Suicide Fatality Data Guide

A short guide to finding and interpreting suicide-related data, nationally and in Maryland.

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PUBLIC DATA SOURCES

Maryland Department of Health Vital Statistics Administration (VSA)

- Aggregates and publishes data on suicide fatalities in Maryland
- VSA publishes a yearly report on trends in population, birth rates, and mortality rates. Official mortality data typically takes ~2 years to finalize.
- Reports: health.maryland.gov/vsa/Pages/reports.aspx

Centers for Disease Control and Prevention (CDC WISQARS)

- Interactive online database for suicide fatalities in US
- CDC updates the database with national and state-level data. Data includes fatal and non-fatal injury, and cost of injury. Official mortality data takes ~2-3 years to finalize.
- Database: cdc.gov/injury/wisqars/index.html

Maryland Violent Death Reporting System (MVDRS)

- Data surveillance system that organizes and maintains detailed information concerning violent deaths in Maryland
- Produces variety of annual and periodic reports, including suicide-specific reports, that provide insights about circumstances of violent deaths
- Website: health.maryland.gov/phpa/OEHFP/Injury/Pages/mvdrs.aspx

Youth Risk Behavior Survey (YRBS)

- On-site survey of students in Maryland public middle and high schools, focusing on behaviors that contribute to leading causes of death and disability (including self-reported suicide-related ideation and behavior)
- Administered every year during fall semester. Official data takes ~1-2 years to finalize.
- Website: health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-Main.aspx

National Survey on Drug Use and Health (NSDUH)

- National survey data that provides estimates of substance use and mental illness at national, state, and substate levels for population ages 12+
- Conducted annually. Processing and finalizing takes ~2 years.
- Website: samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

The Trevor Project

- Leading suicide prevention and crisis intervention nonprofit for LGBTQ+ young people (ages 13-24) in the US
- Administers, analyzes, and publishes national and state survey data related to the wellbeing of LGBTQ+ young people (including self-reported suicide-related ideation and behaviors). Reports are released on a periodic and annual basis.
- Research page: thetrevorproject.org/research/

Maryland State Data Center - Census Data

- Maryland repository for population data collected every 10 years
- Can be used to calculate rates per 100,000 members of specific populations
- Website: planning.maryland.gov/MSDC/Pages/census/censusdata.aspx

WHY IS MORE CURRENT DATA HARD TO FIND?

Suicide fatality data takes time to finalize. Accurate and precise suicide fatality data can take 1-2 years to be released to the public. It is essential to use complete datasets to draw accurate conclusions, especially with smaller datasets. Thorough investigations for suicides can take months to complete in some cases, which can delay the release of datasets in Maryland.

Provisional data for the United States is occasionally published by the Centers for Disease Control and Prevention (CDC). On the state level, key data organizations (including the Maryland Department of Health's Vital Statistics Administration) do not allow data to be released before processing is complete.

Given the data delay, making timely surveillance decisions can be challenging for implementing organizations. For these organizations, the Maryland Department of Health's Office of Suicide Prevention can provide valuable insight and technical assistance. Reach out for support as needed!

INTERPRETING SMALL NUMBERS

Suicide is a statistically rare event, and counts of suicide deaths are small. With small numbers, it is important to interpret data with caution. [1]

- **Raw numbers/counts that are less than 11 should be suppressed.** Reporting or calculating with numbers lower than 11 can compromise the anonymity of individuals who died by suicide.
- **Use population-adjusted incidence rates instead of counts, whenever possible.** Raw numbers/death counts can be misleading when comparing suicide deaths in populations of different sizes.
    - **Rates per 100,000 should not be calculated using raw numbers below 20.** Rates calculated with numbers that are too small are considered unstable.
- **Incidence rates are generally calculated per 100,000 members of the population of interest.**
    - **For example:** 50 males in ABC County have food poisoning. There are 250,000 males in ABC County. To obtain the rate of food poisoning, you would calculate the value of (50/250,000) x 100,000. The population-adjusted rate would be 20 cases per 100,000 males in ABC county.
    - VSA calculates rates using age-adjusted numbers. This method removes confounding caused by age, since health statistics can be affected by age group.

USING THE DATA

DON'T focus on year-to-year changes, especially with smaller numbers. Given how small suicide fatality counts are on a state/local level, fluctuations are expected and cannot always be linked to causal factors. Identify consistent patterns. Consider using ranges or averages of multiple years.

TRY: The rate of suicide per 100,000 in this county was 3.0 in 2017, 3.4 in 2018, 5.6 in 2019, and 6.5 in 2020. Suicides appear to be increasing.

AVOID: The rate of suicide per 100,000 in this county was 3.4 in 2018 and 5.6 in 2019. Suicides are increasing!

DON'T forget data caveats when reporting on provisional data. Some data sources may have data that is preliminary and subject to change. Ensure that data caveats are communicated clearly in reports, and when using data for decision-making.

DON'T use percentage change without context. Percent change from year-to-year may not be representative on its own, especially with small numbers. Include rates and/or counts where possible.

TRY: In 2018, the suicide rate for ages 0-17 was 3.0 per 100,000 in this county. In 2019, the ages 0-17 suicide rate was 6.0 per 100,000, representing a 200% increase. From 2010 to 2019, there has been an average annual increase of 0.2 per 100,000 in this age group.

AVOID: The rate of suicide for ages 0-17 in this county has increased by 200% from 2018 to 2019!

DO check other data sources. Data about suicide deaths does not capture the full range of suicidal ideation and behavior. Suicide death data should be used in conjunction with other data sources.

TRY: Suicide deaths have decreased 50% from 2022 to 2023, going from 4.0 per 100,000 to 2.0 per 100,000. This is great news! However, calls to the local crisis center have increased by 40%, and law enforcement has reported more suicide-related calls. This is an opportunity to look at how we can support people experiencing crisis.

AVOID: Suicide deaths are down 50% in 2023, compared to 2022. There's no need to implement new measures to prevent suicide in this county.

DO ask questions before drawing conclusions. Suicides can increase or decrease for many reasons. Changes can be fluctuations in the data, or can be a result of a variety of contributing factors. Avoid jumping to conclusions or attributing changes to a single cause.

TRY: For males in this county, suicides increased from 3.3 per 100,000 in 2021 to 4.5 per 100,000 in 2022. What factors could be contributing to this? Is this unprecedented, looking at previous years? How can we identify men at risk of suicidal crisis?

AVOID: Suicides have increased among males in this county from 2021 to 2022. This must be because sports betting has increased among males.

DON'T refer to increases in suicide as an "epidemic" or "skyrocketing rates." Alarmism about suicide can have a negative impact on those at risk of suicide. [2] Focus on messages about hope and connecting to help.

DO advocate for evidence-based responses. There are a wide variety of interventions and programs that can help to prevent suicide. Ensure that any action is based on evidence, and resources are devoted to effective programs.

For general information about evidence-based programs, refer to the Suicide Prevention Resource Center (SPRC): sprc.org/resources-programs

DO ask for help! The Office of Suicide Prevention, housed under the Maryland Department of Health's Behavioral Health Administration, is tasked with providing technical assistance to stakeholders throughout the State of Maryland. If you have questions or concerns, contact us at mdh.suicideprevention@maryland.gov.

LANGUAGE MATTERS

The words we use to describe and discuss suicide are important.

Messages and images should:

- Encourage hope
- Celebrate life
- Not romanticize death
- Not contribute to stigma about suicide or mental health challenges
- Help people understand that suicide is preventable
- Help people understand they can seek help during a crisis
- Help people understand they can seek help to treat a mental health or substance use challenge

DO Use This	DON'T Use This
Died by suicide	Committed suicide
Suicide death; Death by suicide	Successful attempt
Suicide attempt	Unsuccessful attempt
Person living with suicidal thoughts or behaviors	Suicide ideator; Suicide attempter
Suicide; Death by suicide	Completed suicide

REFERENCES

Resources for Safe Messaging Related to Suicide

- **Safe and Effective Messaging and Reporting**
  - Reporting resource from the Suicide Prevention Resource Center (SPRC)
- **Strategic Communication Planning Video Series**
  - Videos from SPRC that focus on a "shift from communicating for awareness to communicating for action."
- **Framework for Successful Messaging**
  - Four critical issues to consider when messaging to the public about suicide from the National Action Alliance for Suicide Prevention
- **Recommendations for Reporting on Suicide Website**
  - Guidelines on safely reporting on suicide
- **Language Matters When Talking about Suicide**
  - Resource on the importance of language related to suicide from Mental Health Center of Denver

Content References

1. Department of Health Agency Standards for Reporting Data with Small Numbers. Washington State Department of Health. 2018 May. Available from: doh.wa.gov/portals/1/documents/1500/smallnumbers.pdf
2. Niederkrotenhaler T, Braun M, Pirkis J, Till B, Stack S, Sinyor M et al. Association between suicide reporting in the media and suicide: systematic review and metaanalysis. BMJ 2020; 368:m575. Doi: 10.1136/bmj.m575.

Behavioral Health Administration
Office of Suicide Prevention
201 W Preston Street
Baltimore, MD 21201
health.maryland.gov/bha