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Suicide Prevention Training for Resident Assistants: Results of the Northwest Training Model

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In 1999 the Surgeon General's Call to Action to Prevent Suicide was published (U.S.

Public Health Service). In this report the Surgeon General identified suicide as a serious public health problem. To support this claim statistics were reported from 1996 that indicated there were 50% more suicides than homicides for that particular year. One of the recommendations from the Surgeon General's report was the development of a National Strategy for Suicide Prevention (NSSP). The NSSP was published in 2001 and created a framework for suicide prevention nationwide. In 2004 the Garrett Lee Smith Memorial Act was passed by the U.S. Congress to support and enhance suicide prevention efforts in the states and at colleges and universities.

Currently in the United States suicide is the second leading cause of death among college students (Commission on Adolescent Suicide Prevention, 2005). The number of college students who commit suicide is difficult to obtain since most surveys list the age range as 15-24. According to the Big Ten Student Suicide Study (Maris, Berman, & Silverman, 2000), the overall student suicide rate on college campuses was 7.5 per 100,000. In addition, the Big Ten study reported that forty-six percent of student suicides occurred in the 20 to 24-year-old age group. To help campuses cope with student suicide , there was a call for the implementation of effective suicide prevention programs. The suicide prevention training used in this study is part of a larger comprehensive suicide prevention program that was implemented at a Midwestern University

Overview of Campus-Wide Suicide Prevention Program

The comprehensive campus-wide suicide prevention program goals were based on the recommendations made by the National Mental Health Association, *Safeguarding Your Students against Suicide: Expanding the Safety Net* (2002). These six goals include the development of: (1) training programs for students and university personnel, (2) a network of student services, (3) targeted educational programs for faculty, staff, coaches, and students, (4) a college crisis line and informational website, (5) broad-based campus-wide public education, and (6) educational materials for parents and families. The suicide prevention training for Resident Assistants (RAs) addresses the first goal of the campus-wide initiative; training programs for students and university personnel.

Resident Assistants are viewed as an important population to educate due to the increasing number of students entering college with severe mental health issues. Due to the recent advances in early identification of mental illnesses and medication therapy, institutions of higher learning are admitting more students with serious psychological diagnoses (e.g., depression, bipolar disorder, schizophrenia, etc.). In previous years many of these students would not have been able to cope with high school, much less the stress of attending college. RAs are often on the "front line" in noticing that a student may be in crisis and thus need training regarding suicide prevention and intervention.

Overview of Suicide Prevention Training for Resident Assistants

The suicide prevention training for RAs consists of intervention, postvention, and

prevention strategies. The program begins with case scenarios of individuals in crisis provided to the participants. They are asked to read the scenario and decide how they should respond to the situation. Two of the scenarios involve students and one scenario involves a supervisor who is contemplating suicide. Students are asked to share their scenarios and how they would respond with the large group. Their responses are then used throughout the training to reinforce presented information.

Suicide intervention. The training continues with an overview of suicide intervention strategies appropriate for RAs. The importance of dealing directly with the topic of suicide, as well as remaining calm is explained. Emphasis is placed on active listening and seeking assistance. RAs are instructed to call for assistance (e.g, Campus Safety, Counseling Center, Residential Hall Supervisor, etc.) in the presence of the person in crisis.

Suicide postvention. Reintegrating the person who has made a suicide attempt and other postvention issues are discussed. Reintegration is a topic that is often not addressed and RAs, as well as students, faculty, and staff, don't know how to respond to someone who has returned to school after making a suicide attempt. Confidentiality issues are discussed with RAs, including the importance of not having a hall meeting about the returning student. RAs are informed that it is appropriate to meet individually with the returning student's roommate and close friends to discuss his/her return. RAs are encouraged to not avoid the returning student and to address the topic of suicide prevention. For example, it is appropriate to say "I am very glad you are back on campus. I know you may encounter stresses in the future and I want you to know that I am here to help." If the RA is concerned about the returning student in the future, he/she is encouraged to call the Counseling Center or Campus Safety for assistance.

Additional postvention issues (i.e., after a suicide attempt or death by suicide) are addressed as part of the training. RAs are encouraged to seek help for those most impacted by a suicide attempt or death by suicide. Circles of influence are discussed, including those socially close to the person, those physically close to the person, and those at-risk due to their own trauma history (Poland, 2006). Persons fitting more than one circle of influence (e.g., a friend of the person who lived on the same floor as the person who attempted suicide) are considered at greater risk. RAs are instructed to consult with Counseling Center staff regarding students identified at risk after the suicide attempt or death by suicide, as well as in the weeks and months following the event. Students may be more at-risk around anniversaries and birthdays, so RAs are encouraged to check in with students regularly during these times.

Suicide prevention. The final portion of the program addresses myths, risk factors, and resiliency factors. Common myths regarding suicide are discussed (see Table 1 for list). One fact that many students typically have trouble identifying is "Reducing access to firearms and other lethal weapons reduces the risk of suicide." A study by Miller, Lippmann, Azrael, and Hemenway (2007) found that states with the highest firearm

ownership had twice as many deaths by suicide compared with states with the lowest firearm ownership (2007). The myth that "Most suicide attempts occur late at night or early in the morning" is discussed and clarified. Most suicide attempts occur mid-morning or early afternoon (SAMHSA, 2006). This information is presented to RAs, including the suggestion to check in with their residents during these high risk times.

Prevention of suicide is highlighted. RAs are told that most suicides are preventable and that most people who contemplate suicide don't necessarily want to die, they want the pain they are experiencing to stop. Developing resiliency factors is noted as a primary prevention effort. RAs are presented with a list of ideas to enhance resiliency, such as positive connections to school and extracurricular participation, access to mental health care, and a school environment that encourages help seeking and promotes health. RAs are instructed to identify specific things that they do to help develop the resiliency of their residents. These ideas are discussed in pairs and then shared with the large group.

The final part of the presentation includes the sharing of resources. Campus resources are identified and discussed, as well as national suicide prevention hotlines and reputable websites. A bookmark titled, "Students in Crisis: How to Help a Friend" is distributed to each of the RAs and they are provided with enough copies for each of their residents. One side of the bookmark outlines a procedure for what to do if you have a friend in crisis, important numbers on campus and a national crisis number. The other side of the bookmark lists warning signs for suicide (e.g., lack of concern about personal welfare, changes in social patterns or isolation, preoccupation with death and violent themes, etc.).

To date there are few empirically based suicide prevention programs that have been shown to be effective. The purpose of this study was to evaluate the effectiveness of the previously outlined suicide prevention training program. Effectiveness was defined as a change in knowledge regarding suicide and suicide prevention.

Methods

Participants and Setting

Resident Hall Advisors (RAs) employed at a moderately sized Midwestern University were asked to participate in the study. A total of 74 RAs completed the pre-test and 63 participants completed the post-test. The majority of the RAs were Caucasian (68). Three students were African-American, two students were Hispanic and one student was Asian-American. Thirty-five males and thirty-nine females completed the pre-test. Demographic data was not obtained from the participants completing the post-tests.

Measures

Twenty-four questions from the Suicide Prevention Exposure, Awareness and Knowledge Survey SPEAKS-S were used for this study. The SPEAKS-S was developed

by ORC Macro International Incorporated for the Garrett Lee Smith Suicide Prevention Program (SAMHSA, 2006). The survey assessed participant's knowledge about myths pertaining to suicide. For example participants answered either true or false to the question "People who talk about suicide or threaten suicide don't do it."

Procedures

After obtaining informed consent participants were asked to complete the self-administered SPEAK-S questionnaire prior to attending a one hour suicide prevention training presentation. The participants' responses were anonymously recorded on a scantron answer sheet and were scored using a computer program. Participants were informed that participation in the study was completely voluntary and that they could refrain from answering questions that made them feel uncomfortable. Refusal to participate in the research study did not negatively impact the RA's employment.

A graduate assistant associated with the Campus Suicide Prevention Project collected the pre-test data. The RAs were then presented with information about risk factors, myths, protective factors and intervention strategies for individuals in crisis. One week after the training presentation participants were asked to complete the SPEAKS-S again. The SPEAKS-S pretest and posttest data were then compared to assess the effectiveness of the training session on participant knowledge regarding suicide prevention.

Results

Changes in the percent correct for the pre-test scores and post-test scores were examined. Table 1 outlines the survey data. Items of significant interest include whether reducing access to firearms and other lethal weapons reduces the risk of suicide. Prior to the suicide prevention presentation 32.4 % of the participants answered the question correctly. After the presentation 84.4% of the participants answered the question correctly. When participants were asked if most suicides occur late at night or early in the morning, 68.9% answered correctly before the presentation whereas 84.5% answered the question correctly after the presentation. In addition, only 43.2% of participants identified that a student with sleep problems was at risk for attempting suicide on the pre-test. On the post-test 90.6% of the participants recognized that sleep deprivation was a risk factor for suicide. Finally, 25.7% of participants on the pre-test knew that suicides don't occur in the greatest numbers around the holidays like Thanksgiving and Christmas. This number increased to 78.1% on the post-test.

There were two items that showed a downward trend when pre-test and post-test scores were compared. On the pre-test 93.2 % correctly identified that people who talk about or threaten suicide don't do it, whereas, 90.6% identified the correct answer on the post-test. When respondents were asked whether people who really want to die will find a way; it won't help to try and stop them, 89.2% answered the item correctly on the pre-test and

87.5% answered the item correctly on the post-test.

Discussion

Our campus has begun to implement the recommendations made by the National Mental Health Association, *Safeguarding Your Students against Suicide: Expanding the Safety Net* (2002). With the implementation of the training programs, our campus is beginning to notice a difference in how suicide is perceived and handled. The results of the SPEAKS-S (SAMHSA, 2006) pre/post-test data indicate that participant knowledge regarding suicide and suicide prevention increased after participating in a training session. Knowledge on two specific items decreased slightly on the post-test which may indicate that those particular items need to be highlighted differently in future training sessions.

Although knowledge increased after the training session, the need for follow-up training sessions is recognized to help effect practices. Anecdotal reports from Residential Hall staff have indicated that the training sessions have helped to alter practices in the residence halls. Prior to these training sessions, there were reports of RAs maintaining "suicide watches" with students in crisis and postvention efforts that involved the unintended sensationalizing of suicide attempts. Anecdotal reports indicate that these practices are no longer occurring and RAs have a better understanding of how to handle residents in crisis. Future research should include formal reporting methods regarding current practices of RAs with students in crisis.

When the efforts of this federal grant were initiated, the University was impacted by several student deaths by suicide. The coordinated prevention efforts included as part of this grant initiative, including the training sessions for RAs, has impacted the suicide rate of the campus. There have been no student deaths by suicide on campus since the grant initiative and off-campus deaths by suicide have decreased. When considering the impact of suicide, reducing the suicide rate by one is a significant difference.

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Table 1

Comparison of Pre-test and Post-test SPEAKS-S Data

	Answer	Pre True	Pre False	Post True	Post* False	Change in percentage score for the correct answer
People often attempt suicide without warning and out of the blue.	F	28.4	71.6	14.1	85.9	14.3
Sometimes a minor event (like a bad exam grade) can push an otherwise normal person to attempt suicide.	F	75.7	24.3	28.6	71.4	47.1
People who are depressed are more likely to attempt suicide.	T	85.1	14.9	95.3	4.7	10.2
The great majority of people who commit suicide do not have psychiatric or substance abuse disorders.	F	52.7	47.3	29.7	70.3	23

Reducing access to firearms and other lethal weapons reduces the risk of suicide.	T	32.4	67.6	84.4	15.6	52
People who talk about or threaten suicide don't do it.	F	6.8	93.2	9.4	90.6	-2.6
If someone is exposed to a suicide (family, friends, and other students) this increases their own risk for attempting suicide.	T	55.4	44.6	93.7	6.3	38.3
People who really want to die will find a way; it won't help to try and stop them.	F	10.8	89.2	12.5	87.5	-1.7
People who are using alcohol more than usual or abusing substances are at greater risk for attempting suicide.	T	85.1	14.9	93.8	6.2	8.7
	Answer	Pre True	Pre False	Post True	Post* False	Change in percentage score for the correct answer
A person with a family history of suicide is at lower risk for attempting suicide.	F	9.5	90.5	6.2	93.8	3.3
Hopelessness is a risk factor for attempting suicide.	T	93.2	6.8	93.8	6.2	.6
You should not talk to depressed people about suicide; it might give them the idea or plants the seed in their minds.	F	12.2	87.8	6.3	93.7	5.9
If a fellow student drops out of school, that puts him/her at a	T	48.6	51.4	92.2	7.8	43.6

higher risk for suicide attempt.						
A fellow student with sleep problems is at increased risk for attempting suicide.	T	43.2	56.8	90.6	9.4	47.4
The majority of suicides are among people of color.	F	5.5	94.5	5.5	94.5	0
People with both mental health problems and substance problems are at even greater risk of attempting suicide than those with either mental health or substance abuse problems alone.	T	67.6	32.4	89.1	10.9	21.5
Suicides occur in the greatest numbers around the holidays like Thanksgiving and Christmas.	F	74.3	25.7	21.9	78.1	52.4
Social isolation/ withdrawal is a risk factor for suicide attempt.	T	91.9	8.1	92.2	7.8	.3
	Answer	Pre True	Pre False	Post True	Post* False	Change in percentage score for the correct answer
Most suicidal people never ask for help with their problems.	F	40.5	59.5	14.1	85.9	26.4
A fellow student who has a sexual identity conflict or is uncertain about their sexual identity is at greater risk for a suicide attempt.	T	66.2	33.8	91.4	8.6	25.2
Many people who talk	F	32.4	67.6	20.7	79.3	11.7

about suicide just want attention.						
Suicide is the leading cause of death among college students.	F	33.8	66.2	43.1	56.9	-9.3
Risk for suicide attempt is not associated with police or law enforcement (arrest or incarceration) contact.	F	31.1	68.9	19	81	12.1
Most suicide attempts occur late at night or early in the morning.	F	31.1	68.9	15.5	84.5	15.6

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