2025

Suicide Epidemiological Profile

Developed: October 2025

CONNECTICUT
Mental Health & Addiction Services

CPES
Center for Prevention Evaluation and Statistics

Table of Contents

INTRODUCTION	02
PREVALENCE	05
RISK & PROTECTIVE FACTORS	10
EFFECTS & CONSEQUENCES	15
CONCLUSIONS & CONSIDERATIONS	18
ADDITIONAL RESOURCES	19
GLOSSARY	20
REFERENCES	22

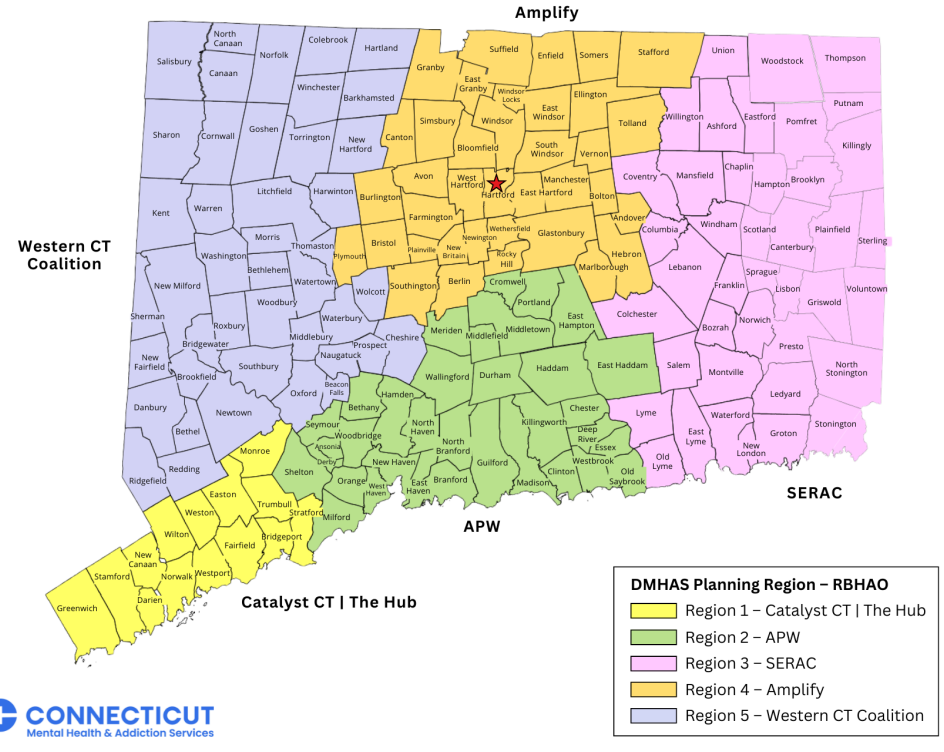
INTRODUCTION

As of 2023, suicide was the 15th leading cause of death in Connecticut. Furthermore, suicide was the fourth leading cause of death among individuals ages 10-54 and the second leading cause of death among young adults (18-34) in the state.[1]

***Suicide** is a death caused by injuring oneself with the intent to die. A **suicide attempt** is self-directed violence that co-occurs with an intent to die from intentional self-harm. Suicide attempts may or may not result in a physical injury or death. **Suicidal ideation** is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide that may not co-occur with intentional self-harm or suicide.*[2]

This epidemiological profile aims to explore the scope of suicide in Connecticut. Data about suicidal ideation, attempts, and deaths, as well as risk and protective factors and effects and consequences, have been synthesized to present a high-level summary. In addition, the profile examines suicide across demographic groups and DMHAS planning regions.

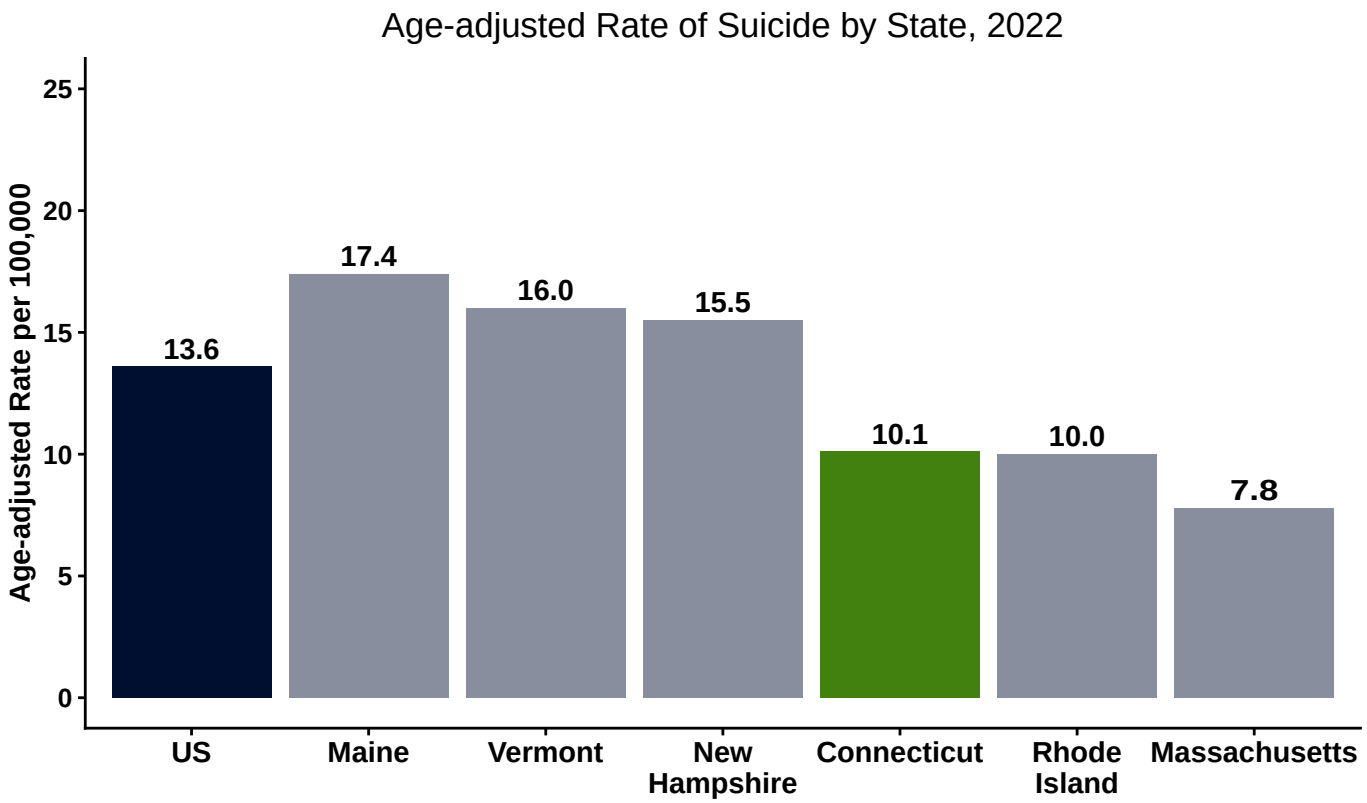
Connecticut consists of five planning regions, designated by the Department of Mental Health and Addiction Services (DMHAS), each of which is managed by a Regional Behavioral Health Action Organization (RBHAO).



BACKGROUND

Connecticut's suicide rate has increased over the past two decades. The age-adjusted suicide rate per 100,000 people in Connecticut increased by 45% between 2000 and 2020.[3] Although the rate has plateaued in recent years, the state's suicide rate in 2022 was more than double its homicide rate of 4.1 per 100,000.[4]

Connecticut's suicide rate is lower than the national rate. In 2022, the age-adjusted suicide rate in the United States (US) was 13.6 per 100,000, while Connecticut's rate was 10.1 per 100,000.[1] Data from 2022 highlight that, compared to other New England states, Connecticut's age-adjusted suicide rate was higher than Massachusetts but in line with Rhode Island and lower than Maine, New Hampshire, and Vermont.



Source: National Violent Death Reporting System, 2022

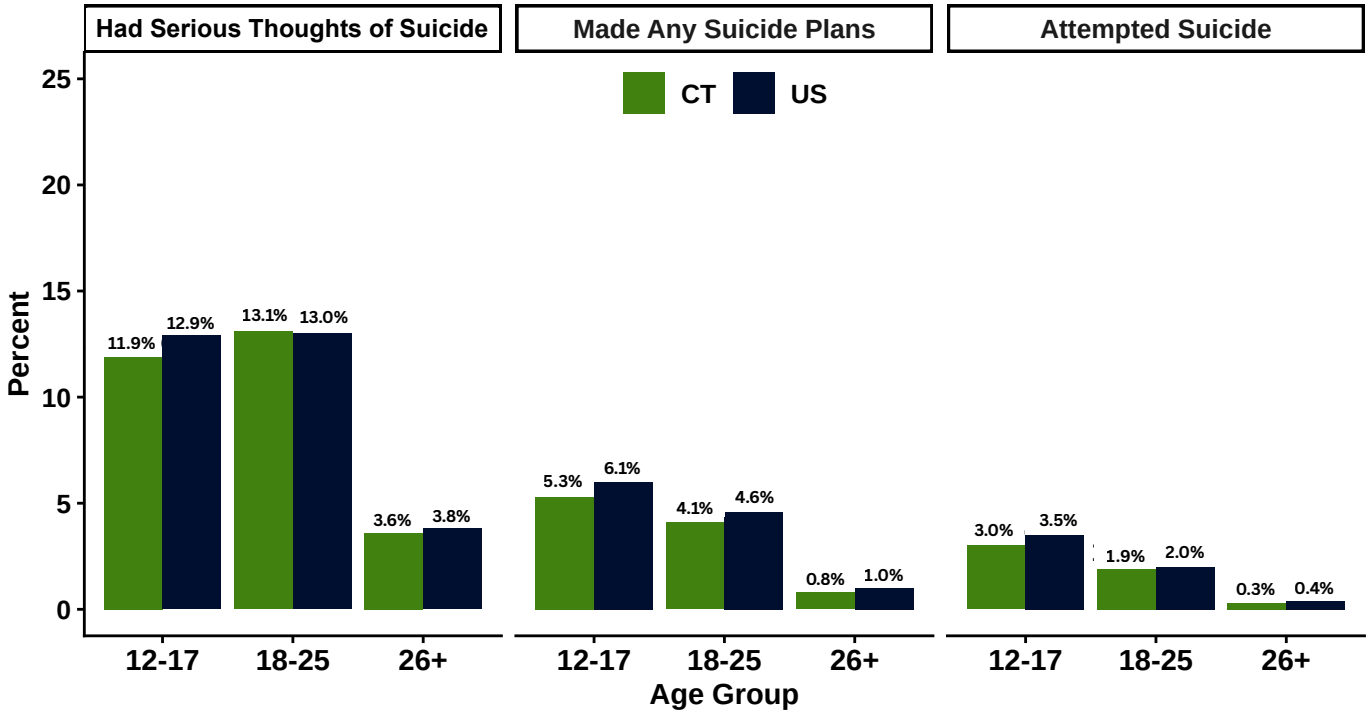
Connecticut has developed mechanisms to address the issue of suicide in the state. The Connecticut Suicide Advisory Board (CTSAB) was established in January 2012 through the merger of the 1989 legislatively mandated CT Youth Suicide Advisory Board and the Interagency Suicide Prevention Network, to create a single state-level advisory board. The CTSAB is currently tri-chaired by representatives from the CT Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), and the Brian Dagle Foundation, and addresses suicide prevention, intervention, and response across the lifespan per revised legislation (PA 22-58; CGS Chapter 319, 17a-52). Additionally, Public Act 23-167 was passed in 2023, mandating local and regional Boards of Education to develop and adopt written policy and procedures to address prevention of youth suicides and attempts.[5]

Connecticut's 988 Suicide and Crisis Lifeline went live in 2022, as part of a national network of local crisis centers.[6] In 2022, the legislatively mandated national 988 suicide and crisis line went live. Connecticut transitioned its existing Lifeline services to the 988 number as a means of increasing ease and timeliness of access to suicide and crisis response services, with United Way of CT continuing to take the lead in handling calls, texts, and chats from residents. Between 2022 and 2024, United Way received nearly 150,000 requests related to suicide and crisis response services, via calls, texts, chats, and online requests.[7]

PREVALENCE

Suicidal ideation (having serious thoughts of suicide or making any suicide plans) and suicide attempts are more prevalent among youth (12-17) and young adults (18-25) compared to other adults (26+).[8]

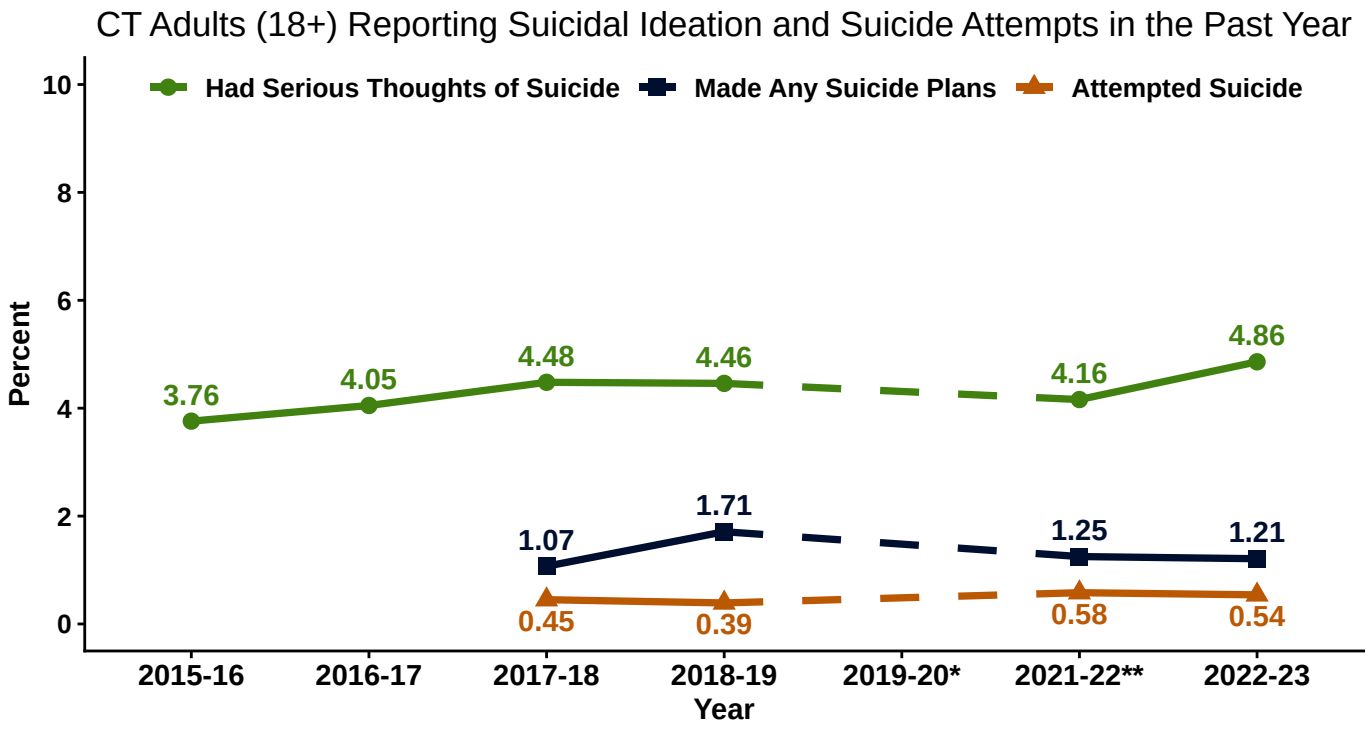
Individuals Aged 12+ Reporting Suicidal Ideation and Suicide Attempts in the Past Year by Age Group



Source: National Survey on Drug Use and Health (NSDUH), 2022-2023

PREVALENCE AMONG ADULTS

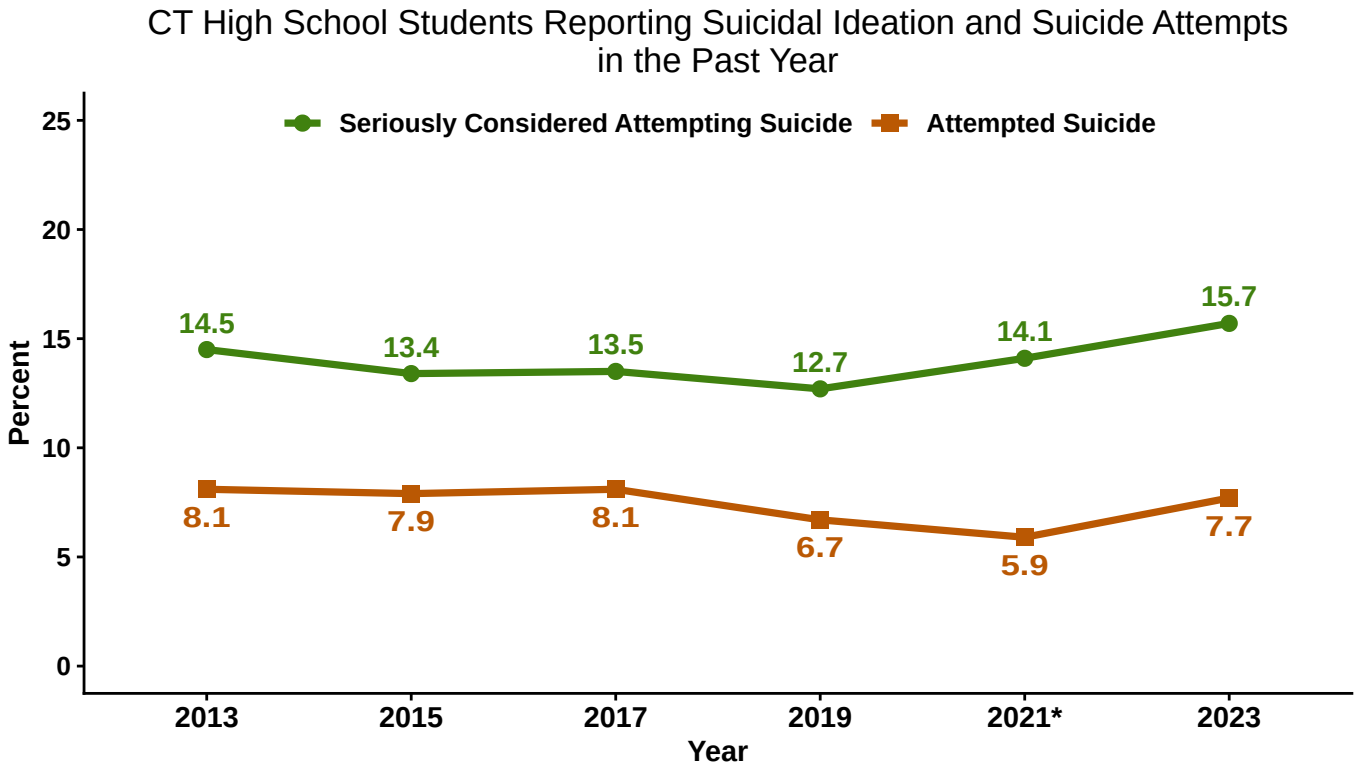
In Connecticut, the *prevalence* for both suicidal ideation (having serious thoughts of suicide or making suicide plans) and suicide attempts has stayed relatively low and mostly consistent since 2017.[9]



*State estimates for these years are no longer available due to impact of COVID-19 on survey methodology.
**Estimates from 2021-2022 are not comparable to estimates from previous years due to changes in NSDUH survey methodology.
Source: National Survey on Drug Use and Health (NSDUH), 2015-2023

PREVALENCE AMONG YOUTH

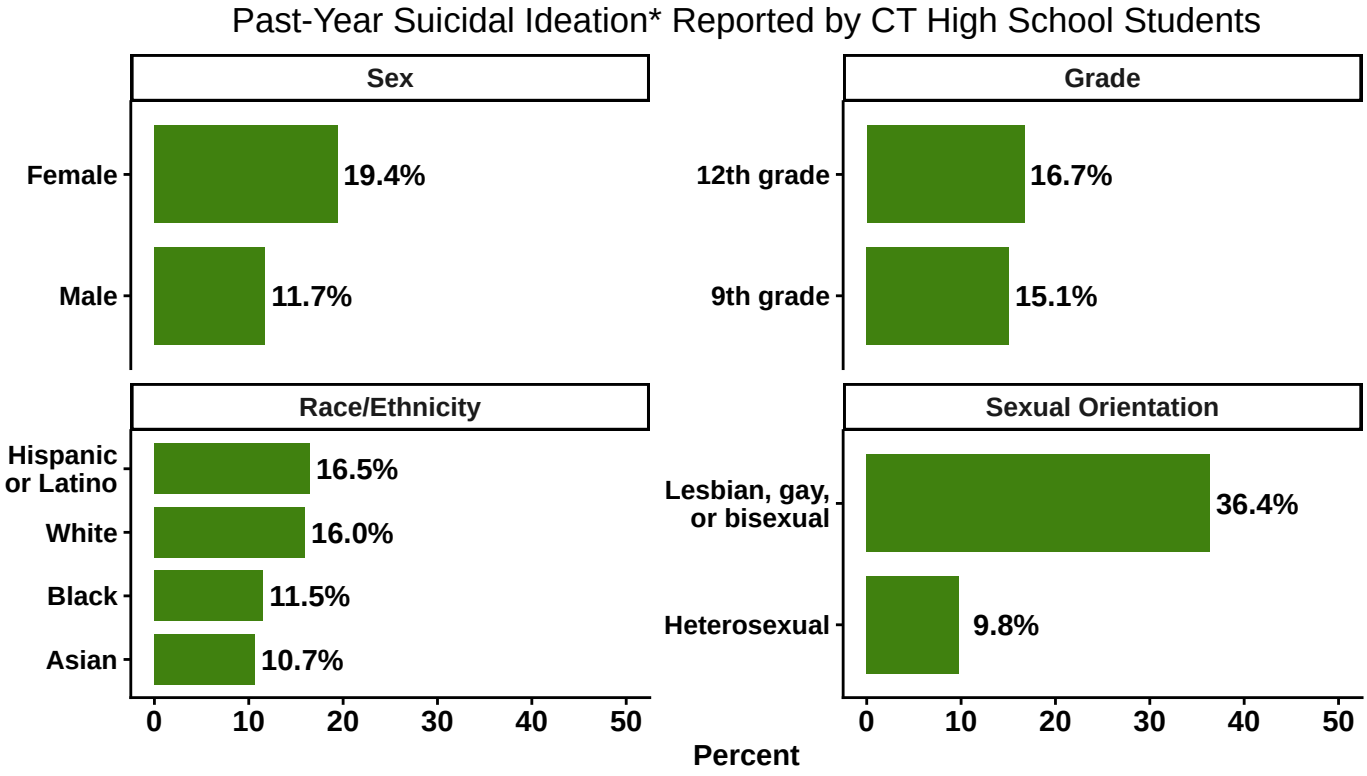
Between 2017 and 2021, the percent of high school students in Connecticut who reported attempting suicide declined, falling from 8.1% to 5.9%.[4]
However, in 2023, both the percentage of high school students who reported **attempting suicide** and the percent who reported **seriously considering attempting suicide** increased.[10]



*Caution should be taken when comparing 2021 results to other years due to differences in survey methodology.
Source: Connecticut School Health Survey (CSHS), 2013-2023

Youth suicide rates have remained relatively low. The age-specific rate of suicides between 2020 and 2023 among youth (10-17) was 2.7 per 100,000.[11] However, findings from the 2023 Connecticut School Health Survey (CSHS) show that some subgroups of youth face elevated suicide risk including, but not limited to, those who are female, Hispanic, and lesbian, gay, or bisexual. These youth subgroups also report higher prevalence of poor mental health, which may explain their increased risk of suicide.[10]

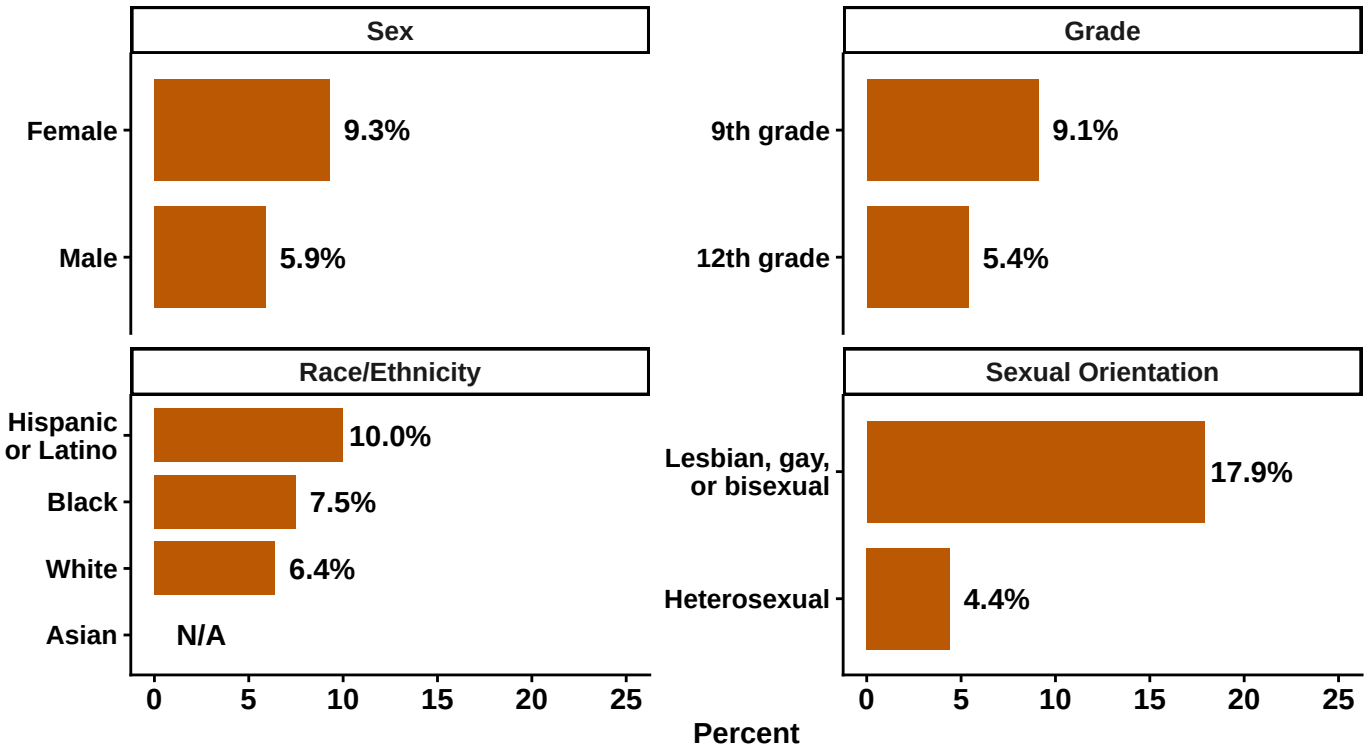
Overall, 15.7% of CT high school students reported that they seriously considered attempting suicide in the past year. More than one third (36.4%) of lesbian, gay, or bisexual high school students reported that they seriously considered attempting suicide in the past year.[10]



*Suicidal ideation = reporting seriously considering attempting suicide in the past 12 months.
Source: Connecticut School Health Survey (CSHS), 2023

Overall, 7.7% of CT high school students reported that they attempted suicide in the past year. A much higher percentage of lesbian, gay, or bisexual high school students (17.9%) reported that they attempted suicide in the past year compared to their heterosexual peers (4.4%).[10]

Suicide Attempts in the Past Year Reported by CT High School Students



Source: Connecticut School Health Survey (CSHS), 2023

RISK & PROTECTIVE FACTORS

Suicide is rarely caused by a single circumstance or event. Risk factors are characteristics at the individual, social, and environmental level that can increase risk for suicide attempts and deaths by suicide.

Risk Factors for Suicide [12,13,14,15]

Individual	Social & Environmental
• Biological factors • Age • Family history of mental health conditions in a blood relative, such as a parent or sibling • Family history of substance use or substance use disorder (SUD) • A previous or co-occurring mental illness • Sense of hopelessness • History of misusing substances (licit or illicit) • Prior or current substance use • Gambling addiction • History of *adverse childhood experiences (ACEs)* • Previous suicide attempt • Experiencing *stigma* associated with mental health help-seeking • Stress of *acculturation* • Serious illness or chronic pain • Impulsivity and sensation seeking	• Social isolation or unhealthy relationships • Suicide of family member or loved one • Loss of relationships • Individual or community violence • *Suicide cluster* in the community • Trauma (e.g., abuse, neglect, military combat, victimization or assault, witnessing violence, experiencing natural disasters, etc.) • Childhood trauma • *Historical trauma* • Discrimination • Media portrayals that glorify or trivialize suicide • Easy access to lethal means of suicide among people at risk • Criminal or legal problems • Limited access to basic resources • Stressful life situations

Warning Signs for Suicide

Warning signs for suicide can include emotional and behavioral changes in the individual considering suicide. Some of these changes include[12]:

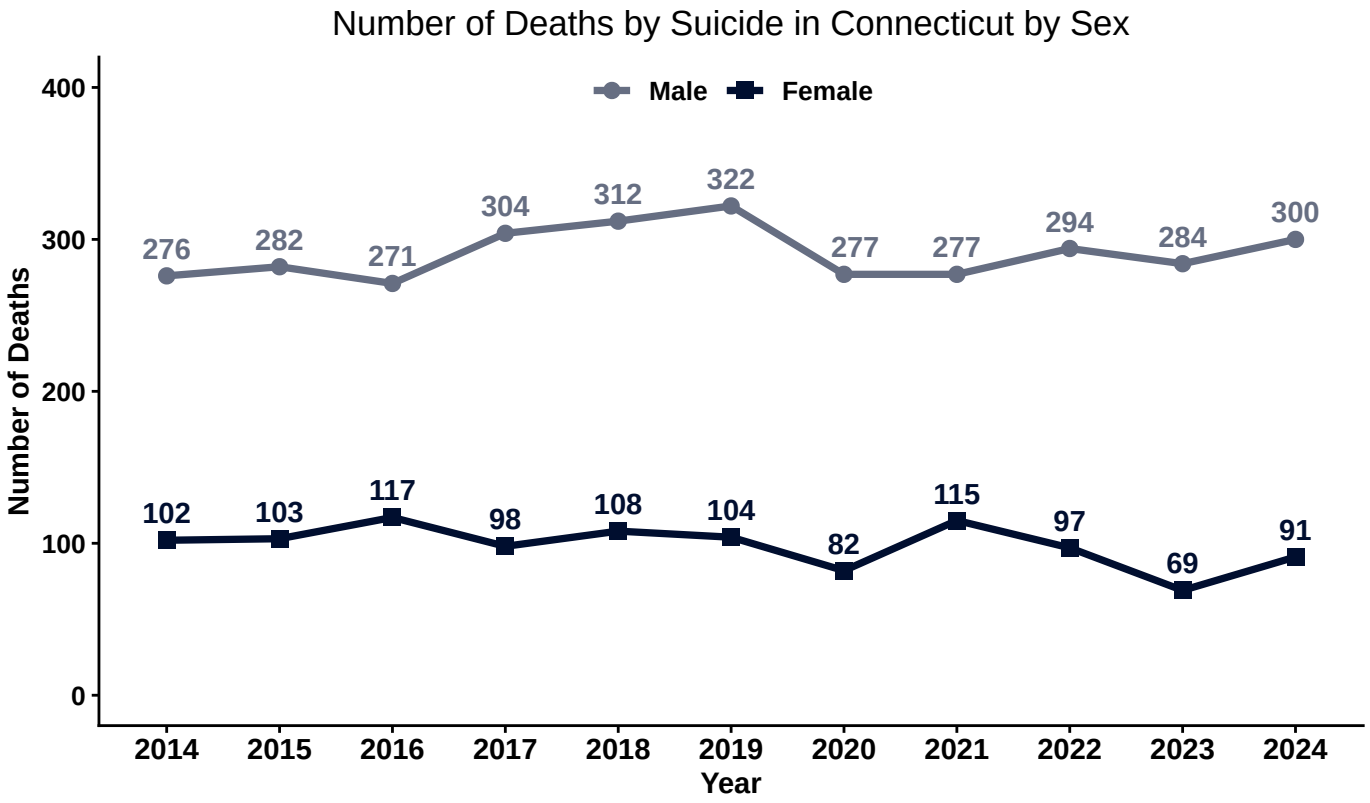
- Extreme mood swings
- Increased anxiety, anger, or rage
- Self-isolation
- Sleeping too little or too much
- Increased substance use
- Expressing hopelessness
- Talking about feeling trapped or being a burden
- Talking or posting about wanting to die
- Making plans for suicide
- Seeking access to *lethal means*

A review of 2023 data from Connecticut's Violent Death Reporting System showed that the following were the most commonly identified circumstances (i.e., events that preceded and may have contributed to the victim's death) among individuals who died by suicide across age groups:

1. perceived depressed mood
2. history of mental health or substance use treatment
3. current diagnosis of a mental health issue
4. current receipt of mental health treatment

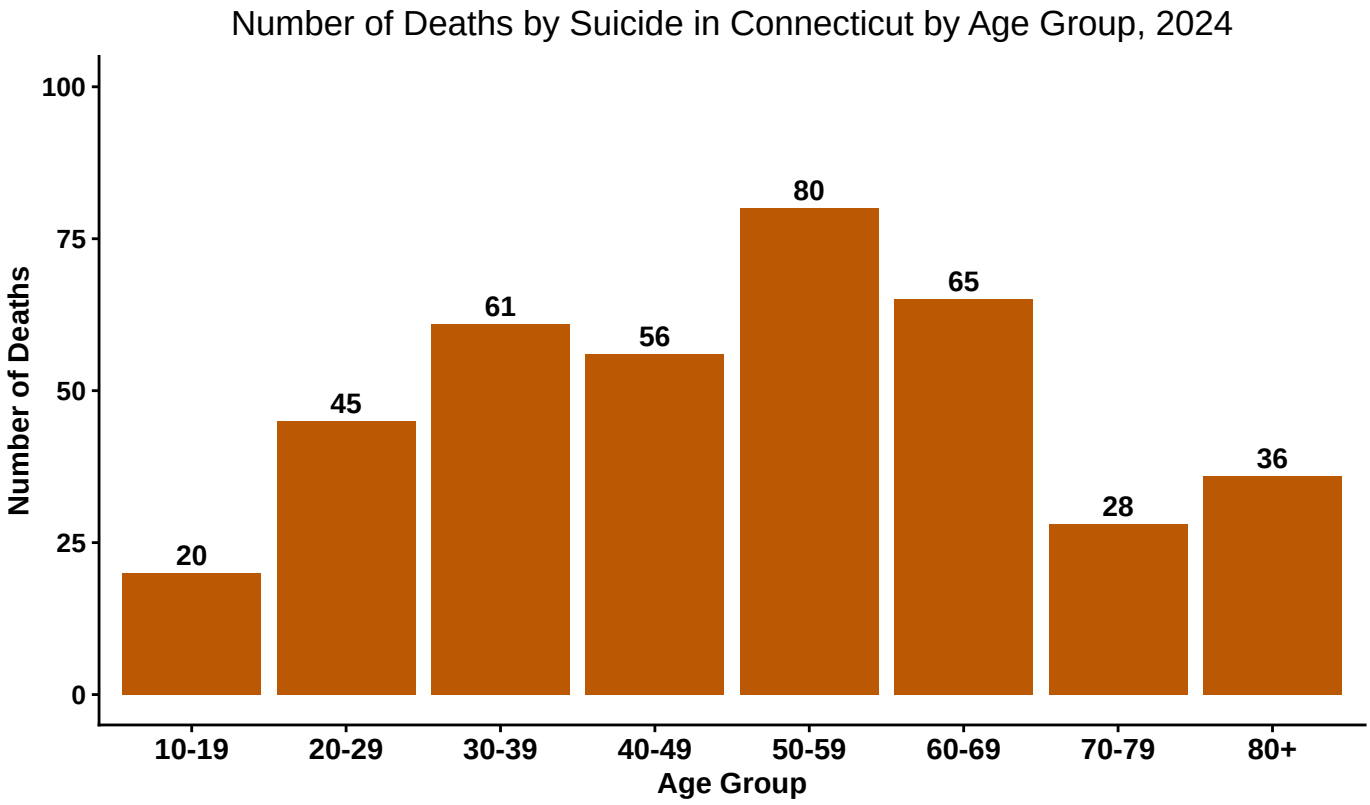
For those who died by suicide: a history of a suicide attempt was a commonly identified circumstance for those under the age of 25; a substance use issue at time of death was a commonly identified circumstance among adults 25 to 64 years old; and a contributing physical health problem (including chronic pain or illness) was among the top five circumstances identified for older adults (65+).[16]

In 2024, males accounted for 76.7% of deaths by suicide in CT. This percentage has consistently remained around 75% for the past decade.[17]



Source: Connecticut Office of the Chief Medical Examiner (OCME), 2014-2024

Individuals in their fifties accounted for the highest number of deaths by suicide in 2024.[17]



Source: Connecticut Office of the Chief Medical Examiner (OCME), 2024

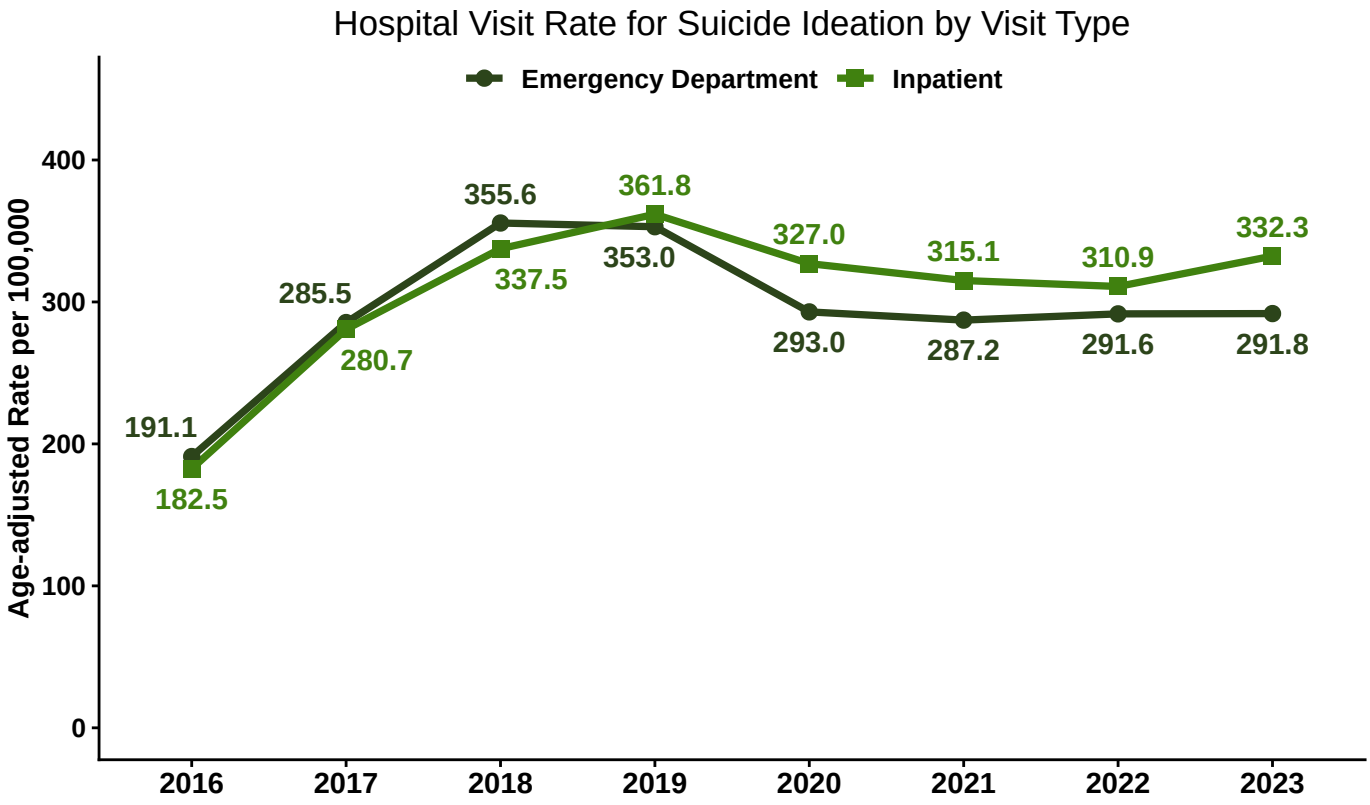
Protective factors are conditions or circumstances that protect individuals from suicide or reduce the likelihood of a suicide attempt in individuals considering death by suicide. Similar to risk factors, protective factors exist at various levels relative to the individual.

Protective Factors against Suicide [12,13,18,19,20]

Individual	Social & Environmental
• Effective coping and problem-solving skills • Reasons for living (e.g., family, friends, and pets) • Avoiding or limiting substance use (including prescription medications) and using medications only as directed • Strong sense of cultural identity	• Social connectedness and/or support • Supportive relationships • Safe living environment or neighborhood • Access to support and clinical care for mental, physical, and substance use disorders • Reduced access to lethal means of suicide among people at risk • Cultural, religious, or moral belief systems that object to suicide • Adequate access to resources

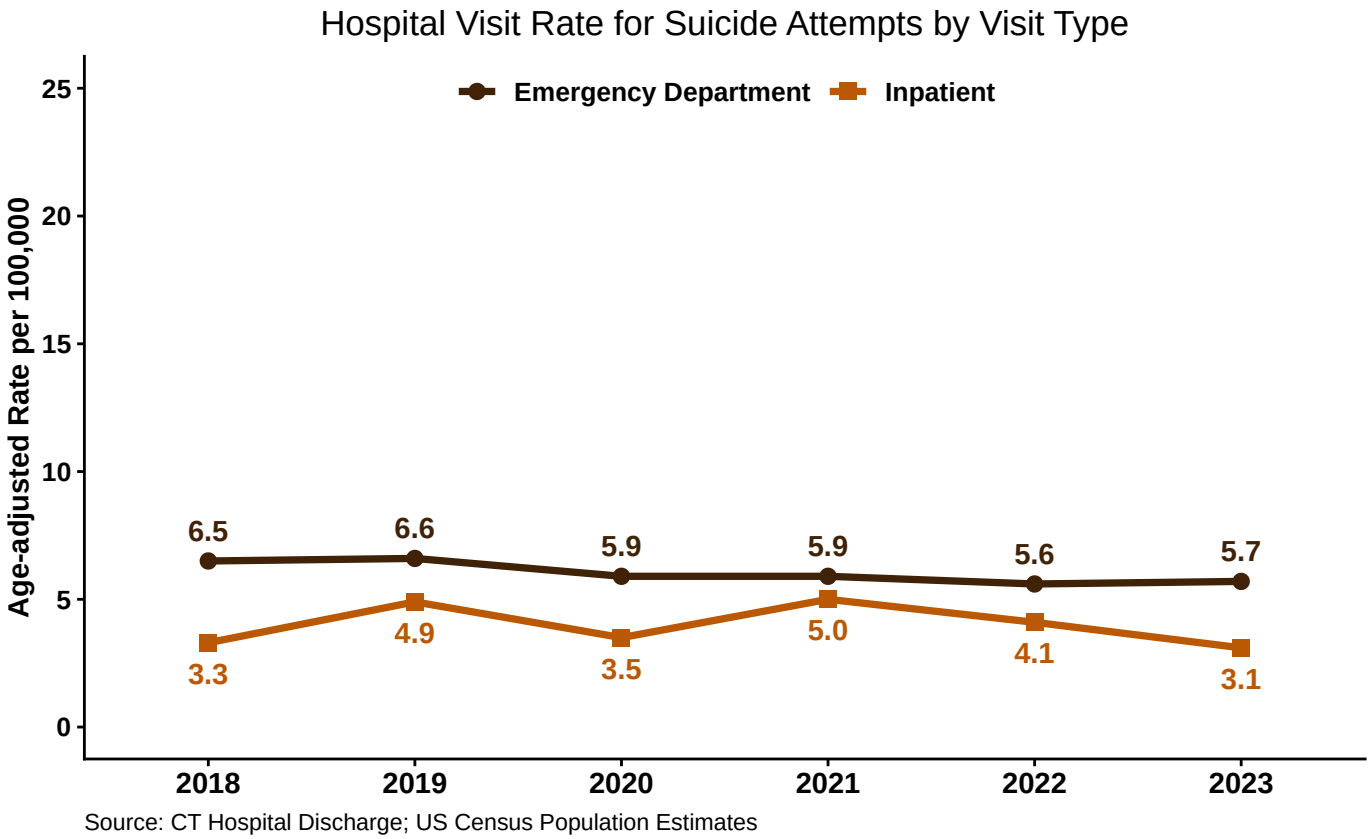
EFFECTS & CONSEQUENCES

Connecticut's rate of inpatient and emergency department hospital visits for suicidal ideation rose markedly from 2016 to 2018. Both rates decreased between 2019 and 2020, and have remained consistent throughout the post-pandemic period. The trends for emergency department (ED) visits and inpatient visits for suicidal ideation remained constant, with inpatient visits increasing slightly from 2022 to 2023.[11]



Source: CT Hospital Discharge; US Census Population Estimates

The rates of inpatient and emergency department hospital visits due to suicide attempts have remained low since 2018. While the rate of inpatient visits has shown a consistent decrease since 2021, the rate of ED visits has remained steady throughout the years, ranging from a high of 6.6 per 100,000 people in 2019 to a low of 5.6 in 2022.[11]



Source: CT Hospital Discharge; US Census Population Estimates

Suicide is a major public health problem that has far-reaching personal, social, and economic implications.[11] Suicide, including suicide attempts and deaths, can have direct and indirect effects for individuals, families, and communities. For example, individuals who survive a suicide attempt can experience serious injuries which can have long-term health effects and can increase risk of a future suicide attempt.

Family, friends, and other loss survivors of a person who died by suicide can experience: ✦ grief, shock, guilt, and loss; ✦ depression and other mental health issues (e.g., *Prolonged Grief Disorder*, also known as "complex grief"); and ✦ potentially greater risk of suicide themselves.[21]	Effects of a suicide death can have an **indirect or ripple effect in communities**, which can result in: ✦ communal grief, guilt, and loss; ✦ increased anxiety and fear; ✦ community isolation of those affected due to stigma; and ✦ community cohesion.[22]

Suicide also results in effects on systems and society. In addition to the loss of individuals and what they contribute, the effects of suicide may take the form of medical costs, losses to the workforce, and effects associated with *years of potential life lost (YPLL)*. In Connecticut, based on 2023 data, the economic cost of suicide averaged $3.72 billion USD, including medical costs and *value of statistical life (VSL)*. Based on these data, CT experienced an estimated 6,166 YPLL.[1]

CONCLUSIONS & CONSIDERATIONS

Key takeaways:

- Connecticut's suicide rate has increased over the past two decades.
- Despite an increase, Connecticut has a lower suicide rate compared to many other states, but its rate is similar to or higher than some New England states.
- Reports of having suicidal thoughts are more prevalent among younger populations (those ages 12-17 and 18-25) compared to adults (26+).
- The prevalence of reported suicidal ideation and suicide attempts among lesbian, gay, and bisexual high school students is much higher compared to heterosexual students.
- Female high school students report higher prevalence of both suicidal ideation and suicide attempts than male students.
- Males in Connecticut accounted for the majority (~75%) of deaths by suicide and this trend has remained consistent over the past decade.
- Hospital visits due to suicidal ideation have increased over the past decade and have remained consistent in the past few years while hospital visits related to suicide attempts remain low.
- Suicide has considerable direct and indirect effects on individuals, families, communities, and systems (e.g., healthcare, workforce) in Connecticut.

Considerations:

- This profile makes use of multiple data sources; the most recent data available from these sources are utilized in developing this profile.
- Due to changes in federal guidance, analyses based on some sociodemographic subpopulations are not included.
- Prevalence estimates from the 2021 Connecticut School Health Survey data should be interpreted with caution and should not be considered an accurate timepoint in trend analyses due to a COVID-precipitated shift to Fall semester administration from its traditional Spring administration. Prevalence estimates from the 2021 data should be interpreted with caution because (1) the reporting of risk behaviors tends to be lower in the fall semester and (2) the survey asked about students' behavior in the past 12 months which included a time when there were restricted opportunities for social interaction due to COVID-19.
- Prevalence estimates are omitted from this profile if they meet the following criteria:
  - **CSHS**: (a) cell count < 30 OR (b) coefficient of variation > 0.30

ADDITIONAL RESOURCES

For more data and information on suicide in Connecticut, visit the:

Connecticut SEOW Prevention Data Portal: http://preventionportal.ctdata.org/

CTData Collaborative: https://www.ctdata.org/

CT Suicide Advisory Board: https://www.preventsuicidect.org/

DataHaven: https://ctdatahaven.org/

The Trevor Project: https://www.thetrevorproject.org/state-reports-connecticut-2024/

988 Suicide & Crisis Lifeline:

GET HELP 24/7
Call **2-1-1** in CT
988 Suicide & Crisis Lifeline: **988**
Call/Text: **988**

GLOSSARY

Term	Definition
Acculturation	The processes by which groups or individuals adjust the social and cultural values, ideas, beliefs, and behavioral patterns of their culture of origin to those of a different culture. Psychological acculturation is an individual's attitudinal and behavioral adjustment to another culture, which typically varies with regard to degree and type.
Adverse childhood experiences (ACEs)	Potentially traumatic events that occur in childhood (e.g., abuse, neglect, and household challenges) that may increase the risk for mental health problems, chronic illnesses, health-risk behaviors, and adverse social outcomes later in life.
Historical trauma	The cumulative psychological and emotional wounding experienced by a group of people across generations due to prolonged and systematic oppression, violence, and loss.
Lethal means	Instruments, objects, or materials used for suicidal behavior that have a high rate of causing death.
Prevalence	The proportion of a population who have a specific characteristic in a given time period. It may be reported as a percentage (5%, or 5 people out of 100), or as the number of cases per 10,000 or 100,000 people.
Prolonged Grief Disorder (PGD)	A diagnosable persistent, pervasive mental health condition characterized by longing for and persistent preoccupation with the deceased, Also known as "complicated grief", PGD is associated with symptoms of emotional pain, identity disturbances, loss of meaning and purpose, and functional impairment.
Protective factors	Individual, social, or environmental characteristics that reduce individuals' vulnerability to negative health outcomes.

GLOSSARY

Term	Definition
Risk factors	Characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.
Self-directed violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as either suicidal or non-suicidal.
Subpopulation	A subgroup of a larger population of individuals or cases. It describes a specific group of individuals with common characteristics (e.g., race/ethnicity, age, risk factors)
Stigma	A set of negative beliefs, often unfounded, that a society or group of people have about something.
Suicide cluster	A group of suicides, suicide attempts, or self-harm events that occur closer together in time and space than would normally be expected in a given community.
Value of Statistical Life (VSL)	A monetary estimate of the collective value placed on mortality risk reduction as derived in research studies through revealed preferences or stated preferences from surveys of individual persons' willingness to pay for mortality risk reduction.
Years of Potential Life Lost (YPLL)	A measure of premature mortality (early death) calculated by subtracting the age at death from the standard year (i.e., 65, 70, 75, 80, 85+) and then summing the individual YPLL across each cause of death.

REFERENCES

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). Accessed September 23, 2025. www.wisqars.cdc.gov

2. Centers for Disease Control and Prevention, Suicide Prevention. Facts About Suicide. cdc.gov. Published March 26, 2025. Accessed September 23, 2025. https://www.cdc.gov/suicide/facts/index.html

3. USAFacts. How many people die by suicide in Connecticut each year? usafacts.org. Data updated July 19, 2024. Accessed September 5, 2025. https://usafacts.org/answers/how-many-people-die-by-suicide/state/connecticut/

4. CT Department of Public Health (DPH). Suicide and Self-Directed Injury Prevention. Accessed September 5, 2025. https://portal.ct.gov/en/dph/health-education-management--surveillance/the-office-of-injury-prevention/suicide-and-self-inflicted-injury-prevention-program

5. Public Act No. 23-167 (2023). Accessed October 30, 2025. https://www.cga.ct.gov/2023/ACT/PA/PDF/2023PA-00167-R00SB-00001-PA.PDF

6. 988 Lifeline. About 988. Accessed October 30, 2025. https://988lifeline.org/about/

7. 211 Counts. 211 Counts Connecticut. Data updated October 29, 2025. Accessed October 30, 2025. https://ct.211counts.org/

8. Substance Abuse and Mental Health Services Administration (SAMHSA). NSDUH State Estimates, 2022-2023. samhsa.gov. https://www.samhsa.gov/data/data-wecollect/nsduh-national-survey-drug-use-and-health/state-releases

9. Substance Abuse and Mental Health Services Administration (SAMHSA). National Survey on Drug Use and Health (NSDUH) 2015-2023. samhsa.gov. https://datatools.samhsa.gov/saes/state

10. Connecticut State Department of Public Health (DPH). Connecticut School Health Survey (CSHS). portal.ct.gov. Published 2023. https://portal.ct.gov/dph/health-information-systems--reporting/hisrhome/connecticut-school-health-survey?language=en_US

11. Connecticut Suicide Advisory Board (CTSAB). About Suicide. preventsuicidect.org. Accessed September 23, 2025. https://www.preventsuicidect.org/about-suicide/

REFERENCES

12 Centers for Disease Control and Prevention, Suicide Prevention. Risk and Protective Factors for Suicide. cdc.gov. Published April 25, 2024. Accessed October 10, 2025. https://www.cdc.gov/suicide/risk-factors/index.html

13 AFSP. Risk factors, protective factors, and warning signs. American Foundation for Suicide Prevention website. https://afsp.org/risk-factors-protective-factors-and-warning-signs/#risk-factors

14 CDC. Health Disparities in Suicide. Centers for Disease Control and Prevention website. Suicide Prevention. Published May 16, 2024. Accessed December 19, 2025. https://www.cdc.gov/suicide/disparities/index.html

15 CDC. About Adverse Childhood Experiences. Centers for Disease Control and Prevention website. Adverse Childhood Experiences (ACEs). Published September 24, 2025. Accessed December 19, 2025. https://www.cdc.gov/aces/about/index.html

16 Makowski, M. Summary of CTVDRS Data for CTVDRS Advisory Board Meeting. PowerPoint and Lecture presented at: CTVDRS Advisory Board Meeting hosted by CT Department of Public Health Injury and Violence Surveillance Unit; August 12, 2025; Virtual.

17 CT Office of the Chief Medical Examiner (OCME). Statistics Spreadsheet. portal.ct.gov. Accessed October 10, 2025. https://www.cdc.gov/suicide/risk-factors/index.html

18 CDC. Preventing Suicide. Centers for Disease Control and Prevention website. Suicide Prevention. Published September 10, 2024. Accessed December 19, 2025. https://www.cdc.gov/suicide/prevention/index.html

19 Connecticut Suicide Advisory Board. Protective factors for suicide. Connecticut Suicide Advisory Board. Accessed January 29, 2026. https://www.preventsuicidect.org/about-suicide/protective-factors/

20 SAMHSA. Warning Signs and Risk Factors for Emotional Distress. Substance Abuse and Mental Health Services Administration website. Last Updated October 10, 2024. Accessed December 19, 2025. https://www.samhsa.gov/mental-health/disaster-preparedness/warning-signs

REFERENCES

21 Eisma MC. Prolonged grief disorder in ICD-11 and DSM-5-TR: Challenges and controversies. Aust N Z J Psychiatry. 2023 Jul;57(7):944-951. doi: 10.1177/00048674231154206. Epub 2023 Feb 6. PMID: 36748103; PMCID: PMC10291380.

22 Sandler EP. National Alliance on Mental Illness (NAMI). The Ripple Effect of Suicide. nami.org.
Published September 10, 2018. Accessed September 23, 2025.
https://www.nami.org/family-member-caregivers/the-ripple-effect-of-suicide/