March 3, 2020

The Honorable Delores G. Kelley
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: Support with Amendments – SB 789: Suicide Mortality Review and Prevention Act of 2020

Dear Chairman Kelley and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) is a state medical organization whose physician members specialize in the diagnosis, treatment, and prevention of mental illnesses including substance use disorders. Formed more than sixty years ago to support the needs of psychiatrists and their patients, MPS works to ensure available, accessible and comprehensive quality mental health resources for all Maryland citizens; and strives through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branch of the American Psychiatric Association covering the state of Maryland excluding the D.C. suburbs, MPS represents over 700 psychiatrists as well as physicians currently in psychiatric training.

MPS strongly supports Senate Bill 789: Suicide Mortality Review and Prevention Act of 2020 (SB 789) with the two amendments outlined at the end of this testimony that we hope will afford protections to psychiatrists who provide patient information to the M

Over the past 20 years, the US suicide rate has climbed at an alarming rate and is now at its highest level since World War II. While other major causes of death such as heart disease and cancer have declined significantly, suicide is now the second leading cause of death for Americans under age 40[1], despite both the US Surgeon General and the World Health Organization recognizing suicide as a preventable public health problem.

Maryland is not immune from the climbing suicide rate. From 2016 to 2017, Maryland experienced a 9% increase in the total number of suicide deaths. This increased death rate accounted for an additional 53 Marylander lives lost to suicide in 2017 as compared to 2016.[2] In recent years, suicide has disproportionately impacted Marylanders in rural areas, and those under the age of 40, with increased suicide rates in both groups.[3]

In addition to the loss of life, the economic burden of suicide is significant. The American Foundation for Suicide Prevention estimates that suicides cost Maryland a total of $586,391,000

[1] NCHS Data Brief, 2020
[2] MVDRS, 2017
[3] CDC WONDER, 2020

combined lifetime medical and work loss cost in 2010, or an average of $1,168,110 per suicide death. Without a cohesive body specifically dedicated to reviewing and reporting on the circumstances of suicide deaths in Maryland, it is difficult for public health officials to create and implement effective and sustainable suicide prevention efforts. SB 789 provides that avenue to us.

SB 789 establishes the Maryland State Suicide Fatality Review Committee [SFRC]. Suicide is the tragic outcome of complex interactions between societal, community, family, and individual risk factors; hence its prevention requires collaborative efforts from multiple sectors including health, social, justice and education. Further, an individual's vulnerability to be suicidal and his/her intention to act toward taking his/her life may wax and wane over time and across multiple sectors where interventions could occur to alter a trajectory toward suicidal death.

The SFRC would possess the authority to collect a wide range of personal information about those who have died by suicide and, in turn, a responsibility to securely protect that information. The unique data collection power of a SFRC enables it to match data from different government and otherwise private data sets and to conduct in-depth case and systems reviews of agency reports and inquiries. SFRC would also facilitates necessary collaborations among key stakeholders to bring together existing data sources, such as medical records, death records, and other healthcare data. Such information would provide the most detailed picture of the life and death of the deceased, which would then inform the committee's recommendations for sector change and guides future prevention efforts, harnessing data into impactful prevention programs and practices.

The SFRC would operate over a longer time period compared to general hypothesis-driven research. Because of this, the impact of the SFRC can be seen gradually through improvements in mortality trends that span the life of the SFRC.

Historically, fatality review teams have been extremely successful in preventing other kinds of unnatural deaths, such as overdoses. Overdose Fatality Review Teams (OFRTs) arose from the success of Child Fatality[4] and Domestic Violence Fatality Review Teams.[5] In Maryland, local OFSTs began convening in 2013 and have brought their unique systems-level expertise to bear in making several recommendations primarily involving integration of care, prevention education, and harm reduction strategies to prevent overdose deaths.[6] The latter examples provide sound evidence that an SFRC will likely be an extremely valuable addition to bolstering Maryland's current efforts for reducing suicide.

Although our state currently participates in more superficial data collection enterprises, such as National Violent Death Reporting System (NVDRS), a SFRC has its own unique facets that would

[4] Durfee 2009, Onwuachi-Saunders 1999
[5] McHardy 1999
[6] Rebbert-Franklin 2016 and Haas 2018

address existing gaps within our current systems. Here are some examples that set an SFRC apart from the NVDRS:

- NVDRS estimates if a decedent was a veteran, but does not tell us about deployment history, combat history, etc.
- NVDRS tells us what the weapon was that was the mechanism of the suicide (e.g. a firearm), but does not tell us who owned the firearm or how it was stored, whether the pills used in an OD were prescribed, OTC or illicit, whether a fall was from a building or a bridge or if the site of a fall/jump was the site of multiple suicides (a suicide magnet), etc.
- NVDRS tells us whether mental health problems were known/present, but nothing more specific about diagnoses, treatments or the lack thereof, adherence to prescribed medication, compliance with treatment recommendations, the profession of the caregiver, or their last known interaction with a clinician who might have helped.
- NVDRS tells us about a history of suicide attempt, but does not differentiate single versus multiple attempts, does not tell us about the how recent the last attempt was, the methods used in past attempts, or missed warning signs that led to the event.
- NVDRS tells us about disclosed thoughts and plans, but not to whom these were disclosed, what was or was not done in response to disclosures, and what opportunities were neglected.

In summary, the SFRC has the potential to:

- provide additional information on contributing factors and patterns in population subgroups that have higher rates of suicide
- provide insights that point to potential indicators, intervention points or levers to prevent suicide among these subgroups
    - establish agencies and systems in which suicidal decedents had contact along the pathway toward suicidal death, hence points of intervention
- test a process for cross-agency data collection and capture what has been learned
- reduce the economic burden of suicide
- establish risk profiles based on decedents who have died by suicide yet who did not communicate suicide intent or suicide ideation when last asked before their deaths
- improve the training of clinical providers
- intersect with findings from opiate fatality reviews to better establish decision trees toward manner of death determinations
- provide additional information informing improved continuity of care recommendations

Amidst the increasing suicide rates both nationally and statewide in Maryland, the importance of innovative state-wide efforts to reduce suicide has become unparalleled. The implementation of a Maryland SFRC through SB 789 is an extremely cost-effective venture for reducing suicide rates. By establishing a Maryland SFRC, we can ensure that future suicide prevention-based state policies and programs will be informed by the most complete and reliable suicide data; which will ultimately lead to more sustainable and impactful suicide prevention efforts.

As previously explained, MPS is suggesting 2 amendments to provide some protections to psychiatrist who provide patient information to the committee. The language was borrowed from the Child Fatility Review Team Statute:

1. On page 9, line 9 strike "PROCEEDING" and substitute "CIVIL, CRIMINAL, OR ADMINISTRATIVE ACTION"

2. On page 9, line 18 after "CRIMINAL" insert "ADMINISTRATIVE"; on the same page in line 21 AFTER "KNOWLEDGE" insert "OR INFORMATION OBTAINED INDEPENDENTLY OF THE TEAM OR THAT IS PUBLIC INFORMATION."

The interlineated form of this amendment would read as follows:

THIS SUBTITLE MAY NOT BE CONSTRUED TO PROHIBIT A PERSON FROM:

(1) TESTIFYING IN A CIVIL, OR CRIMINAL**, ADMINISTRATIVE** ACTION ABOUT MATTERS THAT OCCURRED IN A STATE TEAM MEETING IF THE TESTIMONY WILL BE BASED ON THE PERSON'S INDEPENDENT KNOWLEDGE **OR INFORMATION OBTAINED**

INDEPENDENTLY OF THE TEAM OR THAT IS PUBLIC INFORMATION.

With the amendments adopted, MPS would then ask the committee for a favorable report of SB 789. If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Legislative Action Committee for the Maryland Psychiatric Society