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FISCAL IMPACT REPORT

SPONSOR O'Neill ORIGINAL DATE 1/29/21
 LAST UPDATED _____ HB _____

SHORT TITLE Suicide Prevention, Response & Treatment Act SB 128

ANALYST Dinces/Klundt

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY21	FY22	FY23	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		\$134.5- \$2,640	\$134.5- \$2,640	\$269-\$5,280	Recurring	General Fund

Relates to appropriations in the General Appropriation Act executive recommendation of \$3 million for teen suicide prevention programming.

SOURCES OF INFORMATION

LFC Files

Responses Received From

Department of Public Safety

Department of Health

SUMMARY

Synopsis of Bill

Senate Bill 128 (SB128) creates the Suicide Prevention, Response, and Treatment Act to provide standards for treatment in psychiatric facilities, outpatient, and emergency care, and for law enforcement responding to emergency situations. The bill lays out the following:

- Expected standards of treatment for individuals identified as being at risk for suicide,
- Guidelines for suicide risk assessment,
- Expectations for training staff in suicide prevention in facilities that provide treatment services (inpatient, outpatient, emergency department settings) and with personnel involved in responding to and caring for at-risk individuals in community settings (such as with law enforcement),
- Education of police officers about techniques for stabilizing suicidal individuals,
- Appointment of suicide prevention response coordinators in each county,
- Administration of components of the act by the Department of Health, and
- Penalties for non-adherence to act.

FISCAL IMPLICATIONS

While SB128 does not include an appropriation, by creating 33 suicide response coordinator positions, DOH will likely need to determine how to best staff those positions. If DOH decided to create new positions in each county, LFC staff estimate this may cost \$2.64 million per year, based on an average compensation of \$80 thousand for 33 state employees. An alternative to this would be to create regional coordinator positions, staffing 1-2 FTE for each of the five health regions. The cost with this strategy would be substantially less at between \$400 thousand to \$800 thousand. Alternatively the state could also work with local providers, as DOH suggested. This would likely lead to the need for 1 FTE, at a cost of \$134.45 thousand per year.

DOH reported performing the task of appointing and overseeing the county coordinators mandated by the bill would require an additional staff person in the Injury and Behavioral Epidemiology Bureau, at a cost of \$134.45 thousand per year. There is no appropriation to cover this. The bill does provide for levying fines, but it is unclear if these fines, once collected, would accrue to DOH and be used to fund the position and other operating costs. Additional costs would be incurred to promulgate rules in the amount of approximately \$11 thousand per rule.

Therefore, costs associated with this bill range from \$134.45 thousand to \$2.6 million per year, depending on how the state decides to staff the coordinator positions.

SIGNIFICANT ISSUES

The Legislative Finance Committee released the report *Action Plan: Suicide Prevention* in December 2020. The report finds New Mexico has one of the highest suicide rates in the nation, and rates increased faster than in other states from 2014-2018. Based on national cost estimates, LFC staff estimated suicides in 2019 cost \$684.7 million in lifetime lost wages and medical costs. However, there are additional nonmonetary costs as well, including individuals who experience the death by suicide of family members, individuals close to them, and those in their communities are often themselves at greater risk for suicide and at higher risk of behavioral health problems, such as post-traumatic stress disorder and depression.

In regards to prevention activities, the report found that assessing suicide risk and providing continuity of care after a suicide attempt may reduce future suicide attempts and behaviors. The report also highlighted the need to increase trainings for suicide prevention focusing on providers and teachers. In addition to trainings and the transfer of care from one healthcare provider to another with the patient and family in what is called a warm handoff, the report mentions mobile crisis teams as a potential beneficial service, which is similar to the suicide prevention response coordinator position. These mobile crisis teams are currently available in Bernalillo and Doña Ana counties.

DOH reported:

New Mexico's behavioral health system is inadequate to meet the current demand placed on it because the state lacks enough behavioral/mental health services and licensed providers to address the behavioral healthcare needs of residents, especially in rural and frontier communities. In 2020, the federal government's Health Resources and Services Administration (HRSA) designated 31 of the state's 33 counties as Mental Health Professional Shortage Areas (HRSA, 2020). The remaining two counties (Los Alamos

and Bernalillo) were categorized as mental health shortage areas in at least a part of the counties. As a result, finding 33 Suicide Response Coordinators for the state's counties who were available 365/24/7 to pair licensed Behavioral Health providers or specialists with law enforcement officers for suicide-related calls, (who would also need to be available 365/24/7), would be a major challenge.

Not all hospitals in the state have a psychiatric in-patient or behavioral health unit which would allow easier access to psychiatrists who can come immediately to the ED to conduct psychiatric evaluations on suicidal individuals. In New Mexico, mental health hospital inpatient services are provided to adults by three mental health facilities in the state, four private psychiatric hospitals, and 12 general and acute care hospitals with psychiatric or behavioral health units.

(https://www.nmlegis.gov/entity/lfc/Documents/Health_Notes/Health%20Notes%20-%20Cost,%20Use%20and%20Effectiveness%20of%20Inpatient%20Behavioral%20Health%20Services%20for%20Adults.pdf). Emergency Department physicians often discern the disposition of the patients—admission to an in-patient facility or involuntary admission. Patients deemed to be at lower risk are often evaluated and counseled by licensed social workers or psychologists and then referred to outpatient services. However, these services are often difficult to access due to provider shortages or failure of insurers to approve service coverage.

Admission to in-patient facilities is difficult and out-of-state placements are sometimes required, necessitating long travel or the use of local ambulances to transport patients sometimes 4-5 hours from the home community (Personal communications, S. Klassen, 2020; P. Bartok, 2019).

In addition, people seen in EDs for suicide attempts and ideation have reported having difficulty finding an out-patient provider who will take on their care since treating suicidal individuals can be difficult, can typically take more time and energy, and are seen as at higher professional risk than providers feel comfortable managing (Personal communication, M. Brack, 2020; B. Mayne, 2018).

Ultimately, the best solution is upstream and structural. Before people can be referred for care effectively and efficiently, NM needs more in-patient behavioral health and substance use treatment centers and to have more providers educated in caring for suicidal individuals.

The bill as written is likely to place a strain on county resources. In order to have 24-hour availability of a suicide prevention coordinator, each county will need to fund 5 full-time positions, at an estimated entry salary of 24.72/hr. With benefits and office space and all associated costs, each position will cost approximately \$134,450 annually, for a total of more than \$650,000 annually for each county in New Mexico.

The bill has several other challenges:

1. It does not address prevention, response, and treatment related to suicide risk in children and adolescents.
2. It may be overly ambitious or inappropriate in setting standards for how patients ought or should be cared for or monitored. Typically, facilities have standards of care developed

from national guidelines or they vet and adapt their own protocols for how often patents are seen for treatment or consultation. Additionally, DOH cannot regulate how providers will or should speak with or to patients or require the showing of empathy. Some aspects of facilities' adherence to parts of the bill's requirements would be difficult to monitor and enforce.

3. There is an error in the bill's language because it cites a bureau of NMDOH that no longer exists (The Injury Prevention and Emergency Medical Services Bureau of the Public Health Division). Clarification is needed as to which program shall do the tasks proposed in the bill. Is it the Injury and Behavioral Epidemiology Bureau (which now houses Injury Prevention), the Emergency Medical Systems Bureau (which now houses EMS), or the Public Health Division (which houses youth suicide prevention)?

DPS reported:

State statute mandates the following annual in-service training for all certified New Mexico law enforcement officer:

29-7-4.1 NMSA 1978	Domestic abuse incident training (1 hour)
29-7-4.2 NMSA 1978	Child abuse incident training (1 hour)
29-7-7.3 NMSA 1978	Ensuring child safety upon arrest training (2 hours)
29-7-7.4 NMSA 1978	Missing person and AMBER alert training (1 hours)
29-7-7.7 NMSA 1978	Tourniquet and trauma kit training and distribution (1/2 hour)

State statute mandates the following biennial (every two years) in-service training for all certified New Mexico law enforcement officers:

29-20-3 NMSA 1978	Safe pursuit (4 hours)
31-18B-5 NMSA 1978	Detection, investigation, and reporting hate crimes (2 hours)
29-7-7.5 NMSA 1978	Interaction with persons with mental impairments (2 hours) NHTSA Standardized field sobriety testing (4 hours) – for those who may be involved in the arrest of DWI offenders as a normal part of their duties, OR NHTSA Advanced roadside impaired driving enforcement course (16 hrs)

New Mexico annotated code mandates the above listed in-service training for all certified New Mexico law enforcement officers, as well as additional hours to bring the biennial total to 40 hours. The remaining hours shall be in maintenance or advanced areas to meet each agency's needs.

TECHNICAL ISSUES

Page 2, Line 3: The term "...suicidal ideation" is generally used in the singular, not plural as used first in this section and throughout the document

Page 2, Lines 12-16: The definition of "suicidal person" should be changed to: 'Person who is or may be suicidal means a person who may be experiencing an acute mental health crisis, is

experiencing or expressing suicidal ideation or tendencies or is assessed or observed as undertaking or contemplating suicidal actions.”

Page 2, Line 17: The term “psychiatric facilities” is outdated and should be replaced with the term “behavioral health facilities” throughout the document

Page 8, Line 19: Other emergency department providers, such as nurse practitioners and physician assistants, also see patients presenting with attempts and ideation and should be included

Page 13, Line 3: The Injury Prevention and Emergency Medical Services Bureau of the Public Health Division no longer exists and should be replaced with the Injury Prevention Section of the Injury and Behavioral Epidemiology Bureau of the Epidemiology and Response Division.

Page 14, Line 24: Public safety access point is not defined in the bill.

Page 16, Line 10: The section stipulates administrative penalties but does not indicate what account these penalties will be placed in or how they will be used.

KK/al