February 7th 2017

Dear Senators Sara Gelser and Alan Olsen,

Thank you for the opportunity to provide testimony on the matter of mandating suicide prevention training for healthcare professionals and how Washington State is experiencing the enactment of our bills. I am not able to provide an entire overview, but my perception is that the requirement is now seen as less onerous that anticipated and feedback from trainers – both in classroom and online options – is generally quite positive from those trained.

First, my name is Paul Quinnett and I am a senior clinical psychologists and suicide prevention expert with more than 40 years in the field. In full disclosure, upon my retirement from 30 years in public and private practice mental health work, I founded my own training organization on the single premise that excellence in education could save lives from suicide. The website is www.qprinstitute.com.

As you know by now, pushback from membership organization lobbyists is strong, as no provider wants to be told by the government how to practice, what to study, and what continuing education they should take. However, as the past Chair of the Board of Examiners in Psychology for the State of Washington, it is the public's health that matters, not the elective continuing education choices preferred by licensed healthcare professionals.

As to the importance of this legislation, in a recent *Lancet* publication, it is reported that all the gains made in lives saved from cancer and HIV/AIDS through research, improved treatments, and access to competent care have been completely negated by the rise in preventable deaths from addictions and suicide. Make no mistake, suicide is a public health crisis, and some of the only people that can help us prevent these deaths are professionals targeted in your bills.

As I testified to the Washington State Senate Health Committee on this same issue, thousands of people in our state are in active treatment today for a problem they will not die from, while the one they ***will*** die from (a desire to end mental suffering through suicide), will not be detected, assessed, treated or managed. The National Violent Death Surveillance Reporting System has found that 35%+ of all Americans who die from suicide kill themselves *while in active care a licensed health professional*, many of them within hours of their last appointment.

We would not tolerate these missed diagnoses with heart disease or cancer or high blood pressure for one minute.

As to the roll out of the mandate here, I offer the following observations:

1. Resistance to the mandate was robust from some membership organizations, but the legislature recognized the public health need as the commanding priority.
2. Claims by professionals that the training would be redundant have been shown to be false; only psychiatrists are trained in this area of clinical practice.

3. Research, white papers, and recommendations from national organizations for providers to secure suicide prevention training, e.g.., the Institute of Medicine and others, showed that after more than 30 years of recommendations, voluntarily training in this area of practice is failed strategy.
4. Our Department of Health realized that of the training programs initially offered, many were subpar and so put together a committee to review proposed training to assure licensed healthcare professionals that the training they would take under the mandate met the expectations of the law and covered topic areas experts (like me, and I served on the committee) proscribed as essential knowledge and skills needed, e.g., assessment, treatment, and management. The DOH also had its medical quality assurance committee evaluate training programs for physicians to be approved for the "model list" of approved training programs.
5. I believe it helped to frame the mandate as a "patient safety measure," just as we did years ago during the HIV/AIDS crisis when, as you will recall, healthcare professionals fought mandatory training requirements. As you may also know, patient safety initiatives have now gained great momentum under the banner of "zero suicide." In a nutshell, once a suicidal person is in the care of licensed professional they should not kill themselves. Oregon could help lead the way toward this national goal by enacting this legislation.
6. With our veterans at elevated risk, and most never been seen or treated in our VA system, they must rely for care on professionals who remain inadequately prepared to help them with their PTSD, TBI and suicide risk. All of our programs must include at least 30 minutes of content on veterans at risk.
7. While many people resisted the training mandate, once they experienced the training, attitudes changed dramatically, and toward the positive. Here are few examples from some of those we have trained...

"Thank you for the training. It was illuminating!" from a primary care physician whose own son had been suicidal and is now recovering.

"I wanted to reach out and say thank you for the QPR course. It was incredibly valuable and I feel empowered in a way that I never have with regard to understanding how to identify and hopefully help prevent suicide in our colleagues." Emergency Room physician.

""Imparted confidence and a sense of personal responsibility to "own" this material and apply it without hesitation, i.e., stop assuming that someone else will do it. Step up, and be your authentic caring self - that's what "health care" should be all about!" Nurse Midwife

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