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Suicide gatekeeper training outcomes in educational and religious settings

David S. Wood[a], Faheem Ohri[a], Greg Hudnall[b], and Linda Cahoon[a]

[a]School of Social Work, Brigham Young University, Provo, Utah, USA; [b]Hope4Utah, Provo, Utah 84604, USA

ABSTRACT

Summary: Question, Persuade, and Refer (QPR) training also known as gatekeeper training, is a short and effective method for spreading awareness and preparing community members to actively engage in preventing suicide, through appropriate knowledge and actions. This study's purpose was to explore differences in QPR gatekeeper training in educational and religious settings. Outcomes of focus were changes in participants' self-rated readiness, willingness, and ability to help a person at risk of suicide. Measures were administered at baseline and after the training for participants in educational settings (N = 747) and in religious settings (N = 698). Findings: Results were statistically significant for educational settings [$\lambda = .37$, $F(1,776) = 1297.69$, $p = <.001$] and for religious settings [$\lambda = .30$, $F(1,724) = 1690.23$, $p = <.001$]. Strong training effects were noted in both settings.

Application: Suicide prevention gatekeeper training is a ripe opportunity for meso and macro practice in social work. Gatekeeper training can enable social workers to extend their reach far beyond direct practice through empowering community members with awareness of suicide risk factors as well as with confidence to actively intervene with those who may be at risk of suicide. In this way, social workers can enhance connectedness in communities to help prevent death by suicide.

KEYWORDS

Suicide prevention; QPR; gatekeeper training; community intervention

Suicide is a critical community issue that shows increased worsening over the last decade. It was the *third* highest casuse of death among adolescents in the United States (ages 15–19; Centers for Disease Control and Prevention, 2020). One intervention intended to assist with the prevention of suicide death is gatekeeper training. Gatekeeper training helps community members to be ready, willing, and able to make contact with persons at risk of suicide and assist them to get treatment and other resources (U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention). In order to be effective, gatekeeper training needs to reach an array of community settings. The literature review suggests that gatekeeper training is very commonly offered in educational and health care organizations with a focus on adults working in those settings. In order to be maximally effective, gatekeeper training needs to be offered in settings where persons at risk of suicide live, work and play.

CONTACT David S. Wood d_wood@byu.edu School of Social Work, Brigham Young University, 2190 JFSB, Provo, UT 84602

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The current exploratory study examined the impact of gatekeeper training in religious settings relative to those in educational and government institutional settings. Undoubtedly, training in educational and government settings is crucial since workers in these settings will likely have interaction with a large part of the population. Training in religious settings is another setting that has the added potential to extend the reach of gatekeeper training to those who may likely have not had the opportunity to receive this training. We also propose that gatekeeper training in religious settings may extend training to those who have intimate interaction with those who may be at risk of suicide. We also propose that gatekeeper training in religious settings will reach more family members than in educational and government settings. This is important because clinical experience has shown that the most common contact made prior to suicide death is with family members. Additionally, clergy often provide counseling, and therefore, may act as gatekeepers in the lives of the members of the congregation. Indeed, research has shown that faith-based organizations can play a helpful facilitative role in preventing suicide (Bazley et al., 2019).

Research on gatekeeper training

The term "gatekeeper" in suicide prevention means, "individuals who have face-to-face contact with large numbers of community members as part of their usual routine" (U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention, , p. 139). Gatekeeper training helps participants, "identify persons at risk of suicide and refer them to treatment or supporting services as appropriate" (U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention, , p. 139).

The majority of the research literature on gatekeeper training for suicide prevention has focused on training in school settings with less focus on community settings. Among the studies reported on school-based gatekeeper training, including a report by Condron et al. (2014) who examined training effects for school personnel; They found a dose effect of gatekeeper training in schools: longer trainings (3 hours or more) were associated with increased referrals made by gatekeepers. Lamis et al. (2017) tested an online gatekeeper training model and found that online Gatekeeper training produced increased suicide prevention attitudes and beliefs among school personnel. Labouliere et al. (2015) examined gatekeeper training outcomes for high school students and found positive effects for training but noted that open-ended responding on pre and post training assessments gathers a more accurate assessment of gatekeeper knowledge. Tompkins et al. (2009) studied gatekeeper training effects on school personnel and found that from pretest to posttest there was a substantial gain and a statistically significant increase in attitudes, knowledge and beliefs to prevent suicide. Rallis et al. (2018) showed that most college students can identify many suicide signs before QPR training. College students' confidence and capacity increases significantly upon receiving gatekeeper training and follow up analyses suggest that booster training may be helpful in knowledge retention. Reis and Cornell (2008) found that school staff became more effective helpers when they are offered multiple training sessions. Taub et al. (2013) proposed that first time gatekeeper training can significantly increase prevention attitudes among resident assistants.

Research on gatekeeper training in community settings suggests that there is less frequent focus relative to community settings. Hangartner et al. (2018) conducted gatekeeper training with professionals from agencies that serve youth and found positive training effects and that QPR training is consistent with other forms of preventative training. Importantly, these trainees made more referrals when their comfort level of the material was high rather than the amount of knowledge attained. Litteken and Sale (2017) found that adults going through QPR training were more likely to reach out to youth to initiate conversations regarding suicide rather than waiting for a youth to approach them. These researchers also found that QPR training effects were maintained after a 2 year follow up. Another community-based study by Matthieu and Swensen (2014) suggests that the community is not receiving adequate gatekeeper training as much as in other settings, including schools due to the opportunity to require such training for school personnel and students. The fewer studies in community settings may be due to logistical challenges. Community-based training is likely more challenging because organizational mandates or focused promotions for such training are typically not as feasible as in schools or similar institutions.

To address these gaps in the literature we examined gatekeeper training in two different settings: schools and churches. We sought to compare the relative training effects in each of these settings and we also examined the types of attendees that participate in gatekeeper training in these various contexts. This study addresses an important gap in the literature in that it adds to the relatively sparse literature on community-based gatekeeper training as well as a direct comparison of educational and religious-based trainings. Our hypotheses for this study include: 1) training in religious settings would be equivalent in effectiveness as compared to educational settings and 2) training in religious settings will access different demographic segments including more parents and families.

Method

The gatekeeper training sessions were part of a program framed as a faith-based pilot program funded by the Utah State Office of Substance Abuse and Mental Health. The outreach presentations were offered by a local nonprofit organization called Hope4Utah, which provides suicide prevention programs. This organization utilizes a prevention framework called "Circles4hope" that entails connecting various organizations and stakeholders in the community to increase awareness and sharing of resources to prevent suicide. To extend the reach of suicide prevention efforts in this area, Hope4Utah initiated contact with local church leaders of faith-based organizations to do additional community training. The organization identified 270 local churches belonging to a variety of faiths and worked to provide one QPR trainer to each congregation and conducted ongoing QPR training for members of these faith-based communities. Data from these faith-based outreach trainings, as well as, ongoing trainings in educational settings were used for this study. This study is an archival data analysis study that was approved by the Institutional Review Board at Brigham Young University.

Table 1. Gatekeeper participant demographics.

Role	N	Educational	N	Religious
Administrator	49	6.347%	7	1.10%
Clergy	21	2.72%	130	18.71%
Community member	9	1.165%	108	15.54%
Educator	526	68.13%	46	6.62%
Family Member	10	1.30%	232	33.38%
Government worker	4	0.52%	4	0.58%
Health Care	22	2.85%	14	2.01%
Law enforcement	4	0.52%	5	0.72%
Mental Health Worker	46	5.96%	1	0.14%
Self-advocate	8	1.04%	38	5.47%
Student	73	9.46%	110	15.83%
Grand Total	772	100%	695	100%

Participants

In total, there were 747 training participants in educational settings. The largest proportion of these participants designated themselves as educators (68.13%). There were a total of 698 participants in religious settings and the largest proportions included family members (33.38%), clergy (18.71%) and community members (15.54%). Detailed participant demographics are displayed in Table 1.

Measures

All the participants in gatekeeper training were provided a self-report questionnaire before the training and at the conclusion of the training. The questionnaire was developed locally and included two broad dimensions: suicide prevention knowledge (e.g., "I know how to ask someone if they are suicidal.") and self-rated likelihood to take specific actions to prevent suicide (e.g., "Tell a suicidal person who to talk to for help."). The questionnaire also assessed willingness to support a person at-risk with firearm safety (e.g., "Ask someone at risk of suicide about their access to firearms."). The entire questionnaire showed good overall internal consistency reliability (Chronbach's alpha = 0.90). The knowledge subscale (Chronbach's alpha = .89) and the actions subscale (Chronbach's alpha = .84) also showed acceptable internal consistency reliability.

Results

We computed statistical significance and effect size statistics for outreach presentations for the two populations. To compare the effect of QPR training in educational and religious settings, a repeated measures ANOVA test was conducted. There was a significant effect of QPR training in educational settings, Wilks' Lambda = .37, F (1,776) = 1297.69, p = <.001. Also there was a significant effect of QPR training in religious settings, Wilks' Lambda = .30, F (1,724) = 1690.23, p = <.2017001. Two paired samples t-test was estimated to indicate the post hoc difference among training venues. Both the educational and religious settings paired samples t-tests results were significant (Educational Settings: Pre-total [M = 41.7, SD = 8.13] and Post-total [M = 50.74, SD = 4.93]; t = −36.02, p = <.001; Religious Settings: Pre-total [M = 37.70, SD = 9.09] and Post-total [M = 49.39, SD = 5.96]; t = −41.11, p = <.001).

Table 2. Differences between pretest and post test scores on QPR training outcomes.

	Assessment Period							
		Pretest		Posttest				
Outcome Variable	Range	Mean	SD	Mean	SD	*p*	*Cohen's d*	*t*
Educational Settings (N = 747)								
Knowledge	5–25	17.46	4.36	22.89	2.55	<0.001	1.52	38.17
Action	6–30	20.1	3.88	28	2.78	<0.001	2.34	27.07
TOTAL	12–55	41.73	8.08	50.88	4.86	<0.001	1.37	36.02
Religious Settings (N = 698)								
Knowledge	5–25	14.8	4.9	21.97	3.1	<0.001	1.75	44.17
Actions	5–30	18.93	4.36	27.6	3.13	<0.001	2.28	28.30
TOTAL	11–55	37.81	8.99	49.58	5.76	<0.001	1.56	41.11

*p < 0.05, **p < 0.001, ***p < 0.001.

The findings indicate that QPR training has a significant effect on gatekeeper training outcomes. A detailed summary of pre and post means, sample sizes, standard deviations, and effect sizes are reported in Table 2. The within group effect-sizes were large, suggesting a strong training effect. We also assessed the relative difference in terms of effect size between the two groups at pretest and at posttest. Pretest differences between the two categories showed a moderate effect size (Cohen's d = .46) whereas the posttest effect-sizes were much smaller, suggesting that the groups were more similar in their suicide prevention knowledge and actions after the training (Cohen's d = .24). QPR training appears to reduce the gap for participants in religious settings as compared to those in educational settings.

We were also interested in the differences in the frequency of proportions in the two outreach populations. We computed a binomial z test of proportions to compare differences in the proportions of populations of interest: educators, clergy, family members, and community members. We selected these populations because they had large numbers in at least one of the training settings and they are populations of interest for gatekeeper training and suicide prevention. The null hypothesis for the binomial test of proportions was equal distribution of demographic populations across both training settings (i.e., 0.50). As proposed by Green and Salkind (2017), effect size measures were computed from the raw difference between the observed and hypothesized proportions for each population within the setting in which they were more commonly found. One-tailed, z approximation tests were conducted to assess whether the population proportions for the various groups differed statistically between training settings. All observed proportions differed significantly between educational and religious training settings, respectively. This was true for educators (0.93/0.07, p. < 0.001, ES = 0.47), clergy (0.03/0.97, p. < 0.001, ES = .47), community members (0.05/0.95, p. < 0.001, ES = .45) and family members (0.04/0.96, p. < 0.001, ES = 46).

Discussion

Gatekeeper training can help prevent suicide and, as shown in other studies, appears to prepare participants as suicide prevention gatekeepers. The primary objective of this research was to study the effect of QPR training in suicide prevention in different settings

with a focus on educational and religious settings. We found that the training was effective in both settings. In religious settings, however, the participants were more diverse than those found in educational settings, allowing for contact with more community members.

Religious settings showed a larger training effect as compared to educational settings. Output from pretest to posttest means differences showed a statistically significant mean higher difference of 2.62 in religious settings as compared to educational settings. This differential finding was presumably because participants in religious settings had less exposure to such presentations than in educational settings. Educational settings, in contrast, often have policies in place to ensure that school personnel receive gatekeeper training. Given that religious settings do not likely have routine policies for gatekeeper training, suicide prevention specialists will likely find that suicide prevention training in religious settings will continue to show these strong training effects and aid participants in these settings to approximate suicide prevention knowledge and actions as seen in other settings.

Religious settings were composed of very different demographics than those seen in educational settings. For instance, in educational settings there was only 1.30% of the population who were family members, but in religious settings it was 33.38%. Other researchers found individuals with higher chances of attempting suicide often meet and interact with their family members and close relatives before attempting suicide (Wood et al, 2020). This finding suggests the need to expand gatekeeper training to settings where members of the community can be reached. Religious settings likely represent one of these important settings because gatekeeper training can reach a large number of family members rather than indirectly through other institutions. Also, religious leaders may play a gatekeeper role in preventing suicide through interaction with counseling the persons at risk of suicide.

QPR training works in religious settings. Prior research has shown that individuals who belong to Christian faith-based organizations tend to be receptive to suicide prevention and see it as a practice that is consistent with religious teachings (Bazley et al., 2019). Our research supports the finding that QPR training can be effective in these settings.

Limitations to this study include sampling and assessment timeframe. This sample was drawn from a generally small geographical area, which may limit its generalizability to other settings. Also, the data collection at posttest was immediately at the conclusion of the QPR training, which may not reflect training outcomes that might be obtained at later points in time. Research conducted on QPR training in similar settings in other geographical areas will add to this research as will longer follow-up time frames for post-training outcome assessment.

Implications for social work

Suicide prevention gatekeeper training is a ripe opportunity for meso and macro practice. The underlying program theory of gatekeeper training is using existing social connections to prevent death by suicide. Social workers can make an impact on suicide prevention by providing gatekeeper training in a variety of contexts throughout the community. Gatekeeper training does not replace the role or skill set of a clinical social worker, but this type of training can extend the reach of clinical social workers by empowering trainees to have increased skills and confidence to approach and intervene with those who may be at risk of suicide. This study suggests that social workers need not be reluctant to consider religious settings as a place to conduct gatekeeper training. Social Workers can be confident

that outreach presentations in religious settings have a high likelihood of positive impact on the trainees as well as a high likelihood of reaching the populations (e.g., parents and family members) who 1) urgently need suicide gatekeeping skills and 2) will likely be in a crucial position to intervene with a loved one who may be at risk of suicide (e.g., a parent inquiring about a child's possible suicidal thoughts after hours on a weekend). Gatekeeper training is effective in helping participants feel more ready, willing, and able to intervene with suicide and social workers can play a significant role with this important is(2020).(2020).sue.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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