F I S C A L I M P A C T R E P O R T

SPONSOR: Knauer DATE TYPED: 02/15/01 HB 359

SHORT TITLE: Youth Suicide Prevention Strategies SB

ANALYST: Dunbar

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY01	FY02	FY01	FY02		
	$ 200.0			Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

Child Youth and Families Department

SUMMARY

Synopsis of Bill

HB 359 appropriates $200.0 from general fund to the Department of Health for expenditures in FY02 and FY03 to implement youth suicide prevention programs in the public schools, juvenile detention facilities, public post-secondary educational institutions and programs serving out-of-school youth.

Significant Issues

The suicide prevention strategies would enhance current 24 hour toll-free hotlines for youth crisis intervention, additional depression screening tools, provision of emergency assistance and an active mental health referral process. Suicide prevention education and training of adult and youth gatekeepers would also be included.

PERFORMANCE IMPLICATIONS

The bill should provide for evaluation efforts for these prevention programs, preferably based on outcome measures, such as the incidence of suicidal behavior, or measures closely associated with such behavior. However, DOH should be aware that suicide prevention efforts, like all health interventions, may have unforeseen negative consequences. Evaluation measures should be designed to identify such consequences, should they occur.

When developing a youth suicide prevention program in a particular community, the needs and resources of the community must be identified to determine which strategy or combination of strategies is most appropriate.

FISCAL IMPLICATIONS

HB 359 appropriates $200.0 from general fund to the Department of Health for expenditures in FY02 and FY03. The appropriation is recurring and any unexpended or unencumbered balance remaining at the end of fiscal year 2003 shall revert to the general fund.

OTHER SUBSTANTIVE ISSUES

According to the Department of Health and Human Services there are two conceptual categories in suicide prevention programs: (1) strategies to enhance the recognition of suicidal youth and their referral to existing mental health resources, and (2) strategies designed to directly address known or suspected risk factors for youth suicide.

Strategies to enhance recognition and referral: this category includes active strategies to identify and refer suicidal youth (general screening programs, targeted screening in the context of an apparent suicide cluster) as well as passive strategies to increase referrals (training school and community gatekeepers, general education about youth suicide, establishing crisis centers and hotlines). Some of the passive strategies are designed to lower barriers to self-referral for those with suicidal feelings; others are designed to increase referrals by persons who recognize suicidal tendencies in someone they know.

Strategies to address known or suspected risk factors: this category includes interventions designed to promote self-esteem and build competency in stress management (general suicide education, peer support programs); to develop support networks for youths who have attempted suicide or who are otherwise thought to be at high risk (peer support programs); and to provide crisis counseling or otherwise address the proximal stress events that increase the risk of suicide among susceptible youths (crisis centers and hotlines, interventions to minimize contagion in the context of suicide clusters).

Most programs focus on teenagers, with little emphasis given to suicide prevention among young adults. With a few important exceptions, most programs designed to reduce youth suicide were developed with high school-aged youth in mind. This may be due to the fact that adolescents in high school are easier to reach than young adults 20-24 years of age. But it may also be due to a failure to appreciate that the suicide rate is generally twice as great among persons 20-24 years of age as among adolescents 15-19 years of age.

New and existing suicide prevention programs should be linked as closely as possible with professional mental health resources in the community. As noted, many of the strategies are designed to increase referrals of at-risk youth--this approach can be successful only to the extent that there are appropriate, trained counselors to whom referrals can be made.

POSSIBLE QUESTIONS

Should the bill expand suicide prevention efforts for young adults 20-24 years of age, among whom the suicide rate is twice as high as for adolescents?

BD/ar/njw