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Proposal ENG 2010

Suicide Prevention at Utah Valley University

Brigham Young University had a tragic suicide of a student this winter. Who's to say that Utah Valley University isn't next? A lot of mental illnesses make a first appearance in the ages of 19-30, which means that access to good mental health resources are critical in the college years. Though Utah Valley University has the Student Mental Health Services to provide resources and help to students, these resources need to be expanded. Many students can't even get on the waiting list for an appointment. What good are the services if they are not easily accessible to students? To avoid student suicides and to better the general mental health of the student body, I propose that more therapists be added to the staff - specifically peer specialists, that campus wide training programs focusing on suicide risk assessment and the specific issues that plague UVU be created and implemented, and that campus wide marketing campaigns aimed at raising awareness of suicide and educating the student body on the mental health services available on campus be implemented across campus.

The first step to bettering the mental health services and resources of UVU is to expand the staff of therapists in the Student Health Services. One student responded to the spring 2018 Student Omnibus Survey addressing the need for an expansion of staff. The student said, "I think for a university with almost 40,000 students, UVU needs way better, larger, more accommodating Student Health Services. That office is tiny, the wait list is impossible to get on, and it is disappointing not to have access to these services" (2018). To be effective, the Student Mental Health services need to be expanded. The services need to be more accessible to the

students so that the services can actually make a difference to the students. The first thing would be to hire more therapists. I also propose hiring peer specialists.

A peer specialist is someone who has lived or experienced a mental health issue and is trained to help others. In the case of suicide, peer specialists range from having only experienced suicidal thoughts to having attempted suicide and survived. Because of their experiences with suicide, peer specialists are often able to connect at a deeper level with their patients than a normal health professional. The peer specialist and the patient share life experience. This shared life experience often brings a credibility and authenticity to the peer specialists in the eyes of the patients. Annemeik Huisman and Diana D. Van Bergen from the department of Pedagogical Sciences and Education at the University of Groningen in Groningen, Netherlands state in their research on peer specialists that “the open, nonjudgmental approach of peer specialists was perceived to assist care consumers in opening up about their suicidality. Peer specialists may thus fulfill a need in care consumers that is sometimes not met by mental health care providers, through acknowledgment of their struggle with suicidal despair and creating a sense of being heard and listened to” (2018). In times of hard mental challenges, often the tendency is to feel isolated from society, to feel as if they are the only person in the history of the world that has ever felt this way. The introduction of someone else who has felt the same way brings hope into their lives.

I do admit that it might seem backwards to hire someone who has such an intimate experience with suicide as a suicide prevention measure. Huisman and Van Bergen agree,

pointing out that there are some disadvantages and concerns that many professionals have about peer specialists. Though there are obvious advantages to using a peer specialist, there are many medical specialists who don't trust them with high risk suicidal patients or even at all (2018). Paul N. Pfiefer and his associates in the Department of Psychiatry at the University of Michigan Medical School addressed this specific concern in their research article titled *Development and Pilot Study of a Suicide Prevention Intervention Delivered by Peer Support Specialists.* The aim of their research was to figure out if the distrust of the peer specialists by the medical professionals, mentioned by Huisman and Van Bergen, is warranted. They trained peer specialists in suicide risk assessment techniques and assessed their interactions with high risk patients. Pfiefer et al. state that "it is feasible and acceptable for peer support specialists to engage patients at high risk for suicide in a supportive peer relationship that includes semi-structured conversations addressing key suicide risk factors—hopelessness and connectedness—and suicide safety" (2018).

To summarize, they found that peer specialists, especially peer specialists trained in suicide risk assessment, are qualified and capable of working with high risk suicidal patients contrary to what Huisman and Van Bergen mentioned. Not only are peer specialists qualified to assist high risk patients, Pfiefer et al also found that the extra training had no effect on the peer specialists' empathic connection with the patients. The advantages of peer specialists mentioned by Huisman and Van Bergen are still present even after the peer specialists are trained in more traditional suicide risk assessment techniques. Huisman and Van Bergen's

research on peer specialists and Pfiefer et al's refutation of a major disadvantage of peer specialists work together to prove that peer specialists are a viable, more personal way to help those suffering from mental illnesses and suicidal tendencies on UVU campus.

Alongside the addition of peer specialists, I propose performing assessments and completing campus wide trainings on suicide and suicide risk. Lisa D. Hawley and her associates at the University of Oakland detail the results of their campus wide general health evaluation and its implications in their article *Baseline Assessment of Campus-wide General Health Status and Mental Health: Opportunity for Tailored Suicide Prevention and Mental Health Awareness Programming.* The results were used to "create a specific training program to reduce mental and physical health issues before they give rise to increased risk for suicide and other negative health outcomes" (2016). UVU is a unique school with unique challenges and these challenges should be addressed specifically and not generally. A training program should be created with the university specific problems in mind, especially in regards to the mental health of students. By training not only the Student Health Services staff but also other faculty and the student body you create a campus that is not only better equipped to help those around them but also to help themselves.

This idea is continued in the article that Linda Gask and her associates from the Centre for Primary Care in the Institute of Population Health at the University of Manchester wrote titled *Pilot Study Evaluation of Suicide Prevention Gatekeeper Training Utilising STORM in a British University Setting.* Contrary to the campus wide trainings mentioned by Hawley et al,

Gask and her associates explore the results of training gatekeepers in suicide prevention techniques. A gatekeeper is an individual who has face to face contact with large numbers of community members through their daily routine. These gatekeepers can be trained to identify persons at risk of suicide and refer them to treatment. According to Gask et al, the skills of the gatekeepers improved after the training especially in asking about alcohol, exploring suicidal thoughts, and exploring specific plans. The gatekeepers' confidence levels all improved immediately after the trainings and after three months (2017). In an way, every single person on campus is a gatekeeper to someone else, whether they are a student, a teacher, or a staff member. I'm sure that everyone, if they encountered a friend or acquaintance with suicidal thoughts, would want to help. By assuming that at one point everyone will be a gatekeeper, the ideas of both a campus wide training and gatekeeper trainings are merged together. By completing a campus-wide gatekeeper training, you are better equipping the student body to handle these types of situations. You are creating different levels of viable resources that a student can go to for help whether its talking to a friend who has been trained as a gatekeeper or seeing a therapist in the Student Health Center. Now I am not saying that holding these trainings will make everyone on a campus a certified therapist, but I do think that holding these trainings will make people become more confident in talking to someone about suicide and urging them to get professional help.

Even if all of these changes are made, it will do nothing if the student body is unaware of the expansion of resources and if they choose not to use them. Amy Hedman-Robertson is a

contributing faculty for the School of Health Sciences at Walden University in Minneapolis, Minnesota. She wrote an article titled *Undergraduate Students' Exposure, Knowledge, Utilization, and Intended Use of the National Suicide Prevention Lifeline*. In this article, Hedman-Robertson explained that even though a majority of the students that participated in her research recognized an ad for the suicide help hotline, they were not likely to use the suicide help hotline and they doubted the helpfulness of it. Some students said that if they were considering suicide they didn't feel like they would reach out for help. They said that if they already felt like a burden, getting help would make them feel like more of a burden (2018). Hedman-Robertson's research highlights two important points. The first is that the students need to recognize and be aware of the resources that are available to them. The second is that the students need to be educated on suicide and the importance of getting help. These two issues can be addressed through school wide marketing campaigns focusing on the Student Mental Health services that are available on campus and the importance of getting help.

Beth A. Bucher, a faculty member at Ohio State University, stated in the Proceedings of the ASEE Annual Conference & Exposition that among many programs implemented to increase the overall wellness of graduate students at Ohio State, email marketing campaigns educating students on the mental health resources on campus were found to be successful. The emails were part of a program that Bucher, put together to "creat[e] a wellness culture, connection, community, and professional sense of belonging" of the graduate students to help increase their wellness and mental health (2017). I believe UVU will have the same success. I propose

that UVU send out an email once a month to students focusing on the different aspects of the mental health services on campus, how to recognize suicidal thoughts, the importance of getting help, and other topics that will educate them on suicide. These emails can be supplemented with posters throughout campus, tabling events, and banners on the my.uvu.edu website. A critical part of avoiding suicide is raising awareness and educating the students. I believe that the marketing campaigns combined with the expansion of services in the mental health center will raise the mental wellness of the students on campus.

I would like to point out that all of these things will not only help increase the mental health of the student body and prevent suicides, but also all of these things will help to break the stigma of suicide on campus. I believe that a huge block to having an open conversation about suicide and to students getting help when they need it is the stigma that surrounds suicide. The addition of more therapists and peer specialists to the student health services staff will help facilitate open conversations about suicide. A campus wide training will make every person more confident in their ability to talk to someone about suicide. The marketing campaigns will increase awareness of the resources that are available and the importance of getting help. When people know more about something like suicide, the stigma surrounding it starts to break.

Because UVU already has an established mental health service for students, it could be said that nothing needs to be changed. I object to this thought that nothing needs to be changed. The Student Omnibus Survey of spring 2018 and fall 2018, which is a survey

completed by UVU of students about the academics and campus life of the university, received many suggestions to better the mental health services and resources on campus. One student said:

> Please hire more therapists, even if it means taking money away from sports or advertising. I was recently diagnosed with [a mental health condition], but I can't get into a therapist. I can't even get on the waiting list. I had to quit my job a few weeks ago because of my mental health concerns. All UVU can do is give me medication and suggest self-help books. I'm sure my situation is not uncommon. Please, please help us" (2018).

The students themselves are asking for change, to paraphrase the results of these surveys. There are many UVU students that suffer from mental illnesses and who need help. They have looked to the services on campus for support and have found them lacking. I have watched how the BYU student body was affected by the student suicide in December. I don't want that for my fellow UVU students. Adding peer specialists, implementing a campus wide training program, and launching a marketing campaign across campus will improve the caliber of the mental health services on campus. It has been proven in many things in life that preventative action is way better than reparative action. Though there have been no student suicides on campus yet, that doesn't necessarily mean that the existing resources will continue to work. The university shouldn't wait until it experiences a crisis to make better the services that can help save the lives of its students. I ask that you listen to the students and that you take into consideration my suggestions.

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