NAMI New Hampshire
National Alliance on Mental Illness

January 24, 2017

Honorable Frank Kotowski
House Health, Human Services and Elderly Affairs Committee
Room 205 Legislative Office Building
N. State Street
Concord, NH 03301

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to testify today. My name is Kenneth Norton and I serve as Executive Director of NAMI NH, the National Alliance on Mental Illness. I also have a family member with a serious mental illness and co-occurring substance use disorder. On behalf of NAMI NH, I am here today to speak in support of HB 286.

Suicide is the second leading cause of death in NH ages 10-34; third leading cause of death ages 35-44 and fourth leading cause of death ages 45-54. Overall it is the ninth leading cause of death. It is the only leading cause of death (beside drug overdose and accidental injury) that is increasing. Middle age white men are among the highest risk category and other high risk groups include Veterans and law enforcement. Suicide can have a profound negative impact on our families and friends, schools, workplaces and communities.

NH Top Ten Leading Causes of Death 2011-2015

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 44	Unintentional Injury 10	Malignant Neoplasms ---	Malignant Neoplasms 11	Unintentional Injury 252	Unintentional Injury 458	Unintentional Injury 381	Malignant Neoplasms 993	Malignant Neoplasms 2,572	Heart Disease 10,179	Malignant Neoplasms 13,455
2	Short Gestation 41	Congenital Anomalies ---	Unintentional Injury ---	Suicide ---	Suicide 109	Suicide 149	Malignant Neoplasms 207	Heart Disease 570	Heart Disease 1,195	Malignant Neoplasms 9,561	Heart Disease 12,126
3	Maternal Pregnancy Comp. 29	Heart Disease ---	Homicide ---	Unintentional Injury ---	Malignant Neoplasms 20	Malignant Neoplasms 76	Suicide 166	Unintentional Injury 453	Unintentional Injury 355	Chronic Low. Respiratory Disease 2,936	Chronic Low. Respiratory Disease 3,377
4	Placenta Cord Membranes 17	Homicide ---	Cerebro-vascular ---	Benign Neoplasms ---	Heart Disease 14	Heart Disease 38	Heart Disease 119	Suicide 281	Chronic Low. Respiratory Disease 329	Cerebro-vascular 2,082	Unintentional Injury 3,276
5	SIDS 11	Influenza & Pneumonia ---	Congenital Anomalies ---	Congenital Anomalies ---	Homicide 14	Congenital Anomalies 14	Liver Disease 37	Liver Disease 165	Liver Disease 250	Alzheimer's Disease 1,924	Cerebro-vascular 2,319
6	Circulatory System Disease 10	Malignant Neoplasms ---	Heart Disease ---	Heart Disease ---	Cerebro-vascular ---	Homicide 12	Diabetes Mellitus 23	Diabetes Mellitus 106	Diabetes Mellitus 248	Unintentional Injury 1,349	Alzheimer's Disease 1,966
7	Respiratory Distress ---	Benign Neoplasms ---	Suicide ---	Homicide ---	Chronic Low. Respiratory Disease ---	Diabetes Mellitus ---	Homicide 17	Chronic Low. Respiratory Disease 85	Suicide 203	Diabetes Mellitus 1,083	Diabetes Mellitus 1,473
8	Necrotizing Enterocolitis ---				Benign Neoplasms ---	Chronic Low. Respiratory Disease ---	Cerebro-vascular 13	Cerebro-vascular 64	Cerebro-vascular 144	Influenza & Pneumonia 1,022	Influenza & Pneumonia 1,119
9	Neonatal Hemorrhage ---				Congenital Anomalies ---	Liver Disease ---	Chronic Low. Respiratory Disease 13	Viral Hepatitis 27	Septicemia 73	Nephritis 782	Suicide 1,060
10	Unintentional Injury ---				Diabetes Mellitus ---	Complicated Pregnancy ---	Two Tied ---	Influenza & Pneumonia 24	Viral Hepatitis 69	Parkinson's Disease 582	Nephritis 869

Terms for Causes of Death Printer-Friendly Version

Think of a suicide death as the proverbial pebble in a pond. While it is the act of an individual, the effects ripple out to family, friends, coworkers and community members. The duration and degree of impact varies, but can be life changing and debilitating for some suicide loss survivors. A suicide death can also increase the risk for suicide in others.

Statistically, when we know someone who dies by Suicide, we become at increased risk for suicide ourselves.

The US Surgeon General has said that Suicide is a significant public health issue that is largely preventable. Please dwell on that for a moment. *Suicide is preventable*. Ninety percent of people who attempt suicide don't go on to die by suicide. However, we collectively have done a poor job addressing and preventing suicide. Toward that end the Surgeon General's Office has issued a National Strategy for Suicide Prevention. One of the goals of the National Strategy is to improve data collection and analysis efforts as a mechanism for improving suicide prevention efforts. That is the intent of this legislation.

The National Action Alliance for Suicide Prevention is a public private partnership charged with implementing the National Strategy. They have developed a "zero suicide" model which tracks suicide deaths in a health care system as a mechanism for implementing evidenced-based programs and strategies to reduce suicide. For health systems which have adopted this approach, research has demonstrated very good results in decreasing suicide deaths.

New Hampshire's mental health system is a public private partnership including private non-profit mental health centers, New Hampshire Hospital our state psychiatric facility, regional hospitals and other providers and facilities. Think for a moment about what would be an "acceptable" number of suicide deaths within that public mental health system? What if I told you it was 5 people each year who took their life while under the care of our public mental health system? Would you be surprised if it were 10? Would you be upset if I told you the number is somewhere around 25 people each year? Contrast that for a moment with the death of a child under the care of our DCYF, our child protective services system, or the death of an individual in custody of police. One of these deaths would result in headlines and a full investigation. Yet these suicide deaths happen in silence, shrouded in stigma and a collective shrug of our shoulders. While we feel the pain and mourn the loss of each individual death, we rarely step back and try to learn what we can do differently to prevent suicide death.

Given the crossover and high percentage of people with co-occurring mental illness and substance abuse disorders and the fact that a significant percentage of overdose deaths are ruled as suicides, it is essential that we include organizations that provide substance misuse treatment in this process as well. While our current mental health system is under much duress, as you heard in the testimony about Emergency Department boarding last week, I want to be clear that I am in no way trying to imply that this legislation is out to demonstrate that the providers are negligent or providing sub-standard care. That said, I understand that this legislation will make many people uncomfortable. What this legislation offers is the hope that by approaching this issue armed with better data and by working through the uncomfortable questions that public disclosure of this data will surely bring, we can collectively identify better strategies for preventing suicide.

It is also important to note that nationally there is not a clear standard of care, percentage or rate of suicide deaths for a public mental health system. Simply stated, one death is one too many. What I am saying very strongly is that we need to be transparent and publicly disclose that total number as the first step to saying what can we do differently; what can we do better? How can

we approach suicide prevention efforts more effectively? Stated a different way, how can we determine how effective treatment is or changes to the mental health system are, if we are not monitoring the number of overall suicide deaths within that system?

This shouldn't place an additional administrative burden on providers. Providers are currently required to submit sentinel event forms to the Department of Health and Human Services (DHHS) which are reviewed regularly. Nor should it place much administrative burden on the DHHS since they already receive and review these reports. Likewise, for the Department of Justice (DOJ) who already collect and provide statewide suicide death data. What the legislation is proposing is that DHHS and DOJ publicly report these deaths to the Legislature and also propose steps that DHHS and their contractors will take to reduce these deaths.

On behalf of NAMI NH, I strongly encourage you to vote HB 286 as ought to pass. Thank you for your time and consideration.

Respectfully,

Kenneth Norton, LICSW
Executive Director