SENATE BILL REPORT
ESHB 2315

As of February 26, 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: Passed House: 2/17/14, 94-3.
Committee Activity: Health Care: 2/24/14.

SENATE COMMITTEE ON HEALTH CARE

Staff: Bonnie Kim (786-7316)

Background: Required Training. In 2012 the Legislature directed the Secretary of Health (Secretary) to work with certain disciplining authorities to develop a model list of approved training programs in suicide assessment, treatment, and management. Training programs were required to be at least six hours unless a disciplining authority found a three-hour training in suicide assessment only, i.e., screening and referral, to be appropriate based on a profession's scope of practice.

The following six health care professions must complete training in suicide assessment, treatment, and management every six years as part of their continuing education (CE) requirements: (1) counselors and certified advisors; (2) chemical dependency professionals; (3) marriage and family therapists, mental health counselors, and social workers; (4) occupational therapy practitioners; (5) psychologists; and (6) persons holding a retired active credential in any of the affected professions. Disciplining authorities may exempt professionals from the training requirement if a practitioner meets certain other training and experience requirements. In addition, the Board of Occupational Therapy Practice may exempt a professional if the professional has brief or limited patient contact.

The Legislature also directed the Secretary to complete a study evaluating the effect of evidence-based suicide prevention training for licensed health care professionals to identify, refer, treat, and manage patients with suicidal ideation. The study was completed in

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December 2013, and concluded that a prospective study on mandated training would be beneficial because there is only limited existing research on the issue.

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

Washington State Plan for Youth Suicide Prevention. In 1995 the Department of Health (DOH), the University of Washington School of Nursing, and a group of experts and stakeholders developed the Washington State Plan for Youth Suicide Prevention. In 2009 the plan was updated to include statistical and demographic information about youth suicide and the following five goals and action areas: (1) suicide is recognized as everyone's business; (2) youth ask for and get help when they need it; (3) people know what to look for and how to help; (4) care is available to those who seek it; and (5) suicide is a preventable public health problem.

Summary of Bill: Required Training. The following nine health professions are also required to complete training in suicide assessment, treatment, and management: (1) chiropractors; (2) naturopaths; (3) licensed practical nurses, registered nurses, and advanced registered nurse practitioners; (4) physicians, training is required once every eight years and must include related behavioral health conditions; (5) osteopathic physicians; (6) physician assistants; (7) osteopathic physician assistants; (8) physical therapists; and (9) physical therapist assistants.

Disciplining authorities must update the model list of training programs at least every two years, and, to the extent practicable, consult with the Washington State Department of Veterans Affairs (WDVA) to include veteran-specific training. Any disciplining authority may exempt a professional from the training requirement if the professional has only brief or limited patient contact. The Secretary must twice more update the study evaluating the effect of evidence-based suicide prevention training for licensed health care providers to identify, refer, treat, and manage patients with suicidal ideation. The updated studies must be reported to the Governor and the Legislature by November 15, 2018, and November 15, 2022.

Psychiatric Consultation Pilot Program. By November 15, 2014, DSHS and the Health Care Authority (HCA) must, in consultation with experts and stakeholders, develop a pilot program plan 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 to track program outcomes. The program must include two pilot sites, urban and rural, and timely consultation between primary care providers and psychiatric specialists. The plan describes the recommended program design, staffing model, projected utilization rates, and fiscal estimates for both the pilot sites and for statewide implementation.

Washington Plan for Suicide Prevention. The Secretary must, in consideration of national research and practices of federal, tribal, and other state governments, develop a Washington Plan for Suicide Prevention that, at a minimum, examines data relating to suicide to identify

patterns and key demographic factors; identifies key risk and protective factors relating to suicide; and identifies goals, action areas, and implementation strategies relating to suicide prevention. The Secretary must craft the plan in a manner accessible and useful to a broad audience and update the plan as needed. By November 15, 2015, the Secretary must publish the completed plan on DOH's website and submit copies to the Governor and the Legislature.

The Secretary must convene a steering committee to advise in plan development. The committee must consist of representatives from experts on suicide assessment, treatment, and management; institutions of higher education; tribal governments; WDVA; 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.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Washington has a 15 percent higher suicide rate than the national average. Primary care providers are not trained for suicide prevention. Suicide is preventable. There are evidence-based suicide prevention techniques to be taught. The Veteran's Administration estimates veterans are two or three times more likely to commit suicide than the general population. Treatment works and primary care providers are in a good position to catch suicidal ideation early. Health care providers need to have this training to better help patients with suicidal thoughts. This bill is an elementary mental health requirement. Washington has 1000 suicides per year and this bill will help reduce that number. Section 2 of the bill is critical to gather research data. As we integrate health care, all providers should have this training. DOH supports the statewide plan development. Some military members are hesitant to seek help because of their military careers. The key is to identify those at risk and not to wait until they are already in a provider's office. Social workers are required to complete 108 hours of continuing education in six years and the six-hour suicide prevention training requirement is minimal.

OTHER: This bill is well intentioned, but the committee should strike the mandatory training requirement because it is unsupported by evidence. The evidence shows that training will not accomplish the goal of decreasing the suicide rate. Physicians need to be able to determine the training that will best support their practice setting. The problem is not the training but the unfunded, damaged mental health system. It would be better to focus on what happens once a patient presents with suicidal ideation.

Persons Testifying: PRO: Representative Orwall, prime sponsor; Jim Sims, Veterans Legislative Coalition; Margaret “Peggy" West, Suicide Prevention Resource Center, Education Development Center; Enrique Garcia, Recovery Advocates of WA, Forefront; Paul Quinnett, Ph.D., QPR Institute; John Osborn, MD; Jennifer Stuber, Forefront; Ursula Whiteside, Zero Suicides In Health Care National Action Alliance; Cassandra Ando, National

Assn. of Mental Illness WA; Bob Rudolph, Veterans and Military Families for Progress; Martin Mueller, DOH; Hoyt Suppes, National Assn. of Social Workers WA State Chapter; Clista Rakow, American Foundation for Suicide Prevention (AFSP); Melanie Smith, Youth Suicide Prevention Program; Steve Absalonson, AFSP Advocate, SOS.

OTHER: Stephen Albrecht, Mary Clogston, WA Academy of Family Physicians; Charles Meredith, WA State Psychological Assn, WA State Medical Assn. (WSMA); Carl Nelson, WSMA; Melissa Johnson, WA State Nurses Assn.; Leslie Emerick, Home Care Assn., WA, Assn. Advanced Practice Psychiatric Nurses, WA St Hospice Palliative Care Organization; Chris Imhoff, Director, DSHS Division of Behavioral Health and Recovery.