SENATE BILL 128

55TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2021

INTRODUCED BY

Bill B. O'Neill

AN ACT

RELATING TO MENTAL HEALTH CARE; ENACTING THE SUICIDE PREVENTION, RESPONSE AND TREATMENT ACT; PROVIDING STANDARDS FOR TREATMENT; PROVIDING GUIDELINES FOR SUICIDE RISK ASSESSMENTS; REQUIRING SUICIDE PREVENTION TRAINING FOR FACILITIES; PROVIDING GUIDELINES FOR TREATMENT OF AT-RISK PATIENTS IN EMERGENCY CARE; REQUIRING SUICIDE STABILIZATION TRAINING FOR POLICE OFFICERS; PRESCRIBING PUBLIC SAFETY ANSWERING POINT PROCEDURES; CREATING A SUICIDE RESPONSE COORDINATOR; PROVIDING FOR ADMINISTRATION OF THE PROGRAM BY THE DEPARTMENT OF HEALTH; PROVIDING FOR PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Suicide Prevention, Response and Treatment Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the

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Suicide Prevention, Response and Treatment Act:

A. "at-risk patient" means a patient who has attempted suicide or who has suicidal ideations, behaviors or tendencies as indicated by a formal suicide risk assessment;

B. "care transition" means the transfer or transition of an at-risk patient from one health care provider or behavioral health care provider to another;

C. "department" means the department of health;

D. "outpatient treatment facility" means a nonresidential, community-based mental health facility licensed by the department, including a suicide treatment center;

E. "person who is or may be suicidal" means a person who is experiencing a mental health crisis, is experiencing or expressing suicidal ideations or tendencies or is undertaking or contemplating suicidal actions but who has not yet received a formal suicide risk assessment;

F. "psychiatric facility" means an inpatient residential facility, including a psychiatric hospital, a psychiatric unit of a county hospital, a short-term care facility, a special psychiatric hospital or the psychiatric unit of a general hospital or of another health care facility licensed by the department;

G. "rapid referral" means the taking of appropriate steps:

(1) by a psychiatric facility, prior to an at-

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risk patient's discharge from inpatient care, to facilitate the at-risk patient's immediate access to an appropriate outpatient treatment facility appointment as soon as is practicable or within forty-eight hours after discharge; or

(2) by an outpatient treatment facility to facilitate an at-risk patient's immediate access to an appointment with another outpatient treatment facility or a psychiatric facility as soon as is practicable within forty-eight hours after referral;

H. "suicide prevention counselor" means a licensed psychiatrist, licensed clinical psychologist, other licensed mental health professional or qualified crisis counselor who has specialized certification or has completed specialized training in the standardized assessment of suicide risk and suicide prevention counseling to at-risk patients;

I. "supportive contacts" means communications through postcards, letters, email messages, text messages, phone calls or the undertaking of home visits either by an at-risk patient's mental health care professional or suicide prevention counselor or by an outside organization coordinating with an at-risk patient's psychiatric facility or outpatient treatment facility; and

J. "warm hand-off" means a care transition that:

(1) connects an at-risk patient with a new health care provider or interim contact, such as a crisis

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center worker or peer specialist, before the at-risk patient's first appointment with the new health care provider; or

(2) connects a patient directly with a licensed practitioner trained in mental health screening for the purposes of determining whether involuntary commitment to a psychiatric facility is warranted pursuant to the Mental Health and Developmental Disabilities Code.

SECTION 3. [NEW MATERIAL] TREATMENT OF AN AT-RISK PATIENT UNDER THE CARE OF A PSYCHIATRIC FACILITY OR AN OUTPATIENT TREATMENT FACILITY.--

A. A suicide prevention counselor employed by a psychiatric facility shall:

(1) assess each patient's level of suicide risk, as provided for in Section 4 of the Suicide Prevention, Response and Treatment Act;

(2) provide immediate suicide prevention counseling to each patient deemed to be at risk of suicide; and

(3) provide ongoing suicide prevention counseling to each at-risk patient on a daily basis or on a frequency proportionate to a patient's suicide risk assessment for the duration of inpatient care or until a patient is deemed to be no longer at risk.

B. A suicide prevention counselor employed by an outpatient treatment facility shall:

(1) assess each patient's level of suicide

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risk as provided for in Section 4 of the Suicide Prevention, Response and Treatment Act;

(2) provide immediate, individualized, one-on-one suicide prevention counseling to each patient deemed to be at risk of suicide;

(3) provide a warm hand-off of the patient to a licensed practitioner trained in mental health screening to determine whether an involuntary commitment to a psychiatric facility is warranted; and

(4) counsel each at-risk patient for whom involuntary commitment to a psychiatric facility is not warranted in a manner and frequency that is proportionate to the at-risk patient's suicide risk assessment.

C. To conduct suicide risk assessments and provide counseling to at-risk patients:

(1) a psychiatric facility shall ensure that a sufficient number of suicide prevention counselors are available and onsite twenty-four hours a day as provided pursuant to rules prescribed by the department; and

(2) an outpatient treatment facility shall ensure that a sufficient number of suicide prevention counselors are available and onsite during all hours of operation as provided pursuant to rules prescribed by the department.

D. A psychiatric facility and an outpatient

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treatment facility shall establish policies and protocols to provide for the discharge and transition of at-risk patients from care, using warm hand-offs, rapid referrals and supportive contacts.

E. An outpatient treatment facility shall adopt policies and protocols providing for the warm hand-off of an at-risk patient to a psychiatric facility or to a licensed practitioner trained in mental health screening.

F. A psychiatric facility or outpatient treatment facility may enter into contracts or memoranda of understanding with outside organizations, including local crisis centers and other psychiatric facilities and outpatient treatment facilities, to facilitate the care transition of at-risk patients.

G. In no case shall a staff member of a psychiatric facility or of an outpatient treatment facility:

(1) discharge an at-risk patient into a homeless situation; or

(2) arrange an at-risk patient's arrest or incarceration in a jail or prison unless the at-risk patient poses an otherwise uncontrollable risk to others or failure to do so would violate a law of New Mexico.

SECTION 4. [NEW MATERIAL] SUICIDE RISK ASSESSMENT.--

A. A suicide risk assessment shall be conducted:

(1) immediately upon a patient's admission to

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a psychiatric facility or upon a patient's first clinical encounter with an outpatient treatment facility;

(2) when there is reason for attending staff at a psychiatric facility or outpatient treatment facility to believe that a patient is developing new suicidal ideation, behaviors or tendencies;

(3) within three days prior to the discharge of a non-suicidal patient from inpatient care;

(4) when a suicide prevention counselor is called to assess a patient in a hospital emergency department pursuant to Section 5 of the Suicide Prevention, Response and Treatment Act; and

(5) when a suicide prevention counselor is dispatched pursuant to Section 9 of the Suicide Prevention, Response and Treatment Act to assess a person at an emergency scene.

B. A suicide risk assessment shall be performed using standardized tools, methodologies or frameworks and shall be based on:

(1) data obtained from the patient by the attending clinician, assigned suicide prevention counselors and other facility staff having direct contact with the patient; and

(2) data on a patient's past and present suicidal ideation and behavior, obtained with a patient's

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consent, from outside treatment professionals, caseworkers, caregivers, family members, guardians and other persons.

C. The suicide risk assessment shall include an evaluation of the patient's current housing status, existing support systems and close relationships and shall indicate whether there is any evidence that the patient is being subjected to abuse, neglect, exploitation or undue influence by family members, caregivers or other persons.

D. Counseling and treatment provided to address an at-risk patient's suicidal ideations, behaviors or tendencies shall be supplemental to treatment that is received by a patient for that patient's other mental health issues, if any.

E. The results of a patient's suicide risk assessment and notes regarding the progress of suicide prevention counseling shall be documented in the patient's health record.

SECTION 5. [NEW MATERIAL] TREATMENT OF AT-RISK PATIENTS IN EMERGENCY CARE.--

A. A physician providing care in a hospital's emergency department who has reason to believe that a patient under the physician's care is suicidal shall, as soon as is practicable after the patient is stabilized, ensure that the patient is met in the emergency room by a suicide prevention counselor from the hospital's psychiatric ward, who shall:

(1) perform an on-site suicide risk

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assessment;

(2) immediately provide the patient with counseling, commensurate with the results of the suicide risk assessment, prior to the patient's discharge from the emergency room; and

(3) immediately route a patient who is or may be suicidal to appropriate treatment facilities, programs and services through the use of warm hand-offs and supportive contacts as deemed by the suicide prevention counselor to be appropriate based on the results of the on-site suicide risk assessment.

B. If a suicide prevention counselor concludes that inpatient psychiatric treatment is necessary to address an at-risk patient's risks, the suicide prevention counselor shall recommend, and the attending emergency room physician shall effectuate, the patient's voluntary admission and warm hand-off to the hospital's psychiatric facility immediately following the completion of the patient's emergency care.

C. If a patient refuses to be admitted to the hospital's psychiatric facility, the attending emergency room physician shall effectuate the warm hand-off of the patient to a licensed practitioner trained in mental health screening to determine whether involuntary commitment to a psychiatric facility is necessary.

SECTION 6. [NEW MATERIAL] COMMUNICATION WITH AT-RISK

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PATIENTS--TRAINING.--

A. A suicide prevention counselor or other staff member employed by a psychiatric facility or outpatient treatment facility and health care professionals, when interacting with an at-risk patient, shall:

(1) treat the at-risk patient with the same dignity and respect that is shown to other patients;

(2) behave in a manner that reflects empathy, compassion and an understanding of the at-risk patient;

(3) encourage the at-risk patient to use all available services and resources to empower the patient to choose alternatives that address suicide risk;

(4) refrain from activities or communication methods that may result in the increased trauma of the at-risk patient;

(5) not engage in the psychological testing of the at-risk patient if the at-risk patient is in crisis or has recently recovered from a crisis situation except for performing a suicide risk assessment; and

(6) not engage in behavior that discriminates against or stigmatizes the at-risk patient.

B. Psychiatric facilities and outpatient treatment facilities shall administer and require staff to complete two training sessions each year, addressing:

(1) the fundamentals of the facility's suicide

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prevention policies and protocols;

(2) suicide care policies and protocols that are relevant to each staff member's role and responsibilities;

(3) the signs and symptoms that can be used by both clinical and non-clinical staff to identify existing patients who may be developing new suicidal ideations, behaviors or tendencies;

(4) methods and principles to be used in discharge and care transition of at-risk patients; and

(5) methods for respectful treatment of and effective communication with at-risk patients.

SECTION 7. [NEW MATERIAL] INSURANCE COVERAGE.--Each individual and group health insurance policy, health care plan and certificate of health insurance delivered or issued for delivery in this state shall provide coverage for costs associated with the suicide risk assessments that are performed and the suicide prevention counseling services that are rendered pursuant to the Suicide Prevention, Response and Treatment Act.

SECTION 8. [NEW MATERIAL] LAW ENFORCEMENT--SUICIDE RESPONSE TRAINING REQUIRED.--

A. The New Mexico law enforcement academy, in coordination with the department, shall provide or approve training for police officers that shall consist of two hours of in-service training on the appropriate response to emergencies

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that involve a person who is or may be suicidal.

B. The in-service training course required pursuant to this section shall:

(1) include instruction on:

(a) calm, gentle and respectful interactions with a person who is or may be suicidal;

(b) avoidance of the use of unnecessary force;

(c) verbal methods of communication and other nonviolent means to stabilize an emergency involving a person who is or may be suicidal; and

(d) specific techniques, means and methods, consistent with the principles identified under this subsection to facilitate law enforcement officer interactions with a person who is or may be suicidal; and

(2) require training program participants to engage in simulated role-playing scenarios to demonstrate the participants' ability to effectively interact with and stabilize a person who is or may be suicidal.

C. Each instructor who is assigned to teach the in-service courses required by this section shall have received at least forty hours of training in mental health crisis intervention from a nationally recognized organization that educates law enforcement officers in the use of appropriate emergency response methods.

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SECTION 9. [NEW MATERIAL] SUICIDE RESPONSE COORDINATORS--APPOINTMENT.--

A. The injury prevention and emergency medical services bureau of the public health division of the department shall appoint a suicide prevention response coordinator in each county to dispatch suicide prevention counselors to emergency scenes involving a person who is or may be suicidal.

B. A suicide prevention response coordinator appointed pursuant to this section shall compile and maintain a list of qualified suicide prevention counselors in the county in which the coordinator is located.

C. A suicide prevention counselor dispatched to an emergency scene pursuant to this section shall:

(1) provide assistance to the law enforcement officer at the emergency scene as may be necessary to facilitate the nonviolent stabilization of the emergency situation;

(2) perform an on-site suicide risk assessment of a person who is or may be suicidal, pursuant to Section 4 of the Suicide Prevention, Response and Treatment Act;

(3) direct a person who is or may be suicidal to appropriate treatment facilities, programs and services through the use of warm hand-offs and supportive contacts as based on the results of the onsite suicide risk assessment;

(4) facilitate admission of a person who is or

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may be suicidal to an inpatient treatment center or warm hand-off to a psychiatric facility if the suicide prevention counselor believes that person poses harm to the person's own self; or

(5) facilitate the warm hand-off of a person who is or may be suicidal to a licensed mental health screening service provider to determine whether involuntary commitment is necessary if that person refuses to be admitted to a psychiatric facility.

D. The department shall:

(1) establish the necessary qualifications for a person to be appointed as a county suicide prevention response coordinator pursuant to this section; and

(2) establish guidelines and protocols to be used by each county suicide prevention response coordinator in:

(a) compiling a list of qualified and locally available suicide prevention counselors pursuant to Subsection B of this section; and

(b) coordinating dispatch of at least one suicide prevention counselor to each emergency scene involving a person in crisis who is or may be suicidal.

SECTION 10. [NEW MATERIAL] PUBLIC SAFETY ACCESS POINT--PROCEDURES.--

A. When a public safety access point staff determines that a request for emergency services involves a

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person who is or may be suicidal, the staff shall:

(1) notify the county suicide prevention response coordinator that the call involves a person who is or may be suicidal if the public safety access point serves as the dispatch point for the emergency call; or

(2) notify the dispatching entity that the request for emergency services involves a person who is or may be suicidal if the public safety access point does not serve as the dispatch point for the emergency call.

B. Any dispatching entity notified pursuant to Subsection A of this section shall notify the county suicide prevention response coordinator that the call involves a person who is or may be suicidal.

C. Notice shall be provided to a county suicide prevention response coordinator, pursuant to Subsection A of this section, at the time of dispatch or prior to the dispatch of law enforcement to the emergency scene.

SECTION 11. [NEW MATERIAL] DEPARTMENT TO PROMULGATE RULES--AGENCY AND DEPARTMENT COOPERATION.--

A. The department shall promulgate rules as are necessary to implement and enforce the provisions of the Suicide Prevention, Response and Treatment Act.

B. State agencies shall cooperate with the secretary of health to carry out the provisions of the Suicide Prevention, Response and Treatment Act.

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SECTION 12. [NEW MATERIAL] ADMINISTRATIVE PENALTIES.--

A. If the department has reason to believe that an outpatient treatment facility or a psychiatric facility is failing to comply with the provisions of the Suicide Prevention, Response and Treatment Act, the secretary shall order the facility to take corrective action within a reasonable time frame as may be deemed by the secretary to be necessary to ensure future compliance with the Suicide Prevention, Response and Treatment Act.

B. The department may assess an administrative penalty of:

(1) not more than two thousand five hundred dollars ($2,500) for a first offense and not more than five thousand dollars ($5,000) for a second or subsequent offense on a psychiatric facility or outpatient treatment facility that fails to comply with an order of the department issued pursuant to Subsection A of this section;

(2) not more than five hundred dollars ($500) for a first offense, not more than one thousand dollars ($1,000) for a second offense and not more than two thousand five hundred dollars ($2,500) for a third or subsequent offense on an outpatient treatment facility or a psychiatric facility that violates the provisions of Paragraph (4) of Subsection B of Section 3 of the Suicide Prevention, Response and Treatment Act; or

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(3) not more than five hundred dollars ($500) for a first offense, not more than one thousand dollars ($1,000) for a second offense and not more than two thousand five hundred dollars ($2,500) for a third or subsequent offense on an outpatient treatment facility or a psychiatric facility that violates the provisions of Subsection A of Section 6 of the Suicide Prevention, Response and Treatment Act.

SECTION 13. [NEW MATERIAL] HEARING.--

A. An outpatient treatment facility or a psychiatric facility that the department imposes an administrative penalty against shall be entitled to a hearing:

(1) upon request from the licensed outpatient treatment facility or psychiatric facility; and

(2) within ten days after receiving the notice of a penalty imposed by the department pursuant to Section 12 of the Suicide Prevention, Response and Treatment Act.

B. A hearing under this section shall be held in accordance with rules that the department shall adopt, pursuant to the Suicide Prevention, Response and Treatment Act, regarding adjudication procedures.

SECTION 14. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2021.

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