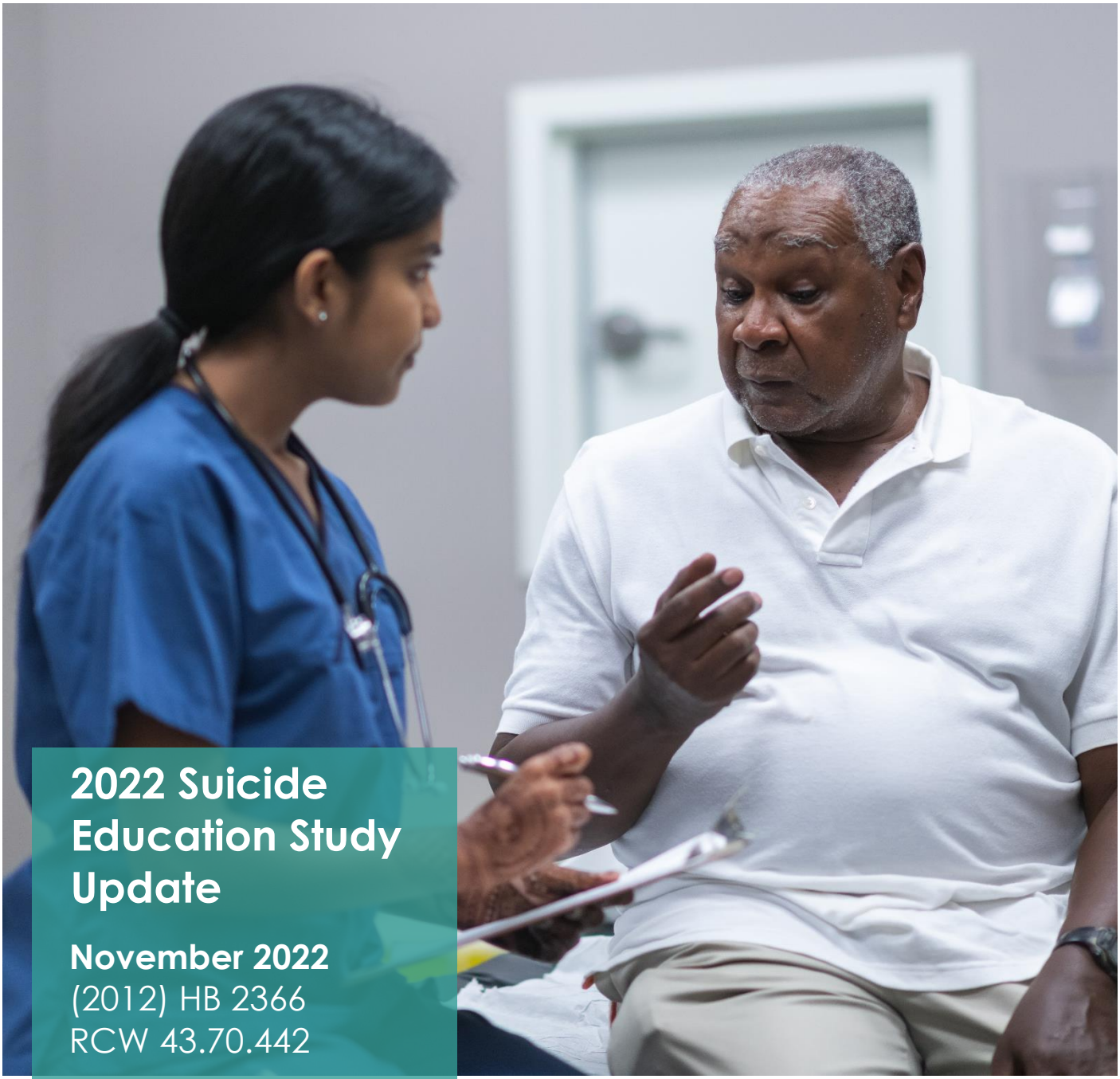
Report to the Legislature



# 2022 Suicide Education Study Update

**November 2022**
(2012) HB 2366
RCW 43.70.442

Prepared by the Office of Healthy & Safe Communities
Division of Prevention & Community Health

Washington State Department of Health

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# Executive Summary

Suicide is the 12th leading cause of death in the United States and the 10th leading cause of death in Washington State. Health professionals frequently interact with patients and clients, which places health professionals in a unique position to prevent suicide deaths. Suicide prevention education for health professionals is one component of a comprehensive suicide prevention strategy.

RCW 43.70.442 requires certain health professionals to complete training in suicide assessment, treatment, and management. Washington was the first state in the country to require education for health professionals and continues to be a leader in this area.

House Bill 2366 of 2012 directed the Washington State Department of Health (Department) to conduct a study to evaluate the effect of evidence-based suicide assessment, treatment, and management training on the ability of licensed health professionals to support and treat people with suicidal thoughts. An initial study was completed in 2013 with updates required in 2018 and 2022. This report is the final update and addresses the following objectives as requested by the legislature, including:

- Objective 1: Review available research regarding the relationship between patient suicide rates and training of health professionals in suicide assessment, treatment, and management.
- Objective 2: Assess which licensed health professionals are best suited to positively influence the mental health behavior of individuals with suicidal ideation.
- Objective 3: Evaluate the impact of suicide assessment treatment and management training on veterans with suicidal ideation.
- Objective 4: Review the curricula of health professions training programs offered at Washington's educational institutions regarding suicide prevention.

Since 2018, additional legislation improved suicide education training standards for health professionals. In 2020, House Bill 2411 directed the Department to adopt rules for advanced standards in suicide assessment, treatment, and management training for specific health professionals. Additional 2020 legislation also required that a specific suicide prevention training course be created for veterinarians.

The Department sees additional opportunities to improve suicide prevention training for health professionals. These opportunities include:

- Adding cultural humility training and culturally relevant interventions, specifically adding for populations at greater risk for suicide to curricula.
- Adding training curricula focusing on suicide prevention among health professionals.
- Adopting suicide prevention training requirements for emergency medical service professionals.

# Background

According to 2020 data, suicide is the 12th leading cause of death in the United States and the 10th leading cause of death in Washington State.[1] Nationally, suicide rates increased 30 percent between 2000-2018, but declined in 2019 and 2020.[2] Suicidal ideation continues to increase among adults nationally, with 4.58 percent of adults reporting thoughts of suicide in 2021.[3] Suicide rates in Washington State have decreased from 17.67 per 100,000 in 2017 to 15.82 per 100,000 in 2020.[4]

Suicide prevention education for health professionals is an important aspect of an overall State suicide prevention strategy. In the 2012 National Strategy for Suicide Prevention (NSSP), Strategic Direction 2, Goal 7 emphasizes the need for clinical providers trained in suicide assessment, treatment, and management, and specifically the importance of suicide prevention education standards for health professionals. Studies indicate that many people who die by suicide see a health professional in the weeks or months prior to their death.[5] Research also finds that one in ten people who die by suicide are seen in an emergency department within two months before their death.[6]

Washington has been on the leading edge of suicide prevention education for health professionals and was the first state in the country to pass legislation requiring suicide prevention education. Since the original legislation passed in 2012, Washington continues to refine and elevate the importance of suicide prevention education for health professionals.

In 2015, the legislature directed the Department to adopt rules creating minimum standards for suicide prevention education for health professionals and to create a public list of suicide prevention trainings that meet these required minimum standards. A Model List of approved courses was posted on the Department's website in early 2017. Starting July 2017, health professionals were required to take a training from the Department's Model List to meet requirements for licensure. Suicide prevention trainings continue to be reviewed by the Department and added to the Model List.

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[1] Centers for Disease Control and Prevention. (2021). *Stats of the state – suicide mortality*. Retrieved May 23, 2022 from https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

[2] Centers for Disease Control and Prevention. *Facts about suicide*. Retrieved May 23, 2022 from https://www.cdc.gov/suicide/facts/index.html

[3] Mental Health America. (2022). *The State of Mental Health in America*. https://mhanational.org/issues/state-mental-health-america

[4] WA National Violent Death Reporting System. Crude rates - sex, age, and race combined. 2021 rates were unavailable. Data retrieved on May 20, 2022.

[5] Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., Lynch, F., Owen-Smith, A., Hunkeler, E. M., Whiteside, U., Operskalski, B. H., Coffey, M. J., & Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, 29(6), 870–877.

[6] Betz, M. E., & Boudreaux, E. D. (2016). Managing Suicidal Patients in the Emergency Department. *Annals of Emergency Medicine*, *67*(2), 276–282.

In 2020, the legislature enacted House Bill 2411 directing the Department to adopt rules creating advanced standards for suicide prevention training for specific health professions.[7] Advanced standards for suicide prevention education address many of the recommendations outlined in previous reports. A full timeline of Washington State legislation regarding suicide prevention training for health professionals can be found in Appendix A, and a full list of health professions and suicide prevention education requirements is listed in Appendix B.

The COVID-19 pandemic increased national attention on mental health and well-being, which has impacted the landscape of suicide prevention training for health professionals. The pandemic highlighted the need for culturally responsive and informed suicide prevention training, especially for populations at higher risk for suicide or that have been disproportionately impacted by the pandemic. Although state and national data shows a recent decreasing trend in overall suicide rates, this is not true across all populations and age groups. Trainings that are culturally relevant and grounded in cultural humility, are needed for health professionals to better address suicide risk in these populations.[8]

The pandemic also highlighted the importance of healthcare professionals' mental health and well-being. The strain of the pandemic on health professionals, especially those serving in front-line response settings, brought attention to the suicide risk among health professionals themselves. This has resulted in a national push for suicide prevention training to specifically address the topic of suicide prevention for health professionals.

# Objective 1

**Review available research and literature regarding the relationship between training of health professionals and suicide rates.**

Mandated suicide prevention training for Washington health professionals became law in 2012. This innovative approach began with behavioral health professionals and has since expanded to other health professionals, including dentists, athletic trainers, and acupuncture and eastern medicine practitioners (see Appendix B). National suicide prevention strategies and best practices continue to evolve, and training for health professionals is considered a crucial part of these comprehensive strategies.

Due to the impact of the pandemic on healthcare and public health systems, research evaluating the impact of suicide prevention training for health professionals on suicide rates

[7] Health professionals required to complete advanced standards training include: psychologists, marriage and family therapists, mental health counselors, advanced social workers, independent clinical social workers, social worker associates-advanced, and social worker associates-independent.

[8] In this context, cultural humility may be defined as a process of being aware of how people's culture can impact their health behaviors and in turn using this awareness to cultivate sensitive approaches in treating patients and clients.

has been minimal. The Department will continue to monitor research developments, as well as federal policy related suicide prevention training for health professionals.

This section outlines research, reports, and evidence-based practices on the topic of suicide prevention and the training of health professionals since 2018.

## National Suicide Prevention Strategy Update

In the 2012 National Strategy for Suicide Prevention (NSSP), Strategic Direction 2, Goal 7 emphasizes the need for trained clinical providers and outlines the importance of the development and promotion of training guidelines on suicide prevention for health professionals. In December 2017, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) released an implementation assessment report on the NSSP. In this report under Goal 7, Washington was highlighted as one of two states requiring suicide prevention training for health professionals. SAMHSA has not released an updated implementation assessment report on the NSSP since 2017.

In January of 2021, the Office of the Surgeon General, in partnership with the Action Alliance for Suicide Prevention, released The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention. This report again highlighted the importance of suicide prevention training for health professionals. Key pieces of the report related to suicide prevention education for health professionals are outlined in Action 4.1 – Increase clinical training in evidence-based care for suicide risk. Key pieces of Action 4.1 include:

- The need for more than minimal suicide prevention training among behavioral health providers.
- The importance of regular training and the importance of integrating training early in clinical education.
- The importance of training on appropriate support for diverse groups, especially sexual and gender minorities.
- The importance of integrating evidence-based treatment for suicidality with mental illness treatment.
- The importance of embedding suicide care into diverse clinical care settings and integrating best practices for preventing, identifying, and treating suicide risk into everyday clinical workflows.
- The potential for telehealth services to reduce disparities in access to suicide management and treatment services and the need for more research on this topic.[9]

[9] U.S. Department of Health and Human Services, National Action Alliance for Suicide Prevention. (2021). *The Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*. https://www.hhs.gov/sites/default/files/sprc-call-to-action.pdf

## COVID-19 Impact

The COVID-19 pandemic has brought an increased focus on mental health generally, and the mental well-being of health professionals specifically. In addition, the pandemic highlighted the need to ensure that suicide prevention training and resources are culturally responsive and effective for those disproportionately impacted by the pandemic or at greater risk of suicide.

### Health Professionals

The COVID-19 pandemic increased concern for, and research on, the mental health and well-being of health professionals. Recent research has focused primarily on the impact to physicians, nurses, and the public health workforce. A 2021 review found that a quarter to a third of physicians reported increased symptoms of mental ill health, with female physicians being at increased risk of suicide.[10] Another 2021 study noted that both male and female nurses have higher rates of suicide than age-matched men and women in the general population.[11] When looking at the broader public health workforce, 8.4 percent of public health workers who responded to an online survey in early 2021 reported suicidal ideation, with COVID-19 response stress and work hours cited as contributing factors.[12]

The Action Alliance's Mental Health and Suicide Prevention National Response to COVID-19 (National Response) identified six strategic priorities to address mental health and suicide prevention during the COVID-19 pandemic and beyond. Priority 6 highlights the need to address mental health and suicide prevention among health professionals and first responders. Specific calls to action in this priority area include assessing the impact of the pandemic on health professionals' mental well-being and health, as well as the mental health and suicide prevention needs of this population, in order to create supportive policy, education, and infrastructure.[13] Assessment and data updates from the National Response may help inform suicide prevention training for health professionals and drive the creation of specific training to address the increased risk of suicide that many health professionals face.

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[10] Harvey, S. B., Epstein, R. M., Glozier, N., Petrie, K., Strudwick, J., Gayed, A., Dean, K., & Henderson, M. (2021). Mental illness and suicide among physicians. *Lancet (London, England)*, *398*(10303), 920–930. https://doi.org/10.1016/S0140-6736(21)01596-8

[11] Moutier, C. Y., Myers, M. F., Feist, J. B., Feist, J. C., & Zisook, S. (2021). Preventing Clinician Suicide: A Call to Action During the COVID-19 Pandemic and Beyond. *Academic Medicine: Journal of the Association of American Medical Colleges*, *96*(5), 624–628. https://doi.org/10.1097/ACM.0000000000003972

[12] Bryant-Genevier, J., Rao, C. Y., Lopes-Cardozo, B., Kone, A., Rose, C., Thomas, I., Orquiola, D., Lynfield, R., Shah, D., Freeman, L., Becker, S., Williams, A., Gould, D. W., Tiesman, H., Lloyd, G., Hill, L., & Byrkit, R. (2021). Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID-19 Pandemic - United States, March-April 2021. *MMWR. Morbidity and Mortality Weekly Report*, *70*(48), 1680–1685. https://doi.org/10.15585/mmwr.mm7048a6

[13] National Action Alliance for Suicide Prevention (n.d.). *Mental Health and Suicide National Response to COVID-19*. Retrieved May 25, 2022 from https://nationalmentalhealthresponse.org/

Although current suicide prevention training for health professionals is aimed at improving the care and treatment of patients and clients, suicide prevention training for health professionals can and should also include content focused on mental well-being and suicide prevention for health professionals.

### Culturally Relevant and Responsive Training

Both the National Action Alliance for Suicide Prevention (Action Alliance) and the Centers for Disease Control and Prevention (CDC) have released reports addressing the need to better serve populations disproportionately impacted by the pandemic. These reports also highlight the need for greater diversity and cultural competence within suicide prevention training.

Priority 5 of the National Response noted above, also addresses the need for culturally relevant and informed suicide prevention training. Priority 5 of the National Response:

*"Ensure the equitable delivery of comprehensive and effective suicide prevention and mental health services for Black Americans; Latinx Americans; American Indians/ Alaskan Natives (AI/AN); lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) individuals; and others disproportionately impacted by the pandemic."*[14]

This priority focuses on the need to develop culturally appropriate, relevant, and effective suicide prevention for Black youth and adults and LGBTQA+ individuals. Priority 5 also calls for education and training programs to address the mental health and suicide risk impacts of systemic racism and discrimination.

The CDC's Suicide Prevention Strategic Plan FY2020-2022 calls out comprehensive suicide prevention programing for vulnerable populations across all four of its strategic priorities, including Data, Science, Action, and Collaboration. In the priority area of Science, the plan discusses how data clearly indicates that certain populations, including, but not limited to, veterans, rural populations, sexual and gender minorities, middle-aged adults, and tribal populations experience higher rates of suicide than the general population. Despite these data, there remains a substantial gap in the understanding of how to prevent suicide effectively and appropriately in these vulnerable populations. To bridge this gap, the CDC recommends additional research to determine specific factors that reduce suicide risk in vulnerable populations, along with the development of new strategies to prevent suicide in more tailored and population-specific ways.[15]

## Objective 2

[14] National Action Alliance for Suicide Prevention (n.d.). *Mental Health and Suicide National Response to COVID-19*. Retrieved May 25, 2022 from https://nationalmentalhealthresponse.org/

[15] U.S. Centers for Disease Control. Suicide Prevention Strategic Plan FY2020-2022. https://www.cdc.gov/suicide/pdf/SuicidePrevention_StrategicPlan-508.pdf

**Assess which licensed health care professionals are best situated to positively influence the mental health behavior of people with suicidal thoughts.**

In previous reports, the following professions were recommended as potentially benefiting from receiving suicide prevention training and contributing to an overall suicide prevention strategy: emergency medical services (EMS) providers, midwives, home care aides, veterinarians, and podiatrists.

In 2020, House Bill 2411 called for the creation of specific suicide prevention training for veterinarians in consultation with the University of Washington's Forefront Suicide Prevention Center. RCW 18.92.280 requires veterinarians and veterinary technicians to complete this three-hour training starting July of 2022. Training content focuses specifically on mental health and well-being for veterinarians and veterinary technicians due to their increased risk of suicide.

The Department continues to see the benefit of suicide prevention education for the other professions mentioned in the 2018 report, especially EMS providers. EMS providers respond to intentional and unintentional self-injury situations and may be able to support people who are experiencing chronic or situational suicidal thoughts. Increased emotional stress due to the pandemic may also make EMS providers more vulnerable to behavioral health concerns and suicide. This increased vulnerability provides additional support for the need for suicide prevention training among EMS providers.

Midwives and home health care aides may also benefit from suicide prevention training due to their more intimate knowledge of living situations and potential major life stressors that could be warning signs of suicide risk. Midwives may work with parents grieving the unexpected loss of a child or parents who are experiencing post-partum depression. Podiatrists are also recommended to receive suicide prevention training because they often work with patients experiencing chronic pain. People living with chronic pain are at least twice as likely to report suicidal thoughts or die by suicide than the general population.[16]

Suicide prevention training for community health workers (CHW) may also be beneficial. The 2015-2016 Washington State Community Health Worker Task Force defined a CHW as:

*"A frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery."*[17]

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[16] Racine M. (2018). Chronic pain and suicide risk: A comprehensive review. *Progress in Neuro-psychopharmacology & Biological Psychiatry*, *87*(Pt B), 269–280. https://doi.org/10.1016/j.pnpbp.2017.08.020

[17] Farrell-Sheffer, Anne. (2019, June). *Report and Recommendation for Implementing Training and Education for Community Health Workers.* Washington State Department of Health. https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//349-037-CommunityHealthWorkersReport.pdf

This growing and diverse workforce may be uniquely positioned to play a role in community suicide prevention and could benefit from suicide prevention training like other health professionals. CHWs may be able to provide more culturally responsive support for people experiencing suicidal thoughts by drawing upon their knowledge of community and cultural strengths. Additional research and conversations with CHWs and organizations that offer training for CHWs is needed to determine if suicide prevention training would be appropriate.

House Bill 2411 of 2020 addressed the need for advanced standards in suicide prevention training. These advanced standards trainings build on the minimum standards for training to improve health professionals' skills and knowledge in assessing, treating, and managing suicide. The advanced standards trainings also aim to provide an opportunity for focused curricula on populations at increased risk for suicide (e.g., LGBTQA+) and a greater emphasis on cultural competence and humility in suicide prevention education.

Culturally responsive training may also be advanced by working with community partners to co-create trainings for specific populations that are at increased risk of suicide or that have been disproportionately impacted by the pandemic. Trainings that address the impacts of social determinants of health and racial and gender discrimination as suicide risk factors would also advance equity in suicide prevention training.

# Objective 3

**Evaluate the impact of suicide assessment, treatment, and management training on veterans with suicidal ideation.**

Minimum standards for suicide prevention training for health professionals in Washington State require 30 minutes of veteran-specific content for each six-hour training module. To help training developers meet the required 30 minutes of veteran specific content for the six-hour trainings, the Washington Department of Veteran Affairs (DVA) created a Veterans Module in August 2016.

Ongoing evaluation of the impact of suicide prevention training for health professionals on veterans with suicidal ideation has not occurred. An evaluation that addresses the impact of health professional training on veteran suicidal ideation would require a significant study that is beyond the scope of what the department can reasonably achieve. However, the department is considering alternative evaluation options. One possibility is to include a survey as part of the health professionals training that assesses what health professionals learned and how confident they are in applying that information when working with veterans as well as the general population. The remainder of this section will summarize current data that can be used as a baseline to continue to monitor suicide trends in the veteran population. In addition, an update is provided on recent suicide prevention efforts focused on veterans in Washington State.

Washington is currently home to 546,892 veterans.[18] In 2020, 221 veterans in Washington State lost their lives to suicide, and preliminary data from 2021 indicates similar numbers (see Table 1).[19] Data indicates an overall downward trend since 2017 that mirrors a trend seen nationally. In 2020, veterans accounted for 18.2 percent of all suicide deaths in Washington. This also reflects a decrease from 2017 and 2019. Current preliminary data does not indicate a change in this trend.

## Table 1: Deaths by Suicide Among WA Veterans (2017-2021)

| | 2017 | 2018 | 2019 | 2020 | 2021* |
|---|---|---|---|---|---|
| Count | 255 | 233 | 255 | 221 | 218 |
| Annual Percent Change | -- | -9% | 9% | -13% | -1% |

*Data retrieved on May 20, 2022. 2021; data is preliminary and subject to change.

Nationally, adjusted suicide rates from 2018 to 2019 decreased 7.2 percent among veterans, but the adjusted rate for veterans was still 52.3 percent greater than for non-veteran adults.[20] The decrease in the adjusted suicide rate for veterans from 2018 to 2019 was the largest decrease observed nationally in 20 years, and there is hope that this trend will continue.[21]

## COVID-19

In response to the ongoing COVID-19 pandemic in 2020, the United States Department of Veterans Affairs (VA) began monitoring trends and early warning indicators among veterans seeking health care through the VHA.[22] Key findings from this monitoring did not show an increase in suicide-related indicators.[23] National data from the pandemic will continue to emerge and clarify the trend seen through this monitoring, and the 2022 annual report on

[18] US Department of Veterans Affairs. Geographic Distribution of VA Expenditures for Fiscal Year 2021. https://www.va.gov/vetdata/stateSummaries.asp
[19] WA National Violent Death Reporting System. 2021 data is preliminary and subject to change. Data retrieved on May 20, 2022.
[20] Age and sex adjusted rates.
[21] US Department of Veterans Affairs (2021, September). *National Veteran Suicide Prevention Annual Report*. https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf
[22] VA early warning surveillance included: Site reports, emergency department data, primary care data, high risk flag activity, on-campus events, mortality trends, and non-fatal suicide attempts.
[23] US Department of Veterans Affairs., op. cit.

veteran suicide prevention should provide further clarity on the impact of the pandemic on national suicide rates among veterans.

## Service Member, Veteran, and Family Suicide Prevention Strategic Plan

Since the original legislation passed in 2012 requiring suicide prevention training for health professionals, Washington continues to be on the forefront of suicide prevention, with a special focus on veterans. As part of this ongoing prevention work in 2020, the Service Members, Veterans, and their Families (SMVF) Advisory Committee was formed and developed the Washington State Service Member, Veteran, and Family Suicide Prevention Strategic Plan 2021-2023 (SMVF Strategic Plan).

The first priority in the SMVF Strategic Plan is to identify and screen service members, veterans, and their family members for suicide risk, with a focus on promoting and conducting military cultural competency trainings and moral injury trainings for healthcare providers outside of the VA.[24,25] Veterans and members of the military community are part of a distinct culture with unique risk and protective factors, as well as mental health challenges. Training that includes cultural competency specifically focused on military culture will assist health professionals in providing culturally informed care, and hopefully improve treatment and management outcomes for veterans with suicidal thoughts. A full list of the SMVF Strategic Plan priorities and goals can be found in Appendix C.

Advanced standards for suicide prevention training includes the option of adding cultural competence curriculum for populations at higher risk for suicide. As the DVA continues to implement the SMVF Strategic Plan, the Department will seek to align health professional trainings, especially advanced standards trainings, with the priorities outlined in the SMVF Strategic Plan.

# Objective 4

**Review the curricula of health care profession programs offered at Washington's State educational institutions regarding suicide prevention.**

Washington State's public and private educational institutions continue to be key partners in developing health professional suicide prevention education. Many bachelors, graduate, and postgraduate programs now incorporate suicide prevention training in health professional

[24] Moral injury occurs when a person performs or witnesses behaviors opposing their individual values or moral beliefs. This can lead to feelings of guilt and sadness rather than the anger and fear seen in post-traumatic stress disorder.

[25] Garza, Codie Marie. (2020). Washington State SMVF Suicide Prevention Plan. Olympia: Washington State Department of Veterans Affairs. Available from: https://www.dva.wa.gov/sites/default/files/2020-12/Washington%20State%20SMVF%20Suicide%20Prevention%20Strategy%2021-23%20FINAL%2012.17.2020.pdf

curricula. As an update to the 2018 report, the Department again sampled education instructions across the State and specifically looked at those health professions that are more recent additions to the list of health professionals who are required by RCW 43.70.442 to complete training in suicide assessment, treatment, and management. The more recently added professions include dentists, dental hygienists, and athletic trainers.

- **The University of Washington**
  - **School of Dentistry**: Since the fall of 2019, the University of Washington School of Dentistry has included three hours of suicide prevention training in the second year of their curriculum, which utilizes the Forefront Suicide Prevention LEARN® program created by the Forefront Suicide Prevention Center. The School of Dentistry initiated suicide prevention training for predoctoral students in 2015, utilizing the Husky Hope and Health program. RCW 43.70.447 required the University of Washington to develop suicide assessment, treatment, and management for dental students and licensed dentists in accordance with the minimum standards for suicide prevention education for health professionals. The School of Dentistry also offers suicide prevention education through their continuing education program for dentists and dental hygienists who have graduated from a professional program.
  - **School of Pharmacy**: Since September 2017, the University of Washington School of Pharmacy has offered suicide prevention training for student pharmacists (PharmD students). Currently, suicide prevention training is integrated into the Pharmacist Provider Series for second year PharmD students. This training occurs through online modules offered by the Washington State Pharmacy Association's Suicide Awareness and Referral for Pharmacy Professionals. Starting in September 2022, PharmD students must also complete in-person practice applying and verbalizing the Forefront Suicide Prevention LEARN® model for suicide awareness communication in a 50-minute live session skills lab.
  - **School of Medicine**: Medical students complete suicide prevention training in year one of the Foundation Phase program course *Mind, Brain, and Behavior*. Content in the course covers suicide risk and protective factors, management, and treatment. Course content also addresses the increased risk of suicide among physicians.
  - **Other Programs**: At the University of Washington School of Social Work, all bachelor's and master's degree students receive more than three hours of suicide prevention training in their first year of study. In the School of Nursing, the Doctor of Nursing Practice's Psychiatric Mental Health Nurse Practitioner track requires 10 hours of training on suicide prevention.

    - **Continuing Education**: The University of Washington offers three- and six-hour suicide prevention trainings to a wide variety of health professionals seeking to fulfill the requirements needed for licensure. The All Patients Safe: Training for Medical Professionals is also used by other schools and programs, including the Athletic Training program at Washington State University.
- **Washington State University**
    - Athletic Training: Students pursuing a Master's in Athletic Training are required to complete six hours of training in suicide assessment, treatment, and management. The school does not provide the training directly, but refers students to the All Patients Safe: Suicide Prevention for Medical Professionals offered by the University of Washington. Three hours of content on suicide prevention is also included within their curriculum.
- **Central Washington University**
    - School Psychology Program, Education Specialist (EdS): Suicide assessment is covered in PSY593A - Practicum in Counseling I, and PSY 566 - Social/Behavioral/Emotional Assessment covers schoolwide suicide assessment, screening, and prevention programs.
    - Mental Health Counseling Program: Suicide assessment and crisis prevention are integrated into required coursework that also covers psychological first aid and clinical documentation.
- **Eastern Washington University**
    - Doctor of Physical Therapy: All students receive suicide prevention training to meet minimum standards.
    - The College of Social Sciences: Enrolled undergraduate students are able to complete a Certificate in Addiction Studies: Suicide Assessment, Treatment, and Management as part of their Addiction Studies program. The certificate includes a total of four courses (15 credit hours).
- **Western Washington University**
    - Community Training: Students and faculty can receive suicide prevention training through the Counseling and Wellness Center. The campus Suicide Prevention program created a cohort of certified Question, Persuade, Refer (QPR) trainers to offer additional trainings on campus. The Counseling and Wellness Center is also now offering Forefront Suicide Prevention LEARN® trainings.
- **Bastyr University:**
    - Doctor of Naturopathic Medicine: Suicide prevention is covered in *Fundamentals of Behavioral Medicine*, which is required for all students in the program. The training includes suicide risk assessment, prevention, and safety planning, with a total of four hours of lecture.

    - Master of Arts in Counseling Psychology: Students receive three-hours of suicide risk assessment training as part of an existing required course. The curriculum includes information on current data trends, risk and protective factors, warning signs, and how to use the Columbia Suicide Severity Risk Scale (C-SSRS) to assess and document suicide risk.
- **Gonzaga University**
    - Department of Nursing: Students enrolled in the Master of Science in Nursing, Psychiatric Mental Health Nurse Practitioner program complete the QPRT Suicide Risk Assessment and Management Training Program. Students then come to campus and complete a suicide assessment with a standardized patient with formative feedback provided by faculty.
- **Seattle University**
    - Department of Nursing: Bachelor of Science in Nursing program students are required to complete seven hours of suicide prevention training through a both online and in-person modules, including a four-hour training provided by the Suicide Prevention Resource Center. The *Nursing Psychiatric Mental Health Theory* course also includes a two-hour lecture devoted to suicide prevention, including additional hands-on activities using case studies and discussions. Undergraduate students also receive training in trauma informed care as it relates to suicide risk assessment and documentation.
    - Department of Nursing: All doctoral Nurse Practitioner students receive two hours of suicide prevention content regardless of their specializations. Students of the Psychiatric Mental Health Nurse Practitioner program receive eight hours of suicide prevention training spread over six courses. Content in these courses includes screening, assessment, referral, and risk and protective factors. These students also participate in clinical seminars and standardized patient activities, including additional hours for skills practice and documentation.
    - Clinical Mental Health Counseling: The Department of Education requires a course in Crisis Counseling, which includes suicide assessment.

# Conclusion

House Bill 2366 of 2012 directed the Department to conduct a suicide education study to evaluate the effect of evidence-based suicide prevention training for health care professionals on their ability to support and treat people with suicidal thoughts. This is the third and final update of the suicide education study.

From 2012 to present, Washington has continued to support and prioritize suicide prevention training for health professionals. Specific recommendations outlined in previous suicide education studies have been realized, such as expanding the list of health professionals required to complete suicide prevention training and creating advanced standards for training.

The COVID-19 pandemic brought increased attention to mental health and suicide. Key lessons from the pandemic related to suicide prevention training for health professionals include the need for training on mental health and suicide risk among health professionals and developing trainings that are culturally relevant and appropriate for populations at higher risk of suicide or who have been disproportionately impacted by the pandemic. In addition, suicide prevention training requirements for EMS providers remains a priority.

Washington has been on the leading edge of suicide prevention training for health professionals, and this training is an important aspect of a comprehensive suicide prevention strategy. The Department will continue to evaluate the impact of suicide prevention training for health professionals and look for ways to improve current trainings to meet the need of health professionals in Washington.

# Appendix A: Timeline of Suicide Prevention Training for Health Professionals Legislation

| 2012 | 2014 | 2015 | 2016 | 2017 | 2020 |
|---|---|---|---|---|---|
| ***House Bill 2366*** Required mental health professionals to complete six hours of suicide prevention training every six years. Directed the Department of Health to complete a suicide education study. | ***House Bill 2315*** Required other health professionals to complete one-time, six-hour training in suicide prevention. Required the Department of Health to develop a list of model training programs. | ***House Bill 1424*** Required the Department of Health to adopt rules regarding minimum standards for suicide prevention training and create a list of approved trainings (Model List). | ***House Bill 2793*** Required pharmacists and dentists to complete suicide prevention training with added lethal means content. Also added dental hygienists and athletic trainers. Required minimum standards to include content on veterans. | ***July 1, 2017*** Health professionals required to take suicide prevention training must take an approved course on the Department of Health's Model List . | ***House Bill 2411*** Directed the Department of Health to adopt rules for advanced standards training. Expanded required suicide prevention training to optometrists, acupuncture and eastern medicine practitioners, and veterinarians. |

# Appendix B: Health Professionals and Suicide Prevention Training Requirements

| Health Professions | Training Length and Content |
|---|---|
| Advanced social workers, advanced social worker associates, independent clinical social workers, independent clinical social worker associates<br><br>Licensed mental health professionals<br><br>Marriage and family therapists<br><br>Psychologists | Six-hour training: suicide assessment, treatment, and management; veterans; and imminent harm via lethal means or self-injurious behaviors.<br><br>(Taken at least once every 6 years) |
| Licensed practical nurses (LPN), registered nurses (RN), and advanced registered nurse practitioners (ARNP)<br><br>Naturopaths<br><br>Osteopathic physicians and surgeons and physician assistants<br><br>Physicians and physician assistants<br><br>Retired active licensee: naturopaths, LPNs, RNs, ARNPs, osteopathic physicians and surgeons and physician assistants, allopathic physicians and physician assistants<br><br>Athletic trainers (effective August 1, 2020)<br><br>Acupuncturist; acupuncture and Eastern medicine practitioners (effective August 1, 2021) | Six-hour training: suicide assessment, treatment, and management; veterans; and imminent harm via lethal means or self-injurious behaviors<br><br>(Taken once) |
| Certified counselors and certified advisers<br><br>Chemical dependence professionals<br><br>Occupational therapists | Three-hour training: suicide screening and referral<br><br>(Taken at least once every 6 years) |

| | |
|---|---|
| Chiropractors<br>Dental hygienists (effective Aug. 1, 2020)<br>Physical therapists and assistants<br>Optometrists (effective Aug. 1, 2021) | Three-hour training: suicide screening and referral<br>(Taken once) |
| Pharmacists<br>Dentists and retired active licensees<br>(effective Aug. 1, 2020) | Three-hour training: screening, referral, and risk of imminent harm via lethal means<br>(Taken once) |
| Veterinarians (effective July 1, 2022) | Three-hour training: specific training created in collaboration with University of Washington Forefront Center for Suicide Prevention<br>(Taken once) |

# Appendix C: Washington State SMVF Suicide Prevention Plan 2021-2023: Priorities and Goals

## IDENTIFY SMVF & SCREEN FOR SUICIDE RISK

**Goal 1: Culturally informed healthcare providers and community partners**

1.1 – Promote and conduct military cultural competency trainings for healthcare providers outside the VA and community partners who interact with SMVF

1.2 – Promote and conduct moral injury trainings for healthcare providers outside the VA who serve SMVF

**Goal 2: Screening in community healthcare**

2.1 – Promote and support implementation of consistent suicide screening and referral process of SMVF by community providers

2.2 – Promote VA "Never Worry Alone" program for community providers to access for support

2.3 – Launch "Ask the Question" campaign

**Goal 3: Improved environment among SMVF for help-seeking, growth, & wellness**

3.1 Create National Guard targeted media campaign to promote help seeking behavior and available community resources

3.2 WDVA collaboration with various Tribal SMEs regarding training and education to local (non-tribal) law enforcement

## PROMOTE CONNECTEDNESS & IMPROVE CARE TRANSITION

**Goal 4: Promote cultural competency trainings for direct service providers and frontline staff**

4.1: Organize training opportunities for cultural competency allowing providers to receive training outlined in priority area 1

**Goal 5: Increase and encourage SMVF to access community resources and enroll with VHA and VBA**

Objective 5.1: Explore programs to improve Service Member transition to Veteran status

Objective 5.2: Strengthen and expand peer support programming to provide outreach and connection to local resources for service members at critical periods of transition in collaboration with the VA health system

5.3 – Increase the number of eligible Veteran Service Officers (VSOs), in each county, to process claims

**Goal 6: Sufficiently fund programs for community and non-profit programs that serve Veterans**

6.1 – Identify funding availability and ensure agencies are aware of funding opportunities

## INCREASE LETHAL MEANS SAFETY & SAFETY PLANNING

**Goal 7: Increase public and policymaker awareness about lethal means**

6.1 – Educate local, state, and federal policymakers about firearms fatalities and any policy needs

**Goal 8: Education SMVF about firearm safety inclusive of lethal means safety**

8.1 – Continue and expand dissemination of a free online course on firearms and lethal means safety

8.2 – Disseminate a toolkit to federal firearms licensees (FFLs) about their potential role in suicide prevention and public education about lethal means safety

8.3 – Build into transition planning an opportunity to educate about lethal means safety as part of the SMVF transition program

8.4 – Continue to offer the SAFER structured conversation in community-based settings frequented by Veterans

8.5 – Expand LEARN SAVES LIVES across Washington State for SMVF and those who come in contact with SMVF

**Goal 9: Improve current Safety Planning Intervention (SPI) training among VA and community healthcare providers**

9.1 – Develop and disseminate a course on firearms cultural competency and its impact on lethal means counseling to assist providers serving Veterans having informed conversations about how means matter in the prevention of suicide

9.2 – Develop a training on the SPI intervention for use with Tri-Care


Washington State Department of
Health