

New Hampshire Suicide Prevention



Annual Report 2013

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 2013 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 2013:

- The 2013 Suicide Prevention Conference had its largest turnout in the history of the ten-year conference, with over 300 attendees.
- NAMI NH's *Connect* staff trained over 650 individuals in suicide prevention and/or postvention across the state, numerous additional trainings having been conducted by second generation trainers (not *Connect* staff).
- Survivors of suicide loss have had increasing involvement in statewide planning and have established a Survivor of Suicide Loss Subcommittee of the State Suicide Prevention Council.
- In 2013, as NH prepared for the winding down of the second statewide federal grant, the state was notified that the application for a third Garrett Lee Smith (GLS) Suicide Prevention Grant was approved, to commence in October 2013.

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

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

What's New in this Year's Report?

Some of the new highlights this year include:

- New suicide death data from the Centers for Disease Control
- Updated data from the NH Department of Corrections.
- New examples of positive outcomes and testimonials related to suicide prevention work being done in NH. These examples are included as text boxes interspersed throughout the report.

Primary Partners

NAMI NH and the *Connect* Suicide Prevention Program

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

NAMI NH's *Connect* Suicide Prevention Program is designated as a National Best Practice (www.sprc.org/bpr). *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). The *Connect* Program assists the Youth Suicide Prevention Assembly and the State Suicide Prevention Council with implementation and oversight of the NH Suicide Prevention Plan. *Connect* provides consultation, training, technical assistance, information, and resources regarding suicide prevention throughout the state. NH specific data, news and events, information and resources, and supports to survivors are available on the *Connect* website at www.theconnectprogram.org.

State Suicide Prevention Council

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

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

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

As part of SB 390, which legislatively established the Suicide Prevention Council, the Council is required to annually report on its progress, to both the Governor and the legislature. This report serves that purpose, as well as providing an annual update on the accomplishments of our collective achievements and data regarding suicide deaths and suicidal behavior in NH.

Youth Suicide Prevention Assembly

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

YSPA is an ad hoc committee of individuals and organizations that meet monthly to review the most recent youth suicide deaths and attempts in order to develop strategies for preventing them. Over the years, YSPA and its partners have been involved with a wide range of suicide prevention efforts in the state – including but not limited to: collecting and analyzing timely data on suicide deaths and attempts, collaborating on an annual educational conference, creating the original NH Suicide Prevention Plan and identifying the need for statewide protocols and training, which were developed through NAMI NH into the *Connect* Program.

Accomplishments of Suicide Prevention Efforts in NH

State Suicide Prevention Council

This year marked the fifth anniversary of NH's Suicide Prevention Council since its legislative inception. 2013 was a year of continued growth for the council as it embraced its mission to reduce the incidence of suicide in NH. The work of the council falls to the established subcommittees which themselves grew from six to seven to include a Survivors of Loss subcommittee. Survivors had previously participated throughout many of the committees but the council recognized the power and potential of this group. The strength of the voices of families and friends affected by a suicide is seen as pivotal and inspirational in our prevention efforts. The annual conference grew in its participants and saw the largest attendance in its history. The Public Policy subcommittee took on legislation and certification standards to improve education standards for both school personnel and practitioners. The Cross Training and Professional Education subcommittee expanded its outreach concepts and efforts to include professions at risk for suicide. Our public education efforts have grown with our strong partnership with Public Health, calling attention to suicide as a clear public health issue and one that requires clear messaging and education for our journalists and media partners. In 2013 the council expanded its partnerships with the military, law enforcement, legislators and seniors. The council looks forward to 2014 its on-going work in promoting evidence based initiatives and refining and expanding the state plan to ensure the very best outcomes for our citizens'. It was gratifying to also see numbers that this year showed a substantial decrease, as the overall suicide rate for NH dropped from of 15.4 to 13.8.

If you would like to join any of the Suicide Prevention Council Subcommittees, please contact the designated committee chair. The committee meeting schedule has been included on page 57 of this report.

The Youth Suicide Prevention Assembly (YSPA)

In 2013, YSPA continued to meet monthly in efforts to understand ways to promote resources and prevent youth suicide. This including looking at trends to promote creative new approaches to suicide prevention and postvention. Included in this examining methods of suicide and lethal means restriction; new audiences to educate about suicide prevention; and ways to support those affected by suicide. Included in topics presented at the meetings were postvention; the newly revised national strategy; hearing from a loss survivor and learning about substance misuse in youth and new designer drugs leading to overdoses. YSPA participants also began spotlighting different members to learn about the background and expertise present in the assembly.

The NH Suicide Survivor Network

In 2013 **Survivors of Suicide Loss (SOSL)** continued in their efforts to help build more capacity for more **Support groups** throughout NH, with those groups already in motion maintaining a steady level of membership. Loss Survivors helped to mentor each other in facilitating and co-facilitating these groups by providing a safe environment to share their experience of suicide loss, and for fellow loss survivors to give support, encouragement and strength for those that attend. These Support Groups continue to meet on a weekly, bi-weekly and monthly basis.

Positive Outcomes and Testimonials

“My goal is to provide hope to an aching survivor’s heart. Hope for those who may think there is no hope. If my voice can be a voice of hope for one person, like Kristyn was for me, then we have succeed.”

Elaine St. Jean speaking on her experience of being trained as a survivor of suicide loss speaker in the Decade of Hope video
<https://www.youtube.com/watch?v=KWgnkumVsaY>

An ever growing number of **Loss Survivor Speakers** continued to share their personal stories and experiences of suicide loss to help educate the public and provide healing and support, within their communities and throughout the state. In 2013 there were over 20 presentations by Loss Survivors.

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, is called “Healing the Hurt Spirit: Daily affirmations for people who have lost a loved one to suicide”. It continues to be available to new Loss Survivors with an online survey to solicit feedback on the folder and provide additional avenues to connect Loss Survivors to help was implemented.

Viewings of the American Foundation for Suicide Prevention (AFSP) **International Survivors of Suicide Loss Day Teleconference** were held in 4 sites on the last Saturday before Thanksgiving and gathered many Loss Survivors together in healing, support and understanding.

The annual **NH Survivor of Suicide Loss newsletters** were distributed throughout the state, with hard copies made available at trainings, Loss Survivor speaking presentations, the Suicide Prevention Conference, health fairs, and in public venues such as libraries, hospitals, healthcare

facilities, and mental health centers. In addition, the newsletter was distributed electronically to many email lists.

More and more Survivors of Suicide Loss in NH are becoming involved in advocacy and fundraising efforts for various local and national suicide prevention organizations and efforts. This included the 3 **Life Keeper Memory Quilts** lovingly put together by Survivors of Suicide Loss in NH, which were displayed along with Loss Survivor resources at many of these events such as NH Seacoast AFSP “Out of the Darkness Walk”, other community and overnight walks, the NAMI NH Walk, Nathan’s Ride, Paddlepower, Rails to Trails, Memorial Tree Lighting, and Compassionate Friends. These Quilts were also displayed with resources for Loss Survivors at all of the Loss Survivor Speaker Presentations and the State Suicide Prevention Conference.

Late fall the **NH State Suicide Prevention Council** welcomed in the new **SOSL Sub-Committee**. The SPC continues to include Survivors of Suicide Loss in their work by encouraging each existing sub-committee to include Loss Survivors on the membership. Recent surveys to the NH Loss Survivors network clearly indicated great interest in forming a separate Survivor of Suicide Loss Sub-Committee to address Loss Survivor issues. One of the underlying principles in the 2013 NH Suicide Prevention State Plan is “Promoting healing and reducing risk following a suicide (postvention) for both individuals and communities” and the 2013 NH Suicide State Plan specifically recommended exploring the establishment of a statewide survivor of suicide loss (SOSL) committee as part of the SPC to provide oversight and coordination of resources and to lend a survivor voice and perspective to planning at the state level.

The SOSL Sub-Committee is continuing to grow and encourage new members to join the Sub-Committee and attend the monthly meetings.

Positive Outcomes and Testimonials

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

Feedback from a respondent on the NH Survivor of Suicide Loss survey.

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

In October 2013 NH was awarded its third consecutive state suicide prevention grant, funded through SAMHSA (Substance Abuse and Mental Health Services Administration). This grant, managed by NAMI NH, provides funding for three years to focus on the following goal: to reduce suicide incidents by increasing access to essential care and supports through a systemic approach to identified high risk youth. Anticipated outcomes of the project are:

1. Youth/young adults admitted to NH Hospital will have reduced rates of suicide attempts and completions pre and post discharge, as well as reduced readmissions.
2. Youth/young adult National Suicide Prevention Lifeline callers will have reduced rates of suicide attempts and completions and demonstrate increased follow-through with treatment.
3. Community capacity and infrastructure will be strengthened to reduce suicide attempts and completions among high risk youth/young adults in the three targeted regions of Lakes Region, Capital Region, and Greater Manchester Region.
4. Statewide capacity for implementing state and national goals for suicide prevention is strengthened through technical assistance and consultation. Some of the target populations identified within the 24 year old and under focus for this youth suicide prevention grant include: military personnel, young adults not in college, youth and young adults with co-occurring disorders; refugee populations, and lesbian, gay, bisexual and transgender youth.

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

In 2013, Plymouth State University entered its second year of a 3 year SAMHSA suicide prevention grant. During this year, the Transitions Theater Arts Program was established and conducted multiple performances on campus for students, bringing awareness about a variety of issues facing college students and the resources and solutions available to keep students safe. Through this grant period, Plymouth State University had conducted *Connect* Prevention Train the Trainer and Planning sessions to expand and strengthen knowledge, skills, practice and protocols around suicide prevention across campus and with community partners. Assessing and Managing Suicide Risk (AMSR) was offered to clinical providers on and off campus to enhance skills in working with students at risk for suicide. A CARE form, developed to identify and outreach to students who might be at any kind of risk became an important tool in this grant for early intervention. The project director of the grant, Delilah Smith, was a speaker at the keynote for NH's Tenth Annual Suicide Prevention Conference in November 2013, providing an overview of the grant objectives and accomplishments.

Annual NH Suicide Prevention Conference

The State Suicide Prevention Council, NAMI NH, and the Youth Suicide Prevention Assembly partnered to present the Annual Suicide Prevention Conference on November 8th, 2013 in Bedford NH. This year brought the greatest number of attendees and sold out six weeks prior to the date of the conference. The conference provided a venue for a diverse audience from many sectors of the community to learn about statewide and national suicide prevention efforts and best practices. This year's opening plenary focused on the many aspects of Safe Messaging. Opening remarks by Ken Norton, Executive Director, who served on the committee which helped to revise the national media recommendations were followed by presentations from a journalism professor, a loss survivor, and a faculty member of a school that had lost several students to suicide, all of whom gave their perspective about the importance of safe messaging when discussing suicide. A closing panel gave illustrations of local, regional and statewide initiatives in NH. The finale of the conference was a 15 minute video called A Decade of Hope, produced by a college student at St. Anselm's, reflecting the progress that has been made in NH in the last 10 years in the field of suicide prevention. The video is a collage of interviews from people across the state including representatives from the SPC, law enforcement and corrections, providers, members of suicide prevention coalitions and refugee communities, a gun shop owner, loss survivors, and youth who had been affected by suicides of classmates. This powerful video can be viewed at: <https://www.youtube.com/watch?v=KWgnkumVsaY>

Positive Outcomes and Testimonials

“This Conference saved my life”

Feedback from an attendee at the 2013 Annual NH Suicide Prevention Conference

Local Coalitions: Suicide Prevention at a Grassroots Level

An array of NH communities and coalitions have addressed suicide in 2013; many continue in an informal grassroots way, such as the Moultonborough Coalition, which continues to receive its funding through the town and utilizes these resources to provide education, health promotion and access to mental health services. The Public Health Network and Regional Substance Abuse Prevention Network contracts began consolidating in July of 2013 and suicide prevention was included the scope of work for some of the regions and is expected to become a growing priority in the next year. Three regions (Lakes, Capital and Greater Manchester) were identified as target regions for the NH Nexus Suicide Prevention Project, funded through SAMSHA starting October 2013, and began comprehensive suicide prevention activities as partners in this three year grant initiative.

State and National Attention on NH initiatives

NH Firearm Safety Project

The “Gun Shop Project”, a NH initiative born out of the NH Firearm Safety Coalition, developed informational materials on suicide prevention and lethal means reduction for gun shops and firing ranges in NH in 2011 and disseminated these materials to more than 65 gun shops across the state. In 2012, revisions to materials were made based on feedback and dissemination continued throughout 2013. Follow-up surveys indicated that nearly half of the businesses that received them were making use of these materials.

This initiative has continued to gain interest from around the country. Many states and communities are adapting the materials and using them in their own collaborative efforts to bring together the firearm and the suicide prevention communities. More information about the Gun Shop Project is available at: www.nhfsc.org

National Best Practice Training Programs

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).

The *Connect* Suicide Prevention and Postvention program also continues to expand its geographical reach with trainings and workshops occurring across the U.S and Canada. 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. In 2013, the *Connect* Program delivered trainings and consultation in six states as well as Guam; several campuses and over 20 tribes nationally, with ongoing contracts in several areas. 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 and was offered in several states and tribal regions across the United States over the past several years.

Positive Outcomes and Testimonials

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

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

Education and Training Initiatives in NH

Through a blend of state and federal funds, a variety of best practice programs continued to be offered across NH. CALM trainings were offered throughout NH and the first CALM Training of Trainers was conducted in 2013 to 30 mental health and emergency room providers throughout the state, expanding the sustainability of this program in NH. The Connect Suicide Prevention and Postvention program was offered for a variety of sectors of the community including dozens of schools and community providers. ASIST Training was offered through the NH National Guard.

Systemic implementation of suicide prevention training was implemented for organizations and providers working in child welfare and substance misuse and movement towards including suicide prevention training as part of required standards for various professions was under discussion during the year.

Postvention education and support continued to be offered through NAMI NH and the *Connect* Program, and having built infrastructure throughout the state with training and protocols, many communities and schools indicated in increased preparedness in dealing with suicide as well as other traumatic events such as the Boston Marathon bombing. One school in particular was able to organize an effective response, based on their training in postvention, for their students who were in Boston at that time. Some schools who had been trained and had developed protocols indicated a confidence in their ability to respond to suicides and to offer their assistance to other schools in the event of a tragic death.

When the Bhutanese Community in NH experienced several incidents of suicide attempts and deaths, specialized outreach was offered. As a result, dozens of members of the Bhutanese Community in several regions participated in *Connect* Suicide Prevention and Healing Words events. In addition, National Suicide Prevention Lifeline materials were translated into Nepali and distributed widely through the refugee communities.

2013 Data

SPC/YSPA Data Subcommittee Membership Representation 2013-2014

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

Introduction

The data presented in this report is the result of collaboration between 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 several years, combining historical expertise with emerging methods. YSPA has been collecting and analyzing data about youth and young adult suicide deaths and behavior over the last 17 years and first created this report format in 2003. The SPC has been analyzing and planning for data capacity improvements for the last 5 years. Key areas of interest and concern for suicidal behavior in NH are included in this report. A data interpretation and chart reading section has been included at the end of the report.

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

When reading this report it is important to note that two primary sources of NH data were used. One main data source is Vital Records data (official death records for NH residents) for the State of NH obtained from Health Statistics and Data Management (HSDM), Division of Public Health Services, NH DHHS. 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 and how often it is collected/reported. The time periods reported for each data source are indicated with the corresponding Table or Figure.

Demographic profile of New Hampshire

Comparing New Hampshire to the US

Tables 1 through 6 below present NH and US demographic characteristics, as well as indicators of substance use and mental health. NH is a small state, with just over 1.3 million residents (US Census, 2013). Overall, NH is relatively homogeneous in terms of race and ethnicity, and has above average ratings for economic factors and education. NH is above the US average for alcohol and illegal drug use, with the 4th highest and 15th highest rates of usage respectively.

Table 1

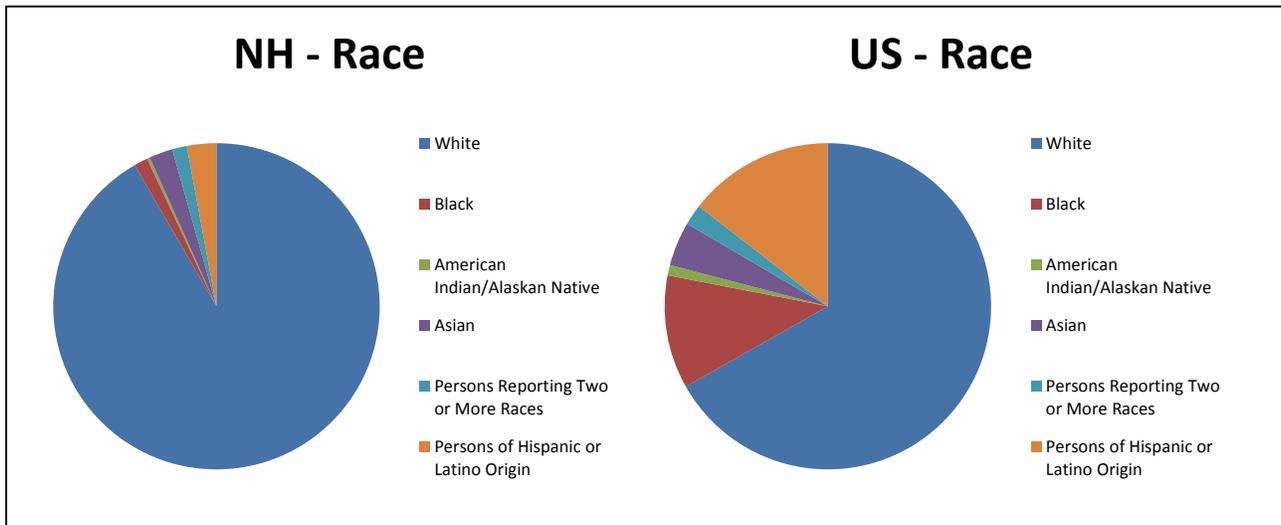
Race/Ethnicity

	New Hampshire	United States
White	94.4%	77.9%
Black	1.4%	13.1%
American Indian/Alaskan Native	0.3%	1.2%
Asian	2.4%	5.1%
Persons Reporting Two or More Races	1.5%	2.4%
Persons of Hispanic or Latino Origin	3.0%	16.9%

Source: US Census Bureau 2012

Figure 1

NH and US Race/Ethnicity



Source: US Census Bureau 2012

Table 2

Age

	New Hampshire	United States
Under 18	20.9%	23.4%
18 to 24	9.5%	10.0%
25 to 44	24.1%	26.3%
45 to 64	30.9%	26.4%
65 to 74	8.3%	7.6%
75 and Up	6.4%	6.2%

Source: US Census Bureau American Community Survey 2012

Table 3

Economic Factors

	New Hampshire	United States
Unemployed Residents	6.6%	9.3%
Persons Below Poverty Level	8.4%	14.9%
Persons Without Health Insurance	10.5%	14.9%
Per Capita Income (Yearly)	\$32,758	\$28,051
Median Household Income	\$64,925	\$53,046
Owner Occupied Homes	72.0%	65.5%
Median Home Value	\$245,600	\$181,400

Sources: US Census Bureau American Community Survey 2012

Table 4

Education – population age 25 and older

	New Hampshire	United States
Less Than High School Graduate	8.6%	14.2%
High School Graduate or Associates Degree	58.0%	57.2%
Bachelors Degree or Higher	33.5%	28.5%

Source: US Census Bureau American Community Survey 2012

Table 5

Substance Use – Individuals Age 12 and Up

	New Hampshire	United States
Illicit Drug Use – Past Month	10.34%	9.0%
Alcohol Use – Past Month	62.9%	51.9%
Tobacco Use – Past Month	26.1%	26.6%

Source: National Survey on Drug Use and Health, 2011-2012

Table 6

Mental Health Indicators – Individuals Age 18 and Up

	New Hampshire	United States
Serious Mental Illness – Past Year	4.05%	3.97%
Major Depressive Episode – Past Year	7.2%	6.7%
Had Thoughts of Suicide – Past Year	4.0%	3.8%

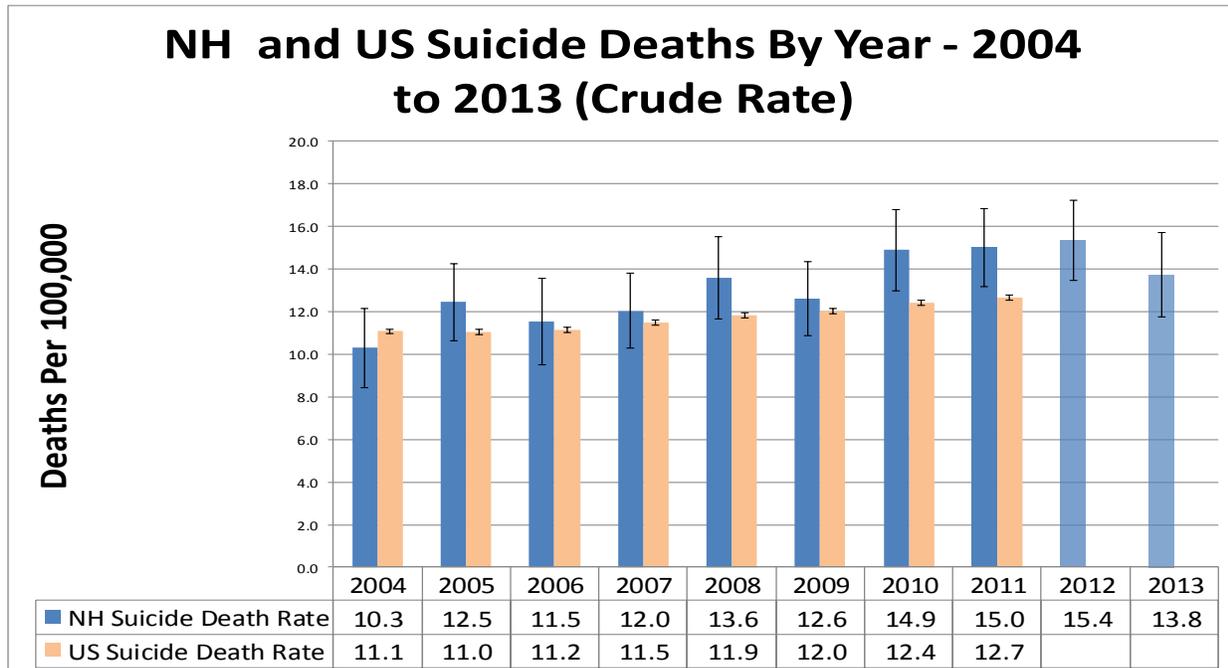
Source: National Survey on Drug Use and Health, 2011-2012

The Big Picture: Suicide in NH and Nationally

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

Figure 2 presents the suicide rate in NH and the US for the past ten years. The rate in NH has varied from year to year, due to its small size, while the US rate has remained more consistent. Even though the NH rate has varied, 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 2010-2012 suicide rates are significantly greater than the rates for 2000, 2002, and 2004. This appears to be consistent with changes in the rates of suicide nationally.

Figure 2
Crude Suicide Death Rates per 100,000 in NH by Year 2004-2013



Source: 2004-2011 – CDC Data; 2012-2013 – NH OCME Data

Table 7 displays the 10 leading causes of death for people of different age groups in NH. From 2007-2011, suicide among those aged 10-24 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 individuals age 25-34 during 2007-2011 were behind only deaths due to unintentional injury; primarily motor vehicle crashes in NH within these age groups. Suicide among individuals of all ages was the 10th leading cause of death in NH and nationally.

Table 7
10 Leading Causes of Death, New Hampshire, by Age Group, 2007 – 2011

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 49	Unintentional Injury (*see note)	Unintentional Injury 14	Unintentional Injury 17	Unintentional Injury 245	Unintentional Injury 266	Unintentional Injury 293	Malignant Neoplasms 1,098	Malignant Neoplasms 2,431	Heart Disease 9,867	Malignant Neoplasms 13,012
2	Short Gestation 39	Malignant Neoplasms (*see note)	Malignant Neoplasms 10	Suicide (*see note)	Suicide 97	Suicide 111	Malignant Neoplasms 255	Heart Disease 576	Heart Disease 1,156	Malignant Neoplasms 9,108	Heart Disease 11,811
3	SIDS 27	Congenital Anomalies (*see note)	Congenital Anomalies (*see note)	Malignant Neoplasms (*see note)	Malignant Neoplasms 31	Malignant Neoplasms 65	Heart Disease 154	Unintentional Injury 386	Chronic Low. Respiratory Disease 301	Chronic Low. Respiratory Disease 2,796	Chronic Low. Respiratory Disease 3,210
4	Maternal Pregnancy Comp. 23	Homicide (*see note)	Chronic Low Respiratory Disease (*see note)	Heart Disease (*see note)	Homicide 16	Heart Disease 39	Suicide 154	Suicide 240	Unintentional Injury 278	Cerebro-Vascular 2,216	Unintentional Injury 2,567
5	Placenta Cord Membranes 20	Septicemia (*see note)	Heart Disease (*see note)	Congenital Anomalies (*see note)	Congenital Anomalies 11	Homicide 13	Liver Disease 38	Liver Disease 161	Diabetes Mellitus 187	Alzheimer's Disease 1,943	Cerebro-vascular 2,462
6	Respiratory Distress 15	Benign Neoplasms (*see note)	Influenza & Pneumonia (*see note)	Homicide (*see note)	Heart Disease 11	Complicated Pregnancy (*see note)	Diabetes Mellitus 36	Diabetes Mellitus 104	Liver Disease 185	Unintentional Injury 1,051	Alzheimer's Disease 1,969
7	Unintentional Injury (*see note)	Heart Disease (*see note)		Influenza & Pneumonia (*see note)	Benign Neoplasms (*see note)	Diabetes Mellitus (*see note)	Cerebro-vascular 22	Chronic Low. Respiratory Disease 96	Suicide 156	Diabetes Mellitus 1,030	Diabetes Mellitus 1,369
8	Circulatory System Disease (*see note)	Cerebro-vascular (*see note)		Five-Tied (*see note)	Chronic Low Respiratory Disease (*see note)	Congenital Anomalies (*see note)	Homicide 17	Cerebro-vascular 67	Cerebro-vascular 146	Influenza & Pneumonia 931	Influenza & Pneumonia 1,023
9	Neonatal Hemorrhage (*see note)	Nephritis (*see note)		Five-Tied (*see note)	Septicemia (*see note)	Cerebro-vascular (*see note)	Septicemia 14	Viral Hepatitis 38	Septicemia 74	Nephritis 793	Suicide 897
10	Atelectasis (*see note)	Pneumonitis (*see note)		Five-Tied (*see note)	Complicated Pregnancy (*see note)	Chronic Low Respiratory Disease (*see note)	Congenital Anomalies 13	Septicemia 35	Nephritis 51	Parkinson's Disease 459	Nephritis 866

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

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

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

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

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

Table 8
Crude Suicide Death Rates per 100,000 in NH & US, by age group, 2006-2010

	ALL AGES	YOUTH AND YOUNG ADULTS 10-24	YOUTH 10-17	YOUNG ADULTS 18-24
NH	13.67	7.91	3.23	13.31
US	12.10	7.30	2.95	12.11

	AGES 25 TO 39	AGES 40 TO 59	AGES 60 TO 74	OVER 75
NH	15.41	20.17	15.31	15.06
US	14.09	18.21	14.12	16.31

Source: CDC WISQARS

Adults age 40 to 59 had the highest suicide rates of all age groups identified above (20.17 NH, 18.21 US) from 2007-2011 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 2004-2013, 188 NH youth and young adults aged 10-24 have lost their lives to suicide. **Table 9** (pg. 18) depicts the most up-to-date information about these youth and young adults as reported by the OCME in NH and collected and aggregated by YSPA. Males are much more likely to die by suicide in NH (82%) and nationwide. Hanging and firearms were used with nearly the same frequency among youth and young adult deaths during this period. Nationally, a greater proportion of youth and young adults who die by suicide use firearms.

From 2004 to 2006 a decreasing trend among youth suicide deaths was noted. This trend reversed in 2007. The decrease in suicide deaths among youth and young adults from 2004 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 drug-related deaths are ruled as accidental unless there is direct evidence of suicide intent as determined by the OCME. Refer to pages 38-39 for more information on drug-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, object covering nose and mouth) and “Drugs/Poison” refers to all suicide cases of drug-related deaths or ingested poisons. Suicides where carbon monoxide poisoning was the cause of death are reported in the “Other” section. These categories are slightly different from those used by the Center for Disease Control and Prevention (CDC), which places suicides by carbon monoxide into the “Poison” category (e.g., **Figure 20**).

Positive Outcomes and Testimonials

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

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

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

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

Table 9**NH Youth Suicide Death Trend, by Gender, Age Group and Method, 2004-2013**

Year	Total	Male	Female	≤ 19	20-24	Firearms	Hanging/ Asphyxiation	Drugs/ Poison	Other
2004	19	15	4	8	11	6	13	0	0
2005	17	15	2	8	9	8	6	0	3
2006	12	10	2	1	11	6	3	1	2
2007	13	9	4	3	10	5	4	2	2
2008	15	10	5	8	7	5	9	1	0
2004- 2008 Sub Total	76	59	17	28	48	30	35	4	7
Percent of Sub- Total¹	100%	78%	22%	37%	63%	39%	46%	5%	9%
2009	20	18	2	10	10	12	7	0	1
2010	24	22	2	11	13	11	11	2	0
2011	29	23	6	9	20	10	15	2	2
2012	18	15	3	8	10	10	7	0	1
2013	21	17	4	6	15	7	10	3	1
2009 - 2013 Sub Total	112	95	17	44	68	50	50	7	5
Percent of Sub- Total¹	100%	85%	15%	39%	61%	45%	45%	6%	4%
Total	188	154	34	72	116	80	85	11	12
Percent of Total¹	100%	82%	18%	38%	62%	43%	45%	6%	6%

Produced by: NAMI NH

Data Source: NH OCME

¹ Note: Rounding may cause percentages to not total to 100%

Figure 3
NH Youth, Ages 10-24, Suicide Deaths

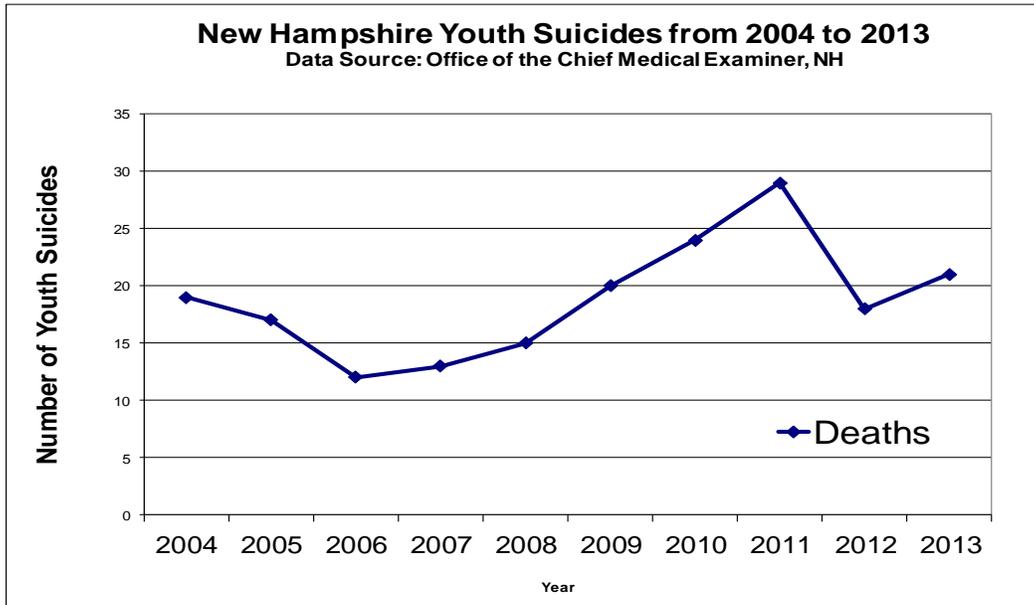
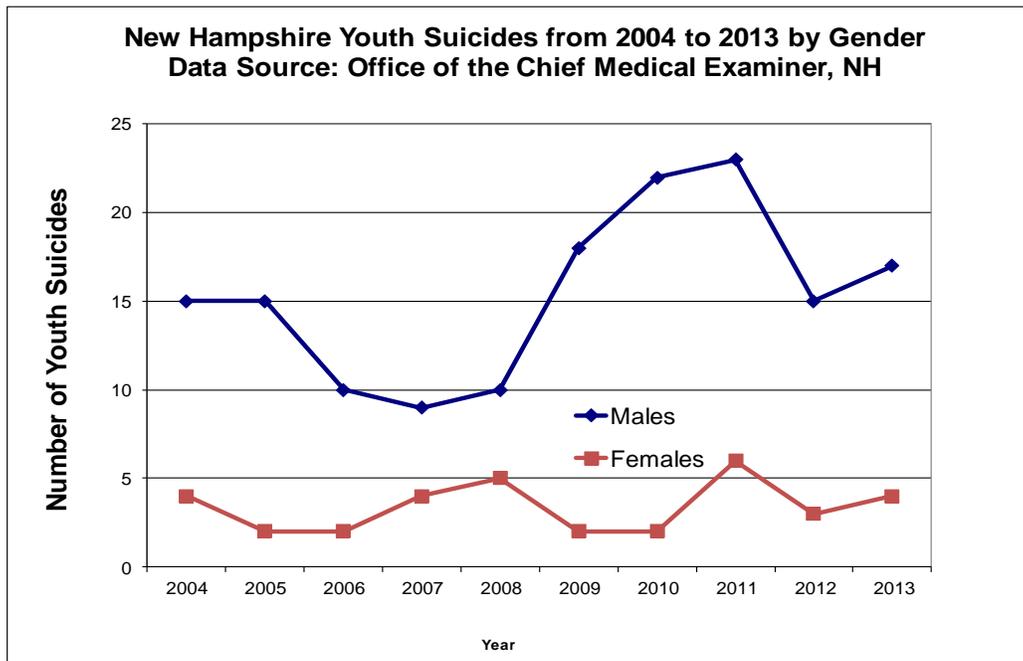


Figure 4
NH Male Youth Suicide Deaths Decrease then Increase 2004-2013, While Female Youth Rates have Remained Relatively Stable



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 the tracking all ages data through the OCME is a more recent state initiative. The number of deaths by year has been plotted in **Figure 5** (pg. 22) and **Figure 6** (pg. 22).

Table 10
NH All Ages Suicide Death Trend, by Gender, Age Group and Method, 2007-2013

Year	Total	Male	Female	≤ 24	25-44	45-64	65+	Firearms	Hanging/ Asphyxiation	Drugs/ Poison	Other
2007	150	115	35	13*	47	68	22	69	31	28	22
2008	175	135	40	15	64	66	30	86	42	20	27
2009	167	136	31	20	51	73	23	80	48	31	8
2010	206	159	47	24	56	89	37	103	49	40	14
2011	200	162	38	29	49	98	24	77	61	37	25
2012	203	160	43	18	60	96	29	97	56	29	21
2013	182	140	42	21	46	92	23	81	60	31	10
Total	1283	1007	276	127	373	582	188	593	347	216	127
Percent of Total	100%	78%	22%	10%	29%	45%	15%	46%	27%	17%	10%

Produced by: NAMI NH
Data Source: NH OCME

Figure 5
NH Residents, All Ages, Suicide Deaths 2007 - 2013

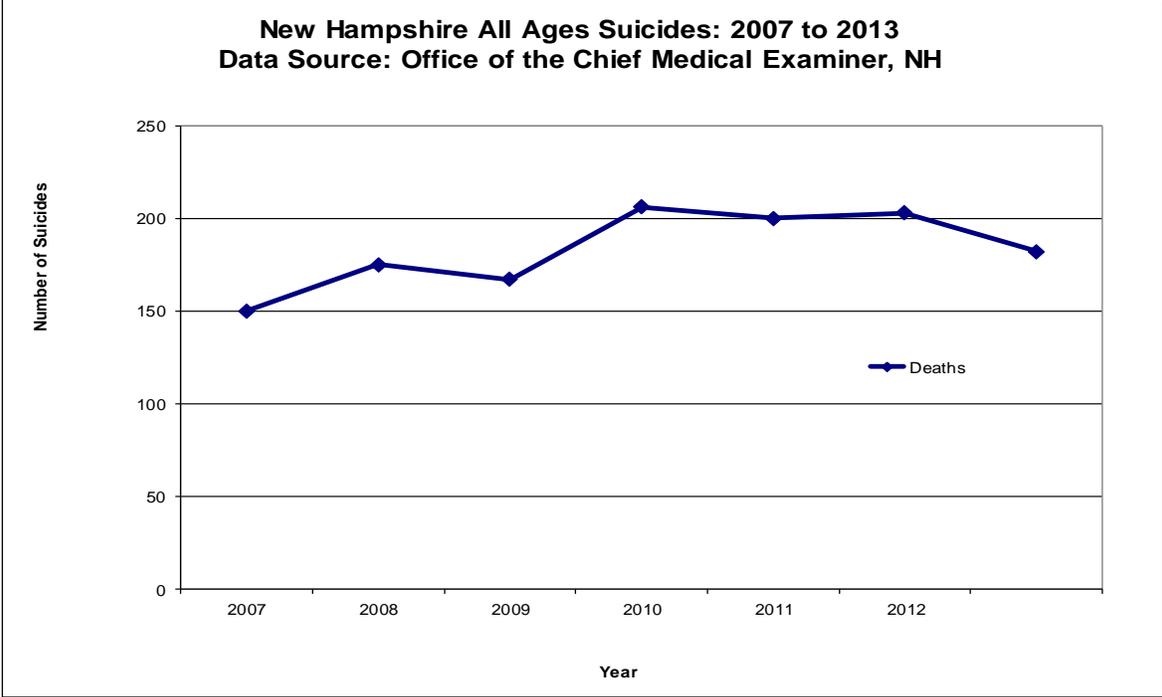


Figure 6
NH Male and Female Suicide Rates 2007 – 2013

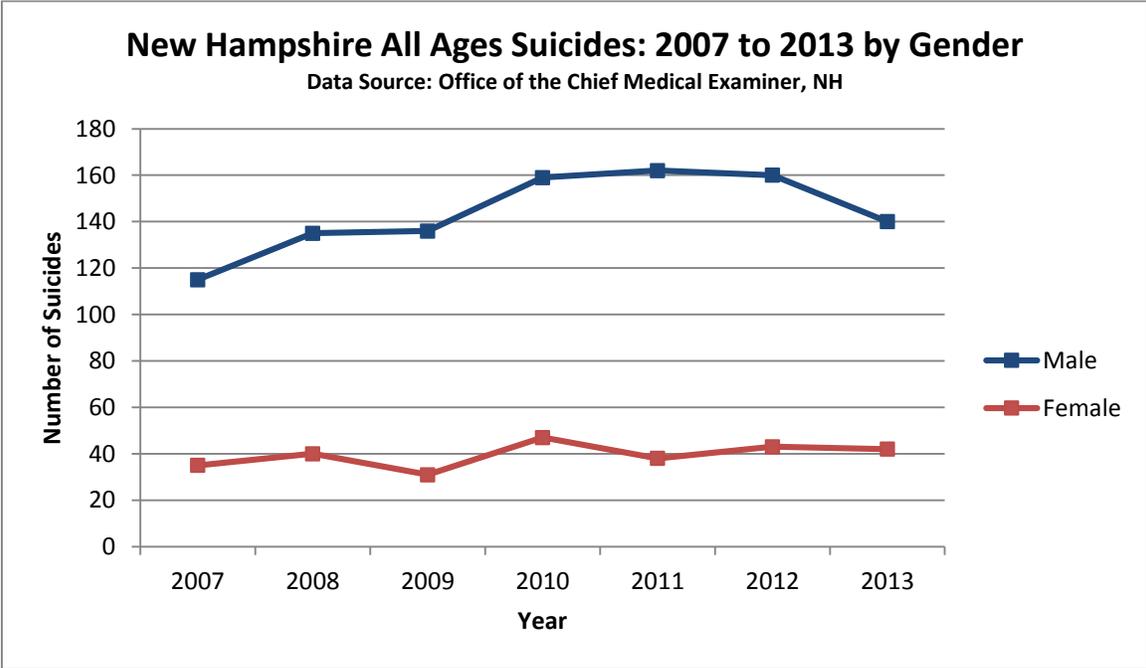
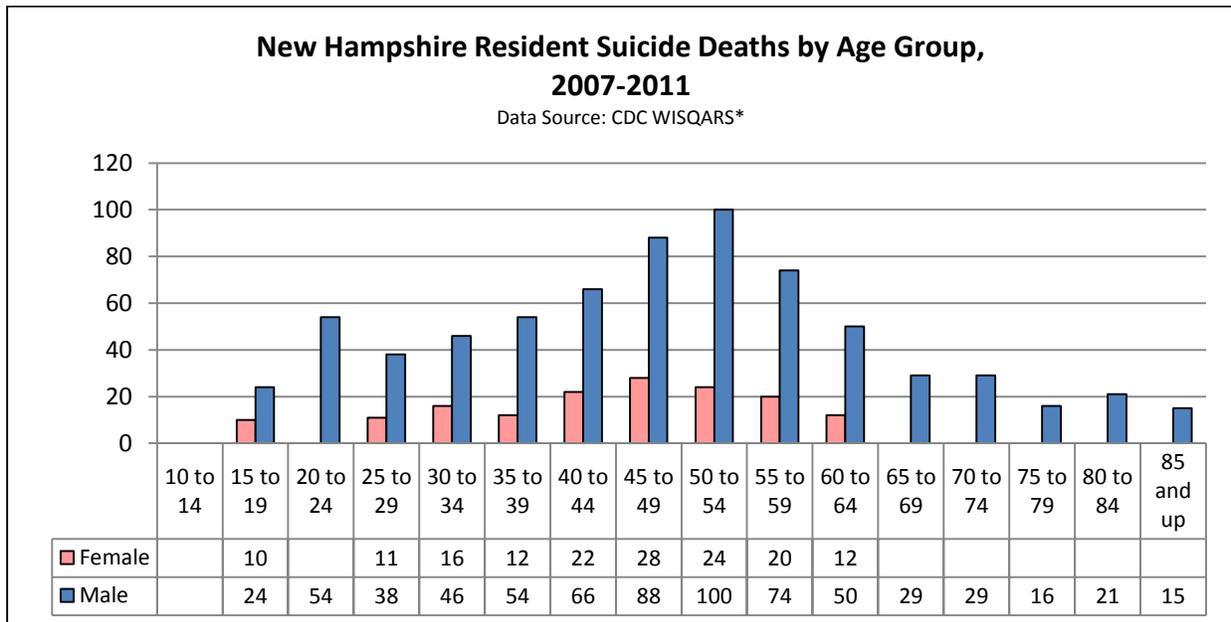


Figure 7 (below) and **Figure 8** (pg. 24), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and gender from 2007-2011. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal how death rates correct for 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 deaths are seen in males and females in the 40 and 50 year-old age groups.

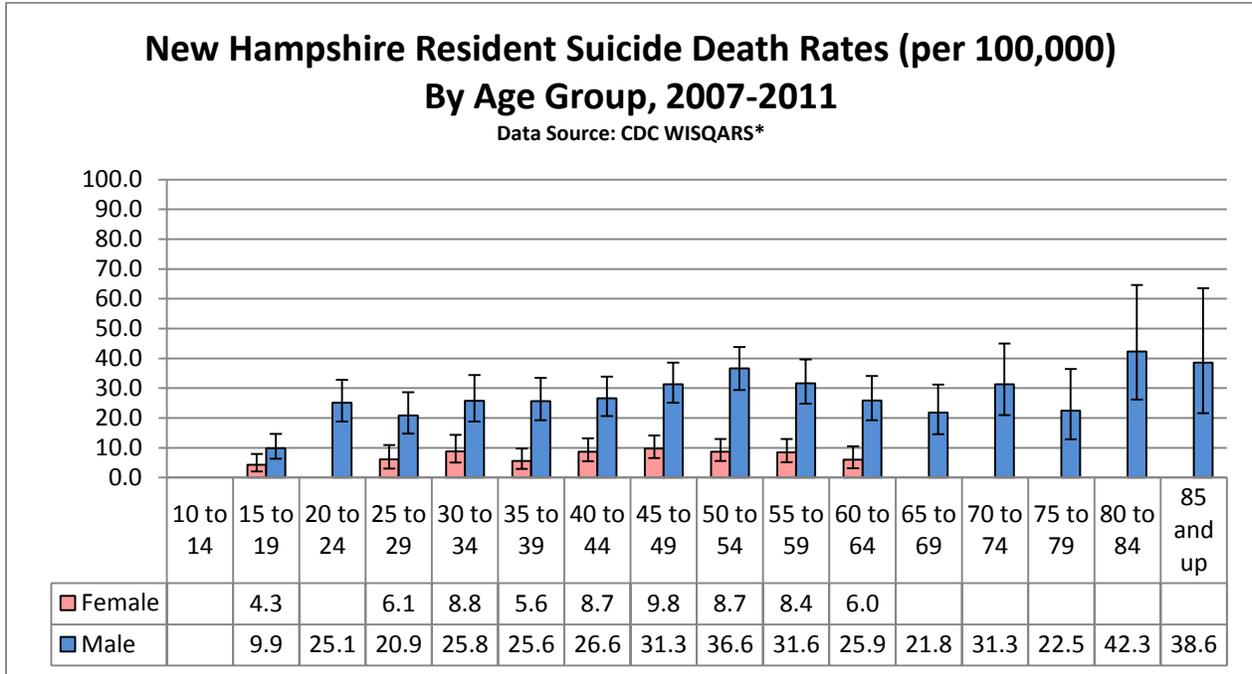


*Note: Beginning with 2008 data, the CDC has suppressed state-level counts/rates for categories with fewer than ten deaths

Suicide death rates are also important in determining vulnerable age groups and age-related transitions. The suicide death rate in males rises rapidly from ages 10-14 to 15-19 and then again from ages 15-19 to 20-24, pointing to a rise in vulnerability during the transitions from early adolescence to middle adolescence and then middle adolescence to late adolescence/early adulthood. Similarly, suicide rates among elderly males increase substantially at 80-84 years compared to the younger age groups, indicating another vulnerable time of life for men.

Figure 8

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.

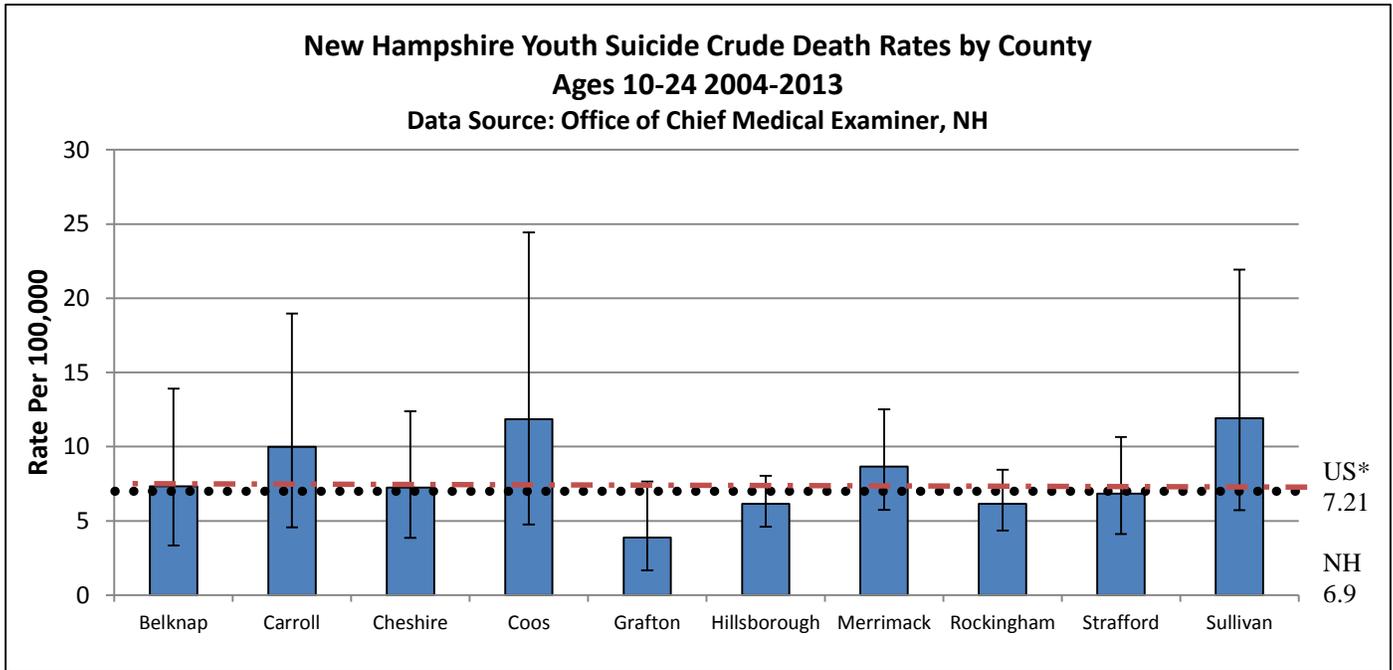


*Note: Beginning with 2008 data, the CDC has suppressed state-level counts and rates for categories with fewer than ten deaths

Geographic Distribution of Suicide in NH

The numbers and rates of suicide in NH are not evenly distributed throughout the state. **Figure 9** (pg. 25) shows youth and young adult suicide rates by county in NH. **Figure 10** (pg. 25) presents this data for NH residents of all ages. The county suicide death rate chart indicates geographical locations that may be particularly vulnerable to suicide (youth and young adult and/or all ages). Due to small numbers, most of these differences are not statistically significant. However, Carroll County (Carroll County all ages rate: 17.6 per 100,000) did have a significantly higher all ages suicide rate than Hillsborough County (all ages rate: 11.7 per 100,000) and Rockingham County (all ages rate: 10.0 per 100,000), as well as being significantly above the US rate (US all ages rate: 12.1 per 100,000). Additionally, the rate for Rockingham County was significantly below the rates for Belknap County (all ages rate: 15.2 per 100,000), Grafton County (all ages rate: 14.9 per 100,000), and Sullivan County (all ages rate: 15.7 per 100,000). County limits are neither soundproof nor absolute. A suicide that occurs in one county can have a strong effect on neighboring counties, as well as across the state, due to the mobility of residents. **Figure 11** (pg. 26) presents the suicide rates for all ages from 2007 to 2013 as a NH map broken down by county.

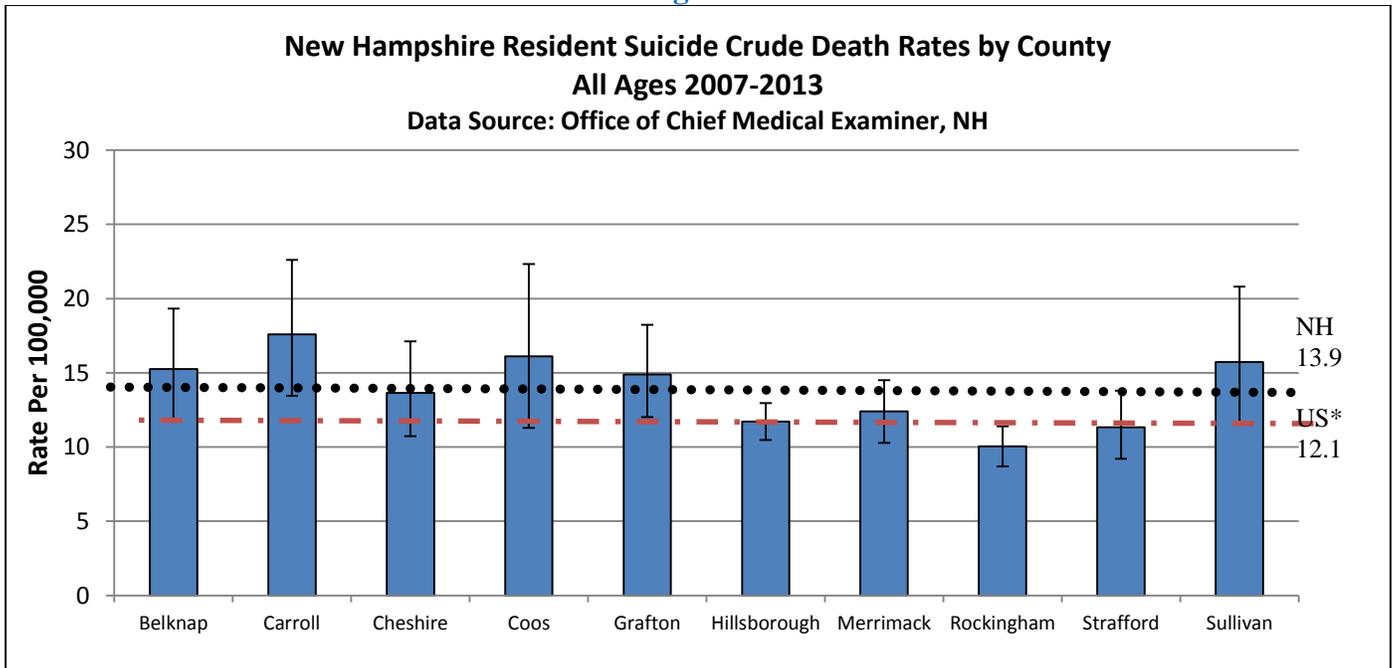
Figure 9



*US Rate is only through 2011

Source: CDC WISQARS

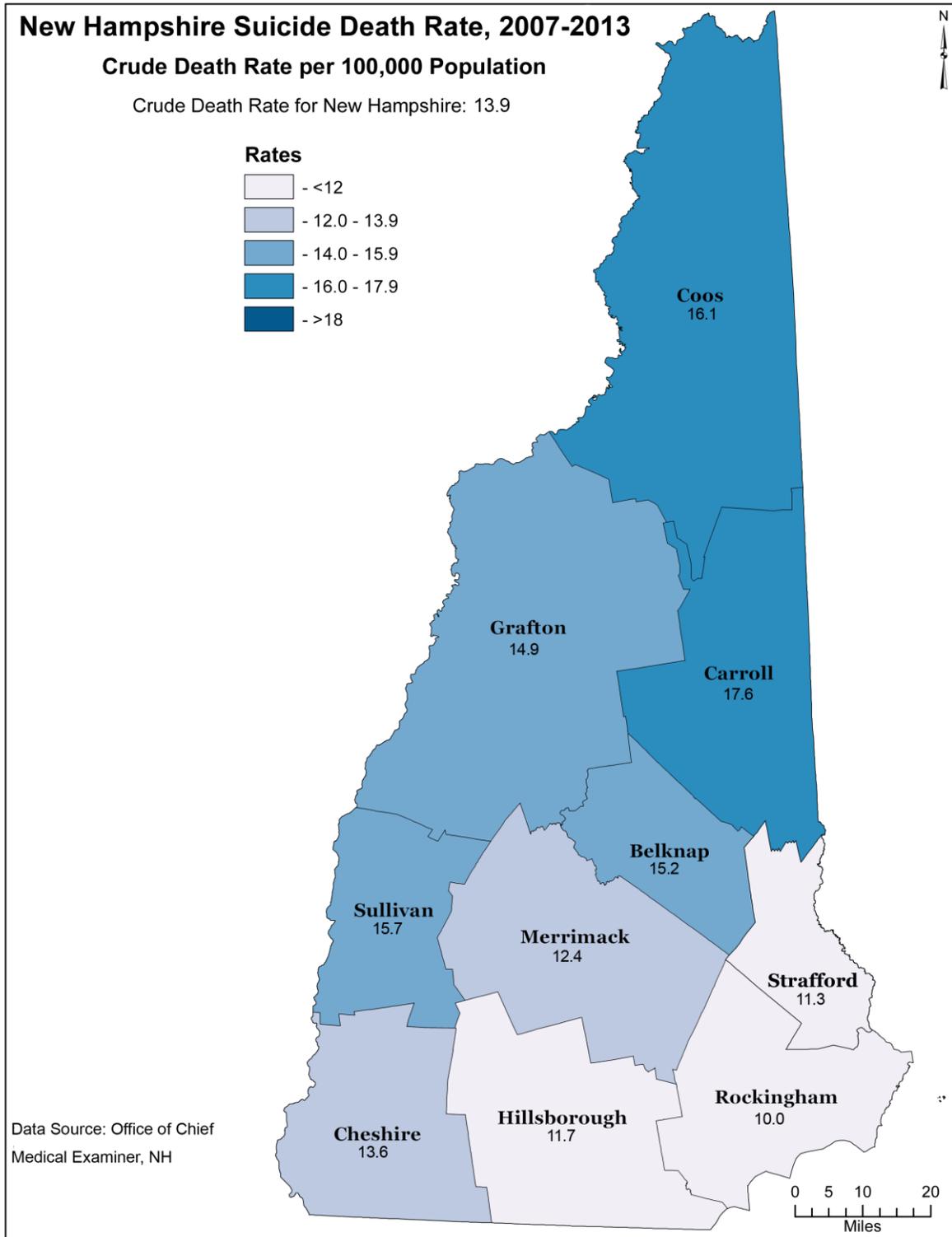
Figure 10



*US Rate is only through 2011

Source: CDC WISQARS

Figure 11
Map of NH suicide death rates



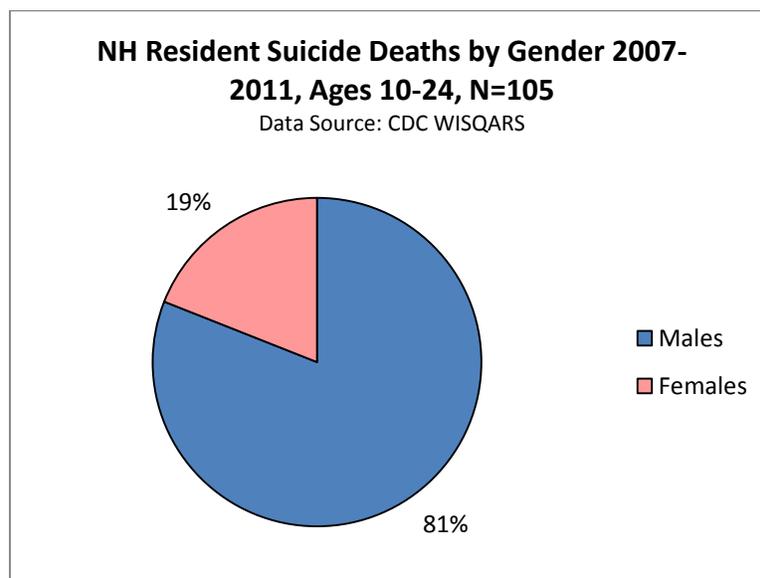
Suicide Behavior in NH: Gender Differences - Attempts and Deaths

Youth and Gender

While males represent over 80% of the youth and young adult suicides from 2007-2011, the fact that males *die* by suicide at a higher rate than females may largely be due to males using more lethal means. See **Figures 12** (below) and **13** (pg. 28). In fact, females *attempt* suicide at a higher rate than males. When examining how many NH youth and young adults were hospitalized and then discharged for self-inflicted injuries from 2005-2009, it is shown that 64% of the 921 inpatient discharges represent females, while only 36% represent males. Likewise, the 2013 NH Youth Risk Behavior Survey (YRBS) reports approximately 1.7 times as many female youth attempt suicide as males each year (8.6 % of females and 5.0% of males). Emergency department (ED/ambulatory) data reveals the same gender ratio, based on self-inflicted injury rates.²

Figure 12

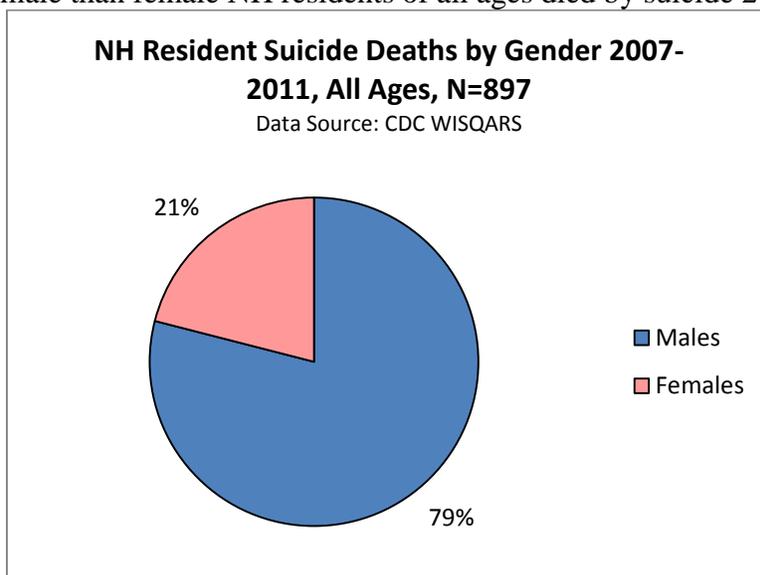
Three times more male than female NH residents ages 10-24 died by suicide 2007-2011.



² Classifying an injury as self-inflicted is another way of stating that the injury was an instance of deliberate self-harm. Not all self-inflicted injuries necessarily represent suicide attempts. However, analysis of these injuries is the best currently available proxy for estimating suicide attempts.

Figure 13

Three times more male than female NH residents of all ages died by suicide 2007-2011.



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. 29). 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 (also called Ambulatory Discharges). Inpatient data refers to patients who were admitted to the hospital for more than 24 hours. If a patient goes to an ED and is admitted for inpatient services, they are removed from count in the ED data and listed as inpatients. The hospital discharge data records the number of hospital visits, not the number of individual persons who went to the hospital for care. For example, if one patient went to the hospital three different times it would be counted as the same number of visits as three different patients who went to the hospital one time each over the course of one calendar year.

Quick Facts/Talking Points

- Males in NH die by suicide at a rate that is nearly four times the rate for females (CDC WISQARS, 2011).
- Although males are more likely than females to die by suicide, females report attempting suicide at nearly twice the rate of males (NH YRBS, 2013)
- Over ¾ of NH adults report that they feel suicide is preventable (2012 Granite State Poll - UNH Survey Center)

Figure 14

A greater percentage of female than male NH residents attempted suicide, as seen in inpatient self-inflicted injuries 2005-2009.

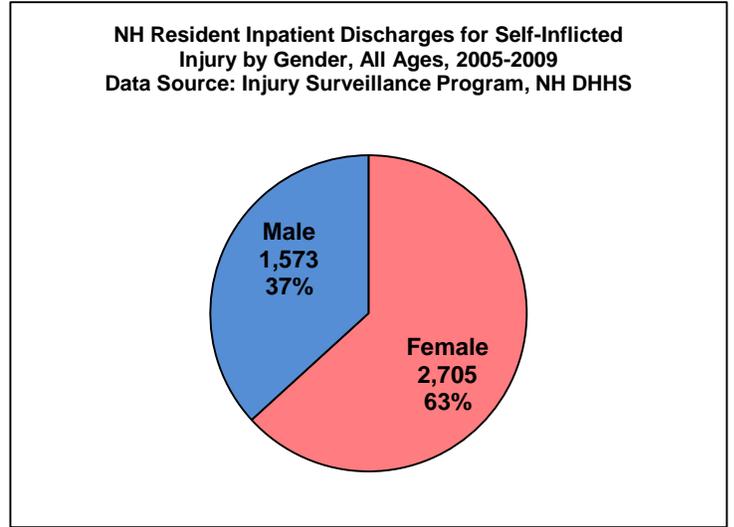
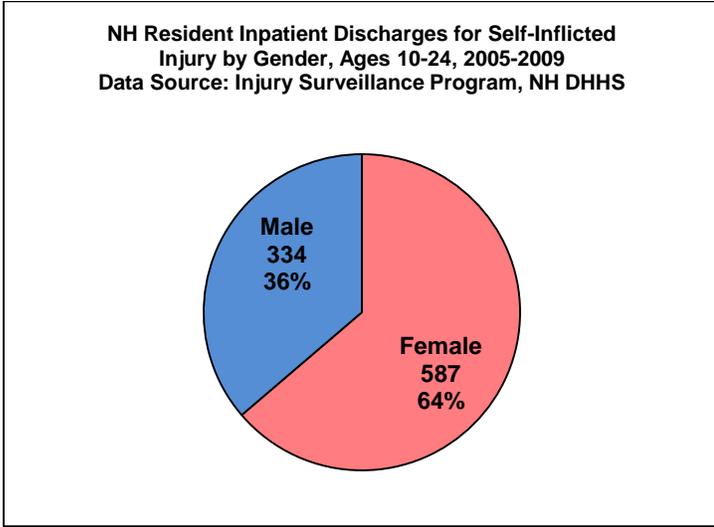
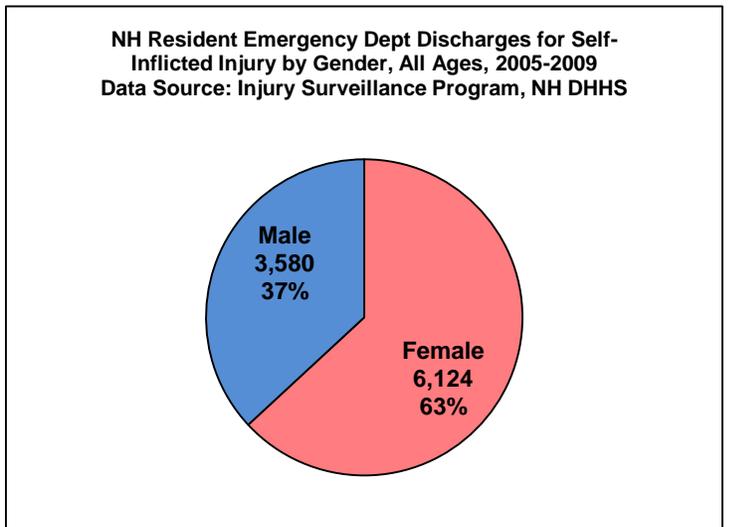
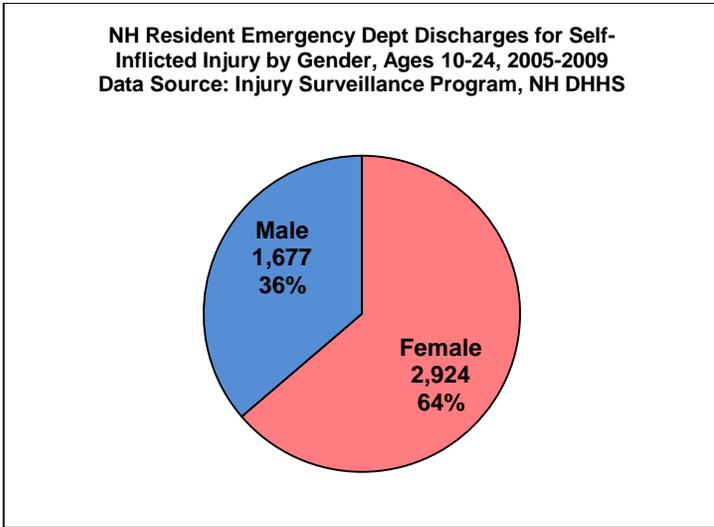


Figure 15

A greater percentage of female than male NH residents attempted suicide, as seen in ambulatory self-inflicted injuries 2005-2009.



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.

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 disorders³. Yet a much smaller percentage were receiving treatment. In NH, over 17,000 people received treatment at one of the state's ten Community Mental Health Centers (CMHC)⁴ for depression during 2012. This works out to approximately 1

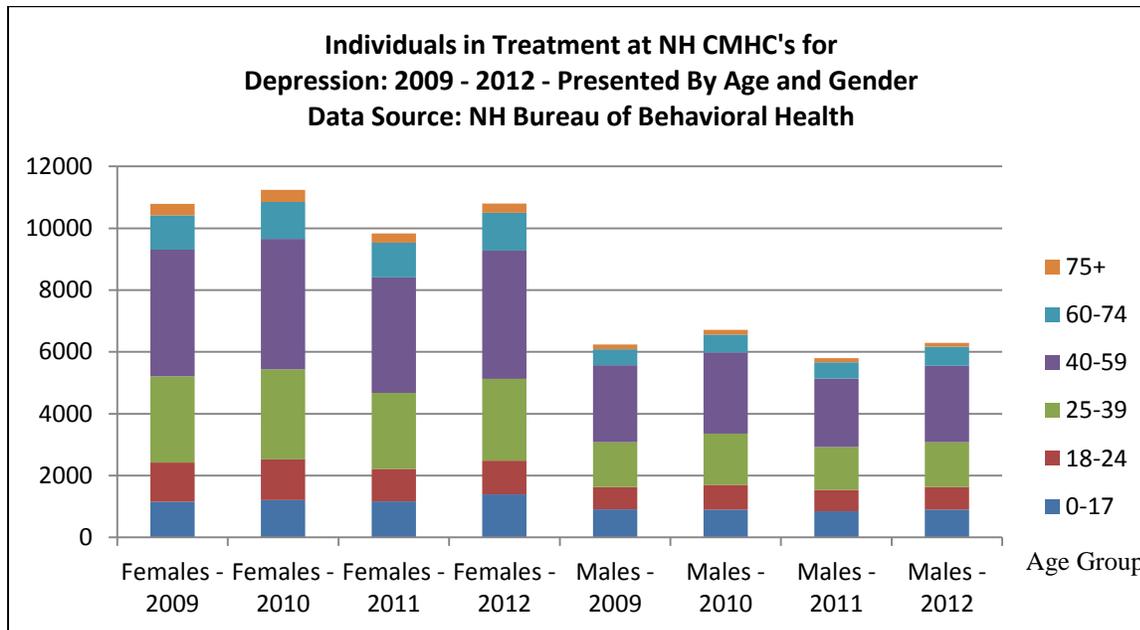
out of every 77 residents in the state. Of those individuals in treatment for depression, approximately 2/3 of them were female and 1/3 were male. This is illustrated in **Figure 16** (pg. 31). Without additional data it is not possible to say how these numbers relate to the comparative incidence of 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.

³ Conwell Y, Brent D. Suicide and aging I: patterns of psychiatric diagnosis. *International Psychogeriatrics*, 1995; 7(2): 149-64.

⁴ Community Mental Health Centers are private not-for-profit agencies that have contracted with the NH Department of Health and Human Services, Bureau of Behavioral Health, to provide publicly funded mental health services to individuals and families who meet certain criteria for services. More information on the centers is available from <http://www.dhhs.state.nh.us/dcbcs/bbh/centers.htm>

Figure 16

Individuals receiving treatment for depression at NH CMHCs presented by age and gender.⁵



Patients that cannot be treated in an outpatient setting, such as involuntary admissions due to potential suicide risk, will generally be admitted to New Hampshire Hospital, the NH state psychiatric hospital. In an average year there are approximately 2,218 admissions to New Hampshire Hospital (estimates based on New Hampshire Hospital admissions for fiscal years 2010 - 2012). The gender differences for individuals receiving treatment at New Hampshire Hospital are much smaller than for those receiving treatment for depression through the CMHCs. The admissions are approximately an even split between females and males.

Positive Outcomes and Testimonials

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

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

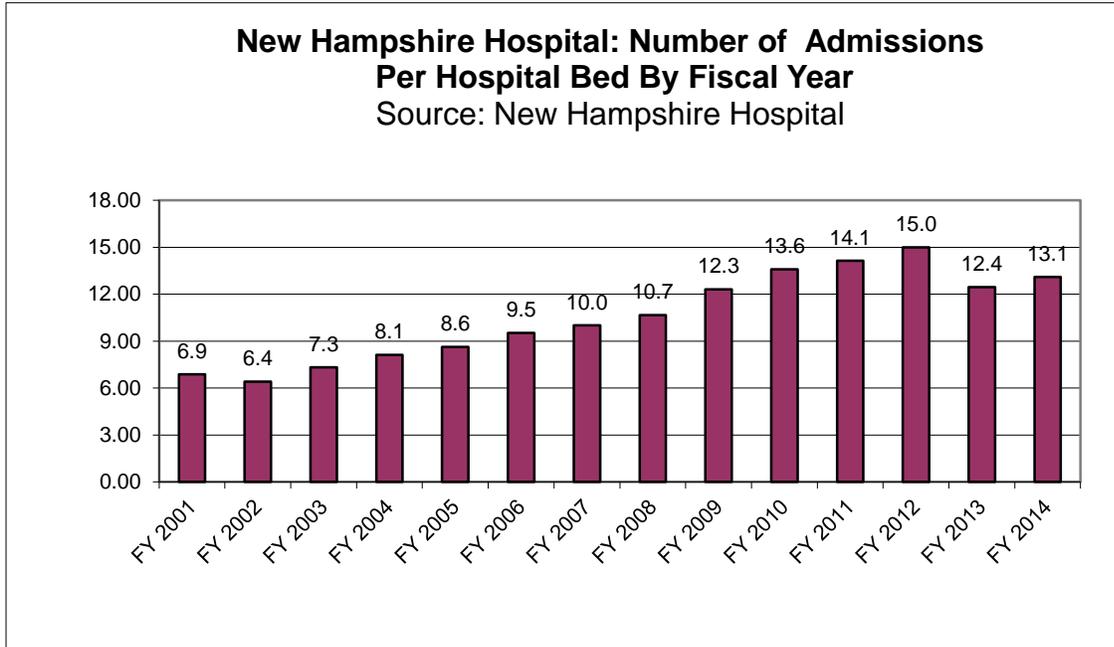
Maggie Pritchard
Executive Director, Genesis Behavioral Health
Vice-Chair, NH Suicide Prevention Council

Although the number of admissions were comparable for males and females, this does not guarantee that severity of the cases were similar or that the lengths of stay were similar. **Figure 17** (pg. 32) presents the number of admissions per bed at New Hampshire Hospital. The increase over time on this chart has been due to both an increase in the number of admissions at the hospital (from 1460 admissions in 2001 to 1967 admissions in 2013), and a decrease in the number of available beds (from 212 beds in 2001 to 158 beds in 2013).

⁵ These numbers include all individuals with a primary or secondary diagnosis of depression.

Figure 17

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



Age, Gender and Self-inflicted Injury

When 2005-2009 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 18 and 19** – pg. 33). As above, these data refer to number of visits; therefore, individuals may be counted more than once if they were admitted or seen more than once during the year.

Female NH residents have a higher overall rate of inpatient hospitalizations/discharges for self-inflicted injuries, yet for ages 80 and up, males may, with some uncertainty due to overlapping confidence intervals, have a greater rate of self-inflicted injuries. For those females aged 15-19, the rate of those being discharged from inpatient care (**Figure 18** pg. 33) is close to 125/100,000, more than two times the rate for males of the same age. The peak age for males is between 25 and 29 for self-inflicted injuries requiring hospitalizations. Again, ED usage rates, depicted in **Figure 19** (page 33), point to females aged 15-19 as a population particularly vulnerable to self-injury and/or suicide attempts, with a rate over 660/100,000, about 194 times the suicide death rate for this population. Males also peak in self-injury around this age group with the male rates for ages 20 to 24 being slightly higher than those for ages 15 to 19. Although male rates peak around this age group, their rates are much lower than those for females. Also of note, the total number of youth and young adult ED visits (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 the transition from middle adolescence to late adolescence/early adulthood is a time of great risk for suicidal thinking, self-harm and suicide attempts.

Figure 18

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

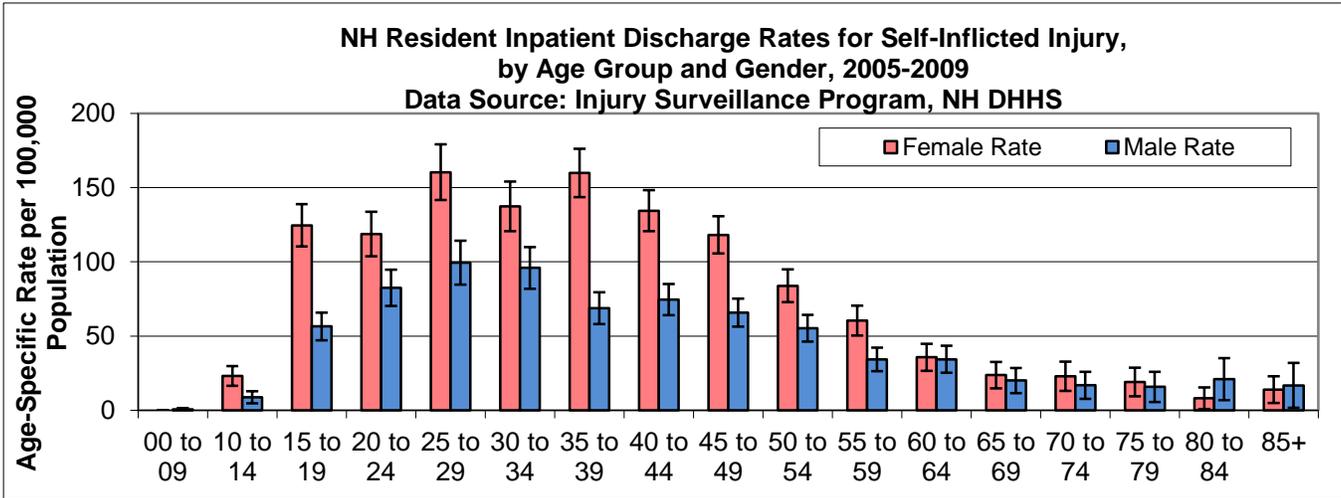
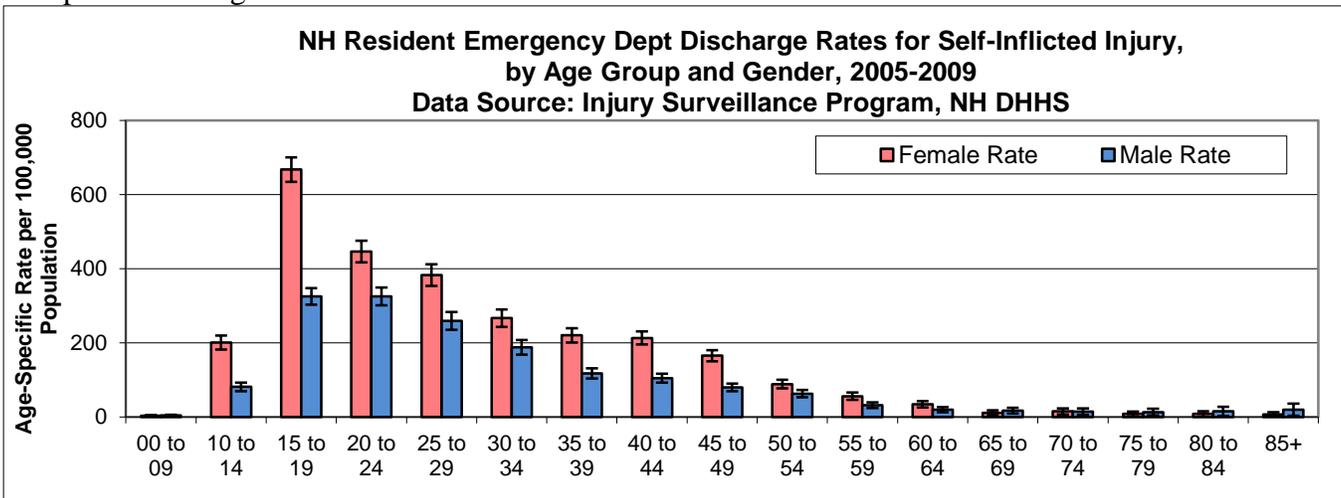


Figure 19

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 17 suicide attempts for every suicide death. This number does not include attempts that go unreported, unrecognized, or without a hospital or ED visit which required medical intervention. Further, the rates of attempts for young people and females create an even greater ratio of suicide attempts to deaths. Based solely on hospital and emergency department self-injury data, it is estimated that over 700 youth and young adults (age 24 and under) attempt suicide each year in NH.

In contrast to the above data, which are based on cases where medical intervention is required, the results of the YRBS presents data collected from high school aged youth by self-report. In 2013, nearly 7 percent of high school students completing the YRBS reported having attempted suicide at least one time over the previous year. Based on the YRBS figures, this works out to over 3,900 high school age youth in NH who may attempt suicide each year. The YRBS reports may account for attempts not included in hospital self-injury data. This could be the case for any attempts with relatively non-lethal means where medical assistance was not sought. Of particular concern for this data is the likelihood that in many of these cases, the youth have never sought help or disclosed the attempt to any adult.

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

While the great majority of self-inflicted injuries⁶ are not fatal, because of the larger incidence they directly and indirectly affect a substantially greater number of people than do fatalities. A significant risk factor for suicide is a previous attempt: in one study 21-33% of people who die by suicide have made a previous attempt (Shaffer & Gould, 1987). 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 2007 and 2011, 51% used firearms compared to 28% of females (**Figure 20** – pg. 35). 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 21** (pg. 36) compares firearms, hanging, poisoning, and cutting/piercing in terms of the percentage of various outcomes (emergency department visit, inpatient admission, or death) for each method. Over 80% of self-injuries using a firearm result in death (**Figure 21**). 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

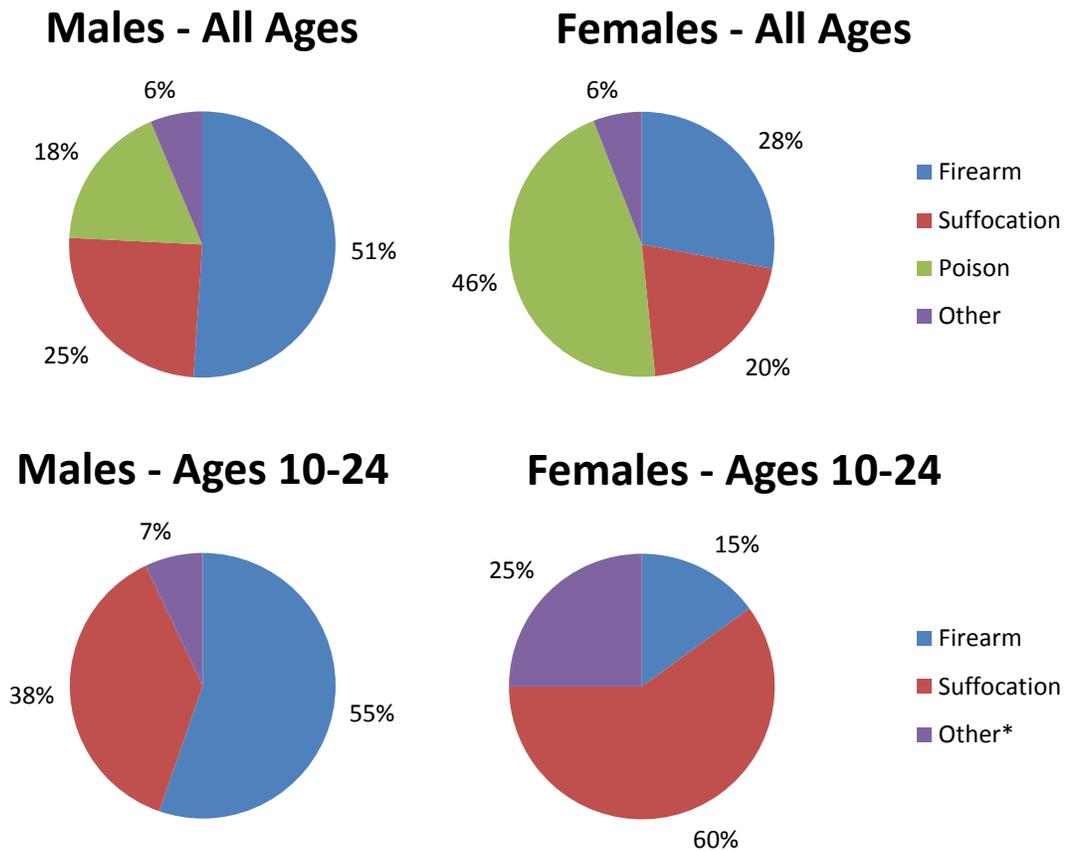
⁶ Classifying an injury as self-inflicted is another way of stating that the injury was an instance of deliberate self-harm. Not all self-inflicted injuries necessarily represent suicide attempts. Analysis of these injuries, however, is the best currently available proxy for approximating suicide attempts.

percentage of suicide deaths due to a firearm increases to almost 70% for those ages 60+. The use of suffocation as a suicide method peaks in early adolescence, and decreases steadily throughout the lifespan (**Figure 22** – pg. 36).

Figure 20

Variation in Method of Completed Suicide Deaths by Gender and Age Group, 2007-2011.

Method Used in Completed Suicides, 2007-2011



Data Source: CDC WISQARS

*Poisoning deaths have been included in the “Other” category for the charts of individuals age 10-24 due to exceedingly small numbers in that category for those groups.

Figure 21

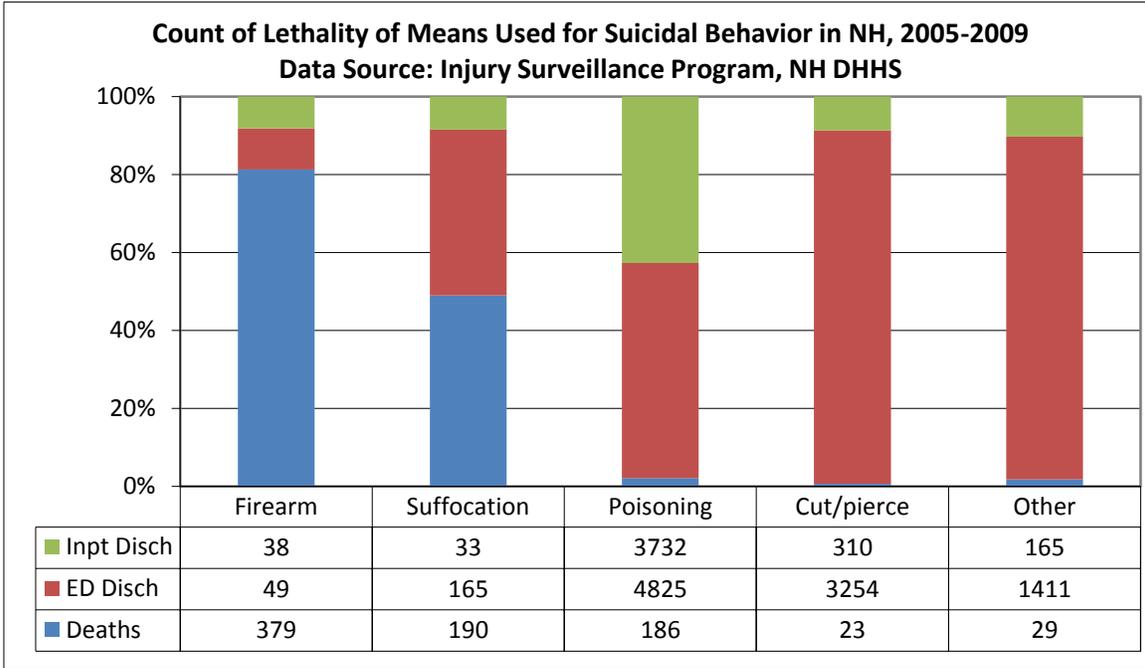


Figure 22

Suicide methods used in NH vary by age group, as seen in 2007-2011.

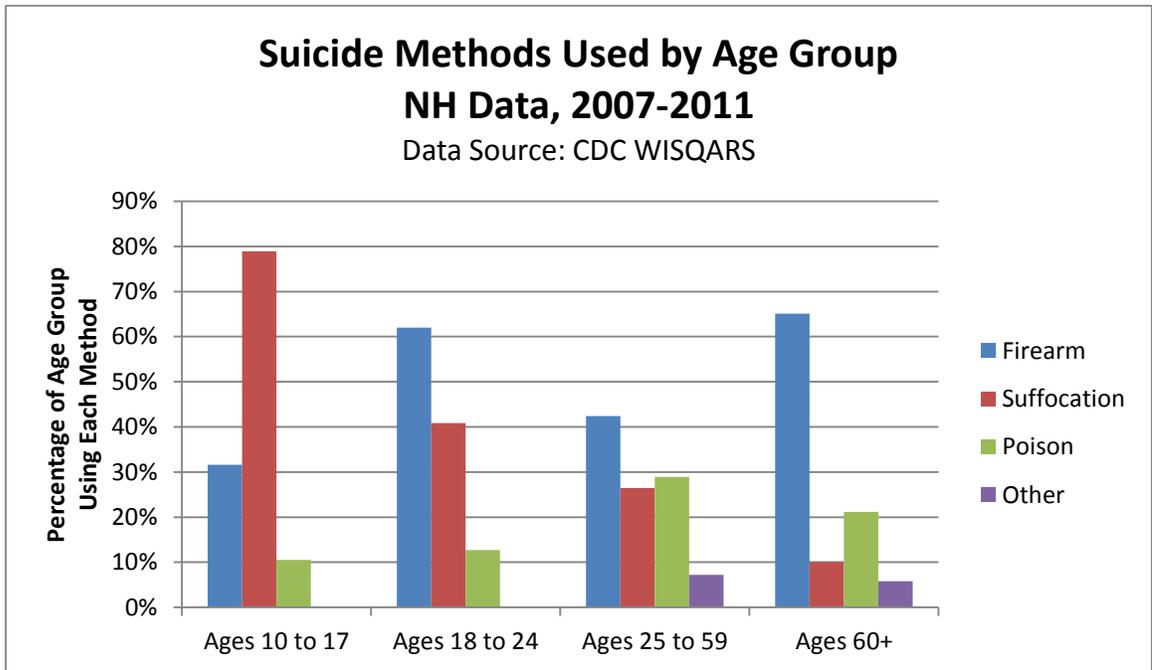
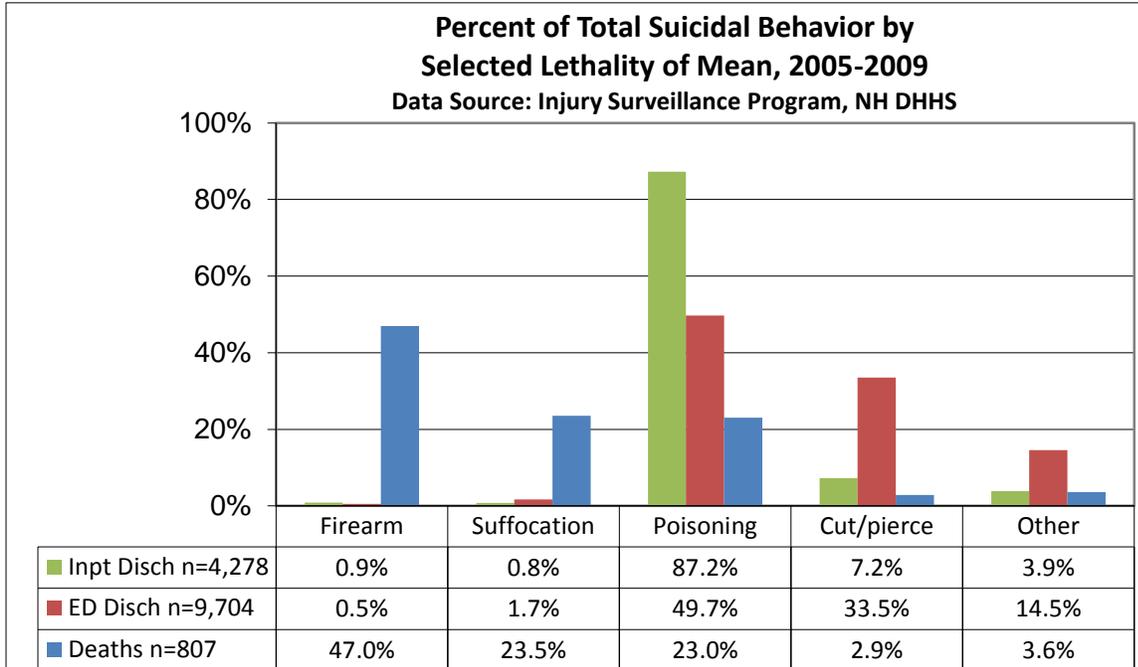


Figure 23

Poisoning is the most frequent method of suicide attempt, as seen in hospital discharge data 2005-2009.

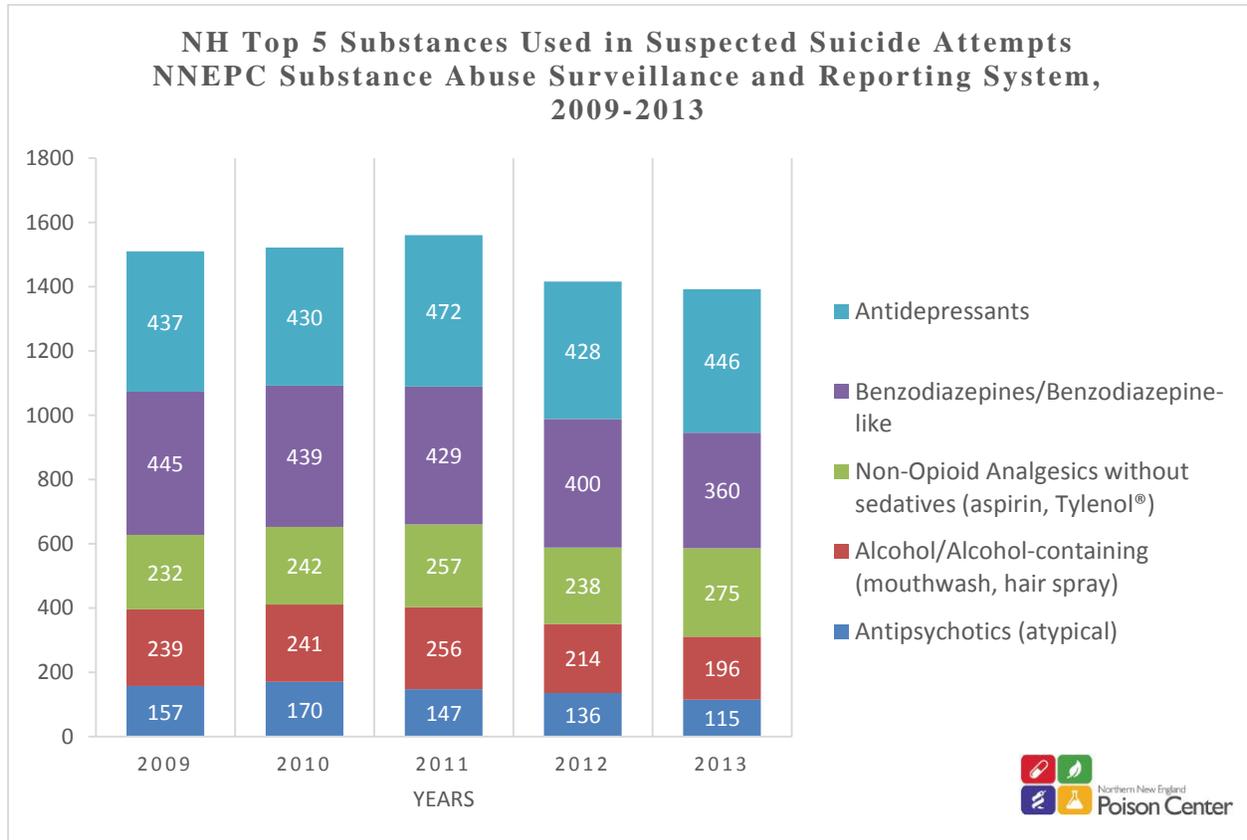


Although suicide attempts employing poison do not account for as many deaths in NH as firearms or hangings, intentional poisonings account for the overwhelming majority of inpatient and ED admissions for suicide attempts (**Figure 23** – above). **Figure 24** (pg. 38) depicts the prevalence of the five most common substances used in suspected suicide attempts in NH as collected by the NNEPC. The top two from 2009 through 2013 have been Antidepressants and Benzodiazepines.⁷

⁷ The suspected suicide attempt cases presented were determined by self-report or the report of an individual acting on behalf of the patient (e.g., a health care professional), or a NNEPC staff assessment.

Figure 24

Antidepressants and Benzodiazepines have been the top substances used in suspected NH suicide attempts from 2009-2013.

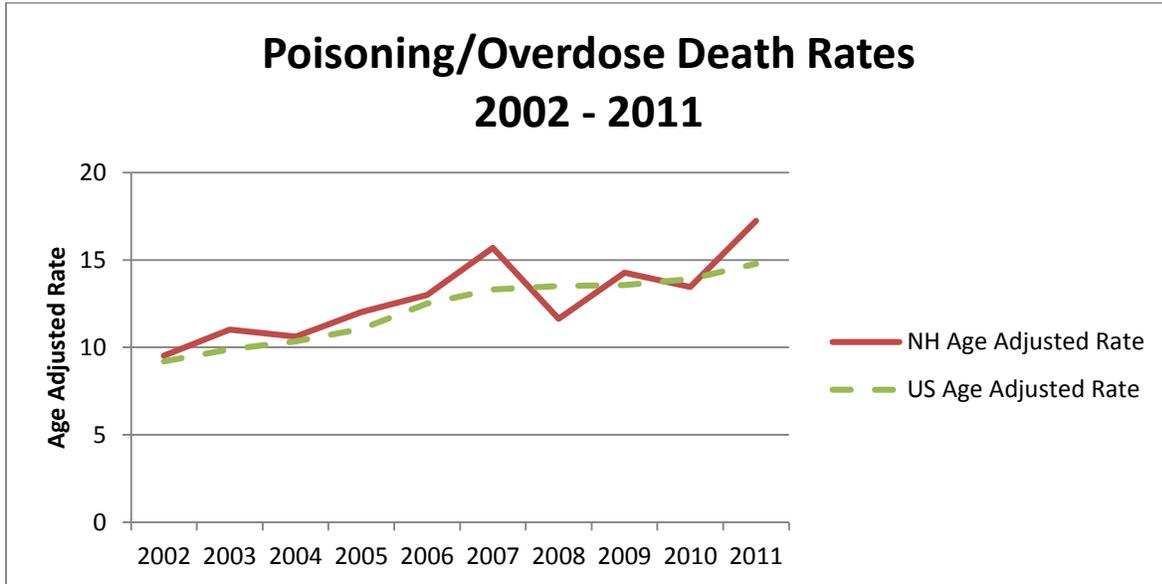


Increasing Accidental Poisoning and Drug-Related Death Rates – Cause for Concern

As seen in **Figure 25** (pg. 39), the accidental poisoning and drug-related death rates in NH and the US as a whole have steadily increased from 2002 to 2011. During this time the NH and US rates have nearly doubled. Although it is not possible to determine an exact number, it is likely that these accidental poisoning and drug-related deaths include suicide deaths where there was not enough evidence for the Medical Examiner to classify them as such. This trend is a cause for concern as both a potential increase in poisoning and drug-related suicide deaths, and as a potential indicator of increased risk taking behavior.

Figure 25

Poisoning/Drug-related death rates in NH have nearly tripled from 2002 to 2011



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 CALM. It has not been conclusively demonstrated that

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

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 suicide).

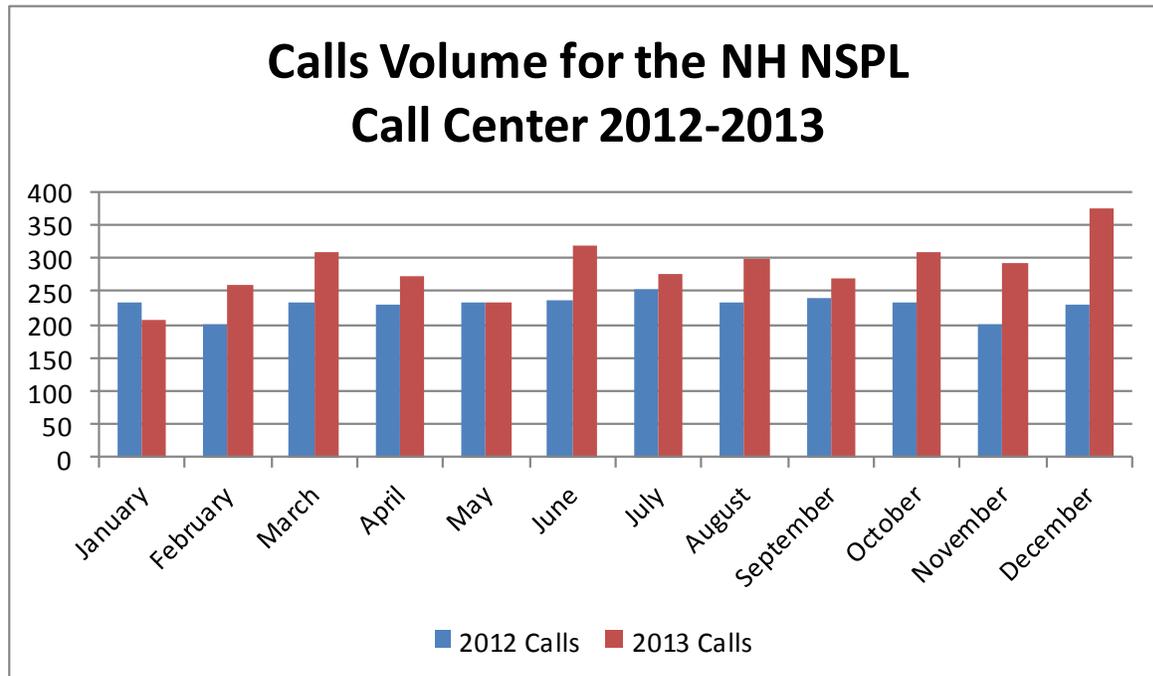
Linking At-Risk Individuals with Help

Crisis lines, such as the National Suicide Prevention Lifeline (NSPL) are vital to suicide prevention efforts in NH and nationally. In 2013, there were approximately 1,590,750 calls made to the NSPL. 3,423 of these calls, or roughly 285 per month were received by the NH NSPL call center (see **Figure 26** pg. 40). 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 26

NH NSPL call center responds to an average of 285 calls per month.



Costs of Suicide and Suicidal Behavior

There were between 25,263 and 33,845 years of potential life lost to suicide from 2007-2011 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 suicide attempts or deaths by employees or their loved ones.

Additional Data Sources

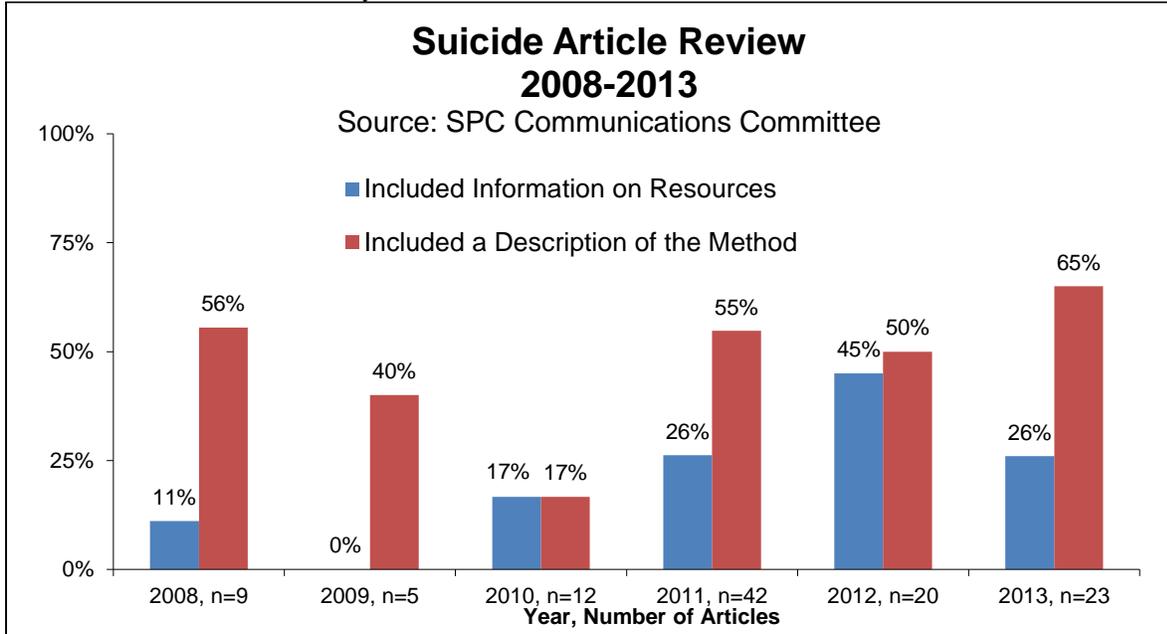
Suicide Prevention Council Communications Subcommittee Media Review

In 2013 the Communications Subcommittee of the NH Suicide Prevention Council updated its review of known articles published by NH media from 2008 to 2013 that focused on an individual who died by suicide. Known articles include those that were identified by committee members and those that were sent to committee members by other individuals. The articles included in this review may not include all articles published in NH during this timeframe. The Communications Subcommittee established guidelines for rating whether articles included resource information, lists of warning signs, detailed descriptions of the method of suicide, inappropriate visuals, or glorification of the life of the deceased individual. Two trends emerged from this review and are presented in **Figure 27** (pg. 42). From 2008 to 2012 the percentage of articles including detailed descriptions of the method of suicide remained relatively constant. During that same period the percentage of articles that featured resource information quadrupled. In 2013 the percentage of articles reporting resources had decreased from the high seen in 2012. The 2013 percentage is still equal or greater than the percentages seen from 2008 through 2011. In 2013 there was also an increase in the percentage of articles reporting a detailed description of the method of suicide.

Additional work is still needed to educate the media on the potential risk of suicide contagion when articles publish detailed information around the method of suicide. As part of this outreach the Suicide Prevention Council hosted a media summit discussion on suicide reporting guidelines. This summit, held at the Nackey Loeb School of Communications, brought together professionals in the media as well as those in the field of suicide prevention. The Suicide Prevention Council also continued its work with students in colleges around the state, teaching them the importance of the reporting recommendations and how to incorporate them into their writing.

Figure 27

Articles Reviewed by the SPC Communications Subcommittee from 2008 to 2013

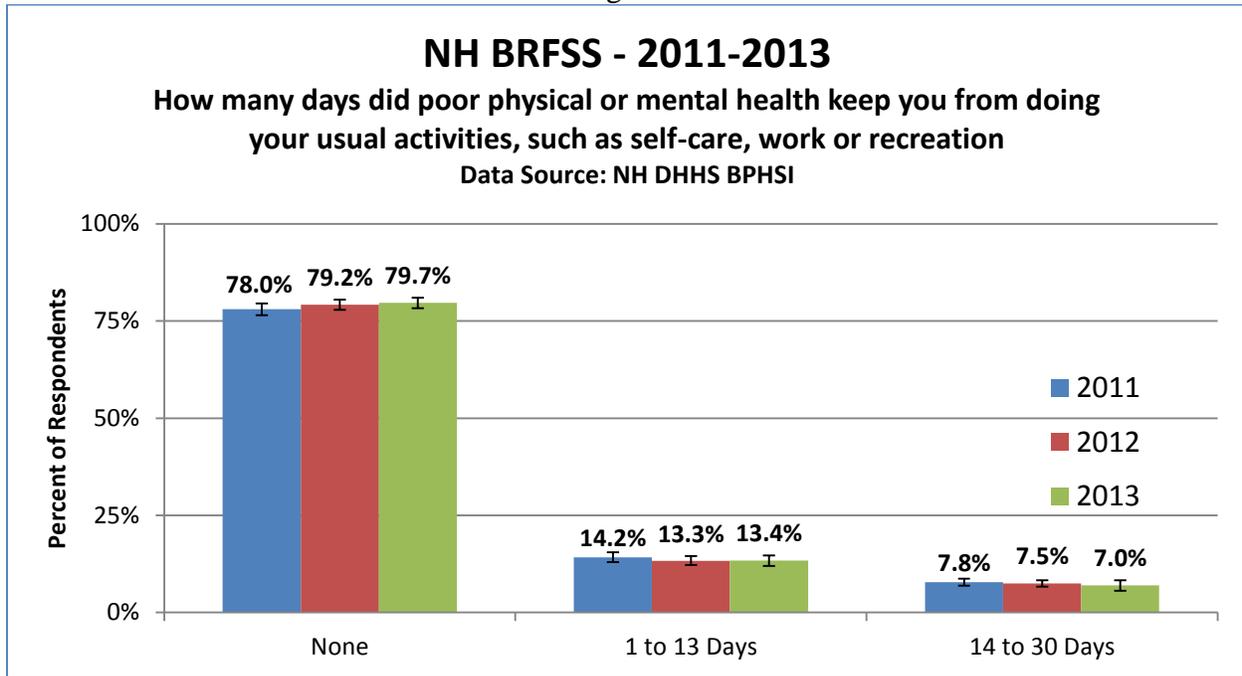


NH Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS), a survey conducted with a representative sample of state residents, includes a core question on the number of days that poor physical or mental health kept individuals from doing their day-to-day activities. Although this is not a perfect proxy measure for depression, it gives one a general sense of the percentage of NH residents that may be experiencing depression. The results from this item are included in **Figure 28** (pg. 43).

Figure 28

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



Data from the NH National Guard

From 2009 through 2013 the NH National Guard recorded a total of 122 suicide related incidents of varying levels of severity (ideation, plan in place, attempt, or death), with the majority being ideation or having a plan in place. Of these incidents, 28% were from individuals under the age of 22 and 35% were age 22-26, 12% were age 27-31, 6% were age 32-36, and 11% were age 37-41. The remaining 8% were age 42 and above. Forty-three percent of the incidents were by non-

Positive Outcomes and Testimonials

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

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

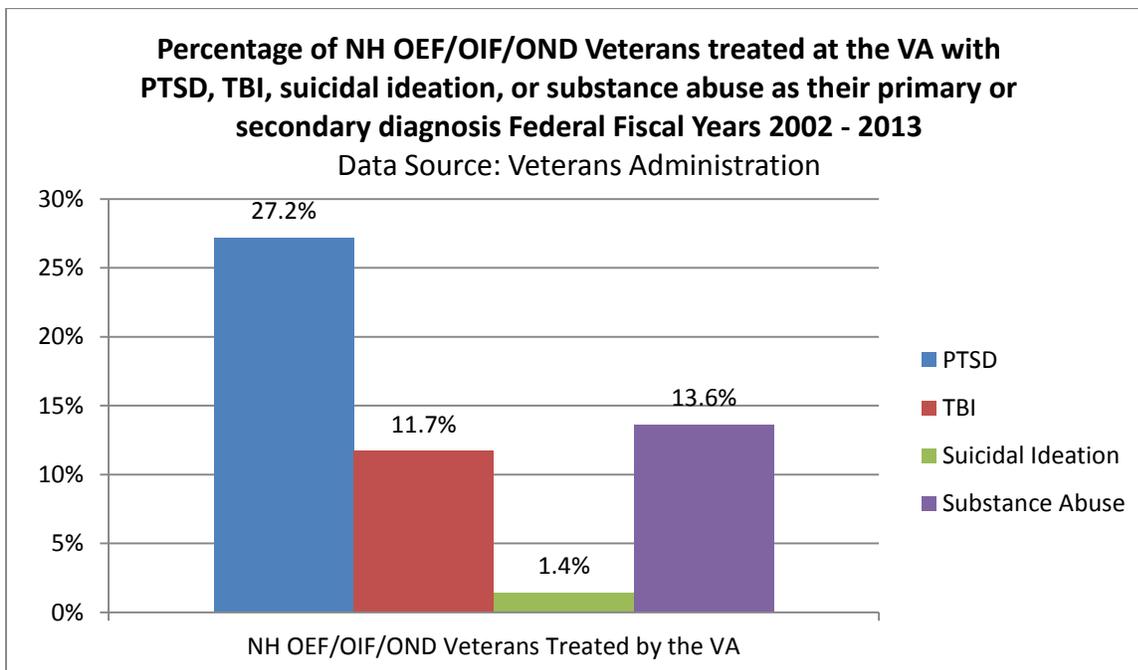
deployed personnel. Of the incidents recorded, 80% were by males and 20% were by females (males may be disproportionally represented among NH National Guard compared with the general population).

Data on NH Veterans from the Veterans Administration (VA)

The VA provides care to many of the Veterans in the State of NH including those recently returned from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). Of the NH Veterans who served in OEF/OIF/OND, 5,575 have been treated at the VA since 2002. The percentage of these individuals treated for post-traumatic stress disorder (PTSD), traumatic brain injuries (TBI), suicidal ideation, and substance abuse are presented in **Figure 29** below.

Figure 29

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



Data from the NH Department of Corrections

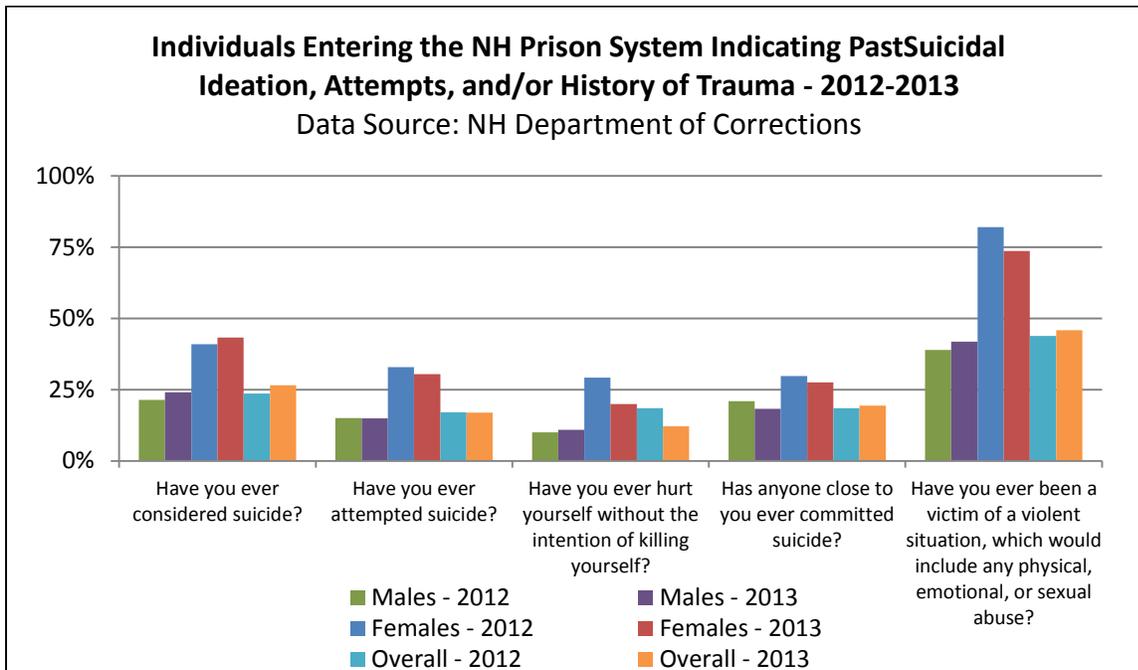
In 2011, the NH Department of Corrections had a total of 1,226 males and 139 females who were screened for suicidality and history of trauma upon their entry into the prison facilities. (**Note:** this does not reflect the populations in county or local facilities.) After an immediate screening by a 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 2013 show that at intake nearly 24% of males and 43% of females indicated past suicidal ideation and approximately 15% of males and 30% of females indicated a past suicide attempt⁸.

⁸ 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).

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 30** (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 30

Percentage of individuals entering NH prisons in 2012 and 2013 indicating past suicidal ideation, attempts, and/or history of trauma by gender.



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 flat or on a downward trend. It is nearly impossible to firmly establish causality for such trends. Statewide collaborative prevention efforts, including the work of YSPA, the SPC, implementation of NH’s Suicide Prevention Plan, the *Connect* Program, GLS funding through the SAMHSA, CALM and the work of many community partners likely played a role in that downward trend. Even though rates have recently increased, the value of prevention efforts should not be discounted. Without the continued work of these individuals and organizations, a greater increase in NH suicide rates may have occurred.

Figure 31 (below) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2002 to 2011. **Figure 31** shows a small dip for the 2005-2007 and 2006-2008 intervals. However, this decrease and the subsequent increase are not statistically significant differences. The rolling three-year intervals for NH residents of all ages combined does show a significant difference between 2002-2004 and 2008-2010. The 2004-2006 period was also significantly lower than the 2008-2010 period (**Figure 32** – pg. 47).

Figure 31

Suicide rates among 10-24 year old NH residents have remained relatively consistent, as seen from 2002-2011.

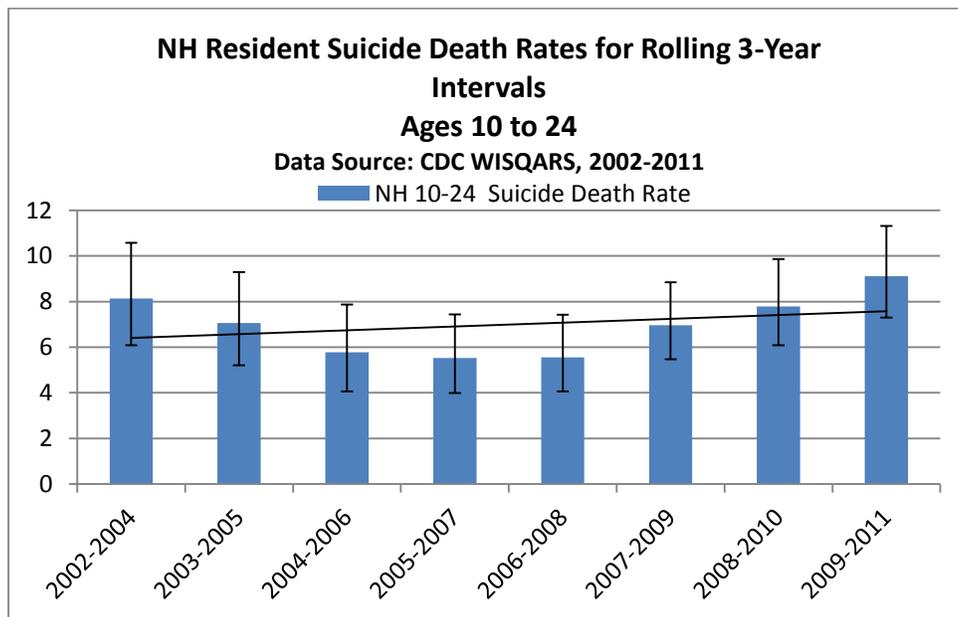


Figure 32

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

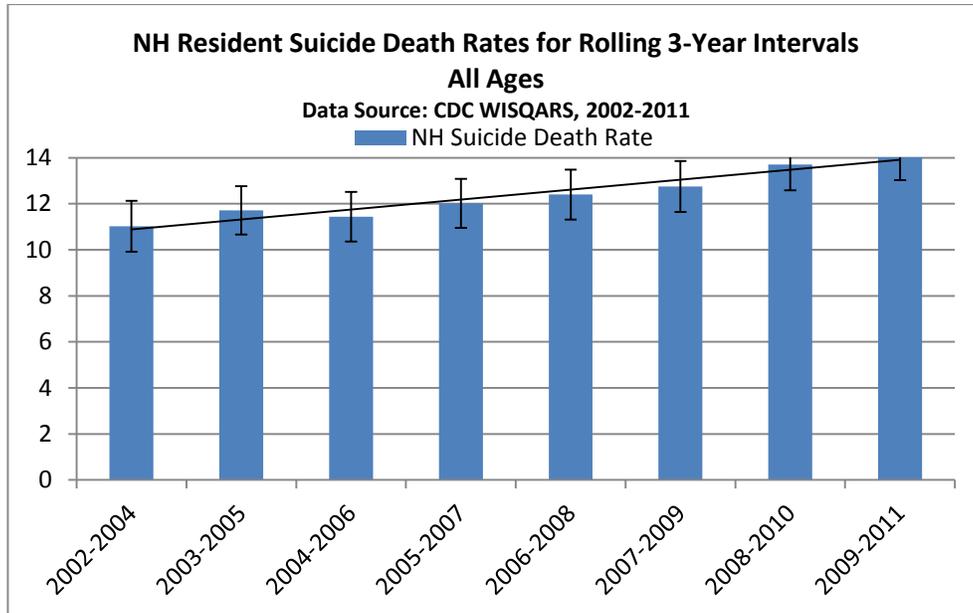
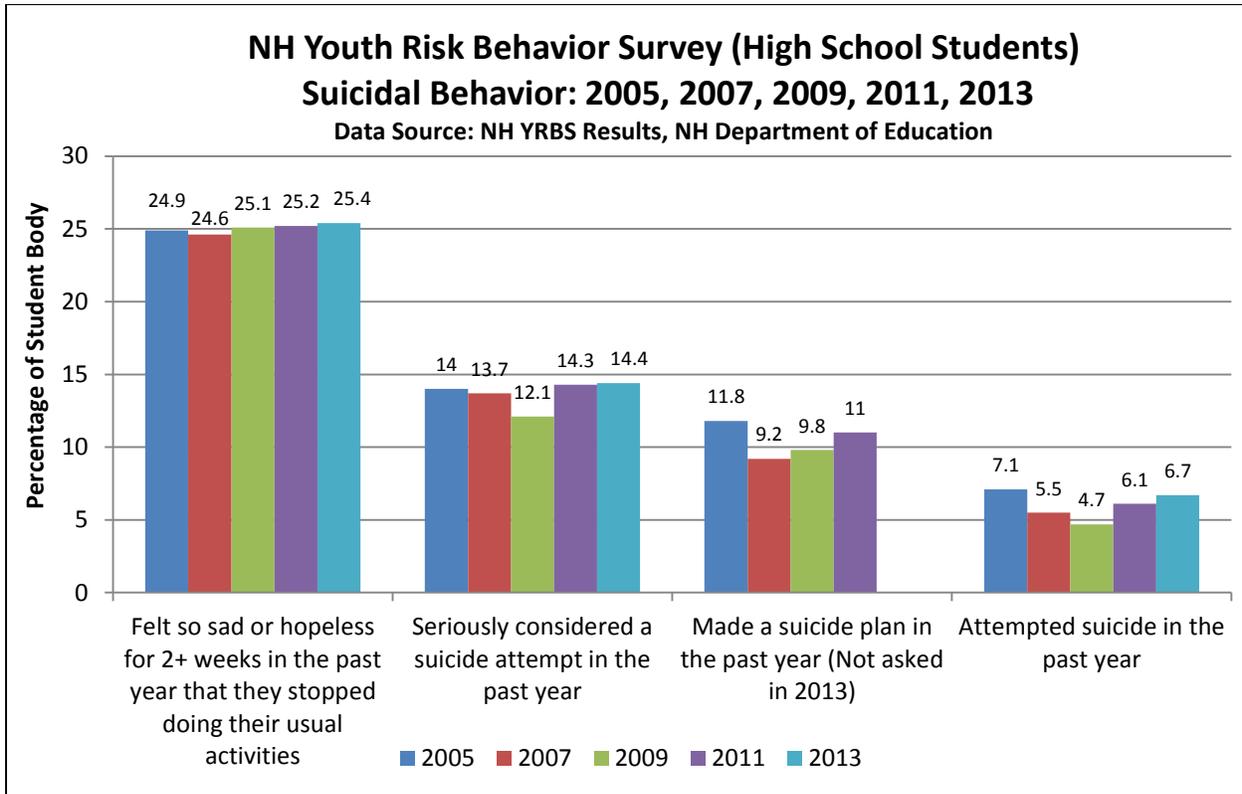


Figure 33 (pg. 48) indicates results of the NH YRBS from 2003, 2005, 2007, 2009, 2011, and 2013. The percentage of high school youth in NH who seriously considered a suicide attempt in the past year and the percentage of those who made a suicide plan in the past year both decreased since 2003. However, in 2013, 1 in 7 youth surveyed still seriously considered attempting suicide in the past year, while 1 in 15 reported actually having made an attempt.

Figure 33

Depression among high school youth remains at about one fourth of the population despite decreases in suicide attempts and suicidal ideation from 2005 to 2013.



While suicide attempts reported by NH high school students on the YRBS have decreased in comparison with data from 2005, they still affect a large proportion of the student body. The NH YRBS item addressing whether students have made a suicide plan in the past year was not asked in 2013. This was done due to the similarity to the question asking whether youth had seriously considered a suicide attempt during the past year. The removal of this question allowed for the addition of a question addressing non-suicidal self-inflicted injuries (e.g., cutting or burning oneself without the intent of dying). The results of that new question indicate that 17.9% of NH high school age youth (10.1% of males and 26% of females) report intentionally hurting themselves without the intent to die during the past year.

Reading Tables and Figures

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

Types of Charts

- **Line Chart:** A line chart presents a series of connected observations in order. For example, the line chart in **Figure 3** of this report shows the number of youth and young adult suicides over a 10-year span in NH.
- **Pie Chart:** A pie chart gives the percent values for the individual parts of a whole using a circle that is divided into wedges. For example, a pie chart (**Figure 12**) of this report shows the percent of male and female youths and young adults in NH that died by suicide from 2006 to 2010.
- **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 2006 to 2010 and the rate of suicide deaths by age group in NH from 2006 to 2010.

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 2004 to 2013. 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 Rockingham County.

Frequently Used Scales

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

Interpreting Information from Charts

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

Glossary of Terms

Acronyms

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

Age Adjustment and Rates

All rates in this document are age-adjusted to the 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:

Where,

m = number of age groups

d_i = number of events in age group i

P_i = population in age group i

S_i = proportion of the standard population in age group i

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

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

Age Specific Rate/Crude Rates

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

Confidence Intervals (Ci)

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

The formula used is:

Where,

R = age-adjusted rate of one population

z = 1.96 for 95% confidence limits

SE = standard error as calculated below

$$R \pm z (SE)$$

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

Data Collection

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

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

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

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

Data Confidentiality

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

Graphs

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

Incidence

Incidence refers to the number or rate of new cases in a population. Incidence rate is the probability of developing a particular disease or injury occurring during a given period of time; the numerator is the number of new cases during the specified time period and the denominator is the population at risk during the period. Rates are age-adjusted to 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:

Where,

w_j = fraction of the standard population in age category

n_j = number of cases in that age category

p = person-years denominator

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

Frequently Asked Questions about NH Suicide Data

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

A: Statistical significance, which this document focuses on, is used to look at whether the change in the number of suicide deaths from one time period to another has truly increased/decreased, or whether the difference is 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?

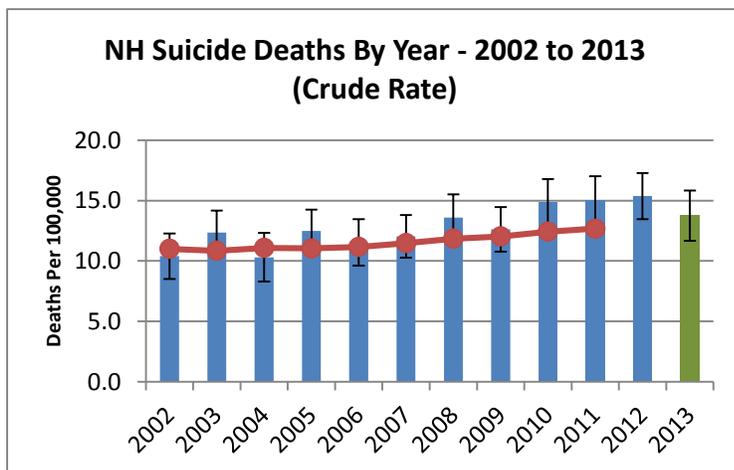
A: It is best to focus on data from a full year or multiple years rather than periods of just a few months. Over brief periods these numbers are too volatile to draw accurate conclusions from them.

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 2002, and 2004 do not overlap with the 2010 through 2012 confidence intervals, meaning that the rate for 2010 - 2012 was significantly higher than the rate for 2002 and 2004.



Change in Rate per 100,000 from Year to Year	
2002-2003	10.40 to 12.35 (Up 19%)
2003-2004	12.35 to 10.31 (Down 17%)
2004-2005	10.31 to 12.48 (Up 21%)
2005-2006	12.48 to 11.54 (Down 8%)
2006-2007	11.54 to 12.04 (Up 4%)
2007-2008	12.04 to 13.60 (Up 13%)
2008-2009	13.60 to 12.61 (Down 7%)
2009-2010	12.61 to 14.89 (Up 18%)
2010-2011	14.89 to 15.02 (Up 1%)
2011-2012	15.02 to 15.40 (Up 3%)
2012-2013	15.40 to 13.80 (Down 10%)

2001-2010 = CDC Data, 2011-2012 = 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?

A: 10 Leading Causes of Death, New Hampshire, by Age Group, 2007 – 2011

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 49	Unintentional Injury ---	Unintentional Injury 14	Unintentional Injury 17	Unintentional Injury 245	Unintentional Injury 266	Unintentional Injury 293	Malignant Neoplasms 1,098	Malignant Neoplasms 2,431	Heart Disease 9,867	Malignant Neoplasms 13,012
2	Short Gestation 39	Malignant Neoplasms ---	Malignant Neoplasms 10	Suicide ---	Suicide 97	Suicide 111	Malignant Neoplasms 255	Heart Disease 576	Heart Disease 1,156	Malignant Neoplasms 9,108	Heart Disease 11,811
3	SIDS 27	Congenital Anomalies ---	Congenital Anomalies ---	Malignant Neoplasms ---	Malignant Neoplasms 31	Malignant Neoplasms 65	Heart Disease 154	Unintentional Injury 386	Chronic Low Respiratory Disease 301	Chronic Low Respiratory Disease 2,796	Chronic Low Respiratory Disease 3,210
4	Maternal Pregnancy Comp. 23	Homicide ---	Chronic Low Respiratory Disease ---	Heart Disease ---	Homicide 16	Heart Disease 39	Suicide 154	Suicide 240	Unintentional Injury 278	Cerebrovascular 2,216	Unintentional Injury 2,567
5	Placenta Cord Membranes 20	Septicemia ---	Heart Disease ---	Congenital Anomalies ---	Congenital Anomalies 11	Homicide 13	Liver Disease 38	Liver Disease 161	Diabetes Mellitus 187	Alzheimer's Disease 1,943	Cerebrovascular 2,462
6	Respiratory Distress 15	Benign Neoplasms ---	Influenza & Pneumonia ---	Homicide ---	Heart Disease 11	Complicated Pregnancy ---	Diabetes Mellitus 36	Diabetes Mellitus 104	Liver Disease 185	Unintentional Injury 1,051	Alzheimer's Disease 1,969
7	Unintentional Injury ---	Heart Disease ---	---	Influenza & Pneumonia ---	Benign Neoplasms ---	Diabetes Mellitus ---	Cerebrovascular 22	Chronic Low Respiratory Disease 96	Suicide 156	Diabetes Mellitus 1,030	Diabetes Mellitus 1,369
8	Circulatory System Disease ---	Cerebrovascular ---	---	Five Tied ---	Chronic Low Respiratory Disease ---	Congenital Anomalies ---	Homicide 17	Cerebrovascular 67	Cerebrovascular 146	Influenza & Pneumonia 931	Influenza 1,023
9	Neonatal Hemorrhage ---	Nephritis ---	---	Five Tied ---	Septicemia ---	Cerebrovascular ---	Septicemia 14	Viral Hepatitis 38	Septicemia 74	Nephritis 793	Suicide 897
10	Atelectasis ---	Pneumonitis ---	---	Five Tied ---	Complicated Pregnancy ---	Chronic Low Respiratory Disease ---	Congenital Anomalies 13	Septicemia 35	Nephritis 51	Parkinson's Disease 459	Nephritis 866

Source: CDC WISQARS, 2007-2011

---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: Debbie Robinson – drobinson@dhhs.state.nh.us

Meets 2nd Monday – Every **other** month 10:00 am – 12:00 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 10:00 – 12:30 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: Deb Baird – dbaird@naminh.org

Suicide Prevention Council Subcommittees

Communications & Public Education

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

Meets 4th Thursday of the month 1:00 pm – 3:00 pm
DHHS, 29 Hazen Drive, Concord

Cross Training & Professional Education

Co-Chairs: Maggie Pritchard – mpritchard@genesisbh.org

Jennifer Schirmer – Jennifer.schirmer@dhhs.state.nh.us

Meets 1st Friday of the Month 8:30 am – 9:30 am
129 Pleasant Street, Concord

Data Collection & Analysis

Chair: Patrick Roberts – proberts@naminh.org

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

Military & Veterans

Co-Chairs: Dale Garrow – dale.garrow@accenturefederal.com

Loren Haberski – loren.haberski@va.gov

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

Public Policy

Co-Chairs: Kevin Stevenson – kevin.stevenson@nhdoc.state.nh.us
Keith Pomkoski – kjpomkoski@comcast.net

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

State Suicide Prevention Conference Meetings

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

Contact Mary Forsythe-Taber for current meeting schedule

Suicide Fatality Review

Contact: Catrina Watson – Catrina.Watson@nhms.org

Attendance is by invitation only

Survivors of Suicide Loss

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

Meets 3rd Wednesday of the Month 4:00 pm – 6:00 pm
NAMI NH, 85 North State Street, Concord

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 Prevention Lifeline (24/7) **1-800-273-TALK (8255)** (press “1” for veterans)
 - * The Lifeline also offers text based chat through their website: <http://www.suicidepreventionlifeline.org/>
 - * Head rest – For teens and adults (24/7) **1-800-639-6095** or your local mental health center



Appendix

2014 Suicide Fatality Review Committee Report

2014 Suicide Fatality Review Committee Report

ACKNOWLEDGMENTS

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

BACKGROUND:

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

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

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

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

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

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

Legislative Process:

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

The legislation established that the SFRC committee shall:

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

Key aspects of the legislation included:

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

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

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

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

Setting Up the Committee:

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

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

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

Membership:

Please see Appendix for the list of members.

Recommendations:

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

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

The Executive Committee of the SFRC has identified five recommendations in each category that it feels are reasonable, accomplishable and will have a positive impact.

Category	Recommendation	
Policy	1	<p><u>Release of confidential information</u> Current releases of confidential information need to be reviewed and revised as needed in order to eliminate barriers to effective communication among all providers, particularly community mental health centers and substance use service providers.</p>
	2	<p><u>Prescription oversight</u> Methadone clinics should be included in prescription drug monitoring initiatives.</p> <p>Need to determine if access to pain medication through pain clinics is effectively monitored.</p>
	3	<p><u>Drug Court</u> Each county should have a drug court.</p> <p>Need to review the drug court protocols to determine if they comply with national best practices and, if not, to make recommendations to bring the protocols into alignment with national best practices.</p>
	4	<p><u>Access to mental health services</u> Clients residing in assisted living facilities have access to limited mental health services; need to determine the gaps in services and make recommendations for improving access to needed services</p>
	5	<p><u>Substance use services</u> Community Mental Health Centers need to build capacity regarding substance use services recognizing that some of the challenges involve differences in credentialing and licensing.</p> <p>Short-term recommendation: identify training needs of providers regarding co-occurring mental health and substance use disorders.</p> <p>Longer-term recommendation: strategize how to have the following implemented:</p> <ul style="list-style-type: none"> • both MSW⁹ degree and Master LADC¹⁰ degree requirements include relevant competencies • make supervision requirements more easily attainable • make work experience requirement for LADC more easily attainable • billing rules/regulations become consistent with these strategies

⁹ Master of Social Work

¹⁰ Licensed Alcohol and Drug Counselor

Category	Recommendation	
Training and Education	1	Increase training for professional staff: <ul style="list-style-type: none"> • to develop an enhanced understanding of the availability of military resources and benefits, • to develop an enhanced recognition and understanding of post traumatic stress (PTSD) and traumatic brain injuries (TBI)
	2	<u>Access to residential treatment</u> Identify the difficulties accessing residential treatment facilities, e.g., waiting lists, and make recommendations for improving access
	3	<u>Comprehensive treatment</u> Recommend a combined treatment approach that includes trauma-informed care, substance use services, mental health services, services to the homeless and those in the criminal justice/corrections system that includes consistent training and ability to release confidential information among/between systems (see Policy #1). Recommend including ACT ¹¹ teams in the criminal justice/corrections system.
	4	<u>Neuropsychological screening</u> All residents of assisted living facilities should have access to mental health screening. Protocols regarding requesting neuropsychological testing based on the outcome of mental health screening should be developed.
	5	<u>Mental health and substance use</u> Recommend identifying training needs of providers regarding co-occurring mental health and substance use disorders, designing and providing needed training. (see Policy #5)
Public Awareness	1	Recommend drafting an article emphasizing the need to discuss and document reducing access to lethal means for anyone at risk.
	2	Recommend investigating training for providers to assist with developing an internal sentinel event policy to determine if all risk factors were identified and everything was done to prevent a person's suicide.
	3	Access to services in rural areas is a challenge with one factor being lack of transportation.
	4	The Bureau of Drug and Alcohol Services (BDAS) Access to Recovery (ATR) grant-funded program ¹² , which pays for outpatient treatment and transportation among other things, would have benefited the individual in the case reviewed and likely others in similar situations. Recommend BDAS investigate ways to continue the ATR services beyond the end of the grant period.

¹¹ Assertive Community Treatment

¹² A four year grant was awarded to BDAS in October 2010

Category	Recommendation	
	5	Recommend substance use screening for all individuals living in residential settings and pursuing integrating substance use services into all community mental health and residential services clients' individual services plans.
Professional Collaboration	1	Recommend having police attend pertinent SFRC case reviews and provide relevant police reports. Recommend inviting a member of the NH Association of Chiefs of Police to join the SFRC.
	2	Recommend investigating whether Bureau of Behavioral Health Peer Support Agencies could be aligned with BDAS Recovery Coaches as Peer Support is often an under-utilized mental health resource.
	3	Medication management can be a concern when there are a number of prescribers; of particular concern is coordination between primary care physicians and psychiatrists. Recommend investigating a means to identify individuals with known addiction and/or drug-seeking behavior to ensure their treatment is appropriate and that they are informed of the risks of their addition(s) and/or drug-seeking.
	4	Assisted living facilities are not staffed with mental health professionals resulting in staff having to rely on other providers such as primary care physicians and case managers to identify concerns and to develop plans of care that address clients' mental health needs. Recommend that assisted living facilities have direct access to mental health professionals and that staff are trained on how to address changes in behaviors, etc. (see Policy #4)
	5.	Recommend collaboration with the state's regional Public Health Networks (http://nhphn.org/) to collaborate on resource development and sharing of resources and expertise.

APPENDIX

1. Legislation establishing the Suicide Fatality Review Committee

CHAPTER 109

HB 1384 – FINAL VERSION

03Mar2010... 0660h

05May2010... 1865eba

2010 SESSION

10-2492

05/04

HOUSE BILL ***1384***

AN ACT establishing a suicide fatality review committee.

SPONSORS: Rep. Wells, Rock 8

COMMITTEE: Health, Human Services and Elderly Affairs

AMENDED ANALYSIS

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

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

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

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

03Mar2010... 0660h

05May2010... 1865eba

10-2492

05/04

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Ten

AN ACT establishing a suicide fatality review committee.

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

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

126-R:4 Suicide Fatality Review Committee Established.

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

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

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

IV. The committee shall:

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

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

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

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

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

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

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

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

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

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

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

Approved: June 1, 2010

Effective Date: July 31, 2010

2. Case Review Protocol

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

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

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

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

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

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

3. Members

**Suicide Prevention Council
Suicide Fatality Review Team
Membership: July 2014**

Name	Affiliation	e-mail
Alex de Nesnera, Chair	New Hampshire Hospital	adenesnera@dhhs.state.nh.us
Thomas Andrew Kim Fallon	Office of the Chief Medical Examiner	thomas.andrew@doj.nh.gov kim.fallon@doj.nh.gov
Elaine Frank	Dartmouth Hitchcock	elaine.m.frank@dartmouth.edu
Michele Harlan	Bureau of Behavioral Health	michele.a.harlan@dhhs.state.nh.us
Lindy Keller	Bureau of Drug and Alcohol Services	lskeller@dhhs.state.nh.us
James MacKay	N.H. House of Representatives	james.mackqy@mygait.com
Ken Norton	National Alliance On Mental Illness (NAMI NH)	knorton@naminh.org
Dan Potenza	Department of Correction	dpotenza@mhm-services.com
Sally Varney	Bureau of Elderly and Adult Services	svarney@dhhs.state.nh.us
Catrina Watson Vice Chair	N.H. Medical Society	catrina.watson@nhms.org
Roger Wells	Retired; family member	rockinrw@aol.com

New Members as of July 2014

Name	Affiliation	e-mail
Dale Garrow	NH National Guard	Dale.garrow@accenturefederal.com ; dale.e.garrow.ctr@mail.mil
To be determined	Physician (family practice)	
To be determined	Department of Safety	

Membership ended-prior to July 2014

Name	Affiliation
Caryl Ahern	Veterans Administration
Angela Crane	Physician
April Deroser	Department of Education
Egon Jensen	Department of Health and Human Services
Diane Langely	Bureau of Elderly and Adult Services
Sandi Matheson	Department of Justice
Karen Orsini	Bureau of Behavioral Health
Timothy Pifer	Department of Safety, State Police