Legislation for CEUs by State

Marielena R. McWhirter
UO Suicide Prevention Lab
June 2022

States that *Require* Training

- Nevada
- Washington
- West Virginia
- Utah

- Indiana (restricted to emergency medical staff)
- Oregon (restricted to ER staff)

States that *Encourage* Training

- Colorado
- Hawaii
- Illinois
- Indiana
- Louisiana
- Michigan
- Montana
- Missouri

States that have Proposed Bills

Bill made it into consideration

- Missouri
- Texas
- New Jersey
- Virginia
- North Carolina

Bill Failed

- Connecticut
- Maine
- Minnesota

All 50 states have some form of Suicide Prevention Plan.

(https://www.reuters.com/article/us-health-suicide-prevention/gaps-remain-in-u-s-state-policies-on-suicide-prevention-training-idUSKBN1IA2VU)

Nevada

AB 92, 2015

- **Nestled in a bill requiring trainings on medical consequences of acts of terrorism using weapons of mass destruction.**
- Requires psychiatrists to receive minimum of 2 hours of instruction on clinical suicide prevention and awareness. Requires evidence of training to be submitted.
- Also requires the professional licensing boards for certain physicians and advance practice registered nurses to encourage their licensees to receive training concerning suicide prevention, detection, and intervention as a part of their continuing education.

Nevada cont.

AB 442, 2021

- **Nestled in a bill requiring a CEU for substance use disorder screening, brief intervention, and referral to treatment approach.**
- States that Board must require each holder of a license to practice medicine to receive CEUs of at least 2 hours of instruction every 4 years on evidence-based suicide prevention and awareness. Lists required suicide prevention skills.
- Holders of a license to practice medicine cannot substitute SP CEU requirements with any other trainings.

Utah

HB 400, 2022

- **Bill on Associate Physician License**
- Requires associate physicians to view a suicide prevention video at the time of license renewal.
- States licensure cannot last longer than a total of 6 years (i.e. trainings occur once every six years at point of renewal).

HB 236, 2022

- Requires state to have suicide prevention coalition, coordinator, and fund.

Indiana

SB 506, 2017

- **Nestled in a bill creating statewide SP coordinator.**
- Division of mental health and addiction is required to develop a statewide SP program and employ coordinator for program. Coordinator required to determine what professionals should receive SP training (assessment, treatment, management), how to fund the training, to report these determinations by end of 2017.
- Requires emergency medical services providers to complete evidence-based trainings for SP.

Indiana cont.

SB 506, 2017

- Requires a school corporation to adopt policy addressing child suicide awareness and clarifies requirements for policy.
- Requires approved postsecondary educational institutions to adopt policy concerning suicide information and resources.

Indiana cont.

HB 1430, 2017

- After June 30, 2018 each school corporation, charter school, and accredited nonpublic school will require all school teachers and any school-determined appropriate school employees employed at schools teaching any grad from 5 – 12th grade to attend or participate in evidence based youth suicide awareness and prevention trainings every three school years.
- Then repeats SB506, 2017

Missouri

HB 1419, 2018

- **Nestled in bill about psychologists and practice certification.**
  - (requiring student counseling services to annually report compliance with national regulations, requiring psychologists seeking licensure to get 2 hours of SP training, and psychiatrists)
- Bill states that "any health care professional in the state of Missouri may annually complete 6 training[s] in the areas of suicide assessment, referral, treatment, and management, [and] 7 may qualify as part of the continuing education requirements for his or her licensure."

New Jersey

HB 1682, 2022

- Bill requires physicians (among other health care and mental health professionals) to report any concern of risk or attempted youth suicide.

Colorado

SB 16-147, 2016

- **This bill is a statewide "Suicide Prevention through Zero Suicide Model" plan based in a broad public health approach.**
- Highly encourages a variety of health care settings to develop, assess, and implement SP trainings in the health care system.

Legislation for CEUs by State

Marielena R. McWhirter
UO Suicide Prevention Lab
June 2022

SENATE BILL 16-147

BY SENATOR(S) Newell and Martinez Humenik, Aguilar, Cooke, Crowder, Donovan, Garcia, Guzman, Heath, Hodge, Jahn, Johnston, Kefalas, Kerr, Merrifield, Roberts, Steadman, Todd, Ulibarri, Carroll, Jones, Lundberg, Scheffel, Cadman;
also REPRESENTATIVE(S) Pettersen, Esgar, Landgraf, Primavera, Tyler, Becker K., Buckner, Court, Duran, Fields, Ginal, Hamner, Kraft-Tharp, Lee, Lontine, McCann, Melton, Mitsch Bush, Pabon, Rosenthal, Ryden, Salazar, Vigil, Winter, Young, Hullinghorst.

CONCERNING CREATING THE COLORADO SUICIDE PREVENTION PLAN TO REDUCE DEATH BY SUICIDE IN THE COLORADO HEALTH CARE SYSTEM.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly finds and declares that:

(a) Colorado has experienced increased suicide death rates and numbers since 2009, and the trend continued in 2014;

(b) In 2014, the most recent year of data available nationally, Colorado had the seventh-highest suicide rate in the country and is

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

consistently among the states with the top ten highest suicide rates;

(c) In 2014, Colorado recorded its highest number of suicides at 1,058 suicide deaths;

(d) In comparison, the number of deaths in 2014 from homicides was 172, from motor vehicle crashes was 486, from breast cancer was 553, from influenza and pneumonia was 668, and from diabetes was 826;

(e) Suicide is highest in men and middle-aged Coloradans; while men account for over seventy-five percent of suicides, there are more attempts by women;

(f) Veterans, especially those who seek care outside of the veterans administration system, are at high risk;

(g) Data from the Colorado crisis services system show that nearly one in ten persons using crisis services presented with suicidal intentions, and the Colorado department of human services reports that a staggering seventy percent of mobile services users were suicidal;

(h) The rate of suicide in rural and frontier Colorado counties is higher than in other regions of the state;

(i) Health care settings, including mental and behavioral health systems, primary care offices, physical and mental health clinics in educational institutions, and hospitals, are valuable access points to reach those at risk for suicide; and

(j) National data indicate that over thirty percent of individuals are receiving mental health care at the time of their deaths by suicide, and forty-five percent have seen their primary care physicians within one month of their deaths. Primary care is often the first line of contact for individuals who would be less likely to seek out mental health services, particularly men, who are disproportionately represented in suicide deaths each year. National data also show twenty-five percent of those who die of suicide visited an emergency department in the month prior to their deaths. In Colorado, it is estimated that every year about 250 individuals who died of suicide visited an emergency department prior to death.

(2) The general assembly further finds that:

(a) Suicide is a public health crisis in Colorado, and a systems approach is necessary to address this problem effectively;

(b) The "zero suicide" model is a part of the national strategy for suicide prevention, a priority of the national action alliance for suicide prevention, and a project of the suicide prevention resource center;

(c) The "zero suicide" model is built on the foundational belief and aspirational goal that suicide deaths of individuals who are under the care of our health care systems, including mental and behavioral health systems, are frequently preventable;

(d) The "zero suicide" model includes valuable components, such as leadership, training, patient engagement, transition, and quality improvement;

(e) The suicide prevention commission has recommended that health care systems, behavioral health care systems, and primary care providers should be encouraged to adopt the "zero suicide" model and that the office of suicide prevention should examine and coordinate the use of existing data to identify high-risk groups, improve the quality of care for suicidal persons, and provide a basis for measuring progress while protecting the privacy of the individual and complying with all HIPAA regulations; and

(f) Health care systems, including mental and behavioral health systems and hospitals, that have implemented this type of model have noted significant reductions in suicide deaths for patients within their care.

(3) Therefore, because suicide in Colorado is a primary public health concern and is included within the state health improvement plan, the general assembly encourages the suicide prevention commission, criminal justice systems, health care systems, including mental and behavioral health systems, primary care providers, and physical and mental health clinics in educational institutions, throughout Colorado to:

(a) Work in collaboration to develop and adopt a Colorado suicide prevention model based on components of the "zero suicide" model;

(b) Work with advocacy groups, including faith-based organizations, to support the culture shift of health care systems to the Colorado suicide prevention plan;

(c) Examine training requirements that are part of the "zero suicide" model for professionals working in health care and mental and behavioral health care systems, including primary care and emergency department providers in Colorado, for incorporation into the Colorado suicide prevention plan;

(d) Take special care to include men of working age, first responders, veterans, and active duty military, who are at higher risk for suicide, in services provided under the Colorado suicide prevention plan; and

(e) Develop training criteria on seventy-two-hour hold procedures, patient privacy, and procedures related to the key provisions of the federal "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended.

SECTION 2. In Colorado Revised Statutes, **add** 25-1.5-112 as follows:

25-1.5-112. Colorado suicide prevention plan - established - goals - responsibilities - funding. (1) THE COLORADO SUICIDE PREVENTION PLAN, REFERRED TO IN THIS SECTION AS THE "COLORADO PLAN", IS CREATED IN THE OFFICE OF SUICIDE PREVENTION WITHIN THE DEPARTMENT. THE GOAL AND PURPOSE OF THE COLORADO PLAN IS TO REDUCE SUICIDE RATES AND NUMBERS IN COLORADO THROUGH SYSTEM-LEVEL IMPLEMENTATION OF THE COLORADO PLAN IN CRIMINAL JUSTICE AND HEALTH CARE SYSTEMS, INCLUDING MENTAL AND BEHAVIORAL HEALTH SYSTEMS.

(2) THE SUICIDE PREVENTION COMMISSION, TOGETHER WITH THE OFFICE OF SUICIDE PREVENTION, THE OFFICE OF BEHAVIORAL HEALTH, THE DEPARTMENT, AND THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, IS STRONGLY ENCOURAGED TO COLLABORATE WITH CRIMINAL JUSTICE AND HEALTH CARE SYSTEMS, MENTAL AND BEHAVIORAL HEALTH SYSTEMS, PRIMARY CARE PROVIDERS, PHYSICAL AND MENTAL HEALTH CLINICS IN EDUCATIONAL INSTITUTIONS, COMMUNITY MENTAL HEALTH

CENTERS, ADVOCACY GROUPS, EMERGENCY MEDICAL SERVICES PROFESSIONALS AND RESPONDERS, PUBLIC AND PRIVATE INSURERS, HOSPITAL CHAPLAINS, FAITH-BASED ORGANIZATIONS, TO DEVELOP AND IMPLEMENT:

(a) A PLAN TO IMPROVE TRAINING TO IDENTIFY INDICATORS OF SUICIDAL THOUGHTS AND BEHAVIOR ACROSS CRIMINAL JUSTICE AND HEALTH CARE SYSTEMS;

(b) A PLAN TO IMPROVE TRAINING ON:

(I) THE PROVISIONS OF THE EMERGENCY PROCEDURES FOR A SEVENTY-TWO-HOUR MENTAL HEALTH HOLD PURSUANT TO SECTION 27-65-105, C.R.S.;

(II) THE PROVISIONS OF THE FEDERAL "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996", PUB.L. 104-191, AS AMENDED; AND

(III) OTHER RELEVANT PATIENT PRIVACY PROCEDURES; AND

(c) PROFESSIONAL DEVELOPMENT RESOURCES AND TRAINING OPPORTUNITIES REGARDING INDICATORS OF SUICIDAL THOUGHTS AND BEHAVIOR, RISK ASSESSMENT, AND MANAGEMENT, AS DEVELOPED IN COLLABORATION WITH THE DEPARTMENT OF REGULATORY AGENCIES, THE DEPARTMENT OF CORRECTIONS, AND HEALTH CARE AND MENTAL HEALTH PROFESSIONAL BOARDS AND ASSOCIATIONS.

(3) AS A DEMONSTRATION OF THEIR COMMITMENT TO PATIENT SAFETY, CRIMINAL JUSTICE AND HEALTH CARE SYSTEMS, INCLUDING MENTAL AND BEHAVIORAL HEALTH SYSTEMS, PRIMARY CARE PROVIDERS, AND HOSPITALS THROUGHOUT THE STATE, ARE ENCOURAGED TO CONTRIBUTE TO AND IMPLEMENT THE COLORADO PLAN.

(4) THE FOLLOWING SYSTEMS AND ORGANIZATIONS ARE ENCOURAGED TO CONTRIBUTE TO AND IMPLEMENT THE COLORADO PLAN ON OR BEFORE JULY 1, 2019:

(a) COMMUNITY MENTAL HEALTH CENTERS;

(b) HOSPITALS;

(c) THE STATE CRISIS SERVICES SYSTEM;

(d) EMERGENCY MEDICAL SERVICES PROFESSIONALS AND RESPONDERS;

(e) REGIONAL HEALTH AND BEHAVIORAL HEALTH SYSTEMS;

(f) SUBSTANCE ABUSE TREATMENT SYSTEMS;

(g) PHYSICAL AND MENTAL HEALTH CLINICS IN EDUCATIONAL INSTITUTIONS;

(h) CRIMINAL JUSTICE SYSTEMS; AND

(i) ADVOCACY GROUPS, HOSPITAL CHAPLAINS, AND FAITH-BASED ORGANIZATIONS.

(5) THE OFFICE OF SUICIDE PREVENTION SHALL INCLUDE A SUMMARY OF THE COLORADO PLAN IN A REPORT SUBMITTED TO THE OFFICE OF BEHAVIORAL HEALTH, AS WELL AS THE REPORT SUBMITTED ANNUALLY TO THE GENERAL ASSEMBLY PURSUANT TO SECTION 25-1.5-101 (1) (w) (III) (A) AND AS PART OF ITS ANNUAL PRESENTATION TO THE GENERAL ASSEMBLY PURSUANT TO THE "STATE MEASUREMENT FOR ACCOUNTABLE, RESPONSIVE, AND TRANSPARENT (SMART) GOVERNMENT ACT", PART 2 OF ARTICLE 7 OF TITLE 2, C.R.S.

(6) THE DEPARTMENT MAY ACCEPT GIFTS, GRANTS, AND DONATIONS FROM PUBLIC AND PRIVATE SOURCES FOR THE DIRECT AND INDIRECT COSTS ASSOCIATED WITH THE DEVELOPMENT AND IMPLEMENTATION OF THE COLORADO PLAN. THE DEPARTMENT SHALL TRANSMIT ANY GIFTS, GRANTS, AND DONATIONS IT RECEIVES TO THE STATE TREASURER, WHO SHALL CREDIT THE MONEY TO THE SUICIDE PREVENTION COORDINATION CASH FUND CREATED IN SECTION 25-1.5-101 (1) (w) (II).

SECTION 3. In Colorado Revised Statutes, 25-1.5-101, **amend** (1) (w) (I), (1) (w) (II), and (1) (w) (IV) introductory portion as follows:

25-1.5-101. Powers and duties of department - cash funds.

(1) The department has, in addition to all other powers and duties imposed upon it by law, the powers and duties provided in this section as follows:

(w) (I) To act as the coordinator for suicide prevention programs throughout the state, INCLUDING THE COLORADO SUICIDE PREVENTION PLAN ESTABLISHED IN SECTION 25-1.5-112.

(II) The department is authorized to accept gifts, grants, and donations to assist it in performing its duties as the coordinator for suicide prevention programs. All such gifts, grants, and donations shall be transmitted to the state treasurer who shall credit the same to the suicide prevention coordination cash fund, which fund is hereby created. THE FUND ALSO CONSISTS OF ANY MONEY APPROPRIATED OR TRANSFERRED TO THE FUND BY THE GENERAL ASSEMBLY FOR THE PURPOSES OF IMPLEMENTING SECTION 25-1.5-112. Any moneys remaining in the suicide prevention coordination cash fund at the end of any fiscal year shall remain in the fund and shall not be transferred or credited to the general fund. The general assembly shall make appropriations from the suicide prevention coordination cash fund for expenditures incurred by the department in the performance of its duties under this paragraph (w) AND SECTION 25-1.5-112.

(IV) In its role as coordinator for suicide prevention programs, the department may collaborate with each facility licensed or certified pursuant to section 25-1.5-103 in order to coordinate suicide prevention services, INCLUDING RELEVANT TRAINING AND OTHER SERVICES AS PART OF THE COLORADO SUICIDE PREVENTION PLAN ESTABLISHED IN SECTION 25-1.5-112. When a facility treats a person who has attempted suicide or exhibits a suicidal gesture, the facility may provide oral and written information or educational materials to the person or, in the case of a minor, to parents, relatives, or other responsible persons to whom the minor will be released, prior to the person's release, regarding warning signs of depression, risk factors of suicide, methods of preventing suicide, available suicide prevention resources, and any other information concerning suicide awareness and prevention. The department may work with facilities AND THE COLORADO SUICIDE PREVENTION PLAN to determine whether and where gaps exist in suicide prevention programs and services, including gaps that may be present in:

SECTION 4. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Bill L. Cadman
PRESIDENT OF
THE SENATE

Dickey Lee Hullinghorst
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Effie Ameen
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED 10:54 am 6/10/16

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Preventing Suicide in Oregon

MODEL BILL TO EFFECTIVELY REDUCE THE SUICIDE RATE IN OREGON

While training communities to identify the signs of suicide risk is important, it is not enough to effectively reduce the suicide rate. Legislation must be passed that requires all mental health professionals and primary care physicians to receive training in evidence-based, assessment, management, intervention, and treatment of suicide risk. Because, everyone deserves a life worth living.

Bill Title: Training for Health Professionals in Suicide Assessment, Management and Treatment

WHEREAS, Suicide is the 1st leading cause of death in Oregon for ages 10-24, the 2nd leading cause of death for ages 25-34, the 3rd leading cause of death for ages 35-44, the 5th leading cause of death for ages 45-54, the 8th leading cause of death for ages 55-64, and the 13th leading cause of death for ages 65+. Overall, suicide is the 8th leading of cause of death in the state of Oregon.

WHEREAS, Over 90% of people who die by suicide have a diagnosable mental health disorder at their time of death and will often come into contact with health professionals during their time of suicide risk. Of people who die by suicide, 45% of individuals had contact with their primary care provider in the month before, and 77% of individuals had contact with their primary care provider in the year before death.

WHEREAS, Despite the comorbidity of mental health disorders and suicide, the vast majority of mental health professionals—a group that includes psychiatrists, psychologists, social workers, licensed counselors, and psychiatric nurses— do not typically receive routine training in suicide assessment, treatment, or risk management.

WHEREAS, A key national strategy in suicide prevention is the implementation of a minimum amount of scientifically proven (randomized controlled trials) training for health care providers in suicide risk assessment and treatment of suicidal ideation and behaviors.

WHEREAS, Training mental health professionals in current suicide prevention standards not only increases professional confidence in treating suicidal people but also updates professionals on the most effective, evidence-based treatment options.

WHEREAS, Suicide-specific training enhances the level of care that people who experience mental illness and suicide risk receive while also increasing provider competence and ability to provide effective, life-saving treatment.

WHEREAS, Mandating standards for suicide prevention treatment ensures that health professionals maintain competency and consistency when treating their most vulnerable patients who deserve adequate service.

NOW THEREFORE, It is the intent of the legislature to lower the suicide rate in Oregon by requiring certain health professionals to complete evidence-based training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements.

* Source: American Foundation for Suicide Prevention

Insert into the Oregon Mental Health Act,

(1)(a) Each of the following professionals certified or licensed under OR Code, Art. Health Occupations, shall, at least once every two years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) Psychologists;
(ii) Social Workers;
(iii) Professional Counselors and Therapists;
(iv) Physicians;
(v) Physician Assistants;
(vi) Occupational Therapists;

(b) The training required by this subsection must be at least six hours in length.

(c) Beginning July 1, 2021, the training required by this subsection must be on the model list developed under subsection (5) of this section. Nothing in this subsection (1)(c) affects the validity of training completed prior to July 1, 2021.

(2)(a) 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 July 1, 2021, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(b) 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 two years prior to the application for initial licensure.

(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) Beginning July 1, 2021, the training required by this subsection must be on the model list developed under subsection (5)(a) of this section.

(5)(a) The Secretary of Health and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management.

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

(c) By January 1, 2022, 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 (provided in one six-hour block or spread among shorter trainings) include content that is evidence-based through rigorous scientific methods and suicide-specific. The content must include the assessment of issues related to imminent harm via lethal means, stabilization planning, crisis response plan and suicide-specific treatment aimed at providing the patient a life beyond suicide risk. When adopting the rules required under this subsection (5)(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 Oregon 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 July 1, 2021:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management; 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.

(6) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under Oregon Code, Art. Health Occupations.

#

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**.]

Preventing Suicide in New Jersey

MODEL BILL TO EFFECTIVELY REDUCE THE SUICIDE RATE IN NEW JERSEY

While training communities to identify the signs of suicide risk is important, it is not enough to effectively reduce the suicide rate. Legislation must be passed that requires all mental health professionals and primary care physicians to receive training in evidence-based, assessment, management, intervention, and treatment of suicide risk. Because, everyone deserves a life worth living.

Bill Title: Training for Health Professionals in Suicide Assessment, Management and Treatment

WHEREAS, Suicide is the 2nd leading cause of death in New Jersey for ages 10-34, the 4th leading cause of death for ages 35-44, the 5th leading cause of death for ages 4554, and the 9th leading cause of death for ages 55-64. Overall, suicide is the 13th leading of cause of death in the state of New Jersey.

WHEREAS, Over 90% of people who die by suicide have a diagnosable mental health disorder at their time of death and will often come into contact with health professionals during their time of suicide risk. Of people who die by suicide, 45% of individuals had contact with their primary care provider in the month before, and 77% of individuals had contact with their primary care provider in the year before death.

WHEREAS, Despite the comorbidity of mental health disorders and suicide, the vast majority of mental health professionals—a group that includes psychiatrists, psychologists, social workers, licensed counselors, and psychiatric nurses— do not typically receive routine training in suicide assessment, treatment, or risk management.

WHEREAS, A key national strategy in suicide prevention is the implementation of a minimum amount of scientifically proven (randomized controlled trials) training for health care providers in suicide risk assessment and treatment of suicidal ideation and behaviors.

WHEREAS, Training mental health professionals in current suicide prevention standards not only increases professional confidence in treating suicidal people but also updates professionals on the most effective, evidence-based treatment options.

WHEREAS, Suicide-specific training enhances the level of care that people who experience mental illness and suicide risk receive while also increasing provider competence and ability to provide effective, life-saving treatment.

WHEREAS, Mandating standards for suicide prevention treatment ensures that health professionals maintain competency and consistency when treating their most vulnerable patients who deserve adequate service.

NOW THEREFORE, It is the intent of the legislature to lower the suicide rate in New Jersey by requiring certain health professionals to complete evidence-based training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements.

* Source: American Foundation for Suicide Prevention

Insert into New Jersey Mental Health Act,

(1)(a) Each of the following professionals certified or licensed under NJ Code, Art. Health Occupations, shall, at least once every two years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) Psychologists;
(ii) Social Workers;
(iii) Professional Counselors and Therapists;
(iv) Physicians;
(v) Physician Assistants;
(vi) Occupational Therapists;

(b) The training required by this subsection must be at least six hours in length.

(c) Beginning July 1, 2021, the training required by this subsection must be on the model list developed under subsection (5) of this section. Nothing in this subsection (1)(c) affects the validity of training completed prior to July 1, 2021.

(2)(a) 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 July 1, 2021, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(b) 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 two years prior to the application for initial licensure.

(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) Beginning July 1, 2021, the training required by this subsection must be on the model list developed under subsection (5)(a) of this section.

(5)(a) The Secretary of Health and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management.

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

(c) By January 1, 2022, 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 (provided in one six-hour block or spread among shorter trainings) include content that is evidence-based through rigorous scientific methods and suicide-specific. The content must include the assessment of issues related to imminent harm via lethal means, stabilization planning, crisis response plan and suicide-specific treatment aimed at providing the patient a life beyond suicide risk. When adopting the rules required under this subsection (5)(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 New Jersey 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 July 1, 2021:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management; 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.

(6) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under New Jersey Code, Art. Health Occupations.

#

Our Goals

Oregon’s medical providers feel equipped and competent in assessing, managing and treating suicidality at a level appropriate to their role, in order to reduce suicide among patients and providers.

Individual Training for License Renewal—individual and licensing boards responsible

1. Follow HB 2315 model --- without funding and leave to licensing boards to determine which courses fit the requirement. (One-time 6 hour course? Or renewals overtime?)
2. Ask for full funding to stand up a system that would support & promote training and a process for Approved Trainings to be added to model list
3. Make requirement for selected specialties only

State Offers Specific Mandatory Training – OHA Responsible

1) Develop foundational course – fund the development
2) Choose an existing training to promote and ensure it is available to all required; Clear process for Approved Trainings to be added to the list
3) Subsequent Offerings on Specific elements
4) Recommend specialty specific trainings

Require specific health systems to implement suicide prevention/intervention – Make Health Systems Responsible

1. Health Systems/CCOs Required to provide trainings to relevant employees
2. State can provide funding, training, list of allowed trainings, tech assistance
3. Agencies with existing trainings are exempt from new trainings as long as they receive tech assistance to ensure they meet competencies
4. Fund/mandate Zero Suicide for e.g CCO's

Non-legislative

- Focus on pre-service training
- Partner with medical organizations to develop in-house training

Conceptualizing Policy

Policy Approach	Oregon Current Status	Pros	Cons	Existing Models
Individual Training for License Renewal (all specialties) 1) Follow HB 2315 model 2) Ask for full funding to stand up a system that would support & promote training 3) Process for Approved Trainings to be added to model list				
Individual Training for License Renewal (specific specialties)				
State Offers Specific Mandatory Training 1) Foundational course 2) Subsequent Offerings on Specific elements 3) Specialty – Specific trainings 4) Process for Approved Trainings to				

be added to model list				
Health Systems/CCOs Required to provide trainings to relevant employees 1) State can provide fudning, training, list of allowed trainings, tech assistance 2) Agencies with existing trainings are exempt from new trainings as long as they receive tech assistance to ensure they meet competencies				
Health Systems/CCOs required to take "Zero Suicide" approach (Colodo Example)				

Emergency Staff / ER				
Focus on Preservice / Graduate school program requirments				
Process for Approved Trainings to be added to model list				

Marielena:

- List of Nevada’s required skills included in legislation