



2021

NEW HAMPSHIRE

■ **Suicide Prevention Plan**
2021-2024



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Introduction

The New Hampshire Suicide Prevention Council is dedicated to promoting awareness that suicide is a preventable public health problem. Together, we can raise awareness and increase access to mental health, substance misuse, and suicide prevention services.

Suicide presents a significant and growing public health concern in the United States across the lifespan. Specific subsets of the population, such as first responders, military members, and veterans, have higher rates of suicide than others. Factors such as mental illness and substance use also contribute to an individual's risk of suicide.

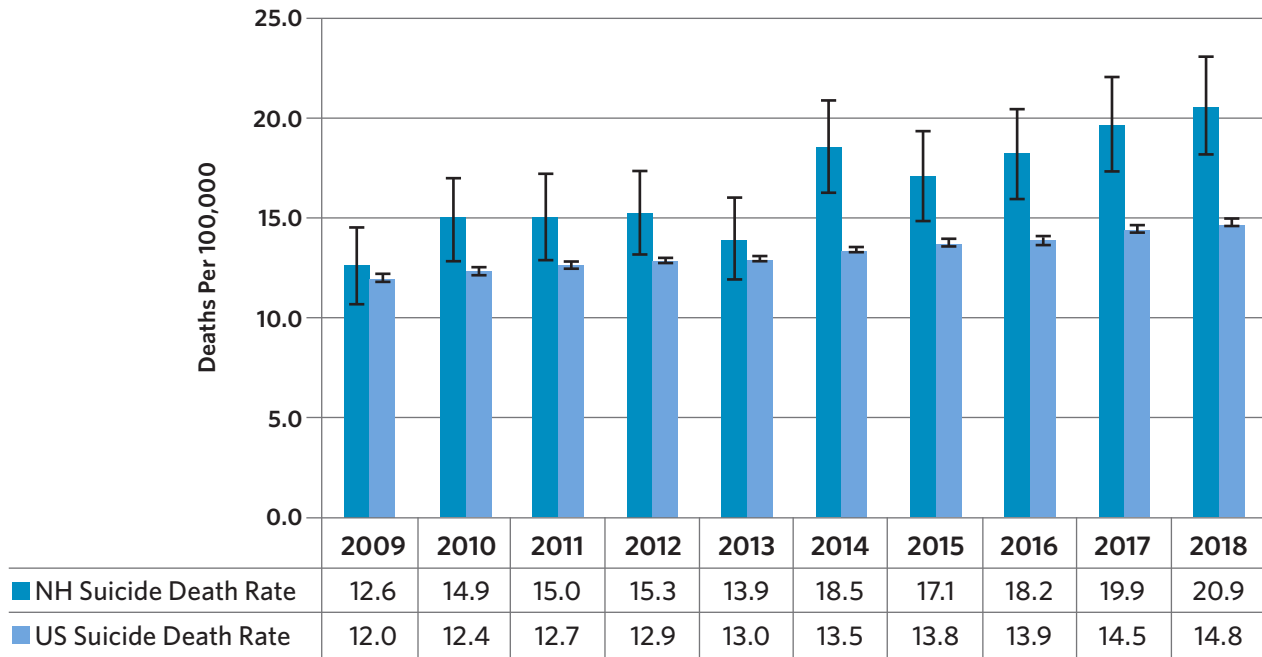
Nationally, suicide is the second leading cause of death for those aged 10 through 34, the 4th leading cause of death for people aged 35-44, and the 8th cause of death for those aged 55-64 (Table 1). Data in Table 2 indicates that suicide death rates in New Hampshire (NH) are approximately 35% higher than the national rate (19.27 per 100,000 in NH compared to 14.21 per 100,000 nationally). The Granite State ranks 12th in the country for suicide deaths, and while suicide is the 8th leading cause of death across all Granite State residents, it is the 2nd leading cause of death for those aged 10-44. In 2018, suicide accounted for the deaths of 279 residents and cost the state over \$222M in lifetime medical and work loss costs (Table 3).

Table 1: 10 Leading Causes of Death, United States, 2018

		Age Group						
		10-14	15-24	25-34	35-44	45-54	55-64	65+
Ranking	1	Unintentional Injury (692)	Unintentional Injury (12,044)	Unintentional Injury (26,614)	Unintentional Injury (22,667)	Malignant Neoplasms (37,301)	Malignant Neoplasms (113,947)	Heart Disease (526,509)
	2	Suicide (596)	Suicide (6,211)	Suicide (8,020)	Malignant Neoplasms (10,640)	Heart Disease (32,220)	Heart Disease (81,042)	Malignant Neoplasms (431,102)
	3	Malignant Neoplasms (450)	Homicide (4,607)	Homicide (5,234)	Heart Disease (10,532)	Unintentional Injury (23,056)	Unintentional Injury (23,693)	Chronic Low Respiratory Disease (135,560)
	4	Congenital Anomalies (172)	Malignant Neoplasms (1,371)	Malignant Neoplasms (3,684)	Suicide (7,521)	Suicide (8,345)	Chronic Low Respiratory Disease (18,804)	Cerebrovascular (127,244)
	5	Homicide (168)	Heart Disease (905)	Heart Disease (3,561)	Homicide (3,304)	Liver Disease (8,157)	Diabetes Mellitus (14,941)	Alzheimer's Disease (120,658)
	6	Heart Disease (101)	Congenital Anomalies (354)	Liver Disease (1,008)	Liver Disease (3,108)	Diabetes Mellitus (6,414)	Liver Disease (13,945)	Diabetes Mellitus (60,182)
	7	Chronic Low Respiratory Disease (64)	Diabetes Mellitus (246)	Diabetes Mellitus (837)	Diabetes Mellitus (2,282)	Cerebrovascular (5,128)	Cerebrovascular (12,789)	Unintentional Injury (57,213)
	8	Cerebrovascular (54)	Influenza & Pneumonia (200)	Cerebrovascular (567)	Cerebrovascular (1,704)	Chronic Low Respiratory Disease (3,807)	Suicide (8,540)	Influenza & Pneumonia (48,888)
	9	Influenza & Pneumonia (51)	Chronic Low Respiratory Disease (165)	HIV (482)	Influenza & Pneumonia (956)	Septicemia (2,390)	Septicemia (5,956)	Nephritis (42,232)
	10	Benign Neoplasms (30)	Complicated Pregnancy (151)	Influenza & Pneumonia (457)	Septicemia (829)	Influenza & Pneumonia (2,339)	Influenza & Pneumonia (5,858)	Parkinson's Disease (32,988)

Source: Centers for Disease Control and Prevention, 2020

Table 2: Crude Suicide Death Rates per 100,000 in NH, 2009-2018



Data Source: CDC WISQARS, 2009-2018

Table 3: Suicide Facts and Figures: New Hampshire 2020

Suicide Facts & Figures: New Hampshire 2020

On average, one person died by suicide every 31 hours in this state.

Almost six times as many people died by suicide in New Hampshire in 2018 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of 5,199 years of potential life lost (YPLL) before age 65.

8th

leading cause of death in New Hampshire

2nd leading
cause of death for ages 10-44

4th leading
cause of death for ages 45-54

6th leading
cause of death for ages 55-64

16th leading
cause of death for ages 65+

Suicide cost New Hampshire a total of **\$222,439,000** combined lifetime medical and work loss cost in 2010, or an average of **\$1,134,894 per suicide death.**

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
New Hampshire	279	19-27	12
Nationally	48,344	14-21	

CDC 2018 Fatal Inquiry Reports (accessed from www.cdc.gov/injurywisquars/fatal.html on 3/1/2020).

Source: American Foundation for Suicide Prevention, 2020

Although these statistics are alarming, evidence suggests that protective factors such as family and community support can reduce the risk of suicidal thoughts and behaviors. The NH Suicide Prevention Council (SPC) was established in 2008 to reduce suicide by raising public and professional awareness of proven suicide prevention strategies. SPC is responsible for developing and implementing a statewide Suicide Prevention Plan, informed by the latest data and stakeholder input.

This document begins with background information about the SPC and the guiding principles that informed the planning process. Next, the Plan presents the Goals and Objectives created and confirmed by SPC members at all Council levels. The Plan also includes a measurement framework to allow SPC members to reflect on progress towards the Goals and Objectives. The Plan contains the planning process methodology and an extensive Appendix with supporting documents to add context to this critical work.

II. Suicide Prevention Council

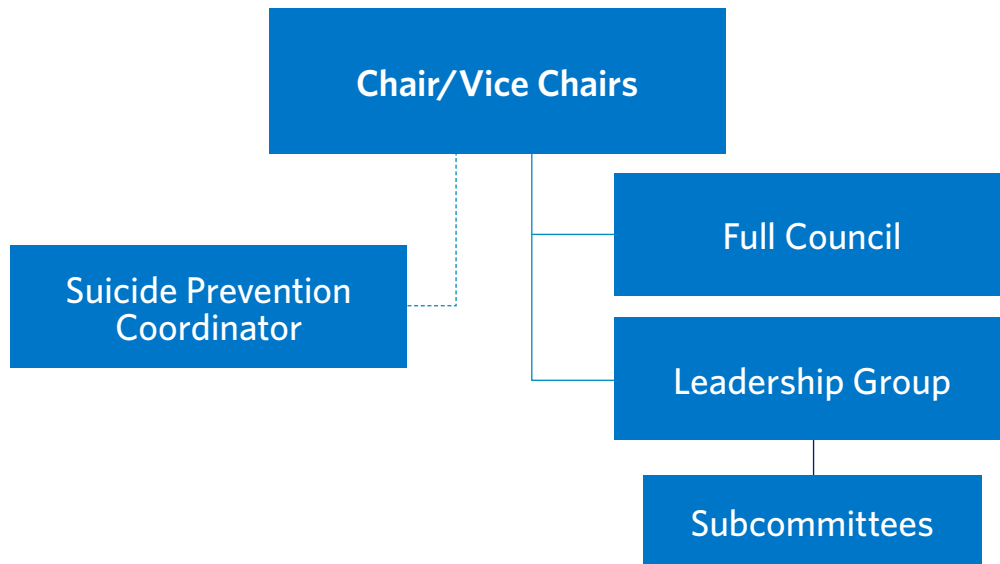
A. Purpose

Established in 2008 through a legislative mandate, the NH Suicide Prevention Council (SPC) aims to reduce the incidence of suicide in the Granite State by raising public and professional awareness of suicide prevention. SPC is also directed to address all residents’ mental health and substance abuse needs and those affected by suicide. Finally, SPC is tasked to promote policy change on suicide prevention-related matters.

According to its statute, NH RSA 126-R, SPC shall “oversee the implementation of the New Hampshire suicide prevention plan. The Council shall ensure the continued effectiveness of the plan by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the plan.”

B. Structure

A Chair leads SPC, with overall responsibility for the Council’s functioning; two Vice-Chairs support leadership efforts. Russell Conte from the New Hampshire State Police is the current Chair. The Vice-Chair positions are held by Mary Forsythe-Taber, Executive Director of Makin’ It Happen, and Candice Porter, Executive Director of Connor’s Climb Foundation.



NH Suicide Prevention Council Structure

SPC’s Leadership Group is comprised of the chairs of each of the Subcommittees, which include:

- **Communications Subcommittee**, which promotes awareness that suicide is a public health problem that is generally preventable, encourages safe messaging, media reporting, and portrayal of suicidal behavior;
- **Data Collection and Analysis Subcommittee**, which improves and expands suicide surveillance systems;
- **First Responders Subcommittee**, which collaborates with partners and implements training to address at-risk behaviors among these populations;
- **Military/Veterans Subcommittee**, which collaborates with partners and implements training to address at-risk behaviors among these populations;

- **Public Policy Subcommittee**, which provides subject matter expertise to the NH Legislature regarding the public health impact of suicide; and
- **Survivors of Suicide Loss Subcommittee**, which supports survivors (family, friends, and associates of people who died by suicide) through the implementation of support and education programs.
- **Education Committee**, which will be reestablished to support prevention education efforts across the state, aligning with recommendations in the NH 10-Year Mental Health Plan.
- **Suicide Fatality Review Committee**, which meets the legislatively mandated role of reviewing suicide deaths in NH to determine trends, risk factors, and prevention strategies.

While membership is open to all interested participants who wish to serve as an ambassador for SPC and suicide prevention efforts in NH, the SPC Charter outlines the representing agencies required by statute (see Appendix 1). Members often work within their affiliated organization and system to promote suicide prevention efforts, ensuring consistency with the SPC statewide plan. SPC generates support and excitement for initiatives through its diverse membership while addressing priorities and resources.

III. Strategic Plan Guiding Principles

SPC’s Suicide Prevention Plan is comprehensive and data-driven. Additionally, it is aligned with the National Action Alliance priority areas, best practices developed the Suicide Prevention Resource Center (SPRC), supports the Zero Suicide framework, and helps fulfill the NH 10-Year Mental Health Plan.

A. The National Action Alliance

The National Action Alliance is dedicated to advancing the National Strategy for Suicide Prevention. Working with more than 250 national partners, the National Action Alliance is implementing efforts to reduce the annual suicide rate by 20 percent by 2025. Towards that end, the National Action Alliance has identified three priority areas that hold the most promise for reducing suicide in the nation:

- transforming health systems,
- transforming communities,
- changing the conversation about suicide.



In addition to these three priorities, the National Action Alliance is committed to ensuring progress in the following areas, which support and contribute to efforts across all three National Action Alliance priority areas: research, data and surveillance, access to lethal means, and lived experience.

B. Suicide Prevention Resource Center

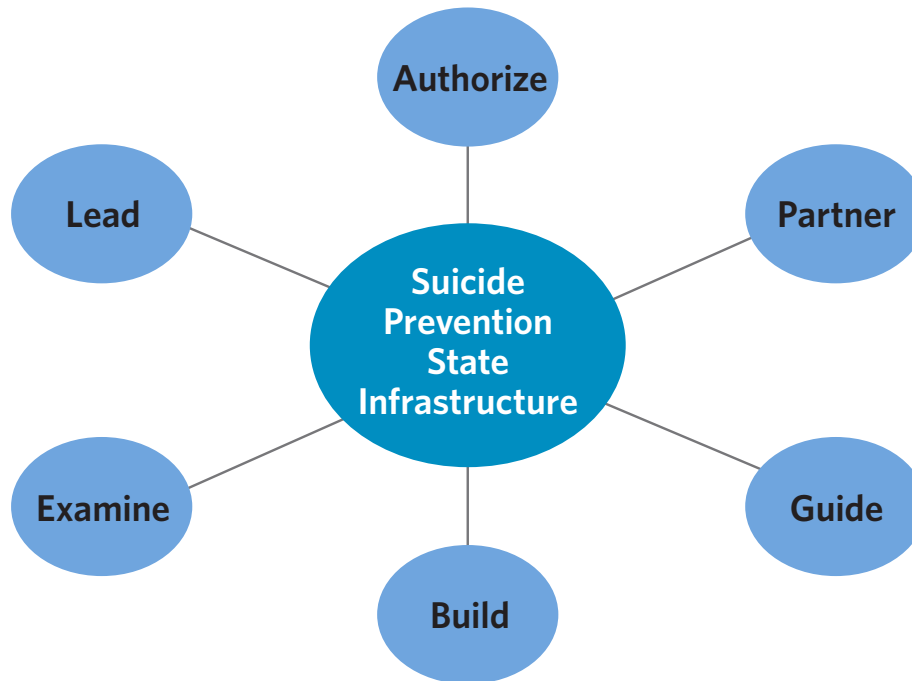
Funded by the US Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA), the Suicide Prevention Resource Center (SPRC) advances the National Strategy for Suicide Prevention.

Suicide prevention requires a combination of efforts, addressing the different aspects of the issue to be most effective. SPC has reviewed and adopted the nine strategies SPRC asserts for a comprehensive approach to suicide prevention and mental health promotion:

1. Identify and Assist Persons at Risk
2. Increase Help-Seeking
3. Access to Effective Mental Health and Suicide Care and Treatment
4. Support Safe Care Transitions and Create Organizational Linkages
5. Respond Effectively to Individuals in Crisis

6. Provide for Immediate and Long-Term Postvention
7. Reduce Access to Means of Suicide
8. Enhance Life Skills and Resilience
9. Promote Social Connectedness and Support

SPC has embraced SPRC's recommendations for a suicide prevention infrastructure at the state level to carry out these strategies. These recommendations are organized into six essential elements with specific guidance in each area, summarized below.



Authorize — Suicide is both a public health issue and a mental health issue. As a result, multiple state-level departments and agencies, in addition to non-government organizations, are responsible for prevention activities.

- **Partner** — Suicide prevention requires a multifaceted approach focused on risk and protective factors at the individual, family, community, and societal levels. Accordingly, prevention strategies are more successful when multiple partners from both the public and private sectors are involved, allowing for increased capacity and effectiveness of suicide prevention efforts and expanding their reach and impact.
- **Guide** — State suicide prevention programs play an essential role in providing consultation and training to local health departments and other organizations at both the state and community levels.
- **Examine** — State suicide prevention efforts are most effective when they are data-driven. Activities need to be evaluated to assess the effectiveness and allow for continuous improvement.
- **Build** — State suicide prevention councils have an essential role in managing the implementation and evaluation of suicide prevention activities.
- **Lead** — Suicide prevention strategies are more likely to succeed when spearheaded by experienced, capable leaders with skills in program administration, coalition building, goal setting, and communication.

C. Zero Suicide Framework

SPRC encourages the adaptation of the Zero Suicide Framework for Safer Suicide Care by health and behavioral health care systems. Evidence shows that the best prevention approaches do not focus on a single strategy or policy. Models such as Zero Suicide utilize multiple components and methods to help prevent suicide deaths for individuals under care within health and behavioral health systems. SPC has embraced these elements of Zero Suicide in its past work and will continue to do so moving forward.

<p>Zero Suicide Elements</p> <p>LEAD <i>Lead system-wide culture change committed to reducing suicides.</i></p> <p>TRAIN <i>Train a competent, confident, and caring workforce.</i></p> <p>IDENTIFY <i>Identify individuals with suicide risk via comprehensive screening and assessment.</i></p> <p>ENGAGE <i>Engage all individuals at-risk of suicide using a suicide care management plan.</i></p> <p>TREAT <i>Treat suicidal thoughts and behaviors directly using evidence-based treatments.</i></p> <p>TRANSITION <i>Transition individuals through care with warm hand-offs and supportive contacts.</i></p> <p>IMPROVE <i>Improve policies and procedures through continuous quality improvement.</i></p>
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D. The NH Department of Health and Human Services 10-Year Mental Health Plan

Beyond national best-practices, SPC will align its work with statewide initiatives. Most recently, the New Hampshire Department of Health and Human Services developed a 10-Year Mental Health Plan that addresses the needs of individuals and families across the continuum of care. This Mental Health Plan provides innovative strategies to address the evolving environment and increasing complexity of the mental health system. Key recommendations from the plan that align with SPC efforts include:

- **Strengthening Suicide Prevention and Education Efforts.** The Mental Health Plan calls out the alarming increase in suicide rates over the past 20 years. As such, the state recommends strengthening evidence-based suicide prevention and education efforts to address this problem.
- **Preparing Gatekeepers to Recognize and Respond to Mental Health Concerns in the Community.** The Mental Health Plan suggests increased training and technical assistance to enhance gatekeepers’ ability to recognize signs of distress and respond in a supportive and soothing manner and connect people to appropriate supports.

In addition to its alignment to national and state suicide prevention initiatives, SPC is committed to increasing knowledge about suicide prevention resources and support. SPC promotes the National Suicide Prevention Lifeline, which connects a person with a local operator trained to handle suicide emergencies.



HOTLINES

National Suicide Prevention Lifeline: call 1-800-273-TALK (8255) for free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.

Veterans: veterans and their loved ones can call 1-800-273-8255 and Press 1, chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

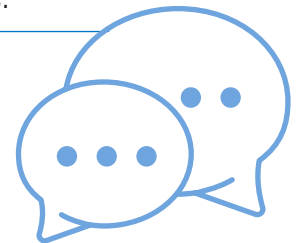
Crisis Text Line: free, 24/7 support for those in crisis. Text 741741 from anywhere in the US to text with a trained Crisis Counselor.

Trans Lifeline: call 1-877-565-8860 for a hotline staffed by transgender people for transgender people. Trans Lifeline volunteers are ready to respond to whatever support needs community members might have.

Disaster Distress Helpline: call 1-800-985-5990 for a 24/7 national hotline dedicated to providing immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster.

The Trevor Project: a national 24-hour, toll free confidential suicide hotline for LGBTQ youth. If you are a young person in crisis, feeling suicidal, or in need of a safe and judgment-free place to talk, call 1-866-488-7386 to connect with a trained counselor.

The LGBT National Help Center: call 1-888-843-4564. Open to callers of all ages. Provides peer-counseling, information, and local resources.



IV. NH Suicide Prevention Council: Updated Goals for 2021-2024

SPC's overarching goals, which are consistent with the previous plan, remain as follows:

- **Goal 1: Promote awareness that suicide in New Hampshire is a public health problem that is generally preventable.**
- **Goal 2: Reduce the stigma associated with obtaining mental health, substance misuse, and suicide prevention services.**

For each goal, SPC identifies why this goal is vital to NH and then shares objectives and strategies to enable the Council to move forward with its efforts. All objectives align with the SPRC strategies for an effective state suicide prevention infrastructure.

Goal 1: Promote awareness that suicide in New Hampshire is a public health problem that is generally preventable.

Why This Matters: As mentioned previously, data indicates that suicide death rates in New Hampshire (NH) are approximately 35% higher than the national rate (19.27 per 100,000 in NH compared to 14.21 per 100,000 nationally); the Granite State ranks 12th in the country for suicide deaths.¹ While suicide is the 8th leading cause of death across all Granite State residents, it is the 2nd leading cause of death for those aged 10-44. As the evidence suggests, suicide can be prevented. SPC hopes to promote awareness that suicide is a preventable public health problem.

Objective 1.1: SPC embraces its role as the lead organization for suicide prevention in NH and maximizes coordination with DHHS as the **AUTHORIZED** lead organization.

- *Strategy 1.1.1: Collaborate with the Program Coordinator representing NH DHHS to access state resources (i.e., funding, data, expertise).*
- *Strategy 1.1.2: Work in partnership with the DHHS-employed Suicide Prevention Coordinator to carry out SPC goals.*

Objective 1.2: SPC will **PARTNER** with key stakeholders to build awareness of suicide prevention, increase knowledge of best practices for prevention, intervention, and response to suicide, and increase collaboration, networking, and support.

- *Strategy 1.2.1: Serve in a technical assistance capacity as needed to establish best practice prevention, intervention, and response services in their communities.*
- *Strategy 1.2.2: Develop or promote existing campaigns to raise awareness of best practice suicide prevention strategies.*

Objective 1.3: SPC will **GUIDE** SPC members' efforts to promote effective suicide prevention strategies in communities across the state.

- *Strategy 1.3.1: Increase awareness among local health departments and other community-based providers about prevention best practices.*

Objective 1.4: SPC will **LEAD** healthcare providers to promote adopting the seven concepts of Zero Suicide in health and behavioral health care systems statewide.

- *Strategy 1.4.1 Identify and build leaders to create a safety-oriented culture statewide, committed to reducing suicide among people under care.*
- *Strategy 1.4.2: Encourage leaders to promote the identification and assessment of suicide risk among people receiving care, ensuring that pathways to care are both timely and adequate and meet individuals' needs.*

¹ 2020-state-fact-sheets-new-hampshire.pdf (aws-fetch.s3.amazonaws.com)

Objective 1.5: SPC will **EXAMINE** a range of data sources to inform suicide prevention efforts.

- *Strategy 1.5.1: Collect, compile, synthesize and present data on suicide rates and prevention efforts through an Annual Report.*
- *Strategy 1.5.2: Conduct an Asset and Gaps analysis to inform where there are greatest needs in the state.*
- *Strategy 1.5.2: Disseminate an Annual Report to stakeholders throughout the state to raise awareness about data trends.*

Objective 1.6: SPC will support efforts to **BUILD** sufficient funding streams for awareness and prevention activities.

- *Strategy 1.6.1: Collaborate with partners to provide education and raise awareness among policymakers and other key decision-makers regarding suicide prevention best practices.*
- *Strategy 1.6.2: Maintain the pulse on legislative policy efforts and mobilize members to advocate for change.*
- *Strategy 1.6.3: Work with members organizations to identify, solicit, and leverage existing funds in support of suicide prevention efforts.*

Goal 2: Reduce the stigma associated with obtaining mental health, substance misuse, and suicide prevention services.

Why This Matters: Stigma is often defined as a mark of disgrace or a stain on one’s reputation, and there is much stigma surrounding suicide. People may experience psychological scars inflicted by the hurt and shame of attempting suicide or knowing someone who has died by suicide. Stigma is rooted in misunderstanding, ignorance, and fear, which can be addressed through increased awareness about suicide and the related issues of mental health and substance misuse and abuse. By reducing the stigma associated with obtaining mental health and substance use disorder services, SPC hopes people will feel comfort and safety in accessing the resources they need to prevent suicidal thoughts or behaviors.

Objective 2.1: SPC coordinates the creation of the data system used by NAMI NH as the **AUTHORIZED** lead data organization.

- *Strategy 2.1.1: Review data metrics annually and disseminate through the Annual Report.*

Objective 2.2: SPC will **PARTNER** with member organizations to educate the public and key gatekeepers that accepting persons with mental illness and substance use disorders and addressing suicide openly can reduce suicide risk and prevent suicidal behaviors.

- *Strategy 2.2.1: Annually disseminate updated information to legislators, policymakers, educators, and providers that there are effective treatments for mental illness and substance use disorders.*
- *Strategy 2.2.2: Raise awareness among the general public that mental disorders are real illnesses, equal and inseparable components of overall health, that respond to specific treatments.*
- *Strategy 2.2.3: Ensure formal representation from the Youth Suicide Prevention Assembly on SPC.*

Objective 2.3: SPC will **GUIDE** NH to integrate the latest best practices by planning and implementing an annual conference.

- *Strategy 2.3.1: Empower Subcommittees to take an active role in planning and participating in the Annual Conference.*
- *Strategy 2.3.2: Identify the latest data and trends to share at the annual conference.*

Objective 2.4: SPC will **LEAD** statewide prevention efforts by identifying and mobilizing stakeholders to participate in the Council.

- *Strategy 2.4.1: Identify diverse stakeholders representing the various regions, racial/ethnic diversity, youth group, and high-risk populations present in the Granite State.*
- *Strategy 2.4.2: Identify stakeholders who understand and serve high-risk populations in varying regions, from diverse racial/ethnic backgrounds, and represent targeted subpopulations.*

Objective 2.5: SPC will **EXAMINE** attitudes related to obtaining mental health, substance misuse or use disorder, and suicide prevention services through an annual survey.

- *Strategy 2.5.1: Delegate survey development, dissemination, and analysis to the appropriate subcommittees.*
- *Strategy 2.5.2: Ensure survey input represents diverse stakeholder perspectives by leveraging SPC members who serve various populations.*

Objective 2.6: SPC will support efforts to **BUILD** sufficient funding streams to expand access to mental health, substance misuse, and suicide prevention services.

- *Strategy 2.6.1: Support initiatives that increase access to treatment for mental illness and substance use disorders.*

V. Measuring Success

Evaluation is a critical component of any prevention strategy, allowing the opportunity to measure success and refine future efforts. Effective program evaluation is a systematic way to improve and account for public health actions.⁵ Strong program evaluation can also help identify the most successful strategies and help establish and sustain them as optimal practice.²

SPC identified the following measures to assess the success of the Plan:

- SPC will align Subcommittee activities with broader SPC goals.
- SPC will reach a consensus among the membership on goals, activities, and progress.
- SPC will conduct an 'asset and gap' analysis as needed.
- SPC will monitor the number of effective partnerships in place with key suicide prevention stakeholders.
- SPC will ensure leadership is 'at the table' when state-level policy/legislative decisions are being made.
- SPC will ensure its members are represented in statewide initiatives such as the Suicide Prevention Annual Report.
- SPC will ensure that data is used for advocacy and information-sharing, ultimately establishing a state mandate related to data collection.

² <https://www.cdc.gov/eval/index.htm>

Appendices

Appendix 1 – NH Suicide Prevention Coalition Charter

Introduction

Purpose

NH RSA 126-R establishes a Council on Suicide Prevention (referred to more commonly as the Suicide Prevention Council or SPC). By statute, the SPC shall “oversee the implementation of the New Hampshire suicide prevention plan. The Council shall ensure the plan’s continued effectiveness by evaluating its implementation, producing progress reports, and recommending program changes, initiatives, funding opportunities, and new priorities to update the plan. The Council shall also be a proponent for suicide prevention in New Hampshire.”

1.2. Chair and Vice-Chairs

The SPC chair has the overall responsibility for the functioning of the SPC. The SPC vice-chairs supports the SPC chair and the overall SPC as needed. In financial matters, the chair shall sign contracts and the treasurer shall authorize payments.

1.3. SPC Leadership Team

The SPC Leadership Team is comprised of the SPC chair, vice chairs, coordinator, subcommittee chairs, clerk, and other selected members (identified by Chair). The Leadership Team meets two weeks prior to each SPC meeting in order to provide oversight and guidance to subcommittees, to review priorities, state plan issues, sustainability, and set the agenda. The Leadership Team also approves all revisions to the State Plan.

Administration

The DHHS designated SPC Coordinator will handle meeting administrative functions and coordination responsibilities (per job description created and approved by the SPC Leadership Team). He or she will ensure that all meetings follow an agenda and record and distribute minutes. At specific designated meetings, subcommittee chairs/co-chairs shall furnish oral or written progress reports of their subcommittee’s actions and/or recommendations.

Suicide Prevention Council Structure

Membership

The Committee will consist of the following members at a minimum (as required by statute):

-
- (a) One member of the Senate, appointed by the President of the Senate.

 - (b) Two members of the House of Representatives who shall be members of the Health, Human Services and Elderly Affairs Committee, appointed by the Speaker of the House of Representatives.

 - (c) The Commissioner of the Department of Health and Human Services, or designee, appointed by the Commissioner.

 - (d) The Commissioner of the Department of Education, or designee.

 - (e) The Commissioner of the Department of Safety, or designee, appointed by the Commissioner.

 - (f) The Commissioner of the Department of Corrections, or designee.

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- (g) The Chief Medical Examiner, or designee.
-
- (h) The Adjutant General of the National Guard, or designee.
-
- (i) A representative of the Injury Prevention Center, Dartmouth-Hitchcock Medical Center, appointed by the President of the Medical Center.
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- (j) A representative of the National Alliance on Mental Illness, appointed by the Alliance.
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- (k) A representative of the New Hampshire Disability Rights Center appointed by the Center.
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- (l) A member of the Commission to Develop a Comprehensive State Mental Health Plan, established by 2005, 175:15, appointed by the Chairperson of the Commission.
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- (m) A representative of the Bi-State Primary Care Association, appointed by the Association.
-
- (n) A representative of the Endowment for Health, appointed by the Endowment.
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- (o) A representative of the New Hampshire Hospital Association, appointed by the Association.
-
- (p) A representative of the New Hampshire Community Behavioral Health Association, appointed by the Association.
-
- (q) A representative of New Futures, appointed by the organization.
-
- (r) A person representing families who have lost a loved one to suicide, appointed by the Governor.
-
- (s) A person representing the youth community, appointed by the Governor.
-
- (t) A person representing the older adult community, appointed by the Governor.
-
- (u) A person representing the clergy, appointed by the Governor.
-
- (v) A physician, appointed by the New Hampshire Medical Society.
-
- (w) A county corrections superintendent, appointed by the New Hampshire Association of Counties.
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The term of office for statutory members (i)-(w) shall be 2 years, or until a successor is appointed and qualified in the case of a vacancy. The term of office for all other members shall be coterminous with the term of office for the position that qualifies that member to serve on the Council. A vacancy shall be filled in the same manner, but only for the unexpired term.

There are also members who serve on the Council who are not statutory members. The only difference between statutory and non-statutory members shall come in the case of a vote. Only statutory members may vote. Members may serve unlimited consecutive terms. All meetings are open to the public.

Subcommittees

Much of the SPC work is accomplished through subcommittees, which shall be comprised of, at a minimum, SPC members or their designees, as well as individuals who are non-SPC members. Subcommittees include:

- Communications & Public Education
- Data Collections & Analysis
- Military & Veterans
- First Responders
- Cross Training and Professional Education
- Public Policy

- Suicide Fatality Review
- Survivors of Suicide Loss

The SPC also works on the Suicide Prevention Conference in collaboration with other organizations.

According to statute, “The SPC chairperson shall appoint at least two council members to serve on each committee and shall designate a chairperson for each.” If a vacancy occurs, subcommittees may identify potential chairpersons as needed and share those names with the leadership team for discussion and approval. The SPC chairperson will approve all subcommittee chairs or co-chairs. Whenever possible, this will include a balance of public and private organizational representatives. Subcommittee chairs shall identify and solicit community member participation as required and/or needed to accomplish their identified goals.

Sub-committee chairs may determine appropriate meeting schedules. It is expected that a minimum of quarterly meetings are required for meeting Goals and Objectives included in the Suicide Prevention Council State Plan. Sub-committee members need not hold seats on the SPC or attend SPC meetings.

2.3. The SPC Network

The SPC Network includes all members of the SPC Leadership Team and all members of each of the SPC Subcommittees.

Role of Council Members

The Council shall elect a statutory member to serve as chairperson for a 2-year term. The Council shall also elect a vice-chairperson and a clerk. The chairperson shall also designate a treasurer.

Members, or their designees, are expected to:

- Serve as an ambassador for SPC and for suicide prevention efforts in NH
- Promote collaboration and partnerships throughout the state
- Attend a minimum of four out of six scheduled meetings per year
- Actively participate in a subcommittee and/or other Council initiatives
- Be familiar with the state plan and use it to guide Council activities
- Work within their own member organization and system to promote suicide prevention efforts and to insure they are consistent with the State Plan
- Understand the strategic implications of initiatives under consideration
- Generate support and excitement for initiatives
- Help address issues related to priorities and resources
- Support change and help your colleagues with adoption of new tools, processes and procedures
- Review any status reports and meeting related materials, and be prepared to participate in discussions and decision making processes

Meetings

General Guidelines

- Be engaged in the meeting
- No mobile phone or other distracting tech devices to be used
- Phones and pagers must be on vibrate or silent

Decision Making Rules

- Decisions are generally made by informal consensus.
- When consensus is not reached or appropriate, statutory members of the Council shall vote. In such cases, a simple majority will determine deciding votes.

Meeting Schedule and Process

The SPC will meet every other month on the second Monday (of the month), or as required to address items that cannot be delayed.

- Meetings will be scheduled for 120 minutes, but may end earlier based on completion of the agenda.
- If there are no agenda items, the chairperson may cancel the meeting with notification of at least 1 business day.
- Meeting agendas and supporting documents will be distributed at least 3 days in advance of the meeting.
- Meeting minutes will be distributed within 5 days after the meeting and will include agreed upon action items and decisions.
- Committee members will be expected to review the action items and follow-up on their items before the next meeting or on the schedule agreed to during the meeting.

Consent Agenda

The meetings shall use a Consent Agenda and include, but not be limited to:

- Guest presentations as identified in advance by the SPC Leadership Team
- Monitoring and review of subcommittee reports to ensure progress on plan
- Communicating and documenting all priority Council decisions as needed
- Providing assistance and guidance when needed

2.6. Fiscal Sponsor

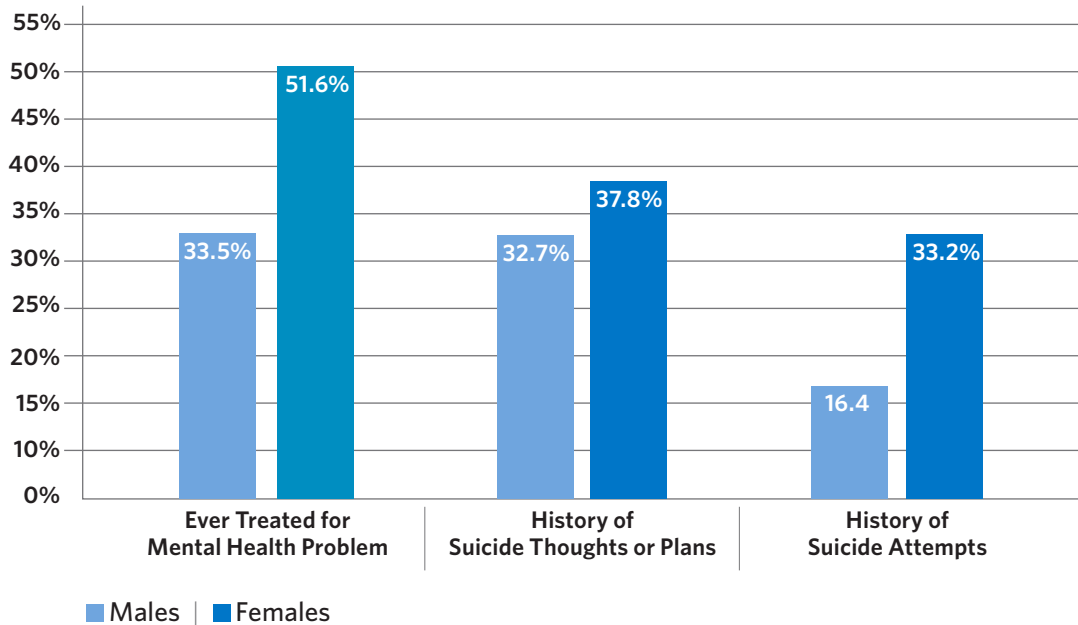
The Suicide Prevention Council's finances, which includes but is not limited to grants, donations, etc. shall be handled by a 501 (c) member organization which volunteers in this role.

<http://www.gencourt.state.nh.us/rsa/html/x/126-r/126-r-mrg.htm>

Appendix 2

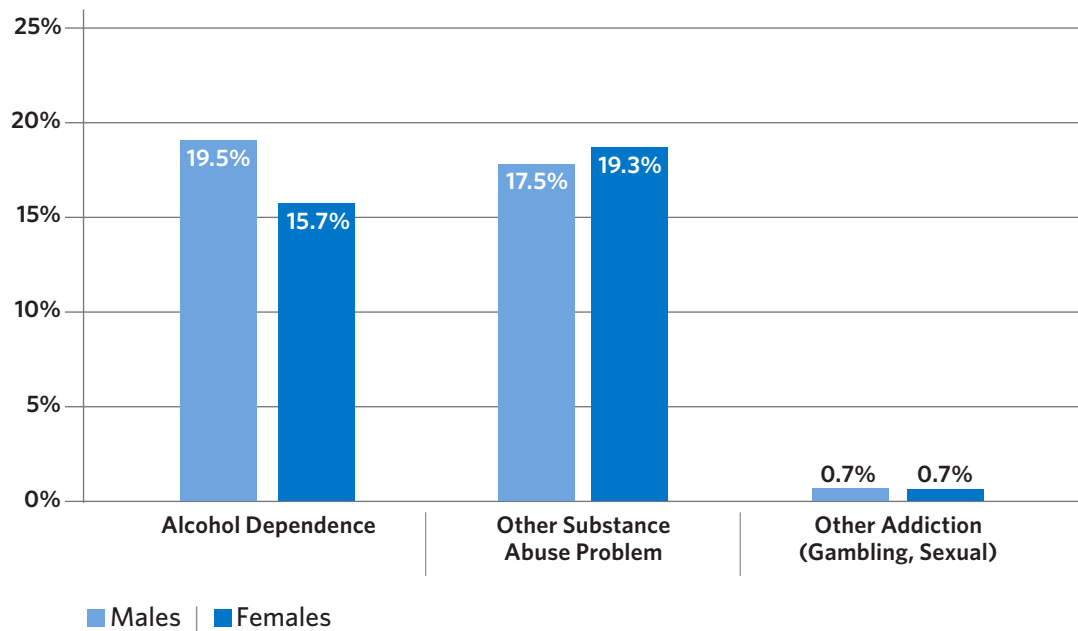
Supporting Data

Mental Health and Suicide History of Suicide Decedents in 36 US States by Gender, 2017



Source: Centers for Disease Control and Prevention, 2020

Substance Abuse and Dependence Among Suicide Decedents in 36 US States by Gender, 2017



Source: Centers for Disease Control and Prevention, 2020

