



**YOUTH SUICIDE PREVENTION ASSEMBLY  
(YSPA)**

**2005 ANNUAL REPORT**

**Accomplishments and Data Update**

**Final Draft**

**June 2006**

**PREFACE**  
**Letter from Tom Andrew, NH Chief Medical Examiner**

Embarking on my tenth year as your Medical Examiner, I would immensely enjoy reporting on the dramatic, measurable decrease in completed suicides and suicidal behavior of New Hampshire youth due to our superlative teamwork. I cannot, but that does not negate in any way, shape or form the last two words of the previous sentence. The truth and proof of this lies in the tangible progress made in raising public awareness, promoting the effectiveness of assessment and treatment of mental health issues and, generally, marshaling statewide support and resources to tackle this ugly reality of life.

We continue to live in a time of immense opportunity. Who, 10 years ago, would have dared to believe that the Frameworks Project would have been successfully piloted and on the cusp of being launched in multiple sites? Who would have predicted the development of a formal state suicide prevention plan and formation of a multidisciplinary Suicide Prevention Council enjoying the full-throated support of the tissue-thin spread Department of Health and Human Services? We collectively stand at the threshold of the real possibility of raising the first generation of Granite Staters with rates of suicidal thoughts, behaviors and completed suicides below, rather than above, the national averages reflected by the Youth Risk Behavior Survey.

The notion that some, or even most, suicide deaths are in one way or another preventable has taken hold of New Hampshire. We are no longer willing to chalk up the loss of two dozen young people a year as the unavoidable price of being an adolescent with its attendant "emotional baggage." Fascinating recent research by Dr. Abigail Baird at Dartmouth provides a scientific evidence base for what we grizzled adults have intuitively perceived for some time -- the adolescent brain is different in qualitative, biochemical ways from the adult brain. This may well prove to be yet another piece of the puzzle we can use to the advantage of our youth and those who love them. The line between adolescent risk taking behavior and a true suicide is fine indeed. If we carefully deploy our collective assets as well as listen to our hearts, we should be able to reduce both behaviors.

My renewed challenge to you, the reader of this report, is the same today as it was last year. **Today**, clearly define **your role** in trying to prevent youth suicide. It is no longer sufficient to "leave it to the experts." None of us are experts. If collectively we truly had expertise, we would not be having this discussion in the first place. What we do have is each other and the determination to see our children become happy, responsible, well-adjusted adults. They are our only worthwhile legacy. We dare not fail them.



## **Summary of Accomplishments for 2005**

2005 was a productive year for the Youth Suicide Prevention Assembly (YSPA) and its members. We are particularly proud of the progress being made on a number of our long-term activities. The accomplishments listed are those achieved in 2005. They are, however, the results of the ongoing efforts of many people working collaboratively and informed by the open exchange of ideas and resources that have characterized YSPA for almost a dozen years.

### **NH State Suicide Prevention Plan**

Adopted in November 2004, this has been the blueprint for activities within YSPA and in other statewide organizational planning. The state plan addresses suicide prevention for all ages. YSPA members attended a regional meeting with representatives from other Northeast states in June 2005 to work on our state plans and exchange ideas. At this meeting, the NH delegation agreed to:

- continue to focus efforts on implementation of the Frameworks Project
- address Suicide Prevention beyond youth
- strengthen its work with and for survivors, and
- ensure implementation of the State Suicide Prevention Plan

The recently developed Suicide Prevention Council is an outgrowth of this meeting and the State Plan Meeting that followed it in August 2005.

### **Garrett Lee Smith**

This three year federal grant was awarded to NAMI NH commencing in October 2005 to accomplish multiple goals in collaboration with other groups and organizations in NH including continued implementation of the Frameworks Project. The long-term leadership of YSPA was a key element in this proposal. Project goals and their current status include:

- Facilitate accomplishment of the goals of the State Suicide Prevention Plan by establishing a statewide environment that supports and enhances efforts to address the needs of youth at risk for suicide. Status: Discussions and Memoranda of Agreement are under way with state-wide organizations who provide services to high risk populations.
- Strengthen the ability of community coalitions to recognize youth at risk for suicide and provide an integrated culturally-competent response in connecting them to appropriate resources. Status: The Frameworks Project is being offered in three NH communities with full implementation and evaluation.
- Enhance the capacity of existing data surveillance systems related to NH specific suicide prevention, intervention and postvention activities and, in collaboration with YSPA, disseminate evidence supported practices in suicide prevention, intervention and postvention. Status: Organization of available and needed data is being looked at from a statewide perspective,

with an effort to ensure the most comprehensive and streamlined methods of collection and utilization.

### **Frameworks Youth Suicide Prevention Project:**

In developing the Frameworks Project, YSPA identified the need to have guidelines to:

- ensure a consistent response to suicidal events (threats, attempts and deaths)
- identify and reduce gaps among service delivery systems.

With initial funding from the Suicide Prevention Partnership (SPP), NAMI NH proceeded to meet this need by developing protocols based on best practices identified both in NH and nationally with the involvement of over 125 NH citizens.

A comprehensive set of protocols for Attempts and Threats and Postvention were developed and are now available on the NAMI NH website ([www.naminh.org](http://www.naminh.org)).

- With additional funding from SAMHSA (the Garrett Lee Smith Act), the Endowment for Health, the French Foundation, and the NH Charitable Foundation, accomplishments also include: training modules developed for gatekeepers and all of the other disciplines identified in the protocols.
- This training program was then introduced to the pilot site, Mascoma Valley, in early 2005.
  - In Mascoma Valley, 26 trainers of diverse backgrounds were trained and they subsequently trained over 100 colleagues.
  - Youth have also been trained as trainers and have trained 9<sup>th</sup> grade students and other classes in the high school.
  - A coalition focusing specifically on youth suicide prevention is forming in Mascoma Valley.
  - Evaluation has been a key component of the project and results compiled from the first year are demonstrating consistent positive outcomes in increasing the confidence and skills to respond to youth suicide events.
- Frameworks will be implemented in the communities of Raymond and Berlin/Gorham, through local community coalitions.
- Through funding from Endowment for Health, a focus on the impact of stigma on suicide prevention will be part of the implementation.

The Frameworks Project continues to receive national and international attention for its focus on a coordinated, community-wide approach to youth suicide prevention including presentations at the American Association of Suicidology and at a conference in Northern Ireland as part of the development of their national strategy.

**Survivors Committee:** The Survivors of Suicide (SOS) committee gained some new energy and new members in the past year including technical assistance as part of the Frameworks/Garrett Lee Smith project. The SOS group proceeded to accomplish the following:

- Updated information on survivor groups around NH and established an ongoing process for keeping it current.
- Published the first statewide newsletter to help survivors of a loss from suicide find support groups and other resources.
- Posted the SOS newsletter on the NAMI NH website ([www.naminh.org](http://www.naminh.org)).

- Worked at sustaining existing groups and forming new ones wherever possible.
- More actively promoted the annual Survivors Teleconference event which occurs in November.

**Community Healing Fund:** As a result of needs identified at monthly YSPA meetings, funds from the Garrett Lee Smith Grant were set aside to assist communities in the aftermath of a death from suicide. Funds can be used for consultation or technical assistance, holding a community forum, providing training, or other activities that will help a community to heal after a tragic loss. This fund was activated to assist a volunteer to attend training to become the leader of a survivor support group as well as to fund outreach efforts to media after a high profile death in one region.

For more information on how to access these funds, contact Elaine Frank [Elaine.m.frank@dartmouth.edu](mailto:Elaine.m.frank@dartmouth.edu) Elizabeth Fenner Lukaitis [EFenner-lukaitis@dhhs.state.nh.us](mailto:EFenner-lukaitis@dhhs.state.nh.us) or Ken Norton [knorton@naminh.org](mailto:knorton@naminh.org).

### **YSPA On and In the Media**

- In response to several articles about high profile deaths in various parts of the state, several YSPA members contacted editors to make them aware of the media guidelines and/or provided editorial responses. Outreach to editorial boards led to some meetings and, in some cases, follow up articles.
- The YSPA Media Committee will be developing training and guidelines for members to use to set up and implement these Editorial Board meetings.
- New Media Guidelines have been released that include a comprehensive manual on working with the media to promote suicide prevention as well as a two page summary for specifically for reporters/editors. They are available at the NAMI NH website or: <http://www.sprc.org/news/pressroom/index.asp>
- The Frameworks Project was featured in the fall issue of *The Advocate*, the quarterly newsletter of the National Alliance On Mental Illness.
- The *Upper Valley News* carried an article on Mascoma Valley Health Initiative's implementation of the Frameworks Project.
- Dr. Tom Andrew appeared on 20/20 talking about "Space Monkeys", the dangerous choking game among youth that has resulted in some accidental deaths. YSPA was involved in early discussions about this "game" and how it could be distinguished from suicidal behavior.

**Training and Education:** The following activities reflect some of the education and training opportunities extended through YSPA and its members:

- The 2<sup>nd</sup> YSPA statewide annual conference was offered in November. The audience has included policy makers, health and social service providers, first responders, survivors, and interested community members. The 2006 Conference will be held on November 3 at the Wayfarer Inn in Bedford.
- CALM Training (Counseling on Access to Lethal Means) is being offered to staff of Community Mental Health Centers statewide. Funded by SPP, CALM is being evaluated by the Harvard Injury Control and Research Center.
- CISM Training was provided to DBHRT members and others throughout the state in 2005 and 2006.

- YSPA members have provided training and educational outreach and support to communities where a suicide has occurred.
- YSPA members and NAMI NH staff have offered presentations on suicide prevention in numerous settings including UNH, Plymouth State University, and several high schools.
- YSPA brings speakers to its monthly meetings for ongoing professional development. These offer opportunities to hear about important topics and to interact with those involved. For example, in 2005, Dr. James Knoll was a guest speaker on Psychological Autopsies. Future topics and speakers are listed in the YSPA minutes and announcements.

Submitted by Elaine deMello and Elaine Frank, YSPA Co-chairs

# *YSPA 2005 Annual Data Report*

## ***Introduction***

The Youth Suicide Prevention Assembly (YSPA) has been collecting and analyzing data regarding youth suicide deaths and suicidal behavior over the last 12 years. The graphs, tables, and charts on the following pages represent some key areas of interest and concern. These data are the result of the collaborative efforts of a variety of organizations and people, and the various data sources are cited on each chart.

Although suicide amongst youth aged 10-24 in NH is the primary area of concern for YSPA, our focus in this report is broader, and represents residents of all ages. After all, the effects of a community suicide reverberate throughout all age groups and affect everyone. For example, having a parent or family member who is depressed, suicidal, or has killed him/herself is a significant risk factor for suicidal behavior, both for youth and adults. Moreover, YSPA is directly involved in implementation of the NH State Suicide Prevention Plan, which focuses on suicide prevention across the lifespan. Therefore, this report will be seasoned with data that examines suicide behavior across the lifespan to yield a greater sense of the “big picture” of suicide behavior in NH.

While each suicide is an individual act affecting individuals, families, and communities, aggregate data is presented in this report. Aggregate data helps inform us which populations/age groups are most at risk, reveals points of particular vulnerability, and thus leads us in determining where to put our prevention and intervention efforts, and where to direct program funding.

## ***The Big Picture: Suicide in NH and Nationally***

The following two tables display the 10 leading causes of death for people of different age groups, both in NH and nationally. From 1999-2003, suicide was the 2<sup>nd</sup> leading cause of death for NH youth aged 10-24 (second to deaths due to unintentional injury), compared to the 3<sup>rd</sup> leading cause of death for those youth nationally (third to deaths due to unintentional injuries and homicides). In NH, suicide was the 9<sup>th</sup> leading cause of death for all ages; nationally, it did not register as one of the 10 leading causes of death for all people.

The vast majority of violent deaths in NH are suicides. For every homicide in NH, there are approximately 8 suicides. This ratio is in sharp contrast to national statistics, which show that there are less than 2 suicides for every homicide. Moreover, deaths classified as suicides occur about half as often as deaths classified as unintentional injuries in NH; nationally there are approximately 6 deaths classified as unintentional injuries for every suicide. Therefore, suicide constitutes a much larger proportion of traumatic deaths in NH than in the US as a whole.

## 10 Leading Causes of Death, New Hampshire 1999 - 2003, All Races, Both Sexes

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 70	Unintentional Injury 16	Unintentional Injury 18	Unintentional Injury 33	Unintentional Injury 238	Unintentional Injury 185	Malignant Neoplasms 391	Malignant Neoplasms 1,092	Malignant Neoplasms 2,006	Heart Disease 11,851	Heart Disease 13,898
2	Short Gestation 47	Congenital Anomalies 11	Malignant Neoplasms 13	Suicide 9	Suicide 104	Suicide 122	Unintentional Injury 278	Heart Disease 645	Heart Disease 1,142	Malignant Neoplasms 8,689	Malignant Neoplasms 12,304
3	SIDS 29	Malignant Neoplasms 8	Cerebro-vascular 1	Malignant Neoplasms 8	Malignant Neoplasms 32	Malignant Neoplasms 65	Heart Disease 208	Unintentional Injury 218	Chronic Low. Respiratory Disease 243	Cerebro-vascular 2,875	Cerebro-vascular 3,127
4	Placenta Cord Membranes 25	Benign Neoplasms 2	Diabetes Mellitus 1	Eight Tied 1	Heart Disease 15	Heart Disease 33	Suicide 167	Suicide 144	Diabetes Mellitus 181	Chronic Low. Respiratory Disease 2,563	Chronic Low. Respiratory Disease 2,897
5	Intrauterine Hypoxia 19	Heart Disease 2	Homicide 1	Eight Tied 1	Homicide 11	Homicide 16	Liver Disease 42	Liver Disease 108	Unintentional Injury 144	Alzheimer's Disease 1,423	Unintentional Injury 1,786
6	Maternal Pregnancy Comp. 16	Influenza & Pneumonia 2	Influenza & Pneumonia 1	Eight Tied 1	Congenital Anomalies 8	Congenital Anomalies 10	Diabetes Mellitus 37	Cerebro-vascular 83	Cerebro-vascular 122	Diabetes Mellitus 1,181	Diabetes Mellitus 1,493
7	Atelectasis 9	Chronic Low. Respiratory Disease 1		Eight Tied 1	Chronic Low. Respiratory Disease 6	Diabetes Mellitus 9	Cerebro-vascular 33	Diabetes Mellitus 81	Liver Disease 112	Influenza & Pneumonia 960	Alzheimer's Disease 1,441
8	Respiratory Distress 9	Homicide 1		Eight Tied 1	Benign Neoplasms 3	HIV 8	HIV 32	Chronic Low. Respiratory Disease 69	Suicide 77	Unintentional Injury 647	Influenza & Pneumonia 1,038
9	Unintentional Injury 9	Kidney Infections 1		Eight Tied 1	Cerebro-vascular 3	Three Tied 6	Homicide 19	Viral Hepatitis 32	Septicemia 43	Nephritis 554	Suicide 725
10	Bacterial Sepsis 8	Septicemia 1		Eight Tied 1	Three Tied 2	Three Tied 6	Congenital Anomalies 14	HIV 21	Nephritis 36	Parkinson's Disease 368	Nephritis 626

**WISQARS™** 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 (NCHS), National Vital Statistics System

## 10 Leading Causes of Death, United States 1999 - 2003, All Races, Both Sexes

Rank	Age Groups										All Ages
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 27,973	Unintentional Injury 8,796	Unintentional Injury 6,405	Unintentional Injury 7,837	Unintentional Injury 72,864	Unintentional Injury 60,608	Malignant Neoplasms 81,415	Malignant Neoplasms 243,757	Malignant Neoplasms 457,378	Heart Disease 2,923,393	Heart Disease 3,518,130
2	Short Gestation 22,685	Congenital Anomalies 2,672	Malignant Neoplasms 2,544	Malignant Neoplasms 2,638	Homicide 25,821	Suicide 25,079	Unintentional Injury 80,065	Heart Disease 182,175	Heart Disease 319,346	Malignant Neoplasms 1,952,614	Malignant Neoplasms 2,770,870
3	SIDS 11,862	Malignant Neoplasms 2,052	Congenital Anomalies 966	Suicide 1,318	Suicide 19,864	Homicide 22,604	Heart Disease 67,395	Unintentional Injury 67,773	Chronic Low. Respiratory Disease 56,559	Cerebro-vascular 722,557	Cerebro-vascular 818,926
4	Maternal Pregnancy Comp. 7,720	Homicide 1,946	Homicide 725	Homicide 1,084	Malignant Neoplasms 8,522	Malignant Neoplasms 19,528	Suicide 33,116	Liver Disease 34,963	Cerebro-vascular 49,059	Chronic Low. Respiratory Disease 538,843	Chronic Low. Respiratory Disease 620,401
5	Placenta Cord Membranes 5,232	Heart Disease 940	Heart Disease 516	Congenital Anomalies 1,040	Heart Disease 5,254	Heart Disease 15,599	HIV 29,065	Cerebro-vascular 29,666	Diabetes Mellitus 48,606	Influenza & Pneumonia 287,853	Unintentional Injury 513,316
6	Respiratory Distress 4,894	Influenza & Pneumonia 618	Benign Neoplasms 260	Heart Disease 823	Congenital Anomalies 2,323	HIV 10,694	Homicide 17,042	Suicide 29,249	Unintentional Injury 39,963	Diabetes Mellitus 267,598	Diabetes Mellitus 356,540
7	Unintentional Injury 4,593	Septicemia 458	Influenza & Pneumonia 252	Chronic Low. Respiratory Disease 419	Cerebro-vascular 969	Diabetes Mellitus 3,099	Liver Disease 16,183	Diabetes Mellitus 26,186	Liver Disease 29,686	Alzheimer's Disease 267,361	Influenza & Pneumonia 321,921
8	Bacterial Sepsis 3,676	Perinatal Period 387	Chronic Low. Respiratory Disease 217	Influenza & Pneumonia 258	HIV 958	Cerebro-vascular 2,933	Cerebro-vascular 12,549	HIV 21,085	Suicide 16,619	Unintentional Injury 163,940	Alzheimer's Disease 270,269
9	Circulatory System Disease 3,210	Benign Neoplasms 285	Septicemia 195	Cerebro-vascular 230	Chronic Low. Respiratory Disease 953	Congenital Anomalies 2,301	Diabetes Mellitus 10,039	Chronic Low. Respiratory Disease 16,697	Nephritis 16,509	Nephritis 163,854	Nephritis 195,683
10	Intrauterine Hypoxia 2,918	Chronic Low. Respiratory Disease 268	Cerebro-vascular 151	Benign Neoplasms 213	Influenza & Pneumonia 940	Liver Disease 1,941	Influenza & Pneumonia 5,077	Viral Hepatitis 10,050	Septicemia 15,735	Septicemia 127,945	Septicemia 162,076

**WISQARS™** 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 (NCHS), National Vital Statistics System

The most effective way to compare NH to the US is to look at suicide death rates. Suicide rates are presented in terms of numbers of suicides per 100,000 people. The following chart presents NH and US suicide death rates for all ages and select groups of youth.

	All ages	Youth 10-24	Youth 10-17	Youth 18-24
NH	11.41	8.65	4.73	13.93
US	10.69	7.02	3.11	11.66

Crude Suicide Death Rates in NH & US, CDC WISQARS, 2000-2002

For all of the age categories presented, NH rates are higher than national rates. For both NH and the US, suicide rates about triple from ages 10-17 to 18-24, revealing the transition from middle/late adolescence to late adolescence/early adulthood as a particularly vulnerable time.

***Youth Suicide in NH***

In the 12 years from 1994-2005, 271 NH youth aged 10-24 have lost their lives to suicide. The table on the following page depicts the most up-to-date information about these youth, as collected/aggregated by YSPA and reported by the Office of the Chief Medical Examiner in NH. Most youth who die by suicide in NH (83%) are male, a phenomenon that is echoed nationally. Moreover, slightly over 50% of youth who die by suicide in NH use a firearm, followed by 32% who hang themselves. Again, these figures are similar to national data.

Please note that in the Medical Examiner data, “Hanging/Asphyxiation” refers to all forms of suffocation (e.g. hanging, bag over the head) and “Drugs/Poison” refers to all suicide cases of overdoses or ingested poisons. Suicides where carbon monoxide poisoning was the cause of death are reported in the “Other” section. These categories are slightly different than those used by the CDC, which places suicides by carbon monoxide into the “Poison” category.

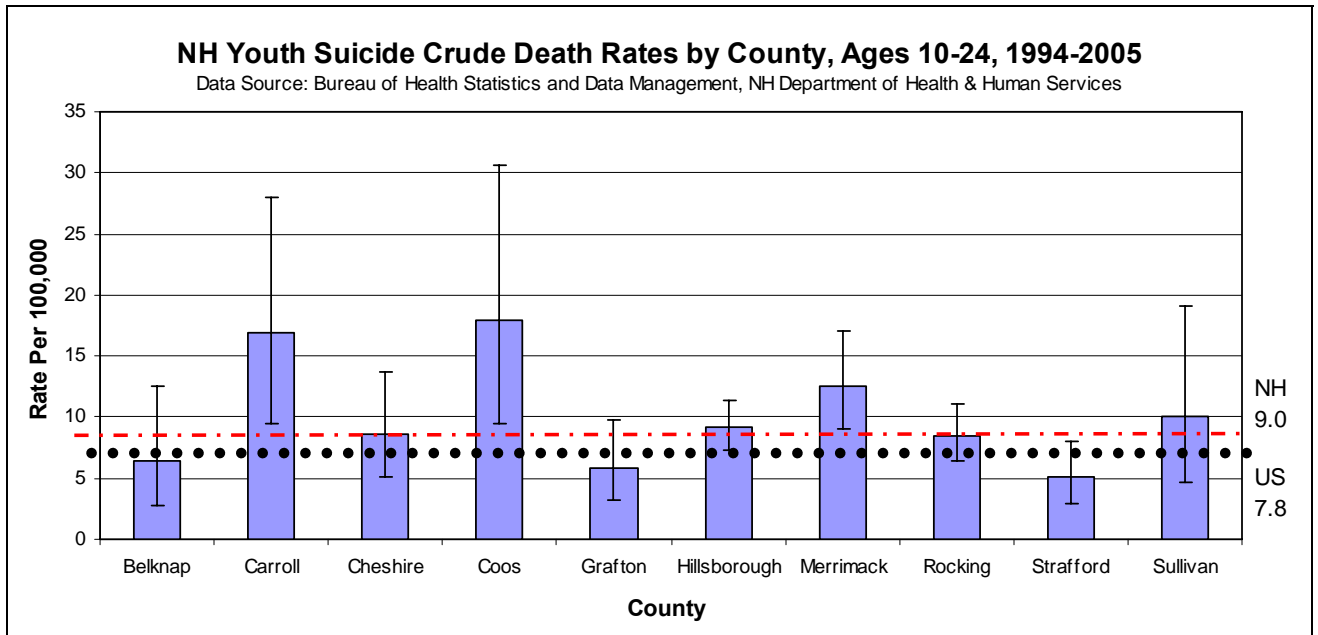
The chart that follows shows how youth suicide rates vary by county in NH. Due to small numbers, most of these differences are not statistically significant. The error bars, or confidence intervals, represent the range of possible suicide death rates for each county. We are always uncertain to some degree when calculating rates, not only due to statistical error (captured by the confidence intervals), but also due to data quality issues (which there is no real way to estimate). The width of the confidence interval tells us just how uncertain we are- if the width is wide, it means we are more uncertain, and likely need more data. When counties’ error bars overlap in any place, one cannot state with certainty that there is a significant difference between county rates. Therefore, it might be misleading to say that Coos County has the highest youth suicide rate, though one could with confidence say that Strafford County has a significantly lower youth suicide death rate than Merrimack, Coos, and Carroll counties.

The county youth suicide death rate chart indicates geographical locations that may be particularly vulnerable to youth suicide; however, it is important not to put all resources into the counties that register the highest rates on this chart. First, the rates are based on such small numbers that these rates are highly variable from year to year. Secondly, and most importantly, county limits are neither soundproof nor absolute. A suicide that occurs in one county can have a strong effect on neighboring counties, as well as across the state, due to the mobility of our residents in work and recreation.

## NH YOUTH SUICIDE DEATHS, 1994-2005

	TOTAL	MALE	FEMALE	≤19	20-24	FIREARMS	HANGING/ ASPHYXIATION	DRUGS/ POISON	OTHER
1994	23	20	3	11	12	11	7	4	1
1995	33	28	5	14	19	22	7	3	1
1996	21	17	4	6	15	14	5	2	0
1997	18	13	5	7	11	9	8	1	0
1998	34	28	6	15	19	21	5	6	2
1999	24	19	5	8	16	12	8	2	2
2000	16	15	1	11	5	6	6	2	2
2001	29	26	3	13	16	17	7	4	1
2002	22	19	3	12	10	9	11	2	0
2003	20	15	5	8	12	9	8	3	0
2004	17	13	4	7	10	6	11	0	0
2005	14	12	2	6	8	6	5	2	1
<b>TOTAL</b>	<b>271</b>	<b>225</b>	<b>46</b>	<b>118</b>	<b>153</b>	<b>142</b>	<b>88</b>	<b>31</b>	<b>10</b>
		<b>83%</b>	<b>17%</b>	<b>44%</b>	<b>56%</b>	<b>52%</b>	<b>32%</b>	<b>11%</b>	<b>4%</b>

Produced by YSPA Data Committee. Data Source: Office of the Chief Medical Examiner, NH.



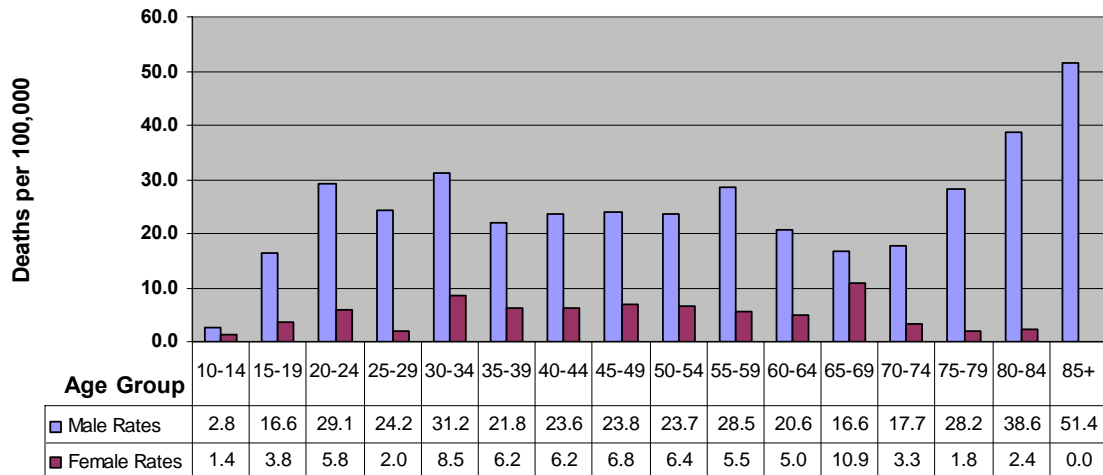
***Suicide Across the Lifespan in NH***

The next two charts display NH resident suicide deaths and suicide death rates by age groups and gender from 2001-2003. Rates are expressed as the number of suicide deaths per 100,000 people. Displayed together, these charts reveal the importance of examining death rates along with the number of deaths to correct for differences in age group sizes. For example, looking just at the number of deaths for males, one may conclude that males are at greatest risk of suicide between the ages of 30 and 60, and at a relatively low risk after the age of 60. However, upon examination of death rates, one recognizes that males over the age of 80 are at the greatest risk for suicide, followed by males in their 30's. Similarly, although more women between the ages of 30 and 50 die by suicide, the rate peaks in women who are in their late 60's, followed by women who are in their 30's.

Suicide death rates are also important in determining vulnerable age groups and age-related transitions. For example, the suicide death rate in males rises rapidly from 10-14 to 15-19, and then again from 15-19 to 20-24, pointing to the possibility that the transitions from early adolescence to middle adolescence and then middle adolescence to late adolescence/early adulthood may be times of particular vulnerability for young males. The suicide death rate in females increases over 400% from 25-29 to 30-34, suggesting a female-specific period of vulnerability as women enter their 30's.

### New Hampshire Resident Suicide Death Rates by Age Groups, 2001-2003

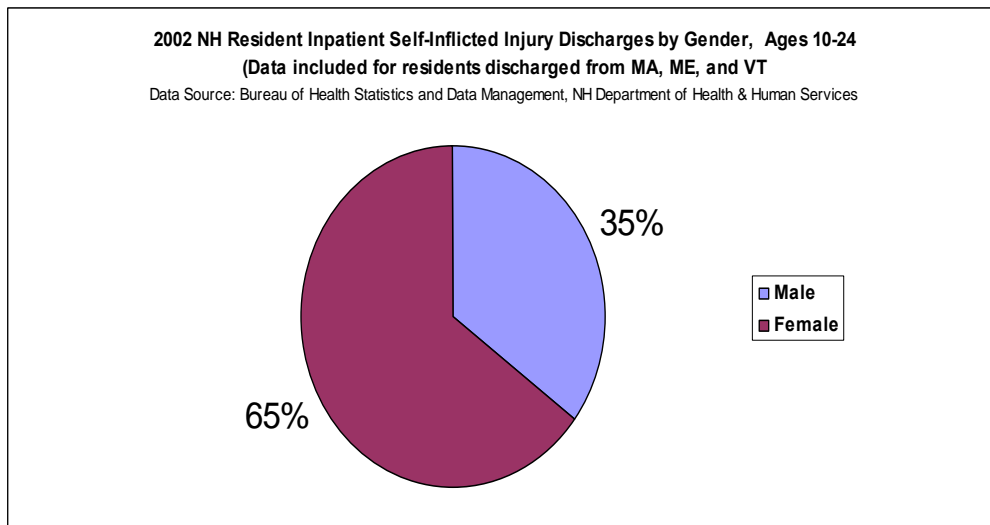
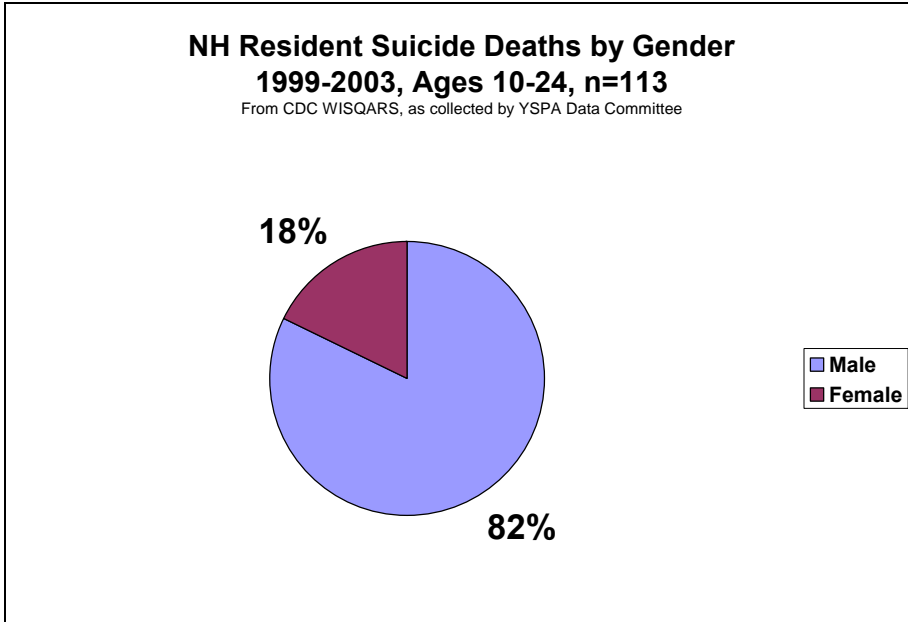
Data Source: Bureau of Health Statistics and Data Management, NH Department of Health & Human Services



#### ***Suicide Behavior in NH and Gender: Attempts and Deaths***

Because 82% of the youth suicides from 1999-2003 represented males, one may be inclined to call suicide a male problem. However, this is not the case. The fact that males *die* by suicide at a higher rate than females is largely due to the fact that they use more lethal means. In fact, females *attempt* suicide at a higher rate than males do. When examining how many NH youth were hospitalized and then discharged for self-inflicted injuries in 2002, it is shown that 65% of these 193 discharges represent females, while only 35% represent males. Emergency department use (ambulatory) data reveals almost the same gender ratio, although the total number of youth ED visits, at 891, is almost 5 times higher than the number of inpatient discharges.

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, though analysis of these injuries is the best way we have of approximating attempts. Therefore, although male youth in NH complete suicide about 4 times as often as females, female youth in NH attempt suicide about twice as often as males.

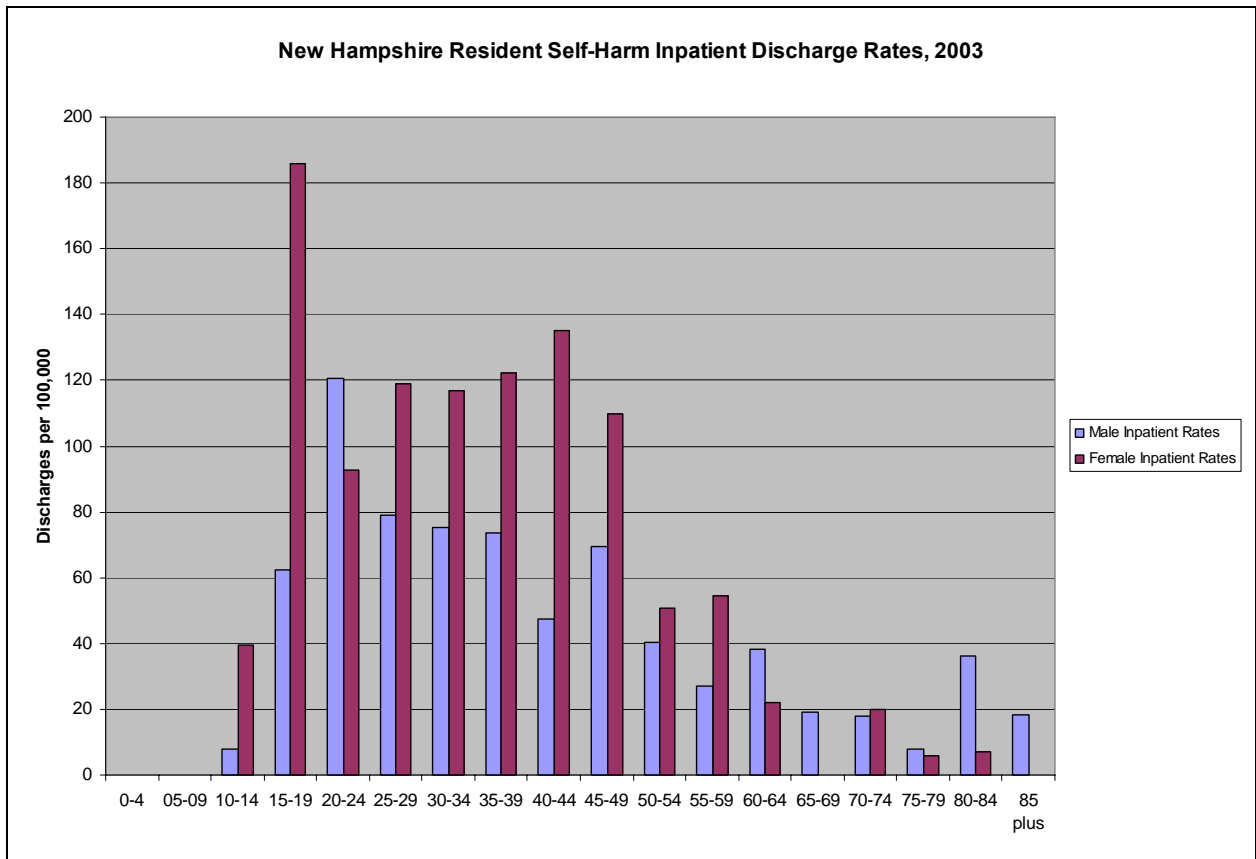


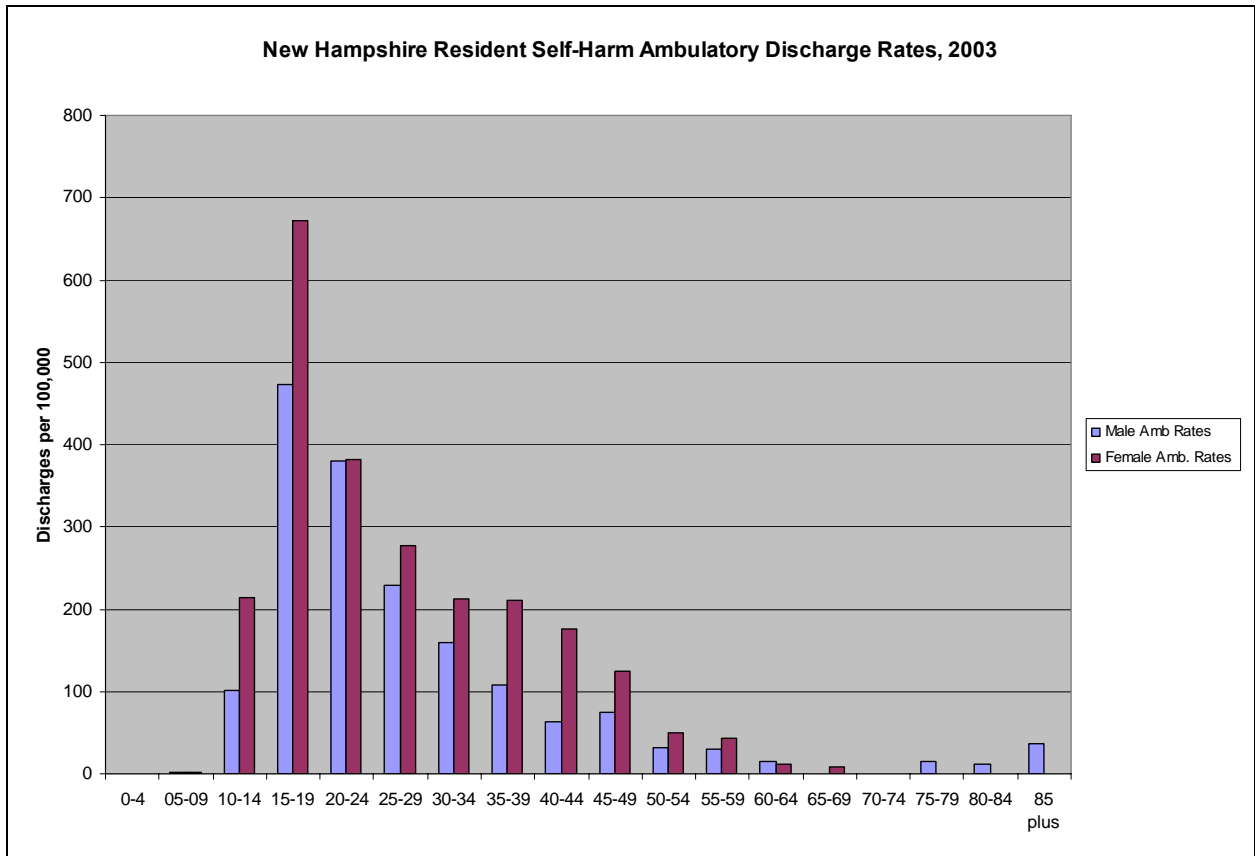
When 2003 *rates* of inpatient hospitalizations/discharges and emergency department use for self-inflicted injuries are examined and older age groups are also represented, the gender differences show variability by age group. The following two charts show these rates for different age groups in NH from 2003. Neither chart includes NH residents treated in Maine, Massachusetts, or Vermont. Also, these data refer to number of visits. Therefore, individuals may be counted more than once.

For the most part, females predominate in inpatient hospitalizations/discharges for self-inflicted injuries, except for the age group 20-24, where males experience a greater rate of self-inflicted injuries. For those females aged 15-19, the rate of those being discharged from inpatient care is close to 200/100,000, 3 times the rate for males of the same age,

and well above the rate for any other age group. Again, emergency department (ambulatory) use rates point to females aged 15-19 as a population particularly vulnerable to self-injury and/or suicide attempts, with a rate close to 700/100,000, about 180 times the suicide death rate for this population. Males also peak in self-injury in this age group, though their rates are much lower. This data reinforces the theme 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.

Data courtesy of Bureau of Health Statistics and Data Management, NH Department of Health and Human Services





These rates of inpatient admissions/discharges and ED/ambulatory use are hundreds of times higher than the suicide death rates for NH residents. Therefore, while these injuries are not fatal, they affect a substantially greater number of people than do fatalities, directly and indirectly, and should be taken seriously.

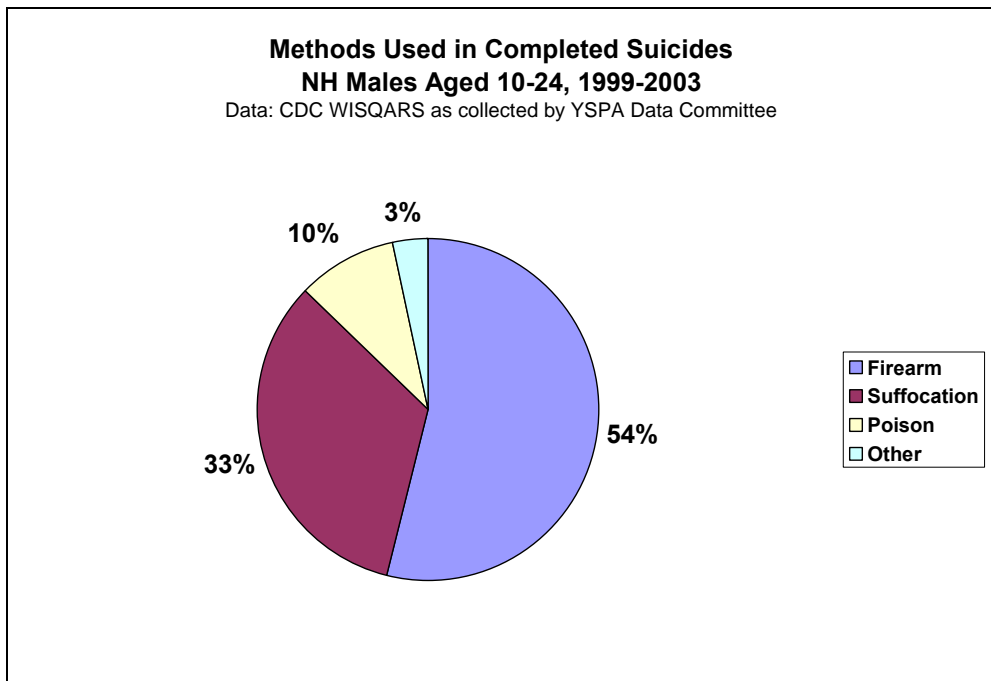
In fact, a significant risk factor for suicide is a previous attempt: 21-33% of people who die by suicide have made a previous attempt (Shaffer & Gould, 1987). Therefore, once an individual has made an attempt, prevention efforts should be increased. It should be noted, however, that only a small proportion of those who do survive an attempt will eventually die by suicide. One study (Motto, 1984) set this number at only 9%. That means that more than 90% of those who survive an attempt will NOT die as a result of suicide.

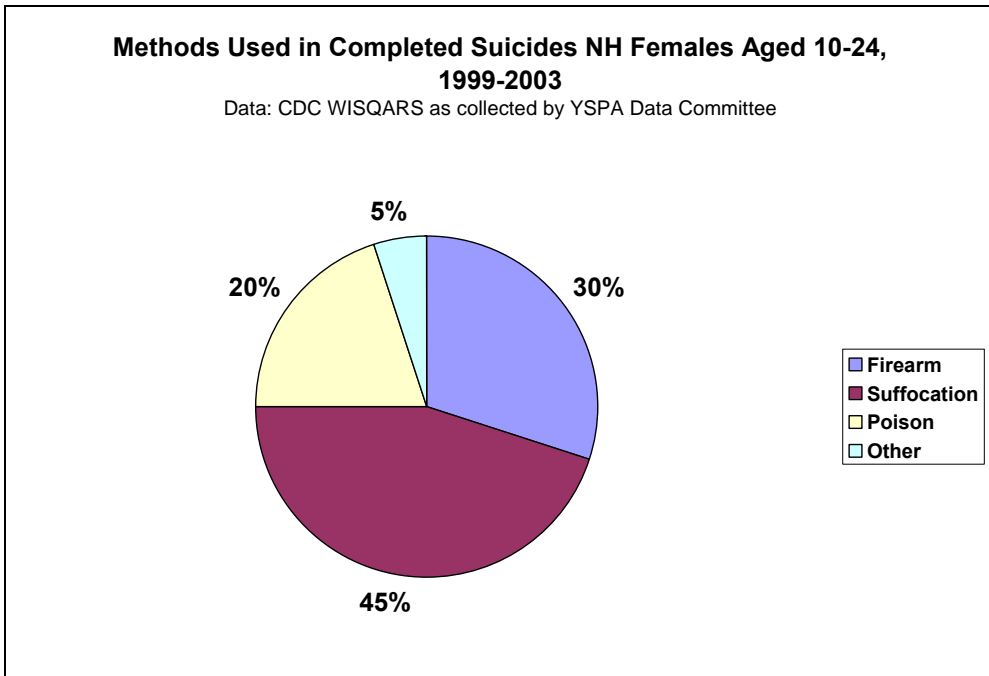
According to inpatient admissions/discharges and ED/ambulatory use data across all ages in NH, there are approximately 18 suicide attempts for every completed suicide. Of course, many suicide attempts go unreported, unrecognized, or never make it to the emergency department or hospital, in part due to the stigma associated with help-seeking behavior for mental health problems, depression, and suicide behavior. Moreover, up to 20% of NH residents who visit emergency departments and hospitals for self-inflicted injuries do so in neighboring states, cases which are not reflected in the data presented

here. Therefore, the ratio of 18 attempts per every suicide death is most likely an underestimation, especially for youth and females. Because there are an average of 23 youth suicides in NH every year, there are most likely well over 400 youth suicide attempts in NH every year.

***Suicide in NH: Suicide Methods***

The gender difference in suicide deaths/attempts may be explained by the fact that males, in general, use more lethal means. Of NH male youth who died by suicide between 1999 and 2003, 54% used firearms compared to 30% of females. This gender disparity in firearm use becomes even greater as residents enter their late 20's, 30's, and 40's. Male rates stay about the same, while females' use of firearms lessens and rates of both poisoning and suffocation increase (CDC WISQARS, 1999-2003).

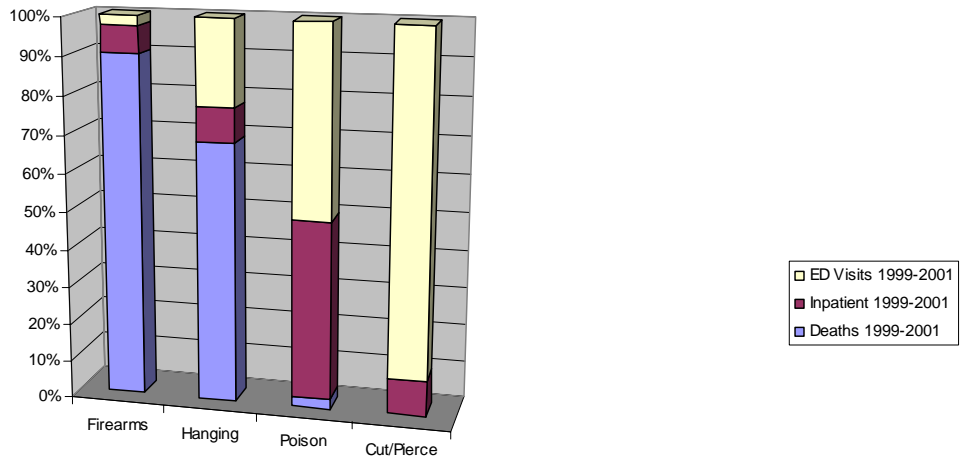




It is important to examine the comparative lethality of the most commonly used methods of suicide. The following chart compares firearms, hanging, poisoning, and cutting/piercing in terms of the percentage of various outcomes (emergency department visit, inpatient admission, death) for each method. The lethality of firearms is obvious. About 90% of self injuries using a firearm result in death. This is a grim statistic in light of the fact that many people who kill themselves are ambivalent about dying, and that for many people, especially youth, suicide is a highly impulsive act. In fact, poor impulse control is a significant risk factor for suicide. The implications for intervention are clear. Every effort must be made to restrict youth access to firearms, particularly among those at risk for suicide, and those who have poor impulse control.

Data courtesy of Bureau of Health Statistics and Data Management, NH Department of Health and Human Services

**Lethality of Means Used for Suicidal Behavior in NH for all ages  
1999-2001**

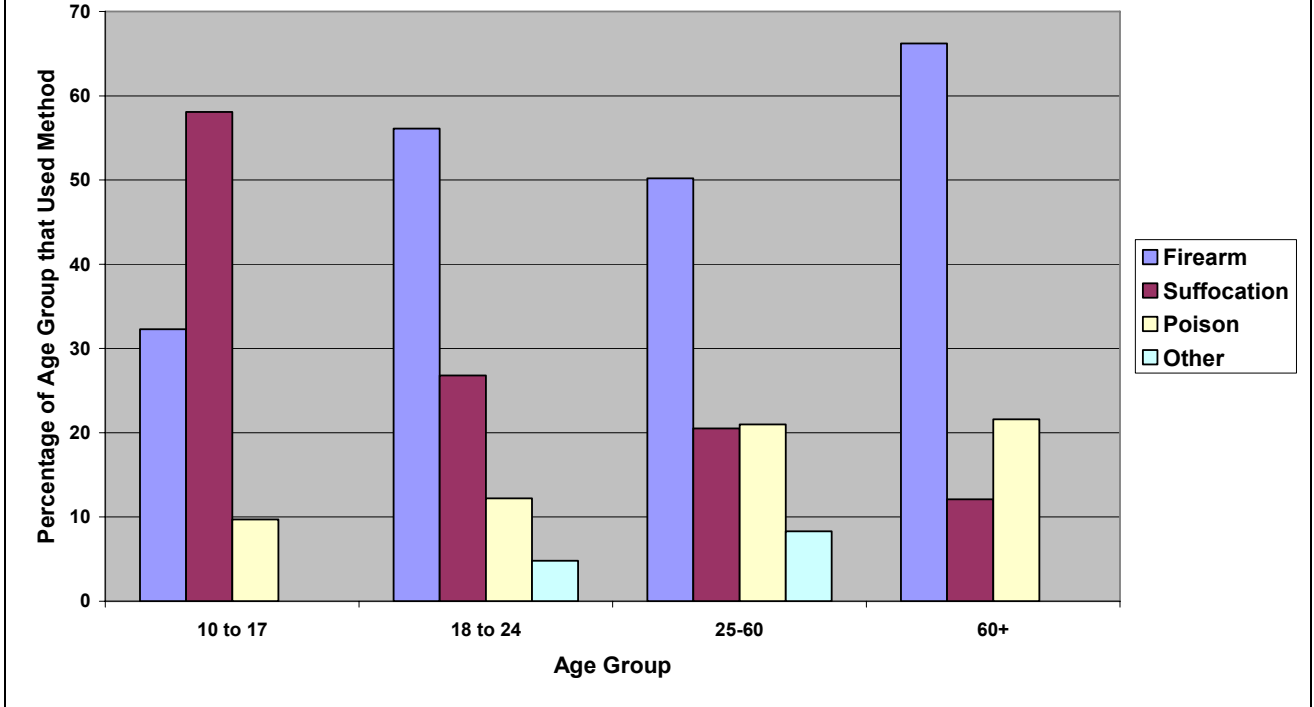


	Firearms	Hanging	Poison	Cut/Pierce
ED Visits 1999-2001	6	33	1976	1365
Inpatient 1999-2001	17	13	1852	143
Deaths 1999-2001	216	101	102	5

Firearms remain the most commonly used method of suicide throughout the lifespan in NH. In fact, the percentage of suicide deaths due to a firearm increases to close to 70% for those ages 60+. Rates of suicide due to poisoning also increase as people age, suggesting that older adults may use prescription drugs for pain and chronic illness as a method of suicide. The use of suffocation as a suicide method peaks in early adolescence, and decreases steadily throughout the lifespan.

### Suicide Methods Used by Age Groups NH Data, 1999-2003

Data: CDC WISQARS, collected by YSPA Data Committee



#### *Costs of Suicide and Suicidal Behavior*

Suicide's most obvious cost is the loss of individuals who die by suicide, and their potential contribution to their loved ones and to society. From 1999-2003 in NH, there were an estimated 29,695 years of potential life lost to suicide (CDC WISQARS).

For each suicide death, there are an estimated 6 survivors of suicide (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 those who feel that they did not do all they could to prevent the death.

In NH, the attempts and suicidal deaths treated in acute care hospitals alone represented an estimated \$6.2 million in health care costs in 2001. This does not include the costs associated with mental health services on an inpatient or outpatient basis. (BHSDM, NHDHHS, 2003) Harder to measure is the cost to employers of lower or lost productivity due to suicidal behavior by employees or their loved ones.

### ***Suicide Rates in NH: Moving in a Better Direction***

Recent data suggests that rates of youth suicide and suicidality overall in NH may be on a downward trend. It is nearly impossible to firmly establish causality for this trend, although there are several variables that are likely contributing. Recent statewide prevention efforts, including the work of YSPA, implementation of the State Suicide Prevention Plan, the Frameworks Youth Suicide Prevention Project, and the work of many community partners undoubtedly play a role. Reduced access to firearms and growing awareness about the link between firearms and suicide has likely also been a factor. Finally, the increased identification and treatment of depression and other mental illnesses has certainly contributed as well.

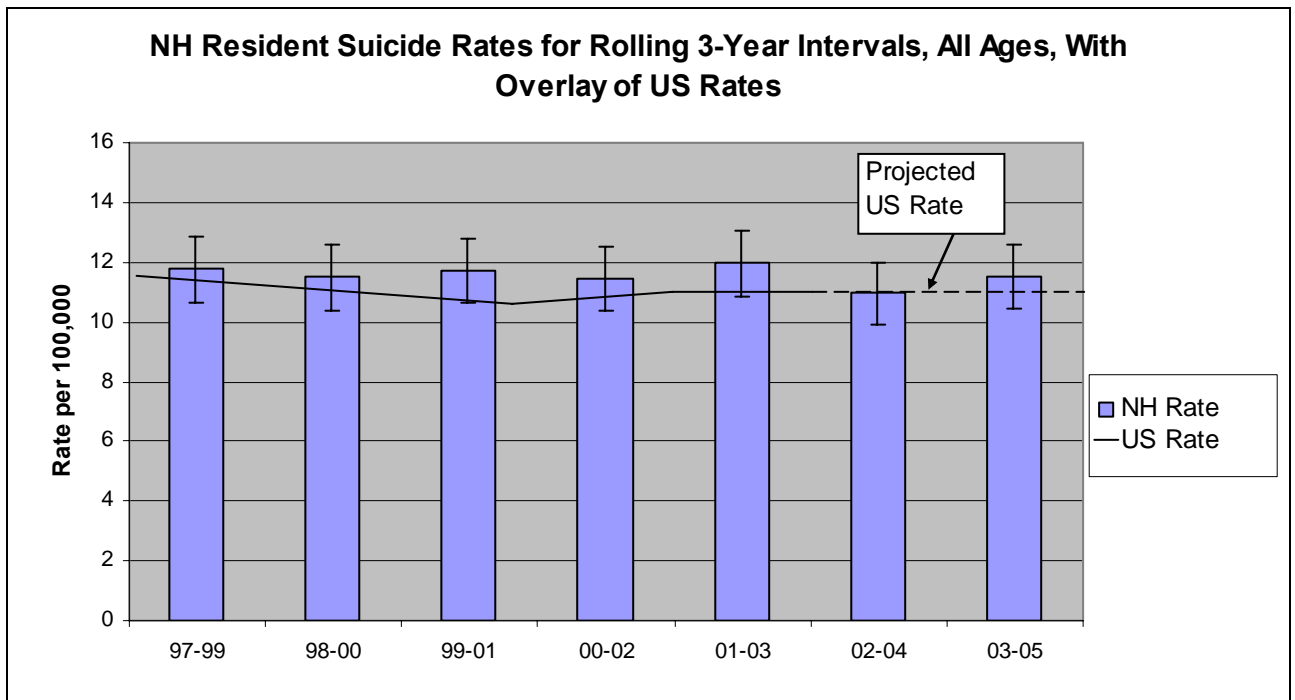
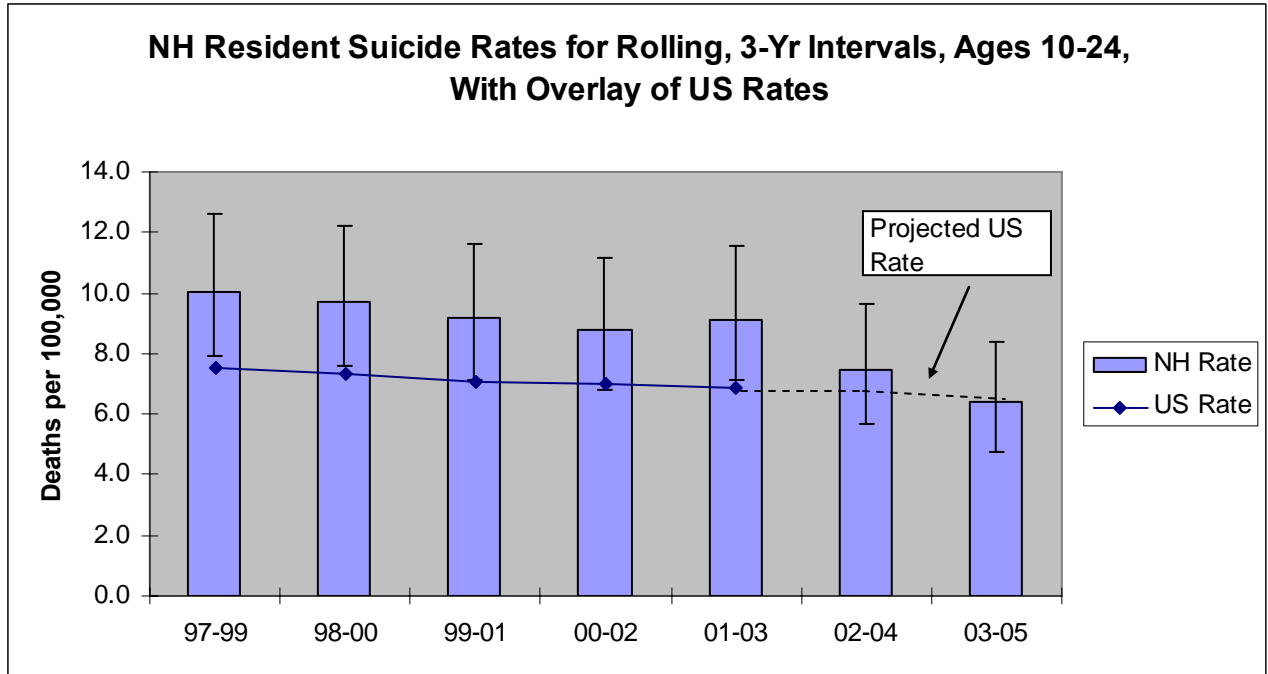
The first chart reflects NH and US suicide death rates for youth aged 10-24 in rolling 3-year intervals from 1997 to 2005. Again, overlapping error bars mean that one cannot say for certain that there is a significant difference between any of the 3-year intervals. It is also important to keep in mind that the numbers upon which these rates are based are still quite small. That being said, the error bars for 97-99 and 03-05 come very close to not overlapping for NH. Therefore, youth suicide rates appear to have significantly decreased in the last 10 years in NH. Moreover, the NH youth suicide death rate is approaching the lower US youth suicide death rate.

The chart that follows is similar to this first one, except that it represents NH and US residents of all ages. As evidenced by this chart, the suicide death rate for people of all ages in both NH and the US has remained relatively constant over the last 10 years. Again, the gap between NH and US rates appears to be closing.

The final chart indicates results of the NH Youth Risk Behavior Survey (YRBS) from 1993, 2003, and 2005. The percentage of high school youth in NH who seriously considered a suicide attempt in the past year and the percentage of those who made a suicide plan in the past year both decreased by about 50% from 1993 to 2005. However, in 2005, 1 in 7 youth surveyed still seriously considered attempting suicide in the past year, while 1 in 14 actually made an attempt.

Although these final charts represent what may, in fact, be “good news” for NH youth suicide prevention, it is important to ask ourselves what our standard is, and what outcomes and rates we would like to see before we celebrate our successes. These statistics show that while suicidal thinking and attempts are decreasing amongst NH high school students, they still affect a large proportion of the student body. NH youth suicide death rates, as well as rates for all of the NH YRBS survey items, are steadily dropping, and we hope that they fall even more as the public and private sectors continue to pool their efforts and resources to respond to the challenge of suicide prevention in an integrative and collaborative way.

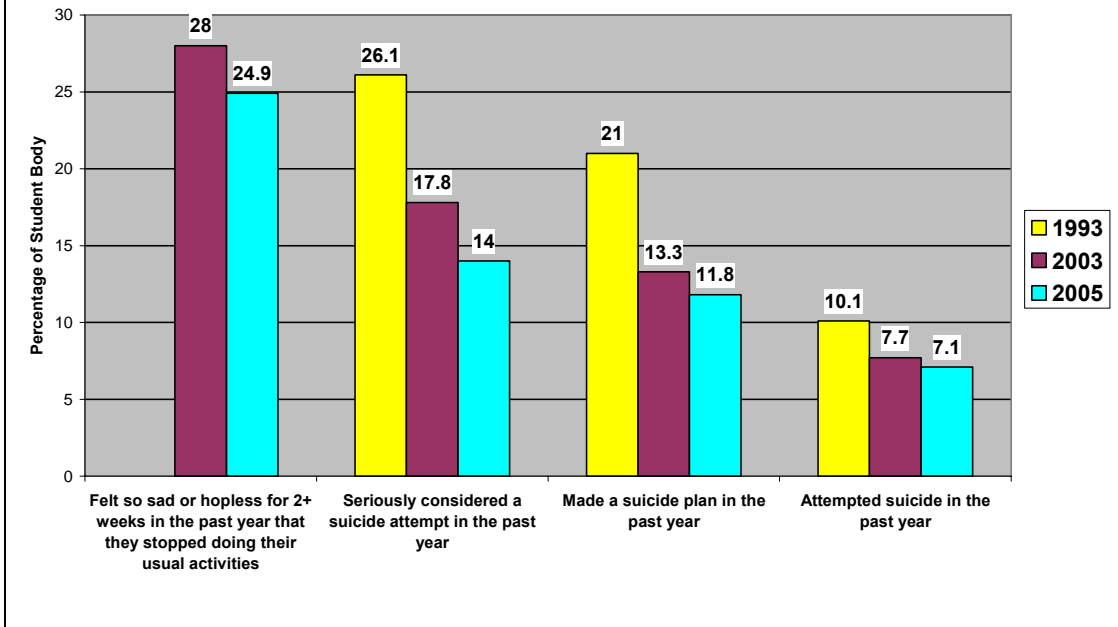
Data courtesy of Bureau of Health Statistics and Data Management, NH Department of Health and Human Services



Data courtesy of Bureau of Health Statistics and Data Management, NH Department of Health and Human Services

**NH Youth Risk Behavior Survey (High School Students)  
Suicidal Behavior: 1993, 2003, 2005**

Data Source: NH YRBS Results, NH Department of Education



Thanks to Abby Winzeler, NAMI NH and David Reichel, BHSDM, NH DHHS for their efforts in completing this section of the Annual Report.



## **Do You Want to Be Involved with YSPA? The Youth Suicide Prevention Assembly**

### **YSPA Mission**

The Youth Suicide Prevention Assembly (YSPA) is dedicated to reducing the occurrence of suicide and suicidal behaviors among New Hampshire's youth between 10 and 24 years old. We will accomplish this through a coordinated approach to providing communities with current information regarding best practices in prevention and postvention strategies and by promoting youth safety in our communities and organizations.

### **YSPA Goals**

*To help implement the State Suicide Prevention Plan to include:*

- 1) promoting awareness in the state of youth suicide and risk and protective factors;
- 2) fostering interagency collaboration, communication and information sharing particularly among mental health professionals, primary care providers and schools;
- 3) increasing the accessibility of emergency and ongoing mental health services;
- 4) assisting communities, community-based organizations, schools, service clubs, local and state agencies and others in action planning for youth suicide prevention including: identifying resources, creating constructive crisis response plans, and
- 5) any other means agreed to by the membership.

### **Join Us If You Would Like to be Part of Our Efforts**

The Youth Suicide Prevention Assembly (YSPA) normally meets on the second Thursday of each month at the Center for Health Promotion in Concord. Anyone is welcome to join us. You should contact one of the co-chairs before coming, however, to be sure that the meeting is on and is in the usual place. Things change from time to time due to holidays, summer schedules, conferences, etc.

To be added to the YSPA E-Mailing List – which provides you with regular updates on issues of interest as well as meeting minutes, agendas, committee meeting schedules and so forth, please contact Elaine deMello at NAMI-NH.

Email Elaine at [edemello@naminh.org](mailto:edemello@naminh.org) or call 603-225-5359 or 1-800-242-6264.

Elaine Frank at the Injury Prevention Center is the other co-chair. She can be reached at [Elaine.frank@dartmouth.edu](mailto:Elaine.frank@dartmouth.edu) or at 603-653-1135 or 1-877-783-0432.

RECOGNIZE THE **WARNING SIGNS** FOR SUICIDE  
TO SAVE LIVES!

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

Although some of the warning signs are youth-specific, most can also be applied to adults:

- **Difficulties at school or work**
- **“Rollercoaster” moodiness or sadness**
- **Drug or alcohol abuse, especially an increase in use from prior habits**
- **Changes in sleep or eating patterns**
- **Difficulty concentrating, restlessness**
- **Feeling like a failure, worthless**
- **Hopelessness or helplessness**
- **Preoccupations with death (often expressed through music or poetry)**
- **Isolating self from friends, family, and activities they used to enjoy**
- **Putting life in order**
- **Sudden improvement in mood after being down or withdrawn**
- **A detailed plan for how, when, where**
- **Talking about suicide or death – directly or indirectly. (Examples: “I’m just going to end it all” or “Everything would be easier if I wasn’t around.”)**

For a more complete list of warning signs, as well as comprehensive lists of risk factors and protective factors, please consult the Frameworks Youth Suicide Prevention Project *Community Response to Attempts & Threats Protocols*. They can be accessed at: <http://naminh.org/frameworks.php>. Follow the “Community Protocols” link.

**CONNECT WITH YOUR LOVED ONE,  
CONNECT THEM TO HELP.**

- 1.) Ask directly about their suicidal feelings. Talking about suicide is the first step to preventing suicide!
- 2.) Let them know you care.
- 3.) Stay with them until a parent or professional is involved.
- 4.) Offer a message of hope- Let them know you will assist them in getting help.
- 5.) Connect them with help:

\*National Suicide Lifeline (24/7) **1-800-273-TALK (8255)**

\*Teen Head Rest (24/7) **1-800-639-6095**

\*NH Helpline **1-800-852-3388** (8AM to 8PM)  
or your local mental health center