Provider Training

Research has shown that "skill-based" and "action-oriented" trainings produce greater gains than information alone. Activity-based trainings can help providers "demonstrate appropriate helping competencies in simulations, and [they] report being comfortable when helping". Best practices recommend that trainings include mock assessment or intervention role-plays and that "booster" trainings be provided "every 2 to 3 years".[1]

Current practices in San Diego County

- Suicide prevention training in schools to students, staff, and families on signs of suicide ideation
- Enhanced training for professionals, including online classes and webinars.
- Police officer training on how to work with the mentally ill.
- Training to community providers

Existing Confidence, Knowledge, and Attitude Regarding Suicide Risks

In order to fully assess confidence in addressing suicide risk, knowledge of suicide risk factors and attitudes regarding suicide, two, separate, online surveys were distributed to County staff and contractors, and community providers. Overall, providers exhibited high levels of confidence as well as knowledge and attitude regarding suicide risks. The table below summarizes how factors such as position, years working in Behavioral Health, and experience regarding suicide impact provider confidence, knowledge, and attitudes regarding suicide.

County Mental Health Services	County Alcohol and Drug Services	Community Providers
Confidence		
Position: Lower confidence was reported by support services vs. other positions. **Experience** ▪ Those with more years in Behavioral Health exhibited higher confidence ▪ Those with more experience conducting suicide risk assessment had higher confidence levels.	**Experience:** Those with more experience conducting suicide risk assessment had higher confidence levels.	**Position:** Managers and Board Members had the highest average confidence level while Administrative positions had lower levels.
Knowledge of Suicide Risk Factors		
Position: Managers had higher knowledge scores while those working in Support Services had lower scores. **Experience:** Those with more experience conducting suicide risk assessment had higher knowledge scores.	Consistent across all factors.	Consistent across all factors.
Attitudes regarding Suicide		
Position: Managers and Directors had higher scores than Direct Service or Support Services. **Experience:** Those with more experience conducting suicide risk assessment had higher knowledge scores.	Consistent across all factors.	Consistent across all factors.

These findings indicate that training on basic suicide risk factors is needed for MHS direct services and support services staff. Targeted training to dispel myths such as the assumption that someone who is suicidal is fully intent on dying is needed for all groups. This information can increase knowledge about suicide as well as increase confidence in providers' ability to address suicide risk in the clients they serve.

[1] Reducing Suicide: A National Imperative

Feedback on Existing Training

- Most training occurred within the last four years and was provided through agencies other than San Diego County or County contractors. At least 63 different training entities or programs were named, ranging from private individuals to foundations and government agencies, suggesting low uniformity in curricula.
- Contractors shared that training was helpful for providing information on available resources, reviewing suicide risk factors, and teaching about suicide risk assessment and how to manage high-risk clients. However, stakeholders shared that most trainings are not specifically devoted to suicide prevention.
- Fewer MHS respondents reported attending trainings on suicide than their ADS counterparts.
- County MHS and ADS providers identified training areas and topics that complemented those provided by Behavioral Health Services (i.e. skill based training that supports the integration of primary care, dual diagnosis, culture, and spirituality).

"ADS programs are getting a lot more clients with co-occurring disorders and they are not as prepared as mental health programs to address those issues so it would be really important to have a stronger collaboration between MHS and ADS in the County."

- Community Stakeholder

Top Eight Stakeholder Training Recommendations

1. **Make trainings mandatory.** Contractors interviewed felt strongly that all staff should be required to attend suicide prevention trainings.
2. **Increase training frequency:** There should be more frequent and more in-depth suicide prevention training opportunities. These should be offered in multiple languages.
3. **Tailor content based on experience.** Trainings should be separated into basic training and higher level training for topics such as co-occurring disorders.
4. **Support providers' mental and emotional health.** Training around suicidality should address: coping with counter transference and the anxiety of working with suicidal clients, including training on appropriate reactions for direct-service staff when initially dealing with a suicidal individual; developing a supportive process within the agency to help staff members cope and maintain their own mental health, treatment of suicidal behaviors and mental health treatment, and managing the chronically suicidal.
5. **Give providers tangible skills.** Agencies should provide training on safety plans for clients who are suicidal. Non-clinical staff in community organizations may not know what to do when a client is suicidal.
6. **Provide training and support after a suicide occurs.** There should be training and support available for agencies dealing with a completed suicide, including a coping plan for employees.
7. **Focus on dual-diagnosis populations.** Specialized prevention trainings should be tailored for dual-diagnosis populations (e.g., populations with schizophrenia and drug use, etc).
8. **Address current issues.** Training and data on bullying (including cyber bullying, via twitter, texting, sexting, etc.) should be provided.