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Training Mental Health Professionals to Assess and Manage Suicidal Behavior: Can Provider Confidence and Practice Behaviors be Altered?

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Remarkably little systematic research has studied the effects of clinical suicidology training on changing practitioner attitudes and behaviors. In the current study we investigated whether training in an empirically-based assessment and treatment approach to suicidal patients administered through a continuing education workshop could meaningfully impact professional practices, clinic policy, clinician confidence, and beliefs posttraining and 6 months later. At the 6 month follow-up we found that 44% of practitioners reported increased confidence in assessing suicide risk, 54% reported increased confidence in managing suicidal patients, 83% reported changing suicide care practices, and 66% reported changing clinic policy. These results suggest that a brief and carefully developed workshop training experience can potentially change provider perceptions and behaviors with a possible impact on clinical care therein.

Despite the pervasiveness of suicidal patients in clinical practice, mental health professionals typically receive little curriculum-based training on assessment and management of suicidal behaviors during the course of their professional education. For example, Bongar and Harmatz (1991) found that only 40% of graduate programs in clinical psychology provided *any* formal training on clinical work with suicidal patients. Existing training occurs in the context of direct clinical supervision (Ellis & Dickey, 1998), which may or may not include exposure to the empirical literature (Jobes, 1995, 2000). Moreover, this type of training may emphasize outdated or inadequate clinical practices; for example, an over-emphasis on inpatient care or the routine use of "no-suicide" contracts (Jobes, Rudd, Overholser, & Joiner, 2008; Rudd, Mandrusiak, & Joiner, 2006). It is quite likely

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that insufficient training on this important topic may in part contribute to the significant fears and anxieties that many mental health professionals have in relation to working with suicidal patients (Pope & Tabachnick, 1993).

Moreover, while suicide-specific training in graduate, medical, and nursing school curricula may be limited, remarkably little is known about additional training or education in clinical suicidology that may be gained professionally "downstream" after a mental health practitioner is established and credentialed. Broadly speaking, resources for professional training can be largely defined in two domains. The first domain is a burgeoning clinical literature in the assessment and treatment of suicidal patients, which has becoming increasingly empirically based. For example, clinically focused books (e.g., Berman, Jobes, & Silverman, 2006; Bongar, Maris, Berman, & Litman, 1992; Jobes, 2006; Rudd, Joiner, & Rajab, 2001; Shea, 2002) and peer-reviewed journal articles (e.g., Joiner, Walker, Rudd, & Jobes, 1999; Rudd, Joiner, Jobes, & King, 1999) have provided a great deal of guidance for clinicians who are interested in learning more about clinical suicidology. While these resources may be helpful, the inclination for typical practitioners to seek and read these may be quite marginal (Jobes, 2003). In response to many of the inherent professional training challenges, Shea and colleagues have developed and studied an educational framework for helping both inexperienced trainees and veteran clinicians to develop a personalized and flexible strategy for eliciting suicidal ideation responses (Shea et al., 2007; Shea, Mezzich, Bohon, & Zeiders, 1989). Shea et al.'s educational framework and interview strategy—the Chronological Assessment of Suicide Events (or CASE approach)—represents an excellent example of an assessment model that can be readily taught to a broad range of clinicians (Shea, 2002).

The second major domain of professional training/education in clinical suicidology is seen in systematic organizational efforts to distill and disseminate essential information in the form of practice guidelines, recommendations, and best practices. For example, the American Psychiatric Association (APA, 2003) has published guidelines for care of suicidal patients, and there are other similar type efforts (Risk Management Foundation, Harvard Medical Institutions, 1996). While appealing at face value, the dissemination of clinical practice guidelines may not actually effect direct changes in provider behaviors (Freemantle et al., 2002; Worrall, Chaulk, & Freake, 1997). In an ambitious effort to go beyond the development and dissemination of practice guidelines, a joint initiative between the Suicide Prevention Resource Center (SPRC) and the American Association of Suicidology (AAS) brought together an expert workgroup to develop an intensive 1-day train-the-trainer model in best practices of clinical assessment and management of suicide (Litts, 2007). Additionally, educational intervention studies in Sweden (Rutz, 2001) and Hungary (Szanto et al., 2007) have shown promising results related to reducing community suicide rates by improving general practitioners' knowledge of depression and its treatment (including recognizing suicide risk and responding appropriately) through training seminars.

THE AIR FORCE MANAGING SUICIDAL BEHAVIOR PROJECT

As we have described elsewhere (Oordt et al., 2005), in an effort to respond to the above noted issues and challenges, the U.S. Air Force Suicide Prevention Program (AFSPP) convened an expert workgroup to develop a comprehensive clinical guide for effectively working with suicidal patients. This unique initiative derived the best of empirically-based knowledge in clinical suicidology to develop the *Air Force Guide for Managing Suicidal Behavior*, a document that includes 18 recommendations for effective clinical work with suicidal patients (the guide itself is available at http://afspp.afms.mil). Critically, beyond developing the guide, the initiative also included a series of trainings that ultimately reached 75% of mental health providers in

the U.S. Air Force. To date, there are no published studies on the outcome of any systematic effort to improve the suicide-related clinical practices in the assessment and management of suicidal behavior across a large health care system. Obviously, such data could be beneficial for other health care systems, agencies, or group practices to determine whether an investment in training resources and education may reasonably enhance clinical care in this critical area.

Given the import of the topic and the dearth of empirical data about the potential impact of training on clinicians' behaviors over time, the present investigation was undertaken to study the impact of a continuing education program on assessing and managing suicidal behavior (MSB) for mental health professionals working within the U.S. Air Force's (AF) 74 medical treatment facilities. In this study, our principal research questions were:

1. Would systematic MSB training change clinicians' *confidence* in their ability to assess, manage, and treat suicidal behaviors?
2. Would systematic MSB training provide changes in *provider beliefs* about clinical practices?
3. Would systematic MSB training lead to increased standardization of written *clinic policies and procedures*?

METHOD

The present study is a pre/post/post study of a large-scale effort to systemically enhance the mental health care provided to active duty suicidal Air Force personnel. The AF's MSB educational intervention consisted of 12 hours of instruction over a 1-1/2 day period at an AF mental health continuing education symposium. Four hours were dedicated to assessment; 4 hours focused on management and treatment of suicidal behavior; and 4 hours covered military-specific content areas and issues, continuity of care, follow-up practices, and concerns related to monitoring high-risk patients.

The training format included lectures with PowerPoint® presentations; role-plays of clinical scenarios; and panel discussions with audiences for questions and answers, discussion, and problem solving. Trainees were provided a copy of the *Air Force Guide for Managing Suicidal Behavior* as well as suggested strategies, tools, and resources for practicing according to the recommendations. The 18 recommendations in the guide formed the outline of topics for the training, with each presenter covering a subset of the recommendations (as outlined in Table 1). Two internationally recognized experts in the study of suicide provided the training on assessment and management, each of whom has served as president of the American Association of Suicidology (AAS) and has authored over 50 publications in the field. The third section, which covered military specific applications, was taught by an active duty AF clinical psychologist.

Participants

Eighty-two active duty AF mental health professionals who were trained at a MSB workshop symposium were included in the study. Fifty-two percent were male. Years of experience as a mental health professional ranged from 6 months to 27 years (mean 8.2 years, median 5.5 years). Approximately half (48%) were doctoral-level psychologists, 27% were masters- and doctoral-level clinical social workers, and 13% were psychiatrists. Mental health technicians (highly trained mental health assistants; 7%) and psychiatric nurses (4%) were also present (one participant did not provide information on discipline).

Consistent with prior research, many participants reported not having had much formal training in suicide assessment and management. Forty-three percent reported having had little or no formal training in suicide assessment and management in their graduate programs and 42% reported having had little or no postgraduate training (i.e., continuing education). Most of the partici-

TABLE 1
Recommendations Covered in the Three Sections of the MSB Intervention

Assessment of Suicide Risk (4 hours)
1. Formally assess suicide at every initial evaluation, and as clinically indicated at follow-up contacts
2. Use appropriate measures to assess suicidality
3. Document suicide risk assessment thoroughly

Management of Suicidal Behavior (4 hours)
4. Determine suicide risk level based on assessment information and match to appropriate suicide-specific interventions
5. Specifically target suicidal symptoms and risk factors in the formal outpatient treatment plan
6. Take steps to safeguard the environment
7. Establish processes for ongoing monitoring of suicide risk

Military Specific Applications and Other Issues (4 hours)
1. Use management strategies that are uniquely applicable to active duty members
2. Establish a process for coordination when patients are hospitalized
3. Reassess needs following hospitalization
4. Use a High-Interest Log as a clinic tracking procedure
5. Consult professional peers regularly
6. Use a standardized follow-up procedure for suicidal patients dropping out of treatment prematurely
7. Ensure clinical coverage when the primary provider is unavailable
8. Establish a clinic procedure for ensuring continuity of care during both provider and patient transitions
9. Establish a written plan for after-hours evaluations
10. Serve as consultants to unit leadership regarding the management of at-risk personnel
11. Use community support resources in the management of suicidal behavior

pants had worked with suicidal patients, with 93% reporting being somewhat (22%), moderately (52%), or highly (19%) experienced with suicidal patients.

Measure

The content of the questionnaire administered at each assessment time period is displayed in Table 2. Individuals who were present at the symposium but who did not complete both a pretraining and immediate posttraining questionnaire were not included in the sample and were not sent the follow-up questionnaire since there was no way of knowing that they attended the training and change scores could not be calculated.

Provider Confidence. Three questions on the assessment tool addressed provider confidence. Each was targeted for change by the intervention (toward increased confidence and decreased hesitance). Response options were: *strongly disagree, disagree, neutral, agree,* and *strongly agree.* The statements were:

- I am confident in my ability to successfully assess suicidal patients
- I am confident in my ability to successfully treat suicidal patients
- I am hesitant to ask a patient if he or she is suicidal

Provider Beliefs. Three additional questions on the assessment tool addressed beliefs about clinical practices for suicidal patients:

- I believe that suicidal patients are best treated by hospitalization
- I believe clinicians should be legally responsible for protecting patients from self-harm
- I believe my current practices are sufficient to protect me about liability issues in the case of suicidal death

TABLE 2
Content of the Pretraining, Immediate Posttraining, and Follow-Up Questionnaires

Content	Pretraining	Immediate posttraining	6 month follow-up
Demographics	X		
Self-rating of level of experience with suicidal patients	X		
Self-rating of amount of prior training in suicide care	X		
Confidence and beliefs regarding suicide care	X	X	X
Existence of clinic policies on key areas of suicide management	X		X
Intent to change work with suicidal patients in response to training		X	
Actual changes in response to training (individual practices or clinic procedures)			X

Only the first of these "belief" questions was targeted for change in the intervention (toward disagreement). The others were included as exploratory items, and we had no expectation for change in a specific direction.

Clinic Policies and Procedures. Questions on clinic policies and procedures asked whether the practitioner's clinic had a written policy document generally covering assessment and management of suicidal patients, and whether the clinic policies and procedures covered key areas targeted by the intervention. These key areas included: (a) screening all patients for suicide risk, (b) use of a "high-interest log," (c) communicating high risk status to other providers who might be providing care to a patient (including on-call and emergency department providers), and (d) following-up with high risk patients who miss appointments.

Procedure

Anonymous questionnaires were administered to all training participants immediately prior to the training and immediately following the workshop training. At the 6 months posttraining intervention, follow-up questionnaires were mailed to all the original participants. Mother's maiden name was requested on each questionnaire to enable matching of pre- and posttraining questionnaires.

RESULTS

Forty-one participants ultimately returned the questionnaire for a 50% overall response rate. Response rates by professional discipline varied substantially between psychologists (62%), psychiatrists (55%), social workers (23%), nurses (67%), and technicians (50%). The follow-up sample had a higher proportion of males (63%) and psychologists (59%), and a lower proportion of social workers (12%), than the entire sample of trained practitioners. Years of experience as a mental health professional still ranged from 6 months to 27 years; however, the mean and median were slightly higher (9.6 and 7.5 years, respectively).

Confidence and Beliefs Regarding Suicide Care

The impact of the training on participants' confidence and beliefs was analyzed by calculating the percentage of participants who agreed or strongly agreed with a question (or disagreed/strongly disagreed for the two questions in which the intervention promoted disagreement) at pretraining assessment, at immediate posttraining assessment, and at 6-month follow-up assessment. These data are presented in Table 3. All participants ($N = 82$) were included in the pretraining/posttraining comparison percentages. Only

TABLE 3
Percent Responding with Each Option on Confidence and Belief Questions at Pretraining, Posttraining, and Follow-Up Assessments

	Strongly Disagree			Disagree			Neutral			Agree			Strongly Agree		
	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU	Pre	Post	FU
1. Confidence to assess	0	3	0	2	0	0	10	0	0	68	74	46	20	23	54
2. Confidence to treat	0	0	0	5	3	0	27	9	2	59	80	59	10	9	39
3. Hesitance to ask	83	89	90	12	9	5	2	0	0	0	0	0	2	3	5
4. Hospital is best	3	6	5	33	54	46	58	40	37	5	0	12	3	0	0
5. Clinicians should be legally responsible	24	20	12	39	37	37	17	26	39	20	17	12	0	0	0
6. Current practices are sufficient re: liability	0	0	0	10	6	5	27	14	24	61	77	59	2	3	12

Pre = Pretraining assessment; Post = Immediate posttraining; FU = 6 month follow-up assessment

those who completed the follow-up assessment ($n = 41$) were included in the pretraining/follow-up comparison percentages.

To evaluate bidirectional change in confidence and beliefs for each individual, change scores were calculated from pretraining to posttraining assessments, and from pretraining to follow-up assessments, for each individual on these six items. Single sample t tests with a test value of zero were used to evaluate the changes. The percentages of participants with change toward greater agreement and toward greater disagreement are presented in Table 4. Again, only those who completed the follow-up assessment were included in the pretraining/follow-up analysis.

Professional Practices and Written Clinic Policies

Immediately following training, 97% of participants reported that they agreed or strongly agreed that they were going to make a change to at least one aspect of their work with suicidal patients in response to the training. At the 6-month follow-up, 83% reported they agreed or strongly agreed that they had made a change in the way they work in response to the training. Additionally, 66% agreed or strongly agreed that they had made a change to clinic policy related to assessment and/or management of suicidal behavior.

The *Air Force Guide for Managing Suicidal Behavior*, on which the training was based, makes specific recommendations for written clinic policy in several key areas. To evaluate the impact of training on written policy, frequencies were calculated as to whether or not participants had written policies on these areas at the time of the pretraining assessment and again at the 6-month follow-up (refer to Table 5).

DISCUSSION

Generally speaking, the fact that almost all the participants who received the MSB training reported some intent to change at least one aspect of their work with suicidal patients is particularly noteworthy. This finding suggests that training in suicide assessment and management was both needed and valued by this sample of AF mental health professionals. Furthermore, the high percentage of practitioners who reported having implemented a change in their clinical work with suicidal patients and changes to clinic policies and procedures *in direct response to the training* indicates that

TABLE 4
Change in Confidence and Belief Responses Pretraining to Posttraining and Pretraining to Follow-Up

	Pretraining to Posttraining ($N = 82$)				Pretraining to Follow-up ($N = 41$)			
	Change toward agree	Change toward disagree	t	p	Change toward agree	Change toward disagree	t	p
1. I am confident in my ability to successfully assess suicidal patients[1]	23%	9%	.842	*ns*	44%	0%	4.901	<.01
2. I am confident in my ability to treat suicidal patients[1]	31%	6%	2.253	<.05	54%	0%	6.137	<.01
3. I am hesitant to ask a patient if he or she is suicidal[2]	14%	6%	−.488	*ns*	10%	2%	−.206	*ns*
4. I believe that suicidal patients are best treated by hospitalization[2]	31%	6%	−2.652	<.05	34%	17%	−.561	*ns*
5. I believe clinicians should be legally responsible for protecting patients from self-harm[3]	20%	17%	.000	*ns*	39%	32%	1.034	*ns*
6. I believe my current practices are sufficient to protect me against liability issues in the case of suicidal death[3]	23%	3%	1.950	*ns*	32%	15%	1.853	*ns*

Note. 2-tailed t tests, $df = 40$.
[1]Intervention promoted greater agreement with these statements
[2]Intervention promoted greater disagreement with these statements
[3]Intervention did not target these beliefs

there was room for enhancing quality of care in this area as well. While the results related to our main research questions were somewhat mixed, overall the pre/post/post results were primarily in the desired direction.

In terms of the effect of training on clinician confidence, the data show that participants did not report increased confidence in assessing suicidal risk immediately following training but did show statistically significant change at 6-month follow-up. Confidence in treating suicidal behavior, however, did show a statistically significant increase immediately following training; an effect that was sustained at the 6-month follow-up. Only 18% of participants reported increased confidence on assessment between pretraining and posttraining, while 26% reported increased confidence on treatment. This difference in change between confidence in assessment and treatment may reflect that there was greater pretraining confidence among the group as a whole regarding assessment (89% marked *agree* or *strongly agree*) than regarding treatment (71% marked *agree* or *strongly agree*); thus there was more room for change in the area of treatment. Critically, there were no instances where confidence decreased following training for either assessment or treatment. The vast majority of participants reported no hesitancy in asking patients about current suicidal ideation, and no significant change was evident immediately following the training or at 6-month follow-up. As discussed elsewhere by Jobes (2003), for anyone involved in training estab-

TABLE 5
Percent of Participants with Specific Written Policy, Pretraining and at Follow-Up

	Yes		No		DK		NA	
Does your clinic have a written policy on:	*Pre*	*FU*	*Pre*	*FU*	*Pre*	*FU*	*Pre*	*FU*
1. Assessment and management of suicidal behavior?	83	78	7	12	10	7	0	2
2. 100% screening of all patients?	76%	83%	17%	12%	7%	2%	0%	2%
3. Criteria for entry and removal of patients from a "high interest log?"	76	68	17	22	7	7	0	2
4. Communication regarding high-risk patients with on-call mental health providers?	88	88	5	7	7	2	0	2
5. Communication regarding high-risk patients with other relevant clinics	80	85	8	7	13	5	0	2
6. Communication regarding high-risk patients with emergency room personnel	53	49	15	15	10	7	12	5
7. Follow up with high-risk patients who do not keep scheduled appointments	76	83	12	10	12	5	0	2

Pre = Pretraining assessment; FU = 6 month follow-up assessment; DK = Don't Know; NA = Not Applicable

lished and credentialed mental health professionals, there is often the challenge of "teaching old dogs new tricks." In that sense, perhaps some of our "sleeper" training effects reveal a reflective process that occurred among our participants over time, where the training actually sank in and modified perceptions in a delayed manner.

Interestingly, strength in the belief that hospitalization is the best treatment for suicidal behavior showed a statistically significant decrease immediately following training but not at the 6-month follow-up. It is notable that although the MSB training taught that some high-risk patients (i.e., those who are not imminently suicidal) could be effectively treated on an outpatient basis, beliefs about this issue changed in both directions between pretraining and posttraining assessments. Although not statistically significant, the percentage of participants who changed toward increased agreement with the statement that hospitalization was the best treatment for suicidal patients was greater at follow-up than at immediate posttraining. It may be that the MSB training initially convinced some participants, from an evidence-based perspective, that outpatient treatment for high-risk patients was reasonable and prudent. Over time, however, these same participants may have reverted to previously held beliefs given the clinical and legal realities of real-life practice and the widespread perception that inpatient hospitalization is more protective from a malpractice perspective (Jobes, 2000, 2003, 2006; Jobes & Berman, 1993).

The results related to clinic policy questions provided useful information on the prevalence of written policy across the health care system (but did not really address the potential impact of training in this area). As noted, at pretraining, over 75% reported having written policies on the designated key areas. The only exception was for communicating risk status with the emergency room, for which only 53% had a written policy. This outlier was likely accounted for by the fact that 23% of respondents reported not having an emergency room at their facility. When only those with emergency facilities were included in the analysis, 68% reported having written policies in this area, with another 14% indicating "don't know."

The difficulty of more directly evaluating the impact of the training on the prevalence of written policy was evident when the 6-month follow-up was analyzed. At follow-up, some recommended policies were reported to have been implemented by a greater percentage of participants than at pre-training; however, other recommended policies were reported to be implemented by a smaller percentage compared to pretraining reports. This may be due to the fact that the pretraining assessment was conducted at a symposium and participants could only recall or guess as to whether a written policy actually existed. In contrast, the follow-up questionnaire was completed at their clinic where participants presumably had immediate access to any existing policy documents and could thereby verify their responses if unsure. Additionally, approximately one third of military personnel relocate every year, usually in the summer months. Since a move cycle passed between the delivery of the intervention in March 2003 and the 6-month follow-up in September, it is likely that, at follow-up, many of the participants were working in different clinics from when they received the training. Thus, they may have responded with regard to their current clinic each time with each having different local policy. Nevertheless, the changes were small in both directions.

Implications

Overall, the results of this investigation show that a brief and professional training on clinical care for suicidal patients can: (a) increase provider confidence and (b) favorably impact the clinical practice of practitioners. We would, therefore, conclude that suicide-specific training to professional audiences along the lines of our MSB training or similar models (e.g., the SPRC curriculum noted earlier) are clearly warranted.

While the exact components of the training that contributed to its apparent effectiveness remain unknown, we nevertheless have distinct impressions of what may have contributed to the success of the MSB training effort described in this study. Based on our experience, we would offer a list of key recommendations for others who may aspire to impact providers with suicide-specific training within agencies or even larger health care systems.

1. Target clinical topic areas commonly encountered by practitioners. Examples are depression, anxiety, suicidality, and other conditions that are the "bread and butter" of mental health practice. This will ensure that the intervention is relevant to those being trained.
2. Use recognized experts as trainers. The influence of authority figures on beliefs and behaviors is well documented in the psychological literature (see Oordt, 1991). There is potential additional effect from using trainers with established name-recognition and credibility based on their research activities, publications, and professional positions (e.g., elected offices in professional organizations).
3. Ensure that the content of the didactic training includes relevant theory, empirically based perspectives, and meaningful translation of theory and data into clinical practice.
4. Train at a location away from the clinic environment. This will allow personnel to avoid the distractions of patient care or administrative tasks and focus on the training.
5. Specify concrete recommendations for clinical practice and policy to include "what not to do" as well as "what to do." Each recommendation should be in sufficient detail to allow multiple providers within a clinic to apply it in the same manner. This can be particularly important for standardizing practice in large organizations with multiple clinics.
6. Teach strategies to make it easy to meet recommendations. Provide ma-

terials such as flowcharts, tables, record-keeping forms, assessment instruments, and interview templates to facilitate consistency between providers and across clinics.
7. Provide written materials to supplement the training and to facilitate recall when the practitioner returns to the clinic.
8. Include demonstration role-plays or video vignettes to demonstrate specific strategies and skills. This will help clarify recommendations and potentially elicit questions and areas needing further discussion. Small groups allow for immediate feedback on specific skills or decision making in role-play sessions.
9. Leave time for questions and answers. Encourage practitioners to recall past or current suicidal clients and think through how the recommendations would be applied in those cases. This will invariably bring up important questions and discussion. Our use of panel discussions was particularly important for audience members to become involved in the material and problem-solve how the training could be applied in their clinical setting.

Limitations

There are several limitations with our study. First, the sample size is small and the response rate was relatively low. As with any study of this type, one always wonders about nonresponders. However, given the considerable demands of military life (e.g., the frequent moves of AF personnel), we were actually quite pleased with a 50% response rate at 6 months follow-up. Nevertheless, the response rate does limit the external validity of the findings. In a different vein, as with any self-report measure, our results may have been colored by social desirability (which we attempted to minimize by anonymously administering our pre/post/post measures). A related issue is that with such measures one must rely on participants' self-report about changes in perceptions and behaviors—as to whether in truth they actually *did* change, we do not know. Furthermore, the intervention did not include a controlled comparison group, so conclusions about effectiveness of the intervention must remain tentative. Finally, we really do not know what aspect of the training may have had the most impact on our participants. We considered adding more questions of this nature to our measure but worried that too many questions would ultimately decrease our response rate. Undoubtedly, the study of exactly what aspects of training are most salient is an important area for future research.

CONCLUSION

This investigation of the impact of professional training has clearly shown that it is apparently possible to favorably change provider perceptions and practices related to assessing and managing suicidal behavior, even among experienced and credentialed providers. We know that across the field of mental health there are several important areas where clinical practice is known to be substandard. Such examples include screening for problem drinking (Friedmann, McCullough, Chin, & Saitz, 2000), screening for depression (Williams et al., 1999), and the management of depression and anxiety disorders (Wang, Berglund, & Kessler, 2000; Young, Klap, Sherbourne, & Wells, 2001). This has most likely been similarly true for routine clinical practices in the assessment and treatment of suicidal patients provided by mental health professionals in general practice (Jobes, 2003).

A comprehensive training workshop that addresses (a) current empirical knowledge, (b) evidence-based optimal practice examples, (c) facilitated examination of providers' current practice for concordance, and (d) resources for redesigning processes of care can help improve delivery of mental health care and outcomes (Wells et al., 2004). A quality improvement effort is likely to fail

unless redesigning the process of care is addressed at the same time that practitioners are being educated about the clinical importance of the various aspects of care (Von Korff et al, 1998). As applied science develops and new knowledge is applied to clinical care, health care delivery processes should also be improved to help providers integrate this knowledge into their practice. Considering the life and death implications of clinical work with suicidal patients, further study on effective ways to impact and improve provider behaviors is a worthwhile and potentially life-saving endeavor.

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