DCF YOUTH SUICIDE BRIEF

2020 to 2022

REPORT RECOMMENDATIONS

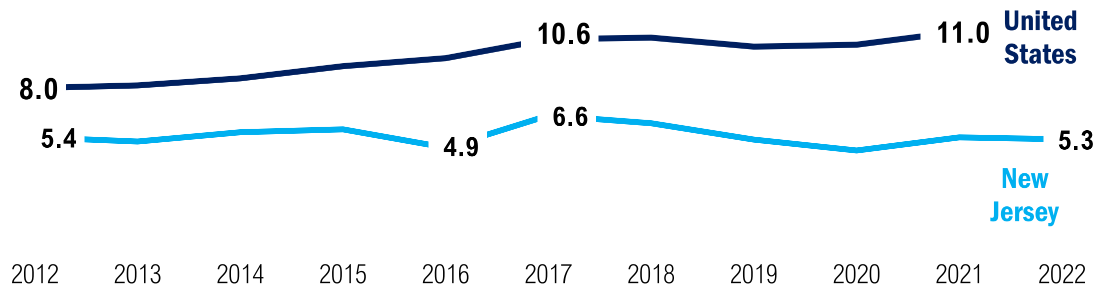
Every life lost to suicide is a tragedy. The New Jersey Department of Children and Families (DCF) is committed to preventing youth suicide and helping families be safe, healthy, and connected. While New Jersey's rate of youth suicide is low when compared to national rates overall, continued and enhanced support services, collaboration with local communities and data collection are needed to holistically serve the youth of New Jersey.

THEMES	HIGHLIGHTS	RECOMMENDATIONS
UNDERSTAND NEED	▪ In New Jersey: ○ Male youth suicide rates were 3 times higher than female rates. However, female youth attempted suicide more often. ○ Female youth and Black non-Hispanic youth are seen in Emergency Departments and hospitalized for suicide attempt-related injuries more often than any other race or gender. ○ Suicide was the third leading cause of death for youth 10 to 24 years old ▪ Nationally, high school students who identified as LGBT reported attempting suicide at a rate 5 times higher than heterosexual students.	▪ Streamline **data collection** and information sharing to better inform communities and youth serving providers. ▪ Utilize **feedback & input** from providers and **people with lived experience** to better understand unmet needs. ▪ **Encourage collaboration** among youth serving agencies and providers to bridge gaps in youth mental health care. ▪ **Identify** areas within New Jersey that have lower levels of engagement in mental health services. ▪ Implement **treatment** and **prevention** efforts that meet the needs of the groups and/or individuals being served.
PREVENTION EFFORTS	▪ Over **sixty percent** of all youth who died by suicide between 2020-2022 had a known mental health challenge at the time of their death. ▪ **Asphyxiation** was the most common method of suicide. ▪ The second most common causes of suicide were **Firearms** among males, and **poisonings** among females.	▪ Reduce access to **lethal means** through education such as **gun safety** and **medication use**, storage, purchasing and disposal.
PROVIDER'S ROLE	▪ Understand social, behavioral and environmental **risk factors** for youth suicide. ▪ Share local resources focused on improving youth's protective factors.	▪ Implement **screening** and risk assessment tools among mental, behavioral, and medical professionals working with youth. ▪ **Educate** youth serving providers on how to identify warning signs and risk factors while treating youth. ▪ Share resources with parents/caregivers to increase awareness and provide support in the youth's home environment. ▪ Youth serving providers should implement **safety planning and lethal means assessment** to assist in ongoing case planning for youth.

SUICIDE RATES

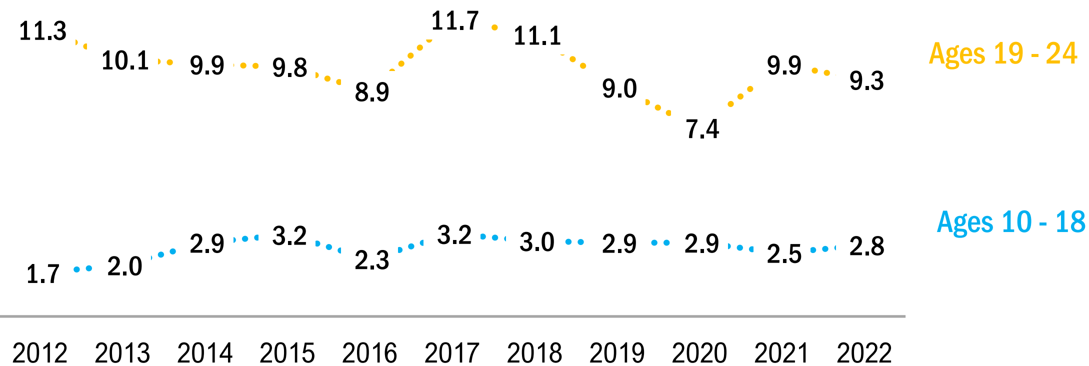
Youth suicide rates remained relatively stable in NJ through 2022.

National (WISQARS data) vs. New Jersey (NJVDRS) Youth Suicide Rates Among 10-24-Year-Olds, 2012-2022;



Suicide rates among older youth in NJ decreased from 2017-2020, but increased from 2020 to 2021.

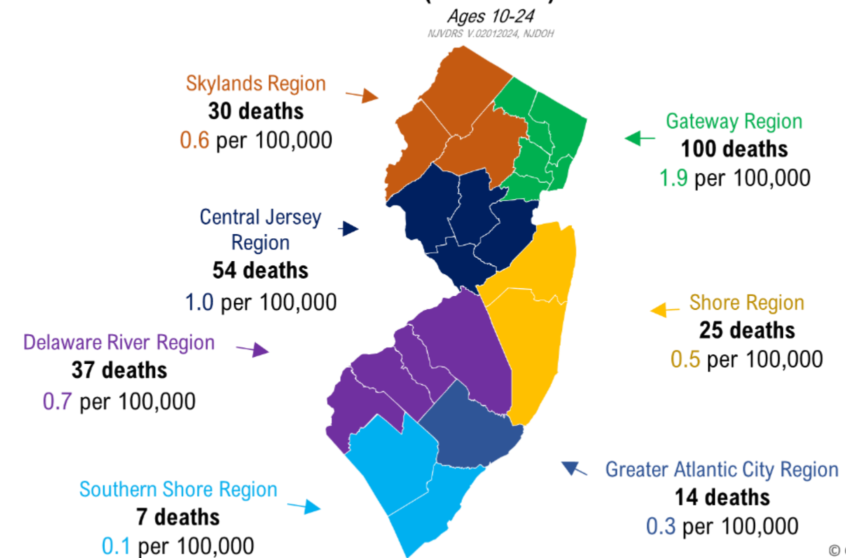
Youth suicide rates by age group, New Jersey, 2012 - 2022; NJVDRS v12272023, NJDOH



This report reflects deaths by suicide and suicide attempts among youth, ages 10 to 24 years, that occurred between 2020 to 2022. In this brief, **suicide** refers to a death caused by self-inflicted injury with the intent to die. This report includes the time periods during which the COVID-19 pandemic occurred. The pandemic had significant, negative effects on the mental health of individuals, families, and communities around the world. New Jersey youth continued to face challenges shared by youth across the nation, but rates of youth suicide in New Jersey in 2022 remained stable to those observed in 2019 (5.3 per 100,000 youth).

In 2021, suicide was among the top three causes of death in both New Jersey and the United States among children aged 10 to 24 (WISQARS, 2021). Most New Jersey youth suicides occurred among males (75%) at a rate of 7.6 per 100,000 youth. Suicide rates among older New Jersey male youth (ages 19 to 24) were **4.5 times** greater than females in the same age group; rates of suicide in males in younger age groups (ages 10 to 18) were **2 times** greater than females.

NJ Youth Suicides by Region of Residence (2020-2022)



Suicide rates were 3 times higher in males than females in NJ*.

Youth suicide rates by sex, ages 10-24, New Jersey, 2020 - 2022; NJVDRS v.09052023, NJDOH

**Current data collection identifies sex as male and female and does not account for gender identity*

Youth suicide rates in NJ by Race/Ethnicity.

Youth suicide age-adjusted rates by age and race, New Jersey, 2020 - 2022; NJVDRS v.09052023, NJDOH

Race/Ethnicity	NJ Count of Youth Suicides	NJ Rate of Youth Suicides per 100,000 Youth
White non-Hispanic	133	5.4
Black non-Hispanic	35	4.8†
Hispanic	54	3.9
Asian/Pacific Islander	31	6.2†
Other Races Not Listed	15	*
Total	**268**	**5.1**

†Rates with upper and lower confidence intervals greater than 30% from the rate estimate may be too volatile to draw conclusions from. In this table, rates for Black non-Hispanic and Asian/Pacific Islander are sensitive to changes in number of suicides and thus may fluctuate. These rates should be used with caution.

**Rates are not calculated for fewer than 20 observations.*

A review of three-year rolling average rates of youth suicide* by race showed that rates were highest among Asian/Pacific Islander (6.2) and White Non-Hispanic (5.4) youth. Asian/Pacific Islander youth had the biggest increase in average rates from 2010-2012 (3.3), nearly doubling by 2020-2022 (6.2). Average rates in 2020-2022 for White (5.4) and Black (4.8) youth have both decreased since 2010-2012 (5.8 and 5.9, respectively). Between 2017 and 2022, rates of youth suicide across all races dropped (see Graph 8A in Appendix 2).

**Rates per age-adjusted 100,000 youth*

RISK FACTORS FOR YOUTH SUICIDE

The American Foundation for Suicide Prevention (2023) identifies risk factors for suicide related to individual health, environment, and historical factors, such as depression, prolonged stress like that caused by harassment or bullying, and previous suicide attempts or childhood abuse. Despite this, it is important to acknowledge the ways in which some populations may have greater exposure to specific risk factors.

In the past two decades, suicide rates for Asian/Pacific Islander youth (5-24 years) in the US has doubled, rising from 3.6 to 7.1 per 100,000 youth, with an increasing trend starting in 2014 (Reyes, et al., 2024). Specific risk factors for poor mental health include cultural stigma, underreporting of depressive symptoms, low orientation to US culture, and high parental conflict (Wyatt et al., 2015).

The Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health outlined mental health trends in Black youth and found trauma to be a risk factor that can commonly impact Black youth, such as exposure to racism, neighborhood violence, and economic insecurities. Compared to other communities, trauma is experienced disproportionately in Black communities and is likely to be more severe.

In 2021, the rate of high school students identifying as lesbian, gay, or bisexual who reported attempting suicide was five times higher than the suicide attempt rate for heterosexual students (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2023). According to the CDC's report on the Youth Risk Behavior Survey, the rates of seriously considering, planning, and attempting suicide were all higher among female LGBTQ+ students when compared to heterosexual female students (Gaylor EM, Krause KH, Welder LE, et al., 2023).

The Trevor Project's 2023 U.S. National Survey on the Mental Health of LGBTQ Young People surveyed 28,000 young people ages 13- 24 across the US and found 41% of LGBTQ young people seriously considered attempting suicide in the past year. Additionally, 56% of LGBTQ young people who wanted mental health care in the past year were not able to get it.

Young people and adolescents are especially at risk in the face of mental health challenges. Suicide often stems from a dynamic and unique combination of risk factors. Increasing awareness of protective factors and providing integrated care can help mitigate risk. Risk factors are characteristics or conditions that can increase the chance that someone may try to take their own life. Warning signs are changes in someone's existing behaviors or new behaviors, for example, isolating from friends and family (American Foundation for Suicide Prevention, 2023). When protective factors are increased, people are less likely to have a suicide attempt, however, no single risk or protective factor can fully predict someone's risk of suicide (Suicide Prevention Resource Center, 2020). To increase protective factors it is important to include education and awareness on ways to increase resiliency, limiting access to lethal means, targeting prevention for high-risk groups within communities, improving mental health treatment, and providing crisis line information and other resources (Bilsen, 2018)

WARNING SIGNS	RISK FACTORS	PROTECTIVE FACTORS
❖ **Talking about:** ○ **Killing oneself** ○ **Feeling hopeless** ○ **Feeling like a burden** ○ **Having no reason to live** ❖ **Mood changes, depression, anxiety, and/or agitation** ❖ **Increased substance use** ❖ **Withdrawing from activities** ❖ **Isolating from family and friends** ❖ **Sleeping too much or not enough** ❖ **Giving away prized possessions** ❖ **Irritability**	❖ Specific mental health diagnoses such as Depression and Bipolar Disorder ❖ Issues with substance use ❖ Poor ability to maintain relationships ❖ Serious physical health conditions that involve pain ❖ Access to lethal means including firearms and drugs ❖ Exposure to prolonged stress, including through harassment, bullying, relationship problems or unemployment ❖ Discrete stressful life events such as rejection or immediate financial crisis ❖ Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide ❖ Previous suicide attempts ❖ Family history of suicide ❖ Childhood abuse, neglect, or trauma	❖ Access to mental health care ❖ Problem solving and stress management skills that promote resilience ❖ Limited access to lethal means ❖ Connectedness to family and community support ❖ Supportive relationships with caregivers ❖ Cultural and religious beliefs that encourage help-seeking behavior & create a strong sense of self ❖ Knowledge of adolescent development for both adults and youth ❖ Concrete support in times of need ❖ Cognitive and social-emotional competence

American Academy of Pediatrics. (2022, February 04). *Risk Factors, Protective Factors, Warning Signs of Youth Suicide. American Academy of Pediatrics. Retrieved November 8, 2023,* from [Risk Factors, Protective Factors, Warning Signs of Youth Suicide (aap.org)]

American Academy of Pediatrics. (2022, February 04). *Risk Factors, Protective Factors, Warning Signs of Youth Suicide. American Academy of Pediatrics. Retrieved November 8, 2023,* from [Risk Factors, Protective Factors, Warning Signs of Youth Suicide (aap.org)]American Foundation for Suicide Prevention. (2022, March 30). *Risk factors, protective factors, and warning signs*. American Foundation for Suicide Prevention. Retrieved July 22, 2022, from https://afsp.org/risk-factors-protective-factors-and-warning-signs ; Youth Thrive Protective Promotive Factors. (2018) https://cssp.org/wp-content/uploads/2018/08/youth-thrive-protective-promotive-factors.pdf . American Academy of Pediatrics. (2022, February 04). *Risk Factors, Protective Factors, Warning Signs of Youth Suicide. American Academy of Pediatrics. Retrieved November 8, 2023,* from [Risk Factors, Protective Factors, Warning Signs of Youth Suicide (aap.org)]

COMMON METHODS & SUBSTANCES USED IN SUICIDES

The most common method of suicide for youth in New Jersey was asphyxiation (which includes hanging, strangling, and suffocation) (50%), followed by firearms (17%), which were utilized primarily by males. Poisonings (19% vs. 8%) were more frequent in female compared to male suicides and falls (9% vs. 7%) were more frequent in male compared to female suicides.

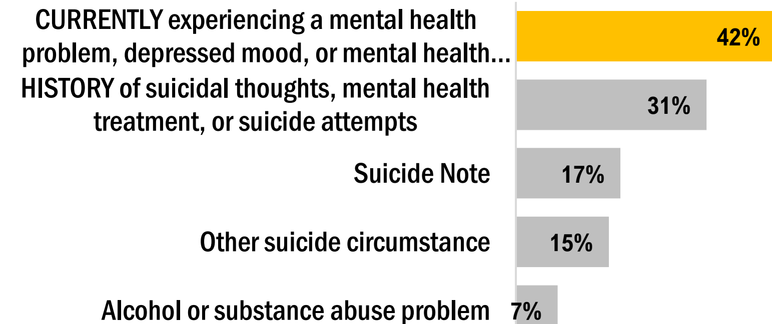
While there has been an increase in unintentional deaths due to the misuse or combination of illicit, prescription, and over-the-counter medications, or other potentially toxic substances in New Jersey, some fatal drug overdoses and poisonings are suicides. In addition to prescribed and over-the-counter medications, 12 youth utilized readily accessible chemicals and gases for suicide. Chemicals used during 2020-2022 included sodium azide, sodium nitrate, and cyanide. Gases included nitrous oxide, helium, difluoroethane and unspecified gases or vapors.

Some of these chemicals and gases can be found in everyday products. Sodium nitrate is used as an ingredient in fertilizers and pyrotechnics, and as a food preservative (National Center of Biotechnology Information, 2024). In a ten-month study, almost one third of the products listed on the Environmental Protection Agency's List of Extremely Hazardous Substances were available to be purchased online. Additionally, one third of those substances (31 total) were sold in single units that equated to toxic amounts. Of the 31 available substances, only 4 required a business account for purchase (Leonard, Hines, Anderson, 2019).

Safety from lethal means is a pivotal component to suicide prevention. Time between thinking about and acting out a suicide attempt can be just a few minutes. Making lethal means, like a firearm or poisonous substance, less accessible during a time of crisis can potentially result in the attempt not being made (Delphin-Rittmon, 2023). Though researchers have noted that "reducing access to a "preferred" method for suicide can reduce attempts and deaths for many, but not all, suicidal individuals, educating caregivers, youth-serving professionals, and youth and families alike on how to restrict lethal means and increasing awareness of warning signs remains crucial for suicide prevention (Morris-Perez et al, 2023; Hawton, 2007; Yip et al., 2012).

Suicide is a complex issue with multiple factors contributing to risk. Over sixty percent of all youth that died by suicide from 2020 – 2022 were facing known challenges at the time of their death including previous suicide attempts, mental health issues, problems at school, violence, and/or substance use problems. In 17% of suicides that occurred during this timeframe, suicide notes were reported, and in 7% there was a known alcohol or substance abuse problem.

Mental health challenges were the most frequently reported characteristics associated with youth who died by suicide in New Jersey



Top 5 youth suicide associated characteristics, New Jersey, 2020 - 2022; NJVDRS v. 12272023, NJDOH

SUICIDE ATTEMPTS & SELF-INFLICTED INJURIES

A **suicide attempt** is an incident in which someone harms themselves with the intent to end their life, but they do not die as a result of their actions.

A suicide attempt is not the same as a self-inflicted injury and/or self-harm. However, in this report, reference to a "**suicide attempt**" includes records of suicide attempts and/or self-inflicted injuries as defined by the International Classification of Diseases, 10th Revision (ICD-10-CM) in which individuals are either treated and released in the Emergency Department or discharged from the hospital after inpatient care for treatment of the injury[1].

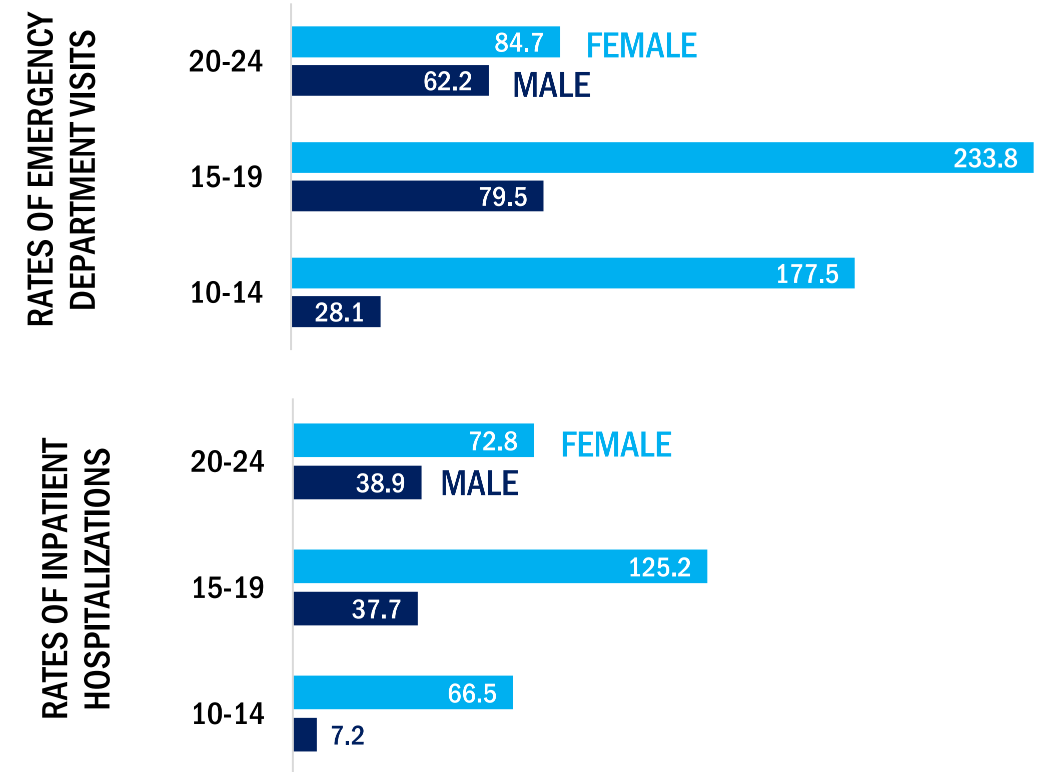
Results of the CDC's 2019 and 2021 Youth Risk Behavior Surveys have highlighted that the prevalence of suicidal thoughts and behaviors among male students has remained steady during this time period. However, there have been increases observed among subgroups of male students, along with significant increases among female students in relation to suicidal thoughts, plans, and attempts. Rising rates of suicide risk among females may be linked to intensified feelings of social isolation and anxiety during the COVID-19 pandemic (Gaylor EM, Krause KH, Welder LE, et al. 2023).

The average cost of treating physical injuries from youth suicide attempts in NJ hospitals was over $61.5 thousand per patient from 2020-2022.

Per visit and total costs for hospitalizations and ED visits for non-fatal suicide attempts/self-inflicted injuries in NJ, 2020-2022; NJVDRS New Jersey Hospital Discharge Data Collection System, Inpatient and ED data NJDOH

	Inpatient Hospitalizations	Emergency Department Visits
Males Ages 10-24	**COST: $56,966,464** *TOTAL VISITS: 746*	**COST: $13,974,422** *TOTAL VISITS: 1,515*
Females Ages 10-24	**COST: $127,582,354** *TOTAL VISITS: 2,254*	**COST: $41,022,946** *TOTAL VISITS: 4,228*
Total Treatment Cost	**COST: $184,548,818** *TOTAL VISITS: 3,000*	**COST: $54,997,368** TOTAL VISITS: 5,743

Females aged 15-19 had the highest rates of ED & Inpatient utilization for suicide attempts
(Out of all youth seen in ED or inpatient for a suicide attempt)

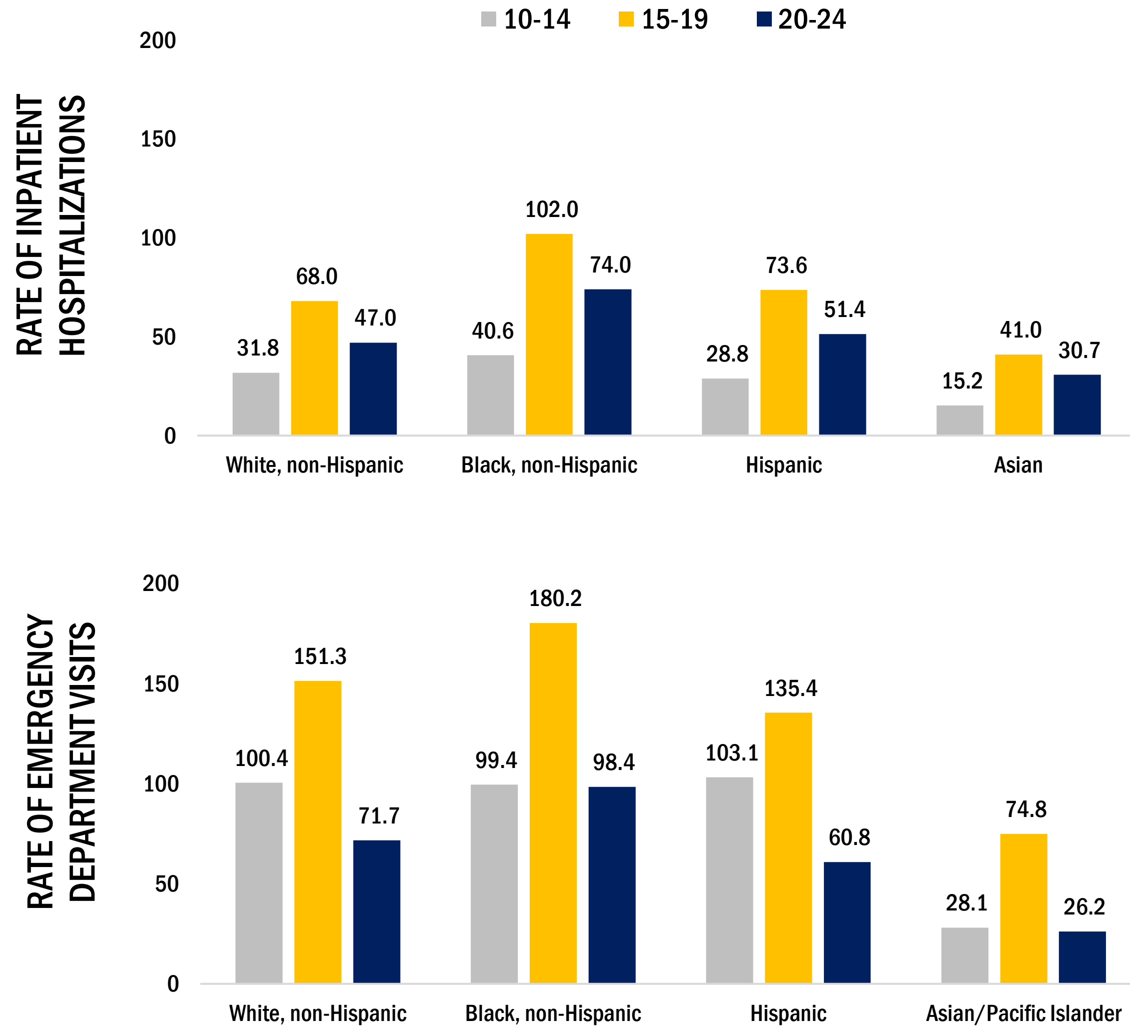


Rates of suicide attempts resulting in hospitalizations or treatment in emergency departments by age group and sex in NJ per 100,000 age-specific population, 2020-2022; NJVDRS New Jersey Hospital Discharge Data Collection System, NJDOH

[1] As of 2023 a new ICD code that addresses instances such as cutting without a suicide attempt has been added to the list of classifications. As more data become available on youth seen in the Emergency Department or the hospital for inpatient care under this updated ICD code, future reports will reflect clearer distinctions between these behaviors.

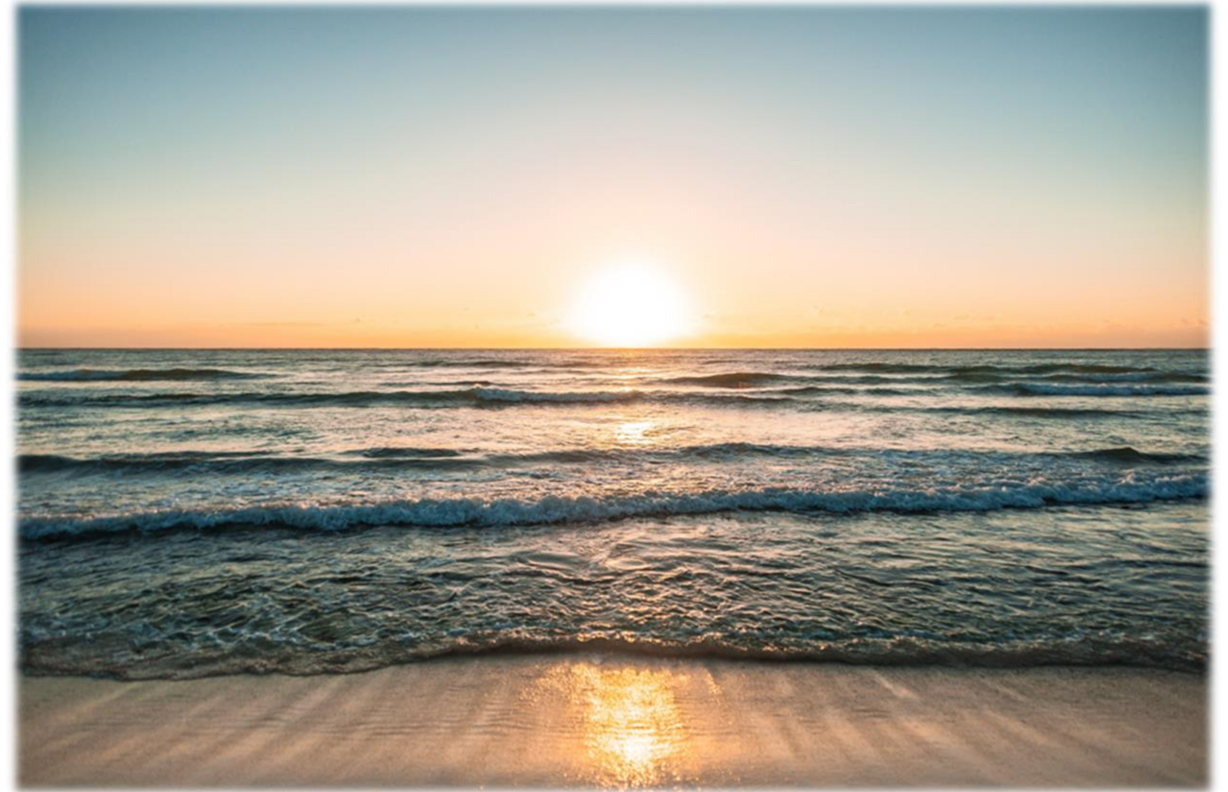
Rates of Youth Suicide Attempts treated in inpatient settings were highest among Black youth across all age groups

Suicide attempts resulting in hospitalizations or treatment in emergency departments by age group and race in NJ per 100,000 age-specific population, 2020-2022; NJVDRS New Jersey Hospital Discharge Data Collection System, NJDOH



In New Jersey, female youth and Black non-Hispanic youth are seen in the Emergency Department and inpatient hospitalizations for suicide attempt-related injuries at higher rates than any other gender or race. Data from 2021 YRBS show significant increases in the prevalence of Black, Hispanic, and White female students who considered attempting suicide between 2019 and 2021. Increased prevalence of suicidal behaviors during this time has been suggested to be linked to substance misuse, family issues, relationship problems, discrimination, and a lack of access to mental health services at schools due to COVID-19 closures (Gaylor EM, Krause KH, Welder LE, et al., 2023).

MOVING FORWARD



New Jersey will continue to support communities and youth mental health by putting a concerted focus on:

- Understanding the specific needs, risks, and challenges among youth and families
- Engaging stakeholders, providers, and community members in prevention efforts
- Continuing to move our prevention efforts further upstream

New Jersey has a variety of resources that can support youth, families, and communities including, but not limited to, services accessible through the New Jersey Department of Children and Families' *Children's System of Care*, the 2NDFLOOR Youth Helpline, the Traumatic Loss Coalition, NJ Statewide Student Support Services (NJ4S), as well as the national 988 suicide and crisis lifeline.

For more information about this report, please email: DCF-Suicide.Prevention@dcf.nj.gov

SUICIDE RESOURCES IN NEW JERSEY

RESOURCE	DESCRIPTION	WHO MIGHT FIND THIS USEFUL	CONTACT
988 Lifeline	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. The service is available to callers of all ages for confidential telephone support (except when a suicide attempt is in progress), assessment, and referral. 988 is a few and confidential support number for people in suicide crisis or emotional distress.	Anyone	www.njhopeline.com Call or Text: **988**
Crisis Text line	Crisis Text Line is a free, 24/7 support for people of all ages in crisis.	Anyone	Text “NJ” to **741741** from anywhere in the US to connect with a trained Crisis Counselor.
New Jersey Youth Suicide Prevention Advisory Council	The Council’s purpose is to: examine existing needs and services and to make recommendations for youth suicide reporting, prevention and intervention; advise on the content of informational materials to be made available to people who report attempted or completed suicides, and advise in the development of regulations	Anyone	DCF-Suicide.Prevention@dcf.nj.gov
Anonymous Youth Suicide Event Reporting	Under NJ Statute 30:9A-24 any teacher, school staff member, mental health provider, or a professional person working with youth, who obtain information through their employment to have suspicion or reasonable cause that a youth has attempted or died by suicide is to report that non-identifying information into the event form.	Anyone	Anon Reporting Form
Prevent Suicide New Jersey	Prevent Suicide NJ (PSNJ) is the state’s most comprehensive resource for suicide prevention. PSNJ strives to collaborate with state departments, professional and community organizations, schools and families to reduce suicide, diminish the stigma of suicide, and support those touched by suicide.	Anyone	About Us - Prevent Suicide NJ
Society for the Prevention of Teen Suicide	SPTS is dedicated to increasing awareness, saving lives and reducing the stigma of suicide through specialized training programs and mental health resources that **empower students, parents, school staff and community members** with the skills needed to help youth build a life of resiliency	Anyone	The Society for the Prevention of Teen Suicide
Trevor Project	The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13 to 24.	Youth	www.thetrevorproject.org
2NDFLOOR Youth Helpline	Accredited by the American Association of Suicidology, 2NDFLOOR serves youth and young adults through anonymous hotline, text, and message board. Youth who call are assisted with their daily life challenges by professional staff and trained volunteers.	Youth	www.2ndfloor.org Call or Text 24/7 at 1-888-222-2228
Traumatic Loss Coalition	TLC offers collaboration opportunities and support to professionals working with school-age youth via education, training, consultation and coalition building to reduce suicide attempts and suicides, promote recovery of persons affected by suicide, and provide guidance and support in response to a traumatic event.	Youth-Serving Organizations	Traumatic Loss Coalitions for Youth Program (TLC) (rutgers.edu)
Screening and Screening Outreach Programs	Available in each county 24-hours a day, seven-days a week to individuals in emotional crisis needing immediate attention. An individual may be seen without an appointment or be brought to the screening center by a parent, friend, spouse, law enforcement official, mental health worker or any other concerned individual.	Parents or Guardians	Department of Human Services | Division of Mental Health and Addiction Services Home (nj.gov)
DCF’s Division of Children’s System of Care (CSOC)	CSOC provides information and treatment referral support to families in crisis. For more information, visit: https://www.nj.gov/dcf/families/csc/.	Parents or Guardians	Perform Care :1-877-652-2764
Pediatric Psychiatry Collaborative	The PPC builds capacity and comfort for pediatric primary care providers to screen, identify, and provide care management related to mental/behavioral health care for their patients, as well as psychiatric evaluation, consultation, and linkage for services.	Pediatric Primary Care Providers	https://njaap.org/mental-health-ppcwelcome/

Appendix 1. References

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Appendix 2: Data Tables

TABLE 1. WISQARS SUICIDE RATE, UNITED STATES AND NEW JERSEY, AGES 10-18 AND 19-24 YEARS, 2001-2021

YEAR	United States Age Groups						New Jersey Age Groups					
	10-18		19-24		Total		10-18		19-24		Total	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
2001	1,393	3.7	2,850	11.9	4,243	6.9	13	**	52	8.9	65	4.0
2002	1,327	3.5	2,943	12.1	4,270	6.9	14	**	39	6.6	53	3.2
2003	1,279	3.4	2,953	12.0	4,232	6.7	17	**	48	8.0	65	3.9
2004	1,469	3.8	3,130	12.5	4,599	7.3	32	2.9	52	8.6	84	4.9
2005	1,406	3.7	3,076	12.2	4,482	7.0	20	1.8	55	9.0	75	4.4
2006	1,293	3.4	3,112	12.3	4,405	6.9	18	**	47	7.6	65	3.8
2007	1,227	3.2	3,093	12.2	4,320	6.8	20	1.8	57	9.2	77	4.5
2008	1,337	3.5	3,176	12.4	4,513	7.0	20	1.8	46	7.3	66	3.8
2009	1,461	3.8	3,169	12.2	4,630	7.2	22	2.0	46	7.2	68	4.0
2010	1,449	3.8	3,418	13.1	4,867	7.6	27	2.5	65	10.0	92	5.3
2011	1,563	4.1	3,541	13.3	5,104	7.9	27	2.5	58	8.8	85	4.9
2012	1,585	4.2	3,593	13.3	5,178	8.0	20	1.9	73	11.0	93	5.4
2013	1,636	4.4	3,628	13.3	5,264	8.1	21	2.0	67	10.0	88	5.1
2014	1,783	4.8	3,732	13.7	5,515	8.5	30	2.9	64	9.5	94	5.5
2015	1,867	5.0	4,033	15.0	5,900	9.2	31	3.0	64	9.5	95	5.6
2016	2,016	5.4	4,143	15.6	6,159	9.6	23	2.3	58	8.7	81	4.8
2017	2,332	6.2	4,437	16.9	6,769	10.6	31	3.1	77	11.7	108	6.4
2018	2,379	6.3	4,428	17.0	6,807	10.7	30	3.0	72	11.1	102	6.1
2019	2,144	5.7	4,344	16.7	6,488	10.2	28	2.8	57	8.8	85	5.2
2020	2,157	5.6	4,486	17.4	6,643	10.3	31	2.9	51	7.7	82	4.7
2021	2,287	5.9	4,839	18.8	7,126	11.0	25	2.4	67	10.2	92	5.3

WISQARS, CDC (SEPTEMBER 2023). Prepared by the New Jersey Violent Death Reporting System, Center for Health Statistics, NJDOH
Rates are per 100,000 age-specific population. 1999 to 2016 are coded with ICD-10 (X64-X84, Y87.0, U03).

TABLE 2. NJVDRS SUICIDE RATE, NEW JERSEY, AGES 10-18 AND 19-24 YEARS, 2013-2012

YEAR	Age Groups					
	10-18		19-24		10-24	
	N	Rate	N	Rate	N	Rate
2013	2	**	28	4.8	59	10.5
2014	5	**	34	5.9	58	10.2
2015	8	**	30	5.3	61	10.7
2016	7	**	24	4.3	51	9.1
2017	8	**	39	7.0	63	11.3
2018	8	**	27	4.9	67	12.2
2019	8	**	29	5.2	50	9.2
2020	7	**	34	5.7	41	7.2
2021	6	**	29	5.0	60	10.4
2022*	6	**	31	5.4	54	9.4

New Jersey Violent Death Reporting System (NJVDRS) v. 09052023, Center for Health Statistics, NJDOH
Rates are per 100,000 age-specific population.
**rate not calculated due to fewer than 20 observations

TABLE 3. SUICIDES BY AGE GROUP AND SEX, NEW JERSEY, 2020-2022

SEX	Age Groups							
	10-14		15-19		20-24		10-24	
	N	Rate	N	Rate	N	Rate	N	Rate
MALE	7	**	68	7.5	127	14.4	202	7.6
FEMALE	12	**	25	2.9	28	3.3	65	2.5
TOTAL	19	**	94	5.4	155	9.0	268	5.1

New Jersey Violent Death Reporting System v. *09052023*, Center for Health Statistics, NJDOH.
Rates are per 100,000 age-specific population. If the range of upper and lower confidence intervals (indicated by the brackets) are greater than 30% from the rate estimate, rate(s) may be too volatile to draw conclusions.
† Error estimate rate is greater than 30%
**Rate not calculated due to fewer than 20 observations

TABLE 4. SUICIDES BY SEX AND METHOD/WEAPON USED, AGES 10 - 24, NEW JERSEY, 2020-2022

METHOD/WEAPON	Sex of Youth					
	Male		Female		All Youth	
	N	%	N	%	N	%
ASPHYXIATION *(INCLUDES HANGING, STRANGLING, SUFFOCATION)*	82	51.4%	26	56.4%	108	52.7%
FIREARM	56	22.7%	7	1.3%	63	17.1%
POISONING	16	8.2%	19	19.2%	35	11.1%
FALL	18	8.6%	2	6.4%	20	8.1%
TRANSPORT *(INCLUDES MOTOR VEHICLE, TRAIN)*	16	4.1%	7	9.0%	23	5.4%
OTHER *(INCLUDES SHARP INSTRUMENT, DROWNING, FIRE OR BURN)*	12	3.2%	3	6.4%	15	4.0%
UNKNOWN WEAPON	2	1.8%	1	1.3%	3	1.7%

New Jersey Violent Death Reporting System v. 09052023, Center for Health Statistics, NJDOH.

TABLE 5. NON-FATAL SUICIDE ATTEMPTS/SELF-INFLICTED INJURIES RESULTING IN HOSPITALIZATION, BY AGE GROUP AND SEX, NEW JERSEY, 2020-2022

SEX OF YOUTH	Age Groups							
	10-14		15-19		20-24		10-24	
	N	Rate	N	Rate	N	Rate	N	Rate
MALE	64	7.2	340	37.7	342	38.9	746	27.9
FEMALE	567	66.5	1,069	125.2	618	72.8	2,254	88.2
TOTAL	631	26.2	1,409	80.2	960	55.6	3,000	57.4

NJVDRS, New Jersey Hospital Discharge Data Collection System, Inpatient Data, NJDOH. Rates are per 100,000 age-specific population.

TABLE 6. NON-FATAL SUICIDE ATTEMPTS/SELF-INFLICTED INJURIES TREATED IN THE EMERGENCY DEPARTMENT AND RELEASED, BY AGE GROUP AND SEX, NEW JERSEY, 2020-2022

SEX OF YOUTH	Age Groups							
	10-14		15-19		20-24		10-24	
	N	Rate	N	Rate	N	Rate	N	Rate
MALE	241	28.1	717	79.5	547	62.2	1,515	56.7
FEMALE	1,513	177.5	1,996	233.8	719	84.7	4,228	165.5
TOTAL	1,764	101.1	2,713	154.5	1,266	73.3	5,743	109.8

NJVDRS, New Jersey Hospital Discharge Data Collection System, Emergency Department Data, NJDOH . Rates are per 100,000 age-specific population.

TABLE 7. MOST COMMON SUBSTANCES INVOLVED IN FATAL SUICIDAL OVERDOSES, NEW JERSEY, 2020-2022

SUBSTANCE	Youth Ages 10 - 24 N
RX OPIOID-INVOLVED [1]	4
ILLICIT OPIOID-INVOLVED	3
ANY OPIOID-INVOLVED	6
BENZODIAZEPINE-INVOLVED	3
ANTIDEPRESSANT-INVOLVED	10
RX-INVOLVED, NON-OPIOID	17
ALCOHOL-INVOLVED	4
NSAID-INVOLVED (ACETAMINOPHEN, IBUPROFEN, NAPROXEN)	5
GASES AND VAPORS 3,4 (NITROUS OXIDE, HELIUM, NITROGEN, DIFLUOROETHANE, UNSPECIFIED)	4
CHEMICAL (SODIUM AZIDE, SODIUM NITRATE/ITE, CYANIDE)	8
TOTAL NUMBER OF SUICIDES INVOLVING DRUGS, CHEMICALS, AND GASES	**39**

TABLE 8. SUICIDES BY AGE GROUP AND RACE/ETHNICITY, NEW JERSEY, 2020-2022

RACE/ETHNICITY	Age Groups							
	10-14		15-19		20-24		10-24	
	N	Rate	N	Rate	N	Rate	N	Rate
WHITE NON-HISPANIC	10	**	49	5.8	74	8.8	133	5.4
BLACK NON-HISPANIC	1	**	10	**	24	9.4	35	4.8
HISPANIC	2	**	20	4.4	32	7.4	54	3.9
ASIAN	2	**	13	**	16	**	31	6.2
NATIVE HAWAIIAN & OTH PAC ISLANDER	*	*	*	*	*	*	*	*
MULTIPLE RACES (2 OR MORE)	3	**	*	*	8	**	11	**
OTHER RACE	1	**	1	**	1	**	3	**
UNKNOWN	*	*	1	**	*	*	1	**
TOTAL	19	**	94	5.4	155	9.0	268	5.1

New Jersey Violent Death Reporting System 09052023, Center for Health Statistics, NJDOH. If the range of upper and lower confidence intervals (indicated by the brackets) is greater than 30% from the rate estimate, rate(s) may be too volatile to draw conclusions.
† Error estimate rate is greater than 30%
**Rate not calculated due to fewer than 20 observations

Graph 8A. 3-YEAR ROLLING AVERAGE RATE YOUTH SUICIDES BY RACE & ETHNICITY IN NJ 2010-2022

AVERAGE YOUTH SUICIDE RATE

6.0
4.0
2.0
0.0

2010-2012 | 2011-2013 | 2012-2014 | 2013-2015 | 2014-2016 | 2015-2017 | 2016-2018 | 2017-2019 | 2020-2022

Asian/ Pacific Islander
White Non-Hispanic
Black, Non-Hispanic
Hispanic

New Jersey Violent Death Reporting System v.08222022, Center for Health Statistics, NJDOH.

TABLE 9A. NON-FATAL SUICIDE ATTEMPTS/SELF-INFLICTED INJURIES TREATED INPATIENT IN NEW JERSEY HOSPITALS, BY AGE GROUP AND RACE/ETHNICITY, NEW JERSEY, 2020-2022

RACE/ETHNICITY	Age Groups							
	10-14		15-19		20-24		10-24	
	N	Rate	N	Rate	N	Rate	N	Rate
WHITE, NON-HISPANIC	250	31.8	573	68.0	394	47.0	1,217	49.3
BLACK, NON-HISPANIC	96	40.6	240	102.0	188	74.0	524	72.2
HISPANIC	139	28.8	338	73.6	223	51.4	700	50.9
ASIAN	27	15.2	68	41.0	48	30.7	143	28.6
NATIVE HAWAIIAN & OTH PAC ISL	1	**	3	**	2	**	6	**
AMERICAN INDIAN & AK NATIVE	-	-	6	**	3	**	9	**
MULTIPLE RACES (2 OR MORE)	5	**	11	**	1	**	17	**
OTHER RACE(S)	53		100		78		231	
UNKNOWN RACE	60		70		23		153	
TOTAL	631	26.2	1,409	80.2	960	55.6	3,000	57.4

NJVDRS, New Jersey Hospital Discharge Data Collection System, Inpatient Data, NJDOH. Rates are per 100,000 age-specific population. Rate for "other" and "unknown" not calculated due to lack of equivalent denominator. Race and ethnicity in hospital discharge data are known to be incomplete, and these data should be used with caution.
**rate not calculated due to fewer than 20 observations

TABLE 9B. NON-FATAL SUICIDE ATTEMPTS/SELF-INFLICTED INJURIES TREATED IN NEW JERSEY EMERGENCY DEPARTMENTS, BY AGE GROUP AND RACE/ETHNICITY, NEW JERSEY, 2020-2022

RACE/ETHNICITY	Age Groups							
	10-14		15-19		20-24		10-24	
	N	Rate	N	Rate	N	Rate	N	Rate
WHITE NON-HISPANIC	790	100.4	1,274	151.3	601	71.7	2,665	108.0
BLACK NON-HISPANIC	235	99.4	424	180.2	250	98.4	909	125.2
HISPANIC	498	103.1	622	135.4	264	60.8	1,384	100.5
ASIAN	50	28.1	124	74.8	41	26.2	215	43.0
NATIVE HAWAIIAN & OTH PAC ISL	3	**	4	**	1	**	8	**
AMERICAN INDIAN & AK NATIVE	4	**	2	**	2	**	8	**
MULTIPLE RACES (2 OR MORE)	20	35.1	18	**	5	**	43	29.1
OTHER RACE(S)	109		164		74		347	
UNKNOWN RACE	55		81		28		164	
TOTAL	1,764	101.1	2,713	154.5	1,266	73.3	5,743	109.8

NJVDRS New Jersey Hospital Discharge Data Collection System, Emergency Department Data, NJDOH. Rates are per 100,000 age-specific population. Rate for "Other" and "Unknown" not calculated due to lack of equivalent denominator. Race and ethnicity in Hospital Discharge data are known to be incomplete, and these data should be used with caution.
**Rate not calculated due to fewer than 20 observations

TABLE 10A. FREQUENTLY REPORTED SUICIDE CIRCUMSTANCES BY SEX AND AGE GROUP, NEW JERSEY, 2020-2022

SUICIDE CIRCUMSTANCE	Male Age Groups								Female Age Groups								All Youth	
	10-14		15-19		20-24		10-24		10-14		15-19		20-24		10-24		10-24	
	N	%^	N	%^	N	%^	N	%^	N	%^	N	%^	N	%^	N	%^	N	%^
Crisis within 2 weeks	*	**	*	**	8	6%	12	6%	*	**	*	**	*	**	*	**	13	5%
Current depressed mood (dx & no dx)	*	**	5	7%	13	10%	19	9%	*	**	*	**	*	**	6	9%	25	9%
Current mental health problem	*	**	15	22%	27	21%	43	21%	*	**	9	36%	9	32%	22	34%	65	24%
Current mental health treatment	*	**	7	10%	10	8%	17	8%	*	**	*	**	*	**	5	8%	22	8%
History of mental health treatment	*	**	10	15%	13	10%	23	11%	*	**	*	**	*	**	5	8%	28	10%
Substance abuse problem	*	**	*	**	13	10%	13	6%	*	**	*	**	*	**	*	**	14	5%
Alcohol problem	*	**	*	**	5	4%	6	3%	*	**	*	**	*	0%	*	0%	6	2%
Either alcohol or substance abuse problem	*	**	*	**	17	13%	17	8%	*	**	*	**	1	4%	1	2%	18	7%
History of suicide attempts	*	**	9	13%	6	5%	15	7%	*	**	*	**	5	18%	10	15%	25	9%
History of suicidal thoughts	*	**	5	7%	10	8%	16	8%	*	**	6	24%	5	18%	13	20%	29	11%
Disclosed intent	*	**	*	**	6	5%	10	5%	*	**	*	**	*	**	*	**	13	5%
Suicide note	*	**	10	15%	23	18%	34	17%	*	**	*	**	6	21%	11	17%	45	17%
Intimate partner problem	*	**	*	**	10	8%	12	6%	*	**	*	**	*	**	*	**	12	4%
Family stressors	*	**	*	**	6	5%	8	4%	*	**	*	**	*	**	*	**	10	4%
Other suicide circumstance	2	25%	12	18%	18	14%	32	16%	3	25%	4	16%	1	4%	8	12%	40	15%
Number of suicides in age group	8		67		128		203		12		25		28		65		268	
Number of suicides w/ known circs	4		39		81		124		7		17		18		42		166	
% of suicides w/ known circs		50%		58%		63%		61%		58%		68%		64%		65%		62%
Circumstances with fewer then 5 observations	Recent death of friend or family, School problem, Financial problem, Physical health problem, Recent criminal legal problem, Perpetrator of interpersonal violence, and Eviction or loss of home																	
Circumstances with zero observations	Recent suicide of friend or family, Job problem, Legal problem, Other relationship problem, Victim of interpersonal violence, Other addiction, Anniversary of traumatic event, and History of childhood sexual abuse.																	

NEW JERSEY VIOLENT DEATH REPORTING SYSTEM v.12272023, Center for Health Statistics, NJDOH.

^Percent of all suicides. Circumstances are updated as new information becomes available; these are minimum estimates. *Number suppressed due to fewer than 5 observations ** Percentage suppressed due to fewer than 5 observations

TABLE 10B. FREQUENTLY REPORTED SUICIDE CIRCUMSTANCES BY GENDER AND AGE GROUP, NEW JERSEY, 2020-2022

Suicide Circumstance	10-14			15-19			20-24		
	N	%*	Gender (M/F)	N	%*	Gender (M/F)	N	%*	Gender (M/F)
Crisis within 2 weeks	*	**		*	**		9	6%	
Current depressed mood	*	**		7	8%		17	11%	
Current mental health problem	5	25%		24	26%		36	23%	
Current mental health treatment	*	**		9	10%		11	7%	
History of mental health treatment	*	**		12	13%		14	9%	
Substance abuse problem	*	**		*	**		14	9%	
Alcohol problem	*	**		*	**		5	3%	
Either alcohol or substance abuse problem	*	**		*	**		18	12%	
History of suicide attempts	*	**		13	14%		11	7%	
History of suidical thoughts	*	**		11	12%		15	10%	
Disclosed intent	*	**		5	5%		6	4%	
Suicide note	*	**		14	15%		29	19%	
Physical health problem	*	**		*	**		5	3%	
Intimate partner problem	*	**		*	**		10	6%	
Family stressors	*	**		*	**		7	4%	
Other suicide circumstance	5	25%		16	17%		19	12%	
Suppressed categories due to fewer than 5 observations:	Recent death of friend or family, School problem, Financial problem, Recent criminal legal problem, Job problem, Perpetrator of interpersonal violence, and Eviction or loss of home.								

New Jersey Violent Death Reporting System v.12272023, Center for Health Statistics, NJDOH.

*^Percent of all suicides. Circumstances are updated as new information becomes available; these are minimum estimates. *Number suppressed due to fewer than 5 observations. ** Percent suppressed due to fewer than 5 observations. Bars show male vs female percentages of reported circumstance with light blue representing males and dark blue indicating females.*

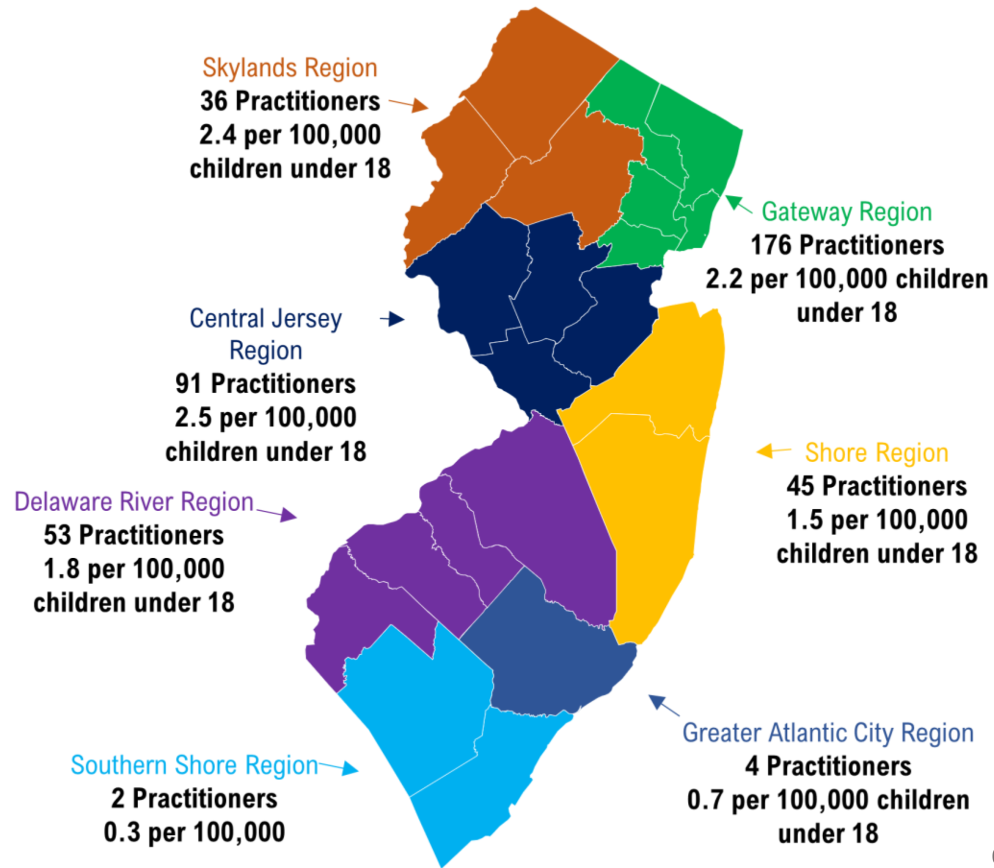
TABLE 11. NON-FATAL SUICIDE ATTEMPTS/SELF-INFLICTED INJURIES RESULTING IN TREATMENT IN THE EMERGENCY DEPARTMENT OR INPATIENT HOSPITAL, BY AGE GROUP, SEX AND COUNTY OF RESIDENCE, NEW JERSEY 2020-2022

COUNTY	Inpatient Hospital Treatment for Youth Ages 10 - 24						Emergency Department Treatment for Youth Ages 10 - 24					
	Male		Female		All Youth		Male		Female		All Youth	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate
ATLANTIC	30	37.4	62	80.6	92	58.5	54	67.3	179	232.6	233	148.2
BERGEN	59	22.0	188	73.2	247	47.0	91	33.9	361	140.5	452	86.1
BURLINGTON	36	27.9	133	109.4	169	67.4	83	64.3	183	150.5	266	106.1
CAMDEN	55	36.5	217	149.8	272	92.0	71	47.1	172	118.8	243	82.2
CAPE MAY	4	**	20	96.1	24	56.1	6	**	38	182.7	44	102.8
CUMBERLAND	22	47.3	53	121.3	75	83.1	45	96.7	104	238.1	149	165.2
ESSEX	82	31.6	277	111.4	359	70.6	151	58.1	463	186.2	614	120.7
GLOUCESTER	17	**	48	52.3	65	34.6	28	29.1	116	126.4	144	76.6
HUDSON	45	25.9	148	89.7	193	57.0	56	32.3	229	138.8	285	84.2
HUNTERDON	7	**	25	74.4	32	46.4	27	76.5	69	205.4	96	139.3
MERCER	33	27.5	88	75.6	121	51.2	70	58.4	174	149.4	244	103.3
MIDDLESEX	52	19.9	165	65.9	217	42.4	147	56.3	429	171.3	576	112.7
MONMOUTH	61	32.9	149	84.0	210	57.9	98	52.8	283	159.5	381	105.0
MORRIS	44	30.1	126	90.7	170	59.6	71	48.6	235	169.1	306	107.4
OCEAN	36	19.9	123	71.7	159	45.2	172	95.2	420	244.9	592	168.1
PASSAIC	48	30.0	167	107.2	215	68.1	107	66.9	208	133.6	315	99.8
SALEM	6	**	7	**	13	**	14	**	26	150.1	40	112.3
SOMERSET	28	27.7	56	58.6	84	42.7	45	44.5	145	151.7	190	96.6
SUSSEX	17	**	45	120.7	62	80.9	31	78.8	87	233.4	118	154.0
UNION	56	33.1	134	82.6	190	57.3	111	65.6	217	133.7	328	98.9
WARREN	8	**	23	80.0	31	53.0	36	121.1	89	309.6	125	213.7
TOTAL	746	27.9	2,254	88.2	3,000	57.4	1,515	56.7	4,228	165.5	5,743	109.8

NJVDRS NEW JERSEY HOSPITAL DISCHARGE DATA COLLECTION SYSTEM, INPATIENT DATA AND EMERGENCY DEPARTMENT DATA, NJDOH. Rates are per 100,000 age-specific population.
* number suppressed due to fewer than 5 observations and complimentary cells **rate not calculated due to fewer than 20 observations

FIGURE 12: PRACTICING CHILD AND ADOLESCENT PSYCHIATRISTS PER CHILD POPULATION UNDER 18, BY REGION OF RESIDENCE, 2020-2022

Source: AMA Health Workforce Mapper (Physician data from AMA Physician Professional Data, February 2023); 2022 Population Estimates from US Census, Vintage July 2023



Counties with fewer than 5 practitioners: Atlantic, Cape May, Cumberland, Gloucester, Hunterdon, Sussex; Salem and Warren have 0 practitioners