HOUSE BILL REPORT
ESHB 2315

As Passed House:
February 17, 2014

Title: An act relating to suicide prevention.

Brief Description: Concerning suicide prevention.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Orwall, Harris, Cody, Roberts, Short, Morrell, Manweller, Green, Jinkins, Fitzgibbon, Tharinger, Ryu, Goodman, Ormsby, Pollet and Walkinshaw).

Brief History:
Committee Activity:
Health Care & Wellness: 1/22/14, 2/3/14 [DPS];
Appropriations Subcommittee on Health & Human Services: 2/6/14 [DPS(HCW)].
Floor Activity:
Passed House: 2/17/14, 94-3.

Brief Summary of Engrossed Substitute Bill

- Expands the professions that must complete training in suicide assessment, treatment, and management.
- Requires the model list of training programs in suicide assessment, treatment, and management to be updated periodically and, when practicable, to contain content specific to veterans.
- Requires the development of a plan to create a pilot program for adult psychiatric consultation.
- Requires the development of the Washington Plan for Suicide Prevention.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Clibborn, DeBolt, Green, G. Hunt, Jinkins, Manweller, Moeller, Morrell, Ross, Tharinger and Van De Wege.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Staff: Jim Morishima (786-7191).

HOUSE COMMITTEE ON APPROPRIATIONS SUBCOMMITTEE ON HEALTH & HUMAN SERVICES

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 10 members: Representatives Morrell, Chair; Harris, Ranking Minority Member; Cody, Green, G. Hunt, Kagi, Ormsby, Ross, Schmick and Tharinger.

Staff: Andy Toulon (786-7178).

Background:

Training in Suicide Assessment, Treatment, and Management.

The following health professions must complete training in suicide assessment, treatment, and management every six years as part of their continuing education requirements:

- counselors and certified advisors;
- chemical dependency professionals;
- marriage and family therapists, mental health counselors, and social workers;
- occupational therapy practitioners;
- psychologists; and
- persons holding a retired active credential in any of the affected professions.

The first training must be completed during the first full renewal period after initial licensure or January 1, 2014, whichever is later. A person is exempt from the first training if he or she can demonstrate completion, no more than six years prior to initial licensure, of the required training.

The training must be approved by the relevant disciplining authority and must include the following elements: suicide assessment, including screening and referral; suicide treatment; and suicide management. A disciplining authority may approve a training program that includes only screening and referral elements if appropriate for the profession in question based on the profession's scope of practice. The Board of Occupational Therapy may approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting. A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length.

The relevant disciplining authorities were required to work collaboratively to develop a model list of training programs by December 15, 2013. When developing the list, the disciplining authorities were required to consider training programs listed on the Best Practices Registry of the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center and to consult with experts and stakeholders.

A disciplining authority may specify minimum training and experience necessary to exempt a practitioner from the training requirement. The Board of Occupational Therapy may exempt

occupational therapy practitioners from the training based on brief or limited patient contact. A state or local government employee, or an employee of a community mental health agency or a chemical dependency program, is exempt from the training requirements if he or she has at least six hours of training in suicide assessment, treatment, and management from his or her employer. The training may be provided in one six-hour block or in shorter segments at the employer's discretion.

The Secretary of Health (Secretary) was directed to complete a study evaluating the effect of evidence-based suicide assessment, treatment, and management training on the ability of a licensed health care professional to identify, refer, treat, and manage patients with suicidal ideation. The study, which was completed in late 2013:

- reviewed available research and literature regarding the relationship between completion of the training and patient suicide rates;
- assessed which licensed health care professionals are best situated to positively influence the mental health behavior of individuals with suicidal ideation;
- evaluated the impact of suicide assessment, treatment, and management training on veterans with suicidal ideation; and
- reviewed curricula of health profession programs offered at state educational institutions regarding suicide prevention.

The Partnership Action Line.

In 2007 the Department of Social and Health Services (DSHS) was directed to implement a pilot program to support primary care providers in the assessment and provision of appropriate diagnosis and treatment of children with mental and behavioral health disorders. The resulting program, the Partnership Action Line (PAL), provides psychiatric consultations by telephone to primary care providers statewide. The PAL is based out of Children's Orthopedic Hospital in Seattle and is staffed by child psychiatrists and social workers.

The Washington State Plan for Youth Suicide Prevention.

In 1995 the Department of Health, the University of Washington School of Nursing, and a group of experts and stakeholders developed the Washington State Plan for Youth Suicide Prevention. The plan was updated in 2009. The plan contained a variety of statistical and demographic information about youth suicide and set forth five goals (and action areas related to those goals):

- Suicide is recognized as everyone's business.
- Youth ask for and get help when they need it.
- People know what to look for and how to help.
- Care is available to those who seek it.
- Suicide is a preventable public health problem.

Summary of Engrossed Substitute Bill:

Training in Suicide Assessment, Treatment, and Management.

The list of health professions required to complete training in suicide assessment, treatment, and management is expanded to include:

- chiropractors;
- naturopaths;
- licensed practical nurses, registered nurses, and advanced registered nurse practitioners;
- physicians (who must complete the training on an eight-year cycle, and whose training must include related behavioral health conditions);
- osteopathic physicians;
- physician assistants;
- osteopathic physician assistants;
- physical therapists; and
- physical therapist assistants.

The model list of training programs must be updated at least once every two years. When updating the list, the disciplining authorities must, to the extent practicable, endeavor to include training that includes content specific to veterans. The disciplining authorities must consult with the Washington State Department of Veterans Affairs (WDVA) when identifying content specific to veterans.

Any disciplining authority, instead of just the Board of Occupational Therapy Practice, may exempt a professional from the training requirement if the professional only has brief or limited patient contact.

The Secretary must update the study evaluating the effect of evidence-based suicide assessment, treatment, and management training on the ability of a licensed health care professional to identify, refer, treat, and manage patients with suicidal ideation. The study must be updated twice, once in 2018 and once in 2022, and must be reported to the Governor and the appropriate committees of the Legislature by November 15, 2018, and November 15, 2022.

Psychiatric Consultation Pilot Program.

The DSHS and the Health Care Authority (HCA) must develop a plan for a pilot program to support primary care providers in the assessment and provision of appropriate diagnosis and treatment of adults with mental or other behavioral health disorders and track outcomes of the program. The program must include two pilot sites, one in an urban setting and one in a rural setting, and must include timely case consultation between primary care providers and psychiatric specialists.

The plan must include:
- a description of the recommended program design, staffing model, and projected utilization rates for the two pilot sites and for statewide implementation; and
- detailed fiscal estimates for the pilot sites and for statewide implementation, including:
    - a detailed cost breakdown of the elements of the pilot, including the proportion of anticipated federal and state funding for each element; and
    - an identification of the elements and costs that would need to be funded though new resources and existing funding.

When developing the plan, the DSHS and the HCA must consult with experts and stakeholders, including primary care providers, experts on psychiatric interventions, institutions of higher education, tribal governments, the WDVA, and the Partnership Action Line.

The DSHS and the HCA must provide the plan to the appropriate committees of the Legislature by November 15, 2014.

Washington Plan for Suicide Prevention.

The Secretary must develop a Washington Plan for Suicide Prevention. The plan must, at a minimum:

- examine data relating to suicide in order to identify patterns and key demographic factors;
- identify key risk and protective factors relating to suicide; and
- identify goals, action areas, and implementation strategies relating to suicide prevention.

When developing the plan, the Secretary must consider national research and practices employed by the federal government, tribal governments, and other states, including the National Strategy for Suicide Prevention. The plan must be written in a manner that is accessible and useful to a broad audience. The Secretary must periodically update the plan as needed.

The Secretary must convene a steering committee to advise him or her in the development of the plan. The committee must consist of representatives from:

- experts on suicide assessment, treatment, and management;
- institutions of higher education;
- tribal governments;
- the WDVA;
- the DSHS;
- suicide prevention advocates, at least one of whom must be a suicide survivor and at least one of who must be a survivor of a suicide attempt;
- local health departments or districts; and
- any other organizations or groups the Secretary deems appropriate.

The Secretary must complete the plan by November 15, 2015, must publish the plan on the Department of Health website, and must submit copies of the plan to the Governor and the appropriate committees of the Legislature.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony (Health Care & Wellness):

(In support) This bill is about saving lives. These suicides are happening every day; we must take action to stop these preventable deaths. This is a community problem that demands community action. This bill is an example of what happens when we prioritize policy for our state. The suicide assessment, treatment, and management training requirement that is being expanded in this bill has resulted in cutting edge trainings being developed in our state. Of the health care professionals who responded to a recent Department of Health survey, 85 percent felt that they would benefit from this training and over 50 percent felt the training should be mandatory. Washington's suicide rate is 15 percent higher than the national average. Of the people who commit suicide in this state, 25 percent had military experience. This training is particularly important with all of the veterans who are coming home. Veterans are two to three times more likely to die from suicide than from any other cause. Washington has the eighth highest veteran population in the nation. The issue of suicide affects veterans of all ages. This training needs to be mandatory because most professionals will avoid this training like the plague if it is voluntary. Up to 75 percent of suicide victims saw a primary care provider before killing themselves; 32 percent of suicide victims are in active care. Health care professionals are currently not adequately trained in suicide assessment, treatment, and management. The idea that they cannot spend six to eight hours in training every six to eight years is an insult to suicide victims and survivors. Requiring periodic training is not unduly burdensome and is supported in the literature. Training in HIV and CPR is mandatory; suicide training should not be any different. This bill does not add to the total number of continuing education hours that must be completed. This will help move the state toward the goal of zero suicides.

(Opposed) Training in suicide assessment, treatment, and management, while important, should not be mandatory. Continuing education should be relevant to a professional's practice area. Clinical training requires hours of continuing education specific to the profession. Suicide assessment, treatment, and management training may not be relevant in certain practice areas, such as intensive care and end-of-life care. This bill is not a good use of resources when lean practices are needed to control costs. Regulation increases costs. The state should not set the precedent of regulating a professional's choice of training. Many professionals already receive this training. Each provider should be able to choose continuing education programs based on the provider's assessment of his or her learning needs. Training needs to be customized based on need and education level. The training mandate should not be expanded across all professions and care settings with a broad brush.

Staff Summary of Public Testimony (Appropriations Subcommittee on Health & Human Services):

(In support) Washington state continues to have a higher rate of suicide than the national average. For youth, the rate is second only to automobile accidents in terms of deaths. According to the latest healthy use survey, 44 percent of high school students are suffering from some type of depression or have had suicidal thoughts within the last year.

This bill sets the stage for the important integration of mental health and physical health in two ways. The first is development of a suicide plan that addresses a full continuum of life. We have a suicide plan in Washington state for youth that was developed in 2009. It is insufficient in addressing youth because it does not take into account new technologies such as cyber-bullying. Additionally it does not take into account younger adults, older adults, or

college-aged kids that may have other pressures. The second is that the two pilots will help find a way to better integrate mental health treatment into a primary care setting. This is important because in most cases, suicide attempts are made by people who have previously been seen by a primary physician.

A lot of the professionals that would be covered under this bill say they already know this. The problem is they usually do not know what isn't known. The evidence seems to show that identification of someone with suicidal thoughts is something that many front line providers do not know enough about, and the cost in human lives is way too high. This bill teaches physical health professionals how to deal with mental health problems and refer patients to cost effective and appropriate treatment.

The kind of people being lost to suicide include parents with young children, veterans, and young people. Eight of the 10 members on this committee live in counties where the suicide rate is higher than the state average, and the suicide rate in the state is higher than the national average. Back when the first bill on this topic was created, it was noted that efforts to improve training would have little value if they did not include primary care. The pilot program is the compromise in this bill because you do not want to leave primary care providers sitting out in the cold, and there are not always sufficient mental health resources available.

Washington is one of the few states without a comprehensive suicide plan and there are a number of people who want to work on this. There is a plague of veterans coming back from Iraq and Afghanistan committing suicide. If a little bit of training could prevent the heartache and trauma caused by suicide, then this will be an outstanding bill.

(In support with concerns) A statewide plan for suicide prevention makes sense if the Legislature is able to fund it.

(Opposed) The two pilot projects and the ability for physicians to find a place for patients to get timely follow-up mental health care are very important. There needs to be better access to emergent care and mental health appointments within the one or two days after being seen by the primary physician. The mandated educational requirement is a problem and would be best handled at the medical commission level which knows the needs of the practicing community physicians. The funds identified in the fiscal note would be better used for a call center where a primary care professional can call in and find resources to send a patient to.

Persons Testifying (Health Care & Wellness): (In support) Representative Orwall, prime sponsor; Paul Quinnet, Question Persuade Refer Institute; Jennifer Stuber, Forefront: Innovation in Suicide Prevention; John Osborn; Sarah Clingan, Now Matters Now; Ursula Whiteside, Zero Suicides in Healthcare; Enrique Garcia; Jim Sims, Veterans Legislative Coalition; and Sandi Ando, National Alliance on Mental Illness Washington.

(Opposed) Doris Visaya, Home Care Association of Washington; Mary Langley, Association of Advanced Practice Psychiatric Nurses; and Lisa Butler, Washington State Hospice and Palliative Care Organization.

Persons Testifying (Appropriations Subcommittee on Health & Human Services): (In support) Melanie Smith, Youth Suicide Prevention Program; Bob Cooper, National Association of Social Workers; Jennifer Stuber, Forefront; and Ted Wicorek, Veterans Legislative Coalition.

(In support with concerns) Chris Imhoff, Division of Behavioral Health and Recovery.

(Opposed) Carl Nelson, Washington State Medical Association.

Persons Signed In To Testify But Not Testifying (Health Care & Wellness): Martin Mueller, Washington Department of Health; Charles Allen, Now Matters Now; John Corr; Kevin Martin, Washington Academy of Family Physicians; Carl Nelson, Washington State Medical Association; Maggie Hood, Washington Chapter American Academy of Pediatrics; Gary Goldbaum, Snohomish Health District; Jane Beyer, Department of Social and Health Services; Grace Huang, Washington State Coalition Against Domestic Violence; Melissa Johnson, Washington State Nurses Association, Physical Therapy Association and Washington Association of Nurse Anesthetists; and Melanie Smith, Youth Suicide Prevention Program.

Persons Signed In To Testify But Not Testifying (Appropriations Subcommittee on Health & Human Services): None.