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).

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**Introduction**

The 2011 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 2011:

- NH held its first Suicide Prevention Summit, bringing together over 100 key stakeholders to plan strategically around suicide prevention in NH.
- The 2011 Suicide Prevention Conference had its largest turnout in the history of the eight-year conference, with over 220 attendees.
- The Deployment Cycle Support Program – Care Coordination Program intervened successfully in 21 service members and family members who were at risk of suicide.
- **Connect** trainers led over 40 suicide prevention and postvention trainings across the state, with several second generation trainings also taking place.
- Survivors of suicide loss have had increasing involvement in statewide planning. An additional survivor support group was added in Manchester, which has the largest population base; and project evaluators recognized NH as having very engaged survivors who are actively involved in SP committees.
- The legislatively mandated Suicide Fatality Review Committee started holding its first meetings. Committee goals include determining trends, risk factors and prevention strategies, as well as identifying barriers to safety and gaps in system response.
- SPC Data and Media Committees have partnered together in sharing data with suicide prevention stakeholders in a way that addresses trends and longitudinal changes in suicide.

Many achievements will be described further throughout this report. What is critical to NH in the next few years is 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 would like to thank everyone who has been involved in suicide prevention and postvention efforts in our state.
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. *Connect’s* community-based approach 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). Designated by Governor Lynch as the state recipient of the federal Garrett Lee Smith Memorial Act funding through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), the *Connect* Program assists the Youth Suicide Prevention Assembly and the State Suicide Prevention Council with implementation and oversight of the NH’s Suicide Prevention Plan. *Connect* provides consultation, training, technical assistance, and information and referral regarding suicide prevention throughout the state. NH specific data, news and events, information and resources, and supports to survivors are provided on the *Connect* website at [www.theconnectprogram.org](http://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’s 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; Data Collection and Analysis; Military and Veterans; Professional Practice and Education; Public Policy; and Suicide Fatality Review.

As part of SB 390 legislatively establishing the Suicide Prevention Council, the Council must report on its progress, to both the Governor and the legislature, annually. 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 NH's youth and young adults between 10 and 24 years old. This is accomplished through a coordinated approach of providing service providers and communities with current information regarding best practices in suicide prevention and postvention strategies, and by promoting youth and young adult 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.

2011 Accomplishments of Suicide Prevention Efforts in NH

Many of our successful efforts are summarized here using the SPC Subcommittee activities and accomplishments. In NH, we pride ourselves on the public/private partnerships and the collaborative nature of our work that focuses more on the activities than on the actors.

State Suicide Prevention Council Subcommittees

Communications and Public Education
Chair: Rhonda Siegel – rsiegel@dhhs.state.nh.us

- Promoted the use of feature length films for public awareness and dialogue; screenings occurred throughout state (Ordinary People, Sensation of Sight, Helen, Prayers for Bobbie).
- Coordinated news stories on suicide prevention and mental health topics through the Public News Service (e.g. postpartum depression, theories of risk taking behavior, community suicide prevention coalitions, etc.).
- Monitored and responded to news stories across the state on suicide deaths; looking for adherence to media guidelines.
- Dispersed new, national media guidelines to contacts throughout the state.
- Hosted a media workshop at annual suicide prevention conference.
- Partnered with educators on providing classes on media guidelines for college journalism and English students.
- Added media focus at suicide prevention retreat (that included media attendance).
Data Collection and Analysis
Chair: Patrick Roberts – proberts@naminh.org

- Produced the Annual NH Suicide Prevention Data Report, which provides timely information and statistics on suicide deaths and attempts across all age groups in NH. Expanded the report to include new sources of data and provide greater information on individuals of all ages in NH.
- Developed a new data-reporting template for Suicide Prevention Council and sub-committee meetings.
- Convened representatives of key state programs and agencies to focus specifically on the issue of quality and accessibility of data.
- Tracked suicide deaths and attempts through collaboration with the Office of the Chief Medical Examiner (OCME), the NH National Guard, the NH Bureau of Behavioral Health, the Bureau of Emergency Management Services and the Northern New England Poison Center. Shared this information with the SPC and YSPA on a regular basis.

Military and Veterans
Co-Chairs: SFC Dale Garrow – dale.garrow@us.army.mil  
Loren Haberski – loren.haberski@va.gov

- Worked with the Office of Veterans Services in contacting all returning Veterans being discharged that reside in New Hampshire to assist them in understanding what benefits they are entitled to.
- Developed a letter and brochure that was mailed to every returning Veteran. This mailing also included sending a copy to the family of that Veteran. This brochure will also be distributed to Veteran Service Organizations, post offices, libraries and various community organizations to help get the word out to all Veterans in New Hampshire.
- Added representation from the survivor of suicide loss community and from Head Rest, the call center receiving all calls to the National Suicide Prevention Lifeline originating from within the state.
- Conducted Applied Suicide Intervention Skills Training (ASIST) workshops including community members to participate, enhancing their training and interaction with military personnel.
- Committee members presented at the NH Suicide Prevention Conference.
- Committee members provided Suicide Prevention Training for the VFW and the Ladies Auxiliary of the VFW at multiple locations throughout the state.

Professional Practice and Education
Co-Chairs: Elizabeth Fenner-Lukaitis – elizabethfl@dhhs.state.nh.us  
Betty Welch – bwelch@elliot-hs.org

- Conducted focus-group discussions and exploration of some of the issues raised by the survey results from over 200 licensed outpatient behavioral health professionals in the state.
- Synthesized the feedback into a cover page summary of the survey results.
- Distributed the survey to respondents, attendees of the Suicide Prevention Conference and posted on the Department of Health and Human Services and NAMI NH websites.
• Began collaboration with the Emergency Room Nurses Association to explore ways to partner to promote suicide prevention, assessment and intervention for individuals who may be at risk for suicide while in the Emergency Departments.

• Developed and distributed a survey to over three hundred members of this association

• Began discussions and partnership with the SPC Public Policy Subcommittee as to the feasibility of requirements for education on suicide, suicide risk and assessment, and suicide interventions.

On-going focus:
• Emergency Departments.
• Literature review on research regarding suicide prevention, intervention and training.

**Public Policy**
Co-Chairs: Linda Saunders Paquette – lpaquette@new-futures.org
Kevin Stevenson – kevin.stevenson@nhdoc.state.nh.us

• Public Policy took a hiatus during 2011 while members addressed the Medicaid Managed Care proposal. At the end of 2011, Public Policy committee was substantially reorganized. Linda Saunders Paquette, Executive Director of New Futures, and Kevin Stevenson, Administrator of the Secure Psychiatric Unit at the Department of Corrections, were designated as co-chairs of the committee. The co-chairs began the process of reviewing the committee’s work to date, assessing the priorities in the January 2010 Suicide Prevention Plan, reviewing plan priorities with the Suicide Prevention Leadership Council, and conducting outreach to previous subcommittee members.

• In 2012, the subcommittee intends to continue to conduct outreach to members, and identify potential new members with particular emphasis on including legislative members. Once membership is re-established, the committee will review its charter and priorities. It will develop a work plan that includes clear objectives in line with committee priorities, and will define measures to assess success in achieving objectives. Also, it is anticipated that the committee will develop a legislative tracking document to assist it in following legislation of interest during the upcoming legislative session.

**Suicide Fatality Review**
Chair: Diane Langley – dlangle@dhhs.state.nh.us
Vice Chair: Catrina Watson – Catrina.Watson@nhms.org

• Created a committee comprised of a multidisciplinary group of individuals. Have started to hold meetings and provide education/overview to the committee membership.

• The review of cases will be under the auspices of system improvement making any review a process that does not assign blame. The specifics of the case reviews will be confidential and the outcomes will be used solely as a learning experience to improve suicide prevention efforts.

*If you would like to join any of these Subcommittees, please contact the designated committee chair. The committee meeting schedule has been included on page 62 of this report.*

In addition to the work of the Suicide Prevention Council Subcommittees, there are many accomplishments by NAMI NH, SPC and YSPA members, along with other partnering organizations and local coalitions. These include:
The Youth Suicide Prevention Assembly (YSPA)

YSPA continued to review cases of confirmed suicides of youth in NH aged 24 and younger to look for trends and opportunities to increase prevention efforts. Along with a review of cases brought forward from the Office of Chief Medical Examiner, data reports from statewide Emergency Medical Services and New England Poison Control on suicide attempts in NH were also provided throughout the year. YSPA also assisted with the annual suicide prevention conference and discussed other statewide initiatives such as Department of Education promotion of training for schools in suicide prevention, postvention, bullying, and substance use prevention.

The YSPA meetings also offered educational presentations. The following topics that were presented during 2011 included: an overview of Transcranial Magnetic Stimulation; suicide prevention efforts at the NH Department of Corrections; and suicide prevention and postvention resources offered through Samaritans in Keene.

YSPA is an open monthly meeting that is attended by a diverse group of individuals including mental health, health care and social service providers, state representatives, individuals affected by suicide, law enforcement and emergency medical responders, school personnel, faith leaders, and many others. Participants note that as a result of the information shared and learned in YSPA many outcomes have resulted including changes in practice, such as including discussion of lethal means restriction into assessments and treatment services; an increased awareness of dangerous substances being utilized for self harm; expanded use of existing resources and programs within and beyond NH; mobilization of information and training to help schools, communities and individuals affected by a suicide; greater collaboration between services and providers and an increased understanding of social networking sites and their role in suicide prevention with youth.

The NH Suicide Survivor Network

Survivors of Suicide Loss

- NH Life Keeper Quilt displayed along with survivor of suicide loss resources at 35 events.
- Two new Survivors of Suicide Loss Bereavement groups were started in NH in the July of 2011, both in Manchester, NH. The Portsmouth Group is no longer meeting because of decreased attendance and the loss of one facilitator, but there are efforts to start a new seacoast group within the next year. The total number of survivor groups in NH is now 12-Concord, Exeter, Gorham, Hampstead, Keene area (2), Lebanon, Manchester (2), Greater Nashua, North Conway and Plymouth. Both North Country groups have had difficulty maintaining a steady membership and therefore meet as the need arises. Most other groups with the exception of Keene and Hampstead meet monthly. Keene and Hampstead meet weekly.
- The annual American Foundation for Suicide Prevention (AFSP) Survivors of Suicide Loss Day Teleconference on November 19th gathered approximately 125 survivors of suicide loss together in healing, support and understanding at nine sites throughout the state. Sites included Portsmouth, Manchester (2), Concord, North Conway, Merrimack, Littleton, Westmoreland, and Hampstead.
• Two Survivors of Suicide Loss Speaker trainings were held in Concord. The two-day public speaking trainings were held for survivors interested in telling their personal stories of suicide loss to educate the public and provide healing and support. Twenty-two survivor speaker presentations were made throughout the state in 2011.
• The annual 2011 NH Survivors of Suicide Loss newsletter was distributed throughout the state with 8,000 hard copies made available at trainings and health fairs as well as in public venues such as libraries, hospitals, healthcare, and mental health centers. In addition, the newsletter was distributed electronically to many email lists.
• The NH Survivors of Suicide Loss resource packet was updated and disseminated through the Office of the Chief Medical Examiner to the next of kin of all those who died by suicide. The book authored by a NH Survivor called “Healing the Hurt Spirit: Daily affirmations for people who have lost a loved one to suicide” continued to be available to new survivors and an online survey to solicit feedback on the folder and provide additional avenues to connect survivors to help was implemented.
• Six Survivors of Suicide Loss conference calls were held in 2011 and the number of attendees per call ranged from 1-7 per call. This gives survivors of suicide loss the opportunity to hear what is happening throughout the state and learn ways they can seek support and get involved. Survivor input on these calls was instrumental in guiding many of the projects in NH for survivors.
• Survivors of Suicide Loss are becoming more and more involved in advocacy and fundraising efforts for various local and national suicide prevention organizations and efforts. Some of these events included: the AFSP Out of The Darkness Community and Overnight Walks, the NAMI NH Walk, Nathan’s Ride, Paddlepower, Rails to Trails, Memorial Tree Lighting at The Mental Health Center of Greater Manchester, and Compassionate Friends.

Positive Outcomes and Testimonials

“[NAMI NH’s SurvivorVoices Speakers Bureau] helped me so much and now I can help others when I’m out there speaking. I can feel it in their eyes – it’s making an impact. Learning about safe messaging makes it easier to speak about my loss because I know where I should and shouldn’t go.”

Linda Mayo, SurvivorVoices Participant
State and Tribal Youth Suicide Prevention and Early Intervention Grant Program (Garrett Lee Smith Grant)

The State and Tribal Youth Suicide Prevention and Early Intervention Grant Program covers work supported by NAMI NH’s Connect Suicide Prevention Program, as well as several sub contractors including Headrest, North Country Health Consortium, Counseling On Access to Lethal Means (CALM) and Antioch University New England. The grant supports key aspects of the National Strategy for Suicide Prevention and strives to reduce suicide incidents by supporting the NH Suicide Prevention Council (SPC) to implement the NH State Suicide Prevention Plan (SSPP) and increase capacity on the individual, community and systems level for suicide prevention and postvention. The Connect suicide prevention program uses the ecological approach to work across systems and engage communities from the bottom up and top down simultaneously through a public health approach. The result is a comprehensive implementation of best practices through training, protocols, and collaboration.

Throughout the year the Connect Suicide Prevention staff continued providing support and technical assistance to the New Hampshire Suicide Prevention Council (SPC) and all its subcommittees, the Youth Suicide Prevention Assembly (YSPA), and all regional coalitions throughout the state. The work has also focused on community outreach, awareness presentations, trainings for multiple groups including high-risk populations and evaluation efforts. The overall approach in working with community stakeholders continues to be improving mental health care through early intervention and referral; building caring and culturally competent communities prepared to recognize the warning signs for suicide; changing attitudes and reducing stigma around mental illness, suicide, and help-seeking; and enhancing skills to respond to community needs after a suicide death. The project has five goals that guide the three-year work plan.

Goal #1: Promote implementation of the SSPP by providing technical assistance and consultation to the SPC. Connect partners with SPC through its six subcommittees to strengthen relationships across systems, educate policy leaders, and enhance suicide prevention education and awareness statewide.

Goal #2: Establish a statewide environment that improves the understanding and response capacity of systems to high risk youth by educating, training, and reducing stigma related to mental health/substance use disorders. Connect trains key service providers to address target populations: survivors of suicide loss, veterans/military personnel and families, GLBT (Gay, Lesbian, Bisexual, and Transgender) serving organizations, substance involved youth, youth in foster care and attempt survivors by training statewide leaders in respective fields utilizing Best Practice trainings in the Connect Program Assessing and Managing Suicide Risk and Counseling on Access to Lethal Means. Connect has disseminated media products annually promoting help-seeking behavior and the National Suicide Prevention Lifeline.
Goal #3: Strengthen the ability of regional coalitions and key stakeholders to recognize youth at risk, provide an integrated culturally-competent response, and connect them to appropriate resources by implementing the Connect National Best Practice suicide prevention, intervention and postvention program. Coos County is the northernmost part of the state. It is a rural community, isolated, economically depressed, with substance use and suicide rates that greatly exceed both the state and national averages. Connect works with regional coalitions and service providers in Coos County and elsewhere in NH to strengthen relationships in addressing target populations.

Goal #4: Improve the quality of New Hampshire’s suicide prevention, intervention and postvention activities by conducting local and cross site evaluation and enhancing the capacity of existing statewide data surveillance systems. Connect works with the SPC Data Committee to improve data collection, data analysis and reporting between systems so key decision makers can allocate resources based on objective information. Local and cross-site data will be used strategically to inform and improve project performance.

Goal #5: Promote sustainability of suicide prevention, intervention and postvention efforts in New Hampshire by implementing the NH State Suicide Prevention Plan. Connect is involved in: a. developing an educated leadership, b. strengthening public/private partnerships, c. expanding help-seeking efforts through public education, d. improving data monitoring and surveillance activities, e. improve statewide public policy. Evaluation guides all of the project activities.

2011 Target Area Accomplishments

Coos County
- The Connect program in collaboration with the North Country Health Consortium (NCHC) continues to provide community-wide suicide prevention and intervention efforts throughout Coos County, the top third of the state. At this point, over 400 community members from multiple disciplines have been trained in Connect Prevention and Intervention. NCHC and Connect staff provide technical support to both the North Country Suicide Prevention Coalition and the Coos County Coalition for Substance Abuse and Prevention, and has held both CALM and AMSR trainings. Technical assistance has been provided to local schools and agencies in the development of standard operating procedures. In year three, Connect and NCHC will continue with suicide prevention and intervention training to meet the continued need, and will offer train the trainer postvention trainings with key stakeholders. Efforts have been made to include this northernmost rural region in other aspects of statewide suicide prevention including a Coos County AFSP International Survivor Teleconference sites in Littleton and North Conway and a web conferencing location in Littleton to include North Country residents in the statewide NH Suicide Prevention Conference in November.
Youth in Foster Care
• Worked closely and partnered with the NH Department of Children, Youth and Families (DCYF) and Granite State College to provide two trainings specific to individuals working with foster and adoptive youth. A total of 19 participants representing new foster and adoptive parents and childcare staff of NH residential facilities were trained in suicide prevention and intervention.

Youth Engaged in Substance Abuse
• Collaborated with statewide substance abuse providing organizations to train staff on suicide prevention and intervention discipline specific protocols. A total of 82 participants were trained from the following agencies: Communities for Alcohol Drug Free Youth in Plymouth, Tri County CAP in Berlin, and Serenity Place in Manchester. Connect staff also had meetings and ongoing discussions between the NH Bureau of Behavioral Health and NH Bureau of Drug and Alcohol Services to discuss ways to improve collaboration through focus on co-occurring disorders and suicide prevention efforts for substance abuse prevention and treatment service providers.

Veterans/Military
• Two Connect trainings for military personnel - one in suicide prevention with the NH National Guard with 14 participants and one in suicide postvention with the Air Guard with 11 participants. Staff continues to play an active role within the NH military community by actively serving on the following committees: The SPC’s Military and Veterans sub-committee, The NH National Guard’s Health Promotion Council, the North Country Veteran’s Committee, and the planning committee for the North Country Veterans Conference. Connect Project Staff continued to provide technical assistance to the Care Coordinators working in the NH Deployment Cycle Support – Care Coordination Program of the NH National Guard and to the Veterans Administration regarding suicide postvention and the community’s response. Despite the Veterans Administration repeatedly needing to delay implementation of the NAMI Family to Family program due to a lack of space in their current facility and several delays in the planned opening of their new facility, Connect Program staff continued to build relationships within the VA to pave the way for implementation of this program as soon as the VA is ready.

LGBTQ
• Outreach to the Lesbian Gay Bisexual Transgender Queer community within New Hampshire continued and focused on building relationships and providing support, presentations and trainings. Staff held four trainings with a total of 28 participants. Presentations and trainings were provided to the following: LGBT Conference in North Country; Sexuality, Anti-Violence, Gender Equality (SAGE) Center at Plymouth State University; Diversity Institute; and Seacoast Outright LGBT support group facilitators.
Supports to individuals who have attempted suicide

- Increased awareness of risk and built capacity to respond to individuals who have attempted suicide throughout the state by providing trainings and support through Counseling on Access to Lethal Means (CALM) trainings and Assessing and Managing Suicide Risk (AMSR) trainings.
  - Provided five CALM trainings, a national best practice training, to the 55 participants as follows: staff at Lamprey Healthcare, a community health center; home healthcare providers in the seacoast area; emergency room department staff at Weeks Medical Center; attendees at the Emergency Room Nurses Association’s annual meeting; and staff at Genesis Behavioral Health Community Mental Health Center.
  - Provided four AMSR trainings to 82 mental health clinicians serving clients throughout the state. Trainings were offered in collaboration with Northern Human Services Community Mental Health Center, New Hampshire Hospital, and the Department of Health and Human Services.

Native Americans

- Continued outreach to the Native American community via Wijokadoak and the New Hampshire Intertribal Native American Council. Staff has engaged Wijokadoak leadership by providing mental health awareness and National Suicide Prevention Lifeline (NSPL) materials and participating in health tents.

Evaluation

Under current GLS funding, NAMI NH has participated in a multi-level evaluation. At a local level, NAMI NH has conducted pre/post-test surveys and/or training exit surveys for all GLS training activities in the state (i.e., Assessing and Managing Suicide Risk, CALM, and Connect Trainings funded under GLS). Additionally, NAMI NH, with the help of an evaluation team from Antioch University – New England has participated in a national cross-site evaluation, as well as a national evaluation of all GLS grantee sites.

Annual NH Suicide Prevention Conference

On November 4th, 2011 over 220 individuals gathered to learn and participate in NH suicide prevention efforts statewide at the 8th Annual Suicide Prevention Conference: Healing, Hope and Health. The State Suicide Prevention Council, NAMI NH, and the Youth Suicide Prevention Assembly partnered to present the Annual Suicide Prevention Conference which provided a variety of workshops addressing co-occurring disorders, the roles and responsibilities of crisis help-lines and perspectives from a suicide survivor as well as many others. National speakers such as Dr. Thomas Joiner and Robert Bryant presented their expertise and experience in the mental health field and addressing suicide. The annual conference has been increasingly growing in size and diversity of attendees, and continues to receive positive evaluation results.
Local Coalitions: Suicide Prevention at a Grassroots Level

Moultonborough Coalition for Suicide Prevention and Mental Health:
The Moultonborough Coalition for Suicide Prevention and Mental Health has had another positive year. The Town continues to financially support the work of the coalition especially as it relates to maintaining access to mental health services and suicide prevention in this rural community.

Among the activities this year were the following:
- Co sponsored a Grief During the Holidays seminar with Shirley Marcroft, Bereavement Coordinator for the Lakes Region.
- Hosted a postvention training for first responders, law enforcement, and medical and mental health providers in the Lakes Region.
- Distributed several grief packets to those residents or visitors who had lost loved ones to suicide.
- Provided Coalition representation at the Suicide Prevention Summit in Concord in May.
- Provided Coalition representation at the Press Conference in September.
- Distributed suicide prevention and additional coalition information to townspeople during town meeting in March.
- Continued to support mental health treatment at the local clinic to increase access to services for residents

We continue to meet monthly at the Town Library on the second Wednesday of the month 4PM-6PM. All are welcome. For more information feel free to contact Peter Whelley at ptw@sau45.org

North Country Suicide Prevention Coalition:
The North Country Suicide Prevention Coalition was formed in 2009 and has met monthly ever since bringing together community members, educators, hospitals, mental health providers, and survivors of suicide loss. The meetings provide a format for suicide prevention and postvention initiative planning in the North Country, offer support and guidance to certified Connect Trainers as they provide suicide prevention trainings in the community and build sustainability for suicide prevention by soliciting local input that best meet the needs of the region. Although coalition members see the need for the coalition to continue, the coalition has struggled with attendance in most part due to member’s decreasing availability caused by ever-demanding economic, work, and family pressures. In the Spring of 2011, the coalition members decided to change the meeting format to conference calls monthly and in-person meetings every quarter in an effort to increase attendance and availability to those who travel a distance to attend. This coalition covers the top third of the state and it was hoped that making the coalition meetings more accessible would increase attendance. The change in format has not affected the number of people attending but does seem to occasionally allow new people to join. The coalition sends out monthly minutes and consistently gets feedback that people do read them and are able to stay involved through this communication. Some highlights from 2011 include the following:
• increased the number of people trained in *Connect* Suicide Prevention in Coos county to over 1100;
• hosted of a North Country Suicide Prevention Conference remote site in Littleton;
• hosted an AFSP Survivor of Suicide Loss Teleconference in Littleton;
• training Colebrook Key Club youth as suicide prevention youth facilitators and together trained over 70 of their peers;
• Trained the majority of staff at Colebrook Academy and White Mountain Regional High School;
• Trained entire force of bus drivers at WW Berry who provide transportation to all north country schools;
• hosted a community event in the Fall where *Connect* evaluators from Antioch provided feedback and updates to the community on efforts to evaluate the referral network in Lancaster;
• hosted meetings with the public health network in NH to begin postvention training to key players.

The Coalition meets monthly and welcomes everyone. For more information, contact April Allin at aallin@nchcnh.org.

**Seacoast Suicide Prevention Coalition:**

The Seacoast Suicide Prevention Coalition continued to maximize the resources and training developed over the last few years. Through providers who had been trained in *Connect*, several suicide prevention trainings were conducted for social service agencies as well as a gatekeeper training for the community. The gatekeeper training was held at the Portsmouth Library and well attended by a diverse group of interested citizens. Local media were involved with the community training and followed up the training with an article.

Two volunteers who invested time in training to become facilitators started a support group for survivors of suicide loss in Portsmouth. The Coalition hosted a Portsmouth site for the annual Survivor of Suicide Teleconference, which was also well attended.

Coalition leaders attended many local meetings to raise awareness about suicide prevention and worked extensively to provide research and testimony to city and state officials to encourage the inclusion of barriers on the Memorial Bridge in Portsmouth during the planning process to rebuild the bridge.

The SSPC meets monthly on the 2\textsuperscript{nd} Wednesday of each month from 5PM-6PM at the Community Campus in Portsmouth, NH. Contact: Jaydecherico@gmail.com for more information.
State and National Attention on NH initiatives

**NH Office of Chief Medical Examiner**
During 2011, the state of NH benefited from the knowledge and expertise of members of the Office of Chief Medical Examiner in NH and that expertise was recognized elsewhere in the United States. Chief Medical Examiner Dr. Thomasom Andrew gave multiple presentations around the country related to suicides and “asphyxia games” that result in death of young people. Wayne DiGeronimo, one of the Assistant Deputy Medical Examiners, was awarded the Elaine Frank award at the annual NH Suicide Prevention Conference for his investigative work with suicides in NH. All of the Assistant Deputy Medical Examiners continue to gather valuable information at the scene of suicides, which inform NH’s suicide prevention efforts and data for case reviews at YSPA each month.

**NH Firearm Safety Project**
Reducing a suicidal person’s access to lethal means can be effective as part of a comprehensive prevention effort. The NH Firearm Safety Coalition – gun retailers and suicide prevention advocates – is focusing on firearms, the leading method of NH suicide deaths.

- In 2011, the group developed and mailed materials (available at [www.nhfsc.org](http://www.nhfsc.org)) to more than 65 gun shops statewide with two major messages:
  - For gun shop owners – avoiding sales to people seeking a gun for the purpose of suicide to other screening you already do. (Roughly one in ten firearm suicides in NH involve a recently-purchased or rented firearm.)
  - For customers - if you’re concerned that someone may be suicidal, offer to hold onto their guns and call the suicide helpline to learn other ways to get help.

- Evaluation efforts indicate that just about half the stores are using at least some of the materials. Two of the shops are so enthusiastic that they have joined the Coalition! The project is gaining national interest through conference and workshop presentations and national shooting sports magazines.

**National Recognition**
Several training programs developed in NH have been on the American Foundation for Suicide Prevention (AFSP)/Suicide Prevention Resource Center (SPRC) Best Practice Registry and have been transported to states across the country as well as countries outside of the U.S. Included in this are the Counseling on Access to Lethal Means (CALM) training which has since been converted to an on-line training and made available through the Suicide Prevention Resource Center ([www.sprc.org](http://www.sprc.org)). The CALM program has been presented and adopted by states around the country.

The *Connect* Suicide Prevention and Postvention program also continue to expand its geographical reach with trainings and workshops occurring in multiple states, regions across the U.S and Canada as well as a presence in Ireland and Scotland. The *Connect* program has received growing interest from native populations and staff from *Connect* led workshops at several national tribal conferences as well as a training of trainers in postvention for native Alaskan communities. Survivor Voices, a NAMI NH program designed to offer a safe and structured way to tell the story of loss to suicide was added to the national AFSP/SPRC Best Practice Registry in 2011.
The Connect Program was awarded recognition as a Service To Science recipient under the Collaborative for the Application of Prevention Technologies (CAPT) for technical assistance and resources to further efforts around the relationship of substance abuse, mental illness and suicide risk. These critical factors in suicide prevention will be part of further collaboration between systems and educational efforts in NH.

The Rand Report on Military Suicide “The War Within” commissioned by the Department of Defense recognized the Connect Program’s contribution to military suicide prevention by specifically referencing Connect in one of the reports 14 recommendations citing the model postvention program developed by NAMI NH in collaboration with the NH National Guard.

Several staff from NAMI NH were involved on several national committees including the National Suicide Prevention Lifeline, the national Action Alliance and revisions media recommendations for reporting on suicide. Connect staff were also asked to review and provide feedback on the draft for the revisions to the National Strategy for Suicide Prevention.

Representatives from NH’s Firearm Safety Coalition’s gave presentations on the Gun Shop Project at the national American Association of Suicidology.

Other Education and Training Initiatives in NH
In addition to the training and educational resources made possible in NH through the Garrett Lee Smith federal grant, NAMI NH provided suicide prevention and postvention training, education and resources through the support of the NH Department of Health and Human Services’ Bureau of Behavioral Health, the NH Department of Education, and Police Standards and Training Academy.

Hundreds of recipients of suicide prevention and postvention training included faith leaders, social service providers, staff in mental health and health care fields, school, military and law enforcement personnel. Multiple schools received funding through the Department of Education to carry out training and planning in their districts and regions to implement best practices and protocols for a comprehensive and effective response to a suicide incident. Several schools, organizations and individuals were able to benefit from technical assistance and resources after a suicide death occurred to help ease the impact of this tragedy and reduce the potential of further risk. Many people who were trained as Connect trainers proceeded to carry forward Connect Suicide Prevention and Postvention trainings in their schools, communities, and organizations, further expanding information, best practices and capacity for suicide prevention.

There was a noted increase in request for support by individuals, businesses, schools and communities in the aftermath of a suicide, demonstrating an awareness of resources and the necessity of taking action after a suicide to reduce the risk of contagion and promote healing. With the support of state and federal funding, outreach and resources were extended to individuals, communities, and organizations in NH who were impacted by suicide.
Introduction

The data presented in this report is the result of the collaborative efforts of a variety of organizations and people. The data was 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 two 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 16 years and first created this report format in 2003. The SPC has been analyzing and planning for data capacity improvements for the last 4 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/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. All of that said, we acknowledge that the numbers referred to here 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. Another 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, so the time periods covered are also indicated.
What’s New in this Year’s Report?

Some of the new highlights to the report this year include:
- Updated hospital and emergency department discharge data.
- An expanded section on NH data from the Behavioral Risk Factor Surveillance System (BRFSS).
- 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.

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. New Hampshire is a small state, with just over 1.3 million residents (US Census, 2011). Overall, NH is relatively homogeneous in terms of race/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 3rd highest and 9th highest rates of usage respectively. NH is also the state with the 6th highest rate of reported major depressive episodes.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>93.9%</td>
<td>72.4%</td>
</tr>
<tr>
<td>Black</td>
<td>1.1%</td>
<td>12.6%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>0.2%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Persons Reporting Two or More Races</td>
<td>1.6%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Persons of Hispanic or Latino Origin</td>
<td>2.8%</td>
<td>16.3%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau 2010
Figure 1
NH and US Race/Ethnicity

Source: US Census Bureau 2010

Table 2

<table>
<thead>
<tr>
<th>Age</th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>22.5%</td>
<td>24.4%</td>
</tr>
<tr>
<td>18 to 24</td>
<td>9.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>25 to 44</td>
<td>25.6%</td>
<td>27.1%</td>
</tr>
<tr>
<td>45 to 64</td>
<td>29.6%</td>
<td>25.9%</td>
</tr>
<tr>
<td>65 to 74</td>
<td>6.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>75 and Up</td>
<td>6.1%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau American Community Survey 2010

Table 3

<table>
<thead>
<tr>
<th>Economic Factors</th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed Residents</td>
<td>7.8%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Persons Below Poverty Level</td>
<td>8.3%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Persons Without Health Insurance</td>
<td>11.1%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Per Capita Income (Yearly)</td>
<td>$30,949</td>
<td>$26,059</td>
</tr>
<tr>
<td>Median Household Income</td>
<td>$61,042</td>
<td>$50,046</td>
</tr>
<tr>
<td>Homeownership Rate</td>
<td>74.9%</td>
<td>66.9%</td>
</tr>
<tr>
<td>Median Home Value</td>
<td>$243,000</td>
<td>$179,900</td>
</tr>
</tbody>
</table>

Sources: US Census Bureau American Community Survey 2010
Table 4

**Education – population age 25 and older**

<table>
<thead>
<tr>
<th></th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than High School Graduate</td>
<td>8.5%</td>
<td>14.4%</td>
</tr>
<tr>
<td>High School Graduate or Associates Degree</td>
<td>58.7%</td>
<td>57.4%</td>
</tr>
<tr>
<td>Bachelors Degree or Higher</td>
<td>32.8%</td>
<td>28.1%</td>
</tr>
</tbody>
</table>

Source: US Census Bureau American Community Survey 2010

Table 5

**Substance Use – Individuals Age 12 and Up**

<table>
<thead>
<tr>
<th></th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illicit Drug Use – Past Month</td>
<td>11.2%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Alcohol Use – Past Month</td>
<td>63.9%</td>
<td>51.8%</td>
</tr>
<tr>
<td>Tobacco Use – Past Month</td>
<td>28.1%</td>
<td>28.0%</td>
</tr>
</tbody>
</table>

Source: National Survey on Drug Use and Health, 2009

Table 6

**Mental Health Indicators – Individuals Age 18 and Up**

<table>
<thead>
<tr>
<th></th>
<th>New Hampshire</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Mental Illness – Past Year</td>
<td>4.6%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Major Depressive Episode – Past Year</td>
<td>7.6%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Had Thoughts of Suicide – Past Year</td>
<td>3.4%</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

Source: National Survey on Drug Use and Health, 2009

The Big Picture: Suicide in NH and Nationally

The Tables and Figures below depict various suicide related data. Some are specific to NH whiles 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, there have been no statistically significant differences from one year to the next during the ten-year period. 2010 is the first year in recent history where there has been a statistically significant difference compared to any other year. The 2010 and 2011 suicide rates are significantly greater than the rates for 2000, 2002, and 2004. Until 2010 data are released by the CDC in late 2012 or 2013 we are unable to conclude whether this is a trend that is consistent with what is occurring nationally.
Table 7 displays the 10 leading causes of death for people of different age groups in NH. From 2005-2009, suicide among those aged 15-24 was the second leading cause of death for NH compared to the third leading cause nationally. For individuals age 25-34, it was the second leading cause of death both in NH and nationally. Suicide rates for 2005-2009 were behind only deaths due to unintentional injury, primarily motor vehicle crashes in NH within these age groups. Suicide among all ages was the 10th leading cause of death for NH, but not among the 10 leading causes of death nationally.
### Table 7


<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital Anomalies</td>
<td>Malformations</td>
<td>Unintentional Injury</td>
<td>Unintentional Injury</td>
<td>Unintentional Injury</td>
<td>Unintentional Injury</td>
<td>Malignant Neoplasms</td>
<td>Malignant Neoplasms</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>2</td>
<td>Short Gestation</td>
<td>Unintentional Injury</td>
<td>Malformations</td>
<td>Malformations</td>
<td>Malformations</td>
<td>Malformations</td>
<td>Malformations</td>
<td>Malformations</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Malignant Neoplasms</td>
</tr>
<tr>
<td>3</td>
<td>SIDS</td>
<td>Benign Neoplasms</td>
<td>Congenital Anomalies</td>
<td>Congenital Anomalies</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Chronic Low, Respiratory Disease</td>
<td>Chronic Low, Respiratory Disease</td>
<td>Chronic Low, Respiratory Disease</td>
</tr>
<tr>
<td>4</td>
<td>Maternal Pregnancy Comp.</td>
<td>Congenital Anomalies</td>
<td>Homicide</td>
<td>Congenital Anomalies</td>
<td>Congenital Anomalies</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Heart Disease</td>
<td>Unintentional Injury</td>
</tr>
<tr>
<td>5</td>
<td>Placental Cord Membranes</td>
<td>Septicemia</td>
<td>Influenza &amp; Pneumonia</td>
<td>Heart Disease</td>
<td>Homicide</td>
<td>Homicide</td>
<td>Diabetes Mellitus</td>
<td>Liver Disease</td>
<td>Diabetes Mellitus</td>
<td>Alzheimer's Disease</td>
<td>Unintentional Injury</td>
</tr>
<tr>
<td>6</td>
<td>Respiratory Distress</td>
<td>Six Tied</td>
<td>Homicide</td>
<td>Congenital Anomalies</td>
<td>Congenital Anomalies</td>
<td>Liver Disease</td>
<td>Liver Disease</td>
<td>Liver Disease</td>
<td>Diabetes Mellitus</td>
<td>Diabetes Mellitus</td>
<td>Alzheimer's Disease</td>
</tr>
<tr>
<td>7</td>
<td>Atelectasis</td>
<td>Six Tied</td>
<td>Pulmonary Period</td>
<td>Benign Neoplasms</td>
<td>Complicated Pregnancy</td>
<td>Cerebrovascular</td>
<td>Chronic Low, Respiratory Disease</td>
<td>Cerebrovascular</td>
<td>Influenza &amp; Pneumonia</td>
<td>Diabetes Mellitus</td>
<td>Influenza &amp; Pneumonia</td>
</tr>
<tr>
<td>8</td>
<td>Unintentional Injury</td>
<td>Six Tied</td>
<td>Five Tied</td>
<td>Complicated Pregnancy</td>
<td>Diabetes Mellitus</td>
<td>HIV</td>
<td>Cerebrovascular</td>
<td>Suicide</td>
<td>Unintentional Injury</td>
<td>Influenza &amp; Pneumonia</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Neonatal Hemorrhage</td>
<td>Six Tied</td>
<td>Five Tied</td>
<td>Cerebrovascular</td>
<td>HIV</td>
<td>Homicide</td>
<td>Viral Hepatitis</td>
<td>Septicemia</td>
<td>Nephritis</td>
<td>Nephritis</td>
<td>Parkinson's Disease</td>
</tr>
<tr>
<td>10</td>
<td>Circulatory System Disease</td>
<td>Six Tied</td>
<td>Five Tied</td>
<td>Influenza &amp; Pneumonia</td>
<td>Pneumonitis</td>
<td>Congenital Anomalies</td>
<td>Septicemia</td>
<td>Nephritis</td>
<td>Suicide</td>
<td>816</td>
<td></td>
</tr>
</tbody>
</table>

*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 9 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, 2005-2009

<table>
<thead>
<tr>
<th></th>
<th>ALL AGES</th>
<th>YOUTH AND YOUNG ADULTS 10-24</th>
<th>YOUTH 10-17</th>
<th>YOUNG ADULTS 18-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH</td>
<td>12.41</td>
<td>6.28</td>
<td>2.51</td>
<td>10.54</td>
</tr>
<tr>
<td>US</td>
<td>11.51</td>
<td>7.09</td>
<td>2.90</td>
<td>11.75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>AGES 25 TO 39</th>
<th>AGES 40 TO 59</th>
<th>AGES 60 TO 74</th>
<th>OVER 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH</td>
<td>14.09</td>
<td>18.48</td>
<td>14.96</td>
<td>15.73</td>
</tr>
<tr>
<td>US</td>
<td>13.40</td>
<td>17.21</td>
<td>13.61</td>
<td>16.10</td>
</tr>
</tbody>
</table>

Source: CDC WISQARS

Adults age 40 to 59 had the highest suicide rates of all age groups identified above (18.48 NH, 17.21 US) from 2005-2009 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 2002-2011, 195 NH youth and young adults aged 10-24 have lost their lives to suicide. Table 9 (pg. 26) depicts the most up-to-date information about these youth and young adults as reported by the OCME in NH and collected/aggregated by YSPA. Males are much more likely to die by suicide in NH (82%) and nationwide. Hanging is the method used in 46% of youth and young adults suicide deaths in NH, followed closely by 42% who use firearms. Nationally, a greater proportion of youth and young adults who die by suicide use firearms. From 2002 to 2006 a decreasing trend among youth suicide deaths was noted. This trend reversed in 2007. The decrease in suicide deaths among youth and young adults from 2002 to 2006 was accompanied by an increase in drug-related deaths. This increase in drug-related deaths represents a disturbing level of increased risk taking. Most of these deaths are ruled accidental unless there is direct evidence of suicide intent. Refer to pages 41-42 for more information on related deaths in NH.
Please note that Table 9 is based on OCME data. “Hanging/Asphyxiation” refers to all forms of suffocation (e.g. hanging, bag over the head) 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 19).

---

**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 spoke about the fact 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 Suicide Death Trend, by Gender, Age Group and Method, 2002-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>≤ 19</th>
<th>20-24</th>
<th>Firearms</th>
<th>Hanging/Asphyxiation</th>
<th>Drugs/Poison</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>24</td>
<td>20</td>
<td>4</td>
<td>14</td>
<td>10</td>
<td>8</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2003</td>
<td>22</td>
<td>17</td>
<td>5</td>
<td>9</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2004</td>
<td>19</td>
<td>15</td>
<td>4</td>
<td>8</td>
<td>11</td>
<td>6</td>
<td>13</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2005</td>
<td>17</td>
<td>15</td>
<td>2</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>6</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>2006</td>
<td>12</td>
<td>10</td>
<td>2</td>
<td>1</td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2002-2006 Sub Total</td>
<td>94</td>
<td>77</td>
<td>17</td>
<td>40</td>
<td>54</td>
<td>38</td>
<td>44</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Percent of Sub-Total</td>
<td>100%</td>
<td>82%</td>
<td>18%</td>
<td>43%</td>
<td>57%</td>
<td>40%</td>
<td>47%</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>2007</td>
<td>13</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>10</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2008</td>
<td>15</td>
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<td>5</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>9</td>
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<td>2009</td>
<td>20</td>
<td>18</td>
<td>2</td>
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<td>2010</td>
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<td>13</td>
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<td>0</td>
</tr>
<tr>
<td>2011</td>
<td>29</td>
<td>23</td>
<td>6</td>
<td>9</td>
<td>20</td>
<td>10</td>
<td>15</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2007-2011 Sub Total</td>
<td>101</td>
<td>82</td>
<td>19</td>
<td>41</td>
<td>60</td>
<td>43</td>
<td>46</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Percent of Sub-Total</td>
<td>100%</td>
<td>81%</td>
<td>19%</td>
<td>41%</td>
<td>59%</td>
<td>43%</td>
<td>46%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>159</td>
<td>36</td>
<td>81</td>
<td>114</td>
<td>81</td>
<td>90</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Percent of Total</td>
<td>100%</td>
<td>82%</td>
<td>18%</td>
<td>42%</td>
<td>58%</td>
<td>42%</td>
<td>46%</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Produced by: NAMI NH
Data Source: NH OCME
Figure 3
NH Youth, Ages 10-24, Suicide Deaths

![Graph showing New Hampshire Youth Suicides from 2002 to 2011.
Data Source: Office of the Chief Medical Examiner, NH](image)

Figure 4
NH Male Youth Suicide Deaths Decrease then Increase 2002-2011,
While Female Youth Rates have Remained Relatively Stable

![Graph showing New Hampshire Youth Suicides from 2002 to 2011 by Gender.
Data Source: Office of the Chief Medical Examiner, NH](image)
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 cover a shorter period of time than the data for youth because tracking all ages through the OCME is a more recent state initiative. The number of deaths by year has been plotted in Figure 5 (pg. 29) and Figure 6 (pg. 29). At this time there are not enough years of data available to identify possible trends for individuals of all ages.

Produced by: NAMI NH

Table 10
NH All Ages Suicide Death Trend, by Gender, Age Group and Method, 2007-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
<th>≤ 24</th>
<th>25-44</th>
<th>45-64</th>
<th>65+</th>
<th>Firearms</th>
<th>Hanging/Asphyxiation</th>
<th>Drugs/Poison</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>150</td>
<td>115</td>
<td>35</td>
<td>13*</td>
<td>47</td>
<td>68</td>
<td>22</td>
<td>69</td>
<td>31</td>
<td>28</td>
<td>22</td>
</tr>
<tr>
<td>2008</td>
<td>175</td>
<td>135</td>
<td>40</td>
<td>15</td>
<td>64</td>
<td>66</td>
<td>30</td>
<td>86</td>
<td>42</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>2009</td>
<td>167</td>
<td>136</td>
<td>31</td>
<td>20</td>
<td>51</td>
<td>73</td>
<td>23</td>
<td>80</td>
<td>48</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>2010</td>
<td>206</td>
<td>159</td>
<td>47</td>
<td>24</td>
<td>56</td>
<td>89</td>
<td>37</td>
<td>103</td>
<td>49</td>
<td>40</td>
<td>14</td>
</tr>
<tr>
<td>2011</td>
<td>200</td>
<td>162</td>
<td>38</td>
<td>29</td>
<td>49</td>
<td>98</td>
<td>24</td>
<td>77</td>
<td>61</td>
<td>37</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>898</td>
<td>707</td>
<td>191</td>
<td>101</td>
<td>267</td>
<td>394</td>
<td>136</td>
<td>415</td>
<td>231</td>
<td>156</td>
<td>96</td>
</tr>
<tr>
<td>Percent of Total</td>
<td>100%</td>
<td>79%</td>
<td>21%</td>
<td>11%</td>
<td>30%</td>
<td>44%</td>
<td>15%</td>
<td>46%</td>
<td>26%</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Data Source: NH OCME
Figure 5
NH Residents, All Ages, Suicide Deaths 2007 - 2011

New Hampshire All Ages Suicides: 2007 to 2011
Data Source: Office of the Chief Medical Examiner, NH

Figure 6
NH Male and Female Suicide Rates 2007 – 2011

New Hampshire All Ages Suicides: 2007 to 2011 by Gender
Data Source: Office of the Chief Medical Examiner, NH
Figure 7 (below) and Figure 8 (pg. 31), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and gender from 2005-2009. 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 80, followed by males in their 70’s and early 50’s.

Figure 7
The highest numbers of suicides are seen in males and females in the 40 and 50 year-old age groups.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 to 14</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>15 to 19</td>
<td>12</td>
<td>43</td>
</tr>
<tr>
<td>20 to 24</td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td>25 to 29</td>
<td>15</td>
<td>38</td>
</tr>
<tr>
<td>30 to 34</td>
<td>24</td>
<td>51</td>
</tr>
<tr>
<td>35 to 39</td>
<td>29</td>
<td>78</td>
</tr>
<tr>
<td>40 to 44</td>
<td>19</td>
<td>75</td>
</tr>
<tr>
<td>45 to 49</td>
<td>14</td>
<td>83</td>
</tr>
<tr>
<td>50 to 54</td>
<td>43</td>
<td>59</td>
</tr>
<tr>
<td>55 to 59</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>60 to 64</td>
<td>30</td>
<td>83</td>
</tr>
<tr>
<td>65 to 69</td>
<td>17</td>
<td>59</td>
</tr>
<tr>
<td>70 to 74</td>
<td>25</td>
<td>43</td>
</tr>
<tr>
<td>75 to 79</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>80 to 84</td>
<td>16</td>
<td>30</td>
</tr>
<tr>
<td>85 and up</td>
<td>14</td>
<td>17</td>
</tr>
</tbody>
</table>

*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, male elderly suicide rates increase substantially at 80-84 years compared to the younger age groups, indicating another vulnerable time of life for men.
Male NH residents over age 80 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 and 15-19 to 20-24.

Figure 8

The numbers and rates of suicide in NH are not evenly distributed throughout the state. Figure 9 (pg. 32) shows youth and young adult suicide rates by county in NH. Figure 10 (pg. 32) 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 did have a significantly higher suicide rate than Rockingham County, as well as the NH and the US overall rates (NH: 12.3 per 100,000; US: 11.8 per 100,000). County limits are neither soundproof nor absolute. A suicide that occurs in one county can have a strong affect on neighboring counties, as well as across the state, due to the mobility of residents. Figure 11 (pg. 33) presents the suicide rates for all ages from 2004 to 2008 as a NH map broken down by county.

Geographic Distribution of Suicide in NH

The numbers and rates of suicide in NH are not evenly distributed throughout the state. Figure 9 (pg. 32) shows youth and young adult suicide rates by county in NH. Figure 10 (pg. 32) 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 did have a significantly higher suicide rate than Rockingham County, as well as the NH and the US overall rates (NH: 12.3 per 100,000; US: 11.8 per 100,000). County limits are neither soundproof nor absolute. A suicide that occurs in one county can have a strong affect on neighboring counties, as well as across the state, due to the mobility of residents. Figure 11 (pg. 33) presents the suicide rates for all ages from 2004 to 2008 as a NH map broken down by county.

*Note: Beginning with 2008 data, the CDC has suppressed state-level counts/rates for categories with fewer than ten deaths*
**Figure 9**

New Hampshire Youth Suicide Crude Death Rates by County
Ages 10-24 2002-2011
Data Source: Office of Chief Medical Examiner, NH

**Figure 10**

New Hampshire Resident Suicide Crude Death Rates by County
All Ages 2007-2011
Data Source: Office of Chief Medical Examiner, NH

*US Rate is only through 2009
Source: CDC WISQARS
Figure 11
Map of NH suicide death rates

New Hampshire Suicide Death Rates, 2004-2008
Age-adjusted Death Rates per 100,000 Population
Annual Age-Adjusted Rate for New Hampshire: 11.4

Legend
Suicide Rate by NH County
Groupings
- 10.1-10.9
- 11.0-13.9
- 14.0-14.9
- 15.0-17.9

Source: NH Department of State, Bureau of Vital Records, Death Certificate Data
Produced by: NH Injury Surveillance Program, NH DHHS, Injury Prevention Center at Dartmouth College
Suicide Behavior in NH: Gender Differences - Attempts and Deaths

Youth and Gender

While males represent nearly 80% of the youth and young adult suicides from 2005-2009, the fact that males die by suicide at a higher rate than females may largely be due to males using more lethal means. In fact, females attempt suicide at a higher rate than males do. See Figures 12 (below) and 13 (pg. 35). When examining how many NH youth and young adults were hospitalized and then discharged for self-inflicted injuries from 2004-2008, it is shown that 64% of the 929 inpatient discharges represent females, while only 36% represent males. Likewise, the 2011 NH Youth Risk Behavior Survey (YRBS) reports approximately 1.6 times as many female youth attempt suicide as males each year (7.5% of females and 4.8% of males). Emergency department (ED/ambulatory) data reveals the same gender ratio, based on self-inflicted injury rates.¹

Figure 12
Three times more male than female NH residents ages 10-24 died by suicide 2005-2009.

1 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.
Three times more male than female NH residents of all ages died by suicide 2005-2009.

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 – approximately twice as often (Figure 14 and Figure 15 – pg. 36). This report refers to two types of hospital discharge data; Emergency Department Discharges and Inpatient Discharges. Emergency Department (ED) data includes patients who came to the ED and stayed at the hospital for less than 24 hours. This is 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.
A greater percentage of female than male NH residents ages 10-24 attempted suicide, as seen in inpatient self-inflicted injuries 2004-2008.

**Figure 14**

A greater percentage of female than male NH residents ages 10-24 attempted suicide, as seen in ambulatory self-inflicted injuries 2004-2008.

**Figure 15**

A greater percentage of female than male NH residents ages 10-24 attempted suicide, as seen in ambulatory self-inflicted injuries 2004-2008.
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 disorders\textsuperscript{2}. Yet a much smaller percentage were receiving treatment. In NH, approximately 1 out of every 84 residents received treatment at a Community Mental Health Center (CMHC) for depression during 2010. Of those individuals in treatment for depression, approximately 2/3 of them were female and 1/3 were male. This is illustrated in Figure 16 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.

Cases 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. In an average year there are approximately 2,342 admissions to New Hampshire Hospital (Estimates based on New Hampshire Hospital admissions for fiscal years 2010 and 2011). 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 47% females and 53% 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.


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**Positive Outcomes and Testimonials**

NH’s Oldest & Largest Firearms Retailer:

I became interested in suicide prevention in quite a dramatic way. In a very short period of time several years ago, I became aware of several suicides utilizing firearms as a means. At the same time, I was invited to join an effort to examine the problem and possibly develop solutions with the NH Firearms Safety Coalition and a project known as the Gun Shop Project.

As firearms retailers, we do have a social responsibility to simply do the right thing in matters of our consumers and the potential for suicide.

To this end, I believe the project to be most worthy of our efforts. I believe, even though it is difficult to measure, we have been immensely successful.

Ralph Demicco
Owners, Rileys Sport Shop Inc.
Figure 16
Individuals receiving treatment for depression at NH CMHCs presented by age and gender.³

![Individuals in Treatment at NH CMHC's for Depression: 2009 - 2011 - Presented By Age and Gender Data Source: NH Bureau of Behavioral Health](chart)

Age, Gender and Self-inflicted Injury

When 2003-2007 rates of 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 17 and 18 – pg. 39). 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, have a greater rate of self-inflicted injuries. For those females aged 15-19, the rate of those being discharged from inpatient care (Figure 17) is close to 150/100,000, 2+ times the rate for males of the same age. The peak age for males is between 30 and 34 for self-inflicted injuries requiring hospitalizations. Again, ED usage rates, depicted in Figure 18, point to females aged 15-19 having a rate close to 150/100,000.

³ These numbers include all individuals with a primary or secondary diagnosis of depression.

---

**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
15-19 as a population particularly vulnerable to self-injury and/or suicide attempts, with a rate over 760/100,000, about 172 times the suicide death rate for this population. Males also peak in self-injury in this age group, though their rates are much lower. Also of note, the total number of youth and young adult ED visits (5,217) is 4.9 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 transition from middle adolescence to late adolescence/early adulthood is a time of great risk for suicidal thinking, self-harm and suicide attempts.

**Figure 17**

NH female residents ages 25-29 and 35-39 show the highest rates of suicide attempts, higher than males of any age group.

**Figure 18**

NH female residents ages 15-19 show the highest rates of suicide attempts, but male rates also peak at this age.
According to inpatient admissions/discharges and ED/ambulatory use data across all ages in NH, there are approximately 18 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 self-injury data, it is estimated that well over 400 youth and young adults attempt suicide each year in NH.

However the above data, which is based on cases where medical intervention is required, is contrasted by the results of the YRBS. In 2011, approximately 6 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 nearly 3,800 high school age youth in NH who may attempt suicide each year. The YRBS reports may account for some 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 never sought help or disclosed the attempt to any adult.

While the great majority of self-inflicted injuries are not fatal, because of the larger incidence, they affect a substantially greater number of people than do fatalities, directly and indirectly. In fact, 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). 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.

**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 2005 and 2009, 50% used firearms compared to 26% of females (Figure 19 – pg. 41). This gender disparity in firearm use becomes even greater as residents enter their late 20’s, 30’s, and 40’s. Male rates remain relatively constant, while the proportion of female deaths from firearms decreases slightly.

Suicide attempt methods have varying lethality. Figure 20 (pg. 42) compares firearms, hanging, poisoning, and cutting/piercing in terms of the percentage of various outcomes (emergency department visit, inpatient admission, death) for each method. Over 80% of self-injuries using a firearm result in death (Figure 20). 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 and those who are impulsive. Firearms remain the most commonly used method of suicide throughout the lifespan in NH. In fact, the percentage of suicide deaths due to a firearm increases to almost 70% for those ages 60+.

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4 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.
use of suffocation as a suicide method peaks in early adolescence, and decreases steadily throughout the lifespan (Figure 21 – pg. 42).

**Figure 19**
Variation in Method of Completed Suicide Deaths by Gender and Age Group, 2005-2009.

Method Used in Completed Suicides, 2005-2009

Data Source: CDC WISQARS
Suicide methods used in NH vary by age group, as seen in 2005-2009.

**Figure 20**

Lethality of Means Used for Suicidal Behavior in NH - Count, 2004-2008

Data Source: Injury Surveillance Program, NH DHHS

<table>
<thead>
<tr>
<th></th>
<th>Firearm</th>
<th>Suffocation</th>
<th>Poisoning</th>
<th>Cut/pierce</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpt Disch</td>
<td>24</td>
<td>33</td>
<td>3666</td>
<td>333</td>
<td>171</td>
</tr>
<tr>
<td>ED Disch</td>
<td>39</td>
<td>153</td>
<td>4936</td>
<td>3238</td>
<td>1509</td>
</tr>
<tr>
<td>Deaths</td>
<td>357</td>
<td>186</td>
<td>185</td>
<td>23</td>
<td>31</td>
</tr>
</tbody>
</table>

**Figure 21**

Suicide methods used in NH vary by age group, as seen in 2005-2009.
Poisoning is the most frequent method of suicide attempt, as seen in hospital discharge data 2004-2008.

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 22 – above). Figure 23 (pg. 44) 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 2007 through 2011 have been benzodiazepines and antidepressants.\(^5\)

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\(^5\) 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.
Benzodiazepines and Antidepressants have been the top substances used in suspected NH suicide attempts from 2007-2011.

**Figure 23**

As seen in **Figure 24** below, the accidental poisoning/drug-related death rates in NH and the US as a whole have steadily increased from 2000 to 2009. During this time the US rate has nearly doubled, while the NH rate has nearly tripled. Although it is not possible to determine an exact number, it is likely that these accidental poisoning/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/drug-related suicide deaths, and as a potential indicator of increased risk taking behavior.
Poisoning/Drug-related death rates in NH have nearly tripled from 2000 to 2009

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 NH Firearm Safety Coalition, Connect and the CALM Project. 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 and poisons. However, these reductions and the accompanying overall decline in suicide deaths suggest that when access to a highly lethal means is reduced, there is little “means substitution” (seeking a different method of killing oneself).

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 this state and nationally. In 2011, there were approximately 1,134,000 calls made to the NSPL. 2,770 of these calls, or roughly 230 per month were received by the NH
NSPL call center (see Figure 25 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 25**

NH NSPL call center responds to an average of 230 calls per month.

![Calls Volume for the NH NSPL Call Center 2009-2011](image)

**Costs of Suicide and Suicidal Behavior**

There were between 22,879 and 30,627 years of potential life lost to suicide from 2005-2009 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 $2.2 billion in health care costs in 2005. This does not include the costs associated with mental health services on an inpatient or outpatient basis (CDC WISQARS, 2005). In NH, suicide deaths where the individual received treatment in a hospital or emergency department and subsequently died resulted in an estimated $379,000 in medical expenses in 2005 (CDC WISQARS, 2005). Harder to measure is the cost to employers of lower or lost productivity due to suicidal behavior by employees or their loved ones.
Additional Data Sources

NH Baseline Survey on Attitudes

In 2006, YSPA, SPC and NAMI NH Connect collaborated with the UNH Survey Center on a survey of NH residents about their attitudes toward suicide prevention and mental illness. The survey included 500 NH households representative of the state as a whole. The survey was repeated in 2008 to determine if there had been any change in public perception. In fact, no statistically significant differences were found between the answers given in the Spring 2006 Granite State Poll and the Fall 2008 Granite State Poll. The 2008 results are summarized below:

- Three-quarters of NH adults (75%) agree suicide is preventable (45% strongly and 30% somewhat), 6% are neutral, 9% somewhat disagree, 6% strongly disagree and 5% do not know.
- NH adults 18 to 29 years old, who have never been married, and who have lived in NH for less than 2 years or 6 to 10 years are most likely to agree that suicide is preventable.
- Most NH adults (90%) agree that mental healthcare is useful for those who might be thinking about, threatening or had attempted suicide (73% strongly and 17% somewhat), 3% are neutral, 2% somewhat disagree, 2% strongly disagree, and 3% do not know.
- Only about one in ten NH adults (12%) agree they would feel uncomfortable getting mental health care because of what some people might think if they found out (5% strongly and 7% somewhat), 4% are neutral, 15% somewhat disagree, 68% strongly disagree, and 2% do not know.
- A substantial majority of NH adults (81%) agree that if someone were thinking about, threatening, or had attempted suicide, they would know how to find help (52% strongly and 29% somewhat), 2% are neutral, 9% somewhat disagree, 5% strongly disagree, and 3% do not know.
- The vast majority of NH adults (97%) agree if they became aware that a young person was thinking about or had attempted suicide, they would feel that they had a responsibility to do something to help (87% strongly and 10% somewhat), 1% are neutral, 1% somewhat disagree, and 1% do not know.
- A little less than a third of NH adults (29%) think firearms are the most frequent method of suicide used in NH, followed by poisoning (22%), drugs or overdosing (12%), hanging (10%), knives (1%), some other method (4%), and 23% do not know. In fact, firearms are used in over 50% of the suicide deaths in NH. This highlights the need for education about the tie-in between firearms and suicide.

Although it is not possible to determine exactly how these results translate into actual behavior, they do indicate that progress has been made in the battle against overt stigma towards mental health services. They also show that the vast majority of NH residents feel that suicide prevention is a shared responsibility. These conclusions are important in reinforcing collaborative efforts to reduce suicide deaths and attempts. This survey is being repeated in 2012, and an update on this data will be shared in the next edition of this annual report.
NH Behavioral Risk Factor Surveillance System (BRFSS)

In both 2007 and 2009, support was provided to NH DHHS Division of Public Health Services, Health Statistics and Data Management to add five questions on suicide to the NH BRFSS telephone survey. This was made possible through federal funding brought into the state by the first GLS Youth Suicide Prevention grant received by NAMI NH. In order to provide a better estimate of the population prevalence for these relatively low frequency occurrences, the results from 2007 and 2009 have been combined for analysis. The results are presented in Figure 26 below. The BRFSS also 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 27 (pg. 49).

Figure 26
NH BRFSS – Depression and Suicidal Ideation Among NH Residents Age 18 and Over
Data from the NH National Guard

From 2009 through 2011 the NH National Guard recorded a total of 85 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, 27% were from individuals under the age of 22 and 36% were age 22-26, 12% were age 27-31, 6% were age 32-36, and 13% were age 37-41. All others were age 42 and above. Forty-five percent of the incidents were by non-deployed personnel. Of the incidents recorded, 78% were by males and 22% were by females (males may be disproportionally represented among NH National Guard compared with the general population).

Positive Outcomes and Testimonials

Since its inception the Deployment Cycle Support – Care Coordination Program (DCS-CCP) has served over 1,900 service members, as well as family members. Data from the most recent program cycle show that there were over 30 cases where DCS-CCP Care Coordinators intervened when service members or loved ones were at risk for suicide. The supportive, on-going, outreach based relationship that a Care Coordinator develops with a Service Member and family creates and maintains a vital "protective envelope" that aids in the early detection of suicide risk factors and enables proactive, preventative, and at times, reactive interventions. To date no DCS-CCP participants have died by suicide.

The DCS-CCP is a statewide interagency network managed by Easter Seals NH with oversight from DHHS, which provides comprehensive, proactive, local support to service members and their loved ones before, during and after deployment. DCS-CCP Care Coordinators work directly with service members and families to help them address the many clinical, logistical and financial challenges associated with deployment.
Data from the NH Department of Corrections

In 2011, the NH Department of Corrections had a total of 1,226 males and 139 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 2011 show that at intake nearly 21% of males and 47% of females indicated past suicidal ideation and approximately 14% of males and 40% of females indicated a past suicide attempt. Although past suicidal ideation and attempts were relatively high for this group, fewer than 1% of the individuals screened at intake answered yes to the question, “Are you currently thinking about killing yourself?”. Figure 28 (below) displays the percentage of intakes indicating suicidal ideation and/or attempts by gender. In 2011 there were 3 completed suicides in the NH Prison System (facilities operated by the NH Department of Corrections).

**Figure 28**

Percentage of individuals entering NH prisons in 2010 and 2011 indicating past suicidal ideation, attempts, and/or history of trauma by gender.

---

6 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 desirable outcomes from the inmates’ point of view (e.g., allowing them to avoid someone or something that they dislike).
Suicide Rates in NH

Until recently (2010/2011) data have indicated that rates of youth and young adult suicide and suicidality overall in NH were 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 change in NH suicide rates may have occurred.

Figure 29 (pg. 52) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2000 to 2009. There is a significant difference between the span from 2001-2003 and those between 2005-2007 and 2006-2008; showing a decrease in rates during that period. The change seen on the chart for youth suicide deaths for the period from 2007-2009 was not a significant increase from previous years. There were no significant differences between the rolling three-year intervals for NH residents of all ages combined (Figure 30 – pg. 52).
**Figure 29**
Suicide rates among 10-24 year old NH residents are deceasing, as seen from 2000-2009.

![NH Resident Suicide Death Rates for Rolling 3-Year Intervals Ages 10 to 24](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAgAAAAAICAMAAACG2TcSAAAAAElFTkSuQmCC)

**Figure 30** shows that the suicide death rate for people of all ages in NH has remained relatively constant over the last 10 years.

![NH Resident Suicide Death Rates for Rolling 3-Year Intervals All Ages](data:image/png;base64,iVBORw0KGgoAAAANSUhEUgAAAgAAAAAICAMAAACG2TcSAAAAAElFTkSuQmCC)
**Figure 31** (below) indicates results of the NH YRBS from 1993, 2003, 2005, 2007, 2009, and 2011. 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 both decreased by about 50% from 1993 to 2011. However, in 2011, 1 in 7 youth surveyed still seriously considered attempting suicide in the past year, while 1 in 16 reported actually having made an attempt.

**Figure 31**

Depression among high school youth remains at about a fourth of the population despite decreases in suicide attempts and suicidal ideation from 1993 to 2011.

While suicidal thinking and attempts reported by NH high school students on the YRBS have decreased in comparison with data from 2003, they still affect a large proportion of the student body.
Chart Reading Basics

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 12) of this report shows the percent of male and female youths and young adults in NH that died by suicide from 2005 to 2009.
- **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 7 and 8) in this report show the number of suicide deaths by age group in NH from 2005 to 2009 and the rate of suicide deaths by age group in NH from 2005 to 2009.

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 2002 to 2011. 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 10). In that chart you can see there is only one place where the error bars do not overlap; those for Carroll County when compared with Rockingham County. From this we are able to determine that the rates of suicide in Carroll County are significantly different from those in Rockingham County.

**Frequently Used Scales**

- **Standard**: What is being referred to here as standard is a numbered scale that gives the actual value of the variable(s) being presented in the chart (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 deaths that occur to 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)
- 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 Statistics and Data Management (HSDM)
- National Alliance on Mental Illness New Hampshire (NAMI NH)
- National Suicide Prevention Lifeline (NSPL)
- Northern New England Poison Center (NNEPC)
- Office of the Chief Medical Examiner (OCME)
- State Suicide Prevention Plan (SSPP)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Suicide Prevention Council (SPC)
- Suicide Prevention Resource Center (SPRC)
- Veterans Administration (VA)
- Youth Risk Behavior Survey (YRBS)
- Youth Suicide Prevention Assembly (YSPA)

Age Adjustment and Rates

All rates in this document are age-adjusted to the 2000 US standard population. This allows the comparison of rates among populations having different age distributions by standardizing the age-specific rates in each population to one standard population. Age-adjusted rates refer to the number of events that would be expected per 100,000 persons in a selected population if that population had the same age distribution as a standard population. Age-adjusted rates were calculated using the direct method as follows:

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

Where,
- \( m \) = number of age groups
- \( d_i \) = number of events in age group \( i \)
- \( p_i \) = population in age group \( i \)
- \( S_i \) = proportion of the standard population in age group \( i \)

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

Age Specific Rate/Crude Rates

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

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

The formula used is:

\[ R + z \times SE \]

Where,

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

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

Data Collection

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

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

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

State and county population estimates for NH data are provided by HSDM, Bureau of Disease Control and Health Statistics, Division of Public Health Services, and NH DHHS. Population data are based on US Census data apportioned to towns using NH Office of Economic Planning (OEP) estimates and projections, and further apportioned to age groups and gender using Claritas Corporation estimates and projections to the town, age group, and gender levels. Data adds 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 into 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 2000 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:

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

Where,
- \( w_j \) = fraction of the standard population in age category
- \( n_j \) = number of cases in that age category
- \( p \) = person-years denominator
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 2000, 2002, and 2004 do not overlap with the 2010 confidence interval, meaning that the rate for 2010 was significantly higher than the rates for 2000, 2002 and 2004.

<table>
<thead>
<tr>
<th>Year</th>
<th>Change in Rate per 100,000 from Year to Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-2001</td>
<td>10.60 to 13.29 (Up 25%)</td>
</tr>
<tr>
<td>2001-2002</td>
<td>13.29 to 10.39 (Down 22%)</td>
</tr>
<tr>
<td>2002-2003</td>
<td>10.39 to 12.33 (Up 16%)</td>
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<tr>
<td>2003-2004</td>
<td>12.33 to 10.29 (Down 17%)</td>
</tr>
<tr>
<td>2004-2005</td>
<td>10.29 to 12.46 (Up 21%)</td>
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<tr>
<td>2005-2006</td>
<td>12.46 to 11.54 (Down 7%)</td>
</tr>
<tr>
<td>2006-2007</td>
<td>11.54 to 12.04 (Up 4%)</td>
</tr>
<tr>
<td>2007-2008</td>
<td>12.04 to 12.91 (Up 7%)</td>
</tr>
<tr>
<td>2008-2009</td>
<td>12.91 to 12.02 (Down 7%)</td>
</tr>
<tr>
<td>2009-2010</td>
<td>12.02 to 14.90 (Up 24%)</td>
</tr>
<tr>
<td>2010-2011</td>
<td>14.90 to 14.40 (Down 3%)</td>
</tr>
</tbody>
</table>

*2000-2009 = CDC Data, 2010 – 2011 = 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 generally not released until 24 months or more 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 2002 to 2003, the number of deaths were up nearly 20% followed by a 20% decrease from 2003 to 2004; 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?


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<tr>
<th>Age Groups</th>
<th>Rank</th>
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<th>5-9</th>
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<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
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<td>Malignant Neoplasms</td>
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<td>Unintentional Injury</td>
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<td>Malignant Neoplasms</td>
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<td>Congenital Anomalies</td>
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<td>Heart Disease</td>
<td>Suicide</td>
<td>Suicide</td>
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<td>Septicemia</td>
<td>Influenza &amp; Pneumonia</td>
<td>Heart Disease</td>
<td>Homicide</td>
<td>Homicide</td>
<td>Diabetes Mellitus</td>
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<td>Respiratory Distress</td>
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<td>Six Tied</td>
<td>Homicide</td>
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<td>Congenital Anomalies</td>
<td>Liver Disease</td>
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<tr>
<td>8</td>
<td>Unintentional Injury</td>
<td>8</td>
<td>Six Tied</td>
<td>Five Tied</td>
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<td>Neonatal Hemorrhage</td>
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<td>Six Tied</td>
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<td>Circulatory System Disease</td>
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<td>Nephritis</td>
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<td>Nephritis</td>
</tr>
</tbody>
</table>

Source: CDC WISQARS, 2005-2009

---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: Jo Moncher – jamoncher@dhhs.state.nh.us

Meets 2nd Monday – Every other month 1 – 3 PM
Room 460, Brown Building, DHHS, Concord

Youth Suicide Prevention Assembly
Primary Contact: Elaine de Mello – edemello@naminh.org

Meets 2nd Thursday of the month 10 – 11:30 am
Room 232, Brown Building, DHHS, Concord

Connect Program of NAMI NH
Primary Contact: Ken Norton – knorton@naminh.org

NH Suicide Survivor Network
Primary Contact: Becky McEnany – bmcenany@naminh.org

Suicide Prevention Council Subcommittees

Communications & Public Education
Chair: Rhonda Siegel – rsiegel@dhhs.state.nh.us

Meets 4th Thursday of the month 10 am – 12 pm
Hazen Drive, Concord

Data Collection & Analysis
Chair: Patrick Roberts – proberts@naminh.org

2nd Friday of the Month 9:30 – 11:30 am
NAMI NH, Concord

Military & Veterans
Co-Chairs: SFC Dale Garrow – dale.garrow@us.army.mil
Loren Haberski – loren.haberski@va.gov

1st Wednesday of the Month 2:30 – 4:30 pm
National Guard Building, VA Manchester Medical Center Complex

Professional Practice & Education
Co-Chairs: Elizabeth Fenner-Lukaitis – elizabethfl@dhhs.state.nh.us
Dr. Betty Welch – bwelch@elliot-hs.org

Meets 2nd Wednesday of the month 12:30 – 2:30 pm
Room 460, Brown Building, DHHS, Concord
Public Policy
Co-Chairs: Linda Saunders Paquette – lpaquette@new-futures.org
Kevin Stevenson– kevin.stevenson@nhdoc.state.nh.us

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

State Suicide Prevention Conference Meetings
Primary Contact: Elaine de Mello – edemello@naminh.org

Contact Elaine de Mello for current meeting schedule

Suicide Fatality Review
Chair: Diane Langley – dlangle@dhhs.state.nh.us
Vice Chair: Catrina Watson – Catrina.Watson@nhms.org

Attendance is by invitation only
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, as well as comprehensive lists of risk factors and protective factors, please consult the Connect website at http://www.theconnectprogram.org and click on Understanding Suicide.

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) Stay with them until a parent or professional is involved.
4) Offer a message of hope - Let them know you will assist them in getting help.
5) Connect them with help:
   * National Suicide Lifeline (24/7) 1-800-273-TALK (8255) (press “1” for veterans)
   * Head rest – For teens and adults (24/7) 1-800-639-6095 or your local mental health center