Making the Case for Primary Care and Mandated Suicide Prevention Education

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During its 2012 legislative session, Washington State passed ESHB 2366, otherwise known as the Matt Adler Suicide Assessment, Treatment, and Management Act of 2012. ESHB 2366 is a significant legislative achievement as it is the first law in the country to require certain health professionals to obtain continuing education in the assessment, treatment, and management of suicide risk as a requirement to obtain and maintain licensure. However, ESHB 2366 does not apply to primary care providers, an important next step for legislation that has as its goal “to help lower the suicide rate in Washington.” This commentary addresses objections raised against the law and potential responses as Washington considers strengthening its own law to include primary care providers and as other states consider similar legislation.

In February 2011, prominent Seattle attorney Matt Adler died by suicide after battling depression and increasing anxiety. Adler was receiving mental health treatment in the days leading up to his suicide. Adler’s death prompted scrutiny of current suicide prevention proficiencies and led to a state law aimed at increasing the competencies of health professionals in suicide prevention.

Washington State law ESHB 2366, otherwise known as the Matt Adler Suicide Assessment, Treatment, and Management Act of 2012, directly addresses numerous calls to action and recommendations to remedy training deficits among health professionals in the assessment, treatment, and management of suicide risk (Goldsmith, Pellmar, Kleinman, & Bunney 2002; U.S. Department of Health & Human Services, 2001, 2012). In brief, the law requires a minimum of 6 hours of continuing education in the assessment, treatment, and management of suicidal patients every 6 years for psychologists, occupational therapists, mental health counselors, marriage and family therapists, advanced social workers, chemical dependency professionals, certified counselors, and certified advisors. Washington is the first state to pass a mandatory training requirement in this area of clinical practice.

FRAMING THE AGENDA FOR THE LAW

Inadequate training of health professionals in the assessment, treatment, and management of suicide risk is a patient safety
issue and a systemic problem. Prominent in framing the agenda for the law was evidence that the majority of mental health professionals are unprepared to assess and treat suicidal individuals. Only 50% of psychologists, 25% of social workers, and 6% of counselors have training in suicide risk assessment (Schmitz et al., 2012). The vulnerability of veterans to suicide coupled with Washington’s larger than national average veterans’ population (U.S. Department of Veterans Affairs, 2012) also framed the agenda for the law.

A series of meetings with representatives of the health disciplines, advocates, and government officials led to the drafting of a bill to mandate continuing education in suicide prevention as a licensure requirement. Documentation and delivery of both public and expert testimony on the scope of the problem was provided to relevant legislative health committees who were convinced that training health professionals would help to mitigate premature morbidity and mortality by suicide among Washington State residents. The law passed by wide margins in both houses in one legislative session.

THE PROFESSIONAL RESPONSE

During the law’s drafting and deliberations, the majority of the mental health disciplines concurred that there is a training deficit and embraced the continuing education requirement. Their support for the legislation was predicated on using best and evidence-based practices, incentivizing training at the prelicensure stage of professional development, and providing some flexibility in selecting discipline-specific training programs and content.

Psychiatry, medicine, and nursing were a different matter. Spokespersons for psychiatry argued the training would be redundant for them. Proponents of ESHB 2366 argued that while the discipline of psychiatry is unique among the mental health disciplines in their routine exposure of trainees to skills training in suicide risk assessment, training in the treatment and management of suicidal patients in the field of psychiatry is not sufficient (Ellis, Dickey, & Jones 1998). Psychiatry was ultimately neutral on the legislation in Washington.

Other medical providers, including primary care physicians and nurses, resisted the legislative requirement, and these groups were excused from the mandate despite recognition that these providers are important to suicide prevention efforts (Goldsmith et al., 2002; U.S. Department of Health & Human Services, 2001, 2012). Although many patients who are at risk for suicide are reluctant to seek and engage in mental health treatment, up to 75% of those who complete suicide have seen a primary care provider in the previous 30 days (Appleby et al., 2002; Arean, Alvidrez, Barrera, Robinson, & Hicks 2002; Luoma, Martin, & Pearson 2002; Oxman, Dietrich, & Schulberg 2003). The primary care setting is considered an excellent venue for the detection of and early intervention in depression and suicide risk (Katon, Unutzer, & Simon 2004; Schulberg, Bruce, Lee, Williams, & Dietrich 2004).

OBJECTIONS AND RESPONSES

During the legislative session, the authors recorded ten objections to mandated training from health professionals voiced during stakeholder meetings or as part of public testimony given during legislative hearings. In this section, we identify these objections and offer possible responses to them.

Objection 1

The mandate is not necessary because health professionals are sufficiently trained in suicide prevention.

Response. A recent task force report by the American Association of Suicidology identifies serious gaps in the training of U.S. mental health professionals in the
assessments and management of suicidal patients (Schmitz et al., 2012). Severe deficiencies in suicide prevention training and in depression care in primary care specialties and nursing have also been identified (Goldman, Nielsen, & Champion 1999; Robert, Hirschfeld, & Russell 1997; Sudak et al., 2007; Takahashi et al., 2011). To further document the deficiencies among primary care providers a task force report would be useful. Yet, even with research documenting training deficiencies, professional associations in specific states may still call for a state-based assessment of what graduate training programs currently offer in suicide prevention.

**Objection 2**

Mandated continuing education in suicide will lead to other special interest groups attempting to mandate training for health professionals to support their agenda.

**Response.** Given the frequency of suicide in American communities—and notably within the veteran population—proponents of ESHB 2366 argued to move forward with a mandate to correct training deficits. For more than a decade, recommendations to increase training and to ensure the competence of health professionals have gone largely unanswered (Goldsmith et al., 2002; Suicide Prevention Resource Center & SPAN USA, 2010; U.S. Department of Health & Human Services, 2001). In the face of inaction, impacted families and concerned health professionals will look to alternative vehicles for action such as state legislatures.

In Washington State, there are few substantive continuing education licensure requirements. Health professionals are required to devote a specified number of hours to continuing education within certain time frames to maintain licensure. Health professionals applying for licensure in Washington are required to complete one-time HIV/AIDS training. Continuing education in law and ethics is also required for most categories of licensed health professionals (4–6 hours, every 2–3 years). In other states, there are additional substantive continuing education requirements such as training in the assessment of domestic violence, in infection control, and in cultural and linguistic competence. The existence of these additional mandates in other states lends some validity to the objection. Nonetheless, proponents of the law argued for a mandate in suicide prevention training because suicide is a leading cause of death in the United States, and health professionals heretofore have neglected their potential role in mitigating deaths by suicide.

**Objection 3**

Mandated training in suicide prevention will make it difficult for health professionals to get sufficient training in their respective specialty areas.

**Response.** A response to this argument needs to specify the percentage of time spent on continuing education that would be mandated training in suicide prevention relative to the amount of continuing education required overall by each discipline. For example, psychologists in Washington are required to complete 120 hours of continuing education every 6 years. ESHB 2366 requires that 6 of those 120 hours (or 5%) be devoted to training in suicide assessment, treatment, and management. This seems reasonable since psychologists encounter suicidal patients regularly (Kleespies, Penk, & Forsyth 1993). For primary care physicians (in an early version of the bill where they were being considered for the mandate), the proposed requirement was that they devote a minimum of 3 of 400 hours (or <1%) to continuing education required every 8 years to suicide assessment.

During the passage of ESHB 2366, proponents argued and the legislation reflected that the amount of required training should vary with the practitioner’s role and should not expand the providers’ scope of practice. As few as 3 hours could
cover a limited role of screening and referral, whereas the required 6 hours was seen as barely adequate to cover assessment, treatment, and management. If the primary care provider is in a role where there is little or no at-risk patient contact (e.g., research, neonatal care), then exemptions to training can be granted in the legislation or during rule-making processes that follow legislation.

**Objection 4**

If health professionals ask patients about suicide, it will create liability exposure if the patient dies, especially if the health care professional has had training.

**Response.** Health professionals are expected to abide by patient safety rules commonly known as the standards of care. Health professionals are at risk for being sued if they do not assess at-risk patients in their care for suicide and intervene appropriately depending on the level of risk that the patient presents. If a health professional can establish training in assessing and managing patients at risk for suicide, it will likely mitigate, not increase, the risk of being sued (S. Simpson, personal communication). The state of medical knowledge about suicide, its etiology, risk and protective factors, and recommended interventions, has been well established within medicine for decades (Gliatto, 1999; Mann, 2002; Murphy, 1975). Past lawsuits support the expectation that licensed health professionals stay current with research and practice in accordance with approved methods and means of treatment (Williams, 2004). Juries want to know if they or their loved ones become vulnerable to suicide, they can trust their doctors to protect them by knowing the safety rules for treating suicidal patients (S. Simpson, personal communication).

**Objection 5**

Suicide assessment is not the job of the primary care provider.

**Response.** Suicide assessment is the job of the primary care provider as suicidal patients are abundant in medical practice (Robert et al., 1997; Schulberg et al., 2004; U.S. Department of Health & Human Services, 2012). Depression is a robust risk factor for suicide (Harris & Barraclough, 1997); treatment of depression in primary care is common in the United States (Kessler, Bennewith, Lewis, & Sharp, 2002; Olfson et al., 2002; Wang et al., 2006) and is likely to increase in the years to come (Harris & Barraclough, 1997). In addition, studies report that physical illness increases suicide risk (Berman & Pompili, 2011; Kaplan, McFarland, Huguet, & Newsom 2007). Studies indicate the need to integrate suicide prevention within hospital treatment as well as within general medical practice because patients hospitalized for physical illness not only form a well-defined population group at high risk of suicide, but also maintain frequent contact with their general practitioner after hospital discharge.

**Objection 6**

The health care system is not prepared for all the new referrals of suicidal patients that a health professional workforce trained in suicide assessment will generate.

**Response.** In identifying suicidal people, assessment is the first step toward treatment and management (U.S. Department of Health & Human Services, 2012). Primary care providers have an obligation to assess at-risk patients for suicide and to know where to refer patients even if community resources to treat and manage suicidal patients are scarce. Their failure to do so contributes to catastrophic outcomes for patients, affected families, and communities.

The context of this objection is a widely acknowledged workforce shortage in mental health providers that limits the availability of treatment and undermines the quality and appropriateness of treatment that is available for suicidal patients. In Washington, there is the added frustration...
among health professionals that cutbacks in state funding have aggravated problems of providing care for people with suicidal ideation and plans, including an inadequate supply of inpatient psychiatric beds (Washington State Institute for Public Policy, 2011). If there are insufficient psychiatric beds in Washington to address the needs of suicidal patients, it strengthens the case for having a highly trained mental health workforce that can maintain suicidal patients safely in the community when appropriate. Having a well-trained health professional workforce, coupled with increasing the availability of outpatient supports such as assertive community treatment teams, has been shown in Arizona’s public mental health system to reduce the suicide rate and expensive inpatient hospital admissions (Clarke, 2012).

**Objection 7**

Having the state require training is a bureaucratic and potentially counterproductive solution because legislators do not know what health professionals need to be competent in suicide prevention.

**Response.** ESHB 2366 requires that both the Department of Health and the disciplines impacted by the legislation “work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management.” Each discipline is to be engaged in a rule-making process whereby they determine the relevant training competencies, a list of model training programs, rules for how additional training programs are added to the model list, and rules about which organizations, institutions, and individuals are qualified providers of training.

**Objection 8**

This is an unfunded mandate and training is expensive.

**Response.** Health professionals are required to complete continuing education to maintain their licensure. There is an assumption of responsibility for costs to pay for continuing education when one becomes a licensed health professional. ESHB 2366 does not require any additional continuing education hours, only that a small percentage of those continuing education hours be devoted to the assessment, treatment, and management of suicide. That said, mandating training in suicide prevention and then not offering it for free or at low cost to health professionals is a reasonable objection. Ideally, institutions of higher education and graduate training programs, large health care systems, employers, and professional liability insurers will step up to assume some of the costs of suicide prevention training in the future. In the meantime, the potential cost to health professionals of losing a patient to suicide is a major occupational hazard. Raising awareness among health professionals of the “occupational hazard” of losing a patient to suicide, including the frequency and impact on professionals (Chemtob, Bauer, Hamada, Pelowski, & Maraoka 1989; Chemtob, Hamada, Bauer, Kinney, & Torigoe 1988), can offset concerns about the cost of training.

**Objection 9**

There are large numbers of suicidal patients in health care settings. Differentiating those who need urgent attention from those with less need is impossible.

**Response.** There is no single test or panel of tests that right now can accurately identify the emergence of a suicide crisis (Fowler, 2012). These circumstances led the U.S. Preventative Taskforce in 1996 to conclude that there is currently insufficient evidence to recommend for or against routine screening for suicide by primary care providers to detect suicide risk in the general population. While precise prediction of suicide risk is elusive at this time, health professionals are responsible for assessing at-risk patients for suicide risk and for intervening appropriately depending on the level of risk that the patient presents and the scope of practice of the professional
The benefit of assessing depression and suicide risk in primary care settings is not only about saving lives, but about beginning a conversation with patients about mental health problems that may be contributing to physical symptoms.

Objection 10

There is no evidence that training health professionals in suicide prevention impacts the suicide rate.

Response. Many factors affect the suicide rate, only one of which is a trained, competent, and coordinated clinical workforce (U.S. Department of Health & Human Services, 2012). The connection between training, potential improvements in practice, actual improvements in practice, and reductions in suicide is not well established. The effectiveness of ESHB 2366 in reducing the suicide rate on its own will likely be limited without a more comprehensive approach to suicide prevention in Washington State within its health systems and communities. Nonetheless, the potential impact of only training health professionals to help lower the suicide rate in Washington cannot be overstated. To date, all comprehensive approaches to suicide prevention that have positively reduced the suicide rate have the training of health professionals as a critical component of their strategies (Alexopoulos et al., 2009; Clarke, 2012; Coffey, 2007; Knox, Litts, Talcott, Feig, & Caine 2003; While et al., 2012).

There are several training programs that have been recognized for disseminating content that is consistent with core competencies in suicide prevention and in building the skills needed to conduct adequate suicide risk assessment and to manage suicidal patients. Promising studies have linked these training programs to how professionals practice, systemic changes in clinic policy, improved patient safety, and fewer deaths by suicide, including in the provision of primary care (Hampton, 2010; Mann et al., 2005; McNiel et al., 2008; Oordt, Jobes, Fonseca, & Schmidt 2009). These training programs have been cataloged by the Suicide Prevention Resource Center into a best practice registry that is designed to identify, review, and disseminate information about best practices in suicide prevention (the registry is available at http://www.sprc.org/bpr).

CONCLUSION

In overcoming objections to mandated continuing education in the area of suicide assessment, treatment, and management, it is important to validate and be responsive to concerns about maintaining autonomy in the realm of continuing education as well as to the specific objections raised in the passage of ESHB 2366. Thus, it is essential that any proposed legislation mandating continuing education in suicide prevention ensures processes of ongoing consultation and cooperation with disciplinary authorities and health professional associations. There may also be less opposition to a legislative requirement if the suicide prevention training is focused on graduate training programs and institutions of higher education rather than on continuing education. We did not explore this option in Washington.

Ultimately, the success of Washington’s mandate in suicide assessment, treatment, and management to help lower the suicide rate in Washington will depend on its implementation, including the proliferation of choice in training opportunities over time; for example, basic and advanced training options, widespread access, reasonable cost, and the flexibility to incorporate new innovations in the fields of suicide prevention and adult education as they become available. The mandate for continuing education must not become stale; rules must be put in place so that training is of high quality and evidence-based. Passing ESHB 2366 was a first step toward the goal of ensuring that health professionals are adequately trained to prevent suicide in Washington.
Proponents of ESHB 2366 are also hopeful that it is the beginning of a broader strategy that will bring us toward a more comprehensive approach to suicide prevention and the treatment of mental illnesses in Washington. The case of Matt Adler—and so many others who have died by suicide—is a reminder of why we cannot fail.

REFERENCES


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