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Original article

Gatekeeper Training and Access to Mental Health Care at Universities and Colleges

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A B S T R A C T

Purpose: Gatekeeper training (GKT) programs are an increasingly popular approach to addressing access to mental health care in adolescent and young adult populations. This study evaluates the effectiveness of a widely used GKT program, Mental Health First Aid, in college student populations.
Methods: A randomized control trial was conducted on 32 colleges and universities between 2009 and 2011. Campus residence halls were assigned to the intervention (Mental Health First Aid plus pre-existing trainings) or control condition (pre-existing trainings only) using matched pair randomization. The trainings were delivered to resident advisors (RAs). Outcome measures include service utilization, knowledge and attitudes about services, self-efficacy, intervention behaviors, and mental health symptoms. Data come from two sources: (1) surveys completed by the students (resident advisors and residents; N = 2,543), 2–3 months pre- and post-intervention; and (2) utilization records from campus mental health centers, aggregated by residence.
Results: The training increases trainees' self-perceived knowledge (regression-adjusted effect size [ES] = .38, $p < .001$), self-perceived ability to identify students in distress (ES = .19, $p = .01$), and confidence to help (ES = .17, $p = .04$). There are no apparent effects, however, on utilization of mental health care in the student communities in which the trainees live.
Conclusions: Although GKT programs are widely used to increase access to mental health care, these programs may require modifications to achieve their objectives.
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IMPLICATIONS AND CONTRIBUTION

A large-scale multisite study of gatekeeper training programs to increase utilization of mental health services among college students showed mixed results. Trainees experienced improved outcomes but utilization of mental health services in student communities did not increase.

Clinical trial information can be obtained from www.clinicaltrials.gov (Identifier: NCT02021344).
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Most people with mental disorders receive treatment only after a delay of several years, if at all [1]. Access to mental health care is especially important in young adult populations, because nearly three-quarters of all lifetime mental disorders have the first onset by the mid-20s [2]. Among college students, the prevalence of mental health problems appears to be increasing, [3] and over half of students with apparent disorders are untreated [4–6]. With over 20 million students enrolled in U.S. postsecondary education [7], population-level interventions to increase access to mental health care could make a significant societal impact [8].

Gatekeeper trainings

Gatekeeper trainings (GKTs) target individuals ("gatekeepers") who are in frequent contact with others in their communities. The trainings equip nonprofessionals with the skills and knowledge to recognize, intervene with, and link distressed individuals to appropriate mental health resources. There are many different GKT programs that have been used on hundreds of college campuses. Most programs focus on suicide prevention but many also address common issues such as depression and anxiety.

Borrowing from attachment theory, the gatekeeper model posits that individuals may find comfort sharing their feelings with acquaintances [9]. The conceptual model is also guided by the public health principle of mass saturation of awareness [10], whereby the likelihood of community members intervening in a crisis increases with the proportion of capable gatekeepers [11]. Peers may be especially influential for key factors that determine help seeking, such as attitudes and knowledge [12].

Despite the popularity of GKTs, there have been no large-scale studies on college campuses evaluating their effectiveness in increasing service utilization and improving mental health. In the college setting, GKTs typically target residential life staff, specifically resident advisors (RAs) trained to serve as gatekeepers for their residents. A gap also exists more generally in the literature on peer-based GKTs across settings: most studies have measured effects for trainees' self-reported knowledge and skills, without measuring actual helping behavior and population-level service utilization and well-being [13]. The present study reports findings from the first large-scale multisite study of GKTs for college students and one of the first studies of a peer-based GKT in any setting to estimate population-level effects. The study design and scope enable one of the most comprehensive evaluations of a GKT program to date.

Hypotheses

The hypotheses are based on the intended process and outcomes of GKTs, as depicted in Figure 1 and described in the Surgeon General's *2012 National Strategy for Suicide Prevention* [14]. RAs trained as gatekeepers are hypothesized to have improved attitudes and increased knowledge and self-efficacy to respond to mental health issues in their residential communities (H1). This should lead to more contact with residents about mental health concerns (H2), resulting in enhanced knowledge and attitudes at the population level (H3). Ultimately, training is hypothesized to increase residents' service utilization (H4), thus improving mental health (H5).

Methods

Intervention

This study evaluates the impact of one widely used GKT program, Mental Health First Aid (MHFA). Developed in 2001, the version of MHFA evaluated here is a 12-hour course comprising five modules, covering depression, anxiety, psychosis, substance abuse, and eating disorders. Each module includes information about signs and symptoms, appropriate responses, and interactive activities.

A cornerstone of MHFA is the five-step gatekeeper action plan, represented by the acronym ALGEE: (1) assess risk, particularly for suicidality; (2) listen nonjudgmentally to the individual and discuss how she or he feels; (3) give information (e.g., about effectiveness of available treatments); (4) encourage self-management; and (5) encourage help seeking by providing referral information. MHFA is careful to emphasize that self-help is not a substitute for professional care in potential crises.

The evidence base for MHFA comes primarily from Australia, where the training was originally developed by Betty Kitchener, a health education nurse, and Anthony Jorm, a mental health literacy professor. There have been at least three evaluation studies of MHFA: an uncontrolled trial with the public [15], a wait-list randomized control trial in the workplace [16], and an effectiveness trial using a cluster randomized design with the public [17]. Collectively, these studies indicate that MHFA has positive effects on knowledge, attitudes, self-efficacy, helping behavior, and trainees' own mental health [18]. The program has been implemented in 14 countries but has not been evaluated in the U.S. college setting and, like many other GKTs, has not been fully evaluated at the population level.

In the present study, MHFA was delivered by instructors certified by the National Council on Behavioral Healthcare (only the National Council can certify trainers). Most of the instructors (10 of 14) were behavioral health clinicians. All instructors used the same slides, demonstrations, and examples.

Study sites

Campuses were recruited in 2009 via announcements to e-mail lists for campus mental health administrators. Recruitment was compressed because the project was funded by a National Institutes of Health "Challenge Grant" grant under the American Recovery and Reinvestment Act, with a rapid start-up and 2-year maximum study period. To ensure coordination, the study was limited to campuses that volunteered to participate and had clear administrative support. All participating campuses offered free mental health services. This included some form of treatment for at least a few sessions. Campuses also had an effective triaging system, in case demand increased because of the intervention. A total of 32 campuses enrolled in the study at no cost to the institutions. Although this is essentially a convenience sample of institutions, they are diverse along several dimensions, including type, size, and location. The schools are located in 19 states representing all four census regions in the United States. The Montana State University Institutional Review Board (IRB) served as the central institutional review board, and approval was obtained on other campuses as needed. The trial is publicly registered through ClinicalTrials.gov.

Participants

To be included, RAs (second-year and higher undergraduates) and residents had to be enrolled at a participating institution and at least 18 years old. There were no other inclusion or exclusion criteria. Residences were randomized to intervention and control conditions, as detailed in the following section. In intervention

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