Improving Resident Assistant Suicide Prevention Gatekeeper Training Through Focus Group Feedback

Martin A. Swanbrow Becker, APaige Blankenship, Katherine Melo, Katie Spencer, Colleen Thomas, Kate E. McLean, Hillary Singer

College Student Affairs Journal, Volume 35, Number 2, Fall 2017, pp. 117-130 (Article)

Published by Southern Association for College Student Affairs
DOI: *https://doi.org/10.1353/csj.2017.0017*

IMPROVING RESIDENT ASSISTANT SUICIDE PREVENTION GATEKEEPER TRAINING THROUGH FOCUS GROUP FEEDBACK

Martin A. Swanbrow Becker
A. Paige Blankenship
Katherine Melo
Katie Spencer
Colleen Thomas
Kate E. McLean
Hillary Singer
Florida State University

In response to the alarming rates of suicidal distress on college campuses, many institutions have implemented Resident Assistant (RA) suicide prevention gatekeeper training. However, research is limited regarding the effectiveness of these training programs. Focus groups conducted with RAs who participated in suicide prevention training provided insight into RAs' perceptions of training as well as how the training impacted the RAs' ability to intervene with suicidal residents. Recommendations for future trainings are discussed.

Please direct inquires about this manuscript to: Martin A. Swanbrow Becker, mswanbrowbecker@fsu.edu

College Student Affairs Journal, Volume 35(2), pp. 117-130 ISSN 2381-2338

Suicide, considered the second leading cause of death for college students (NMHA & JED, 2002; SPRC, 2004), results in approximately 1,000 to 1,100 deaths per year (Gallagher, 2012; NMHA & JED, 2012). Additionally, suicidal ideation, including thoughts, planning, and attempts, is estimated to be highest for those aged 18-29 (Crosby et al., 2011). Approximately 24% of college students experience suicidal ideation during their time in college (Westefeld et al., 2005). Furthermore, 1 in 12 students make a suicide plan and up to 5% attempt suicide while in college (ACHA, 2015; NMHA & JED, 2012; Westefeld et al., 2005).

Research indicates that fewer than half of college students who consider suicide receive professional help (Drum, Brownson, Burton Denmark, & Smith, 2009). Similarly, the National Survey of Counseling Center Directors (NSCCD) found that 87% of college students who had died by suicide never sought help through counseling or mental health centers on their campus (Gallagher, 2012). Many universities have responded to the prevalence of suicidal ideation among students by implementing suicide prevention and outreach programs, not only to assist in identifying distressed or suicidal students, but also in directing them to professional mental health resources (Westefeld et al., 2006). However, barriers to help seeking remain due to stigma associated with mental illness, denial of the need for help, lack of time within one's schedule, and perceived preference to deal with issues autonomously (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013; Burton Denmark, Hess, & Swanbrow Becker, 2012).

Drum and colleagues (2009) found that two-thirds of college students who seek help during a suicidal crisis approach a peer for support, and of those students who expressed their concerns to peers, only 58% were advised to seek professional help. Due to the tendency for college students to reach out to peers during a suicidal crisis, and the barriers to seeking professional help, college students must receive both appropriate training on how to best respond to suicidal peers and encouragement to seek professional support (Drum et al., 2009). Resident Assistants (RAs) often operate as both peers and authority figures, serving as a primary resource in terms of identifying and intervening with students in distress, and also as gatekeepers to mental health resources (Swanbrow Becker & Drum, 2015). RAs often share the same living environment with students, placing them in a unique position to access students in distress and intervene with them (Drum et al., 2009; Gould, Greenberg, Velting, & Shaffer, 2003; Lewis & Lewis, 1996).

Gatekeeper Training Programs

The rationale and concept behind gatekeeper training lies in the belief that gatekeepers have the capacity to identify, and make primary contact with, individuals who are at risk for suicide (House, Lynch, & Bane, 2013). Currently, the most common gatekeeper training program for college campuses is Question, Persuade, Refer (QPR), used by at least 32% of colleges and universities (Reetz, Barr, & Krylowicz, 2014). Although the content of training may vary depending on target population (Issac et al., 2009), the standard QPR training program consists of a one-hour, three-step program that teaches participants how to question an individual about their suicidal ideation, persuade the individual to seek professional assistance, and then refer the individual to the appropriate local resources (Quinnett, 1995).

The effectiveness of RA gatekeeper training programs lacks sufficient empirical support, especially examining help-seeking behaviors among suicidal students and reduction of overall student distress (McLean & Swanbrow Becker, 2017; Shtivelband, Aloise-Young, & Chen, 2015). The research conducted in this area, however, has produced mixed results. Research indicates that QPR training produces a positive effect in the areas of appraisal of preparation, efficacy, and intentions to perform in a gatekeep-

er role (Tompkins & Witt, 2009) as well as increased confidence in responding, comfort in communication, and effectiveness of the intervention over a three-month time period (Indelicato, Mirsu-Paun, & Griffin, 2011). However, Cross and colleages (2011) reported a significant decrease of gatekeeper skills (i.e., general communication, asking about suicide, and making an appropriate referral) at the three-month post-training follow up, even after allowing half of participants to practice skills with a trained actor. Due to mixed findings in the literature, it is unclear whether gatekeeper's acquired knowledge, skills, and perceptions gained from training will persist over time; whether they will facilitate increased engagement with students in need; and whether gatekeeper training leads to measureable changes, such as a greater number of students accessing professional help or reduced number of suicidal behaviors (McLean & Swanbrow Becker, 2017; Shtivelband et al., 2015). In order to better understand what components of suicide prevention gatekeeper training RAs find effective, this study compares focus group feedback from RAs trained in suicide prevention with those trained to help students with stress and time management.

Method

A randomized control trial of an RA gatekeeper training program was conducted at a large southeastern university during the 2014-2015 academic year. This university had a total enrollment of approximately 41,000 students in 2015, with 6,387 undergraduates that resided on the main campus. Students on campus identified as primarily Caucasian (63%), female (54%) and heterosexual (90%). Matched pair randomization was used to assign 166 RAs to either the treatment or control group based on their campus residence hall. RAs in the treatment group attended gatekeeper training for suicide prevention (SP), and those in the control group attended stress and time management training (STM) and did not receive any training specific to suicide prevention. Two focus groups convened following the conclusion of the fall semester to gain insight into the RAs' experiences with training. This study received approval from the university's Institutional Review Board (IRB), and relied on an interdisciplinary collaboration between researchers, the university's counseling center, university housing, and other mental health advocates on campus. This paper focuses on qualitative feedback gathered from focus groups, including which components of the training RAs found most salient and helpful as well as suggestions to adjust training in order to increase gatekeeper effectiveness.

Training Descriptions

Gatekeeper Training for SP. Eighty-four RAs attended a gatekeeper training session for suicide prevention during pre-semester RA orientation in August 2014. Four SP training sessions occurred during the same one-hour time block. Two licensed mental health professionals from the University Counseling Center (UCC) facilitated each of the four training session with approximately 21 RAs in attendance per group. Different mental health professionals facilitated the four trainings and the small-group environment allowed for some variation in training emphasis, yet all trainings followed the same outline and objectives.

The SP training in this study promoted the main tenants of Communicate concern, Ask questions, Refer to resources, and Encourage help seeking, and strove to account for the culture and needs of the local campus. The significant aspects of the training were similar to those of QPR trainings in that both training models focus on communication, referral, and connecting the individual with appropriate supports. The training in particular emphasized the importance of communicating concern through both verbal and non-verbal behaviors.

The SP training focused on the overarching goal to promote an action stance to ultimately increase RA intervention with their residents. Additionally, the training sought

to shift RAs' perceptions about suicidality as well as demystify the help-seeking process. The four primary objectives of the SP training consisted of: (1) Expanding the RAs' knowledge regarding the prevalence of suicidal experiences in the college population; (2) Promoting an attitude of collective responsibility among RAs to peer wellbeing; (3) Increasing gatekeepers' sense of competence in identifying students in distress and intervening with them; and (4) Engendering appropriate helping actions.

The SP training is conceptualized as a three-phase process. The initial phase of the training sought to elicit participants' emotional investment as well as an understanding of the need to intervene with distressed residents, while providing information about the prevalence and nature of suicidal ideation among college students. The middle phase challenged reported barriers to intervention through collaborative discussion, as guided by Gould and colleagues (2005). Lastly, the final phase exposed RAs to the expected actions they should take to support distressed students, with model acquisition being solidified through a role-play exercise.

STM Training. Eighty-two RAs attended a stress and time management training during pre-semester RA orientation in August 2014. The STM training served as a control group condition and provided RAs with a mental health training distinct from the SP training. UCC staff constructed and adapted this training for RAs and included three primary objectives: (1) Education about healthy lifestyle habits that help reduce distress; (2) Identification of the physical, emotional, cognitive, and behavioral symptoms of distress; and (3) Increased awareness of coping skills in times of stress.

Participants

The SP focus group included seven RAs trained in SP during the August training. This group consisted of six females and one male. Four of the participants identified as Caucasian, one as African American, and two identified as Latino/Latina. The participants in this group included five 19-year-olds, one 20-year-old, and one 21-year-old. Six of the participants reported being in their second year of college, and the other participant was in their fourth year.

The STM focus group, serving as the control group, included eight RAs trained in STM during the August training, and consisted of six females and two males. The group included five students identifying as Caucasian, one as an African American participant, one as a Latino/Latina participant, and one as biracial African American and Latino. Members in this group included one 19-year-old, one 20-year-old, five 21-year-olds, and one 22-year-old. Two of the participants in the STM group reported being in their second year of college, and the remaining six reported being in their fourth year.

Procedure and Data Analysis

The researchers conducted distinct focus group sessions with RAs who participated in the SP training and those who participated in the control group training. Focus group sessions occurred approximately five months after the SP and STM trainings. Either a doctoral-level research faculty member or a UCC licensed psychologist co-led each focus group with three research team members, consisting of doctoral and specialist level students pursuing degrees in counseling psychology, school psychology, and mental health counseling. Participants responded to a semi-structured interview format where they were prompted to discuss information including knowledge and skills remembered from training, whether the RAs intervened with students in distress, whether they felt competent to do so, RAs' opinions of the strengths and weaknesses of the training sessions, recollections of their experiences intervening with residents and suggestions to tailor the training to better meet their needs.

Participants in both focus groups were recruited by their supervisors and volun-

teered to participate. All participants appeared engaged and cooperative, and each participant actively contributed to the focus group discussion. The RAs' supervisors were not present during the focus group and the participants were informed that the results would be de-identified and summarized to protect their confidentiality. This study presents the results of extensive focus group discussions with 9% of the RA population where the content collection appeared to reach saturation as evidenced by RAs endorsing repetitive topics and expressing that they had communicated the extent of their ideas.

Both focus group sessions were audio taped and transcribed. Three research team members reviewed, and individually coded, each transcript to identify common themes discussed by the RAs. In order to thematically categorize the responses, the team followed the principles of representational thematic text analysis, in which themes emerged from the content presented (Roberts, 2001). Following individual coding, the team members met to achieve consensus on the thematic categories and representational items contained in each category.

Results

Five principal themes emerged from the focus group data: (1) Awareness of student distress and ability to intervene; (2) General impact of training on their knowledge, skills, and confidence; (3) Barriers that hindered the RA-resident connection; (4) Impact of training on gatekeeper mental health; and (5) Feedback for future trainings. In addition to these five themes, RAs emphasized the importance of SP training in both groups throughout the session. An RA in the STM group commented that suicidal ideation was "the number one thing that I dealt with" over the past two years as an RA. Additionally, an RA in the SP group noted:

> Everybody knows someone who has gone through something like that [suicidal ideation]. Like, if it's not yourself, [it is] a family member. And I think it was really hard to sit through [the training], but at the same time, it was one of those things that, although it's painful to sit through, it was so incredibly helpful and reassuring.

Theme 1: Awareness of student distress and ability to intervene

Focus group data suggested differences in the level of awareness of residents' emotional states, and the number of reported interventions based on RA training. For instance, six of the seven RAs who received SP training indicated they had encountered either residents or friends with high levels of distress or suicidal ideation. In contrast, only one of the RAs who received STM training reported any suicidal ideation or extreme distress amongst their residents, and commented, "The only reason I knew about it was because it was revealed to me through my head staff. So, it wasn't something I initially picked up." Additionally, RAs in the SP group reported that they confidently and successfully intervened with distressed and suicidal residents, whereas the RAs in the control group reported that they did not engage in any interventions with suicidal residents.

Interventions reported by RAs in the SP group included two students with high levels of distress who exhibited behavioral changes, but did not report suicidal ideation; four students who experienced current suicidal ideation, one of which led to a voluntary commitment to a hospital; two non-student friends who experienced suicidal ideation; and one student who was involuntarily treated for substance abuse. RAs in the SP group attributed their ability to identify and intervene with distressed students to the pre-semester training. For instance, one RA in the SP group stated, "The training gave me a lot of confidence, like the best way to go about that [intervening with residents in mental health distress], and talking with the resident and supporting them through that."

Not only did RAs from the STM group fail to report any interventions related to suicid-

al students from the previous semester, but they also indicated that they felt ill-prepared to intervene with distressed or suicidal residents in the future. It is unclear whether residents in these halls did not exhibit any signs of distress or if the RAs in this group did not know the warning signs to look for. Considering the high rates of suicidal experiences among college students nationally, the matched pair randomization to assign RAs to treatment or control group, and the large number of students assigned to each RA, estimated at 38 residents per RA, it is hypothesized that the RAs in the STM group were less adept at noticing warning signs in their residents. In regards to identifying a resident in distress, one RA in the STM group stated, "It does kind of worry me that I might not know?" In regards to training, another explained, "I think that there's no real way, unfortunately, to fully prepare us for… confronting a resident who is thinking about suicide… just because there's so many things that go into something like that."

Theme 2: Impact of Training on RA Knowledge, Skills and Confidence

Within the area of training impact, striking differences emerged between the SP group and the STM group. While both trainings sought to provide an engaging, dynamic experience, the SP training appeared to stand out in the RA's minds as RAs in the SP group successfully recalled several details from the training they received (e.g., multimedia observed, topics covered in training, specific strategies for talking with residents) as compared to those from the STM group. For example, while those in the SP group recalled several specific details of training, many participants in the STM group made statements to reflect their uncertainty, such as: "I remember bits and pieces," "I don't remember the specifics," and "I'm not sure if I feel like it was helpful."

Further analysis of the qualitative data yielded several components of the SP training that RAs felt directly impacted their ability to reach out to residents successfully, including *increased knowledge of warning signs and skills* as well as a perception of *gained confidence and intentionality in their interventions*.

Increased knowledge and skills. Participants in the SP group reported an increase in knowledge of warning signs of suicide as well as skills and techniques necessary to intervene with a distressed resident. All RAs in the SP group endorsed gaining factual knowledge from the suicide prevention training. RAs in this group accurately listed several warning signs and strategies they remembered learning during the training. One RA in the SP group illustrated this concept by stating:

> I remember the strategies for talking with students that might be depressed or seem like they might be contemplating suicide specifically. How to mention, and actually use, [the word] 'suicide' and be very specific. I remember that especially. It was something I hadn't heard before and that was really good.

Another RA also indicated that the training taught her the importance of being specific and direct with the types of questions asked when assessing a resident for suicidal thoughts. A participant reported that she found learning to regulate her own emotions a valuable part of training, "The training [taught] us how to stay calm, and give a calming environment, but still being able to express the correct amount of concern and worry without putting too much stress on them [the resident]."

Lastly, participants in the SP group endorsed gaining knowledge of the crisis management process; namely, what to do when they identify a student in distress and deem intervention necessary. RAs in the SP group indicated that they learned when and how to approach the student, how to report suicidal ideation, and to whom to report incidents (e.g., Head of Staff, Police Department).

Gained confidence and intentionality. Participants in the SP group also expressed an increase in confidence and intentionality in intervening with distressed

residents. RAs reported working with more purpose and focus with distressed residents, understanding not only what to say, but also why they were saying it. One participant explained, "[Training] really gave me a lot of confidence in talking with him [the resident] and just very intentionally saying, 'Hey, you know, I heard you were thinking about committing suicide,' and talking with him about that." Another RA in the SP group stated, "I felt more confident being able to go out there, …like I can deal with this if it's in my own life, in a friend's life, a resident's life."

Theme 3: Barriers that Hindered the Resident/RA Connection

Participants in both the SP group as well as the STM group endorsed several barriers to establishing a connection with their residents. Qualitative analysis indicated that the most significant barriers included t*he role balance of the RA, challenges created by resident characteristics*, and *the impact of the RA-resident relationship*.

The role balance of the RA. Participants in the SP group explained that RAs serve various roles including helper, authority figure, surrogate parent, and friend. The participants expressed difficulty with balancing these roles when initiating a conversation with a resident. RAs indicated that some residents might be reluctant to discuss personal issues with their RA due to fear that they will be reprimanded as a result of their disclosure. RAs expressed that while they do not want to be seen as an authoritative figure, they also do not want residents to over-rely on them and see them as counselors, due to the fact that they lack sufficient training in the field. RAs in the SP group further noted that they would like additional training in the management of confidentiality, reporting resident issues to supervisors, and the applicability of medical amnesty to mental health concerns. RAs suggested that these issues impact conversations regarding suicidal ideation with residents and they want to ensure residents are fully informed when disclosing mental-health-related symptoms and similar concerns to their RA.

Challenges created by resident characteristics. RAs in both focus groups indicated that some residents, colloquially referred to as "ghost residents," seem unreachable because they actively create a distance between themselves and their RA, making assessment and intervention difficult. One RA in the SP group explained, "Then there's the residents that don't want anything to do with you, and that's always a challenge too because you don't even know if they're struggling with anything because they don't want to talk to you." One of the RAs in the control group made a similar observation, "I've come across a lot of residents that, they just don't want to talk and there's just a wall, and you can't really break through it, and that's really hard sometimes because you want to be there for them, but they don't want you there."

The impact of the RA-resident relationship. RAs in both groups noted that the interpersonal relationship they have with their residents could also be a potential barrier. RAs reported wishing they could identify warning signs and intervene earlier, but the lack of closeness in particular RA-resident relationships hinders the RA's ability to connect with a resident, assess their needs, and intervene. One RA illustrated this idea by stating:

> [If you have a relationship] you can start noticing patterns because you are more familiar with them, and you're seeing them, like, on a regular basis, and you have actually talked to them, so you get to know their personality, and so you're able to notice when things change, and so you're able to catch it.

Additionally, several RAs described the importance of getting to know each resident on a personal level. One RA in the STM group explained, "I just kind of get to learn their personalities and know their comfort zone for each person." However, some RAs acknowledged that it is not realistic to have a personal relationship with each resident. One RA provided insight on how to navigate

these relationships:

> I think it's important to recognize that if you don't have a fantastic relationship with this person, just making sure that they have a connection with somebody… That's a lot of how I perceive my job, is to just make sure that people have those relationships, but not forcing that relationship to be my thing.

Theme 4: Impact on Gatekeeper Mental Health

Participants in the SP group reported that the training had a positive impact on their own mental health. Several of the RAs described the training itself as a bonding experience. One RA explained, "Everyone came close together over the fact that this has affected everybody." Another RA expressed feeling grateful for their own mental health stability as the training provided them with insight into how other students were functioning. RAs in the SP group also felt that the training gave them confidence in their abilities, helping to decrease anticipatory stress related to intervening with distressed residents. RAs further discussed the need for self-care when intervening with residents in distress, and those in the SP group appreciated the encouragement to practice self-care they received during the training.

Theme 5: Feedback for Future Training

Participants in the SP group provided feedback regarding elements of the SP training to improve as well as aspects they felt were missing, while RAs in the STM group were unaware of the SP training content and could only comment on what they would have liked from training. One RA in the STM group described a concept for training that he felt would be helpful, a concept which captures the essence of the SP training, "I think it would be better to have the workshop or the seminar teaching us how to talk to residents about stress."

Feedback from RAs in the SP group touched on both the process and content of training. In regards to the process of the training, RAs suggested that training incorporate more *experiential learning* exercises, a concept also mentioned by the STM group. Participants in the SP group also referenced the content of the SP training, and they advocated for more *intimate exposure to resources, pre- and post-intervention guidance and support*, and information about how to *tailor approaches to meet the needs of individual students and RAs*.

Experiential learning. The SP training included a role-play exercise designed to illustrate the process of intervention delivered through reading pre-developed scripts. Most RAs in the SP group found the scripted role-play exercise not helpful because it lacked "real life application." One RA stated that role-plays are meant "to make us more comfortable to be able to have those difficult conversations," a goal that the RAs felt the training did not achieve through the scripted role-play exercise. Instead, the RAs proposed incorporating more fluid role-plays into future trainings. One suggestion included an RA working through a scenario related to a distressed resident on the spot. The RAs noted that they felt they could learn more by collaboratively solving problems related to intervening with residents.

Intimate exposure to resources. One element of the SP training included exposing RAs to various resources on campus to which they can refer residents. Focus group participants indicated that, while they found it helpful to learn about the resources, they believe more intimate exposure to these resources, such as meeting staff members or visiting facilities would be more beneficial. RAs also suggested that future trainings include a more comprehensive review of all applicable campus resources as well as off-campus resources. One participant, who serves as an RA for a graduate residence hall, noted that information regarding community resources would be beneficial for graduate students, since campus resources may not be available to them in the near future. Participants also suggested

incorporating exposure to mental health related clubs on campus, including the campus branch of the National Alliance of Mental Illness (NAMI).

Tailoring approaches to meet needs of student and RA. In order to address the barriers that can occur due to RA-resident relationships and individual resident characteristics, participants indicated they would like to learn how to adapt their techniques to meet the varying individual needs of residents. RAs expressed having unique relationships with each resident that requires adaptability on the part of the RA. One participant explained, "You kind of have to adapt yourself to what is needed for the particular person and situation." RAs suggested that it would be helpful to learn intervention strategies to use with various personality types; in particular, several RAs expressed a desire to learn how to approach and start a conversation with "emotionally distant" residents. Similarly, one participant brought attention to the fact that RAs have a variety of personality types and conversation styles as well. This participant specifically mentioned that initiating a conversation might be more difficult for introverted RAs than for extroverted RAs and suggested trainers acknowledge these differences and adapt training to such personality styles.

Pre- and post-intervention guidance and support. All RAs in the SP focus group agreed that the SP training provided knowledge and guidance regarding the intervention itself, yet failed to address both pre- and post-intervention processes. Regarding pre-intervention, the RAs would have appreciated more information and practice about how to initiate conversations with distressed residents. Although they reported learning how to facilitate the conversation, they indicated that they found approaching the resident and beginning the conversation "the hardest part." RAs agreed that learning basic counseling skills and role-playing this particular part of the process might provide the most effective learning experience.

The RAs in the SP group also expressed concerns about the post-intervention process, regarding both the resident and RA. The RAs who intervened with residents during the semester wanted to follow-up with these students post-crisis, but felt unsure how to do so or whether it was appropriate. A few RAs also believed they experienced vicarious traumatization to some extent as a result of their intervention with suicidal residents, and they wished that their supervisor or a counselor from the UCC had provided a personal and nurturing follow-up regarding their experience. One RA who reported a resident's suicidal ideation within the first week of the semester disclosed that she began crying while making the report to the head of staff. She highlighted the importance of staff support by stating:

> The support from your staff is really important at that point because that was how I got through it, and I know it's selfish to talk about yourself in that kind of situation, but I think that's something that might be a little bit missing from training… like what do you personally do after you've dealt with that and you're a little bit thrown and upset from the situation?

Discussion

Focus group sessions provided an opportunity to hear from RAs regarding how they applied their recently acquired knowledge and skills, and elicited insight into which specific aspects of SP training RAs perceived as most effective. Qualitative responses highlighted specific areas of training that RAs felt could be improved upon, including the content and the process of gatekeeper trainings.

In regards to the applicability of SP training, a notable discrepancy occurred between the number of interventions conducted in each group, where RAs who received SP training reported identifying more students in distress and initiating more interventions with them as compared to those trained in STM. It is hypothesized that this discrepancy observed between the groups

stems from the SP training focus on identifying signs of student distress and acting accordingly. Not having been trained to identify warning signs, especially the more subtle signs, one could assume those in the control group were unaware of student distress, or perhaps lacked awareness of the significance of these signs. For some RAs in the SP group, the generalization of skills to intervene with individuals in their personal lives provided an unplanned effect of training, yet it illustrates a level of knowledge and confidence such that the RAs felt comfortable extending their skills in other settings. This also illustrates important considerations for developing gatekeeper training in that RAs are exposed to suicidal experiences in their personal lives, and can serve as gatekeepers more broadly on campus and in their communities. The findings highlight the importance of increasing RA knowledge of the prevalence of suicidal distress among residents, building their skill and confidence in initiating conversations with suicidal students, and helping them become more personally familiar with campus supportive resources.

Based on the feedback gathered from the focus group sessions, it appears that several elements of the SP training could be improved upon to better meet the needs of the RAs. Regarding content of training, RAs in the SP group felt knowledgeable and well prepared to identify and intervene with students in distress. Focus group sessions were conducted approximately five months post-training, at which time participants in the SP group recalled specific warning signs, skills, and strategies instilled at time of training. Although the RAs easily recalled these details, indicating the positive and lasting impact of the SP training, they also expressed a need to develop more advanced communication and intervention skills.

Helping RAs to clarify and assert their roles with residents may also aid the intervention process. RAs in both groups spoke to the multiple roles they serve, and how this can impact the relationship they have with their residents. Role management and relationship dynamics appear salient and important to RAs. One RA in the SP group explained, "I feel like a mother with 40 children…It's being the voice of discipline, and the shoulder to cry on, but the compassionate side too. …It's a very different situation with each resident; you're a different mother to each one." Helping RAs communicate clearly with residents the limits of confidentiality, the process of reporting once a resident discloses suicidal ideation to their RA, and providing sources of consultation for RAs to think through difficult situations may help RAs navigate their multiple roles with residents more effectively.

RAs in both groups spoke to the importance of adaptability; adapting to meet the needs of the particular resident in question, and their own needs, all within the context of their previously established relationship. RAs specifically asked for exposure to a greater number of interventions, so that they have a larger knowledge base from which to select strategies appropriate to the given situation. In particular, RAs appeared most concerned about approaching "emotionally distant" or what they termed "ghost residents," (i.e., uninvolved or withdrawn residents) who tend to distance themselves from their RA, either intentionally or unintentionally.

In regards to the training process, RAs in both groups spoke to the importance of experiential learning. As opposed to participating in a scripted role-play, RAs reported that they would rather work through a "real-life" situation on their own merit, potentially with residents portraying different types of traits (e.g., unengaged, multicultural considerations). In reference to the RAs ideal type of training, both groups spoke highly of Behind Closed Doors (BCD), which is a common RA training employed at institutions across the country. In this training, new RAs role-play a scene that requires them to negotiate a difficult situation with a resident without prior indication of what the situation may be. An RA in the STM group

commented on the real-life applicability of BCD training, "It was great seeing firsthand, being able to use situations of how it [would] play out, and like experience things." RAs endorsement of this type of training illustrates a desire to learn not only what to do during intervention, but also to practice intervention skills in an unpredictable, yet safe, setting.

Not only would such role-play exercises require RAs to use the knowledge and skills they are learning, but observing RAs as they attempt to intervene could allow the trainer to assess the RA's skills and barriers. This process may allow for immediate problem solving and feedback, ultimately improving the RAs' ability to connect with residents. This would also support the recommendations of Swanbrow Becker and Drum (2015) by understanding RAs' preexisting perceptions, skills, and knowledge and seeking to correct those aspects that inhibit intervention while enhancing those that promote intervention, rather than primarily providing extensive knowledge enhancing information.

Another important process critique consisted of post-intervention support to RAs. The experience described by one of the RAs illustrates the impact that working with a distressed resident can have:

> The head staff was really helpful, like he answered the phone, and I was like, "I have to report," and then I started crying, and so then I was like, "Hold on a second," and I had to calm down, and he was very helpful, like "We hope you're okay, and we'll send someone to talk to you."

It is imperative to remember that RAs are not mental health professionals. Although RAs often receive training in some basic counseling skills, they must understand their limitations in such situations and learn to care for themselves to prevent burnout or further distress. Although trainings can speak to the importance of self-care, provide resources, and even teach self-care strategies, RAs may need more support. The university or institution that encourages students to serve as mental health gatekeepers may consider finding a way to provide emotional support for gatekeepers themselves.

University staff should also consider logistics when planning and delivering RA gatekeeper trainings. RAs provided feedback that the pre-semester training for RAs comprises several various training sessions, and that some found the quantity of instruction overwhelming. For example, SP trainings often account for only one hour, amidst a 40 hour or more training week. The nature of conducting multiple and unrelated or loosely connected trainings within a condensed time frame may affect the RAs' ability to attend to, and retain, the information and skill development related to any particular topic. It appears that a separate SP training at a different point in time, or even multiple trainings throughout the semester, may strengthen the salience of the training. Feedback from the focus group sessions also confirmed the importance of small training groups as RAs in the SP group appreciated the intimate nature of their instruction, and those in the larger STM group noted that they found the large group size ineffective. Further, some RAs come to training with a considerable amount of prior experience related to others' suicidal experiences, suggesting that an understanding of the RAs' preexisting perceptions, skills, and knowledge may lead to more effective training (Swanbrow Becker & Drum, 2015).

A better understanding of how to help RAs connect with distressed residents, and overcome barriers to help-seeking, is imperative given both the high competition for RAs' attention during training, and the complexity and intensity of the SP training content. As such, additional research pertaining to the efficacy of each component within gatekeeper training programs is imperative. A greater understanding of the gatekeeper experience, including which components of training are considered most relevant, will enable researchers and practitioners to bet-

ter prevent suicide in the general population.

One potential limitation lies in the generalizability to other gatekeeper training programs. The training model utilized in this study emphasizes many of the same elements as QPR training programs, yet SP training effectiveness likely increases when tailored to meet the needs of the particular university. The number of focus group participants was relatively small, representing 9% of RAs trained, suggesting that these results may not reflect the full range of opinions held by the population of RAs. Future research could expand on these findings through soliciting feedback from a larger sample of RAs.

Additionally, the experiences of the 15 RAs participating in the focus groups sessions may not reflect those of RAs as a whole. The RAs who participated in focus group sessions did so voluntarily, which may reflect differences from their peers in interest, intrapersonal qualities, or achievement-driven behavior. Despite these potential limitations, it is believed that the data gathered from the focus groups is still instrumental in understanding RA needs and provides important implications for planning future trainings. This study provides important implications to enhance training across Student Affairs domains. The results support a call for more interactive learning experiences. RAs would also likely benefit from instruction paced to allow for more effective internalization and retention of information and skills. Booster sessions that both support initial training and address barriers to helping experienced during the semester would likely help RAs grow from their experiences. Perhaps most importantly, asking members of the Student Affairs community what they need to better perform their jobs through focus group feedback and then adjusting instruction to meet their needs would lead to improved mental health training and more effective suicide prevention gatekeepers on campus.

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