House Interim Committee on Behavioral Health

Chair	Representative Andrea Salinas	Democrat, District 38 (Lake Oswego)
Vice-Chair	Representative Cedric Hayden	Republican, District 7 (Roseburg)
Vice-Chair	Representative Rob Nosse	Democrat, District 42 (Portland)
Member	Representative Maxine Dexter	Democrat, District 33 (Portland)
Member	Representative John Lively	Democrat, District 12 (Springfield)
Member	Representative Raquel Moore-Green	Republican, District 19 (Salem)
Member	Representative Duane Stark	Republican, District 4 (Grants Pass)

Notes on presenting from different legislators:

- When presenting to legislators start with facts re Oregon's suicide rates. Note no increase in suicide but increase in mental health issues

- Establish relationship and remain in contact with the chairs of the Ways and Means committee and members of the committee. We will not know who that will be until after the November election. This will be key for advocating for continued safety net/behavioral health investments.

- In advocating for CEU legislation, highlight the fact that this is a long-term, strategic response to ongoing issue and not legislation that is primarily a crisis (COVID/Fires etc)

Legislators we have met with as of 12.01.2020

Name	House or Senate	In Support of Bill?	Follow-Up Needed?	Any comments?
Nosse	House	Yes	Yes	-Recommended that we meet with different groups that the bill will impact as this is where he has seen other bills fail – when the group that the bill impacts are against the legislation -Said it's not a partisan issue but is more of a discussion of how much money is available and what the competing priorities are at the time
Dexter	House	Didn't fully express one way or the other. Wants more information. Believe she will be in support.	Yes	-Is a healthcare provider -Also passionate about gun violence prevention -Asked about other ways to have people take training that isn't rule based -Have we looked at other avenues?
Lively	House	Yes	Yes	Questions from lively -What is part of their certification process? Aren't they required to take some kind of training now? -Efforts in the past - what has been the primary reason we haven't been able to get this adopted? -Is there a difference in a standpoint between how people would be trained to help youth vs adults -Send him sb 48 report Concerns 1. Timing of things. 6 years in taking a course seems too long

				2. Would someone reach out vs someone reach out for self
Moore-Green	House	Yes	Yes – want to work with us more on this	-Background not in healthcare, has experience in non-profit work -Send current YSIPP -Wants to do more work with us going forward
Salinas	House	Yes – sponsoring it	Yes	Work closely with Salinas as they are sponsoring the bill

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Dear (Insert OHA Name – Send to Jill to forward on, is there someone else appropriate) and Legislative Committee That Receives the Report:

We are writing on behalf of the Oregon Alliance to Prevent Suicide (Alliance) to support and amplify the conclusion that behavioral health professionals should be required to receive education on suicide assessment, intervention and management in the Oregon Health Authority's October 2020 report to the Legislature, *Suicide-related training for media and behavioral health* providers. [1]' This letter focuses on results for the behavioral health workforce.

Last year suicide was the leading cause of death for Oregonians between ages 10 to 24 and Oregon's suicide rates have continued to rise across the lifespan. We know that well-trained counselors, peer providers, therapists and social workers can identify the signs of suicidality *and* support people through a suicidal crisis while building the skills to live a full life, yet

The core recommendation of the report is: "Physical and behavioral health providers that are confident, competent and equipped to provide the best care to those who experience suicide ideation is an essential part of Oregon's suicide prevention strategy. To ensure Oregon's workforce is meeting the needs of people most at-risk, the law should require suicide prevention education in professional training programs and continuing education for key professions."

Unfortunately, assessment and treatment for suicidality is not a standard part of either undergraduate or post-graduate training for behavioral health therapists, social workers, and counselors. OHA's 2020 legislative report indicates that without a mandate many behavioral healthcare providers received no recent training in suicide risk assessment or management. Only 33.8% of psychologists, 46.9% of social workers and 37.4% of counselors and therapists reported receiving any training. The Teachers Standards and Practices Commission which licenses school counselors had the highest rate of completed trainings at 74.9%. While this is an excellent start, the reality is that school counselors generally only assess suicidal students and count on being able to refer students to well-trained therapists or social workers. The fact that more than half of most behavioral health professionals in Oregon received no training in suicide assessment or treatment means that even when referred to treatment people may not get the help they need.

The 2020 report is a requirement of Senate Bill (SB) 48 (2017), which requires the licensing boards for physical and behavioral health providers to submit a summary of aggregate data to OHA annually on March 1st, SB48 was introduced in 2017 by members of the Alliance and OHA with the intention of requiring continuing education on suicide assessment, intervention and management; however, opposition, especially from the healthcare (specifically medical) sector, led to a compromise bill that simply required licensing board to document how many of their licensees were taking relevant courses, for OHA to publish the results and for OHA to post a list of available trainings.

The Alliance is re-introducing legislation in 2021 to require that Oregon's behavioral health workforce receive training in suicide assessment, intervention, and treatment at least once every six years. We have looked to our neighboring state, Washington, for a model for developing this type of mandate. Our long-term goal is to also ensure that suicide prevention training is widely available and utilized by primary care and other health professionals. Further SB48 reports will help us to assess whether the current voluntary approach is achieving this goal. However, our assessment is that we are a few years

[1] Oregon Health Authority, Public Health Division, Suicide-related training for medical and behavioral health providers: Data report to the Legislature. October 2020.

away from being able to move that forward by addressing and overcoming opposition from various medical licensing entities and professional organizations. This is understandable as doctors and nurses have numerous continuing education requirements, many of which do indeed address life and death matters. However, in the case of the behavioral health workforce, they are the designated "experts" to whom those who are experiencing suicidal ideation are referred. We would go so far as to say that it is unethical that counselors, therapists, social workers, and peer support specialists, who regularly interact with highly suicidal individuals often do not have a strong understanding of how to assess risk of suicide effectively , and how to engage with people through times of suicidal ideation. They also need to understand and convey to their clients that many people live full, productive lives despite living with chronic suicidal thoughts and to help their clients develop the skills to do so.

Preparing this workforce to meet these needs is essential. Requiring continuing education is the least we could do as a start. We look forward to ongoing work in partnership with OHA to ensure that our professionals have the skills to identify suicide risk and help save lives.

California Suicide Prevention Training Requirement

The state of California has always required its clinical practitioners to complete continuing education (CE) requirements in order to maintain their license. Soon, the state will require an additional CE class from new and active clinicians. Beginning on January 1, 2020 for California psychologists and January 1, 2021 for other licensed clinicians, such as MFTs, LCSWs, and LPCs, clinicians must complete six hours of suicide risk assessment and intervention training.

Signed into law in 2017 by former Governor Jerry Brown, the new training mandate is being implemented in response to rising suicide rates. With more individuals at risk than ever in California communities, it's important that clinicians receive standardized training on assessing suicide risk and intervening when clients need support.

The new rule applies to current licensed practitioners as well as new graduates and pre-licensed professionals. Those applying to receive their license after January 1, 2020 (psychologists) or January 1, 2021 (all other clinical licenses) will need to demonstrate they completed this new requirement before taking the licensure exam. Currently licensed clinicians will need to declare they've met the requirement when renewing their license. All applicants need to retain proof of meeting the requirement, as the board might ask them to show documentation.

In order to support clinicians in meeting this requirement, the respective boards will offer a few different ways to meet the new suicide risk and intervention coursework. The three options are: meeting the requirement through a qualifying graduate program, meeting the requirement through applied clinical experience, and by taking an approved continuing education course.

Some clinicians can meet the new requirement through coursework offered at their qualifying graduate program. These applicants must demonstrate that their coursework met the same standard is a CE course on suicide assessment and intervention. They provide proof of completion through receiving a written statement from their graduate program certifying the student met the requirement through essential or supplement coursework.

Other applicants will or have already received the equivalent training on the job, in a setting such as clinical supervision, an internship, or practicum after graduation. In this instance, the applicant or licensed clinician will need to get a written statement from the clinical supervisor of their clinical practical experience, certifying that they completed this training in the workplace.

Applicants who don't obtain the hours in their graduate program or practicum can do so in an approved continuing education course. You'll need to take the course with a provider your board has approved. After completing the course, you will receive a certification, which you'll need to keep as proof of meeting the requirement.

Clinicians can take the coursework to meet the requirement at any time before their licensure application or renewal is due, so encourage everyone to get started on meeting the requirement now. In some cases, clinicians will have already met the requirement in their graduate program or internship, in which case they'll need to obtain proof from their school or suspervisor before the deadline.

State of Washington Health Profession Mandatory Suicide Prevention Training

Tools and Links

Suicide Prevention Training Home | Program Approval Process | Suicide Prevention Plan | Resources
Legislation (RCW 43.70.442) requires that the health professions listed below take a suicide prevention course that meets their hour and content requirement before the end of the next full continuing education reporting period. Implementation dates vary by profession. After identifying the suicide prevention training requirements for a profession, find courses on the Model List.
For specific questions about your own suicide training requirements or whether a particular training is appropriate for your health profession, please contact the program manager or executive director of your profession's board or commission.

People in the following professions must complete suicide prevention training:

Profession	Hours of Training and Frequency	Core Training Components and Content
Social workers • Advanced social workers • Advanced social worker associates • Independent clinical social workers • Independent clinical social worker associates * began January 1, 2014	Six hours at least once every six years	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Certified counselors | certified advisers * began January 1, 2014	Three hours every six years	Suicide screening and referral

Chemical dependence professionals * began January 1, 2014	Three hours every six years	Suicide screening and referral
Chiropractors * began January 1, 2016	Three hours one time	Suicide screening and referral
Dentists * beginning August 1, 2020	Three hours one time	• Suicide screening and referral Assessment of issues related to imminent harm via lethal means
Dental hygienists * beginning August 1, 2020	Three hours one time	• Suicide screening and referral
Licensed mental health professionals * began January 1, 2014	Six hours at least once every six years	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Licensed practical nurses (LPN), registered nurses (RN) and advanced registered nurse practitioners (ARNP) - certified registered nurse anesthetists are exempt * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans

Marriage and family therapists * began January 1, 2014	Six hours at least once every six years	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Naturopaths * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Occupational therapists and assistants * began January 1, 2014	Three hours at least once every six years	Suicide screening and referral
Osteopathic physicians and surgeons - holders of a postgraduate training license issued under RCW 18.57.035 are exempt * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Osteopathic physician assistants * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans

Pharmacists * began January 1, 2017	Three hours one time	• Suicide screening and referral • Assessment of issues related to imminent harm via lethal means
Physicians -residents holding a limited license issued under RCW 18.71.095 (3) are exempt * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Physician assistants * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Physical therapists and assistants * began January 1, 2016	Three hours one time	Suicide screening and referral
Psychologists * began January 1, 2014	Six hours at least once every six years	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans

Retired active licensee for one of these professions: • Naturopaths • LPNs, RNs, or ARNPs (certified registered nurse anesthetists are exempt) • Osteopathic physicians and surgeons (other than a holder of a postgraduate osteopathic medicine and surgery license) • Osteopathic physician assistants • Physician assistants • Physicians (other than a resident holding a limited license) * began January 1, 2016	Six hours one time	• Suicide assessment, treatment and management • Imminent harm via lethal means or self-injurious behaviors • Content on veterans
Retired active license as a dentist * begins August 1, 2020	Three hours one time	Assessment of issues related to imminent harm via lethal means

Suicide assessment, treatment, and management training—Requirement for certain professionals—Exemptions—Model list of programs—Rules—Health profession training standards provided to the professional educator standards board. ***(Effective until July 1, 2022.)***

(1)(a) Each of the following professionals certified or licensed under Title 18 RCW shall, at least once every six years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) An adviser or counselor certified under chapter 18.19 RCW;

(ii) A substance use disorder professional licensed under chapter 18.205 RCW;

(iii) A marriage and family therapist licensed under chapter 18.225 RCW;

(iv) A mental health counselor licensed under chapter 18.225 RCW;

(v) An occupational therapy practitioner licensed under chapter 18.59 RCW;

(vi) A psychologist licensed under chapter 18.83 RCW;

(vii) An advanced social worker or independent clinical social worker licensed under chapter 18.225 RCW; and

(viii) A social worker associate—advanced or social worker associate—independent clinical licensed under chapter 18.225 RCW.

(b) The requirements in (a) of this subsection apply to a person holding a retired active license for one of the professions in (a) of this subsection.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (1)(d) affects the validity of training completed prior to July 1, 2017.

(2)(a) Except as provided in (b) of this subsection:

(i) A professional listed in subsection (1)(a) of this section must complete the first training required by this section by the end of the first full continuing education reporting period after January 1, 2014, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(ii) Beginning July 1, 2021, the second training for a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical must be either: (A) An advanced training focused on suicide management, suicide care protocols, or effective treatments; or (B) a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy-suicide prevention. If a professional subject to the requirements of this subsection has already completed the professional's second training prior to July 1, 2021, the professional's next training must comply with this subsection. This subsection (2)(a)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(a)(ii) is not reasonably available.

(b)(i) A professional listed in subsection (1)(a) of this section applying for initial licensure may delay completion of the first training required by this section for six years after initial licensure if he or she can demonstrate successful completion of the training required in subsection (1) of this section no more than six years prior to the application for initial licensure.

(ii) Beginning July 1, 2021, a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical exempt from his or her first training under (b)(i) of this subsection must comply with the requirements of (a)(ii) of this subsection for his or her first training after initial licensure. If a professional subject to the requirements of this subsection has already completed the professional's first training after initial licensure, the professional's next training must comply with this subsection (2)(b)(ii). This subsection (2)(b)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(b)(ii) is not reasonably available.

(3) The hours spent completing training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education or continuing competency requirements for each profession.

(4)(a) A disciplining authority may, by rule, specify minimum training and experience that is sufficient to exempt an individual professional from the training requirements in subsections (1) and (5) of this section. Nothing in this subsection (4)(a) allows a disciplining authority to provide blanket exemptions to broad categories or specialties within a profession.

(b) A disciplining authority may exempt a professional from the training requirements of subsections (1) and (5) of this section if the professional has only brief or limited patient contact.

(5)(a) Each of the following professionals credentialed under Title **18** RCW shall complete a one-time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority:

(i) A chiropractor licensed under chapter **18.25** RCW;

(ii) A naturopath licensed under chapter **18.36A** RCW;

(iii) A licensed practical nurse, registered nurse, or advanced registered nurse practitioner, other than a certified registered nurse anesthetist, licensed under chapter **18.79** RCW;

(iv) An osteopathic physician and surgeon licensed under chapter **18.57** RCW, other than a holder of a postgraduate osteopathic medicine and surgery license issued under RCW **18.57.035**;

(v) An osteopathic physician assistant licensed under chapter **18.57A** RCW;

(vi) A physical therapist or physical therapist assistant licensed under chapter **18.74** RCW;

(vii) A physician licensed under chapter **18.71** RCW, other than a resident holding a limited license issued under RCW **18.71.095**(3);

(viii) A physician assistant licensed under chapter **18.71A** RCW;

(ix) A pharmacist licensed under chapter **18.64** RCW;

(x) A dentist licensed under chapter **18.32** RCW;

(xi) A dental hygienist licensed under chapter **18.29** RCW;

(xii) An athletic trainer licensed under chapter 18.250 RCW;

(xiii) An optometrist licensed under chapter 18.53 RCW;

(xiv) An acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW; and

(xv) A person holding a retired active license for one of the professions listed in (a)(i) through (xiv) of this subsection.

(b)(i) A professional listed in (a)(i) through (viii) of this subsection or a person holding a retired active license for one of the professions listed in (a)(i) through (viii) of this subsection must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between June 12, 2014, and January 1, 2016, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(ii) A licensed pharmacist or a person holding a retired active pharmacist license must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2017, or during the first full continuing education reporting period after initial licensure, whichever is later.

(iii) A licensed dentist, a licensed dental hygienist, or a person holding a retired active license as a dentist shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2020, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between July 23, 2017, and August 1, 2020, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iii), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(iv) A licensed optometrist or a licensed acupuncture and Eastern medicine practitioner, or a person holding a retired active license as an optometrist or an acupuncture and Eastern medicine practitioner, shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2021, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between August 1, 2020, and August 1, 2021, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iv), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (5)(d) affects the validity of training completed prior to July 1, 2017.

(6)(a) The secretary and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management. Beginning July 1, 2021, for purposes of subsection (2)(a)(ii) of this

section, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal.

(b) The secretary and the disciplining authorities shall update the list at least once every two years.

(c) By June 30, 2016, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors and that three-hour trainings for pharmacists or dentists include content related to the assessment of issues related to imminent harm via lethal means. When adopting the rules required under this subsection (6)(c), the department shall:

(i) Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations; and

(ii) Consider standards related to the best practices registry of the American foundation for suicide prevention and the suicide prevention resource center.

(d) Beginning January 1, 2017:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection and any three-hour trainings that met the requirements of this section on or before July 24, 2015;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management, and three-hour trainings that include only screening and referral elements; and

(iii) A person or entity providing the training required in this section may petition the department for inclusion on the model list. The department shall add the training to the list only if the department determines that the training meets the minimum standards established in the rules adopted under (c) of this subsection.

(e) By January 1, 2021, the department shall adopt minimum standards for advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. Beginning July 1, 2021, all such training on the model list must meet the minimum standards. When adopting the minimum standards, the department must consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations.

(7) The department shall provide the health profession training standards created in this section to the professional educator standards board as a model in meeting the requirements of RCW **28A.410.226** and provide technical assistance, as requested, in the review and evaluation of educator training programs. The educator training programs approved by the professional educator standards board may be included in the department's model list.

(8) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under chapter **18.130** RCW.

(9) The secretary and the disciplining authorities affected by this section shall adopt any rules necessary to implement this section.

(10) For purposes of this section:

(a) "Disciplining authority" has the same meaning as in RCW 18.130.020.

(b) "Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training 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 also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting.

(11) A state or local government employee is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

(12) An employee of a community mental health agency licensed under chapter 71.24 RCW or a chemical dependency program certified under chapter 71.24 RCW is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

[2020 c 229 § 1. Prior: 2019 c 444 § 13; (2019 c 444 § 12 expired August 1, 2020); 2019 c 358 § 5; (2019 c 358 § 4 expired August 1, 2020); 2017 c 262 § 4; 2016 c 90 § 5; 2015 c 249 § 1; 2014 c 71 § 2; prior: 2013 c 78 § 1; 2013 c 73 § 6; 2012 c 181 § 2.]

NOTES:

Effective date—2020 c 229 § 1: "Section 1 of this act takes effect August 1, 2020." [2020 c 229 § 4.]

Effective dates—2019 c 444 §§ 13 and 19: "(1) Section 13 of this act takes effect August 1, 2020.

(2) Section 19 of this act takes effect July 1, 2026." [2019 c 444 § 32.]

Expiration dates—2019 c 444 §§ 12 and 18: "(1) Section 12 of this act expires August 1, 2020.

(2) Section 18 of this act expires July 1, 2026." [2019 c 444 § 33.]

Effective date—2019 c 358 § 5: "Section 5 of this act takes effect August 1, 2020." [2019 c 358 § 8.]

Expiration date—2019 c 358 § 4: "Section 4 of this act expires August 1, 2020." [2019 c 358 § 7.]

Effective date—2017 c 262 § 4: "Section 4 of this act takes effect August 1, 2020." [2017 c 262 § 7.]

Findings—Intent—2017 c 262: "The legislature finds that over one thousand one hundred suicide deaths occur each year in Washington and these suicide deaths take an enormous toll on families and communities across the state. The legislature further finds that: Sixty-five percent of all suicides, and most suicide deaths and attempts for young people ages ten to eighteen, occur using firearms and prescription medications that are easily accessible in homes; firearms are the most lethal method used in suicide and almost entirely account for more men dying by suicide than women; sixty-seven percent of all veteran deaths by suicide are by firearm; and nearly eighty percent of all deaths by firearms in Washington are suicides. The legislature further finds that there is a need for a robust public education campaign designed to raise awareness of suicide and to teach everyone the role that he or she can play in suicide prevention. The legislature further finds that important suicide prevention efforts include: Motivating households to improve safe storage practices to reduce deaths from firearms and prescription medications; decreasing barriers to prevent access to lethal means by allowing for temporary and voluntary transfers of firearms when individuals are at risk for suicide; increasing access to drug take-back sites; and making the public aware of suicide prevention steps, including recognizing warning signs, empathizing and listening, asking directly about suicide, removing dangers to ensure immediate safety, and getting help. The legislature intends by this act to create a public-private partnership fund to implement a suicide-safer home public education campaign in the coming years." [**2017 c 262 § 1**.]

Effective date—2016 c 90 § 5: "Section 5 of this act takes effect January 1, 2017." [**2016 c 90 § 8**.]

Findings—2016 c 90: "The legislature finds that: Washington's suicide rate is fourteen percent higher than the national average; on average, two young people between the ages of ten and twenty-four die by suicide each week; almost a quarter of those who die by suicide are veterans; and many of the state's rural and tribal communities have the highest suicide rates. The legislature further finds that when suicide occurs, it has devastating consequences for communities and schools, yet, according to the United States surgeon general, suicide is the nation's most preventable form of death. The legislature further finds that one of the most immediate ways to reduce the tragedy of suicide is through suicide awareness and prevention education coupled with safe storage of lethal means commonly used in suicides, such as firearms and prescription medications. The legislature further finds that encouraging firearms dealers to voluntarily participate in suicide awareness and prevention education programs and provide certain safe storage devices at cost is an important step in creating safer homes and reducing suicide deaths in the state." [**2016 c 90 § 1**.]

Findings—Intent—2014 c 71; 2012 c 181: "(1) The legislature finds that:

(a) According to the centers for disease control and prevention:

(i) In 2008, more than thirty-six thousand people died by suicide in the United States, making it the tenth leading cause of death nationally.

(ii) During 2007-2008, an estimated five hundred sixty-nine thousand people visited hospital emergency departments with self-inflicted injuries in the United States, seventy percent of whom had attempted suicide.

(iii) During 2008-2009, the average percentages of adults who thought, planned, or attempted suicide in Washington were higher than the national average.

(b) According to a national study, veterans face an elevated risk of suicide as compared to the general population, more than twice the risk among male veterans. Another study has indicated a positive correlation between posttraumatic stress disorder and suicide.

(i) Washington state is home to more than sixty thousand men and women who have deployed in support of the wars in Iraq and Afghanistan.

(ii) Research continues on how the effects of wartime service and injuries, such as traumatic brain injury, posttraumatic stress disorder, or other service-related conditions, may increase the number of veterans who attempt suicide.

(iii) As more men and women separate from the military and transition back into civilian life, community mental health providers will become a vital resource to help these veterans and their families deal with issues that may arise.

(c) Suicide has an enormous impact on the family and friends of the victim as well as the community as a whole.

(d) Approximately ninety percent of people who die by suicide had a diagnosable psychiatric disorder at the time of death, such as depression. Most suicide victims exhibit warning signs or behaviors prior to an attempt.

(e) Improved training and education in suicide assessment, treatment, and management has been recommended by a variety of organizations, including the United States department of health and human services and the institute of medicine.

(2) It is therefore the intent of the legislature to help lower the suicide rate in Washington by requiring certain health professionals to complete training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements.

(3) The legislature does not intend to expand or limit the existing scope of practice of any health professional affected by this act." [**2014 c 71 § 1**; **2012 c 181 § 1**.]

Short title—2012 c 181: "This act may be known and cited as the Matt Adler suicide assessment, treatment, and management training act of 2012." [**2012 c 181 § 4**.]

RCW 43.70.442

Suicide assessment, treatment, and management training—Requirement for certain professionals—Exemptions—Model list of programs—Rules—Health profession training standards provided to the professional educator standards board. *(Effective July 1, 2022.)*

(1)(a) Each of the following professionals certified or licensed under Title **18** RCW shall, at least once every six years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) An adviser or counselor certified under chapter **18.19** RCW;

(ii) A substance use disorder professional licensed under chapter **18.205** RCW;

(iii) A marriage and family therapist licensed under chapter **18.225** RCW;

(iv) A mental health counselor licensed under chapter 18.225 RCW;

(v) An occupational therapy practitioner licensed under chapter 18.59 RCW;

(vi) A psychologist licensed under chapter 18.83 RCW;

(vii) An advanced social worker or independent clinical social worker licensed under chapter 18.225 RCW; and

(viii) A social worker associate—advanced or social worker associate—independent clinical licensed under chapter 18.225 RCW.

(b) The requirements in (a) of this subsection apply to a person holding a retired active license for one of the professions in (a) of this subsection.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (1)(d) affects the validity of training completed prior to July 1, 2017.

(2)(a) Except as provided in (b) of this subsection:

(i) A professional listed in subsection (1)(a) of this section must complete the first training required by this section by the end of the first full continuing education reporting period after January 1, 2014, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(ii) Beginning July 1, 2021, the second training for a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical must be either: (A) An advanced training focused on suicide management, suicide care protocols, or effective treatments; or (B) a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy-suicide prevention. If a professional subject to the requirements of this subsection has already completed the professional's second training prior to July 1, 2021, the professional's next training must comply with this subsection. This subsection (2)(a)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(a)(ii) is not reasonably available.

(b)(i) A professional listed in subsection (1)(a) of this section applying for initial licensure may delay completion of the first training required by this section for six years after initial licensure if he or she can demonstrate successful completion of the training required in subsection (1) of this section no more than six years prior to the application for initial licensure.

(ii) Beginning July 1, 2021, a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical exempt from his or her first training under (b)(i) of this subsection must comply with the requirements of (a)(ii) of this subsection for his or her first training after initial licensure. If a professional subject to the requirements of this subsection has already completed the professional's first training after initial licensure, the professional's next training must comply with this subsection (2)(b)(ii). This subsection (2)(b)(ii) does not

apply if the licensee demonstrates that the training required by this subsection (2)(b)(ii) is not reasonably available.

(3) The hours spent completing training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education or continuing competency requirements for each profession.

(4)(a) A disciplining authority may, by rule, specify minimum training and experience that is sufficient to exempt an individual professional from the training requirements in subsections (1) and (5) of this section. Nothing in this subsection (4)(a) allows a disciplining authority to provide blanket exemptions to broad categories or specialties within a profession.

(b) A disciplining authority may exempt a professional from the training requirements of subsections (1) and (5) of this section if the professional has only brief or limited patient contact.

(5)(a) Each of the following professionals credentialed under Title 18 RCW shall complete a one-time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority:

(i) A chiropractor licensed under chapter 18.25 RCW;

(ii) A naturopath licensed under chapter 18.36A RCW;

(iii) A licensed practical nurse, registered nurse, or advanced registered nurse practitioner, other than a certified registered nurse anesthetist, licensed under chapter 18.79 RCW;

(iv) An osteopathic physician and surgeon licensed under chapter 18.57 RCW, other than a holder of a postgraduate osteopathic medicine and surgery license issued under RCW 18.57.035;

(v) A physical therapist or physical therapist assistant licensed under chapter 18.74 RCW;

(vi) A physician licensed under chapter 18.71 RCW, other than a resident holding a limited license issued under RCW 18.71.095(3);

(vii) A physician assistant licensed under chapter 18.71A RCW;

(viii) A pharmacist licensed under chapter 18.64 RCW;

(ix) A dentist licensed under chapter 18.32 RCW;

(x) A dental hygienist licensed under chapter 18.29 RCW;

(xi) An athletic trainer licensed under chapter 18.250 RCW;

(xii) An optometrist licensed under chapter 18.53 RCW;

(xiii) An acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW; and

(xiv) A person holding a retired active license for one of the professions listed in (a)(i) through (xiii) of this subsection.

(b)(i) A professional listed in (a)(i) through (vii) of this subsection or a person holding a retired active license for one of the professions listed in (a)(i) through (vii) of this subsection must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between June 12, 2014, and January 1, 2016, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b), must be accepted

by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(ii) A licensed pharmacist or a person holding a retired active pharmacist license must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2017, or during the first full continuing education reporting period after initial licensure, whichever is later.

(iii) A licensed dentist, a licensed dental hygienist, or a person holding a retired active license as a dentist shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2020, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between July 23, 2017, and August 1, 2020, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iii), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(iv) A licensed optometrist or a licensed acupuncture and Eastern medicine practitioner, or a person holding a retired active license as an optometrist or an acupuncture and Eastern medicine practitioner, shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2021, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between August 1, 2020, and August 1, 2021, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iv), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (5)(d) affects the validity of training completed prior to July 1, 2017.

(6)(a) The secretary and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management. Beginning July 1, 2021, for purposes of subsection (2)(a)(ii) of this section, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal.

(b) The secretary and the disciplining authorities shall update the list at least once every two years.

(c) By June 30, 2016, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors and that three-hour trainings for pharmacists or dentists include content related to the assessment of issues related to imminent harm via lethal means. When adopting the rules required under this subsection (6)(c), the department shall:

(i) Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and

management, the Washington department of veterans affairs, and affected professional associations; and

(ii) Consider standards related to the best practices registry of the American foundation for suicide prevention and the suicide prevention resource center.

(d) Beginning January 1, 2017:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection and any three-hour trainings that met the requirements of this section on or before July 24, 2015;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management, and three-hour trainings that include only screening and referral elements; and

(iii) A person or entity providing the training required in this section may petition the department for inclusion on the model list. The department shall add the training to the list only if the department determines that the training meets the minimum standards established in the rules adopted under (c) of this subsection.

(e) By January 1, 2021, the department shall adopt minimum standards for advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. Beginning July 1, 2021, all such training on the model list must meet the minimum standards. When adopting the minimum standards, the department must consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations.

(7) The department shall provide the health profession training standards created in this section to the professional educator standards board as a model in meeting the requirements of RCW **28A.410.226** and provide technical assistance, as requested, in the review and evaluation of educator training programs. The educator training programs approved by the professional educator standards board may be included in the department's model list.

(8) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under chapter **18.130** RCW.

(9) The secretary and the disciplining authorities affected by this section shall adopt any rules necessary to implement this section.

(10) For purposes of this section:

(a) "Disciplining authority" has the same meaning as in RCW **18.130.020**.

(b) "Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training 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 also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting.

(11) A state or local government employee is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For

purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

(12) An employee of a community mental health agency licensed under chapter 71.24 RCW or a chemical dependency program certified under chapter 71.24 RCW is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

[2020 c 229 § 1; 2020 c 80 § 30. Prior: 2019 c 444 § 13; (2019 c 444 § 12 expired August 1, 2020); 2019 c 358 § 5; (2019 c 358 § 4 expired August 1, 2020); 2017 c 262 § 4; 2016 c 90 § 5; 2015 c 249 § 1; 2014 c 71 § 2; prior: 2013 c 78 § 1; 2013 c 73 § 6; 2012 c 181 § 2.]

NOTES:

Reviser's note: This section was amended by 2020 c 80 § 30 and by 2020 c 229 § 1, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2020 c 229 § 1: "Section 1 of this act takes effect August 1, 2020." [2020 c 229 § 4.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Effective dates—2019 c 444 §§ 13 and 19: "(1) Section 13 of this act takes effect August 1, 2020.

(2) Section 19 of this act takes effect July 1, 2026." [2019 c 444 § 32.]

Expiration dates—2019 c 444 §§ 12 and 18: "(1) Section 12 of this act expires August 1, 2020.

(2) Section 18 of this act expires July 1, 2026." [2019 c 444 § 33.]

Effective date—2019 c 358 § 5: "Section 5 of this act takes effect August 1, 2020." [2019 c 358 § 8.]

Expiration date—2019 c 358 § 4: "Section 4 of this act expires August 1, 2020." [2019 c 358 § 7.]

Effective date—2017 c 262 § 4: "Section 4 of this act takes effect August 1, 2020." [2017 c 262 § 7.]

Findings—Intent—2017 c 262: "The legislature finds that over one thousand one hundred suicide deaths occur each year in Washington and these suicide deaths take an enormous toll on families and communities across the state. The legislature further finds that: Sixty-five percent of all suicides, and most suicide deaths and attempts for young people ages ten to eighteen, occur using firearms and prescription medications that are easily accessible in homes; firearms are the most lethal method used in suicide and almost entirely account for more men dying by suicide than women;

sixty-seven percent of all veteran deaths by suicide are by firearm; and nearly eighty percent of all deaths by firearms in Washington are suicides. The legislature further finds that there is a need for a robust public education campaign designed to raise awareness of suicide and to teach everyone the role that he or she can play in suicide prevention. The legislature further finds that important suicide prevention efforts include: Motivating households to improve safe storage practices to reduce deaths from firearms and prescription medications; decreasing barriers to prevent access to lethal means by allowing for temporary and voluntary transfers of firearms when individuals are at risk for suicide; increasing access to drug take-back sites; and making the public aware of suicide prevention steps, including recognizing warning signs, empathizing and listening, asking directly about suicide, removing dangers to ensure immediate safety, and getting help. The legislature intends by this act to create a public-private partnership fund to implement a suicide-safer home public education campaign in the coming years." [**2017 c 262 § 1**.]

Effective date—2016 c 90 § 5: "Section 5 of this act takes effect January 1, 2017." [**2016 c 90 § 8**.]

Findings—2016 c 90: "The legislature finds that: Washington's suicide rate is fourteen percent higher than the national average; on average, two young people between the ages of ten and twenty-four die by suicide each week; almost a quarter of those who die by suicide are veterans; and many of the state's rural and tribal communities have the highest suicide rates. The legislature further finds that when suicide occurs, it has devastating consequences for communities and schools, yet, according to the United States surgeon general, suicide is the nation's most preventable form of death. The legislature further finds that one of the most immediate ways to reduce the tragedy of suicide is through suicide awareness and prevention education coupled with safe storage of lethal means commonly used in suicides, such as firearms and prescription medications. The legislature further finds that encouraging firearms dealers to voluntarily participate in suicide awareness and prevention education programs and provide certain safe storage devices at cost is an important step in creating safer homes and reducing suicide deaths in the state." [**2016 c 90 § 1**.]

Findings—Intent—2014 c 71; 2012 c 181: "(1) The legislature finds that:

(a) According to the centers for disease control and prevention:

(i) In 2008, more than thirty-six thousand people died by suicide in the United States, making it the tenth leading cause of death nationally.

(ii) During 2007-2008, an estimated five hundred sixty-nine thousand people visited hospital emergency departments with self-inflicted injuries in the United States, seventy percent of whom had attempted suicide.

(iii) During 2008-2009, the average percentages of adults who thought, planned, or attempted suicide in Washington were higher than the national average.

(b) According to a national study, veterans face an elevated risk of suicide as compared to the general population, more than twice the risk among male veterans. Another study has indicated a positive correlation between posttraumatic stress disorder and suicide.

(i) Washington state is home to more than sixty thousand men and women who have deployed in support of the wars in Iraq and Afghanistan.

(ii) Research continues on how the effects of wartime service and injuries, such as traumatic brain injury, posttraumatic stress disorder, or other service-related conditions, may increase the number of veterans who attempt suicide.

(iii) As more men and women separate from the military and transition back into civilian life, community mental health providers will become a vital resource to help these veterans and their families deal with issues that may arise.

(c) Suicide has an enormous impact on the family and friends of the victim as well as the community as a whole.

(d) Approximately ninety percent of people who die by suicide had a diagnosable psychiatric disorder at the time of death, such as depression. Most suicide victims exhibit warning signs or behaviors prior to an attempt.

(e) Improved training and education in suicide assessment, treatment, and management has been recommended by a variety of organizations, including the United States department of health and human services and the institute of medicine.

(2) It is therefore the intent of the legislature to help lower the suicide rate in Washington by requiring certain health professionals to complete training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements.

(3) The legislature does not intend to expand or limit the existing scope of practice of any health professional affected by this act." [**2014 c 71 § 1**; **2012 c 181 § 1**.]

Short title—2012 c 181: "This act may be known and cited as the Matt Adler suicide assessment, treatment, and management training act of 2012." [**2012 c 181 § 4**.]

LC 1468
2021 Regular Session
11/2/20 (SCT/ps)

D R A F T

SUMMARY

Directs Oregon Health Authority and specified professional regulatory boards to require licensees regulated by authority or board to complete six hours of continuing education related to suicide risk assessment, treatment and management every six years and to report completion of continuing ed- ucation to authority or board. Allows authority and boards to establish minimum requirements that licensee must meet to be exempt from require- ment to complete continuing education.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to continuing education for behavioral health professionals; creating new provisions;

amending ORS 676.860; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 676.860 is amended to read:

676.860. (1) As used in this section:

(a) "Board" means:

(A) Occupational Therapy Licensing Board;

(B) Oregon Board of Licensed Professional Counselors and Therapists;

~~(C) Oregon Board of Naturopathic Medicine;~~

~~(D) Oregon Medical Board;~~

~~(E) Oregon State Board of Nursing;~~

~~(F) Oregon Board of Physical Therapy;~~

~~(G) State Board of Chiropractic Examiners;~~

~~15~~10 (H) State Board of Licensed Social Workers;

~~16~~11 (I) Oregon Board of Psychology; [*and*]

~~17~~12 (J) Teacher Standards and Practices Commission[.]**; and**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

Commented [JF1]: Include something about a waiver or grandparenting in folks? What would this look like? Since this is for people to take CEUs every 6 years, how far should this go back? Would this waiver only count when the bill first goes into effect? Could a waiver go into rules and not the legislation?

Deb - I'm guessing that most recent graduates have a better chance of having had better suicide prevention training than people who have been in the helping profession field for a long time. Just some thoughts in terms "grandfathering".

"We see this as a foundation that we will continue to build on"

2013, 2014, or 2015 legislation was passed to require CEUs around opioids / pain management to do 2 hours whenever licenses have to be renewed. There was no infrastructure in place for how this was to be done; those going to get licensed have to figure out how to complete CEUs

Commented [JF2]: What do we want to require of the non-behavioral health professions? Do we still want them to report data to OHA on suicide prevention, intervention, management training to OHA and have them do a report like the SB 48 report that just came out?

This will be a new bill no matter what. This would be a bill to amend an existing law (SB 48)

(K) Traditional Health Workers Commission.

(b) "Licensee" means a person authorized to practice one of the following professions:

(A) Clinical social worker, as defined in ORS 675.510;

(B) Licensed marriage and family therapist, as defined in ORS 675.705;

(C) Licensed professional counselor, as defined in ORS 675.705;

(D) Licensed psychologist, as defined in ORS 675.010;

(E) Occupational therapist, as defined in ORS 675.210;

(F) Regulated social worker, as defined in ORS 675.510;

(G) School counselor, as defined by rule by the Teacher Standards and Practices Commission;

~~(H) Certified registered nurse anesthetist, as defined in ORS 678.245;~~

~~(I) Chiropractic physician, as defined in ORS 684.010;~~

~~(J) Clinical nurse specialist, as defined in ORS 678.010;~~

~~(K) Naturopathic physician, as defined in ORS 685.010;~~

~~(L) Nurse practitioner, as defined in ORS 678.010;~~

~~(M) Physician, as defined in ORS 677.010;~~

~~(N) Physician assistant, as defined in ORS 677.495;~~

~~(O) Physical therapist, as defined in ORS 688.010; [*and*]~~

~~(P) Physical therapist assistant, as defined in ORS 688.010~~**; and**

(Q) The following professions as authorized by the Oregon Health Authority:

(i) Qualified mental health associate;

(ii) Qualified mental health professional;

(iii) Certified alcohol and drug counselor;

(iv) Prevention specialist;

(v) Problem gambling treatment provider;

(vi) Recovery mentor;

(vii) Community health worker;

(viii) Personal health navigator;

(ix) Personal support specialist;

Commented [JF3]: Should this include "couples and family therapist" as some programs are starting to use this title instead of "marriage and family therapist"

Commented [JF4]: Can we include these? We thought that they couldn't be covered in this legislation due to different oversight with MHACBO vs. licensure organizations. We want them if possible. Do these three categories just need to be in a different section if they are not authorized by OHA like this section states?

(x) Peer wellness specialist;

(xi) Doula;

(xii) Family support specialist; and

(xiii) Youth support specialist.

(2)**(a)(A)** [*In collaboration with the Oregon Health Authority,*] A board shall **require a licensee regulated by the board to complete six hours every six years of continuing education related to suicide risk assessment, treatment and management and shall** [*adopt rules to*] require a licensee [*regulated by the board*] to report to the board[*, upon reauthorization to practice,*] the licensee's completion of [*any*] **the** continuing education [*regarding suicide risk assessment, treatment and management*] **described in this paragraph**.

(B) A board shall approve continuing education opportunities that are applicable and relevant to the licensees regulated by the board.

(b) The authority shall require a licensee regulated by the authority to complete six hours of the continuing education described in paragraph (a) of this subsection.

(3) A licensee shall report the completion of [*any*] **the** continuing education described in subsection (2) of this section to the board that regulates the licensee **or to the authority if the licensee is regulated by the authority**.

(4)(a) **The authority and** a board shall document completion of [*any*] **the** continuing education described in subsection (2) of this section by a licensee regulated by the **authority or a** board. [*The board shall document the following data:*]

[*(A) The number of licensees who complete continuing education described in subsection (2) of this section;*]

[*(B) The percentage of the total of all licensees who complete the continuing education;*]

[*(C) The counties in which licensees who complete the continuing education practice; and*]

[*(D) The contact information for licensees willing to share information about suicide risk assessment, treatment and management with the authority.*]

[*(b) The board shall remove any personally identifying information from the data submitted to the board under this subsection, except for the personally identifying information of licensees willing to share such information with the authority.*]

[*(c) For purposes of documenting completion of continuing education under this subsection,*]

(b) In consultation with the authority, a board [*may*] **shall** adopt rules requiring licensees to submit documentation of completion to the board.

(c) The authority shall adopt rules requiring licensees regulated by the authority to submit the documentation of completion to the authority.

(5) The authority and a board may adopt rules to identify the experience and training that a licensee regulated by the authority or the board must have in order to be exempt from the requirements of subsection (2) of this section.

[*(5)*] **(6)** A board, on or before March 1 of each even-numbered year, shall report to the authority on the [*data documented under*] **information described in** subsection (4) of this section, as well as information about [*any initiatives by the board to promote suicide risk assessment, treatment and management among its licensees*] **the implementation of the continuing education described in subsection (2) of this section**.

[*(6)*] **(7)** The authority, on or before August 1 of each even-numbered year, shall report to the interim committees of the Legislative Assembly related to health care on the information submitted to the authority under subsection [*(5)*] **(6)** of this section **and information collected by the authority under subsection (4) of this section. The authority shall remove any personally identifying information collected by or submitted to the authority under subsections (4) and (6) of this section**. [*The authority shall include in the report information about initiatives by boards to promote*

awareness about suicide risk assessment, treatment and management and information on how boards are promoting continuing education described in subsection (2) of this section to licensees.]

[*(7)*] **(8)** The authority may use the information submitted to the authority under subsection [*(5)*] **(6)** of this section **and information collected by the authority under subsection (4) of this section** to [*develop continuing education opportunities related to suicide risk assessment, treatment and management for licensees and to*] facilitate improvements in suicide risk assessment, treatment and management efforts in this state.

(9)(a) The authority and a board may adopt rules to carry out this section.

(b) The authority may adopt rules to define and regulate the professions listed in subsection (1)(b)(Q) of this section.

SECTION 2. The amendments to ORS 676.860 by section 1 of this 2021 Act apply to applicants for initial authorization and to licensees applying for renewal of authorization on and after the operative date specified in section 3 of this 2021 Act.

SECTION 3. (1) The amendments to ORS 676.860 by section 1 of this 2021 Act become operative on January 1, 2022.

(2) A board, as defined in ORS 676.860 as amended by section 1 of this 2021 Act, and the Oregon Health Authority may take any action before the operative date specified in subsection (1) of this section that is necessary to enable the board and the authority to exercise, on and after the operative date specified in subsection (1) of this section, all of the duties, functions and powers conferred on the board and the authority by the amendments to ORS 676.860 by section 1 of this 2021 Act.

SECTION 4. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.