

2024
Annual Report

NH
SUICIDE PREVENTION
Council

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INTRODUCTION

Introduction

The 2024 Annual Suicide Prevention Report, which includes a summary of accomplishments and data, is the result of the collaborative work of many groups, committees, and organizations in NH who have dedicated time and resources to study the issue of suicide and to look at prevention and postvention across the lifespan.

The work of these groups in suicide prevention and postvention is reaching across the state and into communities, schools, organizations, and individuals' lives.

Many achievements will be described further throughout this report. It is critical to NH that we continue to build on the momentum and collective knowledge that has been gained in suicide prevention to strengthen capacity and sustainability in order to reduce risk of suicide for all NH residents and promote healing for all of those affected by suicide.

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

What's New in this Year's Report?

Some of the new highlights this year include:

- A new streamlined format.
- Data highlights from NH Rapid Response and 988.
- Updated data from the NH Vital Records and the NH Violent Death Reporting System.
- Highlights of activities that took place across the state.

This report was produced by NAMI New Hampshire, the State Suicide Prevention Council (SPC), the New Hampshire Violent Reporting System (NH-VDRS) and Youth Suicide Prevention Assembly (YSPA).

Any individual or organization may freely copy and distribute this report.
Electronic copies are available at www.NAMINH.org/suicide-prevention

Primary Partners

NAMI New Hampshire and The Connect™ Suicide Prevention Program

NAMI New Hampshire (National Alliance on Mental Illness) is a grassroots organization working to improve the quality of life for all by providing support, education, and advocacy for people affected by mental illness and suicide.

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

New Hampshire Violent Death Reporting System

In 2015, the NH Department of Health and Human Services (DHHS) partnered with the Centers for Disease Control and Prevention (CDC) Injury Prevention Division and began a joint surveillance program, also known as the National Violent Death Reporting System (NVDRS), which is now applied in all fifty US states, the District of Columbia, and Puerto Rico[1]. The surveillance program in NH is known as the NH Violent Death Reporting System (NH-VDRS), which is supported by CDC NVDRS grant funding. The NH DHHS is the grant holder and provides administrative oversight for the program. The case abstraction staff are employed by the NH DHHS with support from staff at the Office of the Chief Medical Examiner (OCME). The NH-VDRS program is tasked with compiling case level data on all violent deaths in NH, including suicides, homicides, all deaths involving firearms, and deaths resulting from legal intervention (such as law enforcement or war). The NH-VDRS program's work also entails disseminating information within NH and to the CDC Injury Prevention Division and other affiliates. Since its inception, NH-VDRS has engaged entities focusing on suicide in NH, including suicide prevention advocates, law enforcement, lawmakers and other interested groups. These groups are making use of aggregate data reported by NH-VDRS to enhance prevention efforts in the state. The NH-VDRS data in this report is made possible under Grant Award # 5 NU17CE010125-04-00.

In 2024, NH-VDRS conducted free training sessions for Law Enforcement at their departments. These trainings informed first responders and ranking officers on standardizing data and information when documenting violent death incidents. These trainings assisted law enforcement staff with understanding the large number of variables involved in documenting violent death

[1] CDC National Violent Death Reporting System, https://www.cdc.gov/nvdrs/about/index.html, accessed on 11/4/20205.

scenes and circumstances. NH-VDRS also presented at the Chiefs of Police Association annual meeting on these and related topics.

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

- Adam Burch, Section Administrator, NH-VDRS Co-Principal investigator, Risk Assessment and Data Analysis for Overdose Reduction Section, Division of Public Health Services, NH DHHS, Adam.S.Burch@dhhs.nh.gov.
- Djelloul Fourar-Laïdi, Principal Investigator and Analyst, NH-VDRS, Risk Assessment and Data Analysis for Overdose Reduction Section, Division of Public Health Services, NH Department of Health and Human Services, Djelloul.A.Fourar-Laidi@dhhs.nh.gov.

State Suicide Prevention Council

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

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

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

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

ACCOMPLISHMENTS

Accomplishments of Suicide Prevention Efforts in NH

State Suicide Prevention Council

2024 marked another year of meaningful progress for New Hampshire's Suicide Prevention Council (SPC) as it continued advancing the priorities outlined in the State Suicide Prevention Plan and laying the groundwork for the release of a new five-year plan in 2025. Building on the foundation of state funding secured in recent years and the dedicated work of the State Suicide Prevention Coordinator, the Council strengthened partnerships, expanded outreach, and deepened its focus on evidence-informed strategies to save lives.

Much of this work occurred through the Council's committees and collaborations with state, federal, and community partners. In 2024, highlights included:

- Continued progress on the development of the 2025–2029 State Suicide Prevention Plan through committee work, stakeholder engagement, and input from individuals with lived experience.
- Expanded public engagement through the **Strong as Granite** campaign, raising awareness, reducing stigma, and connecting residents with mental health and suicide prevention resources.
- A September press conference at the Governor's Office highlighting the voices of lived experience and the state's commitment to suicide prevention. While the Governor was unable to attend in person, he signed a proclamation declaring September as Suicide Prevention Awareness Month in New Hampshire.
- Ongoing collaboration with the Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families, ensuring tailored supports for those who serve and have served.
- Participation in the **2024 Suicide Prevention Resource Center's State Needs Assessment**, which identified strengths and opportunities in New Hampshire's suicide prevention system. Findings from this assessment informed the strategic planning process and guided the development of targeted prevention strategies.
- Strategic planning sessions with the **Youth Suicide Prevention Assembly (YSPA)**, an independent grassroots entity dedicated to youth suicide prevention for more than 30 years. While separate from the SPC at the time of these sessions, YSPA's eventual integration into the Council represents a future phase of this work. The focus of these sessions was to shape the strategic direction for youth suicide prevention over the next three to five years, building on YSPA's decades of expertise.
- Support for survivors of suicide loss through ongoing, monthly, peer-led groups and professional development opportunities for providers working in the field.
- A state-level postvention training and planning session with multisector leaders, laying the groundwork for a postvention improvement project in 2025.
- The **Annual 2024 Suicide Prevention Conference**, which brought together professionals from diverse sectors for training, networking, and knowledge-sharing.

As 2024 comes to a close, the SPC remains committed to fostering a coordinated, statewide response to suicide. The collective efforts of Council members, committees, partner organizations, and community advocates reflect a shared vision: ensuring that every Granite Stater has hope, help, and support when they need it most.

Communications Committee

- Coordinated a press conference in September in support of Suicide Prevention Awareness, highlighting 988 and NH Rapid Response Access Point.
- Assisted in the development of the 2024 Annual NH Suicide Prevention Conference, in collaboration with a dedicated conference committee coordinator.
- Ongoing refinement of the content for the committee pages and resource information section of the SPC website.
- Contributed to content development and review for the new SPC Strategic Plan.

Data Collection and Analysis Committee

- Worked with multiple statewide partners to compile and analyze data for inclusion in the 2023 NH Suicide Prevention Annual Report.
- Distributed the 2023 NH Suicide Prevention Annual Report statewide.
- Collaborated with the Principal Investigator/Analyst for the NH Violent Death Reporting System (NH-VDRS) to expand the use of NH-VDRS data in the NH Annual Suicide Prevention Report.
- Collaborated with the NH DHHS Health Statistics and Data Management Section (HSDM) to include Vital Records demographic data on suicide deaths and self-harm hospitalizations.
- Continued to partner with the Crisis Text Line for access to a dashboard summarizing NH contacts.

First Responders Committee

- Trained a Peer Support Unit for the New Hampshire Department of Corrections.
- Trained a Peer Support Unit for the New Hampshire State Fire Marshal's Office.
- Trained a new class of New Hampshire State Police Peer Support Troopers.
- Trained New Hampshire State Marine Patrol Officers as Peer Support Counselors and incorporated them into the NHSP Peer Support Unit.
- Conducted multiple Critical Incident Stress Debriefings with State, local and first responders from around the State of New Hampshire.
- Conducted Critical Incident Stress Debriefings with first responders from neighboring states.
- Conducted Critical Incident Stress Debriefing to include, for the first time, tow truck operators present at the scene of fatalities.
- Supervised over 15 peer support counselors 24 hours a day, 7 days a week.
- Provided around the clock Peer Support for the New Hampshire State Police.

Military and Veterans Committee

The Military & Veterans Committee continued its work in 2024 to reduce suicide among the military and Veteran population in New Hampshire. This work included:

- Held monthly meetings throughout the year including hosting a Community of Practice for professionals who serve military/Veteran families.
- Aligned work with the Governor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families (SMVF) sponsored by SAMHSA and the VA.
- Committee members attended national military and Veteran family focused conferences funded by the Governor's Challenge.
- Worked with SAMHSA and the VA funded experts from Policy Research Associates to conduct an annual site visit in NH to help the committee evaluate progress and further develop an action plan.
- Focused on further development of Ask the Question strategies to identify SMVF in healthcare and social service settings and providing military culture training to providers serving military/Veterans.

Public Policy Committee

- Hosted a Suicide Prevention Advocacy Day at the Holiday Inn in Concord on Wednesday, April 3, 2024.
- Advocated in opposition to certain discriminatory LGBTQ+ bills that would detrimentally impact youth mental health and encouraged the full Council to adopt a statement regarding this issue.
- Met bi-monthly with Public Policy Committee members.

Survivors of Suicide Loss Committee

- Continued holding two monthly virtual support groups, Coffee Chat on the 2nd Friday morning of the month and Teatime on the 4th Tuesday late afternoon of the month. These sessions offer Survivors of Suicide Loss (SOSL) access to a variety of resources as well as an opportunity to support fellow survivors through their loss and healing journeys.
- Focusing on the theme of avoiding burnout and self-care for Clinicians, the committee hosted 6 virtual sessions of "The Nervous System Stabilization Group (NSG)". Led by two trained, licensed independent clinical social workers (LICSWs), NSG is an approach to stabilizing the effects of trauma and high stress, such as after a critical incident, losing a client to suicide, or in on-going high stress professions such as clinical work with high-risk clients. NSG combines aspects of Post Traumatic Stress Management by emphasizing skills and practice with a well-researched Eye Movement Desensitization and Reprocessing-derived approach. These trainings were made available to clinicians engaged in high-stress clinical work who would benefit from this approach to reduce vicarious trauma and burn out.
- Hosted two evening presentations called "Survivor Stories." These presentations consisted of Survivors of Suicide Loss sharing their stories of loss, healing, and hope. All of the survivors who spoke were trained in the SurvivorVoices training provided by NAMI NH.

Both events – one in Concord and one in Nashua – were well attended with 30-40 members of the public present.

- Provided support to NH Survivor of Suicide Loss support groups and promoted the American Foundation for Suicide Prevention (AFSP) International Survivors of Suicide Loss Day (ISOSLD), featuring several in-person NH sites in November 2024, with one virtual event for NH, VT and ME.
- Ensured Loss Survivor participation in community events through targeted outreach.
- The SOSL Committee provided support and participated in many Loss Survivor events throughout NH, including AFSP Out of the Darkness Walks in designated towns and NAMIWalks NH, with Team SOS.

Youth Suicide Prevention Committee – Also known as the Youth Suicide Prevention Assembly (YSPA)

After decades of being a fully independent entity, YSPA officially joined the SPC as the Youth Suicide Prevention Committee in 2024. This change allows the groups to more closely align their work, share resources, and pool expertise. During this year of change, accomplishments of the Youth Suicide Prevention Committee included:

- Participation in SPC strategic planning sessions to help shape the strategic direction for youth suicide prevention in the state over the next three to five years.
- Hosted presentations during YSPA meetings including:
    - Bullying and Suicide Prevention.
    - Data update featuring highlights from the 2023 NH Suicide Prevention Report.

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

The Council continues to collaborate with the NH Department of Health and Human Services for statewide leadership and support as it looks to advance its work in promoting evidence-informed initiatives and refining and expanding the state plan to ensure the very best outcomes for NH citizens.

**If you would like to join any of the Suicide Prevention Council Committees, please contact the designated committee chair. The committee meeting schedule has been included on page 71 of this report. It can also be found at preventsuicidenh.org/get-involved/committees/.*

Suicide Fatality Review Committee (SFRC)

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

Cases Reviewed in 2024
In 2024, the SFRC continued to review cases with specific precipitating factors. This included review of cases who had recent civil and legal implications identified before their death. Due to difficulty obtaining required information, the SFRC reviewed one case in 2024.

SFRC Recommendations

- Suicide risk assessments when: 1) Someone loses a spouse to suicide, 2) Someone is facing abuse and/or neglect allegations with child protection agencies and/or law enforcement, 3) Someone loses one or both parents, and 4) Someone is removed from the home by child protective authorities.
- Law Enforcement assess access to lethal means when present where a family member was recently lost to suicide.

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

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

New Hampshire Behavioral Health Crisis System Overview 2024

The New Hampshire Department of Health and Human Services (NH DHHS) has established a comprehensive framework to address the state's most pressing health and human services challenges through its Departmental Roadmap. The behavioral health crisis system continues to be a cornerstone of this framework, supporting Mission Zero by reducing reliance on emergency departments and expanding timely access to behavioral health care across the state.

Strategic Alignment
Multiple drivers for change remain aligned in support of the state's behavioral health crisis system:

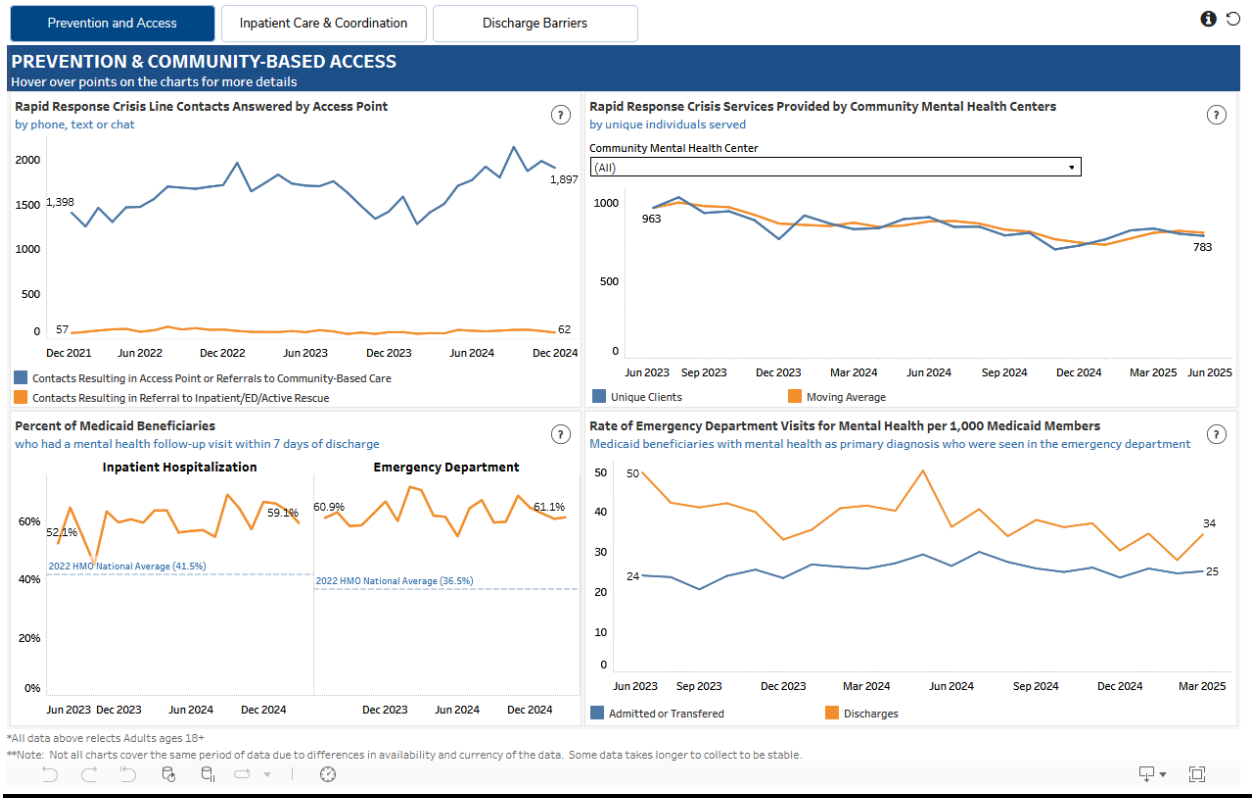
- 10-Year Mental Health Plan
- Children's System of Care
- Governor's Commission on Alcohol and Other Drugs Action Plan
- Statewide Suicide Prevention Strategic Plan

These multi-stakeholder efforts bring together state agencies, providers, and legislative partners to advance solutions for New Hampshire residents.

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

- **Someone to Talk To: Crisis communication services through:**
  - *988 Suicide and Crisis Lifeline:*
    - In calendar year 2024, the primary NH lifeline center (Headrest) answered **10,720 contacts**.
    - Less than 1% of calls required an active rescue intervention.
  - *New Hampshire Rapid Response Access Point (NHRRAP)*
    - Serves as the secondary 988 Lifeline center and answers calls to the state's dedicated 10-digit number (833-710-6477). In 2024, the Access Point answered 31,908 contacts.
- **Someone to Respond: Mobile crisis response services**
  - In 2024, the Access Point coordinated **7,491 mobile crisis dispatch requests**, including requests that were transferred from Headrest.
  - The data continue to show meaningful differences by age group, with **55% of child (ages 0–17) contacts** resulting in a mobile dispatch request compared to **21% of adult contacts**.
  - These patterns help inform planning to meet the needs of children, youth, and adults in crisis.
- **Somewhere to Go: Crisis Centers**
  - Work progressed in 2024 to design and prepare for crisis receiving and stabilization facilities as the third pillar of the crisis system.
  - These developments represent the next stage in building out a comprehensive continuum, offering additional safe and supportive alternatives to emergency departments.

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



Other Statewide Initiatives

AFSP (American Foundation for Suicide Prevention)

The NH Chapter continued its efforts to increase support for Survivors of Suicide Loss in 2024. AFSP NH hosted numerous trainings, presentations, and events throughout the state. These included:

- Eight sites for the 2024 International Survivors of Suicide Loss Day Conferences with a total of over 200 attendees.
- 11 read-along events with a total of 854 elementary school students.
- Four More Than Sad Parent and Educator Trainings for 492 participants.
- Four Suicide Prevention trainings with a total of 425 participants.
- 22 Talk Saves Lives presentations with a total of 755 attendees.

Connor's Climb Foundation

Connor's Climb Foundation (CCF) is a New Hampshire-based nonprofit dedicated to providing suicide prevention education to youth and trusted adults, while working to end the stigma around mental health. In 2024, CCF delivered 72 trainings to schools and communities with more than 6,000 participants across the state. CCF also hosted 13 Stick it to Stigma events with over 300 student athletes.

The foundation supported the SOS Signs of Suicide Program in 53 schools, reaching students, staff, and caregivers with this evidence-based curriculum. CCF also expanded its reach through new partnerships with schools and community organizations, helping bring mental health education to underserved areas.

In 2024, CCF launched two key initiatives to build long-term impact. The new Youth Ambassador Program empowers high school students to lead mental health awareness efforts in their schools. Ambassadors organized events, participated in public speaking engagements, and helped reduce stigma among their peers. The new Train-the-Trainer Program equips trusted partners such as school staff, nonprofit leaders, and community members to independently deliver suicide prevention trainings, extending the foundation's reach and sustainability.

CCF's annual 5K and Family Walk in September 2024 raised over $60,000, with 425+ participants and 40 sponsors. In recognition of its statewide impact, Connor's Climb received the NH Center for Nonprofits' 2024 Small Nonprofit Impact Award. The foundation continues to support state-level suicide prevention policy, including RSA 193-J, through its active role on the New Hampshire Suicide Prevention Council.

NAMI New Hampshire

NAMIWalks NH, the Granite State's largest mental health awareness and suicide prevention event, is held in October during Mental Illness Awareness Week. For over two decades, this event has offered a community of hope for loss survivors and individuals and families affected by mental illness and has shown folks they are not alone. For the past four years, the Walk has raised over $200,000, putting it in the top ten of all NAMI Walks nationwide for four years running. The 2024 Walk had over 2,000 participants and 151 teams.

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

In NH in 2024, there were over 640 participants in Connect Prevention trainings and 465 in Connect Postvention trainings. Over 50 trainers were trained in NH to help sustain suicide prevention and postvention efforts in their respective organizations. In addition to providing in-person and live virtual Connect suicide prevention and postvention trainings, the Connect eLearning training was well utilized, particularly by schools and health care providers. A total of over 1,700 seats for Connect eLearning were distributed in 2024, which expanded access to suicide prevention training in NH and other states around the U.S.

More than 240 law enforcement professionals received training from NAMI NH staff in suicide prevention and postvention through the NH Police Standards and Training Council.

Staff in the Connect Program assisted individuals, schools, and communities to help with their healing after a suicide, with over 100 hours of postvention support and technical assistance to communities and organizations in NH. In 2024 the NH SPC began working with NAMI NH Connect Program staff to develop a statewide postvention response plan. Work on this plan and related efforts is set to continue in 2025 and 2026.

In addition to their work in New Hampshire in 2024, Connect Program staff provided training and consultation in-person and virtually in Alaska, California, Connecticut, Florida, Kentucky, Massachusetts, Missouri, Nevada, Ohio, Oregon, South Carolina, Virgina, Vermont. Wisconsin, and Wyoming.

The NH Firearm Safety Coalition

In 2024, the NH Firearm Safety Coalition (NHFSC) worked on revising and printing a new version of their rack card. The card focuses on firearm safety and is intended to be made available in gun shops with newly purchased firearms. NHFSC members began distributing these cards to gun shops throughout the state in 2024. A downloadable version is also available from https://nhfsc.org/. The NHFSC continued to investigate the possibility of legislation to support and provide protections to individuals and businesses that would be willing to temporarily hold firearms for an individual while they or someone in their home are experiencing a crisis.

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

Suicide remains the second leading cause of death for 15- to 34-year- olds[2] here in New Hampshire and is among the top three leading causes of death nationwide. The GLS New Hampshire Nexus Project 2.0 (GLS NHNP 2.0) is a cross-systems, collaborative approach to reducing suicide incidents among youth by improving pathways to care and offering comprehensive training to provide youth serving organizations with the resources to identify, screen, refer, and treat at-risk youth.

[2] CDC WISQARS, https://wisqars.cdc.gov/, accessed on 6/26/2025.

GLS NHNP 2.0 is focused on youth/young adults ages 10-24 in the Capital Area Public Health Network, Carroll County, and North Country Regional Public Health Networks (RPHN) of New Hampshire. Over the course of the five-year project period, project staff and key partners are working in collaboration to enhance care coordination infrastructure, suicide risk recognition and response, and statewide capacity for suicide prevention and postvention response.

Project partners include NAMI NH, the Behavioral Health Improvement Institute (BHII), Headrest, Northern Human Services, Riverbend Community Mental Health, Granite United Way, North Country Health Consortium, NHTI, and White Mountains Community College. Additionally, regional implementation teams established early in the project are comprised of key stakeholders across multiple community sectors working together to build and sustain capacity and infrastructure around implementation of best practices for suicide prevention and postvention for high-risk youth – and addressing overall access to care issues at a local and systemic level.

Project activities in 2024 included:

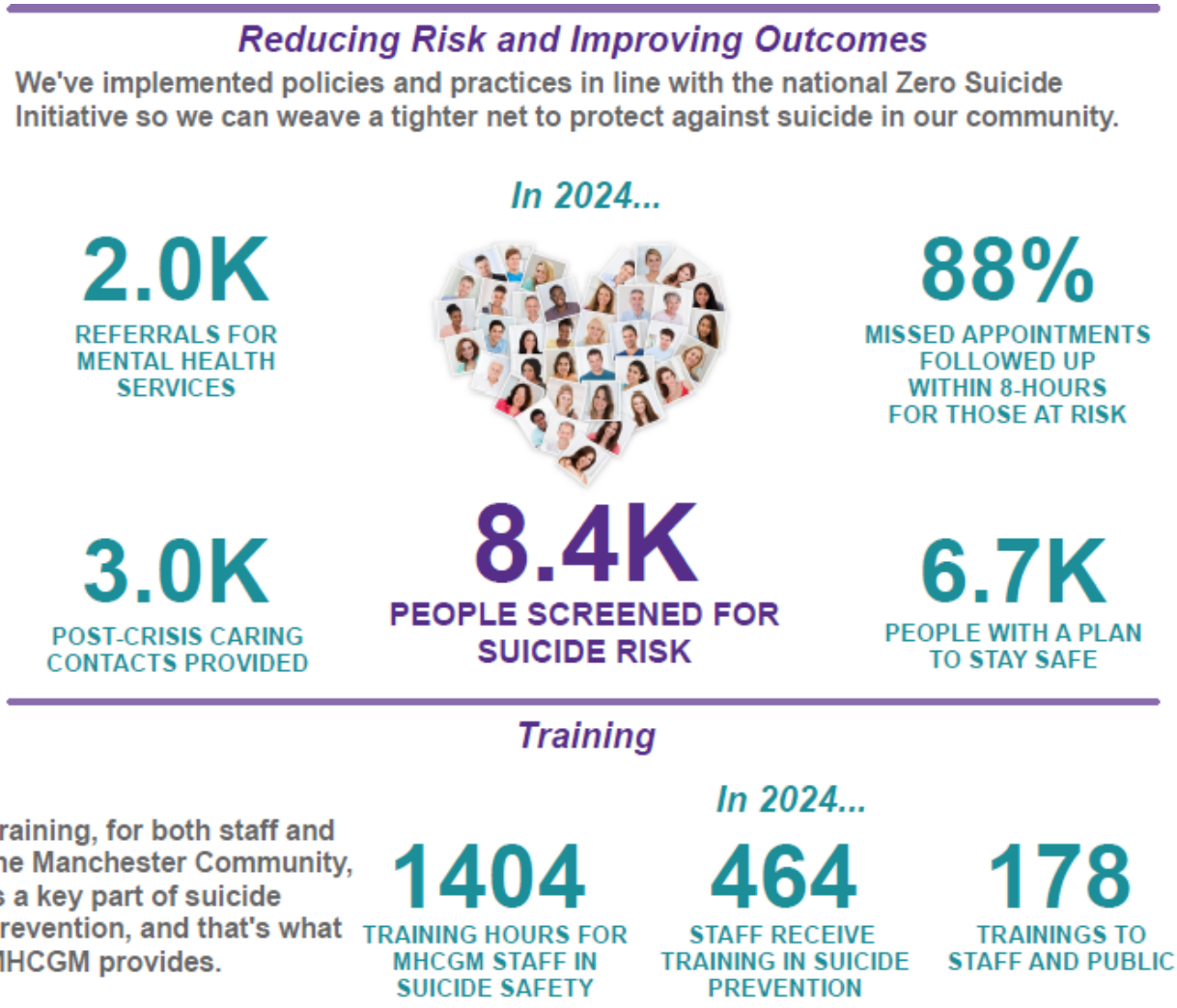
- Implemented Connect™ Suicide Prevention training of trainers.
- Conducted Connect™ Youth Leader Training.
- Supported care liaison positions at two community mental health centers.
- Hosted events for college age individuals in conjunction with NHTI.
- Trained survivors of suicide loss to safely share their stories using the SurvivorVoices curriculum.
- Distributed eLearning seats for the Connect™ Online Suicide Prevention Training.
- Engaged community members in both the Connect™ prevention and postvention planning sessions.

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

Zero Suicide – The Mental Health Center of Greater Manchester

The Mental Health Center of Greater Manchester (MHCGM) has been working with the Veterans Administration and Catholic Medical Center under a SAMHSA funded Zero Suicide grant with the goal of creating a safer community through a reduction in suicide.

In 2024, the outcomes from this initiative included:



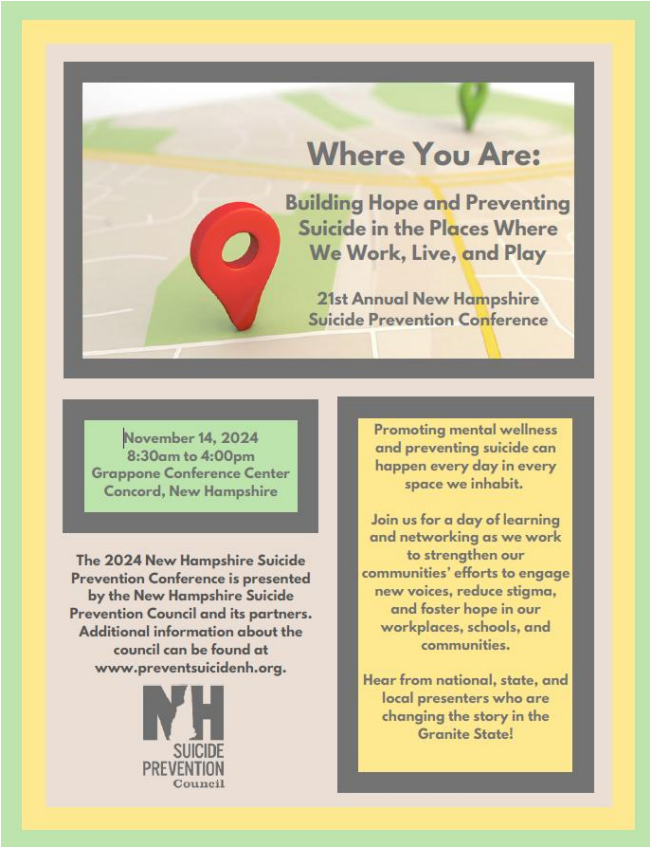
The Foundation for Healthy Communities' Behavioral Health Clinical Learning Collaborative

The Behavioral Health Clinical Learning Collaborative continues to advance behavioral health care across the state in partnership with many organizations and members. Key achievements include the launch of Care Traffic Control (CTC) for centralized processing of adult involuntary emergency admissions (IEA) and standardizing the statewide admissions process to all Designated Receiving Facilities (DRFs). The Collaborative conducted IEA training sessions in Concord, Whitefield, and Portsmouth, with over 200 attendees participating to help enhance the understanding and application of involuntary admission protocols. The Collaborative introduced

and shared statewide behavioral health telehealth and remote resources, highlighted new and upcoming crisis treatment centers, and encouraged increased service utilization of 211. Other Collaborative meetings focused on trauma-informed care initiatives, including managing agitation and preventing violence. The Collaborative worked with the Department of Health & Human Services (DHHS), New Hampshire Hospital Association (NHHA), and NAMI NH to launch a public dashboard aimed at providing transparency in inpatient care coordination. These achievements reflect the power of collaboration and the collective dedication of our members. Thank you for your continued efforts as the Collaborative continues to build on this momentum.

Annual NH Suicide Prevention Conference

The Annual NH Suicide Prevention Conference was held in-person on November 14, 2024 in Concord. The theme for 2024 was Where You Are: Building Hope and Preventing Suicide in the Places Where We Work, Live, and Play. This one day conference began with welcoming remarks and recognition of key community partners and stakeholders. The opening plenary, *How to Have Compassionate Conversations that Build Resilience, Foster Connection, and Provide Hope*, featured Jenniver L. Bashant, Ph.D. The closing plenary of the day was *Play On! An Essential (and Not So Serious) Part of Thriving*, by Type Thompson.



2024 DATA UPDATE

2024 Data Update

SPC Data Committee
Membership Representation 2024-2025

Injury Prevention Center at Dartmouth Health
NAMI New Hampshire (National Alliance on Mental Illness)
State of New Hampshire Department of Health and Human Services
State of New Hampshire Office of the Chief Medical Examiner

Introduction

The data presented in this report are the result of collaboration among a variety of organizations and people. Key areas of interest and concern for suicidal behavior in NH are included in this report. A data interpretation and chart reading section is available at the end of the report to assist readers when needed.

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

In previous years, this report included death data from two primary sources; Vital Records data (official death records for NH residents) for the State of NH obtained from Health Statistics and Data Management (HSDM) Section, Division of Public Health Services, NH DHHS; and Office of the Chief Medical Examiner (OCME) for the State of NH. As of the 2019 NH Suicide Prevention Annual Report, data from NH's implementation of the National Violence Death Reporting System (NH-VDRS)[3] has been included to provide greater detail around the circumstances surrounding suicide deaths in NH.

NH DHHS collaborates with the NH Department of Justice (DOJ) on implementation of the NH-VDRS[4] under the auspices of the OCME. The CDC currently includes all fifty states, the District of Columbia, and Puerto Rico in the NVDRS project. NVDRS is a de-identified secure database system. NH-VDRS utilizes the system to collect data on violent deaths in NH. Violent deaths include suicides, homicides, firearms accidents, and other violent deaths.

Suicide death demographic data is collected from the NH Division of Vital Records Administration death certificate database on all suicide victims who died in the state of New Hampshire. NH-VDRS data included in this report are limited to NH residents who died in NH. NH-VDRS abstracted data comes from Assistant Deputy Medical Examiner (ADME) investigation reports,

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

toxicology, and autopsies reports, all of which are located in the Medical Examiner's office. Another abstracted data resource is law enforcement reports, which include state, local, and sheriff departments.

The NH DHHS HSDM Section provided a data quality assurance check on the outputs for the vital records, NH-VDRS, hospital data, and Youth Risk Behavior Survey (YRBS) and Behavioral Risk Factor Surveillance System (BRFSS) survey data in this report. Some of this mental health data can also be viewed on the DHHS Data Portal.[5] The NH DHHS Data Portal hosts information on a broad number of public health topics.

NH-VDRS reports the outcomes of the data on violent deaths as defined by CDC grant requirements. The analysis as provided is focused on direct validated outcomes and does not engage in policy analysis. Any policy analysis based on the NH-VDRS provided data included in this report was done by the NH Suicide Prevention Council Data Committee.

Additional data sources were used for specific purposes throughout this report that may have varying methods of collection. All of the Tables and Figures in this report include a citation for the data source to prevent confusion. Different data sources also vary regarding how quickly the information is made available, how often it is collected/reported, and which years of data may be combined. The time periods reported for each source are indicated with the corresponding Table or Figure.

Demographic Profile of New Hampshire

Comparing New Hampshire to the US

Tables 1 through **6** below present NH and US demographic characteristics, as well as indicators of substance use and mental health. NH is a small state, with just over 1.4 million residents (US Census Bureau, 2024). While NH is still relatively homogeneous in terms of race and ethnicity, it is becoming more diverse over time. The state has above average ratings for economic factors and education. NH is also above the US average for alcohol and illegal drug use, with the 3rd highest rate in the US for alcohol use in the past month[6] (National Survey on Drug Use and Health, 2022-2023).

Table 1

Race/Ethnicity.

	New Hampshire	United States
Race		
White	92.28%	74.76%
Black	2.15%	13.70%
American Indian/Alaskan Native	0.33%	1.39%
Asian	3.21%	6.71%
Native Hawaiian and Other Pacific Islander	0.06%	0.28%
Persons Reporting Two or More Races	1.96%	3.15%
Ethnicity		
Persons of Hispanic or Latino Origin	5.03%	20.02%

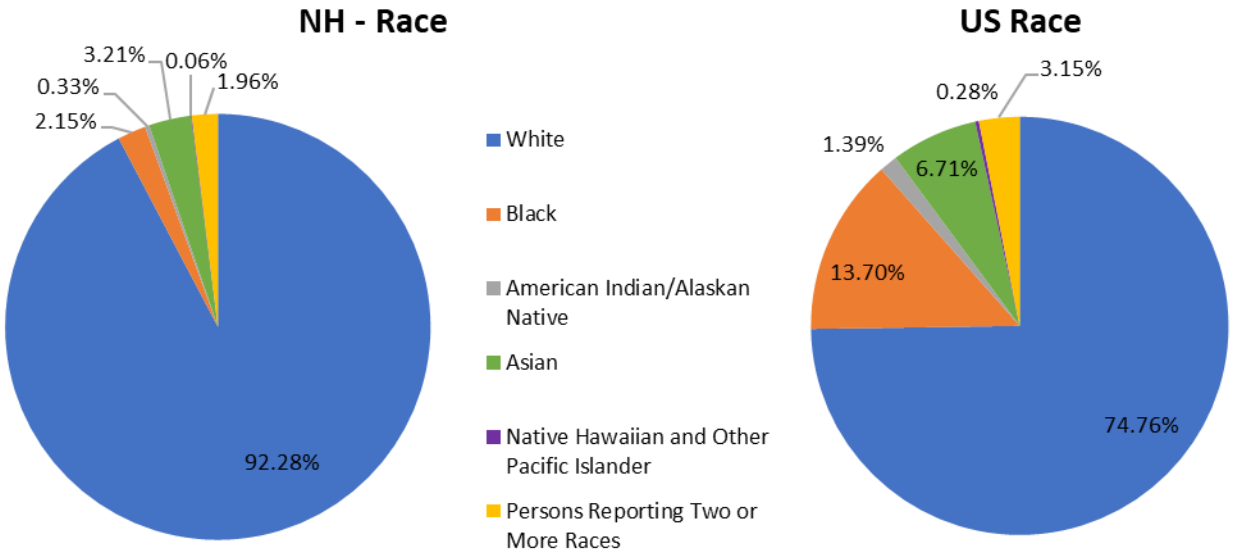
Data Source: US Census Bureau, 2024

[5] NH DHHS Data Portal: https://wisdom.dhhs.nh.gov/wisdom/topics.html?topic=mental-health

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

Figure 1

NH and US Race/Ethnicity.



Data Source: US Census Bureau, 2024

Table 2

Age.

	New Hampshire	United States
Under 18	17.70%	21.50%
18 to 24	8.50%	9.22%
25 to 44	25.51%	27.05%
45 to 64	26.76%	24.24%
65 to 74	12.82%	10.42%
75 and up	8.71%	7.57%

Data Source: US Census Bureau, 2024

Table 3

Economic Factors.

	New Hampshire	United States
Unemployed Residents	2.6%	4.3%
Persons Below Poverty Level	7.2%	12.5%
Persons Without Health Insurance (under age 65)	4.7%	7.9%
Per Capita Income (Yearly)	$51,587	$43,313
Median Family Income	$116,546	$69,401
Median Home Value (Owner Occupied)	$415,400	$340,200

Data Source: US Census Bureau American Community Survey, 2023

Table 4

Education – Individuals Age 25 and Older.

	New Hampshire	United States
Less Than High School Graduate	5.97%	10.36%
High School Graduate or Associate's Degree	55.97%	56.12%
Bachelor's Degree or Higher	38.06%	33.52%

Data Source: US Census Bureau American Community Survey, 2023

Table 5

Substance Use – Individuals Age 12 and Older.

	New Hampshire	United States
Marijuana Use – Past Month	16.96%	15.20%
Alcohol Use – Past Month	58.87%	48.13%
Tobacco Use – Past Month	16.61%	17.83%

Data Source: National Survey on Drug Use and Health, 2022-2023

Table 6

Mental Health Indicators – Individuals Age 18 and Older.

	New Hampshire	United States
Serious Mental Illness – Past Year	7.22%	5.83%
Major Depressive Episode – Past Year	10.47%	8.64%
Had Serious Thoughts of Suicide – Past Year	5.81%	5.06%
Made Any Suicide Plans – Past Year	1.68%	1.45%
Attempted Suicide – Past Year	0.70%	0.60%
Received Mental Health Services – Past Year	26.90%	22.38%

Data Source: National Survey on Drug Use and Health, 2022-2023

The Big Picture: Suicide in NH and Nationally

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

Figure 2 (below) presents the crude suicide rate in NH and the US for a ten-year period. NH's crude rate of suicide deaths has been higher than that of the US for that period. While NH's crude suicide rate fluctuates from year-to-year due to low incidence of suicide deaths, 2014 marked the first time since at least the year 2000 that NH had experienced a statistically significant difference in crude rates from one year to the next. This increase was not seen in other states or for the US as a whole in 2014, and this spike moved the NH rate significantly above the US rate of 13.94 deaths per 100,000 in 2013. Since 2014, crude suicide rates in NH have fluctuated, however there have been no statistically significant differences year-over-year since 2014. With the exception of 2021 and 2023, the annual NH crude suicide rates have remained statistically significantly higher than the US rates.

Figure 2

NH and US Suicide Deaths By Year - 2014 to 2023 (Crude Rate)

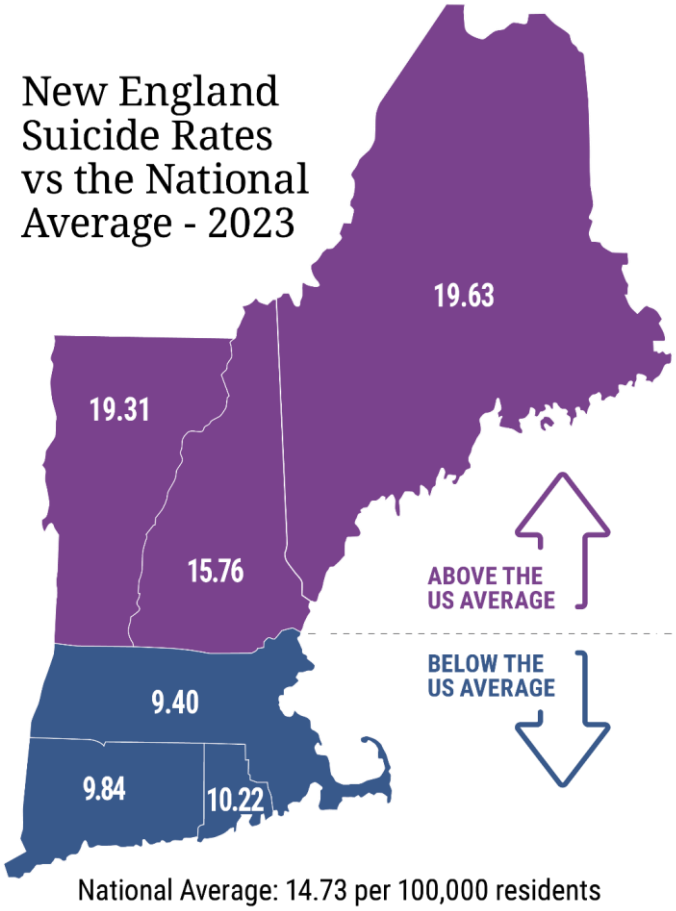


	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
NH Suicide Death Rate	18.51	17.05	18.16	19.62	20.59	18.74	16.98	16.05	17.70	15.76
US Suicide Death Rate	13.45	13.78	13.92	14.51	14.79	14.47	13.87	14.52	14.84	14.72

Data Source: CDC WISQARS

Having a suicide rate above the national average is not isolated to NH. As seen in **Figure 3** (pg. 26), all of the Northern New England states have rates above the national average, while the rates for Southern New England states are below the national average.

Figure 3



Data Source: CDC WISQARS

Table 7 (below) presents NH and US suicide death rates by age group. Adults ages 40 to 59 had the highest suicide rates of all age groups identified above (23.64 NH, 18.83 US) from 2018-2022 in NH and the 2nd highest in the US. There is a substantial difference in the rates from youth (ages 10-17) to young adults (ages 18-24) revealing the transition from middle/late adolescence to late adolescence/early adulthood as a particularly vulnerable time for death by suicide.

Table 7

Crude Suicide Death Rates per 100,000 in NH & US, by age group, 2019-2023.

Age Group	New Hampshire	United States
All Ages	17.03	14.49
Youth & Young Adults 10 to 24	11.17	10.31
Youth 10 to 17	4.19	4.81
Young Adults 18 to 24	18.30	16.51
Ages 25 to 39	23.30	18.53
Ages 40 to 59	20.88	18.61
Ages 60 to 74	18.17	16.07
Ages 75 and over	20.04	20.27

Data Source: CDC WISQARS

Table 8 (below) displays the 10 leading causes of death for people of different age groups in NH. From 2018-2023, suicide was the second leading cause of death for people age 15-34 in NH and nationally, behind only deaths due to unintentional injury. Within that age group, a substantial number of unintentional injuries in NH include motor vehicle crashes and unintentional overdose deaths.

Table 8

10 Leading Causes of Death, New Hampshire, by Age Group, 2019 – 2023.

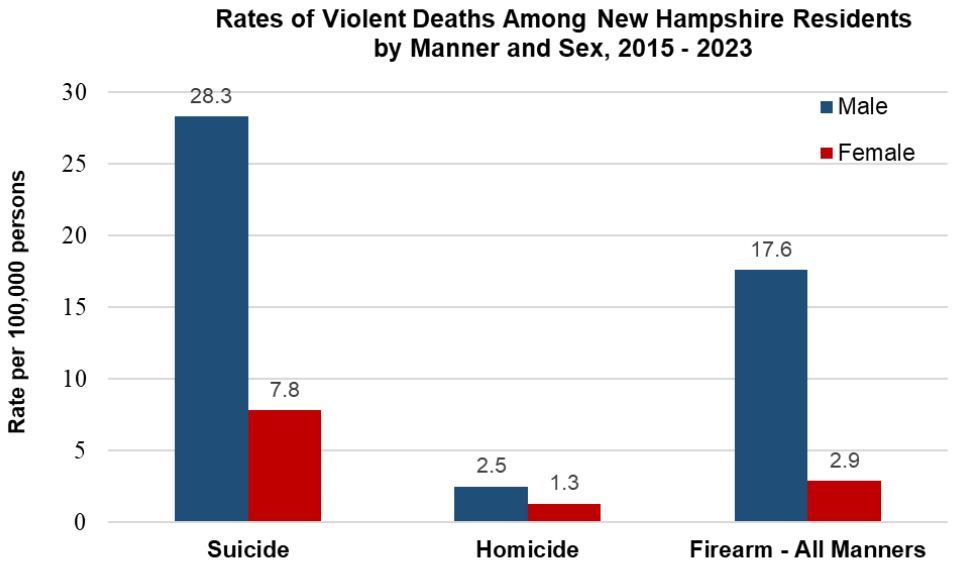
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies **40**	Unintentional Injury **17****	Unintentional Injury **--**	Suicide **12****	Unintentional Injury **218**	Unintentional Injury **687**	Unintentional Injury **746**	Malignant Neoplasms **727**	Malignant Neoplasms **2,525**	Heart Disease **11,964**	Malignant Neoplasms **14,374**
2	Short Gestation **31**	Homicide **--**	Malignant Neoplasms **--**	Malignant Neoplasms **10****	Suicide **125**	Suicide **210**	Malignant Neoplasms **183**	Unintentional Injury **599**	Heart Disease **1,567**	Malignant Neoplasms **10,846**	Heart Disease **14,305**
3	Sids **27**	Congenital Anomalies Heart Disease Influenza & Pneumonia Malignant Neoplasms --	Homicide **--**	Unintentional Injury **--**	Malignant Neoplasms **22**	Heart Disease Malignant Neoplasms **51**	Suicide **168**	Heart Disease **553**	Unintentional Injury **596**	Chronic Low. Respiratory Disease **3,098**	Unintentional Injury **4,742**
4	Maternal Pregnancy Comp. Placenta Cord Membranes **14****		Benign Neoplasms Congenital Anomalies --	Congenital Anomalies Heart Disease --	Heart Disease **19****		Heart Disease **143**	Liver Disease **214**	Chronic Low. Respiratory Disease **400**	Cerebrovascular **2,561**	Chronic Low. Respiratory Disease **3,577**
5					Homicide **15****	Liver Disease **29**	Liver Disease **100**	Suicide **212**	Liver Disease **352**	Covid-19 **2,360**	Cerebrovascular **2,849**
6	Respiratory Distress **10****		Acute Bronchitis Diseases Of Appendix Influenza & Pneumonia --	Benign Neoplasms Diabetes Mellitus Influenza & Pneumonia Perinatal Period --	Congenital Anomalies --	Covid-19 **18****	Diabetes Mellitus **39**	Diabetes Mellitus **112**	Diabetes Mellitus **310**	Alzheimer's Disease **2,350**	Covid-19 **2,758**
7	Bacterial Sepsis Unintentional Injury --	Covid-19 Cerebrovascular Septicemia --			Cerebrovascular Septicemia --	Homicide **16****	Covid-19 **38**	Covid-19 **91**	Covid-19 **249**	Unintentional Injury **1,861**	Alzheimer's Disease **2,385**
8						Diabetes Mellitus **15****	Cerebrovascular **23**	Cerebrovascular **76**	Suicide **204**	Diabetes Mellitus **1,471**	Diabetes Mellitus **1,950**
9	Intrauterine Hypoxia --				Influenza & Pneumonia --	Cerebrovascular **12****	Homicide **18****	Chronic Low. Respiratory Disease **54**	Cerebrovascular **171**	Parkinson's Disease **966**	Suicide **1,180**
10	Circulatory System Disease Maternal Hypertensive Disorders --				Chronic Low. Respiratory Disease Diabetes Mellitus --	Chronic Low. Respiratory Disease **10****	Septicemia **17****	Nephritis **39**	Septicemia **94**	Nephritis **872**	Liver Disease **1,151**

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

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics, National Vital Statistics System

Violent deaths include deaths from suicide, homicide, and firearm-related deaths, regardless of intent. The vast majority of violent deaths in NH are suicides. For every homicide in NH, there are approximately 10 suicide deaths. This ratio is in sharp contrast to national statistics, which show approximately 2 suicide deaths for every homicide. (CDC WISQARS, 2019-2023). The breakdown of violent deaths in NH by sex is presented below in **Figure 4**. This shows that males die of violent deaths of all manners at rates greater than those for females.

Figure 4



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

Youth and Young Adult Suicide in NH

Between 2019 and 2023, 137 NH youth and young adults aged 10-24 lost their lives to suicide. In NH and nationally, the individuals in this age group who died by suicide are much more likely to be male (in NH, 77% of all suicide deaths among individuals aged 10-24 were in males; nationally, 79% of all suicide deaths among individuals aged 10-24 were in males).[7] Firearms were the most frequently used method in NH and nationally among youth and young adults who died by suicide during this period. The next most frequently used method among this age group was suffocation/hanging.[8]

Table 9 (pg. 30) presents the number of suicide deaths by year. The number of deaths within this age group each year is relatively small and may fluctuate from year-to-year. Presenting the suicide death data in rolling three-year intervals as shown in **Figure 45** (pg. 63) helps to smooth out small year-to-year fluctuations, and also addresses population increases by presenting rates per 100,000.

[7] CDC WISQARS
[8] CDC WISQARS

Older Adult Suicide in NH

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

Another driver of suicide deaths among older adults is lethality rate, which is markedly higher for people over 65 years of age in comparison to other age groups. While there is one death for every 36 attempts in the general population, there is one death for every four attempts in individuals over 65. One related factor contributing to the lethality rate is that older individuals may be physically frailer than younger individuals and are therefore less likely to survive self-injurious acts. A second factor is that older adults tend to be more isolated than younger people, making detection and timely intervention less likely. A third factor is the lethality of means; compared to other age groups, adults over 65 are more likely to use firearms as a means of suicide (**Figure 32** – pg. 52).[9]

Suicide Across the Lifespan in NH

Table 9 below presents the number of suicide deaths in NH by year, by sex, and selected age groups. These counts include both NH residents and out-of-state residents who died by suicide in NH. When comparing year-to-year, there is a noticeable increase in the number deaths from 2016 to 2018, followed by a decrease from 2018 to 2021. The proportion of deaths by sex and age group remained relatively consistent from one period to the next. The breakdown of deaths by year and age group have been plotted in **Figure 5** (pg. 30).

[9] Conwell Y. Suicide and suicide prevention in later life. Focus 2013; 11(1): 39–47. https://acl.gov/sites/default/files/programs/2016-11/Suicide%20Prevention%20Webinar%20Presentation%20Slides2.pdf

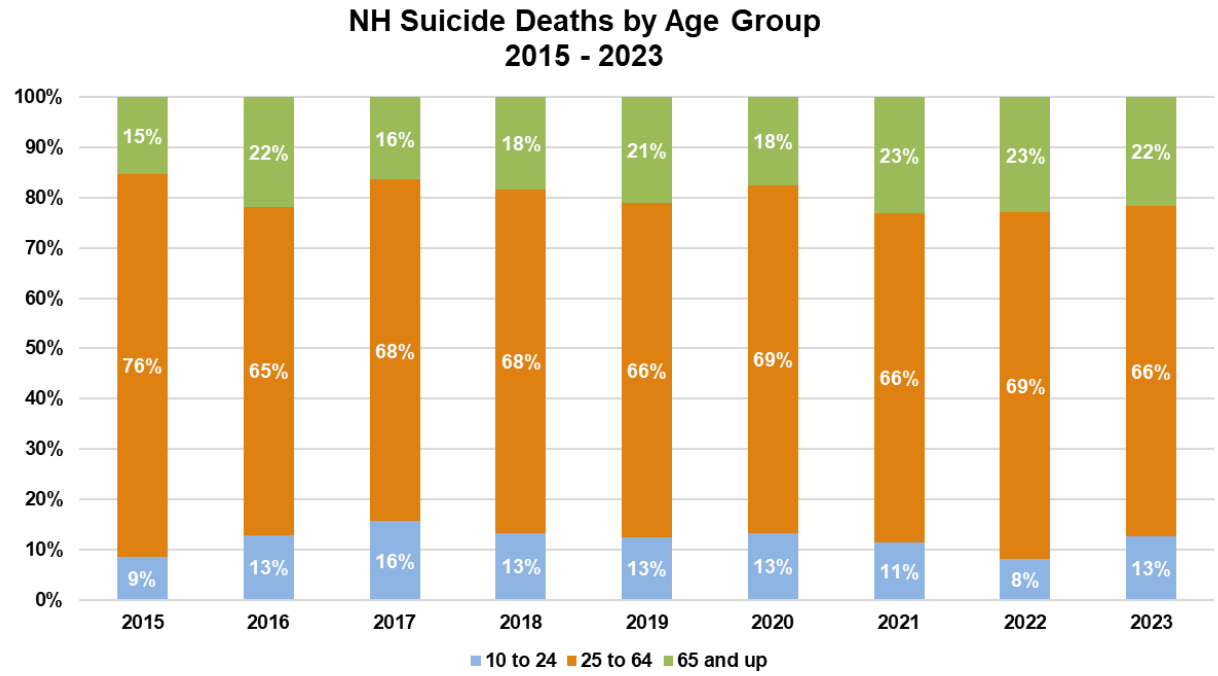
Table 9

NH All Suicide Deaths, by Year, Sex, and Age Group, 2015-2023.

Year	Total	Male	Female	10-24	25-64	65+
2015	235	172	63	20	179	36
2016	248	187	61	32	162	54
2017	262	203	59	41	178	43
2018	279	222	57	37	191	51
2019	256	207	49	32	170	54
2020	234	180	54	31	162	41
2021	229	180	49	26	150	53
2022	248	195	53	20	171	57
2023	222	184	38	28	146	48
Total	2213	1730	483	267	1509	437
Percent of Total	100%	78%	22%	12%	68%	20%

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

Figure 5

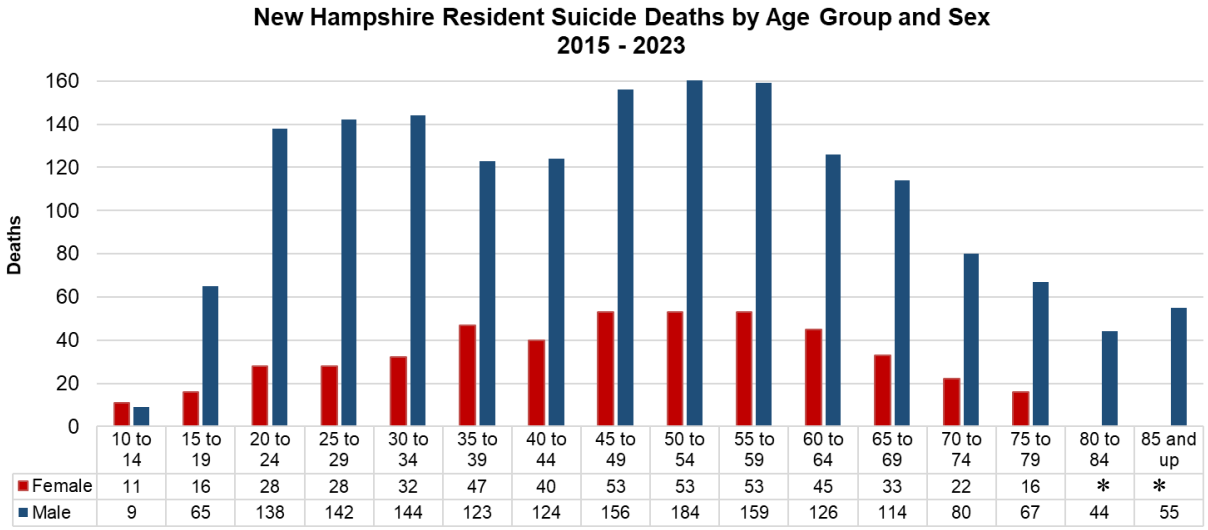


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

Figure 6 (below) and **Figure 7** (pg. 32), respectively, display NH suicide deaths and suicide death rates for all ages by age groups and sex from 2015-2023. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal how death rates account for differences in the number of people in each age group. While the highest *number* of suicide deaths occur in the 50- to 54-year-old age group, the highest *rates* are in males over the age of 80 due to the smaller population within that age/sex group. Males between the ages of 45 and 54 have the second highest rates, representing a shift from prior years in which males in their 70's generally exhibited higher rates of suicide than individuals in their 40's and 50's.

Suicide death rates are important in determining vulnerable age groups and age-related transitions. The suicide death rate in males rises rapidly from ages 10-14 to 15-19, and then again from ages 15-19 to 20-24, pointing to a rise in vulnerability during the transitions from early adolescence to middle adolescence and middle adolescence to late adolescence/early adulthood. Similarly, suicide rates among elderly males increase substantially at 85 years compared to the younger age groups, indicating another vulnerable time of life for men.

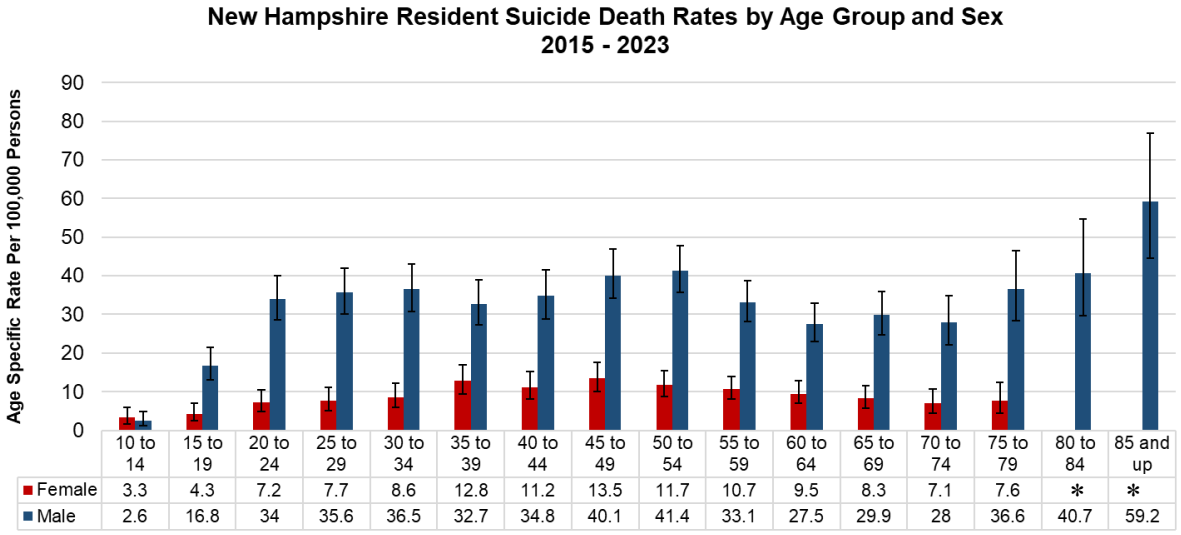
Figure 6



	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 and up
Female	11	16	28	28	32	47	40	53	53	53	45	33	22	16	*	*
Male	9	65	138	142	144	123	124	156	184	159	126	114	80	67	44	55

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

Figure 7



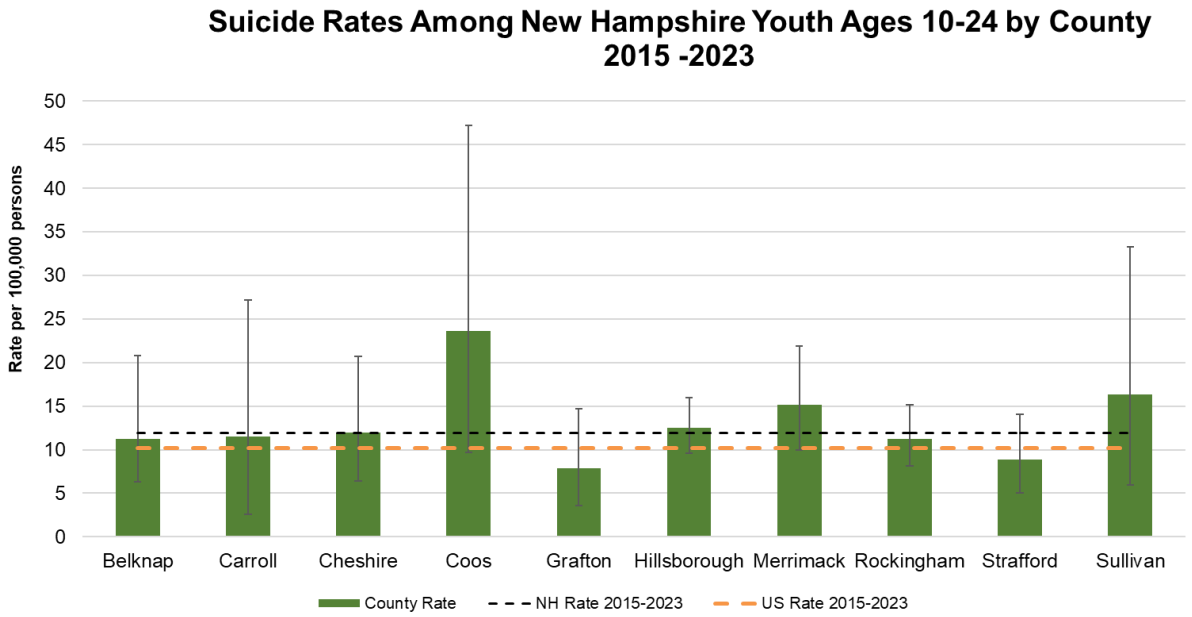
	10 to 14	15 to 19	20 to 24	25 to 29	30 to 34	35 to 39	40 to 44	45 to 49	50 to 54	55 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 and up
Female	3.3	4.3	7.2	7.7	8.6	12.8	11.2	13.5	11.7	10.7	9.5	8.3	7.1	7.6	*	*
Male	2.6	16.8	34	35.6	36.5	32.7	34.8	40.1	41.4	33.1	27.5	29.9	28	36.6	40.7	59.2

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

Geographic Distribution of Suicide in NH

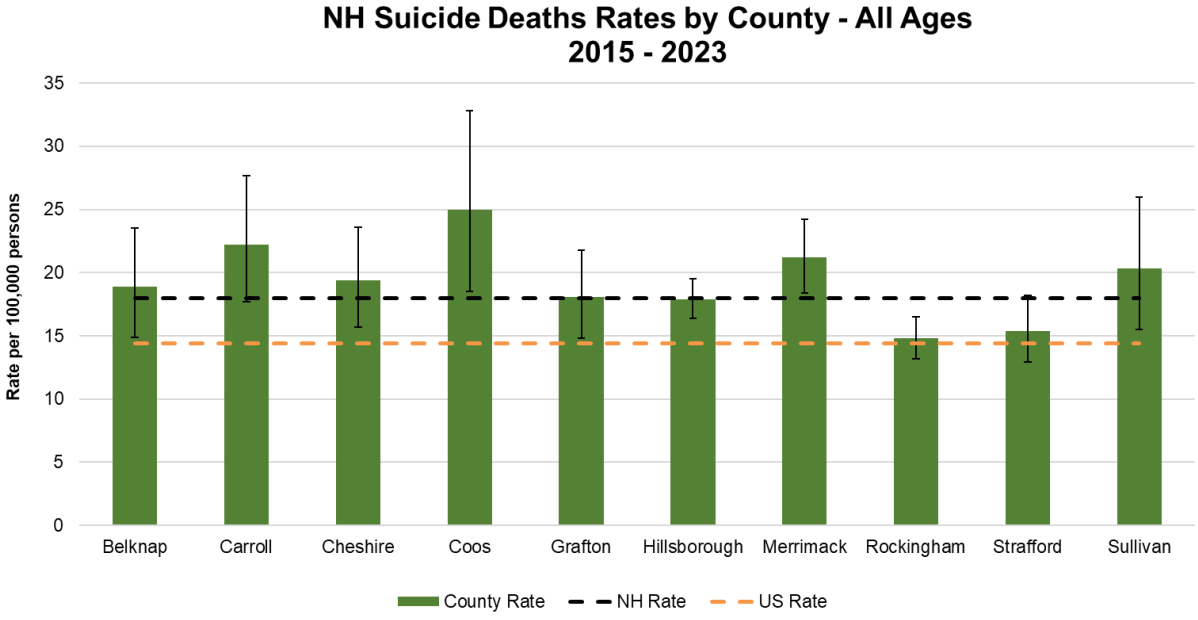
The numbers and rates of suicide in NH are not evenly distributed throughout the state. **Figure 8** (pg. 33) shows youth and young adult suicide rates by county in NH. **Figure 9** (pg. 33) presents this data for NH residents of all ages. The county suicide death rate chart indicates geographical locations that may be particularly vulnerable to suicide (youth and young adult and/or all ages). Due to small numbers, most of these differences are not statistically significant. However, the all-ages rates (**Figure 9** – pg. 33) for Rockingham County (all-ages rate: 14.8 per 100,000) and Strafford County (all-ages rate: 15.4 per 100,000) are significantly lower than the all-ages suicide rates for Coos County (all-ages rate: 25.0 per 100,000) and Merrimack County (all-ages rate: 21.2 per 100,000). County limits are not absolute barriers. A suicide death that occurs in one county can have a strong effect on neighboring counties or across the state, due to the mobility of residents. **Figure 10** (pg. 34) presents the suicide rates for all-ages from 2015 to 2023 as a NH map broken down by county.

Figure 8



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

Figure 9



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

Figure 10
Map of NH suicide death rates

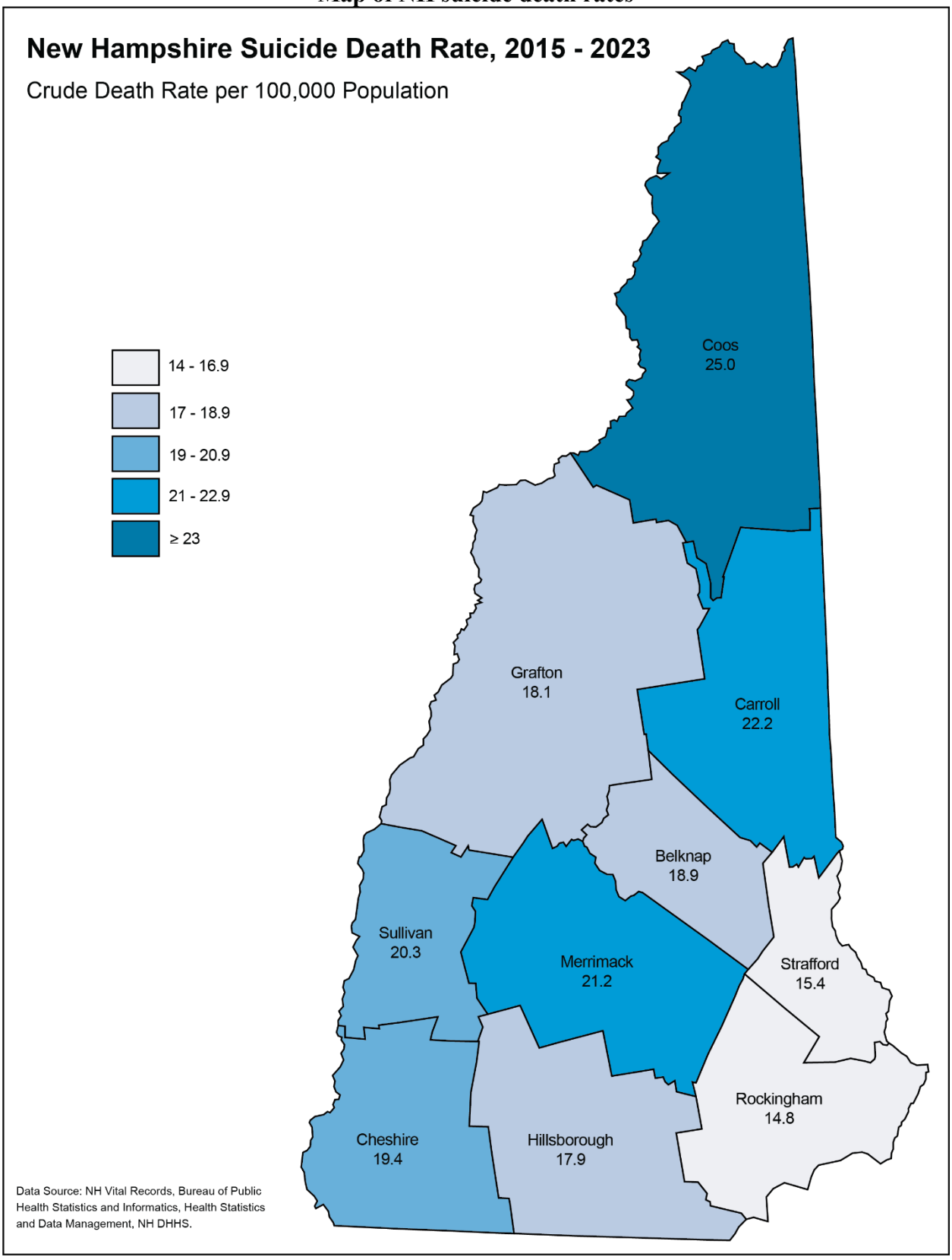


Table 10 (below) further expands upon this county breakdown by presenting the rates of suicide deaths in each county by sex. In the majority of counties, the ratio is three to four male deaths for every one female death. The one exception is Sullivan County where the ratio is 5 male deaths for every one female death. The ratio of males and females residing in each county is approximately one-to-one statewide.

Table 10
2015 – 2023
Suicide Death Rates by Sex in NH Counties

County	Female Rates per 100,000	Male Rates per 100,000	Rate Ratio
Belknap	9.2	28.8	3.1
Carroll	9.4	35.1	3.7
Cheshire	8.6	30.7	3.6
Coos	9.6	38.8	4.0
Grafton	7.5	28.3	3.8
Hillsborough	8.4	27.5	3.3
Merrimack	8.9	33.8	3.8
Rockingham	6.0	23.8	4.0
Strafford	7.4	23.6	3.2
Sullivan	6.6	34.1	5.2

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

Gender Differences in NH[10] – Suicide Attempts, Deaths, and Risk Factors

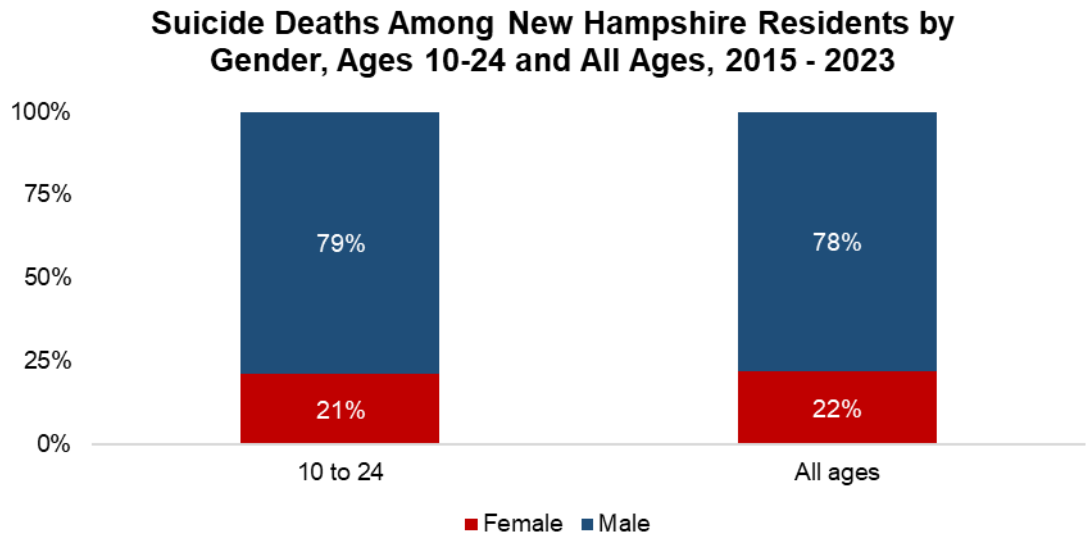
Youth and Gender

The fact that males represent 78% of all suicide deaths, and 79% of youth and young adult suicide deaths from 2015-2023, may largely be due to males using more lethal means. See **Figure 11** (pg. 36). In fact, females *attempt* suicide at a higher rate than males—up to 3 times as often (**Figure 12** – pg. 37 and **Figure 13** – pg. 37). When examining how many NH youth and young adults ages 10-24 were hospitalized and then discharged for self-inflicted injuries in 2019-2023, data shows that females account for 70% of inpatient discharges (**Figure 12** – pg. 37). Likewise, the 2023 NH YRBS reports approximately twice as many female youth attempt suicide as males each year (10.3% of females and 6.5% of males). Emergency department (ED/ambulatory) data reveals a similar gender ratio, based on self-inflicted injury rates.[11]

[10] Gender data included in this report is in most cases only reported as female or male due to limitations in the source data. With most data sources, gender equates to sex assigned at birth.

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

Figure 11

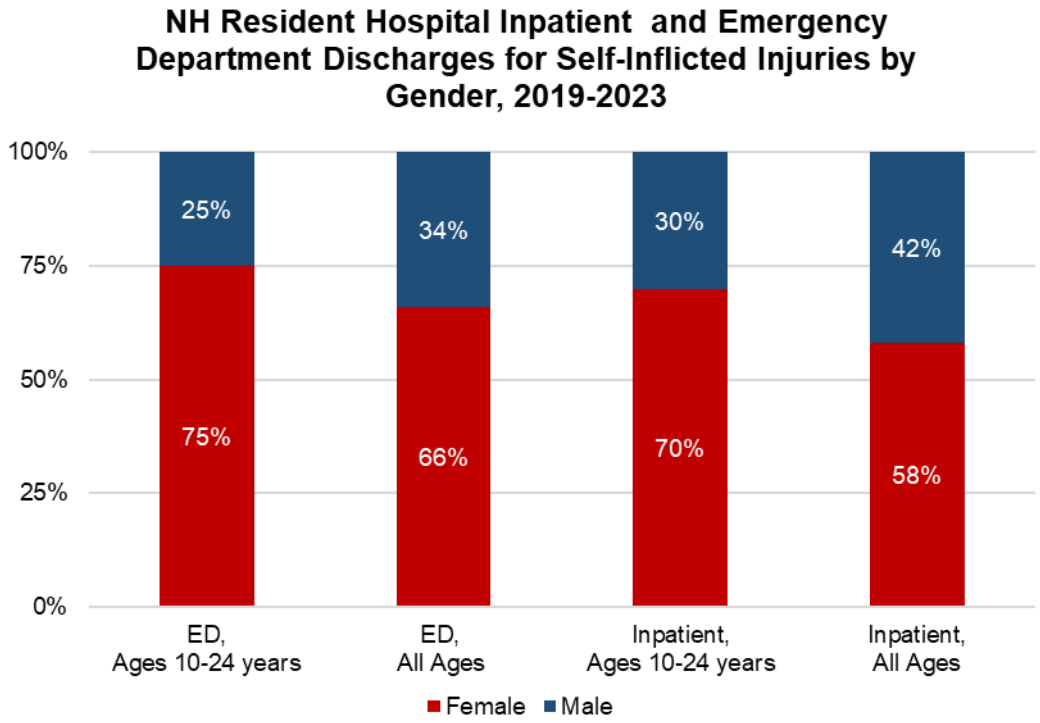


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

This report includes three sources of self-inflicted injury data; Emergency Department Discharges, Inpatient Discharges, and individuals treated/transported by Emergency Medical Services (EMS). Emergency Department (ED) data includes patients who came to the ED and stayed at the hospital for less than 24 hours (also called Ambulatory Discharges). Inpatient data refers to patients who were admitted to the hospital for more than 24 hours. If a patient goes to an ED and is admitted for inpatient services, they are removed from the count in the ED data and listed as inpatients. The hospital discharge data records the number of hospital visits, not the number of individual people who went to the hospital for care. For example, if one patient went to the hospital three different times over the course of a year it would be counted as the same number of visits as three different patients who went to the hospital one time each over the course of a calendar year.

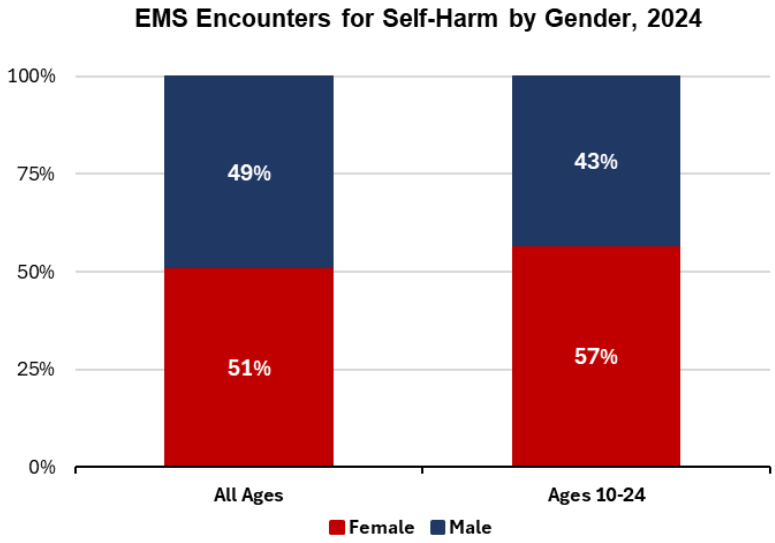
The EMS data presents the number of times individuals were treated and/or transported by an EMS provider where the individual had some type of self-inflicted injury. As with the hospital data, the EMS data looks at the number of visits/incidents, not unique individuals. The EMS data comes from a different source than the hospital data. Therefore, the cases are not de-duplicated between the two datasets (i.e., an individual may be counted in the hospital and EMS datasets for the same incident if they were transported by EMS to an Emergency Department). The cases included in the EMS dataset are ones where the intent of the injury was listed as “self-inflicted”. This does not include incidents where an injury was deemed to be accidental.

Figure 12



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

Figure 13



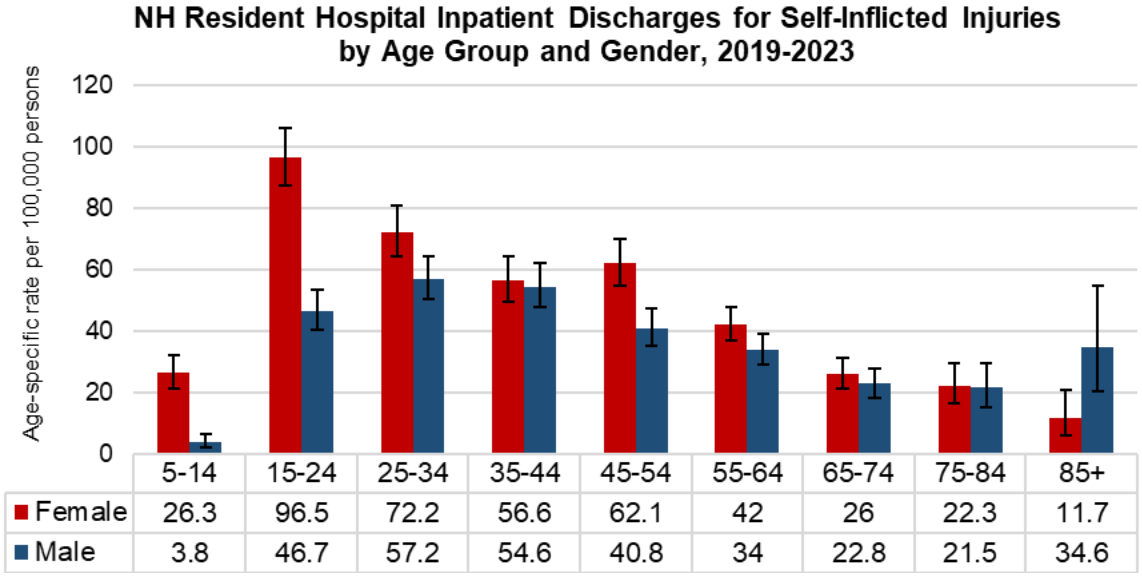
Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

Age, Gender and Self-inflicted Injury

When the rates for NH resident inpatient hospitalizations and emergency department use for self-inflicted injuries from 2019-2023 are examined by gender and age group, the variability can be seen (**Figure 14** – below, **Figure 15 –** pg. 39). As above, these data refer to number of visits; therefore, individuals may be counted multiple times if they were admitted or seen more than once during the year.

Female NH residents have a higher overall rate of inpatient hospitalizations for self-inflicted injuries until the ages 85+ where the male rate exceeds the rate for females. For females aged 15-24, the rate of inpatient hospitalization (**Figure 14 –** below) is 96.5/100,000, more than twice the rate for males of the same age. The peak age for males is between 25 and 34 for self-inflicted injuries requiring an inpatient admission. Again, ED usage rates, depicted in **Figure 15** (pg. 39), point to females aged 15-24 as a population particularly vulnerable to self-injury and/or suicide attempts, with females in this group exhibiting a rate of 506.4/100,000, about 88 times the suicide death rate for this population in NH. Self-injury rates for males also peak in the 15 to 24 age group, at 198.7/100,000, a rate that is much lower than that for females in this age group. This data reinforces the fact that the transition from middle adolescence to late adolescence/early adulthood is a time of great risk for suicidal thinking, self-harm and suicide attempts. EMS data (**Figure 16 –** pg. 39), which includes individuals treated and/or transported by Emergency Medical Services for a self-inflicted injury, presents a similar picture to the hospital data in terms of high-risk age groups. Females aged 15 to 24 present the highest rates of self-inflicted injuries. In many other age groups, male rates are equal to or exceed the rates for females in the EMS data.

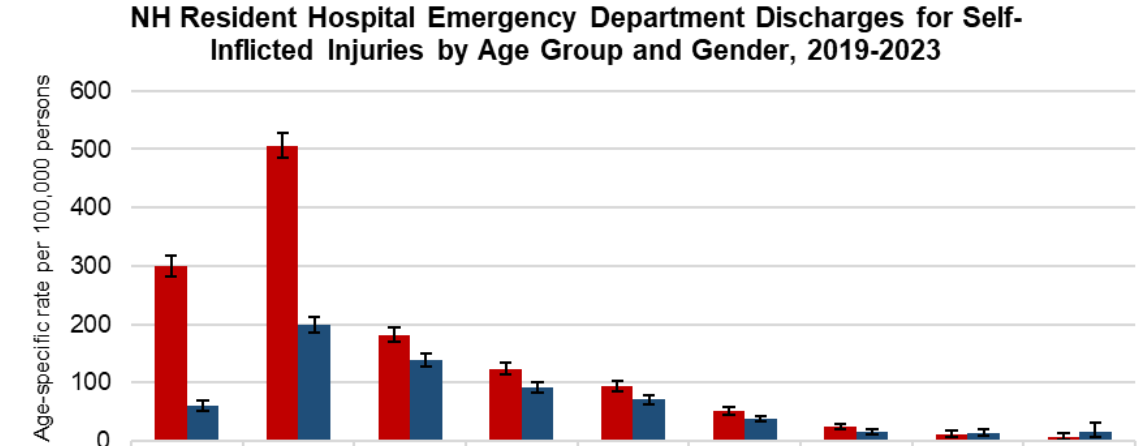
Figure 14



	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	26.3	96.5	72.2	56.6	62.1	42	26	22.3	11.7
Male	3.8	46.7	57.2	54.6	40.8	34	22.8	21.5	34.6

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

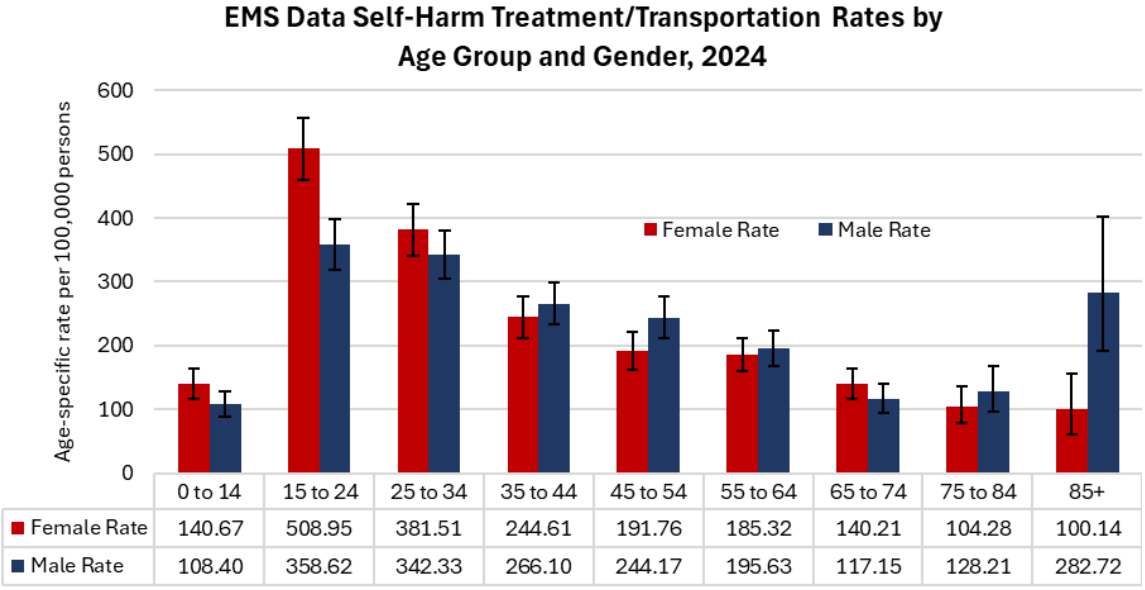
Figure 15



	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Female	299.2	506.4	181.9	123.5	93.3	51.2	23.6	11.9	6.4
Male	59.8	198.7	137.8	91.7	70.4	37.7	15.8	13	15.4

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

Figure 16



	0 to 14	15 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75 to 84	85+
Female Rate	140.67	508.95	381.51	244.61	191.76	185.32	140.21	104.28	100.14
Male Rate	108.40	358.62	342.33	266.10	244.17	195.63	117.15	128.21	282.72

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

Comparing rates of inpatient and emergency department (ED) discharges with rates of death by suicide for all ages in NH, there are approximately 9 hospitalized suicide attempts for every suicide death. This number does not include attempts that go unreported, unrecognized, or without a hospital or ED visit which required medical intervention. Further, the rates of attempts for young people and females exhibit an even greater ratio of suicide attempts to deaths with nearly 36 attempts per death among individuals aged 10-24, and 28 attempts per death among females of all ages.

In contrast to the above data, which are based on cases where medical intervention is required, the results of the YRBS present data collected from high-school-aged youth by self-report (**Figure 47** – pg. 64). In 2023, 8.5 percent of high school students completing the YRBS reported having attempted suicide at least one time over the previous year. Based on the YRBS and 2023 NH high school enrollment figures,[12] this is equivalent to over 4,400 high-school-age youth in NH who may attempt suicide each year. Unlike the inpatient and ED discharge data, the YRBS reports may also include attempts with relatively non-lethal means where medical assistance was not sought. Of particular concern given this data is the likelihood that in many of these cases, the youth have never sought help or disclosed the attempt to an adult. It is also possible that self-reports exaggerate the incidence of suicide attempts among high-school-age youth.

While the majority of self-inflicted injuries[13] are not fatal, a significant indicator of risk for suicide is a previous attempt. A recently published meta-analysis of the existing literature found that one in five individuals who survive a suicide attempt are at risk for making a subsequent attempt (de la Torre-Luque et al, 2023).[14] Therefore, any suicide attempt, regardless of its lethality, must be taken seriously and addressed, as it could be followed by additional attempts. Once an individual has made an attempt, secondary prevention is necessary.

History of Suicide Attempts and Intent Disclosure

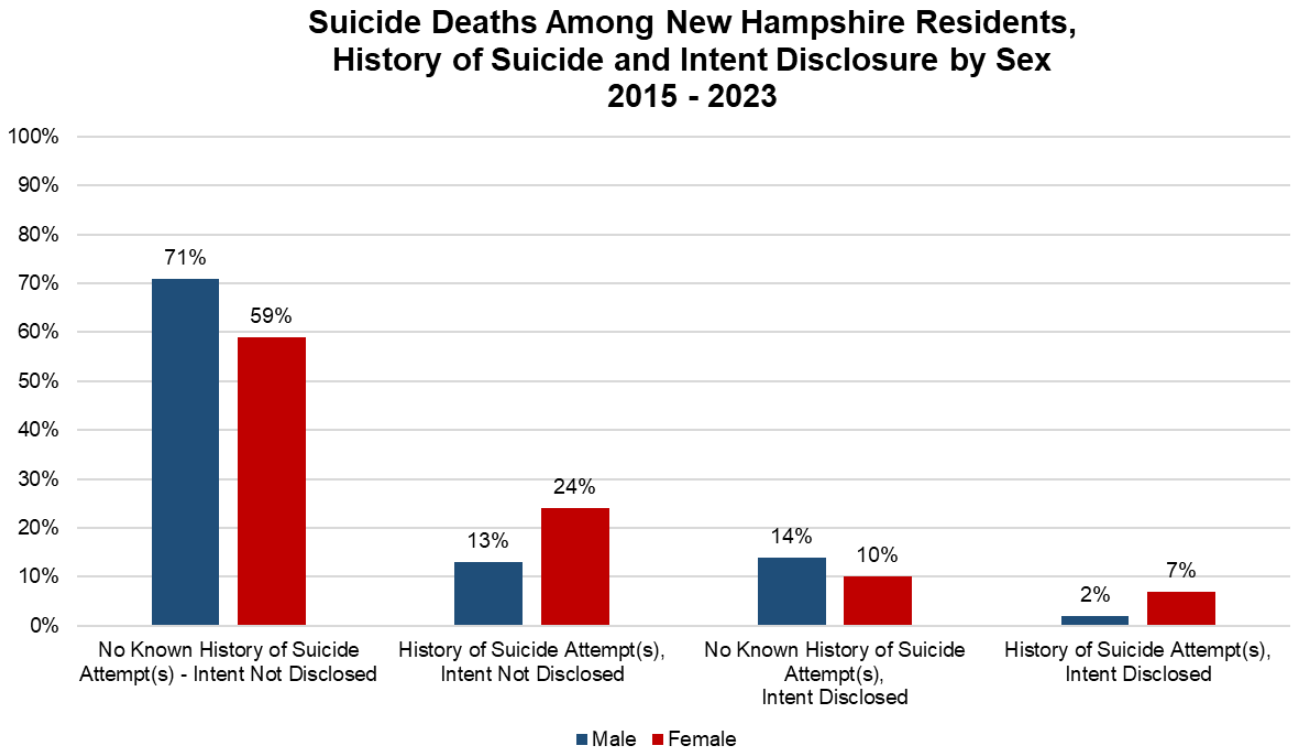
The vast majority of individuals who died by suicide in NH have no reported history of prior suicide attempts or disclosure of suicidal intent. Females who died by suicide in NH were approximately twice as likely as males to be known to have a prior history of suicide attempts. (**Figure 17** – pg. 41).

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

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

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

Figure 17

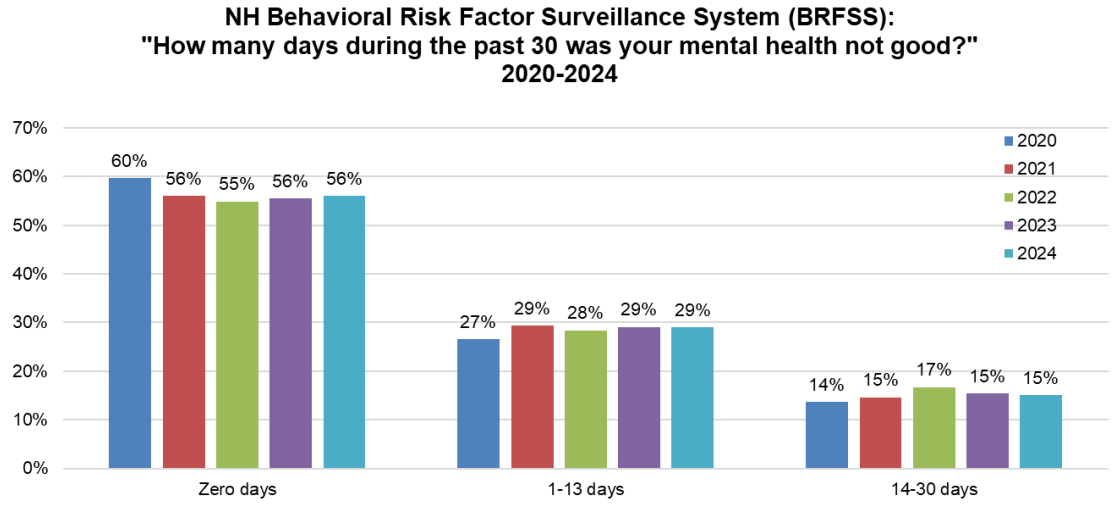


Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

NH Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is a survey conducted with a representative sample of non-institutionalized state residents age 18 years and older. The survey includes the question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Although this is not a perfect proxy measure for depression, it gives one a general sense of the percentage of NH residents that may be experiencing a depressed mood. The results from this item are included in **Figure 18** (pg. 42).

Figure 18



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

A 2018 CDC report indicated that approximately half of individuals who take their own life had a mental health diagnosis, the most common diagnoses being depression, anxiety, and substance use disorders. Yet a much smaller percentage (35.8%) had ever received treatment.[15] As shown in **Figure 19** (pg. 43), in 2024, over 40,700 people received treatment at one of the state's ten Community Mental Health Centers (CMHC).[16] This works out to be approximately 1 out of every 35 residents in the state. Of those individuals in treatment, approximately 47% of them were female and 38% were male, 3% identified as other/non-binary, and 12% of individuals chose not to disclose or the information was otherwise unavailable.[17] Without additional data it is not possible to say how these numbers relate to the connection between these treatment figures and the greater number of suicide deaths among males and/or the greater number of suicide attempts reported among females.

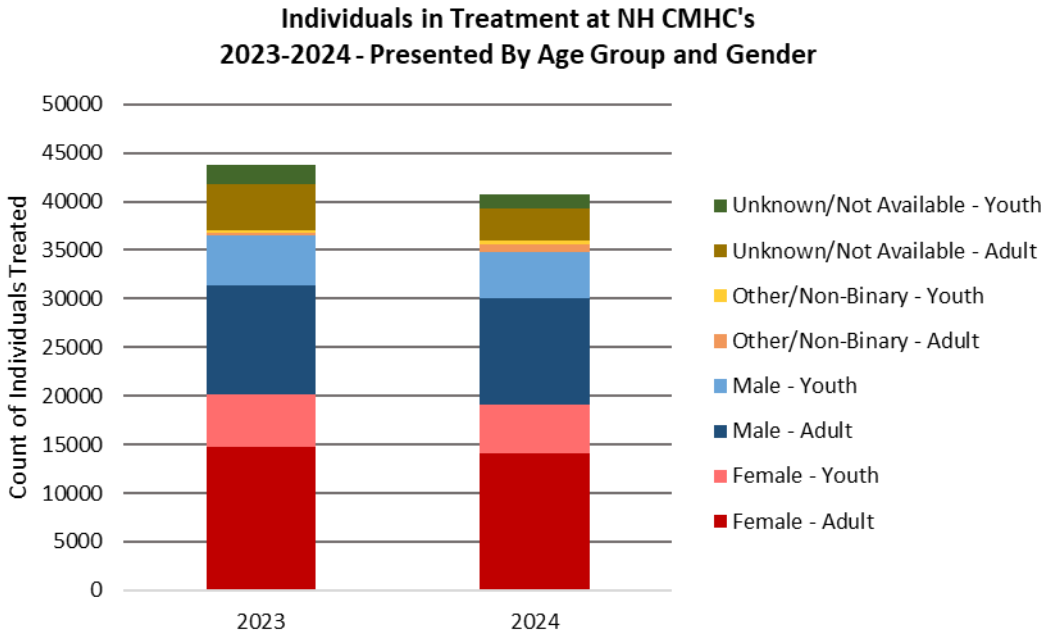
Disclosure of suicidal intent and prior suicide attempt(s) are significant risk factors for suicide. If you are concerned about an individual with these or other risk factors, connect them with appropriate resources such as the 988 Suicide and Crisis Lifeline – Call/Text 988 or visit 988Lifeline.org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

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

[16] 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

[17] Individuals identifying as transgender have been counted within the category for their reported gender identity (i.e., transgender males are counted within the male categories and transgender females within the female categories).

Figure 19

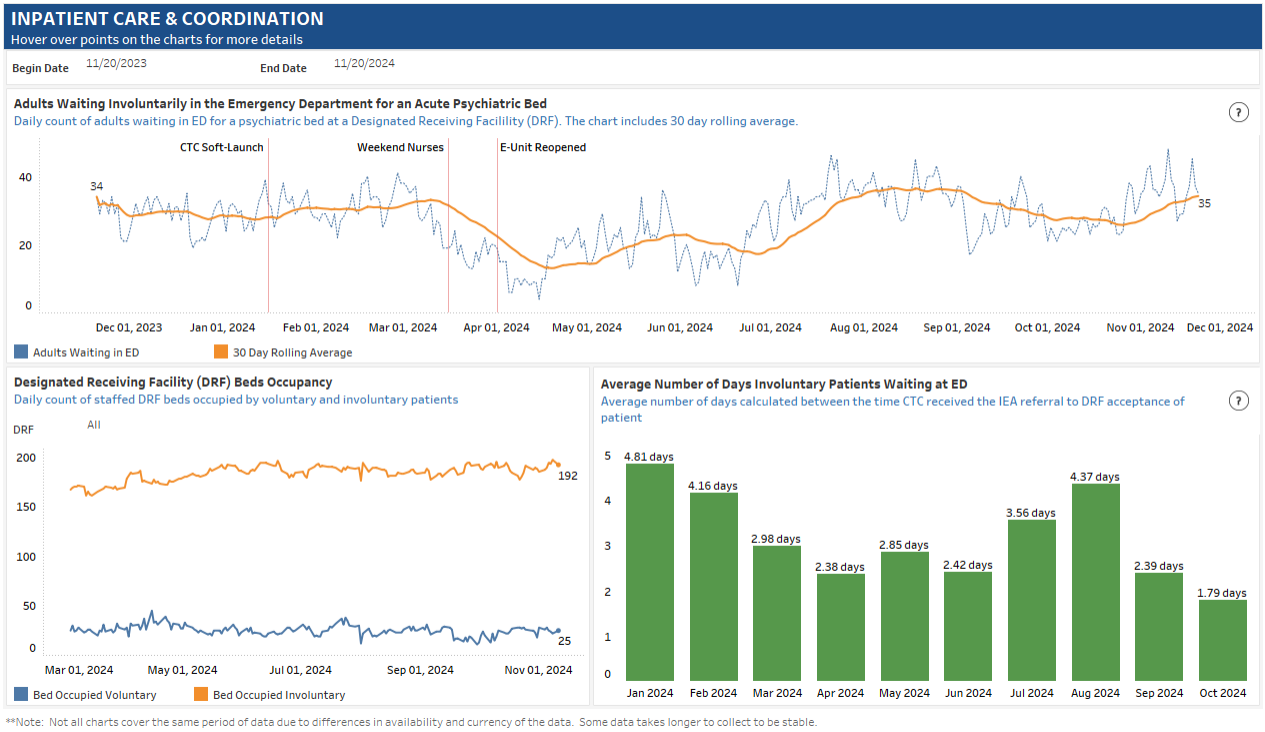


Data Source: NH Bureau of Behavioral Health

Patients that cannot be treated in an outpatient setting, such as people involuntarily admitted due to potential suicide risk, will generally be admitted to New Hampshire Hospital, NH's state psychiatric hospital, or another Designated Receiving Facility. **Figure 20** (pg. 44) presents data from a new Mission Zero adult mental health dashboard addressing inpatient care and coordination. This includes the number of individuals waiting in NH emergency departments for an involuntary acute psychiatric bed, and the average number of days those individuals waited before being accepted at one of the Designated Receiving Facilities. The public facing dashboard featured in **Figure 20** is regularly updated and can be accessed on the NH DHHS Data Portal.[18]

[18] Live dashboard access: https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=mental-health&subtopic=mission-zero-adult-mental-health&indicator=mission-zero-inpatient-care-and-coordination

Figure 20
NH Mission Zero Data Dashboard – Inpatient Care & Coordination

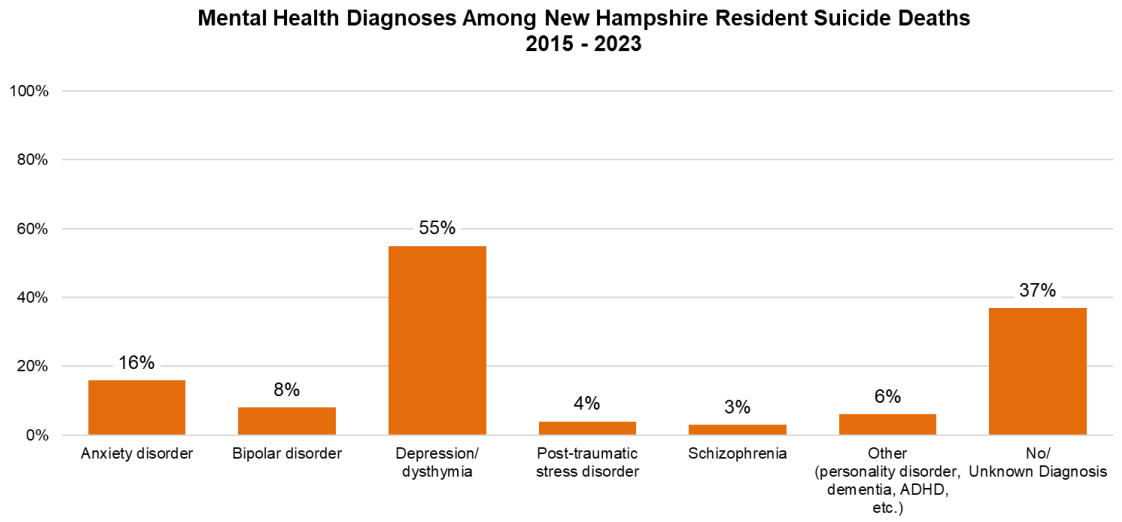


**Note: Not all charts cover the same period of data due to differences in availability and currency of the data. Some data takes longer to collect to be stable.

Data Source: NH DHHS Data Portal

Figure 21 (pg. 45) addresses mental health diagnoses of individuals who died by suicide, where this information was available. The mental health diagnoses are based on evidence at the scene such as medications prescribed to the deceased, information confirming that the individual had a mental health provider (psychiatrist, mental health counselor, etc.), and reports from next of kin. A challenge with reports from next of kin is that they may not have up-to-date knowledge on their loved one's mental health condition and treatment. As a result, there are many suicide deaths for which there is no data available related to mental health diagnosis. The availability of mental health diagnosis information in the NH-VDRS continues to improve as death scene investigators expand their documentation of mental health issues. Some decedents may have had more than one mental health diagnosis and are therefore counted in more than one category.

Figure 21

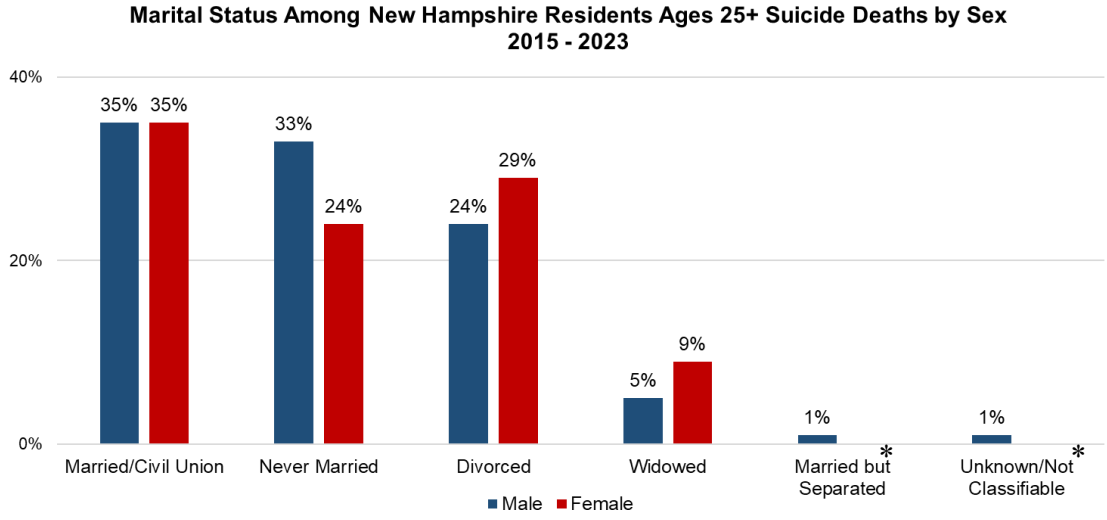


Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Additional Demographic Characteristics of Individuals in NH Who Died by Suicide

Additional demographic factors are correlated with suicide. **Figure 22** (below) presents the marital status of individuals who died by suicide in NH between 2015 and 2023. While approximately 51% of individuals in NH are married and 12% are divorced,[19] only 35% of individuals who died by suicide in NH were married and 25% were divorced.

Figure 22

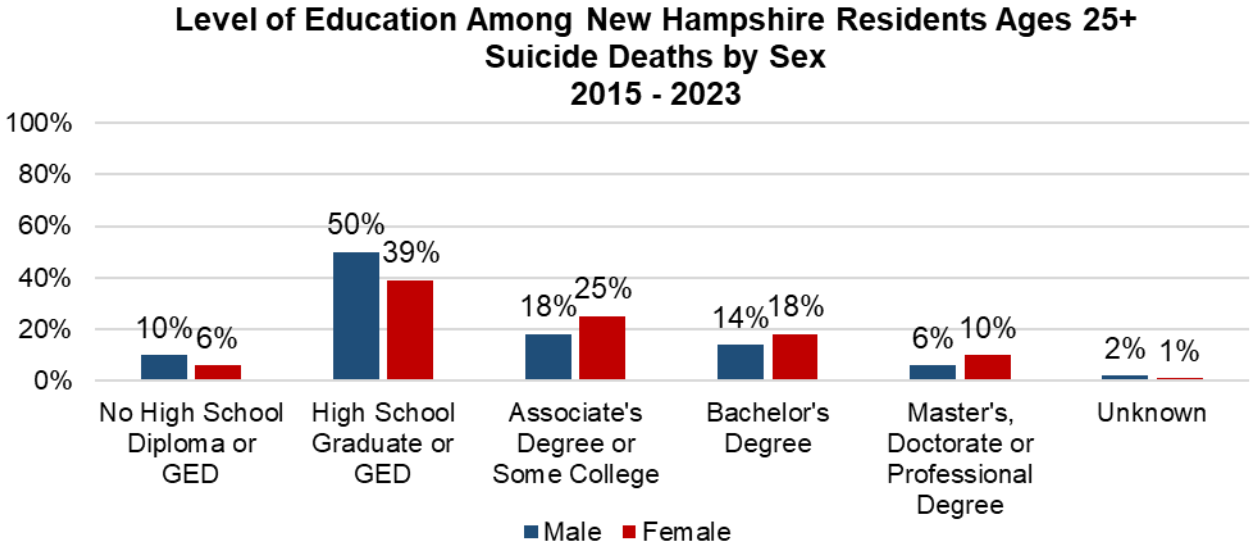


*Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.

[19] US Census Bureau American Community Survey, 2022

Educational attainment may also play a role in suicide. The prevalence of suicides in NH is greatest among individuals who had educational levels of high school or GED (**Figure 23 –** below) and substantially lower among individuals with college degrees. Among adults in NH, over 38% have a bachelor's degree or higher (**Table 4 –** pg. 24), while only 20% of male and 28% of female adult suicide deaths in NH are by individuals with an equivalent educational level. Additionally, adults in NH with no high school diploma or GED make up approximately 6% of the population while accounting for 9% of adult suicide deaths.[20] Nationally, higher levels of education are generally correlated with higher income and lower levels of unemployment.[21] The larger number of suicide deaths among individuals with education levels of high school or less could indicate a greater prevalence of employment or financial stressors among this group. Job and financial stressors were frequently identified among individuals in NH who died by suicide (**Figure** 39 – pg. 57).

Figure 23



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

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

Attitudes Related to Suicide in NH

In 2006, as part of NH's First SAMHSA suicide prevention grant, NAMI NH, the SPC, and YSPA collaborated with the UNH Survey Center on a survey of NH residents about their attitudes toward suicide prevention and mental illness. The survey included 500 NH households representative of the state as a whole. The survey was repeated in 2008, and again in 2012 to determine if there had been any change in public perception. In 2021 the SPC Data Committee began the process to repeat the survey and determine if attitudes in NH had shifted over the past decade. The survey was completed by the UNH Survey Center in May 2022. The SPC Data Committee initiated the process to repeat the survey again in 2024 and 2025 through the UNH Survey Center. This process was completed in May of each year.

The results from the survey are presented below in **Figures 24 – 29** (pgs. 48-50). When the survey was conducted in 2006, 2008, and 2012 it was done as a phone interview. The survey methodology has changed since then and is now conducted via an online survey. Survey participants are recruited from randomly selected landline and cell phone numbers across NH. Individuals who agree to participate will then take part in the UNH Survey Center Granite State Panel.[22] Due to the shift in methodology the survey included data from approximately 930 respondents in 2022, approximately 1,180 respondents in 2024, and approximately 1,340 in 2025 rather than the 500 respondents in prior years. Additionally, the wording of some questions has changed over time. In these cases, the change has been noted below the figure.

While the results for 2022-2025 are similar, they differ from what was found in prior years with fewer individuals selecting the "Strongly Agree" category and more selecting the "Somewhat Agree" category (**Figures 25, 27, and 28 -** pgs. 48-50). This shift may be a result of changes in statewide attitudes, the changes made to the survey items, the change in survey format, or a combination of these and other factors. Even though fewer individuals selected the "Strongly Agree" option in 2022-2025, these results still show the majority of respondents agreeing with the statements in **Figures 25, 27, and 28** (pgs. 48-50).

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

Figure 24

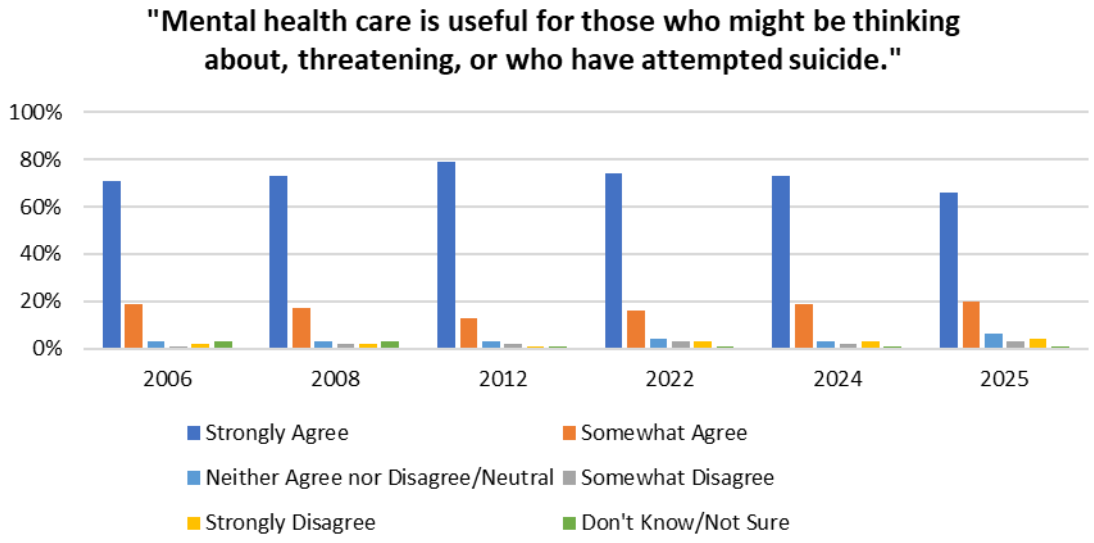
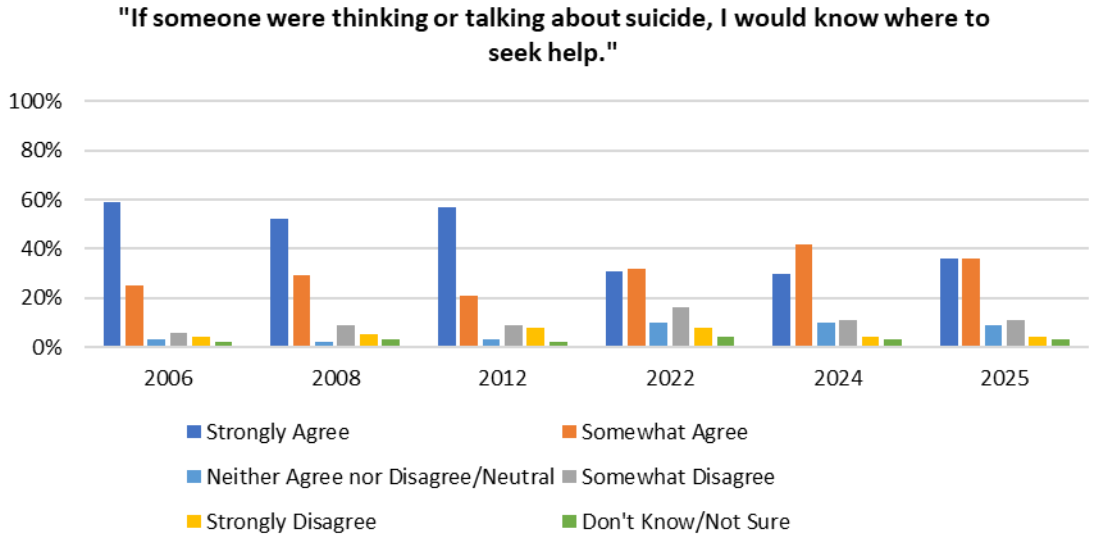


Figure 25



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

Figure 26

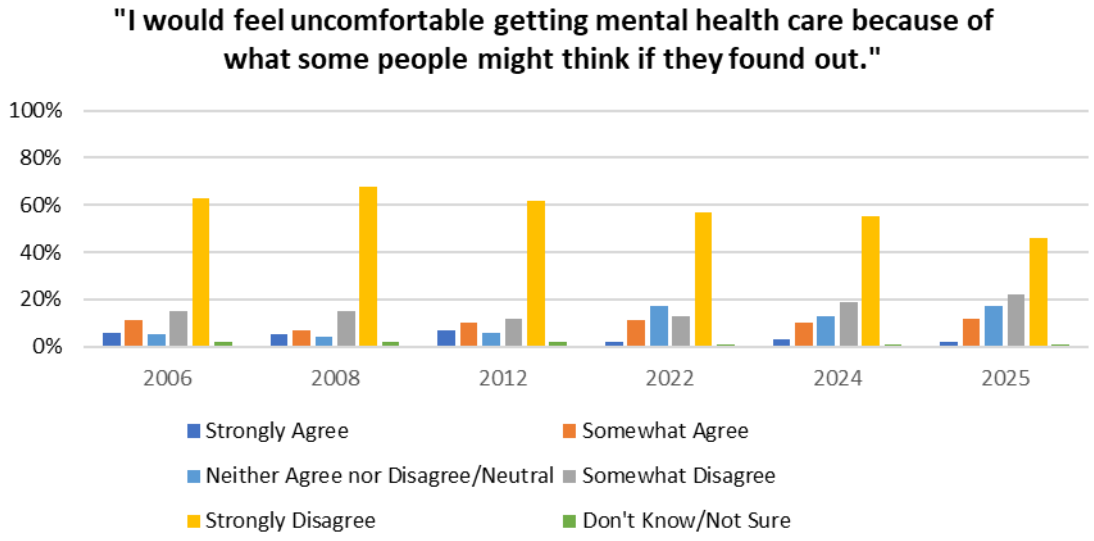


Figure 27

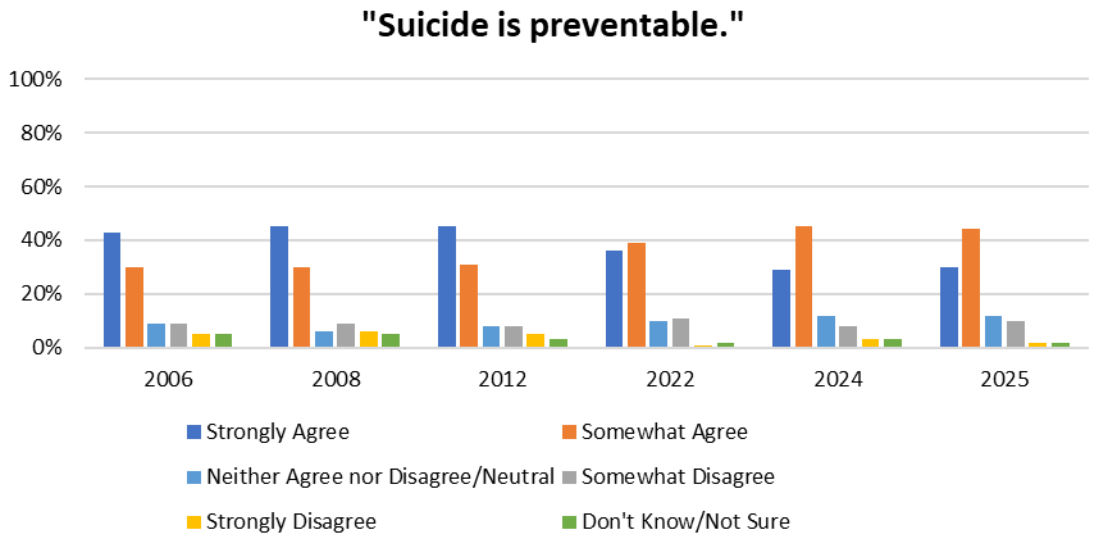
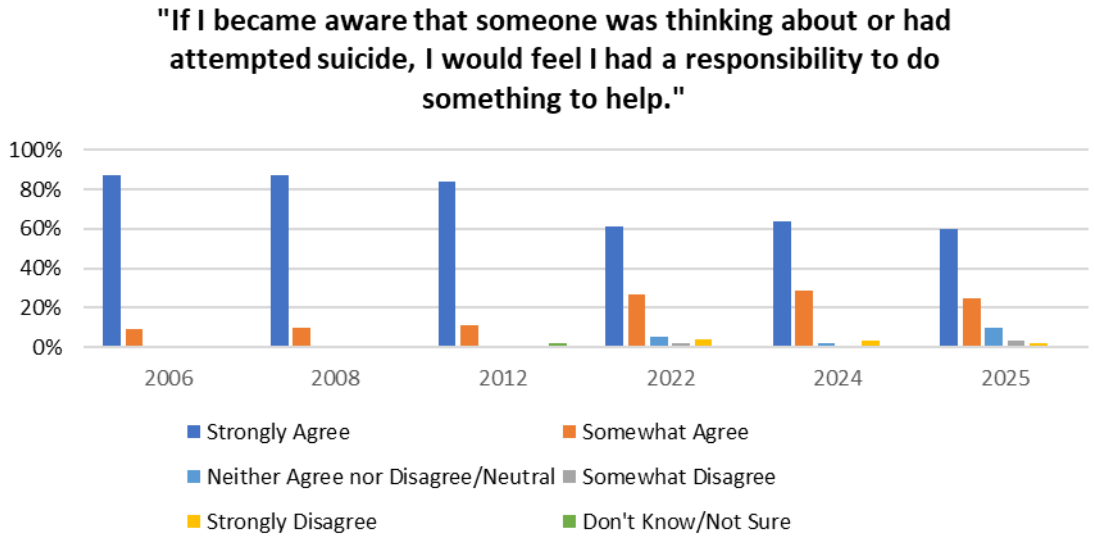
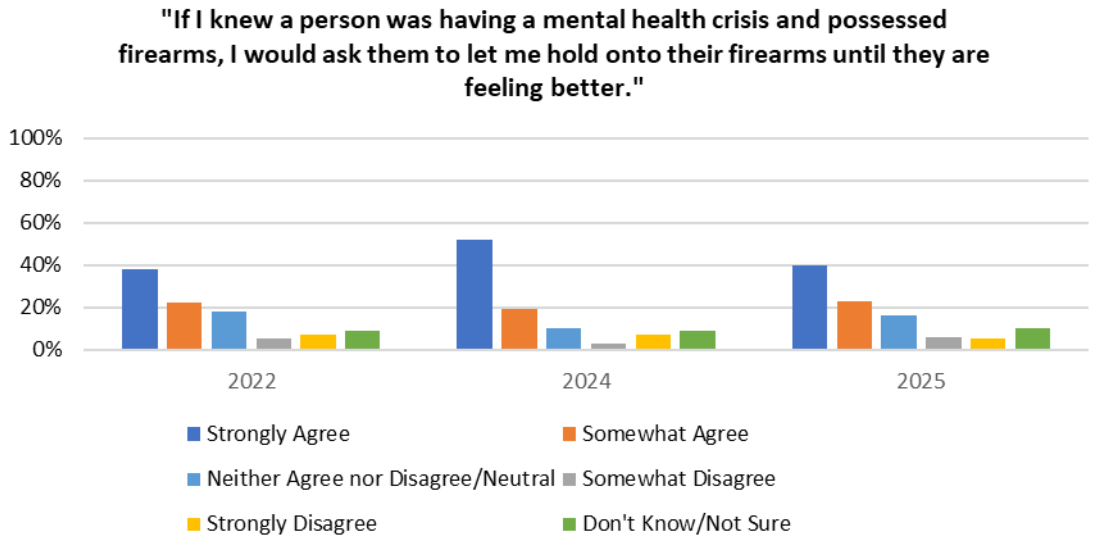


Figure 28



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

Figure 29



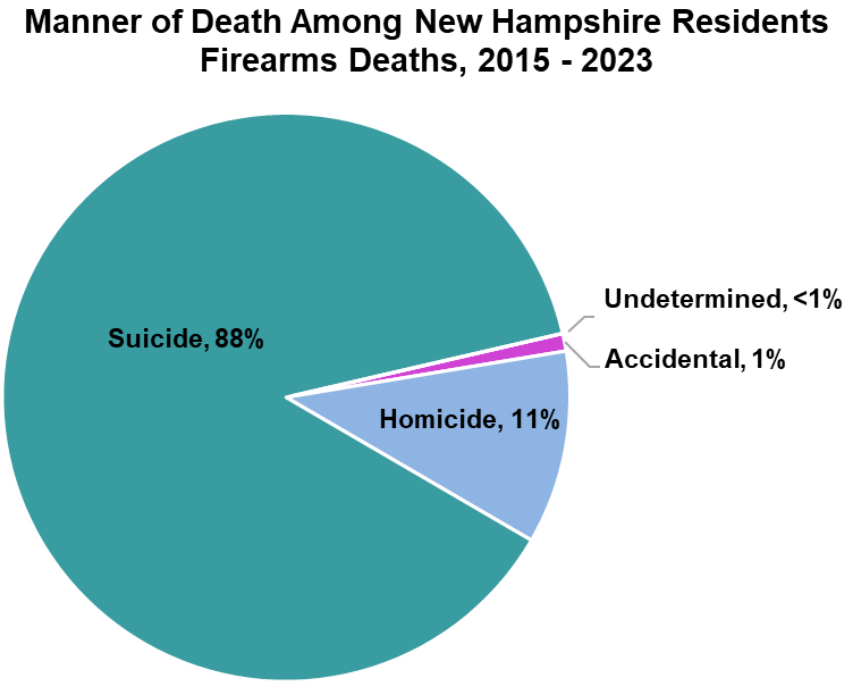
2006-2012 question wording: Not applicable – This question was first included in 2022.

Suicide in NH: Methods

The gender difference in suicide deaths/attempts may be explained in part by the fact that males, in general, use more lethal means. Of NH male youth and young adults (ages 10-24) who died by suicide between 2015 and 2023, 56% used firearms compared to 18% of females (**Figure 32** – pg. 52). This gender disparity in firearm use decreases between the ages of 25 and 64 with 52% of males and 31% of females using firearms. The proportion of firearm deaths then increases sharply after age 65 for males, with 70% of the suicide deaths in that age group involving a firearm. In NH, the vast majority of deaths involving a firearm are suicide. This can be seen in **Figure 30** (below).

Figure 30

From 2015-2023, approximately 88% of all NH deaths involving a firearm were suicides.



Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Suicide attempt methods have varying lethality. **Figures 33 and 34** (pg. 53) show the proportions of suicide methods resulting in death, presentation to the emergency department, or inpatient hospitalization. Suicide deaths account for 88% of all NH firearm-related deaths. Among youth and young adults, suicide is often a highly impulsive act and poor impulse control is one of the risk factors for suicide. Therefore, intervention efforts that reduce access to firearms and other highly lethal means may be effective to reduce suicide among those at risk for suicide, particularly for those who are more likely to be impulsive. Firearms remain the most used method of suicide throughout the lifespan in NH. **Figure 35** (pg. 54) indicates that self-inflicted drug overdoses/poisonings are treated/transported by EMS at several times the rate of most other

mechanisms, followed by self-inflicted cutting/piercing injuries which were also treated/transported at a substantially higher rate than other mechanisms. The use of hanging/strangulation as a suicide method peaks in early adolescence and decreases steadily throughout the lifespan (**Figures 31** and **32** – below).

Figure 31

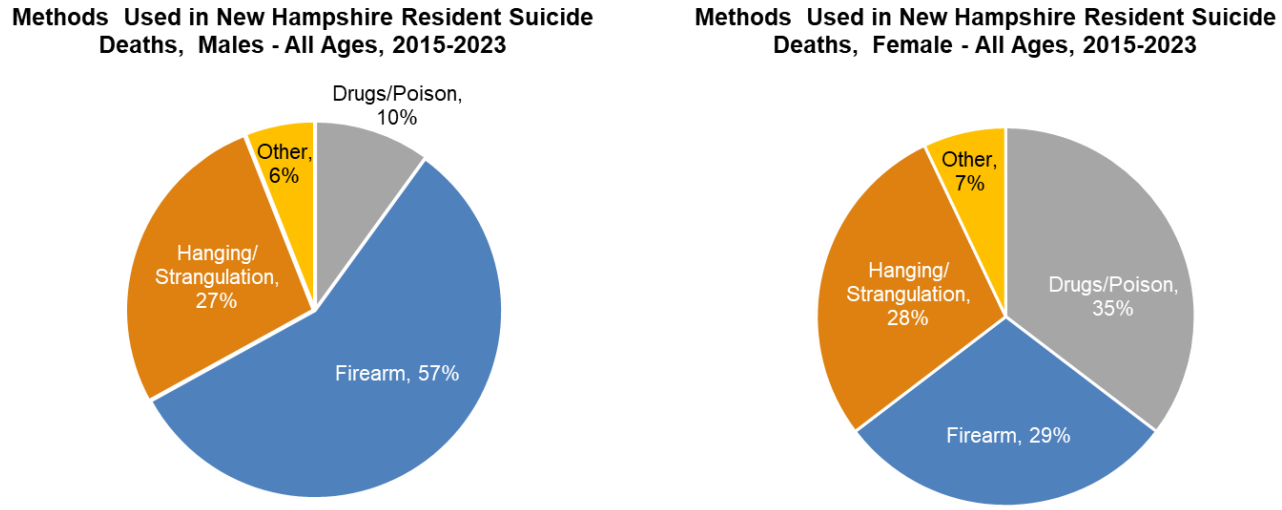
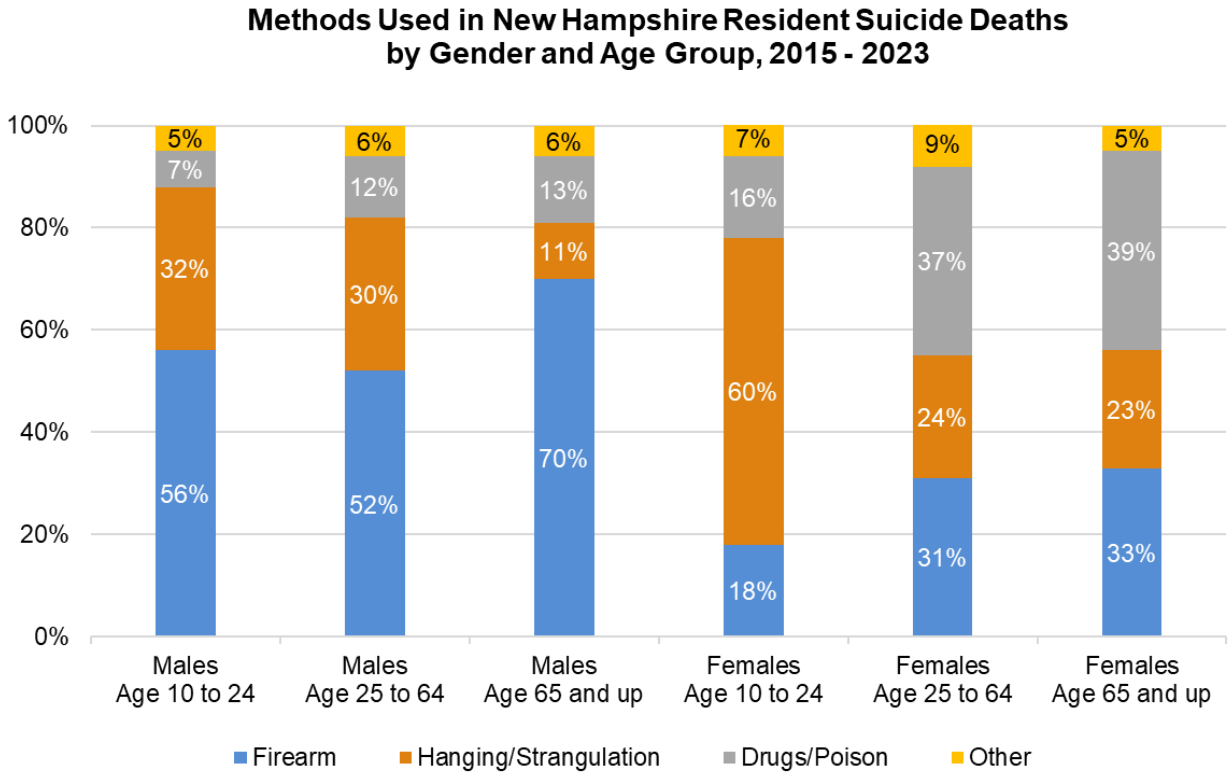
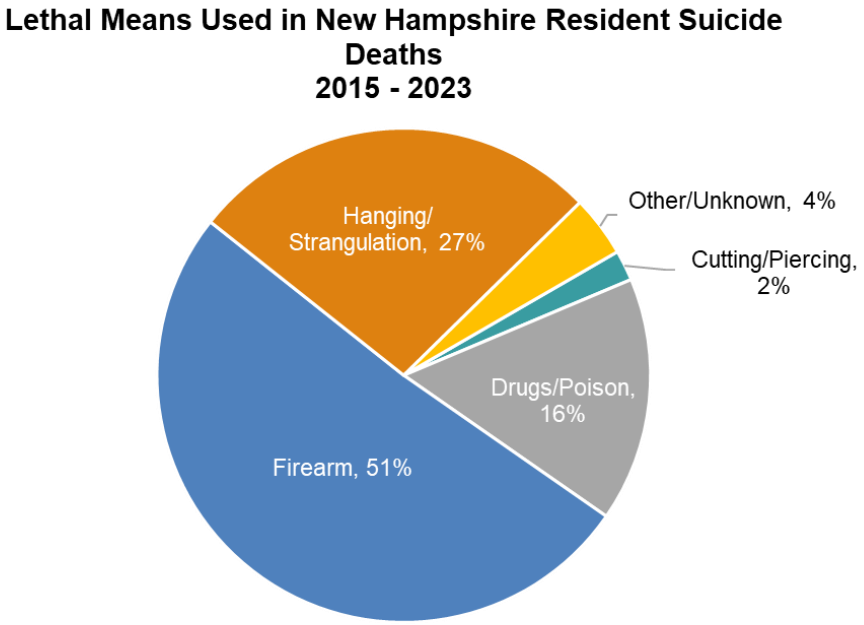


Figure 32



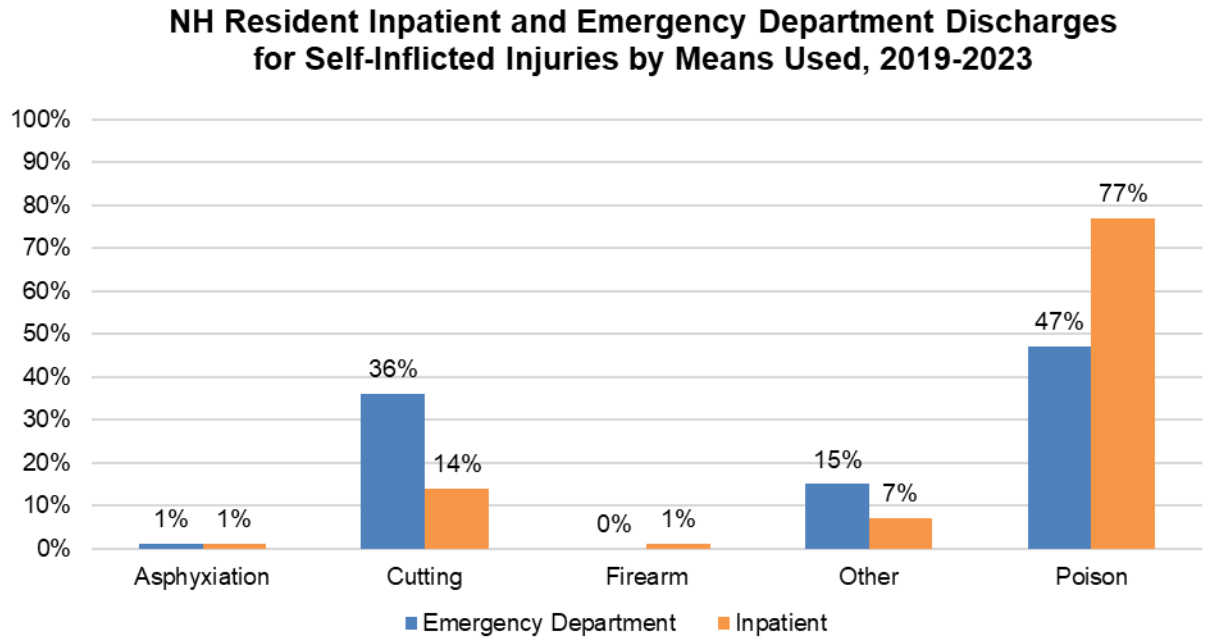
Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Figure 33



Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

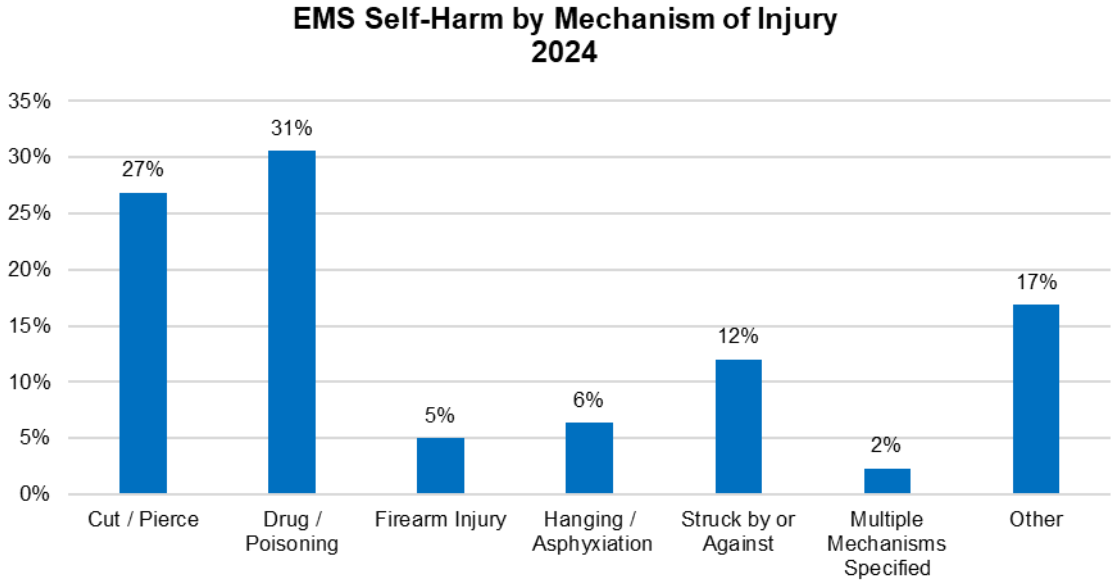
Figure 34



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

Figure 35[23]

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



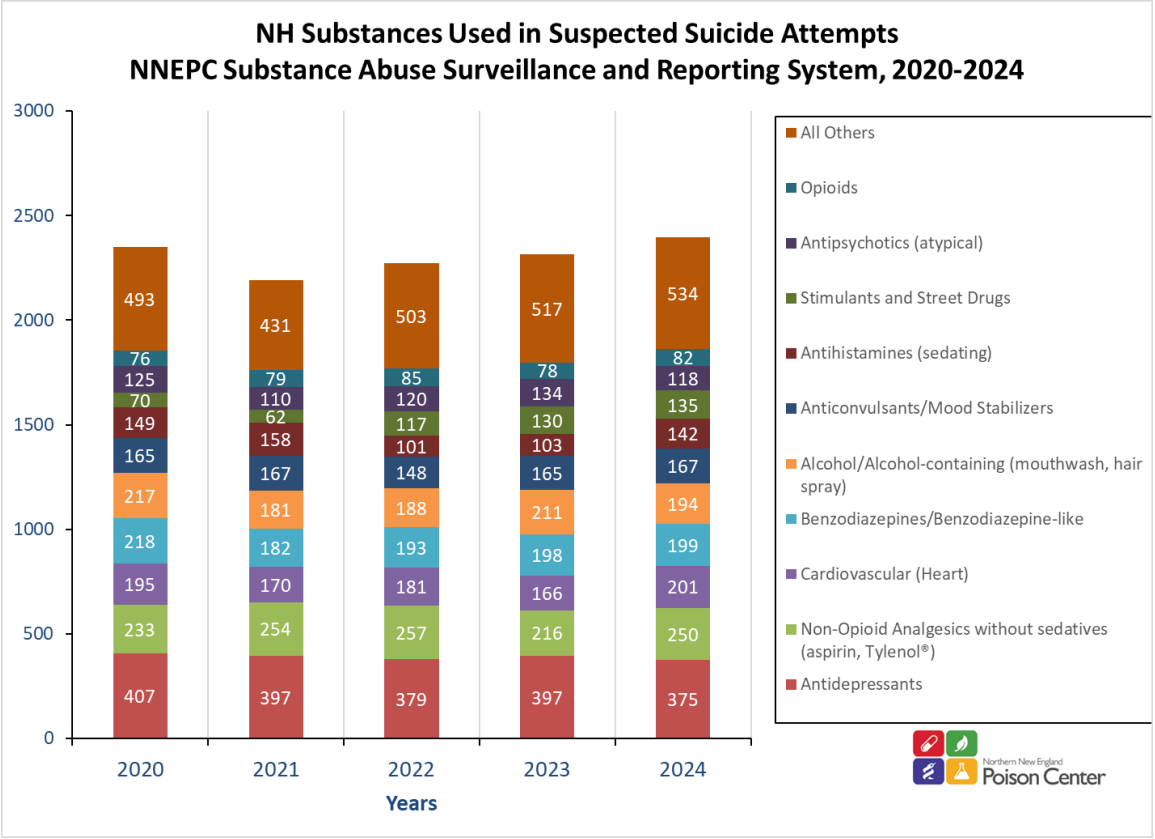
Data Source: New Hampshire Department of Safety, Division of Fire Standards and Training and Emergency Medical Services

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 34 –** pg. 53). **Figure 36** (pg. 55) depicts the prevalence of the most common substances used in suspected suicide attempts and self-harm-related exposures in NH as collected by the Northern New England Poison Center (NNEPC). The top two substances in 2024 were again antidepressants and non-opioid analgesics without sedatives (e.g., aspirin or Tylenol®/acetaminophen).[24]

[23] This figure is based on the field "Trauma Mechanism of Injury". This field is not available for all incidents. The field may also include a response of "Not Recorded" or "Not Applicable". For the purpose of this report, only incidents with a reported mechanism of injury were included above (approximately 37% of all incidents in 2024).

[24] The suspected suicide attempt cases presented were determined by self-report or the report of an individual acting on behalf of the patient (e.g., a health care professional), or a NNEPC staff assessment. For more information on the NNEPC Annual Report, contact Colin Smith - SMITHC12@mmc.org.

Figure 36

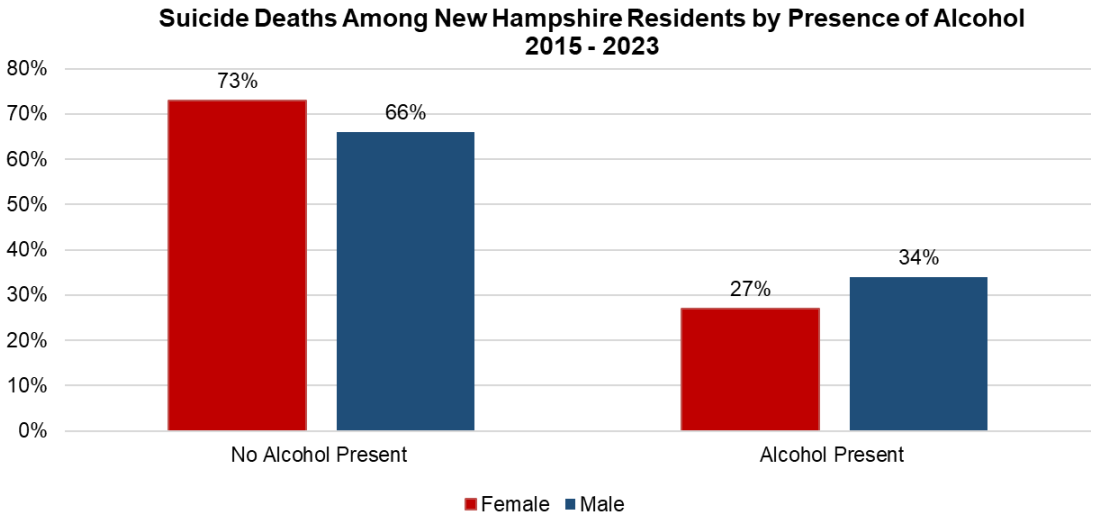


Data Source: Northern New England Poison Center

Alcohol and Drug Use and Suicide

Alcohol was found to be present in 32% of all NH suicide deaths from 2015 to 2023. Alcohol was found in a greater percentage of male deaths (34% of deaths) than female deaths (27% of deaths).

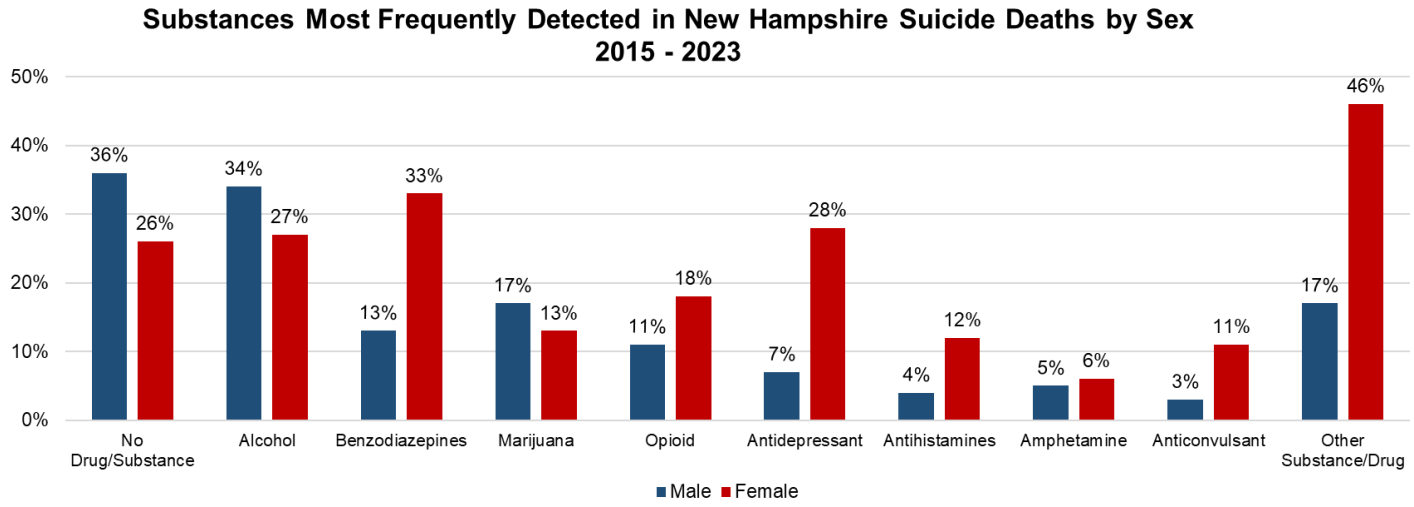
Figure 37



Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

The results of toxicological reports include testing various specimens from suicide victims, at various points of the investigation or autopsy. **Figure 38** (below) shows the categories of the most commonly found substances from toxicology reports. The most frequently detected substances were benzodiazepines, antidepressants, and alcohol among females, and alcohol, marijuana, and benzodiazepines among males. The "Other Substance/Drug" category is a combined total for all other detected substances not otherwise reported in the figure. **Figure 38** is based on a total count of the number of times a substance was found in a positive test. Some decedents tested positive for multiple substances and are therefore counted in multiple categories. Individuals who tested positive in this compilation of substance(s) used may or may not have died of such substance(s). Cause of death for NH resident suicide deaths is presented in **Figure 33** (pg. 53).

Figure 38

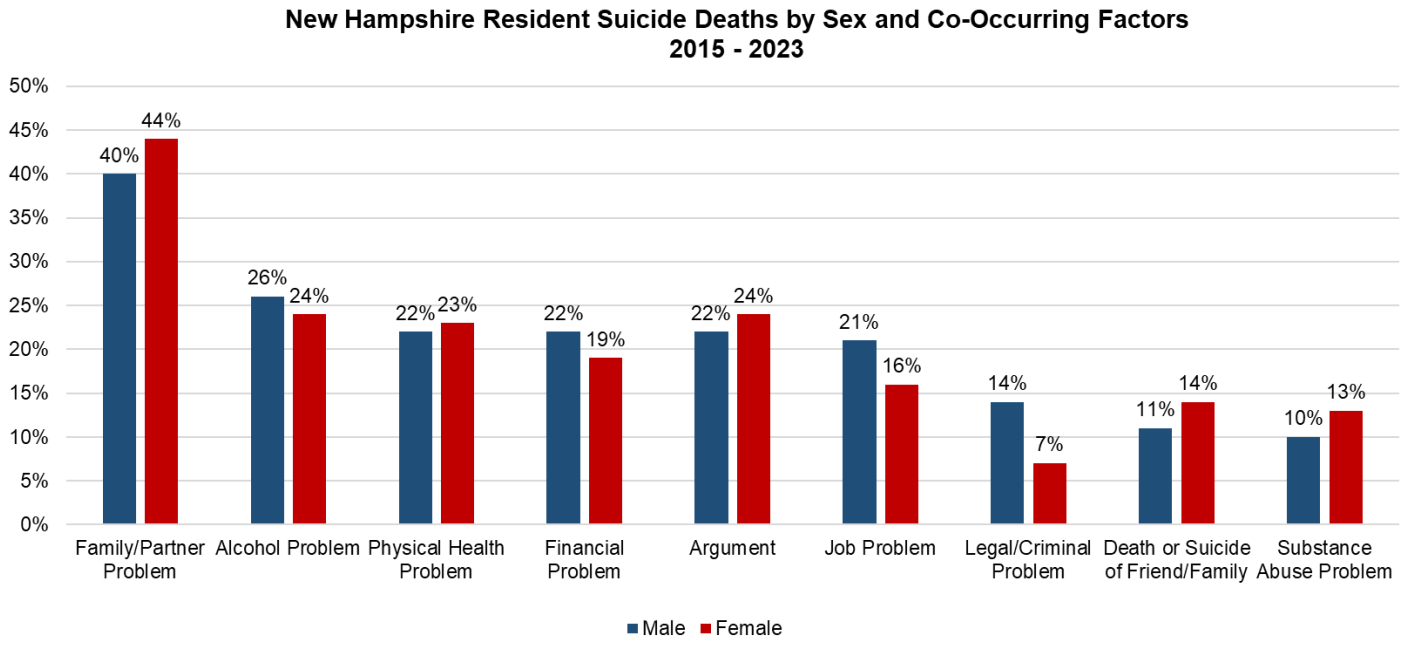


Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Co-Occurring Factors and Suicide

Suicide is most often the result of a number of co-occurring risk factors. **Figure 39** (pg. 57) identifies the most commonly reported risk factors that are tracked in the NH-VDRS. The most frequently reported factor among both males and females was family/partner problems.

Figure 39

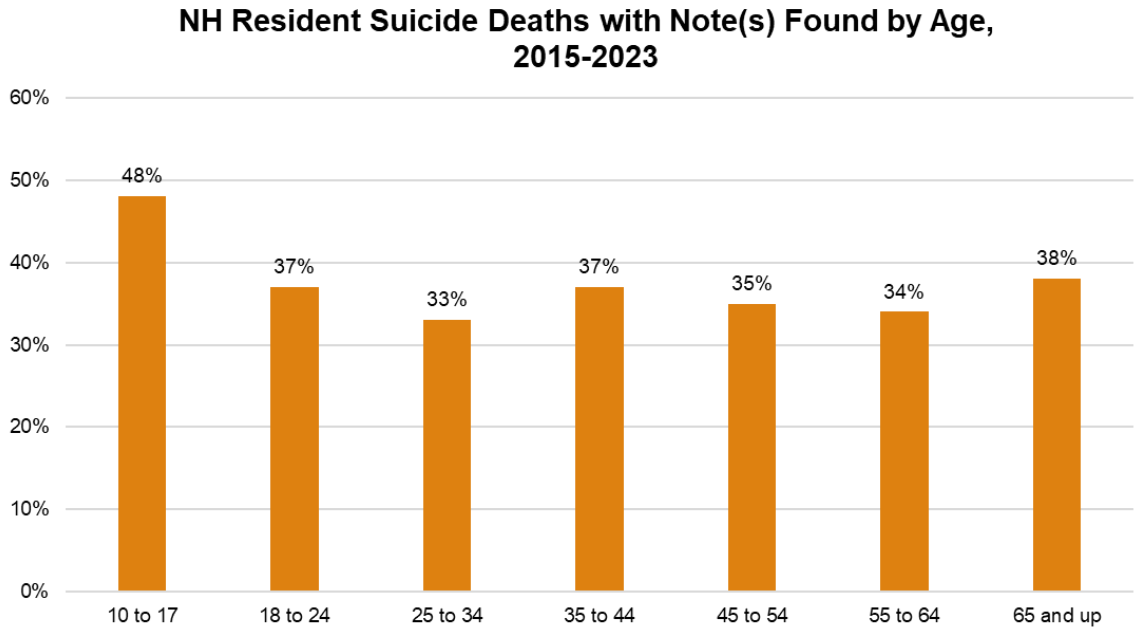


Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Suicide Notes

In just over 36% of NH suicide deaths from 2015 to 2023, individuals left some form of note behind. Females being more likely to have left a note (42% of female deaths) than males (34% of male deaths). As presented in **Figure 40** (pg. 58), younger individuals (age 10 to 17) are more likely than other age groups to leave some form of note. These notes vary in format, content, and intent. Individuals may leave instructions for their loved ones on how to resolve financial, estate, burial, and other affairs; complaints/obstacles that they faced; or planning/details that the deceased went through leading up to the death. Based on anecdotal reports from the individuals left behind after a suicide death, a note will rarely ever give a satisfactory answer to why their loved one died by suicide.

Figure 40



Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Linking At-Risk Individuals with Help

Crisis lines, such as the 988 Suicide and Crisis Lifeline[25] are vital to suicide prevention efforts in NH and nationally. From its launch in July 2022 through December 31, 2024, 988 received approximately 13.9 million calls. In 2024, nearly 12,000 of those calls, or roughly 976 per month, were answered by the NH 988 call center (see **Figure 41** – pg. 59). These calls indicate that individuals in the state who are at risk for suicide are reaching out for help. The large volume of calls may also indicate decreased stigma around help seeking for mental health and/or suicide. The NH Rapid Response (NHRR) system was also active during 2024 with over 21,600 contacts[26] being made through that system. These include contacts where the Access Point de-escalated the situation, referred the individual to community-based services, referred the individual to inpatient/emergency department care, or initiated an active rescue. More information about NHRR can be found in the infographic on page 13.

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

[26] Data Source: Mission Zero adult mental health dashboard - https://wisdom.dhhs.nh.gov/wisdom/dashboard.html?topic=mental-health&subtopic=mission-zero-adult-mental-health&indicator=mission-zero-prevention-and-community-based-access

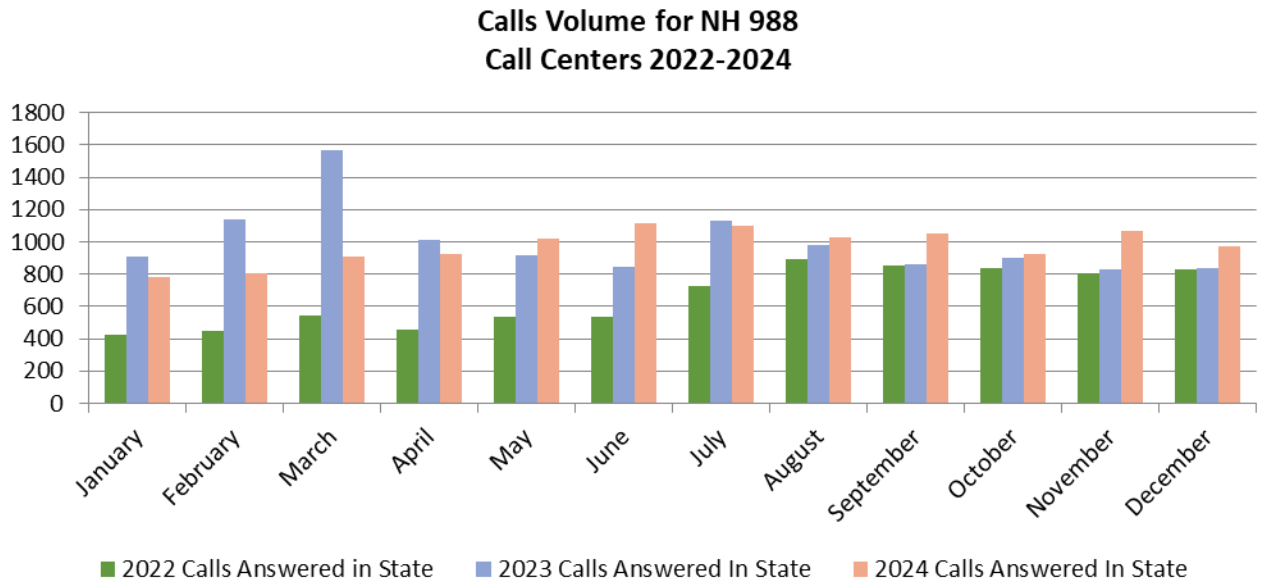
In addition to traditional crisis lines, individuals are increasingly turning to text message-based crisis services (see **Figure 42** – pg. 60). Contacts from NH individuals[27] to Crisis Text Line average 377 conversations per month. From 2018 to 2024, Crisis Counselors at Crisis Text Line deescalated 365 conversations that were deemed to be at imminent risk for suicide by helping texters come up with a safety plan. To protect texters at imminent risk in instances where texters were unable to come up with a safety plan, 194 active rescues were called for New Hampshire-based texters in crisis.

CRISIS TEXT LINE |

Text HOME to 741741 to connect with a volunteer Crisis Counselor

Among the subset of texters who disclosed their demographics through an optional post-conversation survey, 57% of the texters who reached out to Crisis Text Line from NH were age 24 or under, 71% self-identified as female, and over half (52%) self-identified as LGBTQ.[28]

Figure 41

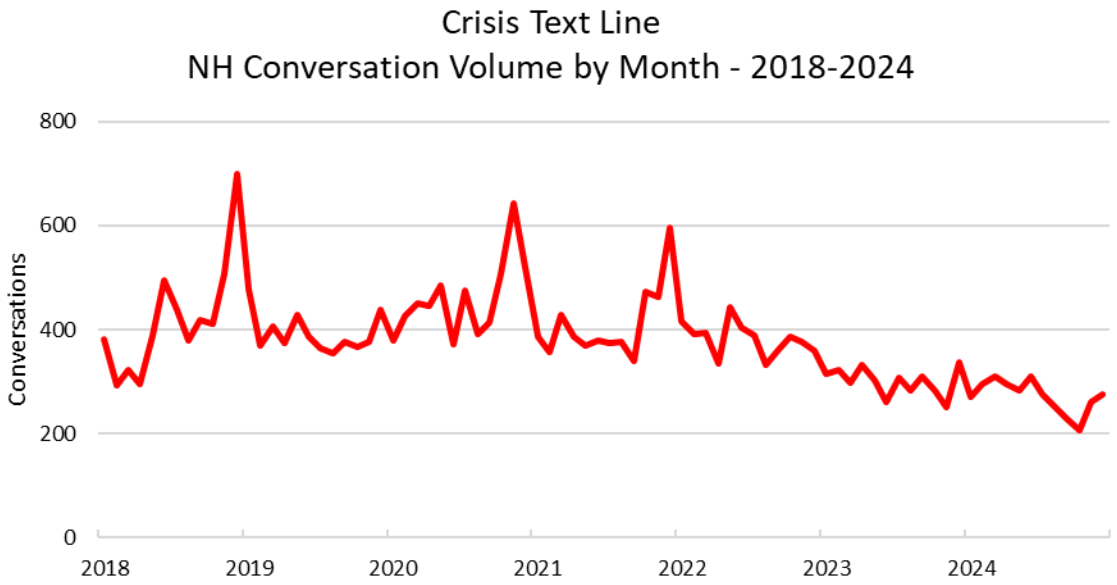


Data Source: 988 Suicide and Crisis Lifeline

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

[28]Surveys are completed by texters following approximately 20% of Crisis Text Line conversations.

Figure 42



Data Source: Crisis Text Line

Costs of Suicide and Suicidal Behavior

There were between 32,441 and 43,638 years of potential life lost[29] to suicide from 2019-2023 in NH (CDC WISQARS, 2025). The most obvious cost of suicide is the loss of individuals and their potential contribution to their loved ones and to society. For each suicide death, there are many survivors of suicide loss (the family and close friends of someone who died by suicide) who are then at higher risk for depression and suicide themselves. In addition, many others are affected, including those who provide emergency care to the victims and others who feel they should have seen the warning signs and prevented the death.

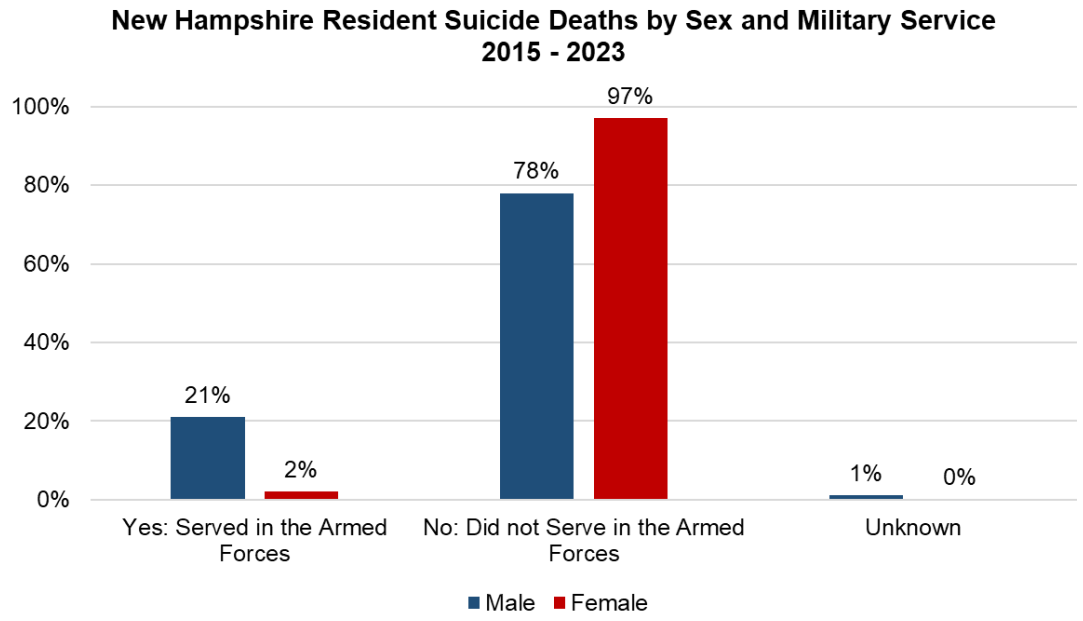
Nationally, suicide attempts treated in emergency departments and hospitals represented an estimated $12.9 billion in health care costs in 2023. This does not include the costs associated with mental health services on an inpatient or outpatient basis (CDC WISQARS, 2025). In NH, suicide deaths where the individual received treatment in a hospital or emergency department and subsequently died resulted in an estimated $728,000+ in medical expenses in 2023 (CDC WISQARS, 2025).

[29] Years of potential life lost (YPLL) is a measure of the extent of premature mortality in a population. This estimate is based on the approximate age at death as well as the number of people who died in that age group in a given year.

Military and Veterans

Suicide Among Veterans in New Hampshire:[30]
Of the individuals who died by suicide in NH from 2015 to 2023, 17% were identified as having current or prior military service (**Figure 43** - below). The use of the term military service is for all those who served in the armed services of the United States or are still serving. The data sources available to NH-VDRS do not distinguish between individuals who are currently active and those who have been discharged. Veterans made up approximately 6% of the NH population as of 2024.[31] With Veterans accounting for 17% of the individuals who died by suicide in the state, this may indicate a high-risk group dying at a greater than expected rate.

Figure 43

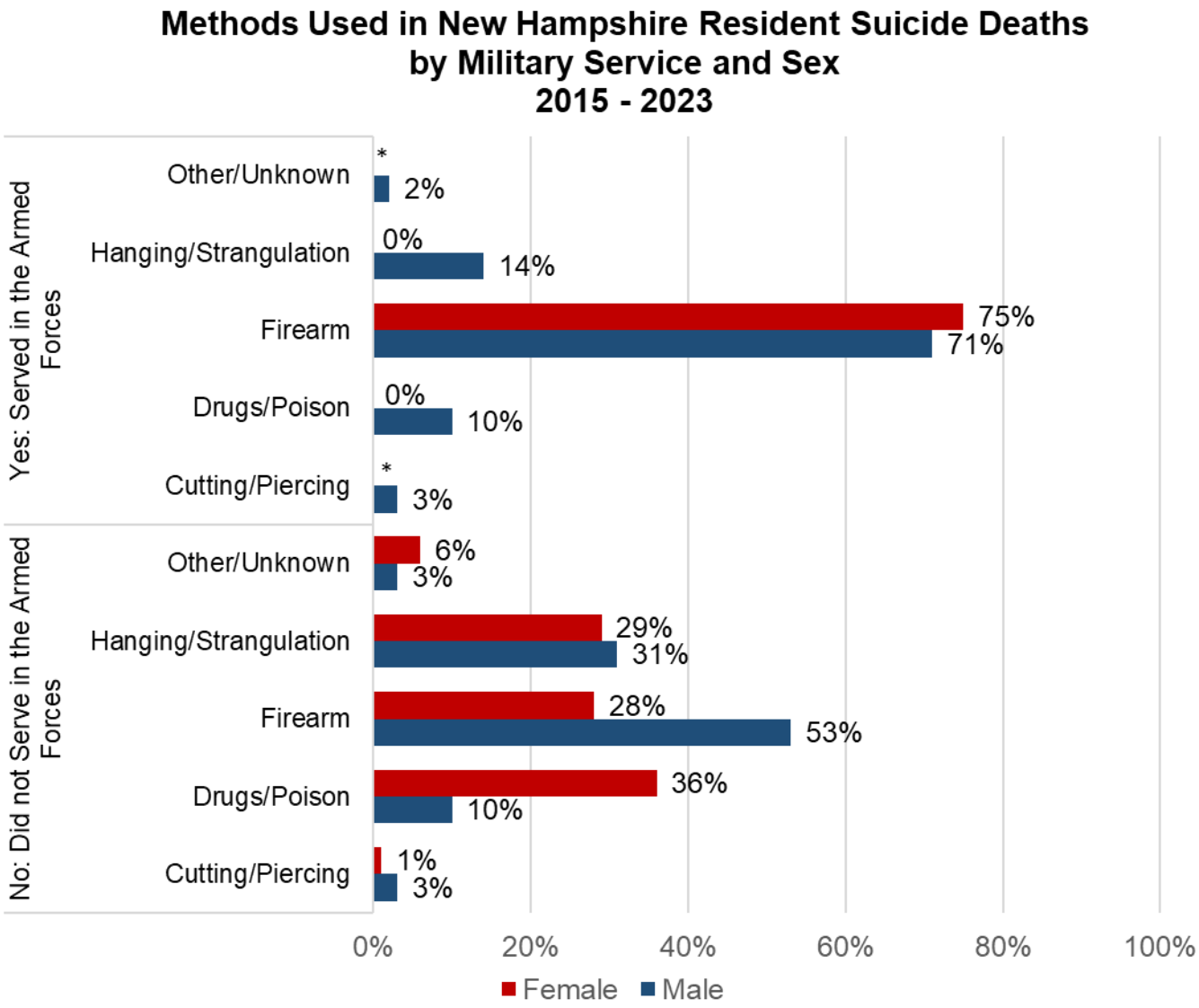


Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

[30]NH-VDRS collects data on Veterans only from standard surveillance data sources. The data collection is based on medical examiner data, death certificates, and law enforcement reports. There is no data used that is sourced from any branch of the military.
[31] Veteran population tables from https://www.va.gov/vetdata/veteran_population.asp

Military Service and Cause of Death:
Individuals in NH who die by suicide that have served in the military are substantially more likely to use a firearm than civilians (**Figure 44** – below). This difference is evident in males with 53% of individuals with no military service using firearm compared with 70% of males with military service using a firearm. While this pattern is also seen in **Figure 44** for females, the overall number of female NH residents who both served in the military and died by suicide during this time period is low. This pattern may shift as additional years of data are included in the total.

Figure 44

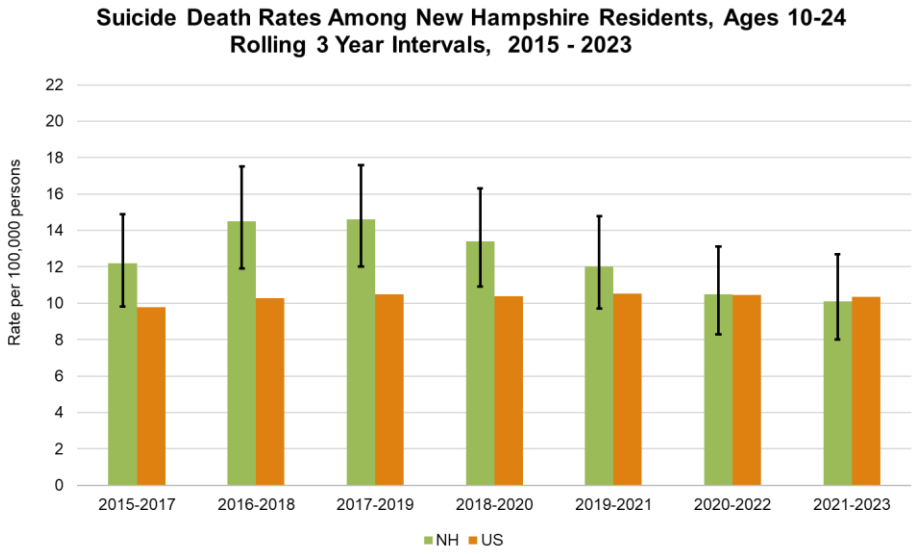


* Due to NH-DHHS suppression rules, non-zero counts less than 5 are suppressed. Higher values may be suppressed to prevent back-calculation of counts less than 5.
Data Source: NH National Violent Death Report System (NH-VDRS), Bureau of Prevention and Wellness, NH DHHS

Suicide Rates in NH

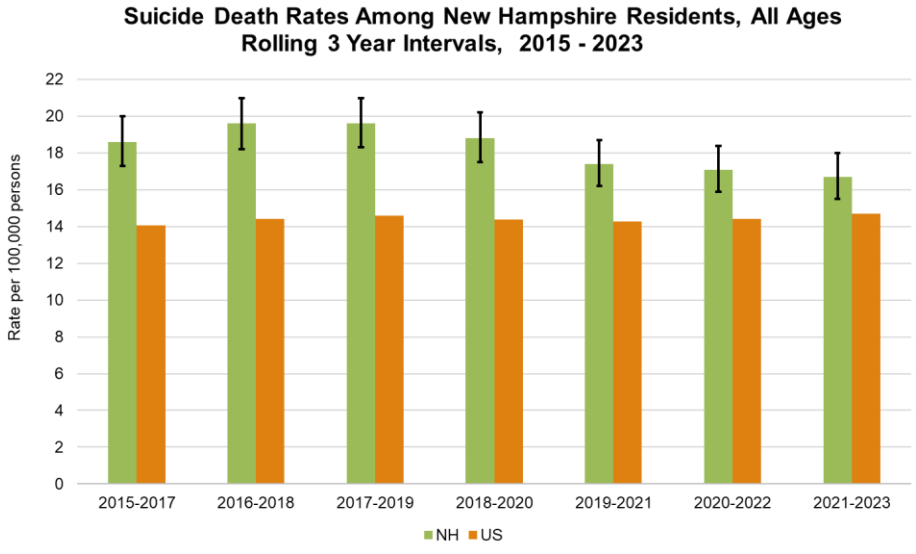
Figure 45 (below) presents NH suicide death rates for youth and young adults aged 10-24 in rolling three-year intervals from 2015 to 2023 and **Figure 46** (below) presents the same information for individuals of all ages. The rolling intervals help to smooth out minor year-to-year variations that often result from small numbers.

Figure 45



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

Figure 46

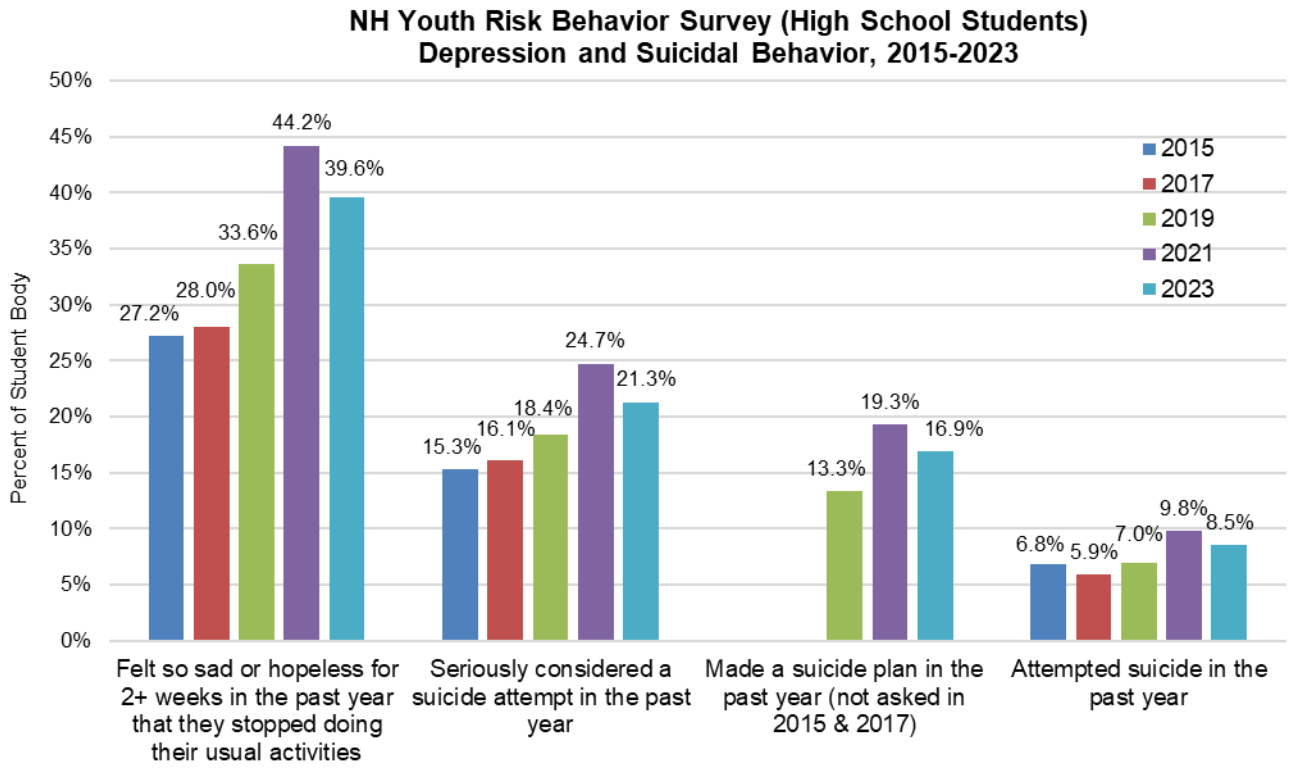


Data Source: NH Vital Records, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH DHHS.
US Rates: CDC WISQARS

Figure 47 (below) presents the results of the NH YRBS from 2015, 2017, 2019, 2021 and 2023. In 2023, 1 in 5 youth surveyed reported having seriously considered attempting suicide in the past year, while 1 in 12 reported having made an attempt. All of the items included in **Figure 47** (below) demonstrated significant increases in the percentage of youth self-reporting these thoughts/behaviors from 2019 to 2021, and significant decreases from 2021 to 2023 ($p < 0.05$).[32] While the percentage of youth reporting these behaviors did decrease in 2023, the measures have not returned to the levels reported prior to the COVID-19 pandemic.

Figure 47

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

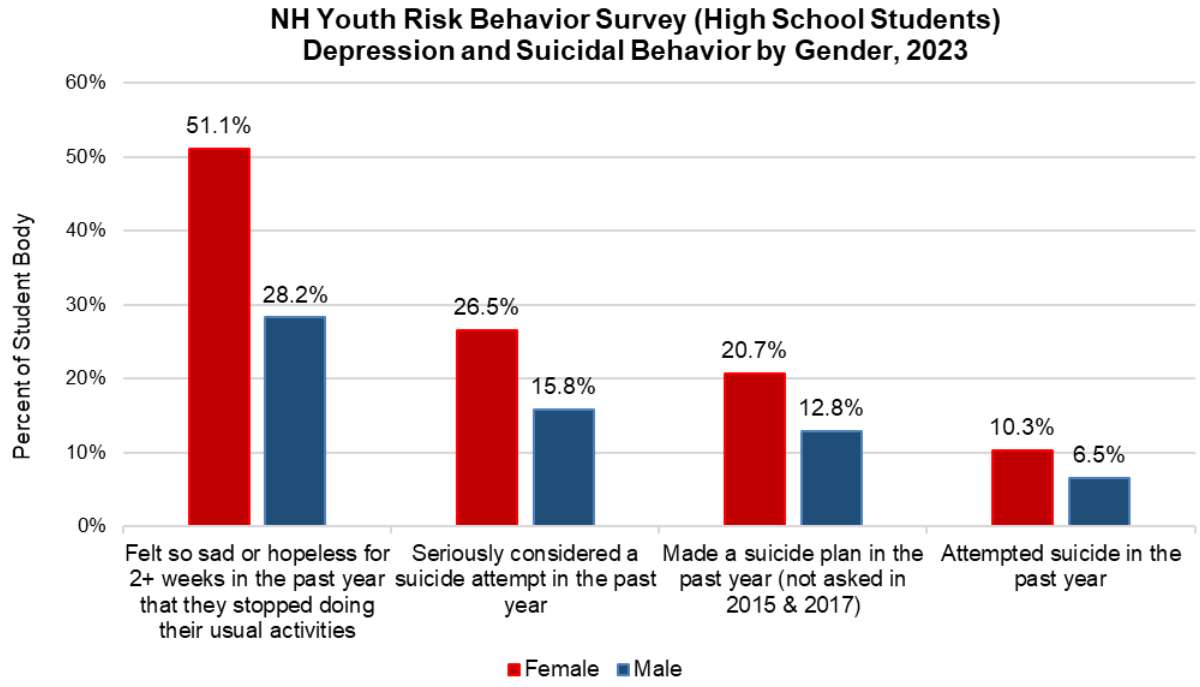


Data Source: NH YRBS, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH, DHHS.

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

Substantial variations are found within the 2023 YRBS results when broken down by gender and sexual orientation. Among the items included in **Figure 47** (pg. 64), females reported experiencing those thoughts, feelings, and behaviors at nearly twice the rate of males. Similarly, students identifying as gay, lesbian, or bisexual reported those thoughts, feelings, and behaviors at two to three times the rate for students identifying as heterosexual. Students identifying as other or questioning reported those thoughts, feelings, and behaviors at a rate slightly below that of students identifying as gay, lesbian, or bisexual. The breakdown by gender and sexual orientation is presented below in **Figures 48** (below) **and 49** (pg. 66). Additional details on these and other YRBS items are available from the NH Department of Education[33] and NH Department of Health and Human Services[34] websites.

Figure 48

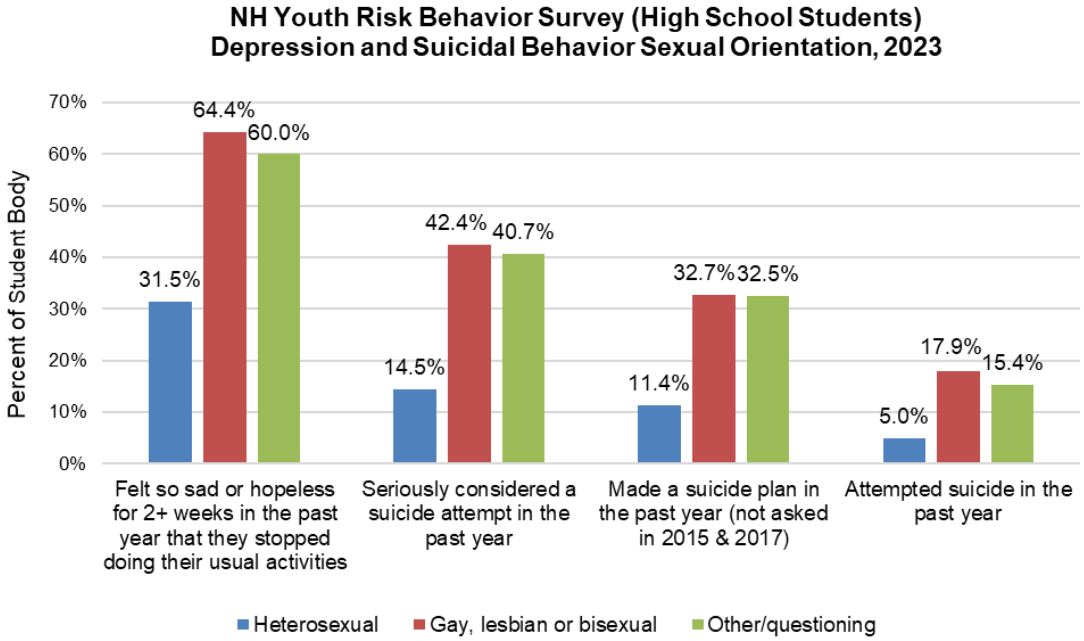


Data Source: NH YRBS, Bureau of Public Health Statistics and Informatics, Health Statistics and Data Management, NH, DHHS.

[33] NH Department of Education YRBS page: https://www.education.nh.gov/who-we-are/division-of-educator-and-analytic-resources/bureau-of-education-statistics/youth-risk-behavior-survey

[34] NH Department of Health and Human Services YRBS page: https://www.dhhs.nh.gov/programs-services/population-health/health-statistics-informatics/youth-risk-behavior-survey

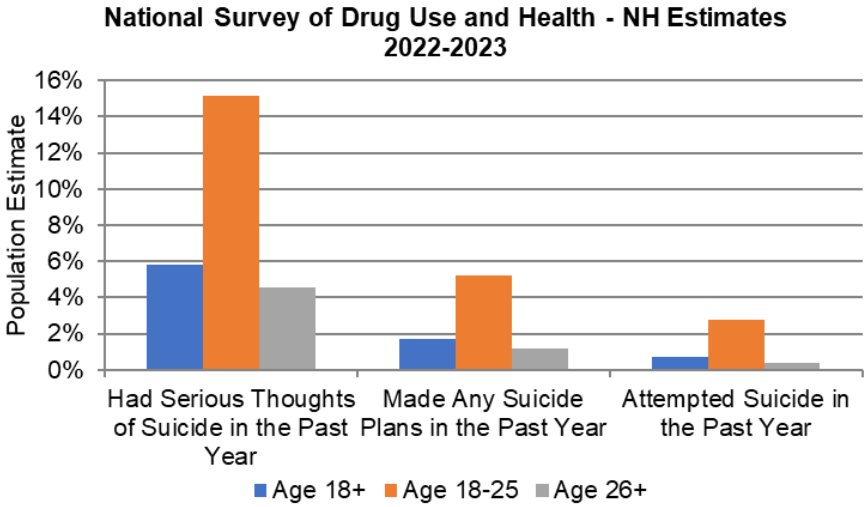
Figure 49



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

Figure 50 (below) presents the results of the National Survey of Drug Use and Health (NSDUH) for questions that are similar to those asked on the YRBS. The included NSDUH data focused on individuals age 18+ and shows that 1 in 17 adults surveyed reported having serious thoughts of suicide in the past year, while 1 in 143 reported having made a suicide attempt in the past year. These numbers are substantially higher for individuals between the ages of 18 and 25, with 1 in 7 reporting serious thoughts of suicide in the past year and 1 in 36 reporting having made a suicide attempt during that time period.

Figure 50



Data Source: National Survey on Drug Use and Health, 2022-2023

Glossary of Terms

Age Adjustment and Rates

When possible, rates in this document are age-adjusted to the 2010 US standard population. This allows the comparison of rates among populations having different age distributions by standardizing the age-specific rates in each population to one standard population. Age-adjusted rates refer to the number of events that would be expected per 100,000 persons in a selected population if that population had the same age distribution as a standard population. Age-adjusted rates were calculated using the direct method as follows:

Where,
- m = number of age groups
- di= number of events in age group i
- Pi= population in age group i
- Si= proportion of the standard population in age group i

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

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

Age Specific Rate/Crude Rates

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

Confidence Intervals (CI)

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

The formula used is:
Where,
- R=age-adjusted rate of one population
- z = 1.96 for 95% confidence limits
- SE= standard error as calculated below

$$R +/- \ z\ (SE)$$

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

Data Collection

The BRFSS is a telephone survey conducted annually by the health departments of all 50 states, including NH. The survey is conducted with assistance from the federal CDC. The BRFSS is the largest continuously conducted telephone health survey in the world and is the primary source of information for states and the nation on the health-related behaviors of adults. The BRFSS has

been conducted in NH since 1987. HSDM develops the annual questionnaire, plans survey protocol, locates financial support, and monitors data collection progress and quality with the assistance of CDC. HSDM employs a contractor for telephone data collection. Survey data are submitted monthly to CDC by the contractor for cleaning and processing and then returned to HSDM for analysis and reporting.

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

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

NH DHHS collaborates with the NH DOJ on implementation of the NH-VDRS under a unified Memorandum of Understanding, including NH-VDRS and Opioid programs, with OCME. NVDRS is a de-identified secure database system used by all US states. NH-VDRS utilizes the system to collect data on violent deaths in NH. Violent deaths include suicides, homicides, firearms accidents, and other violent deaths. NH-VDRS abstracted data comes from death certificates recorded by NH Division of Vital Records Administration, Assistant Deputy Medical Examiner (ADME) investigation reports, toxicology and autopsies reports, and law enforcement reports.

NH-VDRS in collaboration with various Law Enforcement (LE) agencies in NH, collects primary data sources and compiles the data that feeds into the NH-VDRS data entered into the NNVDRS Portal at CDC.

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

In New Hampshire, YRBS is jointly administered by the Departments of Health & Human Services and Education. High schools are given the opportunity to participate in either the random state survey, a comprehensive school level census survey, or both. The survey is usually administered in New Hampshire schools during the early winter[35].

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

Data Confidentiality

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

Graphs

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

Incidence

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

Death Rate

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

Reliability of Rates

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

Small Numbers

With very small counts, it is often difficult to distinguish between random fluctuation and meaningful change. According to the National Center for Health Statistics, considerable caution must be observed in interpreting the data when the number of events is small (perhaps less than 100) and the probability of such an event is small (such as being diagnosed with a rare disease). The limited number of years of data in the registry and the small population of the state require

policies and procedures to prevent the unintentional identification of individuals. Data on rare events, and other variables that could potentially identify individuals, are not published.

Standard Errors

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

Where,

w_j = fraction of the standard population in age category
n_j = number of cases in that age category
p = person-years denominator

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

CONTACTS & MEETING INFORMATION

SPC Contacts and Meeting Information

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

Committee information is also available from preventsuicidenh.org/get-involved/committees/

State Suicide Prevention Council
Chair: Amy Cook – acook@naminh.org
Vice Chair: Shamera Simpson – ssimpson@afsp.org
Meets 4th Monday – Every **other** month 10:00 am – 12:00 pm

Suicide Prevention Council Committees

Communications
Chair: Mary Forsythe-Taber – mft@mih4u.org
Meets 2nd Wednesday of the Month

Data Collection & Analysis
Chair: Patrick Roberts – proberts@naminh.org
Meets 4th Wednesday of Feb., May, Aug., and Oct.

Law Enforcement
Chair: Trooper Seth Gahr - Seth.L.Gahr@DOS.NH.GOV
Meeting schedule to be determined

Military & Veterans
Co-Chairs: Amy Cook – acook@naminh.org
J. Justin Moeling - John.Moeling@va.gov
Meets quarterly on the 1st Wednesday

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

Suicide Fatality Review
Chair: Dr. Paul Brown
Attendance is by invitation only

Survivors of Suicide Loss
Co-Chairs: Steve Boczenowski – boczeno@gmail.com
Megan Melanson - Megan.S.Melanson@centene.com
Meets 4th Monday of the Month

Youth Suicide Prevention - Also known as the Youth Suicide Prevention Assembly (YSPA)
Co-Chairs: Heather Clogston - heather.m.clogston@doe.nh.gov
Susan Ward - sward@naminh.org
Meets 2nd Thursday of the Month

Recognize the Warning Signs for Suicide to Save Lives!

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

Warning signs:

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

For a more complete list of warning signs and more information on suicide prevention, please consult the NAMI New Hampshire website at www.naminh.org/suicide-prevention.

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

Connect with Your Loved One, Connect Them to Help

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

Mental Health and Suicide Prevention Resources

Local Resources

Community Mental Health Centers: nhcbha.org
Peer Support Agencies: dhhs.nh.gov/programs-services/mental-health/peer-support-agencies
Disaster Behavioral Health Response Teams: www.dhhs.nh.gov/disaster-behavioral-health
NAMI New Hampshire: www.NAMINH.org, 603-225-5359

LGBTQIA+ Resources

Trevor Helpline (24/7): 1-866-488-7386 www.thetrevorproject.org
LGBT National Hotline: 1-888-843-4564 lgbthotline.org
LGBT Youth Talkline: 1-800-246-7743
SPRC Library: sprc.org/online-library/

Military Resources

Military One Source: www.militaryonesource.mil
Tragedy Assistance Program for Survivors (TAPS): www.taps.org
US Department of Veterans Affairs: www.va.gov
Veterans Crisis Line: 988 (press 1 after connecting)

National Organizations

American Association of Suicidology: www.suicidology.org
American Foundation for Suicide Prevention: www.afsp.org
National Action Alliance for Suicide Prevention: theactionalliance.org
National Alliance on Mental Illness: www.nami.org
Suicide Prevention Resource Center: www.sprc.org

Older Adults

NH Fact Sheet on Suicide and Aging: www.naminh.org/SuicideAndAging
SPRC Older Adult Suicide Prevention Resources: www.sprc.org/populations/older-adults

Substance Abuse and Mental Health Services Administration (SAMHSA)

Obtaining Prevention Materials:
    Visit their website: library.samhsa.gov (includes downloadable materials)
Treatment Provider Locator: findtreatment.gov
    A searchable list of mental health and substance use disorder providers.

Survivors of Suicide Loss / Individuals Bereaved by Suicide

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