ACKNOWLEDGEMENTS

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2006 SUICIDE PREVENTION COUNCIL

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INTRODUCTION

In the United States, suicide is the eighth leading cause of death for all individuals, but more importantly, the third leading cause of death for young adults aged 15-24. Further, suicide attempts contribute to disability and suffering for hundreds of thousands of Americans each year. Suicide is a leading cause of death in Utah, as well as in other Intermountain states. Risk factors for suicide in Utah are similar to those across the nation; however, in Utah, there are unique challenges that hinder prevention efforts by professionals in the public and private health care sectors.

The stigma associated with suicide and mental illness present as the predominant barriers to preventing suicide death and attempt among Utah residents. According to Utah studies, talking about suicide or symptoms of mental illness is perceived as a sign of weakness or failure, which makes any discussion of how to prevent suicide or seek treatment for symptoms of mental illness difficult for everyone. This plan represents the ongoing efforts of Utah's public and private health professionals, primarily necessitated by families in our local communities, who communicated the emergent need for the most appropriate suicide prevention, intervention, and postvention activities. Addressing this difficult public health problem requires a specific coordinated comprehensive plan for action based.

Since 1992, the allocation of funds by public and private agencies and foundations to address the public health problem of suicide in Utah demonstrates strong commitment at both the local and federal level. State expenditures and the source follow in Table One. Federal expenditures and the source follow in Table Two.

TABLE ONE: $1,366,686.00 OF UTAH FUNDS ALLOCATED FOR SUICIDE PREVENTION

Time Frame	Source	Funds
Aug 1992 - Present	University of Utah, Dept. of Psychiatry (in-kind)	$364,000
Aug 1996 – Aug 2002	Utah Department of Health (MCH Block Grant)	$300,000
Aug 1996 – Aug 2000	Salt Lake County Health Department	$ 10,000
Aug 1996 – Aug 2000	Valley Mental Health	$ 5,000
Sept 1998 – Sept 1999	Mariner S. Eccles Foundation and Primary Children's Medical Center Foundation	$ 46,286
July 2001 – June 2002	Utah Legislature, Health & Human Services	$100,000
Jan 2002 – Jan 2006	Third District Juvenile Court (in-kind)	$200,000
Jul 2002 – Jun 2005	Criminal Commission on Juvenile Justice	$ 83,400
Sept 2003 – Sept 2004	Emma Eccles Foundation	$ 25,000
Feb 2004 - Present	University of Utah, Department of Pediatrics	$200,000
March 2006	Department of Human Services, Division of Substance Abuse and Mental Health	$ 33,000

TABLE TWO: $1,250,000.00 OF FEDERAL FUNDS ALLOCATED FOR SUICIDE PREVENTION

Time Frame	Source	Funds
Oct 2001 – Oct 2002	Centers for Disease Control-National Center for Injury Prevention and Control: Grass Roots Suicide Awareness Supplemental Grant	$ 50,000
Oct 2006 – Oct 2009	Substance Abuse & Mental Health Services Administration: Garrett Lee Smith Memorial Act	$1,200,000

GOVERNMENT AGENCY HISTORY: 1992-2006

1992	Utah's Child Fatality Review Committee (CFRC) at the Department of Health initiated the Utah Youth Suicide Study with Douglas Gray, MD, and Primary Children's Medical Center, as the review process proved insufficient to identify prevention strategies for suicide.
1994	Utah Department of Health (UDOH) declared youth suicide an epidemic.
1996-1998	Utah Department of Health partnered with University of Utah, Department Psychiatry, Juvenile Courts, and the Department of Human Services to conduct a study of 151 Utah youth suicide decedents aged 21 years or younger who died between June 1996 and November 1998.
1998	Utah Representative Trisha Beck passed HCR 6: "Resolution on Teen Suicide Awareness and Suicide Prevention," which, 1) Recognized suicide as a major public health problem with personal effects as well as serious social and economic consequences for Utah residents; and, 2) Initiated the development of a statewide suicide prevention plan.
1999	Utah Department of Health formed the Utah Youth Suicide Task Force.
1999	Utah Department of Health partnered with University of Utah, Department of Psychiatry and Brigham Young University, Department of Psychology to conduct a study on the mental health status of juvenile offenders. *Lead Agency: Brigham Young University, Department of Psychology*
2001	Health and Human Services Appropriations Subcommittee of Utah Legislature: Supplemental Item Appropriation of $100,000 for Youth Suicide Prevention to Department of Health. *Sen. David H. Steele, Co-Chair, Rep. Jack A. Seitz, Co-Chair, Sen. D. Edgar Allen, Sen. Curtis S. Bramble, Rep. Trisha S. Beck, Rep. David L. Hogue, Rep. David Litvack, Rep. Rebecca Lockhart, Sen. L. Steve Poulton, Rep. Matt Throckmorton*
2001-2006	Utah Department of Health partnered with University of Utah, Departments of Psychiatry and Pediatrics, Third District Juvenile Court, Utah Department of Human Services, Valley Mental Health, and Utah Youth Village to conduct a suicide prevention pilot study of probation placed juvenile offenders. *Lead Agency: 2001-2003 Utah Department of Health* *2004-present University of Utah, Department of Pediatrics*
2004	Utah Department of Health, Utah Youth Suicide Task Force finalized Utah Injury Strategic Plan for Suicide Prevention.
April 2006	Department of Human Services, Division of Substance Abuse and Mental Health Services formed Suicide Prevention Council to expand Utah Injury Strategic Plan for Suicide Prevention and publish a Statewide Plan for Suicide Prevention.
June 2006	$1.2 million Federal Award through Garrett Lee Smith Memorial Act for youth suicide prevention services specified in the Utah Strategic Plan for Suicide Prevention. *Lead Agency: 2006-2009 University of Utah School of Medicine, Department of Pediatrics, Intermountain Injury Control Research Center*

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UTAH MORTALITY 2003-2004: SUICIDE DEATH

Statewide

- Utah ranked 8th highest in the nation for suicide death in 2003 and 2004
- In 2004, the suicide death rate for Utah residents regardless of age exceeded the rate for the United States.
- Suicide death rate of residents 17.08 per 100,000 persons (US rate: 10.75 per 100,000 persons)
- Average of 315 residents died by suicide each year
- Average of 6 suicides per week

Sex

- Males: 81% of suicides; rate 24.8 per 100,000; 6th ranking cause of death
- Females: 19% of suicides; rate 5.9 per 100,000; 11th ranking cause of death
- Male suicide rate 4.2 times greater than female rate

Race/ Ethnicity

- White Non-Hispanic (NH): 90% of suicides; rate 16.1 per 100,000
- Hispanic: 6% of suicides; rate 10.6 per 100,000
- Black NH: less than 1% of suicides
- Other NH: 3% of suicides; rate 11.1 per 100,000
- White NH crude suicide rate 1.9 times greater than Black NH rate

Age

- 30-49 years: highest suicide rate, rate 1.8 times greater than rate for 15-19 years

Method

- Firearm: leading method; crude rate 8.4 per 100,000; 2nd ranking cause of injury deaths
- Poisoning: 2nd leading method; crude rate 3.4 per 100,000; 5th ranking cause of injury deaths
- Suffocation: 3rd leading method; crude rate 3.0 per 100,000; 6th ranking cause of injury deaths
- If half of **undetermined intent** poisonings were self-inflicted, suicides in this state would rise 26%

Costs

- Average medical cost per case: $2,871
- Average work-loss cost per case: $1,097,302

This has been published by the Suicide Prevention Resource Center (SPRC) at the Educational Development Center. This material is based upon work supported by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration under grant No. 1 U79 SM55029-01.

Utah Suicide Death by Age Range 2004 (Source: Centers for Disease Control)

Suicide Death Age Range	Rate for Utah Residents	Rate for United States
0-18 years of age	3.45 per 100,000 persons	1.90 per 100,000 persons
19-24 years of age	14.00 per 100,000 persons	12.46 per 100,000 persons
25-34 years of age	21.17 per 100,000 persons	12.68 per 100,000 persons
35-44 years of age	24.27 per 100,000 persons	15.05 per 100,000 persons
45-54 years of age	27.16 per 100,000 persons	16.59 per 100,000 persons
55-64 years of age	24.26 per 100,000 persons	13.79 per 100,000 persons
65+ years of age	17.58 per 100,000 persons	14.31 per 100,000 persons

Utah Suicide Death By County 1999-2005 (Source: Utah Office of the Medical Examiner)

County	Males	Females	Total
Box Elder	32	6	38
Beaver	6	0	6
Cache	50	9	59
Carbon	23	8	31
Dagett	2	0	2
Duchesne	18	2	20
Davis	131	48	179
Emery	16	1	17
Garfield	7	1	8
Grand	15	4	19
Iron	34	6	40
Juab	11	2	13
Kane	8	1	9
Millard	15	5	20
Morgan	8	1	9

County	Males	Females	Total
Paiute	4	0	4
Rich	4	1	5
San Juan	19	1	20
Salt Lake	732	184	916
San Pete	23	5	28
Summit	23	4	27
Severe	19	2	21
Tooele	52	5	57
Uintah	28	5	33
Utah	240	46	286
Weber	174	44	218
Washington	85	17	102
Wasatch	21	6	27
Wayne	4	0	4
UTAH TOTAL	1,804	414	2,218

Utah Suicide Death By County, Sex, Age Range, and Race 1999-2005
(Source: Utah Office of the Medical Examiner)

County	Black		Caucasian		Native American		Asian		Pacific Islander		White		Highest Risk Age Range		Highest Risk Race
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Box Elder	0	0	5	3	0	0	0	0	0	0	27	3	45-54	45-54	White
Beaver	0	0	2	0	0	0	0	0	0	0	4	0	55-64	-	White
Cache	0	0	14	5	0	0	1	1	0	0	35	3	45-54	35-44	White
Carbon	0	0	5	0	0	0	0	0	0	0	18	8	35-44	16-18	White
Dagett	0	0	2	0	0	0	0	0	0	0	0	0	45-54	-	Caucasian
Duchesne	0	0	4	0	2	1	0	0	0	0	12	1	45-54	35-54	White
Davis	2	0	33	12	1	1	1	1	0	0	94	34	35-44	35-44	White
Emery	0	0	5	1	0	0	0	0	0	0	11	0	25-44	25-34	White
Garfield	0	0	3	0	0	0	0	0	0	0	4	1	45-54	55-64	White
Grand	0	0	5	3	1	0	0	0	0	0	9	1	25-54	55-64	White
Iron	0	0	10	2	1	0	0	0	0	0	23	4	35-44	35-44	White
Juab	0	0	6	1	0	0	0	0	0	0	5	1	25-34	35-44	Caucasian
Kane	0	0	5	0	1	0	0	0	0	0	2	1	45-54	45-54	Caucasian
Millard	0	0	7	4	0	0	0	0	0	0	7	1	35-44	45-54	Caucasian
Morgan	0	0	1	0	0	0	0	0	0	0	7	1	25-44	35-44	White
Piute	0	0	2	0	0	0	0	0	0	0	2	0	16-18	-	White/Caucasian
Rich	0	0	1	1	0	0	0	0	0	0	3	0	35-44	45-54	White
San Juan	0	0	5	0	3	1	0	0	0	0	11	0	25-44	35-44	White
Salt Lake	7	2	295	89	8	0	9	4	6	1	406	87	35-44	35-44	White
San Pete	0	0	12	4	0	0	0	0	0	0	11	1	35-44	35-44	Caucasian
Summit	0	0	4	2	0	0	0	0	0	0	19	2	35-44	45-54	White
Severe	0	0	5	1	0	0	0	0	0	0	14	1	25-34	45-54	White
Tooele	0	0	18	1	0	0	0	0	0	0	34	4	35-44	25-34	White
Uintah	0	0	12	1	6	1	0	0	0	0	10	3	25-34	45-54	Caucasian
Utah	0	0	63	15	1	0	0	0	3	0	173	31	25-34	25-34	White
Weber	3	0	51	12	0	1	0	0	1	0	119	30	35-44	35-44	White
Washington	1	0	25	7	2	0	0	0	0	0	57	10	35-44	25-34	White
Wasatch	0	0	7	1	0	0	0	0	0	0	14	5	25-34	16-18	White
Wayne	0	0	1	0	0	0	0	0	0	0	3	0	55-64	-	White
TOTAL	13	2	608	169	26	5	11	6	10	1	1134	233	35-44	35-44	White

Suicide Death among Hispanic Americans (Source: www.sprc.org)

Nationally

- Suicide ranked as the 11th leading cause of death for individuals of Hispanic origin of all ages.
- The suicide rate for Hispanic Americans was 5.09 per 100,000 persons.
- The rate for Hispanic Americans was almost one-half the US rate of 10.75 per 100,000 persons.
- Adult males aged 85+, had the highest rate of suicide death in the Hispanic American population with a rate of 30.69 per 100,000 persons.

Mental Health Considerations

- When compared with non-Hispanic Caucasians, young Hispanic Americans demonstrate more symptoms of mental illness.
- Hispanic Americans do not access health services, as fewer than 1 in 11 contacts a mental health professional, and fewer than 1 in 5 contacts a general health care provider.

Ethnic and Cultural Considerations

- Elements of acculturation are important, because immigrants adapting to a new culture may be at higher risk of depression or suicide ideation.
- Individuals of Hispanic origin born in the US demonstrate higher rates of mental illness than immigrants of Hispanic origin.

Suicide Death among American Indians/Alaska Natives (Source: www.sprc.org)

Nationally

- Suicide ranked as the 8th leading cause of death for American Indians/Alaska Natives of all ages.
- The suicide rate for American Indians/Alaska Natives was 10.84 per 100,000 persons.
- The rate for American Indians/Alaska Natives slightly exceeded the US rate of 10.75 per 100,000 persons.
- Adults aged 25-29, had the highest rate of suicide death in the American Indian/Alaska Native population with a rate of 20.67 per 100,000 persons.

Mental Health Considerations

- When compared with other racial and ethnic groups, American Indians/Alaska Natives demonstrate symptoms of mental illness related to anxiety, substance abuse, and depression.
- Mental health services are not easily accessible to American Indians/Alaska Natives due to lack of funding, culturally inappropriate services and mental health professional shortages and high turnover.

Ethnic and Cultural Considerations

- Elements of acculturation-mission and boarding schools, weakening parental influence, and dislocation from native lands-undermine tribal unity and have removed many safeguards against suicide that Native American culture might ordinarily provide.
- There are very few evidence-based programs that are adapted for American Indian/Alaska Native cultures.

Suicide Death among Black Americans (Source: www.sprc.org)

Nationally

- Suicide ranked as the 16th leading cause of death for Black Americans of all ages.
- The suicide rate for Black Americans was 5.25 per 100,000 persons.
- The rate for Hispanic Americans was almost one-half the US rate of 10.75 per 100,000 persons.
- Adult males aged 20-24, had the highest rate of suicide death in the Black American population with a rate of 18.18 per 100,000 persons.

Mental Health Considerations

- When compared with Caucasians, Black Americans demonstrate similar symptoms of mental illness.
- Black Americans who access mental health services received poorer quality care than White Americans.

Ethnic and Cultural Considerations

- Beliefs about suicide may act as a protective factor for Black Americans, as religious communities condemn suicide, while secular attitudes regard suicide as unacceptable and a behavior of white culture, alien to black culture.
- Suicide risk factors for Black Americans include being under the age of 35, residing in southern or northeastern states, using cocaine, having a firearm in the home and history of threatening others with violence.

Suicide Death among Asian Americans/Pacific Islanders (Source: www.sprc.org)

Nationally

- Suicide ranked as the 8th leading cause of death for Asian Americans and Pacific Islanders of all ages.
- The suicide rate for Asian Americans/Pacific Islanders was 5.40 per 100,000 persons.
- The rate for Asian Americans/Pacific Islanders was almost half the US rate of 10.75 per 100,000 persons.
- Adult males aged 85+, had the highest rate of suicide death in the Asian American/Pacific Islander population with a rate of 27.43 per 100,000 persons.

Mental Health Considerations

- When compared with other racial and ethic groups, Asian Americans do not access mental health treatment due to strong stigma of mental illness. Emotional problems are viewed as shameful and distressing, which may limit help-seeking behaviors.
- Asian Americans concern about negatively affecting their social network prevent them from seeking help.

Ethnic and Cultural Considerations

- Nearly half of Asian American and Pacific Islanders, access to mental health care is limited due to their lack of English proficiency and a shortage of providers with appropriate language skills.
- In Asian American populations, suicide risk increases with age. Some explanations for the increase relate to difficulties adapting to the US culture. Elders are not treated with the level of respect of their native cultures and are sometimes burdensome.

UTAH MORBIDITY 2003-2004: HOSPITALIZATIONS FOR SUICIDE ATTEMPT*

Statewide

- Annually 1,440 hospitalized attempts per year
- Crude average annual hospitalized attempt rate: 67.9 per 100,000
- Average of 4 attempts per day

Sex

- Males: 38% of attempts; rate 51.3 per 100,000
- Females: 62% of attempts; rate 84.5 per 100,000
- Female attempt rate 1.6 times greater than male rate

Race/Ethnicity

- No data available

Age

- 15 to 19 years: highest hospitalized attempt rate, 17% of hospitalized attempts

Method

- Poisoning: leading method; 1,174 annual attempts; crude rate 55.3 per 100,000
- Cut/Pierce: 2nd leading method; 172 annual attempts; crude rate 8.1 per 100,000
- If half of undetermined intent and non-e-coded poisonings were self-inflicted, suicide attempts in this state would rise 10%

Costs

- Average medical cost per case: $8,401
- Average work-loss cost per case: $9,983

This has been published by the Suicide Prevention Resource Center (SPRC) at Educational Development Center. This material is based upon work supported by the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration under grant No. 1 U79 SM55029-01.

*** Because an official source responsible to compile suicide attempt data in the United States does not exist, each state estimates suicide attempt by examining the number of injuries caused by a suicide attempt that required inpatient hospitalization for treatment. Therefore, suicide attempt data can only be speculative. Currently the average estimated ratio, between non-fatal suicide attempt and suicide death in the United States, is 100-200:1.**

SUICIDE PREVENTION COUNCIL STATEMENT:
LACK OF MENTAL HEALTH CARE SERVICES & SUICIDE

While the Utah Suicide Prevention Council is proud of the statewide Suicide Prevention Plan, we want to acknowledge the "elephant in the room," which is the lack of resources available to consumers seeking mental health care. There is a need for mental health parity and mental health resources for the uninsured.

MENTAL HEALTH PARITY

Mental health parity involves treating mental illness the same as other medical problems. Currently many insurance companies put barriers between the mentally ill and the services they need, including higher co-pays, larger deductibles, and many unfunded diagnoses and services. Many consumers believe they are well insured, but are disappointed to find out their mental health benefit is very limited, once they try to access these services.

MENTAL HEALTH RESOURCES FOR THE UNINSURED

The uninsured population in Utah continues to grow. Only a small percentage of this population can self-pay for medical or mental health services. Recent changes in federal law led our public mental health centers to focus their efforts on the Medicaid population, leaving most indigent patients without any available treatment. While emergency departments cannot turn away crisis patients, lack of funding effects provider's ability to hospitalize patients as well as the patient's length of stay. Sometimes patients who need to be in the hospital resist, because of accumulation of debt from medical bills. In addition, patients evaluated and discharged from emergency departments lack resources for treatment, leading to recurrent crises, because their illness never is treated. Substance abuse is a huge burden on our society. A lack of funding for substance abuse treatment leaves many patients who are ready to make a life change, left on long waiting lists for services.

SUICIDE & UNTREATED MENTAL ILLNESS

Research consistently demonstrates that the leading cause of suicide for all age groups is untreated or undertreated mental illness. Risk escalates when mental illness occurs in combination with substance abuse, a deadly combination.

The economic impact of untreated mental illness and substance abuse becomes more remarkable, as potential taxpayers become non-functional. It will be very difficult to have any impact on the rate of completed suicide with Utah's limited resources available to the mentally ill. More importantly, we should judge our society by how we treat our vulnerable citizens.

Utah Suicide Prevention Plan (USPP)

Goal 1: Promote awareness that suicide is a preventable public health problem.

Goal 2: Develop broad-based support for suicide prevention.

Goal 3: Develop and Implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Goal 4: Develop and Implement Suicide Prevention Programs.

Goal 5: Promote Efforts to Reduce Access to Lethal Means and Methods of Self-Harm.

Goal 6: Implement Training for Reporting on Suicide and Recognition of At-Risk Behavior and Delivery of Effective Treatment.

Goal 7: Develop and Promote Effective Clinical and Professional Practices.

Goal 8: Improve Access to and Community Linkages with Mental Health and Substance Abuse Services.

Goal 9: Promote awareness and broad-base support for suicide prevention activities among the minority populations in Utah and increase the number of minority communities addressing suicide.

Goal 10: Promote and Support Research on Suicide and Suicide Prevention.

UTAH SUICIDE PREVENTION PLAN (USPP)

GOAL 1: PROMOTE AWARENESS THAT SUICIDE IS A PREVENTABLE PUBLIC HEALTH PROBLEM.

Objective 1.1 By 2011, increase public information campaigns in Utah designed to provide prevention education and information about suicide to reach at least 50% of the state's population.

Utah Activity:
1. Continue implementation of NAMI Utah's public service announcements by Utah television and radio stations to decrease negative attitudes that surround mental illness and encourage Utah residents to seek help for signs and symptoms of mental illness.
Future Recommendation:
1. Facilitate implementation of Federal Awareness Campaign by Utah television and radio stations: The Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with The Advertising Council, on December 4, 2006 launched a national awareness public service advertising (PSA) campaign designed to decrease the negative attitudes that surround mental illness and encourage young adults to support their friends who are living with mental health problems.

Objective 1.2 Through 2011, continue statewide collaboration with public and private stakeholders for the implementation of goals, outcomes and strategies identified in the statewide plan for suicide prevention in Utah.

Utah Activities:
1. Critical Issues Facing Children Conference: Utah Division of Substance Abuse and Mental Health Services 2. Fall Conference on Substance Abuse: Utah Division of Substance Abuse and Mental Health Services 3. Generations Conference: Utah Division of Substance Abuse and Mental Health Services 4. Statewide Mental Health Conference: NAMI Utah 5. Statewide Suicide Prevention Conference: The HOPE Task Force
Future Recommendations:
1. By 2011, convene conferences in local urban and rural areas. 2. Encourage topics that address needs of diverse populations with cultural competence.

Objective 1.3 Through 2011, continue existing and increase the number of both public and private institutions active in suicide prevention that are involved in collaborative, complimentary dissemination of information on the World Wide Web.

Utah Activities:
1. Caring Connections, University of Utah College of Nursing: www.nurs.utah.edu/caringconnections 2. Department of Human Services, Division of Substance Abuse and Mental Health Services: www.dsamh.utah.gov 3. Hugs for Life: www.hugsforlife.info 4. Intermountain Injury Control Research Center: www.intermountaininjury.org 5. KUED Channel 7: www.kued.org/productions/voicesofhope 6. First Lady Mary Kaye Huntsman, "Power in You" and "Power in Parents": www.powerinyou.org 7. Mental Health Association, Utah Chapter: www.xmission.com/~mhaut 8. National Alliance on Mental Illness (NAMI), Utah Chapter: www.namiut.org 9. The Sharing Place: www.thesharingplace.org 10. Utah Behavioral Healthcare Network: www.networkofcare.org 11. U Lifeline, University of Utah: www.ulifeline.com

GOAL 2: DEVELOP BROAD-BASED SUPPORT FOR SUICIDE PREVENTION.

Objective 2.1 Through 2011, continue to collaborate in order to implement the activities and recommendations of the Utah Suicide Prevention Plan (USSP).

Utah Activity:
1. Utah Suicide Prevention Council will continue to meet quarterly (January, April, July, October), meetings will be coordinated by NAMI Utah and University of Utah School of Medicine Department of Pediatrics and Psychiatry to minimize duplication of efforts.
Future Recommendations:
1. Increase the number of professional, voluntary, faith communities, and other groups that participate in the Utah Suicide Prevention Council in order to facilitate the integration of suicide prevention activities into their ongoing programs. 2. The Utah Suicide Prevention Council may establish sub-committees to address specific suicide prevention activities.

Objective 2.2 Through 2011, continue to collaborate on activities of the Utah Suicide Prevention Action Network (U-SPAN).

Utah Activity:
1. NAMI Utah service as primary Utah liaison for the Suicide Prevention Action Network (SPAN), as the current Outreach Partner for the National Institutes of Mental Health.

GOAL 3: DEVELOP AND IMPLEMENT STRATEGIES TO REDUCE THE STIGMA ASSOCIATED WITH BEING A CONSUMER OF MENTAL HEALTH, SUBSTANCE ABUSE, AND SUICIDE PREVENTION SERVICES.

Objectives 3.1 Through 2011, increase the proportion of the public that views mental health disorders as real illnesses that respond to specific treatments; and, consumers of mental health, substance abuse, and suicide prevention services as pursing fundamental care and treatment for overall health.

Utah Activities:
1. Continue events to raise public awareness: a. NAMI Walk: NAMI Utah b. "Awakening Utah" Annual Walk for Suicide Prevention: Mental Health Association, Utah Chapter c. Car Show and Ice Cream Social: Hugs for Life d. Legislative Reception: Legislative Coalition for People with Disabilities 2. Continue formal program to raise public awareness a. Hope for Tomorrow: NAMI Utah b. "Power in You" & "Power in Parents": First Lady Mary Kaye Huntsman

Objective 3.2 Through 2011, increase the proportion of those suicidal persons with underlying disorders who receive appropriate mental health treatment.

Utah Activity:
1. Utah Garrett Lee Smith Memorial Act-"Expansion of Family Centered Suicide Prevention Services Grant": University of Utah School of Medicine, Departments of Pediatrics and Psychiatry & Third District Juvenile Court.
Future Recommendations:
1. Utah Suicide Prevention Council will partner with Department of Human Services and the Division of Substance Abuse and Mental Health Services to enlist the support of community mental health centers, government clinics, hospitals, emergency departments, ambulatory care centers, and law enforcement agencies in order to track and report number of persons served, as well as persons turned away, when seeking mental health services to better quantify service capacities and limitations of these service providers. 2. Conduct statewide mental health needs assessment survey to determine number of Utah residents who seek mental health treatment and either receive or do not receive mental health services in order to quantify met and unmet mental health needs of Utah residents.

GOAL 4: DEVELOP AND IMPLEMENT SUICIDE PREVENTION PROGRAMS.

Objective 4.1 By 2011, implement the Utah Suicide Prevention Plan with a) coordination across government agencies; b) involve the private sector, and c) support plan expansion and evaluation in Utah communities.

Utah Activity:
1. Utah Suicide Prevention Council: NAMI Utah will continue to coordinate quarterly meetings and partnerships to facilitate inter-agency collaboration required to implement activities of future recommendations specified in the Utah Suicide Prevention Strategy.

Objective 4.2 By 2011, in compliance with the Utah Family Education Right to Privacy Act (Utah FERPA), increase the proportion of school districts and private school associations with evidence-based programs designed to address serious childhood and adolescent distress and prevent suicide.

Utah Activities:
1. Utah's Behavior Initiatives Project: Utah State Office of Education 2. Hope for Tomorrow: NAMI Utah

Objective 4.3 By 2011, increase the proportion of colleges and universities with evidence-based programs designed to address serious young adult distress and prevent suicide.

Utah Activities:
1. University of Utah Counseling Center, Campus Suicide Prevention Grant (Garrett Lee Smith Memorial Act) 2. Utah Valley State University, Campus Suicide Prevention Grant (Garrett Lee Smith Memorial Act)

Objective 4.4 By 2011, increase the proportion of employers that ensure the availability of evidence-based prevention strategies for suicide.

Objective 4.5 By 2011, increase the proportion of juvenile offenders statewide who receive evidence-based suicide prevention services through the Juvenile Court (Assessment and Diversion, Intake, and Probation).

Utah Activity:
1. Utah Garrett Lee Smith Memorial Act- "Expansion of Family Centered Suicide Prevention Services Grant": University of Utah School of Medicine, Departments of Pediatrics and Psychiatry; Third District Juvenile Court; NAMI Utah.

Objective 4.6 By 2011, increase the proportion of Juvenile Justice Services (correctional institutions, jails and detention centers) housing either the adult or juvenile offenders, to implement and evaluate evidence-based suicide prevention services.

Objective 4.7 By 2011, increase the proportion of State Aging Networks that have evidence-based suicide prevention programs designed to identify and refer elderly people at risk for suicidal behavior to obtain treatment.

Objective 4.8 By 2011, increase the proportion of family, youth, and community service providers and organizations with evidence-based suicide prevention programs.

Objective 4.9 By 2011, develop a nationally affiliated (National Suicide Prevention Lifeline) and certified (American Association of Suicidology) Utah Suicide Crisis Services Center in order to coordinate all (prevention, intervention, and postvention) training and provide technical assistance to build the capacity for communities to implement and evaluate suicide prevention programs.

Utah Activity:
1. Utah SPAN Affiliate will identify and approach funding sources to support infrastructure development.

GOAL 5: PROMOTE EFFORTS TO REDUCE ACCESS TO LETHAL MEANS AND METHODS OF SELF-HARM.

Objective 5.1 By 2011, increase the proportion of primary care clinicians, other health care providers, and health and safety officials who routinely assess the presence of lethal means (including firearms, drugs, and poisons) in the home and educate about actions to reduce associated risk.

Objective 5.2 By 2011, expose a proportion of households to public information campaign(s) designed to reduce the accessibility of lethal means, including firearms, in the home.

Utah Activity:
1. Gun Lock Dissemination Program: HOPE Taskforce and local police departments
Future Recommendation:
1. Develop and disseminate gun safety material

Objective 5.3 By 2011, develop guidelines for safer dispensing of medications for individuals at heightened risk of suicide.

Utah Activities:
1. Utah Division of Occupational and Professional Licensing
2. Pharmacy Tracking System to ensure patients do not fill duplicate prescriptions

GOAL 6: IMPLEMENT TRAINING FOR REPORTING ON SUICIDE AND RECOGNITION OF AT-RISK BEHAVIOR AND DELIVERY OF EFFECTIVE TREATMENT.

Objective 6.1 By 2011, define minimum course objectives for providers of physician assistant education programs, medical residency; nursing care; clinical social work, counseling, and psychology graduate program; in assessment and management of suicide risk, and identification and promotion of protective factors. Incorporate this material into curricula for nursing care providers at all professional levels.

Future Recommendation:
1. Compose and disseminate need for training to directors of aforementioned programs.

Objective 6.2 By 2011, increase the proportion of clergy who receive training in identification of and response to mental health crisis and/or suicide risk and behaviors and the differentiation of mental disorders and faith crisis.

Utah Activity:
1. Clergy Training Program: NAMI Utah

Objective 6.3 By 2011, increase the proportion of educational faculty and staff who have received training on identifying and responding to children and adolescents at risk for suicide.

Utah Activities:
1. Hope for Tomorrow: NAMI Utah
2. HOPE Squad: HOPE Task Force

Objective 6.4 By 2011, increase the proportion of law enforcement who receives training on identifying and responding to persons in mental health crisis and/or risk for suicide.

Utah Activity:
Crisis Intervention Team (CIT): Salt Lake Police Department

Objective 6.5 By 2011, provide training to local media representatives to promote the accurate and responsible representation of suicidal behaviors, mental illness, and related issues in compliance with national reporting guidelines available at www.sprc.org.

GOAL 7: DEVELOP AND PROMOTE EFFECTIVE CLINICAL AND PROFESSIONAL PRACTICES.

Objective 7.1 By 2011, develop guidelines for assessment of suicidal risk among persons receiving care in primary health care settings, emergency departments, hospice, skilled nursing facilities, and specialty mental health and substance abuse treatment centers. Implement these guidelines in these settings.

Utah Activities:
1. Division of Substance Abuse and Mental Health: All publicly funded community mental health centers and substance abuse providers will be required to utilize the Outcomes and Youth Outcomes Questionnaire in 2007-2008 in order to assess and measure patient outcomes. 2. Mental Health Integration: Intermountain Healthcare 3. NAMI Provider Training – NAMI Utah 4. Veteran's Administration

Objective 7.2 By 2011, increase the proportion of specialty mental health and substance abuse treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients.

Utah Activities:
1. Crisis Assessment: University Neuropsychiatric Institute 2. 24-Hour Crisis Line: Public Mental Health Centers

Objective 7.3 Through 2011, continue support services to all suicide survivors to address their exposure to suicide and the unique needs of suicide survivors.

Utah Activities:
1. Caring Connections, University of Utah College of Nursing 2. Family and Consumer Support Groups: NAMI Utah 3. The Sharing Place: Adult, Teen and Child Grief Groups 4. Postvention for Families and Community: HOPE Taskforce
Future Recommendations:
1. Implement evidence based postvention mental health services for all Utah residents who survive a suicide attempt. 2. Conduct mental health service needs assessment with immediate and extended family members of Utah residents who die by suicide coordinated through the Utah Office of the Medical Examiner.

Objective 7.4 Through 2011, providing education to family members and significant others of persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

Utah Activities:
1. Campaign for Self-Advocacy, Training the Trainers: Mental Health Association, Utah Chapter 2. Education and Advocacy Program: Utah Pride Center 3. Family Mentoring Program: NAMI Utah 4. Progression: NAMI Utah

Objective 7.5 By 2011, provide education to persons receiving care for the treatment of mental health and substance abuse disorders with risk of suicide.

Utah Activities:
1. BRIDGES: NAMI Utah 2. Basics: NAMI Utah 3. Consumer Mentoring Program: NAMI Utah

GOAL 8: IMPROVE ACCESS TO AND COMMUNITY LINKAGES WITH MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

Objective 8.1 By 2011, increase access to mental health care for uninsured and non-Medicaid population in Utah.

Future Recommendations:
1. Division of Substance Abuse and Mental Health will obtain funding from the Utah Legislature to increase mental health services for the non-Medicaid Population. 2. The Utah Suicide Prevention Council will support community efforts and programs in finding innovative approaches and solutions.

Objective 8.2 By 2011, encourage Utah Congressional Delegation to support federal legislation to require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health.

Future Recommendation:
1. All organizations in support of mental health parity and suicide prevention should advocate for Utah Delegation to vote in favor of appropriate legislation.

Objective 8.3 By 2011, facilitate Utah Legislature to adopt legislation to require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health.

Future Recommendation:
1. NAMI Utah will advocate for legislation in support of mental health parity.

Objective 8.4 By 2011, define guidelines for mental health (including substance abuse) screening and referral of students in universities and colleges. Implement those guidelines in universities and colleges.

Utah Activities:
1. University of Utah Counseling Center, Campus Suicide Prevention Grant (Garrett Lee Smith Memorial Act). 2. Utah Valley State University, Campus Suicide Prevention Grant (Garrett Lee Smith Memorial Act).

Objective 8.5 By 2011, support guidelines for mental health assessment and treatment of suicidal individuals from adult and juvenile incarcerated populations. Implement the guidelines in correctional institutions, jails, and detention centers.

Objective 8.6: Provide referrals for mental health services to the community.

Utah Activities:
1. Service Referral by calling 211: Community Services Council 2. Network of Care: Utah Behavioral Healthcare Network (www.networkofcare.org) 3. Resource Line: Utah Pride Center 4. Mentoring Program: NAMI Utah 5. Warmline: Mental Health Association, Utah Chapter 6. Utah Cares: State of Utah (www.utahcares.utah.edu)

GOAL 9: PROMOTE AWARENESS AND BROAD-BASE SUPPORT FOR SUICIDE PREVENTION ACTIVITIES AMONG THE MINORITY POPULATIONS IN UTAH AND INCREASE THE NUMBER OF MINORITY COMMUNITIES ADDRESSING SUICIDE.

Objective 9.1 Support processes of planning, implementation and evaluation of suicide prevention by minority groups at high risk in Utah.

Future Recommendation:
1. Suicide Prevention Council will support stakeholder meetings to identify appropriate suicide prevention plan activities for the Gay, Lesbian, Bisexual, Trans-gender, Queer and Questioning (GBTQ) populations.

Objective 9.2 Increase awareness, provide training, educational materials, and youth/adult suicide prevention programs for the Hispanic/Latino population.

Utah Activities:
1. BRIDGES: NAMI Utah 2. Family to Family: NAMI Utah 3. Mentoring Program: NAMI Utah 4. Hope for Tomorrow: NAMI Utah

Objective 9.3 Increase awareness, provide training, educational materials and youth/adult suicide prevention programs for Native Americans, which are culturally adapted to unique tribal needs.

Utah Activity:
1. Report on Suicide Prevention from the five (5) federally recognized American Indian Tribes in Utah (October 2006).

Objective 9.4 Support the integration of mental health education into existing culturally competent curricula for minority and refugee populations.

Utah Activities:
1. Advocacy and Outreach: Utah Pride Center 2. Diversity Outreach Program: NAMI Utah

Objective 9.5 Promote awareness of issues specific to persons who may be victimized because they are perceived to be different or unacceptable.

Utah Activities:
1. Outreach: Utah Pride Center 2. Utah State Office of Education: Anti-Bullying Campaign and Program 3. First Lady Mary Kay Huntsman: "Power in You" and "Power in Parents"

GOAL 10: PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION.

Objective 10.1 By 2008, develop a Utah suicide research agenda with input from survivors, practitioners, researchers, and advocates.

Future Recommendation:
1. University of Utah, School of Medicine, Departments of Pediatrics and Psychiatry in collaboration with the Suicide Prevention Council will finalize a research agenda to prioritize research studies in the areas of suicide death and suicide attempts.

Objective 10.2 By 2011, increase funding (public and private) for suicide prevention research, for research on translating scientific knowledge into practice and for training of researchers in Suicidology.

Objective 10.3 By 2011, establish and maintain a volunteer registry of self-identified survivors of suicide.

Future Recommendation:
1. Utah SPAN Affiliate will establish and maintain a volunteer registry of self-identified survivors.

Objective 10.4 By 2011, perform scientific evaluation studies of new or existing suicide prevention interventions.

Utah Activities:
1. Utah Youth Suicide Study: University of Utah School of Medicine, Departments of Pediatrics and Psychiatry 2. MIRECC: Veteran's Administration VISN 19

APPENDIX

Caring Connections: A Hope and Comfort in Grief Program Supportive Groups and Counseling

Caring Connections: A Hope and Comfort in Grief Program has developed a variety of community and hospital programs to meet the grief and bereavement needs of people experiencing loss and death. All people are welcome to participate as their circumstances suggest.

Caring Connections: A Hope and Comfort in Grief Program offers a number of **bereavement support groups**, each tailored for a specific kind of grief, which run for 8 weeks in length. Groups are offered throughout the year. The focus of these groups is on "adjusting to the death of a family member or close friend". Separate groups are available for children and adolescents. The groups are small in order to allow each person full participation in the group activities and discussions. There are separate groups for adults surviving the death of a loved one due to suicide, homicide or traditional.

The group leaders are expert professional in the area of grief and bereavement. Through education and comfort from leaders and others experiencing grief, group members grow stronger in managing their own sorrow and pain.

For some people, group meetings are not the best mode for assisting with grief. **Caring Connections: A Hope and Comfort in Grief Program** has licensed professionals who can provide individual or family counseling to grieving people.

If you have any questions about counseling services, group meetings, or participation in group meetings, please contact **Caring Connections: A Hope and Comfort in Grief Program**, Monday through Friday at 585-9522. Dr. Beth Vaughan Cole or one of her associates will return your call.

Caring Connections Faculty

The faculty from Caring Connection: A Hope and Comfort in Grief Program give public lectures in grieving, death and dying, managing stress, grief and the holidays, etc. Please watch for their public lectures. If you are interested in a speaker for your group on any of these topics please call.

- Kathie Supiano, MS, LCSW
  - Bereavement Coordinator for the University of Utah Hospitals and Clinics
  - Works with the hospital staff to implement programs to meet the grief and bereavement needs of patients, families, and staff.
  - If you have any questions about hospital programs, contact Kathie Supiano at 801-581-2975

The University of Utah Hospital has a specific program addressing **perinatal bereavement**. Parents who have lost a child due to stillbirth, miscarriage, or death during infancy can call 801-585-2766 for more information.

Contact Caring Connections

Mailing Address:
University of Utah College of Nursing
10 South 2000 East
Salt Lake City, UT 84112-5880
Telephone: 801-585-9522
Fax:
Email: **caringconnections@nurs.utah.edu**
Website: **http://www.nurs.utah.edu/caringconnections**

Support Caring Connections

If you are interested in contributing to the efforts sponsored by this program, donations may be sent to:

Caring Connections: A Hope and Comfort in Grief Program
Development Office
University of Utah College of Nursing
10 South 2000 East
Salt Lake City, UT 84112-5880

Crisis Intervention Team of Utah

What is CIT?

Crisis Intervention Teams (CIT) are comprised of specially trained law enforcement officers. These officers are trained in tactics to effectively deal with a person experiencing a mental crisis, as well as every day interaction with mental health consumers.

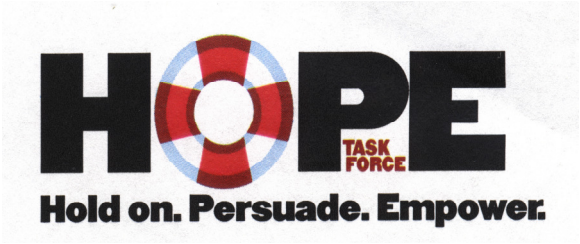
A CIT Officer has successfully completed state authorized training, and passed required testing, to become certified as a Crisis Intervention Team Officer by the Utah State Division of Substance Abuse and Mental Health. Each CIT Officer becomes a member of their agency's Crisis Intervention Team.

Crisis Intervention Teams are comprised of officers from uniformed patrol divisions who volunteer to participate. These officers maintain their responsibilities as patrol officers, but become primary responding units to situations involving a mental health consumer, or persons experiencing a mental health crisis.

A CIT Officer is trained in identifying characteristics of various mental disorders. With a newfound empathetic approach, officers of this program are trained to provide a safer intervention for the consumer, the community, and the officers.

This program does not necessarily advocate the removal of incarceration as a valid option to the resolution of a situation. However, it does provide CIT Officers an understanding of all options and will assist in finding the best solution for the consumer and the community.

Website: www.ci.slc.ut.us/police/specialized.htm



The HOPE Taskforce, organized by community agencies, has a common goal to prevent suicide. Over twenty agencies met for the first time on October 22, 2002 and discussed how to develop a community wide suicide prevention program. Since that first meeting the taskforce has accomplish the following subcommittees were organized:

School Committee, Conference Planning Committee, Speakers Bureau Committee

Prevention

School Committee - The school committee comprised of school counselors, psychologists and social workers met monthly to review suicide prevention programs from other states. After researching for a year, the committee decided to base their model upon two programs: North Dakota's Peer Gatekeeper program and QPR (Question, Persuade, Refer) program. They developed a peer mentor program for high schools, middle schools and 6th grade students in the elementary schools. In the secondary schools, students are selected by their peers to serve on the **"HOPE Squad."** The HOPE Squad meets monthly for training and to plan school prevention activities.

Conference Planning Committee - Each year the conference has targeted different audiences but has always included school personnel. The objective of the conference is to bring people together from throughout the state to learn more about suicide prevention.

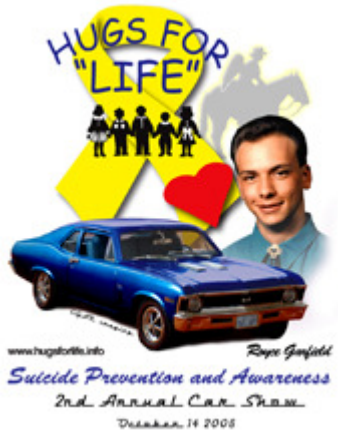
Speakers Bureau – The speaker's bureau is made up of taskforce volunteers. The objective of the speaker's bureau is to meet with groups from throughout the community and the state. A power point presentation is used to educate groups about suicide statistics, risks, and prevention. Presentations have been given to parole officers, college students, hospital boards, scout leaders, civic clubs, school personnel, neighboring communities, and clergy leaders.

Postvention

Crisis Team – In 1999, a school-response crisis team was organized. The crisis team is made up of community and school professionals; therapists, psychologists, counselors, social workers, clergy and police officers. The crisis team responds, when invited, to assist a school during a disruptive event. The goals of the team are to return the school to normalcy, meet with struggling students and staff, identify students that may need further assistance and meet with parents in a community meeting.

Survivors – Two members from the taskforce committee, who personally experience a suicide in their family, formed a survivor support group, "Heart & Soul Survivors." The support group has developed bookmarks and comfort baskets to give to families experiencing suicide. The bookmarks contain names and phone numbers of survivors who are willing to offer support. The support group meets monthly.

Statewide Crisis Team – A statewide crisis team has been organized involving school districts personnel. The statewide team will respond, when invited, to a school district in need of crisis intervention. The team would respond as needed to help restore normalcy and meet with students, school staff and families.




"Hugs for Life" is a Charitable organization that is raising money to provide a Brochure Display Center for all of the schools. The display rack will hold brochures that have come from NAMI, American Psychiatric Publishing, and other reputable places that have the information needed to get suicide prevention and awareness in the hands of those most in need. The brochures are free to anyone with an interest in them. We are hoping for the support of the school districts, and the State in the distribution of these racks, as we feel that Education means Life, and Life means Education.

We hold many fund raising events to raise the money to supply these racks, as to not put any cost burden on the schools.
Hugs for Life would like to play an active roll in the Prevention and Awareness of Suicide and continue in our passion and quest in taking Utah off the statistics of being one of the highest states for suicide deaths.

Hugs for Life is a State and Federal recognized 501(c) (3) registered charity.

Sheri Thomas
Hugs For Life
PO Box 6
West Jordan, UT 84088
801-718-0321
hugsforlife@comcast.net

Website: www.hugsforlife.info

MENTAL HEALTH INTEGRATION-MHI©

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Mental Health Integration (MHI) is a comprehensive approach to promoting the health of individuals, families and communities, based upon communication and coordination of evidence-based primary care and mental health services. The World Health Organization defines health as a complete state of physical and mental well being. The Surgeon General defines mental health as a state of successful performance of mental and physical function resulting in productive activities, fulfilling relationships with others and the ability to adapt and cope with adversity. MHI is mental healthcare that is integrated into everyday healthcare practice. The integration of mental health into primary and medical care simply means *treating* mental health as any other health condition from identification to recovery. This integration is one example of quality healthcare delivery redesign that is team-based outcomes oriented and follows a standardized quality process that facilitates communication and coordination based on consumer and family preferences and sound economics.

MHI Training Program

MHI is a priority area for effective, high quality health care delivery. The lack of effective mental health integration has led clinical researchers at Intermountain to develop an evidence-based integration model. To achieve these quality improvement changes members of the MHI team participate with primary care providers and their support staff in ongoing standardized MHI "Teams and Tools" training. This includes the use of a MHI assessment packet and the electronic medical record (EMR) for documentation and communication with each other regarding treatment progress, patient response and/or recommended changes. The MHI training and role "rethinking" process focuses on team collaboration, family-centered care and health recovery. Families are acknowledged for providing a significant proportion of support for the self-management of a chronic disease and are valued as a sustainable resource to the patient for promoting ongoing adherence. Therefore, educating the practitioner and support staff about engaging the patient and family in a health partnership is a critical part of the self-management component of the Intermountain MHI clinical model.

Practitioners who are able to engage patients and their families in a positive helping relationship will have greater success promoting adherence and achieving improved health outcomes. Team members are acknowledged in, and accountable for, their role in promoting the identified recovery outcomes. Training modules promote upgrading their knowledge regarding mental health diagnoses and treatment, and improving skills in empathic engagement. Providers learn to detect, predict and respond empathically to non-adherence risk and the "difficult to treat." Patients and their families have different levels of comfort and ability when engaging in a helping relationship. Their capacity to seek and use help is guided by their preferences and values, and manifested by how they follow and self manage the advice they receive for their identified condition. PCPs are therefore educated about their critical role in initiating the concept of follow-up for disease management and, more importantly, instilling hope in recovery and family trust in his/her integrated team [10]. Before offering a treatment plan, clinicians are encouraged to assess the patient/family's willingness and capacity to manage the patient's health and anticipate the amount of care management follow-up support that may be required to improve identified outcomes.

The patient and family are responsible for reporting their health needs and preferences and familiarizing themselves with the patient and family education that is provided for them throughout the MHI process. Completion of the MHI assessment packet, in paper or electronically, plays a significant role in helping families and their PCP establish a health partnership that results in accurate diagnoses and culturally congruent treatment and self-management plans. PCPs and their support staff are responsible for screening and stratifying timely access to the MHI integrated team. PCPs establish the diagnosis and treatment plan with MH input as needed. Most importantly, they prepare the patient and family for the MHI team collaboration care protocols. The care manager is responsible for education and follow-up, and for communicating with the MHI team regarding the family's adherence preference and risk. They are specifically trained to help engage difficult families that may be either isolated from or have exhausted their natural support systems.

The MHI APRN/psychiatrist provides onsite and phone consultation to the integrated teams, as well as ongoing training, in assessing complex co-morbid diagnoses and pharmacotherapy. The MHI licensed therapist provides onsite brief solution-focused psychotherapy. Families also have the option of using their EAP or paneled therapist, and this referral link is facilitated and tracked by the care manager. The MHI team has also enlisted the support of National Alliance of Mental Illness (NAMI), a consumer advocacy community resource, in order to enhance the education and peer mentoring support needed by the families at each clinic site. NAMI consumers have completed several focus group reviews of the MHI assessment packet and determined that they were "consumer friendly" with minor changes to the initial introductory page.

The MHI clinical intervention is designed to promote three essential primary care practice changes: (1) to improve the detection, monitoring, stratification and management of depression and other mental health conditions; (2) to reinforce ongoing relational contact with patients and their families to promote adherence; and (3) to adjust treatment and management interventions if there is evidence of an inadequate response.

Description of the Complex Intervention

1. Routine Care is recommended for mild depression. This level of care involves only the primary care physician and support staff (with care management included only by PCP or patient preference). Family and social support are readily available and in use for these patients and their significant others.
2. Collaborative Care is recommended for moderate depression and/or co-morbid complex conditions. This level of care also involves the primary care physician and requires ongoing care management support. Brief onsite mental health team consultation is available as requested. Patients and families who are more isolated from support or who may have also exhausted their family or support resources will benefit from this level of MHI intervention. Care managers are specifically trained to help engage families and promote adherence and self-management.
3. Referral to a Mental Health Specialist(s), along with treatment from the primary care physician, care management, and onsite mental health team, is recommended for severe depression. In cases involving a threat or danger, relational burden, or co-morbid complexity, a consultation is arranged with the MHI specialist, who determines whether patient and family can continue working with the PCP MHI team to achieve stabilization, or whether it is more appropriate to activate community mental health services outside the clinic.

MHI has specifically targeted strategies that have improved the efficient management and outcomes of chronic diseases and co-morbid conditions. Results continue to demonstrate that collaborative primary and mental health care lead to improved functional status and satisfaction in patients and improved satisfaction and confidence among physicians in managing mental health problems as part of routine care at a neutral cost.

Contact:

Brenda.reiss-brennan@intermountainmail.org (801) 442 -2990
Pascal.briot@intermountainmail.org clinical outcomes and data manager (801) 442 -2800

For more information regarding appropriate use of MHI forms, tools and measures, including implementation, data utilization, and training options,

MENTAL HEALTH ASSOCIATION OF UTAH

The ***"Campaign for Self-Advocacy, Training the Trainers"*** proposal is an attempt to address a pressing need in the State of Utah. Faced with shrinking budgets and concomitant staffing limitations, it becomes imperative that more consumers of mental health resources receive the necessary skills to become effective self-advocates. The Mental Health Association in Utah is committed to developing a cadre of well-trained advocates who can then systematically train other consumers in the process of self-advocacy. Self-advocacy is a way of life! It is not limited to a forty-five day legislative session. It happens each moment as part of "Presentation of Self". Most of all it is recognizing the personal power that each person contains within themselves. The sociological indicators of effective self-advocacy can be seen in improved quality of life, better economic conditions, and personal independence.

Contact:

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Salt Lake City, UT 84115
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MIRECC (Mental Illness Research Education and Clinical Center for Suicide Prevention)

There are 24.7 million Veterans in the US and approximately 151,000 veterans in Utah. In 2005, over 38,000 Utah veterans received health care in the VA system. The veterans served by the VA Salt Lake City Health Care System are at higher risk for suicide than the non-veteran population for a variety of reasons. For example, VA patients tend to be older males, a group with a particularly high relative risk of suicide. Given the suicide risk profile of VA patents, the VA Salt Lake City Health Care System (VASLCHCS) has developed a multifaceted suicide prevention program. Some of the key elements of this program include the following:

A) The VASLCHCS has developed a Root Cause Analyses (RCA) Team that convenes on a monthly basis to determine the root causes and contributing factors for any suicide attempt or completed suicide by any patient associated with the Salt Lake City VA Health Care System. The members of the team represent a wide range of disciplines including psychiatry, psychology, nursing, counseling, pharmacy, and suicide research. The team makes specific recommendations to the Medical Center Director regarding implementations in policy, training, assessment and intervention with the goal of preventing suicide in the VA system. The RCA Suicide Team has developed a standardized review procedure for evaluating all instances of suicidal attempts and completions.

B) The VASLCHCS has also implemented a Suicide Attempt Reporting Template that that has been activated since October 1, 2006. This template is incorporated into the computerized record keeping system used in the VA and is completed by any staff member who has knowledge of any suicide attempt by any VA patient. This template is intended to increase awareness of suicide among VA staff and promote the use of effective and timely prevention interventions.

C) As of January 1, 2007, the VASLCHCS will conduct suicide risk assessment on all patients who enter the VA Health Care System for care or treatment. Based jupon the outcome of that risk assessment, VASLCHCS will take the appropriate action to prevent veterans from carrying out impulses or plans of self-harm. Risk assessment will be accomplished at all points of entry into the system including the Emergency Department, Outpatient Clinics, Community-Based Outpatient Clinics, Specialty Clinics and Inpatient hospitalizations.

D) The VASLCHCS has created a VSN 19 Mental Illness, Research, Education and Clinical Center (MIRECC) with a focus on suicide prevention. The MIRECC, established in October of 2004, was developed to improve care for suicidal veterans through integration of research, education, and clinical practice. The MIRECC is staffed by five researchers having a variety of research interests of relevance to suicide prevention. The MIRECC located at the VASLCHCS is part of a larger the Rocky Mountain Network MIRECC project headquartered at the Denver VA.

UTAH'S VOICE ON MENTAL ILLNESS

Our mission is to ensure the dignity and improve the lives of those who suffer with mental illness and their family members through education, support, advocacy, and research. Most of all, we want people to know that treatment works!

Family-To-Family is a free 12-week course for families of people who have mental illnesses. Family members can unite together to support each other, and receive valuable education about signs and symptoms of mental illness, medications, emotional stages, effective coping skills, problem solving, empathy, communications skills, recovery, advocacy and much more. Information is also provided for families with children under age 18 that suffer. Topics include early onset symptoms. Classes offered in Spanish.

BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support) is a free 10-week course for consumers of mental health services and those interested in establishing and maintaining their wellness and recovery. *Topics include* brain biology and mental illness, medications review, schizophrenia and mood disorders, anxiety disorders, problem solving and communication, building support and crisis avoidance planning, community support services, healthy living and whole-body healing.

Hope for Tomorrow **(HFT)** is a school-based mental health education program. HFT was developed by parents, students, educators, school administrators, the Utah PTA, the Utah State Office of Education, with support from the University of Utah Departments of Pediatrics and Child and Adolescent Psychiatry and Primary Children's Medical Center Foundation. Students who participated in the Hope for Tomorrow Program in Utah high schools demonstrated increased knowledge of mental illness, recognition of signs and symptoms of mental illness, as well as appropriate help-seeking behavior from adults, especially from parents and family members. HFT represents the combined efforts and insights of mental health professionals, educators, and other experts to help parents, teachers, students, and communities understand mental illness—a crucial step to improving the lives of those affected by it.

The Mentoring Program provides a personal coach who can empower consumers to reach for more independence and raise their self-esteem. The mentors provide guidance in finding support groups, setting realistic goals, moving back into society, and staying out of the hospital. They advise consumers and/or their family members about different resources available at NAMI and throughout the community. They take the time to help find funding for medication, and other much-needed aid.

Support Groups are available across the state for family members, friends, and consumers looking for the support from those who understand.

Clergy Training and Provider Training provides training to clergy members, general health, and mental health providers. Each training is taught by a panel of family members, consumers, and professionals. Participants receive training on mental illness, ways to offer support to both the consumers and the families, and resources available in the community.

NAMI Utah's Diversity Outreach Program provides outreach to diverse populations and community organizations to exchange resource information and to facilitate access to services. A monthly Diversity Outreach Meeting is held to encourage networking amongst Diverse Groups. In addition, NAMI Utah's programs are available in Spanish.

Contact:

Sherri D. Wittwer, MPA
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Website: www.namiut.org

Power in You mentoring program is based on the principles and concepts First Lady Mary Kaye Huntsman pioneered in two other mentoring programs. Mrs. Huntsman first began a program to help diabetic children. Although it began locally, it is now a national program through the Juvenile Diabetes Research Foundation. The *Bag of Hope* program provides thousands of recently diagnosed diabetes patients with a diabetic peer mentor and a "bag" filled with resource material to help facilitate disease treatment and patient comfort.

Mrs. Huntsman used this "kid-to-kid; heart-to-heart" mentoring concept to create a similar program for children and teens recently diagnosed with cancer and terminal illnesses. These programs not only give hope and comfort to those who receive the service, but also improve the emotional condition and self esteem of those who participate as mentors.

As First Lady of Utah, Mrs. Huntsman has now created the *Power in You* program using the same mentoring concept in order to help teens reach their educational and life potential.

The *Power in You* youth-to-youth mentoring program is a chapter of the Utah Public Education Foundation as of November 2004. The Foundation is a nonprofit IRC 501(c) (3) established to assist individuals, organizations, and their resources to help children reach their educational potential.

Contact:

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Website: www.powerinyou.org

MISSION STATEMENT

"The Sharing Place is dedicated to providing a safe and caring environment where children, teens, and their families who are grieving the death of a loved one may share their feelings while healing themselves."

Our Four Principles

- Grief is a natural reaction to the loss of a loved one
- Within each of us is the capacity to heal
- The length of time for grieving is unique for each individual
- Acceptance, caring and support are essential in the healing process

Our Approach

The Sharing Place is a place where mutual support is offered. Acceptance is practiced through listening and sharing. We respect each other as unique. We believe that within each of us exists our own answers to life's complex problems. As we support each other in listening to our own inner voices, we shall come to know our own inner truths.

We understand that giving and receiving are the same. By extending love, we can feel love within. We recognize that both facilitators and the participants are here for their own growth. The goal for each of us is personal healing and inner peace. The roles of student and teacher are interchangeable: each of us can experience both in this process.

Child Support Group

Each children's group includes 8-12 similar aged children (3 1/2 to 12), a seasoned group coordinator, and 6-8 trained volunteers who meet twice a month for 1 1/2 hours. An adult family member or guardian must accompany each child and stay in the center throughout the meeting. Adults accompanying children are invited to participate in an informal Adult Discussion Group which meets simultaneously.

Opening Circle begins with each children's group meeting with age-appropriate activities such as singing, story-telling, and drawing. These activities help the children focus on, and begin to explore, their feelings. Next, participants move freely among several rooms, each designed to provide a different avenue for expressing and understanding the complex emotions of grief.

The Volcano Room : With its padded floors, walls, and many pillows, it is a safe place to let go of the loud, intense, often physical and wordless feelings of grief

The Art Room : Offers a wide variety of supplies for the creative expressions of the children's emerging feelings

The Soft Room : Provides toys, dress-ups and other props for children to use in role playing activities

The Activity Room : Full of games, puppets and toys, permits children to explore or retreat from their grieving process according to their immediate needs

The Sanctuary Room : Is a space for quiet communion and remembering where children can hang drawings, photographs, and memorabilia

Each children's meeting ends with a Closing Circle. Children, parents and volunteers gather to honor anniversaries and to sing The Sharing Place's special closing song, saying farewell until the next time.

Teen Support Group

Designed to encourage teenagers' natural inclination to rely on each other for support, each teen group includes 10-15 teens and is monitored by a group facilitator and 4 to 5 volunteers. The teen group provides a safe and accepting environment for teens to discuss, explore and share their experiences and feelings. Art, music and other activities sometimes are used to ease the process. The teens close their group by sharing personal thoughts or readings to carry with them until they meet again.

Adult Discussion Group

Parents and guardians are invited to participate in the adult discussion groups which are designed to provide emotional and social support to bereaved caretakers. In the adult group, participants can discuss specific issues or request general information on understanding the needs and behaviors of grieving children and teens. The adult groups are open to adults who have children participating in The Sharing Place's program.

Website: www.thesharingplace.org

ULifeline

ULifeline, an online resource for college student mental health and emotional well-being.

Students
Learn more about mental health, take a mental health screening, ask questions, find answers, and seek help for yourself or someone you care about.

Campus Professionals
Connect with your colleagues at other colleges, customize your ULifeline site, and access ULifeline's information and tools.

About ULifeline
ULifeline is an anonymous, confidential, online resource center, where college students can be comfortable searching for the information they need and want regarding mental health and suicide prevention. ULifeline is available where college students seek information the most - at their fingertips on the Internet.

This most recent version of ULifeline, launched in February 2006, includes a new look, enhanced student features, and a new component called Counseling Central, built exclusively for college mental health and student affairs professionals. ULifeline is a program of The Jed Foundation, the nation's leading organization working to prevent suicide and improve the mental health of college students, and is overseen by an expert board of mental health professionals. The Jed Foundation provides ULifeline to all colleges and universities free of charge, regardless of the size or type of institution. Currently, more than 1,500 colleges and universities participate in the ULifeline Network.

Since its inception, ULifeline and The Jed Foundation have reached millions of parents, students, administrators, and, most importantly, those who have suffered in silence. We will continue to be vigilant in improving ULifeline and its ability to educate, raise awareness, and most importantly reduce the stigma associated with mental health seeking on a college campus, which ultimately, we believe, will help those truly in need.

Website: www.ulifeline.com

UNIVERSITY OF UTAH COUNSELING CENTER
GARRETT LEE SMITH MEMORIAL ACT

The University of Utah (UU) Counseling Center plans to address suicide prevention by accomplishing the following goals: 1) improving on-campus gatekeeper skill in risk assessment and protective factor referral making; 2) measuring efficiency and quality of protective factor referral making on-campus; 3) developing online materials for target populations that address warning signs of suicide, address specific cultural related issues, promote help-seeking behavior, and reduce stigma associated with care seeking; 4) developing online materials for families of UU students that increase awareness of risk and protective factors for suicide; and 5) increasing UU student awareness and use of protective factors available on campus.

Commuter students, students living on campus in Residential Living facilities, and Lesbian, Gay, Bisexual, and Transgendered (LGBT) students are the target populations chosen, based on survey data culled from two separate survey instruments administered on campus during the past year. The data indicate that these populations have high levels of risk factors associated with suicide.

Methods of achieving our goals include: Activity 1) gatekeeper training; Activity 2) creation of uniform forms for tracking and making protective factor referrals; Activity 3) content development for online materials for target populations; Activity 4) content development for online materials for families of UU students; and Activity 5) a professional promotion campaign.

While there are well-established clinical and emergency protocols for UU students in crisis, the campus community currently has no uniform suicide prevention training or response protocol for service delivery offices on campus. This project will help fill this critical gap in services. The Counseling Center is well positioned to conduct this project, using previous outreach work and coalition formation as a foundation. In 2000, Counseling Center and Office of Health Promotion staff formed the Wellness Network (Network) by inviting over 20 campus offices, departments, and groups to meet on a regular basis. The purpose of the Network is to improve communication between departments that serve students and coordinate and share resources, so that services will be provided more effectively, and redundancies and gaps in services minimized.

The Network has enjoyed successful interaction over the past five years and supports this application and proposed activities. Network members include a comprehensive group of UU student service providers: Academic Advising, Associated Student of UU, Center for Ethnic Student Affairs, Counseling Center, Dean of Students, Disability Services, Health Promotion and Education, International Center, Learning Enhancement Program, Lesbian, Gay, Bisexual, and Transgender Center, and many others.

With historical success and effective inter-office collaboration as its foundation, this project and its proposed activities will reduce suicide and suicide risk factors by increasing the availability and accessibility of protective factors for UU students.

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Campus Wellness Connection
201 So. 1460 E. Room 426 Student Services
Salt Lake City, UT 84112-9061

UTAH'S BEHAVIORS INITIATIVE

SCHOOL-BASED MENTAL HEALTH PROGRAMS

PROGRAM NAME: Utah's Behavior Initiatives (UBI)
UBI-Links/School Based Mental Health

PROGRAM DESCRIPTION: Utah's Behavioral Initiative (UBI) is a set of personnel development activities sponsored by the Utah State Office of Education, The Utah Personnel Development Center and The Utah State Personnel Development Improvement Grant. UBI is committed to the implementation of effective behavioral support systems in Utah schools. Adhering to behavioral research, UBI follows a school-wide model of prevention of problem behaviors and support of positive behaviors (PBS). This year UBI has added a system of care component. A system of care is a collaborative network of public and private community-based organizations that provide supports and services to meet the growing needs of children and youth with serious mental health issues and their families. In conjunction with the Utah State Office of Education (USOE) UBI has secured a grant that is providing the means to build meaningful and sustainable linkages between schools and mental health agencies that will result in a system of care for Utah schools. This project is referred to as UBI Links.

UBI activities include:

- Expanding school-wide Positive Behavior Supports (PBS) technical assistance to allow large-scale implementation;
- Emphasizing effective education and support for students with more intense and individualized support needs;
- Expanding school-wide PBS to Utah's School Districts; Increasing accessibility to the concepts, outcomes and research associated with school-wide PBS; and
- Establishing a network of resource agents to build local capacity.

UBI Links activities include:

- Coordinating and facilitating communication between schools and local mental health agencies.
- Providing training to increase understanding and awareness among school staff regarding mental health needs of students.
- Building capacity among school staff to address mental health needs.
- Providing education and training for students with mental health needs and their families.
- Facilitating the establishment of responsive and efficient networks to meet the mental health needs of local communities.

Population Served: Utah School Districts and Charter Schools

COLLABORATIVE PARTNERS: The Utah State Office of Education,
Utah Personnel Development Center and the Utah SIGNAL Grant, Allies for Families, Division of Substance Abuse and Mental Health, Division of Services for People with Disabilities, Local Mental Health Authorities, NAMI, Utah Parent Center, Juvenile Justice, University of Utah and Agencies Serving Ethnic Minority Populations.

OUTCOMES:

- Decrease in Office Discipline Referrals
- Increase in student and staff attendance
- Decrease in referrals to special education
- Increase in effectiveness of targeted and individual intensive behavioral interventions
- Increase in student perception of school safety
- Improved academic performance
- Improved faculty/staff retention
- Increased access to mental health services
- Increased understanding and awareness of community mental health needs
- Increased collaboration among service agencies to meet behavioral and mental health needs.

METHODS OF PROGRAM EVALUATION:

Effective Behavior Support Team Implementation Checklists:
This self-assessment tool has been designed to serve as a multi-level guide for (a) creating school-wide PBS action plans and evaluating the status of implementation activities on a quarterly basis.

The EBS Survey (EBS): The EBS Survey is used by school staff for initial and annual assessment of effective behavior support systems in their school. The survey examines the status and need for improvement of three behavior support systems: (a) school-wide discipline, (b) non-classroom management systems, and (c) systems for individual students engaging in chronic behaviors.

School-Wide Evaluation Tool (SET): The School-wide Evaluation Tool (SET) is designed to assess and evaluate the critical features of school-wide effective behavior support across each academic school year. The SET results are used to:

1. assess features that are in place,
2. determine annual goals for school-wide effective behavior support,
3. evaluate on-going efforts toward school-wide behavior support,
4. design and revise procedures as needed, and
5. compare efforts toward school-wide effective behavior support from year to year.

Information necessary for this assessment tool is gathered through multiple sources including review of permanent products, observations, and staff (minimum of 10) and student (minimum of 15) interviews or surveys.

Independent Evaluation Team: The UBI Links project will be evaluated at least quarterly by an independent evaluation team lead by Dr. Nancy Helper.

Benchmark Completion: The UBI Links project will also be evaluated by the percentage of schools that have comprehensive, detailed linkage protocols in place and the percentage of school personnel trained to make appropriate mental health referrals and specific intervals.

Contacts:

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Utah Personnel Development Center (UPDC)
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Holladay, Utah 84117
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UTAH PUBLIC MENTAL HEALTH CENTERS

Utah Public Mental Health Centers offer mental health services for Utah residents. The organizations listed provide crisis counseling, mental health information, and referrals for mental health treatment. All calls may be made anonymously, and all information discussed will be kept confidential.

For immediate life-threatening emergencies, or concerns of fear or danger, please call 911 immediately**.**

24-Hour National Suicide Prevention Hotline (800) 273-TALK [8255]

Valley Mental Health Crisis Line for mental health services: (801) 261-1442

Public Mental Health Centers

Box Elder County	(435) 452-8612
Cache County	(435) 752-0750
Central Utah	(877) 386-0194
Davis County	(801) 773-7060
Four Corners	Call 911, page on-call worker
Heber Valley	(801) 318-4016
Northeastern Utah	(435) 828-8241
Salt Lake County	(801) 261-1442
Southeastern Utah	(800) 502-3999
Southwestern Utah	(435) 634-5600
Utah County	(801) 373-7393
Weber County	(801) 625-3700

THE UTAH PRIDE CENTER (also known as the Gay and Lesbian Community Center) is located at 361 North 300 West in Salt Lake City, Utah. Founded in 1992, it is a 501(c)(3) non-profit, non-governmental, educational, advocacy and social services agency that serves Utah's gay, lesbian, bisexual, transgender (GLBT) community, their family, friends and allies.

The mission of the Utah Pride Center is to be a catalyst for personal growth, acceptance and equality for GLBT people living in Utah. The Utah Pride Center's staff work tirelessly to serve the GLBT youth and GLBT adult population. **The Youth Program** staff provide information, referrals, programs, and coming out support groups for youth (age 13-18) through a structured Youth Activity Program. **The Adult Program** staff offer a wide range of coming out support groups, social activities and educational programs for GLBT adults.

"Working It Out" is a training program offered by the Utah Pride Center through its **Youth Activity Program** for GLBT youth at risk (i.e., HIV/AIDS, substance abuse, suicide). This program is aimed at reducing the young person's feelings of isolation and stigma and helping them develop healthy communications, true friendships and a healthy self-esteem.

In addition to in-house programming, the Utah Pride Center organizes two major events for the Utah GLBT community, friends, family and allies. The annual **Utah Pride Festival** (held in June) attracts over 20,000 participants and the annual **Salt Lake City Winter Pride Festival** is a hearty 10-day festival featuring 28 individual events.

The professional staff of the Utah Pride Center work to disseminate a broad array of information to educate the broader Utah public about being a member of the GLBT community. The staff are tremendous advocates and teachers of advocates for social change. A common theme for the work at the Utah Pride Center is that "someone you know and love is gay!"

EDUCATION & ADVOCACY PROGRAMS

Education & Training

GLBT Diversity Education
The Center staff is are often asked to offer assistance with diversity training needs. This type of training is often helpful for those working within criminal justice systems, social service agencies, and higher education. Some of the information used for trainings has been developed by national GLSEN (Gay, Lesbian, and Straight Education Network) and other GLBT community centers.

Health Care Provider Sensitivity Training
Finding a health care provider that understands and is sensitive GLBT issues is important! The Center staff has made identifying GLBT-friendly health care providers a priority and is actively working to increase the opportunities for sensitivity training. Many of the resources used to provide sensitivity training are obtained from the work of Kaiser Permanente, The Helen Mautner Project, and the Gay/Lesbian Medical Association.

Advocacy Programs & Coalitions

GLBT Public Safety Liaison Committee
2nd Tuesday of every month, 3:00 pm
Utah Pride Center
For more info, contact Tracy at ttingey@southsaltlakecity.com.
This committee of community groups and police departments works collaboratively on issues that impact the safety and wellbeing of the GLBT community.

Transgender Education Advocates of Utah (TEA)
Website: http://www.tea-utah.us/
Transgender Education Advocacies of Utah exists to educate the community on gender identity and expression as well as advocating to end discrimination against transgender people. **TEA is an affiliate program of the Center.**

Be sure to check our calendar for the listings of these and related events!

Contact:

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Utah Pride Center
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Website: www.utahpridecenter.org

Utah Valley State College (UVSC) & Garrett Lee Smith Memorial Act

Utah Valley State College will undertake a comprehensive approach to suicide prevention on the campus with community gate keepers and stakeholders. The College has formulated its own conceptual model called 3Rs based on best practices to govern the project philosophy and implementation. Multiple strategies and activities will be implemented, targeted at both the general campus population and identifiable at-risk populations over a three year time period. Engagement of key players in the college community in planning, assessment, design, implementation, and evaluation will be incorporated. The Project Director and a campus-based mental health services team of professional advisors and task forces will lead and implement the project. The following allowable activities will be utilized: (1) Training Programs; (2) Networking (institutional and broader community); (3) Educational Seminars; (4) Local and College-based Hotlines; (5) Informational Materials; and (6) Educational Materials for Families and Students. The major goals of the project are centered and aligned on informing, engaging, training and educating the community in best practices aimed at improving early recognition, treatment, help-seeking, and consistent care for the at-risk student population. The UV-CSI project further incorporates a comprehensive ongoing process evaluation and annual self and external evaluations as integral components of the project.

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UTAH YOUTH SUICIDE STUDY (UYSS)
GARRETT LEE SMITH MEMORIAL ACT GRANT

Current suicide prevention services, to prevent the deaths occurring in the group aged 15-19 years (completers), focus on family-centered suicide prevention services for all juvenile offenders aged 13-17 years (highest-risk group).

Due to the high rates of suicide, Dr. Douglas Gray began developing the Utah Youth Suicide Study (UYSS) in 1994 to understand the characteristics of youth suicide in Utah and identify appropriate prevention strategies for children and adolescents [2]. First, the UYSS conducted an epidemiological study using records from government agencies of all Utah residents, ages 13 to 21 years, who completed suicide between August 1996 and June 1999 (N=151). The study collected data from records kept at the Utah Office of the Medical Examiner (OME), Utah Office of the Juvenile Courts, Department of Health and Human Services (Division of Child and Family Services, Public Mental Health System, Utah State Hospital), and Utah State Office of Education between August 1996 and June 1999.

Results showed that 89% (N=134) of the subjects were male; firearms were the most common method of death 58% (N=88); and, handguns were the most common type of firearm used 50% (N=44 of 88). Sixty-three percent of subjects had contact with Juvenile Justice (N=95 of 151). School aged subjects between 13-18 years of age were just as likely to be involved with Juvenile Justice (66%), as they were to be enrolled in school (63%)(Gray, Konkel et al. 2001).

Based on these findings, objectives of the UYSS were: 1) to extend the initial Utah Youth Suicide Study for 3 years to determine the reliability of the preliminary findings; 2) to examine the mental health status of a Juvenile Justice population; and, 3) to determine if mental health status influences recidivism (Douglas Gray et al., 2001). The gender ratio in the Juvenile Court System was similar to the overall preliminary study findings, with males representing 91% of those with Juvenile Court contact. Of the 95 subjects involved with juvenile justice, 54% had a referral(s) for substance possession, use, or abuse. Thirty-two percent had at least one felony referral (Douglas Gray et al., 2001). Referral to the Juvenile Justice System was a risk factor for completed suicide for youth with eight or more offenses, with odds of 5.2. Therefore, the UYSS team hypothesized that the Juvenile Court System would provide new opportunities for mental health screening and suicide prevention (Douglas Gray et al., 2001).

In order to evaluate the mental health status of a Utah Juvenile Court population, researchers at Brigham Young University (BYU) joined the UYSS team. Researchers administered the Youth Outcomes Questionnaire (Y-OQ) among a large sample (N=719) of consecutive juvenile offenders. This BYU study included Utah residents who were consecutively referred statewide to the Juvenile Court System, for either status or criminal offenses, over a one-month period. The procedure required parental consent and child assent. The Y-OQ is a parent and self-report screening tool, which assesses level of distress and dysfunction in children and adolescents. As a psychometric measure, it can determine the subject's similarity to inpatient psychiatric populations, outpatient psychiatric populations, and a large untreated community sample (Burlingame et al., 1996). In this sample, 69% of subjects were male. Results indicated that 49% (N=352 of 719) were above the outpatient cut-off score, indicating an evaluation for outpatient services should be considered. Seventeen percent of the justice population (N=124 of 719) were above the inpatient cut-off score indicating that an evaluation for an inpatient psychiatric hospitalization should be considered. All Juvenile Court participants were compared to a community control group. The mean scores for study subjects vs. controls were as follows: Recidivism was positively correlated with Y-OQ symptom severity; the more offenses, the higher the Y-OQ score. For example, 38% and 9% of subjects with a single offense met outpatient and inpatient cut-offs scores, compared to 66% and 27 % of subjects with 8 or more offenses (Gray, Konkel et al. 2001). Clearly, the Juvenile Court system offers a substantial window of opportunity to screen, identify, and refer high-risk individuals for treatment. Further, the Y-OQ may be an appropriate instrument to identify individuals in Juvenile Justice who are at risk for psychiatric problems, recidivism, and suicide (Gray et al., 2001).

Utah's Third District Juvenile Court serves 42% of the juvenile offender population statewide, approximately 16,700 juveniles per year. Utah judges consider ongoing court supervision of young offenders after the commission of the third minor offense or the first felony offense. Probation supervision is the most common form of ongoing court supervision. Because more offenses correlated with higher Y-OQ scores, the pilot study used the Y-OQ to identify adolescents through the juvenile court system at risk for mental illness, recidivism, and suicide (D Gray, Achilles, & Keller, 2002; Douglas Gray et al., 2001). The juvenile offender pilot study provided a comprehensive and consistent family-oriented treatment intervention and examined two constructs. 1) Does the delivery of an Individual Treatment Plan improve mental health status as measured by the Y-OQ, decrease the rate of recidivism, and increase the rate of suppression among those at highest risk for suicide in Utah (male adolescents aged 13-16 years in Third District Juvenile Court)? 2) Is the systematic identification and earlier intervention at the secondary prevention level, which included more intensive, easily accessible, and coordinated mental health services effective in reducing court placement (days spent in detention centers, corrections, observation and assessment)?

With regard to mental health status as measured by the Y-OQ, results showed an overall increase in mental health status for participants in the intervention group as compared to participants in the comparison group ($p<.001$). An interaction effect was found between participants who received treatment and the number of days in treatment, indicating an improvement in mental health as days in treatment advanced with a relative daily change in Y-OQ score of -0.073 for those in the intervention group compared to those in the comparison group ($p = 0.007$)

Rates of recidivism and suppression were analyzed using McNemar's test for paired comparisons. Recidivism was defined as one or more offenses incurred by a participant after enrollment for one year. These results indicate that the participants in the intervention group progressively decreased throughout the first six months, as 78% did not recidivate, while only 57% of the comparison group did not recidivate; however these results failed to achieve statistical significance ($p=.21$). Data for one-year post enrollment reflects similar findings with 77% for intervention and 57% for comparisons ($p=.22$). Additionally, youth in the intervention group all recidivated at the same level; however, youth in the comparison group recidivated at higher levels, including more violent offenses such as aggravated assaults; assaults; and, threats to life or property by 5 participants; drug related offenses by 5 remaining participants; and, disorderly conduct and unlicensed driving by 2 participants

Suppression was defined as no offenses incurred by a participant after enrollment for one year. Further analyses were conducted to determine significance of suppression for participants in the intervention compared to the comparison group. At six months post enrollment, participants in the intervention group were more likely to not offend when compared to comparisons ($p=.05$) (Table 3). At one-year post enrollment at difference remained; however, failed to demonstrate statistical significance ($p=.14$)

Regarding Juvenile Court placement during the first six months of the study, 11 participants in the intervention group spent a total of 190 days in detention centers, which cost approximately $19,000 and at twelve months 233 days, which cost approximately $23,300. In comparison, during the first six month of the pilot study, 11 of the participants in the comparison group spent a total of 634 days, which cost approximately $63,400 and at twelve months, 777 days, costing approximately $77,700-- over 3 times the cost of the intervention group. During the first six months, one participant in the intervention group spent 58 days in corrections, which cost approximately $14,500, and no additional days during the last six months of the study. Whereas, 6 participants in the comparison spent a total of 286 days in corrections during the first six months of the study, which cost approximately $101,750, and at twelve months 490 days**, which cost approximately $162,950. Concomitantly, 3 participants in the comparison group spent 87 days* in observation and assessment, which cost an additional $17,400. Court placement for the comparison group totaled $258,050, whereas court placement for the intervention group in addition to the cost of the family-centered suicide prevention services including psychiatric evaluation and in-home services totaled $158,800. Days in placement were analyzed using the Wilcoxon signed-rank test to determine significance. Results indicate that participants in the comparison group were more likely to spend time in corrections ($p=.01$) and observation and assessment ($p=.04$).

Wilcoxon Signed-Rank Test for Days of Court Placement

TYPE OF COST	6 MONTHS		12 MONTHS		TOTAL COST	
	Intervention	**Comparison**	**Intervention**	**Comparison**	**Intervention**	**Comparison**
Treatment Services	$121,000 One year PRN	$0	$0	$0	$121,000	$0
Detention Centers	$19,000 190 days	$63,400 634 days	$4,300 43 days	$14,300 143 days	$23,300 233 DAYS	$77,700 777 DAYS
Corrections	$14,500 58 days	$101,750 286 days	$0 0 days	$61,200 204 days	$14,500 58 DAYS	**$162,950 490 DAYS****
Observation & Assessment	$0 0 days	$17,400 87 days	$0 0 days	$0 0 days	$0 0 DAYS	**$17,400 87 DAYS***
TOTAL COST & PLACEMENT	248 DAYS	1007 DAYS	43 DAYS	347 DAYS	$158,800 291 DAYS	$258,050 1354 DAYS

** Wilcoxon signed-rank test significance p=.01
* Wilcoxon signed-rank test significance p=.04

Through funding awarded by The US Department of Health and Human Services, Division of Substance Abuse and Mental Health Services Administration (SAMHSA) under the Garrett Lee Smith Memorial Act, $1.2 million dollars will be spent over the next 3 years to expand the model used in this pilot study to include all offenders involved with Utah's Juvenile Court system. These grant monies will close a gap in Utah's existing service delivery system for juvenile offenders with in-home court placements by providing appropriate mental health screening, referral, and treatment for youth at highest risk for suicide in Utah, youth offenders who struggle with undiagnosed, untreated, or under-treated mental illness.

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