaths of those under age 18 or over age 65.

Legislative Process:

In 2010, the Suicide Prevention Council Public Policy Committee drafted legislation to establish a suicide fatality review committee. The legislation was sponsored by Representative Roger Wells, a member of the Suicide Prevention Council, a survivor of suicide loss, and a pioneer in suicide prevention and postvention efforts in New Hampshire, and supported by Representative James MacKay, the Chair of the Suicide Prevention Council. Due to funding constraints, administrative support from the Attorney General's office was removed from the bill and the legislation placed the Suicide Fatality Review Committee (SFRC) under the auspices of the New Hampshire Suicide Prevention Council (established under RSA: 126-R:2). While this had some clear benefits, it left the SFRC isolated from other Fatality Review Committees who are provided administrative and technical support by the NH Department of Justice. The legislation creating the SFRC took effect on July 31, 2010 (see Appendix for copy of legislation), and to the best of our knowledge, it was the first legislatively established SFRC in the United States. Since that time, several states have created suicide fatality review committees based on NH's legislation.

The legislation established that the SFRC committee shall:

- (a) Review suicide deaths in New Hampshire to determine trends, risk factors, and prevention strategies.
- (b) Determine and report on trends and patterns of suicide deaths in New Hampshire.
- (c) Identify and evaluate the prevalence of risk factors for preventable deaths in New Hampshire.
- (d) Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for individuals at risk for suicide in New Hampshire.
- (e) Recommend improvements in the sources of data relative to investigating reported suicide deaths and preventing suicide.

Key aspects of the legislation included:

- Members and alternates are appointed by the Suicide Prevention Council and include:
 - The Chief Medical examiner or his/her designee;
 - Individuals representing the health care field;
 - Organizations with expertise in suicide prevention, mental health and substance abuse treatment and prevention, law enforcement, and injury prevention;
 - Organizations or individuals who advocate for individuals with mental illness or their families; and
 - Other members the council deems appropriate.
- Instructing the committee to develop a protocol in collaboration with the Chief Medical Examiner for defining which suicide deaths the committee should review;

- Providing the committee with the ability to review “cases ruled as accidental which may inform suicide prevent efforts”; and
- Instructing the committee to avoid any cases where pending litigation is involved.

The legislation also included specific safeguards for the confidentiality of meetings, stating that case specific findings of the committee are to remain confidential and free from discovery, subpoena or any administrative review.

The legislation established a schedule for the SFRC to report to the Suicide Prevention Council on any trends and patterns of suicide death that may lead to prevention efforts, as well as any recommendations in policy, law or practice that may prevent suicide deaths.

Setting Up the Committee:

The Suicide Prevention Council Executive Committee identified Diane Langley from the NH Department of Health and Human Services to serve as Chair and Catrina Watson from the New Hampshire Medical Society to serve as Vice Chair of the SFRC. The Suicide Prevention Council Executive Committee then worked with the Chair and Vice Chair of the SFRC to recruit committee members who met the criteria outlined in the approved legislation.

The SFRC first convened in the fall of 2010 and worked to establish parameters of the committee as well as a protocol (see Appendix for Case Review Protocol) for selecting and reviewing cases. This initial work included:

- Establishing that the purpose of the suicide fatality review committee is to study the incidence and causes of death from suicide in New Hampshire, in accordance with RSA-126 R:4;
- Further defining the confidentiality and limits of legal protection of records and information shared during the review process, requiring that each member sign a confidentiality agreement and turn in any notes at the end of each case review;
- Establishing a mechanism for soliciting records, witnesses and specific information to be used during the case review;
- Identifying a process for inviting non-member guests to observe and participate in reviews; and
- Encouraging consultation and collaboration with the other suicide fatality review committees.

September 2014-July 2015

In 2014-2015 the focus of the committee has been to foster increasing collaboration with the other state fatality review committees. To initiate this process, regular meetings were scheduled with the Chairs of the Domestic Violence Fatality Review Committee (DVFR), the Incapacitated Adult Fatality Review Committee (IAFR) and the Child Fatality Review Committee (CFRC). This led to Suicide Fatality Review Committee participation in three joint reviews (two with the DVFR and one with the IAFR). There is a potential joint review with the CFRC being considered for next year. The purpose of these joint reviews is to allow for expanded discussion and review of systems issues, along with the development of joint recommendations that are more robust given these come from two committees.

Membership:

Please see Appendix for the list of members.

Recommendations:

The members of the SFRC make recommendations based on the information available at each case review and have organized its recommendations into the following categories:

- Policy
- Training and Education
- Public Awareness
- Professional Collaboration

The Executive Committee of the SFRC has continued to identify and build recommendations in each category that it feels are reasonable, accomplishable and will have a positive impact. **The most recent recommendations developed this past year are in bold, along with notation as to their being joint recommendations with either the DVFRC, IAFRC, or CFRC.**

Category	Recommendation
Policy	1 <u>Release of confidential information</u> Current releases of confidential information need to be reviewed and revised as needed in order to eliminate barriers to effective communication among all providers, particularly community mental health centers and substance use service providers.
	2 <u>Prescription oversight</u> Methadone clinics should be included in prescription drug monitoring initiatives. Need to determine if access to pain medication through pain clinics is effectively monitored.
	3 <u>Drug Court</u> Each county should have a drug court. Need to review the drug court protocols to determine if they comply with national best practices and, if not, to make recommendations to bring the protocols into alignment with national best practices.
	4 <u>Access to mental health services</u> Clients residing in assisted living facilities have access to limited mental health services; need to determine the gaps in services and make recommendations for improving access to needed services
	5 <u>Substance use services</u> Community Mental Health Centers need to build capacity regarding substance use services recognizing that some of the challenges involve differences in credentialing and licensing. Short-term recommendation: identify training needs of providers regarding co-occurring mental health and substance use disorders.

Category	Recommendation
	<p>Longer-term recommendation: strategize how to have the following implemented:</p> <ul style="list-style-type: none"> • both MSW¹⁴ degree and Master LADC¹⁵ degree requirements include relevant competencies • make supervision requirements more easily attainable • make work experience requirement for LADC more easily attainable • billing rules/regulations become consistent with these strategies <p>6 <u>Mental Health</u> Mental Health Court to be expanded</p> <p>7 <u>Police Protocols</u> Clarify police department protocols (if there are any) determining when police officers can take guns from individuals due to safety concerns.</p> <p>8 <u>Police Protocols</u> Clarify police department protocol (if there are any) determining when police officers can return guns to individuals when they request their guns back.</p> <p>9 <u>Statutes Related to Police Possession of Guns</u> Review current New Hampshire statutes and rules regarding police taking and returning guns to individuals.</p>
Training and Education	<p>1 Increase training for professional staff:</p> <ul style="list-style-type: none"> • to develop an enhanced understanding of the availability of military resources and benefits, • to develop an enhanced recognition and understanding of post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI) <p>2 <u>Access to residential treatment</u> Identify the difficulties accessing residential treatment facilities, e.g., waiting lists, and make recommendations for improving access</p> <p>3 <u>Comprehensive treatment</u> Recommend a combined treatment approach that includes trauma-informed care, substance use services, mental health services, services to the homeless and those in the criminal justice/corrections system that includes consistent training and ability to release confidential information among/between systems (see Policy #1).</p> <p>Recommend including ACT¹⁶ teams in the criminal justice/corrections system.</p>

¹⁴ Master of Social Work

¹⁵ Licensed Alcohol and Drug Counselor

¹⁶ Assertive Community Treatment

Category	Recommendation	
	4	<u>Neuropsychological screening</u> All residents of assisted living facilities should have access to mental health screening. Protocols regarding requesting neuropsychological testing based on the outcome of mental health screening should be developed.
	5	<u>Mental health and substance use</u> Recommend identifying training needs of providers regarding co-occurring mental health and substance use disorders, designing and providing needed training. (see Policy #5)
	6	<u>Police Training</u> Increased police training addressing ways to effectively interact with mentally ill citizens.
	7	<u>Medical Provider Training</u> Support the education and training of medical providers on suicide risk screening and assessment, domestic violence, and risks of homicide. (DVFRC)
	8	<u>Department of Motor Vehicle Training</u> Explore with, and provide education to, the Department of Motor Vehicles regarding resources for older adults who fail their driving exams. (IAFRC)
Public Awareness	1	<u>Access to Lethal Means</u> Recommend drafting an article emphasizing the need to discuss and document reducing access to lethal means for anyone at risk.
	2	<u>Sentinel Events</u> Recommend investigating training for providers to assist with developing an internal sentinel event policy to determine if all risk factors were identified and everything was done to prevent a person's suicide.
	3	<u>Access to Services</u> Access to services in rural areas is a challenge with one factor being lack of transportation.
	4	<u>Bureau of Drug and Alcohol Services</u> The Bureau of Drug and Alcohol Services (BDAS) Access to Recovery (ATR) grant-funded program ¹⁷ , which pays for outpatient treatment and transportation among other things, would have benefited the individual in the case reviewed and likely others in similar situations. Recommend BDAS investigate ways to continue the ATR services beyond the end of the grant period.
	5	<u>Substance Use</u> Recommend substance use screening for all individuals living in residential settings and pursuing integrating substance use services into

¹⁷ A four year grant was awarded to BDAS in October 2010

Category	Recommendation
	<p>all community mental health and residential services clients' individual services plans.</p> <p>6 <u>Trauma Services</u> Ensure that children and family members exposed to traumatic experiences have access to highly qualified mental health providers that use evidence-based practices in treating trauma victims. (DVFC)</p> <p>7 <u>Murder/Suicides</u> Track the number of murder/suicides in New Hampshire over the next two years to determine possible trends. (DVFC)</p> <p>8 <u>Funeral Directors</u> Work with funeral directors to offer information on accessing help to individuals who may not have any supports when dealing with a suicide. (IAFC)</p>
Professional Collaboration	<p>1 <u>Police</u> Recommend having police attend pertinent SFRC case reviews and provide relevant police reports.</p> <p>Recommend inviting a member of the NH Association of Chiefs of Police to join the SFRC.</p> <p>2 <u>Peer Support and Recovery Coaches</u> Recommend investigating whether Bureau of Behavioral Health Peer Support Agencies could be aligned with BDAS Recovery Coaches as Peer Support is often an under-utilized mental health resource.</p> <p>3 <u>Prescription Management</u> Medication management can be a concern when there are a number of prescribers; of particular concern is coordination between primary care physicians and psychiatrists. Recommend investigating a means to identify individuals with known addiction and/or drug-seeking behavior to ensure their treatment is appropriate and that they are informed of the risks of their addition(s) and/or drug-seeking.</p> <p>4 <u>Mental Health Staffing</u> Assisted living facilities are not staffed with mental health professionals resulting in staff having to rely on other providers such as primary care physicians and case managers to identify concerns and to develop plans of care that address clients' mental health needs. Recommend that assisted living facilities have direct access to mental health professionals and that staff are trained on how to address changes in behaviors, etc. (see Policy #4)</p>

Category	Recommendation
	5. <u>Public Health Networks</u> Recommend collaboration with the state's regional Public Health Networks (http://nhphn.org/) to collaborate on resource development and sharing of resources and expertise.
	6. <u>Domestic Violence</u> Explore providing information to Human Resource managers or Employee Assistance Programs around domestic violence awareness and suicide prevention resources. (DVFRC)

APPENDIX

1. Legislation establishing the Suicide Fatality Review Committee

CHAPTER 109

HB 1384 – FINAL VERSION

03Mar2010... 0660h

05May2010... 1865eba

2010 SESSION

10-2492

05/04

HOUSE BILL ***1384***

AN ACT establishing a suicide fatality review committee.

SPONSORS: Rep. Wells, Rock 8

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

This bill establishes, as part of the council on suicide prevention, a suicide fatality review committee to study trends, risk factors, and prevention strategies for suicide deaths in New Hampshire.

Explanation: Matter added to current law appears in ***bold italics***.

Matter removed from current law appears [~~in brackets and struck through.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03Mar2010... 0660h

05May2010... 1865eba

10-2492

05/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT establishing a suicide fatality review committee.

Be it Enacted by the Senate and House of Representatives in General Court convened:

109:1 New Section; Suicide Fatality Review Committee Established. Amend RSA 126-R by inserting after section 3 the following new section:

126-R:4 Suicide Fatality Review Committee Established.

I. There is hereby established the suicide fatality review committee, which shall be a committee of the council on suicide prevention established in RSA 126-R:2.

II. The council shall appoint members and alternate members to the suicide fatality review committee. The members of the committee shall include the chief medical examiner, or his or her designee, individuals representing the health care field, organizations with expertise in suicide prevention, mental health, and substance abuse treatment and prevention, law enforcement, injury prevention, organizations or individuals who advocate for individuals and families with mental illness, survivors of suicide, and such other members as the council determines will assist the committee in fulfilling its objectives.

III. The committee shall adopt a protocol defining which suicide deaths, as determined by the office of the chief medical examiner, shall be reported to the committee and subject to review, and which suicide deaths may be screened out for review. The committee may also review deaths which are ruled as accidental which may inform suicide prevention efforts. The committee shall not review any case where there is pending litigation. The committee may establish different levels of review, such as comprehensive or more limited review, depending on the nature of the incident or the purpose of the review.

IV. The committee shall:

(a) Review suicide deaths in New Hampshire to determine trends, risk factors, and prevention strategies.

(b) Determine and report on trends and patterns of suicide deaths in New Hampshire.

(c) Identify and evaluate the prevalence of risk factors for preventable deaths in New Hampshire.

(d) Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for individuals at risk for suicide in New Hampshire.

(e) Recommend improvements in the sources of data relative to investigating reported suicide deaths and preventing suicide.

V. Records of the committee, including testimony by persons participating in or appearing before the committee and deliberations by committee members relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding. However, information, documents, or records otherwise available from original sources shall not be construed as immune from discovery from the original sources or used in any such civil or administrative action merely because they were presented to the committee, and any person who appears before the committee or supplies information as part of a committee review, or who is a member of the committee, may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her statements before the committee, participation as a member of the committee, or opinions formed by him or her or any other member of the committee, as a result of participation in a review conducted by the committee.

VI. The suicide fatality review committee shall consult and collaborate with the existing fatality review committees as appropriate.

VII. The committee shall report annually to the council, on or before the first day of September, beginning September 1, 2011, describing any trends and patterns of deaths or serious injuries or risk factors together with any recommendations for changes in law, policy, and practice that will prevent suicide deaths and related serious occurrences. The committee may also issue special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.

VIII. The meetings and records of the committee shall be exempt from the provisions of RSA 91-A. The committee's reports shall not include any private or privileged information. Members of the committee may be required to sign a confidentiality agreement that prohibits any unauthorized dissemination of information disclosed to the committee.

IX. Members shall be appointed within 30 days of the effective date of this section, and the first meeting shall be called by the chairperson of the council, or his or her designee, within 45 days of the effective date of this section.

109:2 Effective Date. This act shall take effect 60 days after its passage.

Approved: June 1, 2010

Effective Date: July 31, 2010

2. Case Review Protocol

The SFRC has chosen cases of adult suicide death recognizing that the Child Fatality Review Committee reviewed cases of individuals up to the age of eighteen. Based on data obtained from the Office of the Chief Medical Examiner, the SFRC has chosen cases for review based on age, gender, cause and region of the state striking to identify cases that represent the most prevalent categories as a means to draft recommendations that would have the most impact on prevention strategies and to meet the legislation's goals of:

- a) Identify and evaluate the prevalence of risk factors for preventable deaths in New Hampshire.
- b) Evaluate and report on high risk factors, current practices, gaps in systematic responses, and barriers to safety and well-being for individuals at risk for suicide in New Hampshire

The SFRC's Case Review Protocol was adopted in 2010 and is listed below:

1. The purpose of the suicide fatality review committee (SFRC), established as a committee of the Council on Suicide Prevention in RSA 126-R:2, is to study the incidence and causes of death from suicide in N.H.
2. Member of the SFRC are required to sign a confidentiality agreement that prohibits any unauthorized dissemination of information beyond the purpose of the review process as a condition of membership.
3. The meetings and records of the SFRC shall be exempt from the provisions of RSA 91-A.
4. Records of the SFRC, including testimony by persons participating in or appearing before the SFRC and deliberations relating to the review of any death, shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial or administrative proceeding.
5. Information, documents, or records otherwise available from original sources shall not be construed as immune from discovery from the original sources or used in any such civil or administrative action merely because they were presented to the SFRC, and any person who appears before the SFRC or supplies information as part of a SFRC review, or who is a member of the SFRC, may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her statements before the SFRC, participation as a member of the SFRC, or opinions formed by him or her or

any other member of the SFRC, as a result of participation in a review conducted by the SFRC.

6. Written materials generated from the meeting such as case summaries or notes pertaining to the case will be collected and destroyed at the end of the meeting.
7. Use of recording equipment during meetings or in conducting the business of the SFRC is not allowed.
8. Once the Chief Medical Examiner has identified an individual death for review, the SFRC Chairperson, Co-Chairperson or Staff Assistant will send any available case specific information to members of the SFRC in a confidential and secure manner. The information distributed may contain the following information: name of victim, name of facility or address of residence where death occurred, name of the providers as relevant, the deceased's date of birth, cause of death and other relevant information.
9. Individual members of the SFRC will gather relevant information for discussion at the SFRC meeting from their respective organizations describing their involvement with the individual prior to his or her death from suicide.
10. The agency that has had the most involvement with the individual prior to his or her death is asked to take the lead in presenting the relevant facts and information at the SFRC meeting.
11. The SFRC may invite non-member guests to observe and participate in a review. Invited guests shall be required to sign a confidentiality agreement prior to participating.
12. The SFRC may consult and collaborate with the existing fatality review committees as appropriate and subject to confidentiality requirements.
13. Upon completion of a full review of the individual's death, members of the SFRC will review the facts and information gathered and make recommendations to strengthen policy, practice, and/or services that can be realistically implemented, promote collaboration among service providers and reduce preventable deaths from suicide in all ages.
14. The SFRC shall report annually to the Suicide Prevention Council, on or before the first day of September, beginning September 1, 2011, describing any trends and patterns of deaths or serious injuries or risk factors together with any recommendations for changes in law, policy and practice that will prevent suicide deaths and related serious occurrences. The SFRC may also issue special reports when doing so is necessary to alert authorities or the public to the need for prompt corrective action.
15. The SFRC's reports shall not include any private or privileged information.
16. Each SFRC member representing a discipline or agency will designate an alternative member from its discipline or agency and will ensure that one member will be present at every meeting.

3. Members

**Suicide Prevention Council
Suicide Fatality Review Team
Membership: July 2015**

Name	Affiliation	e-mail
**Alex de Nesnera, Chair	New Hampshire Hospital	adenesnera@dhhs.state.nh.us
Thomas Andrew Kim Fallon	Office of the Chief Medical Examiner	thomas.andrew@doj.nh.gov kim.fallon@doj.nh.gov
Elaine de Mello (eff. Sept. 2014)	National Alliance of the Mentally Ill-NH	edemello@naminh.org
**Elaine Frank	Dartmouth Hitchcock	elaine.m.frank@dartmouth.edu
Dale Garrow (eff. July 2014)	NH National Guard	dale.garrow@accenturefederal.com dale.e.garrow.ctr@mail.mil
Michele Harlan	Bureau of Behavioral Health	michele.a.harlan@dhhs.state.nh.us
**Lindy Keller	Bureau of Drug and Alcohol Services	lskeller@dhhs.state.nh.us
James MacKay	N.H. House of Representatives	james.mackqy@mygait.com
Dan Potenza	Department of Correction	dpotenza@mhm-services.com
Jennifer Schirmer (eff. July 2015)	Department of Health & Human Services, Disaster Behavioral Health	jennifer.schirmer@dhhs.state.nh.us
**Sally Varney	Bureau of Elderly and Adult Services	svarney@dhhs.state.nh.us
Catrina Watson Vice Chair	N.H. Medical Society	catrina.watson@nhms.org
Roger Wells	Retired; family member	rockinrw@aol.com

**Executive Committee