MEMORANDUM

TO: Assembly Finance Committee

FROM: Margaret Dore, Esq., MBA, Choice is an Illusion

RE: Vote "No" on ABX2-15 (Assisted Suicide)
The Financial Cost Could be "Enormous."

DATE: September 3, 2015

I. INTRODUCTION

ABX2-15 seeks to legalize physician-assisted suicide in California. In Oregon, which has a similar law, government reports show a positive statistical correlation between the legalization and occurrence of physician-assisted suicides and an increase in other (conventional) suicides. The financial cost of these other suicides is "enormous."

If California enacts ABX2-15, the financial cost could also be "enormous." ABX2-15 should be rejected.

II. DISCUSSION

A. In Oregon, Other (Conventional) Suicides Have Increased with the Legalization of Physician-Assisted Suicide.

In Oregon, physician-assisted suicide has been legal for 17 years.[1] According to the Oregon Health Authority, the number of physician-assisted suicides has been small, but is steadily

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[1] See Oregon's "Death with Dignity Act Report for 2014, p.1, line 1 (law "enacted in late 1997"). (Attached hereto at A-29).

increasing.[2] This increase is statistically correlated with an increase in other (conventional) suicides. Consider the following:

- Oregon's assisted suicide act went into effect "in late 1997."[3]
- By 2000, Oregon's conventional suicide rate was "increasing significantly."[4]
- By 2007, Oregon's conventional suicide rate was 35% above the national average.[5]
- By 2010, Oregon's conventional suicide rate was 41% above the national average.[6]

This documented increase in conventional suicides, correlated with a steady increase in physician-assisted suicides, is consistent with a suicide contagion in which the legalization of physician-assisted suicide has encouraged other suicides.

B. Oregon's Apparent Suicide Contagion Makes Sense.

It is well known that suicide is contagious. A famous example is Marilyn Monroe whose suicide was followed by "a spate

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2 Id., page 1.

3 Id., page 1, line one.

4 See Oregon Health Authority News Release, September 9, 2010, at http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf ("After decreasing in the 1990s, suicide rates have been increasing significantly since 2000"). (Attached hereto at A-72).

5 Id.

6 See page A-77, attached hereto

of suicides."[7]

A contagion is more likely to occur when there is excessive graphic publicity about the suicide.[8] The apparent suicide contagion in Oregon makes sense given what's been happening there, in which media reports and relentless advocacy by proponents focus on assisted suicides and the people doing them, for example, Brittany Maynard.[9]

C. Suicide is Expensive for the Government.

The financial significance of increased suicides is that they can be expensive. People who attempt suicide don't always succeed; they can be left injured or disabled, requiring hospitalization or long term care. Sometimes suicidal people take other people with them, for example, during a "suicide by cop." This is when a suicidal person threatens the police or civilians in order to be killed by the police. Consider, for example, Californian Andy Williams, who at age 15 decided that he

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[7] Margot Sanger-Katz, "The Science Behind Suicide Contagion," The New York Times, August 13, 2014, at http://www.nytimes.com/2014/08/14/upshot/the-science-behind-suicide-contagion.html?_r=0&abt=0002&abg=1

[8] Id. and "Recommendations for Reporting on Suicide," The National Institute of Mental Health. See also "Preventing Suicide: A Resource for Media Professionals, World Health Organization, at http://www.who.int/mental_health/prevention/suicide/resource_media.pdf

[9] Consider also the case of Lovelle Svart, whose decision to use Oregon's act was featured in a three-month-long media series in *The Oregonian*, which is Oregon's largest paper. The series conclusion featured her death in which online viewers were invited "to hear and see when [she] swallowed the fatal dose." (See article at this link: https://choiceisanillusion.files.wordpress.com/2015/05/lovelle-svart_001.pdf Such graphic coverage is a well known factor of suicide contagion.

wanted to be killed by the police.[10] He went to school with a gun, killed two schoolmates and wounded 13 others.[11] As of 2013, he was reported as incarcerated and not eligible for parole until age 65.[12] An expensive suicide indeed.

D. In Oregon, the Cost of (Conventional) Suicide is "Enormous."

According to the Oregon Health Authority, the financial cost of other (conventional) suicides is "enormous" for Oregon, a state with just one tenth of California's population.[13] The Oregon Health Authority states:

> The cost of suicide [and attempted, but unsuccessful suicides] is enormous [for Oregon]. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars.[14]

E. The Significance for California.

Oregon is the only state where there has been legalization of assisted suicide long enough to have statistics over time.

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10 Rebecca Jacobson, "School Shooter: 'My Grand Plan Was Suicide by Cop,'" PBS Newshour, 02/18/13, https://choiceisanillusion.files.wordpress.com/2015/05/tab-12-suicide-by-cop.pdf

11 Id.

12 Id.

13 Oregon has 3.9 million people; California has 39 million people. https://en.wikipedia.org/wiki/List_of_U.S._states_and_territories_by_population

14 Oregon Health Authority, (Attached hereto at A-78)

The significant financial cost due to increased conventional suicides in Oregon, positively correlated to physician-assisted suicide legalization, is a significant factor for this body to consider regarding the proposed bill, which seeks to legalize physician-assisted suicide in California.

III. CONCLUSION

If California, with its tenfold larger population, enacts the proposed bill and has the same experience as Oregon, the financial cost could be "enormous" for California, as much as ten times the current Oregon figures (to equal $410 million or more). ABX2-15 should be rejected.

Dated this 3rd day of September 2015

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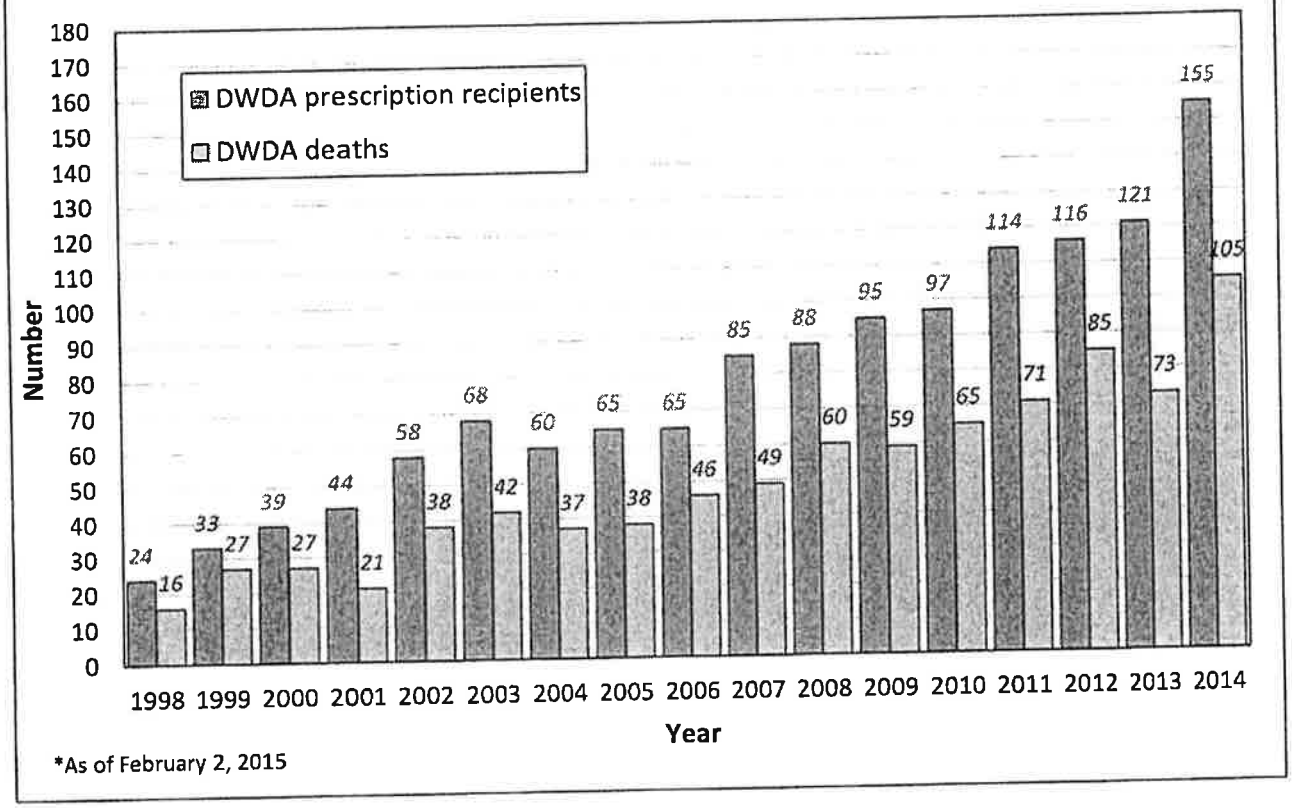
Oregon's Death with Dignity Act--2014

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the DWDA to collect compliance information and to issue an annual report. The key findings from 2014 are presented below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and the resulting deaths from the ingestion of prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of February 2, 2015. For more detail, please view the figures and tables on our web site: http://www.healthoregon.org/dwd.

Figure 1: DWDA prescription recipients and deaths*, by year, Oregon, 1998-2014



*As of February 2, 2015

- As of February 2, 2015, prescriptions for lethal medications were written for 155 people during 2014 under the provisions of the DWDA, compared to 121 during 2013 (Figure 1). At the time of this report, 105 people had died from ingesting the medications prescribed during 2014 under DWDA. This corresponds to 31.0 DWDA deaths per 10,000 total deaths.[1]

[1] Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2013 (33,931), the most recent year for which final death data are available.

NEWS RELEASE

Date: Sept. 9, 2010

Contact: Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.l.stone@state.or.us.

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon's suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000. (for 2007)

After decreasing in the 1990s, suicide rates have been increasing significantly since 2000, according to a new report, "Suicides in Oregon: Trends and Risk Factors," from Oregon Public Health. The report also details recommendations to prevent the number of suicides in Oregon.

"Suicide is one of the most persistent yet preventable public health problems. It is the leading cause of death from injuries – more than even from car crashes. Each year 550 people in Oregon die from suicide and 1,800 people are hospitalized for non-fatal attempts," said Lisa Millet, MPH, principal investigator, and manager of the Injury Prevention and Epidemiology Section, Oregon Public Health.

There are likely many reasons for the state's rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

Stresses such as from job loss, loss of home, loss of family and friends, life transitions and also the stress veterans can experience returning home from deployment – all increase the likelihood of suicide among those who are already at risk.

"Many people often keep their depression a secret for fear of discrimination. Unfortunately, families, communities, businesses, schools and other institutions often discriminate against people with depression or other mental illness. These people will continue to die needlessly unless they have support and effective community-based mental health care," said Millet.

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.
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9/2010

OREGON DEPARTMENT OF HUMAN SERVICES

Public Health Division (PHD)

Suicides in Oregon
Trends and Risk Factors

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Office of Disease Prevention and Epidemiology

DHS | Independent. Healthy. Safe.

Oregon suicide report, issued in September 2010. Data through 2007. Excerpts attached.

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the leading cause of injury death – there are more deaths due to suicide in Oregon than due to car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all Oregonians. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

In 2007, the age-adjusted suicide rate among Oregonians of 15.2 per 100,000 was 35 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among women ages 45-64 rose 55 percent from 8.2 per 100,000 in 2000 to 12.8 per 100,000 in 2007.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (78.4 per 100,000). White males had the highest suicide rate among all races / ethnicity (25.6 per 100,000). Firearms were the dominant mechanism of suicide among men (62%).

Approximately 27 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (45.7 vs. 27.4 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Over 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and just about half of female victims were receiving treatment for mental health problems at the time of death.

Investigators suspect that 30 percent of suicide victims had used alcohol in the hours preceding their death.

The number of suicides in each month varies. But there was not a clear seasonal pattern.

Introduction

Suicide is an important public health problem in Oregon. Each year there are more than 550 Oregonians who died by suicide and more than 1800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon[1]. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars [1,2]. The loss to families and communities broadens the impact of each death.

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"[3]. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Methods, data sources and limitations

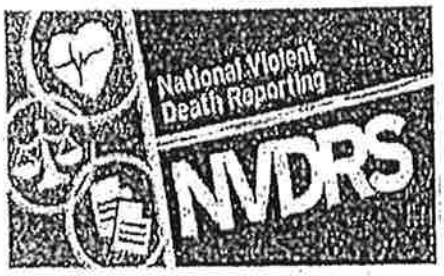
Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with code of X60-84 and Y87.0.[4] Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

[1] Injury in Oregon, 2008 Annual Report. http://www.oregon.gov/DHS/ph/hve/docs/report2008v2_2.pdf. Accessed on March. 25, 2010.

[2] Phaedra S. Corso, James A. Mercy, Thomas R. Simon et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. Am J Prev Med. 2007;32(6):474-482.

[3] Ronald W Maris, Alan L. Berman, Morton M. Silverman. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press. (p378)

[4] Paulozzi LJ, Mercy J, Frazier Jr L, et al. CDC's National Violent Death Reporting System: Background and Methodology. Injury Prevention, 2004;10:47-52.



OREGON

Public Health Division

Suicides in Oregon: Trends and Risk Factors

-2012 Report-

Oregon Violent Death Reporting System

Injury and Violence Prevention Program

Center for Prevention and Health Promotion

Oregon Health Authority

Excerpt printed 2/9/14

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all Oregonians in 2010. The financial and emotional impacts of suicide on family members and the broader community are devastating and long lasting. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data of the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Key Findings

In 2010, the age-adjusted suicide rate among Oregonians of 17.1 per 100,000 was 41 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among adults ages 45-64 rose approximately 50 percent from 18.1 per 100,000 in 2000 to 27.1 per 100,000 in 2010. The rate increased more among women ages 45-64 than among men of the same age during the past 10 years.

Suicide rates among men ages 65 and older decreased approximately 15 percent from nearly 50 per 100,000 in 2000 to 43 per 100,000 in 2010.

Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (76.1 per 100,000). Non-Hispanic white males had the highest suicide rate among all races / ethnicity (27.1 per 100,000). Firearms were the dominant mechanism of injury among men who died by suicide (62%).

Approximately 26 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (44.6 vs. 31.5 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Psychological, behavioral, and health problems co-occur and are known to increase suicide risk. Approximately 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and about 60 percent of female victims were receiving treatment for mental health problems at the time of death.

Eviction/loss of home was a factor associated with 75 deaths by suicide in 2009-2010.

Introduction

Suicide is an important public health problem in Oregon. Health surveys conducted in 2008 and 2009 show that approximately 15 percent of teens and four percent of adults ages 18 and older had serious thoughts of suicide during the past year; and about five percent of teens and 0.4 percent of adults made a suicide attempt in the past year[1,2]. In 2010, there were 685 Oregonians who died by suicide and more than 2,000 hospitalizations due to suicide attempts[3,4]. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 8th leading cause of death among all ages in Oregon[3]. The cost of suicide is enormous. In 2010 alone, self-inflicted injury hospitalization charges exceeded 41 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 680 million dollars [3,4,5]. The loss to families and communities broadens the impact of each death.

The cost $

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"[6]. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2010 and 2003 to 2010 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

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[1] Oregon Healthy Teens 2009 -11th Grade Results.
http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2009/11/Documents/mental11.pdf

[2] Crosby A.E., Han B., Ortega L.A.G., Park S.E., et al, Suicidal Thoughts and Behaviors Among Adults aged >= 18 Years – United States, 2008-2009. MMWR. 2011;60:13.

[3] Oregon Vital Statistics Annual Report, Vol. 2, 2010. Oregon Heath Authority.

[4] Wright D., Millet L., et al, Oregon Injury and Violence Prevention Program Report for 2011 Data year. Oregon Heath Authority.

[5] Corso P.S., Mercy J.A., Simon T.R., et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States.
Am J Prev Med. 2007;32(6):474–482.

[6] Maris R.W., Berman A.L., Silverman A.M. (2000). Comprehensive Textbook of suicidology. New York: The Guilford Press.
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