New Jersey Department of Health
DMHAS Suicide Prevention Week Event
Data and Graphics from
The Center for Health Statistics, New Jersey Violent Death Reporting System

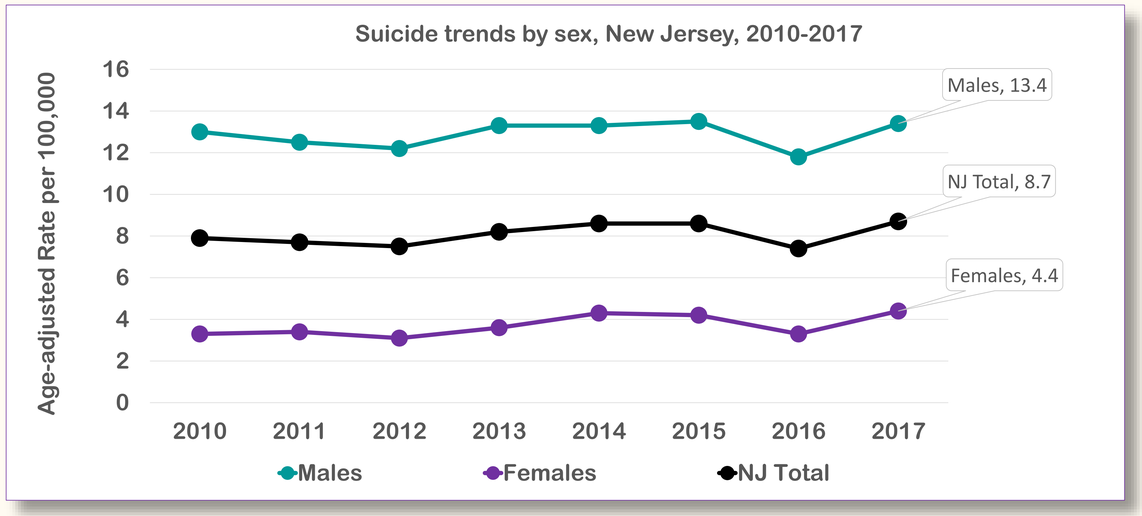
September 10, 2019

(Revised October 22, 2019)

Trenton, NJ

Suicide in New Jersey
At-risk Populations

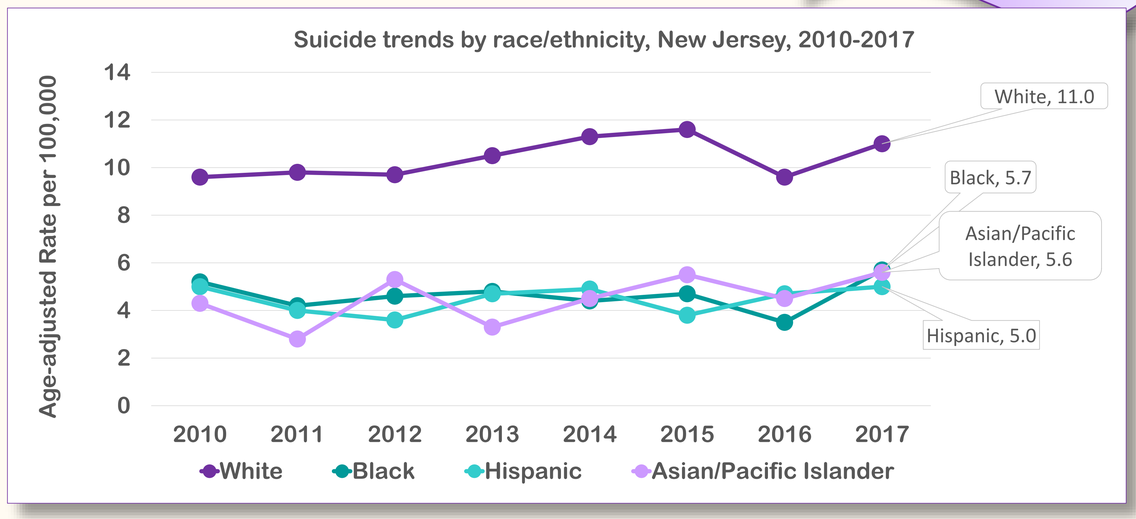
These figures appear in your packet. Please contact us for more data and information! NJVDRS@doh.nj.gov



Males continue to drive the suicide rate in New Jersey, but female rates have increased substantially

Despite a recent one-year drop in the suicide rate for males, females, and overall, 2017 suicide rates for all three groups is at an all-time high in New Jersey.

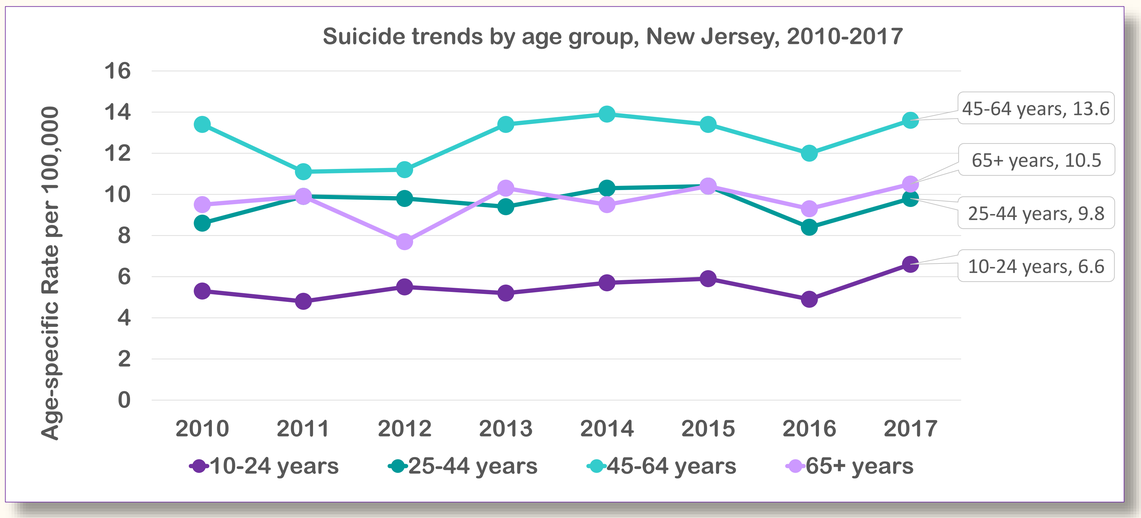
- In 2017 there were 816 New Jersey residents who died by suicide, an age-adjusted rate of 8.7 deaths per 100,000 population and a 10% increase in the rate from 2010.
- The males suicide rate has increased from 13.0 per 100,000 in 2010 to 13.4 in 2017, a 3% increase.
- The female suicide rate has increased from 3.3 per 100,000 in 2010 to 4.4 in 2017, a ***33% increase***.



White non-Hispanics continue to experience disproportionally higher suicide rates than other racial/ethnic groups

The trend in New Jersey resident suicide rates is reflected in the trend among White non-Hispanics. While the 2017 rate of 11.0 per 100,000 is slightly lower than in 2015 (11.6), it is almost 15% higher than in 2010 at 9.6 per 100,000.

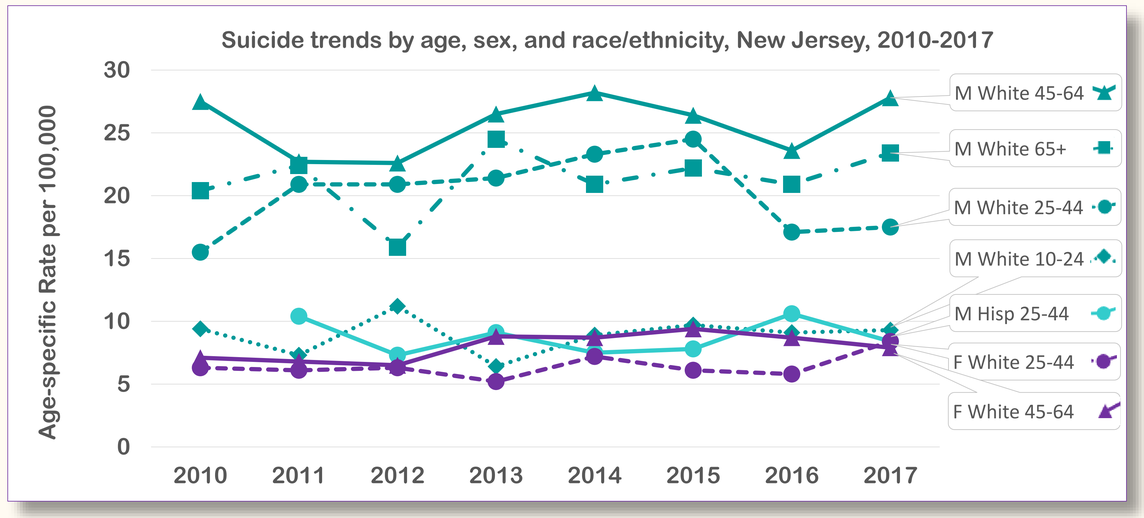
- The suicide rate among Black non-Hispanics increased from 5.2 per 100,000 in 2010 to 5.7 in 2017, almost 10%.
- Among Hispanics, the suicide rate fluctuated slightly between 2010 and 2017, but remained unchanged at 5.0 per 100,000 from the beginning to the end of the time period.
- The suicide rate among Asian/Pacific Islanders increased from 4.3 per 100,000 in 2010 to 5.6 in 2017, ***a 30% increase.***



Suicide rates among middle aged adults (45-64 years) remain elevated compared to other age groups

The suicide rate among 45 to 64-year-olds has only dropped below 12.0 per 100,000 twice since 2010; the highest rate was observed in 2014, at 13.9 per 100,000.

- After consistency from 2010 to 2015, the rate for 10 to 24-year-olds rose to 6.6 per 100,000 in 2017, an increase of nearly 25% since 2010 (5.3 per 100,000).



White males in the 25-44, 45-64, and 65+ age groups consistently have the highest suicide rates in New Jersey

- Despite fluctuations since 2010, the suicide rate in 2017 for White non-Hispanic males aged 45-64 is virtually unchanged at 27.8 per 100,000.
- After 5 years of increases, the suicide rate among younger White non-Hispanic males (25-44) dropped 30% from a high of 24.5 per 100,000 in 2015 to 17.1 in 2016, and remained almost same in 2017.
- White non-Hispanic females aged 45-64 also experienced a high suicide rate in 2015 (9.4 per 100,000) before dropping 16% to 7.9 in 2017.

Data Source: The New Jersey Violent Death Reporting System (NJVDRS) v.08222019; Center for Health Statistics & Informatics, NJDOH (Revised 10/22/2019) #NJVDRS

The New Jersey Violent Death Reporting System is supported by Cooperative Agreement 5 NU17CE002611-05 and 6 NU17CE924938-01 from the Centers for Disease Control and Prevention (CDC), NCIPC, Division of Violence Prevention.

Suicide in New Jersey
Weapons and Mechanisms

These figures appear in your packet. Please contact us for more data and information! NJVDRS@doh.nj.gov

There were 2,325 people who died by suicide in New Jersey, from 2015 to 2017.

Hanging, strangling, and suffocation: Includes asphyxiation by gases including helium, positional asphyxiation, plastic bags, and items wrapped around the neck such as ropes, leashes, belts, electrical cords, etc. This is the most common mechanism of suicide overall. It is the most common method in males under age 65 and is the most common method in females under age 45.

Firearm: Includes handguns, shotguns, and rifles. This is the 2nd most common mechanism of suicide overall and among males, and is the leading method among males 65 years and older. 90% of all firearm suicide deaths are male.

Poisoning: Includes drug overdoses, acute toxic effects by other substances such as anti-freeze, alcohols, bleach and other chemicals, and carbon monoxide. This is the 3rd most common mechanism of suicide overall, and 2nd among females. It is the leading cause of suicide death among females 45 years and older.

Jump/Fall from height: Includes those who died from impact injuries sustained following jumping or falling from a height, including from bridges, highway overpasses, parking decks, through windows, and from the roofs of buildings. This is the 4th most common mechanism among both males and females overall.

Sharp instrument: Includes a wide variety of tools and implements such as knives, razor blades, garden and woodworking tools, saws, scissors, and kitchen blades. Over 4 times as many males as females used a sharp instrument for suicide.

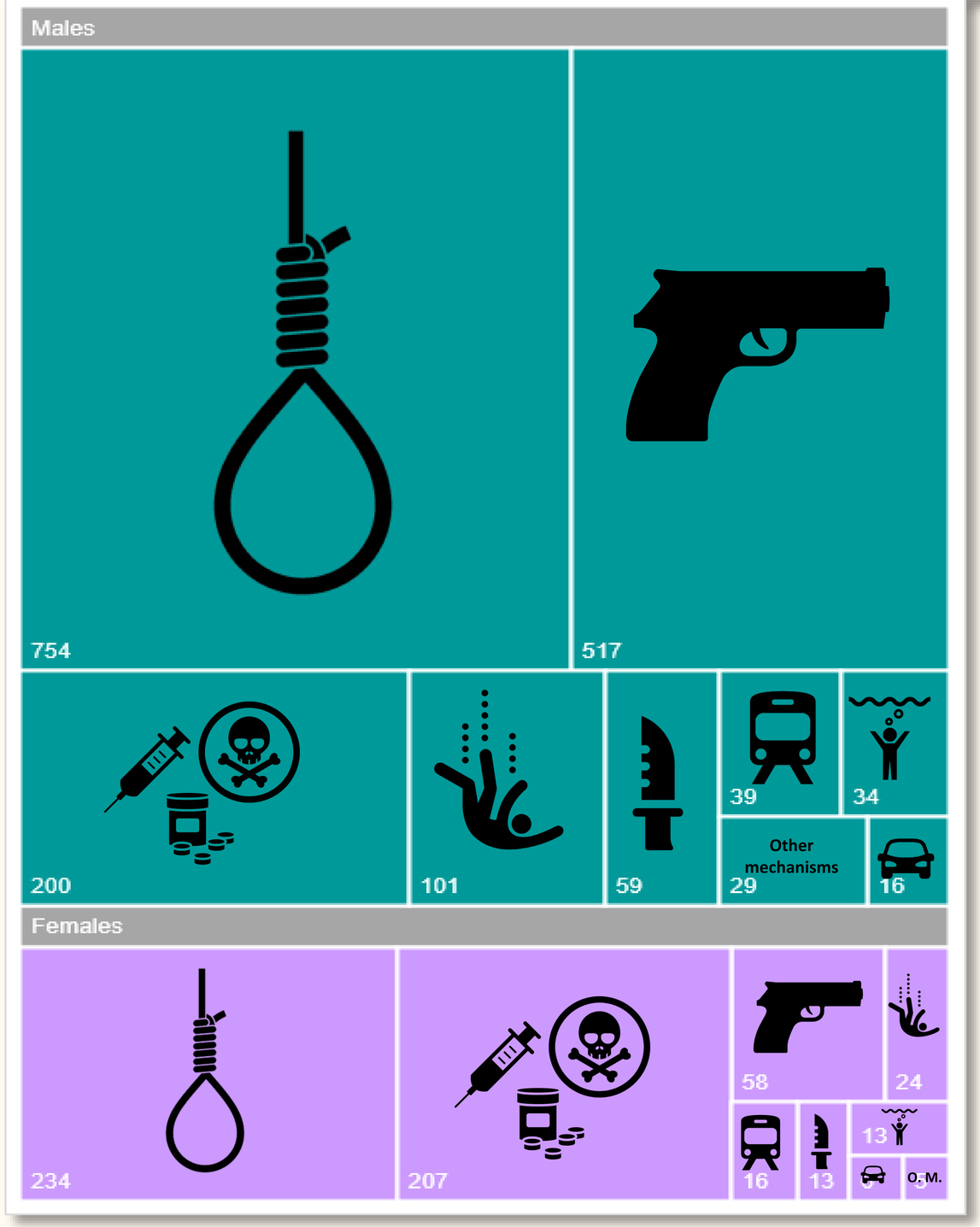
Other transportation: While this category could include several modalities, most of the deaths assigned to "other transportation" in New Jersey are due to train collisions with either pedestrians on the tracks or people in passenger cars sitting on railroad tracks. Nearly 2.5 times as many males as females died using this suicide mechanism.

Drowning: Drowning suicide deaths often present as complex mechanisms- those associated with another mechanism such as a jump or fall from a height, motor vehicle crashes, and drug overdoses. Drownings also occur in bathtubs and natural settings such as lakes, rivers, and the ocean.

Motor vehicle: This mechanism of injury includes drivers intentionally crashing into objects or driving over guardrails on bridges and overpasses, or pedestrians running or jumping into traffic and being struck by moving vehicle(s).

Other Injury Mechanisms

Other injury mechanisms: Includes death attributed to blunt force trauma, non-powder guns, fire/burns, and other and unknown weapons and mechanisms.



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Firearm suicide claimed 575 NJ lives in 2015-2017

How often did a firearm suicide involve…

These figures appear in your packet. Please contact us for more data and information! NJVDRS@doh.nj.gov

…a crisis?

38%

Suicide is often an impulsive act, frequently preceded by a crisis situation such as an argument or a break-up or in anticipation of an impending event such as a foreclosure or court date. Nearly 4 in 10 firearm suicides were related to a crisis situation, compared to 26% of non-firearm suicides.

…males?

90%

Males have consistently higher suicide rates than females in general and across age and race/ethnicity groups. The choice of firearm as a weapon is highly correlated to gender; 9 out of 10 firearm suicide deaths from 2015 to 2017 were male, whereas 7 out of 10 non-firearm suicides were male.

…someone over age 65?

32%

One-third of firearm suicides were over age 65, 2.5 times the number of non-firearm suicides. Firearm suicide among older New Jerseyans were frequently associated with:

- a crisis (30%)
- depressed mood (31%)
- physical health issue (55%)
- mental health issue (33%)
- left suicide note (32%)
- current mental health treatment (18%)

…someone with a physical health problem?

25%

1 in 4 firearm suicides were reported to have had a contributing physical health problem, compared to 14% of non-firearm suicides. While firearm suicides occurred more frequently among those age 65 and older, physical health problems in non-firearm suicides contributed to half of suicides among those age 45-64.

…an intimate partner problem?

22%

125 (22%) of firearm suicides involved an intimate partner problem, which could be an argument between current or former partners, a break-up, or other conflict. 18% of non-firearm suicides were related to intimate partner issues.

21 of these 125 firearm suicides in 2015-2017 were murder-suicides. All incidents had at least 2 people killed with a gun.

…a previous suicide attempt?

5%

Consistent with the often impulsive nature of firearm suicide, just 5% of decedents were reported to have had previous suicide attempts, in contrast to 18.4% of non-firearm suicides having reported a history of prior attempts.

…someone in mental health treatment?

21%

While 33% of non-firearm suicide decedents were reported to be in some kind of mental health treatment at the time of their death, just 21% of firearm suicide victims were reportedly in treatment.

…someone with either a drug or alcohol abuse problem?

17%

More than half (54%) of firearm suicides who had a reported drug or alcohol abuse problem had drugs (prescription, street, OTC) and/or alcohol in their systems at time of death.

…a handgun?

Over half

A little more than half of firearm suicides from 2015-2017 were reported to be due to a handgun. Another 12% involved shotguns, and about 6% involved rifles. Almost one-third of firearm suicides were missing specifics on the type of gun used. Improving data quality is an ongoing goal of NJVDRS and its partners.

…someone recently released from an institution?

3.8%

3.8% of firearm suicides from 2015-2017 mentioned a recent release from an institution such as jail, prison, hospital, or other residential and supervised facilities including psychiatric hospitals. This is comparable to the 4.4% of non-firearm suicides who were reported to have been recently released from a facility.

…someone experiencing a "current depressed mood"?

28%

A "current depressed mood" is defined differently than formal depression diagnoses; this circumstance may include the decedent being described as being "blue", "down", "sad", or "depressed" by friends and family. This percentage is similar to non-firearm suicides, where 25% are coded as experiencing a "current depressed mood".

…someone who disclosed intent?

17%

Those who died by firearm suicide were slightly more likely to have disclosed their intent to take their own lives than those who used another mechanism for suicide (17% vs 14%, respectively).

Data Source: The New Jersey Violent Death Reporting System (NJVDRS) v.08222019; Center for Health Statistics & Informatics, NJDOH #NJVDRS

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NJ Health New Jersey Department of Health

Suicide in New Jersey

Suicide does not occur in a vacuum…

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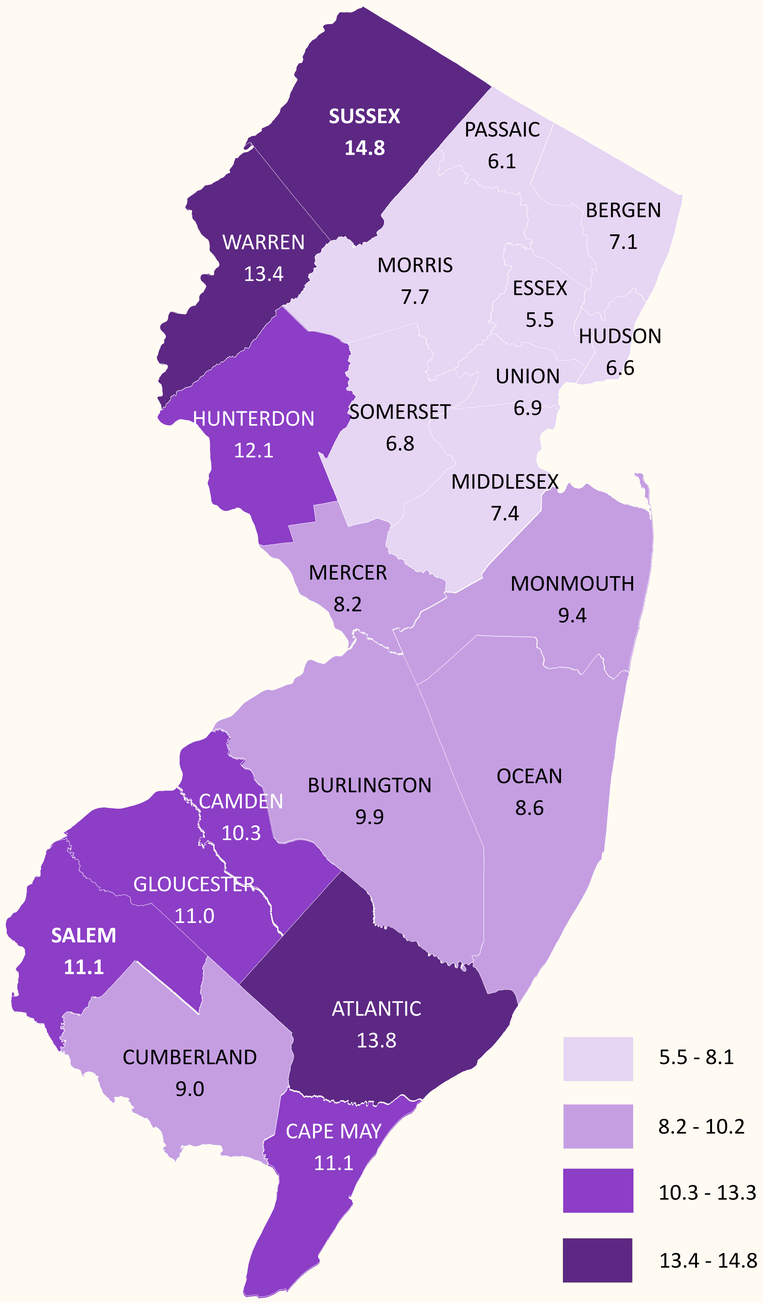
County suicide rates
New Jersey residents, 2015-2017



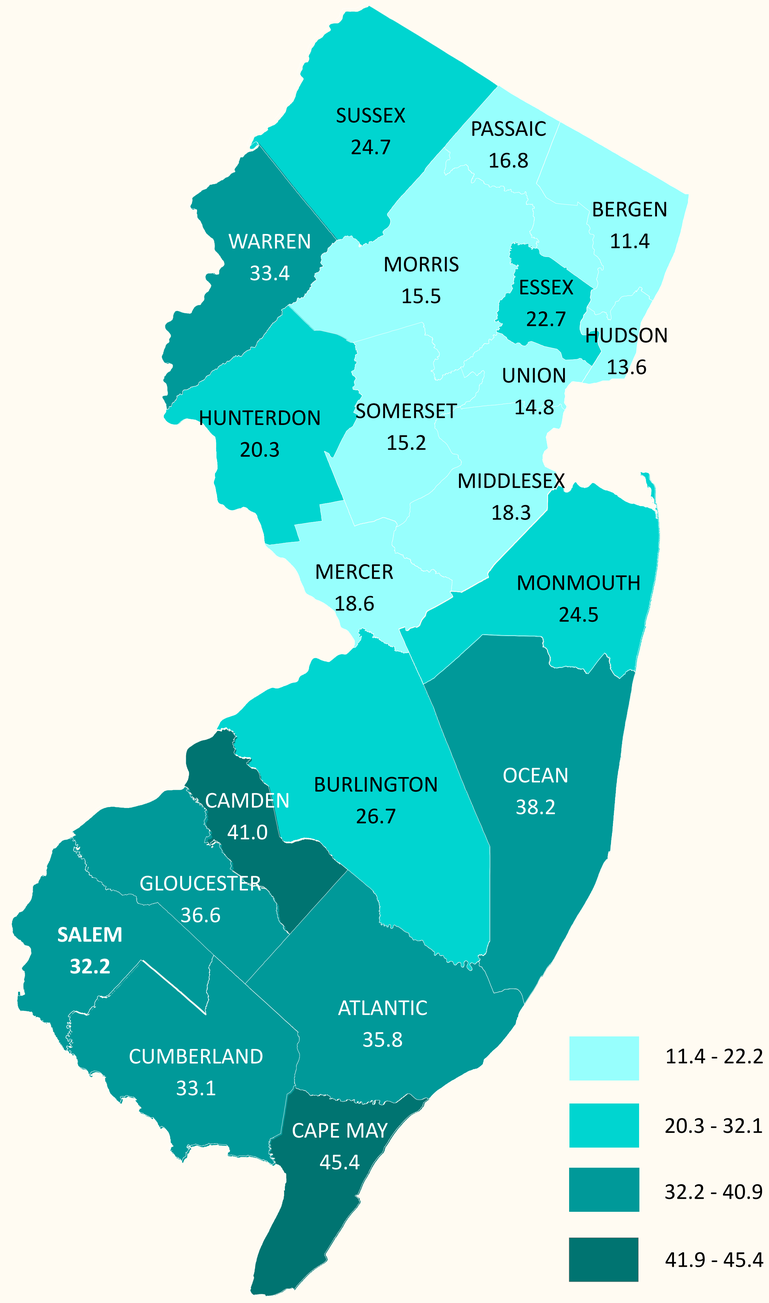
2015-2017 Direction	2012-2014 rate	County	2012-2014 rate	2015-2017 Direction
↑↑	12.5	ATLANTIC	22.3	↑↑
↓	7.8	BERGEN	8.3	↑
↓	10.0	BURLINGTON	15.4	↑↑
↑	9.6	CAMDEN	24.9	↑↑
↓↓↓	14.0	CAPE MAY	27.9	↑↑
↑	8.3	CUMBERLAND	16.6	↑↑↑
↓	6.0	ESSEX	10.7	↑↑↑+
↑	10.7	GLOUCESTER	25.3	↑
↑	6.1	HUDSON	7.7	↑↑↑
↑↑	10.1	HUNTERDON	7.1	↑↑↑+
↑↑↑	6.4	MERCER	9.6	↑↑↑
↑↑	6.4	MIDDLESEX	10.0	↑↑↑
↑↑	8.3	MONMOUTH	14.2	↑↑
↓	8.1	MORRIS	9.3	↑↑
↓↓↓	10.8	OCEAN	23.5	↑↑
↓↓	6.9	PASSAIC	10.1	↑↑
↓↓↓	17.1	SALEM	14.5	↑↑↑+
No change	6.8	SOMERSET	8.4	↑↑↑
↑↑↑	11.8	SUSSEX	10.9	↑↑↑+
↑	6.4	UNION	6.7	↑↑↑+
↑	13.1	WARREN	13.3	↑↑↑+

↑ Increase up to 10%
↑↑ Increase 10% up to 20%
↑↑↑ Increase 20% or more

↓ Decrease up to 10%
↓↓ Decrease 10% up to 20%
↓↓↓ Decrease 20% or more

↑ Increase 25% up to 50%
↑↑ Increase 50% up to 75%
↑↑↑ Increase 75% up to 100%
↑↑↑+ Increase more than double

County overdose rates
New Jersey residents, 2015-2017



Data Sources: Suicide - The New Jersey Violent Death Reporting System (NJVDRS) v.08222019; Center for Health Statistics & Informatics, NJDOH (Revised 10/22/2019) #NJVDRS
Overdose – Retrieved Thu, 05 September 2019 from Department of Health, New Jersey State Health Assessment Data Web site: https://nj.gov/health/shad #NJSHAD

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Suicide in New Jersey
Locations Matter

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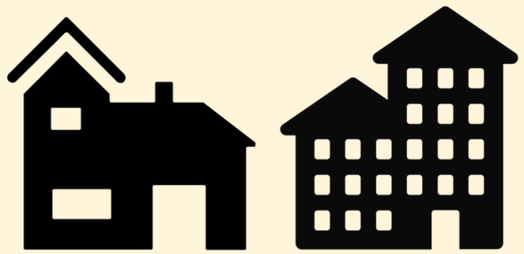
HOME, APARTMENT



At *a* home — 1,604 people, 69%

At *decedent's* home — 1,542 people, 66%

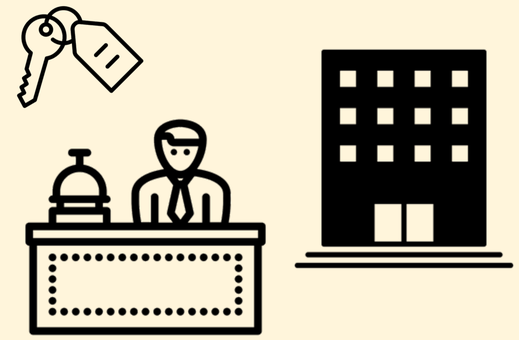
"Home" may include the living spaces, driveway, front porch, and backyard.

Fatal injury occurred in a natural areas such as in the woods, in a body of water, along cliffs and ravines, etc. Often people jump over barriers or bridges and land in these places.

113 people, 5%

NATURAL LOCATION

HOTEL OR MOTEL



60 people, 2.6%

Fatal injury occurred at a hotel or motel; the decedent may have been living in the motel at the time.

IN CUSTODY

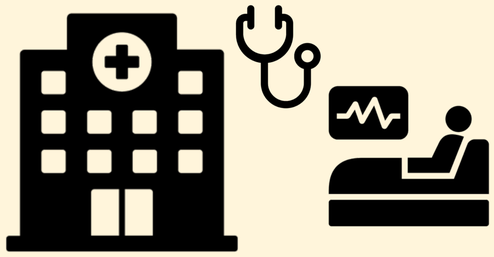
Injury occurred while in custody, which includes jail, prison, or under arrest but not in yet jail.

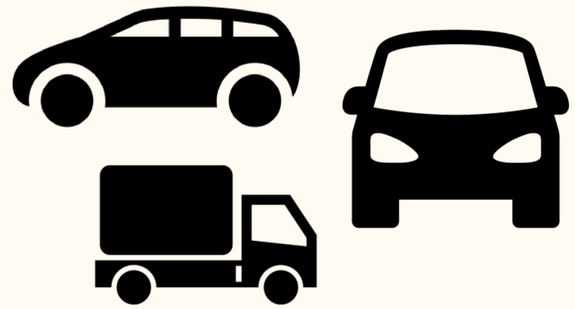
37 people, 1.6%

HOSPITAL OR MEDICAL CENTER

4 people, <1%

Injury itself occurred at a hospital or medical center; the victim does not have to have been a patient at the time of the incident.





MOTOR VEHICLE

Injury occurred in a motor vehicle, on the street, in a driveway, parking lot, or parking garage. Excludes those who are purposely struck by moving vehicles.

71 people, 3%

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Suicide Research and Resources
Primary Care

This information is included in your packet. Please contact us for more information

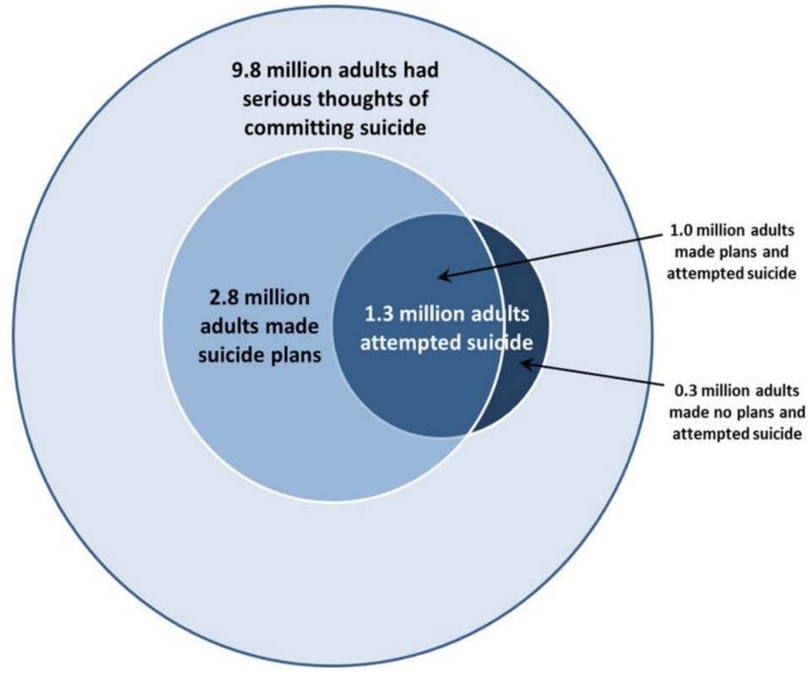
Primary care is the setting in which Americans receive most of their health and behavioral health care. Frequent contacts and long-standing relationships between primary care providers (PCPs) and their patients make primary care an ideal setting for suicide prevention.

One long-standing study found *"…contact with primary care providers in the time leading up to suicide is common. While three of four suicide victims had contact with primary care providers within the year of suicide, approximately one-third of the suicide victims had contact with mental health services. About one in five suicide victims had contact with mental health services within a month before their suicide. On average, 45% of suicide victims had contact with primary care providers within 1 month of suicide. Older adults had higher rates of contact with primary care providers within 1 month of suicide than younger adults." (emphasis added)* (Source: Am J Psychiatry. 2002 June ; 159(6): 909–916)

Another study from 2014 found that 83% of people who died by suicide had made a health care visit within the year of their death, and 49.9% had made a medical visit within 4 weeks of death.
(Source: J Gen Intern Med. 2014: 29(6): 870-877)

Past Year Suicidal Thoughts and Behaviors Among U.S. Adults (2017)

Data Courtesy of SAMHSA



Source: National Institute of Mental Health
https://www.nimh.nih.gov/health/statistics/suicide.shtml

Why Address Suicide Prevention in the Primary Care setting?

- People who die by suicide are more likely to have seen a PCP in the previous month before their death than any other health care provider.
- For a patient at risk for suicide, a visit with the PCP may be the only chance to access needed care.
- National health care improvement efforts (e.g., patient-centered medical homes) are providing new ways to integrate suicide prevention into primary care.

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Primary Care

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HOW PRIMARY CARE PROVIDERS CAN TAKE ACTION

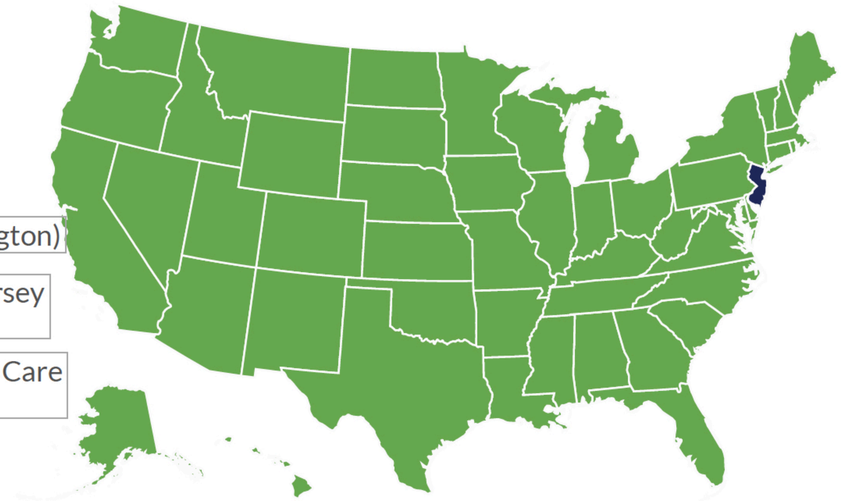
The best way to prevent suicide is to use a comprehensive approach that includes these key components:

- Establish protocols for screening, assessment, intervention, and referral
- Train all staff in suicide care practices and protocols, including safety planning and lethal means counseling
- Create agreements with specific behavioral health practices that will take referrals
- Ensure continuity of care by transmitting patient health information to emergency care and behavioral health care providers to create seamless care transitions and follow up with at-risk patients by phone between visits
- Provide information on the New Jersey Suicide Prevention Lifeline crisis line and services

NEW JERSEY MEMBERS

In New Jersey, there are 5 crisis centers which are members of the Lifeline...

- CONTACT We Care (Westfield)
- CONTACT of Burlington County (Moorestown)
- CONTACT of Mercer County (Pennington)
- Mental Health Association of New Jersey (Verona)
- Rutgers University Behavioral Health Care (Piscataway)



Source: National Suicide Prevention Lifeline State Lifeline Reports (July-December 2018)
http://www.sprc.org/resources-programs/state-lifeline-reports

Crisis Intervention and Support

- Individuals seeking immediate crisis assistance should call the Suicide Prevention Lifeline at 1-800-273-TALK (8255).
- The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals.
- Adolescents seeking immediate crisis assistance should call 1-855-654-6735 or visit the www.njhopeline.com
- The Hopeline is New Jersey's dedicated in-state peer support and suicide prevention hotline staffed by mental health professionals and peer support specialists 24 hours a day, seven days a week.

NJ Health New Jersey Department of Health

Suicide Research and Resources
Primary Care

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RESOURCES TO GET YOU STARTED:

Education and Training

Preventing Suicide in Emergency Department Patients: This free, online course is based on the ED Consensus Guide and teaches professionals who work in emergency departments how to conduct screening, assessment, and brief interventions with patients at risk of suicide. It also addresses patient-centered care for patients with suicide risk, patient safety during the ED visit, and incorporating suicide prevention into discharge planning. This course was created in partnership with the Massachusetts Department of Public Health Bureau of Healthcare Quality and Suicide Prevention Resource Center (SPRC).

The **Suicide Prevention Resource Center (SPRC)**, funded by SAMHSA, provides technical assistance, training, and materials to increase the knowledge of professionals serving people at risk for suicide.

The **SPRC Training Institute** has a variety of available trainings from research to practice webinars to free online trainings to workshops that focus on suicide prevention among specific populations, including for LGBT youth and youth in juvenile justice facilities. The institute also offers a one-day curriculum for mental health professionals on assessing and managing suicide risk. SPRC also offers a database of local community and state-based **prevention resources**

Counseling on Access to Lethal Means (CALM): Access to lethal means can determine whether a person who is suicidal lives or dies. This free, online course helps providers develop effective safety plans for people at risk of suicide. This course was produced through a collaboration between the Harvard Injury Control Research Center; SPRC; the Dartmouth Injury Prevention Center; and the developers of the original CALM workshop, Elaine Frank and Mark Ciocca.

The American Association of Suicidology offers trainings on recognizing and responding to suicide risk and recognizing the warning signs, including **Recognizing and Responding to Suicide Risk: Essential Skills in Primary Care (RRSR-PC),** a one-hour training program that provides physicians, nurses/nurse practitioners, and physicians assistants with the knowledge they need in order to integrate suicide risk assessments into routine office visits, to formulate relative risk calculations, and to work collaboratively with patients to create treatment plans.

Mental Health First Aid is an eight-hour course that teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives the course participant the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.

National Resource Center on Domestic Violence (RCDV) is supported by HHS, with supplemental funds from the CDC and others to provide technical assistance, resources, and an online learning center to educate on domestic violence interventions and prevention efforts.

THE ABOVE RESOURCES CAN BE DOWNLOADED AT:
https://www.integration.samhsa.gov/clinical-practice/suicide-prevention-update

Recommended Resources

Suicide Prevention Toolkit for Primary Care Practices:
This toolkit contains the information and tools needed to implement state-of-the-art suicide prevention practices in primary care settings.
https://www.sprc.org/resources-programs/suicide-prevention-toolkit-rural-primary-care

CALM: Counseling on Access to Lethal Means
This free online course is designed to help mental health professionals counsel people at risk for suicide—and their families—on reducing access to lethal means.
https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

Safety planning guide: A quick guide for clinicians
This guide shows how to work with patients at high risk for suicide to develop a safety plan.
https://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians

Zero Suicide website
This website provides information, resources, and tools for implementing Zero Suicide.
https://www.sprc.org/resources-programs/zero-suicide-website

Training resource guide for suicide prevention in primary care settings
This guide is designed to support county efforts to engage primary care in suicide prevention.
https://www.sprc.org/resources-programs/training-resource-guide-suicide-prevention-primary-care-settings

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)
This center supports the development of integrated primary and behavioral health care services through a wide variety of resources.
https://www.sprc.org/resources-programs/samhsa-hrsa-center-integrated-health-solutions-cihs

NJ Health New Jersey Department of Health