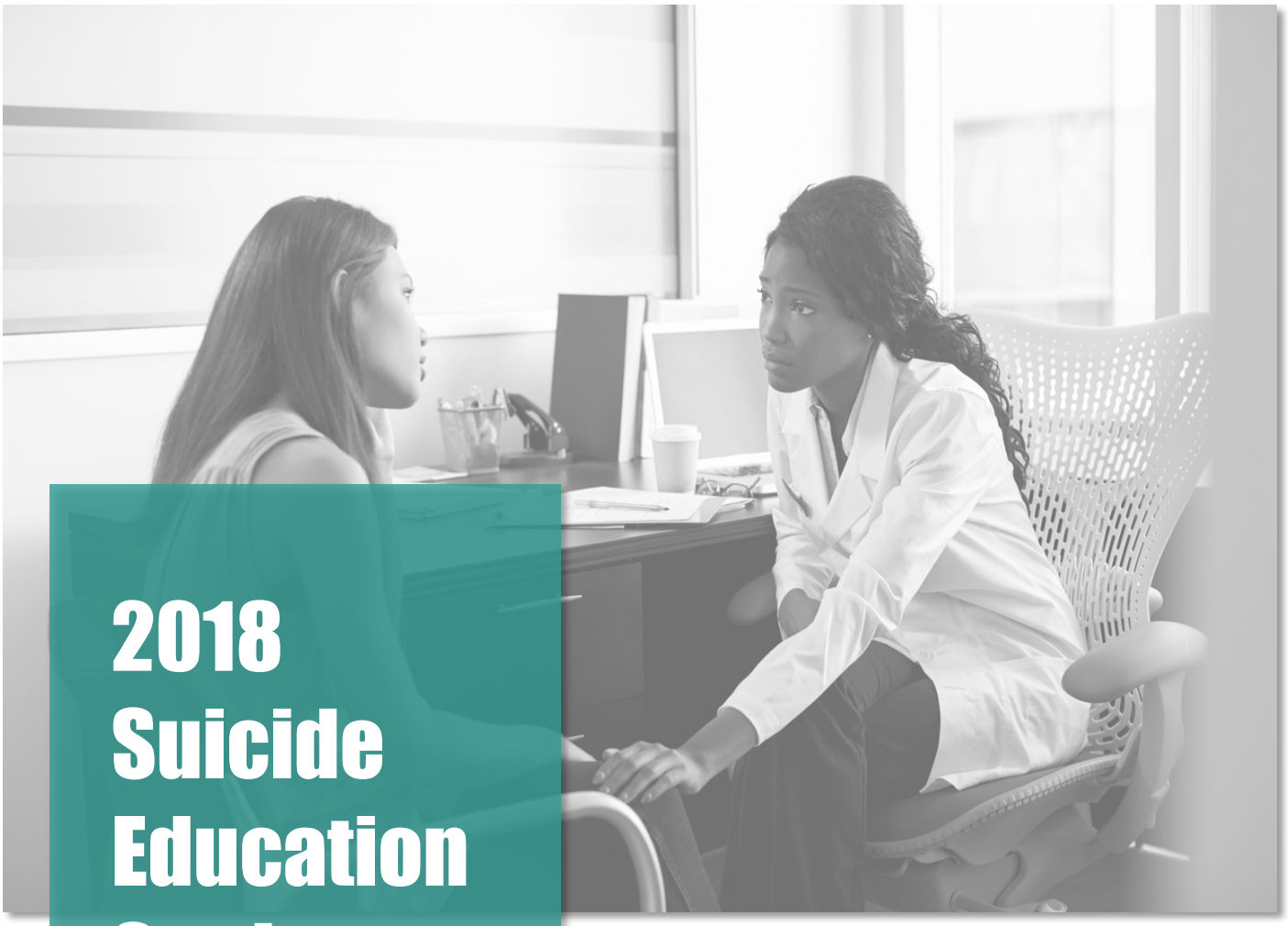
Report to the Legislature



2018 Suicide Education Study

November 2018

RCW 43.70.443

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Health Systems Quality Assurance |
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Executive Summary

RCW 43.70.442 requires certain health care professionals to complete training in suicide assessment, treatment, and management every six years. House Bill 2366, enacted in 2012, requires the 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 care professionals to identify, refer, treat, and manage patients with suicidal thoughts. The initial study was completed in 2013 with updates required per HB 2315 (2014) in 2018 and 2022. Specifically the legislature directed the study to:

- Review available research and literature regarding the relationship between patient suicide rates and training of health care professionals in suicide assessment, treatment, and management.
- Assess which licensed health care professionals are best situated to positively influence the mental health behavior of individuals with suicidal ideation.
- Evaluate the impact of suicide assessment, treatment, and management training on veterans with suicidal ideation.
- Review the curricula of health care profession training programs offered at Washington's state educational institutions regarding suicide prevention.

Washington was the first state to require suicide education for licensed health professionals[1] and we are fortunate that professional boards and commissions have supported this type of education for their fields.

Washington recognizes the importance of educating health professionals on suicide intervention best practices for veterans. Health professionals identified in House Bill 2315[2] are now required to take at least 30 minutes of training on veterans' needs, including population-specific data, risk and protective factors, and intervention strategies.

The department has identified additional health care providers who may benefit individuals by taking suicide prevention education. The department suggests reviewing these proposals further with the impacted providers before taking action. These providers include:

- Emergency medical services (EMS) providers, who respond to many cases of violence and self-injury.
- Midwives and home care aides because they provide an in-home support system for their clients.
- Veterinarians, who help their clients struggling with pet health concerns and loss.
- Podiatrists, whose patients often deal with chronic lower extremity pain.

[1] Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2017). Suicide Prevention Training: Policies for Health Care Professionals across the United States as of October 2017. *American Journal of Public Health*, doi: 10.2105/AJPH.2018.304373. Abstract.

[2] These professions were identified in a 2013 Suicide Education Study completed by the Department of Health.

Suicide prevention education is one aspect of a larger comprehensive system for suicide care. Current best practices include systems and policy approaches to support providers and enhance continuity of care.

The department suggests changes to the currently mandated training for health care professionals. Suggested changes include:

- Adding Washington-specific suicide prevention data, resources, policies, and legislation to required training.
- Requiring more advanced training courses on suicide assessment, treatment, and postvention (care after a suicide or suicide attempt) for mental health professionals.
- Adding information on best practices, such as universal suicide prevention protocols at health care providers' places of employment.

Suicide Education - Background

RCW 43.70.442 requires certain health care professionals to complete training in suicide assessment, treatment, and management every six years. House Bill 2366 (2012) requires the 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 care professionals to identify, refer, treat, and manage patients with suicidal thoughts. The first report was submitted to the legislature in December 2013. The department is required to submit updated reports in November 2018 and November 2022.

Suicide education is important as evidenced by a 2014 study[3] which found that 83 percent of those who die by suicide saw a health care provider within 12 months prior to their death.[4] Also, 29 percent of those who died in the past year were seen in outpatient behavioral health[5]. As a result, suicide prevention and care are now recommended training for many primary care and behavioral health professionals. Washington is one of only 10 states that require suicide prevention training for behavioral health professionals and one of only three states that requires training for other health care professionals.[6] A list of Washington's mandatory suicide presentation education is outlined in Appendix 3.

In 2015, the legislature enacted a law requiring the department to adopt rules establishing a model list of training which included minimum standards for all suicide training programs. As of July 2017, all suicide education training taken by health care professionals for certification must be from the Model List. The 2017 Model List of approved courses, including in-person and online options, was posted on the department's website in January 2017 and approved courses continue to be added. To help training developers meet the required 30 minutes of veterans' content for the six-hour trainings, the Washington Department of Veteran Affairs (DVA) created a Veterans Module in August 2016. More information on the Model List can be found in Appendix 4.

We are unable to measure the impact of provider education on patient well-being, in part, because providers are still within their time limit for taking the mandatory education. We will also look for ways to collect data and other information to measure impact.

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[3] Ahmedani, B. K., et al. (2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine 29(6):870-7.

[4] Washington passed legislation mandating suicide prevention training for health professionals in 2012. The first group of professions completed their mandatory training in 2014, the year this study was issued.

[5] Luoma, et al. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. American Journal of Psychiatry 159(6): 909-916.

[6] Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2017). Suicide Prevention Training: Policies for Health Care Professionals Across the United States as of October 2017. *American Journal of Public Health*, doi: 10.2105/AJPH.2018.304373.

Objective 1.

Review available research and literature regarding the relationship between training of health care 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 broader health professionals, including pharmacists and dentists. Since 2012, national suicide prevention strategies and best practices have evolved, and training is considered a crucial part of a broader health system approach. This section outlines research, reports, and evidence-based practices that have informed the suicide prevention field since the 2013 Suicide Education Report.

Training

In the 2012 National Strategy for Suicide Prevention (NSSP)[7], Strategic Direction 2 emphasized the need for trained clinical providers.

"Clinical preventive services, including suicide assessment and preventive screening by primary care and other health care providers, are crucial to assessing suicide risk and connecting individuals at risk for suicide to available clinical services and other sources of care. Screening for depression and alcohol misuse have been endorsed by the United States Preventive Services Task Force and are now covered as preventive services under Medicare."

In January 2016, the department released the first state suicide prevention plan across the lifespan.[8] The WA State Suicide Prevention Plan[9] follows the NSSP's outline and also emphasizes the need for educating clinical providers and improving treatment options. The first goal under Strategic Direction 2: Clinical and Community Preventive Services is "Tribal, state, local and institutional systems adopt comprehensive suicide prevention programs." The plan states, "Trainings designed to raise suicide awareness, improve clinicians' skills and guide response to a suicide loss are widely available in Washington and are required for certain professionals. But training alone does not solve the problem; it must be part of comprehensive, systems-level suicide prevention programming." Goal 3 refers to training health professionals in suicide assessment, treatment, and management. Under long-term goals, recommendations include requiring suicide content for health and social service courses in Washington higher education programs and possibly adding suicide prevention training in the home care aide basic training.

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[7] Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention. Washington (DC): US Department of Health & Human Services (US); 2012 Sep. Available from: https://www.ncbi.nlm.nih.gov/books/NBK109917/.

[8] Previous state suicide prevention plans were youth-specific.

[9] WA State Department of Health. (2016). Washington State Suicide Prevention Plan. Olympia: WA State Department of Health. Available from: https://www.doh.wa.gov/Portals/1/Documents/Pubs/631-058-SuicidePrevPlan.pdf.

In December 2017, the Substance Abuse and Mental Health Services Administration (SAMHSA) released an implementation assessment report on the NSSP.[10] In it, SAMHSA summarizes the impact of recent reports and legislation on advancing the goals of the 2012 NSSP. Under Goal 7, Washington's "Matt Adler law" is mentioned as one of two states requiring suicide prevention training for their clinical workforce.[11]

While individual training is helpful, research and suicide prevention experts support comprehensive health systems approaches to address suicide. By integrating physical and behavioral health, patients will receive easier access to holistic care and health professionals will be better equipped to support and connect patients to the care they need. The next section summarizes some recent literature on health systems approaches to suicide prevention.

Comprehensive Health System Approaches

In June 2018, the Centers for Disease Control and Prevention (CDC) released a report on suicide trends[12] and circumstances contributing to suicide from 1999 to 2016.[13] The data cited were gathered through the National Violent Death Reporting System. One significant finding in the report was that nearly half of those who died by suicide did not have a known mental health condition at the time of their death. The report also found that many of the people with known mental health conditions had been receiving treatment when they died. The report stressed the need to "prevent the circumstances associated with the onset of mental health conditions and support persons with known mental health conditions to decrease their risk for poor outcomes." The CDC recommended improving doctor-patient collaborative care, evidence-based therapies, and increased access to behavioral health providers.

Experts have placed an emphasis on embedding suicide prevention directly within systems of care, in addition to providing broader based suicide education. Goal 8 of the NSSP is "Promote suicide prevention as a core component of health care services." Most notable is the Zero Suicide model that includes seven elements:

1. **Lead** system-wide culture change committed to reducing suicides.
2. **Train** a competent, confident, and caring workforce.
3. **Identify** patients with suicide risk via comprehensive screenings.
4. **Engage** all individuals at risk of suicide using a suicide care management plan.
5. **Treat** suicidal thoughts and behaviors using evidence-based treatments.

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[10] Substance Abuse and Mental Health Services Administration: National Strategy for Suicide Prevention Implementation Assessment Report. HHS Publication No. SMA17– 5051. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2017.

[11] As of 2017, there were three states.

[12] Washington was not one of the 27 states analyzed in the report since the department began a staged implementation of the system in 2015 and will not have statewide data until 2020.

[13] Stone DM, Simon TR, Fowler KA, et al. *Vital Signs:* Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015. MMWR Morb Mortal Wkly Rep 2018; 67:617–624. DOI: http://dx.doi.org/10.15585/mmwr.mm6722a1.

6. **Transition** individuals through care with warm hand-off[14] and supportive contacts.
7. **Improve** policies and procedures through continuous quality improvement.

The Zero Suicide model was developed after the 2012 NSSP goal to reach zero suicides. This is now a national model for health systems and has been implemented in several states. In Washington, Kaiser Permanente's, Confluence Health's, and CHI Franciscan's inpatient units are following Zero Suicide. The Northwest Portland Area Indian Health Board is supporting Zero Suicide in the Puyallup Tribal Health Authority through a grant and technical assistance. Many other systems have adapted the model to suit their needs, including Coordinated Care[15] that does universal suicide screenings for all their foster youth. In 2017, the Health Care Authority wrote that Coordinated Care's "Zero Suicide initiative reduced emergency rooms visits by 59 percent."[16]

The concept of Zero Suicide is based on the Henry Ford Health System's Perfect Depression Care that resulted in a significant reduction in that health system's suicide rate. In 2001, the Robert Wood Johnson Foundation challenged health care leaders to pursue the Institute of Medicine's framework of "perfect care."[17] The Henry Ford Department of Psychiatry decided that "perfect care" in their behavioral health system meant "no suicides." To achieve this, they identified four key activities:

- Patients as active partners in the treatment plan.
- Development and implementation of suicide risk protocol for out-patient and in-patient settings.
- Improving access to treatment.
- Increasing information flow for clinicians, patients, and families.

In 2000, the suicide rate in their patient population was 89 deaths per 100,000. Through their follow-up care, this was dramatically reduced to an average of 22 suicides per 100,000 from 2002 to 2005. In 2009, Henry Ford achieved their goal of "no suicides." The suicide rate has since increased but remains much lower than their 2000 suicide rate thanks to the organization's commitment to "no suicides."

There have been challenges to this approach. Primary care providers were hesitant to embrace the goal of zero suicides and identify patients at risk for suicide. "Their concern was not that integrating depression care was not the right thing to do in the primary care setting; indeed, they had a strong and genuine desire to provide better depression care for their patients. Their concern was that the primary care clinic was not equipped to manage a suicidal patient safely

[14] A transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family
[15] Coordinated Care is a managed care organization.
[16] Washington State Health Care Authority. (2017, June 21). Coordinated Care of Washington for foster kids provides support to thousands of children. [Blog post]. Retrieved from https://www.hca.wa.gov/about-hca/apple-health-medicaid/coordinated-care-washington-foster-kids-provides-support-thousands
[17] Coffey, M.D. (2006). Pursuing Perfect Depression Care. *Psychiatric Services, 57*(10), 1524-1525.

and effectively."[18] To relieve anxiety, a team created guidelines on how to work with a suicidal patient and make appropriate referral channels to ease the path toward continuity of care. The Depression, Anxiety, Polysubstance Use, and Suicide screen (DAPS)[19] was created as a simple suicide screening tool. Additionally, the Behavioral Health Division guaranteed same-day evaluations for patients referred by primary care providers. While challenging, this approach decreased the number of people seeking suicide assessments in the emergency department.

In April 2018, the National Action Alliance for Suicide Prevention released a report to advance goals 8 and 9 of the NSSP. The Recommended Standard of Care for People with Suicide Risk: Making Health Care Suicide Safe includes evidence-based practices for health care settings (also see Appendix 2: Summary of Recommended Standard Care Elements by Major Care Setting).

Recommendations include:

- Screening patients to identify who is at risk.
- Assessing patients' level of suicide risk.
- Working with patients to create safety plans that include how they will reduce their access to lethal means, such as firearms or poisons.
- Completing caring contacts – following up with patients by phone, email, or text within 48 hours of their health care visits.

Zero Suicide's effectiveness stems from leadership commitment to create a system of suicide care rather than a checklist of best practices. Everyone within the health system (including leadership and administrative staff) is trained in suicide prevention, and treatment providers are trained in evidence-based treatment. There are clear assessment and referral protocols, and data is collected and analyzed for accountability and evaluation. Adherence to the policies is key to success and many health systems have a Zero Suicide coordinator tracking progress. New York and Texas have implemented Zero Suicide in their mental health clinics and are evaluating their progress.

In February 2018, the Bree Collaborative convened a workgroup to develop evidence-based standards for suicide care, focusing on standards for in- and outpatient settings including care transitions, behavioral health, and specialty care that is aligned with the State Suicide Prevention Plan. The workgroup examined the Zero Suicide model when developing its recommendations. In addition to completing the Washington mandatory suicide education, the report suggests the following focus areas:

1. Identification of Suicide Risk
    - Screen all patients over 13 annually for behavioral health conditions (i.e., mental health, substance use) associated with increased suicide risk using a validated

[18] Coffey, J. M. (2015). Perfect Depression Care Spread: The Traction of Zero Suicides. *JCOM Journal*, *22*(3), 7.
[19] DAPS consists of seven questions made up of the Patient Health Questionnaire (PHQ-2) for depression, the Generalized Anxiety Disorder Assessment (GAD-2), question nine from the PHQ-9 for suicidal ideation, the Single Answer Screening Question (SASQ) for problem alcohol use, and a single drug use question for substance use.

instrument(s) including: depression, suicidality (i.e., suicidal ideation, past attempts), alcohol misuse, anxiety, and drug use.

2. Assessment of Suicide Risk
    - Based on results from suicide risk identification above, further identify risk of suicide with a validated instrument and identify additional risk factors including: mental illness diagnoses, severe substance use disorder(s), stressful life experiences, and other relevant psychiatric symptoms or warning signs (at clinician's discretion).
3. Suicide Risk Management
    - Ensure individuals at risk of suicide have a pathway to timely and adequate care (e.g., follow-up contact same day or later as indicated by suicide risk assessment).
    - Keep patients in an acute suicidal crisis in an observed, safe environment.
    - Address lethal means restriction (e.g., guns, medications).
    - Engage patients in collaborative safety planning.
    - If possible, involve family members or other support people in suicidal risk management.
4. Suicide Risk Treatment
    - Use effective evidence-based treatments provided onsite that directly target suicidal thoughts and behaviors rather than focusing on specific mental health diagnoses through integrated behavioral health or offsite with a supported referral.
    - Document patient information related to suicide care and referrals.
5. Follow-up and Support After a Suicide Attempt
    - Ensure the patient is connected to evidence-based follow-up treatment.
    - Provide contact and support during transition from inpatient to outpatient sites.
    - Ensure supported pathway to adequate and timely care, as outlined above (e.g., collaborative safety planning, onsite or referral to offsite behavioral health).
6. Follow-up and Support After a Suicide Death
    - Follow-up and support for family members, friends, and providers involved in care including screening for depression, suicidality, anxiety, alcohol misuse, and drug use.

There are additional stakeholder recommendations for patients and family members, primary care and behavioral health care providers, specialty care, care settings, health plans, employers, and health care. The final recommendations were adopted in September 2018 and submitted to the Health Care Authority.

On the federal level, in January 2016, the Joint Commission[20] released a Sentinel Event Alert on detecting and treating suicide ideation in all settings. The Joint Commission's recommendation for all health care organizations was:

"To develop clinical environment readiness by identifying, developing and integrating comprehensive behavioral health, primary care and community resources to assure continuity of

[20] The Joint Commission is a not-for-profit organization that accredits and certifies health care organizations and programs in the U.S.

care for individuals at risk for suicide. Many communities and health care organizations presently do not have adequate suicide prevention resources, leading to the low detection and treatment rate of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their workflow and disrupt their schedule for the day to find treatment and assure safety for these patients."

The steps to detect and treat suicide ideation are below, and Washington suicide education touches on all the steps.

A. Detect suicide ideation in non-acute or acute care settings
    - Review each patient's personal and family medical history for suicide risk factors.
    - Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool.
    - Review screening questionnaires before the patient leaves the appointment or is discharged.
B. Take immediate action with safety planning
    - Take action using assessment results to inform the level of safety measures needed.
C. Behavioral health treatment and discharge
    - Establish a collaborative, ongoing, and systematic assessment and treatment process with the patient, involving the patient's other providers, family and friends, as appropriate.
    - To improve outcomes for at-risk patients, develop treatment and discharge plans that directly target suicidality.
D. Education and documentation
    - Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation.
    - Document decisions regarding the care and referral of patients with suicide risk.

Some health systems, like Henry Ford, the Veterans Administration (VA), and Kaiser have found value in suicide screening and assessment as part of their systems of suicide care. Coordinated Care does universal suicide assessments of all their foster youth. Acknowledging that suicide risk increases after a release from the emergency department or inpatient hospitalization, the Joint Commission Sentinel Alert recommended proper continuity of care. Continuity of care after a hospitalization is also mentioned in the Washington state suicide prevention plan.

In July 2018, the Suicide Prevention Resource Center created Choosing a Suicide Prevention Gatekeeper Training Program – A Comparison Table. The table includes training objectives, audiences, training format and highlights, and links for more information. The American Foundation for Suicide Prevention (AFSP) also recognizes health care professional burnout,

depression, and high suicide rates. They created materials to support health care professionals, including After a Suicide: A Toolkit for Residency/Fellowship Programs. See the AFSP website.[21]

Objective 2.

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

The department determined that the following additional professions may benefit from receiving suicide prevention training and also positively impact individuals: emergency medical services (EMS) providers, midwives[22], home care aides, veterinarians, and podiatrists. Further conversation with these providers would be beneficial to determine their assessment of impact and training needs. Primary care and behavioral health providers are already required to take suicide prevention education (See Appendix 3 for list of professions and mandatory training hours).

EMS providers respond to many cases of violence and self-injury, both intentional and accidental and, if the patient refuses to go to the hospital, often data is not collected. Midwives and home care aides might witness more warning signs since they are often more aware of living situations and life stressors. They can also support their clients with bereavement support after a miscarriage or death of a loved one. Midwives may also be the first providers to see signs of post-partum depression. Veterinarians are similarly placed to help their clients struggling with pet health concerns and loss. Podiatrists see many patients in chronic lower extremity pain, which can increase suicide risk.

In addition, the department has identified improvements to the current requirements for suicide prevention education for health care professionals (See Appendix for information on Model List of trainings). One improvement suggestion is to add Washington-specific information to required training, such as:

- Resources for referrals and continuity of care;
- Information about the Safer Homes Coalition's (authorized and funded under ESHB 2793 in 2016), Safe Storage Campaign launched in September 2017; and
- Information about the the state's new safe medication return program..

Adding websites or contact lists to training materials would greatly improve our health professionals' knowledge and ability to connect their clients to the appropriate local resources. Awareness of the National Suicide Prevention Lifeline is growing and the state has invested in

[21] For information on suicide prevention trainings, studies and comprehensive lists are available. Suicide and Suicide Prevention in Australia: Breaking the Silence includes extensive research of international best practices and trainings as well as Australia's national strategy.

[22] Doulas are also suggested, however they are not regulated by the state.

improving Washington's in-state answer rate,[23] but the number of calls continues to increase and Washington crisis centers answering these calls are overburdened.

Suicide prevention training can also be strengthened by aligning content with other state practices. In September 2018, the Bree Collaborative, a governor-appointed health care committee, submitted its suicide prevention report to the Health Care Authority. The report includes recommendations for standards of care. Currently approved suicide prevention trainings for health professionals include a range of screening and assessment tools, treatment and management options, and recommendations for continuity of care. If the Bree report's recommended standard of suicide care in Washington is to be achieved, these recommendations should be included in the suicide education for Washington health professional training too. Universal and consistent messaging will reinforce suicide assessment, treatment, and management best practices.

An additional improvement could include more advanced training courses on suicide intervention, treatment, and postvention to build professional skill development for mental health professionals who are required to take suicide prevention training every six years. One example is Applied Suicide Intervention and Skills Training (ASIST), a national evidence-based suicide intervention training primarily for behavioral health providers. These advanced trainings are meant to build upon basic suicide prevention knowledge to improve clinical skills. There are a handful of national evidence-based best practices that can be added on a separate list for behavioral health professionals who want to expand their knowledge and skills in suicide care.

Objective 3

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

A majority (50-70 percent) of veterans who die by suicide were not using Veterans Health Administration (VHA) services.[24] This makes it difficult to identify veterans and provide the most appropriate referrals. The DVA worked with veterans' suicide prevention experts to create a veterans training module. Many suicide prevention trainings did not have specific veterans' information in their course, so the module assisted developers with filling this gap. Since many veterans who die by suicide are not using VHA services, the module recommended providers ask all patients if they have ever served in the armed forces, National Guard, or reserves. If the answer is yes, the provider could inform the client about local and national veterans' services they could access.

[23] Currently our in-state crisis centers are only answering about 70% of Washington calls to the Lifeline and this is after additional state and federal funding. To answer all of the calls by in state crisis centers that Washingtonians make to the national line would require additional resources.

[24] U.S. Department of Veterans Affairs. (2018, June). VA National Suicide Data Report 2005-2015. Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2015_06-14-18_508-compliant.pdf.

The following studies highlight best practices for suicide prevention for veterans:

- (2013) - The United States Department of Veterans Affairs (VA) and the United States Department of Defense (DoD) released assessment and management of suicide risk guidelines for their health systems.[25] The purpose of the report was to provide a framework to reduce suicide, provide evidence-based recommendation for health care providers, and support the development of practice-based evidence.
- (2015) – In a study looking at safety plans and subsequent psychiatric hospitalizations among veterans, the prime recommendation was to improve suicide safety planning training for clinicians working with high-risk patients.[26] The authors mentioned that limitations included lack of knowledge of safety plan implementation fidelity, how safety plans were delivered, and patient safety plan outcomes. Higher quality safety plans might reduce future suicides, suicide attempts, and suicidal ideation.[27]
- (2017) - A review by the VA Portland Health Care System and Oregon-site randomized controlled trials.

Objective 4

Review the curriculum of health care profession programs offered at Washington's state educational institutions regarding suicide prevention.

Some postgraduate programs have been mandated to create suicide prevention curricula for their students. In 2016, RCW 28B.20.746 tasked the schools of pharmacy at the University of Washington and Washington State University with developing suicide assessment, treatment, and management curricula for their pharmacy students. Also, according to RCW 43.70.447, the school of dentistry at the University of Washington must develop a curriculum on suicide assessment, treatment, and management for dental students and licensed dentists by July 1, 2020.

Through our partners, the department collected a sampling of programs offered to health professionals. A full review is planned for the 2022 Suicide Education Study Update.

- Gonzaga University's Psychiatric Nurse Practitioner students are to complete a two-hour QPRT Suicide Risk Assessment/Management course prior to starting their practicum. Students are tested on their competency using a standardized model and are graded by a faculty member during an on-campus immersion.

[25] The Department of Veterans Affairs (VA) and The Department of Defense (DoD). (2013, June). VA/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide. Retrieved from https://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf.
[26] Gamarra, J.M., Luciano, M.T, Gradus, J.L., and Wiltsey, S.S. (2015). Assessing Variability and Implementation Fidelity of Suicide Prevention Safety Planning in a Regional VA Healthcare System. Crisis. 2015;36(6):433-9. doi: 10.1027/0227-5910/a000345.
[27] Green, J.D., et al. (2017). Evaluating the Effectiveness of Safety Plans for Military Veterans: Do Safety Plans Tailored to Veteran Characteristics Decrease Suicide Risk. Behavior Therapy. Doi: 10.1016/j.beth.2017.11.005.

- Walla Walla Community College has an approved suicide assessment, treatment, and management course that students and health professionals can take for credit. HO 169 Suicide Prevention Training was approved by the department in June 2017.
- The University of Washington offers suicide education in various schools.
    - Beginning in September 2017, University of Washington School of Pharmacy's first-year student pharmacists (PharmD students) are required to complete a three-hour training on suicide prevention, screening and referral. This training is currently part of a required core course, PHARM 500 Profession of Pharmacy. With the school's new curricular innovation, the required three-hour training will be relocated to one of the new course designations in the curriculum. Prior to September 2017, suicide prevention was covered in the required Applied Pharmacotherapeutics course series for all third-year PharmD students, under the format of case discussion with referral resources.
    - At the University of Washington School of Social Work, all Bachelors Social Work students receive three hours of training and most Masters Social Work students receive six hours. The school is moving to offer one-credit labs in these skills and a Dialectical Behavior Therapy (DBT)[28] training elective.
    - Since 2016, the UW Doctor of Nursing Practice's Psychiatric Mental Health Nurse Practitioner track requires 10 hours of training on suicide prevention. This includes six hours of department-approved training and four hours of additional training (readings, reflection assignment, case study, and online Columbia Suicide Severity Rating Scale training). The 10-hour training is part of the NCLIN 517 course assignment. Prior to the suicide education legislation, undergraduate students received usually two to three hours of content related to suicide prevention. Now they take the six-hour state-approved training.
- Eastern Washington University (EWU) offers suicide prevention in many ways.
    - The College of Social Sciences has a Suicide Assessment, Treatment, and Management certificate (available undergrad or graduate) through the Addiction Studies program.
    - The MS in Counselor Education (Department of Psychology) requires students to take a Suicide Assessment course.
    - The Doctor of Physical Therapy students all receive suicide prevention training.
    - EWU offers a continuing education workshop on Suicide Prevention.
- Pacific Lutheran University (PLU) has multiple training opportunities for their nursing students.
    - All Bachelor of Science Nursing students take the online state-approved Kaiser Permanente suicide assessment, treatment, and management course and then

[28] Dialectical behavior therapy (DBT) is a specific type of cognitive-behavioral psychotherapy developed to treat borderline personality disorder. Since its development, it has also been used for the treatment of other kinds of mental health disorders.

discuss it in class. Each student has to implement suicide assessment with each and every patient encounter.
    - In the graduate programs, Family Nurse Practitioner students all take a course entitled Management of Common Mental Health Problems in Primary Care. In the course, there is a class devoted to suicide assessment in primary care and the role nurses play, as well as how to report their experiences during their clinical assignments.
    - In the Psychiatric Mental Health Nurse Practitioner program (also a graduate program), students have a two-hour segment on assessment of suicide and mood disorders. The students all participate in a standardized patient assessment in which they have to conduct a suicide evaluation. Suicide assessment is also required with each patient encounter.
- Central Washington University offers suicide education in multiple courses.
    - Masters in Health Counseling:
        - Suicide assessment is covered in PSY 593A, Practicum in Counseling I: Interviewing. This is a two-hour training in class with additional training in supervision.
        - In PSY 593B, Practicum in Counseling II: Assessment, students move beyond simple assessment to a more comprehensive assessment.
        - Suicide management and treatment is included in PSY 593C, Practicum in Counseling II: Advanced. This is done primarily in supervision and the reviewing on client notes and assessments. The PSY 593B&C trainings are for the Mental Health Counseling students only.
    - School Psychology Program, Education Specialist (EdS):
        - Suicide assessment is covered in PSY593A, an option for this program. This is a two-hour training in class with additional training in supervision.
        - PSY 592A, Practicum in School Psychology provides knowledge and competence in school psychology practice, including behavioral analysis and developmental interviews.
        - PSY 566, Social/Behavioral/Emotional Assessment covers cover school-wide suicide assessments/screening and prevention programs.
- The University of Puget Sound's Masters of Education program in Counseling offers EDUC 642 Suicide Prevention, Assessment and Risk Management as an elective for their School of Education students. Course 631 Developmental Counseling (a required course) also includes counseling techniques to help people after a loss or suicide.
- Western Washington University promotes a couple of trainings for students. The Question, Persuade, Refer (QPR) training has been offered widely across campus, and the Youth Mental Health First Aid (YMHFA) training has been more targeted due to the length of the course. They have discussed providing the YMHFA training to their pre-service teaching, human services, and nursing students.

Conclusion

Adoption of the Bree Collaborative suicide care report and the Zero Suicide model statewide could have a positive impact on reducing suicide rates in Washington. Washington has been on the leading edge of suicide education and training for health care professionals and this education is an important aspect of suicide prevention strategies. However, as of this report, many Washington health professionals required to take a suicide prevention training are still within the time limits for completion; therefore, it is too soon to evaluate the impact of this training. The department's 2022 report should be able to provide more definitive data on the impacts of Washington's training requirements.

Appendices

Appendix 1: Status of State Suicide Prevention Plans as of October 9, 2017

TABLE 1—Status of State Suicide Prevention Plans in the United States on October 9, 2017

	Suicide Prevention Plan		Status and Scope of Suicide Prevention Training Policy				
State	Not Revised Since 2012	Revised Since 2012	Adopted, Requires Training	Adopted, Encourages Training	In Progress, Requires Training	In Progress, Encourages Training	No Policy
Alabama		X					X
Alaska		X					X
Arizona		X					X
Arkansas		X					X
California	X		X				
Colorado		X		X			
Connecticut		X					X
Delaware		X					X
Florida		X					X
Georgia		X					X
Hawaii		X		X			
Idaho	X						X
Illinois	X			X			
Indiana		X	X	X			
Iowa		X					X
Kansas		X					X
Kentucky		X	X				
Louisiana	X			X			
Maine		X					X
Maryland		X					X
Massachusetts		X					X
Michigan	X			X			
Minnesota		X					X
Mississippi		X					X
Missouri		X			X		
Montana		X					X
Nebraska		X					X
Nevada		X	X	X			
New Hampshire		X	X				
New Jersey		X			X		
New Mexico		X					X
New York		X					X
North Carolina		X				X	
North Dakota		X					X
Ohio		X					X
Oklahoma		X					X
Oregon		X					X
Pennsylvania		X	X				

Continued

TABLE 1—*Continued*

State	Suicide Prevention Plan		Status and Scope of Suicide Prevention Training Policy				
	Not Revised Since 2012	Revised Since 2012	Adopted, Requires Training	Adopted, Encourages Training	In Progress, Requires Training	In Progress, Encourages Training	No Policy
Rhode Island		X					X
South Carolina	X						X
South Dakota		X					X
Tennessee		X	X				
Texas		X			X		
Utah		X	X				
Vermont		X					X
Virginia		X			X		
Washington		X	X				
West Virginia	X		X				
Wisconsin		X					X
Wyoming		X					X

Appendix 2: National Action Alliance for Suicide Prevention: Summary of Recommended Standard Care Elements by Major Care Setting

Table 1: Summary of Recommended Standard Care Elements by Major Care Setting

Setting	Emphasis	Identification and Assessment	Safety Planning	Means Reduction	Caring Contacts
Primary Care	Identify suicide risk among patients with MI/SUD* conditions or treatment. Enhance safety for those with risk. Refer to specialized care. Provide caring contacts	Identify suicidality in all patients with MI/SUD conditions or treatment (e.g., psychiatric meds) using a standardized scale. If risk is identified, proceed with active referral for hospital or outpatient care as judged appropriate.	Complete the brief Safety Planning Intervention during the visit where risk is identified. With consent, discuss the safety plan with the family to gain support for safety activities.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit or the next business day.
Outpatient BH* Care (Mental health and substance use treatment)	Provide treatment and support for individuals who may have elevated suicide risk.	Identify and assess suicide risk at admission and whenever patients are seen by using a standardized scale. Do not assess more than 1x per day. Use judgement if patients are seen daily.	Complete the brief Safety Planning Intervention during the visit where risk is identified Update the safety plan at each visit as long as risk remains high.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Initiate caring contacts during care transitions or if appointments are missed.
Emergency Department	Identify suicide risk among patients who have harmed/injured themselves or have MI/SUD conditions or treatment. Carry out the brief Safety Planning Intervention to enhance safety for those with risk. Refer to specialized care. Provide two caring contacts.	Identify and assess patients who have harmed themselves or have MI/SUD conditions or treatment (e.g., psychiatric meds) using a standardized scale. If risk is found, proceed with active referral for hospital or outpatient care as judged appropriate. If immediate transfer is not possible, provide a space for the patient that is "safe, monitored, and clear of items that the patient could use to harm himself or herself or others" (The Joint Commission, 2016).	Complete the brief Safety Planning Intervention during the visit where risk is identified. With consent, discuss the safety plan with the family to gain support for safety activities	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit. Make the second caring contact within 7 days of visit.
BH Inpatient Care (Hospital level psychiatric or addiction treatment)	Usually brief hospital treatment for individuals who may have high risk of suicide. Sometimes admission is precipitated by suicide attempt. Emphasis is on keeping patient safe while in the hospital and immediately following discharge.	Identify and assess suicide risk at admission and daily during stay—or more frequently as indicated by level of risk—using a standardized scale. In addition to other safety and treatment expectations during inpatient care, work with patient on a safety plan for their environment immediately post-discharge.	In addition to safety activities oriented at the hospital stay, complete the brief Safety Planning Intervention prior to discharge, aimed at safety in the patient's post-discharge environment. Discuss the safety plan with the family to gain support for safety activities.	As part of the safety plan, discuss any lethal means considered by and available to patient. Arrange and confirm removal or reduction of lethal means as feasible prior to discharge.	Make appointment with mental health professional. Complete one caring contact (phone call or, if preferred by patient, text or e-mail) within 48 hours of visit. Make the second caring contact within 7 days of visit.

*Abbreviation key: BH – behavioral health | MI/SUD – Mental illness/substance use disorder

Appendix 3: WA Health Professionals and Mandatory Training

Training	Health Professionals
Six-hour training: suicide assessment, treatment, and management; veterans; and imminent harm via lethal means or self-injurious behaviors (Taken at least once every 6 years)	Advanced social workers, advanced social worker associates, independent clinical social workers, independent clinical social worker associates (effective Jan. 1, 2014) Licensed mental health professionals (effective Jan. 1, 2014) Marriage and family therapists (effective Jan. 1, 2014) Psychologists (effective Jan. 1, 2014)
Six-hour training: suicide assessment, treatment, and management; veterans; and imminent harm via lethal means or self-injurious behaviors (Taken once)	Licensed practical nurses (LPN), registered nurses (RN), and advanced registered nurse practitioners (ARNP) (effective Jan. 1, 2016) Naturopaths (effective Jan. 1, 2016) Osteopathic physicians and surgeons and physician assistants (effective Jan. 1, 2016) Physicians and physician assistants (effective Jan. 1, 2016) Retired active licensee: naturopaths, LPNs, RNs, or ARNPs, osteopathic physicians and surgeons and physician assistants, allopathic physicians and physician assistants (effective Jan. 1, 2016)
Three-hour training: suicide screening and referral (Taken at least once every 6 years)	Certified counselors and certified advisers (effective Jan. 1, 2014) Chemical dependence professionals (effective Jan. 1, 2014) Occupational therapists and effective Jan. 1, 2014)
Three-hour training: suicide screening and referral (Taken once)	Chiropractors (effective Jan. 1, 2016) Dental hygienists (effective Aug. 1, 2020) Physical therapists and assistants (effective Jan. 1, 2016)
Three-hour training: screening, referral, and risk of imminent harm via lethal means (Taken once)	Pharmacists (effective Jan. 1, 2017) Dentists and retired active licensees (effective Aug. 1, 2020)

Appendix 4: Suicide education training – Model List

In 2015, the Washington State Legislature enacted ESHB 1424 that required the department to adopt rules establishing minimum standards for all suicide training programs. To ensure that approved suicide prevention training courses for Washington health professionals meet the state's minimum requirements, the department created an application and evaluation process. The application form was posted on the department website, and training developers mailed in applications and training materials for evaluation beginning in October 2016. To help training developers meet the required 30 minutes of veterans' content for the six-hour trainings, the Washington Department of Veteran Affairs (DVA) created a Veterans Module in August 2016.

Applications were evaluated by a committee comprised of the department's suicide prevention program manager and two nursing professors from Gonzaga University who volunteered their time. The 2017 Model List of approved courses, including in-person and online options, was posted on the department's website in January 2017 and approved courses continue to be added. Previously approved three-hour training courses were grandfathered into the 2017 Model List. As of July 2017, all training taken by health care professionals for certification must be from the Model List.

Three types of courses are included in the 2017 Model List. As shown in Table 1 in Appendix 3, the type of course required depends on the profession. Six-hour courses include suicide assessment, treatment, and management; veteran content; and risk of imminent harm via lethal means or self-injurious behaviors. Three-hour courses for pharmacists and dentists also include risk of imminent harm via lethal means. Three-hour courses for the remaining professions are limited to screening and referral.

Since the evaluation process began in October 2016, the department has received applications for 90 suicide prevention trainings. Eleven three-hour courses were grandfathered onto the 2017 Model List and were, therefore, not evaluated.


Washington State Department of
Health