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I CARE: Development and Evaluation of a Campus Gatekeeper Training Program for Mental Health Promotion and Suicide Prevention

Marian Reiff, Meeta Kumar, Batsirai Bvunzawabaya, Soumya Madabhushi, Alaina Spiegel, Benjamin Bolnick, and Eran Magen

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ABSTRACT

Addressing the need for suicide prevention on campus, I CARE training, developed and facilitated by counseling center clinicians, trains students, staff, and faculty to provide support to students experiencing distress or mental health problems. We assessed its impact using a mixed-methods approach. Quantitative analyses demonstrated significant increases in knowledge of intervention skills and readiness to intervene from pretraining to posttraining. Knowledge and readiness remained significantly higher than preworkshop for the entire follow-up evaluation period, extending 15 months posttraining. Qualitative analyses revealed the value of experiential activities and emotional processing in increasing participants’ comfort and preparedness to intervene in challenging situations.

KEYWORDS

College students; emotional processing; experiential learning; gatekeeper training; mental health promotion; mixed methods; program evaluation; suicide prevention

Background

Literature review

A substantial body of research attests to the need for mental health promotion and suicide prevention on college campuses. A nationwide study found that 58% of students reported experiencing overwhelming anxiety, 36% felt so depressed it was difficult to function, 9.8% had seriously considered suicide, and 1.5% attempted suicide in the past year. However, according to the same report, only 18.1% of students had received mental health services from their college counseling or health service (American College Health Association, 2016). Other studies also report that most students with mental health problems have not received treatment (Eisenberg, Hunt, Speer, & Zivin, 2011; Hunt & Eisenberg, 2010), and among college students who had seriously considered attempting suicide in the preceding year, over half...
had not received professional help (Drum, Brownson, Denmark, & Smith, 2009; Drum & Denmark, 2012). Further, only 14% of students who died by suicide during the preceding year had sought help at their school’s counseling center (Gallagher, 2015). Most mental disorders have first onset by the mid-20s (Kessler et al., 2007). For some students, obtaining treatment during the college years is vital, since treatment can improve mental health outcomes and reduce suicidal behavior (Drum et al., 2009). Gatekeeper training programs have been developed to train community members to recognize and intervene when others in the community are in distress and to identify people at risk of suicide and refer them to appropriate resources. Generally, gatekeeper trainings address knowledge, beliefs, and attitudes about mental health, suicide, and health care, and teach listening and response skills (e.g., Burnette, Ramchand, & Ayer, 2015; Harrod, Goss, Stallones, & DiGuiseppi, 2014; Lipson, Speer, Brunwasser, Hahn, & Eisenberg, 2014; Quinnett, 2007).

The I CARE training (described as follows) has been designed and facilitated by clinicians trained to explicitly acknowledge, understand, and process difficult emotions, such as anxiety, grief, and fear, which can impede engagement with someone in crisis or distress. I CARE, like several models of gatekeeper training, utilizes experiential learning and role-plays (e.g., Albright et al., 2014; Cimini et al., 2014; Cross et al., 2011; Osteen, 2016; Pasco, Wallack, Sartin, & Dayton, 2012; Tompkins & Witt, 2009). Role-plays increase emotional arousal, which may help to manage the emotions that arise when interacting with a distressed or suicidal person (Cross et al., 2011). However, even after participating in supervised role-plays, participants can still experience difficulty asking questions about suicide directly (Quinnett, 2007). In addition to behavioral rehearsal, it is important for gatekeepers to “explore and understand their own feelings about suicide” (Grosz, 1990; p. 183) in order to “assimilate the skills and knowledge needed to intervene successfully with the suicidal student” (Grosz, 1990; p. 185). Importantly, I CARE integrates these elements of emotional processing; its goals include talking openly and directly about mental health and suicide, and reducing participants’ anxieties and fears around engaging with others in situations of distress or crisis.

**I CARE training**

In 2013 and 2014, a series of student deaths by suicide at the University of Pennsylvania (UPenn) left the university community feeling shaken, and triggered university-wide grief, questioning, and drive to address mental health problems on campus. Following the suggestion of the Counseling and Psychological Services (CAPS) Student Advisory Board and the university’s Task Force on Mental Health, the “I CARE” training was developed by clinicians at UPenn CAPS. I CARE serves to equip participants with skills to
engage and intervene appropriately with students experiencing stress, distress, and/or crisis. The training includes the following components:

- college mental health trends and concerns;
- psychoeducation about mental wellness and suicide prevention;
- campus resources including CAPS services;
- identifying and distinguishing between stress, distress, and crisis situations;
- supportive listening techniques and communication skills;
- crisis intervention skills;
- awareness of cultural factors influencing mental health; and
- awareness of attitudes about help seeking and stigma.

Two sessions of role-plays, facilitated by CAPS clinicians, provide opportunities for participants to practice their new skills, receive feedback from workshop facilitators, and explore any challenges. The training is offered in two formats: (a) a full-day format, comprising a 7-hr in-person workshop; and (b) a hybrid format, comprising a 30-min online module followed by a 3-hr in-person workshop. Training occurs in a supportive environment for participants to practice skills, raise questions, explore personal experiences, process the complex emotions that may arise in connection with the sensitive nature of the material covered, and connect meaningfully with peers and counselors.

At the heart of the training is caring for others, and the mnemonic acronym refers to specific skills to enhance communication with people in distress (inquire, connect, acknowledge, respond, and explore). The central part of the training focuses on the I CARE skills, presented by CAPS clinicians using a variety of didactic and interactive techniques, including presentations, audio clips demonstrating active listening, and short role-plays where clinicians model effective intervention skills. The training utilizes several strategies to enhance engagement and learning, for example, providing metaphors such as not “stealing the spotlight” when someone is talking. Another important component involves teaching the technique of reflecting back, or paraphrasing, what a person has said, making use of the mnemonic acronym “WIG” (What I Got) to help participants understand, remember, and utilize this skill (Magen, 2012). Additionally, the training provides ways to identify and differentiate between situations of stress (a fairly common, nonrisky occurrence), distress (a more severe experience, where mental health support is recommended), and crisis (severe or persistent distress, including suicidality, that requires an immediate response). Simple, layperson language is used throughout to explain mental health states and interventions for suicide prevention.
Experiential activities provide opportunities to address emotional barriers, such as fear and anxiety, which may interfere with effective intervention. During the training, participants interact with each other in dyads (practicing asking each other directly about suicidality), in group discussions (designed to raise awareness about stigma, help-seeking, and cultural influences on mental health), as well as in small group role-plays where they practice crisis intervention and communication skills, and explore the emotions that may arise when having these conversations.

The theoretical approach underlying the I CARE training is aligned with the social-ecological model, and views suicide as a complex problem influenced by multiple intersecting factors including individual, interpersonal, community, and societal influences (U.S. Department of Health and Human Services & National Action Alliance for Suicide Prevention, 2012). The I CARE training is also consistent with the recommendations of The National Strategy for Suicide Prevention (2012). Central to the I CARE training is the notion that building skills to engage and support a distressed student involves cultivating “emotional preparedness,” which refers to a person’s understanding of and willingness to explore emotions (Ivcevic, Brackett, & Mayer, 2007). Participants’ exposure to hypothetical anxiety-inducing situations, facilitated in a safe and supportive setting, allows them to become more comfortable utilizing the skills when engaging with students in distress or crisis in real-life situations. Additionally, the emotional content may help participants engage with the material in a way that makes it more likely for the effects to endure over time. While most studies of gatekeeper trainings have not assessed outcomes of training beyond 6 months (Burnette et al., 2015), the present study assesses the impact of training up to 15 months posttraining.

Methods

Overview

This article describes data from I CARE workshops conducted at the University of Pennsylvania between July 2014 and December 2016. During this time, approximately 1,800 people attended I CARE workshops; 47 training workshops were conducted, 20 for students and 27 for staff/faculty, including 16 full-day and 31 hybrid (online plus 3-hr in-person) trainings.

Evaluation has been integral to the I CARE program since its inception, using a mixed-method approach including quantitative and qualitative methodologies. The goal of this approach was to consistently assess effectiveness and obtain feedback in order to improve specific aspects of the training. Several components of the evaluation are included in this article: (a) pre-workshop and postworkshop assessment, (b) follow-up surveys, and (c) a
staff discussion group (Table 1). The University of Pennsylvania Institutional Review Board approved the evaluation of the I CARE program as a quality improvement project.

**Participants**

**Pre/post workshop assessment**

The sample included 1,054 participants in I CARE workshops who completed pretraining and posttraining surveys between July 2014 and December 2016. There were 595 students and 459 staff/faculty. Of these, 345 participants completed the full-day format and 709 completed the hybrid (online plus 3-hr in-person) format.

**Follow-up survey**

Follow-up surveys were conducted in March 2016 and March 2017 with participants who completed training during each previous calendar year (i.e., between January and December of 2015 and 2016, respectively). Data from the two follow-up surveys were combined for analyses presented in this article. Between January 2015 and December 2016, 882 participants completed preworkshop/postworkshop surveys and provided valid e-mail addresses. The combined follow-up sample included 452 participants, a response rate of 51% (Figure 1).

Responders to the 2016 follow-up survey did not differ significantly from nonresponders regarding their preworkshop and postworkshop scores for knowledge and readiness to intervene. In the 2017 follow-up survey, responders did not differ from nonresponders regarding their postworkshop scores for knowledge and preworkshop scores for readiness, but responders had slightly higher pretraining scores for knowledge \((M = 2.44 \text{ vs. } 2.22, p < .01)\) and posttraining scores for readiness \((M = 6.22 \text{ vs. } 6.02, p < .01)\) compared with nonresponders. In 2016 and 2017, both responders and nonresponders to the follow-up survey, demonstrated significant change from pretraining to posttraining for knowledge of skills and readiness to intervene.

### Table 1. Program evaluation approach.

<table>
<thead>
<tr>
<th></th>
<th>A. Preassessment/Postassessment</th>
<th>B. Follow-up survey</th>
<th>C. Facilitator discussion group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of data</strong></td>
<td>Mixed (quantitative &amp; qualitative)</td>
<td>Mixed (quantitative &amp; qualitative)</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Completed preassessments/postassessments Jan.–Dec. 2015)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. March 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Completed preassessments/postassessments Jan.–Dec. 2016)</td>
<td></td>
</tr>
</tbody>
</table>
The follow-up sample included 182 (40%) students and 270 (60%) staff/faculty. Thirty-five percent of respondents (12% of students and 51% of staff/faculty) had completed the full-day format; 65% of respondents (88% of students and 49% of staff/faculty) completed the hybrid format (Table 3). In the 2016 follow-up sample, 50% (n = 139) of respondents had completed the full-day format, and 50% (n = 137) had completed the hybrid format (online plus 3-hr in-person). In the 2017 follow-up sample, 35% (n = 160) completed the full-day and 65% (n = 292) completed the hybrid format (Table 2).

**Facilitator discussion group**

In November 2016, seven CAPS clinicians with extensive experience facilitating I CARE trainings participated in a group discussion about their experiences with the trainings.
Measures

Preworkshop/postworkshop assessment

Knowledge of support and crisis intervention skills. was assessed using three dichotomous true/false questions. The knowledge score is the sum of correct responses, providing a total knowledge score of 0 to 3 (see Table 3). The items were unrelated questions selected to reflect different aspects of the training, and not intended to measure a single construct. Therefore, reliability was not calculated.

Readiness to intervene. was measured by asking participants to rate their agreement with six statements using a Likert scale ranging from 1 (Disagree Strongly) to 7 (Agree Strongly), with higher scores indicating a higher level of readiness to intervene (see Table 5). The measure showed good internal reliability, $0.72 \leq \alpha \leq 0.76$ across all time points.

Satisfaction with workshop. was assessed by a single item asking: “Would you recommend this workshop to others in a similar position to you?” (yes/no). Open-ended responses allowed for further evaluation and comment on the training.

Follow-up survey

In addition to the measures described previously for Knowledge and Readiness, the follow-up survey also inquired about implementation of skills since completion of the training, and elicited qualitative data.

Table 2. Follow-up survey sample characteristics showing training format by university affiliation (students and staff/faculty).

<table>
<thead>
<tr>
<th>Training format</th>
<th>Student (n = 182)</th>
<th>Staff/faculty (n = 270)</th>
<th>Total (n = 452)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full day in-person</td>
<td>22 (12%)</td>
<td>138 (51%)</td>
<td>160 (35%)</td>
</tr>
<tr>
<td>Hybrid (online + 3-hr in-person)</td>
<td>160 (88%)</td>
<td>132 (49%)</td>
<td>292 (65%)</td>
</tr>
<tr>
<td>Total</td>
<td>182 (40%)</td>
<td>270 (60%)</td>
<td>452 (100%)</td>
</tr>
</tbody>
</table>

Table 3. Knowledge of support and crisis intervention skills.

<table>
<thead>
<tr>
<th>Statement (true/false)</th>
<th>Preworkshop % correct (N)</th>
<th>Postworkshop % correct (N)</th>
<th>Significance (McNemar)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a student is upset, it is best to quickly suggest</td>
<td>78.3 (781)</td>
<td>92.8 (925)</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>solutions in order to help the student calm down. (FALSE)</td>
<td>[N = 997]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a student’s behavior seems odd or unusual, it is</td>
<td>91.8 (915)</td>
<td>95.0 (947)</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>important that I talk about it with someone I trust. (TRUE)</td>
<td>[N = 997]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I suspect that a student might be suicidal, I should</td>
<td>59.5 (592)</td>
<td>98.0 (975)</td>
<td>$p &lt; .001$</td>
</tr>
<tr>
<td>ask the student: “Are you thinking about killing yourself?”</td>
<td>[N = 995]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Implementation of skills. Respondents were asked whether they interacted with any students, colleagues, or people in their private life who were in distress or crisis (yes or no). For each of these types of interactions with a “yes” response, they were asked the extent to which they used the I CARE skills, using a 5-point Likert scale from 1 (not at all) to 5 (very much).

Regarding referrals and support provided, the questions differed slightly in the 2016 and 2017 follow-up surveys. In the 2016 survey, respondents were asked how many students in distress or crisis they provided support to, or if they had referred students in distress or crisis to campus resources, during the past month. In the 2017 survey, they were asked how many students they referred to CAPS and other specific campus resources during the past full semester. Additionally, in the 2017 survey, respondents were asked how many times they had felt concerned that someone they knew might be considering suicide, and if yes, how many times they asked whether the person was considering suicide.

Qualitative data. Open-ended questions elicited qualitative information in response to the following questions: “If you interacted with others who were in distress or crisis, what happened? How did it go?”; “What are some barriers you encountered in applying I CARE skills with students who were stressed, distressed or in crisis?”; “What aspects of the I CARE training have you found most helpful?”; “What would you change about the workshop?”; and a section for additional comments.

Facilitator discussion group
Several open-ended questions were asked to initiate and promote discussion about facilitators’ perceptions regarding their role, especially with respect to the experiential activities. Examples of questions included: “What are your main goals in the training?”; “How would you describe the small group sessions?” and “What is notable about them?”; and “What is the role of the facilitator in the small group sessions?”.

Procedures
Preworkshop/postworkshop assessment
Brief online surveys were completed at the beginning and end of each workshop. Participants used their personal mobile devices (or a tablet provided to them if needed), to access the surveys via an anonymous link displayed on a screen. The surveys took approximately 5 min to complete.

Follow-up survey
A survey link was included in an e-mail sent to e-mail addresses provided by participants when they attended I CARE workshops. The follow-up survey
took approximately 10 min to complete. As an incentive, participants were offered an opportunity to participate in a raffle for a prize with an approximate value of $25.

**Facilitator discussion group**
A discussion group was conducted with I CARE training facilitators according to the principles of focus group data collection (Krueger & Casey, 2014). The discussion lasted 1 hr and was audio-recorded. The discussion was moderated by M. Reiff and notes were taken by B. Bolnick.

**Results**

**Preworkshop/postworkshop assessment**

**Knowledge of support and crisis intervention skills**
To test the effect of the workshop on participants’ knowledge of support and crisis intervention skills, we conducted a paired-sample t-test to evaluate mean difference in knowledge scores at preworkshop and postworkshop assessments. The mean scores of participants upon completion of the training were significantly higher ($M = 2.86, SD = 0.38$) as compared with before the workshop ($M = 2.30, SD = 0.73$), $t(996) = 25.30, p < .001$.

We conducted Chi-squared analyses with McNemar tests of significance to compare proportions of correct responses at preassessments and postassessments for each knowledge item. The proportion of correct responses increased significantly ($p \leq .001$) for each item (Table 3).

**Readiness to intervene**
To test the effect of the workshop on participants’ readiness to intervene in a situation of distress or crisis, we conducted a paired-sample t-test to evaluate mean difference in readiness scores at preworkshop and postworkshop assessments. The mean scores of participants upon completion of the training were significantly higher ($M = 6.11, SD = 0.61$) as compared with before the workshop ($M = 5.21, SD = 0.94$), $t(987) = 37.31, p < .001$. The mean scores for each item are presented in Table 4.

**Training format**
To evaluate the effect of training format (full day vs. hybrid) on knowledge and readiness, we conducted two-way analyses of variance. The main effect of time (from preworkshop to postworkshop) was significant for both knowledge ($\lambda = 0.60, F(995) = 662.42, p < .001$) and readiness ($\lambda = 4.66, F(986) = 1,275.96, p < .001$). In addition, the effect of training format interacted with the effects of time for both knowledge ($\lambda = 0.97, F(995) = 25.42, p = .025$) and readiness ($\lambda = 0.99, F(986) = 4.66, p = .03$).
We conducted paired sample t-tests to follow up the significant interactions. While the mean scores for knowledge and readiness increased more for the full day than the hybrid format from preworkshop to postworkshop, they were also lower at preworkshop for those in the full-day workshop. Despite this, scores for knowledge and readiness increased significantly in both the full-day and the hybrid format of training ($p < .001$; Table 5).

### Satisfaction

Participants’ evaluation of the training was generally very positive, with 97.9% of participants reporting that they would recommend the workshop to others in a similar position to themselves. These comprised 96.8% of students and 99.3% of staff/faculty; and 99.1% of the full day and 97.3% of the hybrid format participants.
**Follow-up survey**

**Application of skills**

**Utilizing skills.** The majority (64.4%, $n = 291$) of respondents reported that they had interacted with a student in distress since their training, and 28.5% ($n = 129$) had interacted with a student in crisis. These comprised 65.4% of students and 63.7% of staff/faculty. Out of 294 respondents who reported interacting with a student in distress or crisis, 92% ($n = 271$) reported using the I CARE skills during these interactions (based on a score of 3, 4, or 5 on a Likert scale, indicating using the skills “somewhat,” “a good deal,” or “very much”).

**Referrals and providing support.** Regarding referrals and providing support, the data collected differed slightly in the 2016 and 2017 follow-up surveys. In the 2016 survey, 39% of respondents reported that they referred at least one student in distress or crisis to campus resources, and 47% provided support to at least one student in emotional distress or crisis during the past month. In the 2017 survey, 64% respondents reported that they referred at least one student to CAPS, and 77% referred at least one student to campus resources during the past full semester. In the 2017 survey, 41.3% (69/167) reported that since the I CARE training they had been concerned that someone they knew might be considering suicide. Of these, 68% reported that they asked the person if they were considering suicide.

**Duration of workshop effects**

The follow-up surveys were conducted in March 2016 and 2017. Respondents had completed training workshops between the previous January and December, and time since training varied between 78–436 days (approximately 3–15 months).

**Knowledge of support and crisis intervention skills.** To test the effect of time since the workshop on knowledge of support and crisis intervention skills, we conducted a hierarchical linear regression, with knowledge as the outcome variable and number of days since the workshop and training format (full day vs. hybrid) as predictors, nested within participants. There was no interaction between number of days since the workshop and training format, and we, therefore, excluded training format from the final model. The effect of time since the workshop on knowledge was marginally statistically significant and negative, with each day associated with a decline in knowledge of 0.0003 points of readiness, $Z = -1.73$, $p = .08$ (Figure 2).

**Readiness to intervene.** To test the effect of time since the workshop on readiness to intervene, we conducted a hierarchical linear regression,
with readiness as the outcome variable and number of days since the workshop and training format as predictors, nested within participants. There was a significant interaction between number of days since the workshop and training format ($Z = 2.02$, $p = .04$), and we, therefore, reran the analysis separately for each training format. For participants who attended a full-day workshop, the effect of time since workshop on readiness to intervene was statistically significant and negative, albeit very small, with each day associated with a decline in readiness of 0.0006 points of readiness, $Z = -2.70$, $p < .01$. The effect was similar for participants who attended a hybrid workshop, with each day associated with a decline in readiness of 0.001 points of readiness, $Z = -5.94$, $p < .001$ (Figure 3).

Figure 2. Change in knowledge as a function of time since training. 
*Note.* “Pre-Workshop” is provided here only for the sake of comparison with subsequent levels of readiness to intervene, and was not included in the hierarchical linear model; remaining data points are based on the intercept and coefficient outputs of the hierarchical linear regression described in the text.

Figure 3. Change in readiness to intervene as a function of time since training. 
*Note:* “Pre-Workshop” is provided here only for the sake of comparison with subsequent levels of readiness to intervene, and was not included in the hierarchical linear model; remaining data points are based on the intercept and coefficient outputs of the hierarchical linear regression described in the text, collapsed across workshop format.
Qualitative data

Qualitative data from the follow-up survey and facilitator discussion group were analyzed with NVivo 11, a software program for qualitative coding and analysis (Bazeley, 2007). We employed thematic content analysis; initial coding remained close to participants’ own expressions, while later coding identified concepts and relationships among conceptual categories (Bernard, 2013; Miles & Huberman, 1994). Two research team members (M. Reiff and B. Bolnick) independently conducted coding for concepts, categorized codes into conceptual categories, and compared these across respondents to identify recurrent themes. The two coders discussed and resolved coding inconsistencies, refined the coding scheme in an iterative process, and generated summaries for each theme.

Qualitative themes from follow-up survey

The main themes regarding interactions with people in distress or crisis were categorized in terms of utilizing skills, making referrals, emotional comfort and perceived barriers.

Utilizing skills. The skills that respondents described utilizing most often were supportive listening and connecting and caring.

Supportive listening. Many respondents reported that they were able to fully focus the “spotlight” on the distressed individual by paying attention to their experience, asking open-ended questions, and reflecting back what they heard rather than giving advice or sharing their own stories. This refers to a component of the skills training that emphasizes not “stealing the spotlight” when having a conversation with someone who may be experiencing emotional distress. “We sat and talked, I tried to pay complete attention to the other person. I tried to acknowledge their pain and not talk about my own problems!!”

Some respondents noticed that sometimes “just listening” can help someone clear their head enough to calmly assess appropriate steps.

A friend was going through a rough time in her relationship … she was very frustrated and was crying in public. I reflected what she said back to me to clarify the situation and make sure we were on the same page, then asked open-ended questions to expand and close-ended questions to clarify. I didn’t try to push advice or suggestions on her and just inquired on the steps she’s taken, and helped her work out what are her options.

Several respondents reported using the “WIG” technique, taught in the I CARE training, a mnemonic to help trainees remember how to reflect back or paraphrase. The training emphasizes that paraphrasing what the other person has said encourages the listener to pay attention; ultimately helping the person in distress to feel validated and understood.
They were stressed out about their situation and I applied the “WIG” concept. I just listened to them and paraphrased what they told me and let them vent on without me interrupting or telling them about mine or another person’s personal experiences. I think the “WIG” was the most important concept that stuck out to me from the workshop.

Many respondents noticed how listening to someone in distress or crisis was often enough to help them calm down.

They just were in almost a panicked state and it took a lot to calm them down. Most importantly, I let them do all the talking and allowed myself to become sort of a guide to sort out their thoughts. We ended up reaching tranquility.

**Connecting and caring.** Many respondents reported that sitting with a distressed individual gave that person a sense that they were not alone, that someone was there to care for them. “I feel as though they felt comfortable talking to me about their problem and I was able to give them the appropriate resources on campus, including a reminder that I am always a resource for them as well.”

Respondents noted that the specific listening skills taught in I CARE enabled them to connect with someone in distress and alleviate their “emotional charge,” a concept that is explicitly taught during the training.

The workshop reminded me that it’s very helpful just to connect and acknowledge the person’s feelings and experience. I think I was able to help a couple people calm down just by hearing them out and reflecting their experience.

I was able to use some of the dialogue I learned in I CARE to more thoroughly discuss the person’s situation. I think I was able to effectively communicate that I cared, and together, we were able to more calmly assess what was going on in the person’s life.

Several respondents expressed how validating it can be to know that someone cares. “Everyone is just looking for someone to tell them that the thoughts and feelings they have are important.”

**Making referrals.** Respondents reported that, due to the training, they were better equipped to evaluate when a person’s distress or situation was beyond their capability to manage. In these situations, several respondents expressed that they were able to refer to resources that could provide appropriate care. They were also able to provide the perspective that seeking help was not a sign of weakness or failure.

[A student] was feeling overwhelmed, anxious, depressed, lost. I was able to have her talk through it, using the skills taught at the I CARE seminar. We were able to find solutions for some of the issues and I suggested she meet with her professors and academic coordinator to resolve the other issues. I also suggested she seek out help (counseling) if those feelings came back. She felt much better when I
reassured her that seeking out help is not a sign of weakness nor should she be embarrassed.

Respondents also expressed that they were able to provide comfort and support by offering to accompany a distressed person to a campus resource.

They came to me stressed and crying and wanting to give up on school, I sat them down, got them to take deep breaths, and then asked for information without prying and allowing them to answer questions as I dug deeper into the cause of the problem and why this event made them break. Once that was assessed, I suggested they talk to CAPS or at the least our house dean and offered to walk them to wherever they needed. Checked up on these residents every day until they were not in crisis.

Respondents acknowledged that knowing how to refer to the appropriate resource can be immensely helpful when helping another in a crisis. “My good friend and fellow student had a complete break down and wanted to kill herself. I was able to go through the steps I learned in I CARE to help her find someone to talk to.”

**Emotional comfort.** Many respondents reported feeling more assured, confident, and ready to utilize the skills they learned to help someone in distress or crisis. “It [the interaction] went well. I just felt more comfortable in knowing how to approach the situation, knowing what to say and ask helped a lot. The response was positive.”

Respondents acknowledged the difficulty of asking if someone is suicidal, and noted that practicing asking these questions can help them feel comfortable enough to ask the questions when the situation calls for it.

[The training helped with] becoming comfortable with the possibility of asking a student if they are thinking of killing themselves. I have not had to do that yet, but I try to practice and prepare myself if I ever find myself in the situation.

Respondents noted some discomfort when practicing the skills, and that processing uncomfortable emotions in the small groups helped to increase their comfort and confidence in applying the skills in the future.

While I often feel uncomfortable participating in role-plays, I think they were very helpful in getting to a deeper understanding of how to address students, and it started to make me more comfortable with dealing with a potential issue in the future. Having the role-plays happen in smaller groups was also useful.

**Perceived barriers.** The overwhelming majority of participants found no significant barriers to using the skills they learned in I CARE. Of those who did report challenges, several expressed that the conversation felt awkward or unnatural. “Getting over the awkwardness of rephrasing what
someone has just said and finding more organic ways to seek clarification in conversation.”

Some respondents ran into logistical issues, such as students not having enough time for an in-depth conversation, or lack of private space for the conversation to happen. “I don’t have a physical private space to talk to them—I have to hope a conference room is available due to our open office layout.”

Several faculty members expressed tension between the faculty and helper roles, for example, when course requirements arouse anxiety for a student. “Students experience stress because of my course, so I have to navigate through feelings that I am causing the student distress.”

Other barriers mentioned included resistance to seeking help, concerns about confidentiality, and encountering cultural differences, for example:

Some people really do not seem to want help … You can’t force people to get help, not that you want to force people to do anything but it is frustrating and sad to see someone in pain and realize that nothing can be done until they are ready to face their pain and issues.

Students are not always willing to open up, and if they do they are very resistant to making time for resources.

Qualitative themes from facilitator discussion group
The facilitator group discussion focused on the importance of the small group interactions among clinicians and participants, including role-plays and discussion. The main themes that emerged were processing emotions, facilitating connection, and the value of experiential learning.

Processing emotions. Facilitators reported that asking directly about suicide tends to raise anxiety levels, and participants may become somber, acutely attentive, and tense. Many participants report personally being affected by suicide, and having suffered losses. Participants also raise common myths about suicide and their questions are addressed. “A pivotal point in the training is when they ask the questions about suicide. You can feel it palpably … all the different emotions and myths that people have around it sort of come up.”

The role-plays in small groups provide a supportive setting for emotions, such as fear and anxiety, to emerge and to be addressed.

I think they gain comfort and confidence in their ability to communicate in a more effective way, to be able to sit and tolerate stress in someone else and discomfort in themselves. I think the role-plays are part of what really gives them that comfort and confidence.
The facilitators expressed a need for trained clinicians to address “in-the-moment” reactions from the participants, especially when an individual’s emotions may affect other group participants:

Our training has so much focus on this emotional capacity to contain anxiety and distress, and it’s not necessarily about how much you know the materials, it’s about how much you can hold those uncomfortable feelings and difficult feelings. And I don’t think these are skills that a lot of people have developed. We [clinicians] are at a unique advantage in our work that we can facilitate that.

It requires group facilitation … skills of being able to see what the impact on the group is, of one person having a reaction. It’s not just about that individual anymore, if that person starts to cry, other people have reactions, and how we respond to the person has an impact on the rest of the people in the group as well. There’s a way in which we’re holding whoever might be having the more significant reaction, but also the other people … it’s holding everyone in some ways.

Facilitating connection. The atmosphere that is developed throughout the training is one of increasing intimacy and connection. The presenters speak candidly, using humor and self-disclosure, around their own personal challenges engaging with people who may be having thoughts of suicide and the need for self-care. Through these interactions, participants develop connections with the clinicians. “When you see people on campus they immediately remember you [from the training] … they feel like they’ve connected with you.”

In addition to connecting with the clinicians, participants also connect with each other, allowing them to feel comfortable in the group, to be vulnerable, and to express themselves freely and receive support.

I think people are actually really vulnerable because we are; we model that. But we also say that there’s hope, that this can help … we say that it’s hard but we also emphasize how powerful it is.

What I’ve seen is that people want to talk about this stuff. It’s hard, and they’re afraid, but they want to go there. And they just need a framework and support and kindness to do that, and when you provide that space, most people find some benefit in that.

The value of experiential learning. A common thread running through each theme was the impact and value of experiential learning. The role-play experience, in addition to providing an opportunity to build skills, also instills in participants the value of using the skills. “It’s not just teaching people how to learn a skill, it’s taking the knowledge that we’re giving and applying it to themselves.”

Facilitators noted that the participants feel empowered when they learn to use the skills.
When people get over that hump of feeling anxious or worried or whatever it is that’s coming up, and they feel like they do it and it works . . . there’s something empowering about that, even if they . . . worry about doing the right thing. They now feel like they know at least what to do, whereas before they maybe came in and really didn’t have a clue of where to start the conversation.

Facilitators reported that the participants playing the role of a distressed student often express that simply being listened to in a nonjudgmental way feels validating. This encourages participants to use the skills even though they may subjectively feel awkward and challenged to do so.

For people at the other end, role playing the distressed student, sometimes . . . the acknowledgement, or a real good WIGing [paraphrasing] that happens in the role play, is a powerful experiential moment for them. It’s like “Wow! That felt really good”!

In addition to learning specific skills, participants also come to realize the value of expressing caring for other people.

[Participants experience that] there is actually value in leaning in and taking the time to slow down and stay and not fix things. Or not feel like you’re not being useful if you couldn’t fix it, but that there is value in just being there with people.

Overall, the qualitative themes indicated that in general, trainees’ interactions with others in situations of distress or crisis tended to have positive outcomes. Using the I CARE skills enabled many respondents to listen and connect with people, and these skills helped to calm others who were experiencing emotional distress. Specific challenges included a sense of awkwardness using the skills, lack of time or private space, as well as encountering resistance to seeking help. The value of the experiential components of the training was evident in the ways that both participants and facilitators emphasized the importance of processing emotions that can arise during role-plays, and developing a deeper sense of connection and caring.

**Discussion**

This article describes the development and implementation of a campus mental health gatekeeper training program and reports the results of preworkshop and postworkshop assessments, a follow-up study, and a facilitator discussion group. The I CARE training includes didactic and experiential components and provides opportunities for emotional processing as well as skill-based learning. The vast majority of participants reported positive evaluations of the program. Significant increases in knowledge of support and crisis intervention skills and readiness to intervene in situations of distress or crisis were demonstrated from preworkshop to postworkshop assessments.
In the follow-up study, the majority of respondents reported interacting with people in distress or crisis since their training and applying the skills they had learned. Respondents’ qualitative descriptions of their interactions with persons in distress or crisis revealed that they readily applied the intervention skills they learned (especially supportive listening and connecting), felt comfortable applying the skills, and made appropriate referrals. Facilitators expressed that experiential activities involving emotional processing helped to prepare participants to engage and intervene in situations of distress or crisis.

The qualitative data from both participants and facilitators highlighted the value of experiential activities in learning skills, feeling comfortable using the skills, and engaging with others in situations of distress or crisis. This is consistent with perspectives reported earlier regarding the benefits of experiential activities (e.g., Albright et al., 2014; Cimini et al., 2014; Cross et al., 2011; Osteen, 2016; Pasco et al., 2012; Quinnett, 2007; Tompkins & Witt, 2009). Further, research found that college resident assistants (RAs) reported feeling scared, concerned, doubtful, and helpless when dealing with suicidal students, and wanted more emotion-based learning to address their discomfort around suicide (Silverman, 2014). In the I CARE training, the explicit emphasis on emotional sharing, processing, and discussion with clinicians may enable participants to engage and connect with others in distress or crisis, retain improvements in outcomes over time, and incorporate the skills into their lives when the situation calls for them. The reported benefits of establishing connections among CAPS clinicians and community members during I CARE trainings is also consistent with findings from other gatekeeper training (Cimini et al., 2014).

Regarding retention over time, reviews of research have noted that while several studies have found that gatekeeper trainings increased short-term suicide-related knowledge (Harrod et al., 2014), a limitation of many studies has been that the time period of follow-up data collection might be insufficient to assess long-term impact of the training (Burnette et al., 2015). While several studies have assessed follow-up between 2 and 6 months posttraining (e.g., Lipson et al. 2014; Osteen, 2016; Tompkins & Witt, 2009), the present study examined duration of training effects for up to 15 months following training. Consistent with one study that found durability of training effects for knowledge, preparedness, and efficacy at 12-month follow-up (Wyman et al., 2008), our findings showed significant increases in both knowledge and readiness levels from preworkshop to follow-up. While scores did decrease from post-workshop to follow-up, the amount of change was slight, compared with the substantial increases from preassessment to follow-up assessment. The effects of the workshop on participants’ knowledge and readiness to intervene appear to have diminished only minimally over the course of our follow-up period, extending
up to 436 days after the workshop. The effect of time on participants’ decline in knowledge was not statistically significant. The effect of time on readiness to intervene, while statistically significant, was very small. It is clear from our data that well after a year following the workshop, participants continued exhibiting higher levels of knowledge of crisis and intervention skills and a higher level of readiness to intervene, compared with before completing the workshop. More research is needed to understand whether specific training components such as experiential activities might influence retention of training effects over time.

It is interesting that the knowledge and readiness scores increased significantly from preassessment to postassessment for both the full-day and hybrid training formats. Our follow-up results suggest that retention over time was adequate for both the full-day and hybrid formats. This finding is not consistent with findings from a review of studies that effect sizes for short-term knowledge of suicide prevention and self-efficacy were greater for interventions of longer versus shorter duration (Harrod et al., 2014). It is noteworthy that in our program, both the full-day and hybrid formats included in-person experiential activities, and this may contribute to the effectiveness of both formats. It is also important to note that over time, more trainings have been conducted using the hybrid rather than the full-day format, due to practicalities involving staffing availability and greater demand for the shorter version. It seems that the hybrid format is sufficiently effective, and saves time for both facilitators and participants. It is, however, important to keep in mind possible confounding with other factors influencing participation in each training format, as discussed in the limitations section as follows.

**Limitations**

The data presented in this article have several limitations and should, therefore, be viewed as exploratory. The findings of this study have limited generalizability due to the collection of data at only one site, which was a large university in an urban setting with a specific history of students who died by suicide, resulting in a high level of concern regarding suicide prevention among students, staff, and faculty. It is possible that this may play a role in motivating participants to retain information, and constrain applicability of the findings to other campuses that may not have had similar experiences. The study is also limited by the lack of a control group and random assignment. A randomized control design was not feasible given the need to devote our resources to providing interventions on campus. An inevitable source of variation in the training is that small groups are facilitated by different clinicians and, of course, have different participants, with varying levels of prior experience and knowledge. The variation in group dynamics might lead to varying levels of skill acquisition and knowledge
retention. However, the overall effectiveness of the training despite these differences suggests the potential for adapting the training to a variety of populations.

Survey nonresponse is a potential source of attrition bias in the follow-up study, despite a fairly high response rate (51%). While differences between respondents and nonrespondents to the 2016 follow-up survey were not significant, respondents to the 2017 survey had slightly higher scores for prior knowledge and postreadiness. It is possible that respondents had slightly greater interest in the topic or benefit from the training than nonrespondents.

While significant effects were found for both the full-day and hybrid training formats, it was not possible to control for confounding with staff/faculty versus student affiliation and other factors affecting whether participants enrolled in the longer or shorter training sessions. A control group design would be needed to fully determine the effects of intervention duration.

Another limitation is the use of self-report measures. While this seems appropriate to measure perceived readiness, the subjective reports of intervention behaviors in the follow-up study may be subject to recall bias.

The lack of demographic measures in the data presented constrains our ability to assess differential effects in different populations; however, these are included in our more recent surveys and will be analyzed in future assessments.

Future studies should also try to examine the broader impact of the training on help-seeking and utilization of mental health resources in the campus community. The finding from our qualitative data that the training seemed to foster an increased ability to connect with others will be investigated in future studies to determine whether the training has an impact on sense of connectedness.

Conclusions and future directions

The I CARE training program, designed and facilitated by CAPS clinicians at the University of Pennsylvania, teaches knowledge and skills to aid in providing support to students who may be experiencing distress and/or mental health problems, including suicidal ideation, and is characterized by a focus on emotional awareness and caring for others.

Participants reported high levels of satisfaction with the workshop. Knowledge of support and crisis intervention skills, and readiness to intervene in situations of distress or crisis significantly increased from preworkshop to postworkshop, and were significantly higher than preworkshop levels at follow-up, even 15 months after the training occurred.

Experiential activities, including practicing skills and addressing difficult emotions like anxiety, fear, and grief, are essential elements of the I CARE
training, and contribute to participants’ comfort intervening in challenging situations. The results of this program suggest that clinicians have an important role to play in primary prevention aimed at college student mental health by teaching intervention skills, creating supportive spaces to explore challenging emotions, and fostering emotional comfort and connection that can help promote mental wellness for individuals and communities.

Another indication of the value of I CARE is the high demand for the training by a wide range of student, staff, and faculty populations on campus. More recently, in response to requests from participants, we have developed and piloted an advanced skills training for people in formal gatekeeper roles, in order to provide opportunities for skill enhancement and engagement in complex scenarios. Our experience of implementing and assessing the I CARE training with groups of varying sizes and populations suggests that the model is robust, and could be adapted and tailored for a variety of populations and settings.

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References


