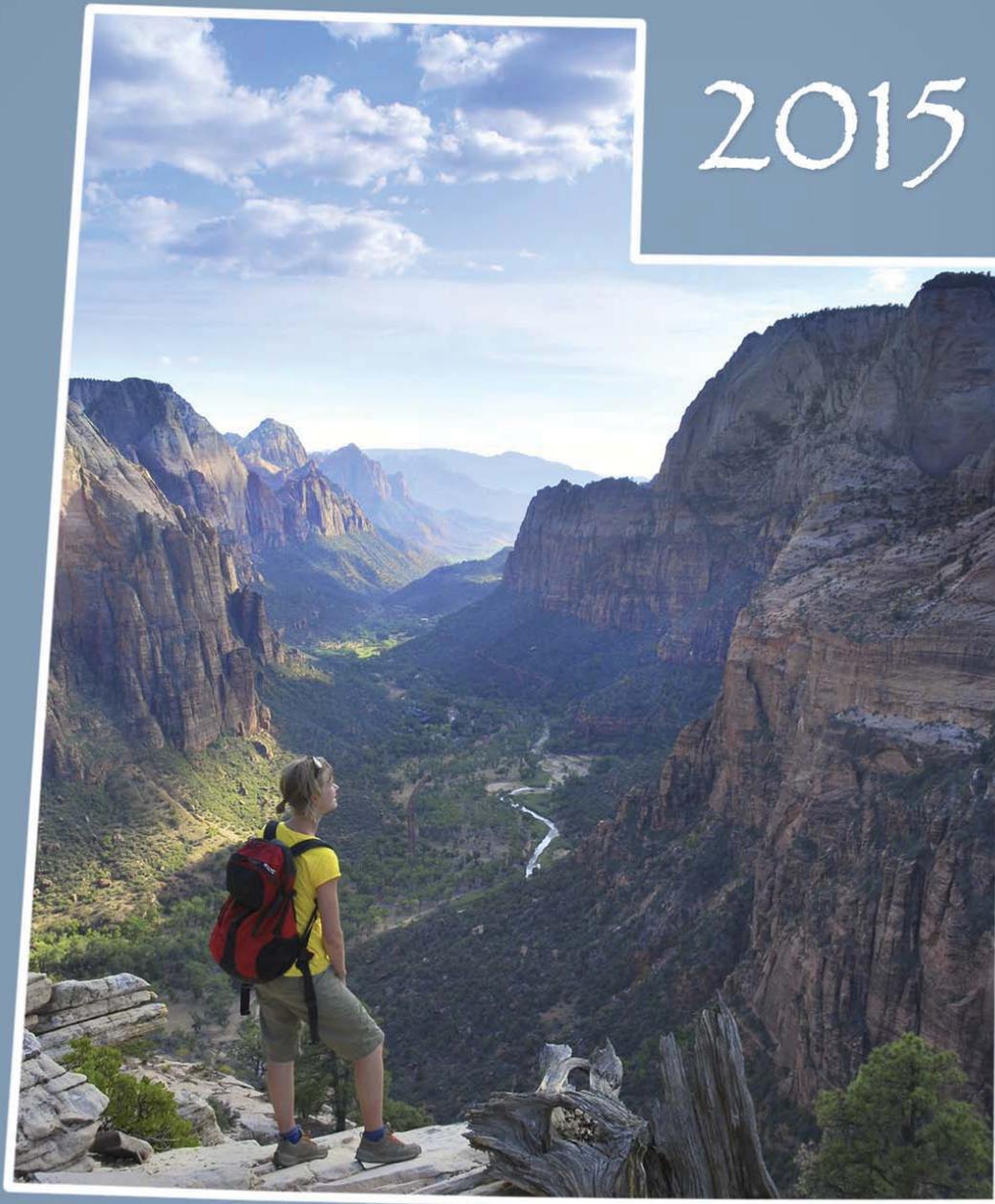


DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
ANNUAL REPORT



Hope • Health • Healing

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2015
Annual Report



Doug Thomas, Director
Division of Substance Abuse and Mental Health
Department of Human Services
195 North 1950 West
Salt Lake City, UT 84116

TABLE OF CONTENTS

Letter from the Director	1
Utah’s Public Behavioral Health System	3
Vision, Mission and Guiding Principles	5
Source of Funding	7
2015 State Strategies	
Strategy One: Focus on Prevention and Early Intervention	8
Strategy Two: Zero Suicides in Utah	8
Strategy Three: Promote Recovery	11
Strategy Four: Improve Services for Adolescents and Children	12
Strategy Five: Health System Integration	13
Who We Serve	15
Total Number Served	17
Utahns in Need of Substance Use Treatment.....	18
Utahns in Need of Mental Health Services	19
Total Number Served (SUD and MH Detail).....	20
Household Income and Poverty	21
Urban and Rural Areas.....	22
Demographics	23
Services and Activities	35
Education and Training	37
Prevention	44
Substance Use Disorder Services	50
Mental Health Services	65
Recovery Support Services.....	81
Outcomes	85
Student Health and Risk Prevention Survey (SHARP)	87
Substance Use Disorder Treatment Outcomes.....	91
Mental Health Treatment Outcomes	96
Consumer Satisfaction	98
Cost Analysis.....	100
Synar.....	102
Local Authorities	103
Local Authority Service Outcomes	105
Bear River	106
Central Utah Counseling Center	110
Davis Behavioral Health.....	114
Four Corners Counseling	118
Northeastern Counseling Center.....	122
Salt Lake County	126

San Juan County.....	130
Southwest Behavioral Health Center	134
Summit County.....	138
Tooele County	142
Utah County	146
Wasatch County	150
Weber Human Services	154
Resources	159
List of Abbreviations	161
Mental Health Reference Table.....	162
Contact Information.....	163
DSAMH Organizational Chart	166
List of Substance Use Disorder and Mental Health Charts.....	167



State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

ANN SILVERBERG WILLIAMSON
Executive Director

Division of Substance Abuse and Mental Health

DOUG THOMAS
Director

January 2016



I am proud to release the Division of Substance Abuse and Mental Health (DSAMH) Annual Report for 2015. I hope this report broadens your understanding of the important role that the public behavioral health system has in the lives of individuals, families, and communities in Utah. “Hope, Health, Healing” is our continued theme. Prevention works, treatment is effective, and people can and do recover from mental health and substance use conditions. Together we can make a difference for those among us who suffer from the symptoms of mental health or substance use disorders. The results of our efforts are stronger and healthier individuals, children, families, and communities in Utah.

The Mental Health Parity and Addiction Equity Act, as well as the Affordable Care Act, have opened the way for people to get their behavioral health needs met just like their physical health needs. Over time, these programs should decrease stigma and increase understanding. The earlier people receive help, the better the outcomes people have, at less cost, with less disability. With Utah’s diverse population, it is more important than ever to have a trauma informed approach that does no harm, generates hope and encourages healing.

DSAMH has set the following priorities to emphasize specific goals and strategies in the coming year(s):

- Focus on prevention and early intervention
- Work toward “Zero Suicides” in Utah
- Promote a recovery-oriented system of care led by people in recovery, that is trauma informed and evidence-based
- Improve the system of care for children and youth
- Promote integrated healthcare

I invite you to look at our strategic plan and find a way to become involved in your local community, or give us feedback about our statewide plan. View the report at the following link; dsamh.utah.gov/provider-information/dsamh-strategic-plan/

I want to personally thank the brave individuals reaching out to confront mental illness and substance misuse head on in their own lives. I also want to thank those who help facilitate this process; the many caring and dedicated family members, friends and professionals, whose support is life-altering for so many. Your support is appreciated by so many.

Sincerely,

Doug Thomas, LCSW
Director

Tara's Journey

Before I got clean and sober I couldn't define hope, I didn't know who I was, I am not even sure that I knew who I wanted to be, or how my life would ever be different. Throughout most of my life there was always these two voices inside, one was shouting: "Tara, you aren't worthy!" And the other, more subtle and quiet one was whispering: "Tara, you are meant to do so much more with your life."

In the beginning, the 12-step process was the vehicle through which I navigated through my shame, my identity and my personal inventory. I worked hard with a sponsor and did my best to be of service to others. I was also a participant in the Felony Drug Court Program and graduated in 2013.

The miracles in my life have been many. I wish I was articulate enough to tell you how and what empowered me to be the woman I am today. It's something that radiates through our souls, it's the forces of the divine that allow a woman like me, one who has been hopelessly addicted, in handcuffs, a jail cell, all alone, to stand before you today as a woman empowered. One who was given a chance, who was able to heal and mend the hearts of her once broken family relationships. One who now has a life full of family, freedom, hope, connectedness, serenity, blessings and a career.

I think that is how I define hope today...that out of the depths of hell we can crawl, together, while we mend the wounds in our souls. Never give up. One day at a time!

Honor your life by following the rules, especially when no one is looking!



Utah's Public Behavioral Health System

This Annual Report summarizes the activities, accomplishments, and outcomes of Utah's public behavioral health system. In Utah, publicly funded behavioral health services are provided through a partnership of State and county government. This report provides information on the State Division of Substance Abuse and Mental Health (DSAMH), the Utah State Hospital and our county partners.

DSAMH is authorized under Utah Code Annotated (UCA) §62A-15-103 as the single state authority in Utah. It is charged with ensuring a comprehensive continuum of substance use and mental health disorder services are available throughout the state. In addition, DSAMH is tasked with ensuring that public funds are spent appropriately.

Vision

DSAMH's vision is to contribute to the development of healthy individuals, families and communities. Substance use disorders and mental illnesses are chronic diseases. However, prevention works, treatment is effective, and people recover.

Mission

DSAMH's mission is to promote hope, health and healing by reducing the impact of substance abuse and mental illness. To achieve this mission, DSAMH provides leadership, promotes quality, builds partnerships, ensures accountability, and operates effective education and training programs. DSAMH uses a public health approach to make its vision a reality.

Guiding Principles

Systems, services, programs, activities, strategies, and policies should be trauma-informed, evidence-based, and culturally and linguistically competent.

Trauma-Informed

Most individuals with mental health and substance use disorders are also dealing with trauma issues. DSAMH recognizes the prevalence of trauma and takes a universal precautions position. Trauma affects all individuals involved, including staff and the local workforce. DSAMH is working to ensure that all aspects of its system recognize the impact of trauma and make every effort to avoid re-traumatization.

Evidence-based Practices

DSAMH provides training and consultation designed to promote evidence based practices. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

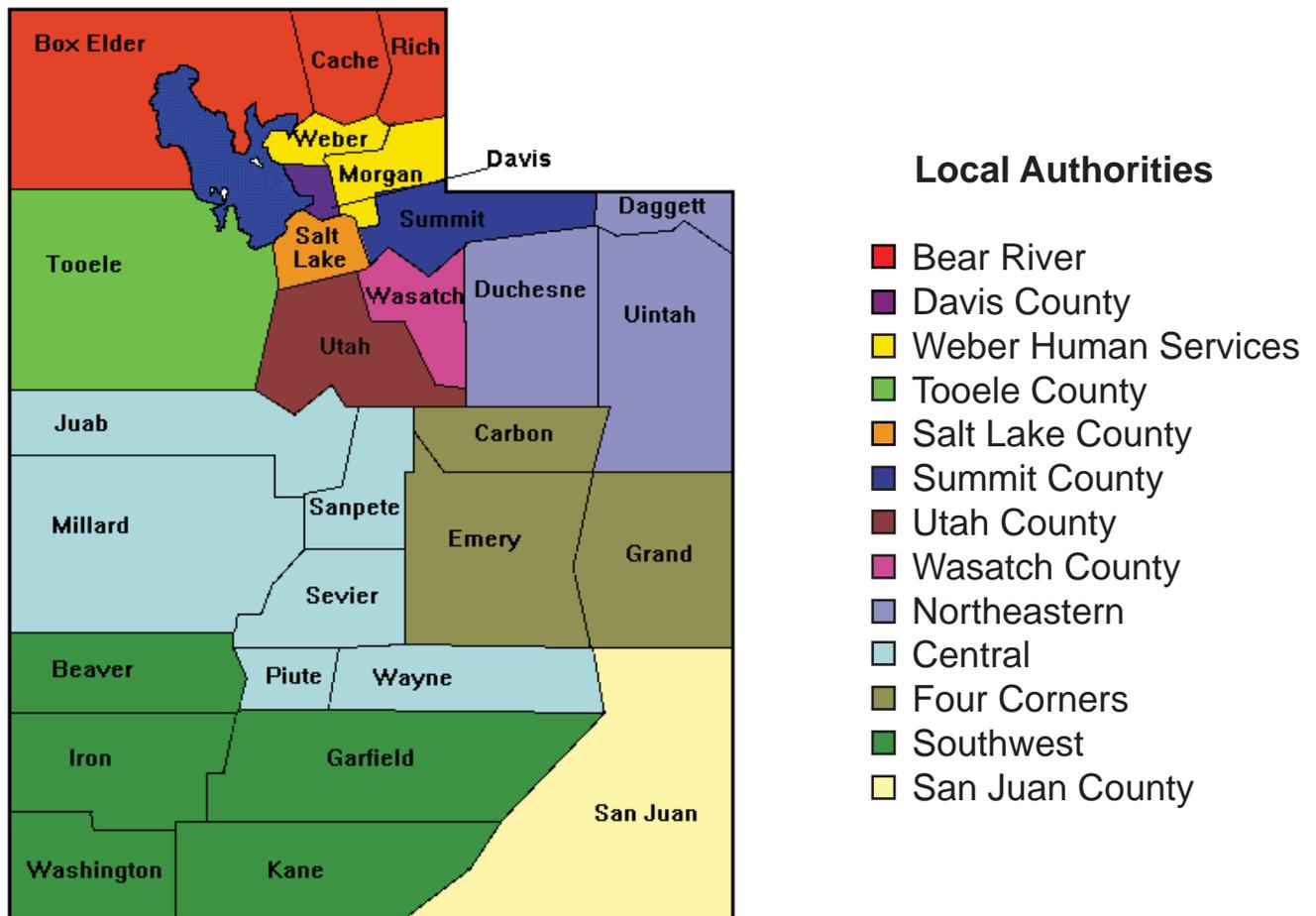
Culturally and Linguistically Competent

Individuals possess diverse cultural, economic, social backgrounds, values, beliefs, sexual orientations, ethnicity, religion, and languages. DSAMH believes all aspects of behavioral health services should recognize and adapt to reflect the diversity of Utah's individuals, families and communities.

Substance Abuse and Mental Health

Under Utah law, DSAMH does not provide services directly. As part of the Utah Department of Human Services, DSAMH contracts with local county governments who are statutorily designated as local substance abuse authorities and local mental health authorities to provide prevention, treatment, and recovery services. DSAMH

provides policy direction, monitoring, and oversight to Utah's 29 counties. Counties have formed 13 local authorities that deliver or contract for a comprehensive array of behavioral health services. The map below shows the organizational structure of Utah's local authorities:

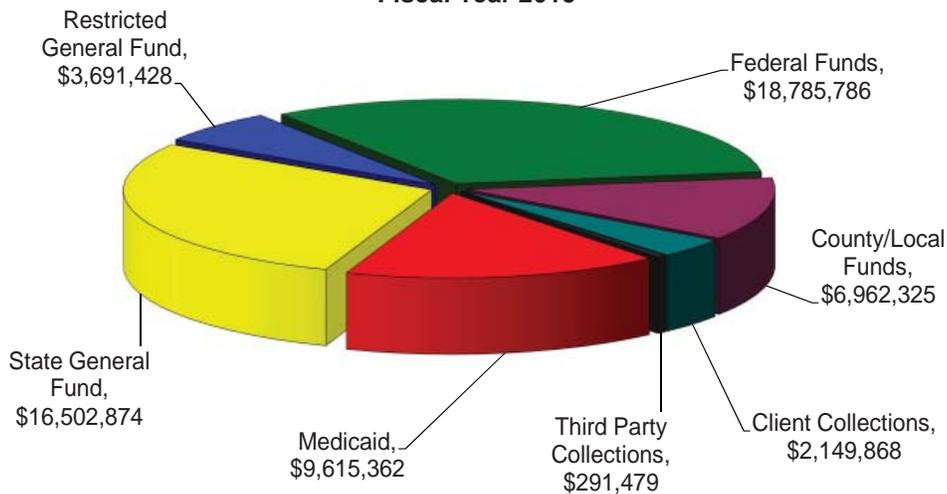


Source of Funding

Funding for services comes from a variety of sources. State, county, and federal funds as well as private insurance and payments directly from clients are used to provide services. For mental health services, the primary funding source is Medicaid. For substance use disorder services, the primary funding source is the Federal Sub-

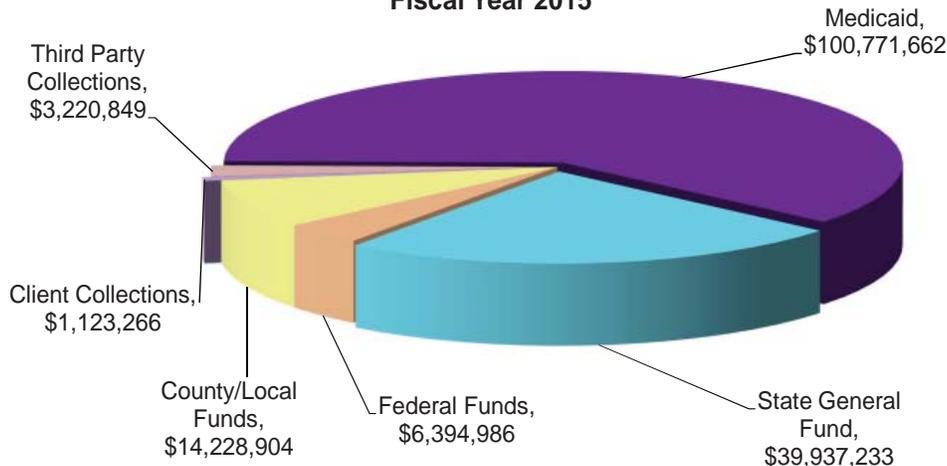
stance Abuse Prevention Treatment block grant. Counties are required by State statute, to provide funding equal to at least 20% of the State contribution. The following provides a breakdown of the sources of funding for both mental health and substance use disorder services.

Substance Use Disorder Services Funding Fiscal Year 2015



Total Revenues: \$57,999,122

Mental Health Services Funding Fiscal Year 2015



Total Revenues: \$165,676,900

The Mental Health figures do not include Utah State Hospital information.

2015 State Strategies

With input from key community stakeholders, DSAMH staff have developed and implemented a strategic plan that strives to enhance Utah's public behavioral health system. Quarterly reviews of goal implementation and outcomes allow the plan to be constantly updated, relevant and flexible to changes in a dynamic service system. The plan outlines five key strategic initiatives. The initiatives were carefully chosen to build on past achievements, and to take advantage of emerging opportunities in a changing world. The goal is to build a better behavioral health system for all.

Strategy One: Prevention and Early Intervention

Expansion of prevention and early intervention is the number one priority for DSAMH.¹ Prevention and early intervention help individuals, families and communities avoid the cost and consequence of addiction or mental illness. The Institute of Medicine and the Centers for Disease Control and Prevention indicate that clear windows of opportunity are available to prevent mental, emotional, and behavioral disorders and related problems before they occur. The Affordable Care Act also places a heavy focus on prevention and health promotion activities at the community, state, territorial, and tribal levels. DSAMH believes that expansion of prevention and early intervention will result in positive outcomes for individuals, families and communities.

Prevention of substance abuse and mental illness are closely related. The risk and protective factors for both substance use disorders and mental illness are well established, with first symp-

¹ Substance Abuse and Mental Health Services Administration (2011). *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014 Executive Summary and Introduction*

toms typically preceding a disorder by 2 to 4 years. DSAMH promotes systems and programs at the community level to target shared factors.

Utah's prevention system follows a strategic, science-based planning process called the Strategic Prevention Framework (SPF). The SPF is used to ensure a culturally competent, sustainable, effective, and cost efficient system. Communities work through a five-step process to implement the SPF. The five steps are:

- Assess community needs
- Build capacity for services
- Plan based on needs, strengths, and resources
- Implement evidence-based strategies
- Evaluate the effectiveness of prevention services and activities

The SPF provides assurance that Utah prevention initiatives are effective, efficient, and address local needs.

DSAMH plays critical roles in several statewide substance abuse, suicide, and mental illness prevention programs as well as mental health promotion programs. These statewide initiatives include an underage drinking prevention campaign (Parents Empowered), a school-based prevention foundation curriculum (Prevention Dimensions), a Suicide Prevention Committee, and a mental illness prevention/mental health promotion project (Prevention by Design).

Additional information about Utah's prevention efforts can be found on page 44 of this report.

Strategy Two: Zero Suicides in Utah

DSAMH has undertaken the aspirational goal of Zero Suicides in Utah. This ambitious goal will be supported through additional short-term goals

and strategies in both the broader community and within the public behavioral health care system. In the quest towards Zero, DSAMH aims to reduce suicide death rates by 10% between 2013 and 2018.

Suicide impacts people from all socioeconomic, racial and ethnic backgrounds, and affects people of all ages. On average, over 500 people in Utah die by suicide every year. Suicide is the 6th leading cause of death for Utahns overall and Utah ranks 4th in the nation for suicide deaths. These statistics are the tip of the iceberg. More people make suicide attempts and consider suicide than are fatally injured. Research suggests that suicide is largely preventable. DSAMH is leading an effort to help communities understand that we all have a role to play in suicide prevention.

DSAMH has identified three overarching goals to guide efforts towards Zero suicides in Utah.

Goal 1: Engage community stakeholders and prevention coalitions in suicide prevention and mental health promotion efforts statewide.

Key efforts and outcomes: In 2012, DSAMH contracted with National Alliance for Mental Illness-Utah (NAMI) and launched the Utah Prevention by Design Project which partners with local community partners and coalitions for suicide prevention and mental health promotion efforts. Key 2012-2014 Prevention by Design outcomes have primarily been achieved by engaging communities, capacity building, and process outcomes.

For 2015, the outcome focus was changed from engagement and process driven to effectiveness of strategies. Pre/Post data collection will be a core priority and that data will be collected and reported out semi-annually.

The Prevention and Promotion contract was released for bid in 2014 and was awarded to NAMI Utah. With support of the DSAMH,

NAMI Utah completed a statewide Mental Health Needs Assessment and Community Action Plan to ensure a data-driven approach to mental health promotion, mental illness prevention and suicide prevention. This Needs Assessment and Action Plan will drive prevention and promotion efforts of NAMI Utah, DSAMH and local stakeholders over the next several years. Over the past 4 years, this project has provided sub-contracting opportunities for up to 13 coalitions statewide. This represents one sub-contract in each of the defined local health authority regions. Through legislatively approved state funding awarded in March of 2015, for fiscal year 2016, the number of sub-contractors has expanded to 22 local groups who are receiving funding for suicide prevention efforts beginning June 30, 2015. This greatly expands the capacity of our state to engage in meaningful prevention strategies.

Goal 2: Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts.

DSAMH chairs the Utah Suicide Prevention Coalition and provides leadership to a variety of groups working to implement the Utah Suicide Prevention Plan. Using the National Strategy for Suicide Prevention as a template, the Utah Suicide Prevention Coalition revised the State Suicide Prevention Plan in 2013. Strategies include partnering with state agencies to examine and use suicide related data, forming public and private partnerships, working with local coalitions to identify and implement suicide prevention strategies, and working to improve clinical care related to suicide prevention statewide. Solid partnerships within the public and private sector are critical. The Utah Suicide Prevention Coalition membership includes: the Utah Department of Health, Veterans Administration, Hill Air Force Base, Utah Air and Army Na-

tional Guard, law enforcement, local health departments, health care providers, behavioral health service providers, suicide survivors, University of Utah researchers, Utah State Office of Education, legislators, mental health consumers, (NAMI) Utah, and other key stakeholders. The Utah Suicide Prevention Plan promotes the message that “Everyone has a Role to Play” in suicide prevention. The plan has nine goals with objectives and activities outlined to meet each goal. For more information on the plan and the coalition visit www.utahsuicideprevention.org.

Goal 3: Improve the ability of health providers (including Behavioral Health) to better support individuals who are at risk of suicide through adoption of Zero Suicide framework.

DSAMH has undertaken the goal of perfect patient safety for individuals receiving care through its public behavioral health system. DSAMH is partnering with community mental health centers to develop suicide safer care in communities through the adoption of best practices. The goals of Zero Suicide in Utah include improving identification, assessment, treatment, and recovery supports for individuals within the public system.

As identified by the National Action Alliance for Suicide Prevention, the core dimensions of Zero Suicide include:

- Creating a leadership-driven, safety-oriented culture that commits to dramatically reducing suicide among people under care and includes suicide attempt and loss survivors in leadership and planning roles.
- Systematically identifying and assessing suicide risk levels among people at risk.
- Ensuring every person has a pathway to care that is both timely and adequate to meet their needs.

- Developing a competent, confident, and caring workforce.
- Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality.
- Continuing contact and support, especially after acute care.
- Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

The following paragraph highlights the commitment to zero suicide within the public mental health, substance use treatment and the prevention system as overseen by the state suicide prevention coordinator.

During fiscal year 2015, local mental health authorities statewide conducted a suicide prevention behavioral healthcare assessment including a comprehensive evaluation of related policies and practices related to suicide prevention, intervention, and postvention. An assessment of staff knowledge, skills, and training related to suicide prevention, intervention, and postvention was conducted. A model tool was provided by DSAMH, or the local authority could choose another assessment tool. Local authorities were required to complete the assessment and submit a written report to DSAMH by June 30, 2015.

During fiscal year 2016, based on assessment results, local authorities will develop a policy and implementation plan to establish, implement and monitor a comprehensive suicide prevention program. A copy of the policy and implementation time line will be submitted to the DSAMH by March 1, 2016.

All of the local mental health authorities (LMHA) have completed a suicide prevention behavioral healthcare assessment and submitted the report

to DSAMH and the state suicide prevention coordinator for review. DSAMH will provide ongoing technical assistance to help all LMHA's use the assessment to form a local strategic plan for care quality improvement.

DSAMH and all LMHA's have partnered to implement a statewide Medicaid Performance Improvement Project for suicide safer care within the public behavioral health care system. Calendar year 2015 is a baseline data collection year designed to provide information regarding current levels of screening and assessing for suicide risk, and providing comprehensive safety planning interventions when warranted. In 2016, targeted interventions will be implemented in order to improve quality of care over the year.

Strategy Three: Promote Recovery

DSAMH's third strategy is to develop a "recovery-oriented system of care" (ROSC). Substance use disorder and mental illness are diseases.² However, people can and do recover. Recovery means more than abstinence from drugs or a remission of symptoms; recovery means achieving a meaningful life in the community, an improved quality of life and overall health. Behavioral health services should align with the needs of individuals seeking recovery or those in recovery. DSAMH recognizes that behavioral health services need to expand beyond acute care to help people recover.

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) found:

"Creating a recovery-oriented systems of care requires a transformation of the entire system as it shifts to becoming responsive to meet the needs of individuals and families seeking services. To

² National Institute on Drug Abuse

be effective, recovery-oriented systems must infuse the language, culture, and spirit of recovery throughout their system of care. They have to develop values and principles that are shaped by individuals and families in recovery. These values and principles provide the foundation for systems that provide:

- *Accessible services that engage and retain people seeking recovery*
- *A continuum of services rather than crisis-oriented care*
- *Care that is age- and gender-appropriate and culturally competent*
- *Where possible, care in the person's community and home using natural supports"*³

With the assistance of the local authorities, DSAMH continues to revise its rules, contract requirements, practice guidelines, division directives and data requirements to ensure that they incorporate ROSC principles in order to facilitate the significant shift in traditional practices that ROSC represents. As the Justice Reinvestment Initiative and the expansion of individuals having insurance coverage continues to expand the availability of prevention, treatment and recovery support services to individuals, DSAMH will continue to ensure services are responsive to the needs of individuals and families. Early identification, client engagement, person centered care, use of evidenced-based practices and appropriate and individualized long-term recovery support are the key factors that DSAMH and its partners are using to ensure high quality care across the continuum.

³ Kaplan, L. (2008). The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration. p. 3

Strategy Four: Improve Services for Children and Adolescents

DSAMH estimates that 11,804 youth (ages 11-18) need substance use disorder treatment and 98,738 children and youth need mental health treatment. Almost 1 in 5 young people have one or more mental, emotional or behavioral disorders that cause some level of impairment within a given year; however, fewer than 20% receive mental health services.⁴ Improving services for children and adolescents will result in healthier individuals, families, and communities.

Children and adolescents are best served in a framework that involves collaboration across agencies, families, and youth, for the purpose of improving services, access and outcomes for children, youth and their families. The core values of the philosophy are:

- Family driven, with families having a primary decision making role and the strengths and needs of the child and family determining the types and mix of services and supports provided
- Youth guided, with the right to be empowered, educated (on the issues), and given a decision-making role in their care
- Community-based, with accessible services available at the community level
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve

⁴ Preventing Mental Emotional and Behavioral Disorders, Report Brief for Policymakers, The National Academies, <http://iom.nationalacademies.org/reports/2009/preventing-mental-emotional-and-behavioral-disorders-among-young-people-progress-and-possibilities.aspx>

A system of care approach provides effective, community-based services and supports organized into a coordinated network for children and youth that helps them function better at home, in school, in their community, and throughout life.

Family Resource Facilitation is available in 25 of the 29 counties in the state and encourages family driven and youth guided care. Family Resource Facilitators (FRFs) provide peer support and wraparound facilitation to families and youth who have complex needs. Wraparound helps to build a plan that incorporates both formal supports (e.g., mental health/substance abuse treatment, educational assistance, juvenile court engagement, etc.) and informal supports (e.g., family members, youth groups, clergy, etc.) that helps increase family stabilization, increase school involvement and decrease involvement with the legal system.

Over 200 schools partner with their LMHA to provide community-based health services to children and youth whose mental, emotional or behavioral health symptoms are interfering with their academic success. Parental consent and involvement is integral for all school-based services. Youth participating in school-based health services experienced a 14% improvement in grade point average (GPA) and children in elementary school experienced a 42% increase in Dynamic Indicators of Basic Early Literacy Skills (DIBELS) scores. Children and youth receiving these services also experienced significant reductions symptoms.

Juvenile Mobile Crisis Teams (MCTs) are another community-based service that helps children and youth remain in their homes and communities. Juvenile MCTs are available in five counties (Davis, Salt Lake, Utah, Iron and Washington counties) which contain 73% of the state's population. Families may contact the MCTs

when their child or adolescent is experiencing a mental, emotional, or behavioral crisis. The two-person team responds in person to a home, school, or other community location. Services include therapeutic intervention and safety planning. Services may also include crisis respite and linking to community resources.

Strategy Five: Health System Integration

Integrating the delivery of behavioral health services and physical health services is a key component to recovery-oriented services and can greatly improve access to effective care and improved outcomes. This is because individuals with a behavioral health condition have poorer health outcomes than the general population.⁵ Individuals with a serious mental illness (SMI) have a life expectancy 25 years shorter than the general population. Almost one fourth of all adult stays in community hospitals involve a mental

⁵ Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states, Colton CW and Mandscheid RW, *Prevention of Chronic Disease*, 2006 Apr 3(2):A42.

health or substance use disorder; making mental health disorders the third most costly health condition, behind only heart conditions and injury-related disorders, in the United States.⁶

The continued implementation of healthcare reform and partnerships with physical health providers highlight efforts over the last year to move toward a more fully integrated system.

Health reform efforts at the national and state level continue to focus on ways to improve health, improve healthcare, and lower costs. A central strategy to achieving this “triple aim,” both nationally and in Utah, is to focus on the integration of behavioral and physical health care. DSAMH collaborates with the Utah State Hospital and LMHAs to integrate individuals with mental illness who are ready for discharge into community placements, to promote recovery and quality of life. In addition, DSAMH is developing and disseminating standards, and establishing and measuring integrated care activities.

⁶ Mental Health: Research Findings: Program Brief. September 2009. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/findings/factsheets/mental/mentalth/index.html>

Roger's Story

My name is Roger and I am in long-term recovery. I haven't used drugs or alcohol since February 28, 2010. My choice is to live free from addiction and the stigma that comes with it. Addiction ruled my life for many years. It led me to a life of crime and incarceration. All I ever wanted to be was a good husband and father.

In 2010, I found myself sitting in the back of a cop car, emotionally broken and spiritually bankrupt. I was heading back to prison again, this time for a long time. All I could think about was my girls and little boy and how selfish I was for making that choice to get high rather than to be present in their lives. I said a prayer. It wasn't my usual prayer to get me out of this situation and I'll change. This time I was okay with my consequences. What I wasn't okay with was making the same mistakes when I got out. After getting out on bail, I went to a 12 step meeting that very same night. I saw a guy I knew from prison. He told me drug court saved his life. All I knew was that he was clean. I wanted some of that! I took his suggestion and asked for drug court the very next day.

After a year in drug court and a lot of hard work, I graduated. While in treatment, I found the real me. I was able to save my marriage and restore my children's trust and love. I am a more committed father, grandfather and husband and am present in their lives every day. As president of our drug court alumni association, I help others find their worth through recovery. Today, I volunteer my free time at a local residential treatment center. I am also a member of a non-profit organization that raises money to help addicts who can't afford treatment.

I am a Certified Peer Support Specialist working at Weber Human Services, helping people with addiction find solutions. In 2016, I will enroll in college to become a substance use disorder counselor. All I ever wanted to be was a good dad. Being clean and sober has helped me achieve that.



"Sobriety delivered everything alcohol and drugs promised!"

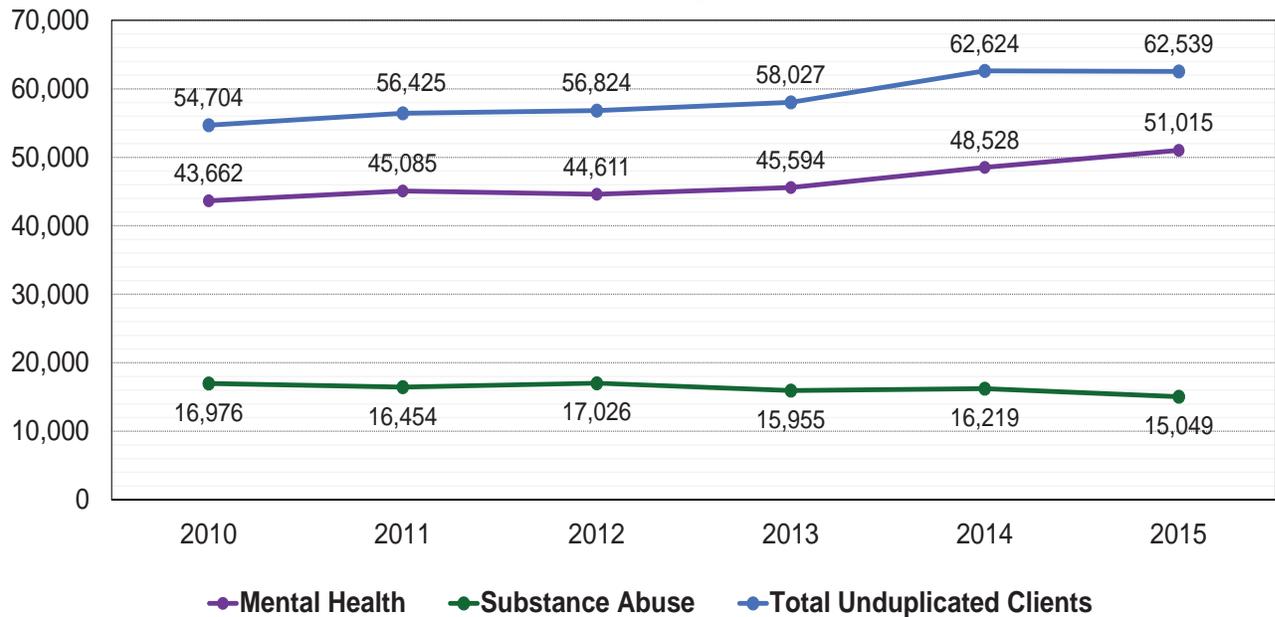
Who We Serve

Who We Serve

The following chart shows the unduplicated total number of individuals served in the public behavioral health system, the number served in substance use disorder services, and the number served in mental health services. This chart shows that there are a number of clients who are

seeking treatment for both substance use disorders and mental health issues. The total number of clients served has increased over the last few years but shows a slight decrease this past year that seems to correlate with a decrease in substance use disorder clients.

Total Number of Individuals Served in the Public Behavioral System Fiscal Year 2010 through Fiscal Year 2015



Utahns in Need of Substance Use Disorder Treatment

The results of the National Survey on Drug Use and Health and the 2015 Student Health and Risk Prevention Survey¹ indicate the following:

- 134,764 adults in Utah were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015.
- 11,804 youth in the 6th through 12th grades are in need of treatment for drug and/or alcohol dependence or abuse.
- The public system is currently serving 14,841 individuals, or 10% of the need.

- A combined total of approximately 131,726 adults and youth are in need of, but not receiving, substance abuse treatment services.

The following table demonstrates the estimated number of adults and youth who need treatment, by local authority. The current capacity of each local authority, or the number who were actually served in fiscal year 2015, is also included to illustrate the unmet need.

Substance Use Disorder				
	Adults (18 years+)		Youth (Ages 12-18)	
	# Need Treatment	Capacity FY2015	# Need Treatment	Capacity FY2015
Bear River	6,962	876	393	72
Central	3,569	390	198	44
Davis County	13,229	896	1,092	113
Four Corners	1,978	488	152	37
Northeastern	2,285	375	362	22
Salt Lake County	56,100	6,925	5,377	657
San Juan County	688	73	57	17
Southwest	10,379	603	726	36
Summit County	1,705	293	139	24
Tooele County	2,385	431	303	47
Utah County	23,128	908	1,796	38
Wasatch County	1,099	117	87	12
Weber	11,215	1,336	1,154	198
State Totals*	134,764	13,535*	11,804	1,306*

* Because of rounding in the percentages, duplication of clients across Local Substance Abuse Authorities (LSAAs) and an additional 208 clients served in non-local authority contracts, LSAA totals do not add up to the unduplicated total of clients served statewide.

¹ Adult–Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth–State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 5.

Utahns in Need of Mental Health Services

The results of the National Survey on Drug Use and Health and the 2015 Student Health and Risk Prevention Survey¹ indicate the following:

- 105,201 adults in Utah were classified as needing treatment for mental health issues in 2015.
- 98,738 or 5.16% of youth in the 6th through 12th grades are in need of treatment for mental health issues in 2015.

- The public system served 49,354 individuals, or 24% of the current need.
- A combined total of approximately 154,585 adults and youth are in need of, but not receiving, mental health services.

The following table demonstrates the estimated number of adults and youth who need treatment, by local authority. The number served in fiscal year 2015, by local authority, is also included to illustrate the unmet need.

Mental Health				
	Adults (18 years+)		Children/Youth (Ages 5-17)	
	# Need Treatment	Clients Served FY2015	# Need Treatment	Clients Served FY2015
Bear River	7,268	1,802	5,123	1,419
Central	2,732	682	2,193	505
Davis County	10,702	3,624	11,185	1,933
Four Corners	1,514	985	1,270	511
Northeastern	2,385	1,483	2,923	854
Salt Lake County	39,043	9,268	38,021	5,998
San Juan County	526	393	570	184
Southwest	7,944	1,482	6,435	1,731
Summit County	1,780	238	876	152
Tooele County	2,490	947	2,766	638
Utah County	19,291	6,766	17,743	3,767
Wasatch County	1,147	391	671	161
Weber	8,380	4,370	8,963	1,675
State Totals*	105,201*	31,742*	98,738*	19,273*

*Because of rounding in the percentages and duplication of clients across Local Mental Health Authorities (LMHA), LMHA's totals do not add up to the unduplicated total of clients served statewide.

¹ Adult-Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

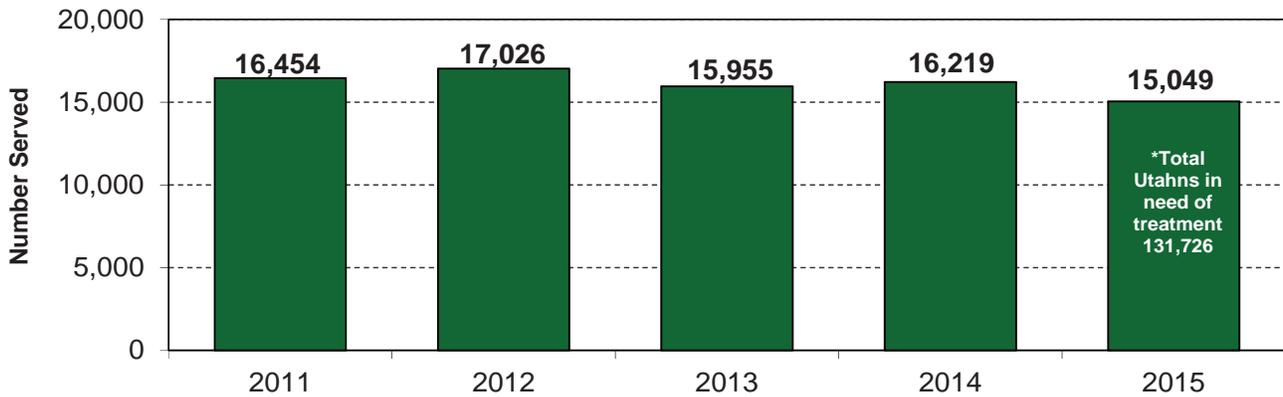
Children/Youth-State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 6.

Total Number Served

The charts below show the total number of individuals served in all publicly funded substance use disorder treatment facilities, and the total

number served for adults and children/youth, by the local mental health authorities for fiscal year 2011 through fiscal year 2015.

Total Number of Individuals Served in Substance Use Disorder Treatment Fiscal Years 2011 - 2015

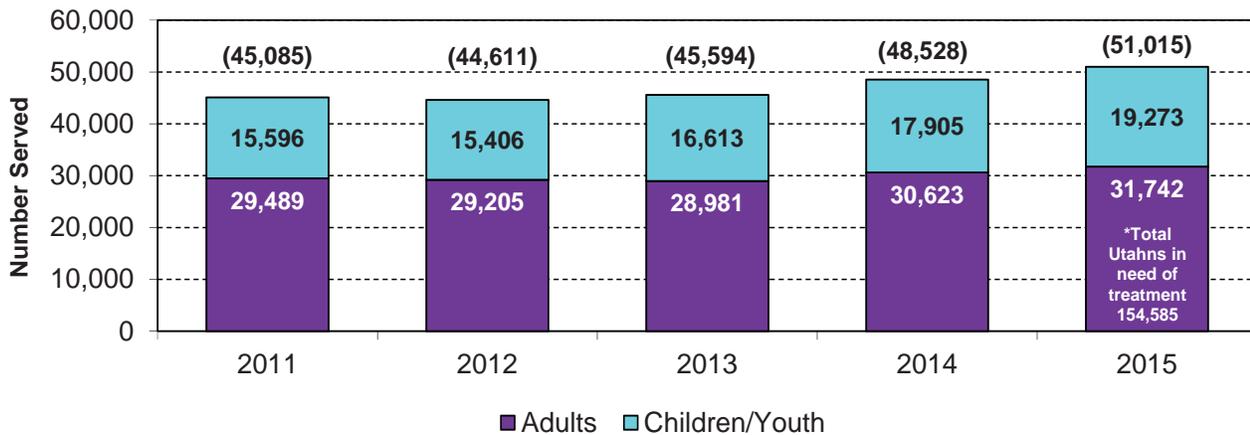


*Estimate of Need

Adult—Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth—State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 5.

Total Number of Adults and Children/Youth Served in Mental Health Services Fiscal Years 2011 - 2015



*Estimate of Need

Adult—Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth—State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 6.

Household Income and Poverty

The following charts show the income levels by household size for those served in the public behavioral health system. Those highlighted in red are self-reported below the Federal Poverty Line

for 2015. The majority of public clients are below the poverty line with 12,828 substance use clients (85%) and 40,784 mental health clients (80%) fitting the criteria.

Substance Use Disorder Clients and Poverty Level Fiscal Year 2015											
		Monthly Income Grouping									Total Clients
		None	\$1 - \$500	\$501 - \$1000	\$1001 - \$1500	\$1501 - \$2000	\$2001 - \$2500	\$2501 - \$3000	\$3001 - \$3500	\$3500+	
Number in Family	1	4,488	643	1,351	522	257	85	53	27	85	7,511
	2	925	304	428	275	160	47	40	27	65	2,271
	3	831	208	348	228	181	53	41	24	84	1,998
	4	613	118	246	165	137	65	45	23	106	1,518
	5	318	73	116	112	89	56	38	19	71	892
	6	180	36	64	58	54	27	16	5	32	472
	7	72	17	12	20	17	9	6	8	7	168
	8	25	7	10	9	4	7	6	3	5	76
	9	11	-	5	4	4	1	-	-	4	29
	10+	49	13	9	7	7	6	-	-	1	92
In Poverty		7,512	1,419	2,589	878	312	106	12	-	-	12,828
Not in Poverty		-	-	-	522	598	250	233	136	460	2,199
Total Clients		7,512	1,419	2,589	1,400	910	356	245	136	460	15,027

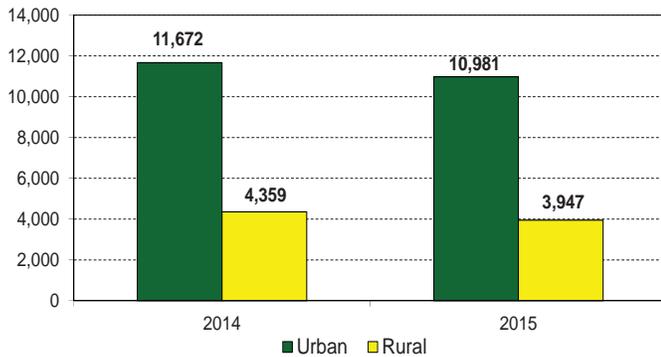
Mental Health Clients and Poverty Level Fiscal Year 2015											
		Monthly Income Grouping									Total Clients
		None	\$1 - \$500	\$501 - \$1000	\$1001 - \$1500	\$1501 - \$2000	\$2001 - \$2500	\$2501 - \$3000	\$3001 - \$3500	\$3500+	
Number in Family	1	7,604	2,323	4,519	915	325	112	68	49	177	16,092
	2	2,263	1,209	1,620	764	397	138	104	45	248	6,788
	3	2,179	1,260	1,530	995	605	260	158	93	354	7,434
	4	2,030	787	1,257	892	665	348	252	128	503	6,862
	5	1,456	468	741	655	532	346	211	124	476	5,009
	6	817	225	372	329	323	256	192	98	342	2,954
	7	381	109	192	150	134	127	116	60	194	1,463
	8	152	58	79	69	70	47	37	33	103	648
	9	74	16	36	21	18	15	22	16	52	270
	10+	210	52	55	37	19	18	19	18	45	473
In Poverty		17,166	6,507	10,401	3,912	1,761	809	194	34	-	40,784
Not in Poverty		-	-	-	915	1,327	858	985	630	2,494	7,209
Total Clients		17,166	6,507	10,401	4,827	3,088	1,667	1,179	664	2,494	47,993

Urban and Rural Areas¹

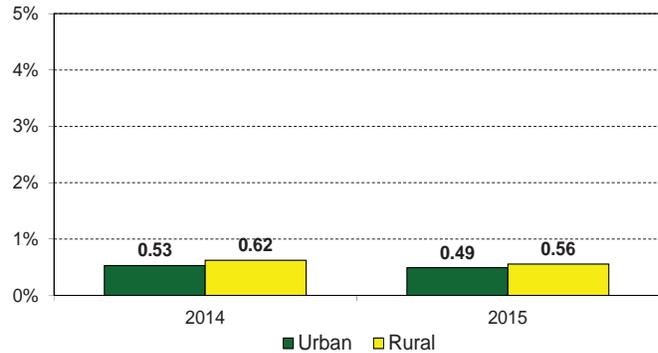
The following graphs show the total number of individuals served in urban and rural communities and the percentage of the total population

served for substance use disorders and mental health.

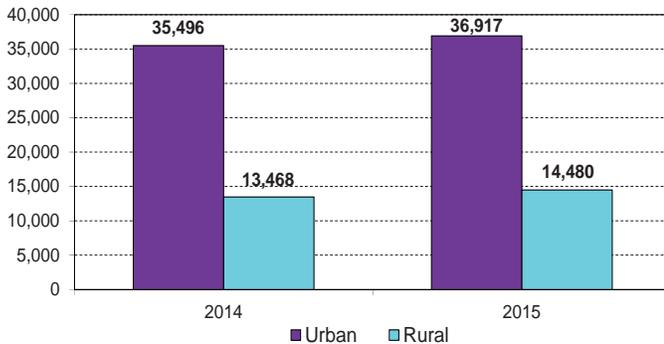
Number of Individuals Served in Substance Use Disorder Services in Urban and Rural Communities
Fiscal Years 2014 - 2015



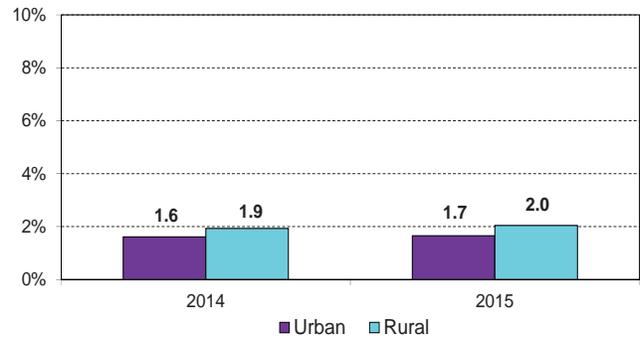
Percent of Total Population Served in Substance Use Disorder Services in Urban and Rural Communities
Fiscal Years 2014 - 2015



Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2014 - 2015



Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2014 - 2015



¹ Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

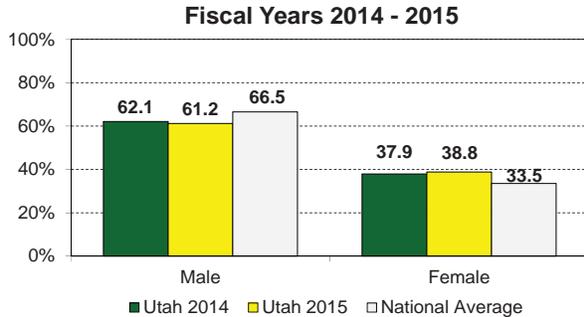
Demographics

Gender and Age

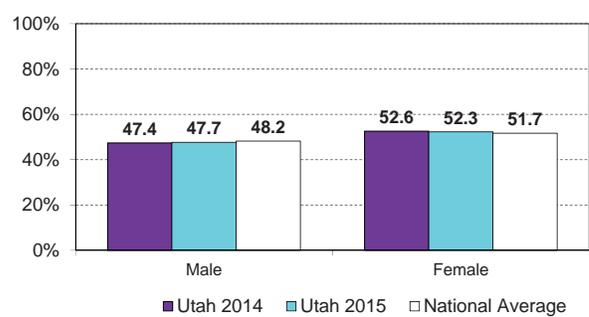
The charts below identify the distribution of services by gender and age for substance use disorder and mental health services.

order and mental health services. There are significant differences between the substance use disorder and mental health populations in both gender and age.

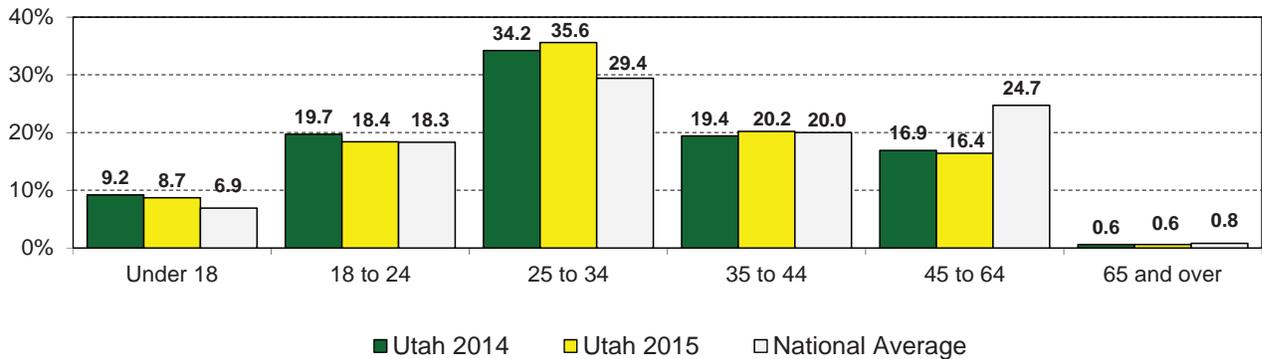
Gender of People Served in Substance Use Disorder Services



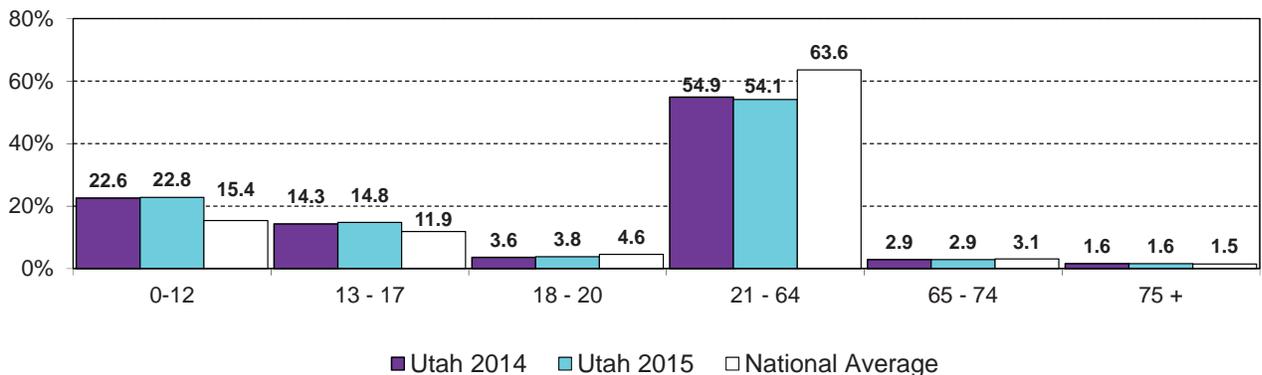
Gender of People Served in Mental Health Services



Age at Admission of People Served in Substance Use Disorder Services



Age of People Served in Mental Health Services

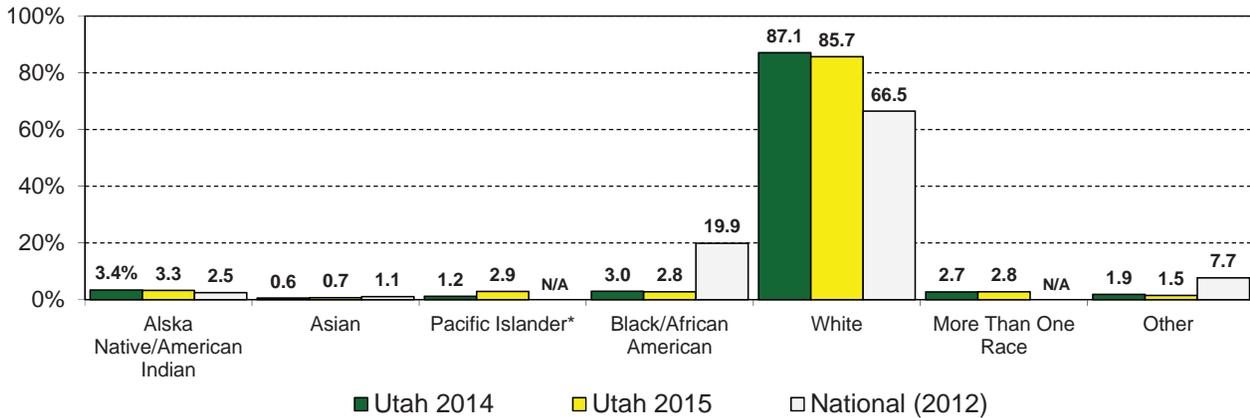


Race and Ethnicity

The charts below report the distribution of the treatment population by race categories. There are no significant differences in race and ethnicity for

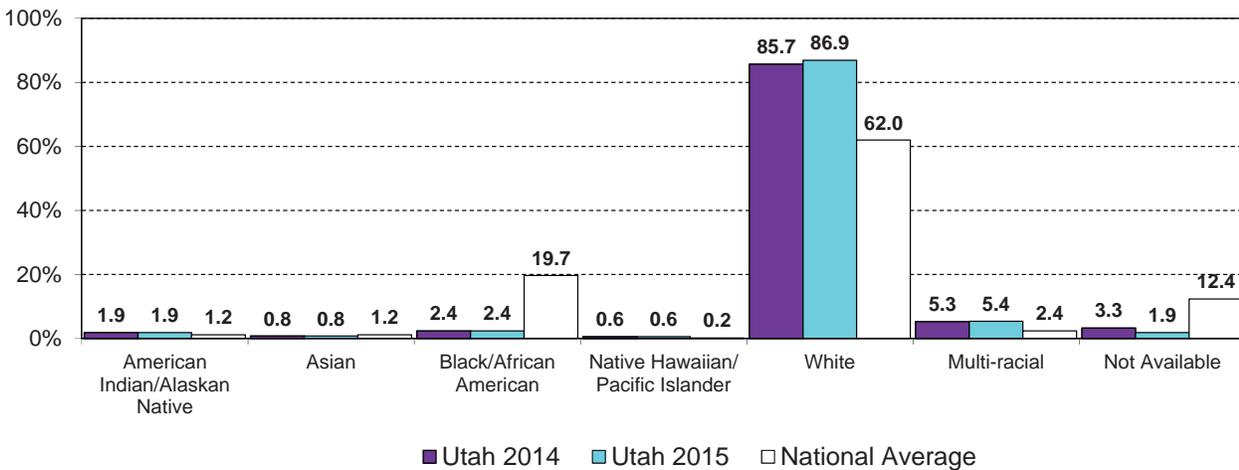
clients receiving substance use disorder or mental health services.

Race of People Served in Substance Use Disorder Services
Fiscal Years 2014 - 2015



*Note: Pacific Islander and Asian reported together in National Averages

Race of People Served in Mental Health Services
Fiscal Years 2014 - 2015

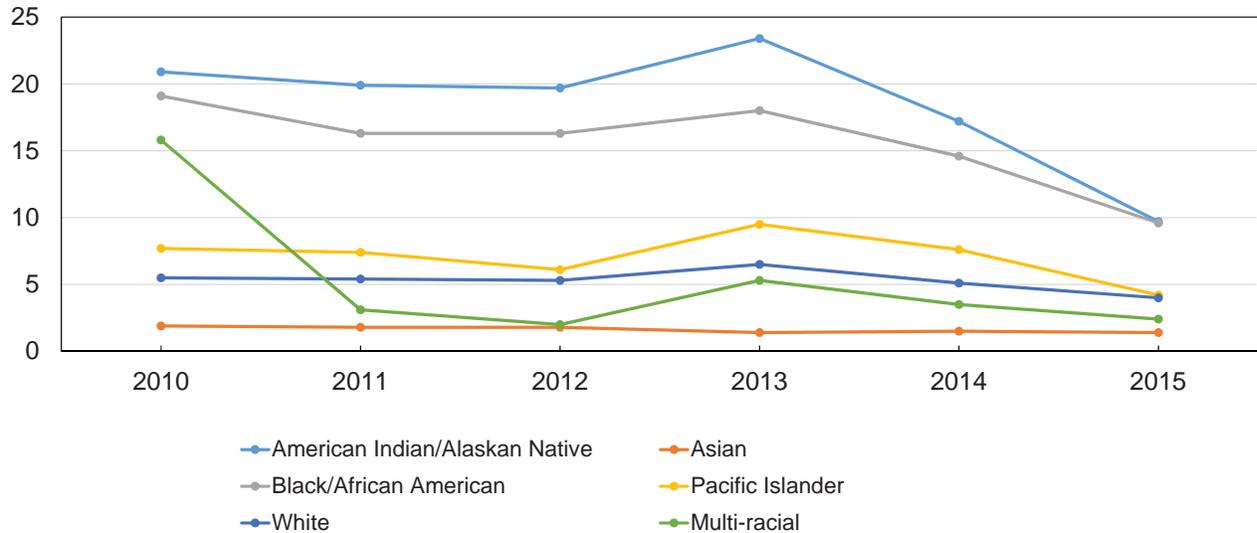


Note: More than one race/ethnicity may have been selected.

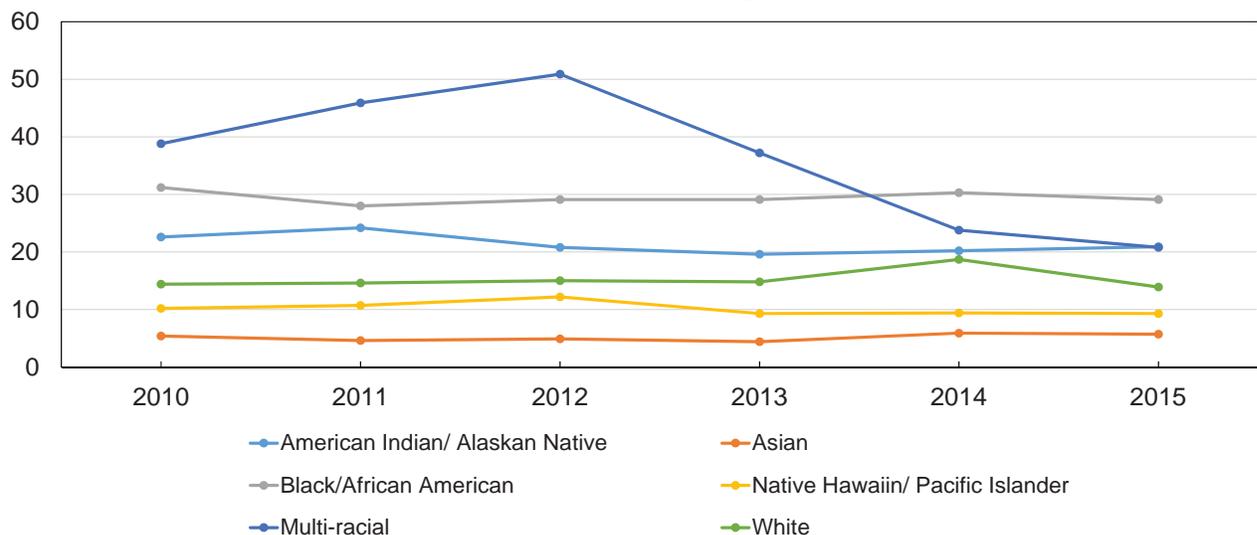
The charts below and on the following page show the trends in penetration of substance use disorder and mental health services by race/ethnicity. These graphs compare the rates that people are

seeking services and account for the widely differing numbers of people in those racial/ethnic groups.

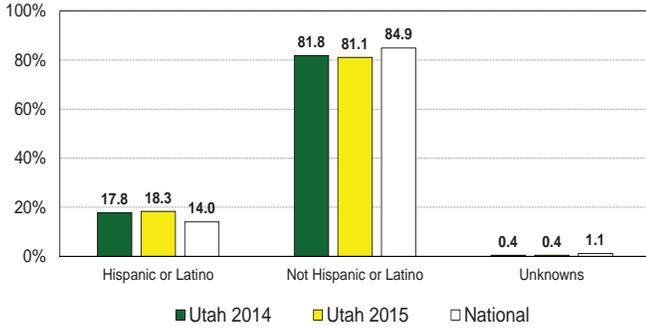
Penetration of People in Substance Use Disorder Treatment per 1,000 Population by Race
Fiscal Years 2010 through 2015



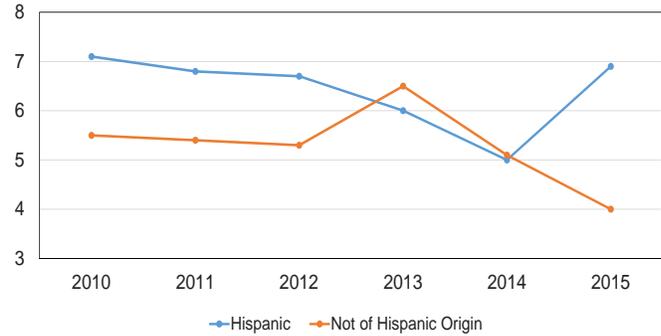
Penetration of People in Mental Health Treatment per 1,000 Population by Race
Fiscal Years 2010 through 2015



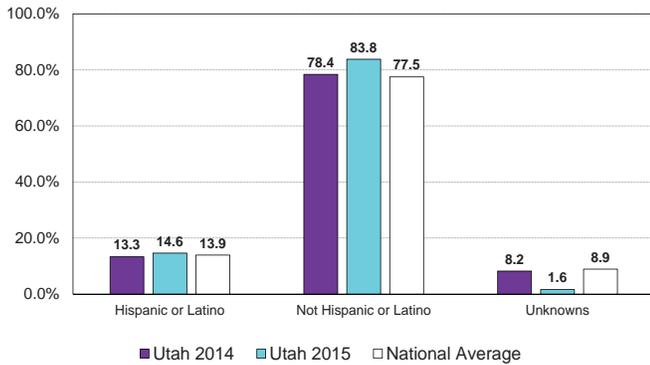
Ethnicity of People Served in Substance Use Disorder Services
Fiscal Years 2014 - 2015



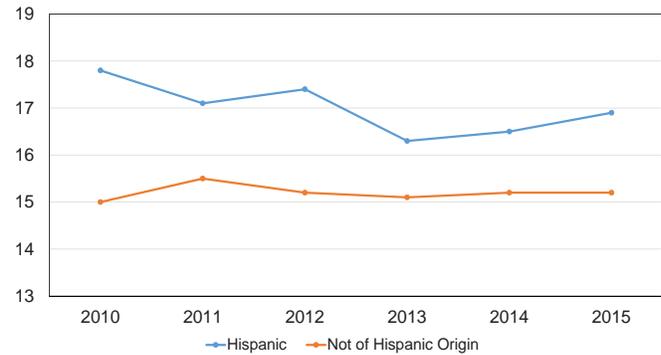
Penetration of People in Substance Use Disorder Treatment per 1,000 Population by Ethnicity
Fiscal Years 2010 through 2015



Ethnicity of People Served in Mental Health Services
Fiscal Years 2014 - 2015



Penetration of People in Mental Health Treatment per 1,000 Population by Ethnicity
Fiscal Years 2010 through 2015

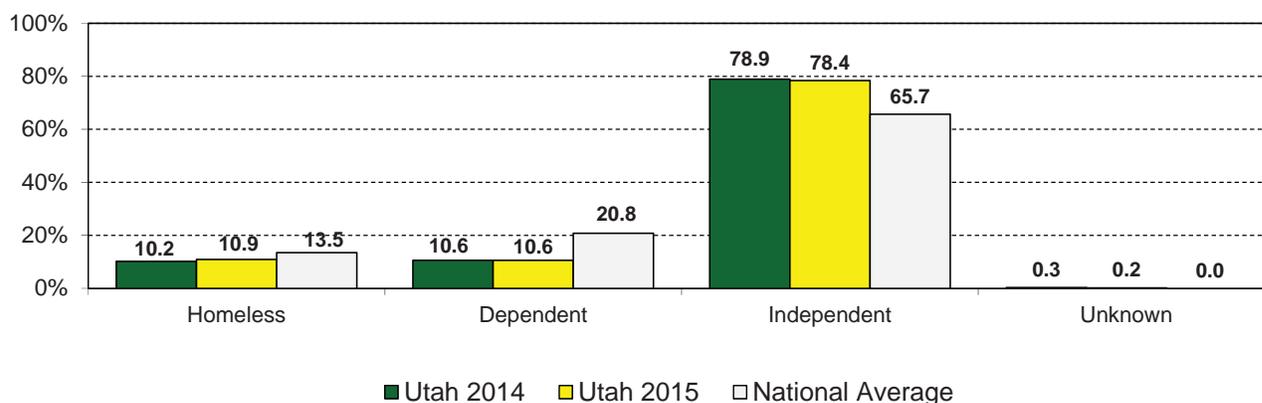


Living Arrangement

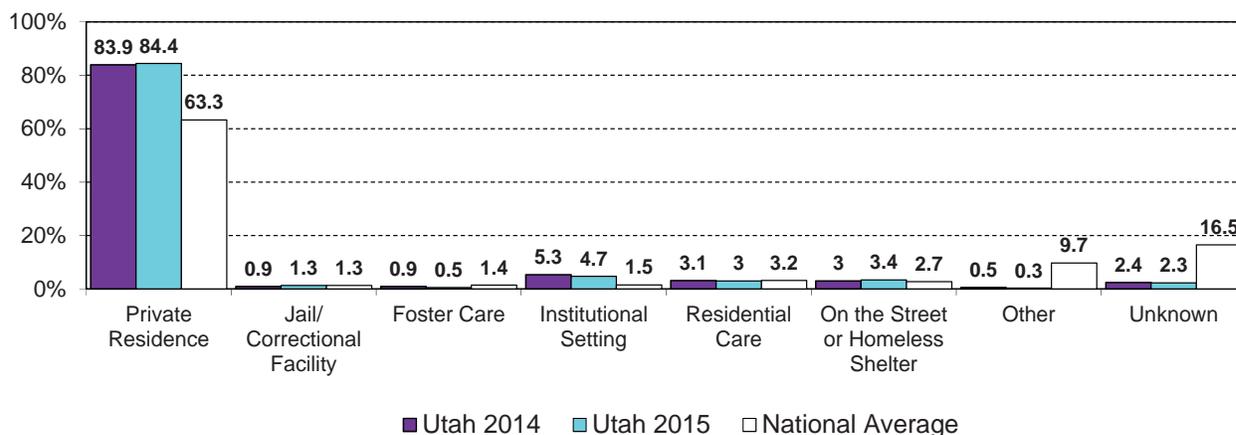
The following charts depict clients' living arrangement at admission for substance use disorder and for mental health clients served in fiscal year 2014 and fiscal year 2015. By far, the majority of clients receiving substance use disorder

and mental health services are in independent living during treatment. Due to reporting requirements, more detailed data on living arrangement categories is available for mental health clients than substance use disorder clients.

Living Arrangement at Admission of Adults Served in Substance Use Disorder Services
Fiscal Years 2014 - 2015



Living Arrangement of Adults Served in Mental Health Services
Fiscal Years 2014 - 2015

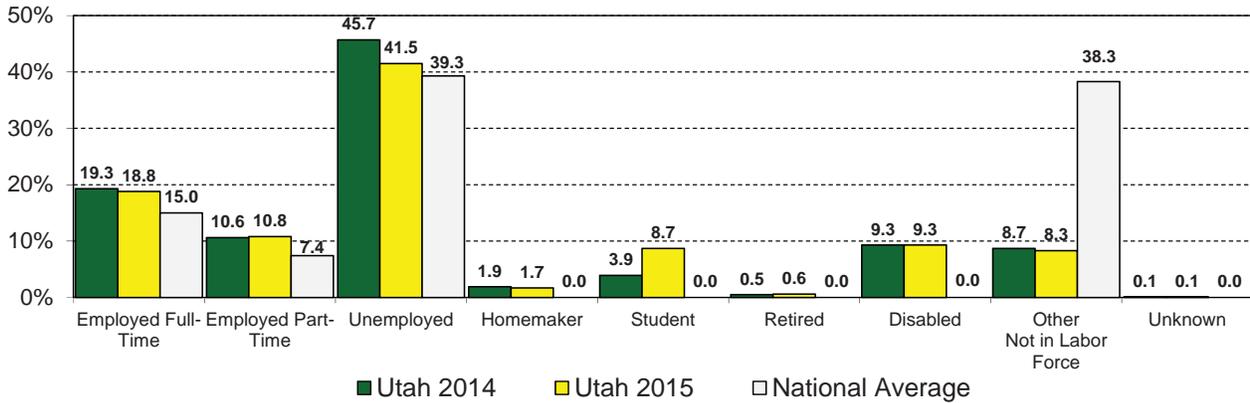


Employment Status

The following charts show the employment status at admission for substance use disorder and for mental health clients served in fiscal year 2014 and fiscal year 2015. The categories for

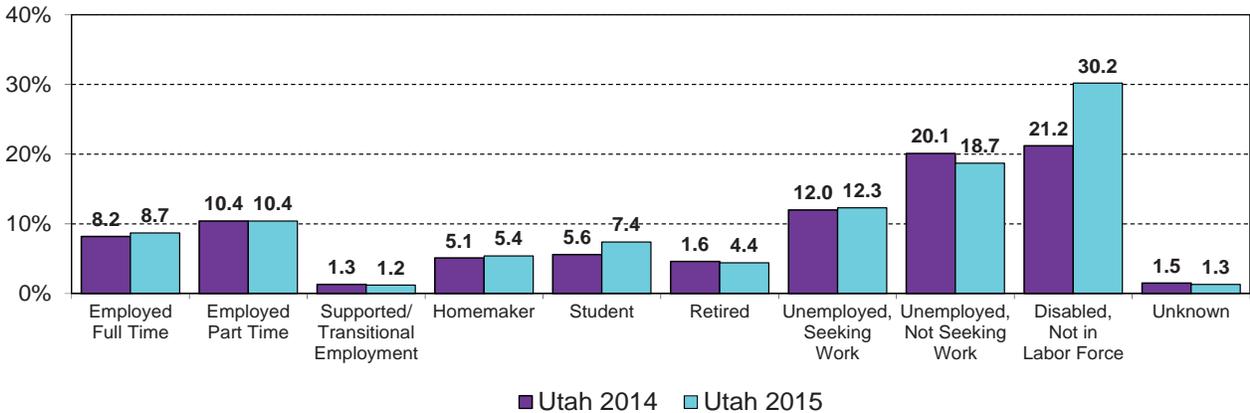
mental health clients are different than those for substance use disorder clients due to different reporting requirements.

Employment Status at Admission for Adults in Substance Use Disorder Services Fiscal Years 2014 - 2015



*Note: All National "Not in Labor Force" categories are collapsed into "Other Not in Labor Force."

Employment Status for Adults in Mental Health Services Fiscal Years 2014 - 2015

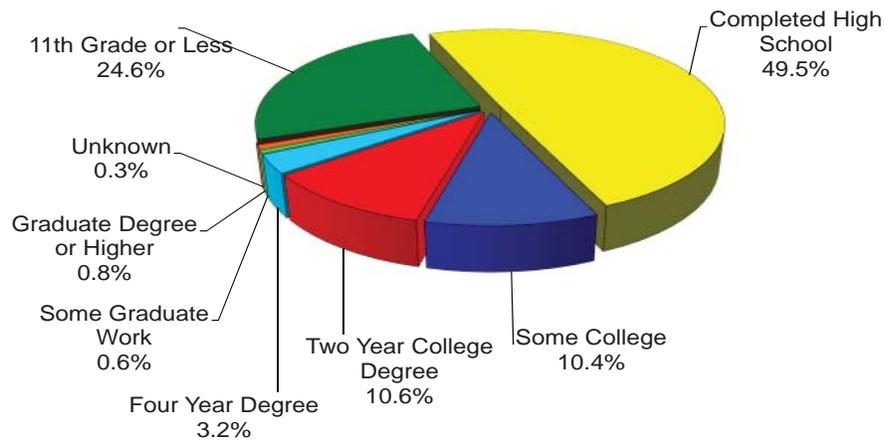


Highest Education Level Completed

In fiscal year 2015, over 75% of adults in substance use disorder treatment statewide completed at least high school. Of those adults, 25.6% had

also attended some college or technical training prior to admission. Still, 25% had not graduated from high school.

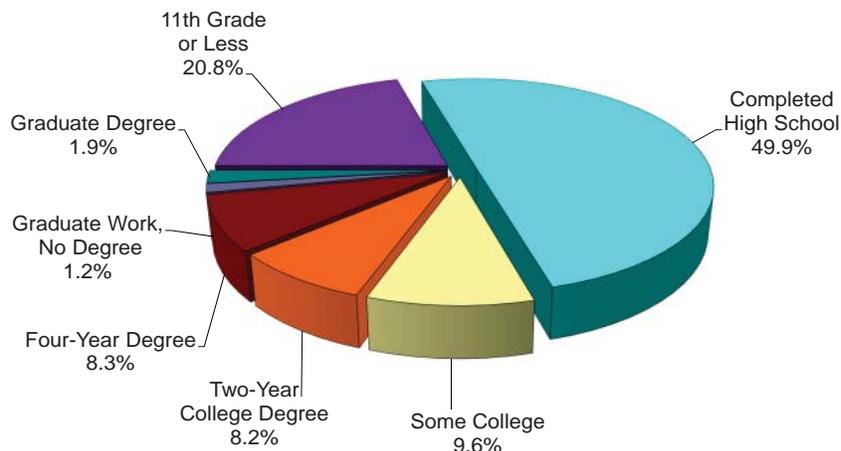
**Highest Education Level at Admission for Adults in Substance Use Disorder Services
Fiscal Year 2015**



In fiscal year 2015, almost 77% of adults in mental health treatment statewide completed at least high school. Of those adults, 28% had also attended

some type of college and/or technical training. Still, 20% had not graduated from high school.

**Highest Education Level of Adults Served in Mental Health Services
Fiscal Year 2015**

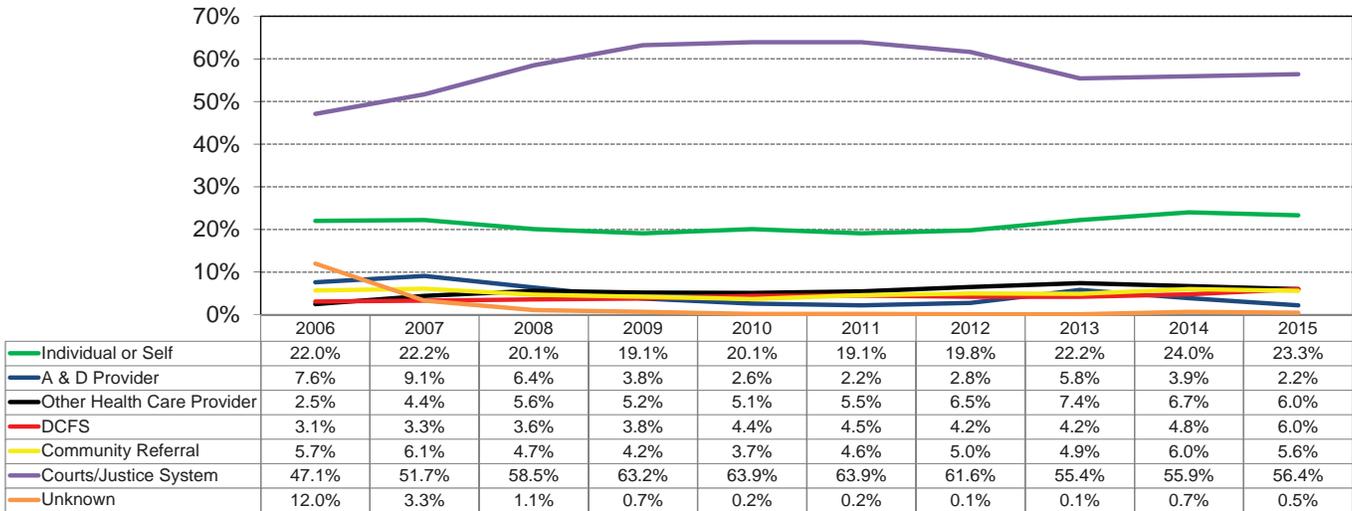


Referral Source

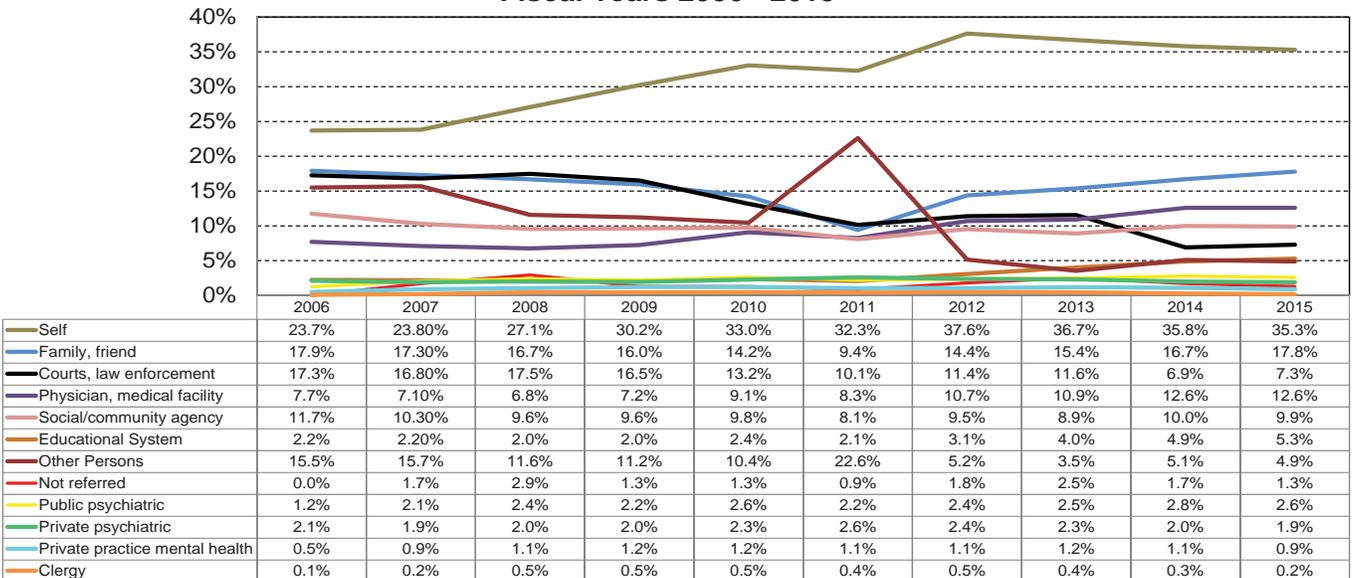
The charts below detail referral sources for substance use disorders for fiscal years 2005 through

2015 and for mental health for fiscal years 2006 through 2015.

Referral Source of Individuals in Substance Use Disorder Services Fiscal Years 2006 - 2015

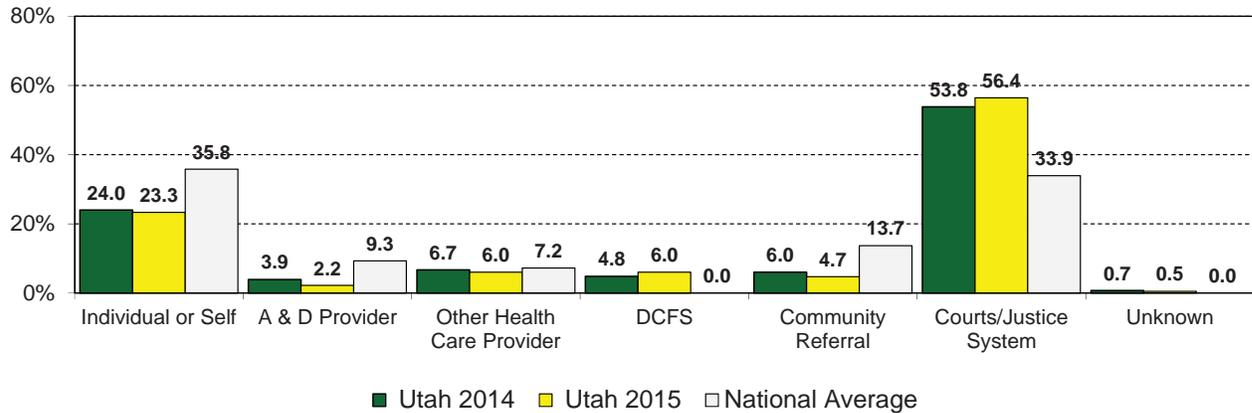


Referral Source of People Served in Mental Health Services Fiscal Years 2006 - 2015



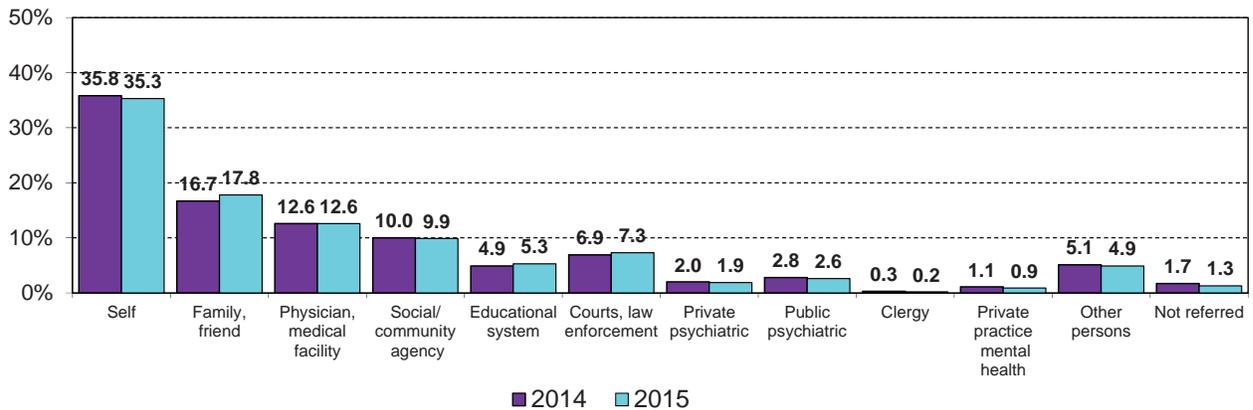
The graphs below detail referral sources for substance use disorder and mental health services for fiscal years 2014 and 2015.

Referral Source of Individuals Served in Substance Use Disorder Services Fiscal Years 2014 - 2015



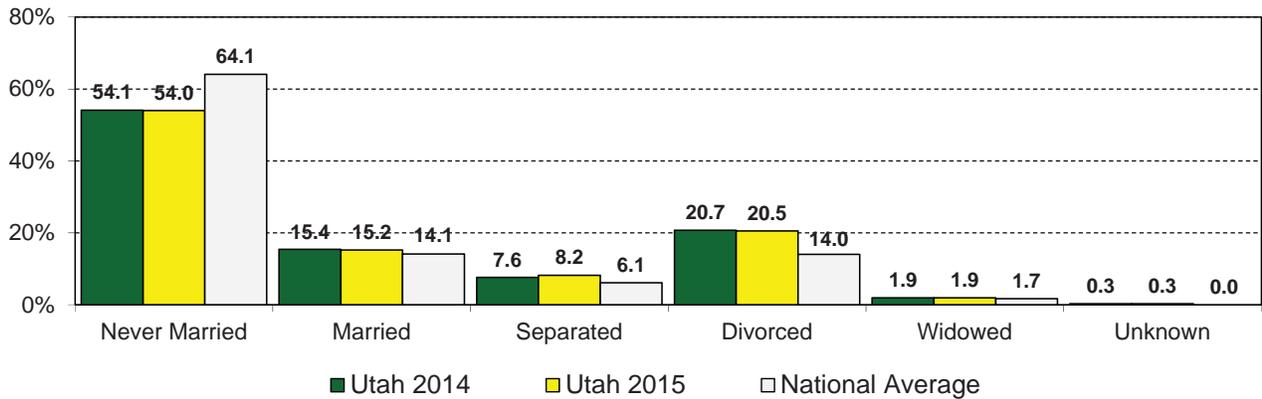
*Note: All other National categories are contained in Community Referral.

Referral Source of People Served in Mental Health Services Fiscal Years 2014 - 2015

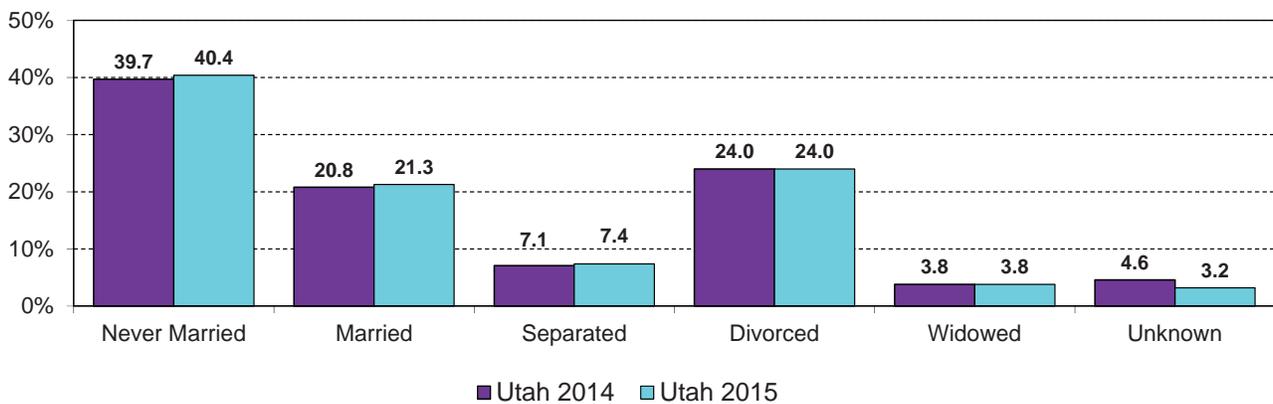


Marital Status

Marital Status of Adults Served in Substance Use Disorder Services
Fiscal Years 2014 - 2015

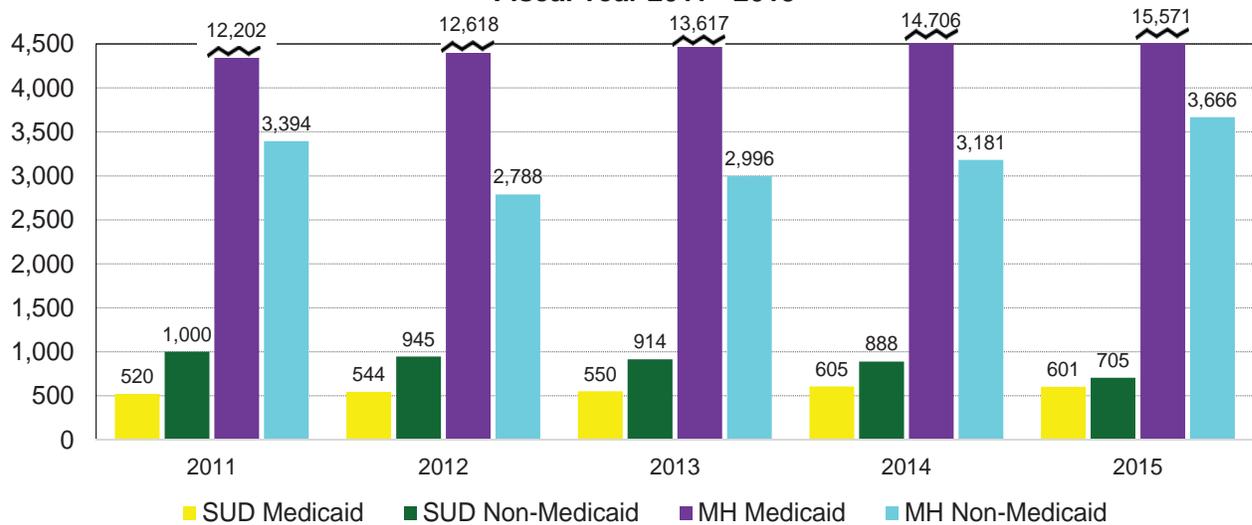


Marital Status of Adults Served in Mental Health Services
Fiscal Years 2014 - 2015

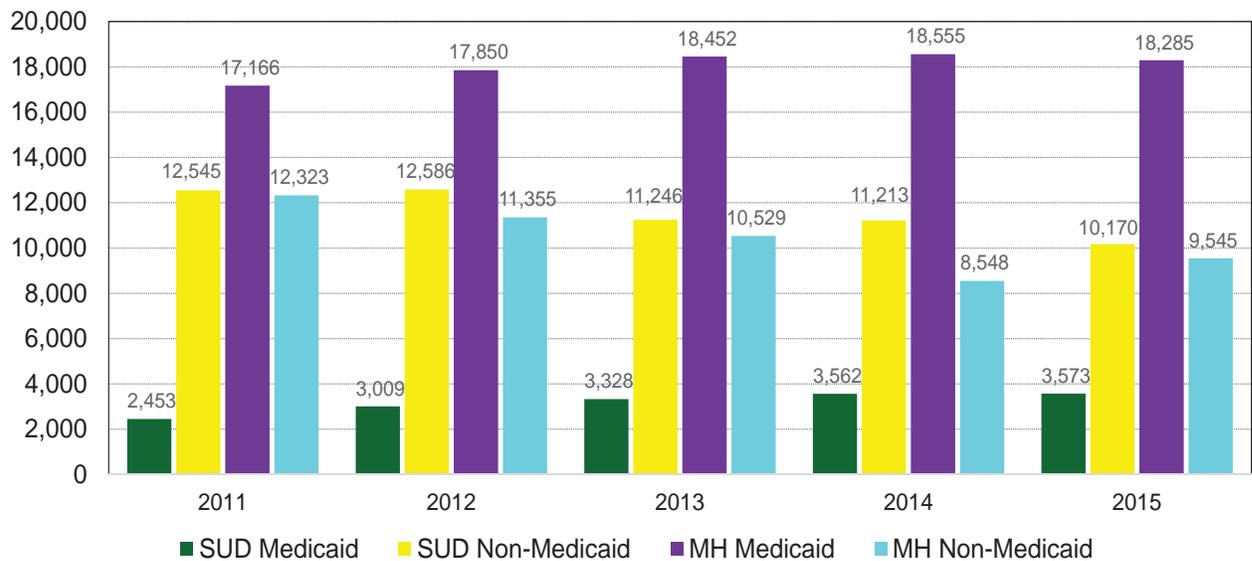


Medicaid vs. Non Medicaid Clients

Substance Use and Mental Health Clients Under Age 18 Medicaid vs. NonMedicaid Fiscal Year 2011 - 2015



Adult Substance Use and Mental Health Clients Medicaid vs. NonMedicaid Fiscal Year 2011 - 2015



Heather - Life After Meth

My father passed away when I was 3 and left me to be raised by my 20 year old mother. She became an alcoholic and substance abuser. She became involved with a man who was very abusive to both of us. I thought that substance abuse and violence was a normal part of life.

My addiction started with marijuana at age 9. As a young teenager, I was in a toxic relationship, using cocaine and drinking regularly. By 21, I had experimented with other drugs including methamphetamine. Although I was surrounded by addicts, I stayed clean during my pregnancy. Because I did not possess the knowledge or life skills to change my behaviors, I started using again 4 months after my son's birth. I did not know how to be alone or how to ask for the help that I knew I needed. We struggled for years moving around and changing schools. My son needed stability so he went to live with his grandparents. That started my downward spiral. I became homeless and figured that was what I deserved. Without insurance, I had to get into trouble with the law before I was approved for treatment.

Thankfully, House of Hope accepted me into their program. They saved my life. While there, I developed the skills to live a different kind of life. A happy, healthy, honest life. They helped me to see that I deserved to be loved and respected. My journey to recovery was hard, but it was worth it. I am worth it!

I have been drug free for over 6 years and am in a healthy, loving relationship with a wonderful man. My son has a mother who lives in the present and is there for him every day. I have an amazing job where I can use my skills to help others who still struggle. I am grateful every day for the gifts that I have been given and for the opportunity to live the happiness that eluded me for so long!

***“Change is possible!
Trust the process!”***

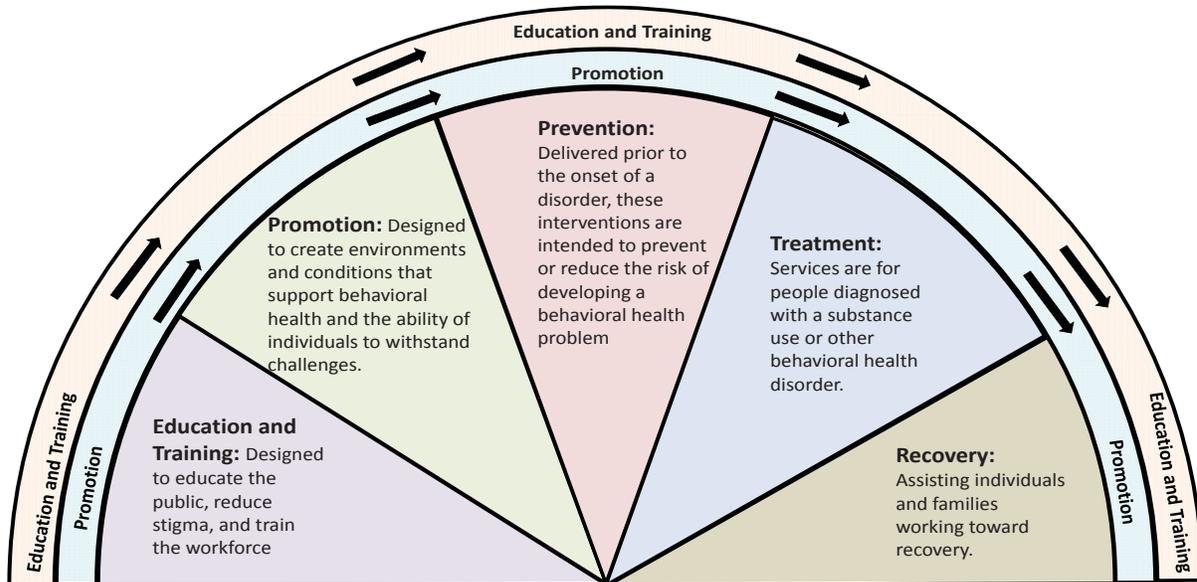


Services and Activities

In partnership with county government, DSAMH oversees a comprehensive array of behavioral health services designed to address the full spec-

trum of substance use and mental health disorders. The following table illustrates the continuum of behavioral health services provided:

Continuum of Services



Education and Training

Utah law assigns DSAMH the responsibility to educate the general public; operate workforce certification programs; and also disseminate information about effective practices (UCA §62A-15-105). DSAMH delivers hundreds of hours training through certification programs, conferences and other events around the state each year. These learning opportunities drive societal change by increasing understanding and improving the response to substance use and mental health disorders.

Certification Programs

A competent workforce is necessary to deliver effective behavioral health services. Behavioral health systems have long faced shortages of qualified workers, difficulties in recruiting and retaining staff, and a lag in implementing evidence-based practice.

DSAMH delivers the following certification programs to ensure the competence of Utah's behavioral health workforce:

Case Management

Case management continues to be a central highlight of community mental health work, working with people with mental illness and/or substance use disorders, both in teams and individually, to help achieve their goals. Case management provides six critical functions connecting with the consumer; planning for services; linking consumers with services; linking family members with services; monitoring service provision; and advocating for consumer rights. Providers of case management services also provide skill development services and personal services, as well as psychosocial rehabilitation groups. DSAMH is responsible to certify both adult and child mental health case managers in the Utah Public Mental Health System, and has successfully worked on improving the quality of case managers through a certification process. DSAMH has developed preferred practices for case management, including a training manual, and an exam with standards to promote, train, and support the practice of case management and service coordination in behavioral healthcare. In fiscal year 2015, DSAMH certified 100 adult and children and youth case managers, for a total of 620 certified case managers throughout the public mental health system.

Crisis Counseling

The DSAMH Crisis Counseling Certification Program supports short-term interventions with individuals and groups experiencing psychological reactions to large scale disasters. These interventions involve the counseling goals of assisting disaster survivors in understanding their current situation and reactions, mitigating additional stress, assisting survivors in reviewing their options, promoting the use of or developments of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that may help survivors recover to their pre-disaster level of functioning. While always cognizant of those individuals with men-

tal illness and/or substance use disorders special needs, the thrust of the Crisis Counseling Program has been to serve people responding normally to an abnormal experience. DSAMH has provided annual training over the past several years and has over 500 certified crisis counselors statewide.

Crisis Intervention Team (CIT)

This program provides law enforcement officers with specialized training to effectively respond to a person experiencing a mental health crisis, improving officer and consumer safety, and redirecting individuals with mental illness from the judicial system to the health care system. A successful CIT program consists of partnerships between law enforcement, advocacy organizations, people in recovery, and mental health professionals. DSAMH has partnered with the Salt Lake City Police Department to provide training. Law enforcement personnel must pass a required state test to achieve the DSAMH certification. The CIT Academy is a 40-hour course that is completed in a one-week session.

A total of 127 law enforcement agencies have sent representatives to the CIT Academies, and 4,021 officers have been certified. For more information, visit the CIT website, www.citutah.com.

Designated Examiner (DE)

Designated Examiners are licensed physicians familiar with severe mental illness (preferably a psychiatrist), who evaluate whether an individual meets criteria for civil commitment. Civil commitment is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment. DE apply the rules of civil commitment to protect public safety and citizen's civil rights. In 2015, DSAMH trained and certified 57 DE. There are currently 366 DE across Utah.

Driving Under the Influence (DUI) Education Instructors

DSAMH oversees the training of instructors who teach DUI Education classes. There are currently more than 200 certified DUI Instructors in Utah. These instructors use the *PRIME For Life* standardized DUI education program consisting of 16 hours of learning, self evaluation, and relevant group activities to help DUI offenders learn to make low-risk choices about alcohol and drug use. During fiscal year 2015, 6,913 people attended DUI Education classes.

Family Resource Facilitator (FRF)

Family Resource Facilitators are trained family members who ensure families have a voice in service delivery and policy decisions. At no charge to families, FRFs provide referrals to local resources and programs; advocacy for culturally appropriate services; links to information and support groups; and family wraparound facilitation. DSAMH contracts with the Utah Family Coalition (NAMI Utah, Allies with Families and New Frontiers for Families) for standardized training, coaching, and supervision. There are 59 certified FRFs statewide. Family Resource Facilitation and Wraparound is accessible in 25 of the 29 Utah counties.

Certified Peer Support Specialists (CPSS)

Peer Support Specialists are individuals in recovery from a substance use or mental health disorder that are fully integrated members of a treatment team. They provide highly individualized services in the community and promote client self-determination and decision-making. CPSS also provide essential expertise and consultation to the entire treatment team to promote a culture in which each client's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.

Since the program's inception, 347 individuals have been certified by DSAMH as CPSS. DSAMH currently contracts with the University of Utah School of Social Work, Utah State University, Optum Health and the Veteran's Administration to provide standardized training across the state.

Off-Premise Alcohol Sales Training

Utah law mandates training for each store employee that sells beer or directly supervises the sale of beer. Training is required within 30 days of hire and at least every 5 years thereafter. Stores may hire a Trainer to train staff in person, purchase a training package to train their own staff, or create and submit their own training for approval, or an individual may take online training. DSAMH establishes the curriculum requirements and approves training providers. In 2015, 10,888 people were trained to sell beer for off-premise consumption.

On-Premise Alcohol Beverage Server Training

DSAMH certifies providers who train servers who sell alcoholic beverages in Utah. All on-premise trainees must recertify at least every 3 years. During fiscal year 2015, 12,082 people were trained to serve alcohol for on-premise consumption.

Substance Abuse Prevention Specialist (SAPST)

DSAMH trains and certifies prevention workers using the Utah-SAPST. Utah-SAPST takes a curriculum developed by the federal government (SAMHSA-CSAP) and adds to it to cover Utah specific issues and strategies. Utah-SAPST provides an introduction to the fundamentals of substance abuse, mental illness, and suicide prevention based on the current research and practice in the field. The training prepares practitioners to reduce the likelihood of substance abuse and

promote well-being among individuals, within families, workplaces, schools, and communities. The Utah-SAPST covers basic prevention science as well as policy issues and how the Utah Prevention System operates. Participants are introduced to Utah specific initiatives such as Parents Empowered, Prevention by Design, and how to build capacity at the local community level.

Conferences

Conferences play a vital role in disseminating information to the public, the behavioral health work force and other community partners such as law enforcement and the judiciary. DSAMH provides or sponsors a number of conferences throughout the year, designed to present emerging research, evidence-based practices and opportunities for professionals to gain a broader understanding of our system.

Critical Issues Facing Children and Adolescents

The 19th Annual Critical Issues Facing Children and Adolescents Conference was held October 7-9, 2015. The focus of this conference was critical behavioral health issues facing youth.

Generations Conference

The 2015 Generations Conference was held March 16 and 17, 2015. This conference provided the latest information and most effective practice techniques to deal with addiction and behavioral health. There were specialized sessions providing education in topics such as forensics, trauma, geriatrics, and autism. Post-conference workshops included Connect Postvention training and Dialectical Behavior Therapy (DBT) skills training.

Utah Drug Court Conference

In partnership with the Utah Administrative Office of the Courts, the 5th biennial Statewide Drug Court Conference was held on October 29 and

30, 2015. The conference ensures that Utah Drug Court teams are aware of the most up-to-date certification requirements and evidence-based practices regarding day to day drug court functions. Over 350 participants attended from every corner of the state. Drug court teams comprised of judges, prosecutors, defense attorneys, treatment providers, court coordinators, and law enforcement professionals were in attendance. The conference featured a variety of learning opportunities related to a variety of behavioral health topics. Revised national drug court certification standards were introduced to the Utah problem solving courts.

Utah Fall Substance Abuse Conference

The 37th Annual Utah Fall Substance Conference was held in St. George, September 23-25, 2015. This conference, planned and hosted by DSAMH, brings the latest research and evidence-based tools to providers and community partners. The conference is divided into four different tracks: treatment, prevention, justice reinvestment and family services. This year over 900 professionals attended.

Utah Peer Summit

DSAMH, in partnership with Latino Behavioral Health Services, hosted a Peer Summit on October 23. Over 120 Peers attended this event. This event is primarily for individuals with lived experience with mental health and substance use conditions. The event was a precursor to the Peer Support Specialist Conference to be held in May 2016.

Utah Valley University Conference on Addiction

This event held on February 27, 2015, addressed a wide-range of issues specific to the topic of addiction. More than 400 individuals attended.

Other Training Events

In addition to conferences, DSAMH provides additional training each year to foster a better understanding of the symptoms, causes, treatment and prevention of substance use disorders and mental illness. In fiscal year 2015, DSAMH staff and partners invested thousands of hours to educate, inform, and motivate stakeholders and constituents to dispel myths surrounding these important societal issues. Some examples are:

Forensic Evaluator

DSAMH trains and contracts with private forensic evaluators to provide forensic evaluations ordered by Utah courts. DSAMH and the Utah State Hospital host an annual conference to provide ongoing training and support to the contracted evaluators. Quality is ensured by forensic evaluation peer review. The evaluations are requested and submitted through the Forensic Evaluations System (FES), an electronic system developed by DSAMH. It is utilized to help standardize the adult and juvenile competency process and provide an interface between DSAMH, the Utah State Hospital, contracted evaluators, and the courts.

For fiscal year 2015, Forensic Evaluators performed approximately 44 court-ordered juvenile competency evaluations and 999 evaluations for 382 adults.

Pre-admission Screening Resident Review (PASRR)

The PASRR Program is mandated by federal law as part of the Federal Omnibus Budget Reconciliation (OBRA) Act, and administered by DSAMH. PASRR was enacted to ensure individuals with mental illness and/or Intellectual Disabilities and/or Related Conditions are appropriately placed in Medicaid Certified Nursing Facilities, as well as to ensure they receive the services required.

Utah's population growth is projected to continue through 2030 and is now ranked 5th in the nation, according to population projections released by the U.S Census Bureau. The projections show Utah's population is expected to approach 3.5 million by 2030, a growth rate of 56% over three decades. The census projections also show a rapidly aging population nationwide. Utah is projected to gain 270,331 people age 65 and older by 2030, more than double the 2000 senior population.

In fiscal year 2015, DSAMH processed 3,104 evaluations. The dramatic growth of the older persons population may have a significant impact on the PASRR Program as the number of PASRR evaluations will likely continue to increase to meet rising demands of this population.

Wellness Recovery Action Plans (WRAP)

WRAP is a SAMHSA Nationally Registered, Evidence-based Peer Support Program that assists individuals in recovery in developing their own self-directed and personalized recovery plan. Formal WRAP groups typically range in size from 10 to 15 participants and are led by two trained co-facilitators, who are peers with lived experience and who use WRAP for their own recovery. Information is delivered and skills are developed through lectures, discussions, and individual and group exercises.

In August 2015, DSAMH held a WRAP Training for Certified Peer Support Specialists, facilitated by the Copeland Center. Sixteen Certified Peer Support Specialists from nine of Utah's local mental health authorities, Latino Behavioral Health and DSAMH were trained in this evidenced-based peer support service.

Applied Suicide Intervention Skills Training (ASIST)

Applied Suicide Intervention Skills Training is a two-day intensive, interactive and practice-

dominated course designed to help clinical, non-clinical caregivers and parents recognize and review risk, and intervene to prevent the immediate risk of suicide. It is by far the most widely used, acclaimed and researched suicide intervention training workshop in the world.

Question, Persuade, Refer (QPR)

QPR stands for Question, Persuade, and Refer—3 simple steps that anyone can learn to help prevent suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR skills can be learned in as little as one hour. In Utah, over 150 individuals have been trained as QPR Training Instructors and over 5,250 community members have been trained in QPR.

Mental Health First Aid

Mental Health First Aid is an 8-hour course that teaches individuals how to assist someone who is developing a mental health problem or experiencing a mental health crisis. The training helps individuals identify, understand, and respond to signs of mental illnesses and substance use disorders. Over 1,000 community members in Utah have been trained in Mental Health First Aid.

Connect Postvention

A suicide can have a devastating impact on a community or organization. The shock and grief can ripple throughout the community affecting friends, co-workers, schools, and faith communities. Connect Postvention training helps service providers respond in a coordinated and comprehensive way in the aftermath of a suicide or any sudden death. A total of 36 individuals are trained as trainers for Connect Postvention, with over 300 community members trained in Connect Postvention.

Columbia Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is a questionnaire used to assess the full range of evidence based suicidal ideation and behavior with criteria for next steps. The C-SSRS can be used across various settings including primary care, clinical practice, military setting, correction facilities and more.

Stanley Brown Safety Plan

Suicidal thoughts can seem like they will last forever—but for many, these thoughts and feelings pass. Having a plan in place that can help guide you through difficult moments can make a difference and keep you safe. Ideally, such a plan is developed jointly with your counselor or therapist. It can also be developed with a Life-line counselor who can help you write down actions to take and people to contact in order to feel safe from suicide. You should keep your plan in a place where you can easily access it (your wallet or cell phone) when you have thoughts of hurting yourself.

Seeking Safety

DSAMH held two Seeking Safety training events during the past two years for approximately 80 treatment providers, prevention and community partners. Seeking Safety is a present-focused therapy to help people attain safety from co-occurring Post Traumatic Stress Disorder (PTSD) and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians. The treatment was designed for flexible use. It has been conducted in group and individual format; for women, men, and mixed-gender; using all topics or fewer topics; in a variety of settings (e.g., outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

Trauma-informed Care

Most individuals with substance use disorders and mental illness are also dealing with trauma. Between 34% and 53% of people with a severe mental illness report childhood physical/sexual abuse. A Center for Substance Abuse Treatment publication states that as many as two-thirds of women and men in treatment for substance abuse report experiencing childhood abuse or neglect. Estimates of lifetime exposure to interpersonal violence in persons with severe mental illness are between 43% and 81%. Child abuse, sexual assault, military combat, domestic violence, and a host of other violent incidents help shape the response of the people we serve.

Adverse childhood experiences are strongly related to development and prevalence of a wide range of health problems, including substance abuse and mental illness. Neurodevelopment is altered by exposure to chronic stressful events. This disruption can impede a child's ability to cope with negative or disruptive emotions and contribute to emotional and cognitive impairment. Over time people exposed to trauma adopt unhealthy coping strategies that lead to substance use, disease, disability and social problems, and premature mortality.

Trauma-informed care is one of the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) primary initiatives.

SAMHSA describes a program, organization or system that is trauma-informed as one that:

1. Realizes the prevalence of trauma and taking a universal precautions position
2. Recognizes how trauma affects all individuals involved with the program, organization, or system, including its own workforce
3. Responds by putting this knowledge into practice
4. Resists re-traumatization

As part of a Department of Human Services (DHS) initiative to implement a trauma-informed approach, DSAMH partnered with Dr. Stephanie Covington in 2012 to provide trauma-informed care training for DHS Directors and Managers. Since this training event, DSAMH and other DHS Divisions have continued efforts in implementing a trauma-informed approach in their services, practices, policies, and procedures through the following measures:

1. Ongoing training at local/national conferences and other events.
2. Ongoing evaluation and consultation through DSAMH and other National Professionals, such as Gabriella Grant, M.S., Director for the California Center of Excellence for Trauma-Informed Care.

Prevention Services

Prevention works. Reliable and valid studies show us what works to decrease a myriad of negative health problems in communities, at the top of the list of these major health issues is the misuse and abuse of alcohol, tobacco, and other drugs. Communities that use effective prevention strategies, programs and policies, see decreases in major health and social issues in their community. An ounce of prevention is worth a pound of cure.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), every \$1 invested in substance abuse prevention in the state of Utah can result in a \$36 savings in health care costs, law enforcement, other state-funded social and welfare services, and increased productivity.¹ Prevention serves a critical role in supporting healthy communities, families, and individuals.

Utah's prevention system follows a strategic, science-based planning process called the Strategic Prevention Framework (SPF). The SPF is utilized throughout Utah to ensure a culturally competent, effective, cost-efficient system is deployed. Communities throughout Utah utilize the five steps of the SPF, which are:

1. Assessing community needs
2. Building capacity for services
3. Making a plan based on needs, strengths, and resources
4. Implementation of evidence-based strategies, and
5. Evaluation of prevention services to ensure effective prevention work

By using the Strategic Prevention Framework, Utahns are assured that services in their area

¹ Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, <http://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf>



match their local needs and factors that lead to costly problems are addressed.

Vital to a successful and sustainable prevention effort is a mobilized and organized community prevention coalition. DSAMH provides incentives to local substance abuse authorities (LSAAs) who utilize the Communities That Care (CommunitiesThatCare.net) system which has been scientifically proven to effectively start, run, and sustain local coalitions.

To support community prevention efforts, DSAMH provides technical assistance including Substance Abuse Prevention Specialist Training; manages a State Epidemiology Workgroup; and conducts a biennial Student Health and Risk Prevention survey. In addition, DSAMH hosts an Evidence-Based Workgroup to provide assistance to communities throughout Utah in identifying and incorporating evidence-based prevention services.

The Division has determined that the statewide priorities for substance abuse prevention are first, to prevent underage drinking and second, to prevent the abuse and misuse of prescription drugs.

Preventing Underage Drinking

According to the 2015 SHARP Survey, alcohol is one of the most commonly abused substance among youth. In fact, nearly one in every three 12th graders reported drinking alcohol sometime in their life. The same survey shows that close to 14% of 12th graders reported using alcohol in the past 30 days. To relate this problem in dollars and cents, underage drinking cost the citizens of Utah \$218 million in 2013 (<http://www.udetc.org/factsheets/ut.pdf>).

DSAMH prevention staff participates on the advisory committee for the highly successful “Parents Empowered” campaign. This campaign is aimed at eliminating underage drinking “by providing parents and guardians with information about the harmful effects of alcohol on the developing teen brain, along with proven skills for preventing underage alcohol use.” DSAMH staff provides research, oversight, and

PARENTS EMPOWERED.org connections between Parents Empowered and community coalitions throughout the state. For more information, visit www.parentsempowered.org.

Preventing the Abuse and Misuse of Prescription Drugs

One of the top two priorities for Utah Prevention is prescription drug abuse. In Utah, the illegal use of prescription drugs has reached epidemic proportions. While Utah has seen some success in prescription drug abuse prevention, it remains a very troubling issue.

- An average of 21 Utahns die as a result of prescription opioids (pain killers) each month
- Opioids contribute to approximately three out of four drug overdose deaths
- Over the last decade, prescription pain medications have been responsible for

more drug deaths in Utah than all other drugs combined

- The number of prescription opioid deaths decreased from 356 in 2010 to 274 in 2013. (Newer data pending)

DSAMH collaborates with the Department of Health, Drug Enforcement Agency, Poison Control, Veterans Affairs and local substance abuse (LSAAs) to positively impact this issue. Following the Strategic Prevention Framework, prevention efforts included coalition work, changing laws, and strategic use of evidence-based prevention programs. Information from the 2015 SHARP survey is encouraging.



The following shows the percent of students who used prescription drugs (stimulants, sedatives, tranquilizers, or narcotics) without a doctor telling them to take them. (SHARP 2015)

Grades	2011	2013	2015
6th	3.2	2.4	2.8
8th	7.5	4.5	4.9
10th	11.7	8.4	7.7
12th	14.5	10.9	10.1
All Grades	9.0	6.4	6.2

For more information, visit: www.useonlyasdirected.org.

Communities That Care

Whether it be public health concerns, environmental concerns, or issues related to major social problems such as poverty, scientists are postulating that the best effort to address large scale social problems is to develop community level coalitions. One example is found in Collective Impact published by Stanford Social Innovation Review, Winter 2011. In this article, Kania & Kramer report that “large-scale social change requires broad cross-sector coordination.” Fur-

thermore, in the Community Youth Development Study, University of Washington scientists compared outcomes between communities that used the Communities That Care (CTC) model of coalition organization to communities that used other coalition models or no coalition model at all. Highlights of the study are listed below:

KEY FINDINGS of CTC Study:

Within 4 years of coalition implementation of the CTC system, communities using CTC experienced significant reductions in youth substance use and delinquency among students completing the eighth grade, compared to control communities:

- 23% less alcohol use in the past 30 days
- 49% less smokeless tobacco use in the past 30 days
- 37% less binge drinking in the past two weeks
- 31% fewer delinquent acts in the past year

Furthermore, youth in CTC communities were less likely to begin using drugs and to engage in delinquent behaviors for the first time by the eighth grade:

- 38% less likely to start using alcohol
- 57% less likely to start using smokeless tobacco
- 45% less likely to start smoking tobacco
- 29% less likely to start delinquent behaviors

CTC helps community stakeholders and decision makers understand and apply information about issues in their community, that are proven to make a difference in promoting healthy youth development. Specific issues include underage drinking, substance abuse, violence, delinquency, school dropout, anxiety, and depression. CTC is grounded in rigorous research from social work, public health, psychology, education, medicine, criminology, and organizational development. It engages all community members who have a stake in healthy futures for young people and sets priorities for action based on community challenges and strengths. Clear, measurable outcomes are tracked over time to show progress and ensure accountability.

The Social Development Strategy is CTCs primary approach. It focuses on strengthening pro-

TECTIVE factors that can buffer young people from problem behaviors and promote positive youth development. Bonding between youth and adults with healthy beliefs and clear standards is an essential piece of this model.

Risk and Protective Factor Model

The Risk and Protective Factor Model was adopted by DSAMH to guide prevention efforts. It is based on the premise that to prevent a problem from happening, we need to identify the factors that increase the risk for that problem developing, and then implement evidence-based practices, programs and policies to reduce the risk of the focus populations. The following chart identifies the Risk Factors for substance use disorder and other problem behaviors.

Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities (2009) presents four key features of risk and protective factors:

1. Risk and protective factors can be found in multiple contexts
2. Effects of risk and protective factors can be correlated and cumulative
3. Some risk and protective factors have specific effects, but others are associated with multiple behavioral health problems
4. Risk and protective factors influence each other and behavioral health problems over time

DSAMH's goal is to increase protective factors and decrease risk factors. Each local authority has prioritized risk and protective factors that are based on their individual community's needs. This allows communities to target specific needs for their area which helps creating the largest impact for their prevention work.

Communities that Care

Risk Factors

	Adolescent Problem Behaviors					
	Substance Abuse (all substances)	Delinquency	Teen Pregnancy	School Drop Out	Violence	Depression and Anxiety
Community						
Availability of Drugs	✓				✓	
Availability of Firearms		✓			✓	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	✓	✓			✓	
Media Portrayals of Violence					✓	
Transitions and Mobility	✓	✓		✓		✓
Low Neighborhood Attachment and Community Disorganization	✓	✓			✓	
Extreme Economic Deprivation	✓	✓	✓	✓	✓	
Family						
Family History of the Problem Behavior	✓	✓	✓	✓	✓	✓
Family Management Problems	✓	✓	✓	✓	✓	✓
Family Conflict	✓	✓	✓	✓	✓	✓
Favorable Parental Attitudes and Involvement in the Problem Behavior	✓	✓			✓	
School						
Academic Failure Beginning in Late Elementary School	✓	✓	✓	✓	✓	✓
Lack of Commitment to School	✓	✓	✓	✓	✓	
Individual/Peer						
Early and Persistent Antisocial Behavior	✓	✓	✓	✓	✓	✓
Alienation and Rebelliousness	✓	✓		✓		
Friends Who Engage in the Problem Behavior	✓	✓	✓	✓	✓	
Gang Involvement	✓	✓			✓	
Favorable Attitudes Toward the Problem Behavior	✓	✓	✓	✓		
Early Initiation of the Problem Behavior	✓	✓	✓	✓	✓	
Constitutional Factors	✓	✓			✓	✓

Utah Student Health and Risk Prevention (SHARP) Survey

The biennial SHARP survey was completed in spring of 2015. The SHARP survey is a combination of three major surveys which include the Prevention Needs Assessment (PNA), the Youth Risk Behavior Survey, and questions from the Youth Tobacco Survey.

The SHARP Survey was designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. The survey was administered to students in grades 6, 8, 10, and 12 in 39 school districts and 14 charter schools across

Utah. Nearly 50,000 students were surveyed. The data was gathered and reported as a full state-wide report and by local substance abuse authority. Some school districts and individual schools elected to survey enough students where results can be analyzed to portray accurate survey results for their district or school.

Key findings of the 2015 SHARP report include:

Alcohol

- There continues to be a decrease overall in the percentage of youth who reported using alcohol in the 30 days prior to the survey. For Utah to continue to decrease the rate, even below 10% in some ages,

demonstrates communities resolve to eliminate underage drinking.

- From 8.6% in 2011 to 6.5% in 2015 for students in grades 6, 8, 10 and 12. The students in the 12th grade reported the largest decrease from 17.0% in 2011 to 13.6% in 2015.
- Harmful drinking, as measured by binge drinking (drinking five or more drinks in a day, any time in the past two weeks), decreased overall from 6.6% in 2011 to 4.2% in 2015 with significant decreases in all but 6th grade. The largest decrease was for students in the 12th grade with 12.2% reporting binge drinking in 2011 and 8.1% in 2015.

Marijuana Use

- Marijuana use in the 30 days prior to the survey increased from 2007 to 2013 in all grades surveyed. In 2015, we saw a slight decrease in grades 6, 8, 10, and 12 overall, to only 5.2% reporting having used marijuana. While the decrease from 2013 to 2015 is not statistically significant, Utah will continue to monitor marijuana use statewide.
- The perceived risk of using marijuana regularly decreased.

E-Cigarette Use

- Utah continues to see staggering increases of e-cigarette use.
- Past 30 day e-cigarette use among all grades has increased. In grade 10, the percentage of youth reporting use increased from 1.0% in 2011 to 12.4% in 2015.

Mental Health and Suicide

- Overall, the number of students who need mental health treatment increased from 11.2% in 2011 to 15.0% in 2015 with a

significant increase in 10th grade from 12.7% in 2011, to 20.0% in 2015.

- The percentage of students considering suicide (those who marked “yes” to the question, “During the past 12 months did you ever seriously consider attempting suicide?”) increased from 7.4% in 2011 to 14.4% in 2015, with significant increases in all grades surveyed, 6, 8, 10, and 12. The largest increase was in the 10th grade with rates of 7.2% in 2011 and 20.0% in 2015.

Prevention Dimensions

Prevention Dimensions (PD) is a statewide curriculum used as a resource to address substance use and other problem behaviors for K-12 students. PD is delivered by trained teachers in a classroom setting to students in Utah. DSAMH collaborates with the Utah State Office of education for implementation of PD to ensure it meets the State Board of Education’s core curriculum requirements. The PD objectives are based on increasing protective factors and decreasing risk factors while adhering to a no-use message for alcohol, tobacco, marijuana, inhalants, and other drugs. PD builds life skills, delivers knowledge about alcohol, tobacco and other drugs, and provides opportunities for students to participate in prevention activities.



Because PD is a product of the Utah Office of Education, it can be adapted to meet current needs such as bullying, suicide or specific prevention priorities related to a school or community, such as prescription drugs. PD also complements drug policies and other prevention strategies practiced in the schools. PD provides means for parents to get involved in preventing problems with their children by including them in homework assign-

ments and providing prevention tools to be used in the home.

Highlights for the 2014-15 year include the following:

- 1,115 individuals participated in PD teacher trainings and received resource materials
- 32 teacher trainings were conducted during the year including seven “whole school trainings”

Partnerships for Success Grant

The Partnerships for Success (PFS) Grant was designed for states to sustain successful efforts of previous grants. Utah applied for the PFS grant to sustain the community level organization and mobilization of prevention services. The purpose of this project is to increase community-centered evidence-based prevention (CCEBP) efforts.

CCEBP includes: increasing readiness of community members; collaborating with businesses, agencies, local government and other groups in

each community; and implementing programs which address community needs.

There are four regions, each with their own prevention director. The regions were determined using the data and geography of the LSAs by the State Epidemiological Outcomes Workgroup (SEOW). The Northern region includes: Bear River, Weber, Davis County, and Tooele County. The Salt Lake region includes Salt Lake County. The Eastern region includes: Summit County, Wasatch County, Northeastern, Utah County, and Four Corners. The Southern region includes: Central, Southwest, and San Juan County.

The primary responsibility of the regional prevention directors is to increase self-efficacy and capacity regarding CCEBP science throughout the LSAs by: advocating and serving as a liaison between the state and LSAs; assessing needs for technical assistance, developing a technical assistance plan, and providing technical assistance as requested; participating on SEOW and Evidence-Based Programs EBP workgroups; and collaborating with the LSAs.

Substance Use Disorder Services

In Utah, a continuum of services has been designed to address the full spectrum of substance use problems. Treatment services are based on the

American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Utah Division of Substance Abuse and Mental Health— Substance Abuse Services Continuum

Function	Prevention/Intervention			Treatment			Recovery Support Services
	Program Level	<i>Universal</i>	<i>Selected</i>	<i>Indicated</i>	<i>Outpatient</i>	<i>Intensive Outpatient</i>	
Appropriate for	<ul style="list-style-type: none"> General Population 	<ul style="list-style-type: none"> High Risk 	<ul style="list-style-type: none"> Using but does not meet DSM IV Diagnostic Criteria 	<ul style="list-style-type: none"> DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Serious Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Severe Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Individuals needing support services outside of treatment in order to maintain their recovery and build a meaningful life in the community

Source of Data

The federal government requires that each state collect demographic and treatment data on all clients admitted into any publicly funded substance abuse treatment facility. This data is called the Treatment Episode Data Set (TEDS). TEDS is the

source that the Division of Substance Abuse and Mental Health (DSAMH) uses for treatment admission numbers and characteristics of clients entering treatment. Unless otherwise stated, the data in the following charts comes from this source.

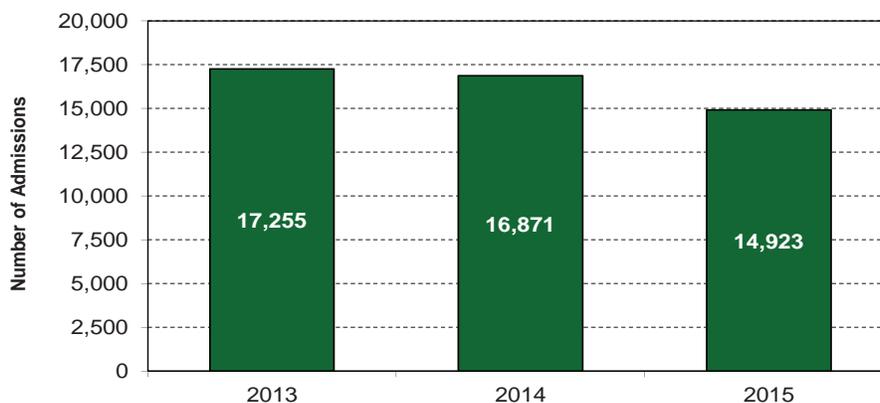
Number of Treatment Admissions

For the past four years, total treatment admissions have hovered around 17,000 admissions per year, but dropped to under 15,000 in fiscal year 2015.

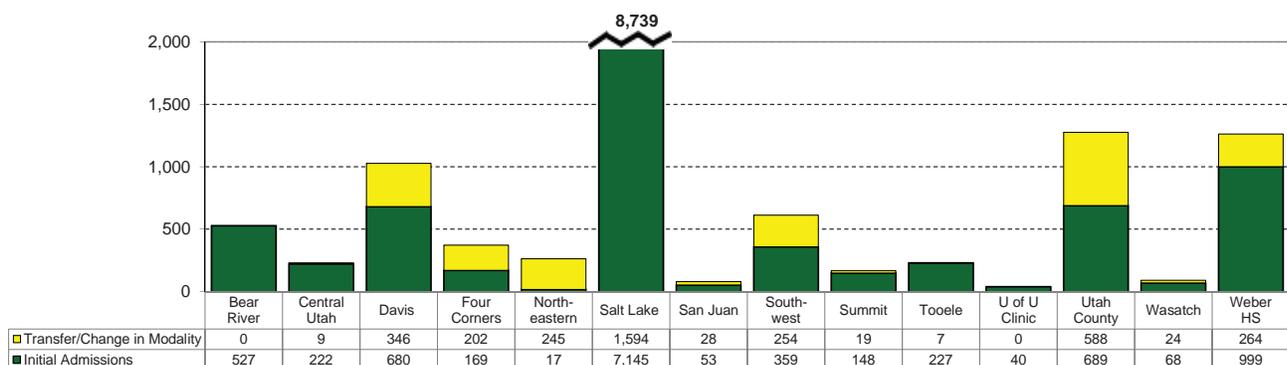
The chart below shows the number of admissions by each local authority and the University of Utah

Clinic in fiscal year 2015. It should be noted that six local authorities each have less than 2% of treatment admissions for the state, and Salt Lake County provides services to almost 61% of the state's admissions.

Substance Use Disorder Initial and Transfer Admissions into Modalities Fiscal Years 2013 to 2015



Substance Use Disorder Treatment Admissions and Transfers in Utah Fiscal Year 2015

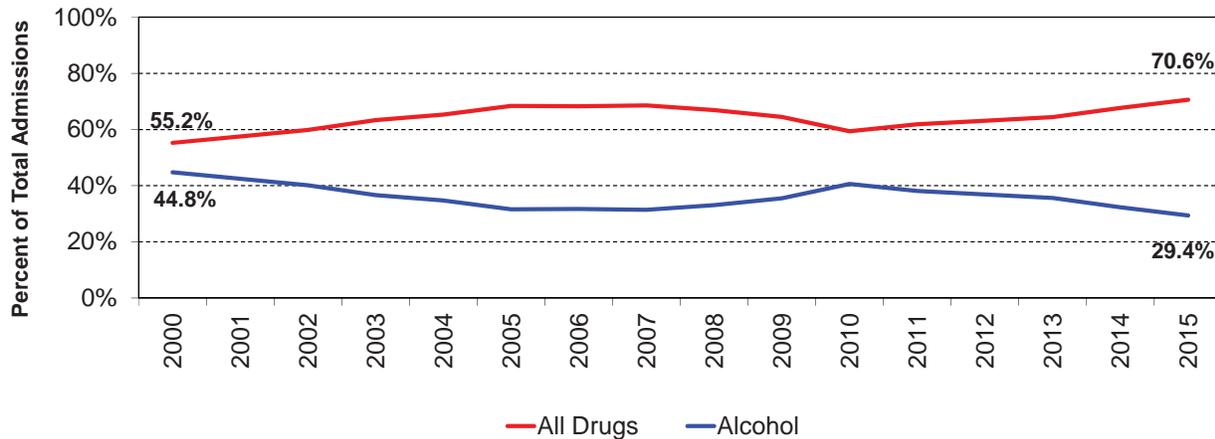


Primary Substance of Abuse

At admission, clients report their primary, secondary (if any), and tertiary (if any) drug use. Alcohol remains the primary substance of abuse, with

29.4% of clients reporting alcohol as their primary substance of abuse at admission.

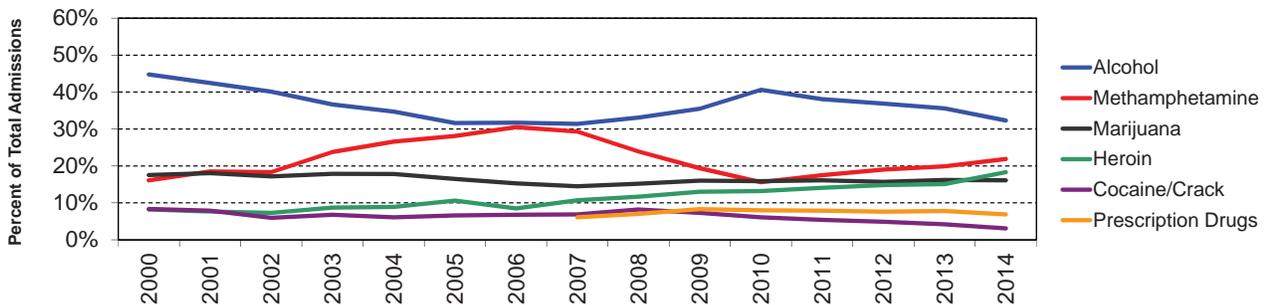
Patient Admissions for Alcohol vs. Drug Dependence
Fiscal Years 2000 to 2015



Opioids are the second most abused drug at admission accounting for just over 26% of all admissions. Methamphetamines and marijuana are the third and fourth most common drugs at

admissions with 23% and 16.1% of admissions, respectively. For the seventh straight year, cocaine/crack dropped and at 2.6%, is the lowest on record.

Top Drugs of Choice by Year
Fiscal Year 2000 to Fiscal Year 2015



Primary Substance by Gender

The primary drug at admission for men remains alcohol, at 32.9% of admissions. However, it is worth noting that alcohol again dropped as a percentage of male admissions by 2.9% in a year. For women, admission rates for alcohol and methamphetamines dropped slightly, admissions for heroin increased and other opiates remained the same, so that they are very close, 23.4%

(alcohol), 28.4% (methamphetamine) and 29.9% (all opiates). This continues a multi-year trend of declining female admissions for alcohol. This has implications for the appropriate treatment of women based on a different pattern of use. Meth use dropped slightly and opiates (all) are on the rise.

Primary Substance by Gender Fiscal Year 2015

	Male	Male %	Female	Female %	Total	Total %
Alcohol	3,091	32.9%	1,298	23.4%	4,389	29.4%
Cocaine/Crack	231	2.5%	153	2.8%	384	2.6%
Marijuana/Hashish	1,700	18.1%	710	12.8%	2,410	16.1%
Heroin	1,947	20.7%	1,193	21.5%	3,140	21.0%
Other Opiates/Synthetics	226	2.4%	245	4.4%	471	3.2%
Hallucinogens	9	0.1%	9	0.2%	18	0.1%
Methamphetamine	1,859	19.8%	1,574	28.4%	3,433	23.0%
Other Stimulants	42	0.4%	42	0.8%	84	0.6%
Benzodiazepines	28	0.3%	44	0.8%	72	0.5%
Tranquilizers/Sedatives	9	0.1%	8	0.1%	17	0.1%
Inhalants	5	0.1%	3	0.1%	8	0.1%
Oxycodone/Hydrocodone	121	1.3%	223	4.0%	344	2.3%
Club Drugs	5	0.1%	1	0.0%	6	0.0%
Over-the-Counter	2	0.0%	2	0.0%	4	0.0%
Other	111	1.2%	31	0.6%	142	1.0%
Unknown	0	0.0%	1	0.0%	1	0.0%
Total:	9,386	100.0%	5,537	100.0%	14,923	100.0%

Primary Substance by Age

Age plays a significant role in drug preference. For adolescents (under the age of 18) marijuana is the primary drug of use at admission. Opiates, which include heroin and prescription pain medication,

remain the number one drug at admission for individuals between 18 and 24, and for individuals between 25 and 34, outstripping alcohol as the drug of choice.

Primary Substance of Abuse by Age Grouping
Fiscal Year 2015

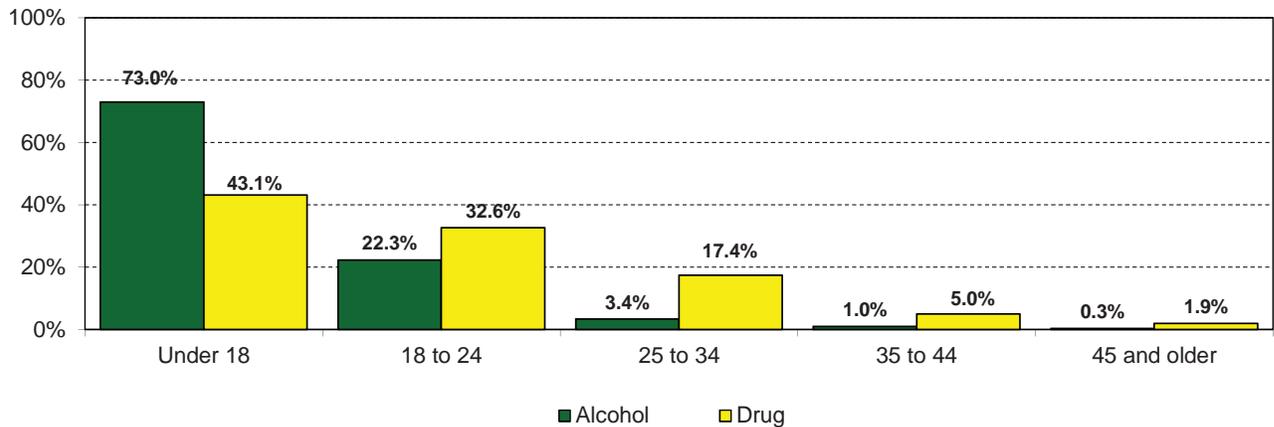
	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	159	436	1,268	1,125	1,356	45	4,389
Cocaine/Crack	2	57	135	87	102	1	384
Marijuana/Hashish	985	645	477	191	111	1	2,410
Heroin	5	636	1,660	517	317	5	3,140
Other Opiates/Synthetics	1	52	229	111	75	3	471
Hallucinogens	4	2	8	3	1	0	18
Methamphetamine	18	488	1,429	902	584	12	3,433
Other Stimulants	2	14	27	20	21	0	84
Benzodiazepines	1	6	32	23	10	0	72
Tranquilizers/Sedatives	0	2	8	3	4	0	17
Inhalants	1	1	2	2	2	0	8
Oxycodone/Hydrocodone	1	38	173	83	49	0	344
Club Drugs	1	3	2	0	0	0	6
Over-the-Counter	0	1	0	2	1	0	4
Other	13	27	51	26	25	0	142
Unknown	0	0	1	0	0	0	1
Total:	1,193	2,408	5,502	3,095	2,658	67	14,923

Age of First Use of Alcohol or Other Drug

In 2015, 73% of individuals who report alcohol as their primary drug began using prior to the age of 18, very slightly down from 2014. Individuals seeking treatment primarily for other drug use

tend to begin their drug use at a later age, with 43.1% beginning their use prior to the age of 18, and 32.6% reporting their first use between ages 18 and 25.

Age of First Use of Primary Substance of Abuse
Fiscal Year 2015

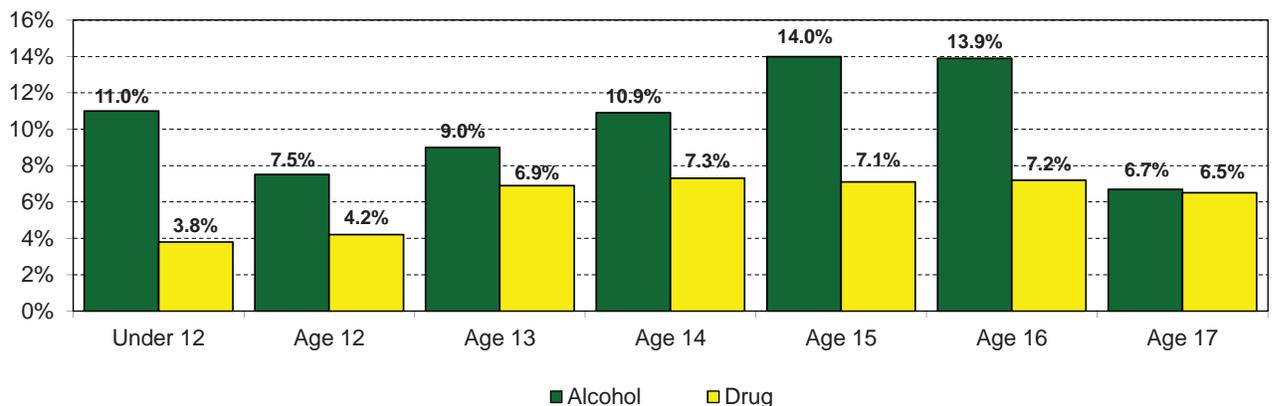


Age of First Use of Primary Substance—Under 18

The following chart breaks down age of first use for individuals who reported using their primary substance prior to age 18. For alcohol and other drugs, age of first use peaks at age 15. About 38% of individuals who report alcohol as their primary substance of abuse started at or before age 14, with another 14% starting during their 15th year. More

than 22% of individuals admitted for drug abuse started under the age of 14. This data is important as the research clearly shows that those that start using drugs or alcohol prior to the age of 18 have a significantly higher probability of becoming chemically dependent as adults.

Age of First Use of Primary Substance—Under 18
Fiscal Year 2015



Multiple Drug Use

Using more than one substance (drug or alcohol) places the client at greater risk for negative drug interactions, overdoses, psychiatric problems, and complications during the treatment process. The

numbers of clients reporting the use of drugs and alcohol in any combination at admission increased from 58.3% in 2014 to 63.8% in 2015.

Multiple Drug Use Fiscal Year 2015

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	334	63.4%
Central Utah	71	30.7%
Davis County	940	91.6%
Four Corners	236	63.6%
Northeastern	120	45.8%
Salt Lake County	5,210	59.6%
San Juan County	5	5.2%
Southwest Center	385	62.8%
Summit County	103	61.7%
Tooele County	143	61.1%
U of U Clinic	33	82.5%
Utah County	1,036	81.1%
Wasatch County	63	68.5%
Weber	845	66.9%
Total:	9,524	63.8%

Injection Drug Use

Individuals who inject drugs are a priority population for receiving treatment, because they are at greater risk of contracting and transmitting HIV/AIDS, tuberculosis, and hepatitis B and C. This table indicates the number of clients who report intravenous needle use as the primary route of administration for any reported drug use in the past year. In 2015, there was a slight increase in

the percentage of individuals requesting services through the public treatment system, who reported IV drug use as their primary route of administration. This increase was not consistent across the state, with Bear River and Central Utah showing the largest increases. This increase could be partially due to the increased use of heroin.

Admissions Reporting IV Injection Drug Use at Admission Fiscal Year 2015

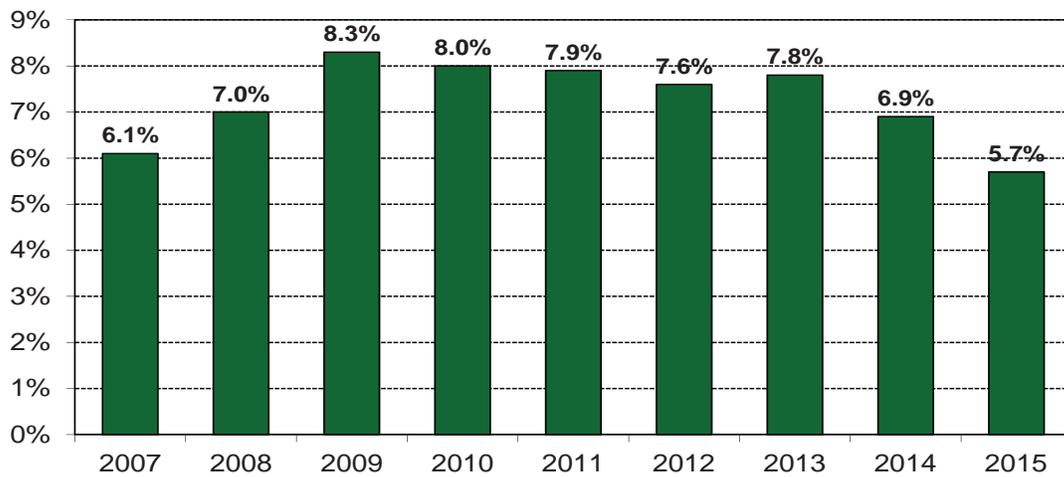
	# Reporting IV Injection Drug Use at Admission	% of Total Admissions for Each Area
Bear River	92	17.5%
Central Utah	33	14.3%
Davis County	357	34.8%
Four Corners	128	34.5%
Northeastern	29	11.1%
Salt Lake County	2,299	26.3%
San Juan County	2	2.5%
Southwest Center	186	30.3%
Summit County	10	6.0%
Tooele County	33	14.1%
U of U Clinic	16	40.0%
Utah County	475	37.2%
Wasatch County	16	17.4%
Weber	226	17.9%
Total:	3,902	26.1%

Prescription Drug Abuse

The nonmedical use or abuse of prescription drugs is a serious and growing public health problem. The abuse of certain prescription drugs—opioids, central nervous system (CNS) depressants, and stimulants—can alter the brain’s activity and lead to addiction. The Utah Department of Health

reports that in 2012, more individuals died from prescription drug overdose (323) than died in car accidents (243). The chart below shows the percent of clients who report prescription drugs as their primary drug at admission:

**Admission for Primary Drug—
Prescription Drugs
Fiscal Years 2007 to 2015**



Opioids (not counting heroin, but other opiates/synthetics and oxycodone/hydrocodone) are the most commonly abused prescription drugs in Utah. Taken as directed, opioids can be used to manage acute pain very effectively. However, if taken inappropriately, their use may lead to ad-

diction. Additionally, mixing prescription drugs with alcohol and other substances can be a deadly combination. Women tend to be admitted to treatment more frequently than men for prescription drugs. The chart below shows prescription drug admissions by gender:

**Prescription Drug Abuse by Gender
Fiscal Year 2015**

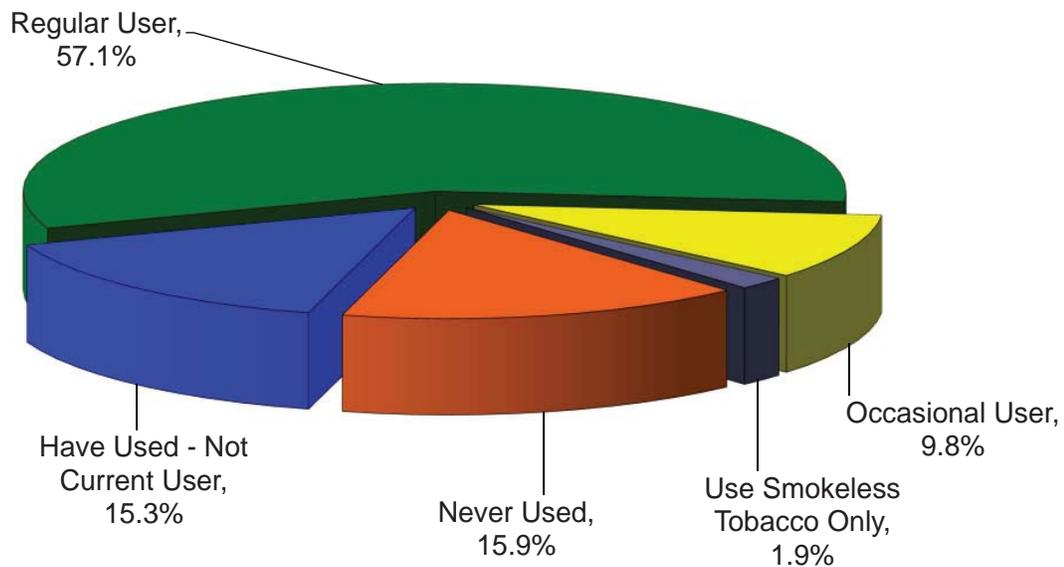
	Male	Male %	Female	Female %	Total	Total %
Other Opiates/Synthetics	226	2.4%	245	4.4%	471	3.2%
Other Stimulants	42	0.4%	42	0.8%	84	0.6%
Benzodiazepines	28	0.3%	44	0.8%	72	0.5%
Tranquilizers/Sedatives	9	0.1%	8	0.1%	17	0.1%
Oxycodone/Hydrocodone	121	1.3%	223	4.0%	344	2.3%
Total:	426	4.5%	562	10.1%	988	6.7%

Tobacco Use

Individuals with substance use disorders are much more likely to use tobacco. In 2015 in Utah, 68.8% of individuals admitted to substance abuse treatment used tobacco compared to only 10.2% of the general population. This is a slight increase from data in 2014 that indicated that over 67.5% of admissions used tobacco. Tobacco use often results in poor health and shorter life expectancy, and an increased risk or a return to alcohol or other drug

use. DSAMH requires that all local authorities' services be provided in a tobacco free environment and that they provide education about benefits of smoking and nicotine cessation, and provide assistance to those desiring to quit. In 2015, the local authorities reported the percentage of individuals who used tobacco at discharge decreased to 56% of clients.

Tobacco Use at Admission Fiscal Year 2015



In fiscal year 2015, almost 69% of clients use some type of tobacco at admission.

Pregnant Women in Treatment

In fiscal year 2015, 5.6% of women entering treatment (308) were pregnant at the time of admission. The percentage of admissions for pregnant women continues to stay relatively constant.

Federal law requires treatment providers to admit pregnant women into care within 48 hours of their first contact with the treatment provider.

Pregnancy at Admission

Fiscal Year 2015

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	191	6	3.1%
Central Utah	102	5	4.9%
Davis County	437	17	3.9%
Four Corners	161	3	1.9%
Northeastern	111	5	4.5%
Salt Lake County	2,837	166	5.9%
San Juan County	24	2	8.3%
Southwest	284	6	2.1%
Summit County	42	0	0.0%
Tooele County	79	4	5.1%
U of U Clinic	14	1	7.1%
Utah County	618	48	7.8%
Wasatch County	38	0	0.0%
Weber	599	45	7.5%
Total:	5,537	308	5.6%

Clients with Dependent Children

Children with a parent who abuses alcohol and/or other drugs are at a higher risk of developing substance use disorders themselves. The table below indicates the percentage of adult clients with dependent children as well as the number of women entering treatment who have dependent children, and the average number of children in those households. In fiscal year 2015, the percentage of all clients with dependent children in Utah was 48.3%, a figure that is slightly higher than the six year average of 45.5%. The average number of dependent children per household increased from 2.17 to 2.23.

The table also depicts the percentage of women entering treatment who have dependent children and the average number of children for those households. A total of 59.8% of women who

are admitted to treatment, report having dependent children and the average number of children for those households.

Both the Utah and Federal governments recognize the importance of treating pregnant women and women with dependent children as a priority for the public treatment system. A portion of the Federal Substance Abuse Prevention and Treatment (SAPT) block grant is required to be set aside for women's treatment, and the Utah Legislature has passed a special general fund appropriation specifically for the treatment of women and their dependent children. DSAMH closely tracks the use of these special funds to ensure that quality treatment is provided to this priority population.

Clients with Dependent Children Fiscal Year 2015

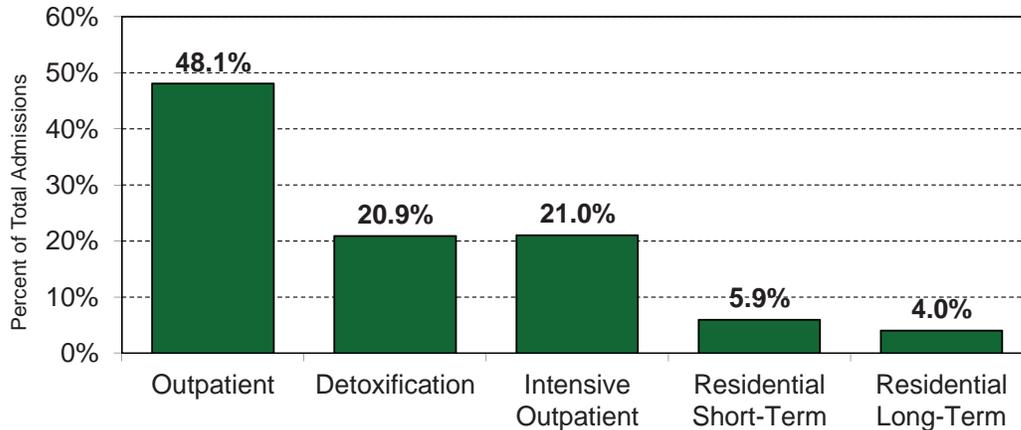
	Percent of all Clients with Children	Average Number of Children (of Clients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	34.8%	2.20	49.1%	2.24
Central Utah	48.4%	2.24	62.8%	2.36
Davis County	60.3%	2.31	77.2%	2.38
Four Corners	46.3%	2.20	57.3%	2.29
Northeastern	50.4%	2.12	56.9%	2.13
Salt Lake County	41.5%	2.08	55.2%	2.14
San Juan County	44.4%	2.73	46.2%	2.58
Southwest Center	55.9%	2.25	62.5%	2.40
Summit County	30.6%	2.08	42.9%	1.82
Tooele County	46.4%	2.08	64.4%	2.02
U of U Clinic	50.0%	2.33	52.6%	2.33
Utah County	71.2%	2.44	72.8%	2.36
Wasatch County	71.3%	2.49	73.2%	2.59
Weber	67.5%	2.53	65.7%	2.23
Total:	48.3%	2.23	59.8%	2.22

Service Types

In contrast to the earlier days of substance use disorder treatment when almost all treatment was residential, today 69.1% of admissions to treatment are to outpatient and intensive outpatient. An

expanded use of the ASAM Placement Criteria has helped place individuals in the level and intensity of care they need.

Service Type at Admission
Fiscal Year 2015

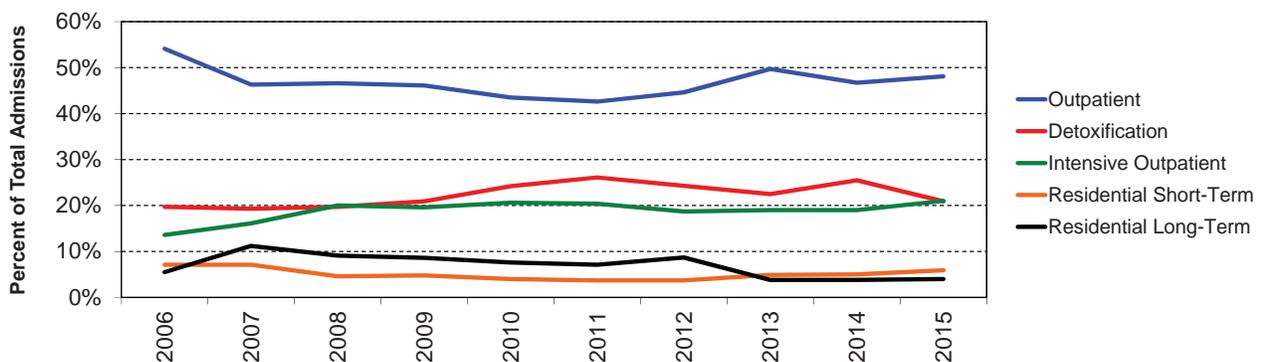


Trends in Service Types

Intensive outpatient services increased from 11.9% in 2005 to 20.4% in 2011. Since 2012 it has stayed steady with a slight increase to 21%. During that same period, residential admissions declined slightly until 2012, but then dropped significantly

in 2013 and 2014, with a slight increase in 2015. Since most of this decrease was in long-term residential admissions, it appears to reflect better use of the ASAM criteria and changes in agency approaches to treatment.

Trends in Service Types
Fiscal Years 2006 to 2015



Drug Courts

Individuals with a substance use disorder are disproportionately represented in our criminal justice system. Evidence indicates that approximately 80% of individuals in the criminal justice system meet the definition of substance use involvement and between one-half to two-thirds meet diagnostic criteria for substance abuse or dependence.

Drug Courts provide an alternative to incarceration for non-violent drug offenders. Drug Courts target offenders who are addicted to illicit drugs or alcohol and are at substantial risk for reoffending, commonly referred to as high-risk and high-need offenders. To effectively work with this population, Drug Courts provide intensive supervision and treatment services in a community environment. Successful completion of the program results in expunged charges, vacated or reduced sentences, or rescinded probation. DSAMH funds 46 drug courts throughout the state of Utah; 26 adult felony drug courts, 15 family dependency

drug courts, and 5 juvenile drug courts. In fiscal year 2015, Utah’s drug court program served 1,906 individuals, the majority of whom participated in the felony drug court program. As the Drug Court program continues to grow, an additional five courts were funded in fiscal year 2015.

DSAMH and our partner agencies (the Administrative Office of the Courts and the Department of Corrections) work to improve quality assurance and monitoring processes of the program. In addition to conducting annual site visits and biennial certifications of courts, DSAMH has partnered with the National Center of State Courts to conduct process and outcome evaluations at select Utah Drug Courts, and develop performance measurements that should be implemented in fiscal year 2016.

The following chart shows drug court outcomes for fiscal year 2015.

Drug Court Outcomes				
Measure Title	Purpose of Measure/Measure Definition	FY2013	FY2014	FY2015
Successful Completion	Percent of participants who complete program successfully	51.5%	57.8%	56.5%
Criminal Justice Involvement	Percent of clients reporting zero arrests while participating in Drug Court	88.0%	82.5%	81.0%
	Percent decrease in clients arrested from 30 days prior to treatment to 30 days prior to discontinuation/discharge	66.1%	65.0%	62.9%
Employment	Percent increase in full/part-time employment from admission to discharge	42.2%	57.1%	52.3%
Substance Use—Alcohol	Percent increase in abstinence from alcohol from admission to discharge	30.7%	45.6%	36.2%
Substance Use—Drug	Percent increase in abstinence from drugs from admission to discharge	194.4%	282.4%	304.8%
Increase in Stable Housing	Percent increase in non-homeless clients admission to discharge	2.9%	2.1%	2.7%

Drug Offender Reform Act (DORA)

The Drug Offender Reform Act, began in 2005 as a pilot project, and as of July 1, 2015, is operating in eight local substance abuse authorities—Bear River, which includes Box Elder, Cache, and Rich Counties; Carbon County; Davis County; Salt Lake County; Southwest, which includes Iron and Washington Counties; and Utah County. In 2015, 383 individuals were admitted to the DORA program statewide. Overall, 642 total DORA clients were served in 2015.

DORA is based on the following premise: Smarter Sentencing + Smarter Treatment = Better Outcomes and Safer Neighborhoods. The key components of DORA are intensive supervision, timely treatment access, and collaboration be-

tween treatment and supervision staff. Retention in, and adherence to treatment, are positively related to post-supervision criminal justice outcomes, according to the latest DORA research conducted by the University of Utah Criminal Justice Center. Individuals who are successful in treatment are less likely to be rearrested and enter or return to prison.

The Drug Offender Reform Act: DORA Statewide Report, is available on the UCJC website at:

<http://ucjc.utah.edu/adult-offenders/dora-statewide>

The following chart illustrates DORA’s effectiveness:

Drug Offender Reform Act Outcomes					
Measure Title	Purpose of Measure/Measure Definition	FY2012	FY2013	FY2014	FY2015
Alcohol	Percent increase in abstinence from alcohol from admission to discharge	23.0%	33.2%	35.3%	24.7%
Drugs	Percent increase in abstinence from drugs from admission to discharge	91.4%	129.9%	115.9%	170.7%
Employment	Percent increase in full/part-time employment from admission to discharge	64.3%	34.1%	46.1%	38.5%
Increase in Stable Housing	Percent increase in non-homeless clients admission to discharge	2.4%	3.9%	2.2%	1.0%
Clients Served	Unduplicated number of clients served	668	706	769	642

Mental Health Services

Under UCA §17-43-301, the public mental health system provides an array of services that assure an effective continuum of care. Under the administrative direction of DSAMH, the counties and their local mental health authority (LMHA) are given the responsibility to provide mental health services to its citizens. Counties set the priorities to meet local needs and submit an annual local area plan to DSAMH describing what services they will provide with State, Federal, and county money. State and Federal funds are allocated to a county or group of counties based on a formula established by DSAMH. While providing the ten mandated services listed below, counties may deliver additional services in a variety of ways to meet the needs of their citizens.

Continuum of Services

DSAMH embraces and promotes the recovery model. The model uses the concept of nonlinear access to care, which means people may receive very limited services or the full continuum of services based on the needs described in their self-directed person-centered plans. The continuum of available services for all Utah residents includes:

1. Inpatient care
2. Residential care
3. Outpatient care
4. 24-hour crisis care
5. Psychotropic medication management
6. Psychosocial rehabilitation, including vocational training and skills development
7. Case management
8. Community supports, including in-home services, housing, family support services, and respite services

9. Consultation and education services, including case consultation, collaboration with other county service agencies, public education, and public information
10. Services to people incarcerated in a county jail or other county correctional facility

In addition to the services described above, many of the local authorities also provide the following:

Clubhouses are a model of psycho-social rehabilitation where attendees are considered members and empowered to function in a work-ordered day. Clubhouses provide a supportive environment where individuals can rebuild their confidence, purpose, abilities, and community through education, productive work, housing, and meaningful relationships. All of this is done within a uniquely supportive and collaborative Clubhouse setting in which members and staff work together in an atmosphere built on principles of mutual respect and caring.

Peer Drop-In Centers are places where individuals in crisis can receive support from peers in recovery to promote connectedness, social interaction, and encourage them to take responsibility for their treatment and recovery. Crisis lines are available in some areas for telephone support as well.

Nursing Home and Hospital Alternatives include community-based care, i.e., intensive case management, outreach services, coordination with other entities such as home health, etc.

Recovery Support Services are provided across the state through various methods and across multiple partnerships. Accessible, effective, comprehensive, and integrated supports may include supported housing, supported employment and recovery-related goods and services.

Source of Data

The federal government requires that each state collect demographic and treatment data on all clients admitted into publicly funded mental health treatment facilities. This data is called the Mental Health Event File (MHE). DSAMH collects this data on a monthly basis from the LMHAs. Unless otherwise stated, the data for the mental health charts come from this source.

Diagnostic Data

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is the standard classification of mental disorders used by mental health professionals in the United States. Each disorder in the DSM-IV has a set of diagnostic criteria that includes applicable symptoms, parameters for duration of symptoms, and symptoms that must not be present for clinical diagnosis. An individual may have more than one diagnosis, and

each diagnostic category listed may have several subsets. For example, an anxiety disorder may include a subset for generalized anxiety disorder, post traumatic stress disorder, or panic disorder.

If an individual has both a substance use disorder and a mental health disorder it is called a “co-occurring disorder.” Today it is clear that the co-occurrence of mental illness and substance use disorders is common. According to the Federal Substance Abuse and Mental Health Services Administration, 50% of individuals with severe mental illness are affected by substance use disorders. This data is driving the need for an integrated approach to mental health promotion, mental illness and substance use disorder prevention, treatment, and recovery services.

The tables on the next page describe the most common diagnoses treated in the public mental health system in Utah by local authority with statewide totals for both children and adults.

Diagnosis of Mental Health Clients 18 years and older, by Local Authority														
Diagnosis	Four Corners													
	Bear River Mental Health	Central Utah Counseling Center	Davis Behavioral Health	Community Behavioral Health	Northeastern Counseling Center	Salt Lake County	San Juan Counseling	Southwest Behavioral Health Center	Summit County	Tooele County	Utah County	Wasatch County	Weber Human Services	Statewide Adults
Anxiety	25.6%	21.6%	23.6%	17.7%	27.2%	24.8%	22.1%	16.9%	28.0%	27.2%	30.3%	23.7%	24.2%	24.8%
Mood Disorder	16.6%	9.7%	16.2%	13.9%	15.1%	16.8%	9.5%	19.2%	13.8%	14.2%	14.3%	13.0%	21.7%	16.2%
Substance Abuse	6.7%	14.0%	19.3%	18.6%	12.6%	12.3%	11.7%	15.4%	16.5%	16.6%	1.0%	20.7%	14.2%	12.5%
Depression	13.6%	13.9%	7.5%	12.8%	18.2%	13.2%	21.4%	7.9%	14.5%	16.7%	14.2%	16.9%	7.0%	12.1%
Schizophrenia and Other Psychotic	5.9%	6.1%	7.7%	4.9%	3.8%	11.3%	2.5%	1.8%	1.8%	3.0%	6.2%	4.5%	8.2%	8.0%
Personality Disorder	10.5%	11.0%	6.9%	8.8%	2.8%	8.5%	5.2%	12.3%	5.6%	6.1%	5.8%	3.6%	7.9%	7.7%
Attention Deficit	6.2%	2.6%	4.9%	1.9%	3.0%	2.8%	5.5%	1.6%	4.4%	3.2%	5.8%	2.0%	2.0%	3.7%
Cognitive Disorder	2.8%	2.3%	2.5%	1.5%	1.8%	2.0%	2.7%	4.1%	1.2%	1.2%	4.4%	0.3%	2.7%	2.5%
Adjustment Disorder	2.3%	1.4%	3.5%	2.3%	2.5%	1.1%	2.9%	2.9%	3.7%	1.5%	2.0%	3.8%	1.3%	2.0%
Pervasive Developmental Disorders	1.2%	0.9%	1.5%	0.5%	0.5%	0.7%	0.9%	2.5%	1.1%	0.7%	1.9%	0.4%	1.0%	1.2%
Neglect or Abuse	0.2%	9.0%	0.2%	0.5%	2.0%	0.1%	0.1%	0.9%	0.7%	0.7%	3.1%	0.9%	1.1%	1.0%
Impulse Control Disorders	1.0%	0.9%	0.8%	0.8%	2.0%	0.6%	1.5%	0.9%	0.5%	0.3%	1.5%	0.6%	0.9%	0.9%
Oppositional Defiant Disorder	0.3%	0.3%	0.3%	0.1%	0.1%	0.1%	0.1%	0.3%	0.0%	0.2%	0.3%	0.0%	0.2%	0.2%
Conduct Disorder	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.3%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
Other	2.5%	2.2%	3.4%	14.8%	1.1%	2.0%	9.1%	1.7%	1.6%	1.6%	3.3%	1.0%	0.9%	2.9%
V Codes	4.3%	4.2%	1.7%	1.1%	7.4%	3.7%	4.4%	6.2%	6.7%	6.8%	5.8%	8.6%	6.7%	4.2%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

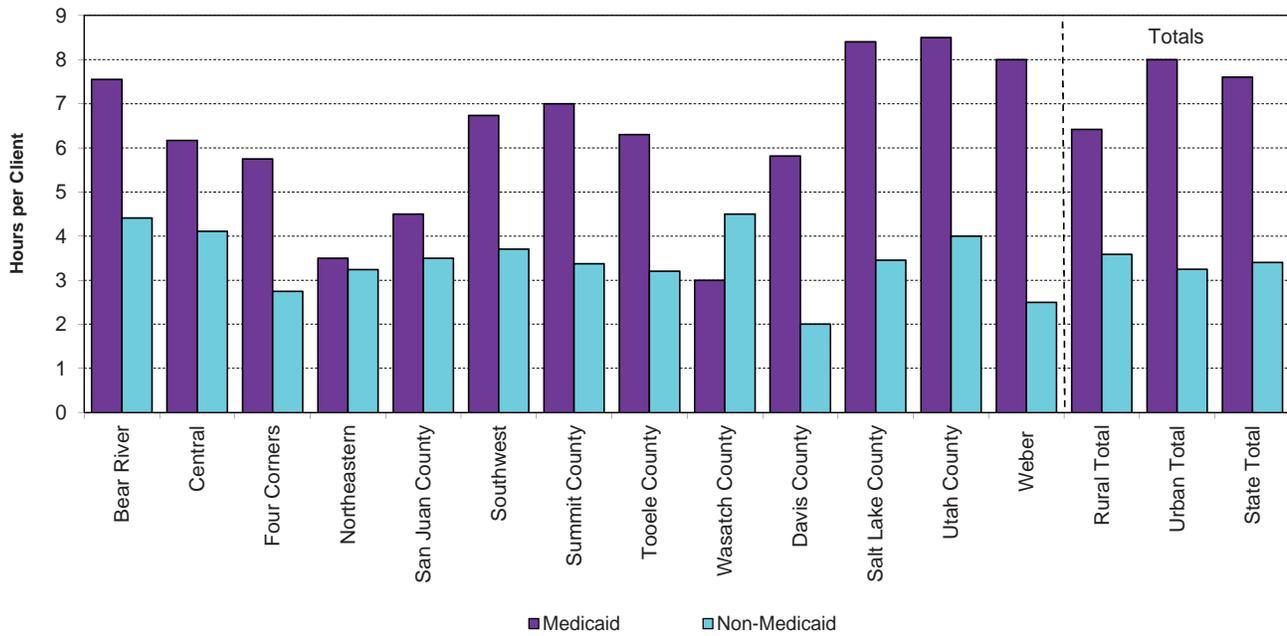
Diagnosis of Mental Health Clients 17 years and younger, by Local Authority														
Diagnosis	Four Corners													
	Bear River Mental Health	Central Utah Counseling Center	Davis Behavioral Health	Community Behavioral Health	Northeastern Counseling Center	Salt Lake County	San Juan Counseling	Southwest Behavioral Health Center	Summit County	Tooele County	Utah County	Wasatch County	Weber Human Services	Statewide Children/ Youth
Anxiety	18.5%	14.5%	18.4%	12.3%	14.2%	25.6%	15.7%	19.1%	21.5%	22.3%	20.1%	15.2%	18.0%	20.5%
Attention Deficit	16.8%	15.1%	19.0%	10.7%	10.6%	13.4%	16.9%	7.7%	13.3%	11.1%	12.4%	7.6%	16.1%	13.9%
Mood Disorder	9.9%	6.6%	15.6%	10.0%	15.8%	14.5%	8.6%	10.2%	8.9%	8.3%	12.5%	6.8%	14.6%	13.1%
Adjustment Disorder	15.6%	13.4%	6.8%	12.4%	11.1%	7.7%	10.2%	10.7%	9.6%	7.5%	9.9%	17.9%	5.1%	8.9%
Oppositional Defiant Disorder	4.5%	11.5%	7.4%	4.1%	2.8%	8.8%	2.6%	2.3%	6.5%	5.4%	3.4%	2.7%	6.9%	6.2%
Neglect or Abuse	4.4%	8.7%	6.3%	4.3%	12.4%	3.4%	3.5%	6.3%	4.1%	7.2%	7.7%	6.5%	5.5%	5.7%
Depression	6.4%	8.3%	3.7%	4.1%	12.1%	6.4%	14.4%	3.7%	5.8%	9.3%	5.7%	9.1%	3.4%	5.7%
Pervasive Developmental Disorders	3.2%	3.1%	4.7%	2.4%	2.3%	4.3%	4.8%	7.7%	2.7%	2.6%	6.1%	1.9%	3.9%	4.6%
Impulse Control Disorders	2.7%	2.3%	2.4%	2.1%	5.0%	4.2%	1.3%	6.4%	3.1%	1.9%	3.3%	4.9%	7.5%	3.9%
Substance Abuse	0.9%	3.9%	2.1%	3.0%	3.0%	1.1%	6.4%	3.5%	1.4%	2.0%	0.1%	5.3%	1.7%	1.7%
Conduct Disorder	0.5%	1.4%	2.0%	0.0%	0.8%	0.8%	1.0%	0.6%	0.0%	0.7%	0.6%	0.4%	0.6%	0.9%
Cognitive Disorder	1.1%	0.6%	1.3%	0.8%	0.3%	0.4%	0.6%	1.0%	0.0%	0.2%	0.8%	0.4%	1.3%	0.8%
Personality Disorder	0.2%	0.3%	0.3%	0.5%	0.1%	0.0%	0.0%	1.3%	0.3%	0.0%	0.1%	0.0%	0.1%	0.3%
Schizophrenia and Other Psychotic	0.1%	0.1%	0.6%	0.0%	0.1%	0.3%	1.0%	0.1%	0.0%	0.0%	0.1%	0.4%	0.2%	0.2%
Other	6.9%	2.9%	6.3%	25.5%	2.4%	2.9%	9.3%	4.8%	4.8%	2.8%	4.1%	3.8%	4.1%	5.0%
V Codes	8.3%	7.4%	3.1%	7.8%	7.0%	6.1%	3.8%	14.4%	18.1%	18.7%	13.1%	17.1%	11.0%	8.6%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Mandated Services by Local Authority

DSAMH monitors the following statutorily mandated services for quality of care. Services provided to individuals and families in the public system are captured in these service areas. The following tables illustrate the service priorities

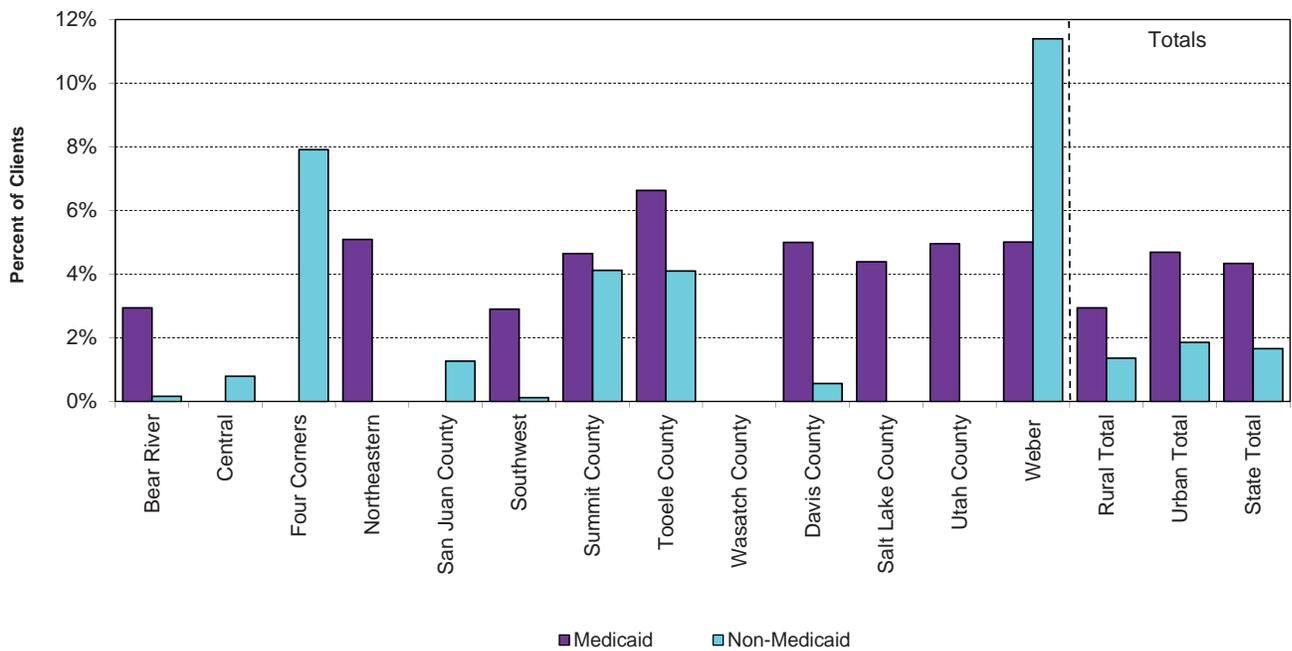
(based on utilization and median length of service) for each of the 13 local mental health authorities with rural, urban and statewide totals. The N= for the utilization charts can be found on page 162.

**Outpatient
Median Length of Service**
Mental Health Clients
Fiscal Year 2015



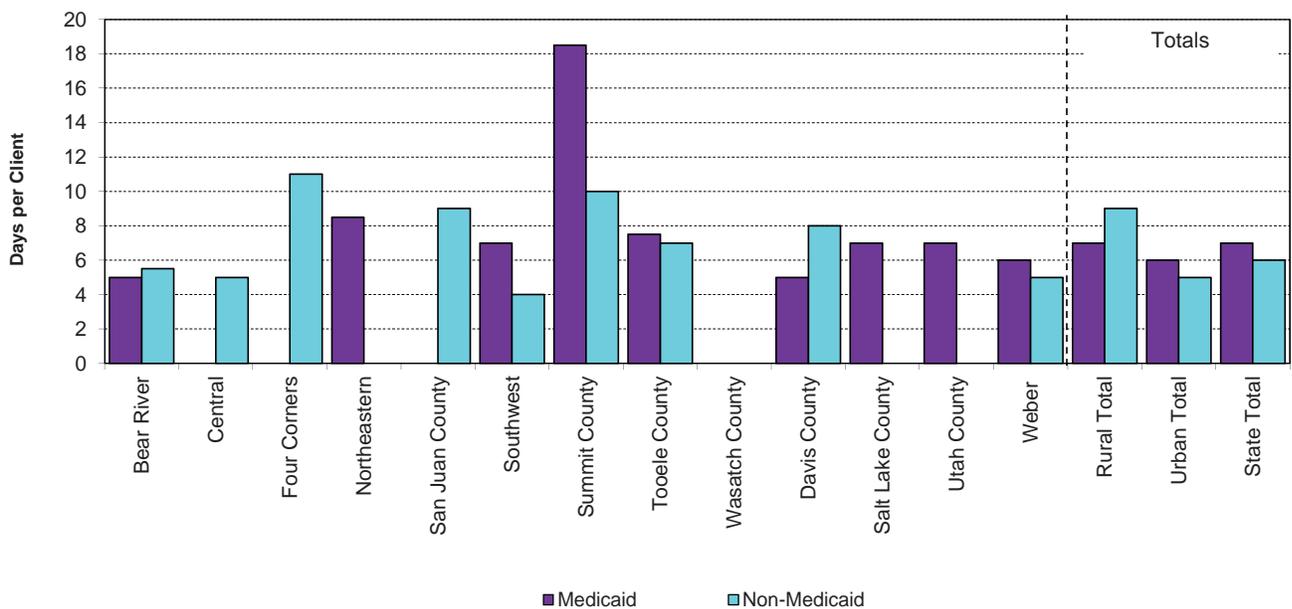
Inpatient Utilization

Mental Health Clients
Fiscal Year 2015



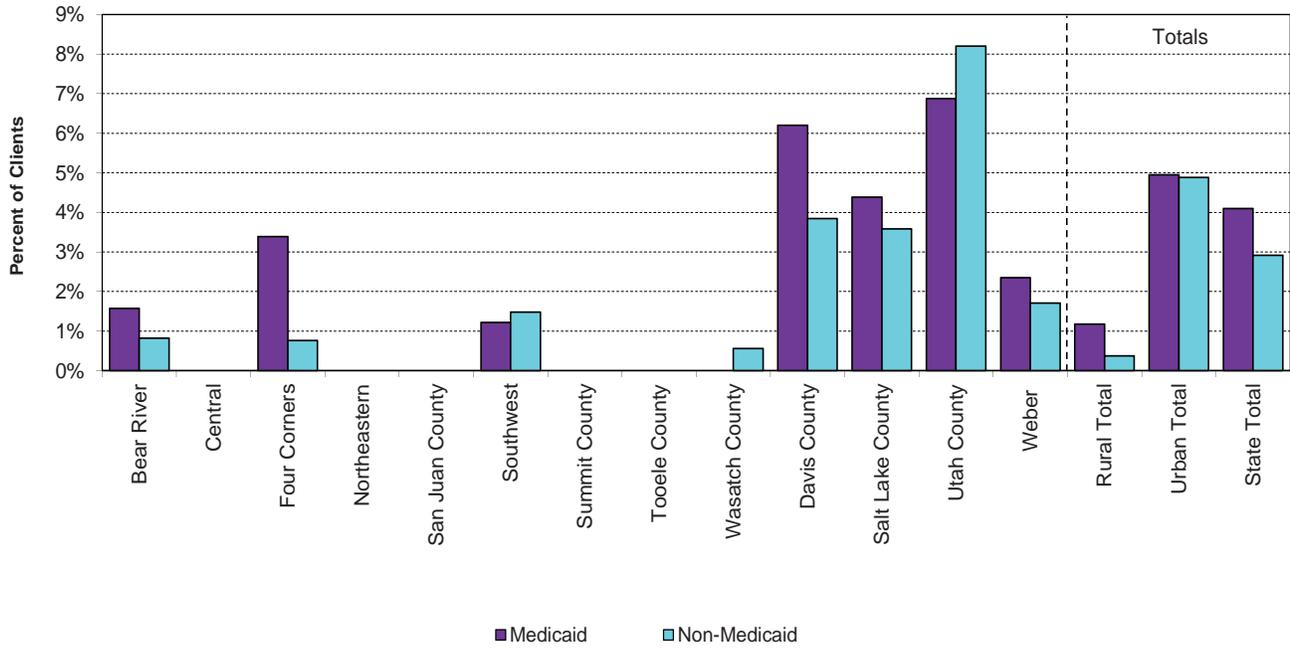
Inpatient Median Length of Service

Mental Health Clients
Fiscal Year 2015



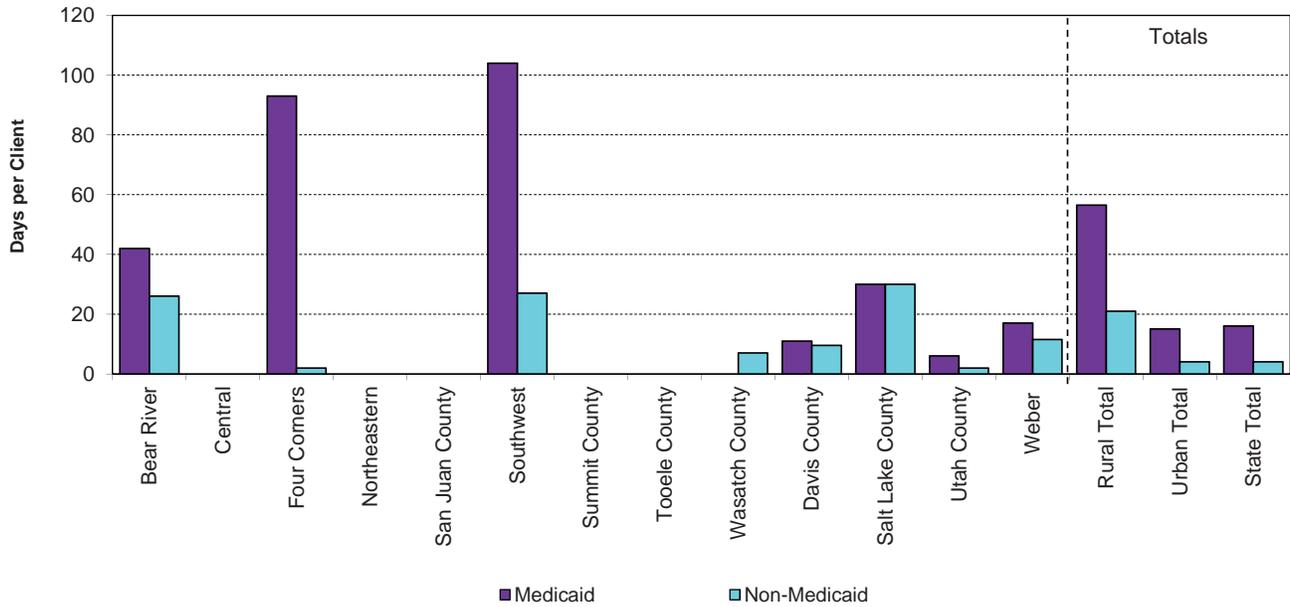
Residential Utilization

Mental Health Clients
Fiscal Year 2015



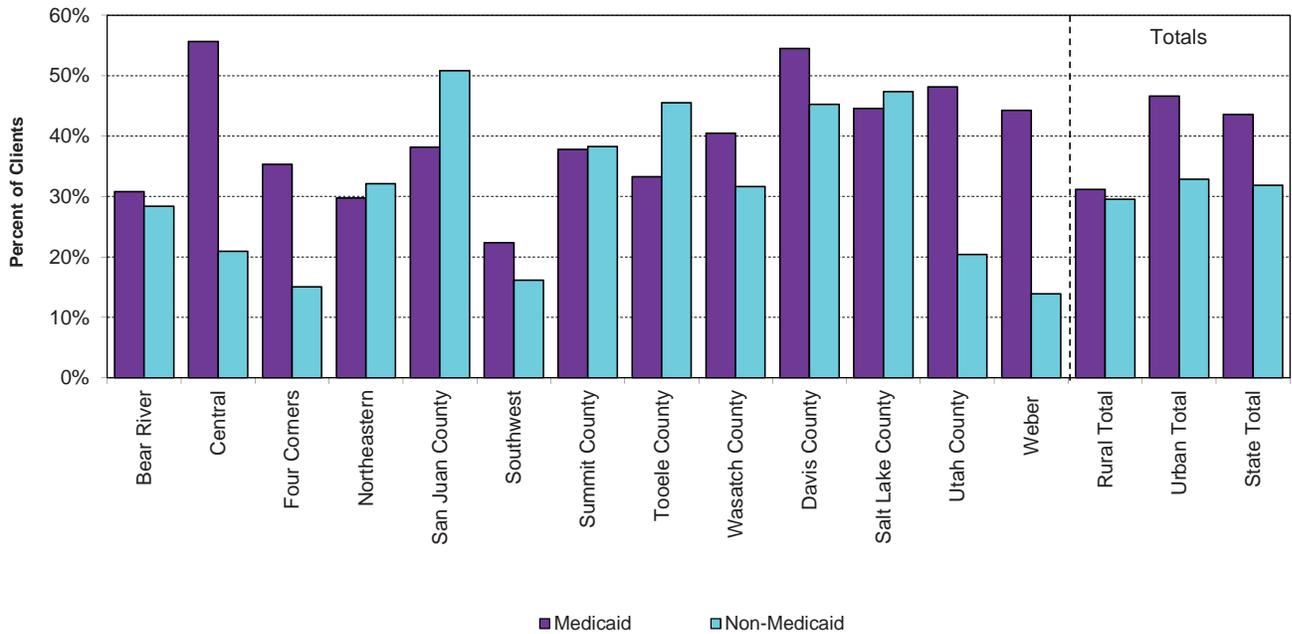
Residential Median Length of Service

Mental Health Clients
Fiscal Year 2015



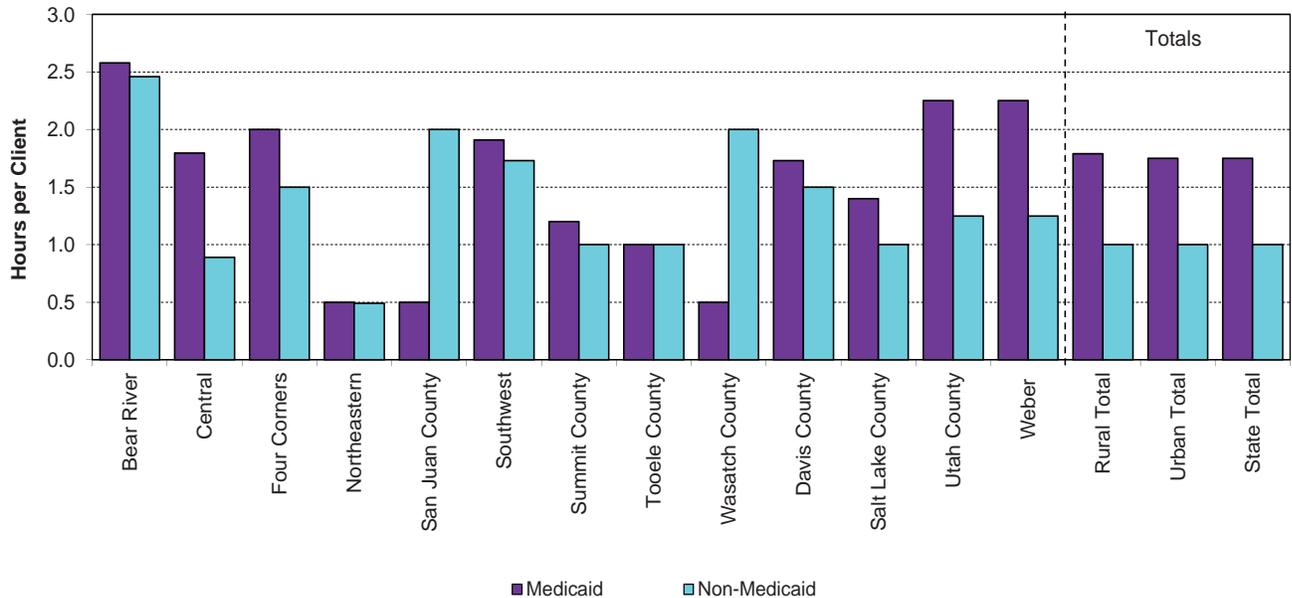
Medication Management Utilization

Mental Health Clients
Fiscal Year 2015



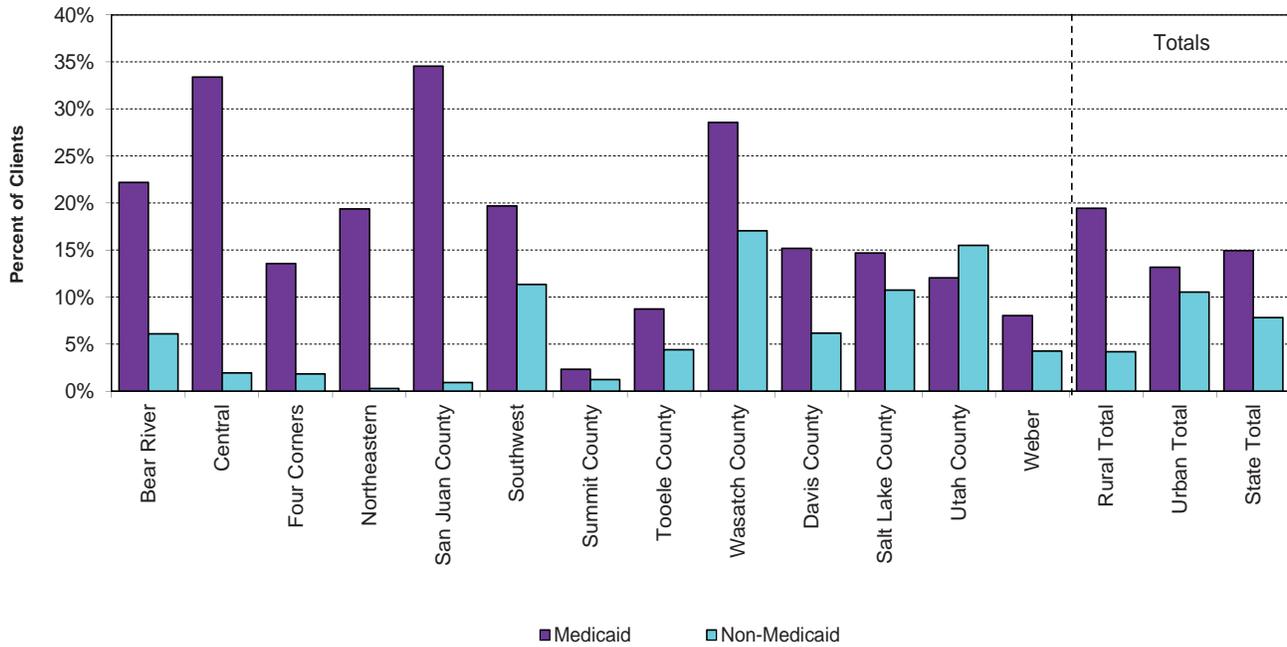
Medication Management Median Length of Service

Mental Health Clients
Fiscal Year 2015



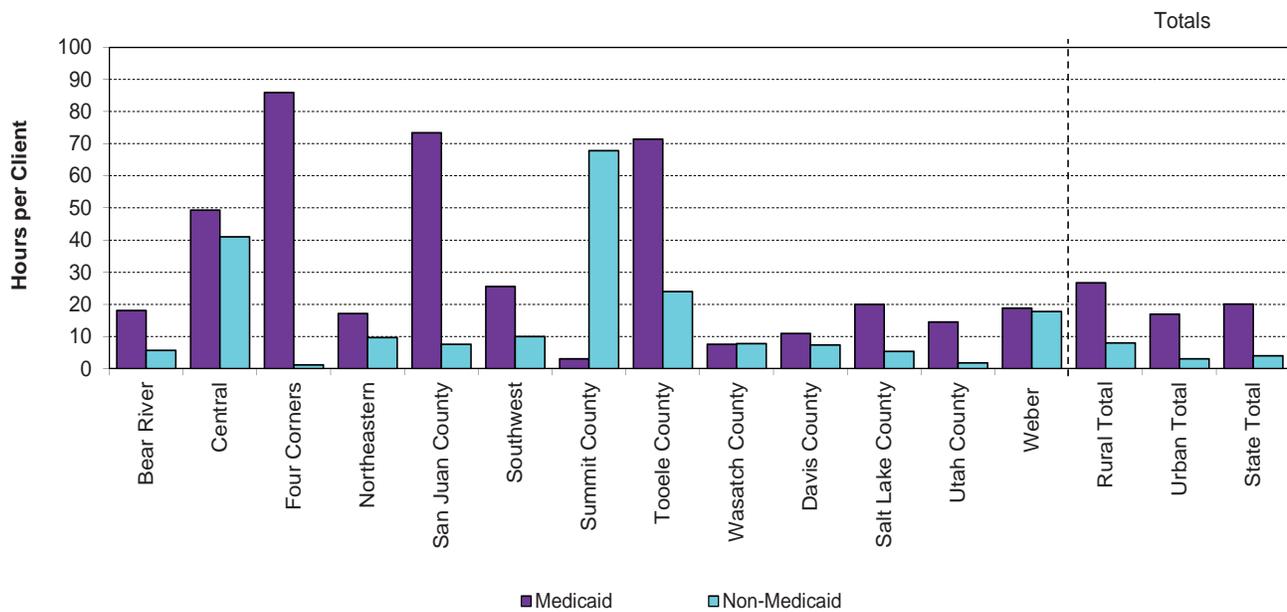
Psychosocial Rehabilitation Utilization

Mental Health Clients
Fiscal Year 2015



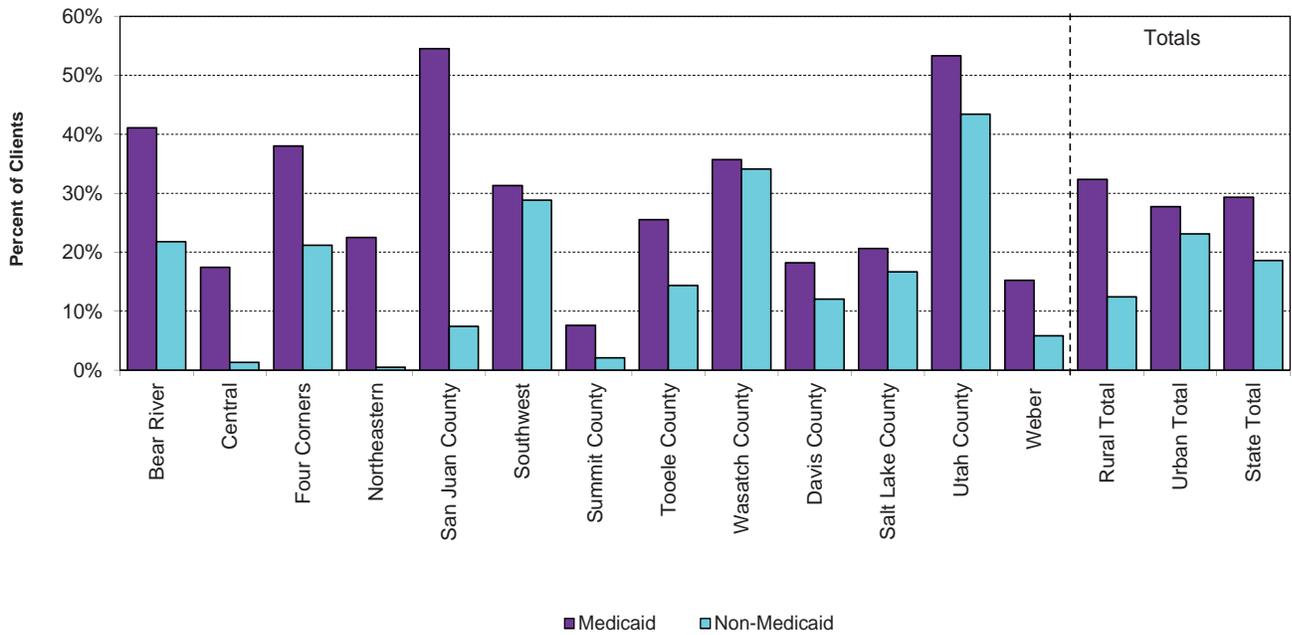
Psychosocial Rehabilitation Median Length of Service

Mental Health Clients
Fiscal Year 2015



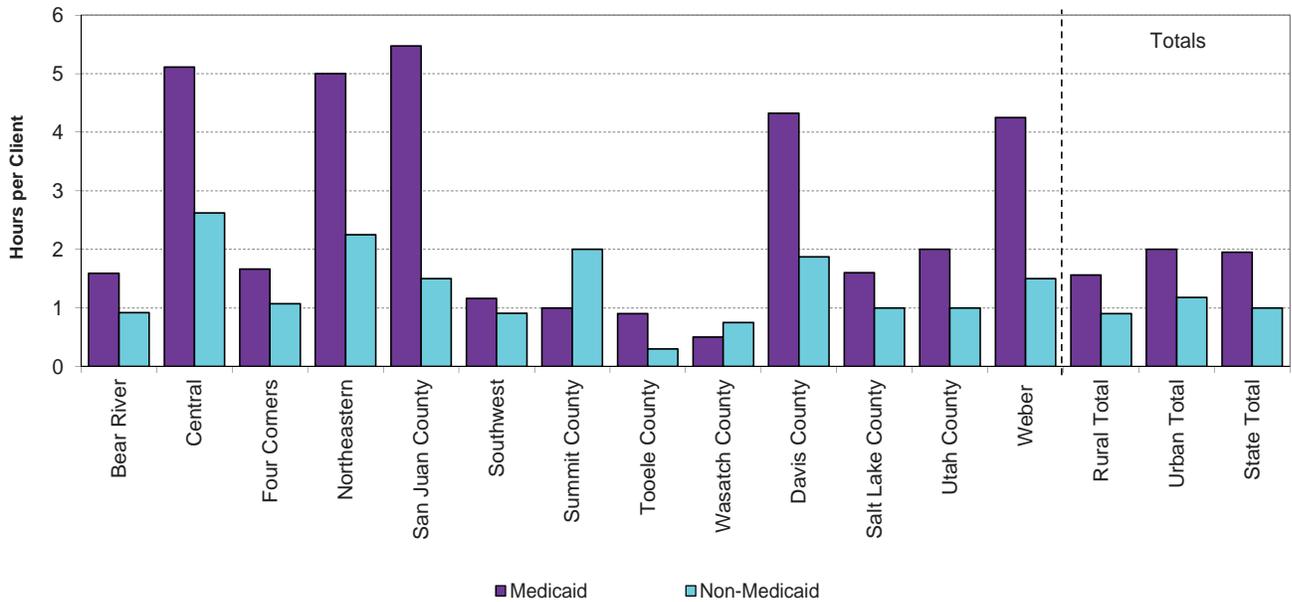
Case Management Utilization

Mental Health Clients
Fiscal Year 2015

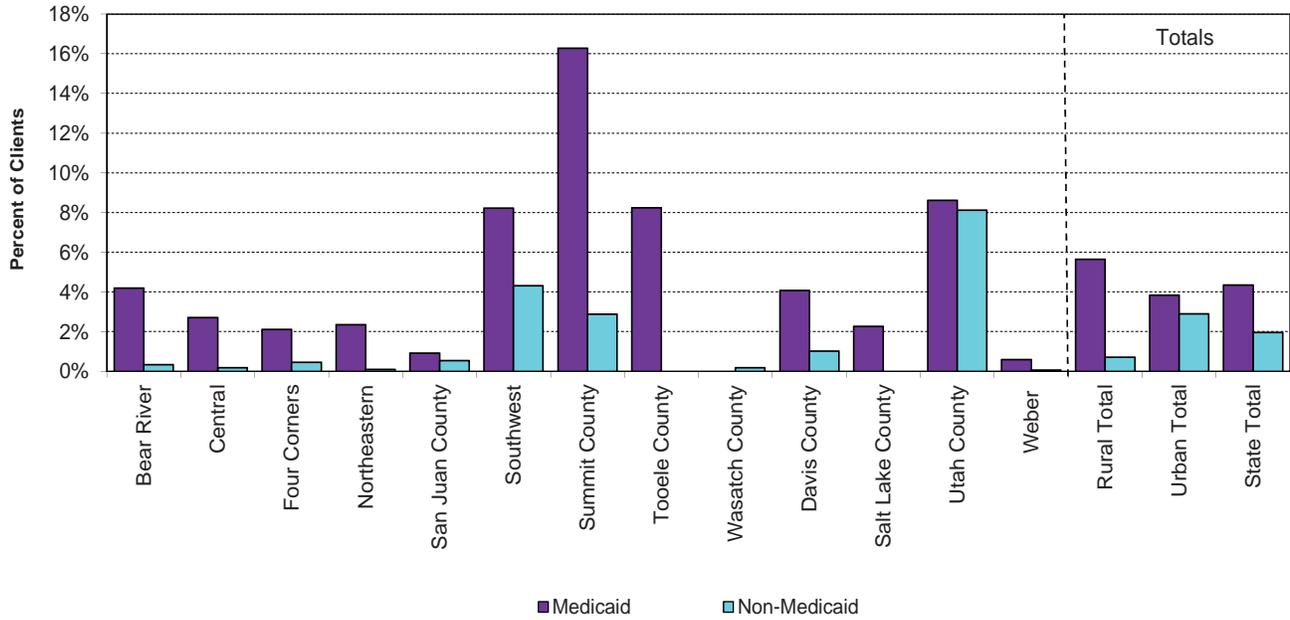


Case Management Median Length of Service

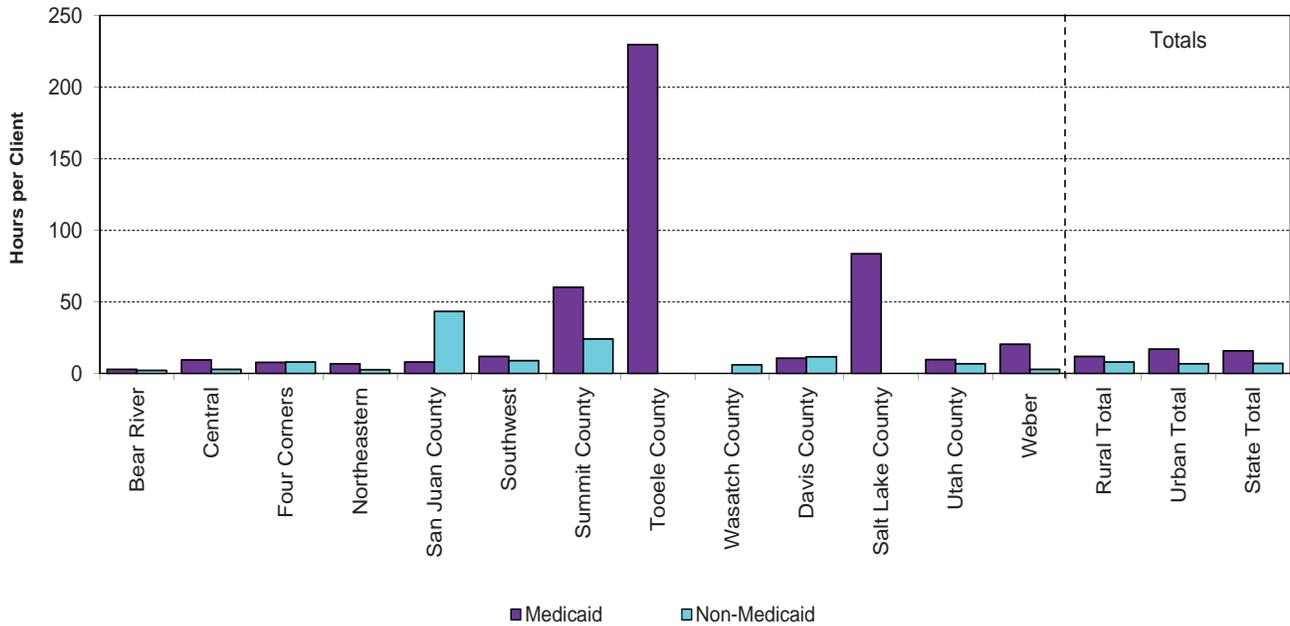
Mental Health Clients
Fiscal Year 2015



Respite Utilization Mental Health Clients Fiscal Year 2015

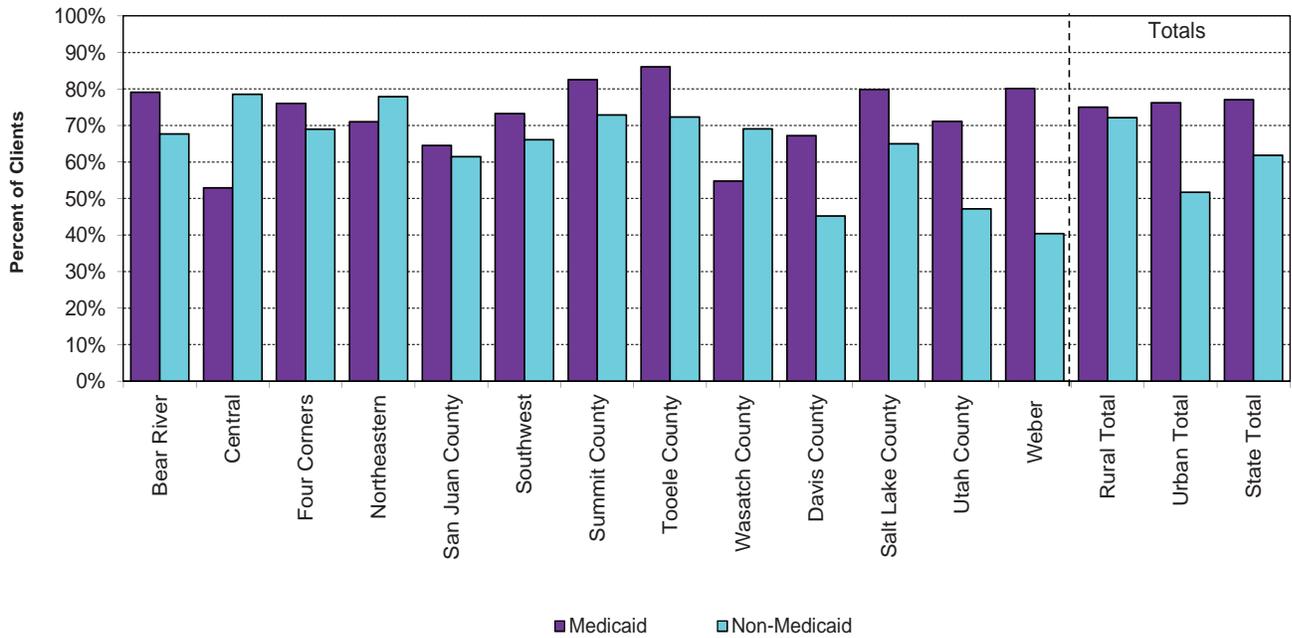


Respite Median Length of Service Mental Health Clients Fiscal Year 2015



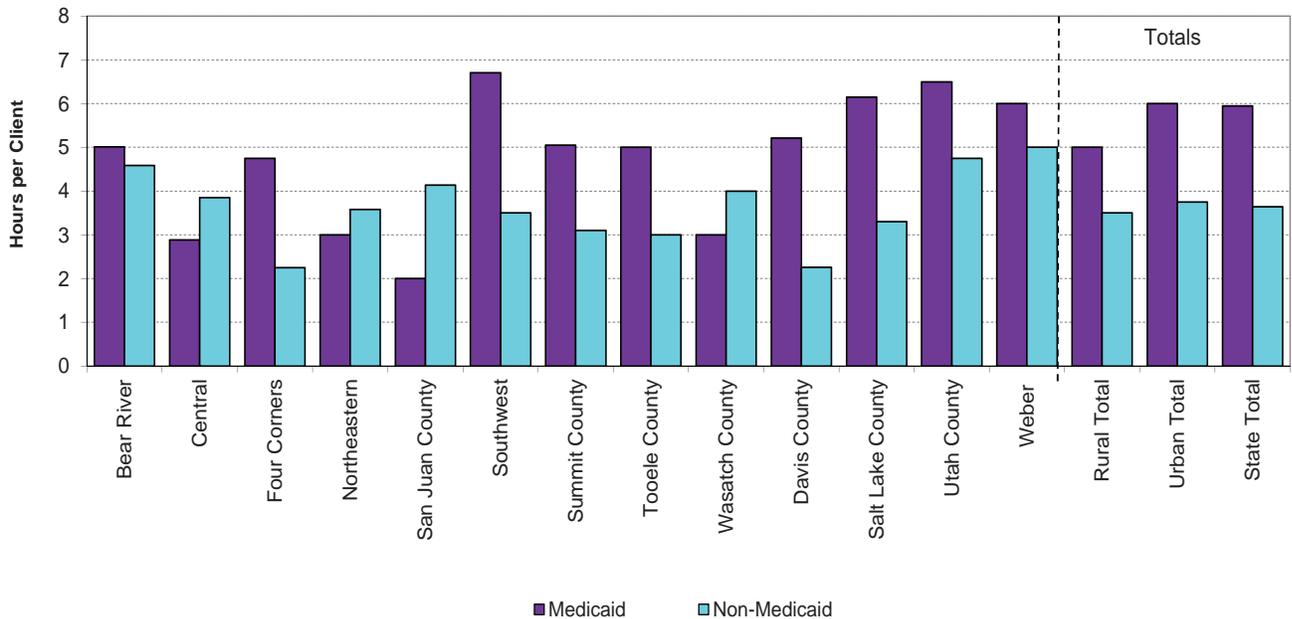
Therapy Utilization

Mental Health Clients
Fiscal Year 2015

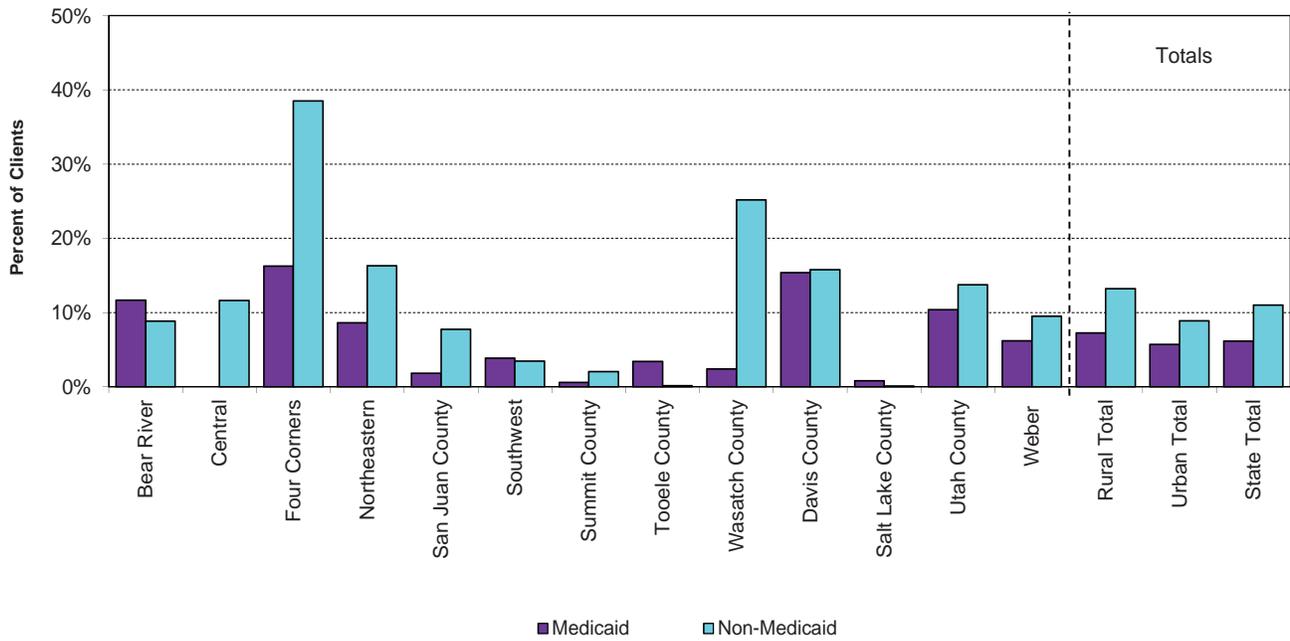


Therapy Median Length of Service

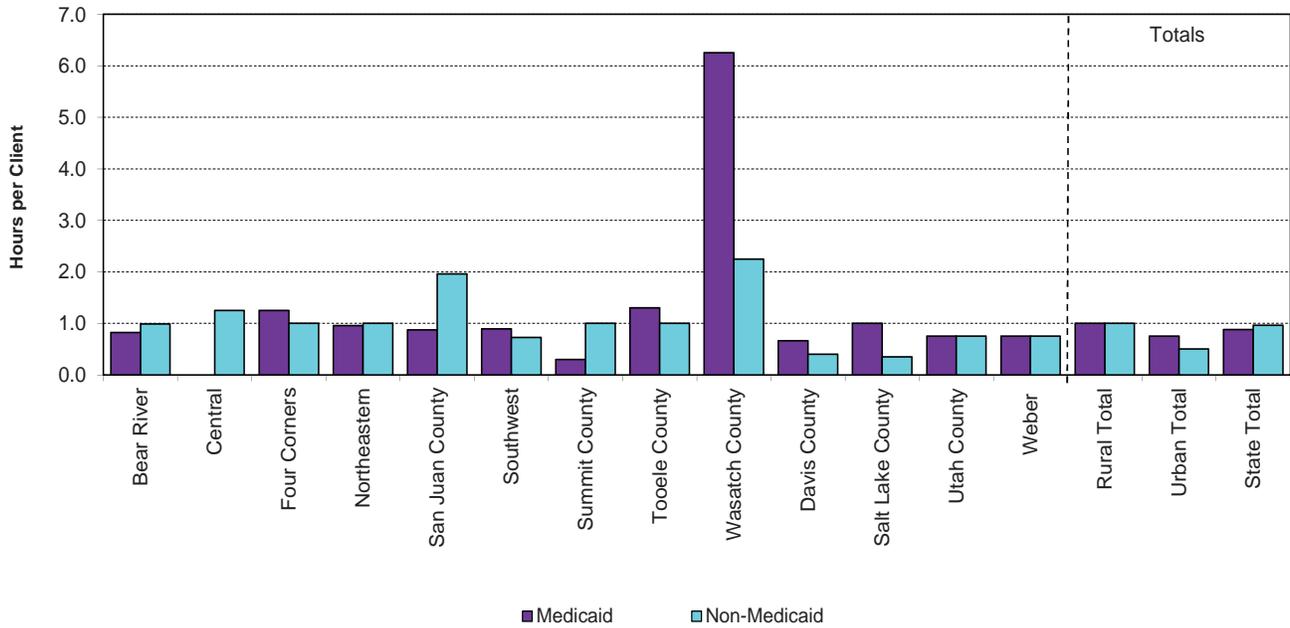
Mental Health Clients
Fiscal Year 2015



Emergency Utilization Mental Health Clients Fiscal Year 2015



Emergency Median Length of Service Mental Health Clients Fiscal Year 2015

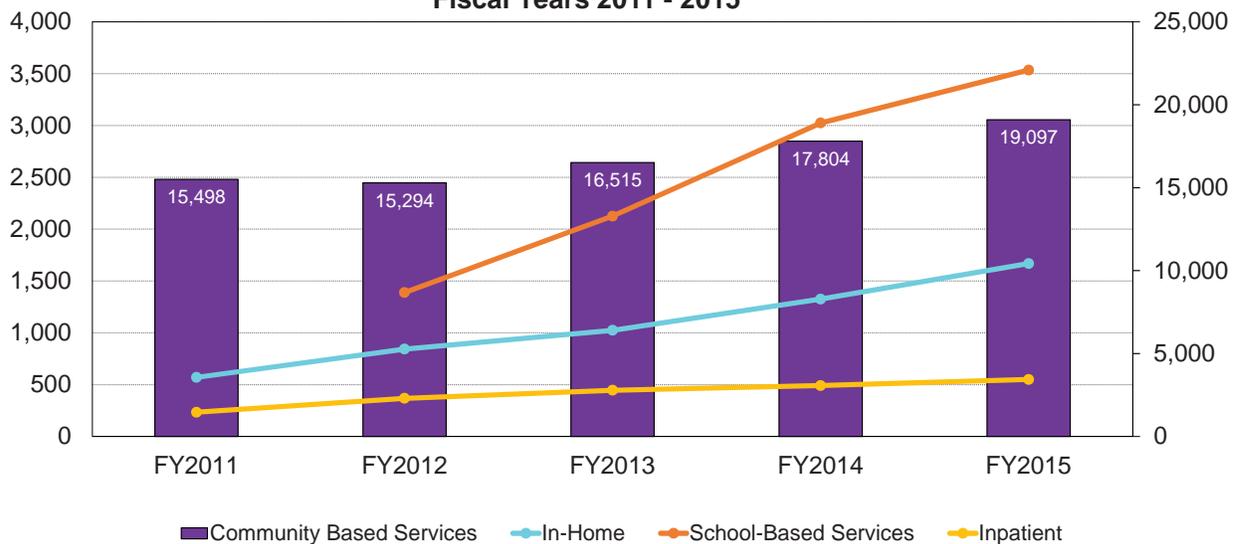


Mental Health Trends

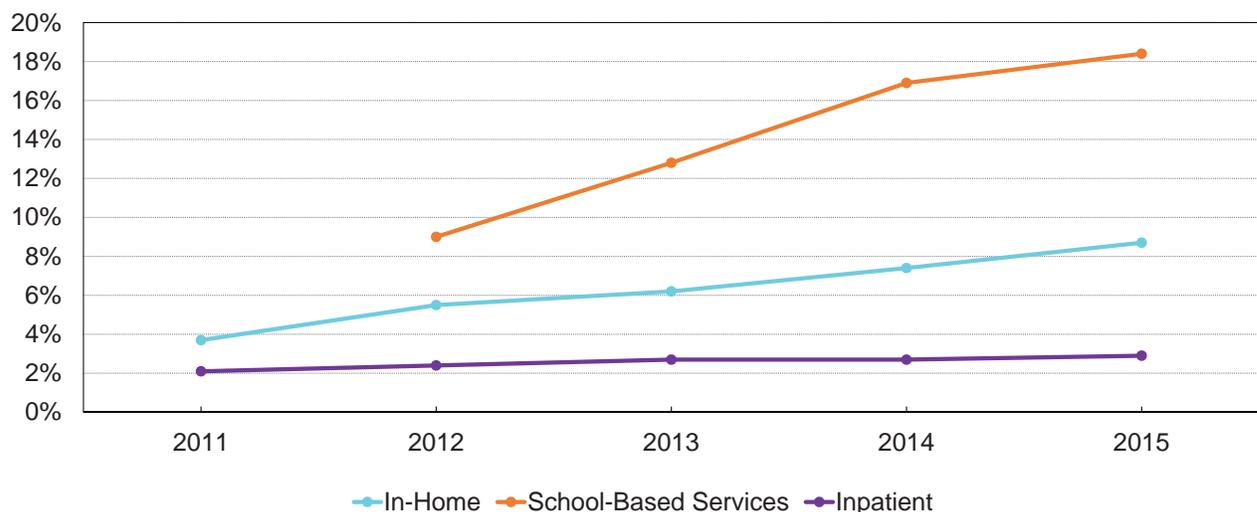
The following charts show trends in locations of services for children and youth (ages under 18) served in mental health services. Most children/youth are being served in the community (over 99%), however, there has been significant increases in services provided in homes and at

school (school-based services) since fiscal year 2012. During the same timeframe services provided at inpatient facilities have remained steady with less than 4% of the children/youth served receiving services.

Total Number of Youth Served by Location of Service
Fiscal Years 2011 - 2015



Percent of Youth Served by Location of Service
Fiscal Years 2011 - 2015

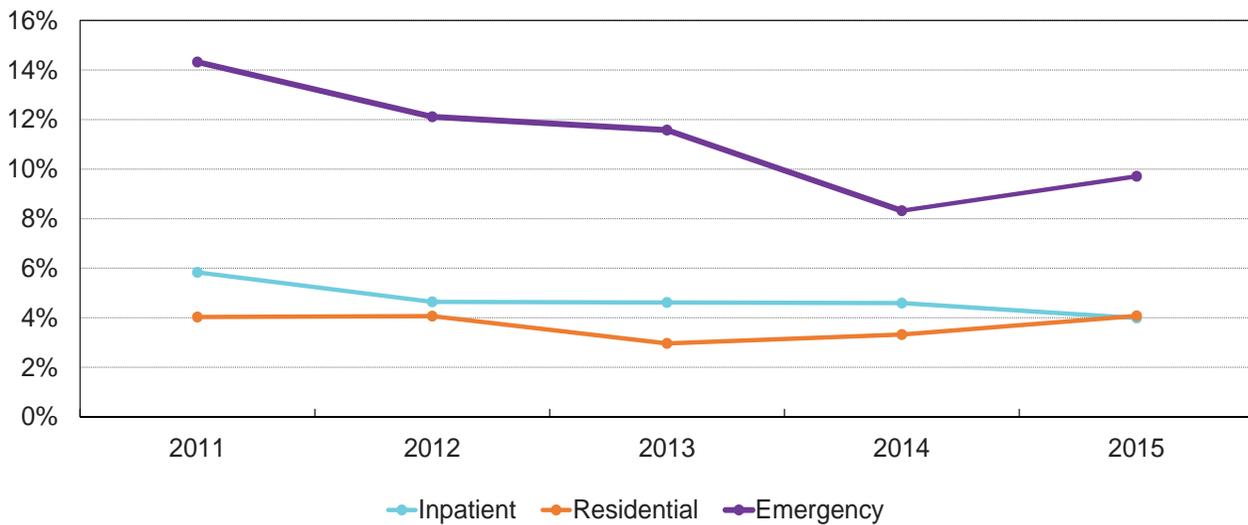


*Over 99% of clients are seen in community-based services.

The following chart shows the percent of adults who are receiving inpatient, residential, and emergency mental health services. It is interest-

ing to note that there has been a decrease in inpatient services while an increase in emergency services between fiscal years 2014 and 2015.

**Percent of Mental Health Adults
in Inpatient, Residential,
and Emergency Services
Fiscal Years 2011 - 2015**



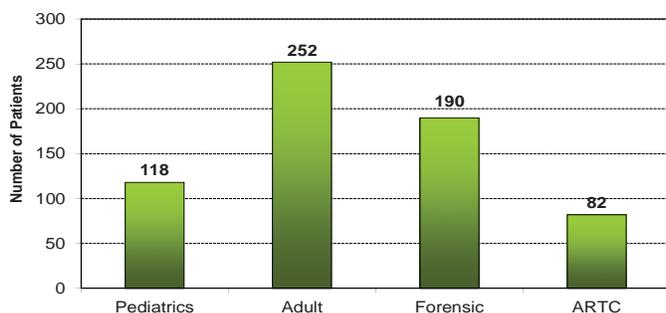
Utah State Hospital

The Utah State Hospital (USH) is a 24-hour inpatient psychiatric facility. In fiscal year 2015, USH had a capacity of 329 patients. The hospital provides active psychiatric treatment services to all age groups for all geographic areas of the state. USH works with the LMHA. All adult and pediatric beds are allocated to the LMHAs based on population.

Major Client Groups at the Utah State Hospital

- Adult patients age 18 and older who have severe mental disorders (civil commitment)
- Children and youth, ages 6-17, who require intensive inpatient treatment
- Persons adjudicated and found guilty and mentally ill
- Persons found not competent to proceed and need competency restoration or diminished capacity evaluations
- Persons who require guilty and mentally ill or diminished capacity evaluations
- Persons with mental health disorders who are in the custody of the Utah Department of Corrections
- Acute treatment service for adult patients from rural centers (ARTC)

Number of Patients Served
Fiscal Year 2015



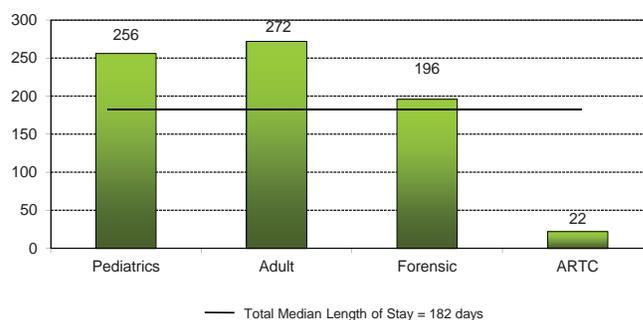
Programs

Children's Unit (ages 6-12)	22 Beds
Adolescent Unit (ages 13-17)	50 Beds
Adult Services (ages 18+)	152 Beds
Adult Recovery Treatment Center (ages 18 and above)	5 Beds
Forensic Unit (ages 18+)	100 Beds

Median Discharged Length of Stay

The median discharged length of stay at the USH in fiscal year 2015 was 182 days. The median discharged length of stay for adult patients with civil commitment was 272 days.

Median Length of Stay in Days
Fiscal Year 2015

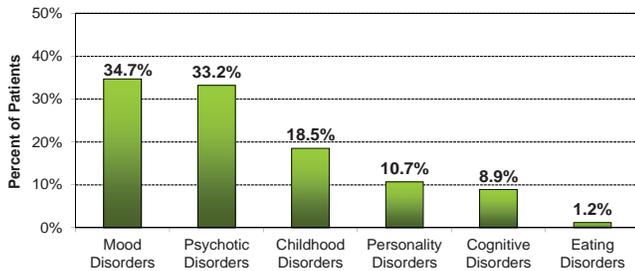


Types of Disorders Treated

- **Mood Disorders:** major depression, anxiety disorders, bipolar disorder, and dysthymia
- **Psychotic Disorders:** schizophrenia, schizoaffective disorder, other psychotic disorders, and delusional disorders
- **Childhood Disorders:** developmental disorders, autism, attention deficit disorder, conduct disorder, and adjustment disorder
- **Personality Disorders:** borderline, antisocial, paranoid, and narcissistic disorders. These are often a secondary diagnosis

- Cognitive Disorders: primary degenerative dementia, mental disorders due to general medical conditions, and intellectual disabilities
- Eating Disorders

Percent of Patients with Major Psychiatric Diagnosis*
Fiscal Year 2015



*Patients can have more than one diagnosis

39% of the patients treated also had a substance use disorder diagnosis.

Services Provided

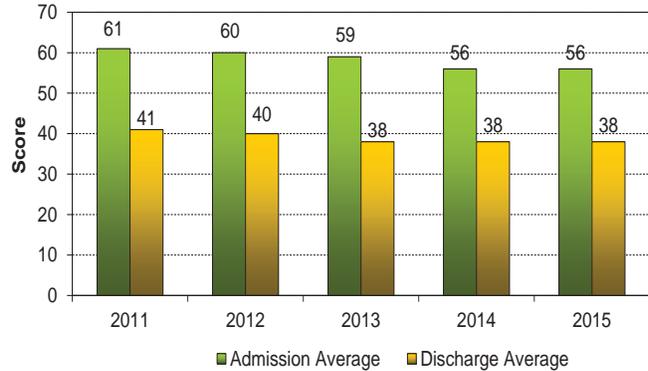
USH provides the following services: psychiatric services, psychological services, 24-hour nursing care, social work services, occupational therapy, vocational rehabilitation, physical therapy, recreation therapy, substance abuse/mental health program (Sunrise), dietetic services, medical/ancillary services, adult education, elementary education (Oak Springs School, Provo School District). USH is also actively involved in research programs to improve patient care, approved through the Department of Human Services Institutional Review Board.

Assessment

In order to assess patient progress, the USH uses the Brief Psychiatric Rating Scale (BPRS). The BPRS is a clinical measurement of patient symptoms. The scores from the BPRS indicate the level of improvement from admission to discharge. The patients at USH continued to show a decrease in psychiatric symptoms from admis-

sion to discharge in the 2015 fiscal year. Lower scores indicate a reduction of symptoms.

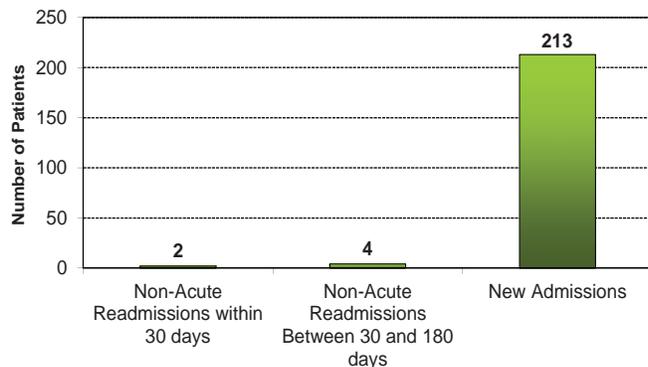
Average Symptom Levels of Patients Discharged Compared to their Admission Symptom Levels as Measured by their Brief Psychiatric Scale



Readmission

The hospital admitted a total of 264 patients (not including 77 ARTC admissions) in the 2015 fiscal year. Of these admissions, 2 were prior patients who had been discharged from the hospital within the previous 30 days. Four of these admissions had been discharged from the hospital between 31 and 180 days prior to the current admission. There were 213 patients admitted to USH for the first time. The readmissions within 30 days accounted for 1% of the total admissions in fiscal year 2015.

Readmissions at the Utah State Hospital
Fiscal Year 2015



Recovery Support Services

Utah's public behavioral health system offers a range of recovery support services that help people develop resiliency and recover from mental and/or substance use disorders. Recovery support services include Access to Recovery, supported employment, supported housing, education, and illness management. Recovery support services may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support services. These services may be provided by professionals or peers.

Access to Recovery

Access to Recovery (ATR) is an innovative program that empowers individuals to help direct their own recovery. This program was based on a four year grant awarded to the Division of Substance Abuse and Mental Health which ended in September, 2015. Participants were issued an electronic voucher which allowed them to directly control a range of services and supports, choose their providers and representatives, and design a recovery plan that aligned with their preferences and needs. Vouchers were used for preventative services, treatment, and recovery support. ATR significantly increased the array of available services. Vouchers were used for bus passes, emergency housing, sober housing, GED testing, helped to secure state ID cards, child care, online recovery support, medication assisted recovery, and educational services. Case managers also help individuals identify other resources in the community not available through ATR. Total clients served with the ATR program

Recovering individuals have multiple and often unique needs. Navigating public resources can be overwhelming. Case managers provide direction, support and motivation. They also assist individuals develop their recovery plan and choose

services and providers. Case managers maintain close contact and are available to resolve concerns or modify recovery plans as needed.

Participants are finding jobs, going to school, and finding permanent places to live. Since its inception ATR has served over 11,578 individuals in Salt Lake, Utah, Weber, and Davis Counties. The average cost per person for ATR services is around \$879. This compares favorably with the cost of serving an individual in the traditional system. In addition, as ATR provides supports such as housing and transportation, it increases the likelihood that an individual attending traditional treatment will maintain services for a longer period of time.

In fiscal year 2013, ATR was expanded and began serving individuals paroling from state prisons. This program is called Parolee Access to Recovery (PATR) and is successful because it is based on the ATR framework. Parolees, parole officers, and corrections administration agree this has filled a need within corrections for parolees entering back into the community with a history of substance use disorders. To date, PATR has served 1,749 individuals with an average cost per parolee of around \$659. Felony and Family Dependency Drug Court participants are also eligible to receive these recovery support services and each Local Authority is awarded funding to allow those individuals access to these services.

In fiscal year 2015, ATR was expanded again through a Transformation Transfer Initiative (TTI) grant from the National Association of State Mental Health Program Directors and began serving adults and youth with mental illness in Salt Lake County. In this fiscal year, 185 individuals with mental illness received self-directed ATR services for an average cost per client of \$790.

Peer Support Services

Peer Support Services are supportive services provided by Certified Peer Support Specialists (CPSS). These are trained specialists with lived experience, who are in recovery from their own or a family member's mental health and/or substance use disorders. They have progressed in their own recovery and are willing to utilize that experience to help others. They work alongside other mental health and substance use professionals to improve the quality of life of those they serve.

Family peer support is provided by Family Resource Facilitators (FRF) who are family members of individuals with complex needs. FRFs act as advocates and resource coordinators for children, youth and families. FRFs are located throughout the state and work in partnership with multiple community providers.

Utah Comrades Peer Support Program

DSAMH has partnered with The National Center for Veterans Studies at The University of Utah, and the Utah Army National Guard, to implement the Utah Comrades Peer Support Program.

Volunteer Veterans are recruited from a variety of veteran service organizations and the community. They receive training in communication skills and available community resources to help them assist other service members in managing the many challenges that may arise throughout the deployment cycle. Volunteer Veterans are trained to help veterans and service members address issues ranging from accessing financial, employment, legal, benefit, or educational resources to identifying mental health providers for emotional, substance abuse, or relationship concerns.

Research shows that a service member's preferred source of support is another service member or veteran. Similarly, military spouses are much more likely to turn to other military spouses

in time of need than to seek out professional assistance. The Utah Comrades Peer Support Program holds considerable promise for improving the mental health and well-being of Utah service members, veterans, and families.

Homeless Services

DSAMH has been actively involved in working to help Utah's homeless neighbors with behavioral health disorders by collaborating with private and public agencies across the state in the development of permanent supportive housing.

In state fiscal year 2014 DSAMH was awarded a federal grant Cooperative Agreement to Benefit Homeless Individuals (CABHI-UT) by the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve the infrastructure of the Utah Public Behavioral Health System. The grant has been implemented in four counties (Utah County, Salt Lake, Davis and Weber), to provide accessible, effective, comprehensive, and integrated evidence-based treatment and recovery services for veterans and other individuals with a behavioral health disorder who are chronically homeless. The CABHI-UT program has been successful over the past federal fiscal year, coordinating Permanent Supportive Housing placements for 41 individuals and providing the needed services and supports for 74 individuals. The goal of the program is to serve a total of 275 individuals over the next two years.

Chronic homelessness in Utah is now approaching "functional zero," following a decade-long effort to address the issue. Chronic homelessness has decreased by 91%, from nearly 2,000 individuals in 2005 to 178 individuals identified in the 2015 statewide point-in-time count, conducted annually on the fourth Thursday in January. Functional zero means there is a system in place to help connect chronically homeless individuals with housing resources and chronic homelessness among veterans has reached an effective zero. Utah has demonstrated being one of the top states in the nation to realistically end chronic

homelessness due to the great work and partnerships with the state, local communities, service providers, advocacy groups and volunteers who care about the individuals we serve. One of the main keys to this success was the implementation of the Housing First model, which combines housing with supportive treatment services in mental and physical health, substance abuse, education and employment.

This past year DSAMH also submitted and was awarded the States—Enhancement Grant (CAB-HI S-E) for an additional \$1.2 million over the next two years, that will assist in our efforts to enhance services to the target population.

DSAMH was also awarded another federal grant; Projects for Assistance in Transition from Homelessness (PATH) to provide flexible, assisted services to adults with serious mental illness or who have co-occurring substance use disorders and are homeless or at imminent risk of becoming homeless. In federal fiscal year 2014, 1,600 people benefitted from PATH services compared to serving 1,667 individuals in 2015.

Supported Employment

The Supported Employment (SE) Program utilizes the evidenced-based model of Individual Placement and Support (IPS) to provide SE services for adults with serious mental illness and co-occurring substance use disorder conditions. According to SAMHSA (2012) Uniform Reporting System, 80.7% of individuals with mental illness in Utah are unemployed and approximately 60% of those individuals desire to work. Providing SE/IPS services assists individuals with mental illness obtain and maintain competitive and integrated employment, thereby increasing an individual's sense of purpose, self-work and social acceptance. SE/IPS is a key component in recovery, decreasing risk of isolation, marginalization, poverty and stigma.

The SE/IPS Program is provided to Utah by a Federal SAMHSA grant. The SE/IPS Program is co-

ordinated with two LMHAs, Weber Human Services and Southwest Behavioral Health Center. Weber Human Services is the LMHA for Weber and Morgan Counties, which include urban and rural areas. Southwest Behavioral Health Center is the LMHA for the rural and frontier southwest region of Utah, which includes Beaver, Garfield, Kane, Iron and Washington Counties. In fiscal year 2015, the two LMHAs provided SE/IPS services to approximately 296 individuals.

Individuals enrolled in SE/IPS receive ongoing supports from multiple agencies including DSAMH, local mental health and substance abuse authorities, Vocational Rehabilitation, State Medicaid, Veterans Administration, Department of Workforce Services, and other partnering agencies, families and community members. With gainful employment as the target outcome, mental health consumers, their treatment providers, and their employers develop mutual understanding and successful relationships. The SE/IPS Program assists people with serious mental illness discover self-sufficiency and recovery.

Recovery Plus

Recovery Plus is an initiative to promote health and wellness in individuals with mental illness and/or substance use disorders. The initiative was designed to improve the health and quality of life by increasing the number of individuals who live tobacco-free while recovering from a mental health or substance use disorder. Nationally, approximately 80-90% of those receiving services within behavioral health treatment facilities smoke cigarettes.¹ More alcoholics die of tobacco-related illness than alcohol-related problems.² Equally striking is that 44% of all ciga-

¹ Richter, K.P. Choi, W.S., and Alford, D.P. (2005). Smoking policies in U.S. outpatient drug treatment facilities. *Nicotine and Tobacco Research*, 7:475-480

² Hurt, R.D., Offord, K.P., Vroghanm, I.T., Gomez-Dahl, L., Kottke, T.E., Morse, R.M., & Melton, J. (1996). Mortality following inpatient addictions treatment. *Journal of the American Medical Association*, 274(14), 1097-1103

rettes are consumed by individuals with addictions or mental health co-morbidities.³ In Utah, 9% of adults smoke, yet 68.8% of individuals in treatment for substance use disorder smoke.

Initially supported by a federal stimulus grant from the Centers for Disease Control and Prevention, the project was focused on two cardinal rules:

1. No one will be denied treatment because of their tobacco use.
2. Assessment, education, treatment planning and Nicotine Replacement Therapy

³ Lasser, K., Boyd, J.W., Woolhandler, S., Himmelstein, D.U., McCormick, D., & Bor, D.H. (2000). Smoking and mental illness: A population-based prevalence study. *Journal of the American Medical Association*, 284

(NRT) will be provided to all clients as appropriate.

Local authorities were given three years to assess their local needs, develop plans to tailor the initiative to their circumstances, implement the needed education, and then fully implement the program. The final implementation date was March 2013, and since that date, local authorities have become tobacco free campuses and have incorporated tobacco cessation into treatment plans.

Recovery Plus initiatives continue in local communities, with plans to expand to address other risk factors (obesity) and chronic diseases (cardiovascular disease, diabetes, asthma).

Dave

I am a Utah native, born and raised in Salt Lake City, and did not drink until the very end of my first year of college. When I started drinking, I really liked it, and found acceptance with it

Going into the Army where drinking and “happy hours” were mandatory events, my drinking took off. After two years in the Army I was told that I was in the top 2% of Lieutenants in the Army. 14 years later, when I was passed over for Lt Colonel, I had slipped to the bottom 40% of Majors. I kept trying to drink like a normal person, but could never quite pull it off.

By that time, I was working in an office that had responsibility for Substance Use Disorder Treatment. After several fruitless discussions about my drinking, I was “ordered” into treatment. At the time I was absolutely convinced that I didn’t have a problem.

Treatment was the turning point in my life. I quickly realized I was truly an alcoholic, but continued to struggle until I hit my “bottom” in the fifth week. I am eternally grateful to the treatment staff for putting up with my arrogance, and for helping me work through my denial. My cathartic experiences in treatment led to my desire to become a substance use disorder therapist.

After two final years in the Army, I retired and immediately started attending school to earn my Masters degree. Since my return to Utah, I have been incredibly fortunate to work in a variety of programs and ultimately was selected to work for the State Division. I have earned national awards and honors that I never could have dreamed of. But most importantly, my wife and I have a totally different and far healthier relationship than we ever thought possible.



“I can look in the mirror and like the person I see looking back.”

Outcomes

DSAMH reviews numerous data sets to assist with assessment, planning, implementation, evaluation and reporting. For Prevention, DSAMH partners with the State Epidemiological Outcomes Workgroup's (SEOW) to review data sets regularly in order to prioritize issues such as the Prescription Drug epidemic, depression and anxiety in children, factors that lead to suicidal ideation, death by suicide and underage drinking. DSAMH looks at a full cadre of data sets in order to prioritize issues and factors that increase negative outcomes in substance use, mental illness and suicide.

For substance use disorder and mental health treatment, DSAMH monitors and evaluates pro-

grams provided by local authorities and their contracted providers. For a number of years, DSAMH has published detailed scorecards that measure and compare local authority providers with State and national standards. The scorecards are used to evaluate the quantity of services, cost, quality, client satisfaction, and outcomes. Innovative research tools, technology, and data are used to monitor, fund, and improve services within the public behavioral health system. This section provides a summary of only a portion of the measures used to ensure that the highest level of clinical standards and efficiencies are incorporated. To view the scorecards, go to: <http://dsamh.utah.gov/data/outcome-reports/>

Student Health and Risk Prevention Survey (SHARP)

The biennial SHARP survey was completed in spring of 2015. The SHARP survey is a combination of three major surveys which include the Prevention Needs Assessment (PNA), the Youth Risk Behavior Survey, and questions from the Youth Tobacco Survey.

The SHARP Survey was designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. The survey was administered to students in grades 6, 8, 10, and

12 in 39 school districts and 14 charter schools across Utah. Nearly 50,000 students were surveyed. The data was gathered and reported as a full statewide report and for each local substance abuse authority. Some school districts and individual schools elected to survey enough students where results can be analyzed to portray accurate survey results for their district or school.

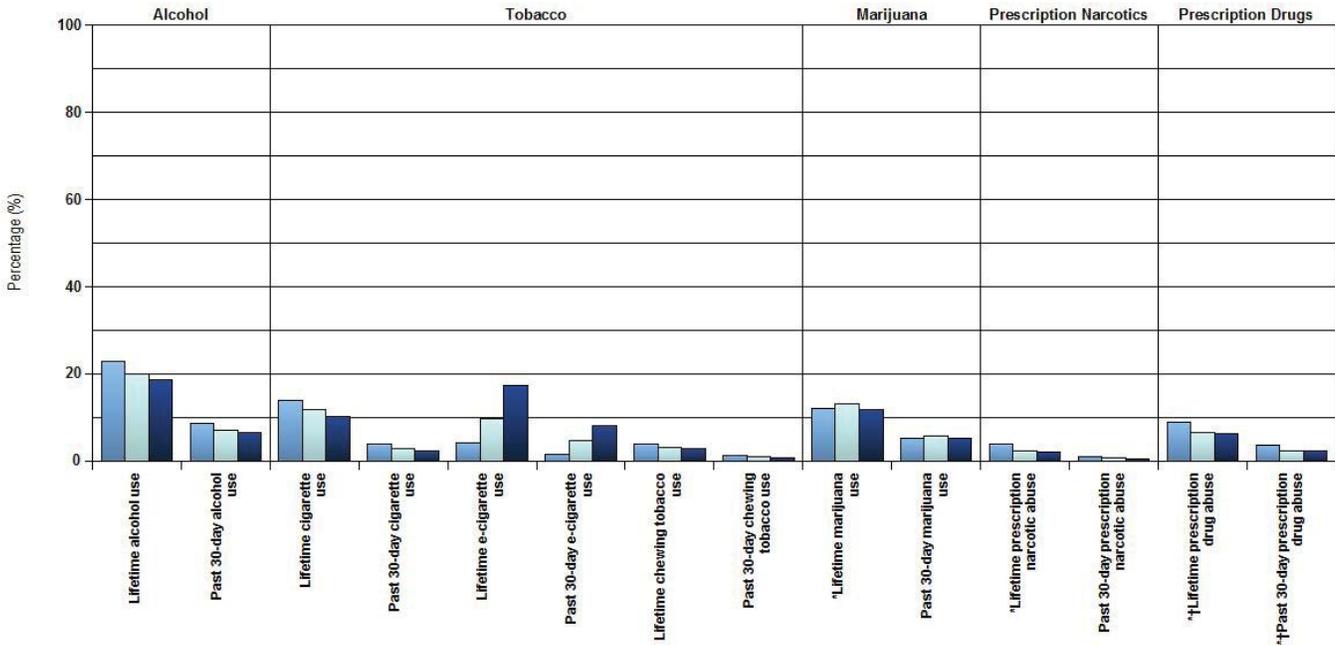
The following five tables show the trends of substance use and mental health needs of the youth in Utah.

State-Identified Prioritized Substance Use—All Grades

The table on the following page highlights the trends of substance use, that have been prioritized by the SEOW, reported by all grades combined. These substances were prioritized based on previous trends and numbers, including death

and treatment admissions. The table shows that most substance use among youth is decreasing. E-cigarettes use is trending upward and marijuana use is remaining about the same.

State-Identified Priority Substance Use
2015 State of Utah Student Survey, All Grades

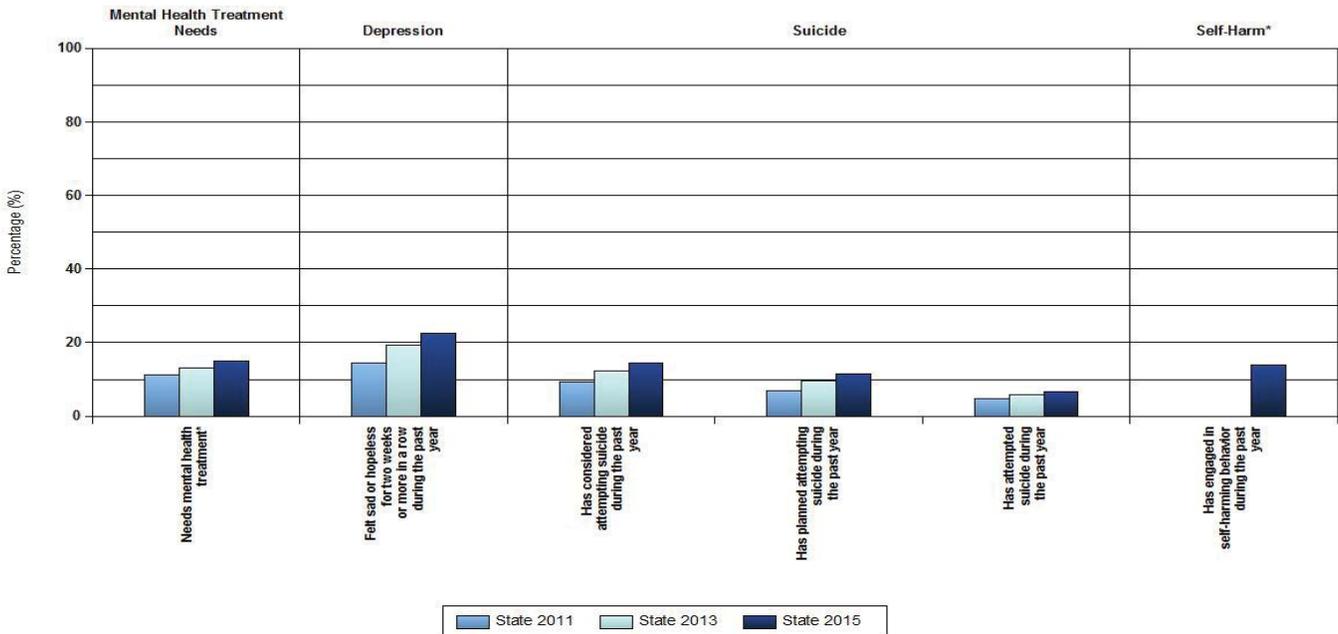


Mental Health and Suicide Indicators—All Grades

This table expresses the increase in need for mental health promotion. All indicators are trending upward. While substance use is mostly decreasing,

our youth’s mental health needs are increasing.

Mental Health and Suicide Indicators
2015 State of Utah Student Survey, All Grades

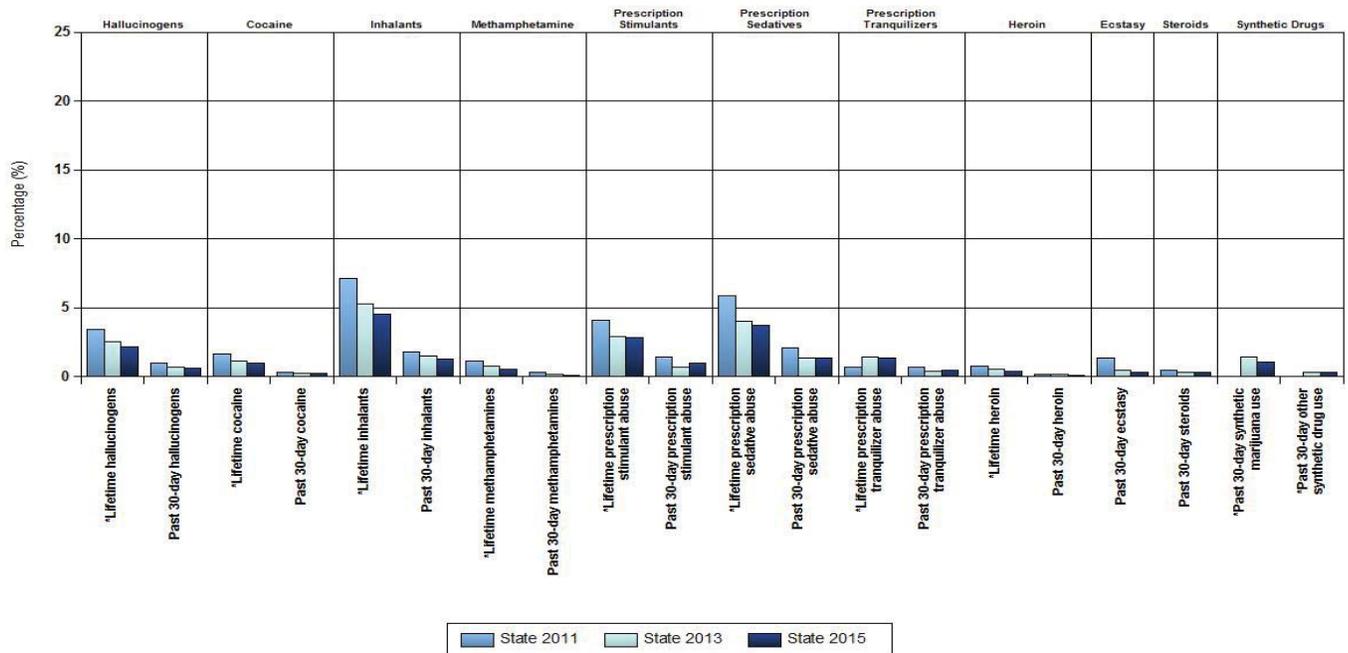


Other Substance Use—All Grades

The table below shows other substances that the survey collects data on. Just like with the prioritized substances, all indicators reflect a decreasing trend. Inhalants and some prescription drugs

may appear high, but the chart reflects both substances are only used by less than 3% of those surveyed.

Other Substance Use
2015 State of Utah Student Survey, All Grades

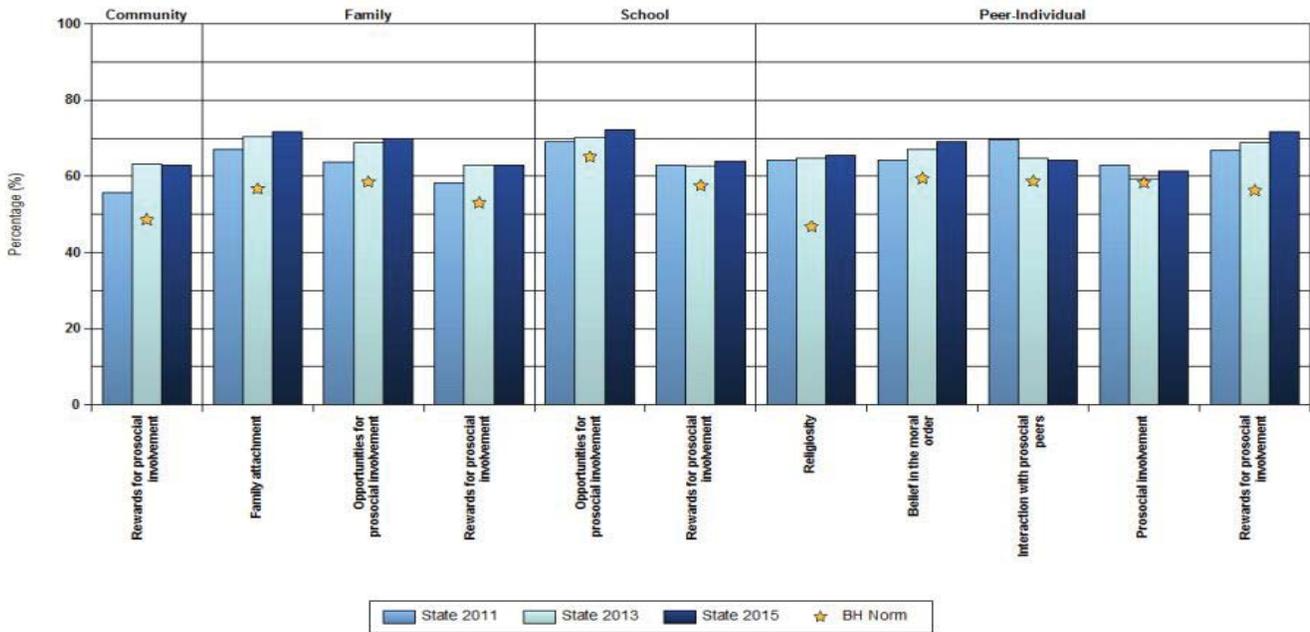


Protective Profile—All Grades

The table on the next page highlights what protective factors, things in place that help a youth be more successful, are great or need bolstering in Utah. This shows that Utah is doing some great things and youth are able to partake. Utah can

still improve, but it is important to see the state does some things well. Most indicators here are trending up, and are above the rates compared to seven other states (the BH Norm).

Protective Profile
2015 State of Utah Student Survey, All Grades

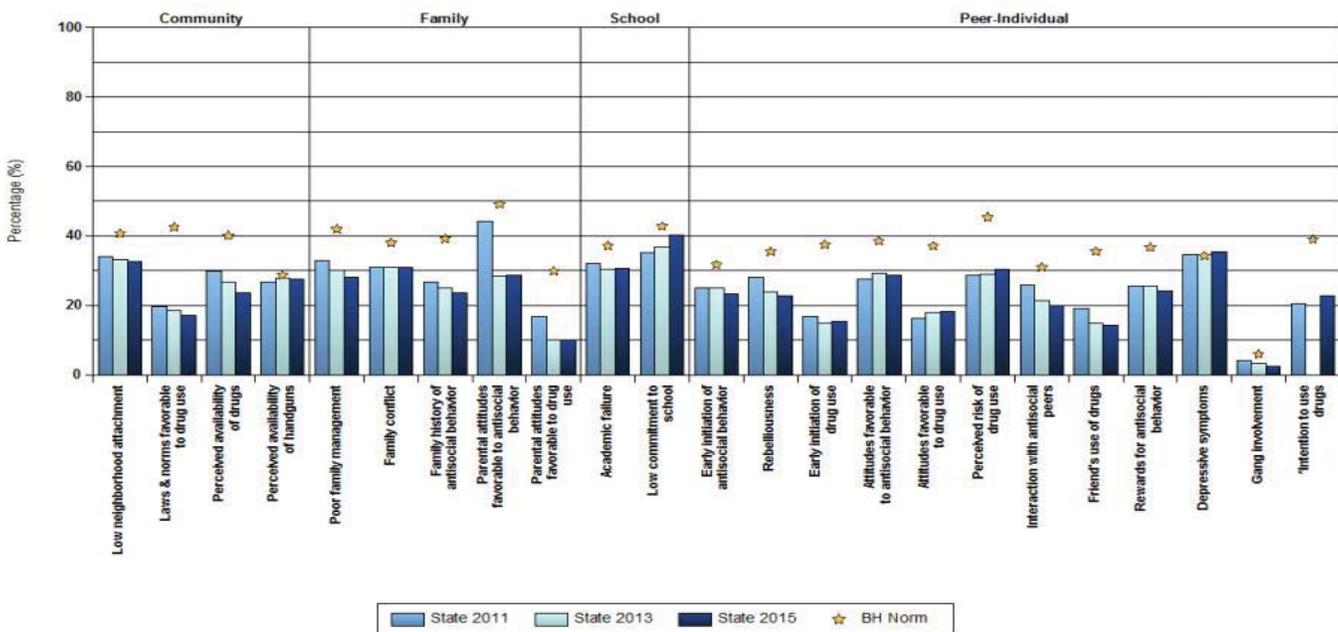


Risk Profile—All Grades

The Risk Profile shows what factors increase a youth’s risk for substance use, mental illness, delinquent behavior and other outcomes. While Utah still has risk rates that below the BH Norm,

some risk factors are increasing. This table helps to prioritize and select strategies that will improve communities.

Risk Profile
2015 State of Utah Student Survey, All Grades



Substance Use Disorder Treatment Outcomes

Substance use treatment outcomes are derived from data collected on each individual served. DSAMH collected final discharge data on 7,716 (non-detox) clients in fiscal year 2015. These are clients discharged from treatment and not readmitted into any treatment within 30 days after discharge. This section includes data of clients who were discharged successfully (completed the objectives of their treatment plan), and of clients who were discharged unsuccessfully (left treatment against professional advice or were invol-

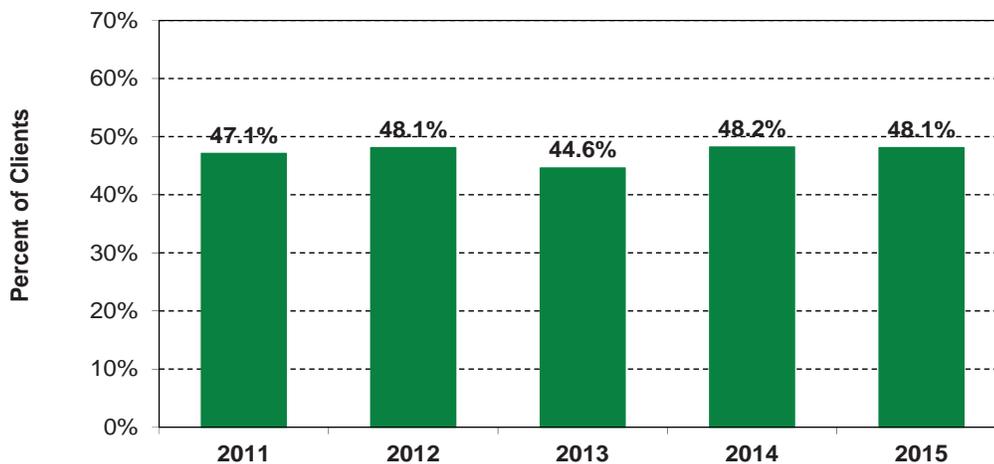
untarily discharged by the provider due to non-compliance). Clients discharged as a result of a transfer to another level of care but not enrolled in that level are considered “unsuccessful.” The data does not include clients admitted only for detoxification services or those receiving treatment from non-local authority contracted providers. For all outcomes, numbers are based on completed treatment episode, rather than a single treatment modality.

Discharge

The following graph depicts the percentage of clients discharged who successfully completed

the entire treatment episode from fiscal years 2011 through 2015.

**Percent of Clients Successfully Completing Treatment Episode
Fiscal Years 2011 - 2015**

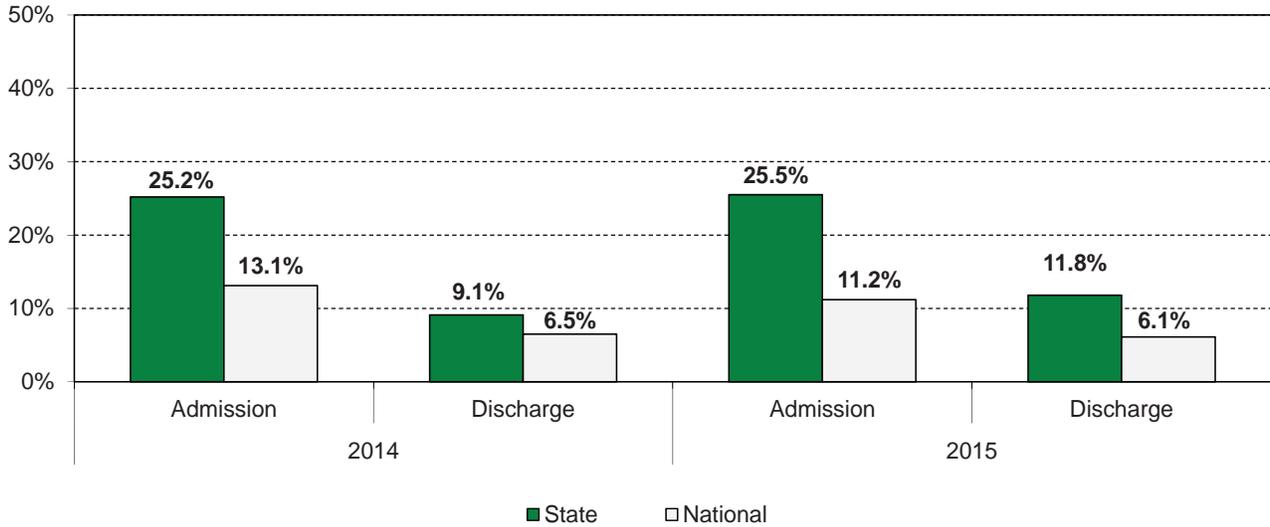


Criminal Activity

The chart on the next page details the approximately 72% of Utah’s clients who are involved with the criminal justice system. Reduction of criminal activity is an important goal for treatment and a good predictor of a client’s long-term success. Treatment results in significant decreases

in criminal activity and criminal justice involvement. In 2014 and 2015, Utah had higher arrest rates at admission than the national average, but showed a considerable decrease at discharge even though the rate was still higher than the national average.

Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment Fiscal Years 2014 - 2015

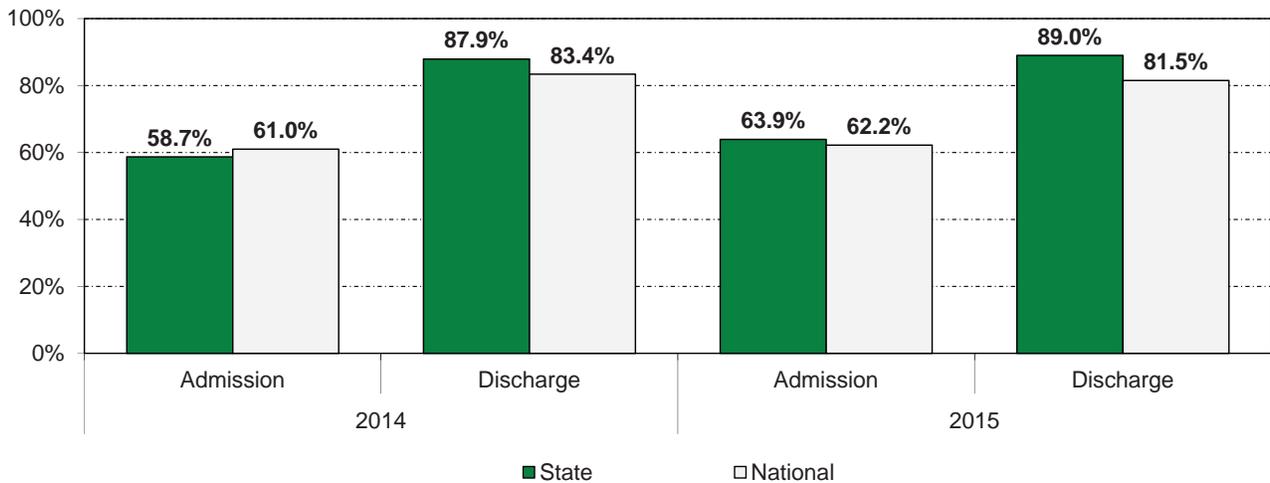


Changes in Abstinence from Drug and Alcohol Use During Treatment

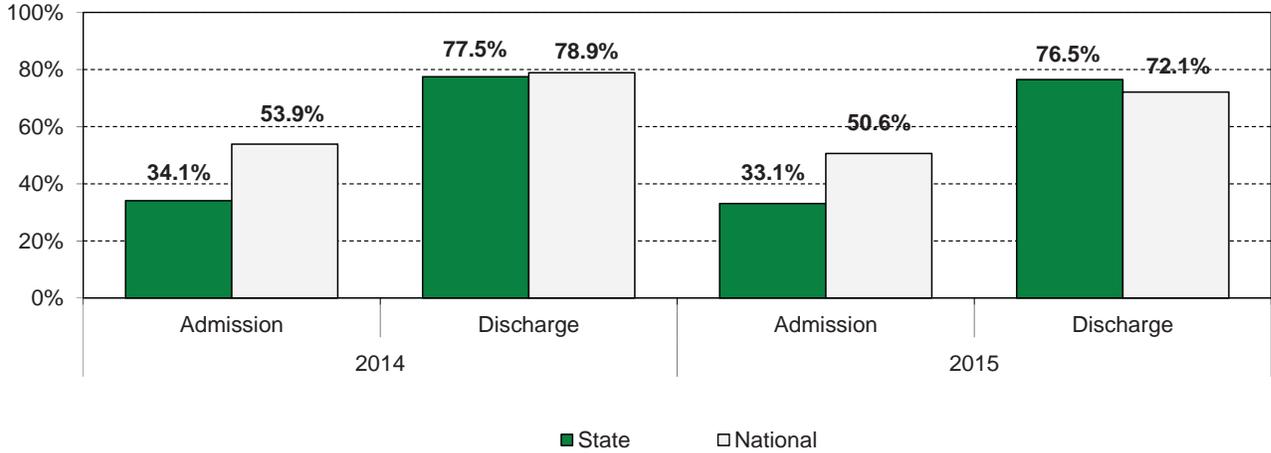
The following charts provide abstinence rates at admission and discharge for clients in all treatment levels except detoxification. Substance use is evaluated 30 days prior to the client entering a controlled environment, such as treatment or jail, and again in the 30 days prior to discharge. As expected, the rate of abstinence increases during

treatment. Utah’s 2015 rate of abstinence from alcohol was comparable to the national rate at admission and slightly higher than the national rate at discharge. For drug use, abstinence was substantially lower at admission and slightly higher at discharge compared to the national rates.

Percent of Clients Reporting Abstinence from Alcohol Use Prior to Admission vs. Abstinence at Discharge Fiscal Years 2014 - 2015



**Percent of Clients Reporting Abstinence
from Drug Use Prior to
Admission vs. Abstinence at Discharge
Fiscal Years 2014 - 2015**

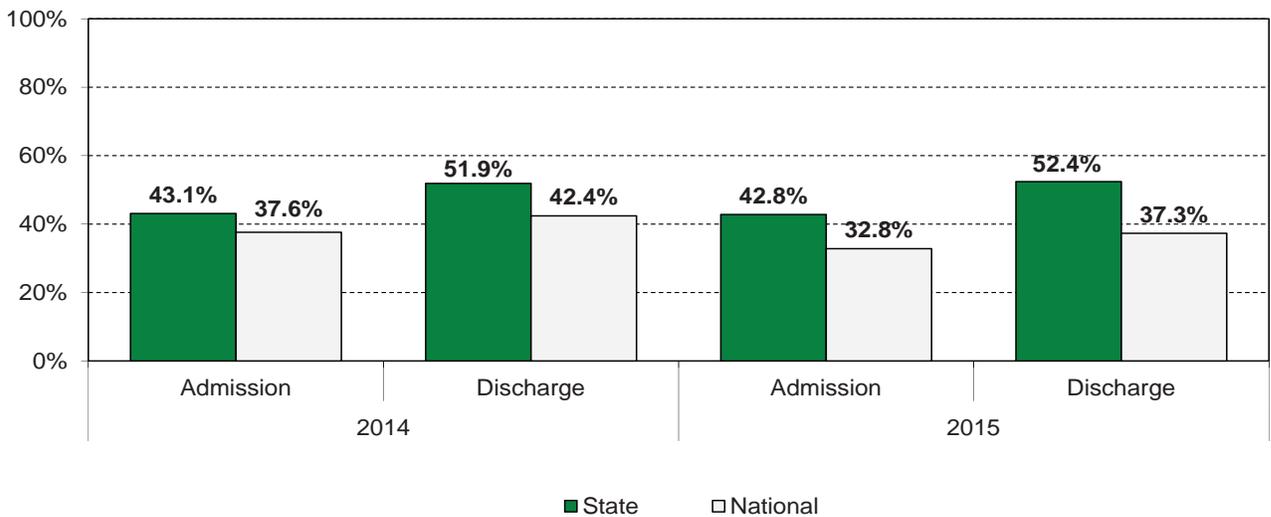


Employment

Clients who are in school or are employed, have much higher treatment success rates than those clients who are unemployed. Consequently, treatment providers work with clients to improve

their employability. At admission the percent of clients employed is considerably higher than the national rate. Similarly, the percent at discharge of clients employed exceeds the national average.

**Percent of Clients Who Are Employed
Admission vs. Discharge
Fiscal Years 2014 - 2015**

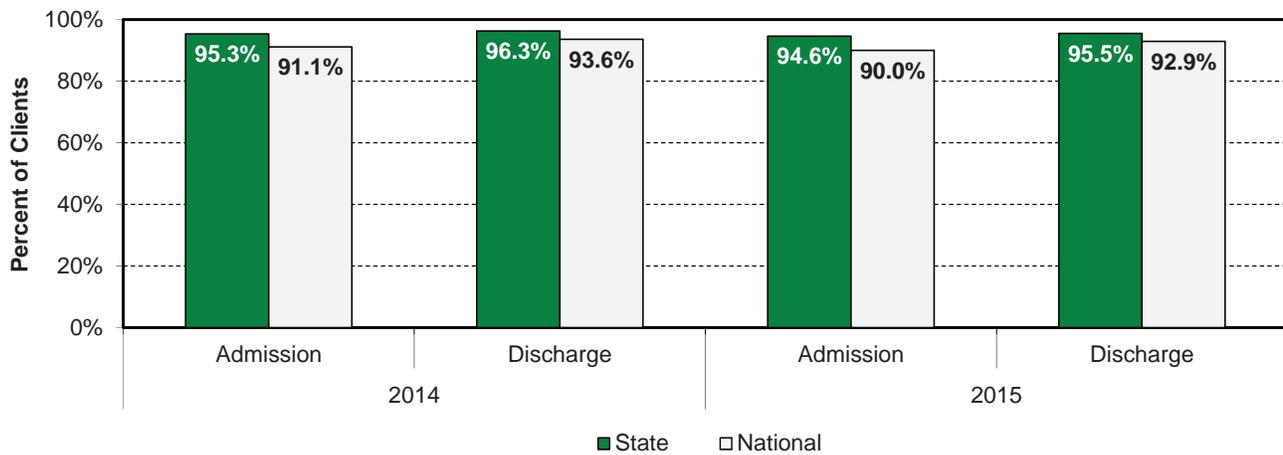


Clients in Stable Housing

Stable housing is an important measure of successful treatment, as outcome studies have revealed that a stable living environment is a critical element in achieving long-term success in the reduction of substance abuse. Treatment also has been shown to help individuals with a substance

use disorder achieve and maintain a stable living environment. Utah’s rate of change is slightly below the national average, but the percentage in stable housing at discharge is higher than the national average.

**Percent of Clients in Stable Housing
Admission vs. Discharge
Fiscal Years 2014 - 2015**



Retention in Treatment

Retention in treatment is the factor most consistently associated with positive client outcomes. The appropriate length of a treatment varies based on the needs of the individual. However, the National Institute of Drug Addiction (NIDA) states: “Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining posi-

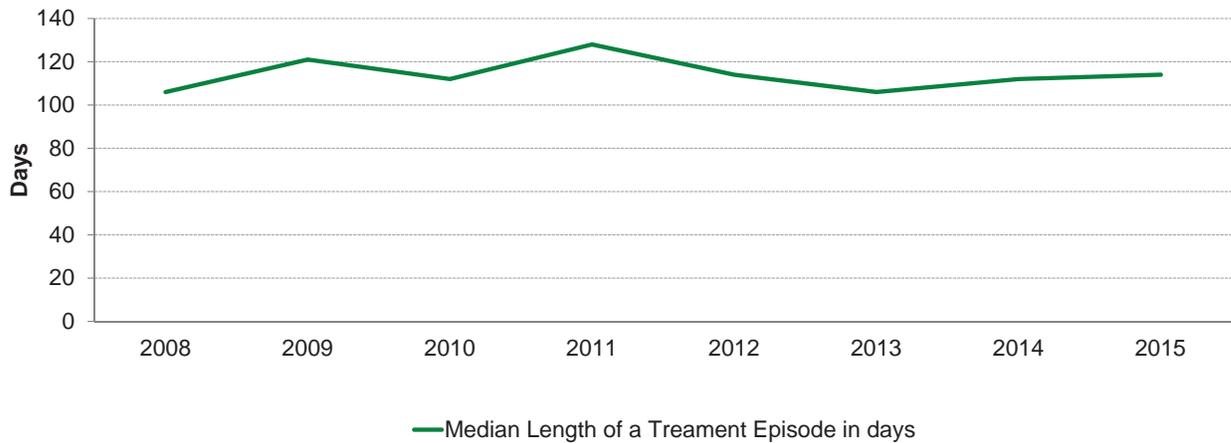
tive outcomes. For methadone maintenance, 12 months is considered a minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.”

Just like treatment for any other chronic disease, addiction treatment must be of sufficient duration to succeed. Client progress over a short period of time should not be seen as a “cure.” Likewise, re-

lapse should not be a reason to discontinue care. Programs should employ multiple strategies to engage and retain clients. Successful programs offer continuing care, and use techniques that have been proven to enhance client motivation.

It is also important to recognize that multiple episodes of treatment may be necessary. The following chart shows the median length of days in a treatment episode from 2008-2015.

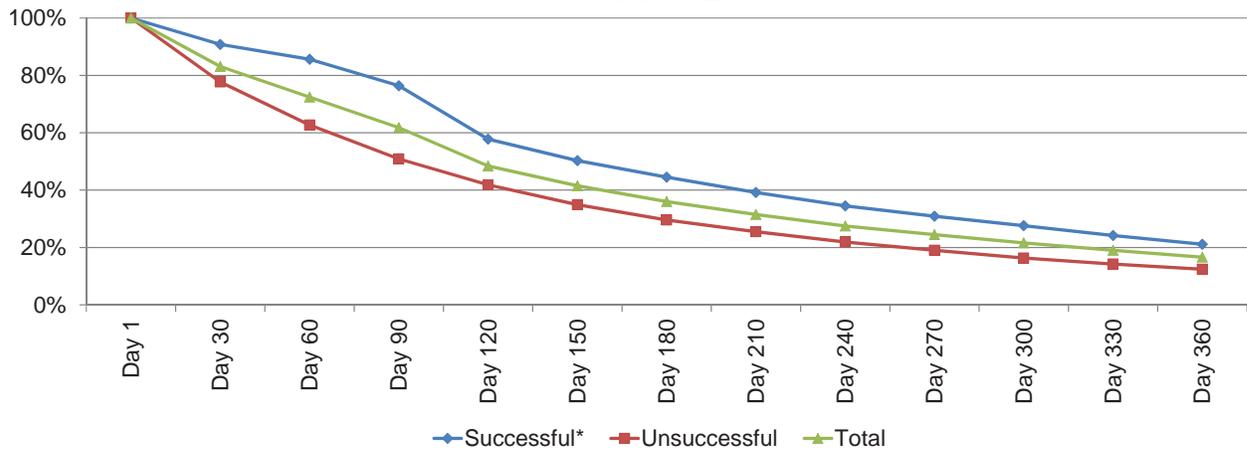
Median Length of a Treatment Episode in Days Fiscal Years 2008 - 2015



The chart below shows the percent of clients retained in treatment by month. Over 60% of all

clients in Utah are in treatment for more than 90 days.

Percent Retained in Substance Abuse Service Treatment Fiscal Year 2015



* Successful completion of Treatment in most cases mean that the client has completed at least 75% of their treatment

Mental Health Treatment Outcomes

Outcome Questionnaire (OQ)/Youth Outcome Questionnaire (YOQ)

People seeking mental health services are generally doing so because of increasing problems with social or functional domains in their lives. Some request services through a self-motivated desire to feel better. Many do so with the encouragement and support of friends, family, and clergy, while others may be compelled by the courts, schools, employers, etc.

The behavioral health sciences have only recently been able to quantifiably measure the effectiveness of treatment interventions. The Utah public mental health system uses the Outcome Questionnaire (OQ) and Youth Outcome Ques-

tionnaire (YOQ), both scientifically valid instruments, to measure change and functioning in people. These instruments are like measuring the vital signs of a person’s mental health status. In fiscal year 2015, 85.5% of people who received mental health services and participated in the OQ/YOQ program either stabilized/improved or recovered from the distress that brought them into services. Of these, almost 23.1% were considered in recovery. In fiscal year 2015, participation in the outcome survey increased to 76% of clients.

Statewide OQ Client Outcomes Report for Fiscal Year 2015

Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River	82%	22.5%	62.8%
Central Utah	78%	26.3%	60.3%
Davis County	95%	22.5%	64.0%
Four Corners	72%	20.8%	63.8%
Northeastern	68%	24.9%	61.9%
Salt Lake County	57%	20.2%	63.1%
San Juan County	45%	20.0%	66.7%
Southwest	67%	21.8%	63.4%
Summit County	99%	27.6%	57.7%
Tooele County	62%	23.3%	59.8%
Utah County	93%	25.9%	60.6%
Wasatch County	89%	26.6%	61.7%
Weber	99%	28.2%	61.7%
Statewide totals	76%	23.1%	62.4%

Youth OQ Client Outcomes Report for Fiscal Year 2015

Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	81%	22.9%	62.3%
Central Utah	83%	23.2%	64.1%
Davis County	99%	27.8%	60.2%
Four Corners	84%	20.7%	64.6%
Northeastern	89%	27.5%	58.9%
Salt Lake County	70%	22.2%	62.8%
San Juan County	51%	18.8%	66.7%
Southwest	79%	22.7%	63.0%
Summit County	99%	29.4%	50.8%
Tooele County	63%	25.8%	58.6%
Utah County	96%	32.4%	55.4%
Wasatch County	88%	28.8%	58.4%
Weber	99%	36.5%	55.3%
Statewide totals	88%	26.5%	60.1%

Adult OQ Client Outcomes Report for Fiscal Year 2015

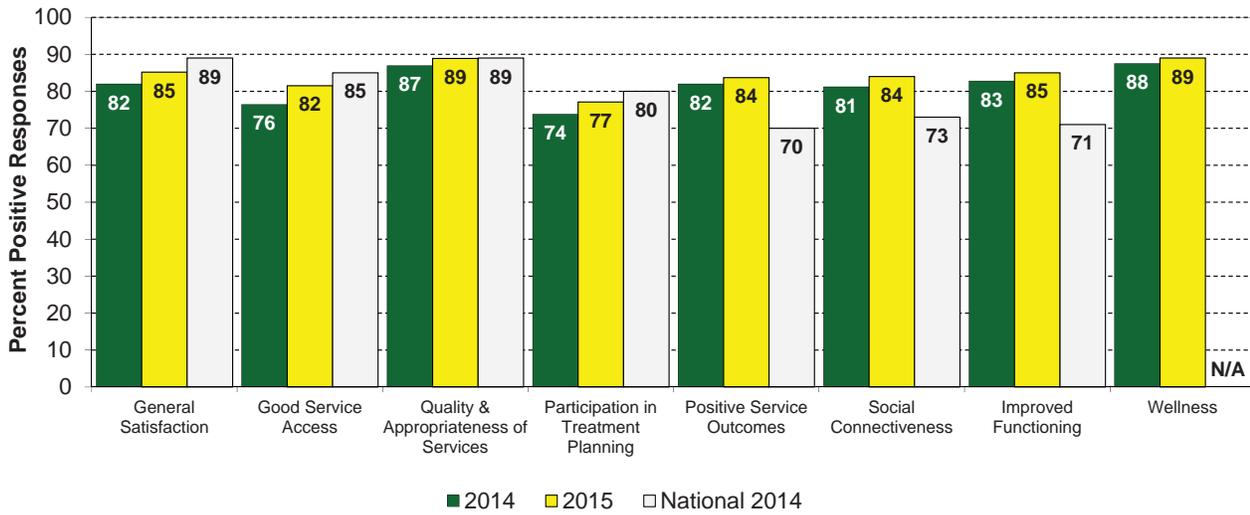
Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	83%	22.1%	63.2%
Central Utah	75%	28.8%	57.4%
Davis County	79%	16.7%	68.1%
Four Corners	66%	20.8%	63.2%
Northeastern	57%	24.1%	62.5%
Salt Lake County	51%	18.4%	63.3%
San Juan County	43%	21.0%	66.2%
Southwest	54%	19.8%	64.2%
Summit County	96%	26.1%	63.5%
Tooele County	62%	21.0%	61.0%
Utah County	90%	20.6%	64.3%
Wasatch County	90%	25.7%	63.0%
Weber	90%	23.4%	63.9%
Statewide totals	68%	20.2%	63.9%

Consumer Satisfaction

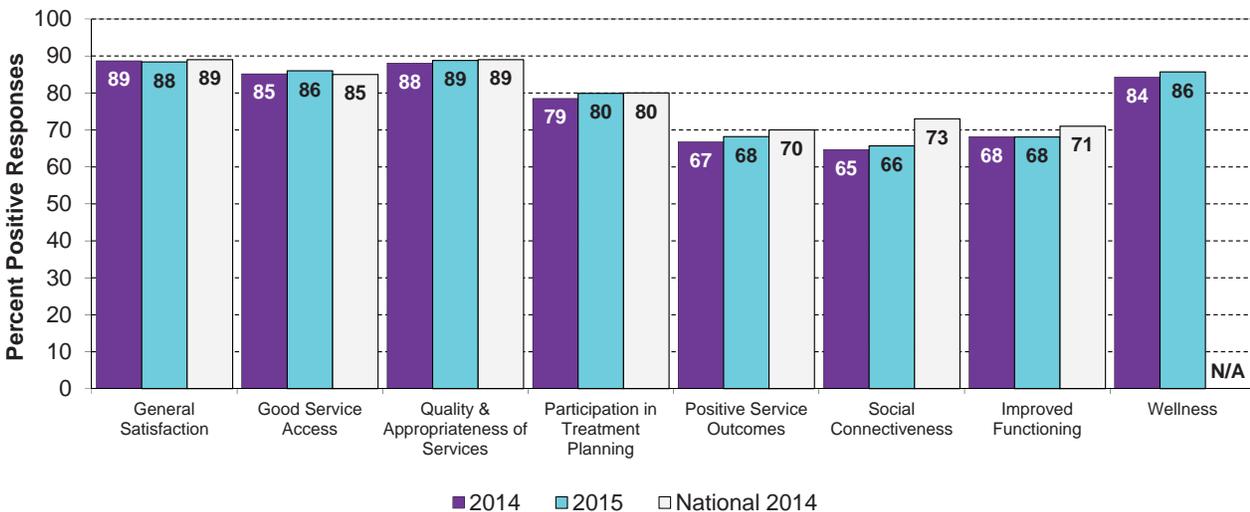
In 2004, DSAMH and Federal funding grants began to require that all providers conduct an annual survey on consumer satisfaction and treatment outcomes. DSAMH requires that the survey is administered to consumers of both substance

abuse and mental health services, and that providers comply with administration requirements and minimum sample rates. Below are the results of this survey comparing results from 2014 to 2015.

**Adult Consumer Satisfaction Survey
Mental Health Statistics Improvement Program (MHSIP)
Completed by Adults with Substance Use Disorders**

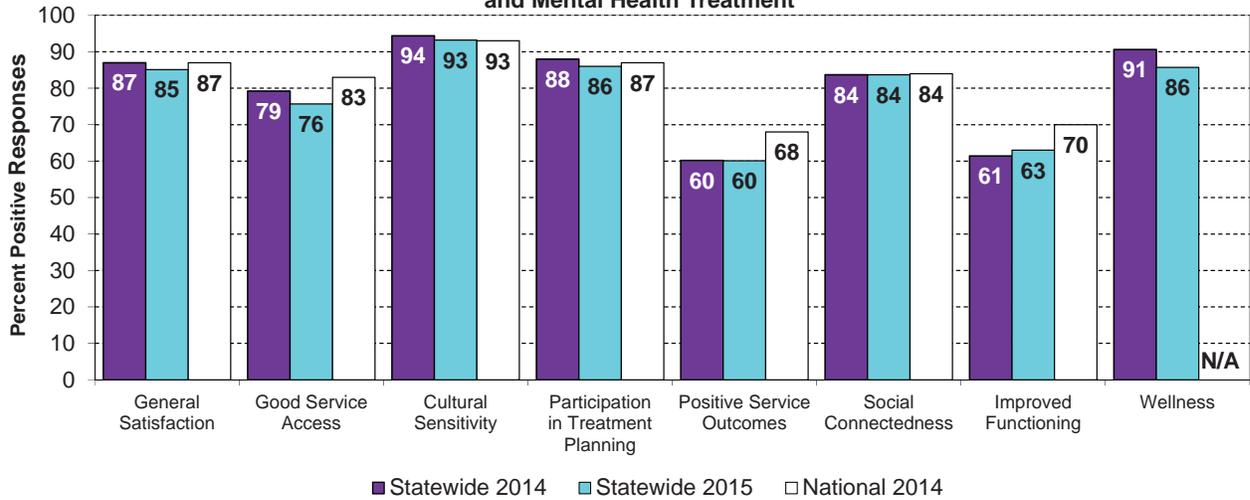


**Adult Consumer Satisfaction Survey
Mental Health Statistics Improvement Program (MHSIP)
Completed by Adults in Mental Health Treatment**



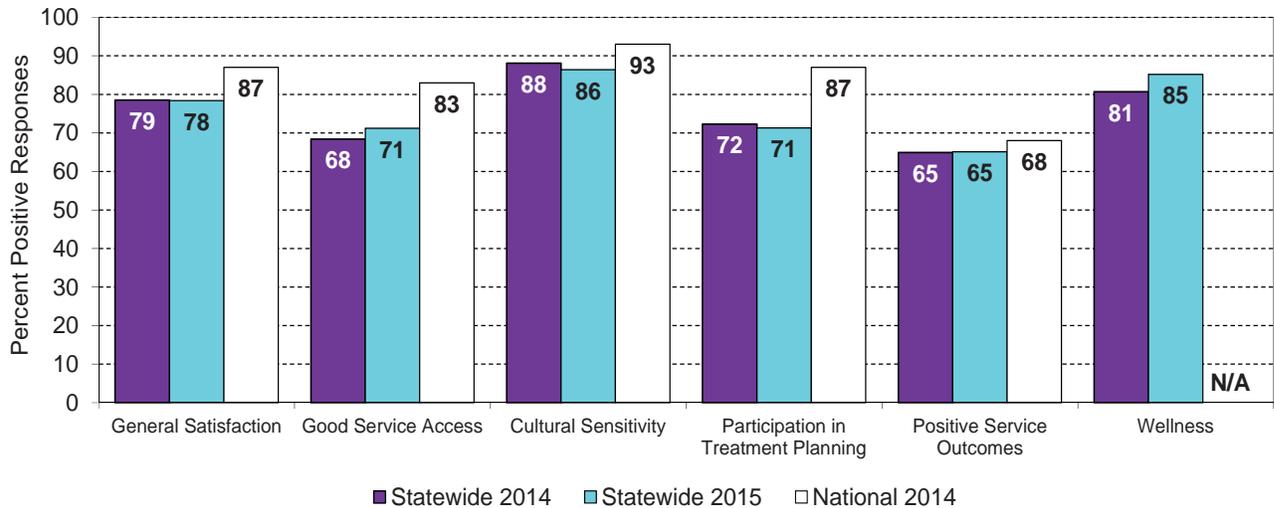
Youth Consumer Satisfaction Survey Youth Services Survey (YSS-F)

Completed by Parent/Guardian of Youth in Substance Use Disorder
and Mental Health Treatment



Youth Consumer Satisfaction Survey Youth Services Survey (YSS)

Completed by Youth (ages 12 to 17) in Substance Use Disorder and Mental Health Treatment



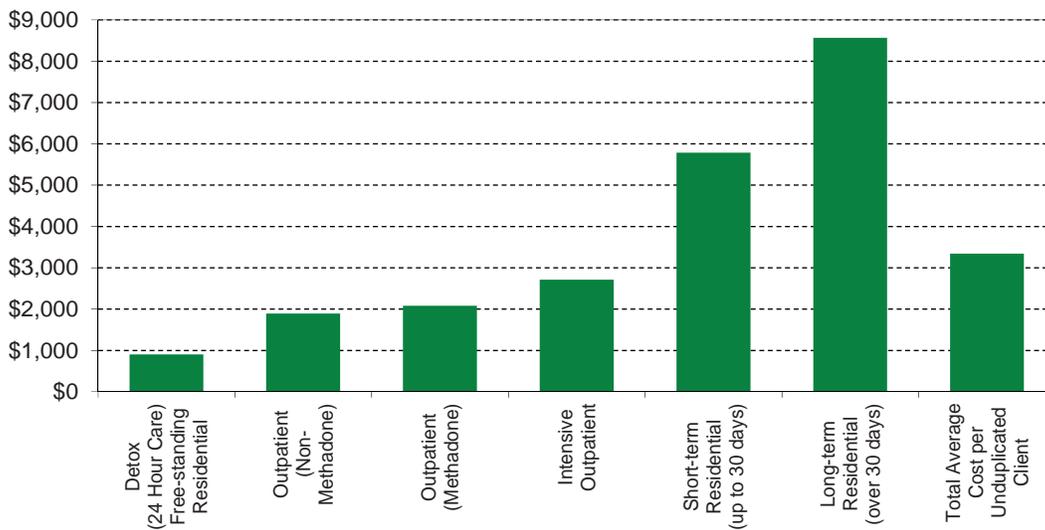
Cost Analysis

Client Cost by Service Category

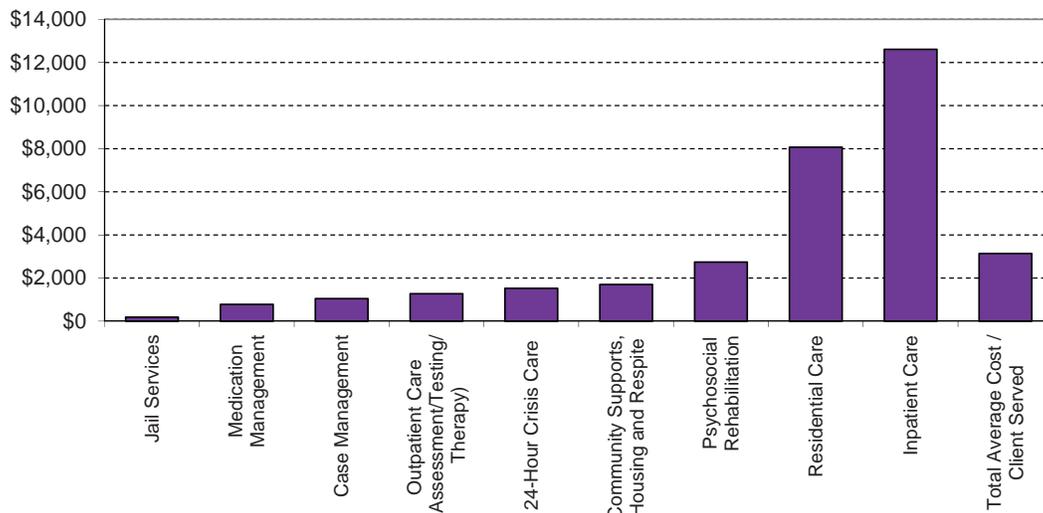
DSAMH requires the local authorities to submit year-end fiscal reports that describe local authority spending in specific categories. This fiscal information is then used to calculate a client cost by service category for both substance abuse

and mental health. In fiscal year 2015, the state-wide average cost for mental health services was \$3,137. For substance abuse services, the average client cost was \$3,343.

Substance Use Disorder Client Cost by Service Category
Fiscal Year 2015



Mental Health Client Cost by Service Category
Fiscal Year 2015

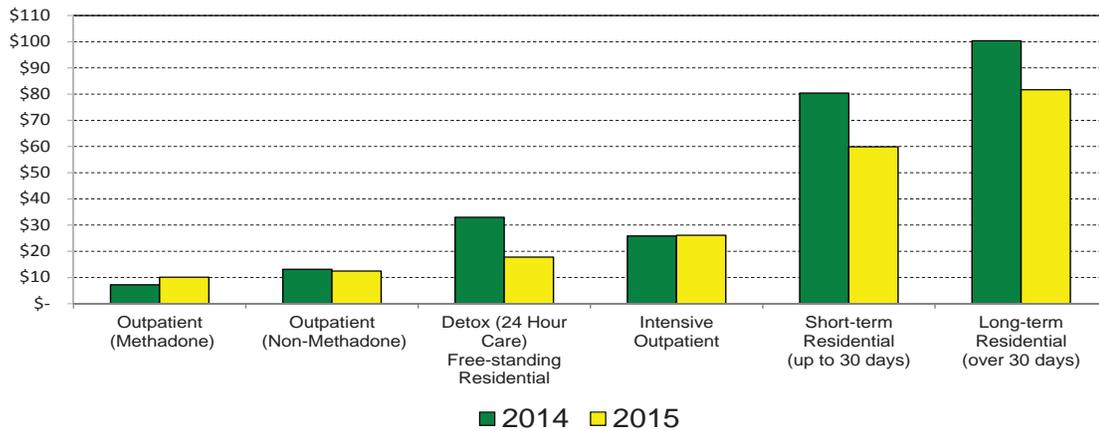


Additional Cost Analysis

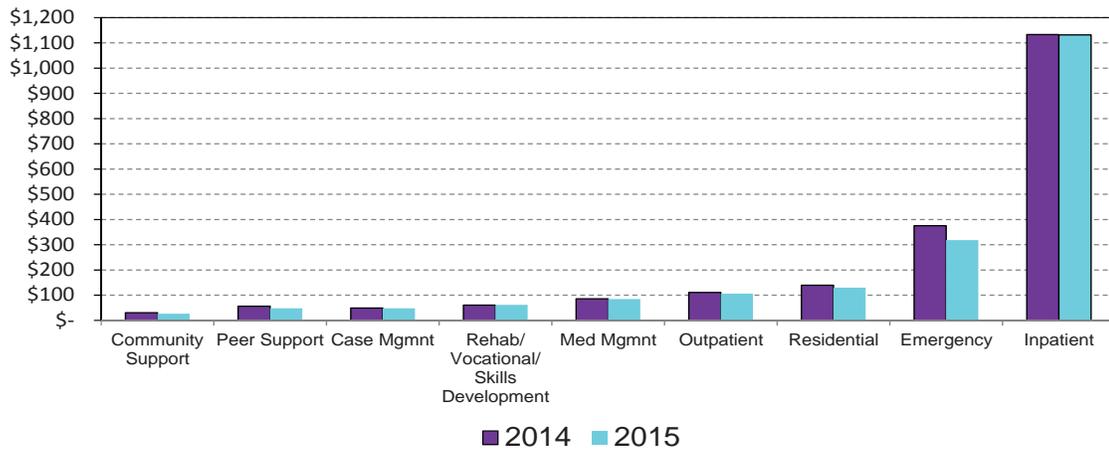
Using the service data reported in fiscal years 2014 and 2015, DSAMH calculated an average

cost per day by substance abuse service type and an average cost per mental health service event.

Substance Use Disorder Average Cost per Day by Service Type Fiscal Years 2014 - 2015



Mental Health Average Cost per Service Event Fiscal Years 2014 - 2015

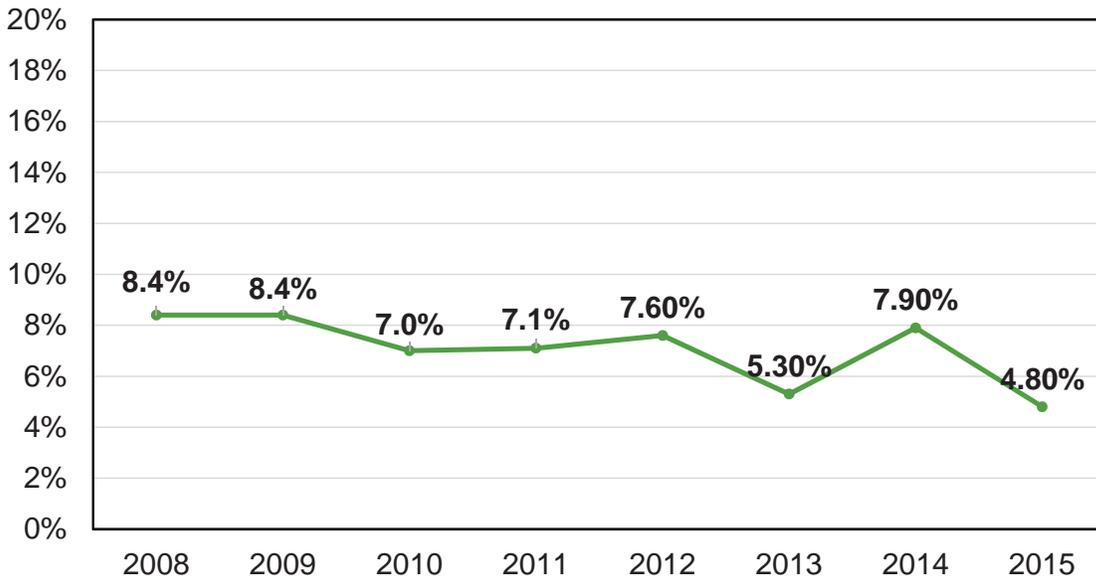


Federal Synar Amendment

The Federal Synar Amendment is designed to protect the nations' youth from nicotine addiction. It requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under the legal age (19 in Utah) and to enforce those laws effectively. States are to achieve a sale to minors' rate of not greater

than 20%. In a collaborative effort between the Department of Health and DSAMH, Utah continues to keep the rates low as shown in the graph below. The rate dropped from 16% in 2001 to its lowest rate of 4.8% in 2015. For more detailed information see: <http://dsamh.utah.gov/data/synar-reports/>

Percentage of Outlets Found in Violation
Federal Fiscal Years 2008-2015



Walking His Crows

“This piece represents how our culture should be. Freedom without judgement and insecurity. The man is able to free himself from darkness. My darkness was addiction.”

Noah Vandyke, UT



2015 Youth M.O.V.E. Art Show

Motivating **O**thers through **V**oices of **E**xperience

Local Authorities

Local Authorities Service Outcomes

Substance Use Disorder and Mental Health Statistics by Local Authority

Under Utah law, local substance use disorder and mental health authorities are responsible for providing services to their residents. A local authority is generally the governing body of a county. Some counties have joined together to provide services for their residents. There are 29 counties in Utah, and 13 local authorities.

Local authorities are responsible for providing a full continuum of prevention and treatment services to their residents. Additionally, they submit data regularly to DSAMH detailing the number and types of services they are providing and some basic information about the people they are serving. This data helps to inform DSAMH, and Utah citizens, regarding the services provided by

the local authorities and provides information regarding how well local authorities are doing in providing services.

The following pages provide data and graphs describing how each local authority provided services to its residents during state fiscal year 2015 (July 1, 2014 to June 30, 2015).

There are four pages for each local authority. Page one provides local authority contact information as well as local substance use disorder prevention services. Page two shows outcomes and data for substance use disorder treatment, and pages three and four include mental health treatment information.

Bear River

Cache, Rich & Box Elder Counties



Population: 172,154

Substance Abuse Provider Agency:
 Brock Alder, LCSW, Director
 Bear River Health Department, Substance Abuse Program
 655 East 1300 North
 Logan, UT 84341
 Office: (435) 792-6420, www.brhd.org

Mental Health Provider Agency:
 C. Reed Ernstrom, President/CEO
 Bear River Mental Health
 90 East 200 North
 Logan, UT 84321
 Office: (435) 752-0750, www.brmh.org

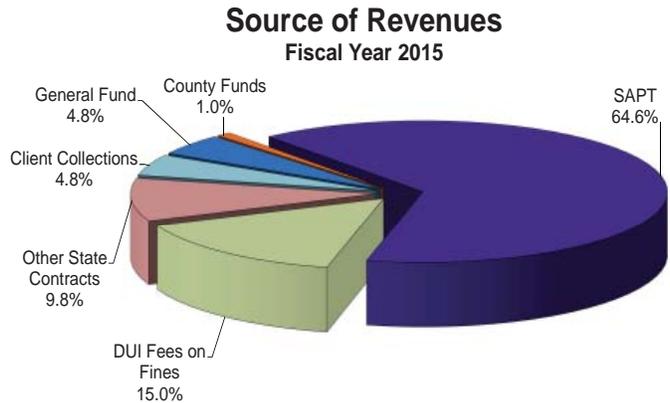
Bear River Substance Abuse—Prevention

Protective Factors:

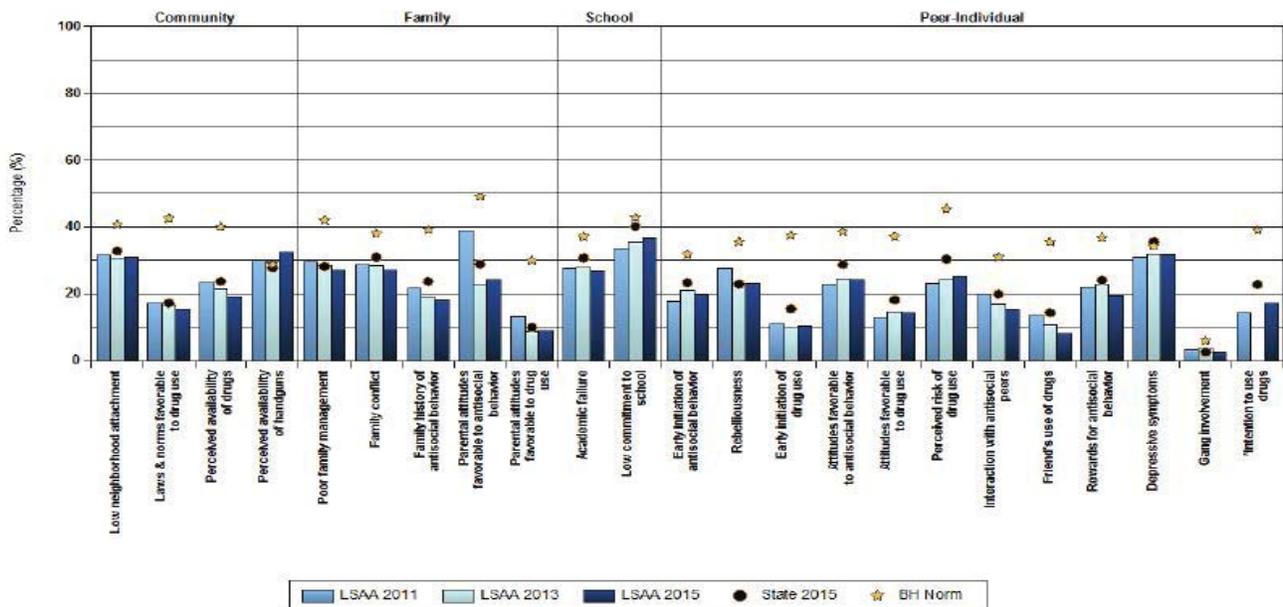
- Community rewards for pro-social involvement

Prioritized Risk Factors:

- Poor family management
- Parental attitudes favorable toward anti-social behavior
- Academic failure



Risk Profile 2015 Bear River District LSAA Student Survey, All Grades

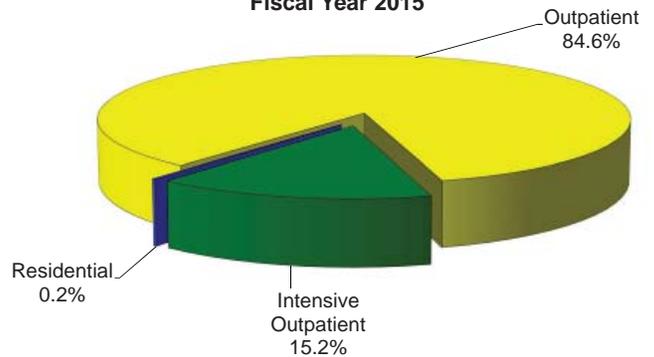


Bear River Health Department—Substance Abuse

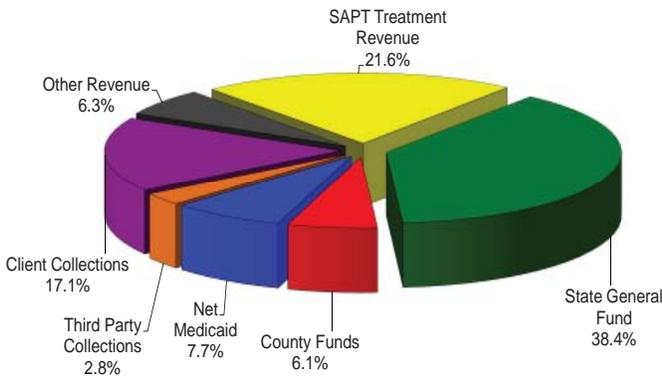
Total Clients Served.....948
 Adult876
 Youth.....72
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....527
 Initial Admissions527
 Transfers.....0

Admission into Modalities
Fiscal Year 2015



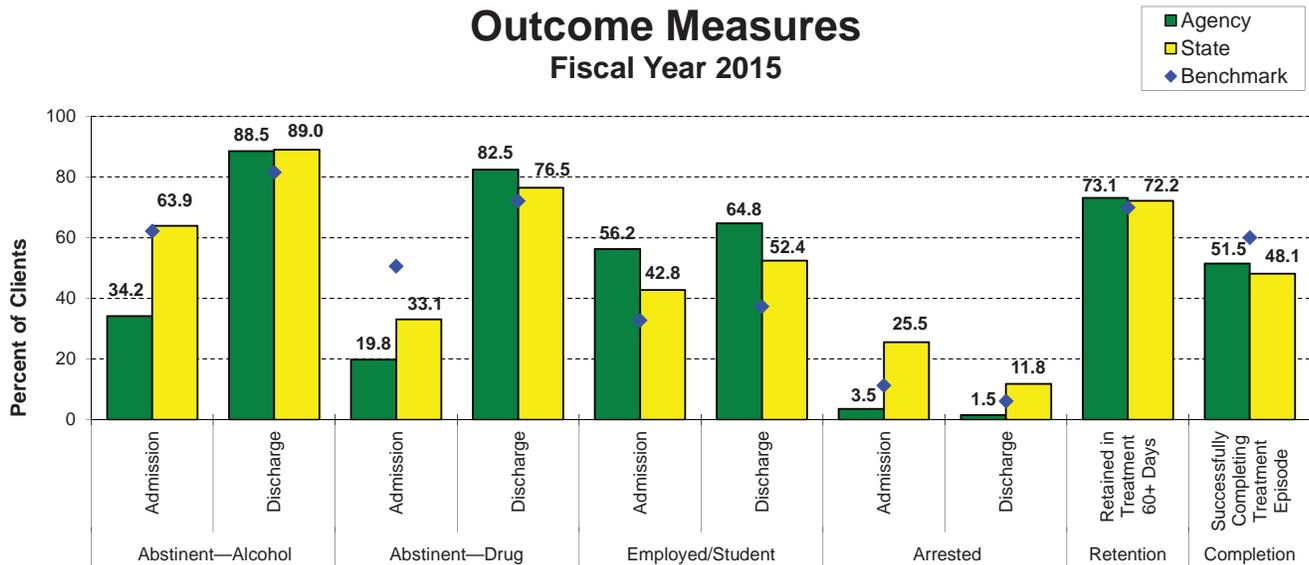
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	119	62	181
Cocaine/Crack	1	2	3
Marijuana/Hashish	98	34	132
Heroin	23	12	35
Other Opiates/Synthetics	25	21	46
Hallucinogens	0	0	0
Methamphetamine	58	45	103
Other Stimulants	2	5	7
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	3	8	11
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	7	2	9
Total	336	191	527

Outcome Measures
Fiscal Year 2015



Benchmark is 75% of the National Average.

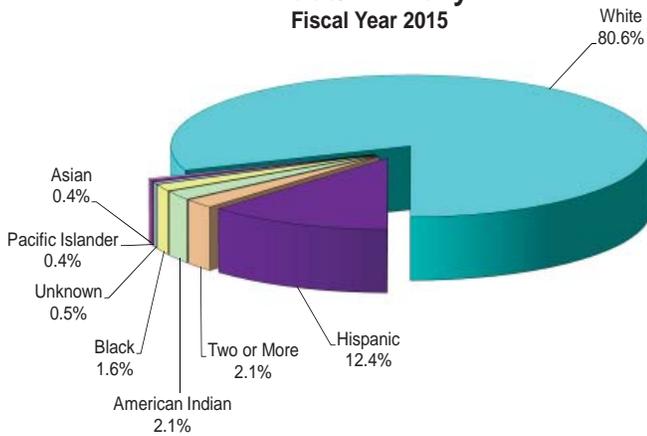
Bear River Mental Health—Mental Health

Total Clients Served.....3,221
 Adult1,802
 Youth.....1,419
 Penetration Rate (Total population of area)..... 1.9%
 Civil Commitment38
 Unfunded Clients Served537

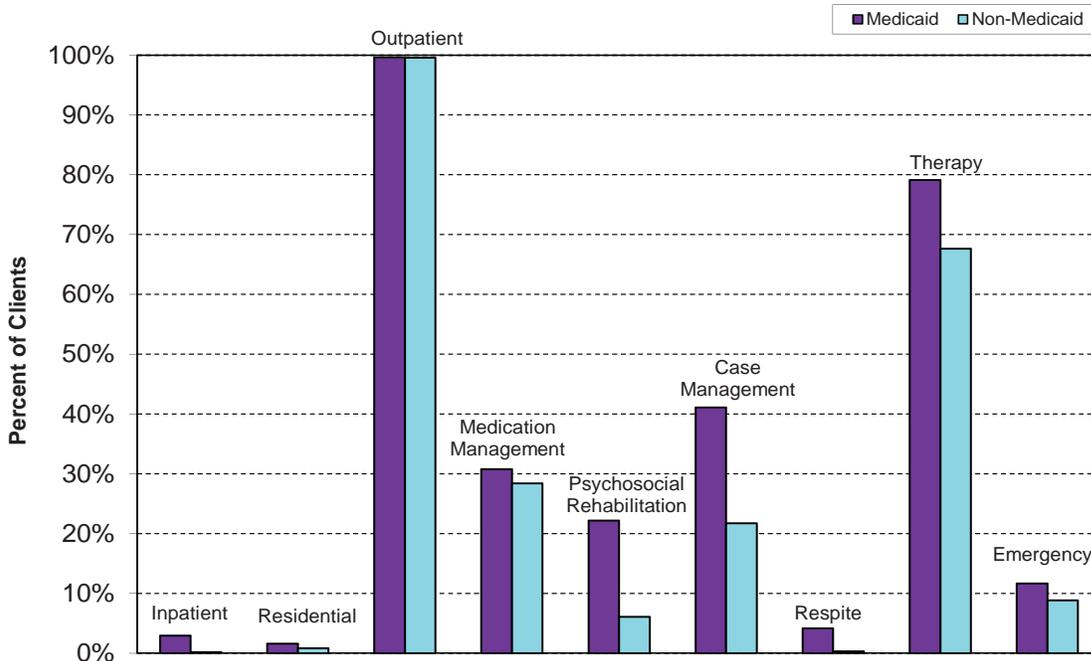
Diagnosis

	Youth	Adult
Adjustment Disorder	409	109
Anxiety	486	1,188
Attention Deficit	441	288
Cognitive Disorder	28	131
Conduct Disorder	13	5
Depression	169	632
Impulse Control Disorders	72	45
Mood Disorder	260	769
Neglect or Abuse	116	11
Oppositional Defiant Disorder	119	13
Personality Disorder	4	489
Pervasive Developmental Disorders	85	58
Schizophrenia and Other Psychotic	2	276
Substance Abuse	24	311
Other	180	118
V Codes	217	202
	2,625	4,645

Race/Ethnicity
Fiscal Year 2015

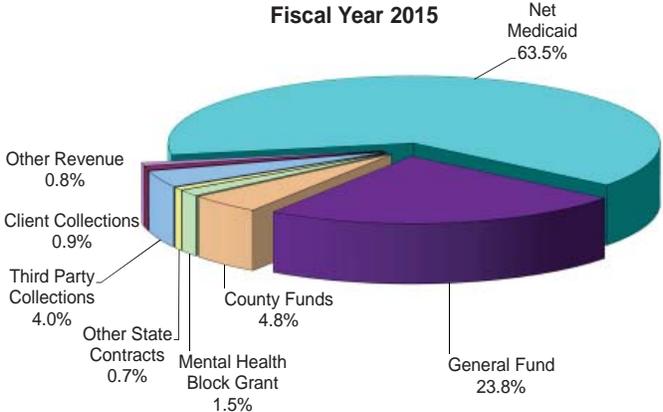


Utilization of Mandated Services
Fiscal Year 2015

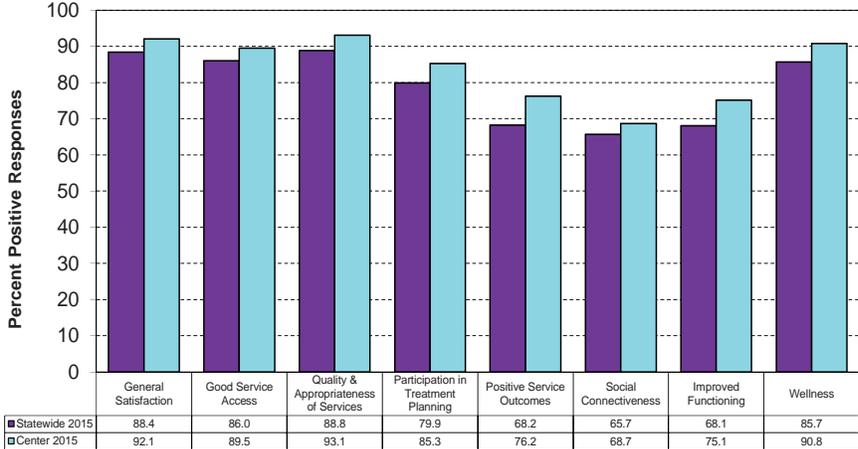


Bear River Mental Health—Mental Health (Continued)

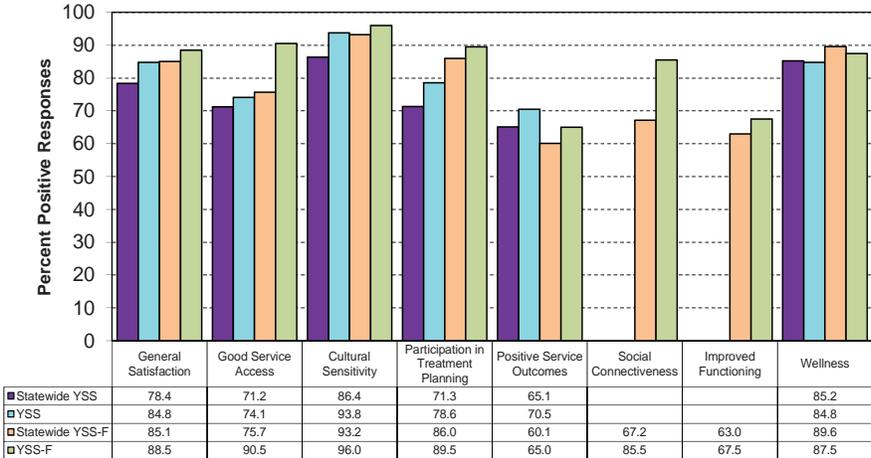
Source of Revenues
Fiscal Year 2015



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Central Utah Counseling Center

Juab, Millard, Sanpete, Sevier, Piute, Wayne Counties



Population: 76,549

Central Utah Counseling

Counties: Juab, Millard, Piute, Sanpete, Sevier, and Wayne

Substance Abuse and Mental Health Provider Agency:

Brian Whipple, Executive Director
Central Utah Counseling Center

152 North 400 West

Ephraim, UT 84627

Office: (435) 283-8400

www.cucc.us

Central Utah Substance Abuse—Prevention

Protective Factors:

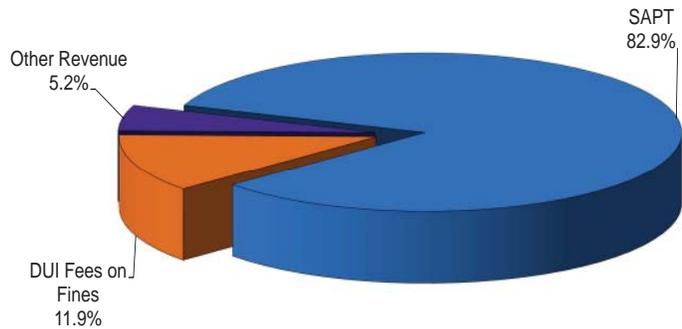
- Rewards for pro-social involvement
- Opportunities for pro-social interaction

Prioritized Risk Factors:

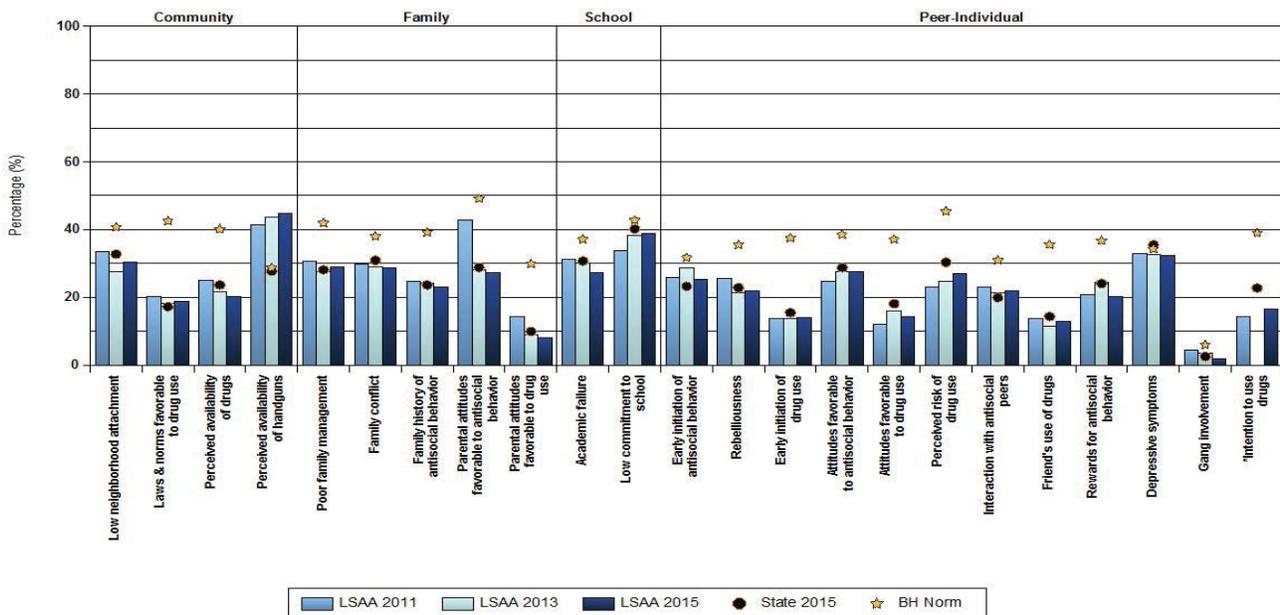
- Perceived availability of alcohol and drugs
- Parental attitudes favorable to anti-social behavior
- Parental attitudes favorable to drugs
- Academic failure, depressive symptoms
- Poor family management

Source of Revenues

Fiscal Year 2015



Risk Profile 2015 Central Utah LSAA Student Survey, All Grades

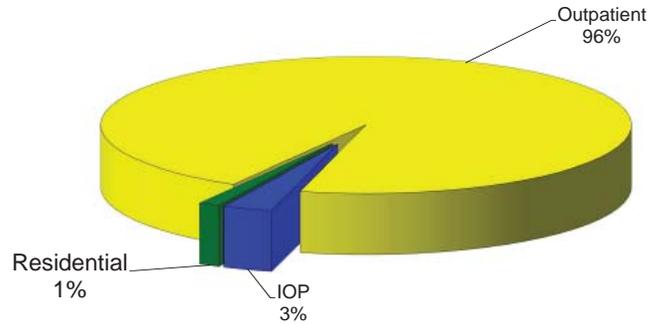


Central Utah Counseling Center—Substance Abuse

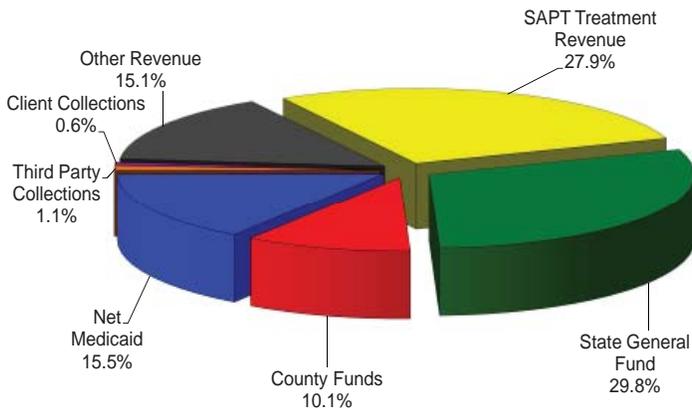
Total Clients Served.....434
 Adult390
 Youth.....44
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....231
 Initial Admissions222
 Transfers.....9

Admission into Modalities
Fiscal Year 2015



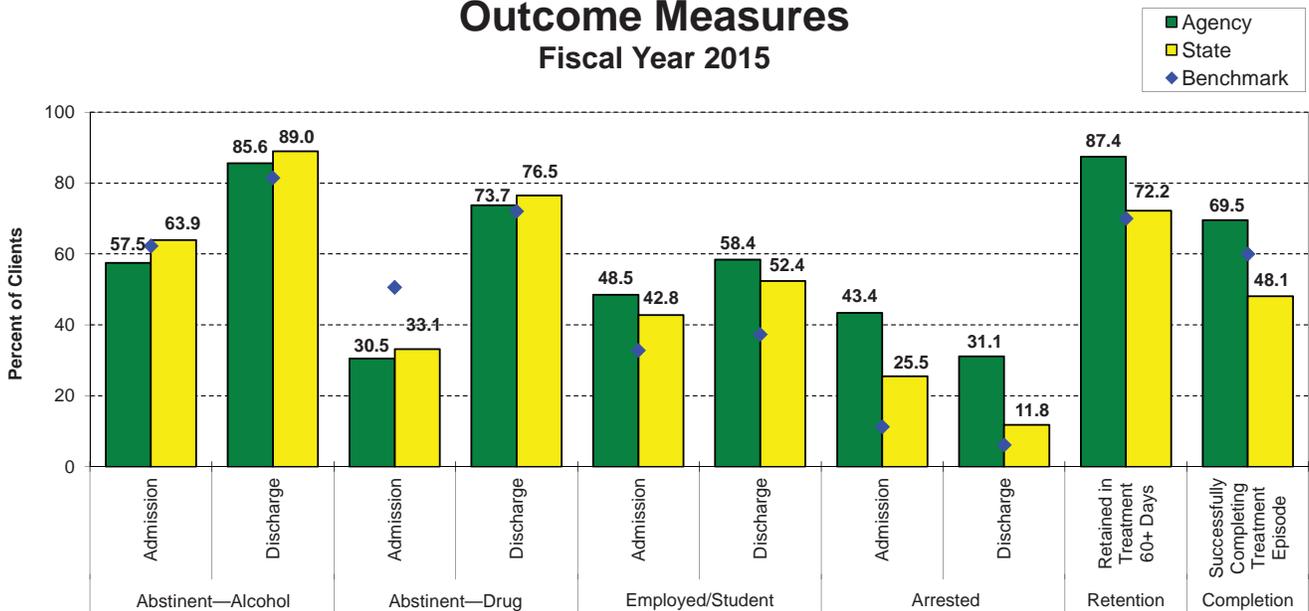
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	48	24	72
Cocaine/Crack	2	0	2
Marijuana/Hashish	31	21	52
Heroin	9	3	12
Other Opiates/Synthetics	5	3	8
Hallucinogens	0	0	0
Methamphetamine	31	34	65
Other Stimulants	0	4	4
Benzodiazepines	1	1	2
Tranquilizers/Sedatives	0	2	2
Inhalants	0	0	0
Oxycodone	2	10	12
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	129	102	231

Outcome Measures Fiscal Year 2015



Benchmark is 75% of the National Average.

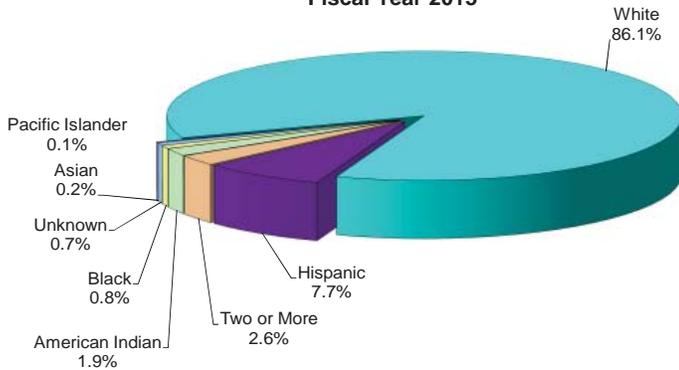
Central Utah Counseling Center—Mental Health

Total Clients Served1,187
 Adult682
 Youth.....505
 Penetration Rate (Total population of area)..... 1.6%
 Civil Commitment30
 Unfunded Clients Served167

Diagnosis

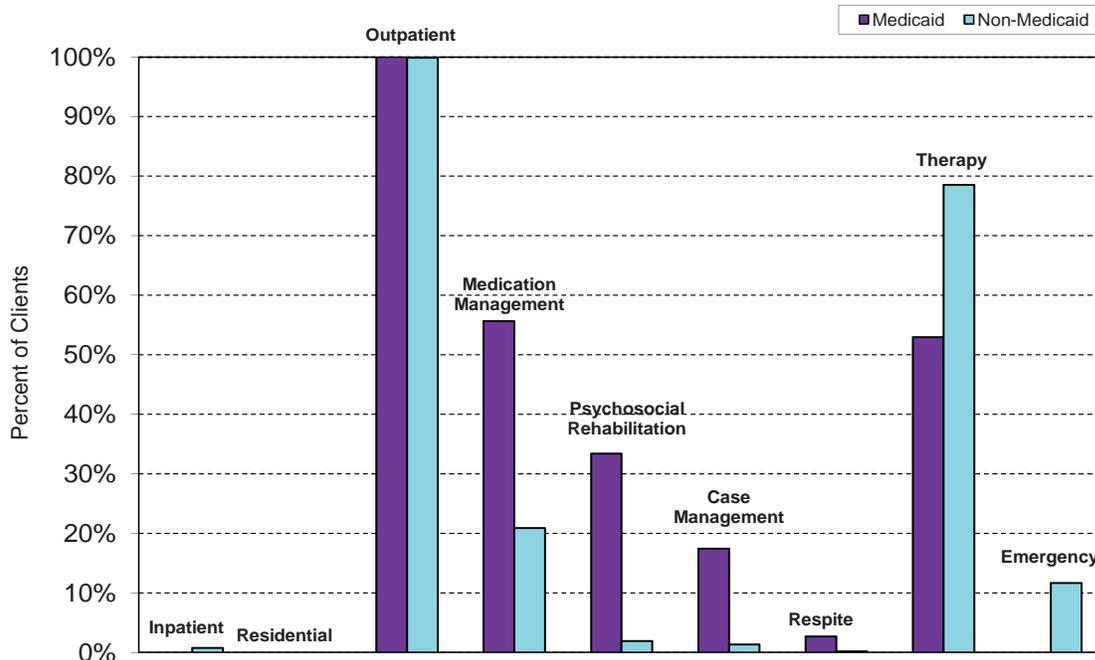
	Youth	Adult
Adjustment Disorder	142	28
Anxiety	154	445
Attention Deficit	161	54
Cognitive Disorder	6	48
Conduct Disorder	15	2
Depression	88	286
Impulse Control Disorders	24	18
Mood Disorder	70	200
Neglect or Abuse	93	186
Oppositional Defiant Disorder	122	7
Personality Disorder	3	226
Pervasive Developmental Disorders	33	18
Schizophrenia and Other Psychotic	1	125
Substance Abuse	41	288
Other	31	45
V Codes	79	87
Total	1,063	2,063

Race/Ethnicity Fiscal Year 2015



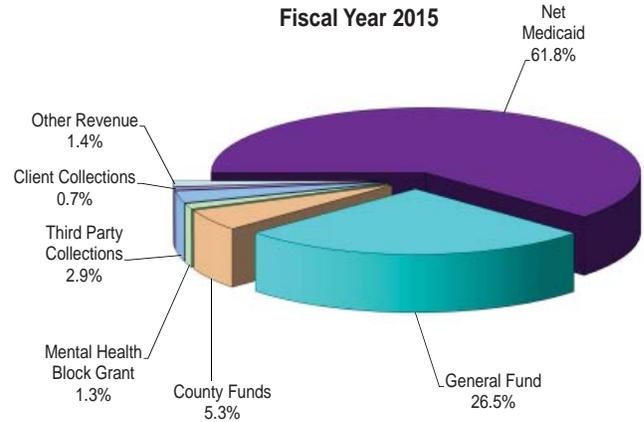
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

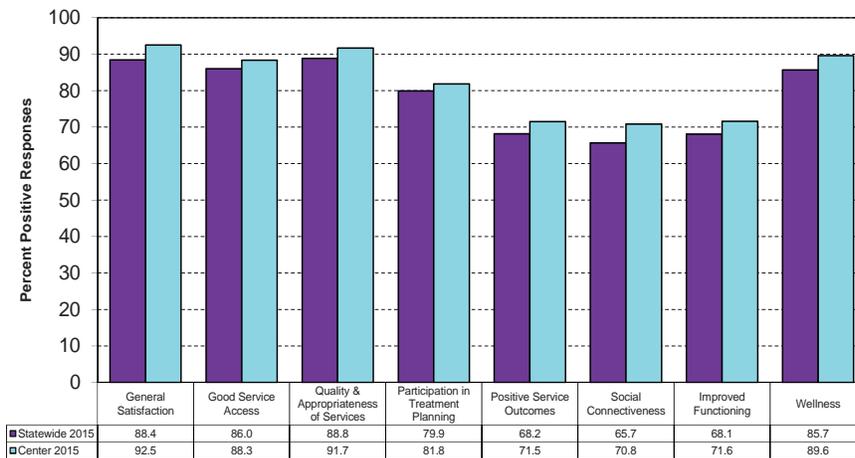


Central Utah Counseling Center—Mental Health (Continued)

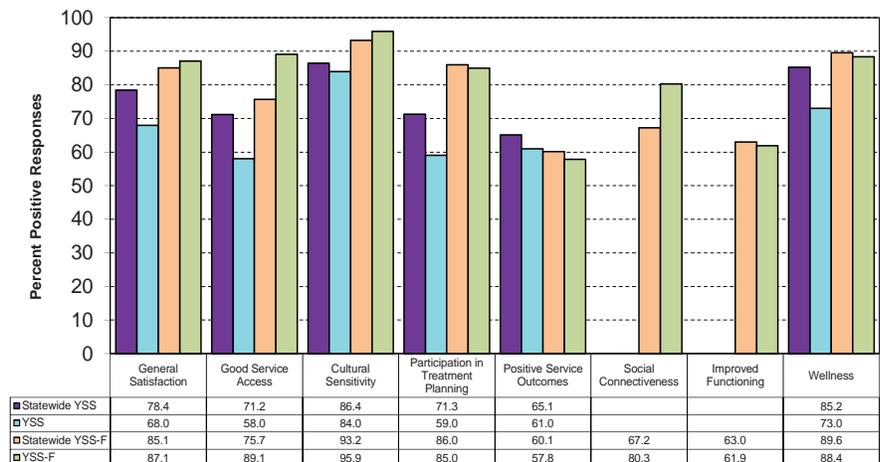
**Source of Revenues
Fiscal Year 2015**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2015**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2015**



Davis Behavioral Health

Davis County



DAVIS BEHAVIORAL HEALTH INC

Population: 329,692

Davis Behavioral Health

County: Davis

Substance Abuse and Mental Health Provider

Agency:

Brandon Hatch, CEO/Director
 Davis Behavioral Health
 934 S. Main
 Layton, UT 84041
 Office: (801) 773-7060
www.dbh.utah.gov

Davis Substance Abuse—Prevention

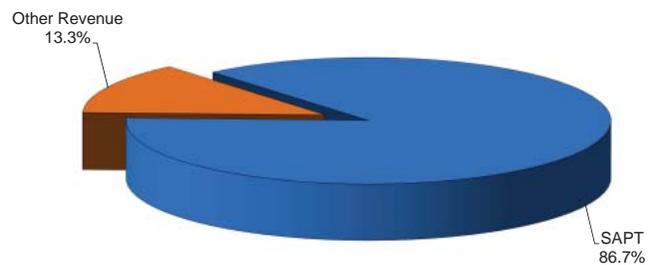
Protective Factors:

- Rewards & opportunities for pro-social involvement

Prioritized Risk Factors:

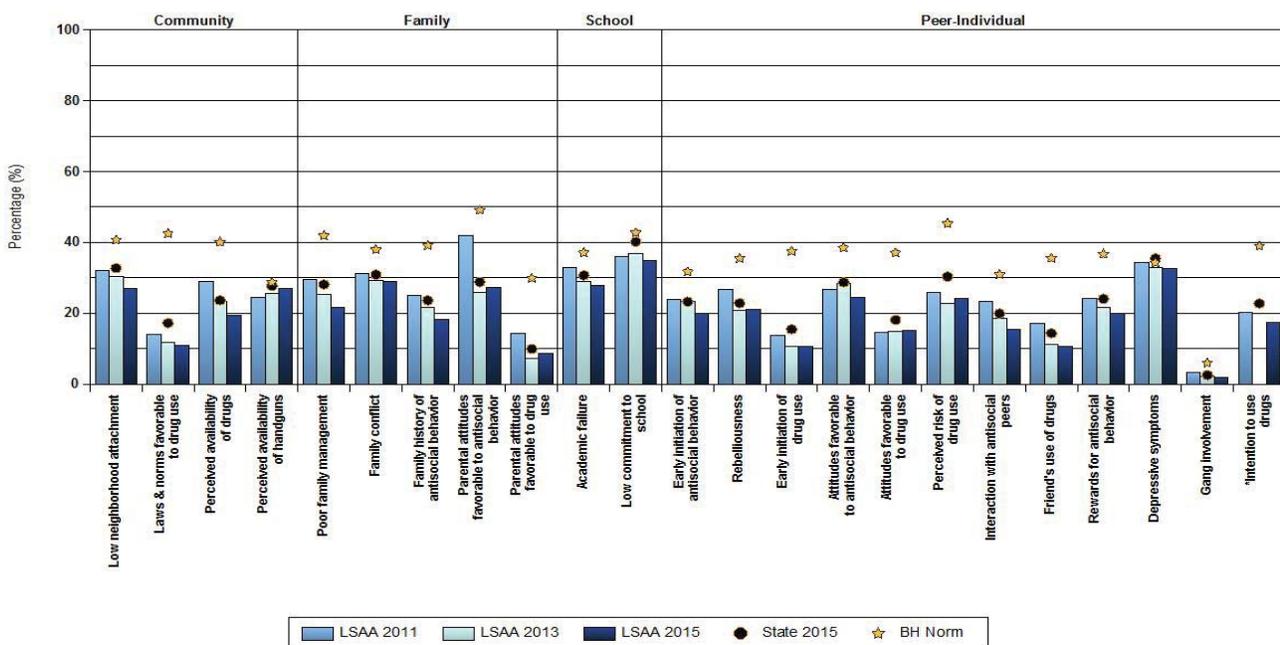
- Family conflict
- Poor family management
- Low commitment to school
- Attitudes favorable to drug use
- Depressive symptoms

Source of Revenues
Fiscal Year 2015



Risk Profile

2015 Davis County LSAA Student Survey, All Grades

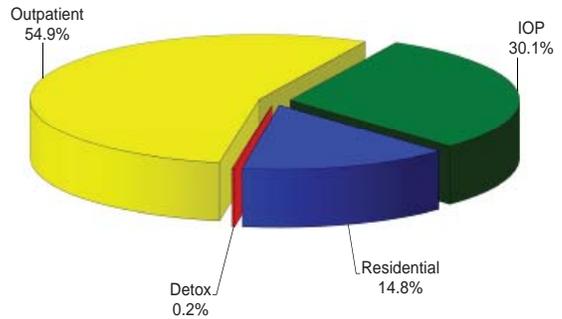


Davis Behavioral Health—Substance Abuse

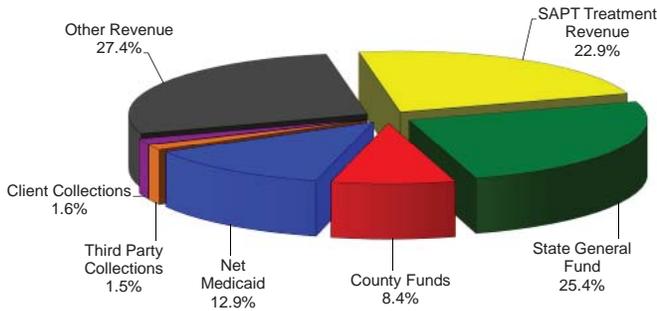
Total Clients Served1009
 Adult896
 Youth113
 Penetration Rate (Total population of area)..0.3%

Total Admissions1,026
 Initial Admissions680
 Transfers.....346

Admissions into Modalities
Fiscal Year 2015



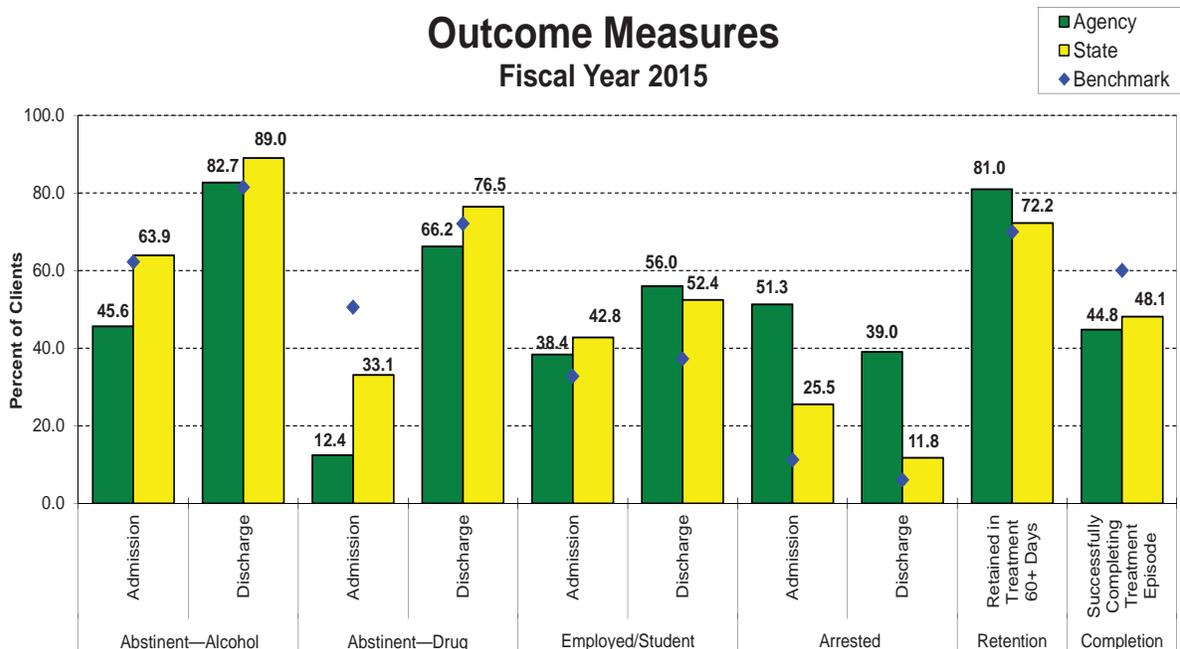
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	77	57	134
Cocaine/Crack	9	10	19
Marijuana/Hashish	126	46	172
Heroin	155	96	251
Other Opiates/Synthetics	17	14	31
Hallucinogens	1	0	1
Methamphetamine	173	159	332
Other Stimulants	8	3	11
Benzodiazepines	1	4	5
Tranquilizers/Sedatives	4	2	6
Inhalants	0	2	2
Oxycodone	15	43	58
Club Drugs	2	0	2
Over-the-Counter	0	0	0
Other	1	1	2
Total	589	437	1,026

Outcome Measures
Fiscal Year 2015



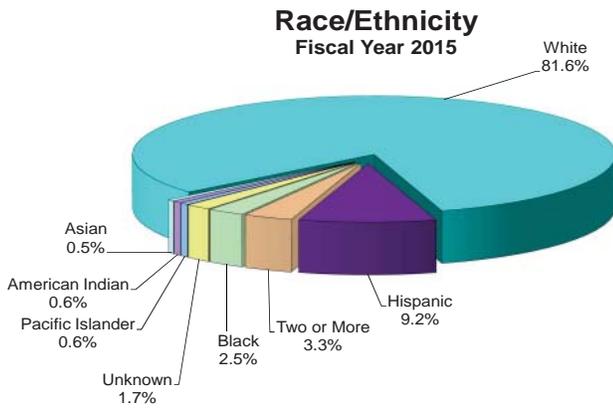
Benchmark is 75% of the National Average.

Davis Behavioral Health—Mental Health

Total Clients Served.....5,557
 Adult3,624
 Youth.....1,933
 Penetration Rate (Total population of area)..... 1.7%
 Civil Commitment107
 Unfunded Clients Served2,073

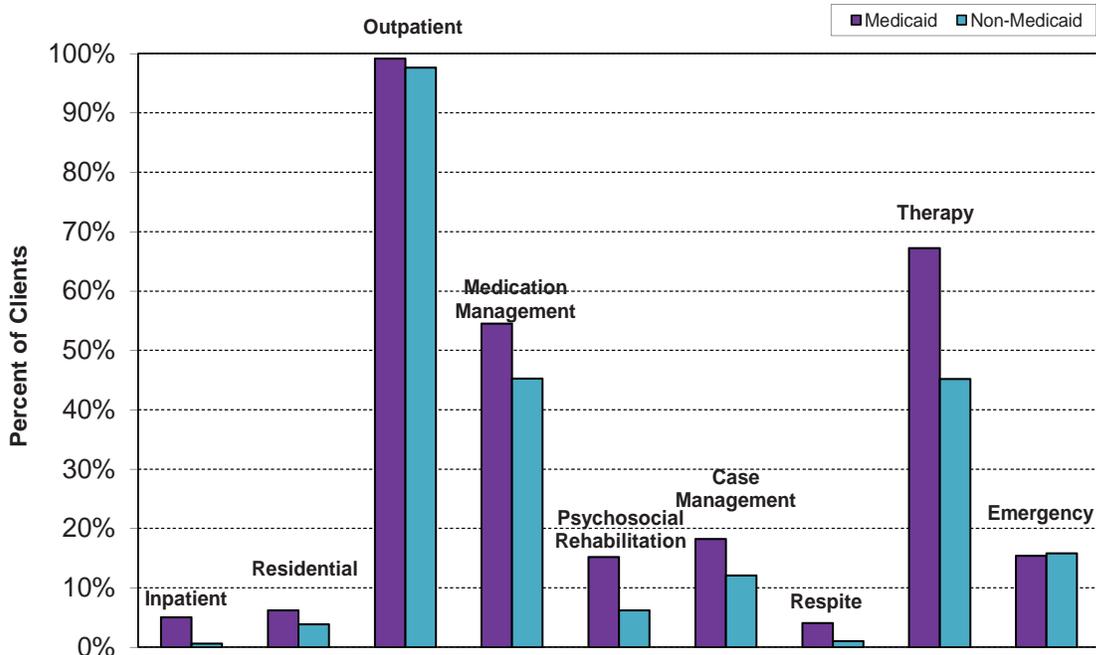
Diagnosis

	Youth	Adult
Adjustment Disorder	553	521
Anxiety	1,506	3,467
Attention Deficit	1,554	716
Cognitive Disorder	103	360
Conduct Disorder	166	8
Depression	299	1,101
Impulse Control Disorders	194	117
Mood Disorder	1,276	2,379
Neglect or Abuse	512	35
Oppositional Defiant Disorder	607	49
Personality Disorder	32	1,009
Pervasive Developmental Disorders	385	226
Schizophrenia and Other Psychotic	45	1,126
Substance Abuse	174	2,832
Other	512	493
V Codes	251	246
Total	8,169	14,685



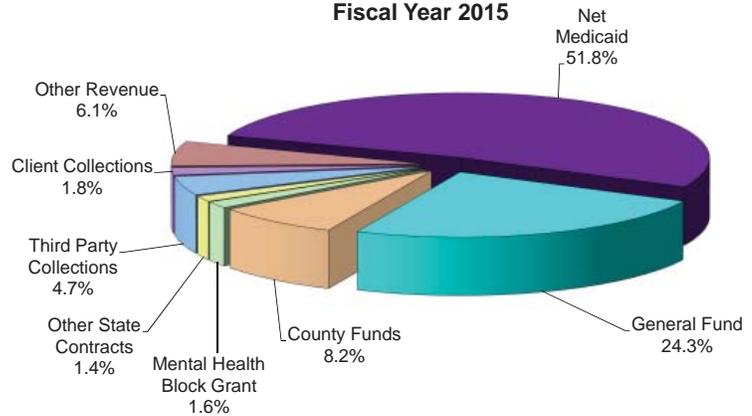
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

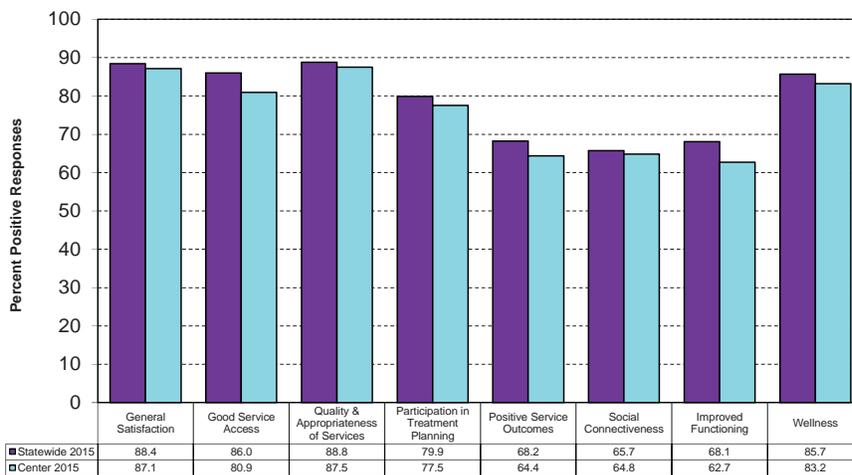


Davis Behavioral Health—Mental Health (Continued)

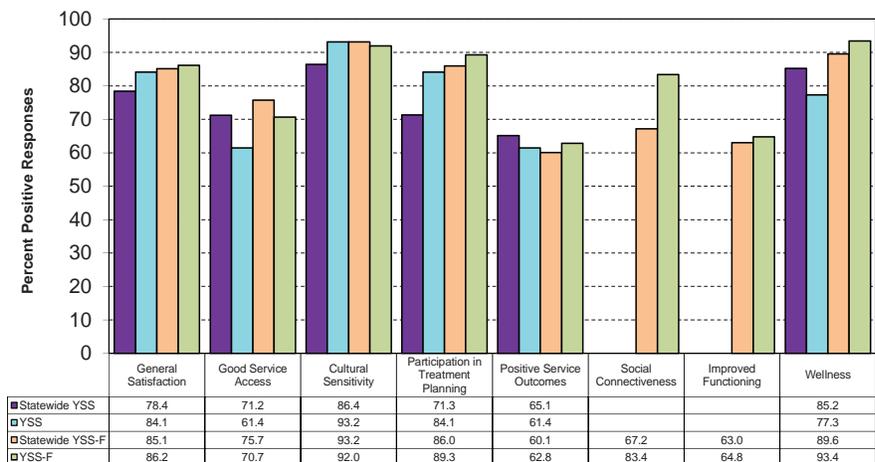
**Source of Revenues
Fiscal Year 2015**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2015**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2015**



Four Corners

Carbon, Emery & Grand Counties



Population: 40,720

Four Corners Community Behavioral Health

Counties: Carbon, Emery, and Grand

Substance Abuse and Mental Health Provider

Agency:

Karen Dolan, CEO Four Corners Community Behavioral Health
 105 West 100 North
 P.O. Box 867
 Price, UT 84501
 Office: (435) 637-7200
www.fourcorners.ws

Four Corners Substance Abuse—Prevention

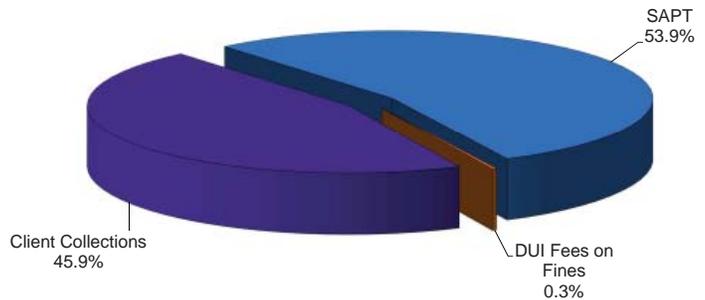
Protective Factors:

- Opportunities and rewards for pro-social involvement

Prioritized Risk Factors:

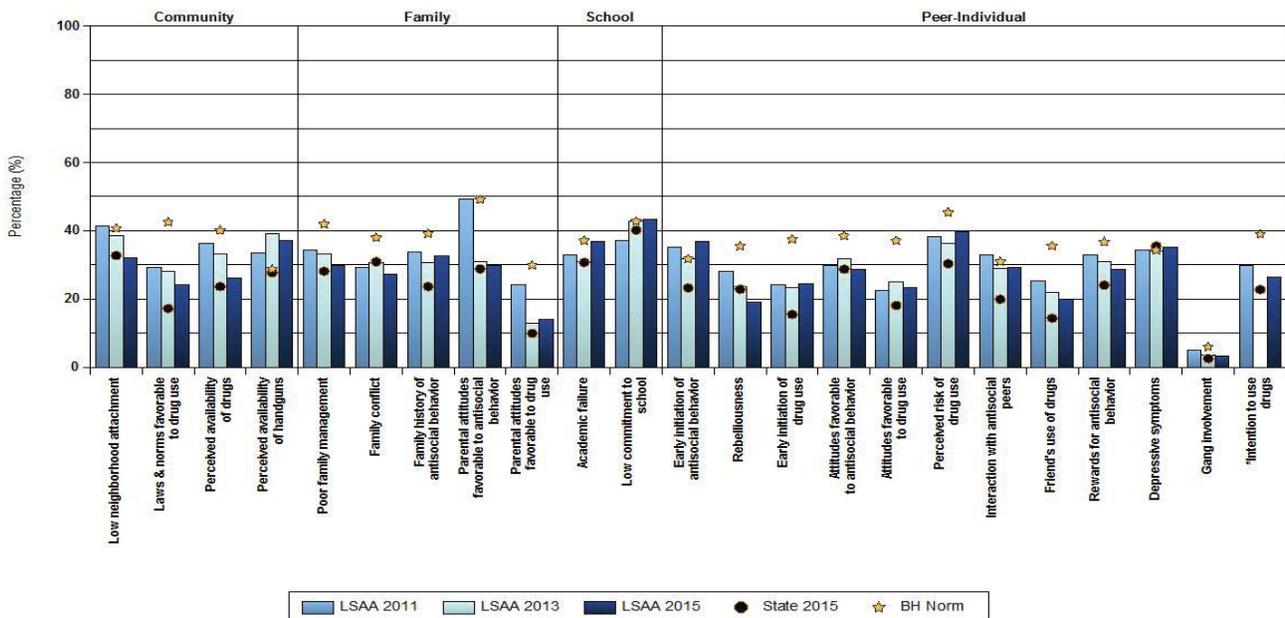
- Low neighborhood attachment
- Family history of problem behavior
- Friends who engage in problem behavior
- Lack of commitment to school

Source of Revenues
Fiscal Year 2015



Risk Profile

2015 Four Corners District LSAA Student Survey, All Grades

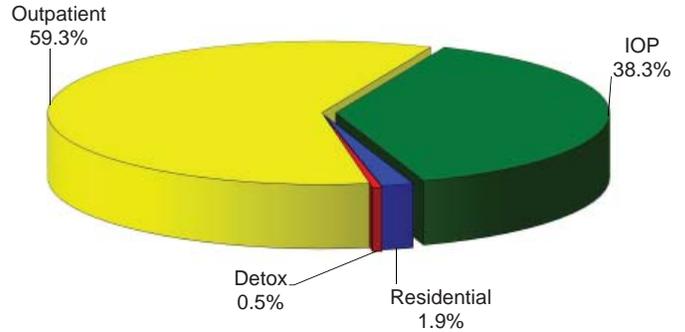


Four Corners Community Behavioral Health—Substance Abuse

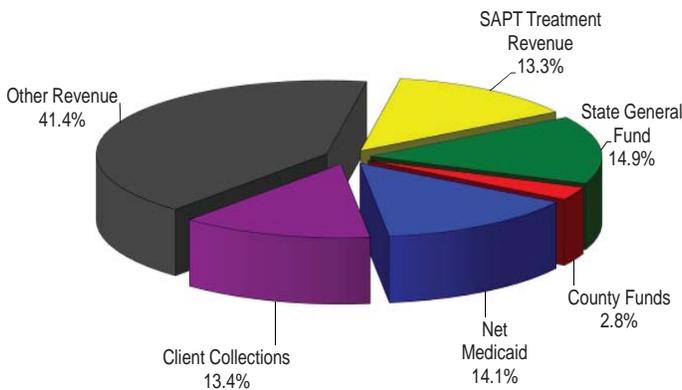
Total Clients Served.....525
 Adult488
 Youth.....37
 Penetration Rate (Total population of area).. 1.3%

Total Admissions.....371
 Initial Admissions169
 Transfers.....202

**Admissions into Modalities
Fiscal Year 2015**



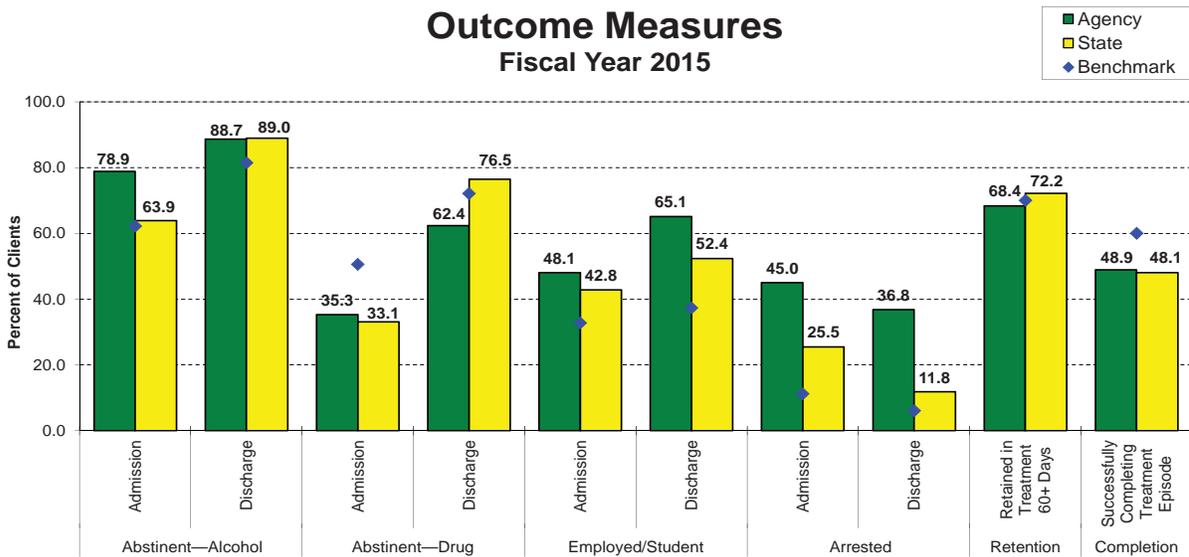
**Source of Revenues
Fiscal Year 2015**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	58	30	88
Cocaine/Crack	0	0	0
Marijuana/Hashish	27	12	39
Heroin	32	21	53
Other Opiates/Synthetics	26	24	50
Hallucinogens	0	0	0
Methamphetamine	61	66	127
Other Stimulants	1	0	1
Benzodiazepines	1	2	3
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	6	7
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	3	0	3
Total	210	161	371

**Outcome Measures
Fiscal Year 2015**



Benchmark is 75% of the National Average.

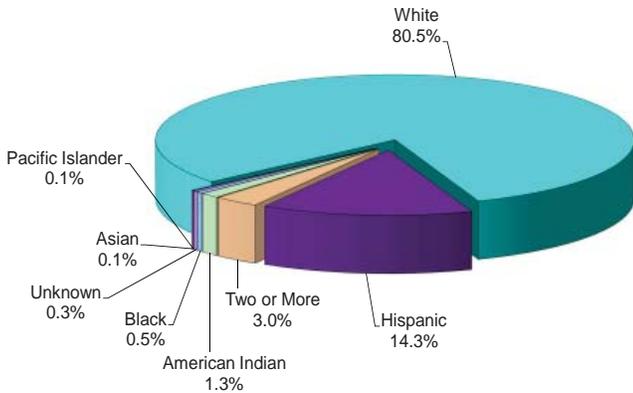
Four Corners Community Behavioral Health—Mental Health

Total Clients Served.....1,496
 Adult985
 Youth.....511
 Penetration Rate (Total population of area)..... 3.7%
 Civil Commitment14
 Unfunded Clients Served567

Diagnosis

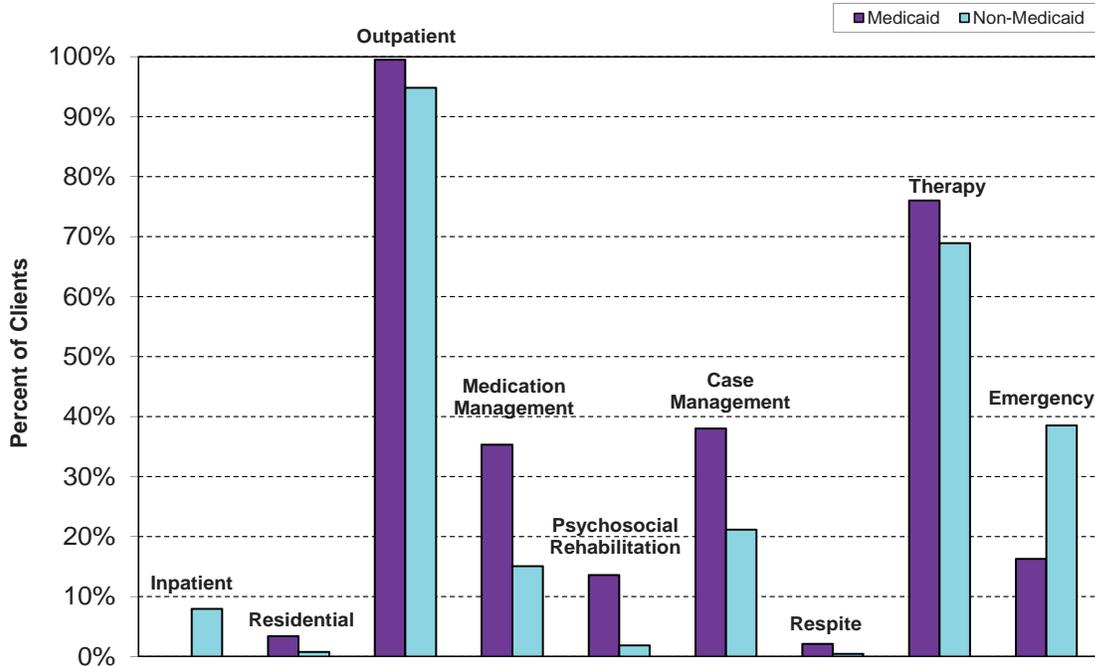
	Youth	Adult
Adjustment Disorder	195	64
Anxiety	193	499
Attention Deficit	169	53
Cognitive Disorder	13	41
Conduct Disorder	0	0
Depression	64	361
Impulse Control Disorders	33	23
Mood Disorder	158	393
Neglect or Abuse	68	13
Oppositional Defiant Disorder	64	3
Personality Disorder	8	249
Pervasive Developmental Disorders	37	14
Schizophrenia and Other Psychotic	0	138
Substance Abuse	47	527
Other	401	418
V Codes	123	30
Total	1,573	2,826

Race/Ethnicity Fiscal Year 2015



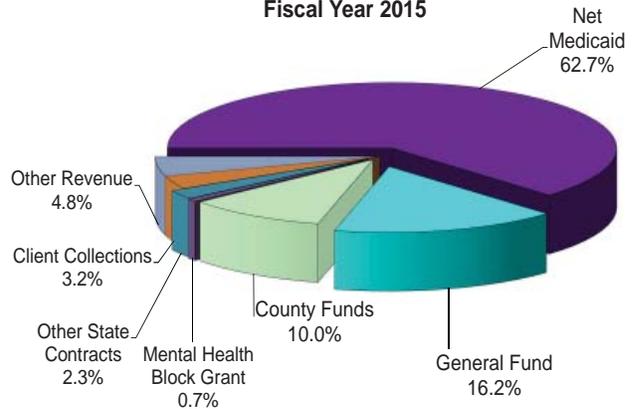
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

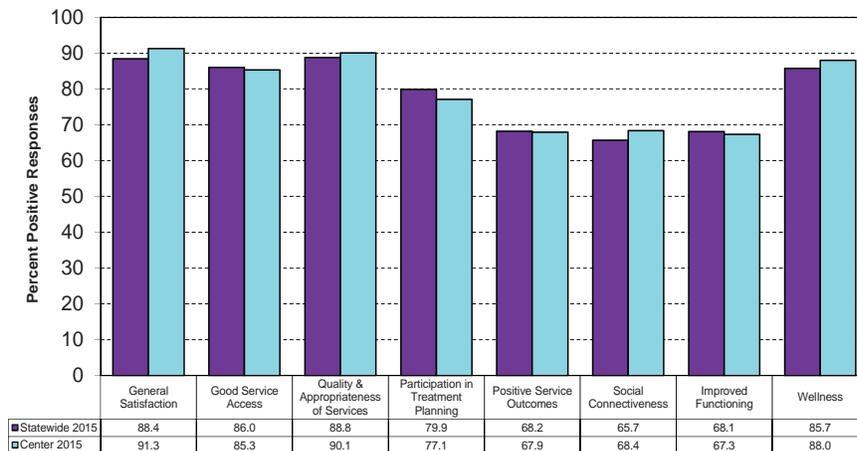


Four Corners Community Behavioral Health—Mental Health (Continued)

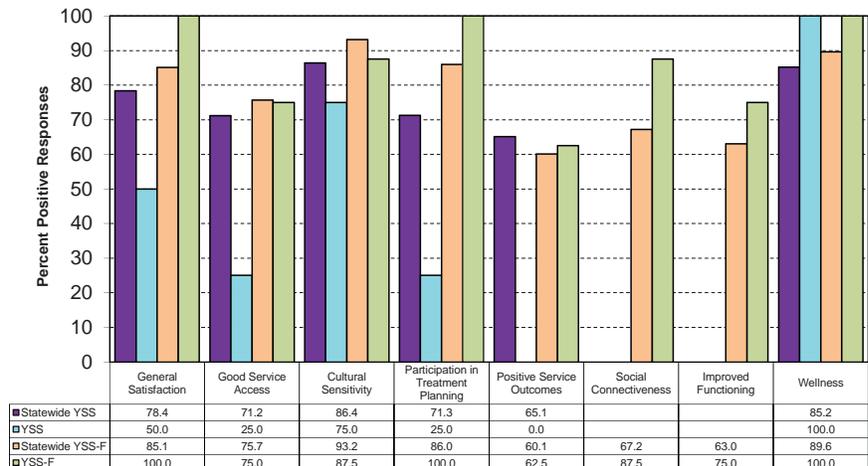
Source of Revenues
Fiscal Year 2015



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2015**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2015**



Northeastern Counseling Center

Daggett, Duchesne, & Uintah Counties



Population: 58,364

Northeastern Counseling Center

Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider

Agency:

Kyle Snow, Director
 Northeastern Counseling Center
 1140 West 500 South #9
 Vernal, UT 84078
 Office: (435) 789-6300
 Fax: (435) 789-6325
www.nccutah.org

Northeastern Substance Abuse—Prevention

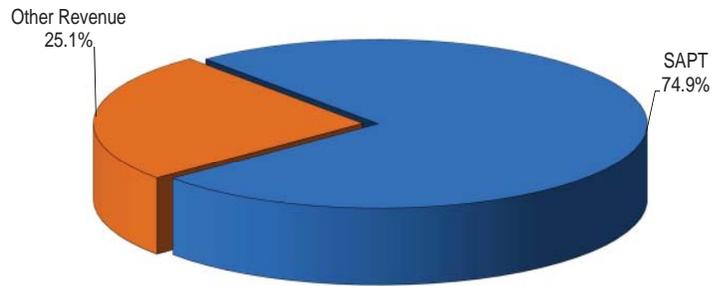
Protective Factors:

- Pro-social involvement

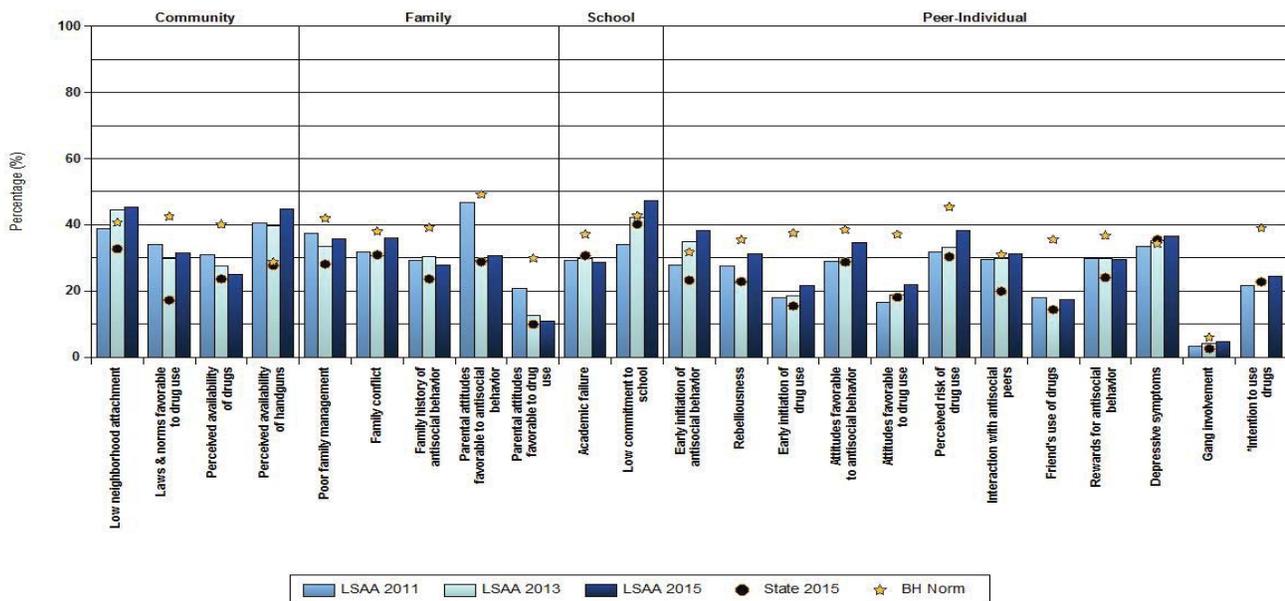
Prioritized Risk Factors:

- Low neighborhood attachment
- Underage alcohol sales
- Low commitment to school
- Community laws and norms favorable to drug use
- Friends who engage in problem behavior

Source of Revenues
Fiscal Year 2015



Risk Profile 2015 Northeastern District LSAA Student Survey, All Grades

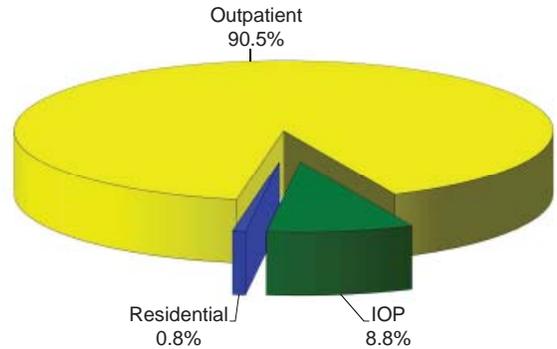


Northeastern Counseling Center—Substance Abuse

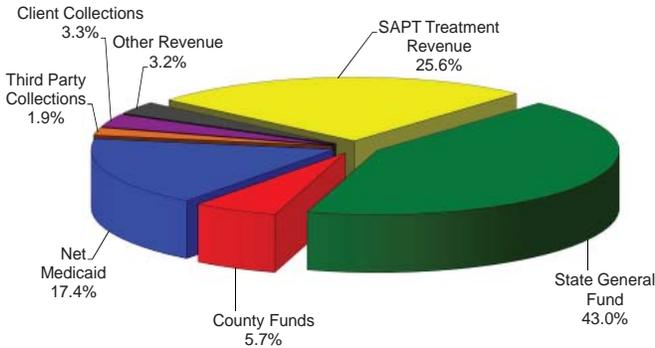
Total Clients Served.....397
 Adult375
 Youth.....22
 Penetration Rate (Total population of area)..0.7%

Total Admissions.....262
 Initial Admissions17
 Transfers.....245

Admission into Modalities Fiscal Year 2015



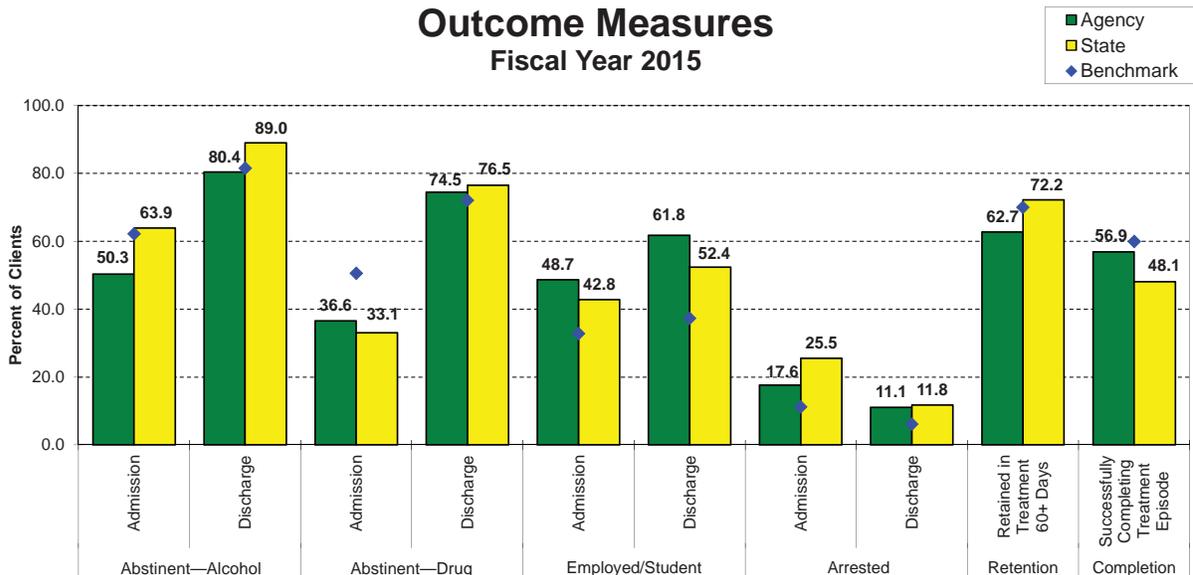
Source of Revenues Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	63	36	99
Cocaine/Crack	0	1	1
Marijuana/Hashish	43	23	66
Heroin	9	4	13
Other Opiates/Synthetics	0	4	4
Hallucinogens	0	0	0
Methamphetamine	26	34	60
Other Stimulants	1	1	2
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	1	1
Inhalants	1	0	1
Oxycodone	7	6	13
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	0	1
Total	151	111	262

Outcome Measures Fiscal Year 2015



Benchmark is 75% of the National Average.

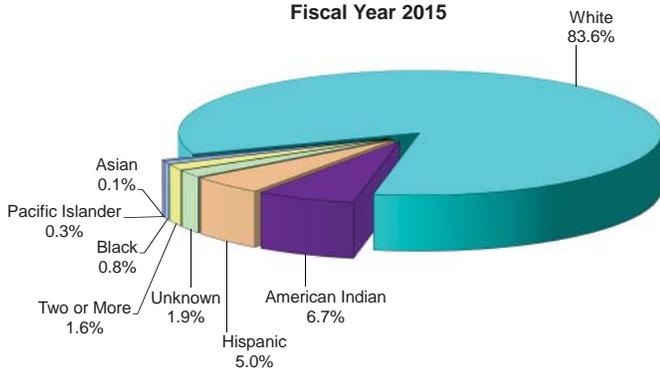
Northeastern Counseling Center—Mental Health

Total Clients Served.....2,337
 Adult1,483
 Youth.....854
 Penetration Rate (Total population of area)..... 4.0%
 Civil Commitment16
 Unfunded Clients Served.....680

Diagnosis

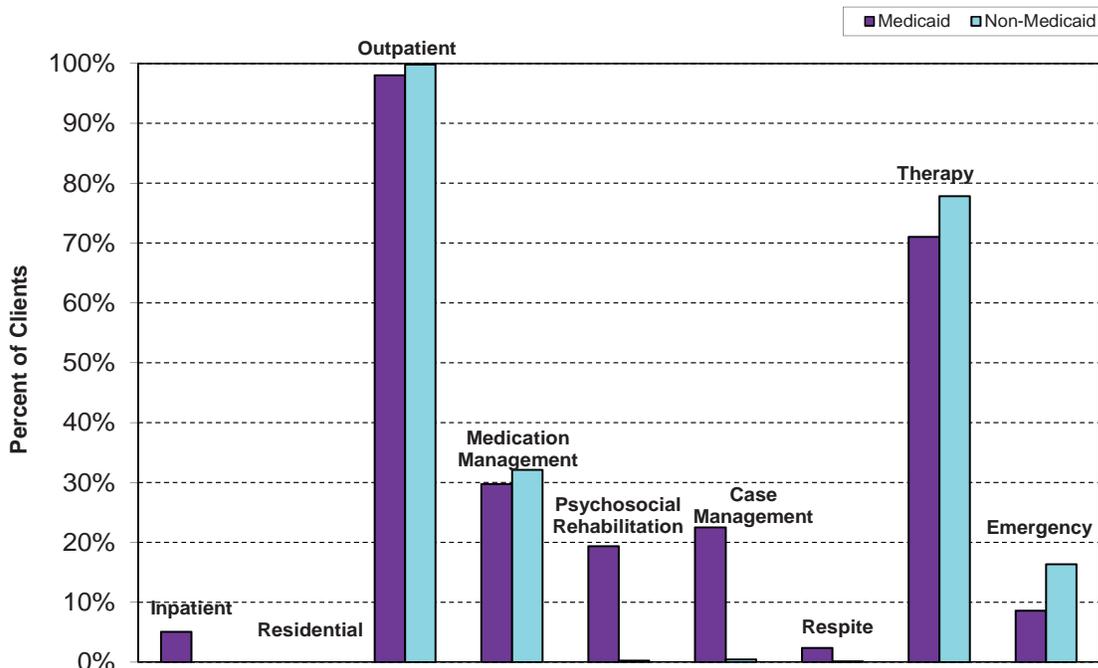
	Youth	Adult
Adjustment Disorder	176	81
Anxiety	226	898
Attention Deficit	169	98
Cognitive Disorder	5	60
Conduct Disorder	13	1
Depression	193	600
Impulse Control Disorders	80	65
Mood Disorder	251	498
Neglect or Abuse	198	67
Oppositional Defiant Disorder	44	2
Personality Disorder	1	93
Pervasive Developmental Disorders	36	16
Schizophrenia and Other Psychotic	1	126
Substance Abuse	48	417
Other	39	37
V Codes	112	243
Total	1,592	3,302

Race/Ethnicity Fiscal Year 2015

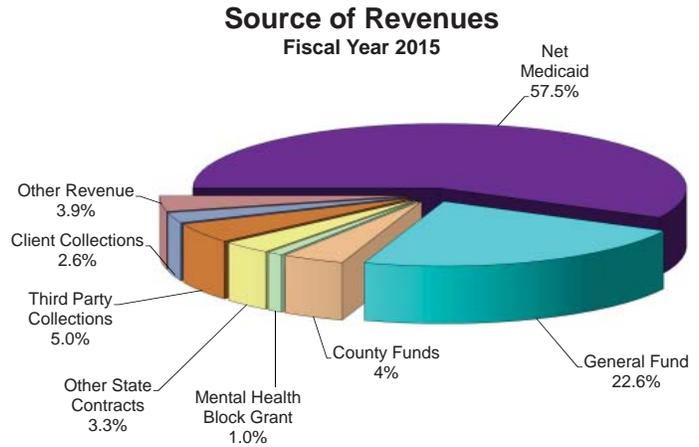


More than one race/ethnicity may have been selected.

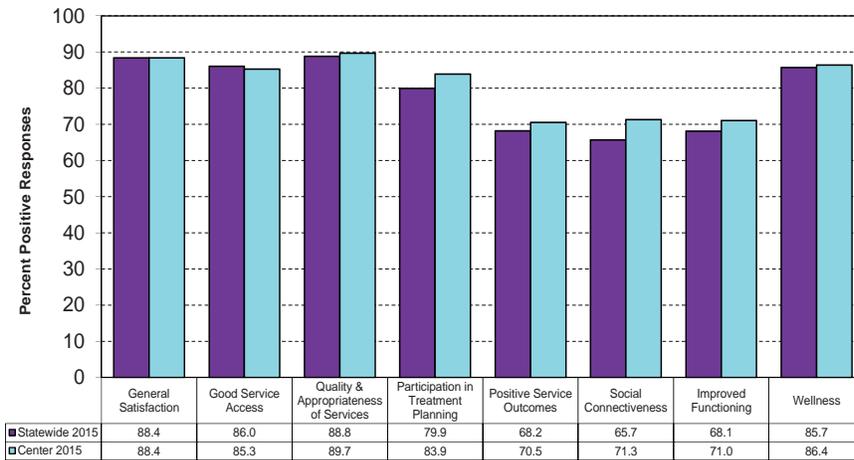
Utilization of Mandated Services Fiscal Year 2015



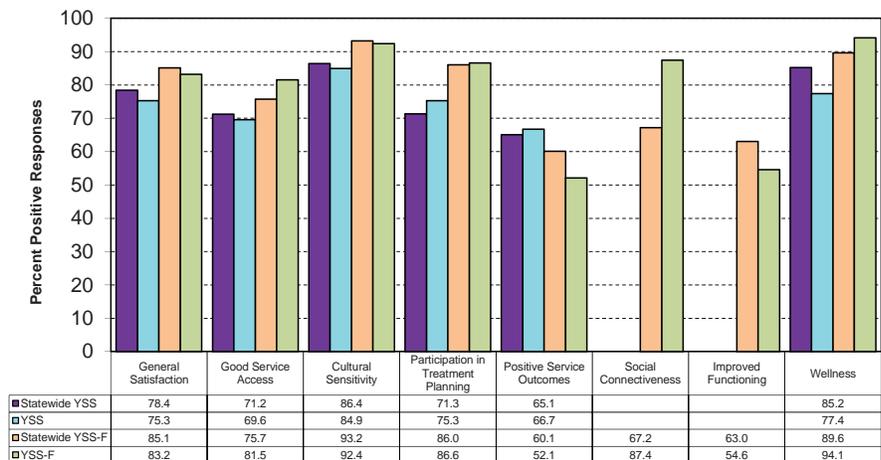
Northeastern Counseling Center—Mental Health (Continued)



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Salt Lake County



Population: 1,091,742

Salt Lake County Behavioral Health Services

County: Salt Lake

Substance Abuse and Mental Health

Administrative Agency:

Tim Whalen, Director
 Salt Lake County
 Division of Behavioral Health Services
 2001 South State Street #S2300
 Salt Lake City, UT 84190-2250
 Office: (385) 468-4707
behavioralhealthservices.slco.org

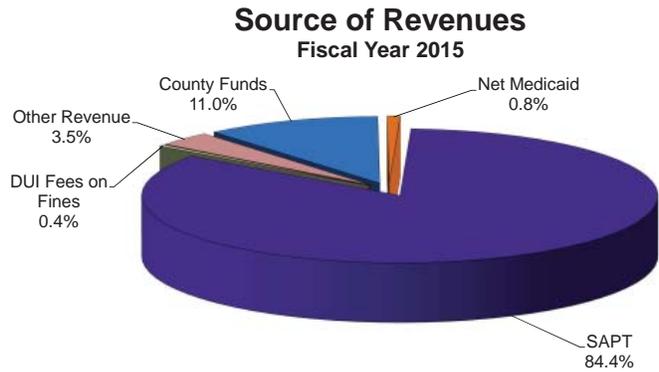
Salt Lake County Substance Abuse—Prevention

Protective Factors:

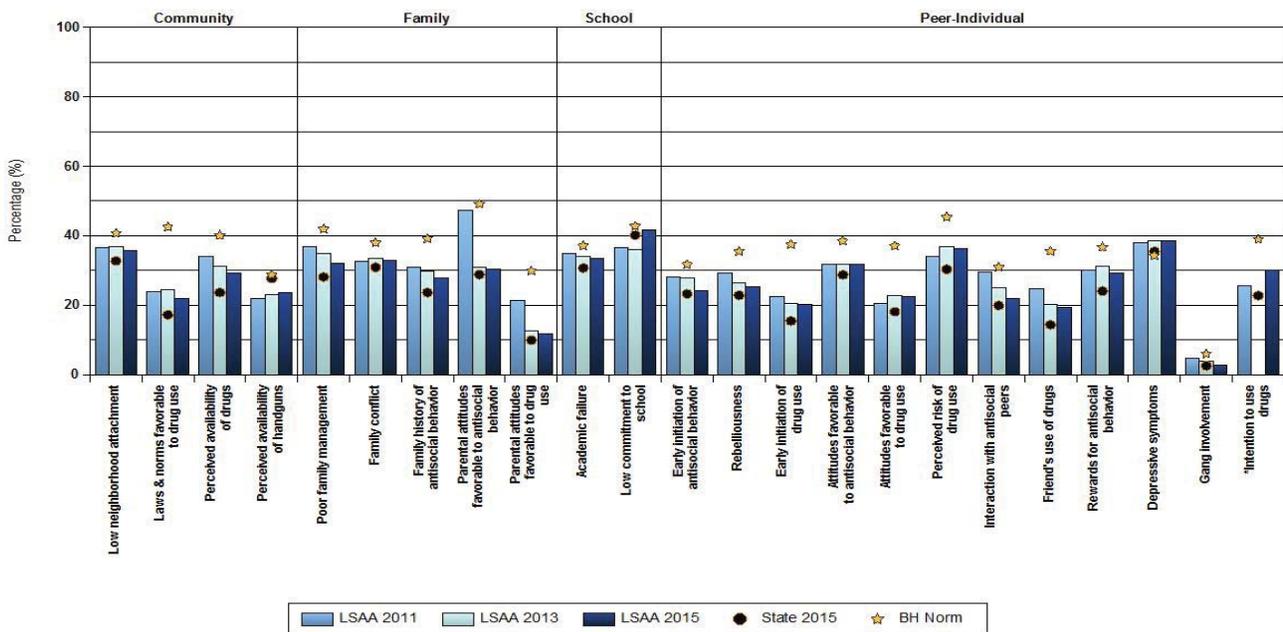
- Rewards for pro-social involvement in family and community domains
- Family attachments
- Opportunities for pro-social interaction

Prioritized Risk Factors:

- Parental/individual attitudes favorable to anti-social behavior
- Early initiation of drug use
- Low perceived risk of drug use



Risk Profile 2015 Salt Lake County LSAA Student Survey, All Grades

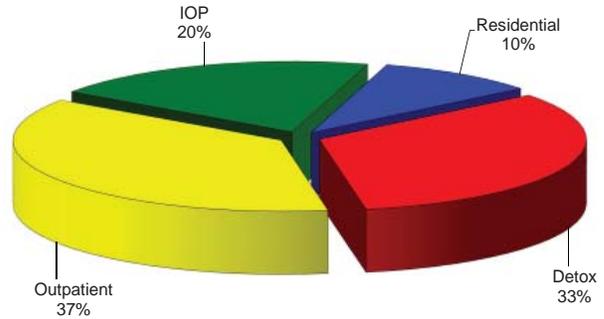


Salt Lake County—Substance Abuse

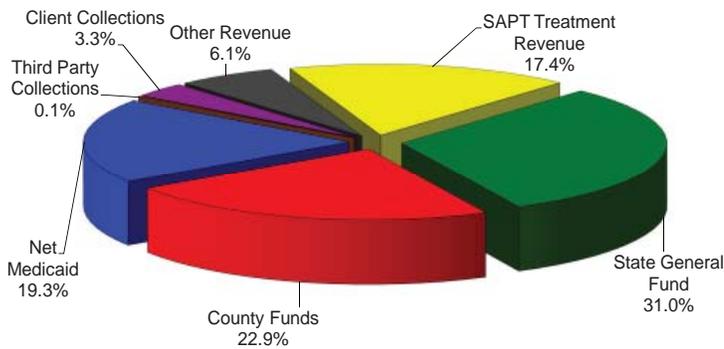
Total Clients Served.....7,582
 Adult6,925
 Youth.....657
 Penetration Rate (Total population of area)..0.7%

Total Admissions.....8,739
 Initial Admissions7,145
 Transfers.....1,594

Admissions into Modalities
Fiscal Year 2015



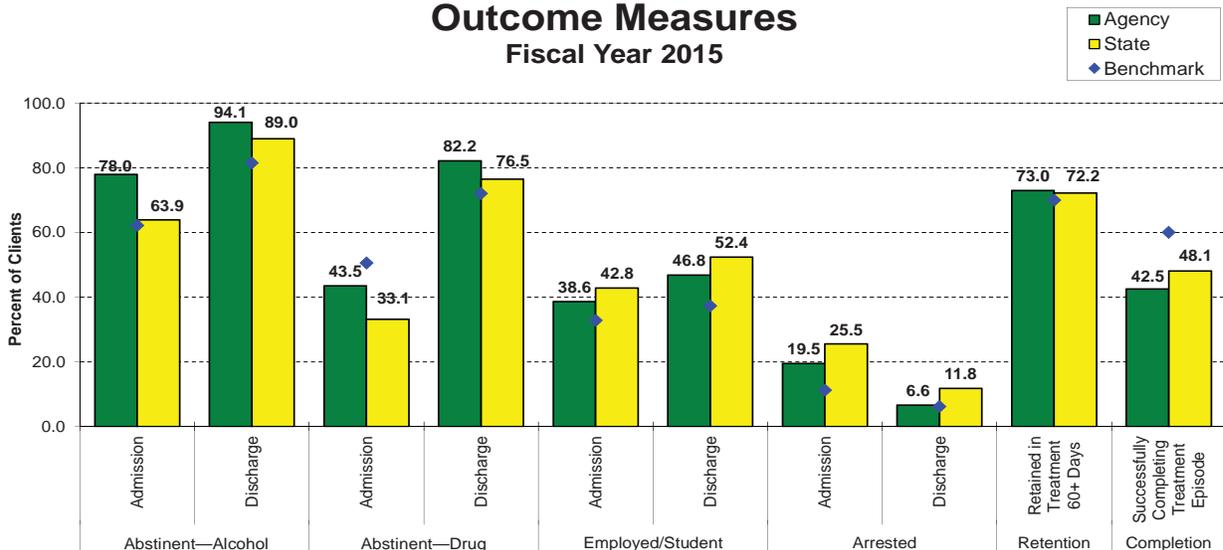
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	1,894	603	2,497
Cocaine/Crack	155	91	246
Marijuana/Hashish	934	309	1,243
Heroin	1,383	719	2,102
Other Opiates/Synthetics	119	125	244
Hallucinogens	6	4	10
Methamphetamine	1,216	840	2,056
Other Stimulants	21	20	41
Benzodiazepines	14	21	35
Tranquilizers/Sedatives	5	1	6
Inhalants	3	0	3
Oxycodone	59	83	142
Club Drugs	3	1	4
Over-the-Counter	1	2	3
Other	89	18	107
Total	5,902	2,837	8,739

Outcome Measures
Fiscal Year 2015



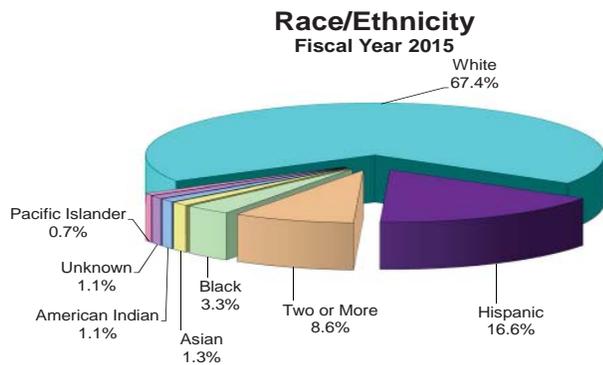
Benchmark is 75% of the National Average.

Salt Lake County—Mental Health

Total Clients Served15,266
 Adult9,268
 Youth5,998
 Penetration Rate (Total population of area) 1.4%
 Civil Commitment645
 Unfunded Clients Served1,689

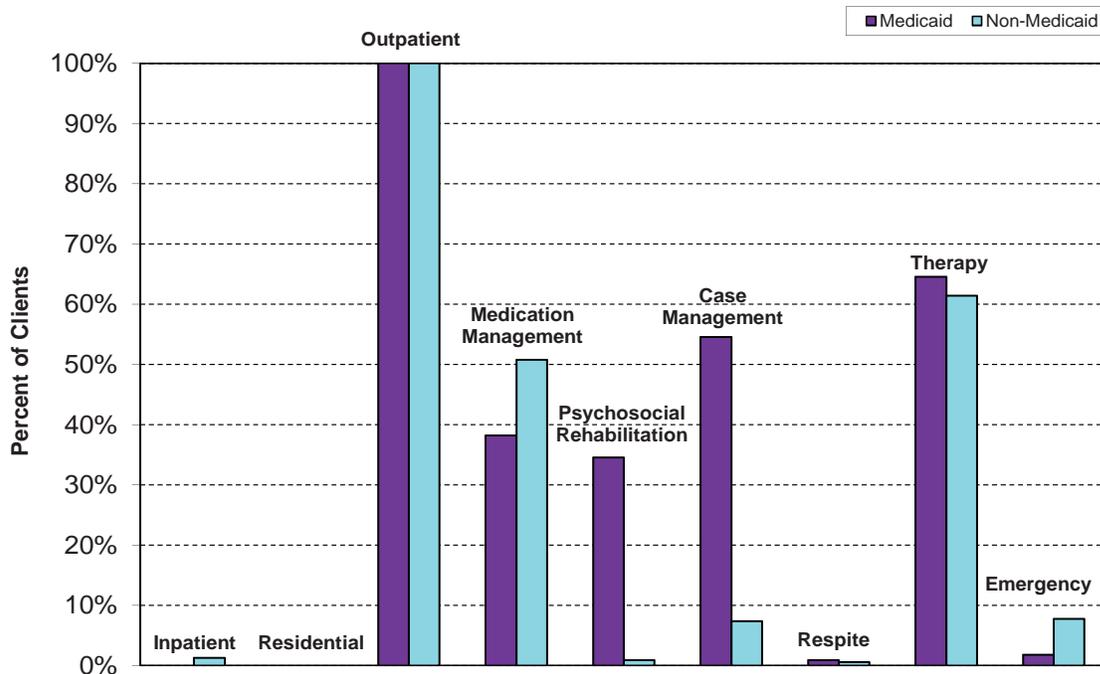
Diagnosis

	Youth	Adult
Adjustment Disorder	1,019	306
Anxiety	3,398	6,601
Attention Deficit	1,787	747
Cognitive Disorder	47	525
Conduct Disorder	109	3
Depression	857	3,511
Impulse Control Disorders	559	161
Mood Disorder	1,933	4,467
Neglect or Abuse	452	31
Oppositional Defiant Disorder	1,171	22
Personality Disorder	6	2,272
Pervasive Developmental Disorders	571	194
Schizophrenia and Other Psychotic	35	3,012
Substance Abuse	147	3,290
Other	387	541
V Codes	813	984
Total	13,291	26,667



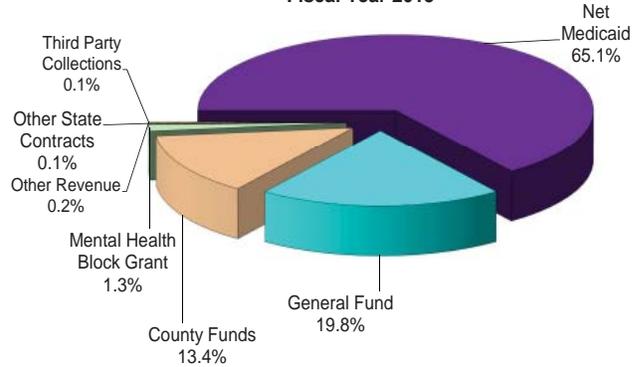
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

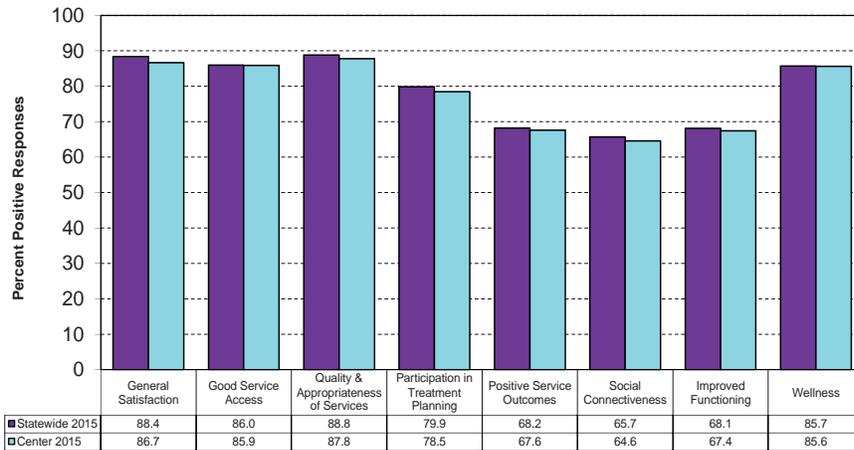


Salt Lake County—Mental Health (Continued)

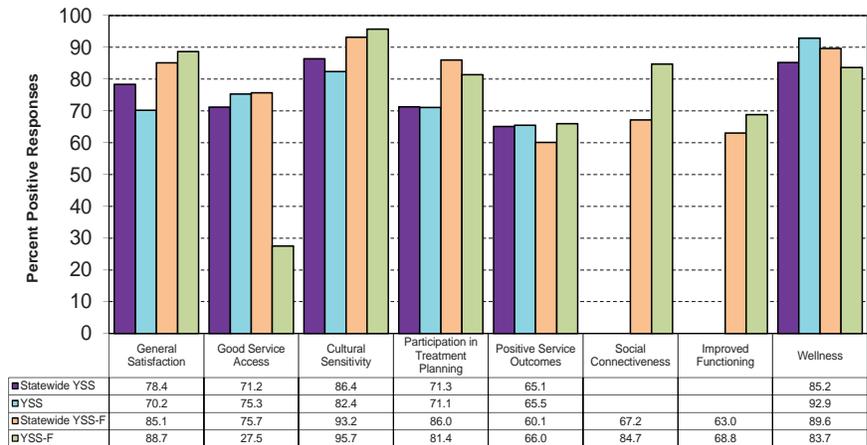
Source of Revenues
Fiscal Year 2015



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2015



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2015



San Juan County



San Juan Counseling Center

County: San Juan

Substance Abuse and Mental Health Provider

Agency:

Tammy Squires, Director
 San Juan Counseling Center
 356 South Main St.
 Blanding, UT 84511
 Office: (435) 678-2992

Population: 15,251

San Juan Substance Abuse—Prevention

Protective Factors:

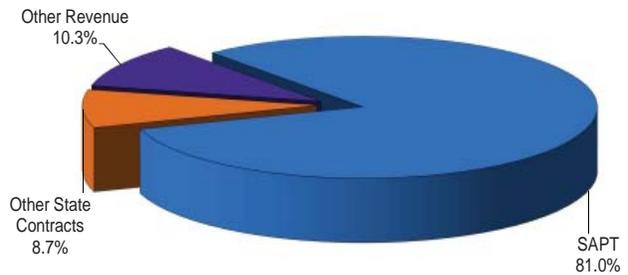
- Belief in the moral social order
- Opportunities for pro-social involvement

Prioritized Risk Factors:

- Perceived availability of drugs
- Parental attitudes favorable to anti-social behavior
- Favorable attitude toward problem behavior

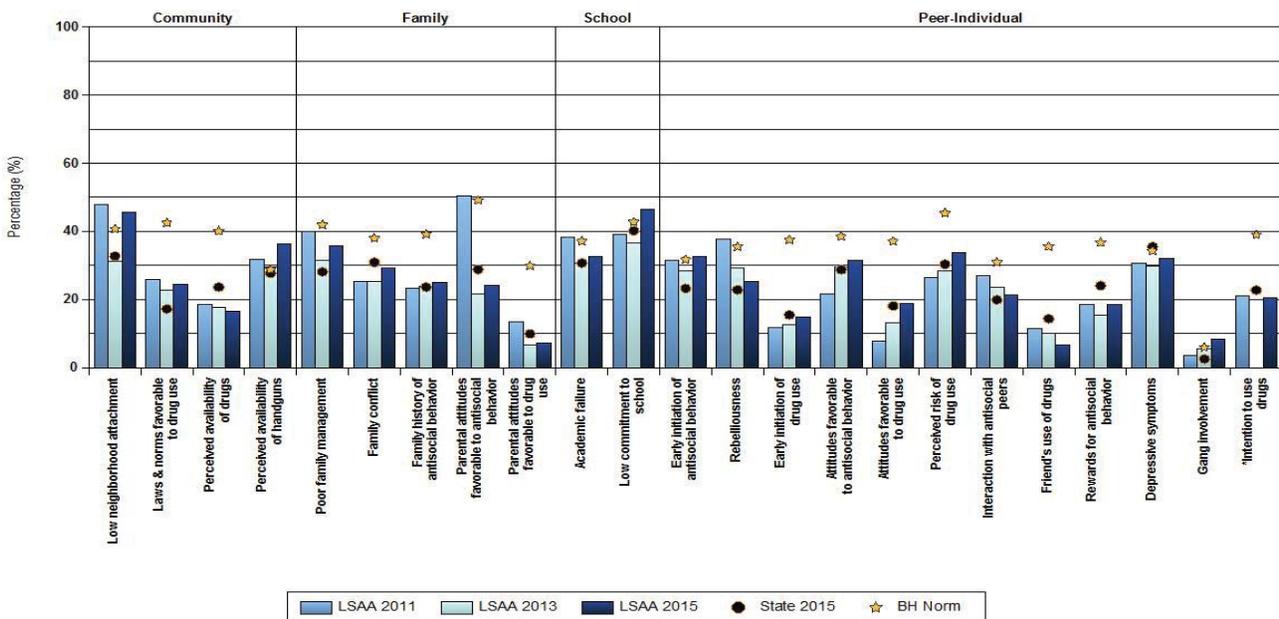
Source of Revenues

Fiscal Year 2015



Risk Profile

2015 San Juan County LSAA Student Survey, All Grades

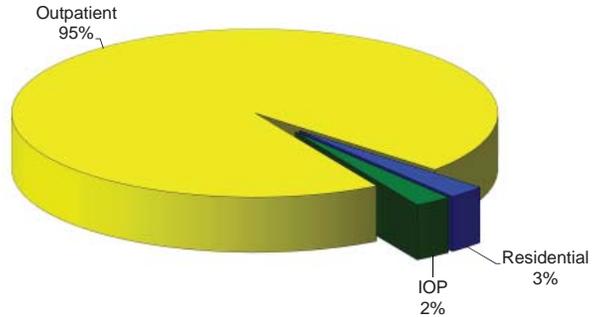


San Juan Counseling—Substance Abuse

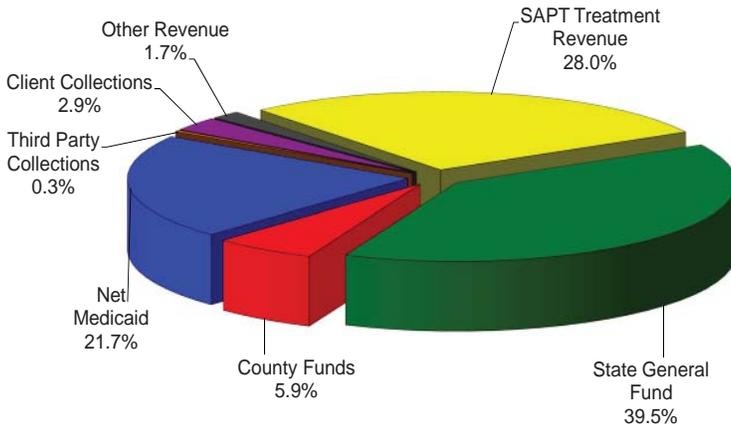
Total Clients Served.....90
 Adult73
 Youth.....17
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....81
 Initial Admissions53
 Transfers.....28

Admissions into Modalities
Fiscal Year 2015



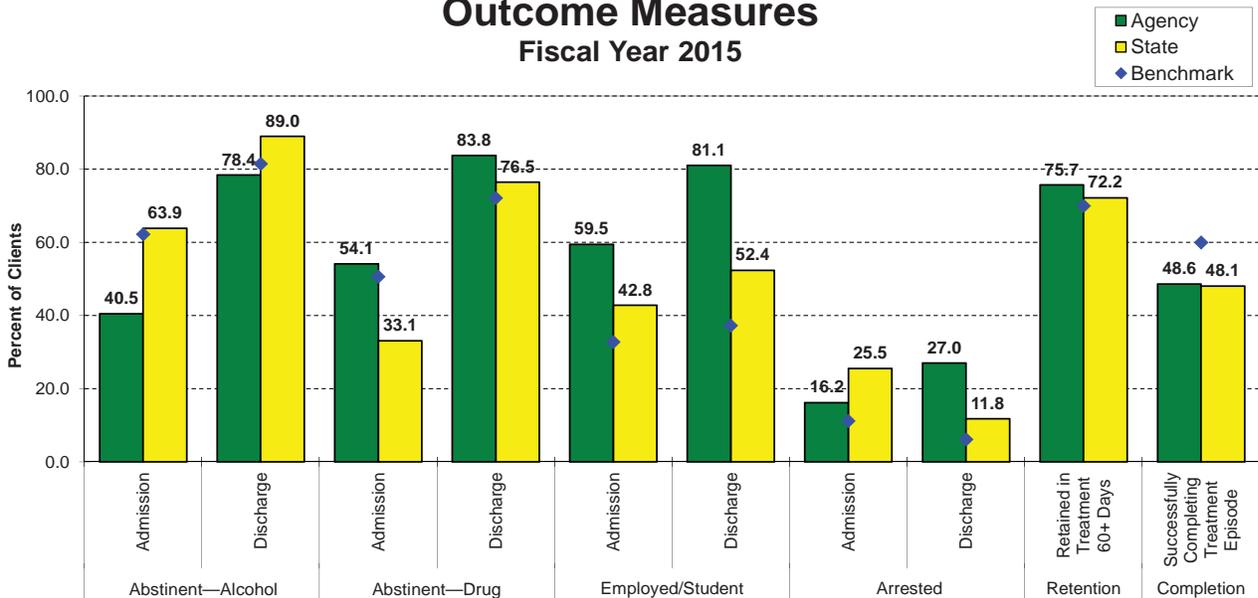
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	28	11	39
Cocaine/Crack	0	0	0
Marijuana/Hashish	17	6	23
Heroin	0	0	0
Other Opiates/Synthetics	0	0	0
Hallucinogens	0	0	0
Methamphetamine	9	6	15
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	3	1	4
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	57	24	81

Outcome Measures
Fiscal Year 2015



Benchmark is 75% of the National Average.

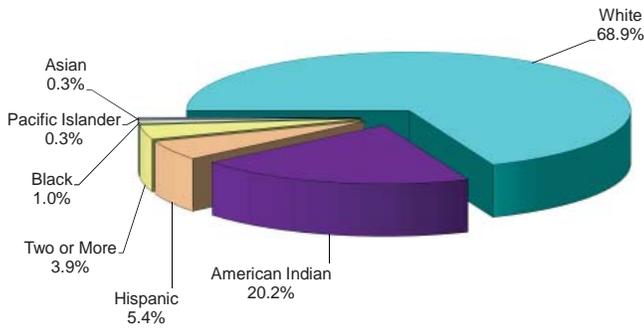
San Juan Counseling—Mental Health

Total Clients Served577
 Adult393
 Youth184
 Penetration Rate (Total population of area) 3.8%
 Civil Commitment 1
 Unfunded Clients Served 118

Diagnosis

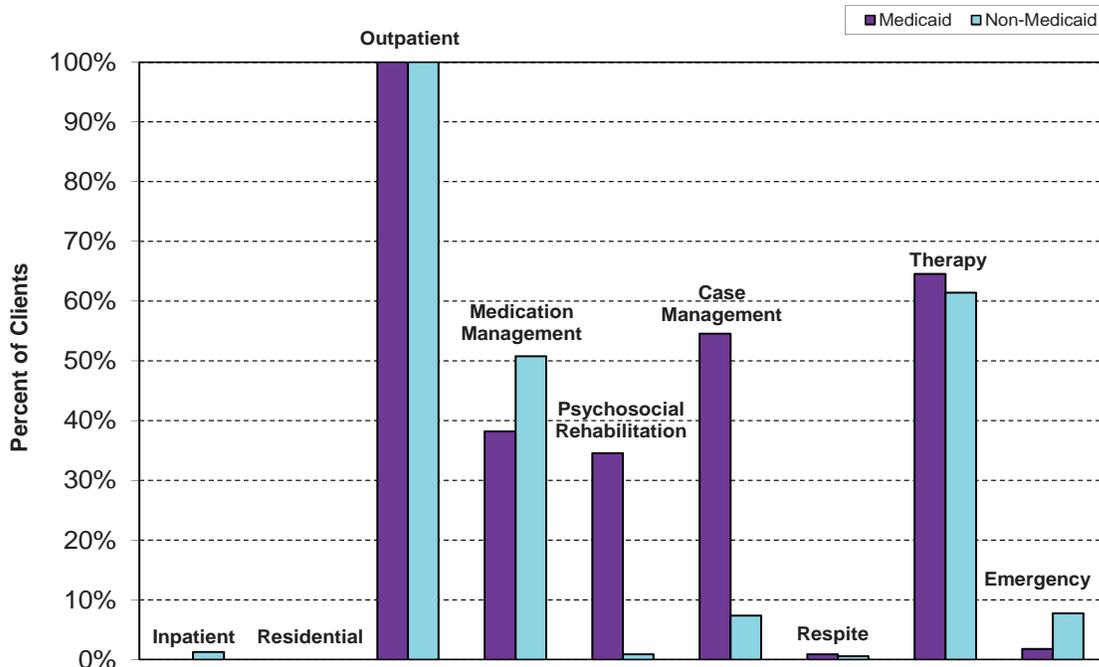
	Youth	Adult
Adjustment Disorder	32	25
Anxiety	49	191
Attention Deficit	53	48
Cognitive Disorder	2	23
Conduct Disorder	3	1
Depression	45	185
Impulse Control Disorders	4	13
Mood Disorder	27	82
Neglect or Abuse	11	4
Oppositional Defiant Disorder	8	1
Personality Disorder	0	45
Pervasive Developmental Disorders	15	8
Schizophrenia and Other Psychotic	3	22
Substance Abuse	20	101
Other	29	79
V Codes	12	38
Total	313	866

Race/Ethnicity Fiscal Year 2015

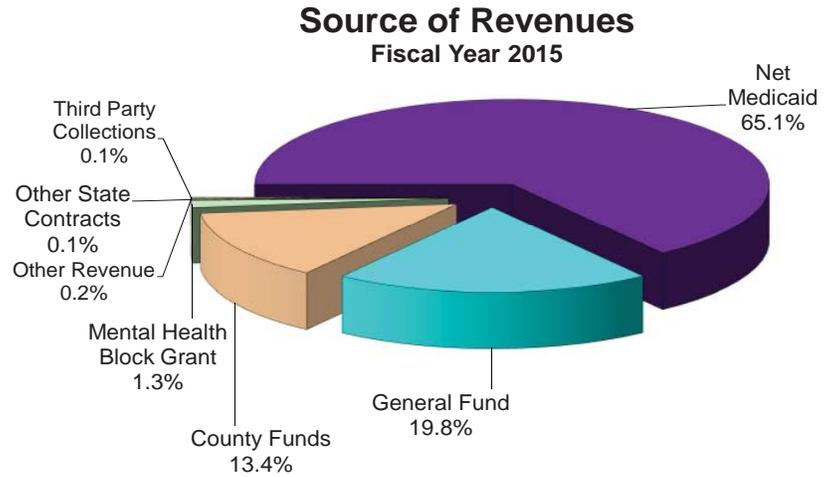


More than one race/ethnicity may have been selected.

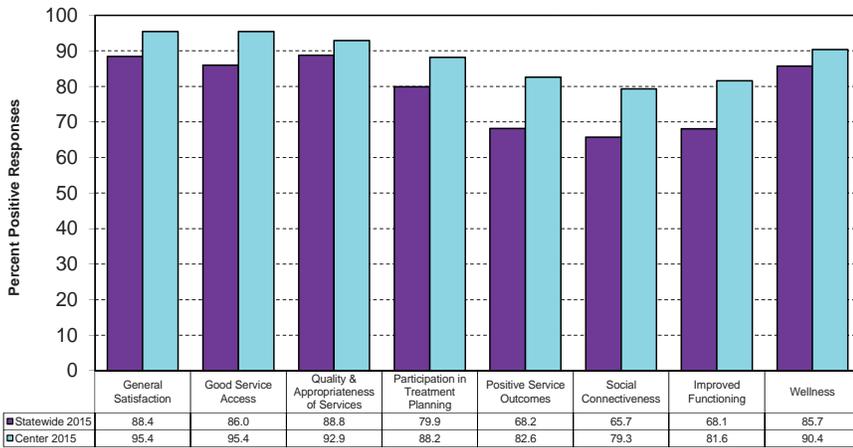
Utilization of Mandated Services Fiscal Year 2015



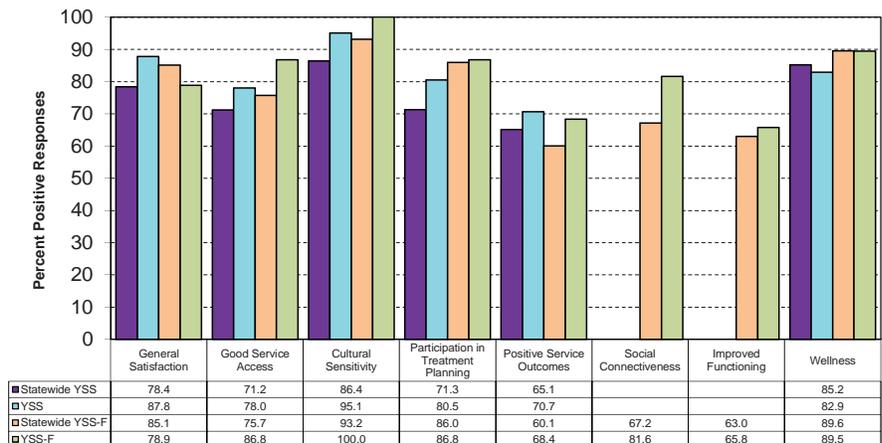
San Juan Counseling—Mental Health (Continued)



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Southwest Behavioral Health Center

Beaver, Garfield, Iron, Kane, and Washington Counties



Population: 217,956

Southwest Behavioral Health Center

Counties: Beaver, Garfield, Iron, Kane, and Washington

Substance Abuse and Mental Health Provider Agency:

Mike Deal, Director
 Southwest Behavioral Health Center
 474 West 200 North, Suite 300
 St. George, UT 84770
 Office: (435) 634-5600
www.sbhc.us

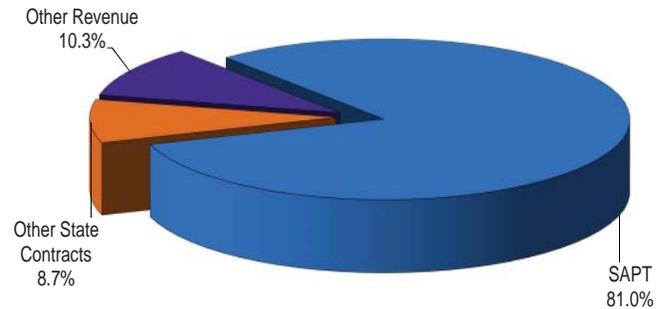
Southwest Substance Abuse—Prevention

Prioritized Risk Factors:

- Family conflict, low commitment to school
- Attitudes favorable towards anti-social behavior
- Parental attitudes favorable to anti-social behavior
- Early initiation of drug use
- Depressive symptoms

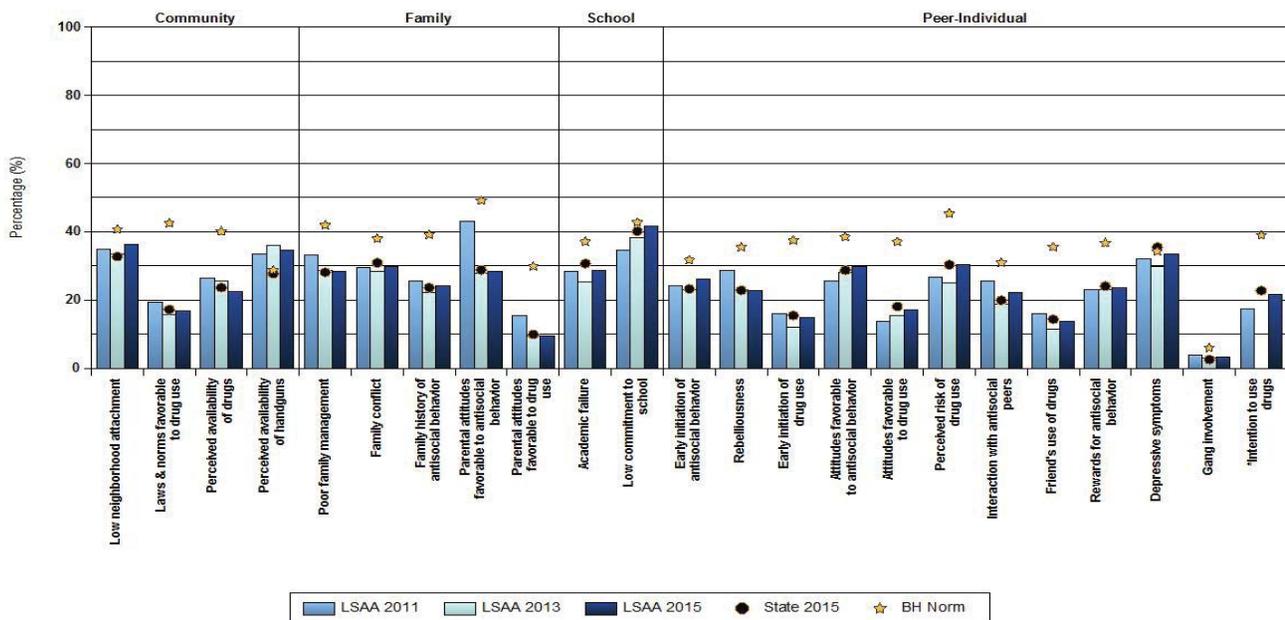
Source of Revenues

Fiscal Year 2015



Risk Profile

2015 Southwest District LSAA Student Survey, All Grades

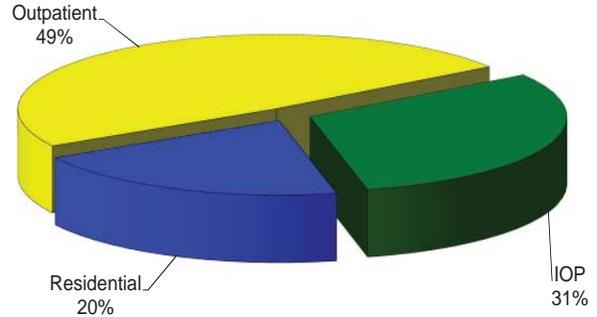


Southwest Behavioral Health Center—Substance Abuse

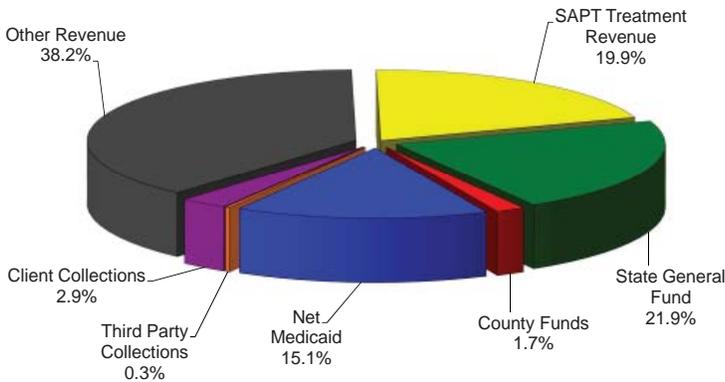
Total Clients Served.....639
 Adult603
 Youth.....36
 Penetration Rate (Total population of area)..0.3%

Total Admissions.....613
 Initial Admissions359
 Transfers.....254

Admissions into Modalities
Fiscal Year 2015



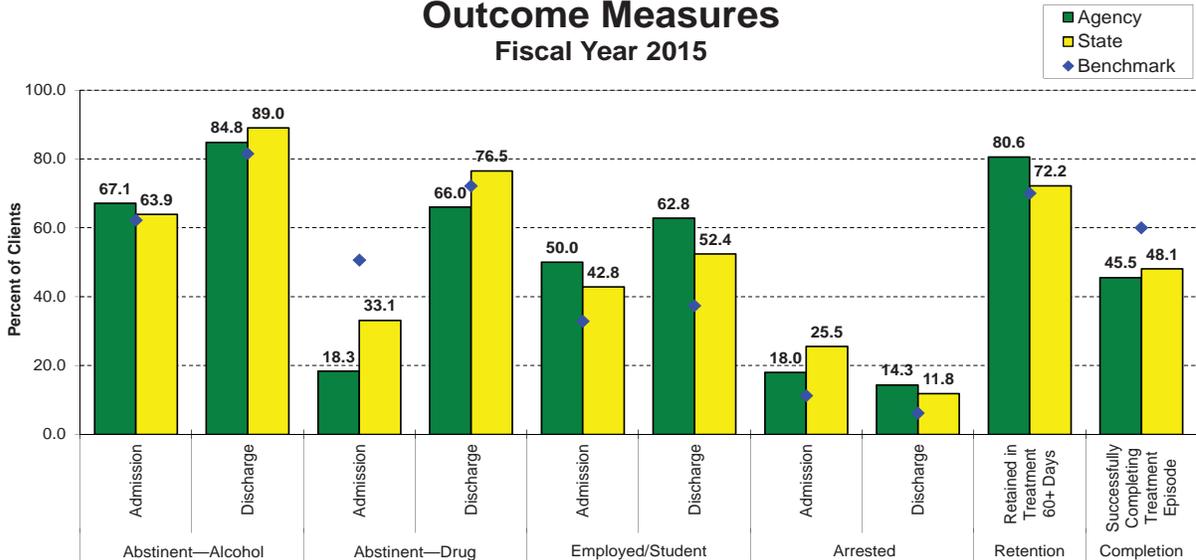
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	75	30	105
Cocaine/Crack	3	1	4
Marijuana/Hashish	59	31	90
Heroin	86	72	158
Other Opiates/Synthetics	11	17	28
Hallucinogens	0	1	1
Methamphetamine	84	108	192
Other Stimulants	1	2	3
Benzodiazepines	3	3	6
Tranquilizers/Sedatives	0	0	0
Inhalants	1	0	1
Oxycodone	5	18	23
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	1	2
Total	329	284	613

Outcome Measures
Fiscal Year 2015



Benchmark is 75% of the National Average.

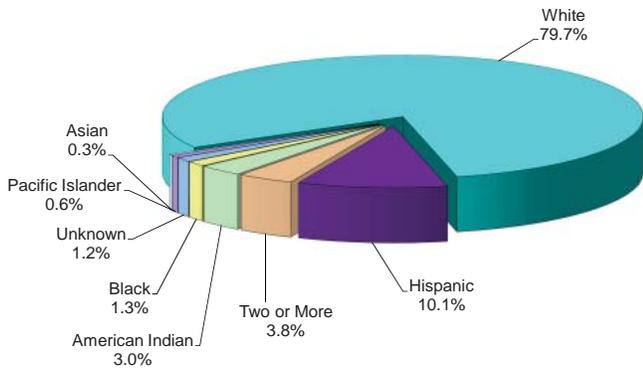
Southwest Behavioral Health Center—Mental Health

Total Clients Served.....3,213
 Adult1,482
 Youth.....1,731
 Penetration Rate (Total population of area)..... 1.5%
 Civil Commitment46
 Unfunded Clients Served441

Diagnosis

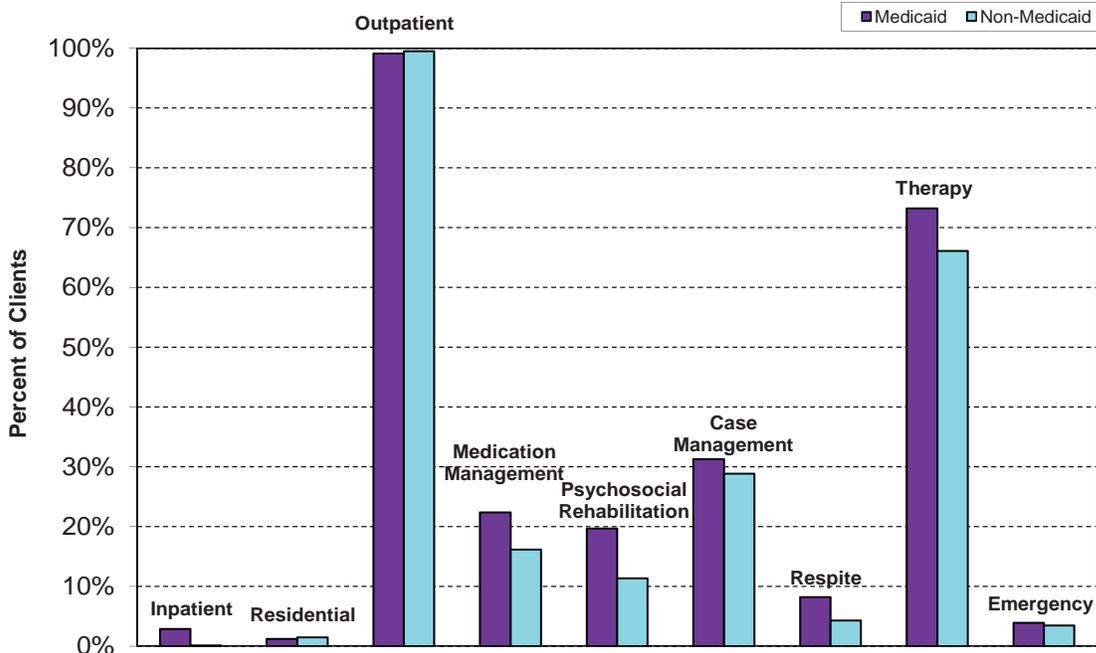
	Youth	Adult
Adjustment Disorder	437	96
Anxiety	777	568
Attention Deficit	315	55
Cognitive Disorder	39	139
Conduct Disorder	24	10
Depression	151	266
Impulse Control Disorders	259	31
Mood Disorder	417	646
Neglect or Abuse	258	31
Oppositional Defiant Disorder	95	11
Personality Disorder	54	413
Pervasive Developmental Disorders	315	85
Schizophrenia and Other Psychotic	4	225
Substance Abuse	143	516
Other	196	58
V Codes	585	207
Total	4,069	3,357

Race/Ethnicity Fiscal Year 2015



More than one race/ethnicity may have been selected.

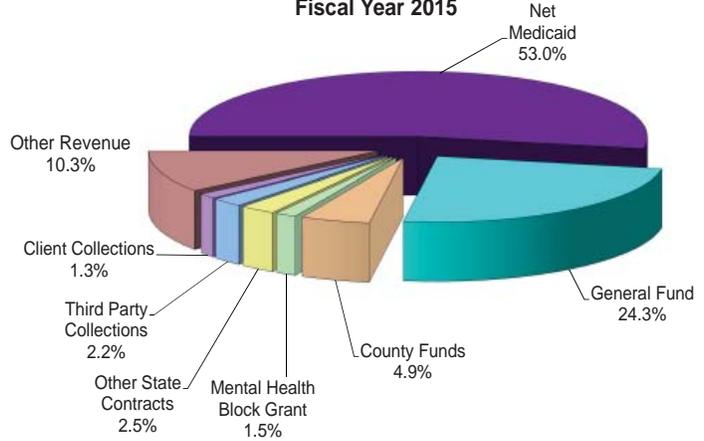
Utilization of Mandated Services Fiscal Year 2015



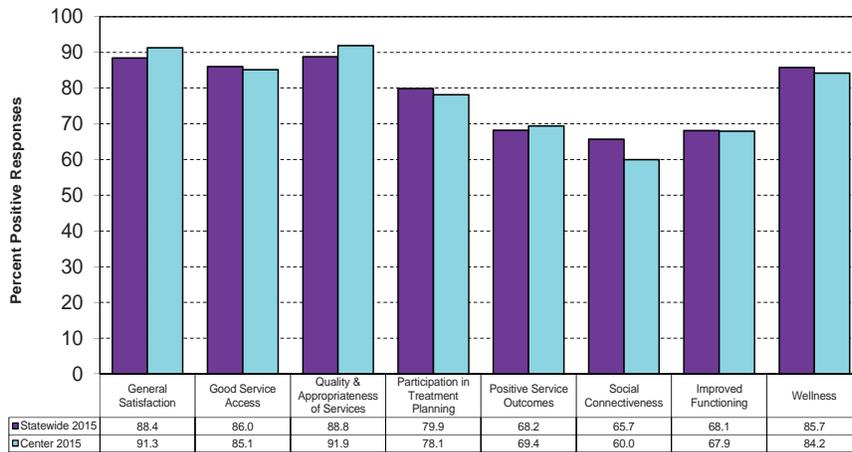
Southwest Behavioral Health Center—Mental Health (Continued)

Source of Revenues

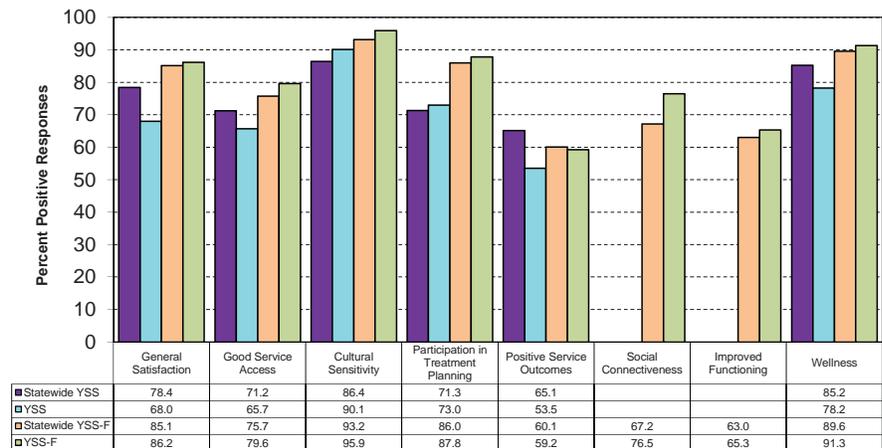
Fiscal Year 2015



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Summit County



Population: 39,105

Valley Behavioral Health

County: Summit

Substance Abuse and Mental Health Provider Agency:

Gary Larcenaire, CEO/President
 Dodi Wilson, Program Manager
 Valley Behavioral Health, Summit County
 1753 Sidewinder Drive
 Park City, UT 84060-7322
 Office: (435) 649-8347
 Fax: (435) 649-2157
www.valleycares.com

Summit Substance Abuse—Prevention

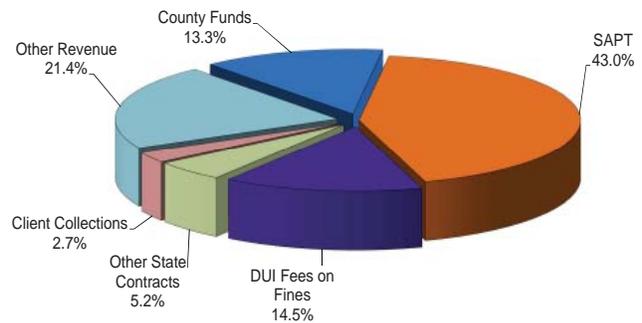
Protective Factors:

- Rewards for pro-social involvement
- Opportunities for pro-social involvement

Prioritized Risk Factors:

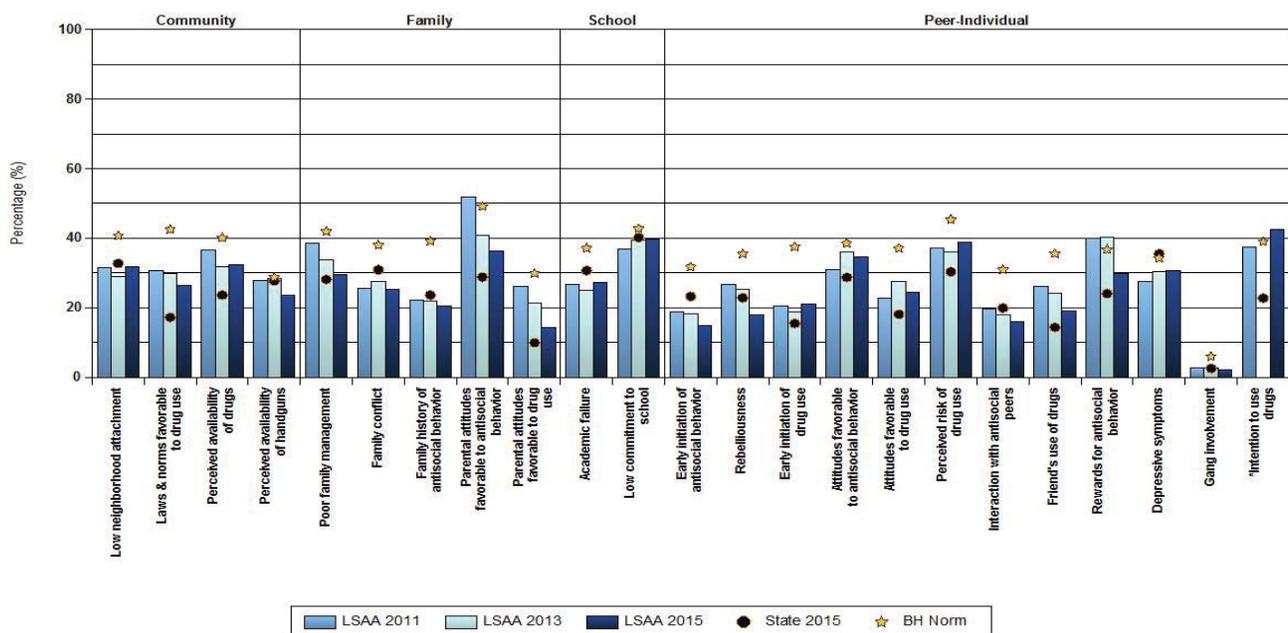
- Parental attitudes favorable to anti-social behavior
- Low perceived risk of drug use

Source of Revenues
Fiscal Year 2015



Risk Profile

2015 Summit County LSAA Student Survey, All Grades

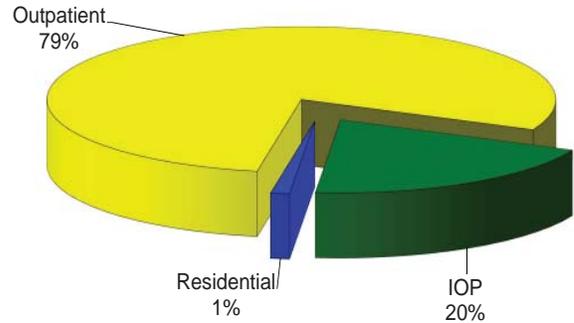


Summit County—Valley Behavioral Health—Substance Abuse

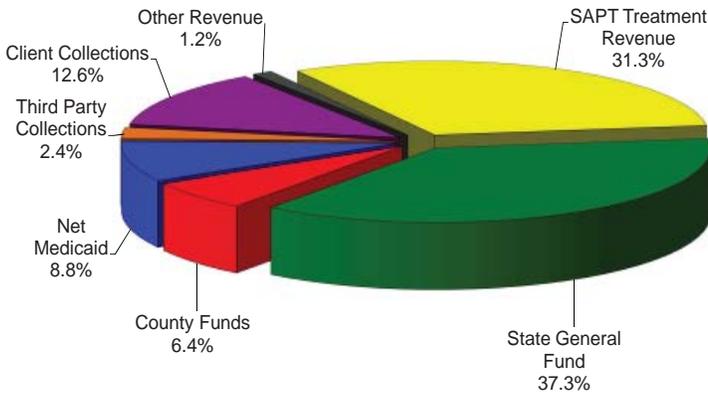
Total Clients Served317
 Adult293
 Youth24
 Penetration Rate (Total population of area)..0.8%

Total Admissions167
 Initial Admissions148
 Transfers.....19

Admissions into Modalities Fiscal Year 2015



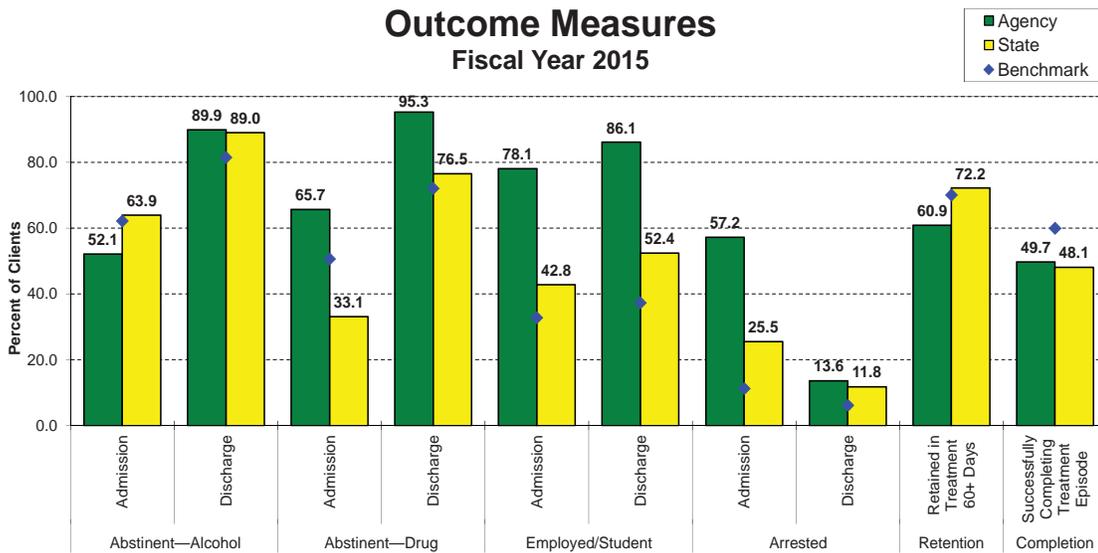
Source of Revenues Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	80	19	99
Cocaine/Crack	0	1	1
Marijuana/Hashish	26	10	36
Heroin	8	4	12
Other Opiates/Synthetics	3	2	5
Hallucinogens	0	0	0
Methamphetamine	4	4	8
Other Stimulants	1	1	2
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	1	2
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	2	0	2
Total	125	42	167

Outcome Measures Fiscal Year 2015



Benchmark is 75% of the National Average.

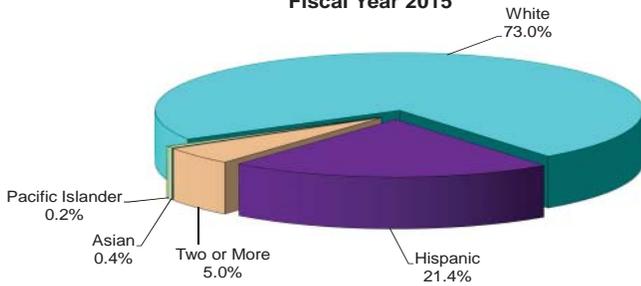
Summit County—Valley Behavioral Health—Mental Health

Total Clients Served390
 Adult238
 Youth.....152
 Penetration Rate (Total population of area)..... 1.0%
 Civil Commitment1
 Unfunded Clients Served26

Diagnosis

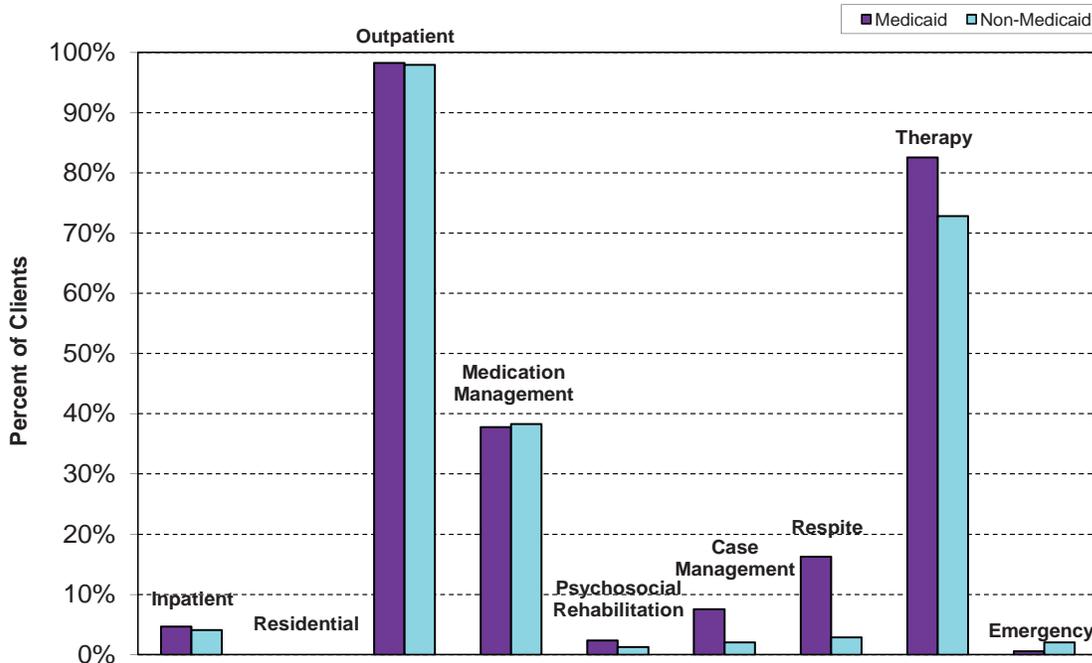
	Youth	Adult
Adjustment Disorder	28	21
Anxiety	63	160
Attention Deficit	39	25
Cognitive Disorder	0	7
Conduct Disorder	0	0
Depression	17	83
Impulse Control Disorders	9	3
Mood Disorder	26	79
Neglect or Abuse	12	4
Oppositional Defiant Disorder	19	0
Personality Disorder	1	32
Pervasive Developmental Disorders	8	6
Schizophrenia and Other Psychotic	0	10
Substance Abuse	4	94
Other	14	9
V Codes	53	38
Total	293	571

Race/Ethnicity
Fiscal Year 2015



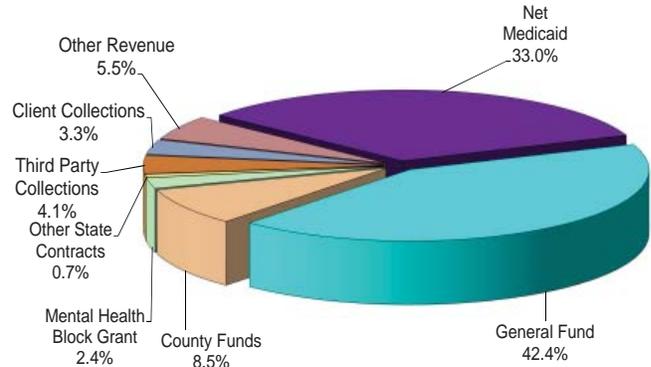
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

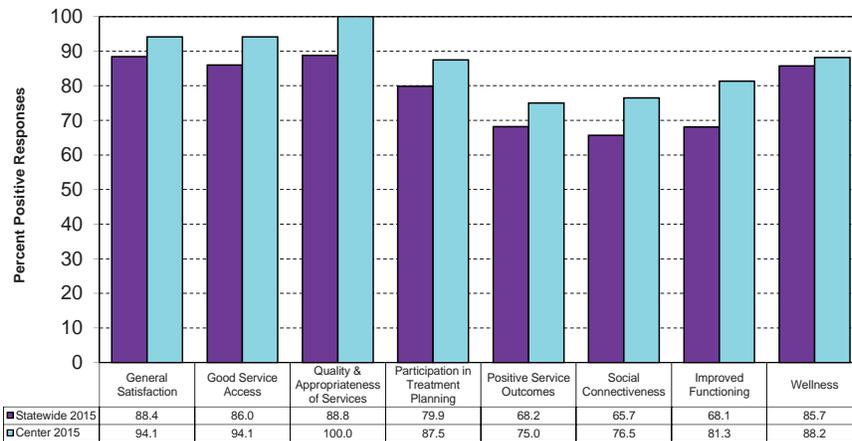


Summit County—Valley Behavioral Health—Mental Health (Continued)

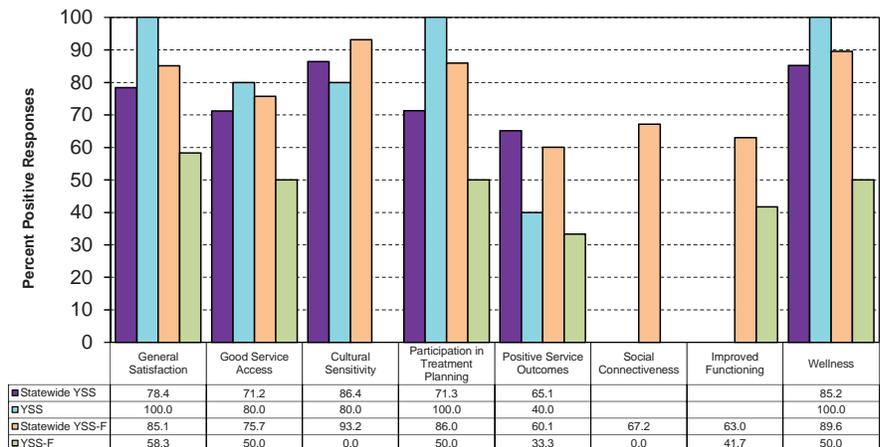
Source of Revenues
Fiscal Year 2015



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Tooele County



Population: 61,598

Valley Behavioral Health

County: Tooele

Substance Abuse and Mental Health Provider Agency:

Gary Larcenaire, CEO/President
 Rebecca Brown, Interim Program Manager
 Randy Dow, Interim Program Manager
 Valley Behavioral Health, Tooele County
 100 South 1000 West
 Tooele, UT 84074
 Office: (435) 843-3520
www.valleycares.com

Tooele Substance Abuse—Prevention

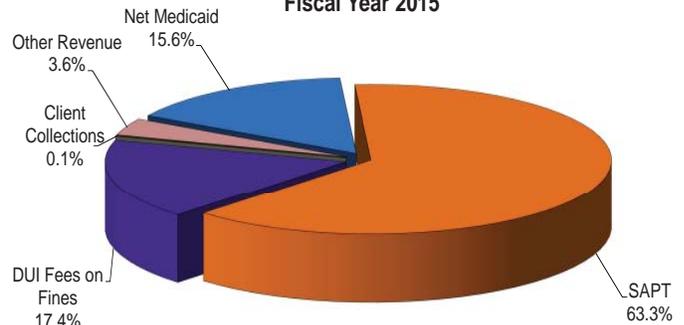
Protective Factors:

- Community opportunities for pro-social involvement
- Rewards for pro-social behavior

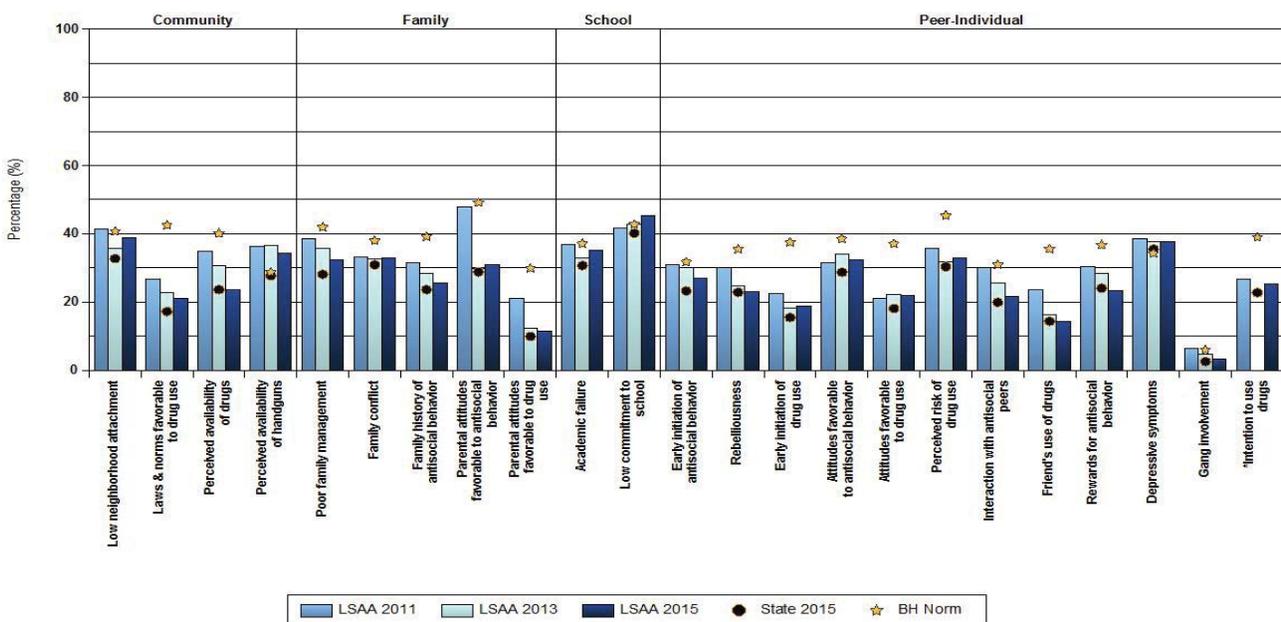
Prioritized Risk Factors:

- Low commitment to school
- Attitudes favorable to anti-social behavior
- Attitudes favorable to drug use
- Depressive symptoms

Source of Revenues
Fiscal Year 2015



Risk Profile 2015 Tooele County LSAA Student Survey, All Grades

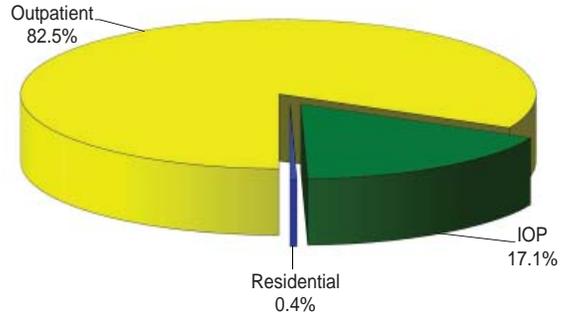


Tooele County—Valley Behavioral Health—Substance Abuse

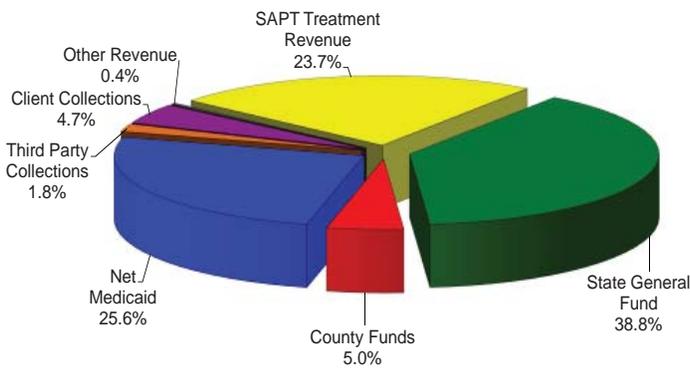
Total Clients Served.....478
 Adult431
 Youth.....47
 Penetration Rate (Total population of area) . 0.8%

Total Admissions.....234
 Initial Admissions227
 Transfers.....7

Admissions into Modalities
Fiscal Year 2015



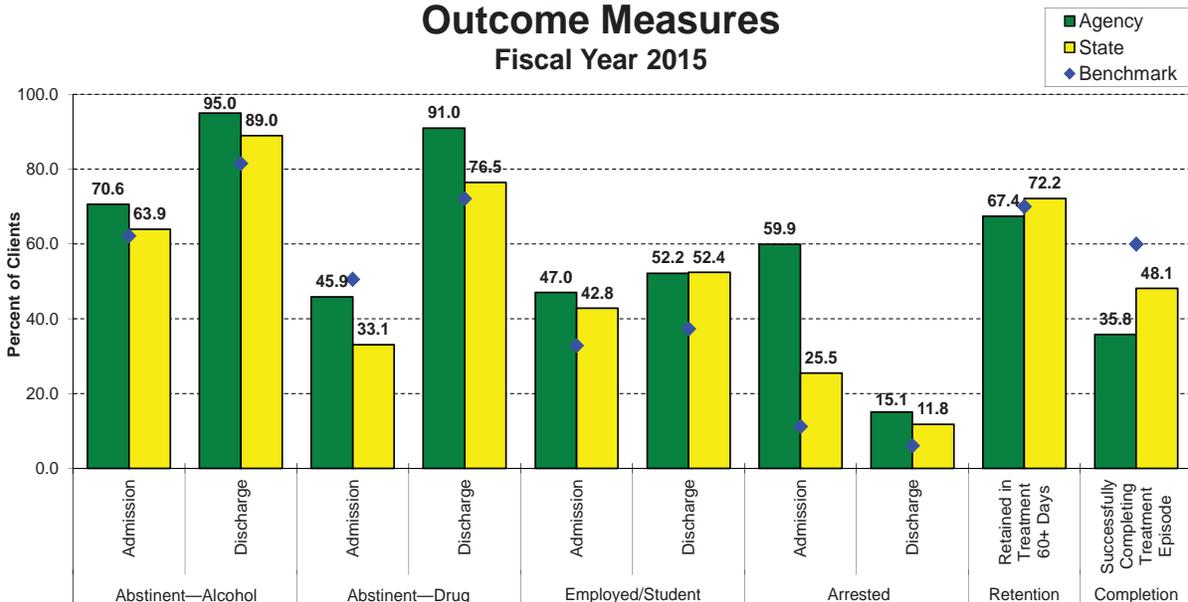
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	52	16	68
Cocaine/Crack	2	2	4
Marijuana/Hashish	43	17	60
Heroin	17	11	28
Other Opiates/Synthetics	9	3	12
Hallucinogens	0	0	0
Methamphetamine	29	21	50
Other Stimulants	3	3	6
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	2	2
Inhalants	0	0	0
Oxycodone	0	2	2
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	1	1
Total	155	79	234

Outcome Measures
Fiscal Year 2015



Benchmark is 75% of the National Average.

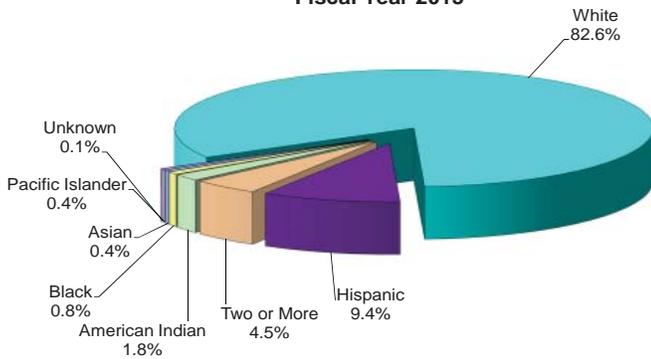
Tooele County—Valley Behavioral Health—Mental Health

Total Clients Served.....1,585
 Adult947
 Youth.....638
 Penetration Rate (Total population of area)..... 2.6%
 Civil Commitment35
 Unfunded Clients Served 113

Diagnosis

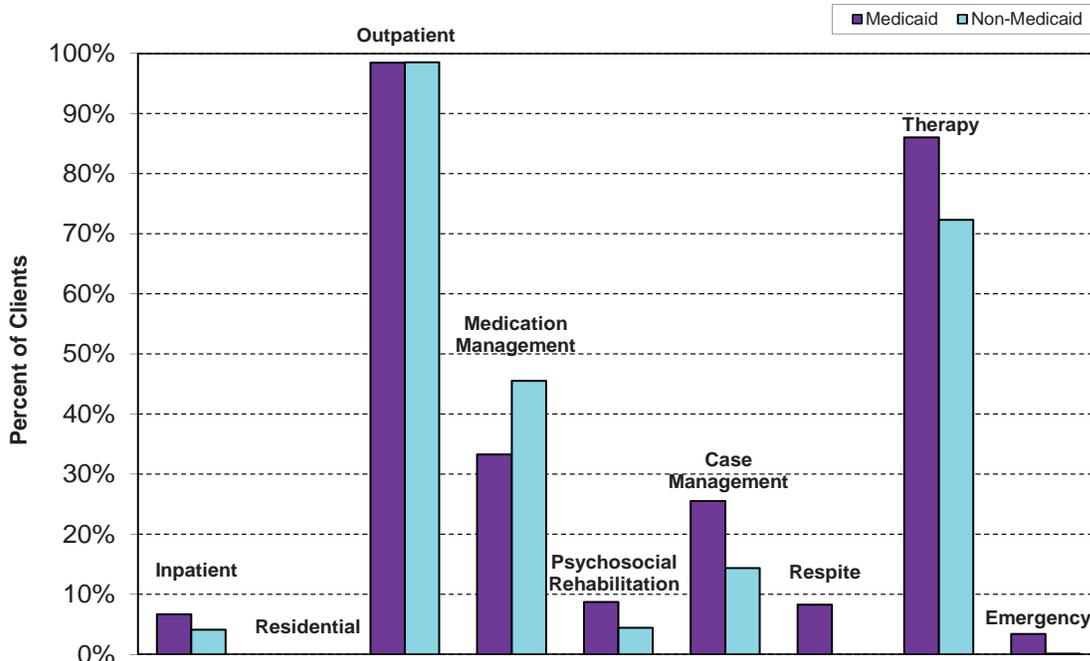
	Youth	Adult
Adjustment Disorder	106	36
Anxiety	316	652
Attention Deficit	158	77
Cognitive Disorder	3	29
Conduct Disorder	10	1
Depression	132	399
Impulse Control Disorders	27	7
Mood Disorder	118	341
Neglect or Abuse	102	16
Oppositional Defiant Disorder	76	4
Personality Disorder	1	146
Pervasive Developmental Disorders	37	16
Schizophrenia and Other Psychotic	0	73
Substance Abuse	28	397
Other	40	38
V Codes	265	162
Total	1,419	2,394

Race/Ethnicity Fiscal Year 2015



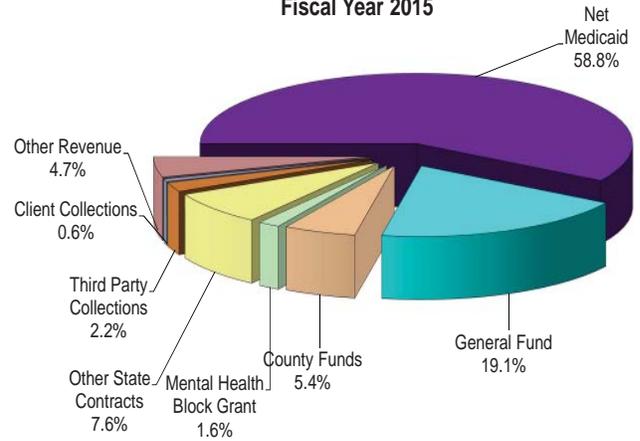
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

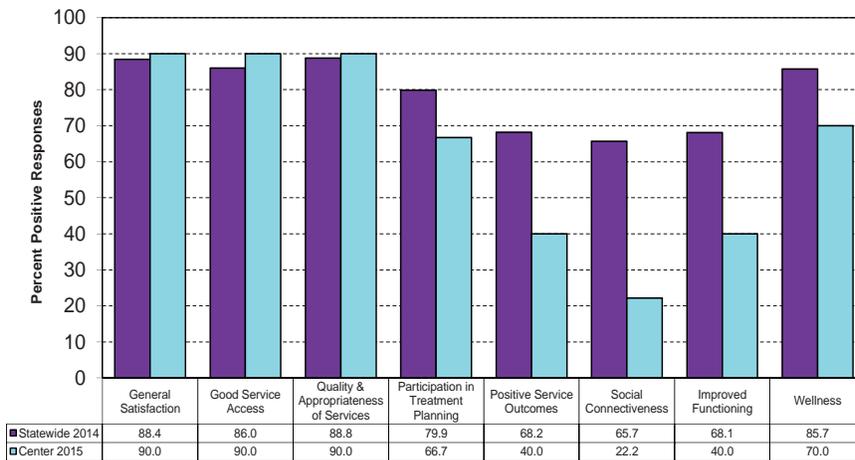


Tooele County—Valley Behavioral Health—Mental Health (Continued)

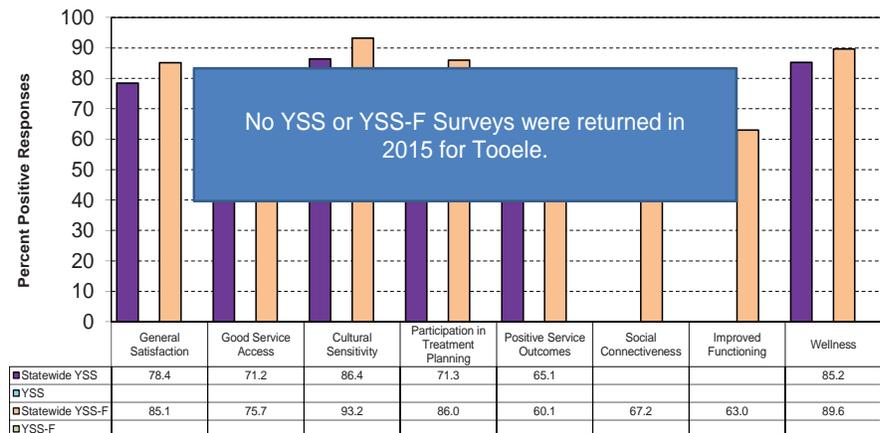
Source of Revenues
Fiscal Year 2015



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Utah County



Population: 560,974

Substance Abuse Provider Agency:

Richard Nance, Director
 Utah County Department of Drug and Alcohol
 Prevention and Treatment
 151 South University Ave. Ste 3200
 Provo, UT 84601
 Office: (801) 851-7127, www.utahcountyonline.org

Mental Health Provider Agency:

Juergen Korbanka, Executive Director
 Wasatch Mental Health
 750 North Freedom Blvd., Ste 300
 Provo, UT 84601
 Office: (801) 852-4703, www.wasatch.org

Utah County—Prevention

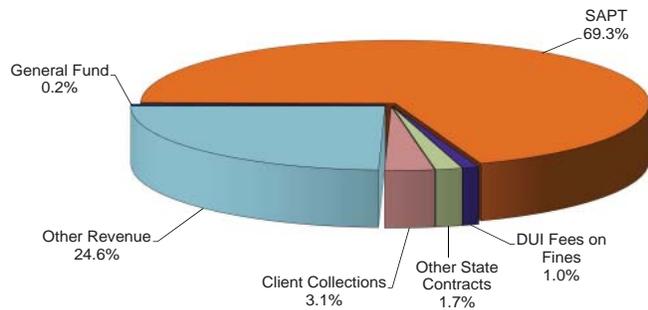
Protective Factors:

- Rewards for pro-social involvement in school
- Family and individual pro-social involvement

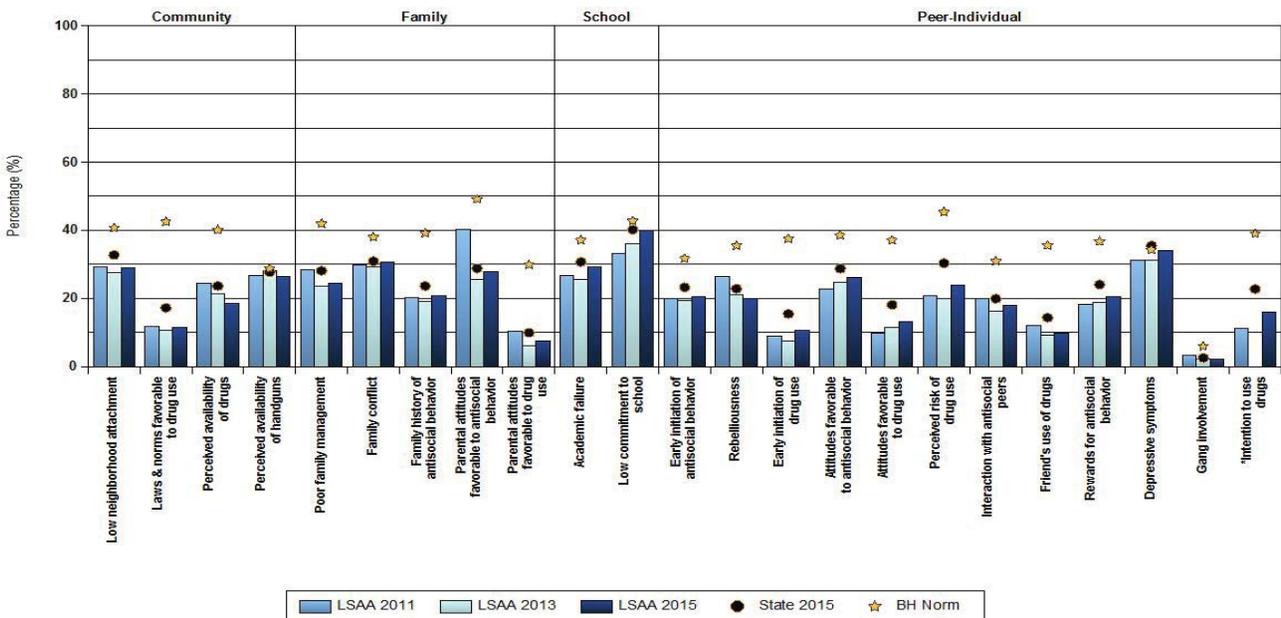
Prioritized Risk Factors:

- Low commitment to school
- Depressive symptoms
- Parental attitudes favorable to anti-social behavior

Source of Revenues
Fiscal Year 2015



Risk Profile 2015 Utah County LSAA Student Survey, All Grades



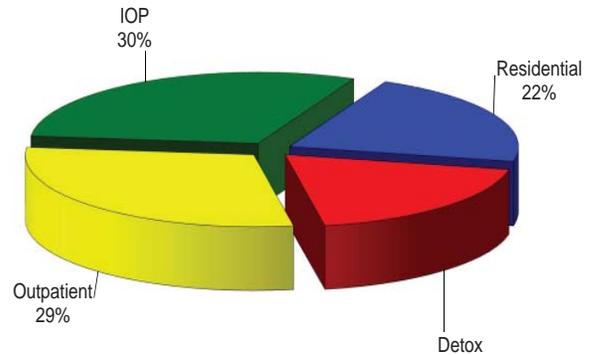
Utah County—Substance Abuse

Total Clients Served.....946
 Adult908
 Youth.....38
 Penetration Rate (Total population of area)..0.2%

Total Admissions.....1,277
 Initial Admissions689
 Transfers.....588

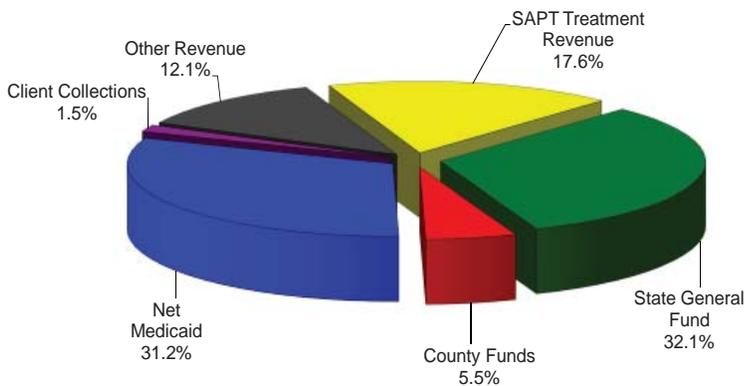
Admissions into Modalities

Fiscal Year 2015



Source of Revenues

Fiscal Year 2015

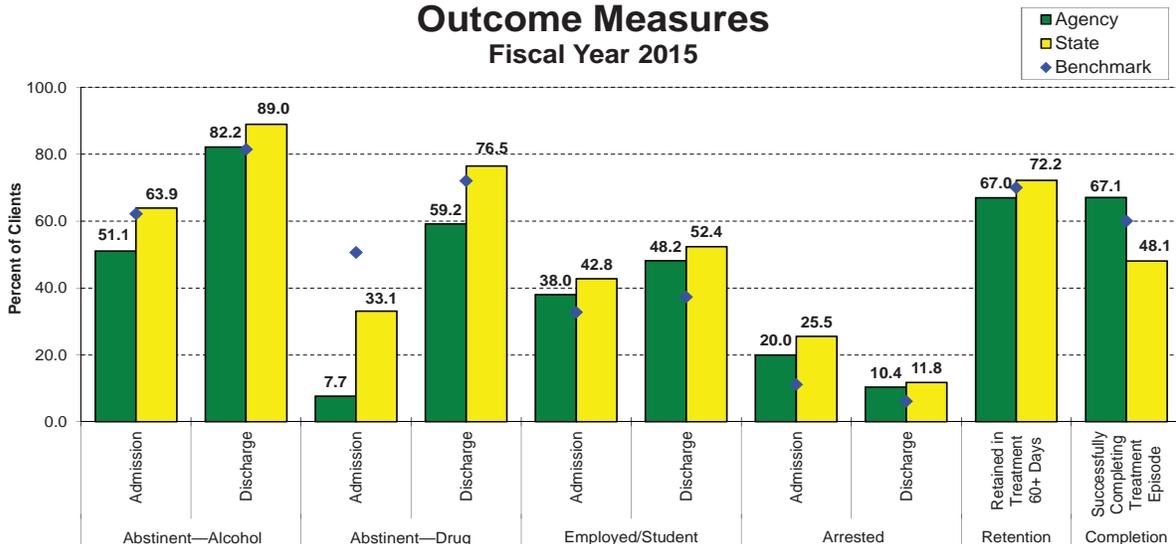


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	234	180	414
Cocaine/Crack	34	19	53
Marijuana/Hashish	108	74	182
Heroin	179	186	365
Other Opiates/Synthetics	5	22	27
Hallucinogens	1	1	2
Methamphetamine	76	101	177
Other Stimulants	3	1	4
Benzodiazepines	5	8	13
Tranquilizers/Sedatives	0	0	0
Inhalants	0	1	1
Oxycodone	13	19	32
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	5	6
Unknown	0	1	1
Total	659	618	1,277

Outcome Measures

Fiscal Year 2015



Benchmark is 75% of the National Average.

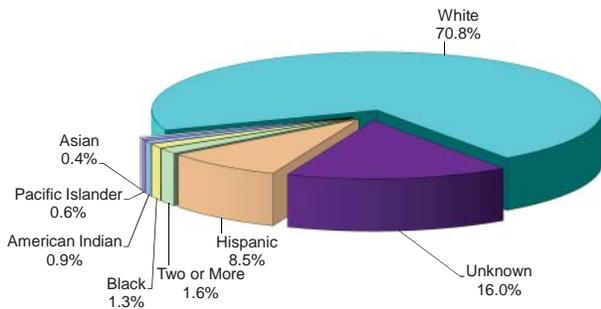
Utah County—Wasatch Mental Health

Total Clients Served10,533
 Adult6,766
 Youth3,767
 Penetration Rate (Total population of area) 1.9%
 Civil Commitment239
 Unfunded Clients Served758

Diagnosis

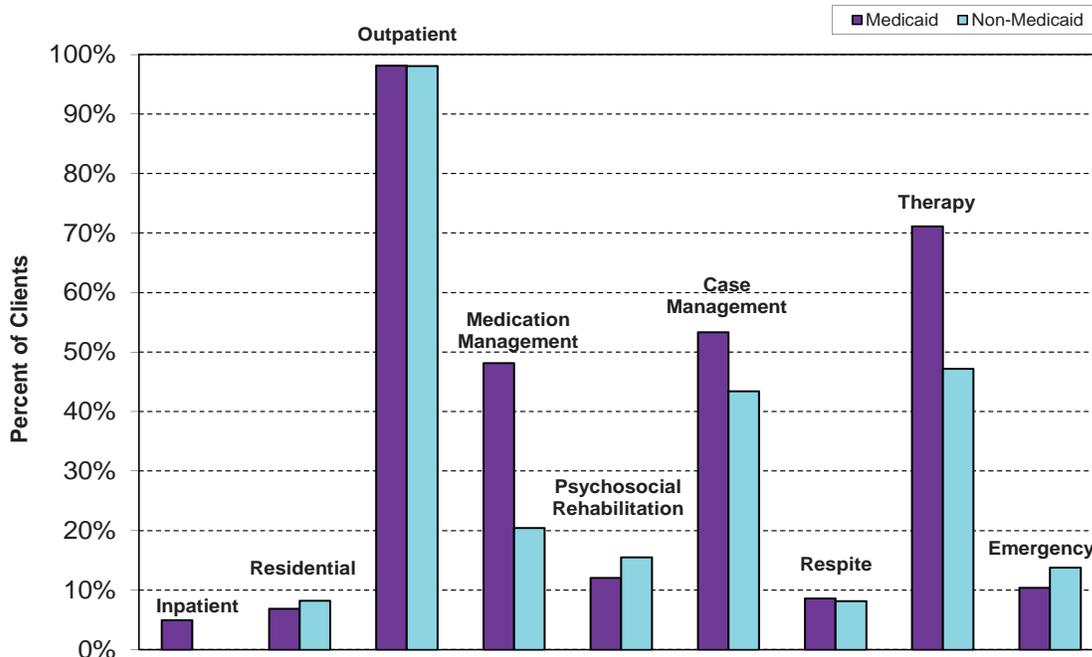
	Youth	Adult
Adjustment Disorder	731	220
Anxiety	1,478	3,349
Attention Deficit	913	641
Cognitive Disorder	57	490
Conduct Disorder	43	10
Depression	416	1,565
Impulse Control Disorders	241	169
Mood Disorder	922	1,583
Neglect or Abuse	566	344
Oppositional Defiant Disorder	250	29
Personality Disorder	8	644
Pervasive Developmental Disorders	448	207
Schizophrenia and Other Psychotic	9	688
Substance Abuse	4	107
Other	302	362
V Codes	963	640
Total	7,351	11,048

Race/Ethnicity
Fiscal Year 2015



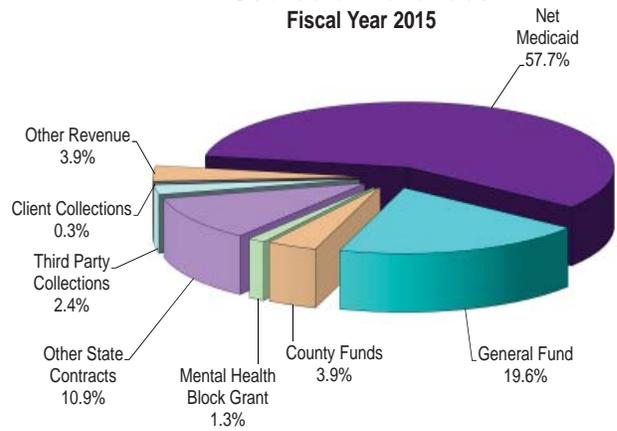
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

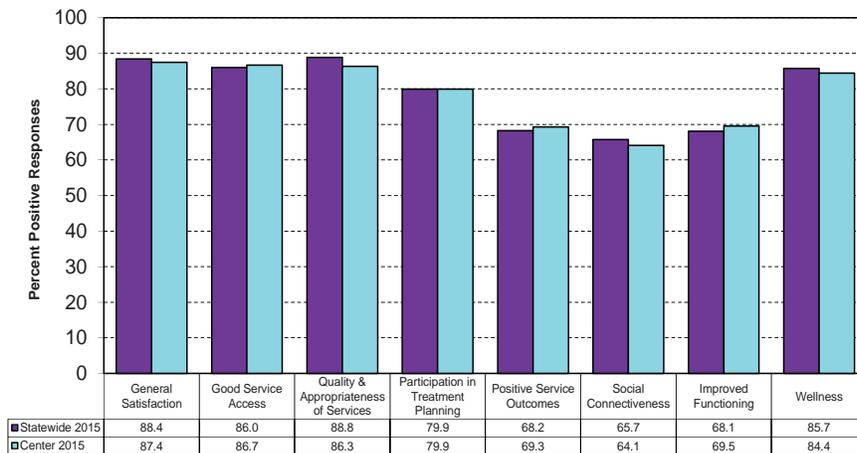


Utah County—Wasatch Mental Health (Continued)

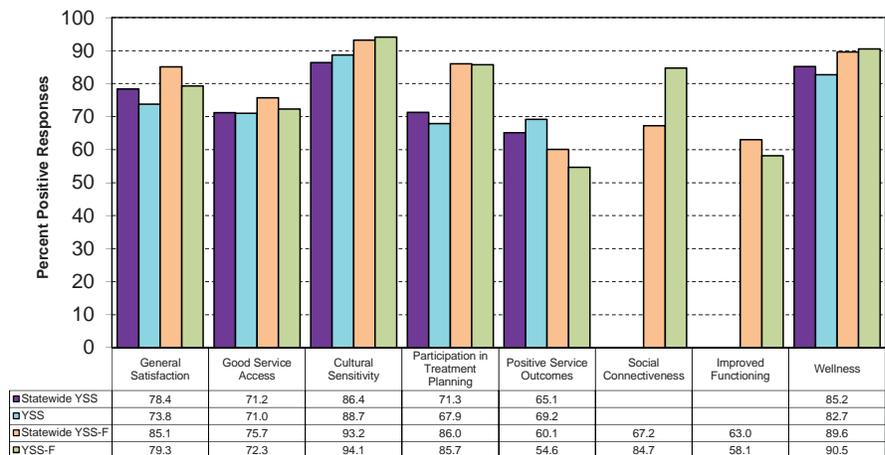
Source of Revenues
Fiscal Year 2015



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2015



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2015



Wasatch County



Population: 27,714

Wasatch County Family Clinic

County: Wasatch

Substance Abuse and Mental Health Provider

Agency:

Richard Hatch, Director
 Wasatch County Family Clinic
 55 South 500 East
 Heber, UT 84032
 Office: (435) 654-3003
www.wasatch.org

Wasatch County Substance Abuse—Prevention

Protective Factors:

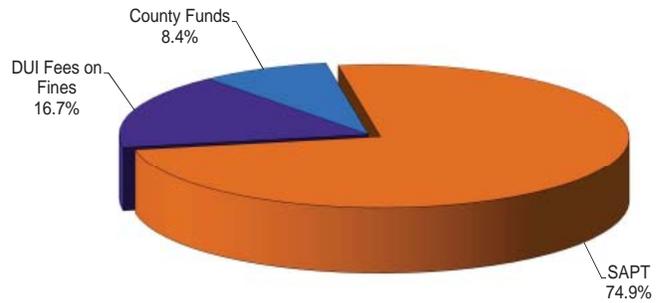
- Opportunities for pro-social involvement in community domain

Prioritized Risk Factors:

- Attitudes favorable towards drug use
- Low neighborhood attachment

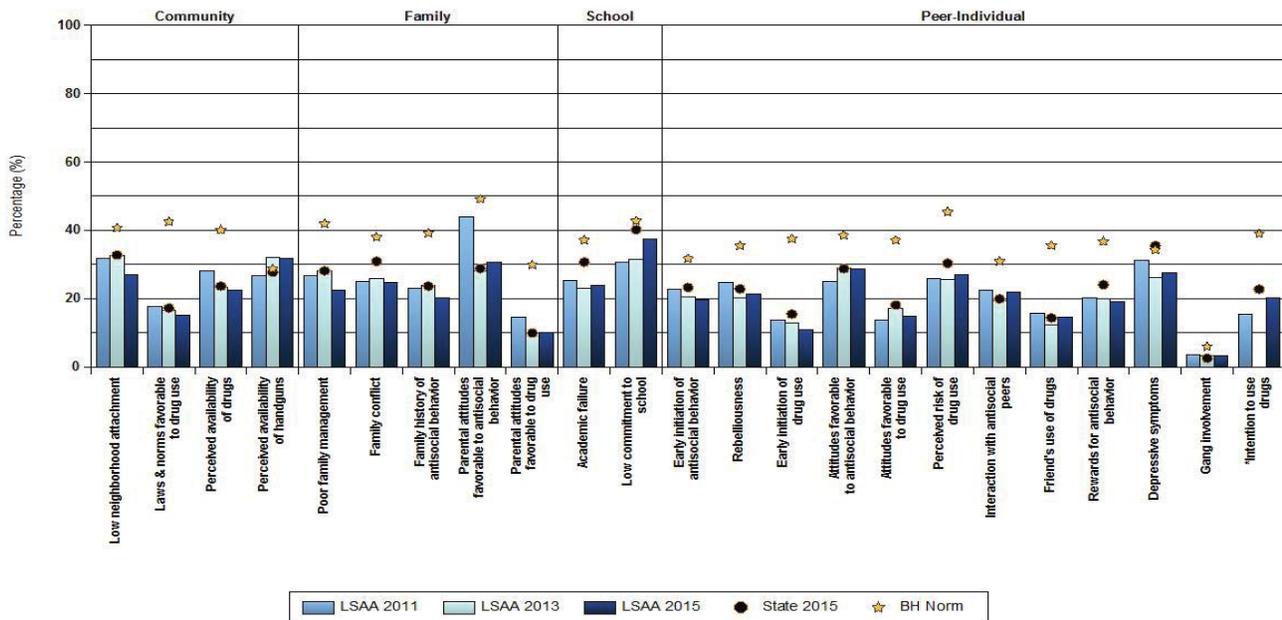
Source of Revenues

Fiscal Year 2015



Risk Profile

2015 Wasatch County LSAA Student Survey, All Grades

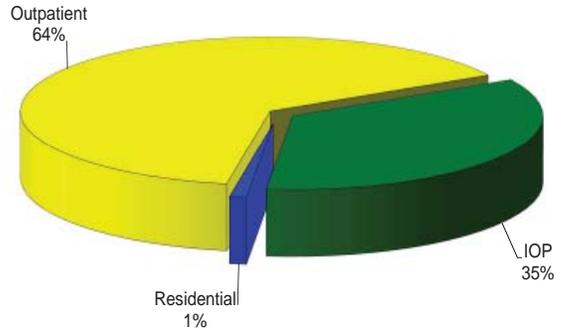


Wasatch County—Substance Abuse

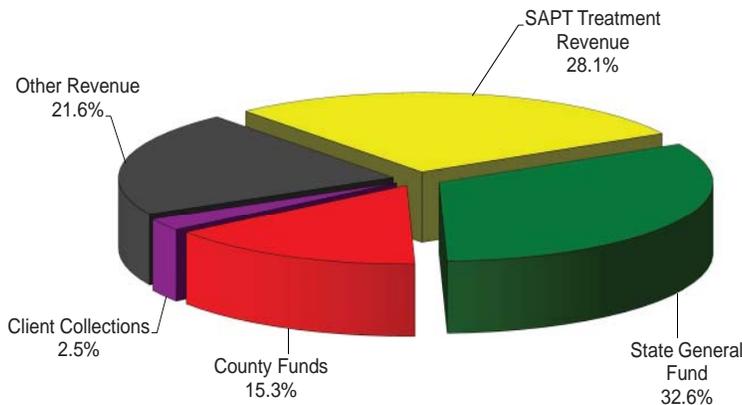
Total Clients Served.....129
 Adult117
 Youth.....12
 Penetration Rate (Total population of area)..0.5%

Total Admissions.....92
 Initial Admissions68
 Transfers.....24

Admissions into Modalities
Fiscal Year 2015



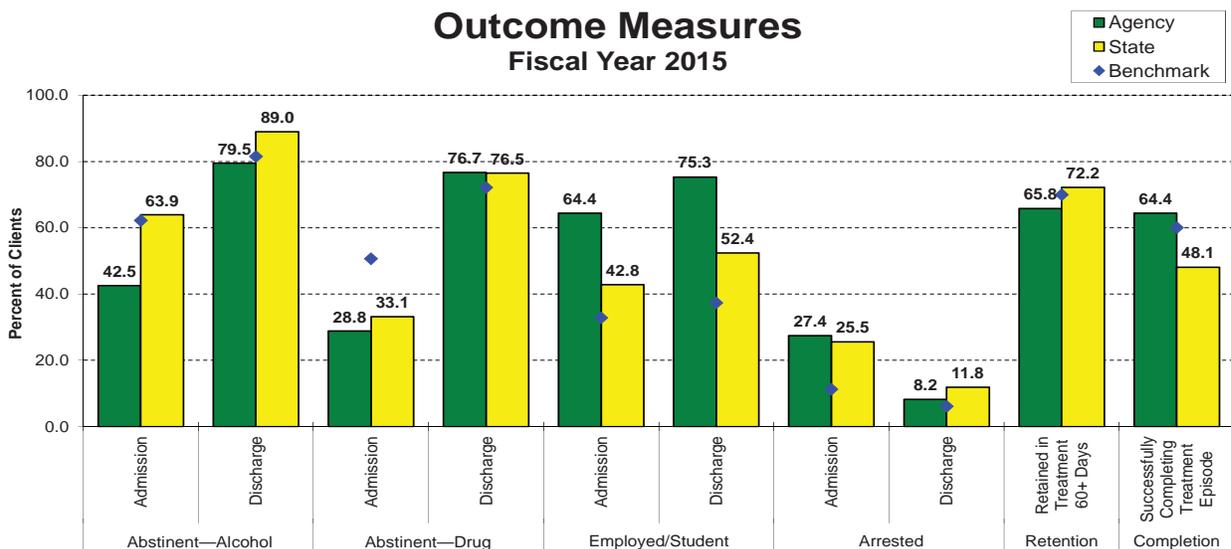
Source of Revenues
Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	36	14	50
Cocaine/Crack	2	5	7
Marijuana/Hashish	9	9	18
Heroin	2	1	3
Other Opiates/Synthetics	0	0	0
Hallucinogens	0	0	0
Methamphetamine	3	6	9
Other Stimulants	1	1	2
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	2	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unknown	0	0	0
Total	54	38	92

Outcome Measures
Fiscal Year 2015



Benchmark is 75% of the National Average.

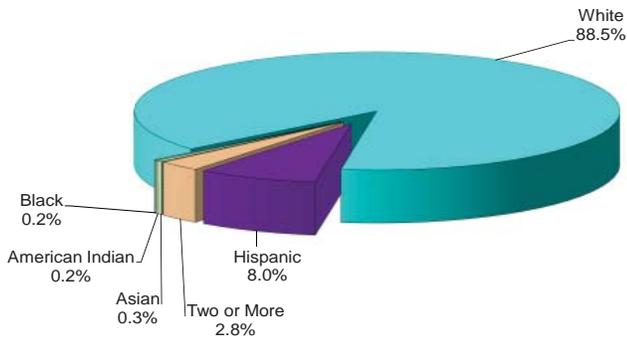
Wasatch County—Mental Health

Total Clients Served552
 Adult391
 Youth161
 Penetration Rate (Total population of area) 2.0%
 Civil Commitment0
 Unfunded Clients Served152

Diagnosis

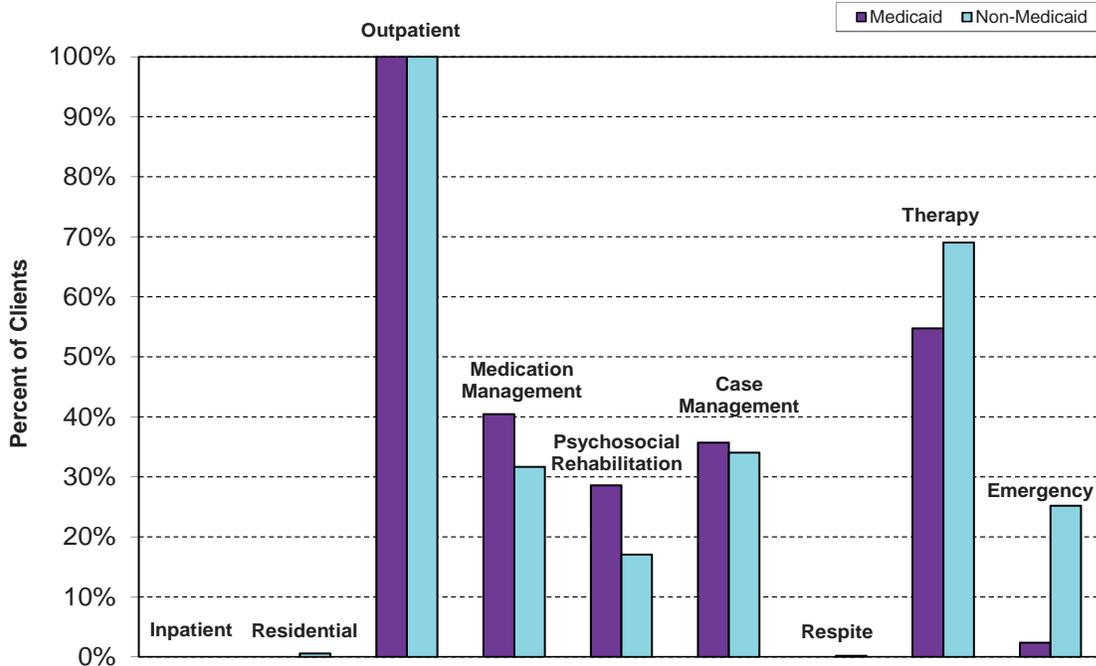
	Youth	Adult
Adjustment Disorder	47	26
Anxiety	40	163
Attention Deficit	20	14
Cognitive Disorder	1	2
Conduct Disorder	1	0
Depression	24	116
Impulse Control Disorders	13	4
Mood Disorder	18	89
Neglect or Abuse	17	6
Oppositional Defiant Disorder	7	0
Personality Disorder	0	25
Pervasive Developmental Disorders	5	3
Schizophrenia and Other Psychotic	1	31
Substance Abuse	14	142
Other	10	7
V Codes	45	59
Total	263	687

Race/Ethnicity Fiscal Year 2015



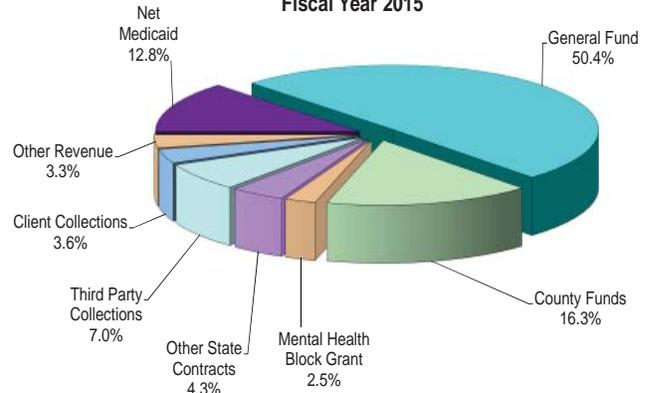
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2015

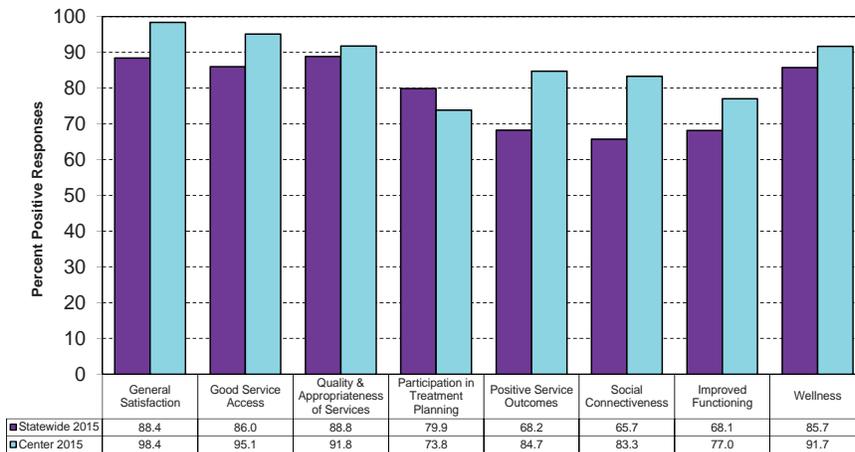


Wasatch County—Mental Health (Continued)

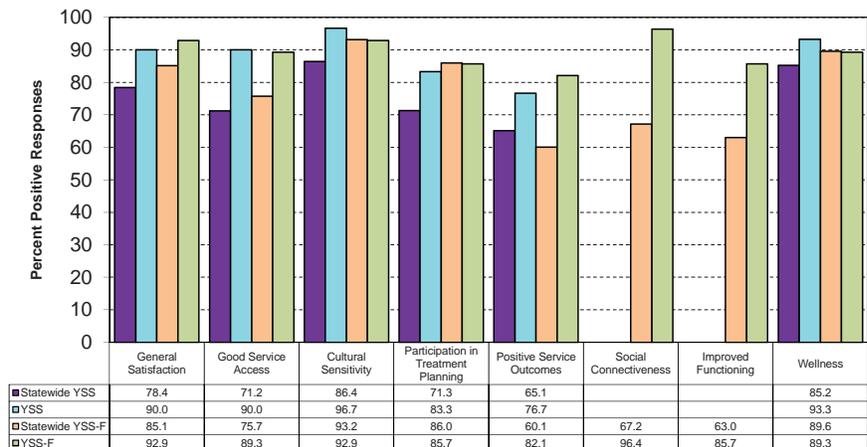
**Source of Revenues
Fiscal Year 2015**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2015**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2015**



Weber Human Services

Weber and Morgan Counties



Population: 251,083

Weber Human Services

Counties: Weber and Morgan

Substance Abuse and Mental Health Provider

Agency:

Kevin Eastman, Executive Director

Weber Human Services

237 26th Street

Ogden, UT 84401

Office: (801) 625-3700

www.weberhs.org

Weber Substance Abuse—Prevention

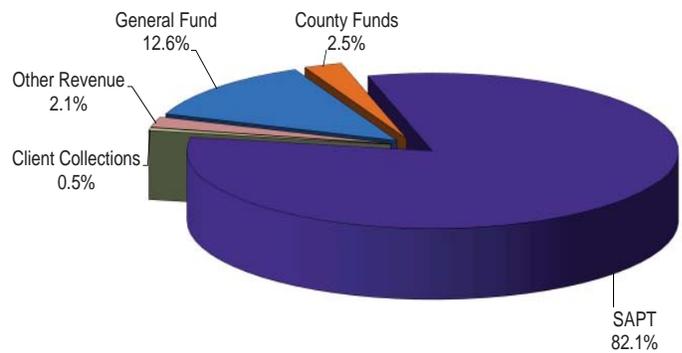
Protective Factors:

- Rewards for pro-social involvement in family and community domain
- Opportunities for pro-social interaction at school and with peers and in peer/individual domains
- Belief in a moral order, family attachment

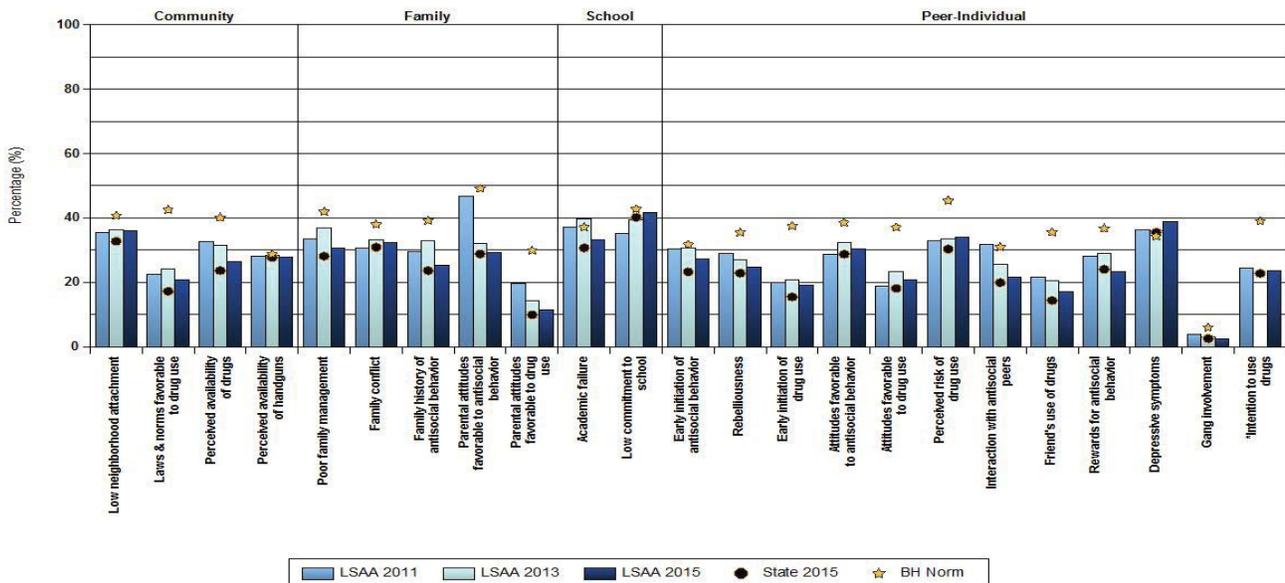
Prioritized Risk Factors:

- Parental attitudes favorable to anti-social behavior
- Academic failure, depressive symptoms
- Low commitment to school
- Early initiation of anti-social behavior

Source of Revenues Fiscal Year 2015



Risk Profile 2015 Weber And Morgan Counties LSAA Student Survey, All Grades

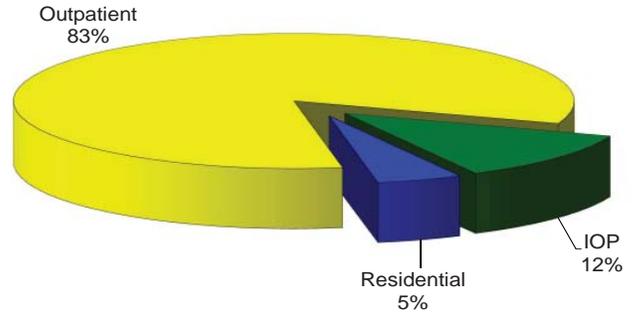


Weber Human Services—Substance Abuse

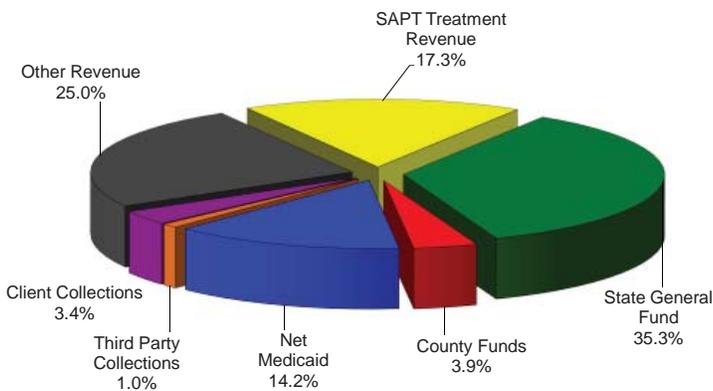
Total Clients Served1,534
 Adult1,336
 Youth198
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....1,263
 Initial Admissions999
 Transfers.....264

Admission into Modalities Fiscal Year 2015



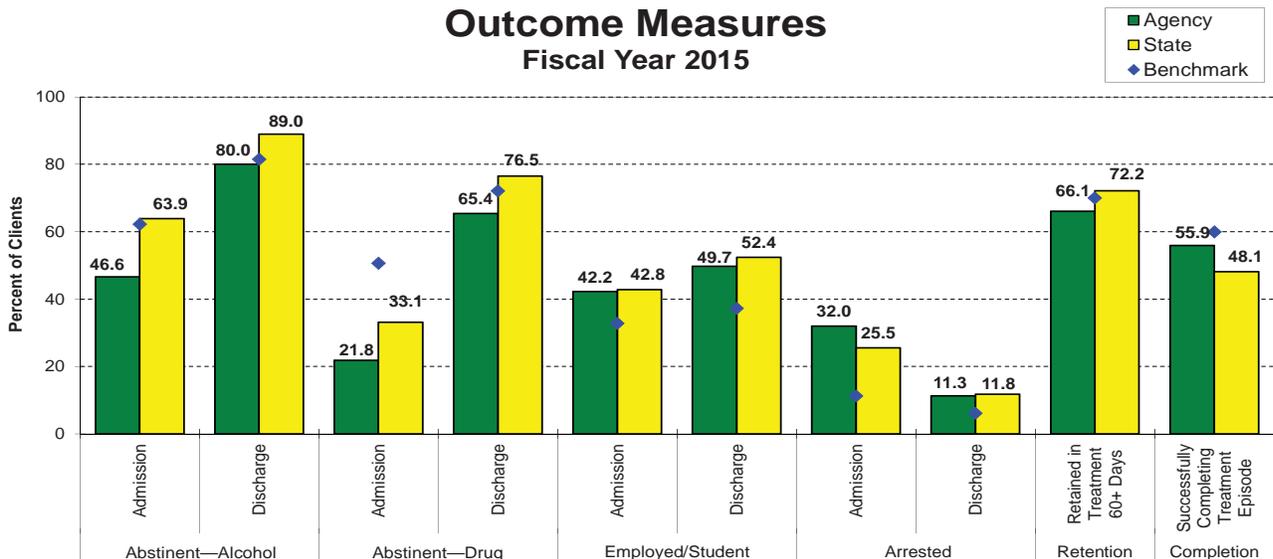
Source of Revenues Fiscal Year 2015



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	321	213	534
Cocaine/Crack	22	19	41
Marijuana/Hashish	178	118	296
Heroin	38	61	99
Other Opiates/Synthetics	6	10	16
Hallucinogens	1	3	4
Methamphetamine	79	145	224
Other Stimulants	0	1	1
Benzodiazepines	3	3	6
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	9	23	32
Club Drugs	0	0	0
Over-the-Counter	1	0	1
Other	6	3	9
Unknown	0	0	0
Total	664	599	1,263

Outcome Measures Fiscal Year 2015



Benchmark is 75% of the National Average.

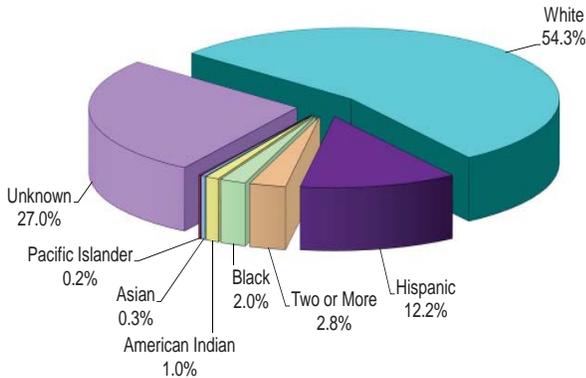
Weber Human Services—Mental Health

Total Clients Served.....6,045
 Adult4,370
 Youth.....1,675
 Penetration Rate (Total population of area)..... 2.4%
 Civil Commitment235
 Unfunded Clients Served719

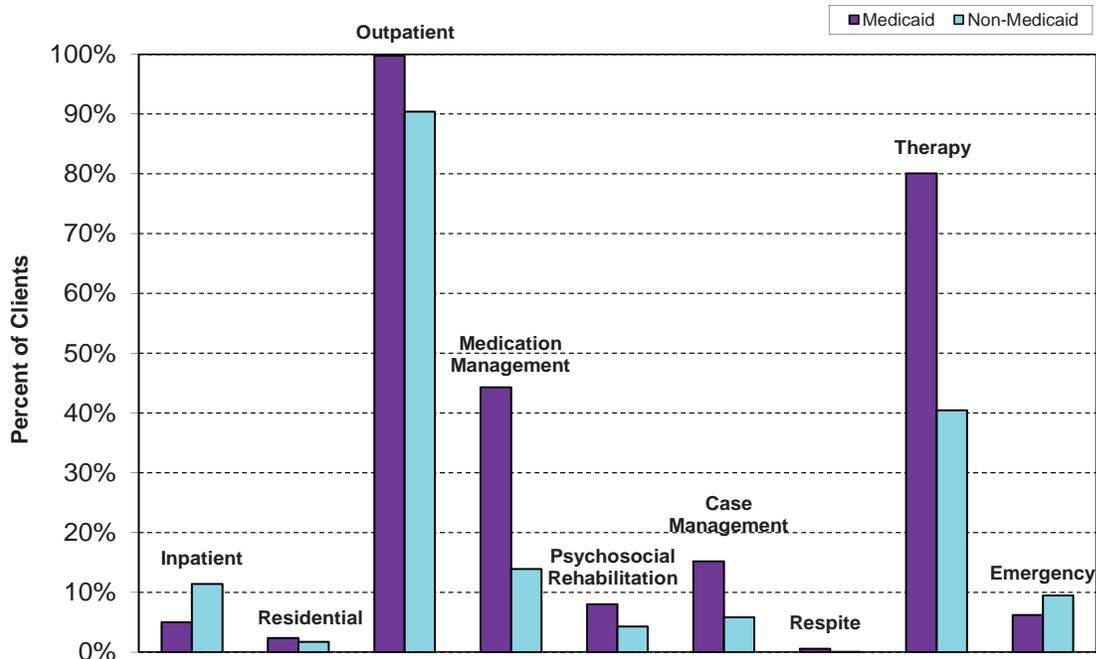
Diagnosis

	Youth	Adult
Adjustment Disorder	166	69
Anxiety	588	1,287
Attention Deficit	527	104
Cognitive Disorder	44	143
Conduct Disorder	19	2
Depression	112	374
Impulse Control Disorders	244	47
Mood Disorder	476	1,151
Neglect or Abuse	181	60
Oppositional Defiant Disorder	227	10
Personality Disorder	2	419
Pervasive Developmental Disorders	129	51
Schizophrenia and Other Psychotic	7	434
Substance Abuse	54	754
Other	133	50
V Codes	358	358
Total	3,267	5,313

Race/Ethnicity Fiscal Year 2015

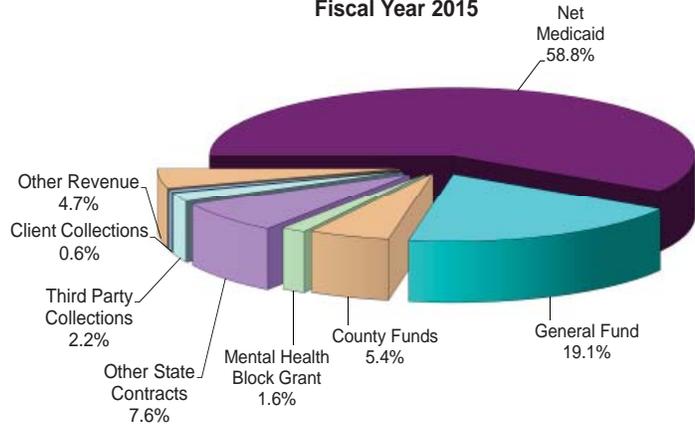


Utilization of Mandated Services Fiscal Year 2015

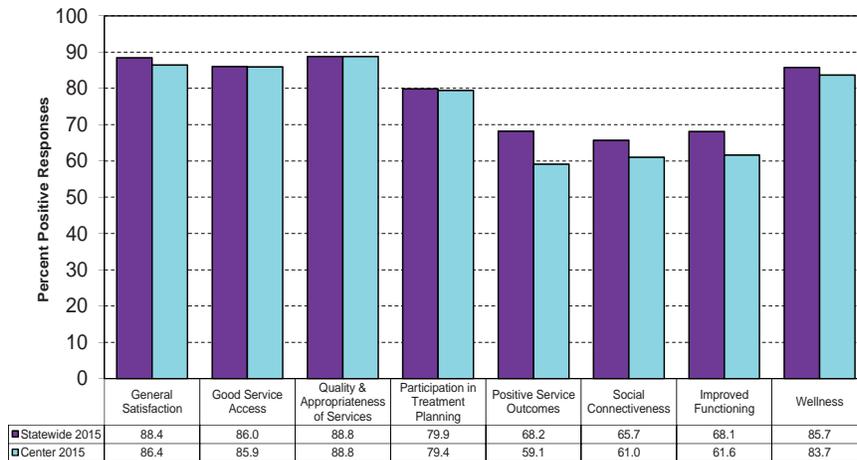


Weber Human Services—Mental Health (Continued)

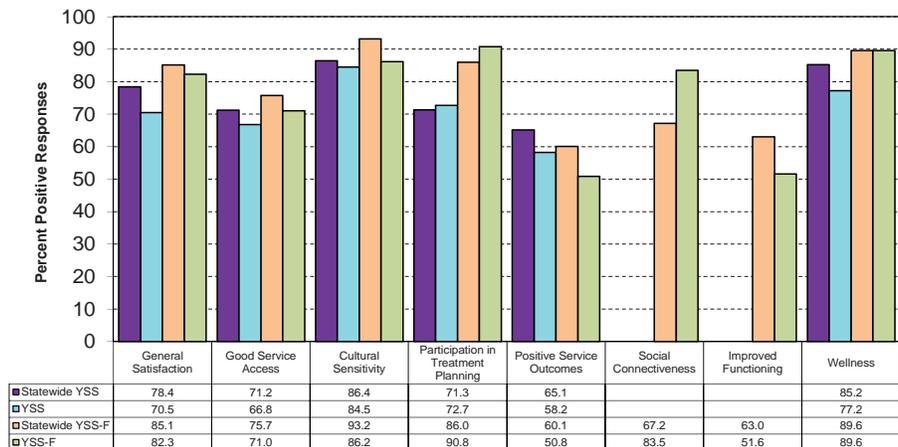
**Source of Revenues
Fiscal Year 2015**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2015**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2015**



Tulips

“This photo represents my journey through treatment and rising against my struggles over the years. The wine colored tulip is me. The yellow tulips are the people who have been a constant support on my road to recovery.”

Tom Gordon, UT



2015 Youth M.O.V.E. Art Show

Motivating **O**thers through **V**oices of **E**xperience

Resources

RESOURCES

List of Abbreviations

ACA—Affordable Care Act

ATR—Access to Recovery

ASAM—American Society of Addiction
Medicine

BPRS—Brief Psychiatric Rating Scale

CABHI-UT—Cooperative Agreement to Ben-
efit Homeless Individuals-Utah

CCEBP—Community-Centered Evidence-based
Prevention

CTC—Communities that Care

DORA—Drug Offender Reform Act

DSAMH—Division of Substance Abuse and
Mental Health

DUI—Driving Under the Influence

IOP—Intensive Outpatient Program

IV—Intravenous

JRI—Justice Reinvestment Initiative

LMHA—Local Mental Health Authorities

LOS—Length of Stay

LSAA—Local Substance Abuse Authorities

MHSIP—Mental Health Statistical
Improvement Program

NAMI—National Alliance on Mental Illness

NASMHPD—National Association of State
Mental Health Program Directors

OTP—Outpatient Treatment Program

PASRR—Pre-Admission Screening and
Residential Review

PD—Prevention Dimensions

SAMHSA—Substance Abuse and Mental
Health Services Administration (Federal)

SAPT—Substance Abuse Prevention and
Treatment Block Grant

SED—Serious Emotional Disturbance

SHARP—Student Health and Risk Prevention

SMI—Serious Mental Illness

SPF—Strategic Prevention Framework

SPMI—Serious and Persistent Mental Illness

TEDS—Treatment Episode Data Set

USH—Utah State Hospital

Mental Health Reference Table

The following table provides the number or N= that was used to calculate the percentages of all tables where mental health mandated programs are divided by Medicaid or non-Medicaid clients. These numbers are duplicated across local men-

tal health authorities but unduplicated on totals. The “Both Medicaid and non-Medicaid” column includes clients who received at least one Medicaid service and at least one non-Medicaid service sometime during the fiscal year.

Medicaid/Non-Medicaid Client Counts			
Fiscal Year 2015			
Local Mental Health Authority	Medicaid	Non-Medicaid	Both Medicaid and Non-Medicaid
Bear River	1,920	725	493
Central	43	521	622
Four Corners	789	591	66
Northeastern	128	1,762	383
San Juan County	13	458	97
Southwest	2,401	658	154
Summit County	147	218	25
Tooele County	902	590	93
Wasatch County	10	508	32
Davis County	2,787	1,393	375
Salt Lake County	11,945	2,362	959
Utah County	5,679	2,500	803
Weber	3,116	1,105	421
Rural Total	6,353	6,031	1,965
Urban Total	23,527	7,360	2,558
State Total	29,436	13,205	4,426

Contact Information

Single State Substance Use Authority and Mental Health Commissioner

Doug Thomas, Director
Utah Division of Substance Abuse and Mental Health
195 North 1950 West
Salt Lake City, UT 84116
Office: (801) 538-3939
Fax: (801) 538-9892
www.dsamh.utah.gov

Utah State Hospital Superintendent

Dallas Earnshaw,
Utah State Hospital
1300 East Center Street
Provo, Utah 84606
Office: (801) 344-4400
Fax: (801) 344-4291
www.us.h.utah.gov

Local Authorities and Providers

Bear River

Counties: Box Elder, Cache, and Rich

Substance Abuse Provider Agency:

Brock Alder, LCSW, Director
Bear River Health Department, Substance Abuse Program
655 East 1300 North
Logan, UT 84341
Office: (435) 792-6500
www.brhd.org

Mental Health Provider Agency:

C. Reed Ernstrom, President/CEO
Bear River Mental Health Services
90 East 200 North
Logan, UT 84321
Office: (435) 752-0750
www.brmh.com

Davis Behavioral Health

County: Davis

Substance Abuse and Mental Health Provider Agency:

Brandon Hatch, CEO/Director
Davis Behavioral Health
934 S. Main
Layton, UT 84041
Office: (801) 773-7060
www.dbhutah.org

Central Utah Counseling

Counties: Juab, Millard, Piute, Sanpete, Sevier, and Wayne

Substance Abuse and Mental Health Provider Agency:

Brian Whipple, Executive Director
Central Utah Counseling Center
152 North 400 West
Ephraim, UT 84627
Office: (435) 283-8400
www.cucc.us

Four Corners Community Behavioral Health

Counties: Carbon, Emery, and Grand

Substance Abuse and Mental Health Provider Agency:

Karen Dolan, CEO Four Corners Community Behavioral Health
105 West 100 North
P.O. Box 867
Price, UT 84501
Office: (435) 637-7200
www.fourcorners.ws

Northeastern Counseling Center

Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider

Agency:

Kyle Snow, Director
Northeastern Counseling Center
1140 West 500 South #9
Vernal, UT 84078
Office: (435) 789-6300
Fax: (435) 789-6325
www.nccutah.org

Salt Lake County Behavioral Health Services

County: Salt Lake

Substance Abuse and Mental Health

Administrative Agency:

Tim Whalen, Director
Salt Lake County
Division of Behavioral Health Services
2001 South State Street #S2300
Salt Lake City, UT 84190-2250
Office: (385) 468-4707
behavioralhealthservices.slco.org

San Juan Counseling Center

County: San Juan

Substance Abuse and Mental Health Provider

Agency:

Tammy Squires, Director
San Juan Counseling Center
356 South Main St.
Blanding, UT 84511
Office: (435) 678-2992

Southwest Behavioral Health Center

Counties: Beaver, Garfield, Iron, Kane, and Washington

Substance Abuse and Mental Health Provider

Agency:

Mike Deal, Director
Southwest Behavioral Health Center
474 West 200 North, Suite 300
St. George, UT 84770
Office: (435) 634-5600
www.sbhcc.us

Valley Behavioral Health

County: Summit

Substance Abuse and Mental Health Provider

Agency:

Gary Larcenaire, CEO/President
Christy Calderon, COO
Dodi Wilson, Program Manager
Valley Behavioral Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157
www.valleycares.com

Valley Behavioral Health

County: Tooele

Substance Abuse and Mental Health Provider

Agency:

Gary Larcenaire, CEO/President
Christy Calderon, COO
Rebecca Brown, Interim Program Manager
Randy Dow, Interim Program Manager
Valley Behavioral Health, Tooele County
100 South 1000 West
Tooele, UT 84074
Office: (435) 843-3520
www.valleycares.com

Utah County

County: Utah

Substance Abuse Provider Agency:

Richard Nance, Director
Utah County Department of Drug and Alcohol
Prevention and Treatment
151 South University Ave. Ste 3200
Provo, UT 84606
Office: (801) 851-7127
www.utahcountyonline.gov

Mental Health Provider Agency:

Juergen Korbanka, Executive Director
Wasatch Mental Health
750 North Freedom Blvd, Suite 300
Provo, UT 84601
Office: (801) 852-4703
www.wasatch.org

Weber Human Services

Counties: Weber and Morgan

Substance Abuse and Mental Health Provider

Agency:

Kevin Eastman, Executive Director
Weber Human Services
237 26th Street
Ogden, UT 84401
Office: (801) 625-3700
www.weberhs.org

Wasatch County Family Clinic

County: Wasatch

***Substance Abuse and Mental Health Provider
Agency:***

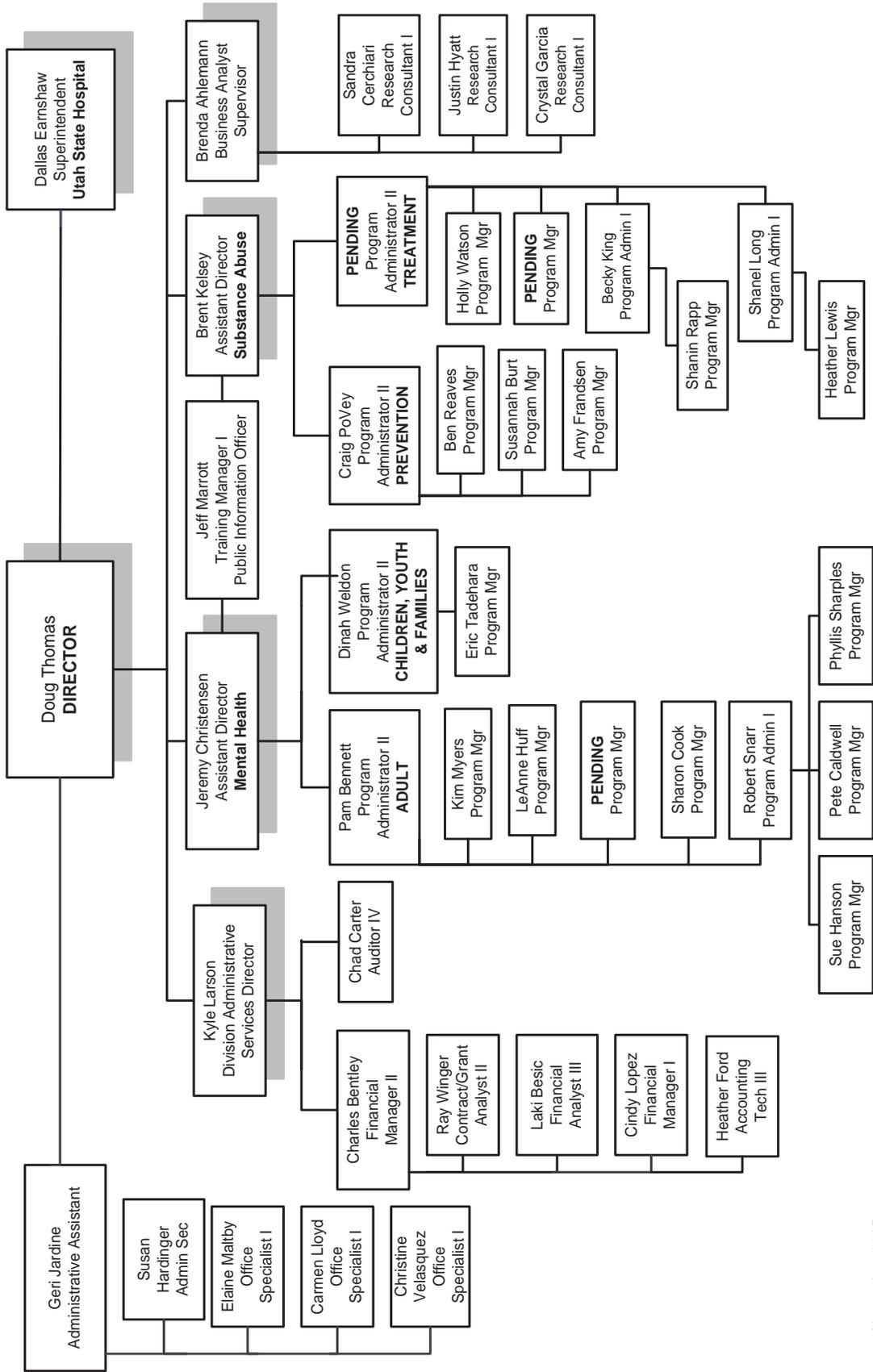
Richard Hatch, Director
Wasatch County Family Clinic
55 South 500 East
Heber, UT 84032
Office: (435) 654-3003
www.wasatch.org

Local Authorities/Local Providers

Utah Association of Counties

Utah Behavioral Health Committee
5397 S. Vine St.
Murray UT 84107
Office: (801) 265-1331
www.uacnet.org

Utah Division of Substance Abuse and Mental Health



November 2015

Substance Use Disorder and Mental Health Charts

Substance Use Disorder Charts

Total Numbers Served in Public Behavioral System.....	17
Utahns in Need of Substance Use Treatment	18
Total SA Numbers Served Over Five Years.....	20
Clients and Poverty Level.....	21
Number of Individuals Served in Urban and Rural Communities	22
Percent of Total Population Served in Urban and Rural Communities	22
Gender.....	23
Age at Admission	23
Race/Ethnicity and Race Penetration per 1,000 Population.....	24-26
Living Arrangement at Admission for Adults	27
Employment Status at Admission for Adults	28
Education Level at Admission for Adults.....	29
Referral Source	30, 31
Marital Status of Adults.....	32
Medicaid vs. Non-Medicaid, Adults and Adolescents/Children.....	33
Admission into Modalities, Initial and Transfer	51
Admissions and Transfers In Utah by local authority.....	51
Primary Drug, Alcohol vs. Drug	52
Primary Drug, Top Drugs of Choice by Year	52
Primary Substance by Gender	53
Primary Substance by Age	54
Age of First Use of Alcohol or Other Drug	55
Age of First Use of Primary Substance—Under 18	55
Multiple Drug Use	56
IV Injection Drug Use at Admission	57
Prescription Drugs, Admission for Primary Drug	58
Prescription Drug Abuse by Gender	58
Tobacco Use at Admission	59
Pregnancy at Admission	60
Dependent Children.....	61
Service Type at Admission	62
Service Types, Trends	62
Drug Courts	63
Drug Offender Reform Act (DORA) Outcomes.....	64
Successfully Completing Treatment Episode	91
Arrested Prior to Admission vs. Arrested During Treatment	92
Abstinence from Alcohol Use Prior to Admission vs. Abstinence at Discharge	92
Abstinence from Drug Use Prior to Admission vs. Abstinence at Discharge	93
Employed Admission vs. Discharge	93
Stable Housing Admission vs. Discharge	94
Median Length of a Treatment Episode in Days.....	95

Percent Retained in Substance Abuse Service Treatment.....	95
Adult Consumer Satisfaction Survey (MHSIP)	98
Client Cost by Service Category.....	100
Cost per Day by Service Type, Average	101
Synar	102

Mental Health Charts

Total Numbers Served in Public Behavioral System.....	17
Utahns in Need of Mental Health Services	19
Total MH Numbers Served Over Five Years	20
Clients and Poverty Level.....	21
Number of Individuals Served in Urban and Rural Communities	22
Percent of Total Population Served in Urban and Rural Communities	22
Gender.....	23
Age at Admission.....	23
Race/Ethnicity and Race Penetration per 1,000 Population.....	24-26
Living Arrangement at Admission for Adults	27
Employment Status at Admission for Adults	28
Education Level at Admission for Adults.....	29
Referral Source	30, 31
Marital Status of Adults.....	32
Medicaid vs. Non-Medicaid, Adults and Adolescents/Children.....	33
Diagnosis of Mental Health, Adult and Youth by Local Authority	67
Mandated Services	
Outpatient, Median Length of Service	68
Inpatient, Utilization and Median Length of Service.....	69
Residential, Utilization and Median Length of Service.....	70
Medication Management, Utilization and Median Length of Service	71
Psychosocial Rehabilitation, Utilization and Median Length of Service.....	72
Case Management, and Median Length of Service.....	73
Respite, Utilization and Median Length of Service	74
Therapy, Utilization and Median Length of Service	75
Emergency, Utilization and Median Length of Service	76
Total Number of Youth Served by Location of Service	77
Total Percentage of Youth Served by Location of Service.....	77
Percentage of Adults Served by Type of Service	78
Utah State Hospital Outcome Charts	79, 80
OQ Client Outcomes Report.....	96
OQ Client Outcomes Report, Youth.....	97
OQ Client Outcomes Report, Adults.....	97
Consumer Satisfaction Survey (MHSIP), Adults.....	98
Consumer Satisfaction Survey—Family (YSS-F)	99
Consumer Satisfaction Survey—Youth (YSS)	99
Client Cost by Service Category.....	100
Cost per Service Event.....	101

utah department of
human services

Division of Substance Abuse and Mental Health

195 North 1950 West
Salt Lake City, UT 84116
(801) 538-3939
dsamh.utah.gov