

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2006 Annual Report on Public Substance Abuse
and Mental Health Services in Utah



*“Hope and Recovery through
Alliance and Science”*

State of Utah
Department of Human Services

dsamh.utah.gov

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2006
Annual Report

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and Mental Health
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December 2006

On behalf of the Utah State Board of Substance Abuse and Mental Health, it is my pleasure to present you with DSAMH's 2006 Annual Report on Public Substance Abuse and Mental Health Services in Utah.

We appreciate the work that has gone into this report and we hope you will find the information in the report useful. The report outlines the efforts of the mental health and substance abuse system for the past year and identifies some of the initiatives, outcomes, and challenges that face us. We encourage you to read the report and become familiar with what is happening in your own community, as well as statewide. We would also invite you to take an active role in making your community stronger and healthier.

The State Board supports DSAMH's theme of "Hope and Recovery." We also recognize and appreciate the many efforts of the dedicated staff, advocates, and volunteers throughout the substance abuse and mental health system who make a difference in the lives of those who are served.

We welcome your comments or suggestions for future editions of this report or for ways to improve our programs and services. You can contact DSAMH with your input at (801) 538-3939 or by e-mail via the website at dsamh.utah.gov.

Respectfully,

UTAH BOARD OF SUBSTANCE ABUSE AND MENTAL HEALTH

Michael Crookston, M.D.
Chair

The State Board of Substance Abuse and Mental Health



MICHAEL CROOKSTON, M.D., CHAIR

Psychiatrist; Medical Director, LDS Hospital Dayspring; Assistant Clinical Professor of Psychiatry, University of Utah; Member, American Medical Association, American Academy of Addiction Psychiatry, and American Society of Addiction Medicine



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Thirty-year mental health advocate; Co-chair of a fund raising committee and former Board Member of Alliance House; Former chair of the Mental Health section of The Governor's Coalition for People with Disabilities; Legislative activist; mental health consumer



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Member, Davis Hospital Board of Trustees; Chair, Utah Prevention Advisory Council; Former Co-chair, Governor's Council on DUI; Member, State FACT Steering Committee; Former Member, Utah House of Representatives



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Division of Substance Abuse and Mental Health

MARK I. PAYNE
Director



December 2006



We appreciate this opportunity to share the DSAMH's Annual Report for Fiscal Year 2006. We hope this report will be helpful as you review the efforts being made throughout the system in providing treatment to individuals who have involvement with public substance abuse and mental health services.

The ongoing theme at DSAMH is "Hope and Recovery." This report reflects the progress made toward the following key principles: 1) **Partnerships** with consumers and families through a unified state, local and federal effort, 2) **Quality** programs that are centered on "recovery," 3) **Education** that will promote understanding and treatment of substance abuse and mental health disorders, 4) **Leadership** which meets the needs of consumers and families, and 5) **Accountability** in services and systems that are performance focused. The model on the following page provides additional detail on each of the principles.

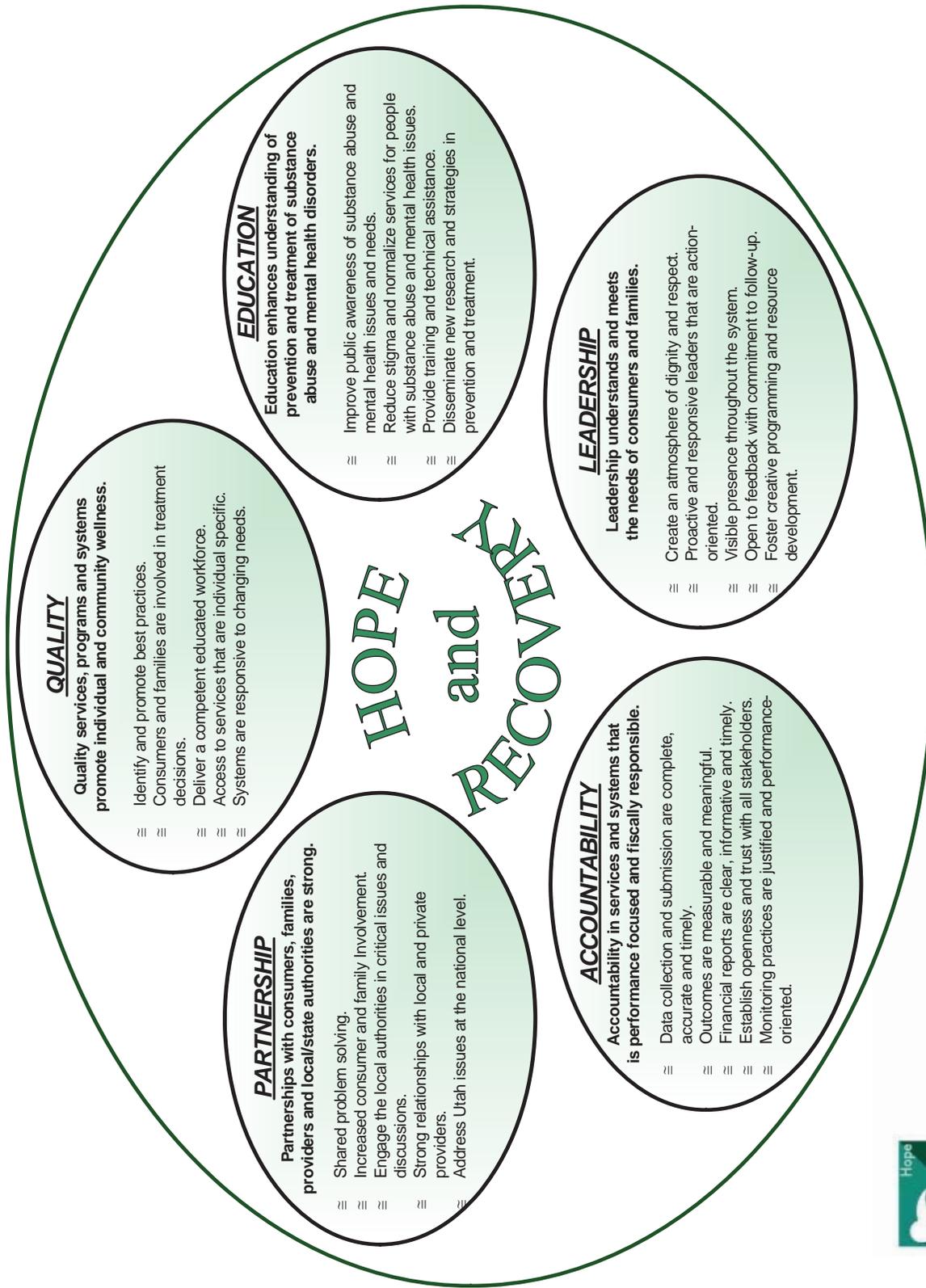
We recognize the significance of the work and services delivered to individuals throughout the local substance abuse and mental health system. We thank all of the dedicated staff, advocates and volunteers who make a difference in the lives of the people and communities we serve.

The Division is working to increase accessibility for Utahns who are in need of prevention and treatment services in substance abuse and mental health.

Sincerely,

A handwritten signature in black ink that reads "Mark I. Payne".

Mark I. Payne, LCSW
Director



**Utah Division of
Substance Abuse and Mental Health**

About Utah's Public Substance Abuse and Mental Health System

Division of Substance Abuse and Mental Health (DSAMH)

DSAMH is the Single State Authority for public substance abuse and mental health programs in Utah, and is charged with ensuring that prevention and treatment services are available throughout the State. As part of the Utah Department of Human Services (DHS), DSAMH receives policy direction from the State Board of Substance Abuse and Mental Health, which is appointed by the Governor and approved by the Utah State Senate. DSAMH contracts with the local county governments statutorily designated as local substance abuse authorities and local mental health authorities to provide prevention and treatment services. The Board of Substance Abuse and Mental Health and DSAMH provide oversight and policy direction to these local authorities.

DSAMH monitors and evaluates mental health services and substance abuse services through an annual site review process, the review of local area plans, and the review of program outcome data. DSAMH also provides technical assistance and training to the local authorities, evaluates the effectiveness of prevention and treatment programs, and disseminates information to stakeholders.

In addition, DSAMH supervises administration of the Utah State Hospital.

Local Authorities

Under Utah law, local substance abuse 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. By legislative intent, no substance abuse or community mental health center is operated by the State. Some local authorities contract with community substance abuse centers and mental health centers, which provide comprehensive substance abuse and mental health services. Local authorities not only receive state and federal funds to provide comprehensive services, they are also required by law to match a minimum of 20% of the state general funds. However, Counties overmatch and contribute 48%¹ statewide.

Website

The DSAMH website (dsamh.utah.gov) is filled with information about substance abuse and mental health prevention and treatment. The Reports and Statistics section provides valuable information such as, annual reports, fact sheets, program evaluation reports, etc. There are also other resources, such as, links to treatment facilities, other State of Utah agencies, affiliated consumer advocacy groups, mental health crisis lines, the national suicide prevention hotline, and UBHN and the Network of Care.

¹NACBHD County Contributions Data Request, 8/17/2006, UBHN.

Report on Statewide Initiatives

Recovery

DSAMH is committed to the values, beliefs, and principles of recovery as reflected in its logo, “Hope and Recovery.” In February 2006, Substance Abuse and Mental Health Services Administration (SAMHSA) published the first consensus statement on recovery from mental illness. We believe this statement captures the essence of what should drive quality mental health services and programs. The consensus statement is published in its entirety below.

The 10 fundamental components of recovery include:

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual’s unique strength and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual’s whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services (such as recreational services, libraries, museums, etc.), addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with

an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support including the sharing of experiential knowledge and skills and social learning plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one’s self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identity coping strategies

and healing processes to promote their own wellness.

- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Currently, DSAMH is monitoring the public mental health system regarding their use of these recovery principles. Consumers and families have given strong feedback (in surveys and interviews) that they embrace the principles of recovery and want them incorporated into the mental health delivery system. Response to the “recovery model” by mental health providers has been mixed. Some of their concerns include possible conflicts with the medical necessity standards of care required by various funders, as well as some resistance to a fundamental change in philosophy of consumers/families taking a critical role in the design of individual treatment plans and helping to shape policies that govern programs.

On the other hand, many providers have demonstrated a vigorous adoption of these principles. The evidence of this is found in policy changes, increased utilization of National Alliance on Mental Illness (NAMI) and other family based programs, invitations to consumers/families to belong to oversight boards, and creating peer support employment positions for consumers. UBHN published a document known as “The Utah Recovery Model” to help guide the public mental health system to adopt these principles.

The core components of Recovery from mental illness resonate with the values of our state. Respect, responsibility, self-direction, and hope give all of us an identity that we are proud of.

System in Transformation/ Treating the Unfunded Gap

The Problem

In 2003 a dramatic change occurred which reduced the amount of funding available for mental health services to non-Medicaid consumers in Utah. The Center for Medicare and Medicaid Services (CMS) embraced the Balanced Budget Act and declared that surplus Medicaid revenues could only be used for those clients with Medicaid. As a result of this new Federal policy Utah's mental health system lost access to over \$7 million in federal funds that had been available to provide services to the non-Medicaid population. Thousands of Utah residents

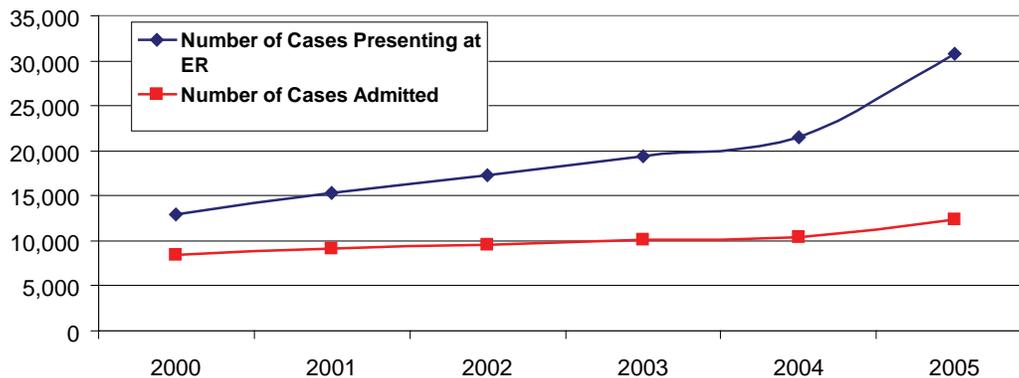
found themselves either prematurely discharged from treatment or unable to access services because they did not meet the requirements to qualify for Medicaid.

The Medicaid ruling increased an already existing service gap for indigent, uninsured, and underinsured mental health consumers.

The Impact

The following charts describe the increases in emergency room visits by persons with a primary or secondary diagnosis of substance abuse or a behavioral disorder since 2000, and reveals a steep increase between 2004 and 2005:

Hospital Cases* Presenting at ER and Admission Totals for 2000 - 2005



*Patients presenting at the ER and admitted to the hospital with primary or secondary alcohol/chemical dependency and/or psychoses diagnoses and/or acute self harm risk.

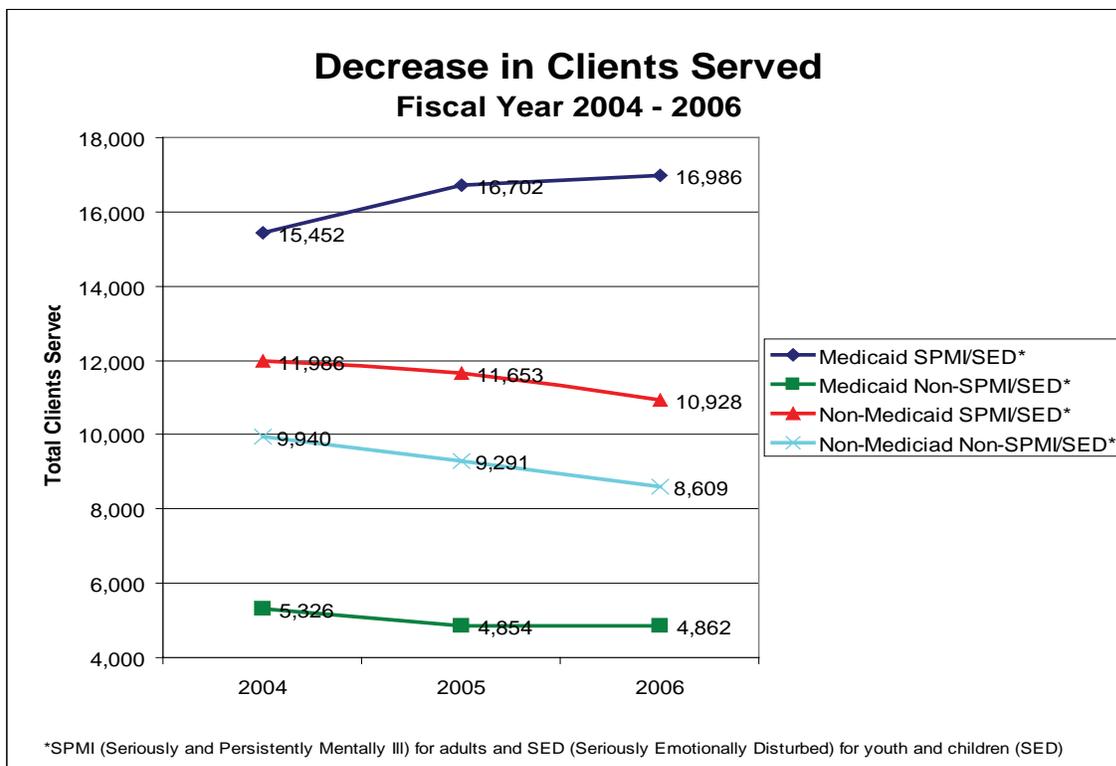
Behavioral Health Cases and Uncompensated Care Totals							
BEHAVIORAL HEALTH SURVEY TOTALS							
ER Visits and Hospital Admissions	2000	2001	2002	2003	2004	2005	Aggregate 2000-2005
(i.) Patients presenting at the ER with primary or secondary alcohol/chemical dependency and/or psychoses diagnoses and/or acute self-harm risk.							
Number of Cases Presenting at ER	12,903	15,367	17,275	19,418	21,525	30,767	117,255
Uncompensated Care Presenting to ER	\$ 3,550,945	\$ 4,162,515	\$ 4,932,330	\$ 4,810,838	\$ 8,875,505	\$ 12,274,141	\$ 38,606,274
(ii.) Patients admitted to the hospital with primary or secondary alcohol/chemical dependency and/or psychoses diagnoses and/or acute self-harm risk.							
Number of Cases Admitted	8,447	9,192	9,551	10,152	10,442	12,338	60,122
Uncompensated Care Admitted	\$ 9,162,625	\$ 10,429,566	\$ 10,815,890	\$ 13,237,876	\$ 17,812,248	\$ 33,766,806	\$ 95,225,011

Another alarming effect of untreated and/or delayed treatment of mental illness is longer stays at psychiatric hospitals. Comments made by Dr. Madhumathy Gundlapalli, Clinical Director, Acute Rehabilitation Treatment Center (ARTC), Utah State Hospital reflect a system-wide consensus opinion regarding increasing lengths of inpatient hospital stays. She has observed trends that reflect the impact of late interventions. It appears that consumers who are unable to access services early on in their illnesses, due to financial constraints, often exhibit increases in symptoms and a civil commitment becomes necessary. Consequently, after successful treatment is completed, community re-entry is hampered because these individuals are no longer employed and have lost their housing and natural community supports. Dr. Gundlapalli

speculates earlier interventions would alleviate or avoid many of the identified problems that are secondary to these consumers' mental illnesses.

The following chart exemplifies the decrease in opportunities for individuals to receive early intervention services within the community. Between 2004 and 2006 community mental health has decreased services to more than 3,100 individuals. Nearly 50% of the decrease has been experienced by non-Medicaid clients most in need of services: the seriously mental ill and seriously emotionally disturbed (SPMI/SED).

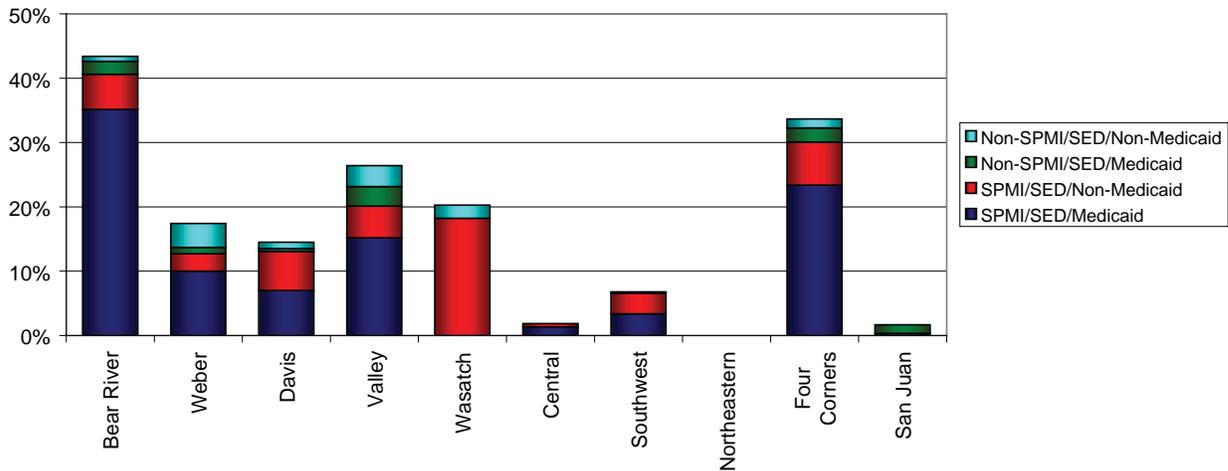
This decrease in services within the community conversely correlates to the sharp increase depicted in the previous emergency service charts.



Note that treatment for SPMI/SED clients is typically more expensive in that these consumers require multiple services and non-SPMI/SED

consumers do not. It is essential that the mental health system has adequate funding to treat those most in need.

Percent of Clients Who Received More Than One Type of Treatment Program by Provider Fiscal Year 2006



The Legislative Response

The Legislature recognized the need to fill the service gap and provided relief in the form of \$2 million one-time monies in fiscal year 2006 and \$1 million one-time monies in fiscal year 2007.

The Community Responses

There is an exciting emergence of new partners in the community mental health system that have shown early signs of success. Several new mental health delivery systems have been created or led by agencies outside of the public mental health system.

DSAMH would like to applaud the following organizations that have stepped up to provide innovative and cost effective programs to our citizens, who have a limited chance (due to their insurance/fiscal circumstances) of receiving public or private mental health services.

Ogden’s Midtown Clinic

The Midtown clinic is a federally funded health clinic that saw the need for increased mental health services after the implementation of the Balanced Budget Act. In order to meet that need, doctors at the clinic sought out courses and information necessary to increase their competency in mental health diagnosis and treatments. The clinic currently serves 1,567 people who exemplify the unfunded population. These people are given an assessment, diagnosis, medications, and follow-up checks on medication efficacy and side effects.

St. George’s Doctor’s Free Clinic

The Doctor’s Free Clinic is staffed by volunteers and offers mental health and substance abuse services on a sliding fee scale. Funding for these services comes from a unique partnership of agencies, which includes

the United Way, Intermountain Health Care (IHC), and Southwest Behavioral Health.

Wasatch Mental Health's Award Winning Wellness Recovery Clinic

The Wellness Recovery Clinic is a no-fee clinic that opened on July 1, 2005, to provide short-term mental health services to the unfunded population and served 449 consumers in fiscal year 2006.

The Adolescent Development and Outreach Program

A group of University and Community-based researchers and practitioners have established an Adolescent Development and Outreach Program or ADOP. ADOP includes faculty, students, and staff from the Departments of Psychology, Educational Psychology, and Pediatrics.

The primary mission of ADOP is to improve the psychological well being of at-risk and underserved youth through treatment-research programs. ADOP also provides specialized training to mental health and medical professionals working with at-risk adolescents and their families. We have already created an integrated system of service delivery that includes a clinical branch, a training branch, and a research branch.

IHC's Integration Model of Mental Health Services

The Mental Health Integration model is a comprehensive approach to promoting the health of individuals, families, and communities. This model allows primary care providers to identify patients who appear to have a mental illness such as depression. Once identified, the patient is given a self-reporting diagnostic packet to fill out. Through this packet, the physician is able to screen, diagnose, and treat the presenting illness through the assistance of an evidence-based mental health care planner.

GAP Group

The GAP Group is a unique coalition of federal, state, private and religious organizations with the goal of developing a model of practice that would serve the mental health needs of uninsured citizens within Utah's communities. The leadership for the group is provided by NAMI Utah and Salt Lake County Mental Health. The model of practice proposed by this group would be used in local federal health clinics and includes the use of private and public funds.

The following is a description of their proposed model that will be opened as a pilot project.

The WholeHealth Clinic is developed in order to (1) integrate mental health and physical health care in a single site, and (2) to deliver behavioral healthcare services in an innovative, cost-effective manner.

The WholeHealth Clinic will be sited at one public health clinic. In addition to the health services usually provided at the clinic, patients will be universally screened with standardized instruments to detect the need for mental health services. When mental health conditions are identified, patients will receive: (1) a medication evaluation from the Health Center physician with available psychiatric consultation; (2) short-term psychotherapy services from an in-house clinician, or (3) will be referred to community providers for longer term treatment; and (4) care management from the Clinic (5) access to free NAMI family and consumer education and support classes on site.

The WholeHealth Clinic is substantially based on the mental health integration project of Intermountain Health Care. The project has demonstrated improvements in healthcare delivery when mental health assessment and treatment is included. This project would extend the IHC model into the community with

the uninsured population and with a higher incidence of behavioral health conditions.

The Support

The DSAMH supports these innovative and integrated models of physical and behavioral health services. These programs have a limited array of mental health services (i.e. no housing, inpatient, limited psychotherapy, etc.). However, they provide a critical unmet need in our communities. These community based private/public endeavors are redefining and transforming the identity of the public mental health system.

DSAMH is appreciative of the funds that have been allocated for mental health service in Utah; furthermore, the DSAMH recognizes its own increased responsibility to account for those funds. DSAMH encourages these new partnerships to develop a community based mental health system that is coordinated, evidence based, consumer driven, and accessible to all citizens.

DSAMH in partnership with UBHN is continuing efforts with the Utah Legislature to identify funding sources and system innovations to reduce this gap in service.

The Governor's Methamphetamine Joint Task Force

Governor Huntsman and the Utah Association of Counties established the Joint Methamphetamine Task Force (Meth Task Force) on January 9th, 2006, to help fight the methamphetamine epidemic statewide. The Meth Task Force established a five phase comprehensive action plan: 1) establish the joint task force; 2) heighten Utah's public awareness about methamphetamine through a public awareness campaign; 3) attend the Western Region Methamphetamine Legislative and Policy Conference; 4) finalize Utah's comprehensive methamphetamine action plan; and 5) implement Utah's methamphetamine action plan.

The Meth Task Force is made up of 50 individuals from multiple agencies statewide. Five subcommittees have been established; prevention, treatment, law enforcement, public health, and public awareness.

Prevention:

Chaired by Verne Larsen, Utah Department of Education, the prevention subcommittee is working to establish education and prevention services targeted at children and women in their late teens through early twenties.

Treatment:

The treatment subcommittee, chaired by Pat Fleming, Director of Salt Lake County Substance Abuse Services, is working to increase treatment programs for mothers and children as this population is the largest effected by methamphetamine in our communities.

Law Enforcement:

Chaired by Mark Shurtleff, Utah Attorney General, the law enforcement subcommittee is working to eliminate the importation of methamphetamine from Mexico.

Public Health:

The public health subcommittee, chaired by Bill Cox, Commissioner for Rich County, is working to establish a database for contaminated properties which would be available to the public.

Public Awareness:

Chaired by Michele Christiansen, General Counsel to the Governor, the public awareness subcommittee is identifying established strategies to combat the use of methamphetamine and developing an overall public awareness campaign.

All subcommittees have been working diligently in their areas of expertise since the Meth Task Force was established. Task force members have been involved in numerous activities to help fight the methamphetamine epidemic, to include Utah's Recovery Day (September 9th, 2006), National

Meth Awareness Day (November 30, 2006), and two public screenings of the documentary film “Mother Superior.”

Utah’s Underage Drinking Initiative

Last Fall, the Governor’s office was invited to send an “underage drinking prevention team” to a meeting to rally forces to combat underage drinking. During this meeting, Utah’s underage drinking prevention team made goals to support a nationwide effort to reduce underage drinking and to reduce the often times lethal consequences of alcohol consumption.

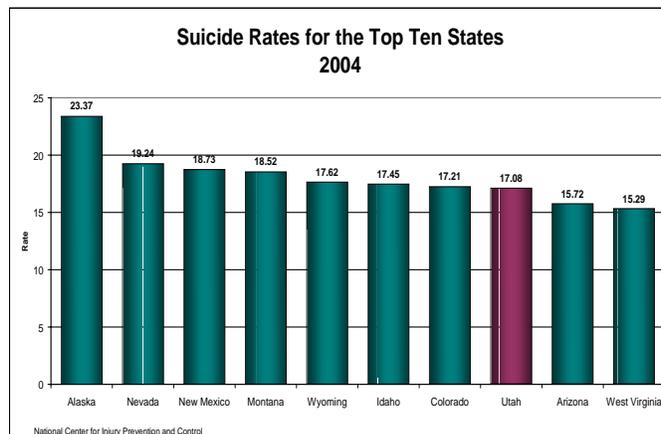
Every state was encouraged to host Town Hall Meetings. The Utah team decided to support this direction and decided to set a goal to have a town hall meeting in every county of the state. Utah’s Prevention Coordinators and the Underage Drinking Prevention Team partnered to bring about these town hall meetings and this combination proved to be successful. Utah held more town hall meetings (24) than any other state in the nation and Utah led the nation in the number of people who attended the town hall meetings (2,168).

The Underage Drinking Prevention Team also provided information to steer a \$1.6 million media campaign to reduce underage drinking by targeting Utah parents.

Utah’s Suicide Initiative

Suicide is the 8th leading cause of all deaths in the United States. In 2005, the Utah medical examiner’s office recorded over 350 deaths by suicide but suspects the number is much higher albeit unverifiable. Utah has the 8th highest suicide rate in the nation.

This tragedy, that leaves trauma to generations of families, occurs despite great efforts by our communities and their institutions to prevent it.



Virtually every citizen of the State of Utah has 24-hour access to a trained professional for crises intervention services.

DSAMH believes Utah needs a comprehensive State Suicide Prevention Plan. The purpose of the Plan is to save lives. In July 2006, DSAMH contracted with NAMI Utah and convened a suicide prevention council made up of representatives from the following agencies: DHS Division of Aging and Adult Services, AARP, Veteran’s Administration, Utah Pride Association, Mental Health Association, University of Utah Department of Psychiatry, University of Utah School of Social Work, University of Utah Department of Pediatrics, Davis School District, Weber Human Services, Salt Lake Police Department, Christmas Box House, Hope Task Force (Provo School District), Episcopal Diocese, Juvenile Justice, Department of Health, family survivors, and consumer survivors.

Clinical and research leadership has been provided by Dr. Douglas Gray, M.D., University of Utah Child and Adolescent Psychiatry, and Dr. Michelle Moskos, Ph.D., M.P.H., of the University of Utah Department of Psychiatry. The effort will identify current resources, suggest development for new resources and identify strategies to decrease the rate of suicide, policy priorities, community-based interventions, and coordinated strategies to prevent suicides.

DSAMH recognizes unique factors that affect the State's Native American population. The Mental Health Association of Utah received a contract to determine the specific needs of the Native American population and decrease suicides and suicide attempts.

The problem is clear; people die at their own hands regardless of age, ethnicity, social economic status, or religion. The effects of the loss to our families, workforce, and community cannot be measured. To make a difference, we need a plan that identifies specific strategies that our families, schools, religious entities, professionals, law enforcement, employers, and lawmakers can carry out.

Education and Awareness

Eliminate Alcohol Sales to Youth (E.A.S.Y.)

The E.A.S.Y. Law (S.B. 58) was passed by the 2006 Legislature and became effective July 1, 2006. The E.A.S.Y. Law limits youth access to alcohol in grocery and convenience stores, authorizes law enforcement to conduct random alcohol sales compliance checks, and requires mandatory training for each store employee that sells beer or directly supervises the sale of beer. Additionally, funds were allocated for a statewide media and education campaign to alert youth, parents, and communities of the dangers of alcohol to the developing teen.

On September 23, 2006, Utah's First Lady, Mary Kaye Huntsman, launched the statewide media campaign directed by R & R Partners. The campaign called ParentsEmpowered is designed to educate parents about the dangers of underage drinking and the proven skills to prevent it. The ParentsEmpowered.org website offers parents information to help combat underage drinking and useful guidelines to facilitate healthy discussions with their children.

To help eliminate the sale of alcohol to minors through grocery and convenience stores, 105 providers have been certified to conduct the Off Premise Alcohol Training and Education Seminar. Seminars conducted by 516 trainers across the state have certified over 17,000 store clerks and supervisors in techniques that facilitate the elimination of alcohol sales to underage youth.

Efforts to protect youth and the community will continue through the media campaign, training of sales clerks, and other prevention and treatment initiative.

Voices of Consumers and Families

Utah Mental Health Recovery Network

April 6, 2006, was the first network meeting of the consumer counsel now known as the Utah Mental Health Recovery Network. The Recovery Network was formed in collaboration with DSAMH and consumers from NAMI affiliates and clubhouses throughout Utah. This was accomplished through the efforts of DSAMH Consumer Advocate Specialist Roy Castelli who visited consumers at the clubhouses and NAMI affiliates and provided education on the hopes and goals of the Recovery Network. A core group of 12 members have been meeting consistently since April.

On May 17, 2006, Recovery Network members attended the Mental Health Conference in Park City and enjoyed a half-day session with Dr. Dan Fisher from the National Empowerment Center. The members were trained on advocacy and how to be an effective group. During this meeting, the Consumer Council chose to be identified as the Utah Mental Health Recovery Network, and developed the mission statement: "The mission of the Utah Mental Health Recovery Network is to provide a peer driven organization that

empowers all those who have been touched by mental illness to embrace recovery.”

Members were also given an opportunity to be trained at the State Capital on advocacy by some of our legislators, and that information will be used to advocate during the next legislative session.

The Recovery Network has identified the following issues for which it would like to advocate and raise public awareness: 1) access to services by the unfunded and underinsured people who require mental health services; 2) the implementation of a Statewide mental health court system like those found in Salt Lake and Provo; 3) standardization and uniform use of mental health advance directives; and 4) being a meaningful partner with DSAMH, UBHN, NAMI, and other mental health advocate organizations in the transformation process of mental health services as outlined in the President’s New Freedom Commission on Mental Health Report.

Utah Family Coalition

One of the primary efforts of the Mental Health-Pediatric Team at DSAMH is to strengthen family and youth involvement and voice at all levels of the service delivery system. In order to accomplish this, DSAMH has contracted with The Utah Family Coalition (UFC) which consists of three family organizations that focus on children’s mental health issues: Allies With Families, New Frontiers for Families, and NAMI Utah.

The UFC has defined family involvement along the following continuum:

1. A family is struggling and looking for help and answers: they begin articulating needs through the intake and referral process.
2. A youth/child/family enters services: they bring personal involvement and the ability to provide input into their individual service plans.

3. During and/or after the service delivery process the family is ready to join other families to receive support and education from families in similar situations.
4. As a family heals, they may become ready to change things and build a community that supports youth and families with their complex needs.
5. From the service delivery system, family facilitators/advocates emerge with the core competencies to act as a guide for new families. These facilitators work as partners with professionals to insure a full range of treatment and support service programs are in place. Advocates who want to change the service delivery process will also emerge from this level and join advisory boards and/or other local or state political activities.

From the desire for full family involvement, the Utah Family Coalition developed the following mission: “To bring families and youth together to create and protect the family and youth voice in transforming the child and adolescent mental health and substance abuse systems.” The vision of the Family and Youth Coalition is to assist families and youth to have access to mental health services, and to develop a meaningful, educated, and authentic voice for policy and advocacy.

By gathering families and youth together, the Family Coalition is able to achieve its objectives which are to advise DSAMH on the issues pertaining to children’s mental health and substance abuse issues, to provide education, training and support for families, and to encourage family involvement with local community activities regarding mental health and substance abuse.

Substance Abuse Recovery Alliance of Utah (SARA)

SARA Utah is a new, grassroots, community-based membership organization of individuals in support of recovery from alcohol and other drug

addictions, their families, friends, and committed community supporters. The mission of SARA Utah is to celebrate recovery, identify, and advocate for needed services, and decrease stigma and discrimination by educating the public about the nature of substance abuse. This mission is best met when there is a strong membership in the Alliance.

SARA Utah was created in July 2006. The goal of the organization was to have 500 Alliance members by July 2007. To date SARA Utah has had 440 individuals sign up to become Alliance members and has voted in 16 members to serve on the Board Of Directors. SARA Utah is living proof that recovery is possible. If you would like to sign up or find out more information about the organization, please visit our website at www.sarautah.org.

Balanced Scorecard

The balanced scorecard report was initiated statewide by the Governor’s Office. The information will provide the Governor a summary review of all departments and agencies within State Government. Information will be specific to departments, divisions, and agencies, which will speak specifically to the most critical indicators identified.

The balanced scorecard is a management system (not only a measurement system) that enables organizations to clarify their vision and strategy and translate them into action. It provides feedback for both the internal business processes and external outcomes in order to continuously improve strategic performance and results. The outcome of the balanced scorecard planning shows how an individual, department, and/or an agency is doing on its key performance indicators.

The scorecards will help DSAMH meet its goal of accountability at all levels of service. It also provides a means of communicating, through a scorecard format, critical information to stakeholders that include advocate groups, county commissioners, legislators, etc. We believe this feedback is critically important and will help develop a service profile on a statewide basis as well as by local area. This feedback will help us move our system forward based on information that will be critical over time. The information also allows us to adjust our goals and strategy to best meet the needs of those being served.

As this initiative progresses, we welcome feedback on the process and on specific information that is being shared concerning our system.

The scorecards that follow are examples of performance-based measures that will be reported in this format.

Division of Substance Abuse and Mental Health - Balanced Scorecard

Mission Statement: To promote Hope and Recovery through substance abuse and mental health services to Utahns.

Contacts:
Mark I. Payne, Director - 801-538-3939

Metric	Status	Trend	Target	Current	Previous	Frequency	Metric Definition
DHS improves the life of clients in meaningful ways:							
Substance Use		▲	43.8%	50.6%	43.4%	quarterly	Abstinence during treatment
Employment SA		▲	14.3%	15.9%	12.6%	quarterly	Increase from admission to discharge
Employment MH	0	±				quarterly	Increase from admission to discharge
Decreased Homelessness SA		▲	26.3%	18.5%	8.6%	quarterly	Decrease from admission to discharge
Living arrangements MH	0	±				quarterly	Decrease from admission to discharge
Patient Functioning	0	±				TBD	Measure of client symptoms
DHS uses taxpayers funds efficiently and responsibly:							
Criminal Justice		▲	67.6%	80.8%	75.9%	quarterly	Decreased arrests
Successful Treatment Completion		▲		53.7%	54.5%	quarterly	Percent of clients completing modality
Numbers served SA*		▲	21,245	19,272	18,642	quarterly	
Numbers served MH*		▲	45,524	41,385	42,480	quarterly	
Unfunded served		▲		51%	48%	quarterly	Percent of total served that are unfunded
Service costs	0	±				quarterly	Cost per service unit
Customers/Clients are satisfied with DHS services:							
General satisfaction adults		▲	88%	86%	84%	yearly	
General satisfaction youth		▲	81%	77%	67%	yearly	
General satisfaction youth (family)		▲	81%	85%	76%	yearly	
Participation in treatment planning adult		▲	83%	86%	72%	yearly	
Participation in treatment planning youth		▲	86%	63%	53%	yearly	
Participation in treatment planning youth (family)		▲	86%	82%	75%	yearly	

STATUS - Default Ranges
90% or greater of target = green
>=75% to <90% of target = yellow
less than 75% of target = red

*10% increase in clients served SA/MH
Other Targets are National Averages

Adult Consumer Satisfaction Survey 2006

Agency	Number Served FY2005	Number of Forms Returned	Percent of Clients Sampled	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes					
Bear River Health Dept.	1,408	13	0.9% *	--	--	--	--	--					
Bear River Mental Health	1,846	240	13.0%	↑	86	↑	88	↑	92	↓	61		
Central Utah	929	160	17.2%	↑	91	↑	90	↑	86	↑	88	↑	67
Davis County	2,737	149	5.4%	↑	91	↑	86	↑	90	↑	91	↓	67
Four Corners	2,004	147	7.3%	↑	92	↓	87	↓	77	↑	86	↑	75
Heber Valley Counseling	255	26	10.2%	→	100	↓	92	↑	89	↓	96	↑	73
Northeastern	1,227	37	3.0%	↓	89	↓	95	↓	92	↓	94	↓	73
Salt Lake County	7,024	739	10.5%	→	84	↓	74	↓	83	↑	85	→	80
San Juan	524	17	3.2% *	--	--	--	--	--	--	--	--	--	--
Southwest	2,101	239	11.4%	↑	88	↓	80	↓	86	↑	89	↑	74
Utah County	1,509	372	24.7%	↑	89	→	80	→	90	↑	93	↑	90
Valley Mental Health	12,972	1,005	7.7%	→	83	↑	76	↓	77	↑	80	↓	65
Wasatch	3,877	214	5.5%	↑	87	↑	79	↓	77	↑	80	→	67
Weber	5,667	334	5.9%	↑	85	↑	89	↓	83	↑	86	↓	71
Statewide Average	44,080	3,692	8.4%	↑	86	→	80	↓	83	↑	86	↓	73
National Average (2005)					88		84		85		83		71

* Insufficient sample rate.

Youth Satisfaction Survey 2006

Agency	Number Served FY2005	Number of Forms Returned	Percent of Clients Sampled	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes					
Bear River Health Dept.	155	2	1.3% *	--	--	--	--	--					
Bear River Mental Health	886	44	5.0%	↑	80	↑	74	↑	84	↑	68	↑	55
Central Utah	567	31	5.5%	↑	84	↑	73	↑	87	↑	71	↓	74
Davis County	1,247	9	0.7% *	--	--	--	--	--	--	--	--	--	--
Four Corners	364	35	9.6%	↑	67	↑	74	↑	82	↑	73	↑	77
Heber Valley Counseling	24	3	12.5%	*	100	*	100	*	100	*	100	*	100
Northeastern	594	5	0.8% *	--	--	--	--	--	--	--	--	--	--
Salt Lake County	1,379	119	8.6%	↑	89	↓	67	↑	95	↑	87	↑	83
San Juan	274	1	0.4% *	--	--	--	--	--	--	--	--	--	--
Southwest	1,412	40	2.8%	↓	71	↓	87	↓	84	↓	81	↓	63
Utah County	206	24	11.7%	↑	92	↑	50	↑	92	↑	88	↑	92
Valley Mental Health	5,312	403	7.6%	↑	74	↑	67	↑	83	↑	58	↑	71
Wasatch	1,595	57	3.6%	↓	77	↓	87	↓	89	↓	71	↓	76
Weber	1,739	52	3.0%	↓	79	↓	78	↓	83	↓	82	↓	73
Statewide Average	15,754	825	5.2%	↑	77	↑	71	↑	85	↑	63	↑	73
National Average (2005)					81		82		91		86		73

* Insufficient sample rate.

* Trend data unavailable for previous year.

Youth Satisfaction Survey (Family) 2006

Agency	Number Served FY2005	Number of Forms Returned	Percent of Clients Sampled	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes					
Bear River Health Dept.	155	0	0.0% *	--	--	--	--	--					
Bear River Mental Health	886	71	8.0%	↑	87	↑	96	↓	39	↑	94	↑	59
Central Utah	567	27	4.8% *	--	--	--	--	--	--	--	--	--	--
Davis County	1,247	14	1.1% *	--	--	--	--	--	--	--	--	--	--
Four Corners	364	26	7.1%	↑	89	↑	85	↓	85	↓	73	↑	69
Heber Valley Counseling	24	1	4.2% *	--	--	--	--	--	--	--	--	--	--
Northeastern	594	12	2.0% *	--	--	--	--	--	--	--	--	--	--
Salt Lake County	1,379	40	2.9%	↓	70	↓	87	↓	71	↓	55	↓	80
San Juan	274	0	0.0% *	--	--	--	--	--	--	--	--	--	--
Southwest	1,412	112	7.9%	↓	76	↑	89	↓	89	↑	86	↑	54
Utah County	206	13	6.3%	↑	92	↑	92	↑	92	↓	62	↑	77
Valley Mental Health	5,312	423	8.0%	↑	88	↑	82	↑	91	↑	82	↑	67
Wasatch	1,595	45	2.8%	↓	84	↓	85	↓	90	↓	74	↓	49
Weber	1,739	39	2.2%	↓	95	↓	92	↓	100	↓	82	↓	62
Statewide Average	15,754	823	5.2%	↑	85	↑	85	↑	90	↑	82	↑	65
National Average (2005)					81		82		91		86		73

* Insufficient sample rate.

Green = Percentage meets or exceeds the higher of the National Average or the Statewide Average (percentage used as the target is bolded).

Yellow = Percentage between the National Average and Statewide Average.

Red = Percentage below the lessor of the National Average or Statewide Average (percentage used as the target is bolded).

↑ ↓ Trend from prior year. → No change from prior year.

Chart results are based on round numbers.

Measuring Patient Outcomes

“Utilizing science and evidence based practices to evaluate and support clinical effectiveness and cost benefits for public behavioral health”

Measuring patient outcomes is essential to Utah’s plan for transforming the public behavioral healthcare system. The implementation of science and evidence based treatments will be a priority for 2007/2008. DSAMH announced plans to require all publicly funded community mental health and substance abuse providers to utilize a statewide system for assessing and measuring patient outcomes. In a report to the Health and Human Services Interim Committee, DSAMH Director, Mark I. Payne, presented information regarding the new requirements and details regarding the new system, its use, and the expected benefits:

- Empirically supported research and results.
- Indicates a successful level of outcome and provides clinical feedback and support that treatment may be terminated.
- Indicates when a less intensive and less costly level of treatment may be appropriate.
- Clients are more involved in treatment, increasing their responsibility to change.
- Clinicians and managers can see which cases are in trouble and can focus on these, which based on research account for approximately 15-20%.
- Evaluate effectiveness of centers, programs, clinicians, methods, treatment options, etc. (can compare with statewide and national results).
- Cost control (avoid expending resources without positive results).

- Terminating treatments when normal range of functioning is sustained, increasing access to services for other patients.
- Measuring patient response to treatments, and prompting clinicians on the status of patients mental health vital signs.*

*Treatment Failure Alerts—an outcome measure’s ability to use rational or empirically based algorithms to detect possible treatment failures and alert clinicians accordingly.

*Change Metrics—an outcome measure’s ability to use a Reliable Change Index (RCI) and cutoff score to define standards for clinically significant change achieved during mental health treatment (i.e., classifying patient change as—recovered, improved, no change, or deterioration).

The OQ-HS[®], offered under contract to providers of DSAMH, by OQ Measures, automates the administration and reporting on the adult Outcome Questionnaire[®] (OQ[®]) and its closely related child-adolescent version, the Youth Outcome Questionnaire[™] (Y-OQ[®]). These instruments have, for a number of years, been recognized as one of the leading outcome tracking methodologies for quantifying and evaluating the progress of behavioral health therapy. These outcome measures have been widely adopted by a variety of behavioral and other health care service organizations (e.g. small clinics, large health care institutions, university counseling centers, and all branches of the military) since their release in the early 1990s. However, leveraging the full power of these tools in everyday clinical practice requires a software program that incorporates the latest technology and research findings. This software solution is called OQ-HS[®] Analyst and was developed by OQ Measures in partnership with Lanark Systems. Some key characteristics of the OQ-HS[®] Analyst system are:

- A platform that allows for distributed, on-line reporting and electronic administration, scoring, feedback, and reporting;

- The ability to measure positive or negative change in a patient's mental health and alert clinicians to possible negative outcomes prior to treatment failure;
- Various feedback reports designed to provide information to clinicians, administrators, and patients;
- Algorithms that faithfully incorporate the rigorous OQ[®] and Y-OQ[®] research findings; and
- Built-in security protocols to comply with HIPPA regulations and protect private patient information.

The Utah OQ-HS Analyst system is designed to run in a wireless or local area network environment and allows users to access the application from multiple computers through the use of a secure web portal. The software also includes a scanning utility that is installed on any computer used for scanner input as well as a Microsoft Pocket PC version of the software that is installed

on handheld PDA devices for electronic administration. The Utah contract with OQ Measures also includes the ability to complete the instruments (input) using a tablet or PC kiosk workstation.

The Utah OQ-HS[®] system will be rolled out to all combined providers for public mental health and substance abuse in fiscal year 2007. Providers for substance abuse services only will be added to the system in 2008/09. The instruments will generally be used at intake, every encounter, and at discharge, and will offer immediate feedback to both the clinician and the patients. Valley Mental Health and Wasatch Behavior Health will begin utilizing the OQ-HS[®] system in January of 2007. Other providers will follow once these pilot providers have established routine success with the system and integration of the tools and techniques into the clinical process.

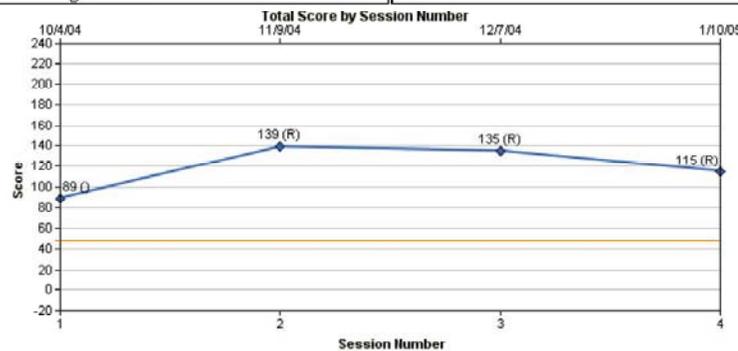
The picture below illustrates the instruments and PDA input device.



Below are examples of feedback reports and graphs provided to the clinician and patient.

Below is an example of a Clinician Feedback Report generated by the OQ Analyst software for a patient who has completed the Y-OQ90-2.01. The report indicates an alert status of Red, meaning that the patient has deviated from the expected rate of change and that there is a high chance of negative outcome. Included in the report is the patient's response to critical items, a subscale breakdown of the total score, and a graph tracking the total score of previous administrations.

Name: Child, Miranda, R ID: ABCDE075 Session Date: 1/10/2005 Session: 4 Clinician: Clinician, Randy Clinic: South Clinic Diagnosis: Unknown Diagnosis Completed by: Mother		Alert Status: Red Most Recent Score: 115 Initial Score: 89 Change From Initial: Reliably Worse Current Distress Level: High																																	
Most Recent Critical Item Status: 12. Obsessive Thoughts Sometimes 20. Hallucinations Sometimes 21. Self Injurious Behavior Never 22. Substance Abuse Never 28. Paranoia Frequently 38. Delusions Never 41. Suicidal Never 44. Hypomania Frequently 46. Fear of Going Crazy Unanswered 51. Aggression Frequently 58. Eating Disorder Never		<table border="1"> <thead> <tr> <th>Subscales</th> <th>Current</th> <th>Output. Norm</th> <th>Comm. Norm</th> </tr> </thead> <tbody> <tr> <td>Intrapers. Distress:</td> <td>39</td> <td>26.4</td> <td>8.9</td> </tr> <tr> <td>Somatic:</td> <td>22</td> <td>7.8</td> <td>3.3</td> </tr> <tr> <td>Interpers. Relations:</td> <td>14</td> <td>10.4</td> <td>0.6</td> </tr> <tr> <td>Social Problems:</td> <td>5</td> <td>6.3</td> <td>0.7</td> </tr> <tr> <td>Behavioral Dys.:</td> <td>20</td> <td>20.1</td> <td>6.8</td> </tr> <tr> <td>Critical Items:</td> <td>15</td> <td>7.7</td> <td>3.0</td> </tr> <tr> <td>Total:</td> <td>115</td> <td>78.7</td> <td>23.3</td> </tr> </tbody> </table>		Subscales	Current	Output. Norm	Comm. Norm	Intrapers. Distress:	39	26.4	8.9	Somatic:	22	7.8	3.3	Interpers. Relations:	14	10.4	0.6	Social Problems:	5	6.3	0.7	Behavioral Dys.:	20	20.1	6.8	Critical Items:	15	7.7	3.0	Total:	115	78.7	23.3
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Critical Items:	15	7.7	3.0																																
Total:	115	78.7	23.3																																



Graph Label Legend:
 (R) = Red: High chance of negative outcome (Y) = Yellow: Some chance of negative outcome
 (G) = Green: Making expected progress (W) = White: Functioning in normal range

Session#:	1	2	3	4
Completed By:	Mother	Mother	Mother	Mother

Feedback Message:
 The patient is not making the expected level of progress. Chances are they may drop out of treatment prematurely or have a negative treatment outcome. Steps should be taken to carefully review this case and identify reasons for poor progress. It may be helpful to assess the quality of the therapeutic alliance, the client's motivation, social support network, or decide upon a new course of action, such as referral for medication or intensification of treatment. The treatment plan may need to be reconsidered.

Monitoring

DSAMH Monitoring Process

DSAMH's monitoring process of the Local Authority system is a complex, essential process and a priority. In the past DSAMH has referred to this process as Governance and Oversight. The overall purpose of monitoring is to provide re-

quired oversight and to ensure mandated services are being provided.

One of DSAMH's recent initiatives has been to improve the monitoring process. By improving the monitoring process DSAMH hopes to increase the accountability and responsibility of the system. Some of the improvements DSAMH has focused on are: providing critical program and operation indicators to key stakeholders,

defining goals and objectives of the monitoring process, incorporating hope and recovery in the monitoring process, and revising the monitoring report to better reflect and address the requirements and outcomes of both the Local Authorities and DSAMH.

Goals and Objective:

- Accountability and responsibility:
 - Ensure reliability and integrity of information
 - Compliance with policies, plans, procedures, laws, and contracts
 - Economical and efficient use of resources
 - The accomplishment of established objectives and goals, for programs and operations
- Implement a monitoring process that strives towards a partnership and ensures an efficient and effective system is available to consumers in the State of Utah.
- Work with stakeholders to form an efficient line of communication with meaningful information.
- Improve perception of the system by providing information regarding the Local Authority’s accountability, responsibility, and outcomes data.

Hope and Recovery:

- As mentioned, one of the improvements to the monitoring process includes a focus on “Hope and Recovery.” DSAMH and UBHN’s commitment to hope and recovery is a goal for all consumers of substance abuse and mental health services. There are ten fundamental components of recovery identified by the Federal Substance Abuse and Mental Health Services Administration necessary to achieve a recovery “system.”

- As part of the monitoring visits, DSAMH will be conducting an assessment of all of the mental health centers to identify which of the ten elements have been or are being implemented. This assessment will establish a baseline and snapshot of the system. Using this baseline data, DSAMH will assist the local centers through technical assistance and training to continue moving forward to operationalize recovery.

Requirements and Process:

- There are several requirements of the Local Authorities and DSAMH. The requirements can be found in State Statute, Administrative Rules, DSAMH Contracts, Area Plan Elements, Local Authority Area Plans, and Division Directives. All of these references are listed on our website which can be found at <http://www.dsamh.utah.gov/ct.htm>
- The process entails the Local Authority submitting a plan by May 1st of every year and approved by DSAMH. Each year DSAMH conducts a site review of each Local Authority. The site review involves program requirements and fiscal accountability. This year DSAMH has developed a new report to provide meaningful, pertinent information to key stakeholders.

Counseling for Recent Returning Veterans and Families

H.B. 407, Counseling for Families of Veterans, sponsored by Representative Tim Cosgrove, passed the legislature and provided \$210,000 in one time funding for developing and implementing a statewide counseling program for service members and their families.

A committee was formed consisting of representatives from all branches of the military, the Veterans Administration, Workforce Services, veterans associations, family advocates, religious groups and the Division of Substance Abuse and Mental Health. The committee met for several months and identified existing resources available to veterans. Interaction between committee members proved to be extremely valuable as a number of programs, which already existed, were identified and referral information shared. Funding was provided for a survey to assess returning Middle East service members knowledge of existing services as well as needs. The survey identified a clear need for educating service members and their families regarding available services. Funding was provided for a media campaign to raise awareness and provide contact information for service members and their families. Funding was also provided for service members and their spouses to attend the Prevention and Relationship Enhancement Program. This program is designed to prevent serious problems and reduce the risk of divorce or marital dissatisfaction.

Early Intervention for Children

In 2006, the Legislature allocated a one-time amount of \$500,000 through DSAMH to provide children's mental health services. DSAMH contracted with the Children's Center to provide training and on-going technical assistance to four rural mental health centers (Price, Bear River, Southwest, and Vernal) and their communities. The target population being children (and their families) from birth to five who are in need of early assessment and intervention as related to health and mental health issues (specifically ADHD, early trauma and loss, and Autism Spectrum Disorders).

The contract requires the cross training of the mental health centers, allied professionals, and parents in these communities. This will assure that

children accessing various community resources (Head Start, daycare, mental health, health, etc.) will have the opportunity to be screened for necessary mental health issues, regardless of funding source. In addition, the four mental health centers will have a staff member specifically trained to provide intervention for those children accessing services.

Utah's Response to Hurricane Katrina

Under the direction of the Governor's office DSAMH managed the crisis counseling response efforts for Hurricane Katrina Evacuees. When plane after plane of evacuees came to Salt Lake City, the Utah National Guard and crisis counselors, along with State officials, faith-based agencies, and other social service agencies were able to provide an effective response. The evacuees were met with many charitable outreach efforts and were then housed at the Utah National Guard Camp Williams Military Reservation. Crisis counselors worked closely with evacuees to help them adjust to Utah's weather and cope with their multiple losses in a new area far from family and friends.

When Camp Williams temporary housing closed September 27, 2005, approximately 450 evacuees decided to stay in Utah and were relocated in Salt Lake County and outlying cities throughout the State. The evacuees are clustered in areas being served by the outreach team "Utah Reaching Out."

Under the direction of DSAMH as the State Mental Health Authority (SMHA), a crisis-counseling program called "Utah Reaching Out" was developed through the Calvary Baptist Church. They are responsible for the ongoing outreach, under the guidance of team leader, Reverend Frances Davis. The outreach team, whose membership is Black/African American and includes one member who is a Hurricane Evacuee, is sensitive to the

needs of evacuees. They have vast experience in working with Black/African Americans and have developed extensive ties in the communities throughout Utah.

Community outreach has included face-to-face contacts, outreach, crisis counseling groups, educational groups, working with community providers, and working on the development of public service announcements designed to help understand grief and loss and awareness of normal phases of recovery for individuals and communities. Utah Reaching Out has also worked with other agen-

cies to distribute material. In addition, a hotline for evacuees requesting information or intervention for disaster behavioral health needs has been established through Valley Mental Health.

Utah Reaching Out is working with local communities across the State to improve and develop community resources and collaboration. Agencies include faith-based organizations, LDS Welfare services, Catholic Community Services, Salvation Army, local community mental health centers, primary care providers, and other local agencies.

Provider Initiatives



*Utah
Behavioral
Healthcare
Network, Inc.*

The Utah Behavioral Health Network (UBHN) has provided the following summary

on initiatives developed within their membership of public providers. DSAMH supports these efforts and is encouraged by the progressive and innovative work being accomplished.

Futures Committee

The UBHN Futures Committee that included representatives of the Utah Department of Human Services, the Utah Department of Health, and the Utah Division of Substance Abuse and Mental Health developed the Utah Recovery Model for Mental Health and Substance Abuse Discussion Draft. Members of the committee are:

UBHN Representatives:

David Dangerfield, Chair
Patrick Fleming
Mick Pattinson
Robert Greenberg
Brian Miller
Rob Johnson
Debra Falvo
Dennis Hansen

Utah Department of Human Services Representative:

Mark Ward

Utah Department of Health Representative:

Michael Deily

Utah Division of Substance Abuse and Mental Health Representative:

Ron Stromberg

Utah Recovery Model for Mental Health and Substance Abuse

Public mental health and substance abuse services in Utah have been provided through a partnership between state and county government according to a 30 year-old model that is no longer viable. This new model recognizes that recovery is possible, that effective treatment is available, that real, measurable returns on investment are possible and that investment in the Recovery Model is in the interest of the State.

The mental health and substance abuse treatment system is falling behind. The number of people who need services far outstrips our ability to provide those services. The gap between system capacity and need continues to widen. The epidemic increase in methamphetamine use is now monopolizing substance abuse treatment resources. All too often services and treatment are based on available funding rather than actual need.

The Recovery Model is based on Utah values: family involvement and responsibility, community reintegration, financial viability, accountability at every step of the process, collaboration and teamwork among healthcare providers, long-range comprehensive planning and workforce development, and a deepening of the partnership between State and county governments.

The Utah Recovery Model is based on utilizing treatment programs proven to be effective. The model recognizes the value of jobs, education, family involvement and community connections. Adults are directly engaged in planning their own recoveries, and families are involved at every

step of planning the treatment for children. Community supports are essential to the model, as are coordinated behavioral and physical healthcare components.

The Utah Recovery Model includes 21 goals encompassing four areas of concern: Prevention Services, Adult Services, Children and Youth Services, and Service Supports.

Treatment and prevention services will be measured by how well they meet these goals, and public policy will be based on emulating what works and discarding what does not.

The Utah Recovery Model represents a new way of doing business, and requires service providers and policy makers to adopt new perspectives, including the incorporation of proven but non-traditional rehabilitation and support services, incentives to providers to render more effective and flexible services. New funding models are needed.

The benefits of the Utah Recovery Model are tremendous. More effective mental illness and substance abuse treatments mean lower state and local criminal and juvenile justice costs, lower child welfare expenses, lower state, county and private homelessness allocations, and lower health care expenditures. More effective treatment means more former mental illness and substance abuse patients holding long-term jobs, establishing homes, paying taxes, strengthening our state as they rebuild ties to their families and communities and participate as productive members of society.

Network of Care

Everyone in Utah will now have access to behavioral healthcare information never before provided on a statewide basis.

The Utah Behavioral Healthcare Network with support from the State of Utah has launched a breakthrough Web solution for individuals, families, agencies and the general public seeking information about mental health and substance abuse.

Through the free Utah Network of Care website (www.utah.networkofcare.org) people in all Utah's counties with online access can find the right services, at the right time. They can educate themselves about issues, understand current policy initiatives, directly advocate their positions to elected officials and better understand and manage their affairs, interactions and important records.

Utah Network of Care extends the reach of scarce public mental health and substance abuse resources for the benefit of all Utahns and it empowers consumers with information to manage their own recovery.

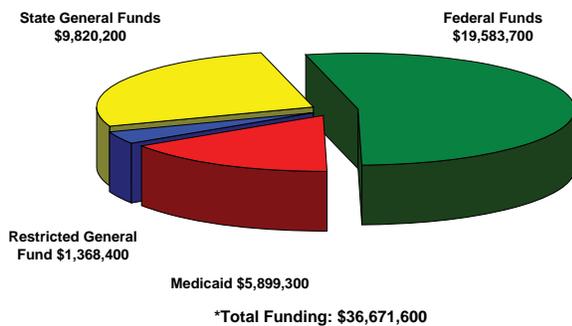
Regardless of where individuals, families, and agencies begin their search for assistance with behavioral health issues, Utah Network of Care ensures they will find what they need.

Source of Funding and Category of Expenses

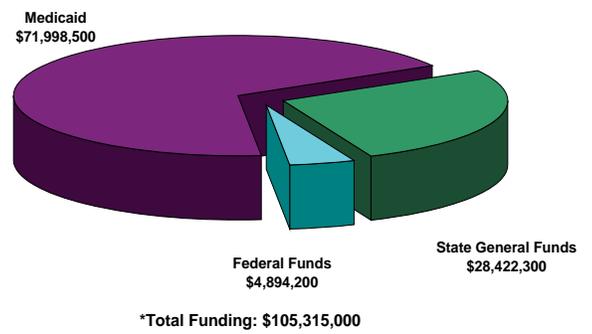
Information regarding the Division's funding is identified in the following charts. The Medicaid funding is actually disbursed to the Local

Authorities by the Department of Health. The Division received funding from approximately 14 different Federal grants.

Substance Abuse Services Funding
Fiscal Year 2006



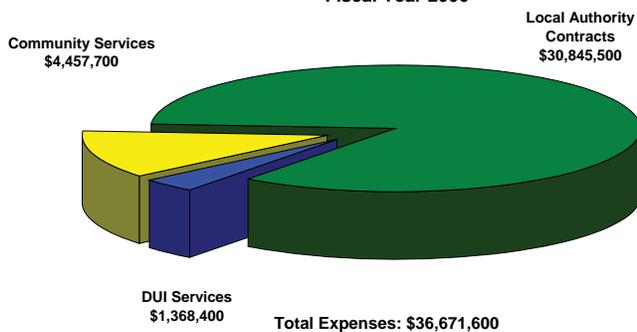
Mental Health Services Funding
Fiscal Year 2006



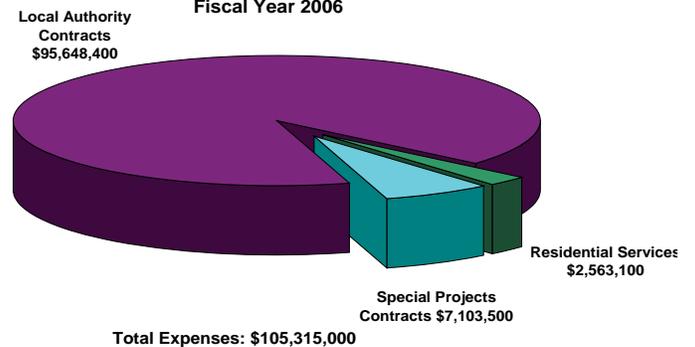
In the following charts the funding is identified in expense categories. The majority of funding is expended through the Local Authority contracts. The Medicaid funding is included in the Local

Authority category. Special project contracts involve programs such as UTCAN, Reconnect, SIG-E, Prevention, etc., which are mentioned in this report.

Substance Abuse Services Expense Categories
Fiscal Year 2006



Mental Health Services Expense Categories
Fiscal Year 2006



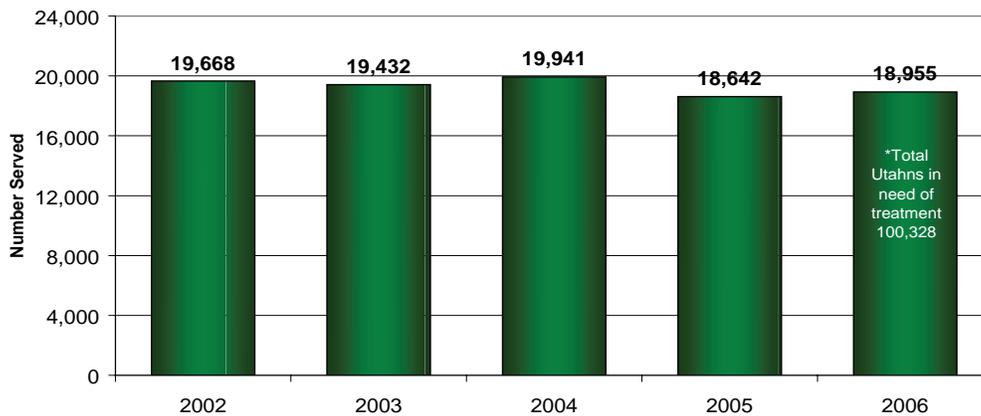
Who Do We Serve

Total Number Served

The following figures show the total number of individuals served in all publicly funded substance abuse treatment facilities for fiscal years 2002

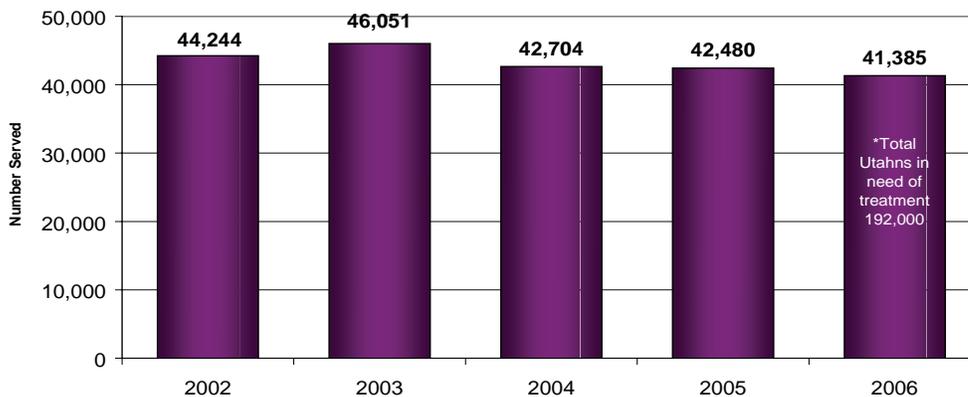
through 2006. The same is depicted for individuals in service within community mental health centers for fiscal year 2002 through fiscal year 2006.

Total Number of Individuals Served in Substance Abuse Treatment Fiscal Years 2002 - 2006



*Taken from the 2005 State Substance Abuse Treatment Needs Assessment Survey and the 2005 SHARP Survey.

Total Number of Individuals Served in Mental Health Services Fiscal Years 2002 - 2006



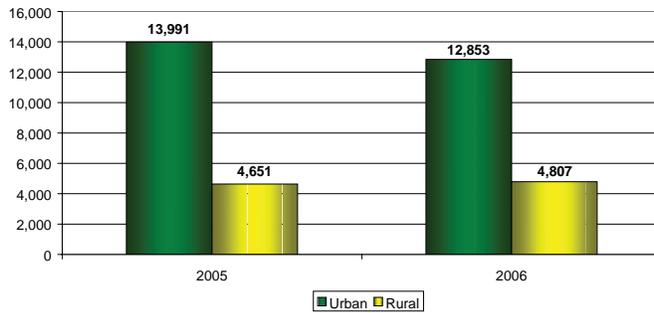
*Taken from the 2005 National Drug Use and Health Survey.

Urban and Rural Areas

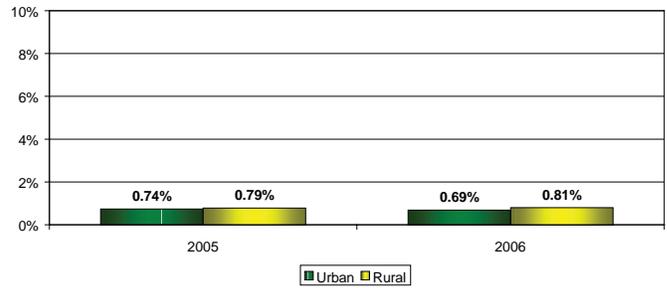
The following graphs show the total number of individuals served in urban and rural communities

and a percentage of the total population served for substance abuse and mental health.

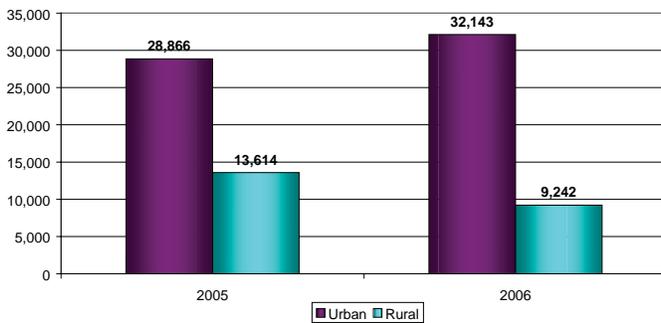
Number of Individuals Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2005 - 2006



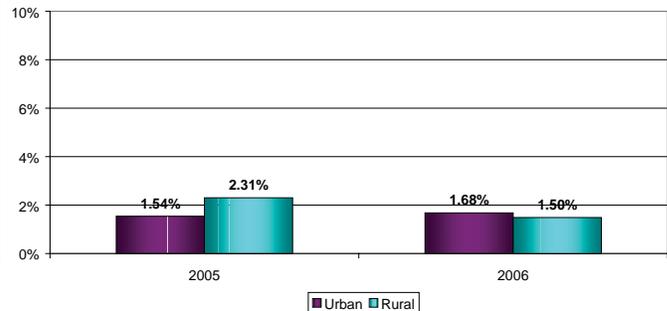
Percent of Total Population Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2005 - 2006



Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2005 - 2006



Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2005 - 2006



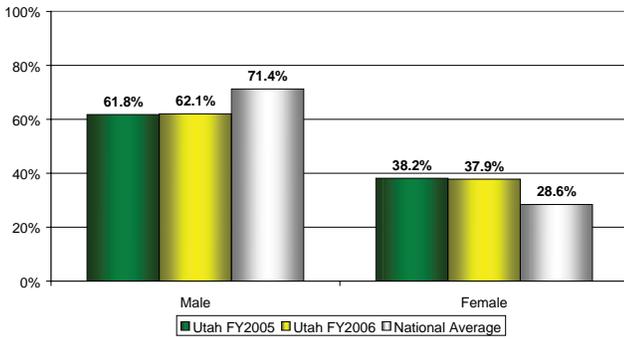
Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

Gender and Age

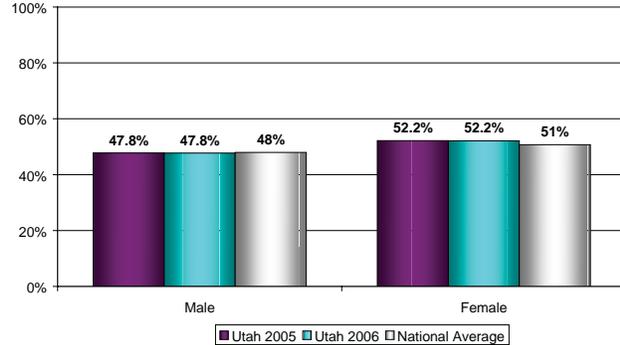
The following figures show the distribution of services by gender and age for Substance Abuse and Mental Health services. There are significant

differences between the substance abuse and mental health populations in both gender and age.

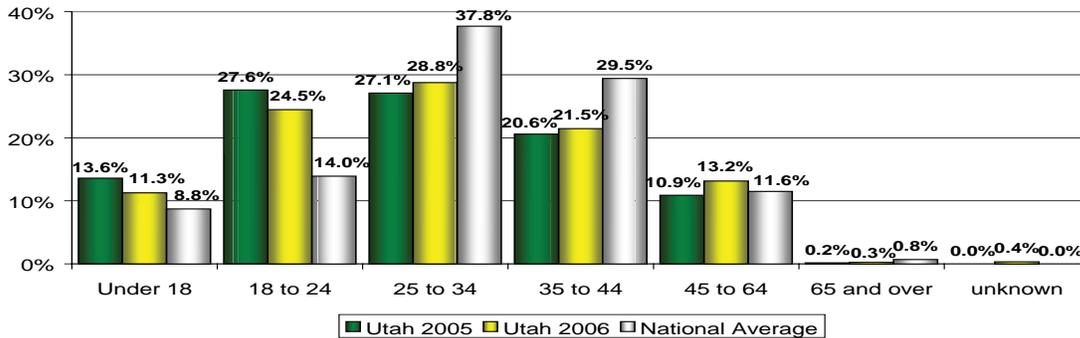
Gender of People Served in Substance Abuse Services
Fiscal Years 2005 - 2006



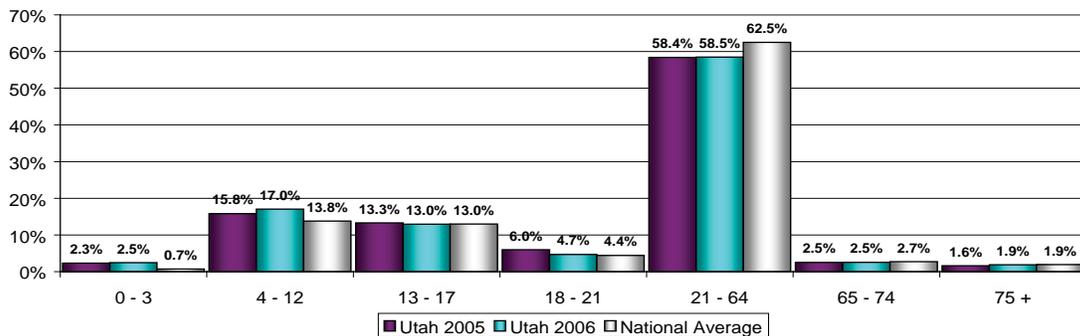
Gender of People Served in Mental Health Services
Fiscal Years 2005 - 2006



Age Grouping at Admission of People Served in Substance Abuse Services
Fiscal Years 2005 - 2006



Age Grouping of People Served in Mental Health Services
Fiscal Year 2006

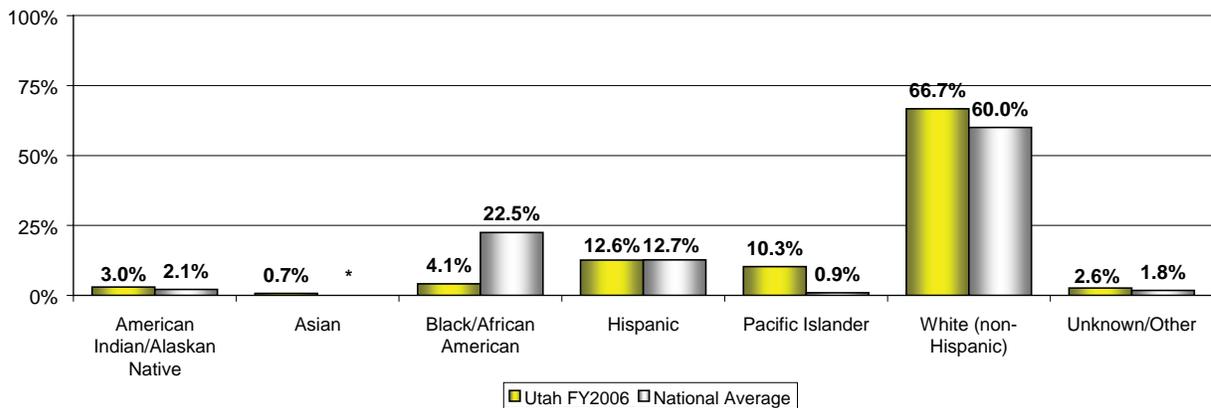


Race and Ethnicity

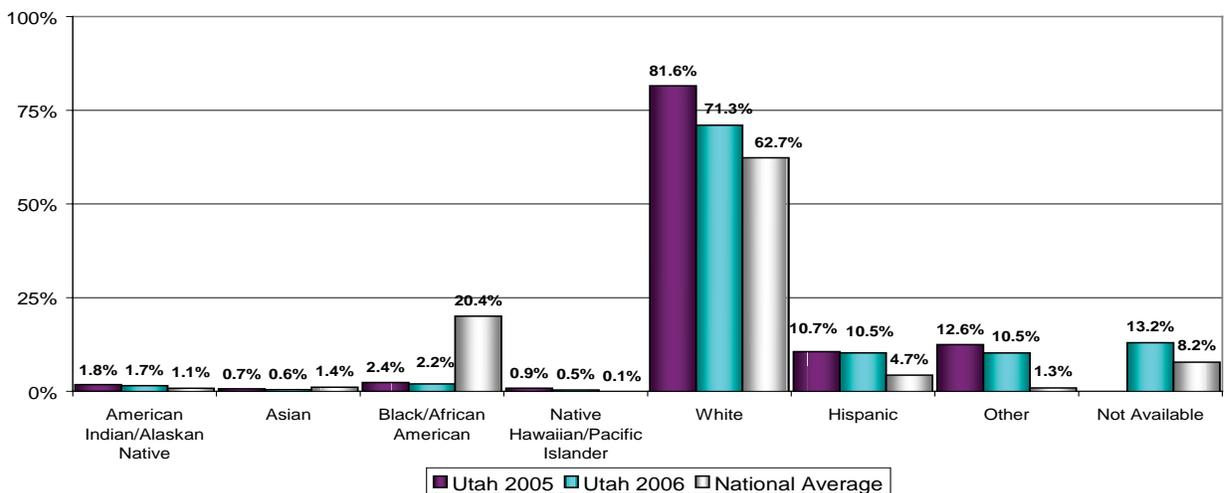
The graphs below report the distribution of the treatment population by race categories. There are no significant differences in race and ethnicity for the clients receiving substance abuse or mental

health services. More detailed data on ethnicity categories are available for substance abuse clients than mental health clients.

Race/Ethnicity of People Served in Substance Abuse Services Fiscal Year 2006



Race/Ethnicity of People Served in Mental Health Service Fiscal Year 2006



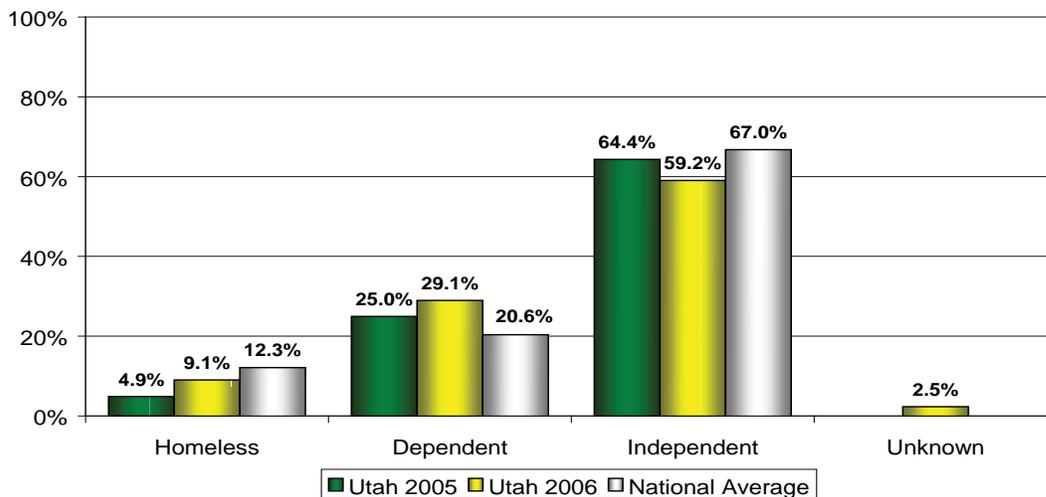
Note: More than one race/ethnicity may have been selected.

Living Arrangement at Admission

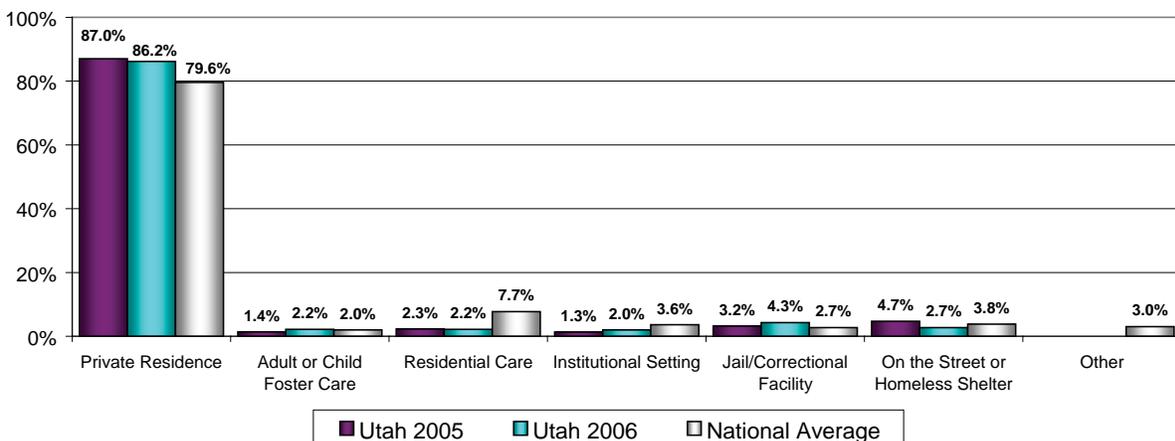
The following graphs depict the living arrangement at admission for substance abuse and mental health clients served in fiscal year 2006. By far, the majority of clients receiving substance abuse and mental health services are independent

citizens at the time they enter treatment. More detailed data on living arrangement categories is available for mental health clients than substance abuse clients.

Living Arrangement at Admission of Adults Served in Substance Abuse Services Fiscal Years 2005 - 2006



Living Arrangement at Admission of Adults Served in Mental Health Services Fiscal Years 2005 - 2006

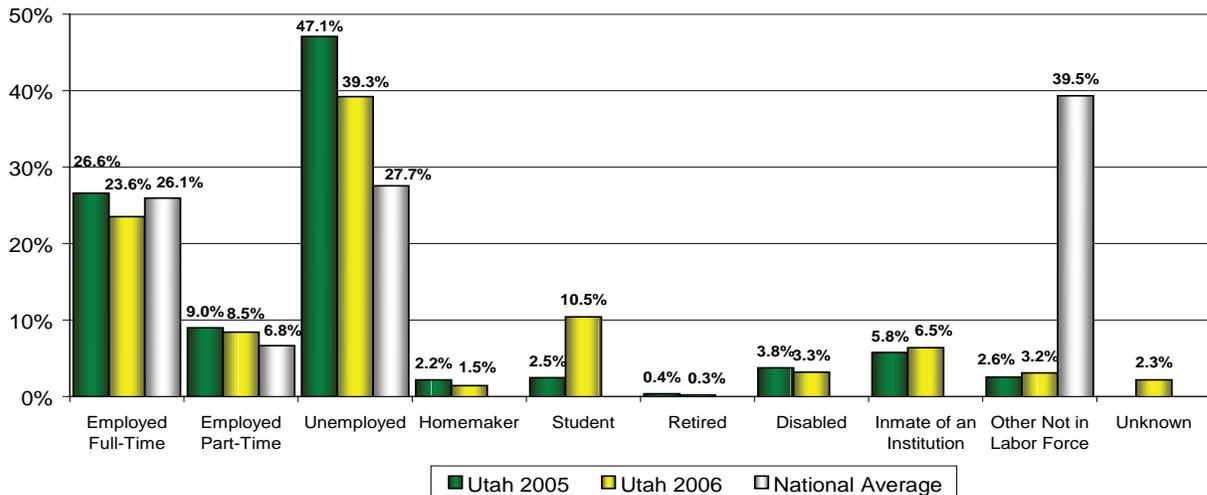


Employment Status at Admission

The following graphs show the employment status at admission for substance abuse and mental health clients served in fiscal year 2006. The categories

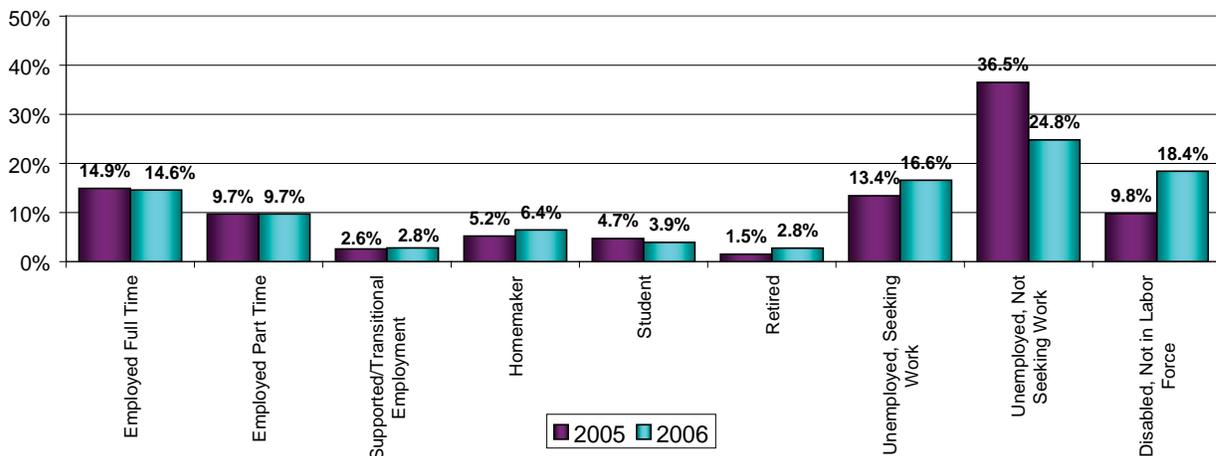
for mental health clients are different than those for substance abuse clients.

Employment Status at Admission for Individuals in Substance Abuse Services Fiscal Years 2005 - 2006



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

Employment Status at Admission for Adults Served in Mental Health Services Fiscal Years 2005 - 2006

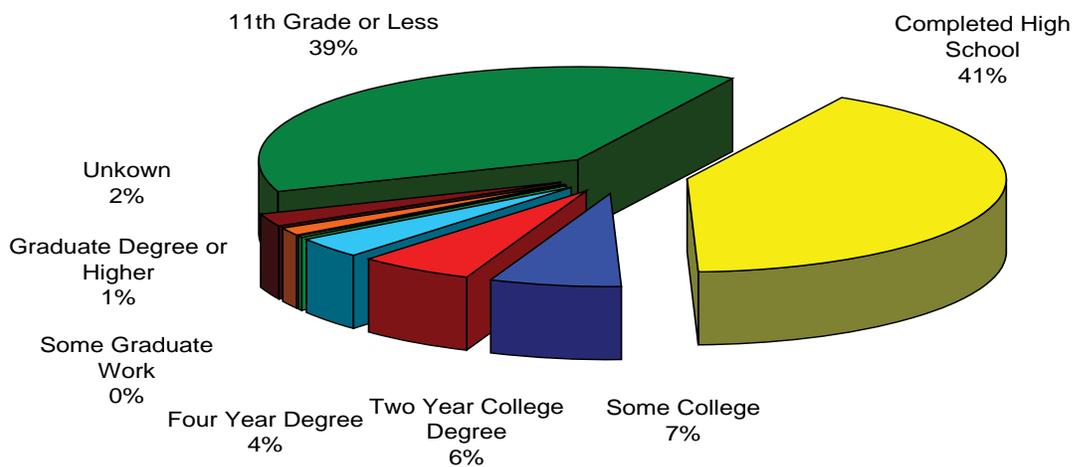


Highest Education Level Completed at Admission

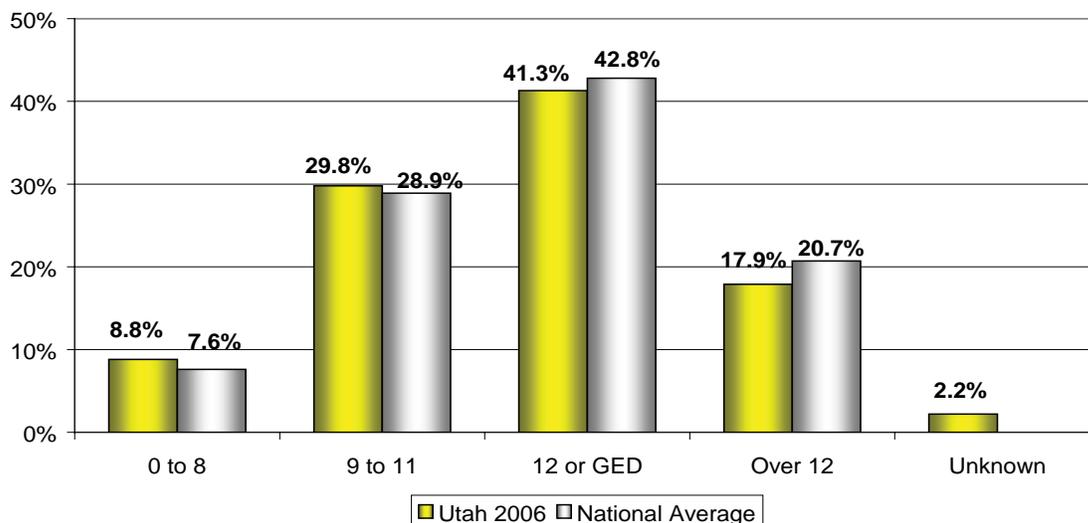
In fiscal year 2006, 59% of adults in substance abuse treatment statewide completed at least high school, which included those clients who had attended some college or technical training.

Additionally, 18% of the clients had received some type of college training prior to admission. Still, over 39% had not graduated from high school.

Education Level at Admission for Individuals in Substance Abuse Services Fiscal Year 2006



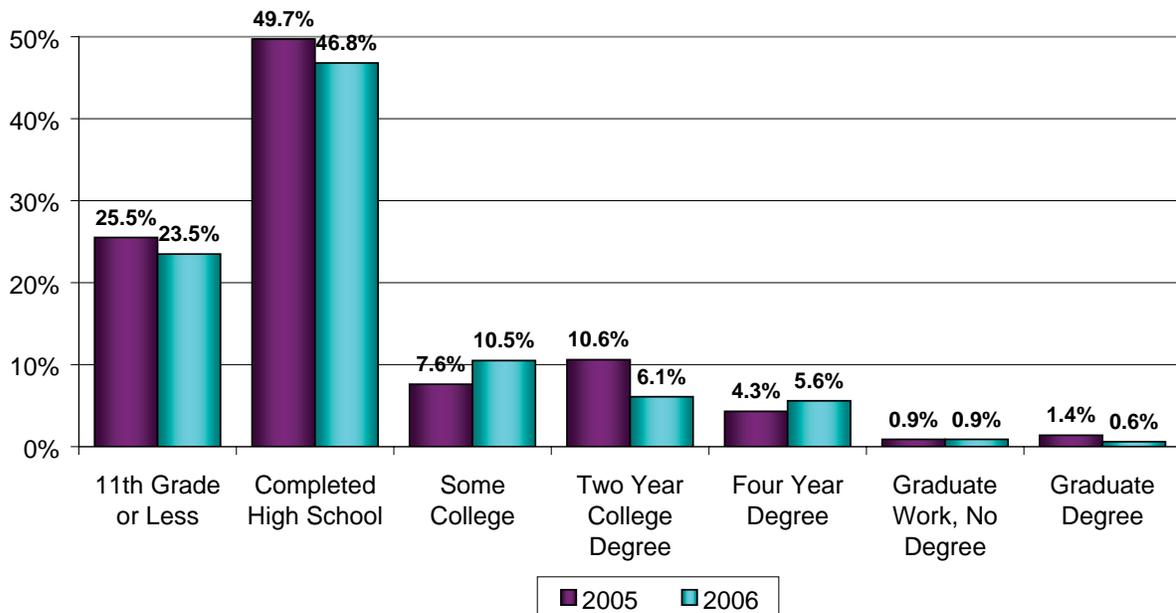
Highest Education Level of Adults Served in Substance Abuse Services Fiscal Year 2006



In fiscal year 2006, 74.5% of adults in mental health treatment statewide completed at least high school, which included those clients who had attended some college or technical training.

Additionally, 24.8% of the clients had received some type of college degree prior to admission. Still, over 23.5% had not graduated from high school.

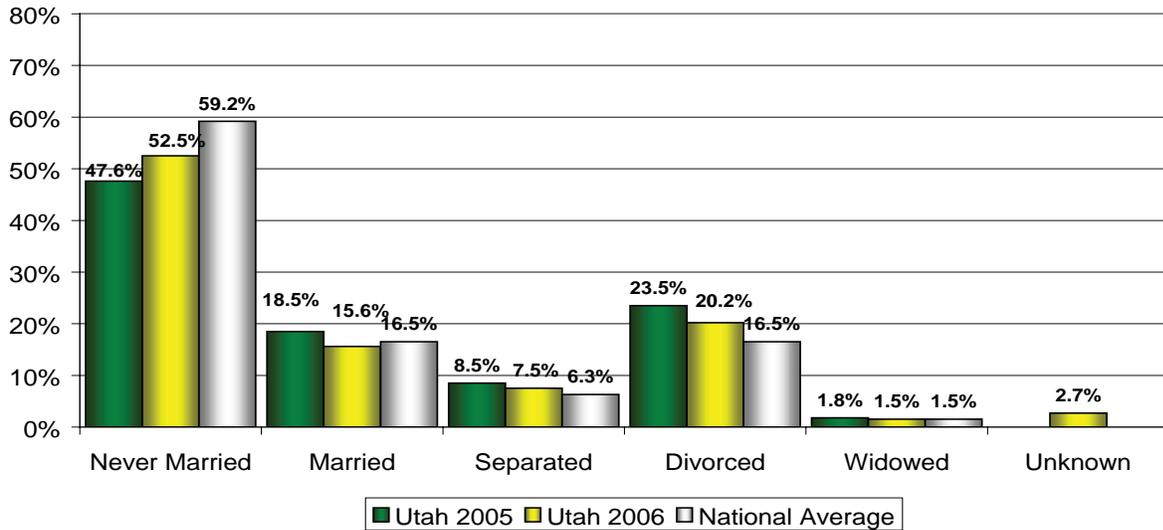
Highest Education Level of Adults Served in Mental Health Services Fiscal Years 2005 - 2006



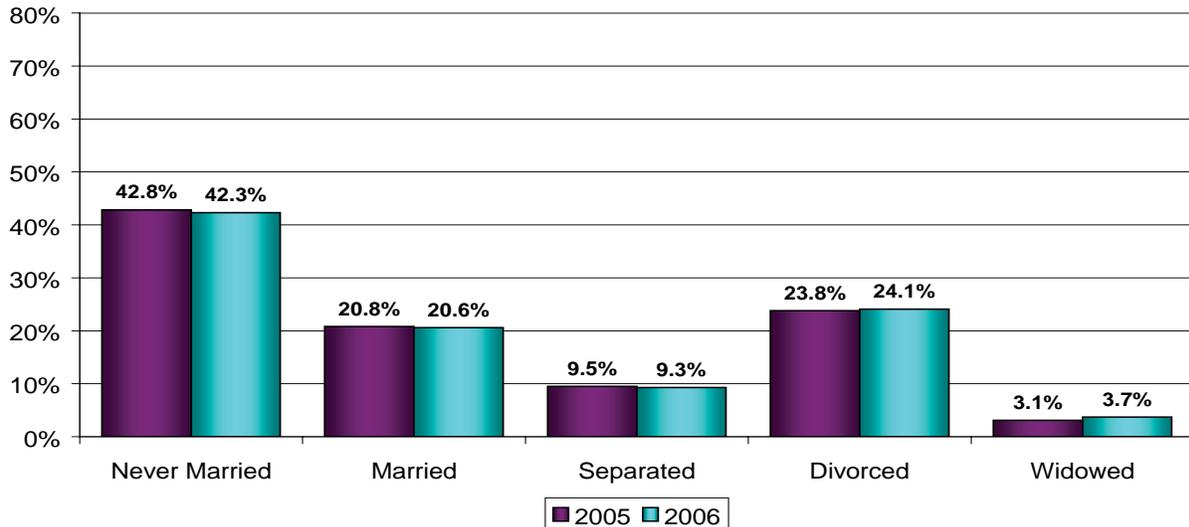
Marital Status at Admission

The following graphs show the marital status at admission for substance abuse and mental health clients served in fiscal year 2006.

Marital Status of Individuals Served in Substance Abuse Services Fiscal Years 2005 - 2006



Marital Status of Adults in Mental Health Services Fiscal Years 2005 - 2006

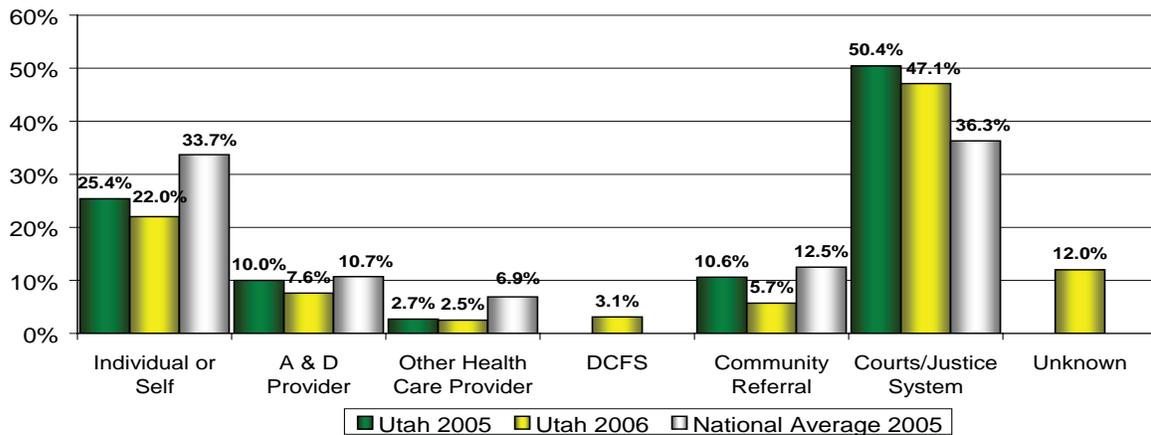


Referral Source

The individual or organization that has referred a patient to treatment is recorded at the time of admission. This source of referral into treatment can be a critical piece of information necessary for helping a patient stay in treatment once there; the

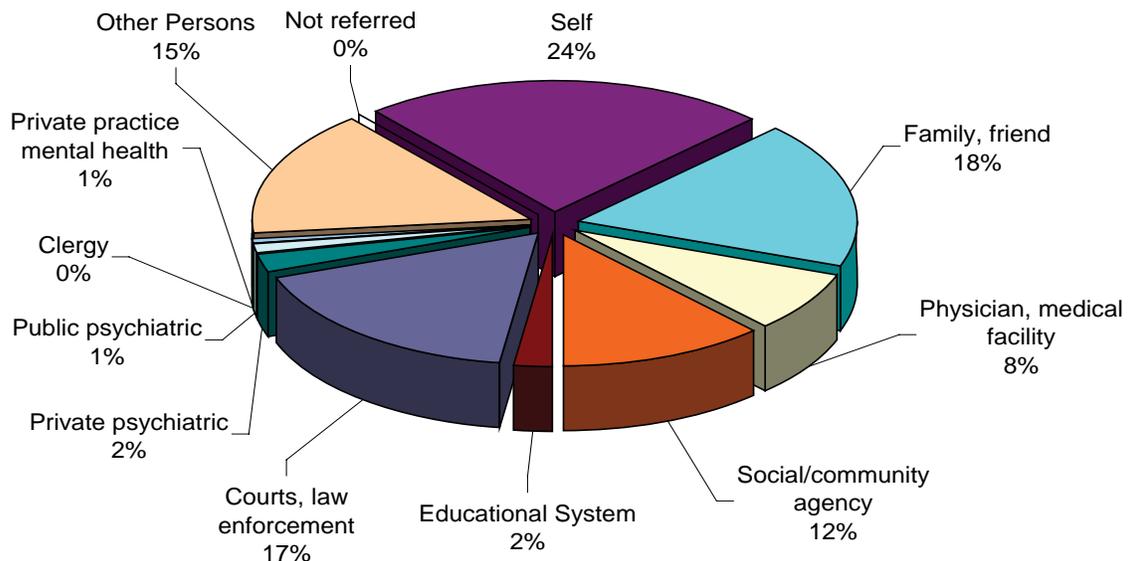
“referral source” can continue to have a positive influence on the patient’s recovery. The graphs below show the detailed referral sources for fiscal years 2005 through 2006 for substance abuse and fiscal year 2006 for mental health.

Referral Source of Individuals in Substance Abuse Services Fiscal Years 2005 - 2006



Note: All other National categories are combined in Community Referral.

Referral Source of People Served in Mental Health Services Fiscal Year 2006



Statewide Report on Consumer Satisfaction

Instruments

For the past two decades, the national Mental Health Statistics Improvement Program (MHSIP) has worked closely with the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), the National Association for State Mental Health Program Directors Research Institute (NASMHPD/NRI), and with various states to develop national mental health standards. Among the outcomes of this work are the three MHSIP survey instruments used to collect data for this report: The MHSIP 28-Item Adult Consumer Satisfaction Survey, the Youth Services Survey (YSS) completed by youth in treatment, and the Youth Services Survey for Families (YSS-F) completed by a parent or guardian of youth receiving treatment. Each survey contains five measured domains.

1. General Satisfaction
2. Good Service Access
3. Quality and Appropriateness/Cultural Sensitivity
4. Participation in Treatment Planning
5. Positive Service Outcomes

Survey Methods

In 2004, the local service providers began conducting point-in-time MHSIP surveys rather than reporting data on a quarterly basis to DSAMH. The survey was administered to consumers of both substance abuse and mental health services. The surveys are completed in the office by anyone who comes in for a service, regardless of the duration they have been in treatment.

Beginning 2005, the YSS and YSS-F surveys were conducted in this same manner. As a result, comparison with 2004 YSS and YSS-F data is not valid.

Following are the total number of surveys completed:

	2004	2005	2006
MHSIP	3,568	3,473	3,692
YSS	N/A	675	825
YSS-F	N/A	536	823

For a copy of the survey instruments see our website dsamh.utah.gov.

Results

The percentage of adults reporting positive responses for all scales in the MHSIP survey did not significantly differ from 2004 to 2006. In all, more than 70% reported positive responses in all scales.

The YSS survey, completed by youth, shows a majority of positive responses. The Cultural Sensitivity scale had the highest percentage of positive responses at 85.3%.

In four of the domains, the YSS-F survey, completed by a parent or guardian, shows a higher rate of positive responses than the survey completed by youth. A higher percentage of youth reported Positive Service Outcomes than did the parents or guardians.

Positive Service Outcomes reported by parent or guardian, and Participation in Treatment Planning and Good Service Access as reported by youth, are

domains that are significantly lower than the national average.

The sample rate for consumers for Youth and Youth Parent/Guardian, were less than 5% for more than half of the providers statewide.

Recommendations:

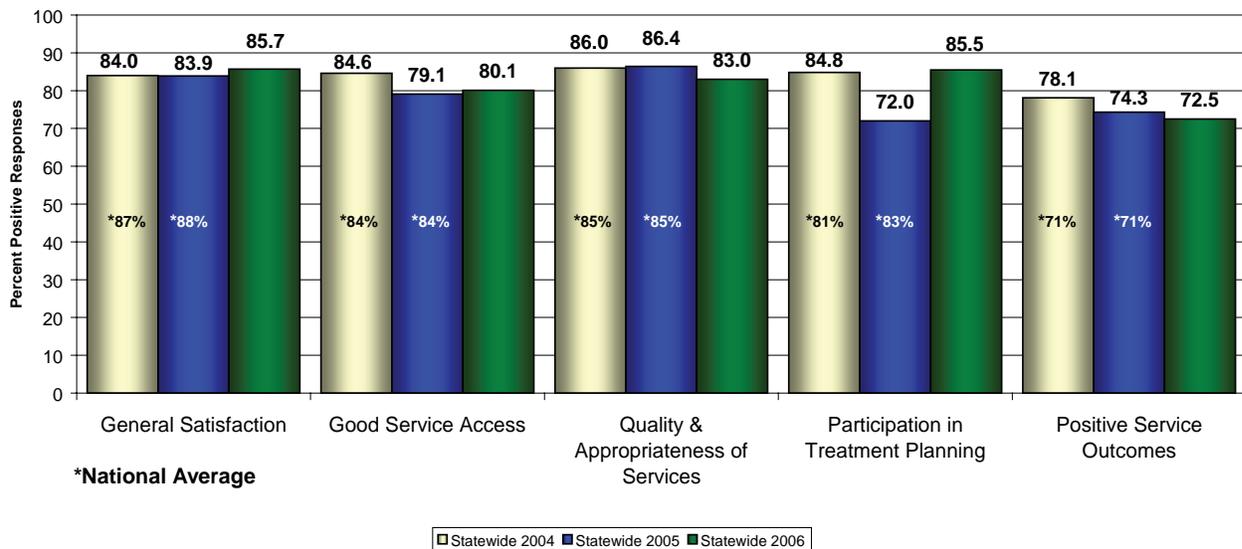
DSAMH takes the results of these surveys seriously and will use the results to improve services by taking the following actions:

- Set a minimum sample rate of 5% or not less than 30 completed surveys (for small centers with minimal clients served).
- Establish a target performance standard to meet or exceed the national average or statewide average (whichever is higher).
- DSAMH will include survey results and sample rates in monitoring reviews and will

use that information to assess the quality of services and to help agencies improve.

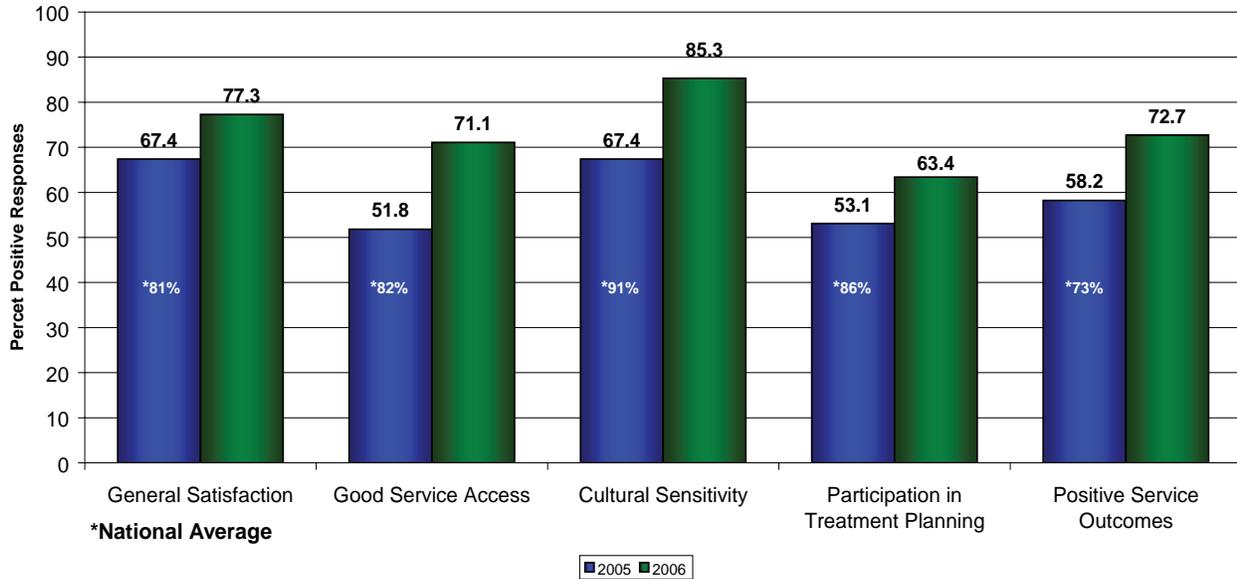
- The results of the surveys will be reported to Local Authorities and Providers as a part of DSAMH’s Balanced Scorecard, along with trends and ideas for improvement.
- DSAMH will review the survey and results in focus groups, consisting of consumers and families, and with local providers, to obtain more specific information and make further recommendations for improvement.
- DSAMH will review sample rates and survey administration with the UBHN’s Performance Development Committee for recommendations.
- NAMI Utah has been awarded a contract to establish a consumer council that will review services and give direction and feedback to DSAMH.

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



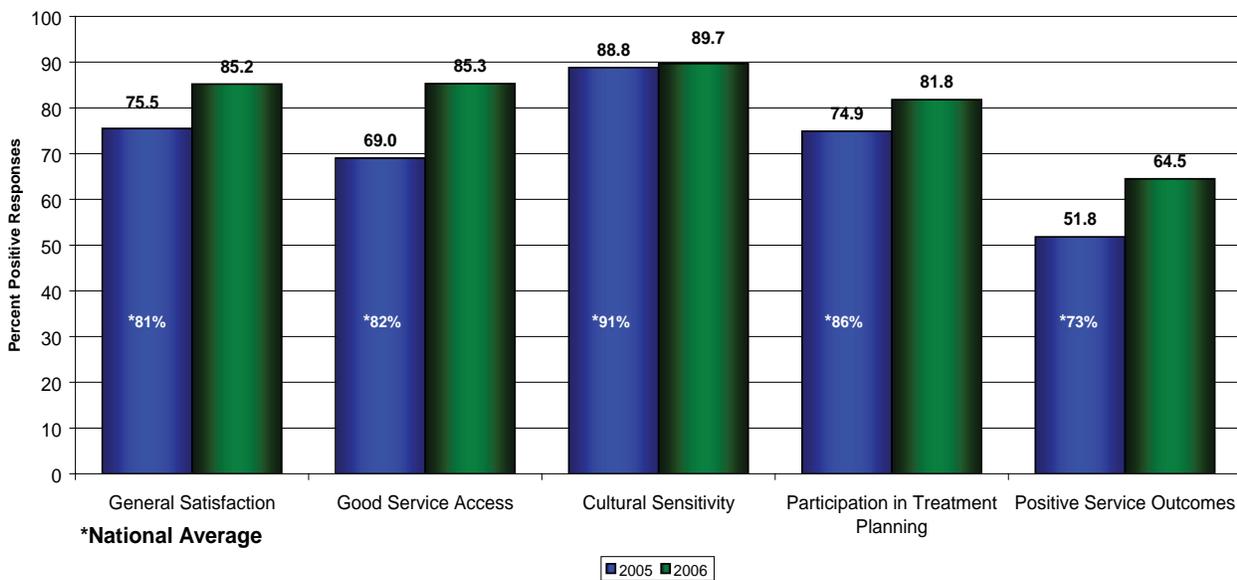
Youth Consumer Satisfaction Survey Youth Services Survey (YSS)

Completed by Youth in Substance Abuse and Mental Health Treatment



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

Completed by Parent or Guardian of Youth in Substance Abuse and Mental Health Treatment



Substance Abuse Prevention

Overview

Following common medical models, the risk factors for substance abuse can be identified and mitigated in order to interrupt the development or progression of the addictive process. Similarly, protective factors buffer the impact of risk factors. The Risk and Protective Factor Model developed by Drs. David Hawkins and Richard Catalano at the University of Washington is the foundation for Utah's prevention services. In determining what prevention services will be implemented in a particular community, a profile of the area's risk and protective factors is created utilizing data from various sources, including periodic surveys and archival indicators. Once the risk and protective factors for the area are identified, local planning bodies select prevention programs that are targeted at reducing risk and enhancing protection.

Each Local Authority is responsible for providing a comprehensive prevention plan for their area. This comprehensive plan is to address prevention needs across the life span being vigilant to use prevention programs shown to be effective with the particular target audience.

Utah K-12 Prevention Dimensions Programs

DSAMH supports and provides resources to the Utah State Office of Education for implementation and evaluation of the Prevention Dimensions program. The Prevention Dimensions program is a statewide curriculum resource delivered by

classroom teachers to students in Utah, kindergarten through 12th Grade. The Prevention Dimensions program was first started in 1982 with curriculum enhancements taking place in 1992 and 2003. The resource lessons are age-appropriate and designed to meet the objectives through a scope and sequence methodology. The lesson 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. Prevention Dimensions has been modeled after other effective science-based curriculum that seeks to build life skills, deliver knowledge about alcohol, tobacco, and other drugs (ATOD), and provide opportunities for students to participate in prevention activities.

Several evaluations of Prevention Dimensions have been conducted since its development. An initial study by Haas et al. indicated that teachers who participate in Prevention Dimensions trainings significantly increase knowledge of the effects of alcohol, tobacco, and other drugs and show an increased willingness to use the curriculum in their classrooms. Student outcomes showed significant increases in knowledge of the effects of alcohol, tobacco, and marijuana as well as improvements in individual decision-making skills. A follow-up study demonstrated significant reductions in the rate of initiation of alcohol, tobacco, and marijuana use as well as a slight decrease in monthly alcohol use.

More recent evaluation findings show significant reductions in risk factors for substance abuse among high-risk students compared to high-risk

students not receiving Prevention Dimensions. Further, students who receive Prevention Dimensions instruction score higher on knowledge of resistance skills and other personal problem solving skills (life skills) than those who do not participate in Prevention Dimensions.

Based on its history and positive outcomes, in 2002 Prevention Dimensions received a U.S. Department of Health and Human Services Exemplary Program award and was accorded “promising program” status. To build upon the previous evaluation strengths, a randomized control design study with control and experimental classroom conditions was implemented during 2003-04. Findings from this study added credence to the effectiveness of Prevention Dimensions and additional program evaluation from 2004-05 has continued to build a case for its implementation as an effective science-based resource for substance abuse prevention in Utah schools.

Utah Prevention Advisory Council (UPAC)

UPAC was developed to meet the needs of two federally funded grants known as the SICA and the SIG-E grants. After showing success at providing oversight for these grants and providing an opportunity for state level agencies to collaborate on prevention issues, it was decided to sustain the committee after the SICA and SIG-E grants end. One way to ensure sustainability of this committee was to move UPAC to the Utah Substance Abuse and Anti Violence Council (USA AV). UPAC is the prevention arm of USA AV and will continue to serve as a vehicle to coordinate prevention services, legislative efforts, policy issues, and prevention grants. The Committee consists of representatives from most major agencies conducting prevention in Utah, with ongoing efforts to identify other prevention agencies.

Currently, UPAC provides oversight to a federally funded State Epidemiology/Outcomes Workgroup administered by DSAMH.

State Incentive Grant Enhancement (SIG-E) Higher Education Grant

DSAMH is managing a statewide grant focused on higher education issues, which includes all Utah public higher education institutions. The grant is from the Federal Center for Substance Abuse Prevention (CSAP) and was awarded in September 2003, in the amount of \$2.25 million for three years. The grant provides substance abuse prevention and early intervention services for the 18-25 year old higher education population. Utah is only one of three states to receive the grant.

Utah received a no-cost extension in the summer of 2005 to fund an additional year. The extension will enable the State to continue to work toward the full achievement of the grants goals and objectives. The State will continue to award funds to Utah’s nine Higher Education Institutions. Each of the nine recipients have developed individualized goals for its campus. These goals address state-level goals and reflect local needs and priorities. The programs that they are implementing have been shown to be effective through evaluation, and will continue to be evaluated throughout the SIG-E Grant.

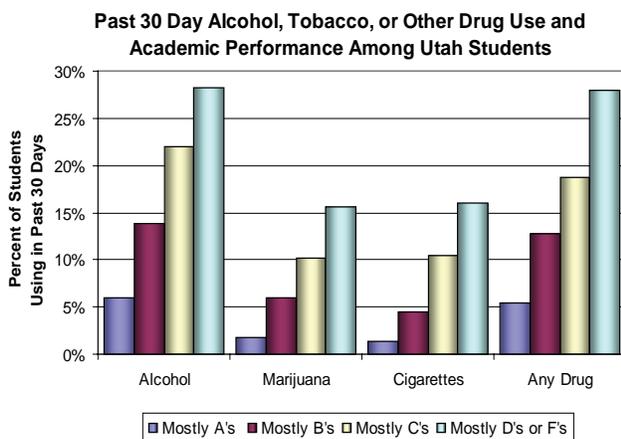
SHARP (Student Health and Risk Prevention) Survey 2007

DSAMH has contracted with Bach-Harrison, LLC, to conduct the third administration of the Student Health and Risk Prevention Survey. This survey will be conducted in the spring of 2007. The bi-annual survey is a collaborative effort by the DSAMH with the Utah State Office of Education and the Utah Department of Health. The survey combines three instruments: the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS), and the Prevention Needs Assessment Survey (PNA). Data obtained through the surveys are utilized to identify key risk and

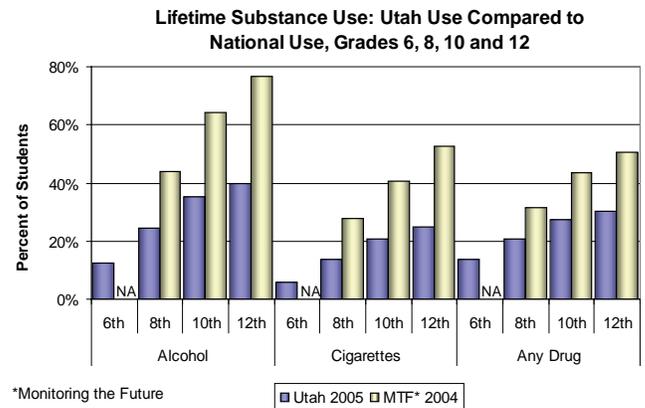
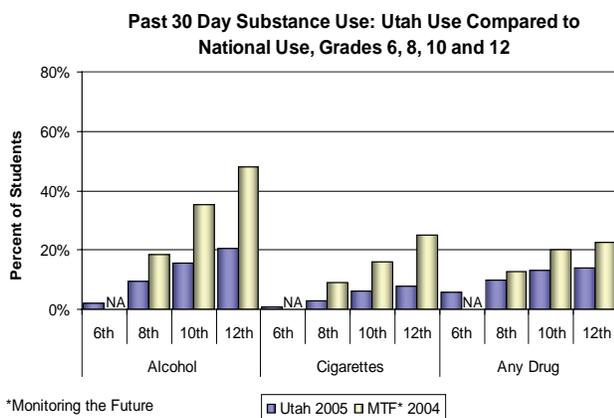
protective factors for substance abuse, in the selection of science-based prevention programs that will reduce risk and increase protection, and to measure progress in reducing substance use/abuse among Utah students in grades 6 through 12.

Highlights of the 2005 SHARP Survey

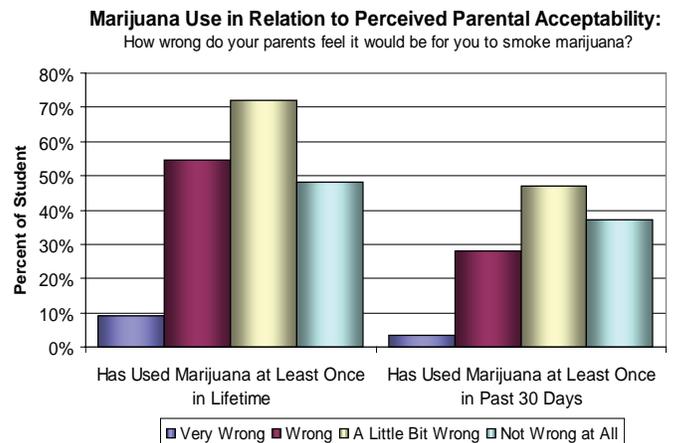
- Students who don't use alcohol or other substances perform better in school



- Utah's students use substances at a rate far less than their national counterparts (Monitoring the Future Study)



- Parents have an influence over their student's use of marijuana—when the student felt that his or her parent thought it would be “very wrong” for him/her to smoke marijuana, very few of those students used it. However, if the student felt that the parent would only think it was “wrong,” use rates increase five-fold.



For more information on the 2005 SHARP survey see dsamh.utah.gov/sharp.htm.

Higher Education Needs Assessment Survey

During spring of 2005, the DSAMH conducted a second statewide survey of college students called the Utah Higher Education Health Behavior Survey; the 2005 survey was completed by a total of 11,828 students attending the nine Utah

public colleges and Westminster College. In the spring of 2007, another survey will take place. The survey has several objectives, including assessing the prevalence of alcohol, tobacco, and other drug use on Utah campuses, measuring the need for substance abuse treatment by college students and measuring the levels of selected risk factors for substance abuse. Analysis of 2003 and 2005 data show improvements on Utah's Higher Education campuses in the following areas.

1. Reduction in the number of students who report it is easy to get alcohol
2. Reduction in the number of students who reported driving under the influence in the past year
3. Increase in the number of students that have never tried an illegal drug

Federal Synar Amendment: Protecting the Nation's Youth From Nicotine Addiction

The Federal Synar Amendment 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 sales-to-minors rate of not greater than 20%. Utah

has effectively decreased the number of tobacco sales to minors and has a violation rate lower than 10%. This effort is a collaboration between the Department of Health and the DSAMH.

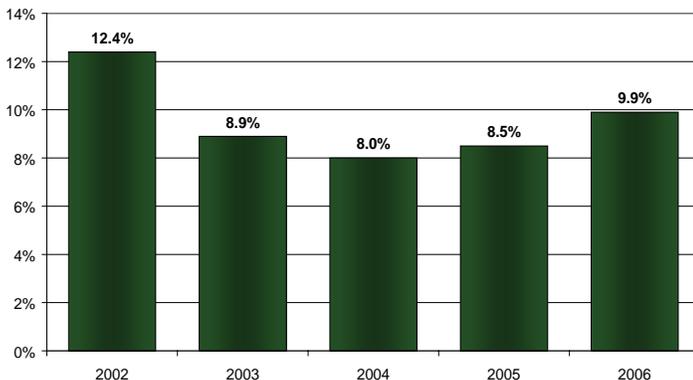
Utah's State Epidemiology/Outcomes Workgroup (USEOW)

In April 2005, DSAMH was given a financial award to implement a Epidemiology/Outcomes Workgroup. The USEOW is made up of prevention experts, survey experts, and epidemiology experts to enable a system that will enhance the availability of data. As a result, prevention workers will better understand the meaning behind the data and be able to accurately assess their community's needs and apply effective prevention activities. The USEOW will provide a process of accumulating data, interpreting the data, and sharing the data in a way that allows the prevention network the ability to glean critical components of prevention data, i.e., trends, consumption rates, and consequences.

Strategic Prevention Framework Grant

In spring of 2005, DSAMH applied for a Strategic Prevention Framework Grant. When awarded, the grant will provide over \$2 million a year, for five years, to enhance the infrastructure of Utah's prevention system. Although Utah already uses strategic planning in each of its Local Authority Districts, resources to implement such planning and programming in each Utah community are currently insufficient. This grant will fill the void of resources and help create a defensible, research based prevention system based on principles and practices that have been proven effective.

Percentage of Outlets Found in Violation
Federal Fiscal Years 2002 - 2006



Substance Abuse Treatment

System Overview

Treatment for substance abuse and dependence disorders has changed dramatically over the past several years. As the data reflects, the drugs of abuse have changed, as have the client characteristics. These changes have resulted in more difficult clients with a wide array of issues with which to deal. In response to these changes, the treatment field has developed evidence-based interventions to more effectively address the needs of the clients presenting for treatment.

Screening and Referral

Screening to detect possible substance abuse problems can occur in a variety of settings. Human service agencies, such as Child and Family Services, Aging and Adult Services, Health Clinics, etc., may screen for possible substance abuse or dependence using simple questionnaires or including appropriate questions in their own evaluation process. Individuals involved in the Criminal or Juvenile Justice systems are at exceptional risk for substance abuse disorders and are screened consistently. As noted in a subsequent section of this document, a significant portion of the substance abuse effort is directed to this population. Referral for treatment comes from many different sources: the client, friends and family, employers, or the justice system. There is no wrong door to treatment!

Assessment

A biopsychosocial evaluation is conducted by the treatment program in order to determine the necessity for treatment. In addition to ascertaining the need for treatment, the assessment is used to determine the diagnosis, generate a treatment plan, access for the appropriate level of care and establish a baseline for determining progress. In addition to a clinical interview,

DSAMH requires that individuals complete the Addiction Severity Index (ASI) for adults. All evaluation tools are science-based and crosswalk directly to the American Society of Addiction Medicine Client Placement Criteria (ASAM PPC) for levels of care and diagnostic criteria.

Placement into Treatment

The client is placed into the appropriate level of care as determined by the ASAM PPC. In addition to diagnosis, factors affecting the proper placement may include availability of a particular level of care, waiting lists, or client preference.

Levels of Care and/or Service Types

DSAMH requires that the ASAM PPC II be used to determine the most appropriate setting for treatment. The criteria are science-based and provide a structure to place the client in the least restrictive, most effective level of treatment possible. ASAM has described several levels of care to treat individuals with a substance abuse/dependence diagnosis. Although all of these levels of care are not available in all areas of Utah, all providers are required to provide at least outpatient counseling and have the ability to obtain residential services. Clients move between levels of care based on their progress or lack of progress in treatment.

Outpatient Treatment: Outpatient treatment is provided in an organized setting by licensed treatment personnel. These services are provided in scheduled individual, family, or group sessions, usually fewer than nine hours per week. The goal of outpatient treatment is to help the individual change alcohol and or drug use behaviors by addressing their attitudinal, behavioral, and lifestyle issues.

Intensive Outpatient Treatment: Intensive outpatient treatment services may take place in outpatient or partial hospitalization settings. These programs provide education, treatment assistance, and help clients in developing coping skills to live in the “real world.” Services include group therapy, individual therapy, case management, crisis services, and skill development and generally are between 9 and 20 hours per week. Intensive Outpatient facilities also arrange for medical, psychiatric, and psycho pharmacological consultation as needed.

Residential/Inpatient Treatment: This level of care is delivered in a 24-hour, live-in setting. The program is staffed 24 hours a day by licensed treatment staff and may include other professionals such as mental health staff and medical staff. The safe, stable, planned environment helps clients develop recovery skills and succeed in treatment. Individual and group therapy are provided as well as skill development, parenting classes, anger management, and other evidence-based treatment. This level of care includes short- and long-term treatment settings.

Detoxification: The main objective of detoxification is to stop the momentum of substance use and engage the client in treatment. This includes addressing the withdrawal syndromes affecting the client physically and psychologically. The goals of care are: 1) avoidance of the potentially hazardous consequences of discontinuation of alcohol and other drugs of dependence; 2) facilitation of the client’s completion of detoxification and linkages and timely entry into continued medical, addiction, or mental health treatment or self-help recovery as indicated; and 3) promotion of dignity and easing of discomfort during the withdrawal process.

Opioid Maintenance Therapy (OMT): “Opioid Maintenance Therapy” is a term that encompasses a variety of treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone, which occupy opiate receptors in the brain that extinguish drug craving, and establish a maintenance state. The result is a continuously maintained state of drug tolerance in which the therapeutic agent does not produce euphoria, intoxication, or withdrawal symptoms.

Treatment

Addiction is a complex interaction of biological, social and toxic factors, heredity, and environment. Given these multiple influences, there is no one treatment that is appropriate for everyone. Treatment should be science-based and individualized to meet the needs of those entering treatment; be they adolescent marijuana users, addicted pregnant women or chronic alcoholics. Certain groups of clients require extraordinary treatment and may require longer lengths of care. These populations include:

- Pregnant and parenting women, especially those addicted to methamphetamine.
- Individuals with co-occurring mental illness disorder.
- Criminal justice referrals.

A variety of interventions, including pharmacological adjuncts, have been validated over the past few years. Self-help and 12-step groups continue to be an important support for those in treatment but should not be considered a stand alone treatment.

Transfer during treatment

DSAMH encourages moving clients from one treatment level to another based on successful completion of treatment objectives or lack of progress at a particular level. Transfer between

programs or Local Authority districts may be necessary based on the needs of a particular client and the resources available.

Discharge

At completion of treatment, the client is discharged from service. A discharge plan is created and

should include aftercare and self-help meetings. Many clients leave programs without completing treatment. This should not adversely affect their return to treatment at a later time.

The following table illustrates the continuum of substance abuse prevention and treatment services provided in Utah.



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

Function	Prevention/Intervention			Treatment		
Program Level	<i>Universal</i>	<i>Selected</i>	<i>Indicated</i>	<i>Outpatient</i>	<i>Intensive Outpatient</i>	<i>Residential</i>
Appropriate for	<ul style="list-style-type: none"> General Population 	<ul style="list-style-type: none"> At 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
Identification Process	<ul style="list-style-type: none"> General Interests 	<ul style="list-style-type: none"> Referral 	<ul style="list-style-type: none"> SA Screening 	<ul style="list-style-type: none"> ASI 	<ul style="list-style-type: none"> ASI 	<ul style="list-style-type: none"> ASI
Populations	<ul style="list-style-type: none"> K-12 Students General Population 	<ul style="list-style-type: none"> School Drop-outs, Truants, Children of Alcoholics, etc. 	<ul style="list-style-type: none"> DUI Convictions, Drug Possession Charges, etc. 	<ul style="list-style-type: none"> Appropriate for general population, Criminal Justice referrals including DUI when problem identified. Women and Children, Adolescents, poly drug abusers, Methamphetamine addicted, alcoholics, etc. 		
Program Methods	<ul style="list-style-type: none"> Risk Protective Factor Model Prevention Dimensions Red Ribbon Week 	<ul style="list-style-type: none"> Risk Protective Factor Model 	<ul style="list-style-type: none"> Risk Protective Factor Model Education Intervention Program 	<ul style="list-style-type: none"> Evidenced Based, Preferred Practices, ASAM Patient Placement Criteria 		

Utahns in Need of Substance Abuse Treatment

The results of the 2005 State Substance Abuse Treatment Needs Assessment Survey and the 2005 SHARP Survey indicated:

- 4.7% of adults in Utah were classified as needing treatment for alcohol and/or drug dependence or abuse in 2005. This rate was similar to the 2000 rate of 4.9%.
- 6.4% of Utah youth in the 6th through 12th grades are in need of treatment for drug and/or alcohol dependence or abuse.
- The public substance abuse treatment system, at capacity, is currently serving approximately 18,955 individuals, or less than 20% of the current need.

- A combined total of approximately 81,446 adults and youth are in need of, but not receiving, substance abuse treatment services.

The percentage of adults and youth needing treatment by service district varies considerably. The following table demonstrates the actual number of adults and youth who need treatment, by district. The current capacity of each district, or the number who were actually served in fiscal year 2006, is also included to illustrate the unmet need. The same data is depicted on the following graphs.

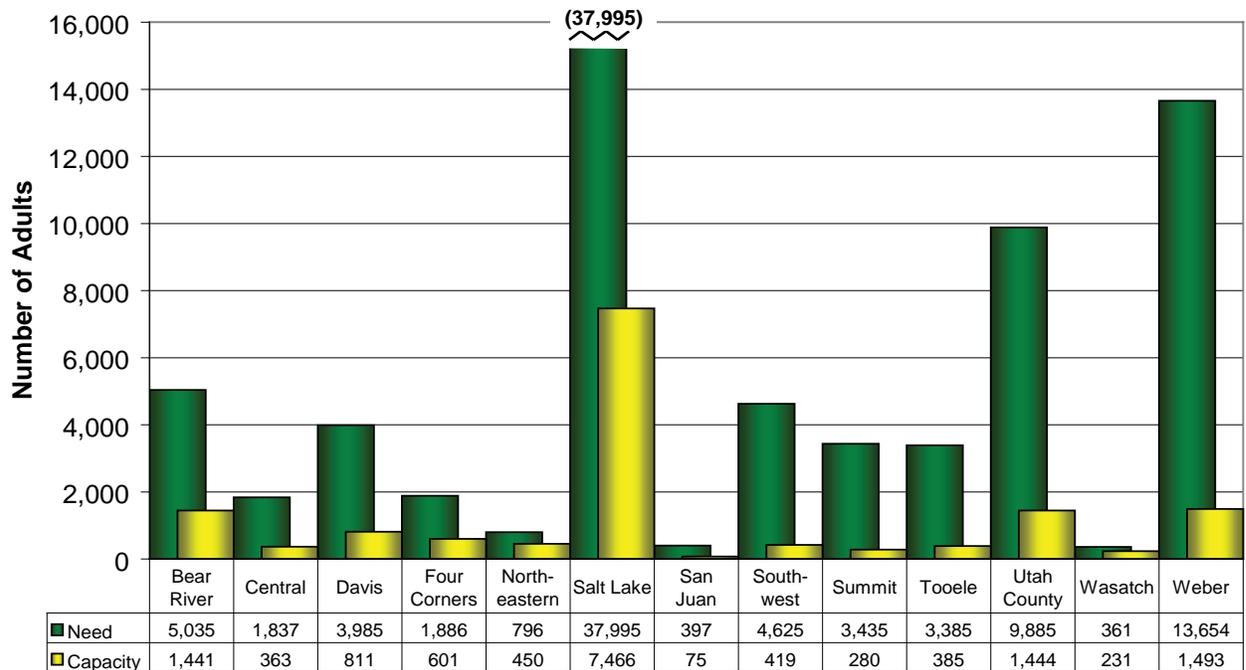
Treatment Needs Vs. Treatment Capacity

	Adults (18 years+)			Youth (Under age 18)		
	% Need Treatment	# Need Treatment	Current Capacity	% Need Treatment	# Need Treatment	Current Capacity
Bear River	4.8%	5,035	1,441	3.8%	534	128
Central	3.7%	1,837	363	5.5%	415	64
Davis	2.1%	3,985	811	5.0%	1,420	49
Four Corners	6.6%	1,886	601	10.8%	1,111	97
Northeastern	2.7%	796	450	8.2%	375	38
Salt Lake	5.4%	37,995	7,466	8.7%	7,574	1,128
San Juan	3.9%	397	75	8.3%	157	19
Southwest	3.4%	4,625	419	5.4%	873	94
Summit	12.9%	3,435	280	10.5%	359	37
Tooele	9.5%	3,385	385	8.6%	433	65
Utah County	3.2%	9,885	1,444	2.8%	1,180	158
Wasatch	2.6%	361	231	2.7%	55	8
Weber	8.7%	13,654	1,493	7.4%	1,517	252
State Totals	4.7%	84,325*	16,745**	6.4%	16,003	2,137

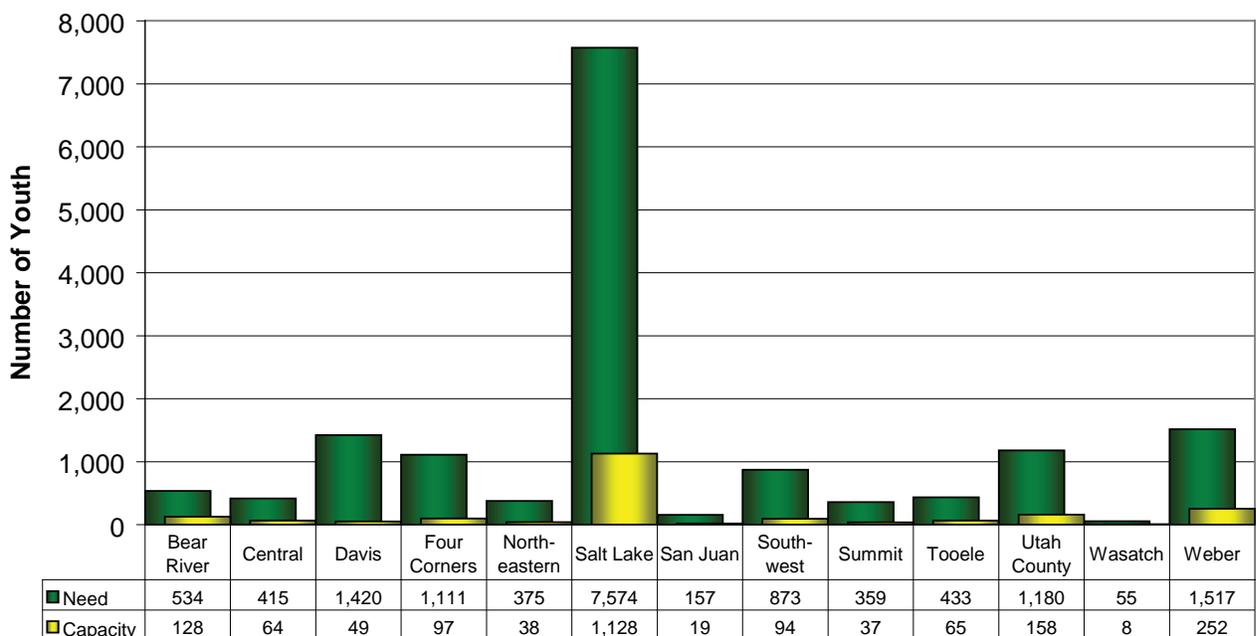
*because of rounding in the percentages, LSAA totals do not exactly add to the State total.

** an additional 1,295 clients that were served by statewide contracts at the U of U Clinic (355) and the Utah State Prison (940) are reflected in the State total.

Number of Adults Who Need Treatment Compared to the Current Public Treatment Capacity



Number of Youth (12-17) Who Need Treatment Compared to the Current Public Treatment Capacity



Number of Treatment Admissions

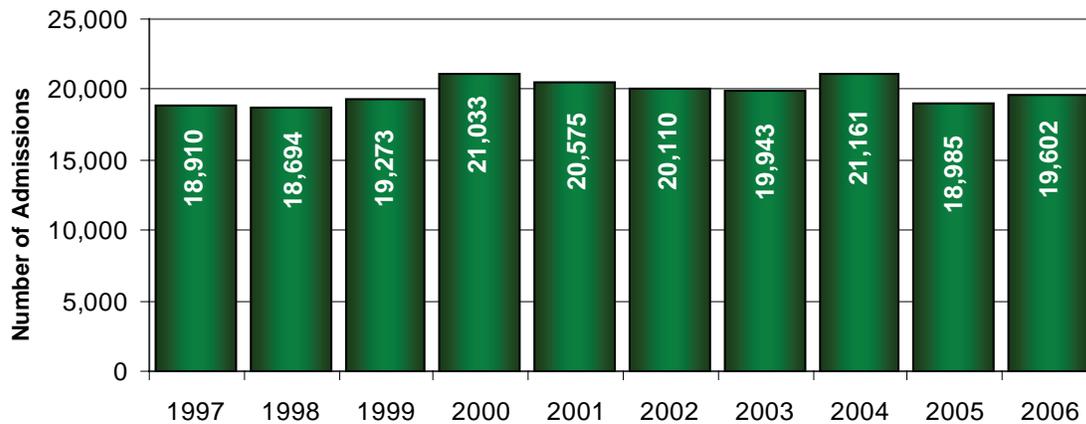
The Federal government requires that each state collect demographic and treatment data on all clients admitted into any publicly-funded substance abuse treatment facility. This data is called the Treatment Episode Data Set (TEDS). TEDS is the source that DSAMH uses for treatment admission numbers and characteristics of clients entering treatment.

DSAMH collects this data from the Local Substance Abuse Authorities (LSAAs) on a quarterly

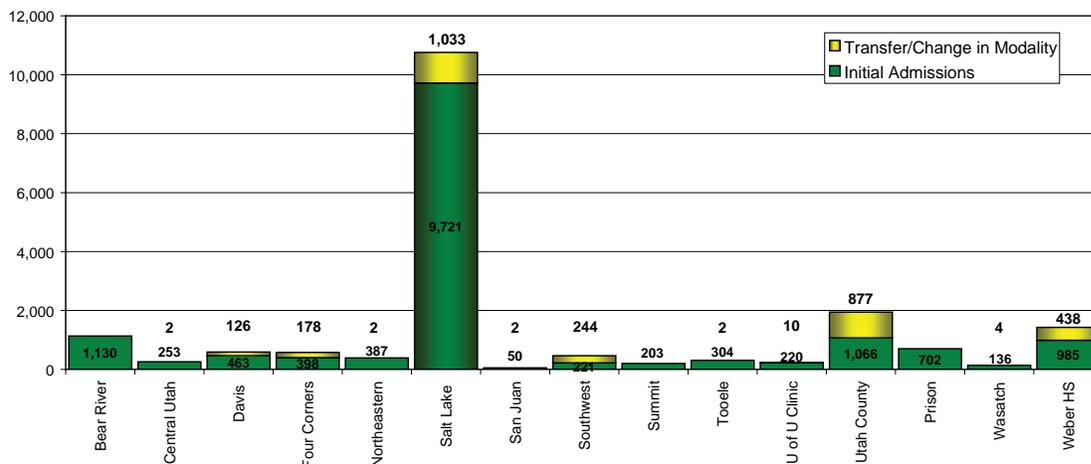
basis. TEDS has been collected each year since 1991. This allows DSAMH to report trend data based on treatment admissions over the past 10 years (see the following chart).

The second chart shows the number of admissions and transfers to each Local Authority, the University of Utah Clinic, and the Utah State Prison area in fiscal year 2006. Over half of all treatment admissions were served by Salt Lake County.

**Substance Abuse Initial and Transfer Admissions into Modalities
FY1997 to FY2006**



**Substance Abuse Treatment Admissions and
Transfers in Utah by Local Authority Area
Fiscal Year 2006**

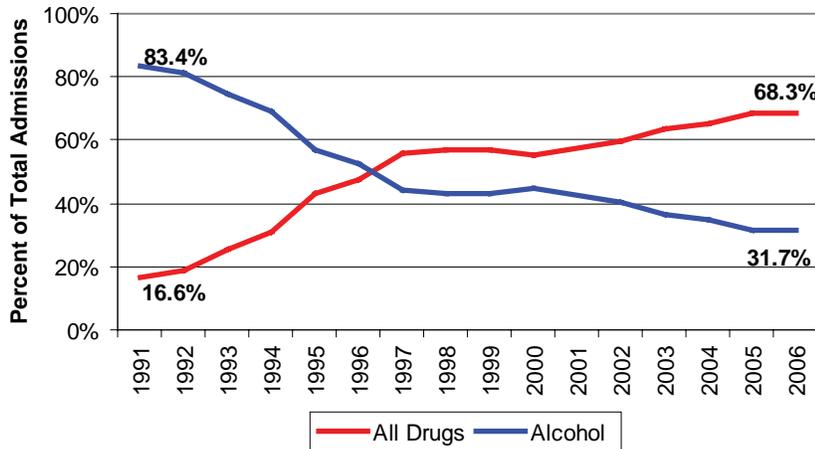


Primary Substance of Abuse

In 1991, 83% of Utah clients came into treatment for help with alcohol dependence; in fiscal year 2006 that percentage fell to 32%.

On the other hand, the percentage of clients entering treatment for illicit drug abuse/dependence has risen from 17% in 1991 to 68% in 2006.

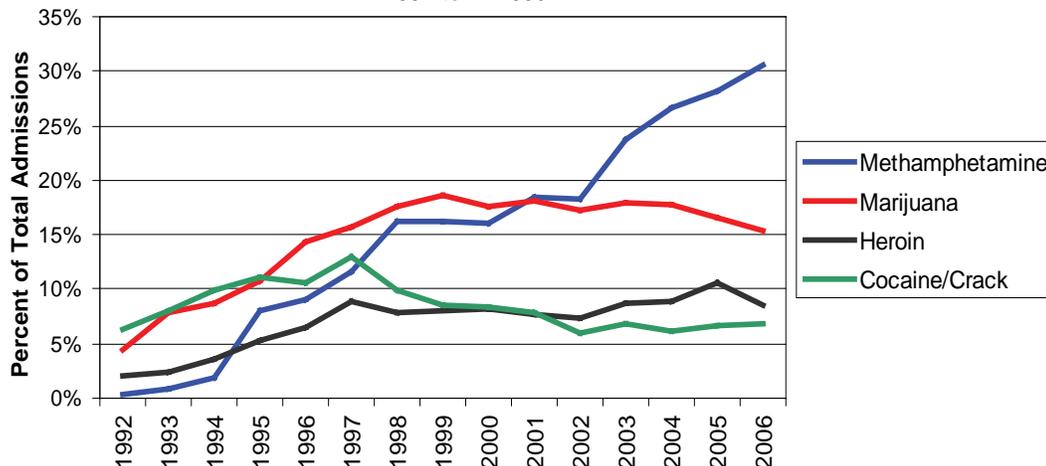
Patient Admissions for Alcohol vs. Drug Dependence
FY1991 to FY2006



Over 60% of the clients use one of four different drugs: marijuana, methamphetamine, cocaine/crack, and heroin. The chart below shows the trends of the use of these four drugs over the past 15 years. In 1991, cocaine was the most common illicit drug used, methamphetamine is now the most common illicit drug used among clients,

surpassing marijuana in fiscal year 2001. The gap between methamphetamine and marijuana has since widened significantly. Marijuana continues to be one of the most common drugs used in Utah, and is often used in combination with other illicit drugs and alcohol.

Top Four Illicit Drugs of Choice by Year (Excluding Alcohol)
FY1992 to FY2006



The next table lists the primary substances used by clients, as reported at admission to treatment. The percentages represent clients, by gender, who reported the substance as their primary substance of abuse. As this table illustrates, the primary drug of choice differs among the male and female treatment populations.

Alcohol continues to be the primary substance of abuse for men, followed by use of methamphetamine and marijuana. The primary substance of abuse for women remains methamphetamine followed by alcohol.

Primary Substance by Gender
FY2006

	Male	Female	Total
Alcohol	4,448	1,668	6,116
Cocaine/Crack	791	538	1,329
Marijuana/Hashish	2,153	845	2,998
Heroin	1,100	573	1,673
Other Opiates/Synthetics	171	261	432
Hallucinogens	26	12	38
Methamphetamine	2,906	3,078	5,984
Other Stimulants	41	34	75
Benzodiazepines	29	63	92
Tranquilizers/Sedatives	6	21	27
Inhalants	15	3	18
Oxycodone	217	214	431
Club Drugs	15	10	25
Over-the-Counter	13	8	21
Other	17	13	30
None/Missing	152	161	313
Total:	12,100	7,502	19,602

The table below contains the raw numbers for the primary substance of abuse by age grouping. Marijuana continues to be the primary drug of abuse

for under 18 with Methamphetamine for 18-24 and 25-34. Alcohol remains the primary drug of choice for individuals over the age of 35.

Primary Substance of Abuse by Age Grouping
FY2006

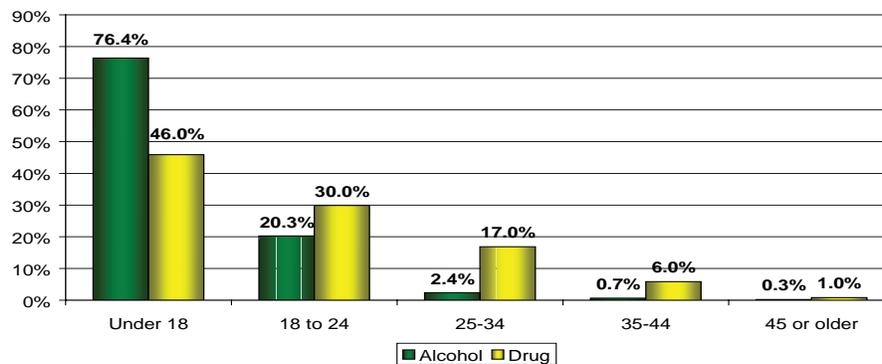
	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Missing	Total
Alcohol	429	1,193	1,350	1,568	1,519	52	5	6,116
Cocaine/Crack	43	201	374	467	241	2	1	1,329
Marijuana/Hashish	1,052	917	621	269	136	1	2	2,998
Heroin	32	522	460	392	260	3	4	1,673
Other Opiates/Synthetics	8	64	186	100	73	1	0	432
Hallucinogens	7	17	10	2	2	0	0	38
Methamphetamine	179	1,458	2,497	1,385	460	1	4	5,984
Other Stimulants	1	19	25	22	8	0	0	75
Benzodiazepines	2	15	35	28	11	1	0	92
Tranquilizers/Sedatives	2	3	6	5	10	1	0	27
Inhalants	11	5	2	0	0	0	0	18
Oxycodone	6	148	148	91	38	0	0	431
Club Drugs	4	15	4	0	2	0	0	25
Over-the-Counter	8	4	7	1	1	0	0	21
Other	1	5	9	10	5	0	0	30
None/Missing	181	22	31	21	17	1	40	313
Total:	1,966	4,608	5,765	4,361	2,783	63	56	19,602

Age of First Use of Alcohol or Other Drug

DSAMH tracks data on age of first use for alcohol and illicit drugs. Knowledge about early onset of substance use or abuse can help target prevention and intervention services. Understanding age of first use can also help treatment providers with wellness strategies for their clients.

As this graph illustrates, most use begins in the early teenage years with 76% of those admitted to the public treatment system reporting their first use of alcohol occurring prior to the age of 18. An additional 20% report their first use of alcohol in their early adult years (18 to 25), with significant decreases in the preceding years.

Age of First Use of Primary Substance of Abuse
Fiscal Year 2006

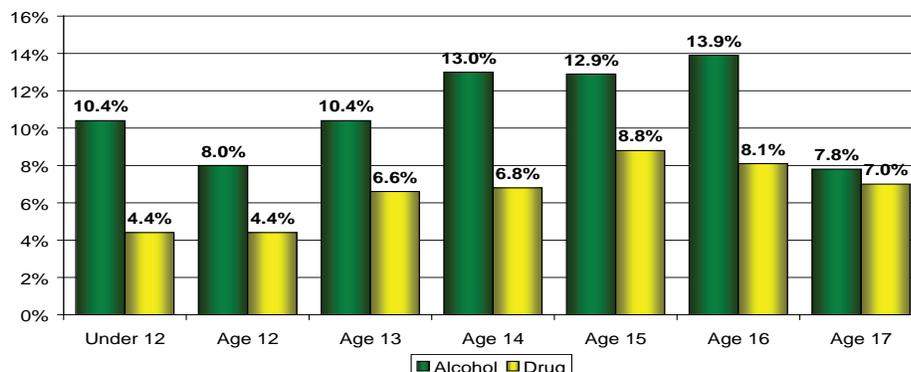


For those admitted to treatment, illicit drug use also begins in the early teenage years with 46% of the youth reporting the use of illicit substances prior to age 18. Another 30% of those clients report beginning use of illicit substances in their early adult years (18-25).

treatment system, 10% report beginning use of alcohol prior to age 12 and 4% report beginning use of illicit drugs prior to age 12. As the graph indicates, both alcohol and illicit drug use steadily increases from age 12 through age 16. At age 17, beginning use of alcohol drops significantly, while beginning use of illicit drugs only slightly decreases.

The use of alcohol and illicit drugs begins at an early age. Of youth admitted to the public

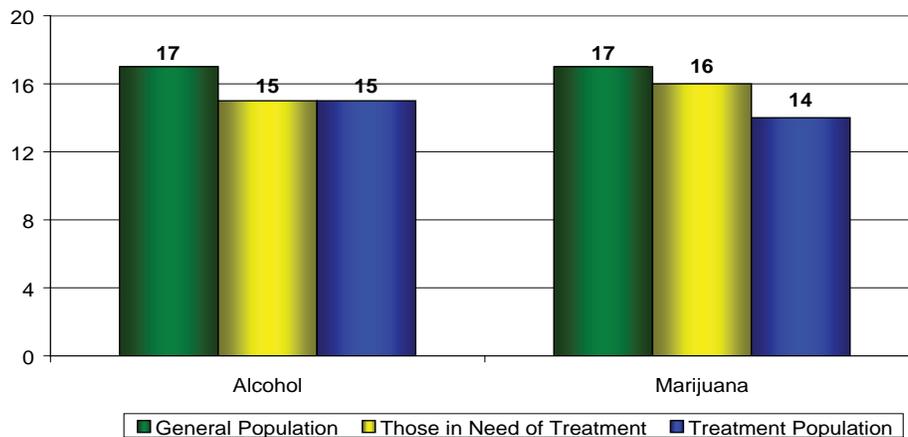
Age of First Use of Primary Substance - Under 18
Fiscal Year 2006



The term **gateway drug** is used to describe a lower classed drug that can lead to the use of “harder,” more dangerous drugs. Cigarettes along with alcohol and marijuana are considered “gateway drugs.” As this graph indicates, the age of first use for alcohol and marijuana, gateway drugs, is

lower for both the treatment population and for those in need of treatment meaning these populations begin using substances at an earlier age than the general population. Delaying the onset of use of any substance becomes a protective factor in helping to prevent abuse in later years.

**Median Age of First Use for
Alcohol and Marijuana
Fiscal Year 2006**

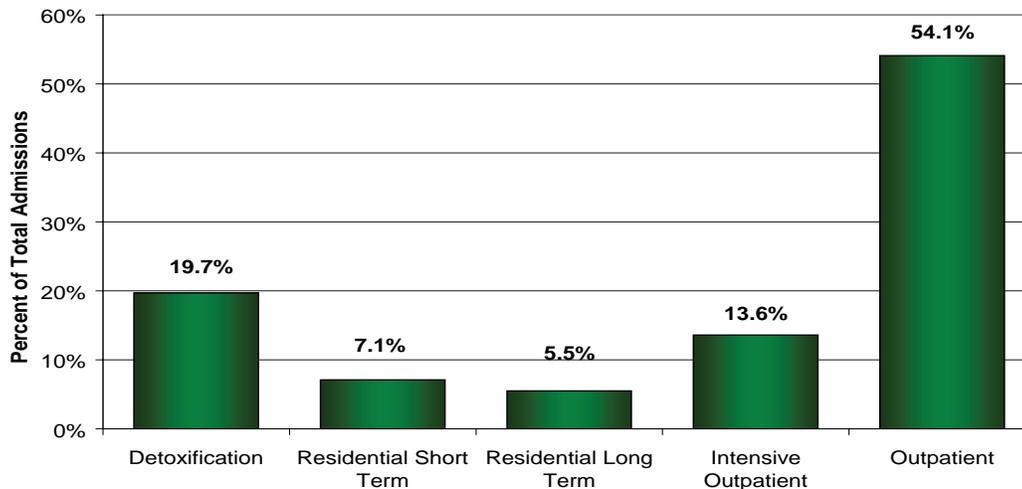


Service Type

The graph below depicts the service type to which clients were admitted upon entering treatment in fiscal year 2006. Treatment service type is based on a client's individual needs and the severity of their situation. Outpatient services remain the

most widely used service type, followed by detoxification services. Statewide, only a small percentage of clients receive treatment in residential settings due to the high cost of service.

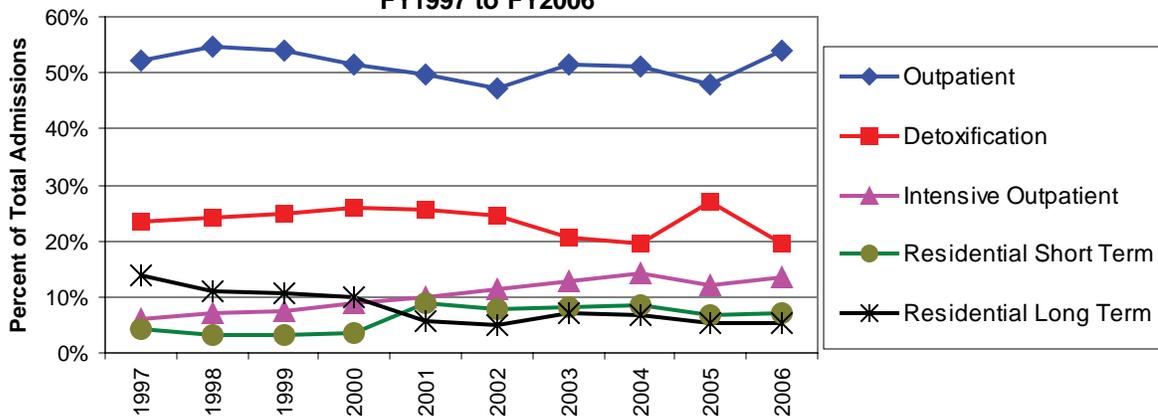
**Service Type at Admission
Fiscal Year 2006**



As the graph below indicates, the provision for all levels of service has remained relatively stable over the past 10 years. Admissions for general outpatient treatment increased this year with

additional small increases in admissions for short- and long-term residential treatment and intensive outpatient services. Admissions for detoxification services decreased in fiscal year 2006.

**Trends in Service Types
FY1997 to FY2006**



Multiple Drug Use

This table illustrates the significant problem of misuse of multiple drugs by clients entering treatment. At admission, clients report their primary, secondary (if any), and tertiary (if any) drugs of abuse. The report of multiple drug abuse by clients at admission averages 57.1% across the State,

ranging from 10.9% in Davis County to 95.6% in Utah County. The abuse of multiple drugs places the client at greater risk for negative drug interactions, overdoses, psychiatric problems, and complications during the treatment process.

**Multiple Drug Use
FY2006**

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	693	44.0%
Central Utah	95	37.3%
Davis County	64	10.9%
Four Corners	293	50.9%
Northeastern	190	48.8%
Salt Lake County	5,696	53.0%
San Juan County	15	28.8%
Southwest Center	171	36.8%
Summit County	40	19.7%
Tooele County	104	34.0%
U of U Clinic	187	81.3%
Utah County	1,858	95.6%
Utah State Prison	604	86.0%
Wasatch County	92	65.7%
Weber HS	1,090	76.6%
Total:	11,192	57.1%

Injecting Drug Use

Injecting drug users are a priority population to receive treatment because they are more likely to suffer from drug addiction and are at greater risk of contracting HIV/AIDS, tuberculosis, and hepatitis B and C. This table indicates the number of clients who report intravenous (IV) or non-IV injection (intramuscular or subcutaneous) as the primary route of administration for the substance that led to their request for treatment. A total of 3,724 clients requesting services through the public treatment system reported IV drug use as their primary route of administration. Salt Lake County reported the highest number of IV drug users at 2,323 while the Utah State Prison reports the highest percentage at 35.8%. Individuals reporting IV drug use increased 2.2% over the previous year.

**Patients Reporting Injecting
Drug Use at Admission
FY2006**

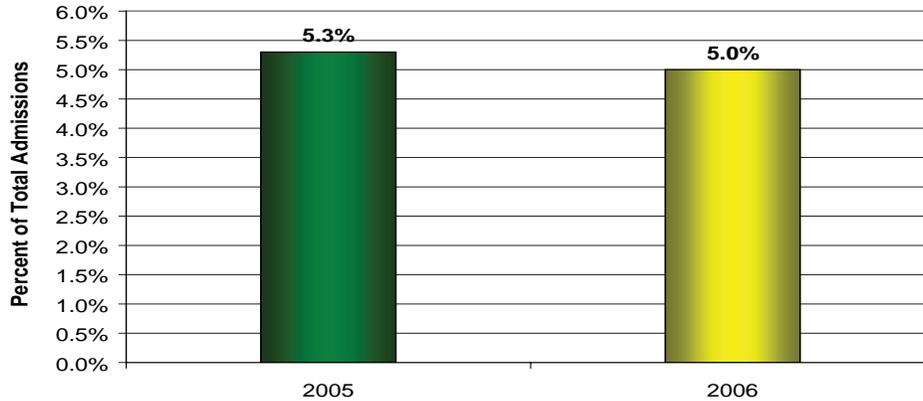
	# Reporting Injecting Drug Use at Admission	% of Total Admissions for Each Area
Bear River	69	4.4%
Central Utah	10	3.9%
Davis County	116	19.7%
Four Corners	49	8.5%
Northeastern	40	10.3%
Salt Lake County	2,323	21.6%
San Juan County	0	0.0%
Southwest Center	77	16.6%
Summit County	5	2.5%
Tooele County	13	4.2%
U of U Clinic	57	24.8%
Utah County	505	26.0%
Utah State Prison	251	35.8%
Wasatch County	4	2.9%
Weber HS	205	14.4%
Total:	3,724	19.0%

Prescription Drug Abuse

Admissions to the public treatment system for prescription drug abuse have remained relatively stable over the past three years. In fiscal year 2006, only 5% of the total admissions to the

public treatment system were due to prescription drug abuse, down slightly from 5.3% in fiscal year 2005.

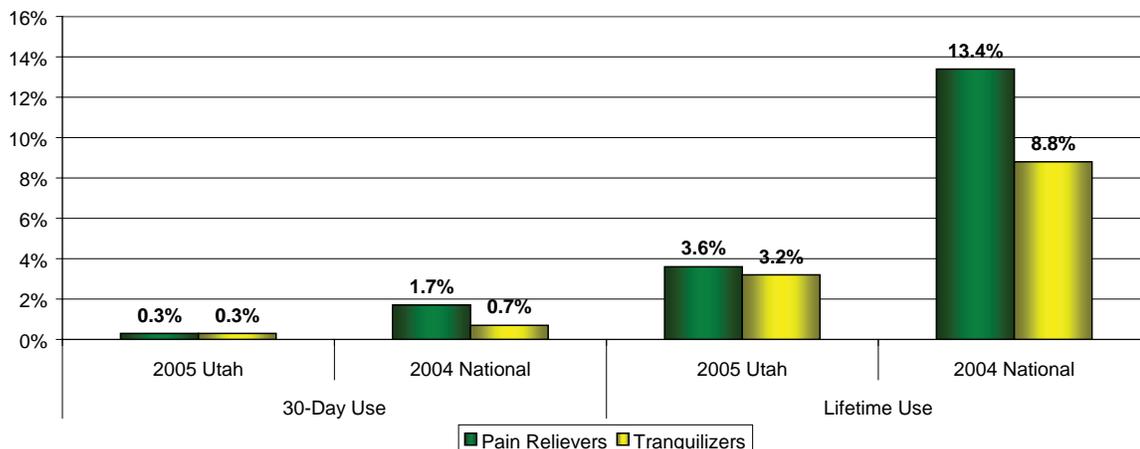
**Admissions for Primary Drug - Prescription Drugs
Fiscal Years 2005 - 2006**



When compared to national incident rates of prescription drug misuse, Utah's report significantly lower levels of abuse. According to the 2005 Utah Substance Abuse Needs Survey, 0.3% of Utah's report misuse of Pain Relievers (Oxycodone, Percocet, Vicodin, etc.) within the last 30

days compared to 13.4% nationally. Also, 0.3% of Utah's report lifetime misuse. These figures are again lower than the national average of misuse for tranquilizers of 0.7% with the last 30 days and 8.8% lifetime misuse.

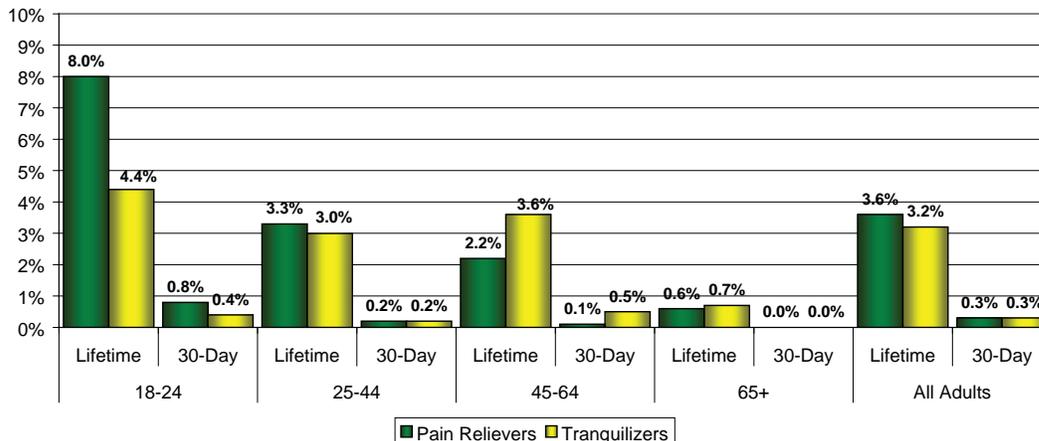
**Adults that Reported Misusing Prescription Drugs
2005**



Note: Data from 2005 Utah Substance Abuse Treatment Needs Survey, 2004 National Survey on Drug Use and Health

For both Pain Relievers and Tranquilizers, the 18-24 year old age category reports the greatest misuse of these substances, far exceeding the other age categories.

Misuse of Prescription Drugs by Age Category



Note: Data from 2005 Utah Substance Abuse Treatment Needs Survey

Pregnant Women in Treatment

Pregnancy and prenatal care information is collected on all female clients entering the public treatment system. At the time of admission 5.3% of the women entering treatment (395 women) were pregnant. This information aids the provider in planning successful treatment strategies

for the woman and her unborn child. Successful treatment planning further minimizes the chance of complications from prenatal drug and alcohol use, including premature birth and physical and mental impairments.

Pregnancy at Admission Fiscal Year 2006

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	510	22	4.3%
Central Utah	100	5	5.0%
Davis County	223	13	5.8%
Four Corners	226	5	2.2%
Northeastern	147	7	4.8%
Salt Lake County	4,309	255	5.9%
San Juan County	12	0	0.0%
Southwest Center	233	18	7.7%
Summit County	51	2	3.9%
Tooele County	73	4	5.5%
U of U Clinic	70	1	1.4%
Utah County	821	36	4.4%
Utah State Prison	112	0	0.0%
Wasatch County	29	0	0.0%
Weber Human Services	586	27	4.6%
Total:	7,502	395	5.3%

Clients with Dependent Children

Substance use disorders seriously impact an individual's physical, emotional and social functioning. Not only does the individual with a substance abuse disorder suffer but those living with the individual also suffer. The table below indicates the percentage of patients with dependent children and the average number of children in those households.

Children with a parent who abuses alcohol and/or other drugs are at a higher risk of developing substance abuse problems themselves. The percentage of adult clients with dependent children in Utah is 43.2%. The average number of dependent children per household is 2.19. Northeastern Local Authority reports the highest percentage of clients with dependent children at 65.3% and the highest average number of children per household at 2.78.

The table also depicts the percentage of women entering treatment who have dependent children and the average number of children for those households. Wasatch County has the highest percentage of women with dependent children at 72.4%; San Juan County has the highest average number of dependent children per household at 3.00.

Appropriate treatment for adults with substance abuse disorders includes the treatment of family members. Treatment providers throughout the State address the emotional needs of all family members and provide services to children in households where parents or siblings are receiving treatment for substance use disorders.

Clients with Dependent Children
Fiscal Year 2006

	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	33.5%	2.05	41.0%	1.91
Central Utah	46.3%	2.46	55.0%	2.62
Davis County	58.2%	2.12	71.3%	2.23
Four Corners	45.1%	2.23	61.9%	2.42
Northeastern	65.3%	2.78	69.4%	2.75
Salt Lake County	42.4%	2.14	58.5%	2.22
San Juan County	25.0%	2.31	8.3%	3.00
Southwest Center	60.2%	2.36	67.4%	2.36
Summit County	27.1%	1.62	41.2%	1.57
Tooele County	27.8%	1.89	41.1%	1.73
U of U Clinic	58.7%	2.36	67.1%	2.32
Utah County	51.6%	2.32	67.6%	2.34
Utah State Prison	33.8%	2.11	46.4%	2.31
Wasatch County	55.0%	2.38	72.4%	2.19
Weber Human Services	36.5%	2.26	49.0%	2.41
Total:	43.2%	2.19	58.1%	2.26

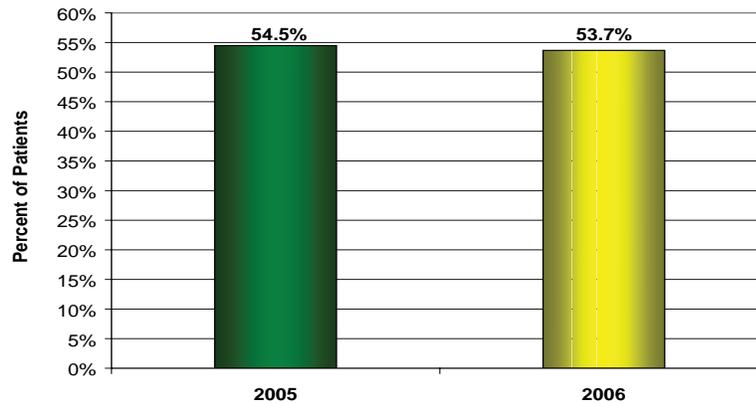
Treatment Outcomes

DSAMH collected data on 9,699 non-detox discharges in fiscal year 2006. The analysis in this section includes data for clients who were discharged successfully (completed the objectives of their treatment plan), and for those clients who were discharged unsuccessfully (left treatment against professional advice or were involuntarily discharged by the provider due to non-compliance). Clients who were discharged as a result of a transfer to another level of care were also included in this data. The transfer was

considered “successful” if the client continued on in treatment. The data does not include clients who were admitted only for detoxification services or who were receiving treatment while they were incarcerated at the Utah State Prison.

The following graph depicts the percentage of clients discharged in fiscal year 2006 who successfully completed treatment. Of the clients entering treatment 53.7% successfully complete their treatment objectives.

Percentage of Patients Successfully Completing Treatment Modality
Fiscal Years 2005 - 2006

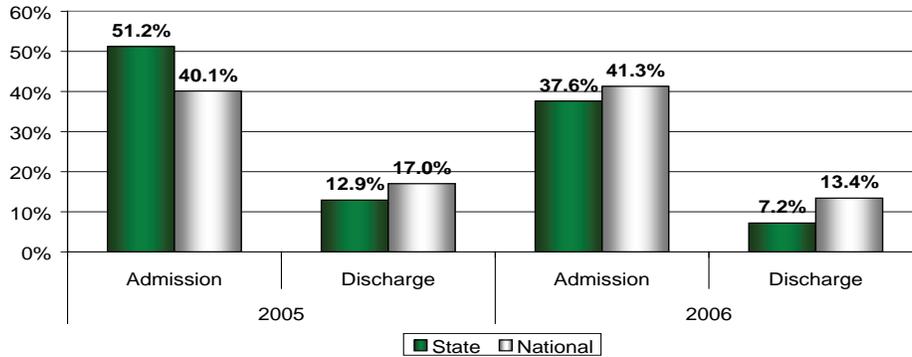


Criminal Activity

In fiscal year 2006, during the six months prior to being admitted to treatment services, 37.6% of the clients reported they had been arrested. Once admitted to treatment, only 7.2% reported further

criminal arrests. For clients in treatment in Utah, arrests during their treatment episode were significantly less than the national average of 13.4%.

**Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment
Fiscal Years 2005 - 2006**

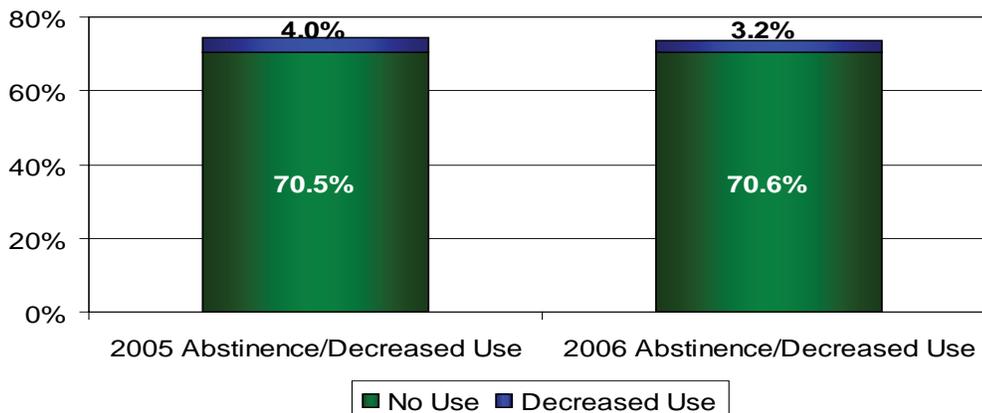


Abstinence and Decrease in Use at Discharge

The following chart provides information about the substance use patterns of clients in all treatment levels except detoxification. Substance use patterns are evaluated 30 days prior to the client entering treatment and again in the 30 days prior to their discharge. As expected, a large majority of

clients entering treatment had been using alcohol or other drugs frequently, many of them reporting daily use. In fiscal year 2006, 70.6% reported no use in the 30 days preceding their discharge from treatment. An additional 3.2% reduced their use of alcohol and drugs.

**Clients Reporting Abstinence or Decreased Use at Discharge
Fiscal Years 2005 - 2006**

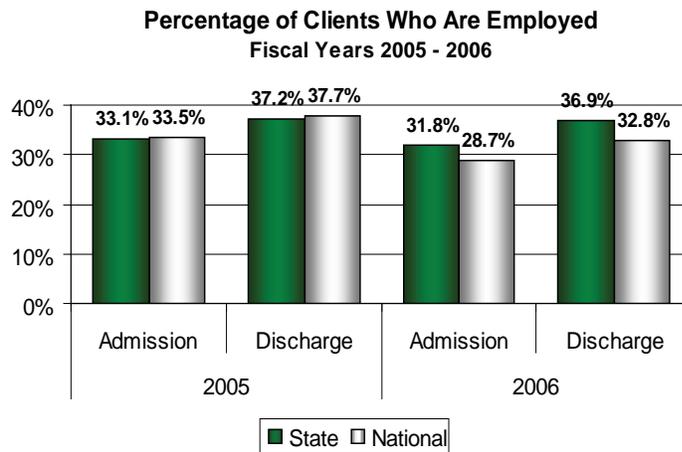


Stability of Clients

Percentage of Clients Employed

The employment status of a client struggling with a substance use disorder is another key element for successful recovery. Outcome research has consistently found that clients who are employed or in school, have much higher treatment success rates than those clients who are unemployed.

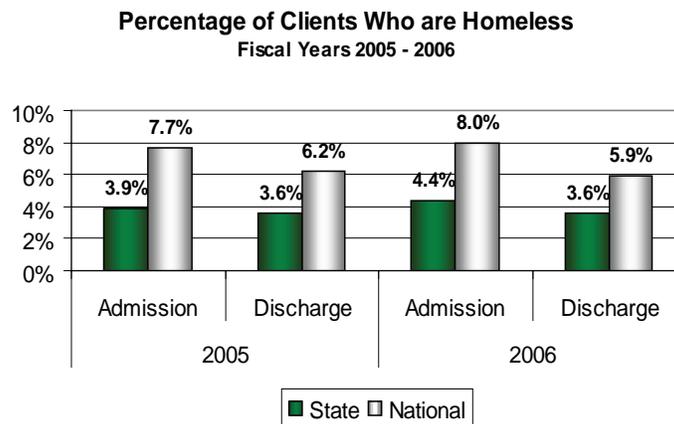
Consequently, treatment providers work with clients to improve their economic development. Of those clients who were discharged from treatment in fiscal year 2006, 31.8% were employed at admission and 36.9% were employed at discharge as compared to national averages of 28.7% and 32.8%, respectively.



Percentages of Clients Who are Homeless

As shown in this chart, 4.4% of clients entering Utah’s public substance abuse treatment in fiscal year 2006 were homeless at the time of their admission to treatment as compared to 8.0% nationally. Outcome studies have revealed that

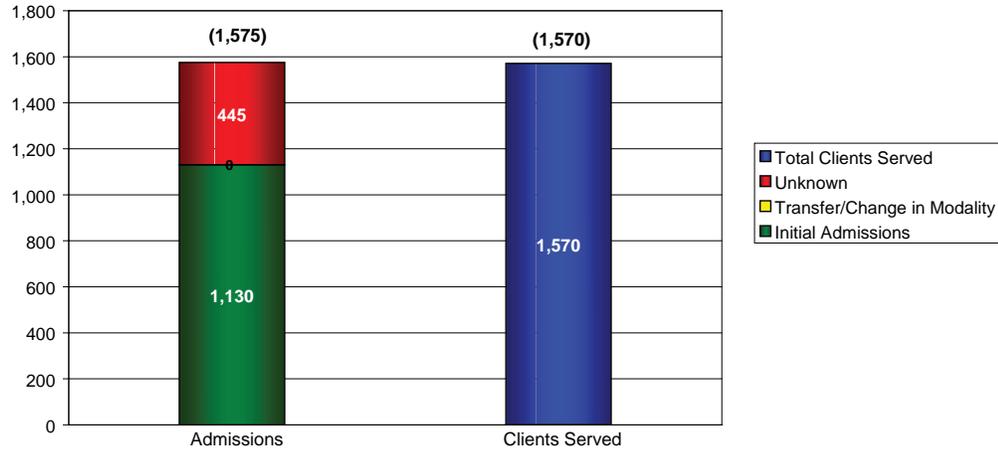
a stable living environment is a critical element in achieving long-term successful results from substance abuse. Providers across Utah assist clients in establishing a more stable living situation during their treatment episode. Research has demonstrated that treatment is an important factor in helping the substance abusing population enter more stable living environments.



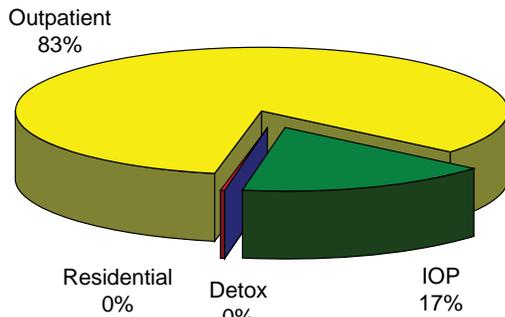
Bear River Substance Abuse

2005 Population	Total Served	Penetration Rate
146,546	1,570	1.1%

Admissions into Modalities and Clients Served Fiscal Year 2006



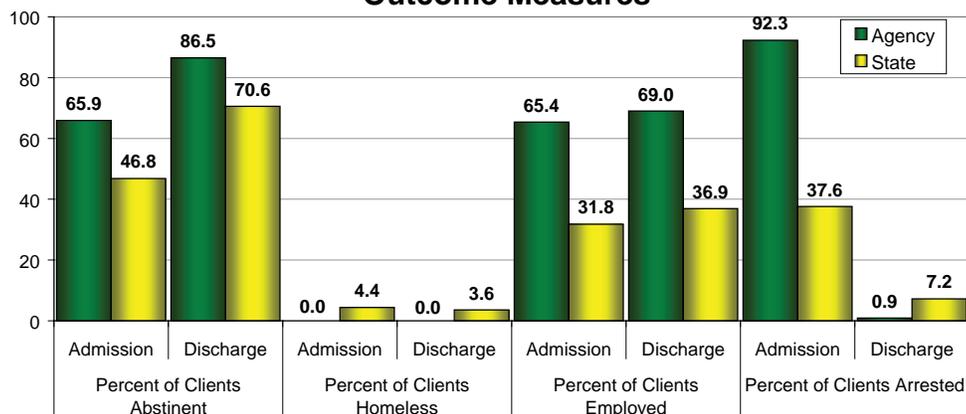
Admissions into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	615	245	860
Cocaine/Crack	9	10	19
Marijuana/Hashish	247	49	296
Heroin	5	2	7
Other Opiates/Synthetics	32	40	72
Hallucinogens	2	0	2
Methamphetamine	149	150	299
Other Stimulants	0	1	1
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	7	7
Inhalants	0	0	0
Oxycodone	5	4	9
Club Drugs	0	1	1
Over-the-Counter	0	0	0
Other	1	0	1
None/Missing	0	0	0
Total	1,065	510	1,575

Bear River Substance Abuse Outcome Measures

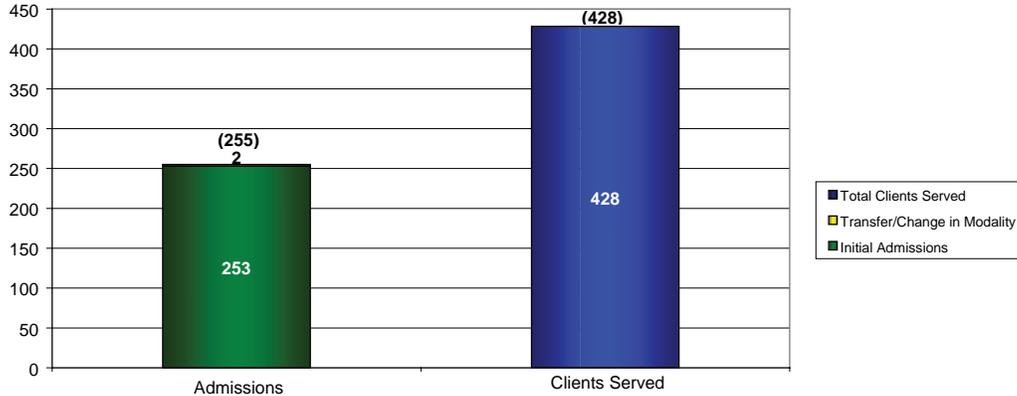


Note: Agency based on 1,071 non-detox discharges. State based on 9,699 non-detox discharges.

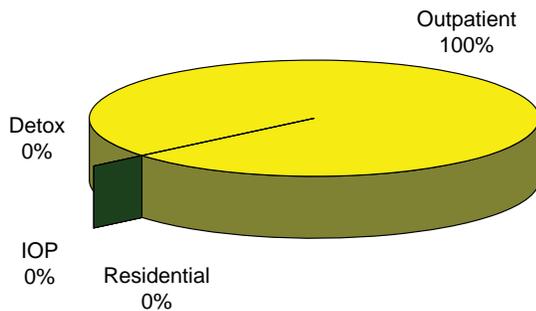
Central Utah Counseling Center

2005 Population	Total Served	Penetration Rate
68,642	428	0.6%

Admission into Modalities and Clients Served
Fiscal Year 2006



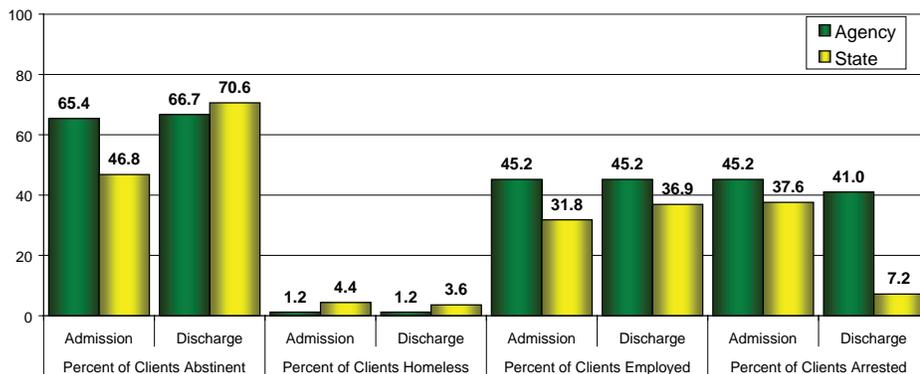
Admission into Modalities
Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	56	41	97
Cocaine/Crack	0	0	0
Marijuana/Hashish	51	9	60
Heroin	3	2	5
Other Opiates/Synthetics	2	3	5
Hallucinogens	0	0	0
Methamphetamine	42	31	73
Other Stimulants	0	1	1
Benzodiazepines	0	4	4
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	6	7
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	0	0	0
None/Missing	0	2	2
Total	155	100	255

Central Utah Counseling Outcome Measures
Fiscal Year 2006

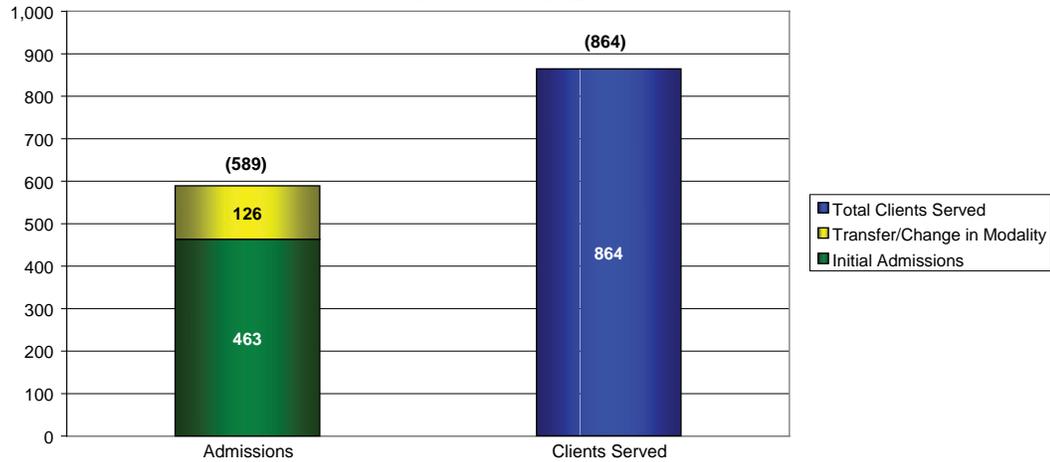


Note: Agency based on 84 non-detox discharges. State based on 9,699 non-detox discharges.

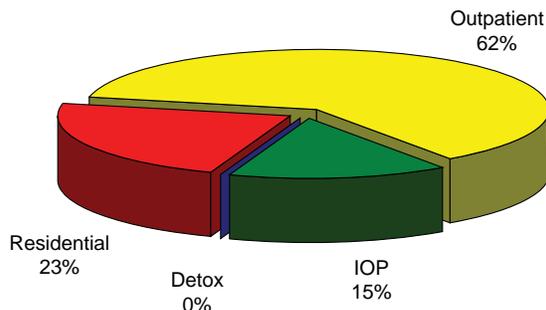
Davis Behavioral Health

2005 Population	Total Served	Penetration Rate
268,187	864	0.3%

Admissions into Modalities and Clients Served Fiscal Year 2006



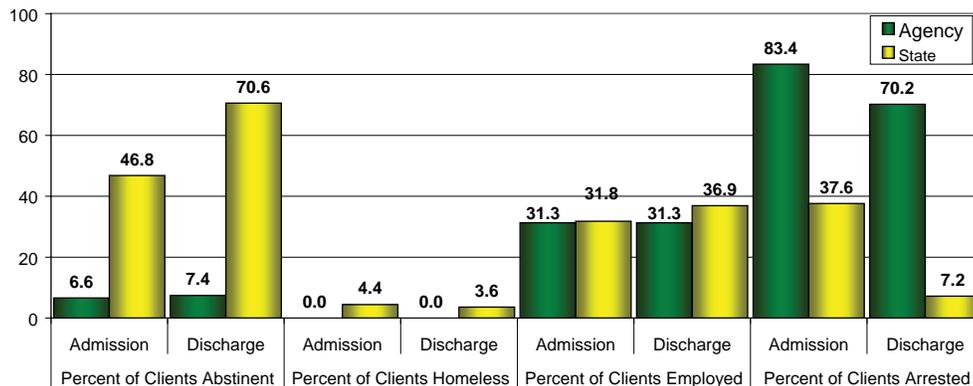
Admissions into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	56	36	92
Cocaine/Crack	18	10	28
Marijuana/Hashish	80	17	97
Heroin	15	5	20
Other Opiates/Synthetics	5	6	11
Hallucinogens	2	0	2
Methamphetamine	154	128	282
Other Stimulants	4	0	4
Benzodiazepines	2	0	2
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	30	19	49
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	1	1
None/Missing	0	0	0
Total	366	223	589

Davis Behavioral Health Outcome Measures Fiscal Year 2006

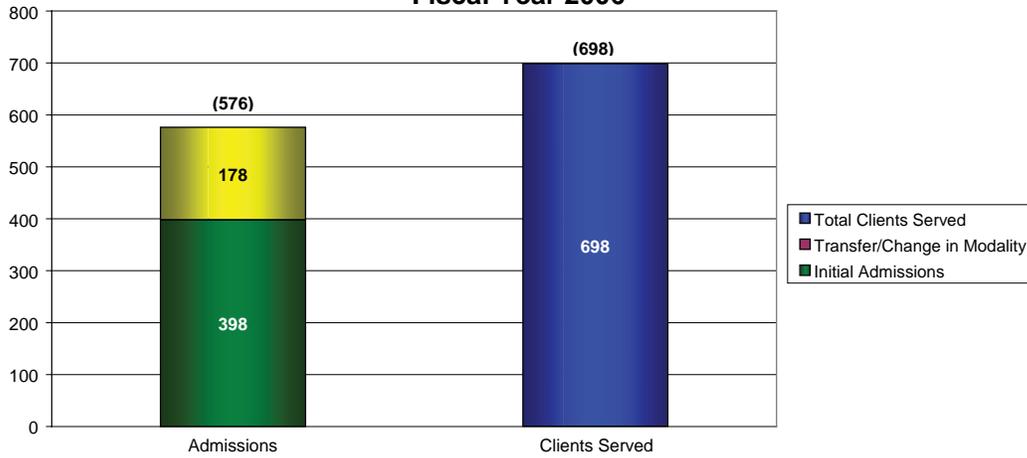


Note: Agency based on 229 non-detox discharges. State based on 9,699 non-detox discharges.

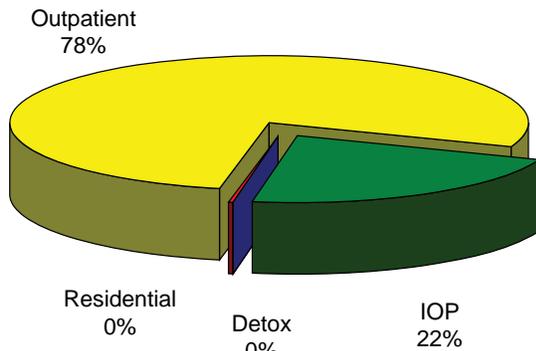
Four Corners Community Behavioral Health

2005 Population	Total Served	Penetration Rate
38,891	698	1.8%

**Admissions into Modalities and Clients Served
Fiscal Year 2006**



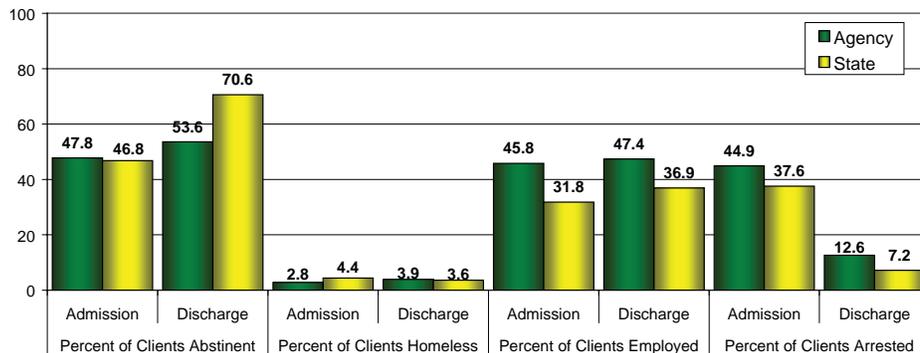
**Admissions into Modalities
Fiscal Year 2006**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	178	88	266
Cocaine/Crack	3	1	4
Marijuana/Hashish	79	32	111
Heroin	1	5	6
Other Opiates/Synthetics	17	25	42
Hallucinogens	1	0	1
Methamphetamine	67	72	139
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	2	2	4
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	2	0	2
None/Missing	0	0	0
Total	350	226	576

**Four Corners Community Behavioral Health Outcome Measures
Fiscal Year 2006**

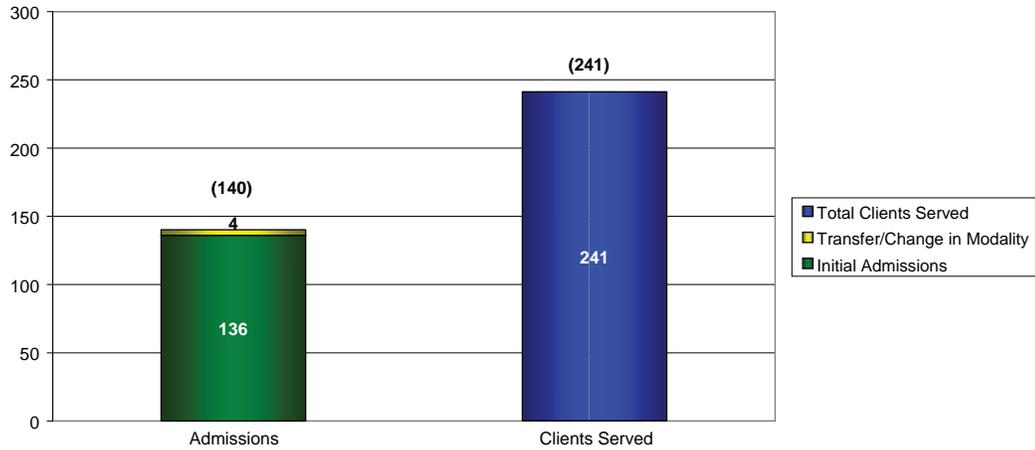


Note: Agency based on 468 non-detox discharges. State based on 9,699 non-detox discharges.

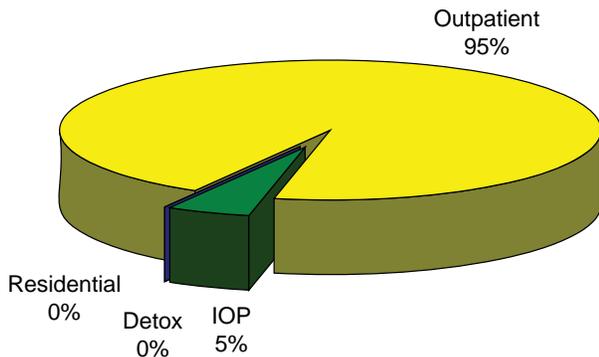
Heber Valley Counseling

2005 Population	Total Served	Penetration Rate
18,974	241	1.3%

Admissions into Modalities and Clients Served Fiscal Year 2006



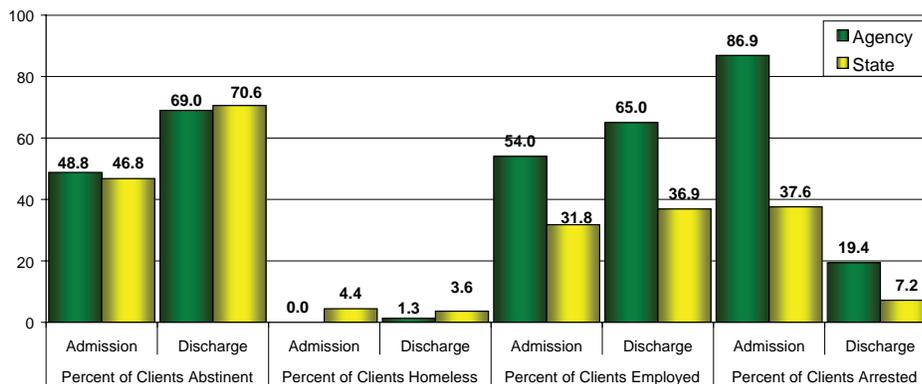
Admission into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	76	15	91
Cocaine/Crack	4	0	4
Marijuana/Hashish	16	3	19
Heroin	1	0	1
Other Opiates/Synthetics	0	3	3
Hallucinogens	1	0	1
Methamphetamine	10	7	17
Other Stimulants	1	0	1
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	0	2
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	0	0	0
None/Missing	0	0	0
Total	111	29	140

Heber Valley Counseling Outcome Measures Fiscal Year 2006

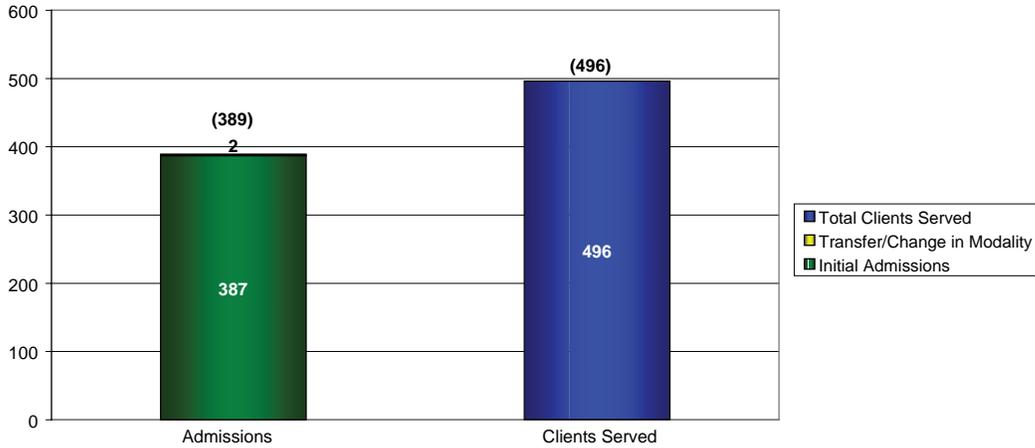


Note: Agency based on 87 non-detox discharges. State based on 9,699 non-detox discharges.

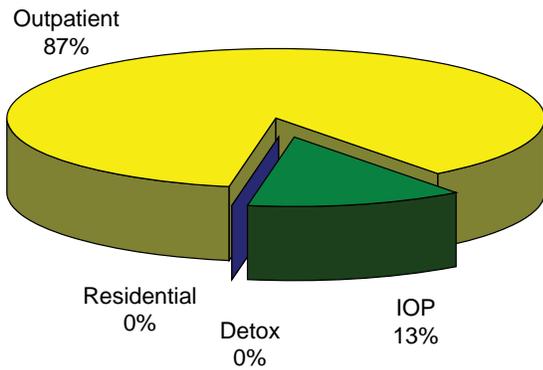
Northeastern Counseling Center

2005 Population	Total Served	Penetration Rate
43,292	496	1.1%

Admissions into Modalities and Clients Served
Fiscal Year 2006



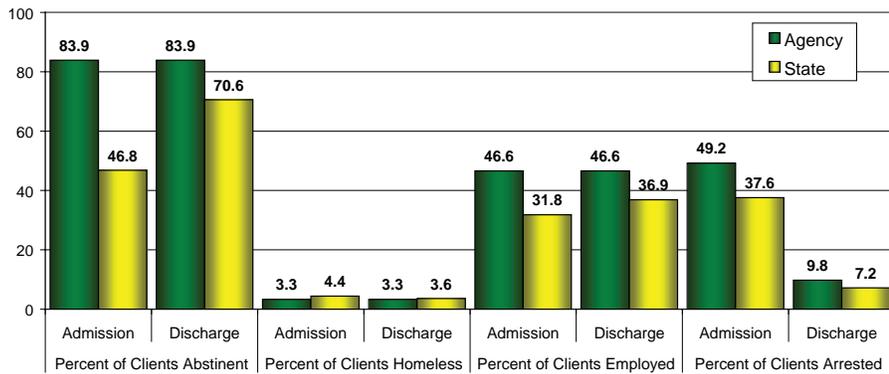
Admission into Modalities
Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	114	51	165
Cocaine/Crack	3	3	6
Marijuana/Hashish	36	20	56
Heroin	0	1	1
Other Opiates/Synthetics	3	8	11
Hallucinogens	0	0	0
Methamphetamine	75	58	133
Other Stimulants	7	4	11
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	0	0	0
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
None/Missing	4	1	5
Total	242	147	389

Northeastern Counseling Center Outcome Measures
Fiscal Year 2006

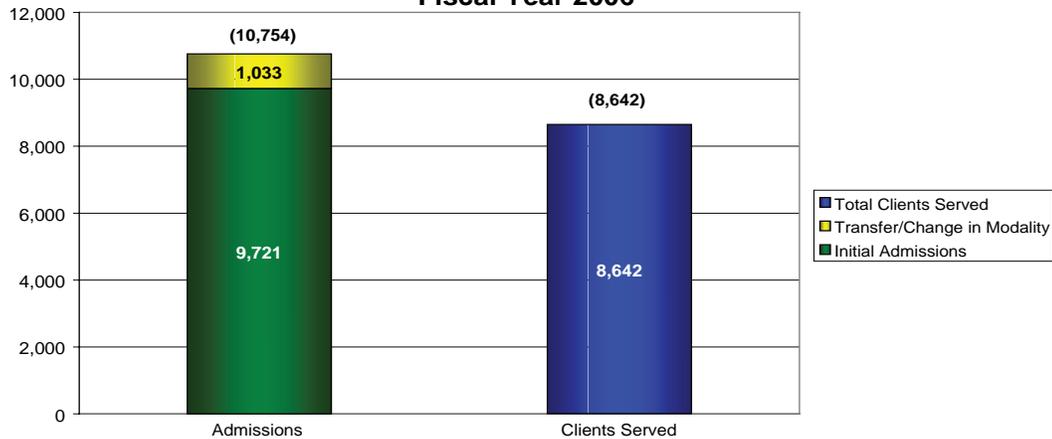


Note: Agency based on 61 non-detox discharges. State based on 9,699 non-detox discharges.

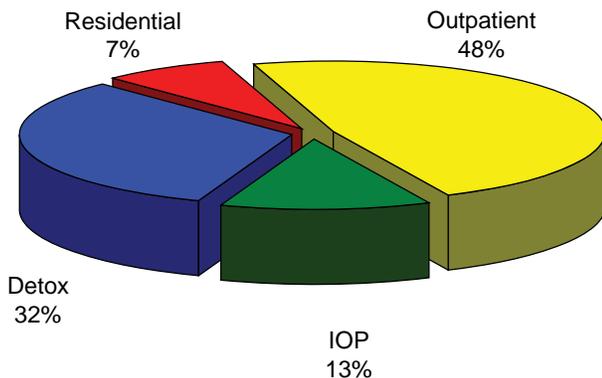
Salt Lake County Division of Substance Abuse

2005 Population	Total Served	Penetration Rate
948,172	8,642	0.9%

Admissions into Modalities and Clients Served Fiscal Year 2006



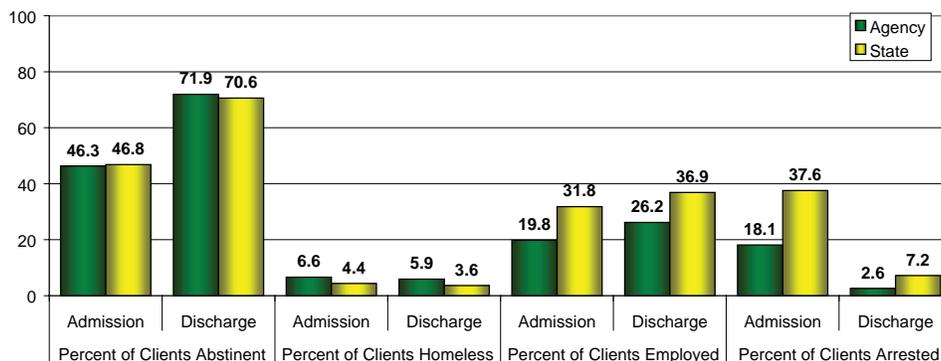
Admissions into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	2,381	837	3,218
Cocaine/Crack	577	402	979
Marijuana/Hashish	892	393	1,285
Heroin	792	440	1,232
Other Opiates/Synthetics	88	136	224
Hallucinogens	6	9	15
Methamphetamine	1,448	1,814	3,262
Other Stimulants	18	8	26
Benzodiazepines	9	21	30
Tranquilizers/Sedatives	5	5	10
Inhalants	7	1	8
Oxycodone	56	80	136
Club Drugs	5	2	7
Over-the-Counter	12	0	12
Other	1	3	4
None/Missing	148	158	306
Total	6,445	4,309	10,754

Salt Lake County Division of Substance Abuse Outcome Measures Fiscal Year 2006

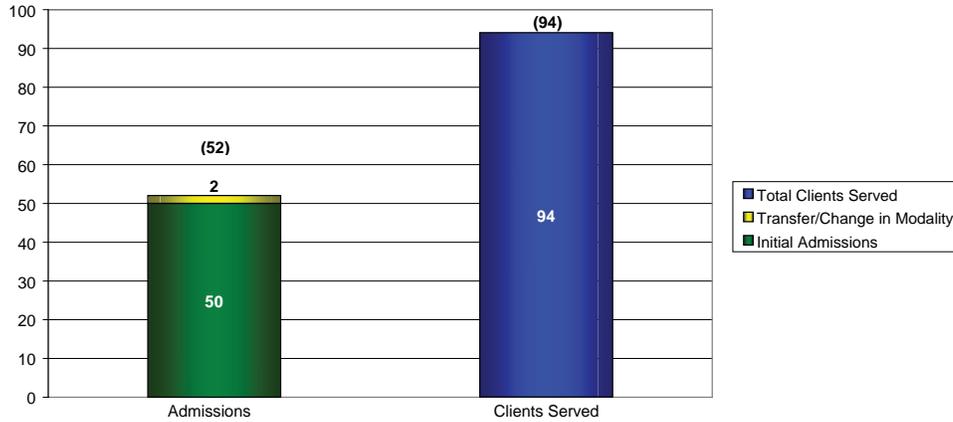


Note: Agency based on 4,558 non-detox discharges. State based on 9,699 non-detox discharges.

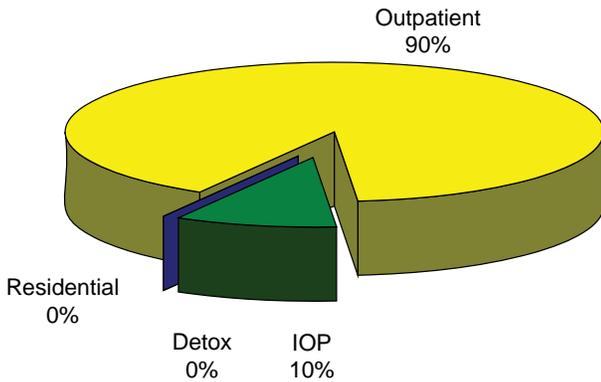
San Juan Counseling

2005 Population	Total Served	Penetration Rate
14,104	94	0.7%

Admissions into Modalities and Clients Served
Fiscal Year 2006



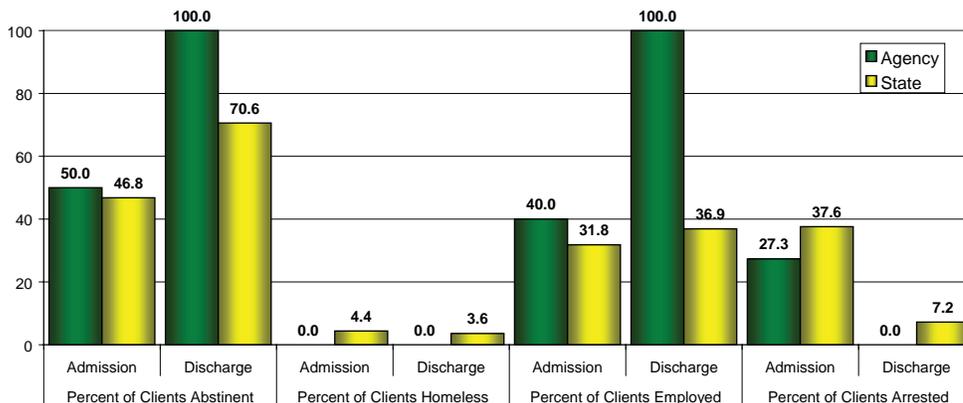
Admissions into Modalities
Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	26	9	35
Cocaine/Crack	0	0	0
Marijuana/Hashish	7	2	9
Heroin	0	0	0
Other Opiates/Synthetics	0	0	0
Hallucinogens	0	0	0
Methamphetamine	2	1	3
Other Stimulants	0	0	0
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	0	0	0
Inhalants	1	0	1
Oxycodone	3	0	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
None/Missing	0	0	0
Total	40	12	52

San Juan Counseling Outcome Measures
Fiscal Year 2006

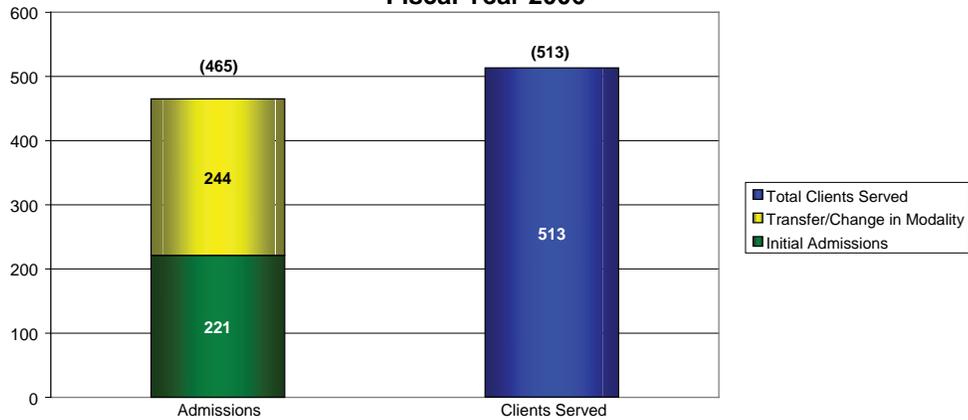


Note: Agency based on 11 non-detox discharges. State based on 9,699 non-detox discharges.

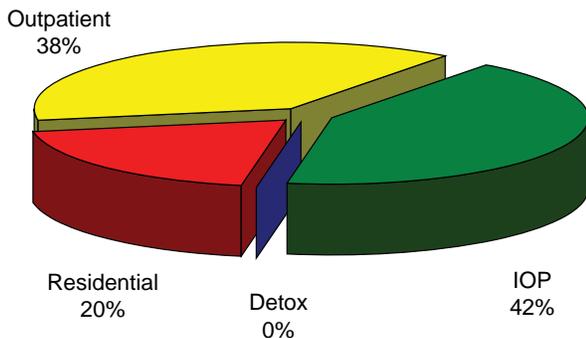
Southwest Behavioral Health Center

2005 Population	Total Served	Penetration Rate
174,072	513	0.3%

**Admissions into Modalities and Clients Served
Fiscal Year 2006**



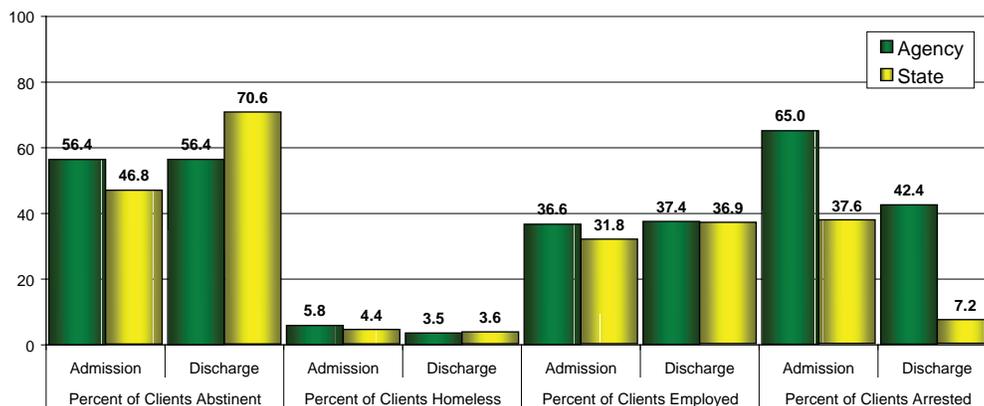
**Admissions into Modalities
Fiscal Year 2006**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	60	33	93
Cocaine/Crack	7	0	7
Marijuana/Hashish	48	43	91
Heroin	18	0	18
Other Opiates/Synthetics	2	1	3
Hallucinogens	0	0	0
Methamphetamine	88	142	230
Other Stimulants	0	2	2
Benzodiazepines	2	4	6
Tranquilizers/Sedatives	0	1	1
Inhalants	1	0	1
Oxycodone	6	7	13
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
None/Missing	0	0	0
Total	232	233	465

**Southwest Behavioral Health Outcome Measures
Fiscal Year 2006**



Note: Agency based on 257 non-detox discharges. State based on 9,699 non-detox discharges.

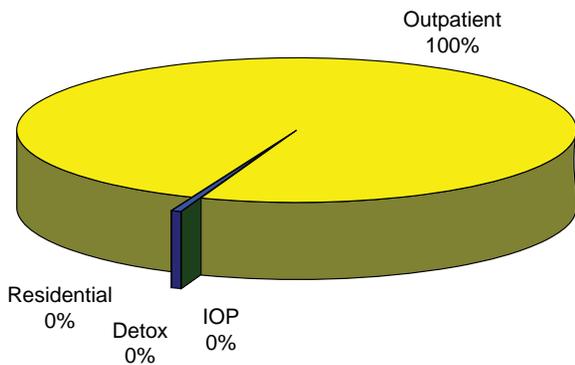
Summit County - VMH

2005 Population	Total Served	Penetration Rate
35,001	317	0.9%

**Admissions into Modalities and Clients Served
Fiscal Year 2006**



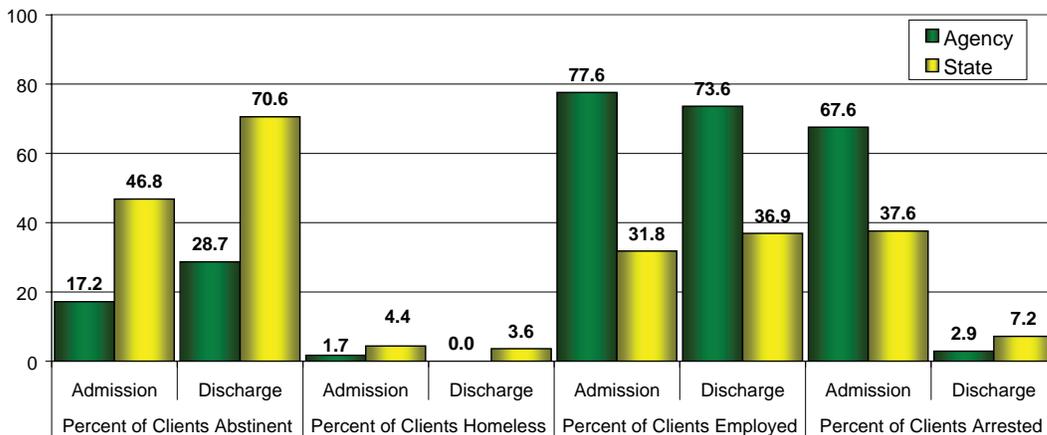
**Admissions into Modalities
Fiscal Year 2006**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	116	31	147
Cocaine/Crack	3	2	5
Marijuana/Hashish	16	5	21
Heroin	2	0	2
Other Opiates/Synthetics	1	3	4
Hallucinogens	0	0	0
Methamphetamine	9	7	16
Other Stimulants	1	1	2
Benzodiazepines	2	0	2
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	1	0	1
Club Drugs	0	1	1
Over-the-Counter	0	0	0
Other	1	0	1
None/Missing	0	0	0
Total	152	51	203

**Summit County - VMH Outcome Measures
Fiscal Year 2006**

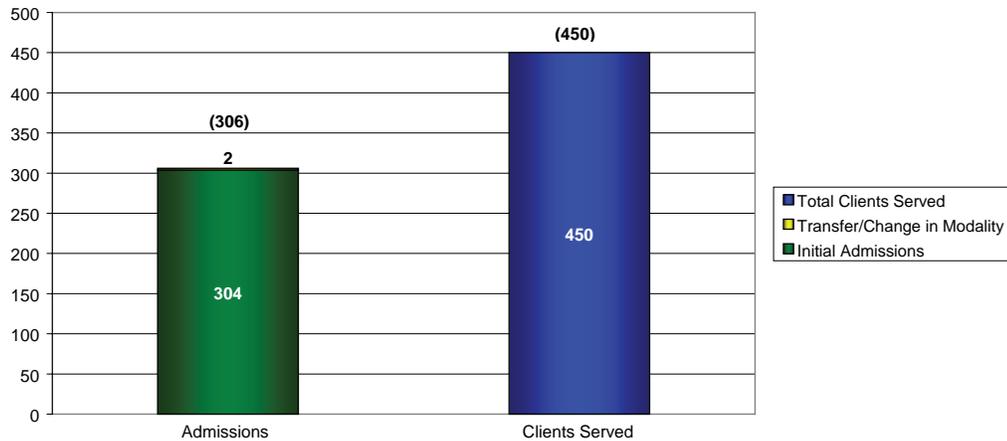


Note: Agency based on 174 non-detox discharges. State based on 9,699 non-detox discharges.

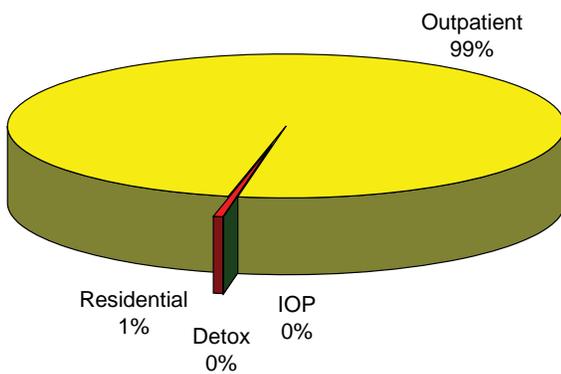
Tooele County - VMH

2005 Population	Total Served	Penetration Rate
51,311	450	0.9%

Admissions into Modalities and Clients Served Fiscal Year 2006



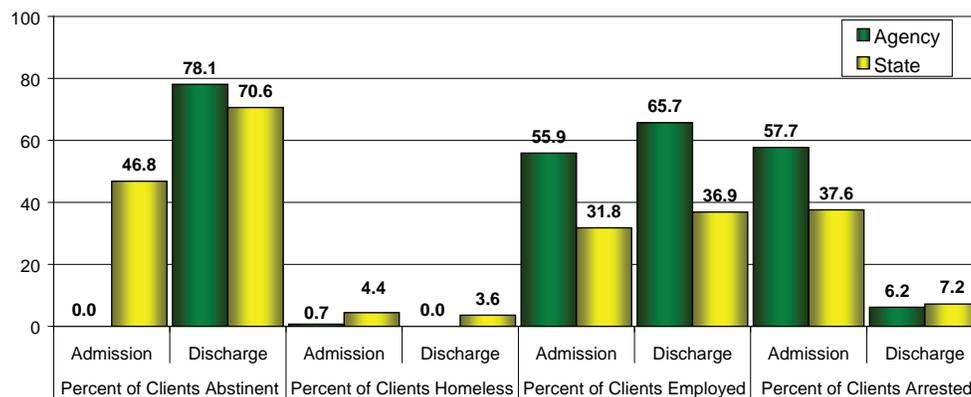
Admissions into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	119	30	149
Cocaine/Crack	4	0	4
Marijuana/Hashish	60	12	72
Heroin	8	2	10
Other Opiates/Synthetics	0	2	2
Hallucinogens	0	0	0
Methamphetamine	38	26	64
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	1	0	1
None/Missing	0	0	0
Total	233	73	306

Tooele County - VMH Outcome Measures Fiscal Year 2006

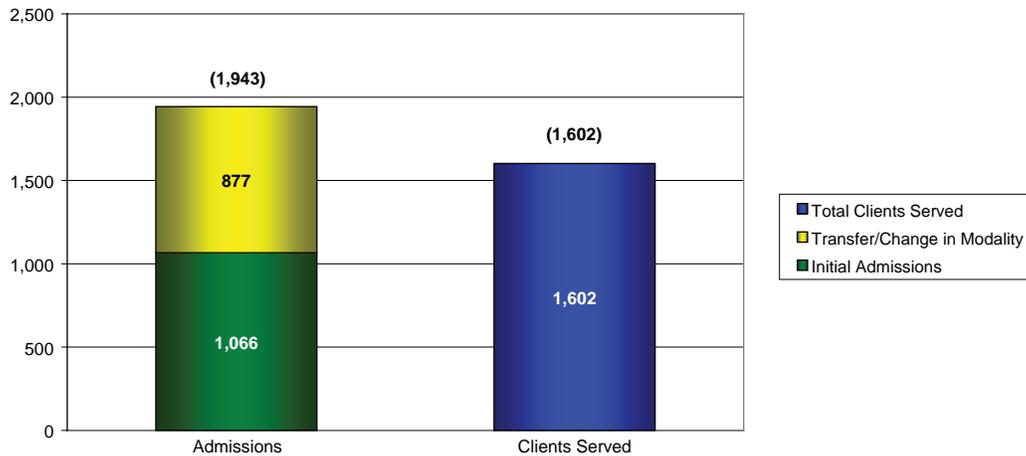


Note: Agency based on 274 non-detox discharges. State based on 9,699 non-detox discharges.

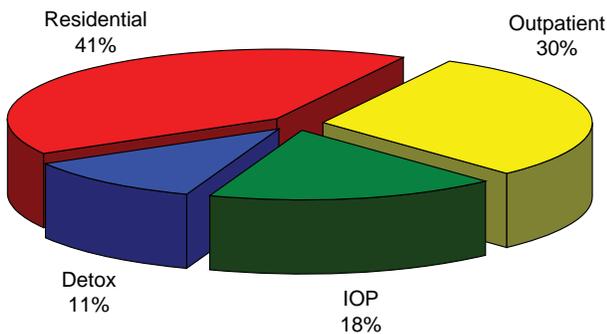
Utah County Division of Substance Abuse

2005 Population	Total Served	Penetration Rate
443,738	1,602	0.4%

Admissions into Modalities and Clients Served Fiscal Year 2006



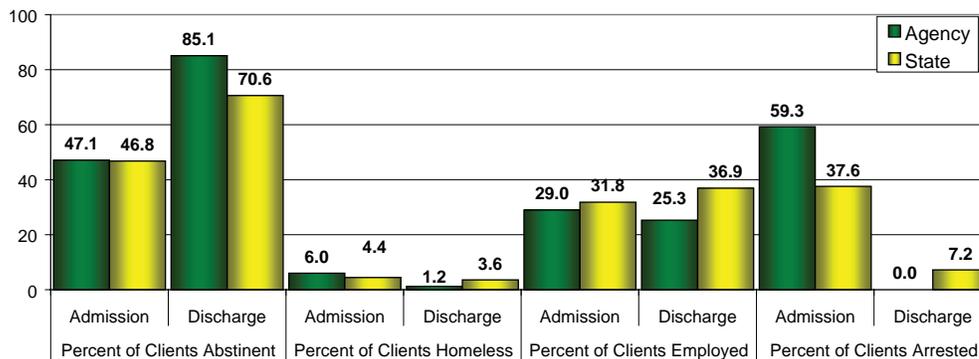
Admissions into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	297	102	399
Cocaine/Crack	43	40	83
Marijuana/Hashish	249	141	390
Heroin	201	96	297
Other Opiates/Synthetics	8	16	24
Hallucinogens	11	3	14
Methamphetamine	196	303	499
Other Stimulants	6	3	9
Benzodiazepines	11	29	40
Tranquilizers/Sedatives	1	3	4
Inhalants	1	2	3
Oxycodone	90	75	165
Club Drugs	8	4	12
Over-the-Counter	0	4	4
Other	0	0	0
None/Missing	0	0	0
Total	1,122	821	1,943

Utah County Division of Substance Abuse Outcome Measures Fiscal Year 2006

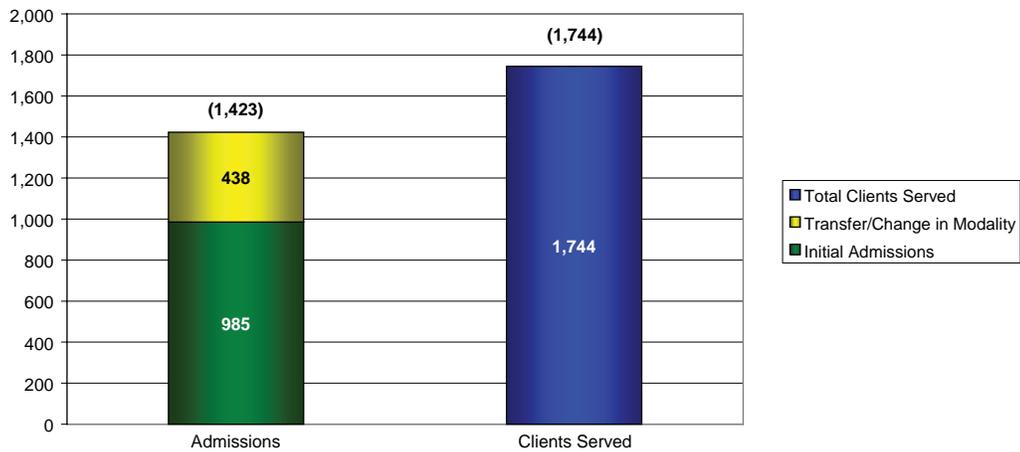


Note: Agency based on 998 non-detox discharges. State based on 9,699 non-detox discharges.

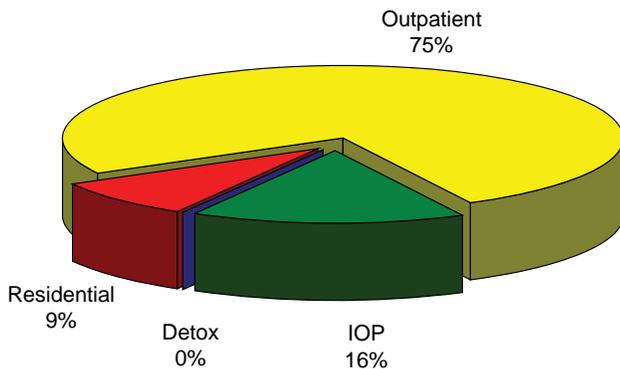
Weber Human Services

2005 Population	Total Served	Penetration Rate
210,749	1,745	0.8%

Admissions into Modalities and Clients Served Fiscal Year 2006



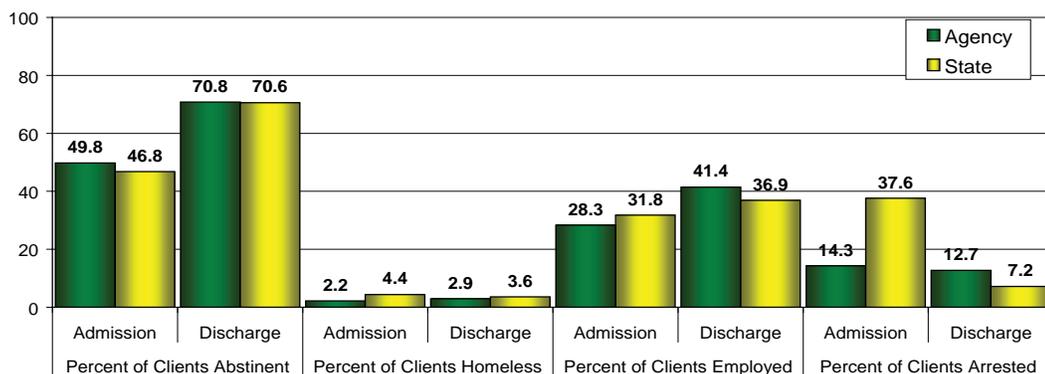
Admission into Modalities Fiscal Year 2006



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	193	121	314
Cocaine/Crack	53	47	100
Marijuana/Hashish	227	103	330
Heroin	5	10	15
Other Opiates/Synthetics	5	9	14
Hallucinogens	3	0	3
Methamphetamine	324	260	584
Other Stimulants	1	1	2
Benzodiazepines	2	3	5
Tranquilizers/Sedatives	0	2	2
Inhalants	5	0	5
Oxycodone	15	19	34
Club Drugs	1	2	3
Over-the-Counter	1	2	3
Other	2	7	9
None/Missing	0	0	0
Total	837	586	1,423

Weber Human Services Outcome Measures Fiscal Year 2006



Note: Agency based on 1,124 non-detox discharges. State based on 9,699 non-detox discharges.

Justice Programs

Alcohol and other drugs are major contributors to Utah's crime rate. More than 50% of violent crimes, 60% to 80% of child abuse and neglect cases, and 50% to 70% of theft and property crimes involve drug or alcohol use (Belenko and Peugh, 1998; National Institute of Justice, 1999). Prior to incarceration 85% of Utah's prison population has used illicit drugs or alcohol. Drug use significantly increases the likelihood that an individual will engage in serious criminal conduct (Marlowe, 2003).

DSAMH has developed a number of innovative programs designed to address the connection between drugs and crime. Drug Court, Drug Board, CIAO, and DORA strive to decrease substance use, enhance public safety, and reduce recidivism by providing individualized services for the justice population.

Drug Court

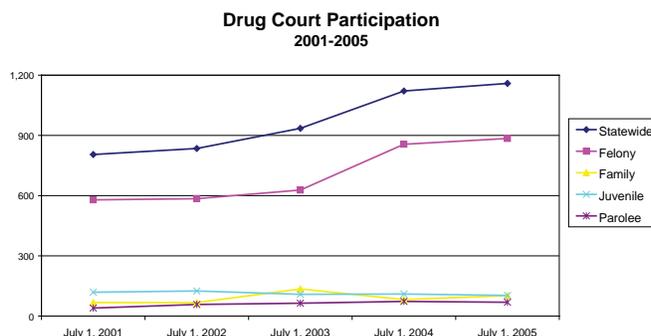
Drug Courts and Drug Boards offer nonviolent, drug abusing offenders' intensive court-supervised drug treatment as an alternative to jail or prison. The Department of Human Services (DHS) provides funding for 19 Drug Court and 2 Drug Board programs.

Caseload Growth

In response to the cycle of criminal recidivism common among drug offenders, local jurisdictions began in the mid 1990's to create Drug Courts in Utah. In 1996, two Drug Courts existed in Utah. By 2005, 32 Drug Courts were operating. Felony Drug Court participation has driven the growth in overall drug court participation. However, a lack of funding prevents Drug Courts from serving many who would benefit. While no waiting lists exist because of the need to process judicial cases in a timely manner, most Drug Courts have adopted caps to admission to control caseload growth.

What Do Drug Courts Require of Participants

Drug Court participants undergo long-term, judicially monitored treatment and counseling, and must appear before a Judge every week. The Drug Court Judge has the authority to impose sanctions and incentives. Successful completion of the treatment program results in dismissal of criminal charges, reduced or set aside sentences, or reduced probation time.



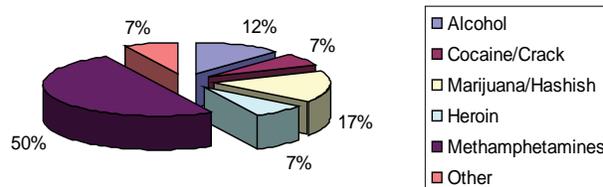
Are Drug Courts Effective

Drug Courts are the most successful model for treating chronic, substance-abusing offenders. Drug Courts significantly reduce substance use and criminal behavior (Belenko, 1998, 2001). "To put it bluntly, we know that drug courts outperform virtually all other strategies that have been attempted for drug-involved offenders" (Marlowe, DeMatteo, & Festinger, 2003). Drug Courts reduce drug use and crime. They also reduce costs. Incarceration of drug using offenders costs between \$20,000 and \$30,000 per person, per year. In contrast, a comprehensive drug court system typically costs between \$2,500 and \$4,400 annually for each offender.

Methamphetamine use is the driving force in the need to expand Drug Courts. Since 2001, methamphetamine has been the number one illicit drug of choice for clients admitted to

the public substance abuse treatment system surpassing marijuana. At admission 50% of Drug Court participants report that methamphetamine is their drug of choice.

**Primary Drug of Choice for Drug Court
Participants Statewide
Fiscal Year 2006**



Drug Courts are of great value in treating offenders addicted to methamphetamine. Treatment providers report that methamphetamine users are often difficult to engage and retain in treatment. Drug Court has proven to be successful in keeping methamphetamine users in treatment for a significant period of time. In Utah, Drug Court participants are involved in treatment an average of 339 days. In comparison, national studies have found that 50% of referrals from the criminal justice system never make it through the front door of a treatment center despite being ordered to do so (Marlowe, DeMatteo, & Festinger, 2003).

Methamphetamine users respond well to the application of contingency strategies (rewards and punishments rapidly applied contingent upon specific behaviors). Drug Courts reinforce positive behaviors (e.g., treatment attendance and drug free urine samples) and punish (e.g., jail) negative behaviors (e.g., continued drug use). By using these strategies, Drug Courts promote a positive treatment response in methamphetamine users.

Data Collected by DSAMH Shows that Drug Court:

Participation is Growing

- 32 Drug Courts are now operating in Utah
- Over 6,300 Utahns have participated, or are currently participating in a Drug Court
- Over 3,800 Utahns have graduated from a Drug Court
- 67% of participants graduate
- Next year, 2,000 Utahns will participate in Drug Court
- Participants are involved an average of 339 days (Graduates = 410, Unsuccessful or terminated participants = 244)

Decreases Substance Use

- 69% of all participants report abstinence at discharge, an additional 9% report reduced use at discharge

Increases Employment Rates

- Statewide, between admission and discharge, employment rates for Adult Drug Court participants rose by 7 percentage points

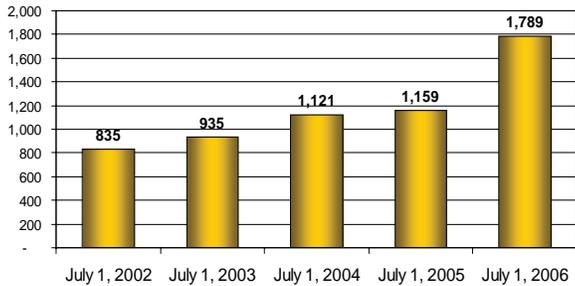
Reduces Recidivism

- Six months prior to involvement, participants report an average of 2.7 arrests
- 84% of participants report zero arrests while in Drug Court

Statewide Drug Court Statistics

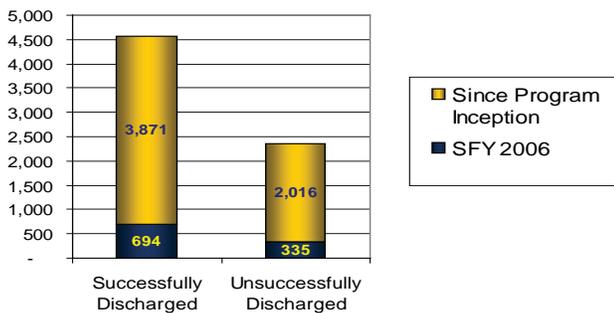
Overall, participation in Drug Court is growing. Since 2002, participation has more than doubled.

State Totals - Drug Courts
Participants Receiving Services as of:



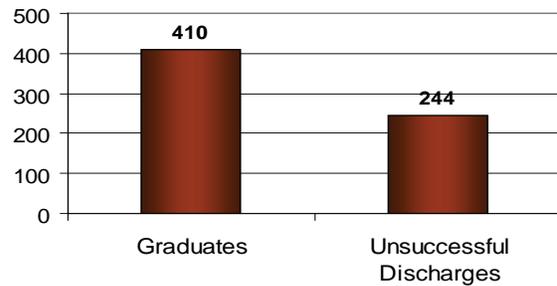
Sixty-seven percent of participants complete Drug Court successfully. This compares well to treatment outcomes for all populations. Given the program length, strict supervision, and chronicity of the target population, the result is outstanding.

State Drug Court Discharges



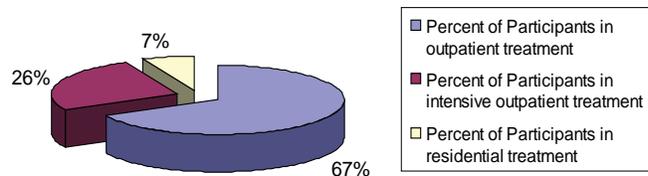
Drug Court retains offenders in treatment. The research suggests that retention is the most critical factor in successful outcomes (Marlowe, DeMatteo, & Festinger, 2003).

Treatment Retention
Days in Treatment for Drug Court Participants



Sixty-seven percent of participants are treated at the outpatient level. In traditional programs, offenders are often placed at higher levels of care due to concerns about public safety. This can be five times as expensive as outpatient care.

State Total Drug Courts -
Level of Care as of July 1, 2006



Utah Drug Courts

There are currently 32 Drug Court and Drug Board programs throughout the state; at this time the DHS provides funding for 19 drug courts and 2 drug board programs. All of the courts are listed separately below, the courts that are provided funding from the Department of Human Services are indicated with an * before the court name.

Adult Felony Drug Courts: Adult Felony Drug Courts focus upon individual adult offenders charged with a felony drug crime. Though restrictions may vary by location and program, adult felony drug court is generally available to: certain nonviolent offenders charged with a felony drug crime which include forged prescriptions, possession with intent, and felony possession of a controlled substance, offenders with at least one previous drug conviction for which a sentence was given, and offenders must be in the country legally.

Utah has 15 functioning Adult Felony Drug Courts, located in *Box Elder, Cache, *Carbon, *Davis, *Emery, *Heber, Millard, *Salt Lake, Sanpete, *Sevier, Tooele, *Uintah, Utah, *Washington, and *Weber counties.

Juvenile Drug Courts: Juvenile Drug Courts emerged in Utah during the late 1990s as an alternative approach for dealing with young drug offenders. Juvenile Drug Courts are aimed specifically at first time or second time juvenile offenders and use a comprehensive approach that involves the family and school system. Requirements of juvenile Drug Courts include 60 hours of community service, written essays on the dangers of drug use, and on-going court supervision. Treatment services are individually tailored and developmentally appropriate. Utah has five Juvenile Drug Courts located in *Weber, Davis, *Salt Lake, *Tooele and *Utah Counties.

Dependency Drug Courts: Dependency Drug Courts hear cases where the state has alleged abuse or neglect on the part of the parent. These drug courts acknowledge that neglect and abuse

may be a product of drug addiction. Subsequently, teams within this court hold parents accountable for their behavior by monitoring their treatment and encourage a focus on recovery so the family may be reunited. Six Family/Dependency Drug Courts operate in Utah, these programs are located in Davis, *Grand, *Salt Lake, *Utah, *Weber, and Washington Counties.

Drug Board: Drug Board provides community-based services through a drug court model to help drug-involved offenders reintegrate into their communities after being released from prison. Drug Board uses the authority of the Board of Pardons and Parole to apply graduated sanctions, positive reinforcement and to coordinate resources to support the prisoner's reintegration. Central to the Drug Board are the goals of tracking, supporting, and supervising offenders upon release. *Davis County and *Weber County currently operate Drug Board programs.

Misdemeanor Drug Courts: Four Justice Court-level drug courts provide nonviolent misdemeanor offenders with the opportunity to participate in judicially supervised, substance abuse treatment. Most of the participants in the misdemeanor courts have been arrested on marijuana or alcohol charges. These courts usually target first time offenders and are generally shorter in duration than Felony Drug Courts. None of the Misdemeanor Drug Courts have received federal or state Drug Court funding. Judges donate time and resources to make these programs a reality. All of the Misdemeanor Drug Courts are found in Salt Lake County.

Independent Evaluations

The general effectiveness of Drug Courts on reducing recidivism has been consistently established in studies from across the country (Belenko, 2001). The Government Accountability Office's (GAO) review of adult drug court evaluations (2005) found that most studies have shown both during program and post-program (up to one year) reductions in recidivism. Utah

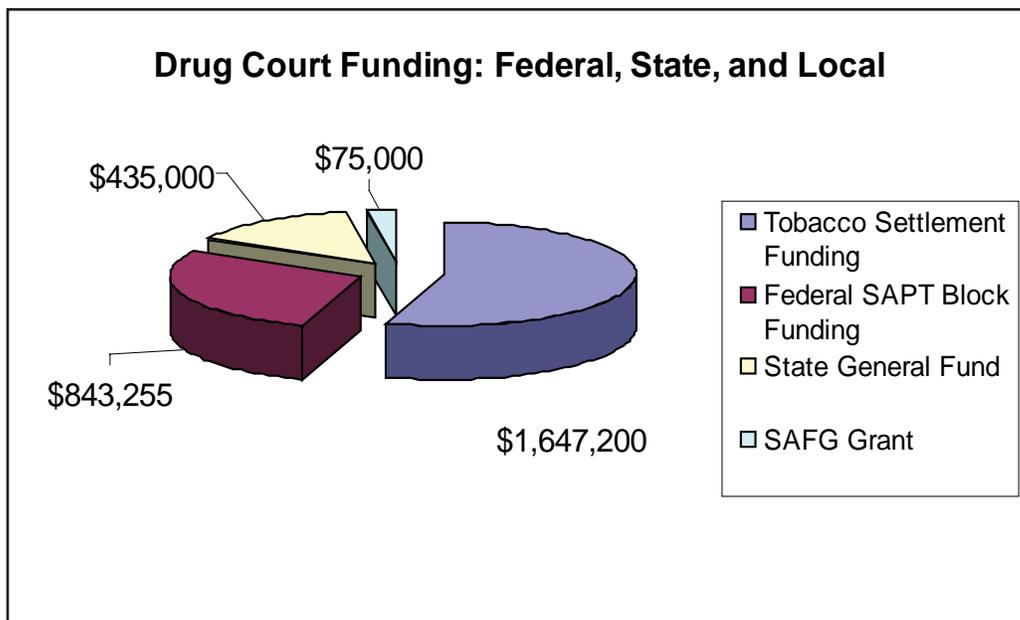
Drug Courts have been the subject of at least eight independent evaluations. All of the independent reports showed positive outcomes. Three of the Salt Lake County Drug Court studies consistently show lower recidivism for Drug Court graduates than non drug court comparison groups and lower recidivism for Drug Court graduates than non successful clients (Van Vleet, 2005). These robust findings across time periods and methodological differences indicate that there are beneficial effects of participation and graduation in the Salt Lake County Drug Court (Van Vleet, 2005).

Appropriations

S.B. 15, Use of Tobacco Settlement Revenues, passed during the 2000 Legislative General Session appropriated a total of \$1,647,200 to the Department of Human Services (DHS), allocating \$1,296,300 for statewide expansion

of the Drug Court Program and \$350,900 for a Drug Board Pilot Program. The Drug Court Allocation Council, created by Utah Code §78-3-32, reviewed requests for funds and dispensed \$1,647,200 in awards to start, expand, or continue Drug Court/Drug Board operations. Another \$352,800 is appropriated to the Courts, Department of Corrections, and the Board of Pardons for administrative costs. In the 2006 Legislative session, \$500,000 of State General Funds was allocated to drug courts. A summary of DHS funding for Drug Court is found in the chart below.

In addition to this funding, federal grant programs and county dollars are also used to support Drug Court. County funding for Drug Court has grown considerably since 2001. The following chart projects the mix of County, Federal, and State funding for Utah Drug Courts:



The charts below shows DHS funding for each Drug Court for 2006:

Drug Court Funding	2001	2002	2003	2004	2005	2006	2007
Tobacco Settlement Funding	\$1,296,300	\$1,296,300	\$1,296,300	\$1,296,300	\$1,296,300	\$1,296,300	\$1,647,200
Federal SAPT Block Funding	\$462,387	\$598,451	\$598,451	\$1,079,703	\$1,199,703	\$1,150,639	\$843,255
State General Fund	\$0	\$0	\$0	\$0	\$0	\$0	\$435,000
SAFG Grant	\$0	\$0	\$0	\$0	\$0	\$0	\$75,000
Total Funding	\$1,758,687	\$1,894,751	\$1,894,751	\$2,376,003	\$2,496,003	\$2,446,939	\$3,000,455

UTAH DRUG COURT FUNDING BY DRUG COURT MODEL								
Model	DRUG COURT	2001	2002	2003	2004	2005	2006	2007
FELONY	Bear River / First District Drug Court	\$125,000	\$125,000	\$125,000	\$125,000	\$125,000	\$125,000	\$131,250
	Carbon County Felony Drug Court	\$0	\$0	\$0	\$0	\$0	\$0	\$95,831
	Davis County Felony Drug Court	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$275,500
	Emery County Drug Court	\$160,000	\$160,000	\$160,000	\$160,000	\$160,000	\$160,000	\$149,998
	Heber Felony Drug Court	\$0	\$0	\$0	\$36,000	\$36,000	\$36,000	\$43,200
	Salt Lake County Felony Drug Court	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000	\$292,500
	Sevier County Felony Drug Court	\$0	\$64,064	\$64,064	\$64,064	\$64,064	\$64,064	\$68,250
	Uintah County / Eighth District Drug Court	\$120,000	\$120,000	\$120,000	\$120,000	\$120,000	\$120,000	\$126,000
	Utah County Adult Felony Drug Court	\$200,000	\$200,000	\$200,000	\$200,000	\$200,000	\$200,000	\$250,000
	Washington County Felony Drug Court	\$46,870	\$46,870	\$46,870	\$50,000	\$120,000	\$120,000	\$192,000
	Weber County Felony Drug Court	\$41,250	\$41,250	\$41,250	\$250,000	\$250,000	\$250,000	\$292,500
	Total	\$1,193,120	\$1,257,184	\$1,257,184	1,505,064.00	1,575,064.00	1,575,064.00	\$1,917,029
FAMILY/ DEPENDENCY	Fourth District Dependency Drug Court	\$75,000	\$75,000	\$75,000	\$125,000	\$125,000	\$125,000	\$137,500
	Grand County Family Drug Court	\$0	\$0	\$0	\$40,000	\$40,000	\$40,000	\$75,900
	Third District Dependency Drug Court	\$105,000	\$105,000	\$105,000	\$105,000	\$105,000	\$105,000	\$136,500
	Weber Child Protection Drug Court	\$0	\$0	\$0	\$80,000	\$80,000	\$80,000	\$124,000
	Total	\$180,000	\$180,000	\$180,000	\$350,000	\$350,000	\$350,000	\$473,900
JUVENILE	Fourth District Juvenile Drug Court	\$0	\$0	\$0	\$75,000	\$75,000	\$75,000	\$86,250
	Third District Juvenile Drug Court	\$0	\$75,000	\$75,000	\$63,372	\$63,372	\$63,372	\$69,709
	Tooele County Juvenile Drug Court	\$35,000	\$32,000	\$32,000	\$32,000	\$32,000	\$32,000	\$32,000
	Weber Juvenile Drug Court	\$0	\$0	\$0	\$0	\$0	\$0	\$126,000
	Total	\$35,000	\$107,000	\$107,000	\$170,372	\$170,372	\$170,372	\$313,959
	STATE TOTAL	\$1,408,120	\$1,544,184	\$1,544,184	\$2,025,446	\$2,095,436	\$2,095,436	\$2,704,888

Davis/Weber Drug Board (Parole)

The Davis/Weber Drug Board protects public safety, decreases drug-related crime, and provides effective treatment services to parolees from Utah’s prison system. The program accepts parolees from the State prison system who are in need of substance abuse treatment. Parolees in jeopardy of returning to prison due to use of illicit substances are also eligible for this program. Drug Board currently serves over 134 parolees a year.

Drug Board participants appear before a Board of Pardons and Parole Hearing Officer every week. Adult Probation and Parole Field Agents conduct home visits and provide case management services. Participants are also required to engage in substance abuse treatment and submit to random urinalysis. Weber Human Services and Davis

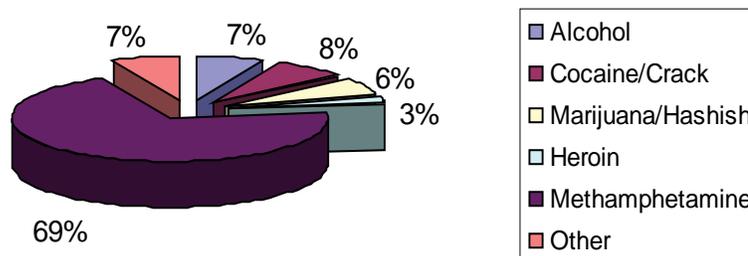
Behavioral Health provide a full continuum of treatment services; therapy groups focus not only on substance abuse, but also on criminal thinking errors and relapse prevention.

Program accomplishments include:

- 70 parolees have graduated since the program’s inception
- Over half of drug board participants are employed at discharge
- 70% of participants report abstinence from primary substance of abuse at discharge
- At admission, 69% of participants report that their primary drug of choice is methamphetamine.

The chart below illustrates drug use among Drug Board participants:

Primary Drug of Choice for Drug Board Participants
Fiscal Year 2006



Drug Offender Reform Act (DORA)

The Drug Offender Reform Act (DORA) Pilot Program is one attempt to improve Utah's response to offenders with drug addictions. In 2005, the Legislature appropriated funds for this innovative pilot project in Salt Lake County. The purpose of this pilot is to examine the impact of providing substance abuse screening, assessment, and treatment services to felony offenders. The Graduate School of Social Work at the University of Utah will conduct a professional and independent review of this program.

In the 2006 legislative session the DORA pilot program was amended to include all felony offenders charged with a crime, rather than only offenders convicted of a felony violation of the Controlled Substances Act. In the 2006 legislative session the last two years of the DORA pilot program were appropriated in the amount of \$918,000.

DORA requires a drug screening and assessment prior to sentencing. Adult Probation and Parole Officers also assess the threat to the community posed by potential clients and, subsequently, provide supervision services specifically designed to reinforce treatment services. Assessment information is shared with Judges prior to sentencing. The screening and assessment provide the Judge with specific information about the offender's substance abuse treatment and supervision needs. Judges then have the choice of imposing prison time or mandating treatment.

Collaborative Interventions for Addicted Offenders (CIAO)

CIAO is a partnership between the Utah Department of Corrections and DSAMH. The program targets parolees and probationers with serious substance abuse issues. In the last four years, CIAO has created an assessment driven linkage between institutional treatment, transition, community treatment, and aftercare for substance abusing offenders.

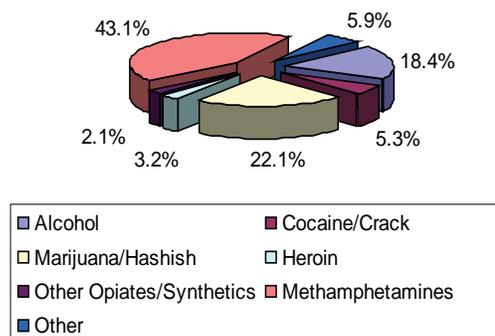
The following numbers demonstrate the effectiveness of the CIAO program:

- Over 1,950 offenders have received services since the program's inception
- More than half of offenders are employed at discharge
- 88.7% of CIAO participants remain arrest-free between admission and discharge.

At admission, methamphetamine is the most common drug of choice:

Primary Drug of Choice for CIAO Clients

Fiscal Year 2006



Recovery Day

September is National Alcohol and Drug Addiction Recovery Month. The month is set aside to recognize the strides made in substance abuse treatment and to educate the public that addiction is a treatable public health problem that affects us all. The observance of Recovery Month lets people know that alcohol and drug abuse can be managed effectively when the entire community supports those who suffer from these treatable diseases.

This year Salt Lake County and the DSAMH hosted Utah's 6th Annual Recovery Day, "Join the Voices for Recovery," on September 9, 2006 at the Gallivan Center. Utah's Recovery Day

is an annual celebration for people in recovery and their families, over 600 people attended this year's event. The event was free and included live entertainment, information, food, family activities, and crafts and games for children. Recovery Day participants had the chance to hear from speakers recovering from addiction as well as local officials such as Utah Department of Human Services Director, Lisa-Michele Church, and Salt Lake County Mayor, Peter Corroon. This year's event also included the 2nd Annual 5K "Run for Recovery" hosted by the Utah Alcoholism Foundation. More than 200 runners participated in this year's run.



Families enjoying the array of children's activities provided by area treatment providers.



Kids interacting with Salt Lake City's crime fighting dog Buster.



Former Utah Jazz Head Coach Frank Layden and his wife, Barbara. Substance Abuse Recovery Alliance (SARA) of Utah supporters!

Mental Health Treatment

System Overview

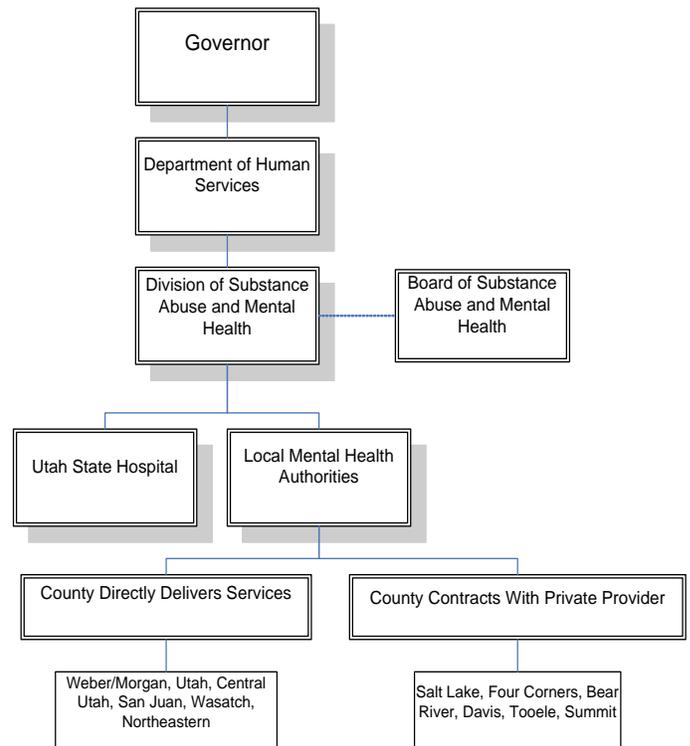
State Division of Substance Abuse and Mental Health (DSAMH)

DSAMH is authorized under UCA 62A-15-103 as the substance abuse and mental health authority for the State. As the mental health authority for the State, it is charged with mental health care administration, and falls under the policy direction of the Board of Substance Abuse and Mental Health.

DSAMH has the following responsibilities:

- Collect and disseminate information pertaining to mental health.
- Develop, administer, and supervise a comprehensive state mental health program.
- Provide direction over the State Hospital including approval of its budget, administrative policy, and coordination of services with local service plans.
- Promote and establish cooperative relationships with courts, hospitals, clinics, medical and social agencies, public health authorities, law enforcement agencies, education and research organizations, and other related groups.
- Receive and distribute state and federal funds for mental health services.
- Monitor and evaluate programs provided by local mental health authorities, and examine expenditures of any local, state, and federal funds.
- Contract with local mental health authorities to provide or arrange for a comprehensive continuum of services in accordance with board policy and the local plan.

- Contract with private and public entities for special statewide or non-clinical services in accordance with board policy.
- Review and approve local mental health authority plans to assure a statewide comprehensive continuum of mental health services.
- Promote or conduct research on mental health issues and submit any recommendations for changes in policy and legislation to the Legislature and the Governor.
- Withhold funds from local mental health authorities and public and private providers for contract noncompliance.
- Coordinate with other state, county, non-profit, and private entities to prevent duplication of services.



- Monitor and assure compliance with board policy.
- Perform such other acts as necessary to promote mental health in the State.

State Board of Substance Abuse and Mental Health

The State Board is the policy making body for mental health programs funded, in part, with state and federal dollars. The Board, comprised of Governor appointed and Senate approved members, determines the general policies and procedures that drive community mental health services. The Board's responsibilities include but are not limited to:

- Establishing minimum standards for delivery of services by local mental health authorities
- Developing policies, standards, rules and fee schedules for the State Division of Substance Abuse and Mental Health
- Establishing the formula for allocating state funds to local mental health authorities through contracts
- Developing rules applying to the State Hospital, to be enforced by DSAMH

Local Mental Health Authorities

Under Utah State Statute UCA-17-43-301 the local mental health authority is given the responsibility to provide mental health services to their citizens. A local mental health authority is generally the governing body of a county. They do this under the policy direction of the State Board of Substance Abuse and Mental Health and under the administrative direction of the State Division of Substance Abuse and Mental Health.

A local authority contracts with a community mental health center; the centers are the service providers of the system. Counties set the priori-

ties to meet local needs, but must submit a plan to DSAMH describing what services they will provide with the state, federal, and county money. They are required by statute to provide at a minimum the following services:

- Inpatient care;
- Residential care;
- Outpatient care;
- 24 hour crisis care;
- Psychotropic medication management;
- Psychosocial rehabilitation, including vocational training and skills development;
- Case management;
- Community supports, including in-home services, housing, family support services, and respite services; consultation and education services, including case consultation, collaboration with other county service agencies, public education, and public information; and
- Services to person incarcerated in a county jail or other county correctional facility.

Additional services provided by many of the mental health centers are also considered important. They include:

- Clubhouses,
- Consumer drop-in centers,
- Forensic evaluation,
- Nursing home and hospital alternatives,
- Employment, and
- Consumer and family education.

State and federal funds are allocated to a county or group of counties based on a formula. Counties may deliver services in a variety of ways that meet the need of citizens in their catchment's area. Counties must provide at least a twenty-percent county match to any state funds. However, a number provide more than the required

match. Counties are required to provide a minimum scope and level of service.

Currently there are 11 community mental health centers providing services to 29 counties. Most counties have joined with one or more other counties to provide mental health treatment for their residents.

Center	Counties Served
Bear River Mental Health	Box Elder, Cache and Rich
Davis Behavioral Health	Davis
Weber Human Services	Weber
Valley Mental Health	Salt Lake, Summit, and Tooele
Northeastern Counseling Center	Daggett, Duchesne, and Uintah
Four Corners Behavioral Health	Carbon, Emery and Grand
Wasatch Mental Health	Utah
Southwest Community Counseling Center	Beaver, Garfield, Iron, Kane and Washington
Central Utah Mental Health	Piute, Sevier, Juab, Wayne, Millard, Sanpete
San Juan Counseling	San Juan
Heber Valley Counseling	Wasatch

Treatment

DSAMH has established “Recovery In a System of Care” as the model of treatment to reach the 41,385 clients currently being served by community mental health centers (CMHC). Although the number of Utah citizens receiving mental health services varies between mental health centers, the DSAMH leads the way in fostering services that are grounded in recovery principles.

The following chart illustrates the number of Utah citizens per CMHC treated under the principles of Recovery in a System of Care; it also demonstrates that the statewide average for those receiving services is 16.8 citizens per every 1,000 in the general population, which means that the public mental health system is treating less than 2% of the general population.

Mental Health Clients Penetration Rate

	2005 Population (Estimated)	Clients Served	Penetration Rate/ 1,000 Population
Bear River	146,546	2,460	16.8
Weber	218,655	5,526	25.3
Davis	268,187	3,378	12.6
Valley	1,034,484	18,259	17.7
Wasatch	443,738	4,980	11.2
Central	68,642	908	13.2
Southwest	174,072	1,829	10.5
Northeastern	43,292	1,152	26.6
Four Corners	38,891	1,749	45.0
San Juan	14,104	738	52.3
Heber	18,974	406	21.4
Statewide	2,469,585	41,385	16.8

Based on the 2005 National Survey on Drug Use and Health (NSDUH) 11.95% of Utah’s adults (192,000) are in serious psychological distress and may be in need of treatment. The following table identifies how many uninsured adults in Utah have a mental illness and are in need of treatment. Of these individuals nearly 35,000 do not have insurance and 52% do not receive treatment.

1	Adults in Utah 2005	1,748,321
2	Number of adults without insurance (16.6%)	290,221
3	The number of uninsured Utah adults who have serious psychological distress and need treatment according to a national survey (11.95%)	34,681
3a	48% receive some services: ER visits, health clinics etc	16,647
3b	52% do not receive any treatment	18,034

According to this survey the primary reasons for not receiving treatment are: Cost/no insurance, not feeling a need for treatment/can handle without treatment, stigma associated with treatment, not knowing where to go for services, not having time, did not believe treatment would work, fear of commitment, and other access barriers.

Throughout Utah, consumers receiving mental health treatment have a variety of illnesses. The following tables indicate the wide array of diagnostic expertise required throughout CMHCs as exemplified by the distribution of diagnostic

categories being treated throughout the state. For children and youth ADHD and Adjustment Disorder are the most commonly treated diagnoses; whereas for adults Major Depression and Substance Abuse are the most frequently occurring.

Diagnosis of MH Clients 17 years old and under by MH Center											
	Bear River	Weber	Davis	Valley	Wasatch	Central	Southwest	North-eastern	Four Corners	San Juan	Statewide <18yrs
ADHD	16%	13%	12%	13%	13%	21%	14%	9%	19%	18%	16.0%
Adjustment Disorders	22%	8%	29%	12%	20%	27%	24%	19%	11%	3%	16.0%
Conduct Disorder	13%	17%	16%	14%	8%	12%	11%	8%	13%	8%	12.9%
Anxiety Disorders	15%	6%	11%	9%	9%	8%	10%	15%	6%	16%	9.3%
Abuse	4%	17%	5%	10%	5%	10%	8%	14%	5%	1%	8.7%
Other Mood Disorders	8%	7%	7%	9%	3%	3%	13%	6%	7%	12%	7.5%
Other MH Disorders	2%	4%	2%	6%	16%	3%	7%	7%	7%	2%	6.8%
Major Depression	4%	3%	7%	5%	5%	6%	6%	13%	12%	26%	5.5%
Mental Retardation	1%	5%	1%	6%	6%	2%	1%	0%	2%	4%	4.6%
Substance Abuse	0%	8%	1%	6%	0%	0%	1%	1%	11%	5%	4.3%
Bipolar Disorder	4%	3%	3%	2%	3%	1%	0%	4%	3%	0%	2.6%
Other Early Childhood Disorders	7%	1%	2%	1%	3%	3%	1%	1%	2%	1%	1.9%
Missing	0%	0%	0%	0%	7%	2%	2%	1%	0%	5%	1.4%
Diagnosis Deferred	1%	7%	0%	0%	0%	1%	1%	1%	0%	0%	1.0%
Personality Disorders	0%	1%	1%	0%	1%	1%	2%	1%	1%	0%	0.6%
Delusional and Other Psychoses	0%	1%	1%	0%	0%	1%	0%	0%	0%	0%	0.4%
Schizophrenia	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0.2%
Alzheimers and Organic Brain Disorders	0%	0%	0%	0%	0%	1%	0%	1%	0%	0%	0.2%
Total	100%	100%	100%	100.0%							

Heber Valley Counseling has reported insufficient data.

Diagnosis of MH Clients 18 years and older, by MH Center											
	Bear River	Weber	Davis	Valley	Wasatch	Central	Southwest	North-eastern	Four Corners	San Juan	Statewide >18yrs
Major Depression	28%	12%	26%	21%	31%	39%	23%	30%	24%	38%	22.2%
Substance Abuse	3%	17%	3%	26%	2%	2%	3%	8%	36%	6%	17.9%
Schizophrenia	11%	10%	15%	12%	19%	13%	13%	7%	9%	4%	12.3%
Bipolar Disorder	12%	7%	16%	8%	13%	9%	12%	9%	8%	7%	9.2%
Other Mood Disorders	10%	4%	12%	10%	6%	5%	12%	9%	3%	7%	8.5%
Anxiety Disorders	14%	6%	10%	6%	9%	9%	10%	14%	8%	13%	7.2%
Diagnosis Deferred	1%	34%	0%	1%	0%	2%	0%	1%	1%	0%	6.6%
Other MH Disorders	6%	4%	2%	6%	3%	8%	5%	5%	4%	2%	5.0%
Adjustment Disorders	5%	2%	7%	2%	2%	5%	10%	5%	2%	3%	3.0%
Delusional and Other Psychoses	2%	1%	2%	4%	2%	3%	4%	1%	1%	2%	2.5%
Alzheimers and Organic Brain Disorders	2%	1%	1%	1%	3%	1%	2%	2%	1%	9%	1.5%
ADHD	2%	1%	2%	1%	2%	2%	1%	1%	2%	1%	1.3%
Personality Disorders	2%	0%	0%	1%	2%	2%	1%	3%	1%	1%	0.8%
Missing	0%	0%	0%	0%	4%	1%	2%	2%	0%	8%	0.6%
Mental Retardation	1%	0%	0%	0%	1%	0%	1%	0%	0%	0%	0.5%
Conduct Disorder	0%	0%	1%	0%	1%	0%	0%	0%	1%	0%	0.4%
Other Early Childhood Disorders	0%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0.3%
Abuse	0%	1%	0%	0%	0%	0%	1%	1%	0%	0%	0.2%
Total	100%	100%	100%	100.0%							

Heber Valley Counseling has reported insufficient data.

Some of the core values in delivering Recovery in a System of Care are:

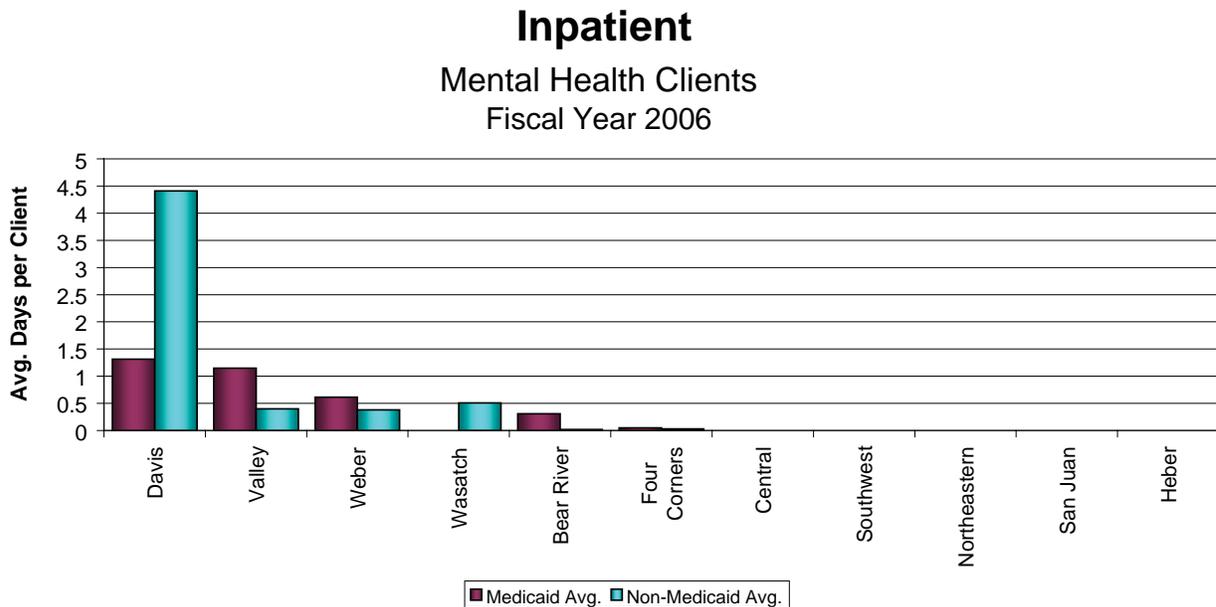
1. Treatment is individualized (youth guided/family driven),
2. Treatment occurs in the least restrictive setting (community-based whenever possible), and
3. Treatment is culturally competent, coordinated and utilizes natural supports.

One of the tools the DSAMH utilizes in disseminating these core values is the monitoring

of statutorily mandated services. Services provided to families and consumers in the mental health system are captured in these service areas. The following tables illustrate the service priorities (based on utilization) for each of the 13 CMHCs.

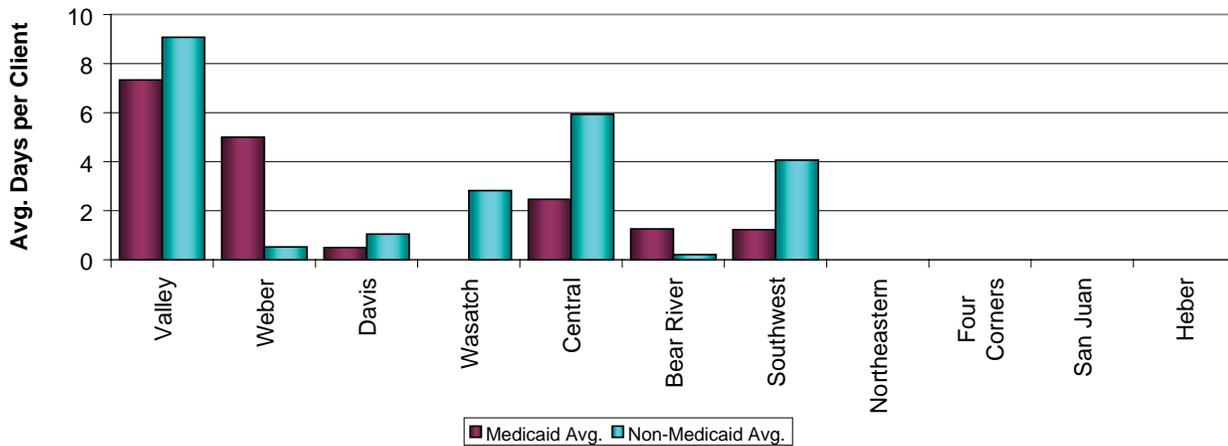
Note that data is currently not collected by DSAMH for persons in correctional facilities and for community outreach and education. DSAMH is following up with providers who have reported a lack of service provision in the other eight mandated service areas.

Mandated Services Data by Local Provider



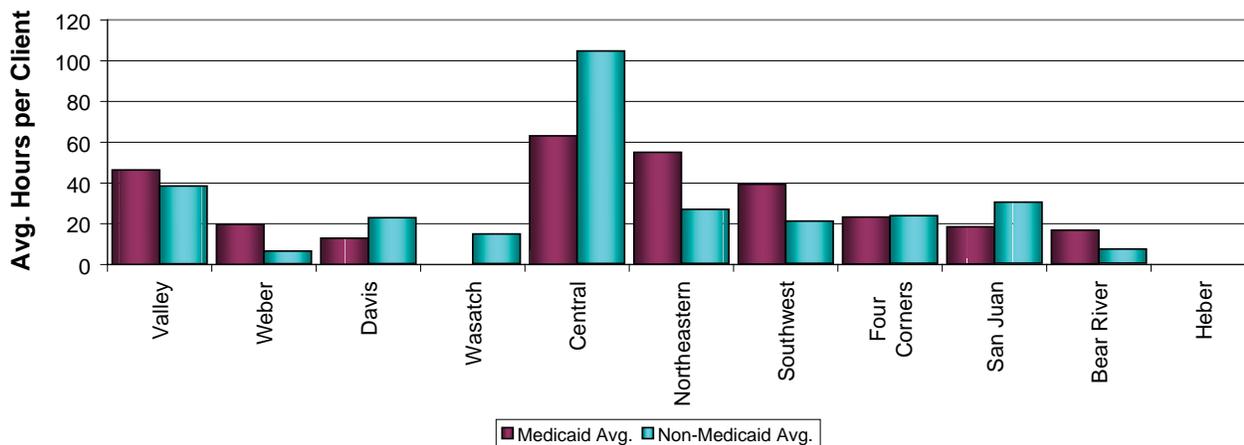
Note: Total inpatient days for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

Residential Mental Health Clients Fiscal Year 2006



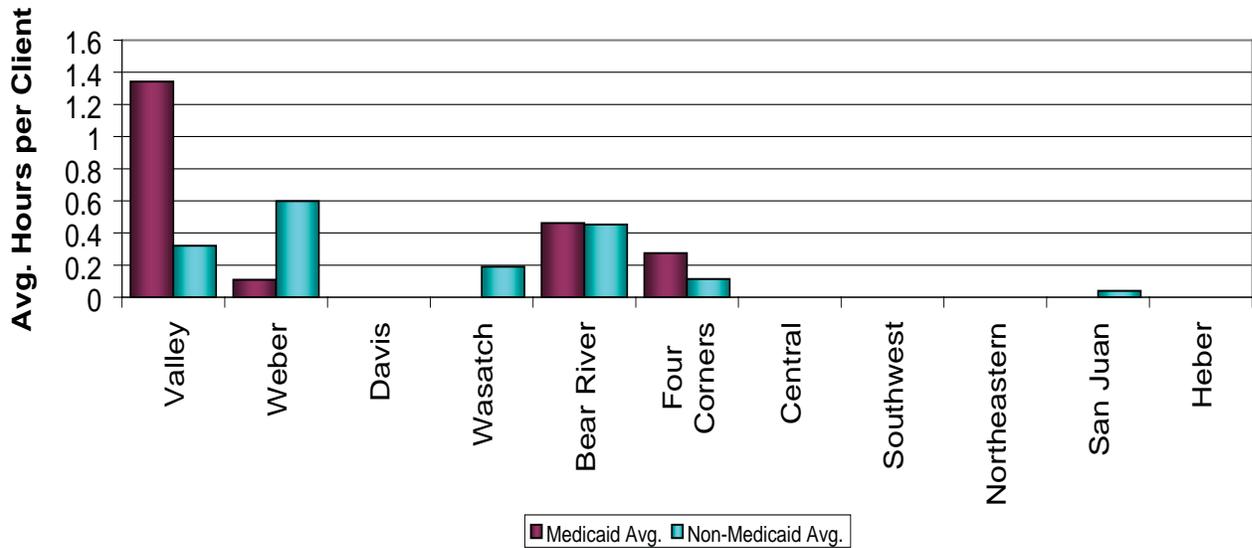
Note: Total residential days for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

Outpatient Mental Health Clients Fiscal Year 2006



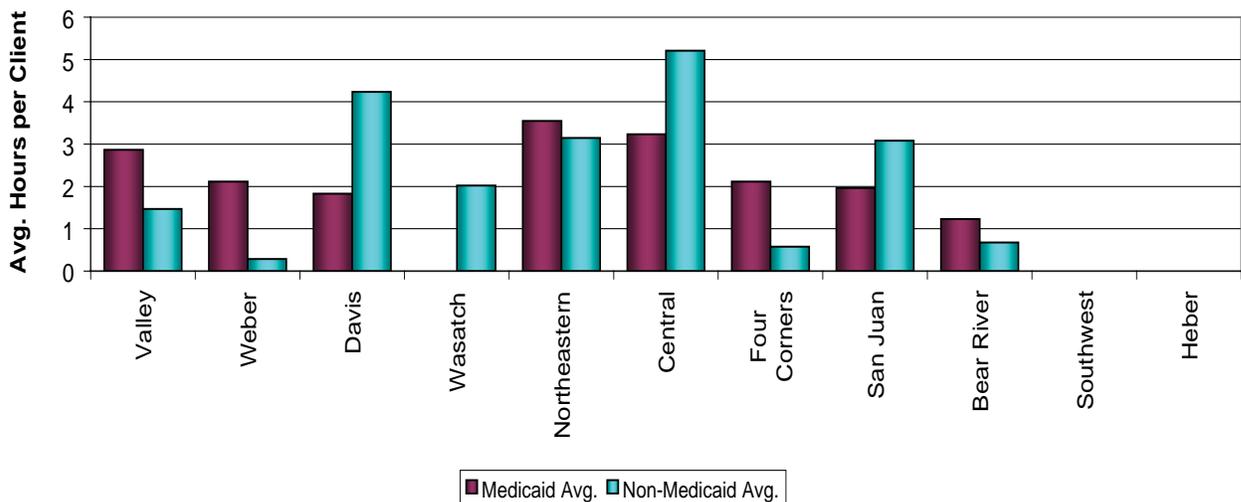
Note: Total outpatient hours for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

Emergency Mental Health Clients Fiscal Year 2006



Note: Total emergency hours for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

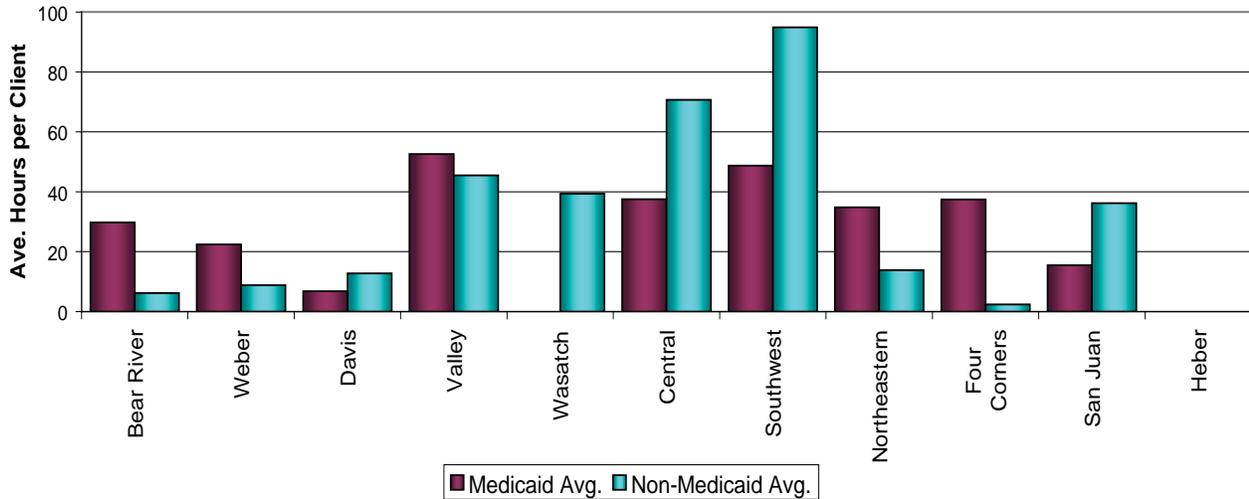
Medication Management Mental Health Clients Fiscal Year 2006



Note: Total Medication Management hours for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

Psychosocial Rehabilitation

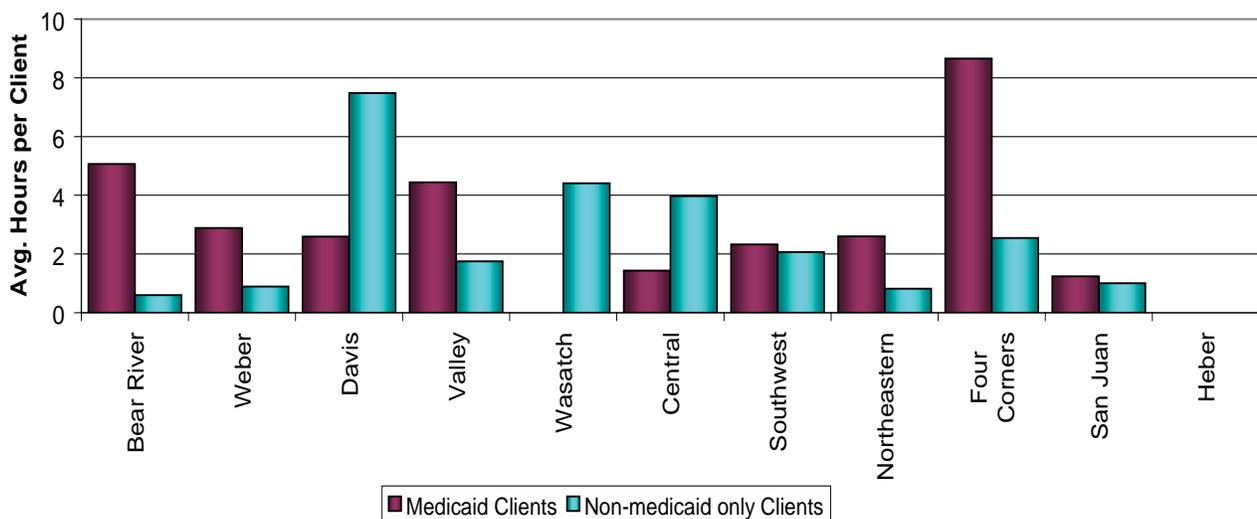
Mental Health Clients Fiscal Year 2006



Note: Total psychosocial rehabilitation hours including vocational and skills development for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center. There was insufficient data to report these services separately.

Case Management

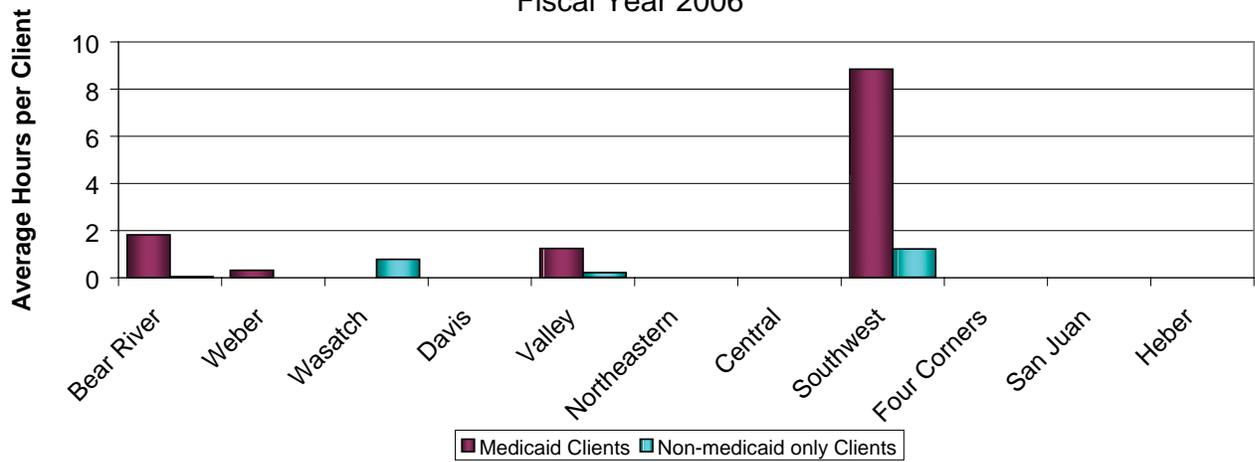
Mental Health Clients Fiscal Year 2006



Note: Total case management hours for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

Respite

Mental Health Clients Fiscal Year 2006



Note: Total Respite Services hours for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center. In addition to Respite services there was insufficient data to report in-home services and housing.

Mental Health Center	Medicaid	Non-Medicaid only	Total
Bear River	1,634	826	2,460
Weber	2,969	2,557	5,526
Davis	2,002	1,376	3,378
Valley	10,999	7,260	18,259
Wasatch	0	4,980	4,980
Central	701	207	908
Southwest	1,164	665	1,829
Northeastern	543	609	1,152
Four Corners	949	800	1,749
San Juan	481	257	738
Heber	406	0	406
Total	21,848	19,537	41,385

This is the N= that was used to calculate the the percentages of all tables where mandated programs are divided by Medicaid, non-Medicaid clients.

Although mental health centers are being criticized for becoming largely a Medicaid only service provider, the following table demonstrates CMHCs are accepting clients from various

funding sources. While 75% of clients receive funding through Medicaid or another funding source, 25% of clients served have absolutely no funding.

**The Expected Payment Source of Clients Admitted
into Mental Health Centers
Fiscal Year 2006**

	Medicaid	Unfunded Provider to Pay Most Cost	Commercial Health Insurance	Service Contract	Other	Medicare	Personal Resources	Veterans Administration
Bear River	60%	2%	13%	5%	13%	4%	3%	0%
Weber	42%	49%	8%	0%	0%	1%	0%	0%
Davis	69%	2%	8%	2%	10%	5%	5%	0%
Valley	50%	34%	9%	3%	0%	3%	0%	0%
Wasatch	66%	3%	1%	24%	0%	1%	5%	0%
Central	88%	2%	1%	0%	0%	2%	4%	3%
Southwest	58%	13%	7%	1%	1%	5%	1%	13%
Northeastern	41%	0%	21%	1%	2%	3%	28%	3%
Four Corners	0%	0%	6%	56%	38%	0%	0%	0%
San Juan	29%	2%	30%	0%	11%	9%	19%	0%
Statewide	48%	25%	9%	8%	4%	3%	2%	1%

Heber Valley Counseling has reported insufficient data.

Pre-Admission Screening/ Resident Review

The process of screening and determining whether nursing facility (NF) services and specialized mental health care are needed by nursing facility applicants and residents is called the Preadmission Screening and Resident Review (PASRR) program. The PASRR program is a required component of the State's Medicaid plan and DSAMH has specific responsibilities under Federal statute and regulations.

This year DSAMH processed 1,623 PASRR evaluations. In an effort to improve the efficiency of PASRR evaluations, DSAMH has implemented a new web-based program in October 2006. The web-based PASRR Program will help alleviate the hospitals and NF staff concerns over placement delays caused by the PASRR screening process and prevent unnecessary institutional placements.

The PASRR Level II evaluation is an in-depth review of medical, social, and psychiatric history, as well as Activities of Daily Living (ADL) functioning. It also documents nursing care services that are required to meet the person's medical needs. This comprehensive evaluation is funded by federal money, which is managed separately

by State mental health and developmental disability authorities. There is no charge to the patient.

Utah has the 6th fastest growth rate in the nation for people age 65 and older. The dramatic growth of the senior population may have significant impact on the PASRR Program, as the number of PASRR evaluations will continue to increase with the need for higher level of medical services that require nursing facility placements.

Project RECONNECT

Utah's Project RECONNECT is devoted to developing, implementing and sustaining a comprehensive transition program for youth and young adults with serious emotional disturbances and serious mental illnesses. The overarching goal of Project RECONNECT is to mobilize and coordinate community resources to assist youth between the ages of 14 and 21 with emotional disturbances or emerging mental illnesses to successfully transition into adulthood and achieve full potential in life.

The transition period from adolescence to adulthood is marked by such events as finishing high school, finding a job to support oneself, furthering one's education, and living independently.

Youth with serious emotional disturbances and serious mental illnesses are at particularly high risk during the transition period. They have the highest rate of dropout from secondary school among all disability groups. In addition, compared to general population entering adulthood, they experience alarmingly poor outcomes in the areas of post secondary education and later employment, arrests and incarceration, unplanned pregnancy and childbearing, and the ability to live independently (Clark, H; Journal of Mental Health Administration; Surgeon General Report)

In October 2002, DSAMH received funding from the Center for Mental Health Services, Substance

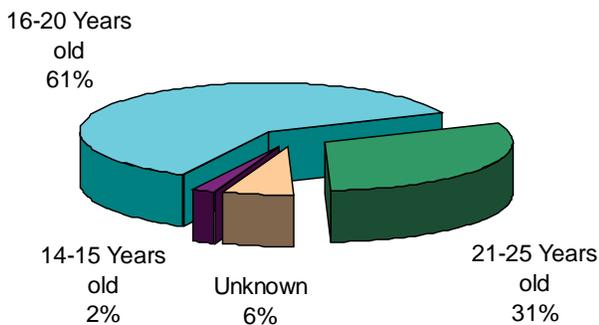
Abuse and Mental Health Services Administration (SAMHSA) to plan and implement a comprehensive transition program through September 2006. Project RECONNECT is operating in counties in the northern and far southern parts of Utah, for youth and young adults with emotional disturbances.

Project RECONNECT strives to empower every young person to realize what it means to reconnect:

- Responsibilities
- Education
- Competency
- Opportunities
- Networking
- Neighborhood
- Employment and
- Collaboration for
- Transition

Project RECONNECT provides services to young people between the ages of 14 and 21. Any young person enrolled prior to their 21st birth date is able to stay involved with the project through age 25.

Age at Intake



Project RECONNECT Most Significant Outcomes for 2005-2006:

- 75% decrease in suicide attempts;
- 71% reduction in psychiatric hospitalizations;
- 66% decrease in homelessness;

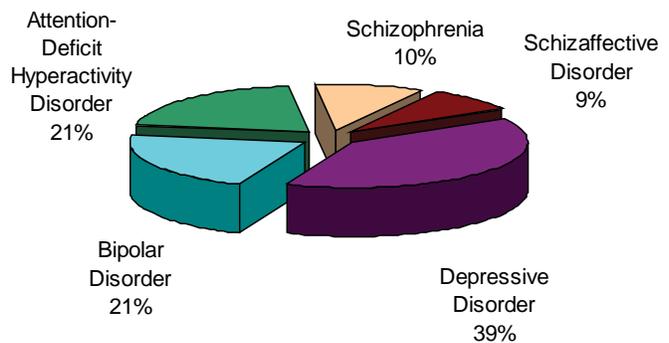
- 52% increase in full-time employment;
- 48% increase in part-time employment;
- 66% increase in post-secondary education enrollment;
- 76% reduction in criminal activity, with a 75% reduction in arrests.

Between October 1, 2003 and September 30, 2006, Project RECONNECT enrolled 274 young people.

Through Project RECONNECT, these young people’s lives are being transformed. The young people are changing their lives as they lean on friends, family, and the Transition Facilitators who bring Project RECONNECT to life with them.

The top five diagnoses at time of intake were: depressive disorder, bipolar disorder, attention-deficit hyperactivity disorder, schizophrenia and schizoaffective disorder.

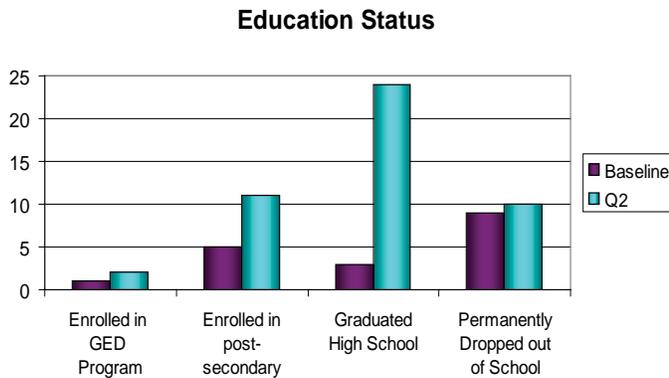
Top 5 Diagnoses at Time at Intake



Project RECONNECT brings young people together in two ways – through a State and Local Youth Action Council (YAC) and an Annual Youth Leadership Conference. Through these groups, young people are taking collective action about leadership development and community action planning.

By integrating positive youth transition values and principles into ongoing services, Project RECONNECT is changing the way the mental health system and other agencies interact with

young people. These changes have shown positive results in young people's lives, increasing employment, decreasing homelessness and improving education status.



Project RECONNECT's "open door" policy allows young people the ability and option of re-entering the program if they leave. Acknowledging that young people are exploring self-determination and independent thinking during this critical time of life, and this phase requires a style and approach toward youth engagement that differs from the traditional mental health system.

Ten Year Plan to End Chronic Homelessness

The State of Utah has accepted President Bush's initiative to be part of the national effort to end chronic homelessness in ten years by supporting the State Homeless Coordinating Committee to end chronic homelessness in Utah by 2014. Over the past year DSAMH has worked with the Public Substance Abuse and Mental Health system to collaborate and actively participate with state and local government, non-profit and private agencies to implement this plan and alleviate the devastating impact chronic homelessness has on people, and provide the needed supports for those with mental illness and substance abuse issues.

One key strategy is to provide the needed supportive services, including case management,

education and training, for employment, and effective treatment for people who suffer with substance abuse and mental illness.

In 2005, an estimated 14,000 people were homeless in Utah, and 2,830 are chronically homeless. In 2006 an estimated 15,000 people will be homeless, of that approximately 2,000 are chronically homeless.

Utah's Transformation Child and Adolescent Network (UT CAN)

In 2005, DSAMH received a five-year federal grant to implement UT CAN (Utah's Transformation of Child and Adolescent Network). The mission of UT CAN is to develop an accountable child and youth mental health and substance abuse system that delivers effective, coordinated community-based services through personal networking, agency collaboration, and active family/youth involvement.

The project is operated at two levels: state and local, and in three phases: strategic planning, implementation, and maintenance. At the state level, there are seven workgroups organized to address key system issues: clinical practice, technology and data, financing and system integration, American Indian, cultural competency, family involvement, and youth empowerment. At the local level, Local Advisory Councils are organized in each local authority planning district to conduct needs and resource assessments, determine community priorities, and develop strategic plans to enhance system capacities. Several projects that are being considered at the state and local levels include: Telehealth, school-based behavioral health services, behavioral health services at a primary care setting, research-based clinical practices, collaborative funding, workforce development, etc.

Three major family and consumer organizations formed a Coalition to assist the Project in enhancing family and youth development within children's mental health and substance abuse services. They are: NAMI Utah, Allies with Families (Utah Chapter of the Federation of Families), and New Frontiers (a family organization established under "Comprehensive Community Mental Health Services for Children and Their Families" grant FY 99-06). The Coalition has developed a training curriculum and will conduct intensive training for family and youth leaders/volunteers to obtain core leadership competencies. After training, these family and youth leaders/volunteers will return to their home communities to develop a strong and meaningful family and youth voice in the children's mental health and substance abuse system.

The Social Research Institute (SRI) at the College of Social Work, University of Utah, is contracted to develop a Technical Assistance Center to provide clinical consultation and training to providers, and to assist them in moving into research-based practices. Specific tasks include developing Preferred Practice Guidelines, providing clinical consultations and training, developing Continuous Quality Improvement processes, organizing a Peer Mentorship Network, and linking research with practice.

Case Management

Case Management is a mandated service in Utah and in most other states, and community mental health centers are responsible for case manage-

ment in their local areas. They help consumers develop goals and see that all participants in the plan cooperate to achieve the goals. Now most community mental health workers have the knowledge, skills and attitudes necessary to help with such basic questions as where to live, how to get food and clothing and more. Case management can be thought of as filling six critical functions: connecting with the consumer, planning for service, linking consumers with services, linking family members with services, monitoring service provision, and advocating for consumer rights. Today case management is becoming the center of community mental health work.

DSAMH is responsible to certify both adult and child mental health case managers in the Utah Public Mental Health System. DSAMH has developed preferred practices for case management, including a training manual, and an exam with standards to promote, train, and support and practice of case management and service coordination in behavioral healthcare. DSAMH is currently working to promulgate standards for certification of mental health case managers addressing criteria for certification and renewal including minimum requirements, examination, supervision requirements and rules of professional conduct according to the Utah Department of Human Services.

This year DSAMH co-sponsored the National Association of Case Management Conference in Salt Lake City, Utah. The conference was a great success with over 300 participants from across the nation and territories.

Utah State Hospital

The Utah State Hospital (USH) is a 24-hour inpatient psychiatric facility located on East Center Street in Provo, Utah. The hospital serves people who experience severe and persistent mental illness (SPMI). The hospital has the capacity to provide active psychiatric treatment services to 357 patients. The USH serves all age groups and covers all geographic areas of the state. The USH works with 11 mental health centers as part of its continuum of care. All adult and pediatric beds are allocated to the mental health centers based on population.

Major Client Groups at the Utah State Hospital

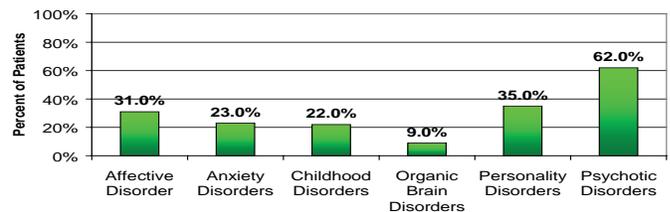
- Adult patients over 18 who have severe mental disorders (civil commitment)
- Children and youth (ages 6-18) who require intensive inpatient treatment
- Persons adjudicated and found guilty and mentally ill
- Persons found incompetent to proceed and need competency restoration or diminished capacity 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)

Children’s Unit (ages 6-12)	22 Beds
Adolescent Unit (ages 13-17)	50 Beds
Adult Services (ages 18+)	182 Beds
Adult Recovery Treatment Center (ages 18 and above)	5 Beds
Forensic Unit (ages 18+)	100 Beds

Types of Disorders Treated

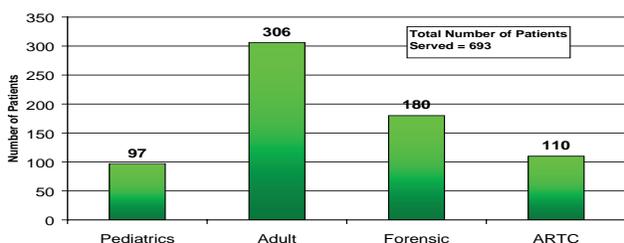
- Psychotic Disorders: schizophrenia and delusional disorders
- Mood Disorders: major depression, bipolar disorder, and dysthymia
- Childhood Disorders: autism, attention deficit disorder, conduct disorder, separation anxiety, and attachment disorder
- Cognitive Disorders: dementia, Alzheimer’s disease, and organic brain syndrome
- Personality Disorders: borderline, antisocial, paranoid, and narcissistic disorders. These are often a secondary diagnosis.

Percent of Patients With Major Psychiatric Diagnosis**
Fiscal Year 2006



**Patients can have more than one diagnosis

Number of Patients Served
Fiscal Year 2006

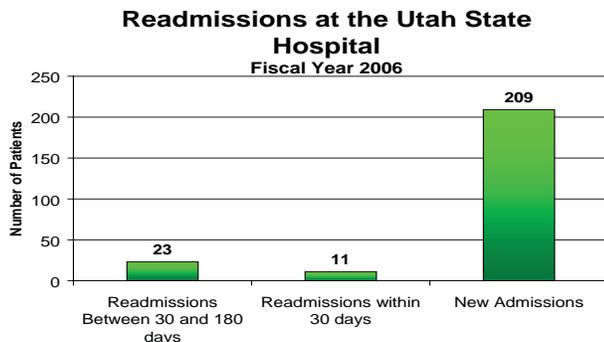


Assessment

In order to assess patient progress, the Utah State Hospital 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 Utah State Hospi-

talcontinued to show a decrease in BPRS scores from admission to discharge in the 2006 fiscal year.

Readmission



Ongoing Issues

- The nursing shortage continues to be problematic. The Utah State Hospital has implemented a bonus program in an attempt to increase incentive for nurse overtime, but the shortage is still an issue.

OUTCOME MEASURES

BPRS (Brief Psychiatric Rating Scale): This is a clinician rated empirically validated measure of change. This number should show a statistically reliable change in the form of a decrease from admission to discharge.

SOQ (Severely & Persistently Mentally Ill Outcome Questionnaire): This is an empirically validated self report questionnaire that measures the amount of change in an adult patient's psychiatric condition and ability to function. There is a statistically reliable change in the form of a decrease in number from admission to discharge.

YOQ (Youth Outcome Questionnaire): This is an empirically validated self report questionnaire that measures the amount of change in his/her condition and ability to function during the hospital stay. There is a statistically reliable change

in the form of a decrease in number from admission to discharge.

Highlights of the Year

Accreditation and Licensing

- Continued full JCAHO accreditation with a successful periodic performance review in February 2006
- Continued full APA accreditation
- Continued full Medical CME accreditation
- Continued to be an active member of the Western Psychiatric State Hospital Association
- Re-licensed by the Department of Health licensure for 384 beds

Legislative Action

- Received funding from the Legislature to re-open 30 Adult beds

Treatment/Programs

- Began implementation of a new recovery model for all patient units
- Developed a Treatment Mall for adult patients
- Realigned configuration of adult units by developing a 16 bed Intensive Treatment Unit
- Developed and implemented intensive programming for the new unit
- Began development of Adult Treatment Tracks
- Developed an acute area on Children's Unit to improve the milieu, safety, and patient care on that unit
- Held a Hospital Family Education Day on April 22, 2006

- Units held several family days for their patients and families
- Provided acute inpatient care for Katrina victims who were displaced to Utah and required inpatient psychiatric hospitalization
- Provided clinical therapists for outpatient psychiatric treatment at Camp Williams for the victims of Hurricane Katrina who were displaced to Utah
- Developed a “report card” for all units to measure their successes
- Developed a patient satisfaction survey
- Widened the scope of spiritual services to include several religious denominations and service projects

Governance Change

- Added a consumer and a NAMI parent to the Governing Body as voting members

Education

- Revised staff education modules to include Recovery concepts and to include consumers teaching “In Our Own Voice” to hospital employees
- Began English as a Second Language classes for our Spanish speaking employees
- Continued to provide CIT training to police officers from the community agencies

Publications

- Published professional journal article—Burlingame, G.M., Rees, F., Seaman, S., Earnshaw, D., Johnson, J.E., Spencer, R., Whipple, J., Payne, M., Richardson, E., O-Neil, B. Sensitivity to change of the Brief Psychiatric Rating Scale—extended (BPRS-E): an item and subscale analysis. *Psychological Services*, 2006, 3 (2): 77-87.

Other Initiatives

- Developed and implemented an employee safety survey with a response of 86% of employees feeling positive about their jobs and about the hospital
- Developed and implemented a new employee incentive program
- Developed and implemented a very successful recruitment and retention plan for nurses—filled 19 of 26 vacancies during a 3 month period
- Continued to develop portions of e-chart including electronic medication orders
- Began the process of updating the hospital web site
- Implemented a computerized volunteer tracking system—volunteers (excluding the spiritual volunteers) provided 18,296 hours of service to the hospital including 10 Eagle Scout projects
- Began implementation phase of changing all hospital policies and procedures from Folio to Adobe Acrobat
- Purchased an automated medication machine to assist in decreasing medication errors
- Completed the new sewer line project
- Received monies for Slate Canyon water project—construction began July 1, 2006
- Completed construction of new warehouse

Utah State Hospital Programs

Admissions, Discharge & Transfer

Our Admissions Office (located in the MS building) coordinates with Utah’s mental health centers on referrals to Utah State Hospital. Since its

inception, ADT has evolved into a kind of “welcoming center” for new patients.

The ADT team (Admission, Discharge and Transfer) try to alleviate the fears and apprehensions felt by patients as they are introduced to their new surroundings. Often times the staff find a cup of coffee and take a few minutes to get acquainted to help ease any misgivings the patient may be feeling.

Paperwork is completed, a picture of the patient is taken for hospital records, and any questions or concerns the patient may have are addressed. Patient rights and legal status are reviewed and a new change of clothes is arranged for, if needed.

The ADT staff consists of two liaisons who work directly with the mental health centers, a patient manager who tracks all ADT activities, and an entitlement officer who coordinates benefits and entitlements for each patient. Patients and their families are responsible to pay for hospital services and they are contacted by the Office of Recovery Services for billing information.

The ADT office is the first area that a new patient experiences upon their admission to Utah State Hospital. The ADT staff help to make this first impression a positive one.

Adult Services

It is the goal of Adult Services to provide a safe and healing environment in which all people are treated with dignity and respect. It is our purpose to assist patients to reach their potential, through individualized treatment with an aim toward their return to the community. A high value is placed on meeting the needs of each patient in a humanistic, caring, and professional way.

Adult Services is comprised of seven adult treatment units, Northwest, Northeast, Southeast, Legacy, LHU, ITC and ARTC. The units are located in the Lucy Beth Rampton Building. Northwest, Northeast, Southeast, and Legacy

each provide care for a total of 30 men and women and utilize several areas designed for patient comfort and interests. These areas include large outdoor courtyards, cooking areas, craft rooms, occupational therapy areas, and day rooms complete with televisions and stereos. The Lucy Beth Rampton Buildings—Rampton I was opened in 1994 and Rampton II was opened in 2002. Both areas were designed to provide a bright and open atmosphere.

LHU (Life Habilitation Unit) is a 46 bed adult psychiatric unit for men and women. The goal of the unit is to clinically stabilize the patient and teach the necessary life skills to maintain a quality of life free from psychiatric hospitalization. The philosophy of LHU is that people will live up or down to expectations put on them. This simple philosophy is reflected in the patient’s treatment plan, the unit’s programming, and discharge planning. Patients are given clear expectations upon admission. When patients meet these expectations, they are given a pass that allows them to come and go from the unit on their own. The hope is that as responsibility for the patients’ well being is restored back to the patient, they will set positive expectations for themselves.

ITC (Intensive Treatment Center) is a 16 bed adult psychiatric unit for men and women. It focuses on behavioral management programs within the patients psychiatric needs. The philosophy of the Intensive Treatment Center is to apply biopsychosociospiritual interventions to the patient with extreme skill deficits in order to promote recovery. The purpose of the Intensive Treatment Center is to provide time limited behaviorally specific interventions, utilizing specialized ancillary services and a higher staff to patient ratio to assist patients with extreme maladaptive behaviors. These patients have demonstrated an inadequate response to current treatment interventions and are significantly interfering with provision of the therapeutic milieu on adult civil units. The patient will be treated for up to three months with an individualized plan to assist the patient’s

return to his community (adult unit) to continue his/her recovery.

ARTC (Acute Rehabilitation Treatment Center) is a 5 bed adult psychiatric unit for men and women who are acutely ill and require a short period of inpatient hospitalization to stabilize and then return to the community. The ARTC Unit provides acute beds for the rural community mental health centers who do not have inpatient psychiatric beds in their communities.

Pediatric Services

Childrens' Unit

The Children's Unit serves 22 boys and girls ages 6 to 13 years. These children have experienced mental, emotional, and behavioral problems such as post traumatic stress disorder, pervasive development disorder, bipolar disorder, attention deficit disorder, psychosis, and major depression.

Adolescent Units—Girls Youth and Boys Youth

The Adolescent Unit serves 50 youth ages 13 to 18 years. Often admittance to this program is considered a "new beginning" for the teenager.

The individualized treatment approach meets the needs of the child/adolescent and utilizes a broad spectrum of therapeutic modalities. Therapies include individual, group, family, play, and therapeutic milieu. Specialized services to deal with abuse, anger management, emotion management, and recreational therapy are used. Participation in a wide variety of activities such as skiing, camping, river running, etc. helps to gain experience in needed social skills, self esteem, and impulse control.

Family involvement is important in the development and progress of the child's treatment program. The Hospital involves families by conducting the Pediatric Services Family Program which includes family therapy, family support,

and advocacy. Home visitation is an integral part of the treatment process and regular family visits are encouraged.

Forensic Services

Forensic Services is comprised of 4 maximum security inpatient psychiatric treatment units and serves 100 male and female patients. The patients are ordered to the Hospital by the District Court under the Utah State Criminal Code. The majority of the patients served in Forensic Services have been found Not Competent to Proceed and have been sent to the Hospital to have their competency restored. When competent the patient returns to court to stand trial. A smaller number of patients have been adjudicated by the courts and have been sent to the Hospital for treatment of their mental illness.

Treatment includes a combination of medication; individual, group, and family therapy; work opportunities; physical therapy; and occupational therapy.

Patient government is an important part of the treatment on the Forensic Unit. It encourages patients to become involved with those around them and provides them a real opportunity to positively influence others.

Patient input is encouraged at all levels of treatment which teaches individual responsibility and accountability. It is the goal of the Forensic Unit to help prepare each patient to re-enter society as a productive, contributing member.

Schools

Mountain Brook Elementary and East Wood High

Mountain Brook (located in MS building) is an elementary school program for children 12 years of age and younger. East Wood High (located in Youth building) is a secondary school for youth between the ages of 13 and 18. Together, these

two programs serve approximately 75 school-age students who are residents of the Utah State Hospital.

Provo City School District is the agent for the Utah State Board of Education to oversee the public school programs operated at the Hospital. The teachers, specialists, administrators and others of East Wood High and Mountain Brook are employees of Provo City School District.

The School staff work closely with treatment staff to enhance the child's total experience at the Hospital and to help the child make dramatic academic gains.

Provo School District also provides Adult Education for those adult patients who want to complete their GED.

Psychiatric Services

Utah State Hospital employs 14 psychiatrists, the majority of whom are board-certified, to provide patient care and carry out administrative duties. Services provided include treatment for adult, forensic, child, adolescent, and geriatric patients. The psychiatrists meet regularly to study cases, review policies, and receive continuing education in order to utilize the most current diagnoses and treatments available.

Psychiatrists serve as leaders for each of the patient care treatment teams. They receive on-site support from faculty of the University of Utah Department of Psychiatry, and some are members of the University faculty. The hospital also serves as a training site for some of the University's psychiatric residents.

Psychology Services

The mission of the Psychology Service staff at the Utah State Hospital is to deliver excellent inpatient care to those who suffer severe or chronic mental illness. The Psychology Service staff provides a range of high quality clinical assessments, consultations, and interventions. Neuro-

psychological, forensic, and health psychology are specialized areas of focus for our internship and training program.

Nursing Services

The Nursing Discipline is composed of registered nurses, licensed practical nurses, and psychiatric technicians. As members of the multidisciplinary team, they provide vital information for the inpatient stay, therapeutic milieu, and discharge planning. They are also the "hands-on" care providers during the patient's stay. The nursing discipline provides 24-hour, 7 day-a-week patient care on each of the patient units.

Social Work Services

The Social Workers at Utah State Hospital are part of an interdisciplinary team that provide clinical interventions to assist the patient in understanding and recovery from mental illness. They provide clinical treatment, i.e., individual, groups, family therapies to patients and, if needed, their families or significant others.

Social workers have completed master level education and are licensed by the State of Utah's Department of Business Regulations.

Occupational Therapy

Occupational therapy treatment is focused on maintaining and improving skills in personal management of activities of daily living and community living is the focus of treatment. Purposeful activities are utilized to give meaning to every day routines. The activities may address areas of need in regards to reality orientation, cognition, work, and social skills. A sampling of the skills would be the ability to work cooperatively with others, attention to task, ability to complete routine daily tasks, ability to take responsibility for own living area, personal hygiene and grooming, and work duties.

Therapeutic Recreation Services

Therapeutic Recreation at the Utah State Hospital is a professional service which uses recreation as a treatment and education modality to help people with disabilities and other limitations exercise their right to a lifestyle that focuses on functional independence, health, and well-being in a clinical setting. The Therapeutic Recreation Staff are individually licensed by the State of Utah.

The Utah State Hospital offers therapeutic recreation services to all patients on all units of the hospital. These services are goal oriented and directed toward the treatment of specific physical, emotional, mental, and social behaviors. The populations served are: Children, Youth, Adult, and Forensic.

Therapeutic Recreation activities may be held on units, on grounds, and in the community. Activity involvement may include: social and cultural skills, physical skills, intellectual skills, craft skills, outdoor/camping skills, and leisure education skills.

Recreational Facilities

Utah State Hospital's ample campus offers opportunities for recreational activities without leaving Hospital grounds. Many patients enjoy visiting the swimming pool where water aerobics and games are a favorite activity. A full-size gymnasium offers varied sports activities and the weight/exercise room is available for a more regimented workout.

A Sports Court and a ROPES course are also located on campus. Team sports are a great way to get some exercise and enjoy some social interaction as well.

The Castle Park and Pavilion is a unique area which includes a barbecue area, rest rooms, volleyball court, and a fish pond (complete with fish). This area is a beautiful setting for group activities and offers individuals a place to relax and enjoy nature.

The Hospital's Wellness Committee has also developed a walking/jogging path on the campus.

Vocational Rehabilitation

The Vocational Rehabilitation Department at USH offers services that will assist the patient with successful transition into the community.

Industrial Therapy, Supported Job-Based Training and Supported Employment are programs designed as training grounds for individuals to learn, work, grow in confidence, and live as independently as possible in the least restrictive environment.

These programs include work training positions on Hospital grounds and in the community. Some positions work with a job coach with the goal of phasing out of the program and continuing to work on their own.

The thrust of Vocational Rehabilitation is in helping people to help themselves.

Excel House

Excel House is a unique program modeled after Fountain House, an international program in New York City, which focuses on community rehabilitation for severely disabled psychiatric patients.

Excel members help to run the clubhouse program and maintain the residence itself. Members are asked to carry out various duties while they learn valuable skills and work at developing problem solving, organizing, and follow-through skills.

The members are expected to use their talents and develop responsibility. The Excel Program provides members with a link between clinical and community environments, maintaining a connection with an individual's home community within a hospital setting.

Dietetic Services

The Dietary Department at Utah State Hospital consists of registered dietitians and a dietetic technician. All members of the Department work together to ensure the patients' nutritional needs are met. This is accomplished by completing a nutrition screen on all patients admitted to USH. Patients requiring further nutrition intervention are tracked monthly or quarterly. During this time, a patient's nutritional status is assessed, he/she receives regular nutrition counseling, and therapeutic diets are implemented.

Our staff also supervise and monitor the production and distribution of food, attend conferences, seminars, and workshops regarding nutrition, and educate other USH employees about nutrition. The Hospital Wellness Committee is chaired by a dietician and focuses on use of diet and exercise to promote well being of each patient.

The Rampton Cafeteria serves nutritious and appetizing meals. Licensed dietitians plan the meals to meet federal guidelines while also meeting the needs of those requiring special diets. The Canteen, located in the Heninger Building, is open daily for a sweet treat or a place to visit with family and friends. The Turn About Café is located in the Forensic building and is open daily to provide a variety of food items to patients and staff. The Eatery in the Rampton building is available to staff for meals during the day.

Specialty Services

Sunrise Program

The Sunrise Program is an intensive day treatment program offered at the Utah State Hospital to patients with a dual diagnosis (mental illness/substance abuse). This program is for patients who are hospitalized and are willing to attend the six week program. Patients are referred to the program by their treatment team.

The treatment philosophy at the Sunrise Program is to involve the patient as an active partner in

the comprehensive treatment of their dual diagnosis. Patients are treated with the utmost respect and treatment is offered in a non-confrontational, sequential approach. Patients are considered experts on themselves. Family participation is highly encouraged.

The Sunrise Program staff consists of a multidisciplinary team: Social workers, substance abuse counselors, registered nurses, dieticians, chaplain, psychiatric technicians, psychiatrists, psychologists, recreational therapists, student interns, and community volunteers.

The patients are educated and taught how to gain insight regarding their mental illness and substance/chemical dependency issues. They are assisted in acquiring skills for recovery and relapse prevention, thus reducing the number of hospitalizations. The patients are taught to develop new and healthy support systems in their recovery program.

Clinics

Dental, Podiatry, Optometry, Neurology, and Audiology services are provided for all patients on hospital grounds. Other medical treatments are obtained for patients through outside providers.

Physical Therapy

Physical Therapy provides treatment for all patient care units and offers a variety of modalities including whirlpool, hydro collar packs, paraffin bath, ultrasound, and electrical stimulation plus various pieces of exercise equipment such as exercycles, Health Rider, Nordic Track, stair steps and assorted weights and apparatus.

Physical Therapy utilizes volunteers and offers a unique experience to do hands-on work and not just observation.

Chaplain Services

Chaplain Services are intended to help meet the spiritual needs of the residents. Holistic health

for our patients necessitates provision for their spiritual recovery as well as healing from physical and mental illness. Residents are encouraged to grow spiritually and are assisted in their efforts to worship according to their personal preference.

Professional pastoral counseling is provided by the Chaplain or by a pastor of a resident's denomination as requested.

Several spiritual groups are held weekly for the various ages of clients including a Women's Issues group, Boy Scouts of America, Youth groups, Alcoholic Anonymous meetings, and other spiritually related groups.

Volunteer Services

Active volunteer involvement accomplishes a dual role at Utah State Hospital. First, it helps our patients to feel accepted by the community and helps them to relate socially. Secondly, community involvement is a teaching experience to help educate the community about mental illness and the programs offered at USH.

Volunteers help in a variety of areas. They are involved with occupational, recreational, and physical therapy. They keep the canteen open during weekend hours and many church and community groups sponsor patient activities.

Volunteers are a valuable resource to the Hospital and their involvement is always encouraged and welcome. There are many opportunities for individuals, groups, students, Eagle Scouts, etc. to volunteer at the hospital especially during the summer months.

Patient Library

The Patient Library (Administration/Heninger Building) helps to keep patients current on what is happening in the world around them. Popular books, current music, monthly periodicals, current movies, and a variety of computer software

are available for those patients wishing to make use of them.

Beauty Shop

The Beauty Shop (Administration/Heninger building) offers the latest in hair fashion and encourages patients to develop good hygiene habits which result in a better self image.

Clothing Center

The Clothing Center, operated by volunteers, offers patients the chance to select needed clothing from donated items as well as new items.

Legal Services

The Hospital Legal Services Department is the liaison between the Hospital and the Attorney General's Office, the courts, and other legal providers.

Legal Services is a resource for patients, family, and staff members who have questions regarding legal issues pertinent to Hospital procedure, patient care, and court functions. They also coordinate court schedules which include adult and juvenile mental health hearings, guilty and mentally ill review hearings, and medication hearings. Patients have access to a hospital contracted attorney to assist with legal matters. In addition, the Patient Advocate may be contacted regarding allegations of Patient Rights Violations.

NAMI

Utah State Hospital works closely with NAMI including active participation in the NAMI provider program and the Bridges program. Consumers and families meet twice monthly at the hospital as a support group.

In support group meetings, those who have faced similar feelings and emotions have a chance to share experiences and gain perspectives on how to keep mentally and physically healthy and

thus better equipped to deal with the diverse and complex situations caused by mental illness. For more information contact NAMI Utah at (801) 323-9900.

The Cottage

A small older home on the grounds of the hospital has been converted to a home like environment where patients' family members from a distance may come to stay while visiting their family member. There is a nominal fee for their overnight stay.

College/University Affiliations

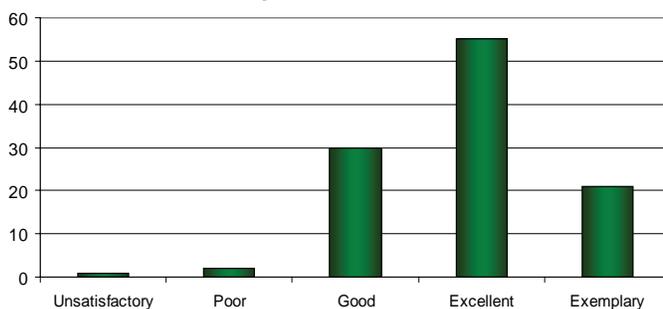
Utah State Hospital provides educational experiences for Nursing, Social Work, Recreational Therapy, and Psychology students as well as Medical School residents from Brigham Young University, University of Utah, Weber State University, Utah Valley State College, College of Eastern Utah, and Salt Lake Community College.

Education and Training

Substance Abuse Fall Conference

The 28th Annual Fall Substance Abuse Conference was held in St. George, Utah, September 20-22, 2006. The Division of Substance Abuse and Mental Health (DSAMH), the Utah State Board of Substance Abuse and Mental Health, and Utah Behavioral Network (UBHN) sponsored the conference. There were over 600 professional attendees from various fields throughout the tri-state area.

**Fall Substance Abuse Conference
Overall Satisfaction with the
Quality of the Conference**



National keynote speakers addressed issues such as Deadly Persuasion: Advertising & Addiction, Senior Moments: Treating Substance Abuse Disorders in Older Adults, Gambling—The Hidden Addiction and Drug Treatment in Criminal Justice Settings. Breakout sessions were offered to conference attendees in three categories—treatment, prevention, and drug court/justice. Breakout sessions were offered throughout the three day conference and included seminars on Housing v. Substance Abuse—The Battle for Shelter, Addiction and Violence in the Family, Drug Trends in Utah: From Acid to Zoloft, Music as a Vehicle to

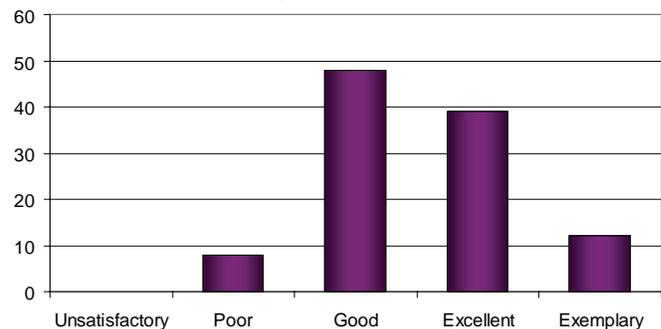
Change, Women in Custody—Innovative Gender Responsive Strategy.

Six distinguished awards were presented this year: the Merlin F. Goode Prevention Award was presented to Art and Janie Brown; the Leon PoVey Lifetime Achievement Award in the Field of Substance Abuse was presented to Joel L. Millard; the Justice Award was presented to Judge Dennis M. Fuchs; the Treatment Award for Substance Abuse was presented to Kelly Lundberg; the Utah Behavioral Healthcare Network Award was presented to Santiago Cortez; and the Stuart Wilkinson Board Award was presented to Lou and Ellen Callister. Brent Kelsey, Associate Director of the Utah Division of Substance Abuse and Mental Health, stated that, “The Fall Conference is the largest annual gathering in the state of Utah, attracting over 600 professional attendees, offering courses in treatment, prevention, and drug court/justice.”

Annual Mental Health Conference

The Annual Spring Mental Health Conference was held in Park City, Utah, May 17-18, 2006. Conference sponsors included DSAMH, Utah

**Mental Health Conference
Overall Satisfaction with the Quality of the
Conference**



State Board of Substance Abuse and Mental Health, and UBHN.

This year's conference, themed "Resiliency and Recovery," was unique as attendees included consumers, families, and professionals. Dr. Daniel Fisher, consumer and professional, set the mood for the conference with a powerful keynote focusing on Transformation: Moving from Philosophy to Practical Recovery. Following the keynote were workshops for Consumer and Family Councils and multiple breakout sessions. The breakout sessions were designed to benefit line staff, clinicians and administration. Topics included The Myth of Burnout, DBT Interventions, Group Therapy, Suicide, Spiritually Oriented Mental Health Practice, Co-Occurring Disorders, Personality Disorders, Eating Disorders, YOQ, Treating Boomers, Hope and Recovery, Consumer's Perspective, and Financial Planning. Day Two of the conference offered three full-day institutes presented by National experts. The institutes focused on Action Oriented Coaching for the Recovery Phase, Recovery Model for Adults, and Social Skills Assessment and Intervention: Improving Prosocial Behaviors for Children and Youth.

Four distinguished awards were presented at the conference. Ann Foster was the recipient of The Lifetime Achievement Award for Outstanding Mental Health Services; The Passionately Committed Provider Award was presented to Jane G. Johnson; Wasatch Mental Health Wellness Recovery Clinic was presented with the Outstanding Program Award; and The State Board of Substance Abuse and Mental Health Award was presented to Jan Ferre.

DSAMH is pleased to announce the merging of the annual public mental health conference with the Generations conference. This new public-private partnership will allow more topics with in-depth education to be presented. The public mental health conference fosters education, support, and "networking" with colleagues. We are excited

to continue this tradition with the new public/private partnership. So mark your calendars, Generations 2007, April 19-20, 2007, Hilton-Salt Lake Center. Please see our website dsamh.utah.gov for conference topics or call 801-501-9446 for more information.

The University of Utah School on Alcoholism and Other Drug Dependencies

This June DSAMH co-sponsored the 55th Annual University of Utah School on Alcoholism and Other Drug Dependencies. The School is recognized internationally and has continually expanded its scope to keep pace with increased awareness of the health and social problems of alcoholism and other drug dependencies. All areas of these problems are presented in training sessions for professional and para-professional personnel. Lecturers are chosen from the best in their field to present at the School. Attendance this year exceeded 1,000 people. The tracks for the School include several areas of special interest including Women's Treatment, Pharmacy, Nursing, and Vocational Rehabilitation. The School provides the opportunity for attendees to hear the latest research on substance abuse, improve their intervention skills, and return to work with renewed insight and energy.

Addiction Center

During fiscal year 2006, the Utah Addiction Center pursued its goals within each of its primary domains of research, clinical training, and community education. Drs. Hanson and Sullivan conducted numerous trainings for professionals working in the substance abuse, criminal justice, family service, health, and mental health fields. Some of these trainings included the 3rd District Court Judges Conference, Women's Health Conference, Eastern Utah DCFS Conference, Utah Substance Abuse Fall Conference, and the Ne-

vada Summer Institute for Addiction and Prevention Studies.

The Center was granted a \$120K contract with the DSAMH to implement an Addiction Training Curriculum for physicians. The Center successfully trained 200 physicians from pediatrics, internal medicine, psychiatry, and rehabilitation medicine in the identification, assessment, and referral of substance abuse patients. Training was also provided to 2nd year medical students as part of their core curriculum. The Center has created a website to assist Primary Care Clinicians and Substance Abuse Professionals with the screening and assessment of substance abuse patients.

The Center continues to circulate over 600 quarterly newsletters to community members and public officials. In addition, Prevention and Treatment Work Group Committees continue to meet monthly and are currently focused on preparing a grant application to develop a Translational Center on Addiction. The theme of the proposal is Methamphetamine Addiction and Nicotine Interactions.

Beverage Server

Utah State Statute and Rules require every person serving alcohol in a restaurant, private club, bar or tavern, for on premise consumption, to complete an alcohol training and education seminar within 30 days of their employment. The seminar focuses on teaching the server the effects of alcohol in the body, helping them to recognize the signs of intoxication and identifying the problem drinker. Seminar instructors teach class participants techniques for dealing with an intoxicated or problem customer and discuss alternative means of transportation for getting the customer home safely to protect them and the community. In FY 2006, DSAMH recertified seven providers to conduct these seminars. These providers trained over 8,000 servers across the state.

DSAMH oversees the certification of providers, approval of the seminar curriculum and maintains the database of certified servers. Local and state law enforcement agencies and the Department of Alcohol Beverage Control regularly conduct compliance checks.

Eliminate Alcohol Sales to Youth (E.A.S.Y.)

The E.A.S.Y. Law (S.B. 58) was passed by the 2006 Legislature and became effective July 1, 2006. The E.A.S.Y. Law limits youth access to alcohol in grocery and convenience stores, authorizes law enforcement to conduct random alcohol sales compliance checks, and requires mandatory training for each store employee that sells beer or directly supervises the sale of beer. Additionally, funds were allocated for a statewide media and education campaign to alert youth, parents, and communities of the dangers of alcohol to the developing teen.

On September 23, 2006, First Lady, Mary Kaye Huntsman, launched the statewide media campaign directed by R & R Partners. The campaign called ParentsEmpowered.org is designed to educate parents about the dangers of underage drinking and the proven skills to prevent it. The ParentsEmpowered.org website offers parents information to help combat underage drinking and useful guidelines to facilitate healthy discussions with their children.

To help eliminate the sale of alcohol to minors through grocery and convenience stores, 105 providers have been certified to conduct the Off Premise Alcohol Training and Education Seminar. Approximately 516 trainers have conducted seminars across the state certifying over 17,000 store clerks and supervisors in techniques that facilitate the elimination of alcohol sales to underage youth.

Efforts to protect youth and the community will continue through the media campaign, training of sales clerks, and other prevention and treatment initiative.

Driving Under the Influence (DUI) Education and Training Seminar

According to the Fourth Annual DUI report to the Utah Legislature, in fiscal year 2006, there were 14,138 DUI arrests, 463 more than in fiscal year 2005. The majority of the arrests, 76%, were for violation of the .08 per statute limit, with an average BAC of .14. Approximately 11% of the arrestees were under the legal drinking age of 21. DUI drivers between the ages of 21 and 36 accounted for over half (55%) of all arrests.

DSAMH is responsible by statute to promote or establish programs for the education and certification of DUI instructors. These instructors conduct seminars to persons convicted of driving under the influence of alcohol or drugs or driving with any measurable controlled substance in the body. To prevent alcohol related injuries and deaths, the DUI program attempts to eliminate alcohol and other drug-related traffic offenses by helping the offender examine the behavior which resulted in their arrest, assist in implementing behavior changes to cope with problems associated with alcohol and other drug use and impress upon the offender the severity of the DUI offense.

DSAMH has a contract with Prevention Research Institute to train instructors and provide all materials needed for the program. The program, PRIME For Life is designed to gently but powerfully challenge common beliefs and attitudes that directly contribute to high-risk alcohol and drug use. The content, process and sequence of PRIME For Life are carefully developed to achieve both prevention and intervention goals.

The program goals are:

- To reduce problems caused by high-risk drinking or drug use
- To reduce the risk for long-term health problems and short-term impairment problems
- To help people successfully protect the things they value

Using persuasion-based teaching, instructors use a variety of teaching approaches, including interactive presentation and small group discussion. Participants use workbooks throughout the course to complete a number of individual and group activities. Material is presented using a DVD platform with animation, full-motion video clips, and audio clips to enhance the presentation.

This 16-hour, research based, standardized curriculum is carefully designed for effective “therapeutic education” for people who make high-risk drinking choices. A decade of evaluation shows the curriculum changes attitudes and behaviors with first and multiple offenders, and has impact across DSM diagnostic categories.

In fiscal year 2006, there were 51 agencies and 234 instructors certified to teach the PRIME for Life curriculum, including 39 certified Spanish-speaking instructors. New Instructor training is conducted semi-annually and recertification is required every two years.

Forensic and Designated Examiner Training

DSAMH provides training for licensed mental health professionals as part of the qualification process to conduct forensic examinations and involuntary commitment evaluations. Forensic examinations are used to determine if a person is competent to proceed, guilty and mentally ill, not

guilty by reason of insanity/diminished capacity, etc. Involuntary commitment to a local mental health authority requires an evaluation by a designated examiner. All individuals who provide these evaluations must attend training provided by DSAMH and have the proper credentials in order to conduct these evaluations.

Crisis Counseling Training

DSAMH as the State Mental Health Authority, has taken the lead in developing a Crisis Counseling Program (CCP) with a trained cadre of crisis counselors and crisis counseling resources for victims of a disaster. DSAMH has enhanced the networking capacity and training of mental health care professionals and paraprofessionals to be able to recognize, treat and coordinate care related to the behavioral health consequences of bioterrorism or other public health emergencies.

DSAMH has trained crisis counselors annually and has developed a group of approximately 450 crisis counselors for disaster response statewide.

The training includes an intensive curriculum, with input from SAMHSA's Center for Mental Health Services (CMHS), the National Center for Post-Traumatic Stress Disorder, SAMHSA, the American Red Cross, Disaster Psychiatry Outreach, the Utah Hospital Association, and other State and local experts.

Hope for Tomorrow

DSAMH prevention team formalized a partnership with NAMI Utah to increase the number of participants in its mental health program "Hope for Tomorrow." NAMI Utah has developed and is implementing Hope for Tomorrow in high schools throughout the state. Data shows that participants of this program are acquiring skills and services that are consistent with efforts to reduce substance abuse. With added support for Hope for Tomorrow, more parents, teachers, and administrators will be trained in this program and more Utah students will be able to participate in this effective prevention program.

Local Authorities

Local Government Authority

LOCAL AUTHORITY							
DSAMH may contract with the Local Authority, or directly with the Agency providing services.							
LOCAL GOVERNMENT AUTHORITY	MH	SA	COUNTIES	CURRENT SIGNATOR	AGENCY PROVIDING SERVICES AND AGENCY STATUS		
					AGENCY	Gov't	Private Non Profit
District 1, Cache County Corporation	X		Box Elder, Cache, Rich	M. Lynn Lemon, County Executive	Bear River Mental Health		X
District 1, Sub Abuse Authority, Bear River Health Dept., Div. Sub Abuse		X	Box Elder, Cache, Rich	M. Lynn Lemon, County Executive	Bear River Health Dept, Division of Substance Abuse	X	
Carbon County	X	X	Carbon, Emery, Grand	Steven Burge, Carbon County Commissioner	Four Corners Community Behavioral Health, Inc.		X
Central Utah Mental Health Substance Abuse Center	X	X	Juab, Millard, Piute, Sevier, Wayne, Sanpete	W. Kay Blackwell, Board Chair	d.b.a. Central Utah Counseling	X	
Davis County Government	X	X	Davis	Carol R. Page, Commission Chairman	Davis Behavioral Health, Inc.		X
Uintah Basin Tri-County MH SA – d.b.a. Northeastern Counseling Center	X	X	Daggett, Duchesne, Uintah	County Commissioner, or Ronald J. Perry, Executive Director	d.b.a. Northeastern Counseling Center	X	
Salt Lake County Government	X		Salt Lake	David A. Wilde, Salt Lake County Councilman	Valley Mental Health, Inc.		X
		X	Salt Lake	Mayor or Designee	Salt Lake County, Division of Substance Abuse	X	
San Juan County	X	X	San Juan	Lynn H. Stevens, Chair San Juan County Commission	San Juan Counseling	X	
Southwest Behavioral Health Center	X		Garfield, Iron, Kane, Washington, Beaver	Gene E. Roundy, Commissioner, or Paul Thorpe, Center Director	Southwest Behavioral Health Center	X	
		X	Garfield, Iron, Kane, Washington, Beaver		Same	X	
Summit County Commission	X	X	Summit	Robert Richer, Chair of Commission	Valley Mental Health, Inc.		X
Tooele County	X		Tooele	Dennis L. Rockwell, County Commissioner Chairman	Valley Mental Health, Inc.		X
		X	Tooele	Colleen S. Johnson, Commissioner	Valley Mental Health, Inc.		X
Wasatch County	X	X	Wasatch	Mike Davis, County Manager	Heber Valley Counseling	X	
Wasatch Mental Health Services	X		Utah	Steve White, Chair, Governing Authority	Wasatch Mental Health Services	X	
Utah County Government, Division of Substance Abuse		X	Utah	Jerry Grover, Commissioner	Utah County, Division of Substance Abuse	X	
Weber Human Services	X	X	Weber, Morgan	Stanton M. Taylor, WHS Board Chairman	Weber Human Services	X	
October 2006							

Innovative Provider Programs

The following are highlights submitted by Local Providers.

Davis Behavioral Health Services

Personal Recovery Oriented Services at Davis Behavioral Health

Davis Behavioral Health will be integrating its Personal Recovery Oriented Services (PROS) and its Mental Health Residential programs into a multidisciplinary program where services will be customized to the individual needs of our consumers through a team approach. The objective of this new program is to help people stay out of the hospital and to develop skills for living in the community, so that their mental illness is not the driving force in their lives.

Cognitive Remediation at Davis Behavioral Health

Davis Behavioral Health is excited to announce the development of a cognitive remediation program using the NEAR approach (Neuropsychological Educational Approach to Remediation).

Those receiving the treatment participate in 1 – 2 training groups per week. In the training groups, the clients work at computers on tasks that allow them to practice cognitive activities at various levels. Staff serve as coaches during these groups and assist and encourage the clients in selecting and completing the cognitive tasks. The tasks come in the form of games and activities, some of which have been popular in education and among youth. Because these tasks are fun, but incrementally challenging, clients enjoy doing them and look forward to participating. There is also a processing group in which staff lead the clients in discussions about their progress and how they are applying the skills to their daily activities.

Youth in Transition at Davis Behavioral Health

Youth in Transition is once again fully operational at Davis Behavioral Health – we have almost 20 active participants in the program. Every youth in this program is very involved in creating their Life Skills Plan. Our Life Skills Plans focus on four transitional domains: Employment & Career, Community Life Functioning, Educational Opportunities, and Living Situation. We have two Transition Facilitators who help these youth accomplish the goals they've written. All of our youth receive one-on-one skills training. We have our weekly "workshops." Some of the workshops we've conducted this year are Food Basics, Money Matters, and Back to School. We will soon begin the next workshop entitled Living Independently where we will discuss living on your own. We also have a monthly social group. The purpose of this group is to learn how to have conversations, have appropriate peer relations, and learn appropriate leisure activities.

Salt Lake County Substance Abuse Services

Salt Lake County - Corrections Addictions Treatment Services Expansion (CATS Program)

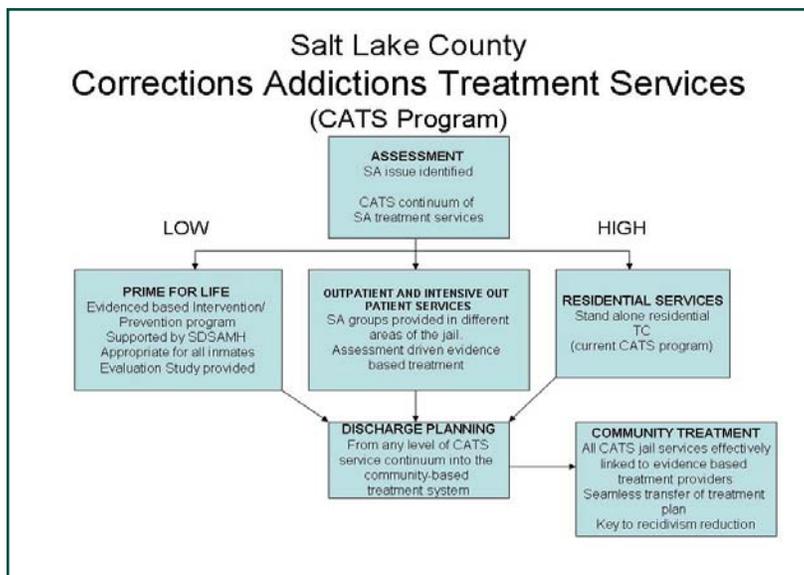
The Salt Lake County CATS program began in 1998 as part of the federal residential substance abuse treatment (RSAT) program through a grant from the U.S. Department of Justice. The RSAT program was designed to promote the provision of residential substance abuse treatment to inmates in state and county correctional institutions.

In 2007, Salt Lake County will expand CATS by adding a psycho-educational component for up to 1,500 inmates as part of a more complete continuum of treatment services with the inclusion of an outpatient and intensive outpatient model. The addition of these new components will almost triple the size of the CATS Program

and allow for the county to move inmates from incarceration in the jail to placement in the community. The objectives of this expansion are to reduce the length of stay in the jail, reduce pressure on the capacity of the jail, move inmates into community-based treatment slots and ultimately, reduce recidivism due to criminal activity or re-use of alcohol or drugs.

working together to develop software for their own needs that can also be used by other agencies in other states or counties with similar needs.

Publicly funded substance abuse and mental health services, as well as many other services, are delivered through state and county-based systems within the United States. Their overall mission is to assure that high-quality, competently managed services are delivered in a manner that guarantees accountability to local, state and federally elected officials and to the public at large. This demands accurate and cost-effective management information systems for administrative and electronic health records (EHR). Collaboration among agencies to share technology and costs enhances both accuracy and cost effectiveness.



From the beginning, the Salt Lake County CATS Program has been a partnership between the county’s Sheriff’s Department and the Salt Lake County Division of Substance Abuse Services. Originally CATS started out as a 64-bed program for males that lasted for six months. In 2001, Salt Lake County decided to reorganize the CATS program by redefining the length of stay from six months to a progress-based length of stay in treatment. In 2003, CATS was expanded to include women.

Public Software Collaborative – UWITS

A partnership of public agencies

Salt Lake County is participating in a groundbreaking initiative called the Public Software Collaborative—a partnership of public agencies working together in order to re-use public software and reduce the expense of software development. In short, it is a cooperative of agencies

Looking Toward the Future

The collaboration seeks to provide a framework for government agencies to share their resources in the enhancement of their systems and to attract new users interested in developing software applications to contribute to the “public software toolbox.”

In support of this vision, the collaborative aims to share software packages and place them in a common “tool box.” These shared resources will make improvements to software packages currently in use, as well as allow expansion of the tools in the box beyond substance abuse and mental health to other related public functions such as jail management, state hospitals or other county or state services.

The focus of development will be on web-based applications that will allow for universal access. The entire process is supported by the concept of “open ownership” so that all partners have comprehensive access to and equal ownership of software that is developed through the collaborative.

(U)WITS* – A collaborative case study***Web Infrastructure for Treatment Services**

Salt Lake County's participation in the WITS project facilitates collaboration among agencies. Its focus is sharing centrally hosted web applications that support substance abuse treatment providers offering services supported with state and federal money.

The strategy to promote the collaboration includes creating a web-based computing environment to enable states and the providers they support to share software application modules supporting substance abuse treatment information management.

Through the first few months of the WITS collaboration, participating members have gained many valuable insights into the continuing viability of this project, and extend the lessons learned onto the Public Software Collaborative as a whole.

Southwest Behavioral Health Center**Telemedicine**

Southwest Behavioral Health Center purchased dedicated telephone lines, cameras, and hardware to begin providing telemedicine services between its five outpatient offices in January 2006. The system allows state of the art video and audio connection between offices, thus allowing psychiatrists, nurses, and therapists to provide assessment and treatment services for clients in outlying offices from the Washington County Office. The system has been accepted and embraced by both mental health professionals and clients. It has saved considerable time and money by allowing client access to treatment without staff having to travel. The system has also allowed the client to be seen as needed, as opposed to the previous face-to-face system in which the psychiatrist traveled to the outlying counties once monthly. The system has also allowed the staff in the smaller counties to receive supervision, con-

sultation and to attend meetings without the costs associated with travel.

Valley Mental Health**Tooele - Peer Counselor Program**

Our Tooele unit has started what some call a peer counselor program. We have been hiring former and current clients as classroom aides for our CCEP (computer) classes, van drivers for transportation needs, and as case manager assistants. We have had these employees pass the van driving test and the case manager test administered by the State and are giving them the same titles as their counterparts in the Valley Mental Health system. We have not limited them by keeping their job title as a generic "peer counselor."

We believe in the recovery of the people we serve and have seen them make great strides with their new employment. Up until now, these have been part-time, non-benefited positions and we have used seasonal money from our budget to do this, but we have plans within the next year to hire a peer counselor into a full-time, benefited position. We think this shows that we "practice what we preach" and ultimately we are happy about this because of what it does and what it means for the people we serve.

Community Response Team

Valley Mental Health has established the Community Response Team (CRT) to work with mentally ill individuals who interface with law enforcement and the Salt Lake County Jail. This team works closely with CIT officers in diverting individuals from being booked into jail and accessing needed mental health services in the community. For those incarcerated, this team also provides a transition back to the community and linkage to appropriate services. CRT has also partnered with NAMI Utah in using mentors that assist in establishing the connection to treatment. As medications are critical for those being released from jail, funds have been made available

to provide medications until a long term funding source can be utilized.

Valley Mental Health's South Valley Outpatient - Recovery Program

This program introduces and prepares individuals for their recovery journey from the first day of their treatment. A new hope and optimism are created and discovered through individual and group meetings. Clients decide their course of recovery-oriented treatment through their own active participation. The positive message of home, empowerment and usefulness in life is very clear and is the highlight of the recovery program. The goal is to train and educate individuals to balance their emotional, physical and spiritual well being through encouragement and support, which will facilitate their return to their occupation or meaningful role in life that they once practiced or have always desired to pursue.

Carmen B. Pingree School for Children with Autism - Partial Day School Program

This program responds to the high demand of needs for intervention for children with autism. This program uses the same Discrete Trial Format as is being used at the Full School Program, however, this program is shorter and less time intensive.

Cultural Diversity Team - Computer Class

This is a computer class for Naturalization of Citizenship and learning English as a Second Language. This approach engages the clients of the team in active learning of the mainstream culture and language progressing to acculturation into the society. Many of the clients have passed naturalization examination and been granted citizenship. This has promoted in the clients a sense of mastery and moved them beyond a state of dependency.

Pain Medication Protocol

This is an established way for helping clients presenting with a need for mental health ser-

vices whose treatment is complicated by their concomitant pain medications. The concerns of pain medications are their abusive and addictive qualities and the danger of inadvertent over-dosage. The protocol ensured attention to the inherent danger and an open and timely collaboration with clients' primary care physicians in the care of these clients.

NIATx Project

Valley Mental Health is participating with Utah Behavioral Healthcare Network in a Robert Wood Johnson Foundation (RWF) sponsored project through the State Association of Addiction Services (SAAS) to train its members in the process improvement technology developed by the Network for the Improvement of Addiction Treatment (NIATx). This technology utilizes W. Edward Deming's model of organizational improvement, which teaches, among other things, that managers should focus on improving process and building quality into their products or services. NIATx utilizes the process improvement tool of Plan, Do, Study, Act (PDSA) for performance improvement initiatives. Using the NIATx techniques, Valley is working to reduce its no-show rate in its two Adult Outpatient Programs and its Adult Alcohol and Drug treatment unit.

Wasatch Mental Health

Wellness Recovery Clinic

In response to dramatic cuts in funding due to Medicaid rule changes for treating uninsured or under insured clients, and with a small amount of state appropriated dollars to treat this highly disadvantaged population, Wasatch Mental Health formed the Wellness Recovery Clinic (WRC). This is a free clinic open to residents of Utah County who meet certain eligibility requirements, including at or below 150% of poverty guide lines adjusted for family size and a qualifying DSM-IV-TR mental health diagnosis. Over the course of the funding year, the WRC set out to provide services to 500 clients (the equivalent

of 70% of clients who lost access to services) with less than 50% of the funding. After one year, the WRC is considered to be highly successful in achieving its goals. A service delivery system demonstrating a significant cost savings over traditional services has been developed and implemented. The program received the Outstanding Program Award for 2006 from the Division of Substance Abuse and Mental Health for its innovation in service delivery. Additionally, the program has been successful in documenting client progress, engaging in education endeavors, and in securing supplemental funding sources. After one year of operation, 94% of the clients served maintained or improved their level of functioning (as measured by the OQ-45, a nationally calibrated outcome instrument).

Mental Health Court

A Mental Health Court, in conjunction with the Fourth District in Provo was established and became the 100th mental health court nationwide. The goal of Mental Health Court is to help engage participants in mental health treatment so that they are less likely to decompensate and re-engage in criminal behaviors. Following a mental health screening for appropriateness, the mental health court offers a plea in abeyance agreement for clients charged with misdemeanors and some non-violent felony offenses. Judge Steven L. Hansen of the Fourth District Court presides at the hearings. The Mental Health Court receives a great deal of community support from agencies and organizations that are working to make the mental health court successful. Data demonstrates significant cost-savings as a result of mental health court, as shown by a significant decrease in both jail nights and inpatient bed days for participants.

Crisis Intervention Team (CIT) Training

In cooperation with NAMI, Wasatch Mental Health launched a national training program for police officers in Utah County. This is a 40-hour training academy for police officers, designed to

facilitate recognition of mental illness and teach effective interventions for those needing mental health treatment. This course has demonstrated highly positive outcomes in improving public safety and assuring effective interventions to the mentally ill. Wasatch Mental Health has conducted two academies to date in 2006, training 37 officers, with a third scheduled in October. Very positive feedback has been received from trained officers, many of whom have stated that the training was the “most meaningful” in their careers.

Weber Human Services

Using Technology to Support a Recovery Model

Weber Human Services has begun a new initiative aimed at using new technology to guide clinicians in planning treatment that encompasses the fundamental components of recovery. Weber’s new electronic medical record, Junction Clinical Suite, is being designed to highlight the role that clients play in determining their own course of treatment, identifying the strengths that client’s can utilize to assist in their recovery and individually identifying deficiencies in any area of a client’s life that need to be addressed to enhance the success of recovery. Some highlights of Junction planning include: electronic signatures of clients to show their involvement in the treatment process; comprehensive individualized assessments that can electronically inform the treatment planning process; the integration of outcomes data in the clinical chart for utilization by staff throughout treatment; and newly designed treatment plans that will focus on the rate of recovery.



RESOURCES

List of Abbreviations

ACLSA - Anell-Casey Life Skills Assessment—Assertive Community Outreach Teams	LMHA - Local Mental Health Authorities
ADHD - Attention Deficit Hyperactivity Disorder	LOS – Length of Stay
ADL - Activities of Daily Living	LSAA - Local Substance Abuse Authorities
ASAM - American Society of Addiction Medicine	MH - Mental Health
ASI - Addiction Severity Index	MHSIP - Mental Health Statistical Improvement Program
ATOD - Alcohol, Tobacco, and Other Drugs	MTF - Monitoring the Future
BPRS - Brief Psychiatric Rating Scale	NAMI – National Alliance on Mental Illness
CARF - Commission on Accreditation of Rehabilitation Facilities	NSDUH - National Survey on Drug Use and Health
CASI - Children’s Addiction Severity Index	OMT - Opioid Maintenance Therapy
CIAO - Collaborative Interventions for Addicted Offenders	OTP - Outpatient Treatment Program
CIT - Crisis Intervention Team	PATS - Prevention Administration Tracking System
CMHC - Community Mental Health Centers	PASRR – Pre-admission Screening and Residential Review
CMS - Center for Medicaid and Medicare Services	PNA - Prevention Needs Assessment Survey
COD - Co-Occurring Disorder	PPC - Patient Placement Criteria
CSAP - Center for Substance Abuse Prevention	QA - Quality Assurance
CSAT - Center for Substance Abuse Treatment	OQ – Outcome Questionnaire
DHHS - Department of Health and Human Services	RECONNECT - Responsibility, Education, Competency, Opportunity, Networking, Neighborhood, Employment, and Collaboration for Transition
DHS - Department of Human Services	SA - Substance Abuse
DORA - Drug Offenders Reform Act	SAMHSA - Substance Abuse and Mental Health Services Administration (Federal)
DSAMH - Division of Substance Abuse and Mental Health	SARA Utah - Substance Abuse Recovery Alliance of Utah
E.A.S.Y – Eliminate Alcohol Sales to Youth	SED - Seriously Emotionally Disturbed
EQ-I - Emotional Quotient—Intelligence	SHARP - Student Health and Risk Prevention
FACT - Families, Agencies, and Communities Together	SICA - State Incentive Cooperative Agreement
FY - Fiscal Year	SIG-E - State Incentive Enhancement Grant
HCFA - Health Care Finance Administration	SMI - Serious Mental Illness
IV - Intravenous	SPD – Serious Psychological Distress
JCAHO - Joint Commission on Accreditation of Healthcare Organizations	SPF – Strategic Prevention Framework
	SPMI - Seriously and Persistently Mentally Ill
	SSDI - Social Security Disability Insurance

TEDS - Treatment Episode Data Set
TIP - Transition to Independence Process
UBHN – Utah Behavioral Health Network
UFC – Utah Family Coalition
UPAC - Utah Prevention Advisory Council
USEOW – Utah’s State Epidemiology Outcomes Workgroup

USH - Utah State Hospital
UT CAN - Utah’s Transformation of Child and Adolescent Network
YOQ – Youth Outcome Questionnaire
YRBS - Your Risk Behavior Survey
YTS - Youth Tobacco Survey

Contact Information

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Weber

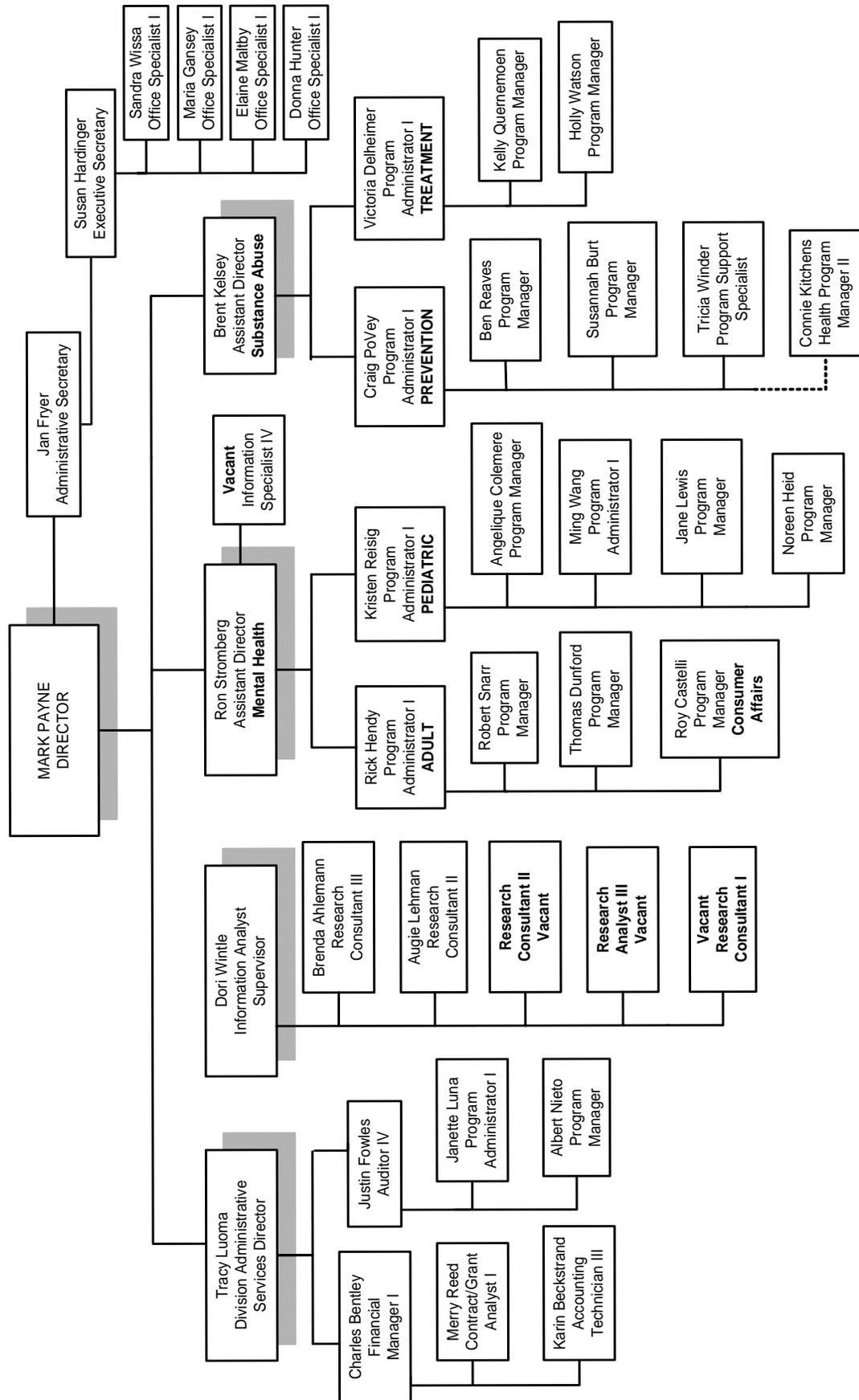
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