Utah Prevention by Design

Community Action Plan

In partnership with Utah Division of Substance Abuse and Mental Health and State Epidemiological Outcomes Workgroup

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EXECUTIVE SUMMARY

NAMI Utah Prevention by Design Project, initiated by contract with Utah's Division of Substance Abuse and Mental Health, is a plan for enhancing and coordinating local community networks in systematic and evidence based approaches to the prevention of mental illness and promotion of mental health. This process is based on the Strategic Prevention Framework (SPF)[1] and will be implemented using the Communities That Care (CTC)[2] prevention planning system.

NAMI Utah developed this plan after a comprehensive needs assessment process was completed in partnership with Utah's State Epidemiological Outcomes Workgroup (SEOW). The SEOW looked at archival mental health data as well as risk and protective factors related to behavioral health and suicide. A review of current resources in place to address suicide prevention, mental illness prevention, and mental health promotion was also completed. Based on the needs assessment, prioritization process, and resource assessment, the goal of the Utah Prevention By Design will be to address suicide deaths through mental illness prevention and mental health promotion.

The next step in the SPF/CTC process was to identify a menu of strategies, programs from which local communities can select based on their individual community needs and current resources. This plan will outline these strategies as well as ideas for additional strategies.

To address suicide prevention communities can explore the Suicide Prevention Resource Centers Best Practices Registry. There will be examples of these programs in the report. To address mental illness prevention the report will identify possible strategies as well as guidance on where to find additional options for communities. To address mental health promotion this report will identify possible strategies as well as guide communities to resources such as SAMHSA's National Registry of Evidence-Based Programs and Policies[3] where communities can find additional opportunities.

As local communities around the state use information from the Prevention by Design needs assessment and community action plan, it will be important for them to focus on the risk and protective factors most relevant to their communities. When viewing the community work through a mental health promotion and mental illness prevention focus, it will be helpful to review SAMHSA's risk and

[1] SAMHSA Strategic Prevention Framework: http://captus.samhsa.gov/sites/default/files/capt_resource/SPF.OverviewDoc.Resource.pdf
[2] Communities That Care: http://www.sdrg.org/ctcresource/
[3] SMMHSA NREPP: http://www.nrepp.samhsa.gov/

protective factors for mental, emotional, and behavioral disorders across the life cycle[4] as well as the Suicide Prevention Resource Center's resources on risk and protective factors.[5] Communities will need to engage in a local assessment process to identify these factors, the resources available to intervene, and the gaps the community has that can be filled through this process. We will then identify strategies to address suicide prevention, mental illness prevention, and/or mental health promotion in communities statewide.

[4] SAMSHA's Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle: http://www.namiut.org/images/Risk%20and%20Protective%20Factors%20for%20Mental.pdf

[5] Suicide Prevention Resource Center Risk and Protective Factors for Suicide: http://www.sprc.org/sites/sprc.org/files/library/srisk.pdf

INTRODUCTION

Purpose of Community Action Plan:

NAMI Utah Prevention by Design Project, initiated by contract with Utah's Division of Substance Abuse and Mental Health, is a plan for enhancing and coordinating local community networks in systematic and evidence based approaches to the prevention of mental illness and promotion of mental health. This process is based on the Strategic Prevention Framework (SPF) and will be implemented using Communities That Care (CTC) prevention system. The purpose of a community action plan is to use the desired community level outcomes to identify strategies that are effective in meeting those outcomes.

This community action plan will outline the statewide work that NAMI will be doing to address the priorities identified through the needs assessment process. The report will also outline the next steps for local communities in determining their resources and gaps in order to address the risk and protective factors for mental health and suicide prevention most prevalent in each of the local communities. It will also introduce a menu of possible strategies and programs to be a guide for communities to address risk and protective factors and community gaps.

The next step for implementation of the plan will be to present the needs assessment, plan, and introduction of opportunity for local engagement in each of the thirteen mental health and substance abuse planning districts in Utah. These districts will identify local prevention oriented councils and coalitions who are willing and able to engage in a resource and gaps analysis as well as planning for the priorities identified. After that process, NAMI Utah will work with each community to implement the plans and goals that are identified.

Mental Illness Overview:

Mental illness affects individuals across every race, class, gender and lifestyle. According to the National Institute of Mental Health, an estimated 26.2 percent of Americans ages 18 and older — about one in four adults — live with a diagnosable mental disorder in any given year. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 — who live with a serious mental illness. Like adults, children and youth experience mental illness disorders at an alarming rate, with 46.3 percent of children ages 13-18 either currently experiencing or having experienced at some point in their life some form of mental illness, and 21.4 percent - about one in five- living with a debilitating or "severe" mental disorder. In an April 2006 study, NIMH revealed that half of all lifetime cases of mental illness are evident by age 14 and

three-quarters by age 24. The Centers for Disease Control and Prevention's National Health and Nutrition Examination Survey (NHANES), reports that about 13 percent of children ages 8-15 had a diagnosable mental disorder within the previous year. The U.S Department of Education reports that over 50 percent of students with a mental disorder age 14 and older drop out of high school—the highest dropout rate of any disability group. The U.S Department of Health and Human Services reports that less than one-third of adults and half of children with a diagnosable mental disorder receive any mental health services in a given year.

Several populations are considered to be at a higher risk of experiencing a mental illness in their lifetime, due to conditions such as chronic medical disorders, genetic and environmental conditions and trauma. Individuals with serious mental illness face an increased risk of having chronic medical conditions. The National Institute of Mental Health reports that adults with serious mental illness die 25 years younger than other Americans, largely due to treatable medical conditions. A 2003 article in the Journal of Consulting and Clinical Psychology reported that most research suggests that GLBT people are likely to be at higher risk for depression, anxiety, and substance use disorders. GLBT groups are about two-and-one-half times more likely than heterosexual men and women to have had a mental health disorder, such as those related to mood, anxiety, or substance use, in their lifetime. In July 2007, a nationwide report published in the Journal of Epidemiology and Community Health indicated that male veterans are twice as likely to die by suicide as compared with their civilian peers in the general U.S. population.

NAMI Utah recognizes that the impacts of mental illness are far-reaching, affecting a wide spectrum of individuals from those living with a mental illness to the general public. Due to the high prevalence and wide-spread effect of mental illness across all populations, accessibility to diverse information and support must be available to all members of the community at all levels of intervention. NAMI Utah Prevention by Design, including NAMI Utah's education programs, support groups, outreach and mentoring, and community partnerships and projects, aims to serve all members of the community.

There are many organizations working across the health and mental health spectrum to reduce the impact of mental illness on individuals, families, and communities. NAMI Utah will partner with mental health providers, health care providers, prevention networks, and other interested community partners to address the ongoing needs of the community by working towards preventing suicide and mental illness, and promoting mental health.

Promotion and Prevention: A National Priority

Right now is the time to act on prevention and promotion activities. There is a national focus on prevention in all aspects of health and health care. The cost of health care is rising and positive health related outcomes are not keeping pace. We are working to change the paradigm of our health care systems from sick care to one with a focus on wellness and positive health. Preventive care and community based prevention practices are essential to this important paradigm shift. A prevention framework will help us get closer to our goal of creating strong and healthy individuals and communities. We must continue our work in educating individuals, providers, communities, and policy makers that mental health must be a part of the conversation. Mental health is integral to overall health and is an important puzzle piece in this transition. As they say, an ounce of prevention is worth a pound of cure.

The Patient Protection and Affordable Care Act (ACA) places an emphasis on prevention in all aspects of healthcare. The law established a National Prevention Council which was tasked with creating a National Prevention Strategy.[6] This strategy is a multi-sector collaborative approach with the goal of increasing the number of Americans who are healthy at every stage of life. The National Prevention Council understands the link between mental health and overall health as well as the impact of mental illness on physical health. One of the priorities in the strategy is to promote mental and emotional well-being. The ACA also focuses on prevention by offering preventive services with no cost-sharing. This means that people can get care such as depression and alcohol misuse screenings and counseling without having to pay a co-pay or meet their deductibles. For more information on prevention and wellness as part of the ACA visit www.healthcare.gov.

Healthy People 2020[7] is an extension of the national effort Health People 2010. Both aim to improve America's overall health through personal empowerment and multi-sector collaboration. This collaboration also includes mental health goals in the plan to improve America's health. There are sub-goals under two main topics. The first is mental health status improvement which has sub-goals on topics such as suicide prevention, eating disorders, and major depression. The second is treatment expansion and includes topics such as increased screening in primary care, access and engagement in mental health services, and helping those with a mental illness be participants in the work force.

[6] National Prevention Strategy: http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf
[7] Healthy People 2020: http://www.healthypeople.gov/2020/LHI/mentalHealth.aspx

The Substance Abuse and Mental Health Services Administration (SAMHSA) works to reduce the impact that substance abuse and mental illness have on communities. To help achieve this SAMHSA created eight strategic initiatives.[8] The first initiative is the prevention of substance abuse and mental illness, which have a massive social, economic, and personal impact on people and systems throughout the nation. SAMHSA recognizes that it takes a multi-sector approach to prevent substance abuse and the likelihood of mental health, and promote positive mental health in our communities. Appropriate implementation of prevention programs and activities along with community education will result in stronger, healthier, and more supportive communities.

NAMI has over thirty years of history advocating, educating, and supporting those living with and affected by mental illness. Advocating for mental health promotion and mental illness prevention fits perfectly with NAMI's mission to ensure the dignity and improve the lives of those who live with mental illness and their families. Working with partners across various sectors is integral to meeting our goals.

Prevention Science Overview:

For decades public health approaches to health promotion and disease prevention have improved the health of millions of people in the United States. The substance abuse field also has engaged in longstanding prevention efforts. The burden of disease brought about by mental illness, including the toll on physical health, co-occurring substance abuse, workplace productivity, education, and overall quality of life, is among the highest of all disease classes and is one of the most common causes of disability according to Healthy People 2020. Using a prevention lens gives us an opportunity to lessen the burden of these diseases and improve overall quality of life for those who experience mental illness. An approach that is mindful of the links in prevention oriented work will allow us to be even more effective with the resources available.

Mental health has often been based in the treatment realm in the continuum of care and it will be a paradigm shift to link this with the broader continuum including promotion and prevention. SAMHSA describes the *Behavioral Health Continuum of Care Model*[9] and encourages those in behavioral health to look for opportunities to address behavioral health issues in multiple settings and across the spectrum. It is important to note that strategies do not always fit clearly into only one category. For

[8] SAMHSA Leading Change: http://store.samhsa.gov/product/SMA11-4629
[9] SAMHSA- A Behavioral Health Lens for Prevention: http://captus.samhsa.gov/sites/default/files/capt_resource/CAPT%20Behavioral%20Health%20Fact%20Sheets%20(2012).pdf

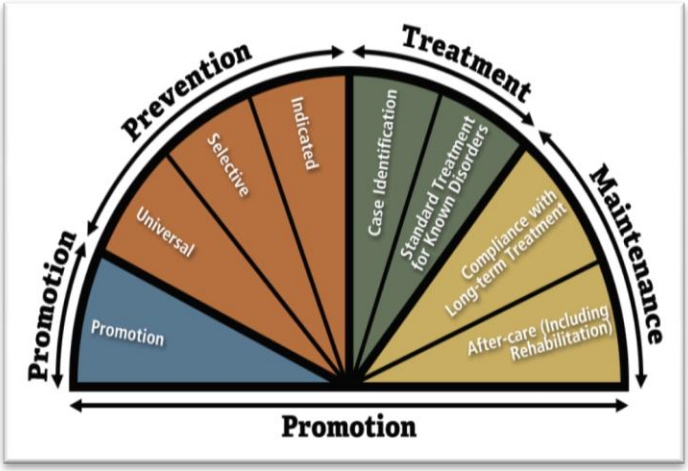
example, suicide **prevention** strategies may include efforts to increase mental illness **treatment** capacity for those in need. Components of this model include:

Promotion- Strategies that are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies should be used across the continuum of care.

Prevention- Often delivered prior to the onset on a disorder and intended to prevent or reduce the risk of developing a behavioral health problem.

Treatment- Services for people diagnosed with a substance abuse or mental health disorder.

Maintenance- Services that support compliance with long term treatment and recovery.



Behavioral Health Continuum of Care Model

People have varying levels of risk when it comes to developing behavioral health disorders. When choosing prevention strategies it is important to gauge the risk level of the groups which will be targeted. The Institute of Medicine[10] defines three targets for prevention interventions

Universal- A broad prevention approach that targets an entire population and the population has not been chosen or identified on the basis of individual risk. Examples include entire communities or schools.

Selective- Prevention approach that targets subsets of the population with increased risk of developing mental health or substance abuse disorders. These interventions target biological, psychological, or other risk factors more prominent in the population subsets than in the wider population. Examples include youth who have a parent with a mental illness or refugee groups.

Indicated- Prevention approach that targets those individuals who are deemed high risk for developing a mental health or substance abuse disorder based on signs that do not meet diagnostic criteria, but are detectable for the increased risk. Examples include a youth who is using alcohol on school grounds or becoming involved in the juvenile justice system.

[10] Institute of Medicine for Prevention: http://www.kitsco.com/casupport/WebHelp_Prevention101/Institute_of_Medicine_IOM_for_Prevention.htm

The relationship between all components of the continuum is important to keep in mind when reaching out to potential partners for collaboration opportunities. Within this model cross sector collaboration is key to maximizing resources and increasing desired outcomes.

How to use the plan:

The purpose of the NAMI Utah Prevention by Design community action plan is to summarize the assessment process, describe resources available, and engage in outcome focused planning and preliminary implementation steps. It includes tools for resource and gaps analysis on the local level and a menu of possible strategies, policies, and programs for communities to utilize to achieve these outcomes depending on the local needs and strengths. This plan can be a guide for communities to use in order to address suicide deaths through mental illness prevention and mental health promotion.

COMMUNITY ACTION PLAN

State Profile

Utah data was compiled and reviewed by the SEOW mental health workgroup. The workgroup identified that in spite of similar rates of mental health disorders, Utahns continue to die from mental illness at higher rates via suicide. Data shows that Utah does rank higher than most states in terms of individuals who experience serious mental illness. This may be one explanation for our continually higher than average suicide rates. Given the finality of suicide, disability adjusted life years lost as a result of suicide, and the overall economic, emotional, and physical impact on families and communities, the group decided to prioritize a focus on suicide deaths. The need for a community based, systematic, and evidence based approach to this complicated issue is needed throughout the state. Utah Prevention by Design will address suicide deaths through mental illness prevention and mental health promotion efforts. (See Appendix B for complete data table)

Data Collection Efforts

To complete the Prevention by Design needs assessment, NAMI Utah has worked with community partners to create a data template for evaluating issues statewide. The data template has been populated with archival data from a variety of sources for prevalence of mental illness and suicide/self-harm data. Data sources include the BRFFS, SHARP, NSDUH, YRBS, NIMH, among others.

Data on additional outcomes exist within the SEOW website (eg…crime related data) (See data sources in appendix A).

Although the CTC Process recommends that a youth survey be administered to better understand the risk and protective profile for each community, we did not do this as the DSAMH already administers a more comprehensive survey in the SHARP. NAMI Utah did conduct a survey in order to better understand what needs are identified by the community. This survey was completed by individuals with mental illness, their family members, health and mental health providers, and more.

Prioritization Process

The SPF and CTC model makes suggestions for the prioritization process based on data and areas of need. It recognizes that it would be ideal to focus on all geographies, populations, and issues, but to achieve the greatest impact, prioritizing is essential. Some important things to keep in mind when prioritizing are data trends, clusters of risk, community readiness and ability to influence. Even when using all of the guidelines, it comes down to making hard choices while paying attention to time, resources, and moving forward. This process led the workgroup to state that NAMI Utah Prevention by Design will address suicide deaths through mental illness prevention and mental health promotion efforts.

Existing Resources

Coordinated state wide efforts related to mental illness and mental health have historically been treatment-based as opposed to prevention-based. The types of services offered throughout the state vary. Statewide mental health initiatives include:

- Public mental health systems divided by 13 regions throughout the state including a statewide prevention workforce,
- Over 40 local coalitions and councils statewide working together to address the needs of their local communities whom are driven by the SPF/CTC data based process,
- The Family Resource Facilitator project,[11]
- Recovery Plus Wellness Initiative,[12]
- NAMI Utah offers free support groups, education classes, school based education, and provider trainings state-wide for those living with mental illness, their family members, and those interacting with people with mental health disorders,
- Crisis Intervention Team mental health training for police officers

[11] Family Resource Facilitator Project: http://www.dsamh.utah.gov/
[12] Recover Plus: http://recoveryplus.utah.gov/

- Army OneSource is coordinating with state partners to address mental health needs of service members and veterans,
- Various additional prevention initiatives for substance abuse, crime, general health, and more that are addressing various elements of risk and protection associated with the onset and exacerbation of mental health disorders.

Utah's Suicide Prevention Coalition is in the process of re-writing the state suicide prevention plan based on the most recent plan formulated in 2007. Through this process and other state initiatives, state wide suicide prevention initiatives are being identified including:

- HB501 (2012 General Session) requires all licensed school district staff to participate in two hours of suicide prevention training for re-licensure,
- Utah chapter of the American Foundation for Suicide Prevention has offered their suicide prevention curriculum to high schools state wide at no cost,
- Utah Department of Health identified strategies for addressing suicide as an injury prevention priority,[13]
- DOH and DSAMH are partnering to release a suicide public awareness campaign- "Speak up to Save Lives",
- Utah Pride Center is working with DCFS to increase cultural competency for working with LGBTQ youth, including an emphasis on the increased risk of suicide.

There are statewide and locally based initiatives throughout the state that are aimed at intervening in potential risk factors and building up protective factors in order to make the communities healthier, more safe, and to improve the quality of life for residents. As this process moves forward at the local level, those communities will need to identify the priority risk and protective factors in their community as well as the resources already available at the local level.

Options for strategies, programs, policies and practices

Communities can find evidence based practices for suicide prevention with the Suicide Prevention Resource Center's Best Practices Registry.[14] Examples of suicide prevention activities are listed below. Communities can choose the examples listed below or other evidence based programs.

STRATEGY	MORE INFO	RISK FACTOR	PROTECTIVE FACTOR	Population
NAMI Connect	http://www.theconnectprogram.org/	All	All	All
Engaging Rural Providers in	http://www.sprc.org/for-providers/primary-care-tool-kit	*Mental Illness/ Disorder	*Effective Clinical Care *Support for	All- Adults

[13] DOH VIPP: http://www.health.utah.gov/vipp/suicide/index.html
[14] SPRC Best Practices Registry: http://www.sprc.org/bpr

Suicide Prevention		*Stigma *Barriers to accessing care	help-seeking *Support through medical care relationships	
HOPE 4 Utah	www.hope4Utah.com	All	All	Youth
Hope For Tomorrow	http://www.namiut.org/find-local-support/free-education/hope-for-tomorrow	*Mental health disorder *Substance Abuse disorders *Hopelessness *Lack of social support *Stigma associated with help seeking	*Support for help-seeking *Connections to community support	School based program

Communities can find evidence based practices for mental illness prevention in various places including the IOM Preventing Mental, Emotional, and Behavioral Disorders Among Young People,[15] the National Council for Community Behavioral HealthCare,[16] and more. Examples of mental illness prevention activities are listed below. Communities can choose the examples listed below and/or other evidence based programs.

STRATEGY	MORE INFO	RISK FACTOR	PROTECTIVE FACTOR	Population
Mental Health First Aid	http://www.mentalhealthfirstaid.org/cs/program_overview/ Outcomes: Improved mental health for participants, improved knowledge mental illness, knowledge and confidence in providing mental health first aid, decrease in stigmatizing, increase in support given to others	*Poor social skills *Mental health disorders *Lack of social support *Stigma associated with help-seeking	*Problem Solving Skills *Opportunities for engagement with community *Presence of support	All
Action Signs Project	http://www.thereachinstitute.org/files/documents/action-signs-toolkit-	All	All	Children & youth

[15] IOM Preventing Mental, Emotional, and Behavioral Disorders Among Young People: http://www.nap.edu/catalog.php?record_id=12480

[16] National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/cs/press_releases/preventionearly_intervention_programs_for_mental_illness_and_addictions

	final.pdf	
Penn Resiliency Program	http://www.ppc.sas.upenn.edu/prpsum.htm	Youth

Communities can find evidence based practices for mental health promotion in various locations including SAMHSA's National Registry of Evidence-Based Programs and Policies[17] and the CTC Tested Programs by Risk Factor Index.[18] Examples of mental health promotion activities are listed below. Communities can choose the examples listed below and/or other evidence based programs.

STRATEGY	MORE INFO	RISK FACTOR	PROTECTIVE FACTOR	Population
Mental Health First Aid	http://www.mentalhealthfirstaid.org/cs/program_overview/ Outcomes: Improved mental health for participants, improved knowledge mental illness, knowledge and confidence in providing mental health first aid, decrease in stigmatizing, increase in support given to others	**Poor social skills *Mental health disorders *Lack of social support *Stigma associated with help-seeking	*Problem Solving Skills *Opportunities for engagement with community *Presence of support	All
The Good Behavior Game	http://nrepp.samhsa.gov/ViewIntervention.aspx?id=201	*Alcohol use *Drug Use *Mental health *Tobacco *Violence *Suicide *Antisocial behaviors	*Social Competence *Pro-social Behaviors *Problem solving skills	6-12
Emergency Dept. Means Restriction Education	http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=15	*Substance Abuse *Violence *Suicide	*Presence of supports	All

NAMI Utah will also work with communities to implement or strengthen NAMI programs statewide. NAMI programs that will be offered throughout the state include (but are not limited to) the following.

[17] SAMHSA NREPP: http://www.nrepp.samhsa.gov/
[18] CTC Tested Programs by Risk Factor Index: http://www.sdrg.org/ctcresource/Prevention%20Strategies%20Guide/indexbyriskfactor.pdf

NAMI STRATEGY	MORE INFO	RISK FACTOR	PROTECTIVE FACTOR	Population
Connection	NAMI Connection is a weekly recovery support group for people living with mental illness in which people learn from each others' experiences, share coping strategies, and offer each other encouragement and understanding.	*Mental health disorders *Substance Abuse *Suicide *Poor social skills: communication and problem solving skills *Family Conflict *Stigma associated with help-seeking *Lack of social support *Peer Rejection	*Opportunities for engagement with community *Presence of supports *Problem solving skills *Coping Skills *Mental Health Literacy *Support for help-seeking *Emotional self-regulation	Adults living with mental illness
Family Support Group	Family Support Groups are an important free resource for families who have a loved one with mental illness. Knowing that others have had the same experiences is a relief to families who have seldom spoken about mental illness to neighbors, friends, or, often, even relatives. Learning that others have been able to work out some common issues can inspire hope.	*Mental health disorders *Substance Abuse *Suicide *Poor social skills: communication and problem solving skills *Family Conflict *Stigma associated with help-seeking	*Presence of supports *Problem solving skills *Coping Skills *Mental Health Literacy *Support for help-seeking *Emotional self-regulation	All
Bridges	The NAMI Bridges Program is a FREE 12-week recovery course that brings together people who share the experience and knowledge of mental illness to empower each other with the tools to build bridges of recovery. Bridges is a peer-to-peer class taught by trained individuals who have personal experience with mental illness.	*Mental health disorders *Substance Abuse *Suicide *Poor social skills: communication and problem solving skills *Family Conflict *Stigma associated with help-seeking *Lack of social support	*Presence of supports *Problem solving skills *Coping Skills *Mental Health Literacy *Support for help-seeking *Emotional self-regulation *Opportunities for community engagement	Adults living with mental illness

		*Peer Rejection		
Family To Family	The NAMI Family-to-Family Education Program is a free, 12-week course for family caregivers of individuals with severe mental illnesses. The course includes current information on mental illness, treatment options, skill building in communication, problem solving, crisis management and more.	*Poor social skills: communication and problem solving skills *Family Conflict *Stigma associated with help-seeking	*Presence of supports *Problem solving skills *Coping Skills *Mental Health Literacy *Support for help-seeking *Emotional self-regulation	All
Progression	Progression is a course focusing on young people between the ages of 13 and 18 who are dealing with mental health issues. The name, Progression, alludes to its purpose of empowering young people with information and tools to advance towards their dreams and goals. Topics include information about mental health issues, resiliency and recovery, supports and allies, self advocacy, transition issues and much more. This is a chance for young people to gather and learn about these issues from those that have been there.	*Parent-child conflict *Poor social skills: communication and problem solving skills	*Presence of supports *Problem solving skills *Coping Skills *Mental Health Literacy *Support for help-seeking *Emotional self-regulation *Opportunities for community engagement	Youth/ Young Adults 13-19
Basics	The fundamentals of caring for you, your family and your child with mental illness NAMI Basics is an education program for parents and other caregivers of children and adolescents living with mental illnesses. The NAMI Basics course is taught by trained teachers who are the parent or other caregivers of individuals who developed the symptoms of mental illness prior to the age of 13 years. The course consists of six classes, each lasting for 2 ½ hours.	*Parent-child conflict *Mental health disorders *Substance Abuse *Suicide *Poor social skills: communication and problem solving skills *Family Conflict *Stigma associated with help-seeking *Lack of social support *Peer Rejection	*Presence of supports *Problem solving skills *Coping Skills *Mental Health Literacy *Support for help-seeking *Emotional self-regulation	Adult Caregiver
Provider	The NAMI Provider Education			All

Education	Program is a 5-week course that presents a penetrating, subjective view of family and consumer experiences with serious mental illness to line staff at public agencies who work directly with people experiencing severe and persistent mental illnesses. The course helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness.	
NAMIWalks	NAMIWalks is the largest and most successful mental illness awareness event in America and Utah. Through NAMIWalks' public, active display of support for people affected by mental illness, we will continue to change our communities and ensure that help and hope are available for those in need.	Universal

NAMI Utah will work with established NAMI affiliates and local communities to provide a variety of the services outlined above depending on the need of each community. NAMI Utah will be able to offer Mental Health First Aid in communities that lack trainers or where current trainers cannot meet the needs. NAMI Utah will provide this at cost for travel and materials.

Next steps for NAMI Utah

NAMI Utah will submit this report to DSAMH staff for review and possible revision. Upon approval NAMI Utah will approach communities through a letter to mental health and substance authority directors with copies of the NAMI Utah Prevention by Design Needs Assessment and Community Action Plan. NAMI Utah will work with these entities to identify local coalitions or councils who are able and willing to take on the scope of work as well as engage local NAMI affiliate members to engage with these groups. NAMI Utah will provide sub-contract funding for the planning as well as implementation and evaluation process (based on contract with DSAMH).

Next steps for communities

NAMI Utah will present the needs assessment and plan information to these communities along with a letter of explanation. This letter will ask the community to gauge the interest and capacity of coalitions and councils to engage in addressing suicide deaths through mental illness prevention and mental health promotion. Through this process communities will be expected to engage in the following: collect and analyze community level data including an analysis of risk and protective factors;[19] define community level outcomes; select strategies, programs, and policies, define program level outcomes; identify possible system change strategies; and develop evaluation and implementation plans. Communities may choose to incorporate effective strategies into existing services, expand existing effective programs, implement new strategies, and/or system change strategies. The Communities that Care model gives guidance on this process in modules three and four.[20] There will be funds available to the communities to engage in planning and implementation of this project.

CONCLUSION AND RECOMMENDATIONS

The NAMI Utah Prevention by Design needs assessment process leads to the goal of addressing suicide deaths through mental illness prevention and mental health promotion. Utah consistently ranks among the highest in the nation for suicide deaths. Suicide has remained a top ten leading cause of death in Utah, with some age groups seeing suicide as a top three leading cause of death. NAMI Utah will work with communities to implement plans for enhancing and coordinating local community networks in systematic and evidence based approaches in suicide prevention, the prevention of mental illness and promotion of mental health.

NAMI Utah recommends that mental health and substance abuse authorities coordinate with the prevention coordinators and/or prevention oriented groups to identify one (or more) local councils or coalitions who have the capacity to take on this scope of work. Those coalitions identified can then engage in the planning process and design S-M-A-R-T goals[21] that outline what strategies will be used and how they will be evaluated. NAMI Utah will continue to partner with the DSAMH and local communities to coordinate efforts and share information on a statewide level.

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[19] SAMSHA's Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders Across the Life Cycle: http://www.namiut.org/images/Risk%20and%20Protective%20Factors%20for%20Mental.pdf Suicide Prevention Resource Center Risk and Protective Factors for Suicide: http://www.sprc.org/sites/sprc.org/files/library/srisk.pdf

[20] CTC Phases of Implementation: http://www.sdrg.org/ctcresource/Phases_of_CTC_NEW.htm

[21] CDC S-M-A-R-T Goals: http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html

APPENDIX

Acknowledgements

NAMI Utah would like to acknowledge the Utah Division of Substance Abuse and Mental Health (DSAMH) for their partnership on this project and report. We are grateful for the ongoing partnership and extend our sincere thanks. We would also like to extend our gratitude to the State Epidemiological Outcomes Workgroup (SEOW). A special thank you to the SEOW mental health sub workgroup- Susannah Burt (DSAMH), Jennifer Oxborrow (DSAMH), Rick Hendy (DSAMH), Edward Ho (Bach Harrison L.L.C.), and Anna Fondario (Utah Department of Health).

NAMI Utah would also like to recognize the dedication and hard work of our local affiliates throughout the state of Utah. Without their work NAMI programs would not be possible in communities around Utah.

We would like to express a final thank you to all of those working in Utah and beyond whose work contributes to the NAMI mission of ensuring the dignity and improving lives of those who live with mental illness, their loved ones, and the communities we live in.

Appendix A

DATA SOURCES

BRFSS: Behavioral Risk Factor Surveillance Survey
http://ibis.health.utah.gov/query/selection/brfss/BRFSSSelection.html

DSAMH: Division of Substance Abuse and Mental Health Annual Report 2011
http://www.dsamh.utah.gov/docs/Revised%202011%20Annual%20Report.pdf

IBIS: Utah Department of Health- Indicator Based Information System for Public Health
http://ibis.health.utah.gov/home

NIMH: National Institute on Mental Health http://www.nimh.nih.gov/statistics/index.shtml

NSDUH: National Survey on Drug Use and Health
http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/index.aspx

SHARP: Student Health and Risk Prevention
http://www.dsamh.utah.gov/docs/State%20of%20Utah%20Profile%20Report.pdf

VIPP: Utah Department of Health Violence and Injury Prevention Program
http://www.health.utah.gov/vipp/suicide/index.html

YRBS: Youth Risk Behavior Survey http://ibis.health.utah.gov/query/selection/yrbs/YRBSSelection.html

Appendix B

Mental Health Prevalence Data

	Indicator	Age Category	Year	Utah	USA	Utah:USA Ratio	Data Source
Youth	Needs Mental Health Treatment (score of 13 or higher on k6)	Grade 6	2011	8.6%	NA	NA	SHARP
		Grade 8	2011	11.7%	NA	NA	SHARP
		Grade 10	2011	12.7%	NA	NA	SHARP
		Grade 12	2011	12.0%	NA	NA	SHARP
		All Grades	2011	11.2%	NA	NA	
	Felt Sad or Depressed Most Days in the Last Year	Grade 6	2011	10.3%	NA	NA	SHARP
		Grade 8	2011	11.5%	NA	NA	SHARP
		Grade 10	2011	11.7%	NA	NA	SHARP
		Grade 12	2011	9.6%	NA	NA	SHARP
	ADHD	3-17	2009	NA	8.6%	NA	NSDUH
	Major Depressive Disorder (MDE) in last year	12-17	2009	8.39%	8.18%	1.03	NSDUH
	Any Mental Disorder	8-15	2001-2004	NA	13.1%	NA	NSDUH
	Mental Disorder with Severe Impairment in the past year	8-15	2001-2004	NA	11.3%	NA	NSDUH
	Mental disorder without severe impairement	8-15	2001-2004	NA	13.1%	NA	NSDUH
Adult	MDE in last year		2009	7.49%	6.49%	1.15	NSDUH
	Serious Mental Illness		2009	6.18%	4.60%	1.34	NSDUH
	Serious Psychological Distress		2009	1.9%	3.2%	0.59	NSDUH
	Any Mental Illness		2009	24.09%	19.67%	1.22	NSDUH

	Major Depression	2005-2007	4.1%	6.7%	0.61	BRFFS
	Anti-Depressant use (18-64)	2009	12.71%	NA	NA	Utah Atlas (DOH)

Mental Health Indicators: Adverse Childhood Experiences

Prevalence of ACE experiences by category	Year	% of Utah Adults
Verbal/Emotional Abuse	2010	37.9%
Household member with Mental Illness	2010	21.0%
Parents Separated/Divorces	2010	19.3%
Physical Abuse	2010	17.1%
Household member with alcohol abuse	2010	16.4%
Witness Domestic Violence	2010	12.4%
Household Drug Abuse	2010	12.0%
Touched Sexually	2010	9.0%
Touched an Adult Sexually	2010	7.3%
Household Member in Prison	2010	6.1%
Raped	2010	2.9%
ACE Score		
0	2010	41.1%
1-4	2010	48.8%
5+	2010	10.1%

	Indicator	Age Category	Year	Utah	USA	UT:USA Ratio	Data Source
Youth	Suicide Deaths	0-14	2003-2007	0.4 per 100,000	0.5 per 100,000 (2007)	0.8	VIPP
		15-19	2009	12.1 per 100,000	7.4 per 100,000 (2008)	1.635	VIPP
	Suicide Attempt last 12 months that required medical attention	Grade 9	2011	2.2767%**	2.8%	**0.82**	YRBS
		Grade 10	2011	3.56%	2.6%	**1.40**	YRBS
		Grade 11	2011	4.45%	1.9%	**2.34**	YRBS
		Grade 12	2011	2.1528%**	2.0%	**1.1**	YRBS
		9-12	2011	3.12%	2.4%	**1.34**	YRBS
	Suicide attempt last 12 months	Grade 9	2011	7.68%	9.3%	**0.83**	YRBS
		Grade 10	2011	8.57%	8.2%	**1.1**	YRBS
		Grade 11	2011	7.96%	6.6%	**1.21**	YRBS
		Grade 12	2011	4.21% **	6.3%	**0.67**	YRBS
		9-12	2011	7.18%	7.8%	**0.92**	YRBS
	Suicide plan last 12 months	Grade 9	2011	11.71%	13.6%	**0.86**	YRBS
		Grade 10	2011	12.64%	14.4%	**0.90**	YRBS
		Grade 11	2011	13.17%	11.9%	**1.15**	YRBS
		Grade 12	2011	11.46%	10.7%	**1.07**	YRBS
		9-12	2011	12.26%	12.8%	**0.96**	
	Suicide- serious consideration	Grade 9	2011	14.02%	17.1%	**0.82**	YRBS
		Grade 10	2011	14.3%	16.5%	**0.87**	YRBS
		Grade 11	2011	16.57%	15.5%	**1.07**	YRBS

		Grade 12	2011	11.38%	13.6%	**0.84**	YRBS
		9-12	2011	14.2%	15.8%	**0.9**	
	Felt sad or hopeless almost every day for 2 weeks or more-stopped doing usual activities in last 12 months	Grade 9	2011	22.05%	27.6%	**.80**	YRBS
		Grade 10	2011	26.98%	28.7%	**0.94**	YRBS
		Grade 11	2011	31.86%	28.8%	**1.11**	YRBS
		Grade 12	2011	25.37%	28.9%	**0.88**	YRBS
		9-12	2011	26.7%	28.5%	**.094**	
Adult	Suicide Deaths		2010	16.98 Per 100,000 (total Utah population)	12 Per 100,000 (2009)	1.415	IBIS Mortality data
	Self Inflicted Injury (result in hospitalization)		2009	76.0 per 100,000 (total Utah population)	64.92 per 100,000 (2010)	1.171	IBIS ED Data/ WISQARS
	Intentional Self Harm- ED Encounters		2009	183.5 per 100,000 (total Utah population)	152.96 per 100,000 (2010)	1.199	IBIS Data/ WISQARS
	Suicidal Ideation		2009	5.43%	3.71%	1.46	NSDUH

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***Use caution in interpreting, the estimate has a relative standard error greater than 30% and does not meet UDOH standards for reliability. Consider aggregating years to decrease the relative standard error and improve the reliability of the estimate.*

****The estimate has been suppressed because 1) The relative standard error is greater than 50% or when the relative standard error can't be determined.*

Public Mental Health Treatment and Unmet Needs

2011	Number Served	Number who Needed Treatment	In Need of, but did not receive services	Percent that need Treatment	Data Source
Adults	29,489	105,369	75,880	5.5%	DSAMH 2011 Annual Report
Youth	15,596	41,373	25,777	4.8%	DSAMH 2011 Annual Report

Public Mental Health: Prevalence by Diagnosis

Diagnosis	**Adults**	**Youth/Children**	**Data Source**
	Percentage/Number	**Percentage/Number**	
Mood Disorder	**30.4%/ 8,965**	16.1%/ 2,511	DSAMH 2011 Annual Report
Anxiety	23.5%/ 6,930	**17.5%/ 2,729**	DSAMH 2011 Annual Report
Substance Abuse	13.9%/ 4,099	3.5%/ 546	DSAMH 2011 Annual Report
Personality Disorder	10.4%/ 3,067	0.2%/ 31	DSAMH 2011 Annual Report
Schizophrenia & Other Psychotic	7.1%/ 2,094	0.2% 31	DSAMH 2011 Annual Report
Attention Deficit	3.7%/ 1,091	16.1%/ 2,511	DSAMH 2011 Annual Report
Cognitive Disorder	3.2%/ 944	1.4%/ 218	DSAMH 2011 Annual Report
Adjustment Disorder	2.0%/ 590	8.6%/ 1,341	DSAMH 2011 Annual Report
Neglect/Abuse	1.5%/ 442	10.5%/ 1,638	DSAMH 2011 Annual Report
Impulse Control Disorders	1.0%/ 295	4.9%/ 764	DSAMH 2011 Annual Report
Pervasive Developmental	0.8%/ 236	5.1%/ 795	DSAMH 2011 Annual

Disorders			Report
Oppositional Defiant Disorder	0.2%/ 59	8.7%/ 1,357	DSAMH 2011 Annual Report
Conduct Disorder	0.1%/ 29	1.5%/ 234	DSAMH 2011 Annual Report
Other	2.3%/ 678	5.7%/ 889	DSAMH 2011 Annual Report
V Codes	7.1%/ 2,094	11.5%/ 1,794	DSAMH 2011 Annual Report

Mental Illness Prevalence by Diagnosis

Based on National Statistics-National Institute of Mental Health

Diagnosis	Avg Age of Onset	Adults	Youth/Children 13-18	12 Month Healthcare Use- Adults	12 Month Any Service Use- Adults	Data Source
Any Disorder	14	26.2% 12 Month Prevalence	46.3 % Lifetime Prevalence 13.1% 12 Month Prevalence	36% adults	41.1% adults	NIMH
Anxiety Disorder	11	28.8% Lifetime Prevalence 18.1% 12 Month Prevalence	25.1% Lifetime Prevalence	36.9% adults	42.2% adults	NIMH
Attention Deficit/ Hyperactivity Disorder	7	8.1% Lifetime Prevalence 4.1% 12 Month Prevalence	9.0% Lifetime Prevalence	NA	NA	NIMH
Any Mood Disorder	30	20.8% Lifetime Prevalence 9.5% 12 Month Prevalence	14.0% Lifetime Prevalence	50.9%	56.4%	NIMH
Bipolar Disorder	25	3.9% Lifetime Prevalence 2.6% 12 Month Prevalence	0-3% Lifetime Prevalence	48.8%	55.5%	NIMH

Dysthymic Disorder	31	2.5% Lifetime Prevalence 1.5% 12 Month Prevalence	11.2% Lifetime Prevalence (Dysthymic & Major Depressive Disorder)	61.7%	67.5%	NIMH
Major Depressive Disorder	32	16.5% Lifetime Prevalence 6.7% 12 Month Prevalence	11.2% Lifetime Prevalence (Dysthymic & Major Depressive Disorder)	51.7%	56.8%	NIMH
Personality Disorder	NA	9.1% 12 Month Prevalence	NA	NA	39.0%	NIMH
Schizophrenia	NA	1.1% 12 Month Prevalence	NA	60%	64.3%	NIMH
Substance Abuse Disorder						