HOUSE BILL REPORT
HB 1354

As Reported by House Committee On:
Children, Youth & Families

Title: An act relating to suicide review teams.

Brief Description: Concerning suicide review teams.

Sponsors: Representatives Mosbrucker, Orwall, Davis, Ramos, Callan, Berry, Valdez, Jacobsen, Bergquist, Dent and Pollet.

Brief History:
Committee Activity:
Children, Youth & Families: 2/1/21, 2/15/21 [DPS].

Brief Summary of Substitute Bill

- Establishes the Washington Youth Suicide Review Team to review the circumstances related to suicides occurring among youth up to age 25.

HOUSE COMMITTEE ON CHILDREN, YOUTH & FAMILIES

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Senn, Chair; Harris-Talley, Vice Chair; Rule, Vice Chair; Dent, Ranking Minority Member; McCaslin, Assistant Ranking Minority Member; Callan, Eslick, Goodman, Klippert, Ortiz-Self and Wicks.

Minority Report: Without recommendation. Signed by 2 members: Representatives Chase, Assistant Ranking Minority Member; Young.

Staff: Luke Wickham (786-7146) and Erik Olson (786-7296).

Background:

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

Suicide Prevention Plans.
The Washington State Suicide Prevention Plan, which was adopted in 2016, identifies goals in the following areas:

- healthy and empowered individuals, families, and communities;
- clinical and community preventive services;
- treatment and support services; and
- suicide surveillance, research, and evaluation.

In addition, Washington State's Plan for Youth Suicide Prevention, last updated in 2014, states the following goals for youth suicide prevention:

- suicide is recognized as everyone's business;
- youth ask for and get help when needed;
- people know what to look for and how to help;
- care is available for those who seek it; and
- suicide is recognized as a preventable public health problem.

Child Mortality Reviews.
Local health departments are authorized to conduct child mortality reviews. A child mortality review is a process for examining factors that contribute to the deaths of children younger than age 18. The process may include:

- a systematic review of medical, clinical, and hospital records;
- home interviews of parents and caretakers of children who have died;
- analysis of individual case information; and
- review by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with the death.

Summary of Substitute Bill:

The Department of Health (DOH) must establish the Washington Youth Suicide Review Team (WYSRT) to review the circumstances related to suicides occurring among youth up to age 25. The WYSRT consists of the following members:

- a psychiatrist who works primarily with youth;
- a psychologist who works primarily with youth;
- an advanced clinical social worker, or an independent clinical social worker, who works primarily with youth;
- a member of the clergy;
- an advanced registered nurse practitioner, a physician assistant, or an osteopathic physician assistant, who works primarily with youth;
- a representative of a tribal health department;
- a representative of an organization that advocates for persons with mental illness and their family members;
- a county coroner or medical examiner;

- a member of the educational community with experience related to existing and potential suicide prevention efforts for students in primary and secondary schools;
- a member of the law enforcement community with experience related to existing and potential suicide prevention efforts for youth who are involved in the law enforcement system;
- a member of the Legislative Youth Advisory Council, or a designee of the council;
- a member of the child protection system with experience related to existing and potential suicide prevention efforts for youth involved with the child protection system; and
- a family member of a youth who died by suicide.

The WYSRT must:

- perform an in-depth review of each instance where a person under age 25 has died by suicide during the 2020 calendar year, excluding any suicide that occurs within Indian reservations if the tribal government opposes the review;
- analyze circumstances affecting the lives of the persons who have been reviewed to ascertain the existence of any common factors that may have contributed to their suicides, including:
    - a review of medical records related to a youth suicide that includes: medical records, including mental health information; school records; social services records, including individual case information; and relevant legal records;
    - voluntary home interviews of parents and caretakers, individual case information;
    - the impact of the COVID-19 pandemic and the state's response to the pandemic; and
    - access to various lethal means; and
- compile statistics to establish a description of the lives of youths who have died by suicide and recommendations for targeting intervention programs to reach youth earlier in life.

For the sole purposes of its analysis and review, the WYSRT has the authority to:

- request and receive data relevant to a specific youth's death by suicide including, but not limited to, all medical records related to the suicide, autopsy reports, medical examiner reports, coroner reports, and schools, law enforcement, justice system, and social services records; and
- request and receive the described data from health care providers, health care facilities, clinics, schools, law enforcement, the justice system, laboratories, medical examiners, coroners, and any other relevant professions and facilities licensed by the DOH, local health jurisdictions, the Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and the Department of Children, Youth, and Families (DCYF).

Upon request by the WYSRT, the following must provide all information and records related to a specific youth's death by suicide to the WYSRT:

- health care providers;
- health care facilities;
- clinics;
- schools;
- law enforcement;
- the justice system;
- laboratories;
- medical examiners;
- coroners;
- any other relevant professions and facilities licensed by the DOH;
- local health jurisdictions;
- the HCA;
- the DOH;
- the DSHS; and
- the DCYF.

The WYSRT shall develop protocols for contacting and interviewing families and caregivers. Such protocols shall be based on trauma-informed care principles and address:

- the review team's collection, use, and disclosure of information and records to families and caregivers related to the youth; and
- the fact that the interviews are voluntary.

No information or data collected or created by the WYSRT may be used for any purpose other than the analysis and work done by the review team.

The DOH must convene the meetings of the WYSRT and provide assistance as necessary. Health care providers are required to disclose, without a patient's authorization, health care information requested by the DOH to support the activities of the WYSRT.

All health care information collected by the WYSRT shall remain confidential. Records collected by the WYSRT may be used only for supporting the WYSRT's activities. No identifying information relating to the deceased person, the person's personal representative, or anyone voluntarily interviewed by the WYSRT may be disclosed, and any such information must be deidentified from any records produced as part of the WYSRT's activities.

Witness statements, documents collected from witnesses, or summaries of those statements or records prepared by the WYSRT are not subject to public disclosure, discovery, subpoena, or introduction into evidence in any administrative, civil, or criminal proceeding related to the death of a person reviewed. This does not restrict or limit the discovery or subpoena from a health provider of records or documents maintained by the provider in the ordinary course of business, regardless of whether the records or documents have been supplied to a local health jurisdiction. The discovery or subpoena of documents from witnesses is not restricted simply because a copy of a document was collected as part of the

WYSRT.

The WYSRT's treatment of records and information must be consistent with federal law regarding health care information, also known as protected health information or patient identifying information.

Any identifying information collected by the WYSRT is exempt from public disclosure.

The WYSRT shall, in the course of its review, consider relevant suicide prevention analyses and recommendations by entities such as the Children and Youth Behavioral Health Work Group, Accountable Communities of Health, the Bree Collaborative, and any suicide review team or committee as may be established concurrent to the WYSRT.

The WYSRT must report its findings and recommendations to the Governor and the Legislature by June 1, 2023. The report must include information regarding the feasibility of establishing locally based youth suicide review teams. Any compilation of data must be summarized in a manner to prevent the identification of information of any specific person who was the subject of review.

The terms "suicide" or "death by suicide" are defined as a death that is identified as a suicide through a death certificate, by a medical examiner or coroner, or by another process that may be determined by the DOH.

Substitute Bill Compared to Original Bill:

The substitute bill makes the following changes to the original bill:

- requires the Washington Youth Suicide Review Team (WYSRT) to include a member of the Legislative Youth Advisory Council or a designee of the council;
- increases the age of the youth that the WYSRT reviews up to age 25;
- specifies that the WYSRT's review of medical records must relate to a youth suicide;
- states that the review of medical records involved in the WYSRT's analysis may include: medical records, including mental health information; school records; social services records, including individual case information; and relevant legal records;
- adds the access to various lethal means to the WYSRT's analysis;
- authorizes the WYSRT, for the sole purposes of its analysis and review, to request medical records relating to a suicide, autopsy reports, medical examiner reports, coroner reports, school records, criminal justice records, law enforcement reports, and social services records;
- requires that, upon request from the WYSRT, the following must provide all information and records related to a specific youth's death by suicide to the WYSRT:
    - health care providers;
    - health care facilities;
    - clinics;
    - schools;

        - criminal justice;
        - law enforcement;
        - laboratories;
        - medical examiners;
        - coroners;
        - professions and facilities licensed by the Department of Health (DOH);
        - local health jurisdictions;
        - the DOH;
        - the Department of Social and Health Services; and
        - the Department of Children, Youth, and Families; and
    - requires the WYSRT to develop protocols for contacting and interviewing families and caregivers that are based on trauma-informed care principles and address the fact that the interviews are voluntary;
    - prohibits information or data collected or created by the WYSRT to be used for any purpose other than the analysis and work done by the review team;
    - states that all health care information collected by the WYSRT shall remain confidential and subject to the Uniform Health Care Information Act;
    - expands that no identifying information related to a deceased person's personal representative may be disclosed;
    - deidentifies identifying information from any records produced as part of the WYSRT's activities in accordance with the requirements set forth by the Health Insurance Portability and Accountability Act;
    - requires the WYSRT, in the course of its review, to consider relevant suicide prevention analyses and recommendations by entities such as the Children and Youth Behavioral Health Work Group, Accountable Communities of Health, the Bree Collaborative, and any suicide review team or committee that may be established concurrent to the WYSRT; and
    - defines that "suicide" or "death by suicide" means a death that is identified as a suicide through a death certificate, by a medical examiner or coroner, or by another process that may be determined by the DOH.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) One in four people will have some sort of mental or neurological disorder in their lifetime. Suicide is the second leading cause of death of those who are between ages 15 and 19. Further, over 16 percent of youth between ages 15 and 19 in Washington have

reported making a suicide plan. Montana and South Carolina currently have suicide mortality review teams. This bill aims to answer the question of "why?" behind the youth suicides and find any commonalities. Reviewing and analyzing the information surrounding youth suicides will help find the nuances behind the deaths by suicide, prevent future youth suicides with knowledge about effective intervention treatments, and shed light on the appropriateness of various legislative actions. Additionally, this bill will provide information and support to families of youth who died by suicide. Adding language about "access to lethal means" will aid the analysis as nearly half of youth suicides involve a firearm. Moreover, the information and knowledge gained by this review should be provided to schools, higher education institutions, work places, and health care providers who help youth. The Washington Youth Suicide Review Team (WYSRT) should also provide support to families impacted by youth suicides.

(Opposed) None.

(Other) Although the WYSRT has good intent and a data first approach, a few changes need to be made to protect medical privacy and to improve the clarity and consistency of the bill. This bill should add language to ensure that it aligns with federal privacy laws. Further, healthcare information should be deidentified rather than redacted, and the review team's records, including medical records, should be exempt from the state public disclosure laws. Also, the review team should only review medical records that relate to the suicide of a particular youth. Overall, the bill needs to be tightened up to bolster and strengthen the review team's mandate.

Persons Testifying: (In support) Representative Mosbrucker, prime sponsor; Jodi Daly, Comprehensive Healthcare; Melissa Kline, Washington State Parent Teacher Association; and Benine McDonnell.

(Other) Jaclyn Greenberg, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: None.