# Proposal related to Training

**Proposal:** To develop legislation mirroring HB2315 (passed in 2021) to require Primary Care Professionals (PCP's) and other related medical professionals to take continuing educational units in suicide assessment through vetted courses that will meet the requirement.

**YSIPP Alignment:** 2.1.1 "Appropriately Trained Adults" - Youth-serving adults (including the peer support workforce) receive the appropriate level of training for suicide prevention (basic awareness, enhanced, and/or advanced) and are retrained appropriately.

**Alliance Committee / Advisory Group Connection:** Workforce Committee

**Problem Statement:** Contact with a primary care physician is common even in the final month before a death by suicide. A comprehensive literature review indicates that 80% contacted healthcare professional in prior year and 44% saw a physician in the month before dying.[1] Yet, healthcare professionals often have little specific training on suicide assessment, treatment, and management. Both AFSP and OHA recommend training healthcare professionals as key policy need. From OHA's SB48 report: "Physical and behavioral health providers that are confident, competent, and equipped to provide the best care to those who experience suicide ideation is an essential part of Oregon's suicide prevention strategy. To ensure Oregon's workforce is meeting the needs of people most at-risk, the law should require suicide prevention education in professional training programs and continuing education for key professions."

**Staff thoughts about Context:** The Alliance's past policy agendas included legislation to ensure both behavioral health and physical healthcare providers receive training in suicide assessment, management, and treatment, and was successful in getting HB2315 which requires behavioral health workforce to receive suicide assessment, treatment and management continuing education. Legislation with a broad mandate to require training of all healthcare clinicians was met with sharp resistance from the medical professional organizations. The Workforce committee is working in close partnership with the Oregon Pediatric Society to develop a legislative concept focused on the healthcare professionals most likely to interact with a youth or family. Also, to be considered is how to implement this for adult medical providers.

**Equity:** Research shows that, in communities where mental health professionals may not be trusted or utilized, physical health providers are still accessed. This legislation would increase the possibility that physical health providers will screen and treat for suicide. However, ensuring that training is culturally responsive will be essential for the success of this proposal.

**Committee or Person who Submitted Recommendation:** Workforce Committee and Gordon Clay, gordonclay@aol.com submitted the same proposal.

[1] Scandinavian Journal of Public Health, 2019; 47: 9–17

## Proposal related to Training

**Proposal:** Require all levels emergency department staff (from the triage desk to security to nurses and doctors) to receive training in trauma informed care as it relates to suicide prevention, intervention, assessment, treatment, and management; training should be standard across the state for all emergency departments.

**YSIPP Alignment:** *2.3.1* "Available Support" - Oregonians who need immediate support or crisis intervention have access to it; *3.1.1* "Coordinated Transitions" - All Oregonian young people who access healthcare for behavioral health crises or suicidal ideation receive coordinated care in transitions between levels of care; *3.3* Appropriate Treatment & Management of Suicidality

**Alliance Committee / Advisory Group Connection:** Transitions of Care Committee and Workforce Committee

**Problem Statement:** Many emergency department staff are not equipped to provide trauma informed and safe suicide management care when folks present in a crisis which can both exacerbate what the person is experiencing and prevent them from seeking help in the future if they experience another crisis.

**Staff thoughts about Context:** The Alliance supported legislation (HB 3090, 3091, 2023) that requires follow-up for people presenting with a behavioral health crisis in the emergency department. However, youth who have presented to emergency departments for a mental health crisis have reported treatment received varied from hospital-to-hospital and even from staff-to-staff within the same hospital. Inconsistent and poor treatment can exacerbate the current crisis and prevent people from seeking help in the future. In addition, if a hospital within one's catchment area is known to provide poor care but one some county's over is known to provide excellent care, folks will travel outside of their catchment area to the one they know they will receive good care from. However, individual hospitals are not equipped to receive an influx of patients from other areas of the state. Lastly, folks may experience more than one mental health crisis in their lifetime and we want to make sure our resources do not prevent them from seeking care again in the future. If they have a negative or harmful experience, they may not ask for help again when they need it. This recommendation aligns with the Healthcare Training recommendation by expands it to include triage desk staff, security officers, and other staff of emergency departments.

**Equity:** This is especially important because emergency departments are often the place of last resort that people who don't or are unable to access traditional behavioral or physical healthcare. This is especially true for people who are undocumented or who have had negative interactions with healthcare providers.

**Committee or Person who Submitted Recommendation:** Lived Experience Advisory, Jenn Fraga on behalf of Noah Rogers

## Proposal related to Training

**Proposal:** There should be a requirement that each suicide prevention, intervention, and postvention training must include equity-centered content. Related, it would be important to have some type of requirement or incentive (i.e. certification) for trainers to receive ongoing equity-focused training.

**YSIPP Alignment:** *2.1.4* "Culturally Relevant Training" - Suicide prevention programming is regularly evaluated and updated to ensure equity, cultural relevance and responsiveness, and linguistic needs are addressed; *3.3.3* "Whole-person Approaches" - Whole-person approaches are used to enhance treatment for suicide and to increase effectiveness of management of long-term symptoms; *4.5* Equity

**Alliance Committee / Advisory Group Connection:** Equity Advisory Group

**Problem Statement:** The state of Oregon is currently supporting a number of evidence-based suicide prevention, intervention, and postvention trainings; however, these trainings generally do not have a strong focus on equity or culturally specific understandings of suicide, mental health. Addressing this gap in the foundational suicide related trainings, aligns both with the Alliance's commitment to equity and OHA's commitment to eliminate health inequities by 2030[2] which includes specific measures such as meaningful language access.

Suicide prevention, intervention, and postvention trainings have been created from dominate culture research and development practices. While their effectiveness has been tested in dominate cultures, there is a lack of research into whether these trainings benefit others outside of the dominate culture. With the rise in suicide risk in diverse and underrepresented populations, it is vital that suicide prevention, intervention, and postvention trainings adjust their content, delivery methods, and implementation strategies so that they address the needs of all Oregonians. In addition to the trainings needing structural changes, it is also important that trainers have a way to grow their skills to implement trainings in a culturally humble, agile, and relevant way. Every trainer comes in with different levels of knowledge, understanding, and experiences which can affect their ability to implement trainings in a relevant way. Ongoing training opportunities would help build a baseline of abilities and competencies of trainers while ensuring attendees are ensured a certain level of training.

**Staff thoughts about Context:** While this is framed as a legislative ask, staff suggests that we include this as a recommendation for the annual update on the YSIPP and assess progress before the next long session in 2025. If significant progress has not been made, perhaps this should move forward as a legislative concept at that time. A policy was enacted in Washington state which forced training developers to embed required content into their trainings, especially those who may be slower or more resistant to including such content. More research on this is needed if the Alliance moves forward with this proposal.

While the Alliance has done great work to ensure suicide prevention, intervention, and postvention trainings for different populations (i.e. HB 2315), it is also important to ensure that those trainings are not only effective for dominate cultures but also to historically underrepresented populations as well. There has been some work to understand concerns from trainers and county coordinators related to the lack of relevance of trainings for various populations though most training developers are slow or uninterested in adapting their trainings.

[2] Oregon Health Authority Equity Advancement Plan

**Equity:** This proposal focus on an equity-centered lens for all suicide prevention trainings.

**Person who Submitted Recommendation:** Tim Glascock, tglascock@aocmhp.org

# HB 2315 Policy Analysis Proposal

## *Introduction*

HB 2315 is designed to increase the number of mental and behavioral health professionals equipped to assess, manage, and treat clients experiencing suicidality in the state of Oregon by requiring license-based mental and behavioral health professionals to receive suicide prevention trainings prior to renewing their license of practice. If the policy is effective, we predict all license-based mental and behavioral health professionals will be trained in various degrees of suicide prevention by 2025. Long term indicators of success include a decrease in deaths by suicide in the state of Oregon as well as documented continuity of care for people experiencing suicidality. Short term indicators of success for HB2315 include increased efficacy of Mental and Behavioral Health Professionals (MBHPs) in treating clients experiencing suicidality, and an increase of MBHPs trained in suicide assessment, management, and treatment in the workforce.

## *Purpose*

The purpose of this study is to examine the effectiveness of HB 2315 to increase the number of MBHPs competent in suicide care. For the purposes of this analysis, effectiveness of HB 2315 will be indicated by an increase in the number of MBHPs trained in suicide assessment, management, and treatment, and an increase in MBHP's confidence, competence, and comfort in providing suicide-related treatments.

## *Methods*

To assess HB 2315's effectiveness in equipping MBHPs to successfully recognize, assess, and treat clients with thoughts of suicide, we plan to gather data from Oregon state licensing boards.

### *Surveys*

Through collaboration with the Oregon Health Authority, the University of Oregon Suicide Prevention Lab, and the Oregon Alliance to Prevent Suicide (Alliance), we will develop a survey to gather information from MBHPs regarding their interactions with suicidal clients, their experience of suicide prevention trainings, and whether they found the suicide prevention trainings useful in their work. We will collaborate with Oregon licensing boards to collect this survey data from MBHPs at the time of license renewal. The waiting period between trainings and re-licensure may benefit our survey results, as professionals will have had the time to assess whether the suicide prevention training/s they took were effective, useful, and sufficient for their specific practice. See Appendix for example questionnaires for trainees post-training.

The purpose of these MBHP-specific surveys will be to assess:

- Estimated number of clients experiencing suicidal thoughts and behaviors MBHPs have treated
- MBHP's perception of integration of the suicide prevention and intervention trainings into their daily practice
- MBHPs level of competence and confidence in utilizing skills gained from the suicide prevention trainings they received
- MBHP's perceived gaps in suicide prevention training for clinical practice

In combination with statewide suicide prevention training evaluation data, the data from these surveys will be utilized to determine the effectiveness of HB2315 in training MBHPs to recognize, assess, and if needed, refer clients experiencing suicidality.

*Appendix*

*Self-Efficacy* (Scale: Disagree/Somewhat Disagree/Somewhat Agree/Agree)

1. I feel confident treating an individual experiencing suicidal thoughts.
2. I feel comfortable treating an individual experiencing suicidal thoughts.
3. I feel competent in providing culturally-responsive treatment to an individual experiencing suicidal thoughts.
4. I feel comfortable in providing culturally-responsive treatment to clients experiencing suicidal thoughts.

*Knowledge* (Scale: Disagree/Somewhat Disagree/Somewhat Agree/Agree)

4. I am knowledgeable about where to refer someone experiencing suicidality to receive treatment
5. I am knowledgeable about how to appropriately respond to an individual experiencing a suicidal crisis
6. I am knowledgeable about how to talk with and treat LGBTQ patients experiencing suicidality.
7. I am knowledgeable about how to talk with and treat BIPOC patients experiencing suicidality.
8. I am knowledgeable about how to talk with and treat patients with disabilities experiencing suicidality.

*Fit* (Scale: Disagree/Somewhat Disagree/Somewhat Agree/Agree)

9. The training resulted in new skills and knowledge being learned.
10. The training increased my ability to identify clients who are at an increased risk of suicide.
11. The training increased my ability to respond to clients who are at an increased risk of suicide.
12. The information and practices from the training will be useful in everyday clinical experiences.
13. In my practice, I have applied the information and skills from the training.
14. The information and practices covered in the training were relevant to my client population.
15. The information and practices from the training will assist in making *suicide safer care* changes in your practice.
16. The training was applicable to my client population.
17. The training was applicable to my specialty.
18. Trainings applicable to my specialty were accessible to me.
19. Trainings applicable to my client population were accessible to me.

*Additional Information* (Scale: Disagree/Somewhat Disagree/Somewhat Agree/Agree)

20. I would like to take more trainings on suicide prevention.
21. I would like to take a suicide prevention training specifically developed for my specialty.

Potential

**assessing whether a person at risk for suicide has access to a firearm, medication, substance or other lethal means**, and. working with them and their family and support system to limit their access until they are no longer at elevated risk.

> Suicide assessment, treatment and management means engagement and collaboration between a behavioral health professional or team and client or individual to resolve suicide risk by addressing the factors contributing to risk, and ongoing monitoring and adjustment of treatment and safety plans.

Suicide Assessment, Treatment and Management Training:

“Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training that includes only screening and referral elements if appropriate for the profession in question based on the profession's scope of practice. The board of occupational therapy may also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting

# Washington State Suicide Prevention Legislation

# Overview

- Legislation first introduced in 2012 and initially required Certain Mental Health Professionals
  - Trainings must come from the best practices registry of the AFSP (or this page) and the SPRC and must include the following elements:
    - suicide assessment, including screening and referral, suicide treatment, and suicide management.
  - A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length.
- In 2014, they added additional health professions to complete training in suicide assessment, treatment, and management. These additional professions were only being asked to complete a one-time training in this area.
  - A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length.
  - A list of trainings can be found here

# Overview

- In 2020, additional requirements were added:
  - Specific requirements were added around advanced trainings for certain mental health professionals.
  - Additional professions were added to the one-time training requirement.
  - Population Specific Requirements were added for veterinarians and the construction industry.

# Overview

- Available trainings are maintained on the Washington State Department of Health website including:
  - Six-hour training for suicide assessment, treatment and management (required for social workers, licensed mental health professionals, nurses, marriage and family therapists, naturopaths, osteopathic physicians/surgeons/physician assistants, physicians and physician assistants, psychologists, and retired active licensees of the above professions).
  - Three-hour training for suicide screening and referral
  - Three-hour training for pharmacists and dentists (suicide screening, referral and imminent harm via lethal means) (Pharmacists and dentists can choose from the three-hour trainings in this section or any of the six-hour trainings).

# Overview

- Available trainings are maintained on the Washington State Department of Health website including:
  - The training program application is available here (PDF). There is no deadline to apply. Please submit an application and materials for evaluation.
  - This evaluation form (PDF) will be used to review training program applications.
  - Six-hour training programs must include 30 minutes of content on veterans. You can use the Veterans Module (PDF) developed by the Washington State Department of Veteran Affairs or a resource with comparable content.
  - Approved trainings will be added to the Model List.

# Current List of Professions

| Ongoing Training Requirement (every 6 years) | HB 2315 added health professionals: |
|---|---|
| certified counselors and certified advisors | chiropractors |
| certified chemical dependency professionals | naturopaths |
| licensed marriage and family therapists, mental health counselors, and social workers | licensed practical nurses, registered nurses, and advanced registered nurse practitioners |
| licensed occupational therapy practitioners | physicians and physician assistants |
| licensed psychologists | osteopathic physicians and osteopathic physician assistants |
| persons holding a retired active license in any of the affected professions | physical therapists and physical therapist assistants |
| | optometrists |
| | acupuncture |

# Training Specific Suicide Prevention Legislation

- HB 2366 (2012) - Requiring certain health professionals to complete education in suicide assessment, treatment, and management.
- HB 2315 (2014) – Adjustments to the training legislation HB 2366.
- HB 1424 (2015) - Adjustments to the training legislation HB 2366.
- HB 2411 (2020) - Adjustments to the training legislation HB 2366.

https://intheforefront.org/2021-legislative-priorities/

# Other Suicide Prevention Legislation

- HB 1336 (2013) - Increasing the capacity of school districts to recognize and respond to troubled youth.
- HB 1138 (2015) - Creating a task force on mental health and suicide prevention in higher education.
- HB 2793 (2016) - Providing for suicide awareness and prevention education for safer homes. (Safe Homes: Safe Homes Task Force (Task Force) is created to raise public awareness and increase suicide prevention education among partners in key positions to prevent suicides.)
- HB 1612 (2017) - Creating a suicide-safer homes project account to support prevention efforts and develop strategies for reducing access to lethal means.
- HB 6514 (2018) - Concerning suicide prevention and behavioral health in higher education, with enhanced services to student veterans.
- HB 1109 (2019) - Making 2019-2021 biennium operating appropriations and 2017-2019 biennium second supplemental operating appropriations.
- HB 6570 (2020) - Concerning law enforcement officer mental health and wellness; a task force on law enforcement officer health and wellness.

# Timeline

HB 2366 passes; initial legislation requiring “Certain mental health professionals” must complete training in suicide assessment, treatment, and management every six years as part of their continuing education requirements.

2012

# HB 2366 (2012)

- They built on their existing state requirement for 'Certain Mental Health Professionals' which states, "All health professions are subject to at **least four hours** of Acquired Immune Deficiency Syndrome (AIDS) education *prior to licensure and have varying requirements for continuing education*."
- Total requirements for certain Washington state mental health professionals:

| Certain Mental Health Professionals | CEU requirements | Frequency |
|---|---|---|
| Certified counselors and certified advisors | 36 hours | 2 years |
| Certified chemical dependency professionals | 28 hours | 2 years |
| Licensed marriage and family therapists, mental health counselors, and social workers | 36 hours | 2 years |

# HB 2366 (2012) Elements

- Beginning January 1, 2014, the following *health professions* must complete training in suicide assessment, treatment, and management every six years as part of their continuing education requirements*:*
  - certified counselors and certified advisors;
  - certified chemical dependency professionals;
  - licensed marriage and family therapists, mental health counselors, and social workers;
  - licensed occupational therapy practitioners;
  - licensed psychologists; and
  - persons holding a retired active license in any of the affected professions.

# HB 2366 (2012) Elements

- Training Specific Requirements:
  - They require people take a training that comes from the best practices registry of the AFSP (or this page) and the SPRC.
  - The training must be approved by the relevant disciplining authority and must include the following elements:
    - suicide assessment, including screening and referral, suicide treatment, and suicide management.
  - A disciplining authority may approve a training program that does not include all of the elements if the element is inappropriate for the profession in question based on the profession's scope of practice.
  - ***A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length.***

# HB 2366 (2012) Elements

- Training Specific Exceptions:
  - A disciplining authority may specify minimum training and experience necessary to exempt a practitioner from the training requirement.
  - The Board of Occupational Therapy may exempt its licensees from the requirements by specialty if the specialty in question does not practice primary care and has only brief or limited patient contact.
  - A state or local government employee, or an employee of a community mental health agency or a chemical dependency program, is exempt from the training requirements if he or she has at least six hours of training in suicide assessment, treatment, and management from his or her employer; the training may be provided in one six-hour block or in shorter segments at the employer's discretion.

# HB 2366 (2012) Elements

- Additional bill requirements:
  - The relevant disciplining authorities must work collaboratively to develop a model list of training programs to be reported to the Legislature by December 15, 2013. When developing the list, the disciplining authorities must:
    - consider suicide assessment, treatment, and management training programs on the best practices registry of the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center; and
    - consult with public and private institutions of higher education, experts on suicide assessment, treatment, and management, and affected professional associations.
  - The Secretary of Health must conduct a study evaluating the effect of evidence-based suicide assessment, treatment, and management training on the ability of a licensed health care professional to identify, refer, treat, and manage patients with suicidal ideation. The study must, at a minimum:
    - review available research and literature regarding the relationship between completion of the training and patient suicide rates;
    - 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; and
    - review curricula of health profession programs offered at state educational institutions regarding suicide prevention.

# Timeline

HB 2366 - initial legislation requiring “Certain mental health professionals” must complete training in suicide assessment, treatment, and management every six years as part of their continuing education requirements.

2012

2014

HB 2315 – legislation that added to the original training legislation (HB 2366) by including additional professions to complete a one-time training in suicide assessment, treatment, and management.

# HB 2315 (2014)

- They added additional health professions to complete training in suicide assessment, treatment, and management. These additional professions were only being asked to complete a one-time training in this area.

| HB 2366 "Certain Mental Health Provider": | HB 2315 added health professionals: |
|---|---|
| certified counselors and certified advisors | chiropractors |
| certified chemical dependency professionals | naturopaths |
| licensed marriage and family therapists, mental health counselors, and social workers | licensed practical nurses, registered nurses, and advanced registered nurse practitioners |
| licensed occupational therapy practitioners | Physicians and physician assistants |
| licensed psychologists | osteopathic physicians and osteopathic physician assistants |
| persons holding a retired active license in any of the affected professions | physical therapists and physical therapist assistants |

# HB 2315 (2014) Elements

- Training Specific Requirements:
  - The training must be *at least six hours in length*, unless the relevant disciplining authority determines that *only screening and referral elements are appropriate*, in which case the training must be *at least three hours in length*.
  - The model list of training programs must be updated at least once every two years. When updating the list, the disciplining authorities must, to the extent practicable, endeavor to include training that includes content specific to veterans. The disciplining authorities must consult with the Washington State Department of Veterans Affairs (WDVA) when identifying content specific to veterans.
- Training Specific Exceptions:
  - Any disciplining authority, instead of just the Board of Occupational Therapy Practice, may exempt a professional from the training requirement if the professional only has brief or limited patient contact.
  - *Previously, per HB 2366, only the Board of Occupational Therapy Practice was allowed this exemption.*

# HB 2315 (2014) Elements

- Additional bill requirements:
  - The Secretary must update the study evaluating the effect of evidence-based suicide assessment, treatment, and management training on the ability of a licensed health care professional to identify, refer, treat, and manage patients with suicidal ideation. The study must be updated twice, once in 2018 and once in 2022, and must be reported to the Governor and the appropriate committees of the Legislature
  - *Psychiatric Consultation Pilot Program*
    - The DSHS and the Health Care Authority (HCA) must develop a plan for a pilot program to support primary care providers in the assessment and provision of appropriate diagnosis and treatment of individuals with mental or other behavioral health disorders and track outcomes of the program. The program must include two pilot sites, one in an urban setting and one in a rural setting, and must include timely case consultation between primary care providers and psychiatric specialists.

# Timeline

HB 2366 - initial legislation requiring “Certain mental health professionals” must complete training in suicide assessment, treatment, and management every six years as part of their continuing education requirements.

HB 1424 – delayed the start date that HB 2315 would take effect by.

2012

2014

2015

HB 2315 – legislation that added to the original training legislation (HB 2366) by including additional professions to complete a one-time training in suicide assessment, treatment, and management.

# HB 1424 (2015) Elements

- Training Specific Requirements:
  - The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors. When adopting the rules, the DOH must:
    - consult with the affected disciplining authorities, public and private institutions of higher education, experts in suicide assessment, treatment, and management, the WDVA, and affected professional associations; and
    - consider standards related to the Best Practices Registry of the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center.
  - The DOH must provide the training standards to the PESB and may provide technical assistance in the review and evaluation of education training programs.
- Training Specific Exceptions:
  - Certified registered nurse anesthetists and medical school graduates with limited training licenses are exempt from the training requirement.
  - A disciplining authority may not grant a blanket exemption to broad categories or specialties within a profession based on training and experience.

# HB 1424 (2015) Elements

- Additional bill requirements:
  - Beginning July 1, 2017, the model list must contain only trainings that meet the minimum standards and any three-hour trainings that met the training requirements on or before July 26, 2015. The trainings on the list must include six-hour trainings in suicide assessment, treatment, and management and three-hour trainings that include only screening and referral elements. A person or entity providing the training may petition the DOH for inclusion on the model list; the DOH must add trainings to the list that meet the minimum standards. Approved educator training programs may also be included on the model list.

# Timeline

HB 2366 - initial legislation requiring “Certain mental health professionals” must complete training in suicide assessment, treatment, and management every six years as part of their continuing education requirements.

HB 1424 – delayed the start date that HB 2315 would take effect by.


HB 2315 – legislation that added to the original training legislation (HB 2366) by including additional professions to complete a one-time training in suicide assessment, treatment, and management.

HB 2411 – legislation that added to the original training legislation (HB 2366) by including additional professions to complete a one-time training in suicide assessment, treatment, and management.

# HB 2411 (2020) Elements

- Training Specific Requirements:
  - Advanced Training
    - The second training for a psychologist, marriage and family therapist, mental health counselor, advanced social worker, independent clinical social worker, or an associate advanced or independent clinical social worker must either be:
      - an advanced training focused on suicide management, suicide care protocols, or effective treatments; or
      - a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy—suicide management.
    - The Department of Health (DOH) must develop minimum standards for this training and include training that meets the minimum standards on the model list. A person is exempt from the training if he or she can demonstrate that the training is not reasonably available.
  - One-Time Training
    - Optometrists and acupuncture and Eastern medicine practitioners are added to the one-time training requirement for suicide assessment, treatment, and management.

# HB 2411 (2020) Elements

- Training Specific Requirements:
  - Population Specific Requirements
    - Veterinarians
      - Beginning July 1, 2022, all veterinarians and veterinary technicians must complete one-time suicide prevention training developed by the Veterinary Board of Governors (VBG). When developing the training, the VBG must consult with the University of Washington's Forefront Suicide Prevention Center of Excellence (FSPCE) and affected professional associations.
      - The training must:
        - recognize that veterinarians treat animal patients and have limited interaction with animal patient owners;
        - focus on mental health and well-being;
        - include general content on suicide risk, prevention, and resources;
        - include specific content on imminent harm by lethal means; and
        - be three hours in length.

# HB 2411 (2020) Elements

- Training Specific Requirements:
  - Population Specific Requirements
    - The Construction Industry
      - Subject to appropriated funds, the FSPCE must develop:
        - an online, interactive training module in suicide prevention; and
        - a series of complementary modules to be delivered by the construction industry, which must include training on available resources, lethal means safety, screening tools, men's mental health, and a refresher on the online training.

# Summary

- Legislation first introduced in 2012 and initially required Certain Mental Health Professionals
  - Trainings must come from the best practices registry of the AFSP (or this page) and the SPRC and must include the following elements:
    - suicide assessment, including screening and referral, suicide treatment, and suicide management.
  - A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length.
- In 2014, they added additional health professions to complete training in suicide assessment, treatment, and management. These additional professions were only being asked to complete a one-time training in this area.
  - A training program that includes only screening and referral must be at least three hours in length. All other training programs must be at least six hours in length.
  - A list of trainings can be found here

# Summary

- In 2020, additional requirements were added:
  - Specific requirements were added around advanced trainings for certain mental health professionals.
  - Additional professions were added to the one-time training requirement.
  - Population Specific Requirements were added for veterinarians and the construction industry.

# Current List of Professions

| Ongoing Training Requirement (every 6 years) | HB 2315 added health professionals: |
|---|---|
| certified counselors and certified advisors | chiropractors |
| certified chemical dependency professionals | naturopaths |
| licensed marriage and family therapists, mental health counselors, and social workers | licensed practical nurses, registered nurses, and advanced registered nurse practitioners |
| licensed occupational therapy practitioners | physicians and physician assistants |
| licensed psychologists | osteopathic physicians and osteopathic physician assistants |
| persons holding a retired active license in any of the affected professions | physical therapists and physical therapist assistants |
| | optometrists |
| | acupuncture |

# Training Specifics

| Profession | Hours of Training and Frequency | Core Training Components and Content |
|---|---|---|
| Social workers<br>• Advanced social workers<br>• Advanced social worker associates<br>• Independent clinical social workers<br>• Independent clinical social worker associates<br>* began January 1, 2014 | Six hours at least once every six years | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Certified counselors \| certified advisers<br>* began January 1, 2014 | Three hours every six years | Suicide screening and referral |
| Chemical dependence professionals<br>* began January 1, 2014 | Three hours every six years | Suicide screening and referral |

https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention/TrainingPrograms/ModelList

# Training Specifics

| | | |
|---|---|---|
| Chiropractors<br>* began January 1, 2016 | Three hours one time | Suicide screening and referral |
| Dentists<br>* beginning August 1, 2020 | Three hours one time | • Suicide screening and referral<br>Assessment of issues related to imminent harm via lethal means |
| Dental hygienists<br>* beginning August 1, 2020 | Three hours one time | • Suicide screening and referral |
| Licensed mental health professionals<br>* began January 1, 2014 | Six hours at least once every six years | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |

https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention/TrainingPrograms/ModelList

# Training Specifics

| | | |
|---|---|---|
| Licensed practical nurses (LPN), registered nurses (RN) and advanced registered nurse practitioners (ARNP)<br>- certified registered nurse anesthetists are exempt<br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Marriage and family therapists<br>* began January 1, 2014 | Six hours at least once every six years | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Naturopaths<br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |

https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SuicidePrevention/TrainingPrograms/ModelList

# Training Specifics

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|---|---|---|
| Occupational therapists and assistants<br><br>* began January 1, 2014 | Three hours at least once every six years | Suicide screening and referral |
| Osteopathic physicians and surgeons<br><br>- holders of a postgraduate training license issued under RCW 18.57.035 are exempt<br><br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Osteopathic physician assistants<br><br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Pharmacists<br><br>* began January 1, 2017 | Three hours one time | • Suicide screening and referral<br>• Assessment of issues related to imminent harm via lethal means |

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# Training Specifics

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|---|---|---|
| Physicians<br><br>-residents holding a limited license issued under RCW 18.71.095 (3) are exempt<br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Physician assistants<br><br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Physical therapists and assistants<br><br>* began January 1, 2016 | Three hours one time | Suicide screening and referral |
| Psychologists<br><br>* began January 1, 2014 | Six hours at least once every six years | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |

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# Training Specifics

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|---|---|---|
| Retired active licensee for one of these professions:<br>• Naturopaths<br>• LPNs, RNs, or ARNPs (certified registered nurse anesthetists are exempt)<br>• Osteopathic physicians and surgeons (other than a holder of a postgraduate osteopathic medicine and surgery license)<br>• Osteopathic physician assistants<br>• Physician assistants<br>• Physicians (other than a resident holding a limited license)<br>* began January 1, 2016 | Six hours one time | • Suicide assessment, treatment and management<br>• Imminent harm via lethal means or self-injurious behaviors<br>• Content on veterans |
| Retired active license as a dentist<br>* begins August 1, 2020 | Three hours one time | Assessment of issues related to imminent harm via lethal means |