

Utah Behavioral Health Planning and Advisory Council
Approved Meeting Minutes
October 3rd, 2019, 12:00 p.m.
Multi-Agency State Office Building, Room 2026
195 N 1950 W, Salt Lake City

“Our mission is to ensure quality behavioral health care in Utah by promoting collaboration, advocacy, education, and delivery of services.”

COUNCIL MEMBERS PRESENT: Sigrid Nolte, Rob Wesemann, Lori Cerar, Ken Rosenbaum, Joann Cleveland, James Park, Donald Cleveland, Aubrey Myers, Andrew Riggle, Dan Braun, Jennifer Marchant (R), Cathy Davis (R), Jason Jacobs

DSAMH STAFF PRESENT: Pam Bennett, Shanel Long, Robert Snarr, LeAnne Huff, Heidi Peterson, Jeremy Christensen, Heather Rydalch, Kim Myers

OTHERS PRESENT: Nettie Byrne, Olivia Shakespeare, Julia Martinez

COUNCIL MEMBERS EXCUSED: Adam Scherzinger, Emily Bennett, Cyndie Moore, Lisa Hancock, Jeanine Park, Dave Wilde, MaryJo McMillen

Welcome, Introductions, August meeting minutes review, new member applications, and announcements:

Sigrid began the meeting and introductions were made around the room.

Sigrid asked for a motion to approve the minutes from September. Dan Braun mentioned that a section was not very clarified, so after that paragraph is removed the minutes would be submitted. Dan gave a 1st motion to approve with changes, Donald gave a 2nd, motion passed unanimously.

LeAnne Huff, DSAMH and CIT updates:

Met with Advocates Gone Rogue and met with the Deputy Chiefs of the Salt Lake Police Department to get feedback from both regarding the language of the proposed CIT code. Going to meet with Unified PD next week for feedback as well. Listed below is part of the CIT Code proposal with the integrated feedback we have received from advocates and stakeholders. Best Practice has been made a bit more prominent and some specifics on council make up and role of Liaisons has been added. Feedback is still welcome as this is still a work in progress.

Part 1

Division of Substance Abuse and Mental Health

62A-15-102 Definitions.

As used in this chapter:

(2) “Crisis Intervention Team” means a law enforcement, mental health provider and advocate collaborative program. “CIT” is used to describe primarily a program in the community and a training in law enforcement, including collaboration with mental health providers and advocates, to help guide interactions between law enforcement and those living with a mental illness or related conditions.

62A-15-103 Division -- Creation -- Responsibilities.

(o) Prioritize crisis intervention efforts by collaborating with law enforcement and statewide advocacy efforts, to develop, implement and oversee a statewide Crisis Intervention Team (CIT) protocol.

(i) The division, in collaboration with individuals with lived experience with mental illness, mental health advocates, mental health providers and law enforcement shall establish a council comprising at a minimum, the division; two members of a statewide mental health advocacy organizations; one family member of a person with lived experience; one person with lived experience; one representative from both urban and rural local mental health authority's; police chiefs association; sheriffs association; and a representative from the Department of Public Safety, to develop and implement a Statewide Crisis Intervention Team Program, training and support to local law enforcement jurisdictions, local mental health authorities and communities.

(iii) By July 1, 2021, the division in coordination with the council shall establish by rule:

(A) A program and standards for crisis intervention team training as required under this section.

Approved local collaborations must use initial CIT team training through council approved CIT team training or curriculum to facilitate the training. The council shall follow Best Practices and consider geographic training needs when establishing programs, standards and curriculum;

(B) Standards for successful qualification for and completion of the initial Crisis Intervention Team Training as well as annual crisis intervention continuing education training. The standards shall include, at a minimum, the requirement of 40 hours of initial training and successful completion of an approved exam. (C) Statewide regional mental health and law enforcement coordinator roles and responsibilities, including representation from individuals with lived experience or advocates from local regions.

Malisa Pearson, FREDLA: FAM-Voc Pilot Survey-

The Family Voice on Councils & Committees (Fam-VOC) is an assessment of organizational support for family voice. The Fam-VOC is designed to gauge the extent to which councils, committees and advisory boards welcome family voice by engaging and supporting family members to be active and influential members. The Fam-VOC assessment was developed as part of an ongoing collaboration between FREDLA (the Family-Run Executive Director Leadership Association), and the Pathways Research and Training Center at Portland State University, with additional input from family leaders.

The Fam-VOC assesses support for family voice in the following four themes:

- Theme 1: Overall Vision and Commitment
- Theme 2: Collaborative Approach
- Theme 3: Empowered Representation
- Theme 4: Support of Family Members Participation

In April and May of 2019, 22 of the 41 members of the UBHPAC completed the Fam-VOC. This was a response rate of 54%. The overall mean score was 3.79 (on a five-point scale with 5 being the highest). The true mean lies somewhere between 3.5 and 4.03. Estimated mean scores for the four themes ranged from 3.53 to 4.07 on a five-point scale. This suggests that the UBHPAC is "almost there" in its policies and practices in support of family voice. The highest mean score was 4.07 on Theme 4, Support for Participation. The lowest mean score was 3.53 on Theme 3, Empowered Representation. The confidence intervals for all the theme means ranged between .48 to .67. Upon review of each theme area and the individual items within each theme area, it appears the UBHPAC has strong scores in most areas of the Fam-VOC assessment.

There are a few areas, however, that could be areas of opportunity as you continue to strive for full implementation in all areas of the assessment. Those areas are assessment of participation efforts, enough and consistent representation, and orientation. As you continue your efforts to fully integrate family voice and participation on the UBHPAC, you may want to consider the following:

- Identify an agreed upon assessment tool and commit to a regular and routine assessment of the UBHPAC.
 - In partnership with the family-run organization, identify, train and support additional family members who can fill vacancies, consider having at least 3 family members serving on the committee at any given time, provide compensation for the family members' time and expertise, travel, and childcare (if any), offer phone-in option if unable to attend in person, etc.
 - In partnership with the family-run organization, explore additional support opportunities for family members and the use of family representative alternates to ensure ample family member participation at all UBHPAC meetings.
 - Ensure all members of the UBHPAC receive a formal orientation that includes best practice strategies for supporting meaningful family voice, participation, and leadership opportunities within the council.
 - As a council, spend time reviewing and discussing the responses to the open-ended questions (included in this report, beginning on page 15) provided by those who completed the Fam-VOC assessment tool. Contained within these comments are several suggestions that speak directly to the areas mentioned above as areas of opportunity. For example, this comment speaks to the enough and consistent representation of family
- For the full report please contact Nettie Byrne for a copy. nettieb@allieswithfamilies.org

Kim Myers, DSAMH- Suicide Prevention in Utah

The Utah Suicide Prevention Coalition is dedicated to long-term suicide prevention efforts. Our goal is to reduce suicide rates in Utah by 10% by 2021, 20% by 2025, with the goal of zero suicides in Utah.

Comprehensive Approach-

Efforts must work to address as many factors in as many settings as possible and create a comprehensive approach to suicide prevention.

The goal of the Utah Suicide Prevention plan is to create a comprehensive approach and roadmap for suicide prevention in which we reach both a universal population and those with increased risk.

To ensure effectiveness:

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- Utilize evidence-based programs and strategies –
 (programs with high evidence of effectiveness that has been proven over time and across multiple replications by independent researchers, preferably in randomized controlled trials)
Suicide prevention is a complex topic and some interventions or efforts, while well intentioned, may cause more harm than good; particularly if they raise awareness of the problem of suicide without giving adequate resources and skills to build protective factors, or if they lead to suicide contagion by normalizing or glorifying suicide unintentionally.
 - Strive to provide opportunities, resources, and training to local Utah communities
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Utah Suicide Prevention Plan: Priorities-

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- Increased availability and access to quality physical and behavioral health care
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Access
 Zero Suicide
 M.A.T.

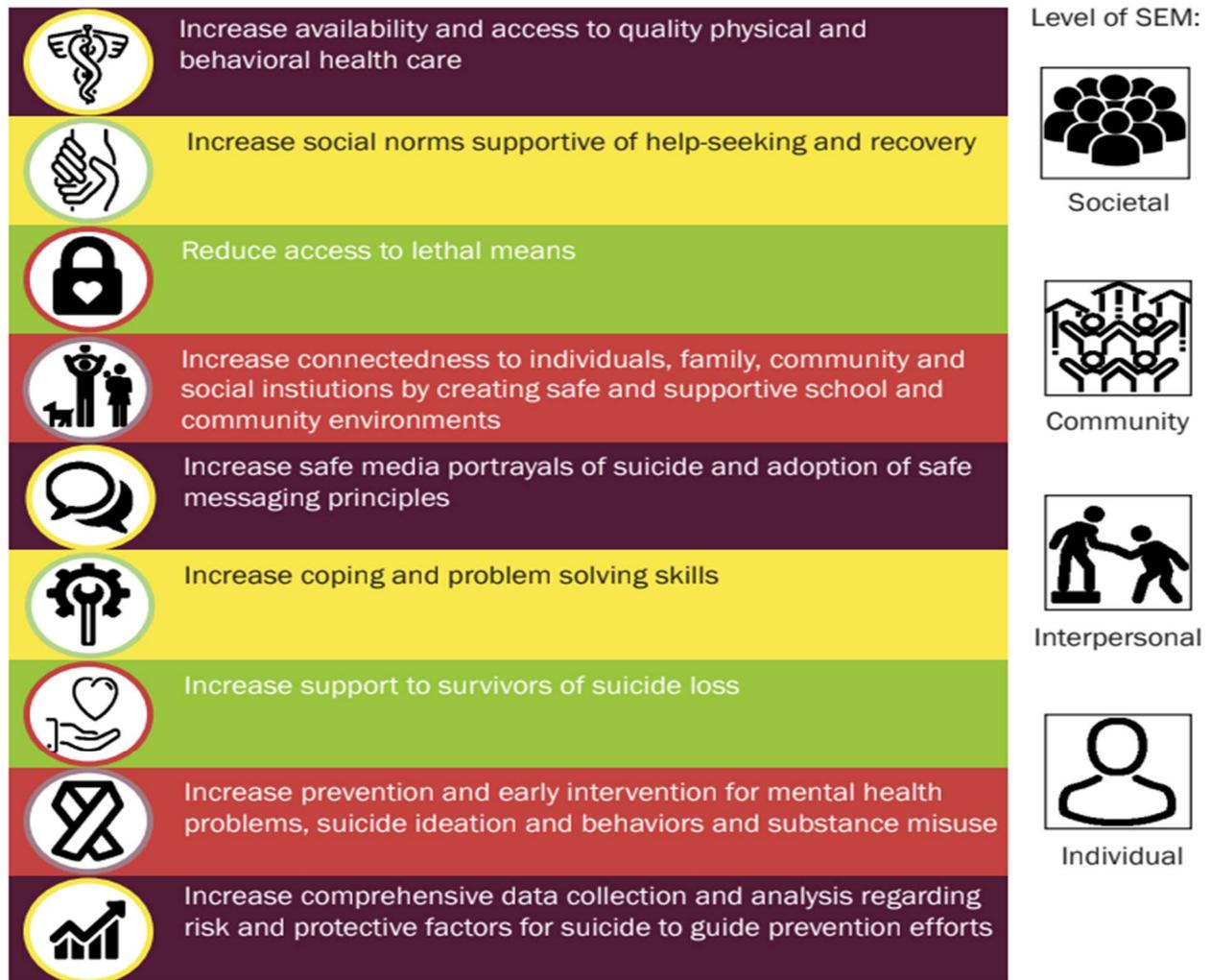
- Increased social norms supportive of help seeking and recovery
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Gatekeeper training
 Recovery stories
 Access

- Reduce Access to Lethal Means
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Counseling on Access to Lethal Means
 Pharmacy/Physician
 Use Only as Directed

The Protective Factor Model:



Three Pillars of Prevention:

- Reduce Risk Factors
- Increase Protective Factors
- Implement Evidence-Based Programs and Strategies

Prevention by Design:

- Contract with NAMI Utah
- Mental Health Promotion and Suicide Prevention Project
- Support, Education, and Advocacy
- Mini grants out to local coalitions for prevention efforts

Local strategic planning

Gatekeeper training

School based prevention

Life-skill development

Workplace strategies

Utah's Mental Health System Report:

Andrew Riggle shared the repost with UBHPAC and once council members have had time to review we will discuss more in depth at the November meeting. Some of the report contents are below:

At-A-Glance interviews held with key industry leaders from Utah's mental health system.

The Demand for Mental Health Care in Utah: Key Statistics

Key points include the following:

- **The demand for mental health care in Utah is increasing.** Close to one in five Utah adults experience poor mental

Close to one in five adults health and demand for youth services is increasing. Almost experience poor mental health. 15 percent of males and 28.5 percent of females age 15-17 seriously considered attempting suicide in 2015-2017.

- **Utah's shortage of mental health providers could worsen over time.** Utah experiences mental health provider shortages in all its counties and has fewer mental health providers per 100,000 people than the national average. A newly expanded Medicaid program coupled with a rapidly growing state population will intensify the effects of existing shortages.

- **Funding for Utah's public mental health system is bifurcated across different systems, making it difficult to consistently deliver coordinated care.** A problem with the bifurcation between physical and mental health services is that chronic disease and poor mental health are closely related, making it difficult for people with both conditions to access timely care.

- **Commercial health insurance coverage of mental health services is often limited, which can result in high out-of-pocket costs.** Not all commercial health insurance plans are required to cover mental health services. And even if they do, there are still applicable copays and deductibles, which can prevent access to care.

Utah Ranked Last on Adult Mental Health Measures in 2018

Mental Health America, a community-based nonprofit organization, compiles publicly available data across all 50 states and the District of Columbia to develop a composite mental health score and ranking for each state (Figure 3). In 2018, Utah ranked 37th on combined adult and youth measures. A low overall ranking indicates a higher prevalence of mental illness and lower rates of access to care. Utah ranked 24th on youth measures, but 51st on adult measures. Utah's high percentage of adults with any mental illness, adults with serious thoughts of suicide, and adults with any mental illness reporting unmet needs influences its low ranking on adult measures.

Each state's ranking is based on measures of mental health prevalence and access to care.⁴ It is important to note that there are limitations to the data used to develop each state's score and that the measures do not provide a complete picture of a state's mental health system.⁵ However, it does provide a snapshot of how Utah ranks on certain public mental health measures compared to other states.

Next meeting will be November 7th, 2019, 12:00 P.M.

Thank you for your support of the UBHPAC!

Accommodations to the known disabilities of individuals in compliance with the Americans with Disabilities Act. For accommodation information or if you need special accommodations during this meeting, please contact the Division of Substance Abuse and Mental Health at (801) 538-3939 or TTY (801) 538-3696.

The State has adopted a stipend policy that will pay for reasonable travel expenses related to consumers and advocates attendance at UBHPAC meetings. For more information please visit www.dsamh.utah.gov – Initiatives – Behavioral Health and Advisory Council – Information & Forms – UBHPAC Stipend Policy.

All meeting minutes and recordings are posted on the Public Notice website at:
<https://www.utah.gov/pmn/sitemap/publicbody/51.html>