FINAL BILL REPORT
ESHB 2315

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Synopsis as Enacted

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).

House Committee on Health Care & Wellness
House Committee on Appropriations Subcommittee on Health & Human Services
Senate Committee on Health Care
Senate Committee on Ways & Means

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

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

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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 requirement 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:

Training in Suicide Assessment, Treatment, and Management.

The following health professions are required to complete one-time training in suicide assessment, treatment, and management:

- chiropractors;
- naturopaths;
- licensed practical nurses, registered nurses, and advanced registered nurse practitioners;
- physicians;
- osteopathic physicians;
- physician assistants;
- osteopathic physician assistants;
- physical therapists; and
- physical therapist assistants.

The training must be at least six hours in length, unless the relevant disciplining authority determines that only screening and referral elements are appropriate, in which case the training must be at least three hours in length. The training must be completed during the first full continuing education reporting period after initial licensure or the effective date of the act, whichever is later.

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 individuals 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 program, 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 PAL.

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, publish the plan on the Department of Health website, and submit copies of the plan to the Governor and the appropriate committees of the Legislature.

Votes on Final Passage:

House	94	3	
Senate	49	0	(Senate amended)
House	96	2	(House concurred)

Effective: June 12, 2014