

Significant Legislative Rule Analysis (SA)

Occupational Therapy Practice Board
Continuing Education on
Suicide Assessment, Screening, and Referral

Amending WAC 246-847-065 – Continued competency

Amending WAC 246-847-010 – Definitions

Adding New Section WAC 246-847-066 – Suicide Assessment Training Program Standards

October 15, 2013

Section 1. What is the scope of the rule?

The proposed rules implement RCW 43.70.442, adopted in 2012 by Engrossed Substitute House Bill (ESHB) 2366, and create a suicide prevention continuing education (CE) requirement for occupational therapists and occupational therapy assistants (occupational therapy practitioners). The proposed rules also incorporate provisions of Substitute House Bill (SHB) 1376 (chapter 78, Laws of 2013), which amends RCW 43.70.442. SHB 1376 allows the Occupational Therapy Practice Board (board) to require a minimum of three hours of training in suicide assessment, screening, and referral that does not include treatment and management based on the occupational therapy practitioner scope of practice. Other provisions of SHB 1376 which are incorporated in the proposed rules clarify that this training is to be completed during the first full CE reporting period after January 1, 2014 or after initial licensure, whichever occurs later. The proposed rules also specify the standards a program must meet to qualify as a suicide prevention training and define the use of the term “board.”

Background

According to the centers for disease control and prevention:

- Each year, more than 36,000 Americans take their own lives and about 465,000 people receive medical care for self-inflicted injuries.¹
- Suicide (i.e., taking one's own life) is a serious public health problem that affects people of all ages. For Americans, suicide is the 10th leading cause of death. It resulted in 36,909 lives lost in 2009. The top three methods used in suicides included firearm (51%), suffocation (24%), and poisoning (17%).²

¹ [National Center for Injury Prevention and Control](http://www.cdc.gov/injury/) - <http://www.cdc.gov/injury/> [Division of Violence Prevention](http://www.cdc.gov/ViolencePrevention/) - <http://www.cdc.gov/ViolencePrevention/>

² ² [National Center for Injury Prevention and Control](http://www.cdc.gov/injury/) - <http://www.cdc.gov/injury/> [Division of Violence Prevention](http://www.cdc.gov/ViolencePrevention/) - <http://www.cdc.gov/ViolencePrevention/>

- Deaths from suicide are only part of the problem. More people survive suicide attempts than actually die. In 2010, about 465,000 people received medical care for self-inflicted injuries at emergency departments across the United States.¹

According to Washington State Department of Health data:³

- Suicide is the second leading cause of death in the state of Washington for youth 10-24 years old and the third leading cause of death nationally.
- There were nearly twice as many suicides as homicides of youth ages 10–24.
- In Washington State and nationally, whites accounted for the highest total number of suicides, while Native Americans accounted for the highest rates of suicide. Suicide rates are lower for African-Americans and Hispanics.
- In Washington State and nationally, females attempted suicide more frequently, yet males died by suicide more often by a ratio of at least 4:1.
- In Washington State, firearms were the leading method of suicide for both males and females.

Nearly one fifth of veterans struggle with depression or Post Traumatic Stress Disorder, and the suicide rates have doubled in the past decade among those who served in Operation Enduring Freedom (in Afghanistan) and Operation Iraqi Freedom.⁴

Suicide is a serious public health problem that can have lasting harmful effects on individuals, families, and communities. While its causes are complex and determined by multiple factors, the goal of suicide prevention is simple: reduce factors that increase risk and increase factors that promote resilience. Ideally, prevention addresses all levels of influence: individual, relationship, community, and societal. Effective prevention strategies are needed to promote awareness of suicide and encourage a commitment to social change.

The board developed these proposed rules collaboratively. Three stakeholder workshops were held on October 25, 2012, May 17, 2013, and July 12, 2013. SHB 1376 authorized the board to determine if only three hours of suicide training would be required based on the occupational therapy practitioner scope of practice. It also authorized the board to exempt certain practitioners who have brief or limited patient contact. The board determined that three hours of training in suicide assessment, screening, and referral was appropriate for occupational therapy practitioners. The board considered allowing certain occupational therapy practitioners who have brief or limited patient contact an exemption from the requirement to complete CE in suicide assessment, screening, and referral. The board chose not to exempt any practitioners from the

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<http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/YouthSuicidePrevention/YouthSuicideFacts.aspx>

⁴ Rudd, M. D., Goulding, J., & Bryan, C. J. (2011, August 15). Student Veterans: A National Survey Exploring Psychological Symptoms and Suicide Risk. *Professional Psychology: Research and Practice*. Advance online publication. doi: 10.1037/a0025164

training requirement as there are very few practitioners who have brief or limited patient contact and the requirement to complete three hours of CE every six years is not a burden to practitioners.

Section 2. What are the general goals and specific objectives of the proposed rule's authorizing statute?

The general goal of RCW 43.70.442 is to help reduce suicide in Washington State. The legislature stated its intent in ESHB 2366 that requiring ongoing training and education in suicide assessment, treatment, and management for certain health professionals will help achieve this goal. In passing SHB 1376, the legislature clarified that the board could require training limited to suicide assessment, screening, and referral based on the occupational therapy scope of practice.

RCW 43.70.442, as amended, requires the following professions to adopt rules related to the completion of CE in suicide assessment, treatment, and management:

- certified counselors and certified advisers
- chemical dependency professionals
- advanced social workers and independent clinical social workers
- marriage and family therapists
- mental health counselors
- occupational therapy practitioners
- psychologists
- practitioners in retired active license status in the above professions

Rules are being developed separately for listed professions other than occupational therapy by their appropriate authorities.

The following are the statute's specific objectives, implemented by these proposed rules:

1. Establish criteria for the content of acceptable suicide prevention training for occupational therapy practitioners.
2. Establish the minimum hours of suicide prevention training required for occupational therapy practitioners.

Section 3. What is the justification for the proposed rule package?

There are no feasible alternatives to rulemaking because RCW 43.70.442, as amended by SHB 1376, requires the board to adopt rules regarding CE requirements for suicide prevention training.

Section 4. What are the costs and benefits of each rule included in the rules package? What is the total probable cost and total probable benefit of the rule package?

1. Identification of total number of rules in package

There are a total of three rules in this package: two non-significant and one significant.

2. Non-Significant Rule Identification Table

Table: Non-Significant Rule Identification

#	WAC Section	Section Title	Section Subject	Reason
1	WAC 246-847-010	Definitions	Definitions	The rule does not meet the definition of “significant legislative rule” under RCW 34.05.328(5)(c)(ii). The rule is interpretive and does not subject any person to a penalty or sanction.
2	WAC 246-847-065	Continued Competency	Continued Competency requirements and categories	The rule does not meet the definition of “significant legislative rule” under RCW 34.05.328(5)(b)(iii). The rule restates what the statute requires without material change.

3. Significant Rule Analysis

WAC 246-847-066 - Suicide Assessment Training Program Standards

Rule Overview: In subsection (1), the board sets the following requirements for a program to qualify as a suicide prevention training:

- It must be a training in suicide assessment that includes risk assessment, screening, and referral;
- It must be at least three hours in length;
- It must be provided by a single provider and must be at least three hours in length which may be provided in one or more sessions.

These standards limit the extent that any training program could elude the intent of RCW 43.70.442. The board considered the need to make qualified programs easily available to licensees.

Subsection (2) clarifies that nothing in the rule is intended to expand or limit the occupational therapist or occupational therapy assistant scope of practice.

Subsection (3) states that the hours spent in completing suicide training count toward meeting continued competency requirements.

Rule Cost/Benefit Analysis: The requirement to complete three hours in suicide assessment, screening, and referral does not add to the total number of CE hours that must be completed. There will be no added costs for the licensee. The cost of obtaining training in suicide assessment, screening, and referral ranges from \$35 to \$225. This information was obtained from the model list of suicide training programs that is being drafted and reported to the legislature. The cost of this CE training is comparable to the cost of other trainings licensees must complete to meet their CE requirement.

4. Rule Package Cost-Benefit Conclusion

The proposed rules implement RCW 43.70.442, as amended by SHB 1376, which creates a new CE requirement for occupational therapy practitioners. The proposed rules establish CE requirements in suicide assessment, screening, and referral; provide clarification about the topics that must be in an approved training; incorporate a three hour requirement set in statute; and clarify the CE due date.

The requirement that a licensee obtain three hours of suicide training every six years does not add to the total number of CE hours required. The three hours of training will count toward applicable CE requirements. Educating occupational therapy practitioners in suicide assessment, screening, and referral may save lives in Washington.

Section 5. What alternative versions of the rule did we consider? Is the proposed rule the least burdensome approach?

Descriptions of alternatives considered

Alternative version: The board developed these proposed rules collaboratively. The collaborative process included sending notice of the rulemaking to the listserv and three stakeholder workshops held October 25, 2012 in Tumwater, May 17, 2013 in Tumwater, and July 12, 2013 in Tumwater. The October 25, 2012 and July 12, 2013 workshops were during board meetings and were noted on the board's agenda. The agenda was sent to the listserv and posted to the program's website.

The board considered requiring six hours of training in suicide assessment, treatment, and management every six years. The board discussed the occupational therapy practitioner scope of practice when considering the six-hour requirement. The board chose to require a three-hour training.

During the May 17, 2013 workshop a representative from the Washington Occupational Therapy Association (WOTA) asked the board to exempt occupational therapy practitioners who have

brief or limited patient contact from the CE requirement. The board considered allowing certain occupational therapy practitioners who have brief or limited patient contact an exemption from the requirement to complete CE in suicide assessment, screening, and referral. The board chose not to exempt practitioners from the training requirement.

Least burdensome determination

The board determined that a three-hour training that included suicide assessment, screening, and referral was appropriate for occupational therapy practitioners based on their scope of practice. The board considered WOTA's request to exempt certain practitioners, but at the July 12, 2013 board meeting, determined that the requirement to complete three hours of CE every six years is not a burden to practitioners. There are very few practitioners who have brief or limited patient contact. The board determined that the requirement to complete three hours of CE every six years is not a burden to practitioners and it is in the public interest for all occupational therapy practitioners to have suicide prevention training.

Section 6. Did you determine that the rule does not require anyone to take an action that violates another federal or state law?

The rule does not require those to whom it applies to take an action that violates requirements of federal or state law.

Section 7. Did we determine that the rule does not impose more stringent performance requirements on private entities than on public entities unless the difference is required in federal or state law?

The rule does not impose more stringent performance requirements on private entities than on public entities.

Section 8. Did you determine if the rule differs from any federal regulation or statute applicable to the same activity or subject matter and, if so, did we determine that the difference is justified by an explicit state statute or by substantial evidence that the difference is necessary?

The rule does not differ from any applicable federal regulation or statute.

Section 9. Did we demonstrate that the rule has been coordinated, to the maximum extent possible, with other federal, state, and local laws applicable to the same activity or subject matter?

There are no federal, local, or other state laws addressing CE in suicide prevention for occupational therapy practitioners.