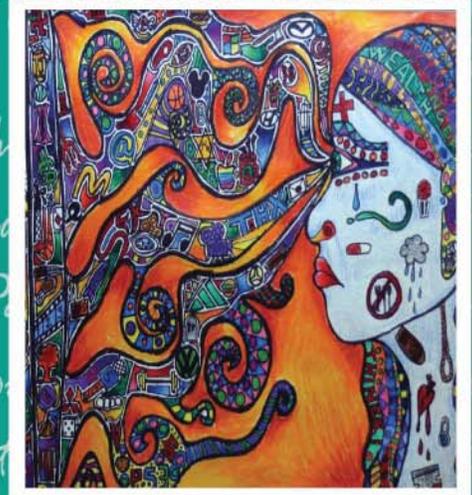
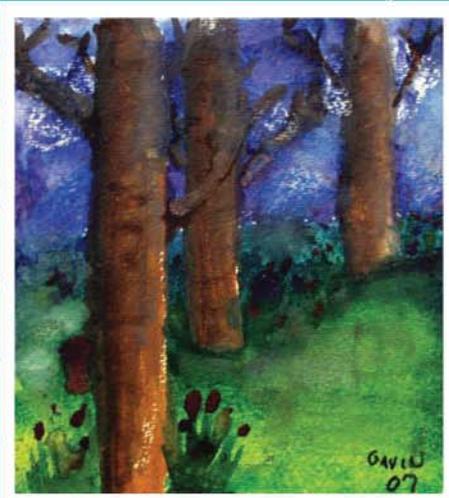
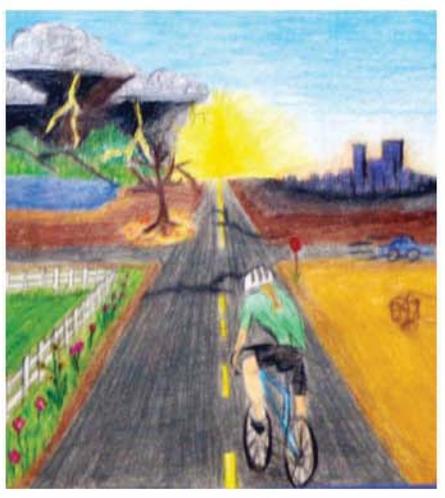


2007 Annual Report



DIVISION OF SUBSTANCE ABUSE & MENTAL HEALTH

**“Helping Families Find
Hope and Recovery”**



featuring artwork from the
Mental Health Art Contest

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2007
Annual Report

Mark I. Payne, Director
Division of Substance Abuse
and Mental Health
Department of Human Services
120 North 200 West, Suite 209
Salt Lake City, UT 84103

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STATE OF UTAH
DEPARTMENT OF HUMAN SERVICES
BOARD OF SUBSTANCE ABUSE & MENTAL HEALTH

Board Members:

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Louis H. Callister

December 2007

On behalf of the Utah State Board of Substance Abuse and Mental Health, it is my pleasure to present you with DSAMH's 2007 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 we are faced with. 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 that are served.

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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JAMES C. ASHWORTH, M.D.

Board Certified in Psychiatry and Child and Adolescent Psychiatry; Chief, Division of Child and Adolescent Psychiatry, University of Utah, School of Medicine; Assistant Clinical Professor, University of Utah; Member, American Psychiatric Association and American Academy of Child and Adolescent Psychiatry.



LOUIS H. CALLISTER

Of Counsel & Chairman Emeritus, Callister Nebeker & McCullough; Chairman of the Board, Grand Canyon Trust; Member, Board of Directors, Goldman Sachs Bank USA; Chairman of the Board, Edward G. Callister Foundation; Member, Utah Substance Abuse & Anti-Violence Coordinating Council; Member, Advisory Committee, Utah Addiction Center.



JOLEEN G. MEREDITH

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.



NORA B STEPHENS, M.S.

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.



DARRYL WAGNER, R.PH.

IHC Outpatient Pharmacy Coordinator; Member, American Pharmacy Association and Utah Pharmacy Association; Member, Utah Division of Occupational and Professional Licensing Pharmacy Diversion Board.



State of Utah

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Governor

GARY R. HERBERT
Lieutenant Governor

Department of Human Services

LISA-MICHELE CHURCH
Executive Director

Division of Substance Abuse and Mental Health

MARK I. PAYNE
Director



December 2007



We appreciate the opportunity to share DSAMH's Annual Report for Fiscal Year 2007. We hope the report will be helpful as you review the efforts being made throughout the system in providing treatment to individuals who have involvement with the public substance abuse and mental health system.

The Division continues to make progress towards our goals of "Hope and Recovery." This report reflects ongoing focus on 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 performed focused. The model on the following page provides specific goals and focus on each of these principles.

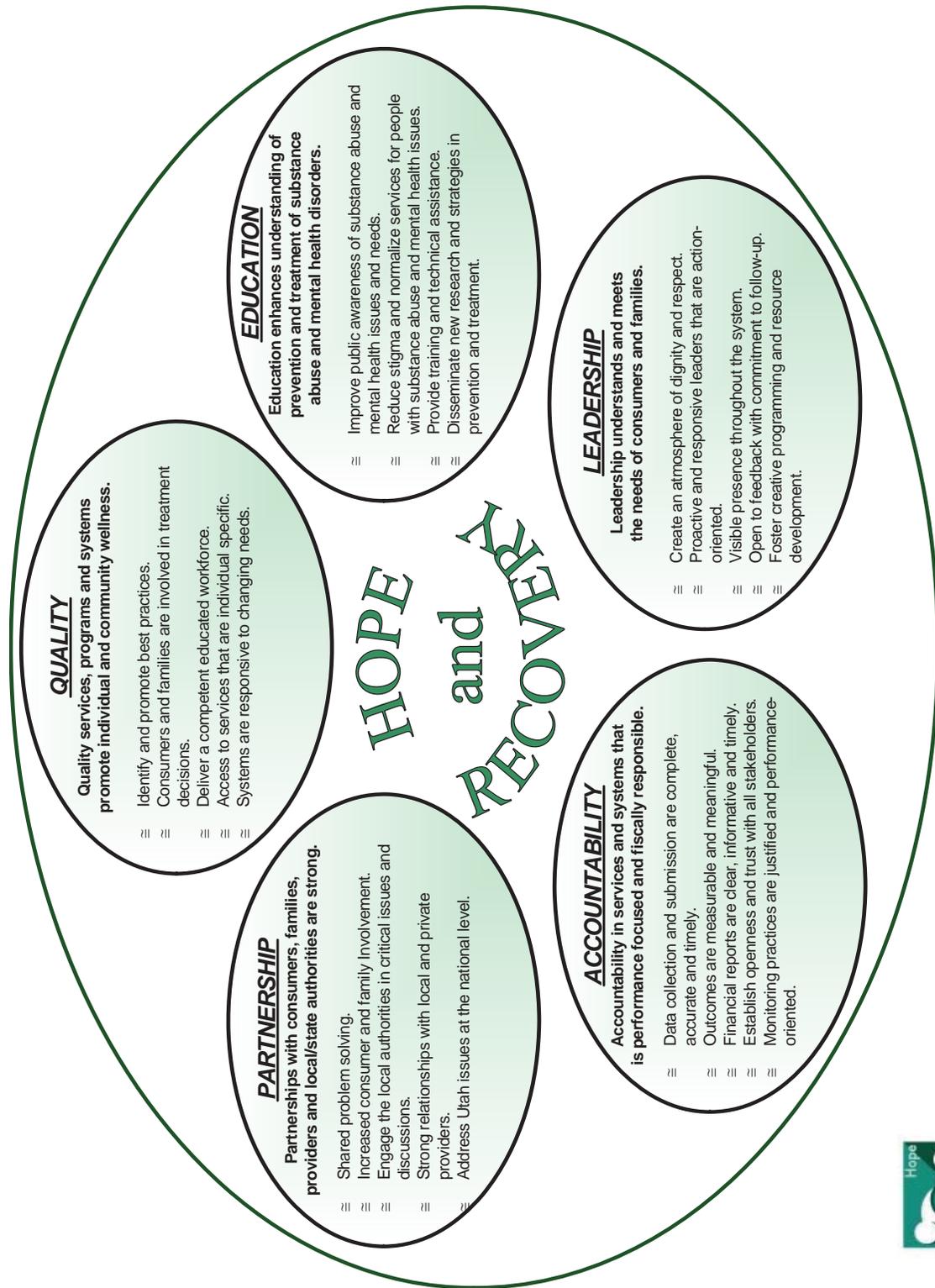
I want to thank the many dedicated staff members who have contributed to this report and work hard to constantly improve our statewide system of care. We thank all of the advocates and volunteers who make a difference in the lives of the people and communities we serve.

We ask you to join the Division as we work 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, appearing to read "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.

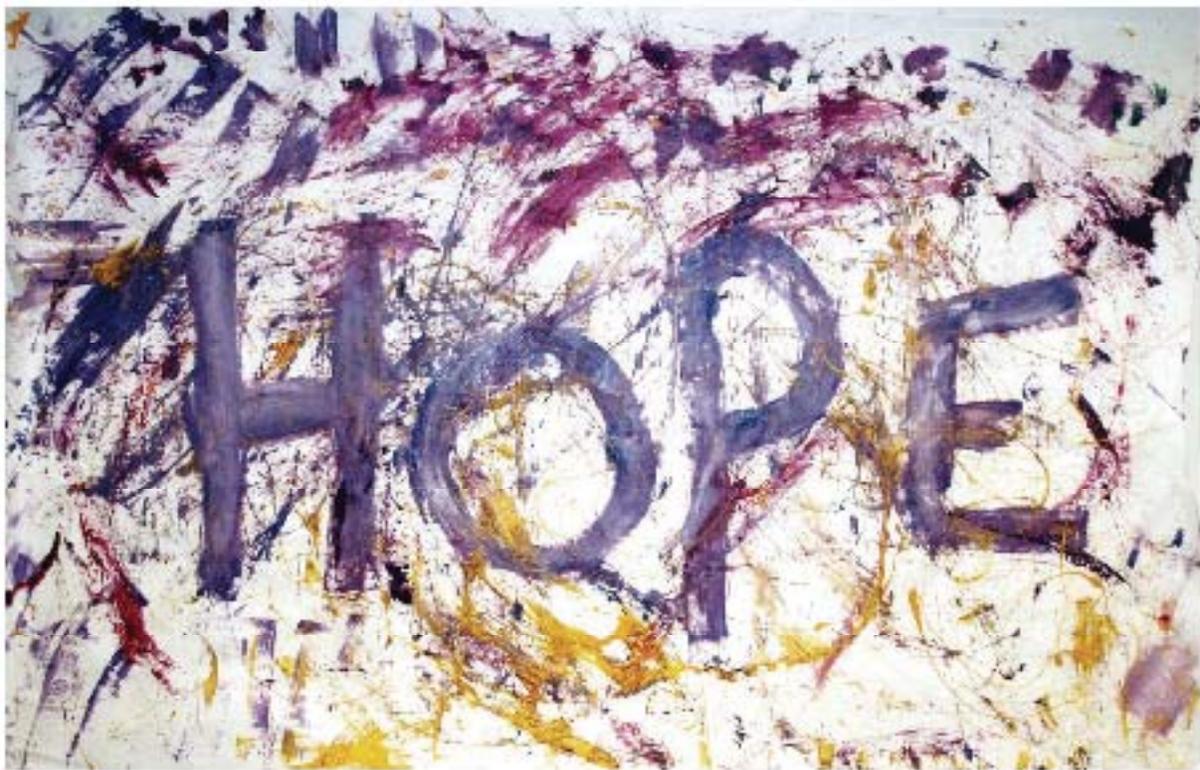
Local Authorities

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 statewide overmatch and contribute 44% for Substance Abuse and Mental Health combined.

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 Utah Behavioral Health Network (UBHN) and the Network of Care.

STATEWIDE INITIATIVES SOURCE OF FUNDING & CATEGORY OF EXPENSES



Report on Statewide Initiatives

Recovery Implementation

Utah Integrated Recovery Plan

During the fiscal year 2007 monitoring season, DSAMH focused on identifying a baseline measure statewide for SAMHSA's (Substance Abuse and Mental Health Services Administration) ten fundamental components of recovery as outlined in the consensus statement.¹ This measure was used to determine an emphasis for fiscal year 2008. DSAMH has decided to focus training and monitoring efforts on person-centered planning and strengths based approach to service delivery. Each year new emphases will be added to the monitoring process in an attempt to help guide mental health centers towards implementing recovery principles into their daily practices.

Person-Centered Planning

Person-centered planning places the consumer's hopes and dreams first and foremost in the recovery process. Results of the DSAMH Audit fiscal year 2007 (feedback from consumers, family, and staff) clearly identified a need for consumers to be more active in their treatment planning. After significant research DSAMH has chosen to promote the Adams/Grieder model (endorsed by SAMHSA) as described in the book *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*.

The elements of an integrated recovery plan are driven by the consumer's hopes and dreams, which are identified as goals on the written plan.

¹ www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4129

Barriers to those goals, short term objectives and the intervention (including natural supports) or services are identified and spelled out in the written plan to facilitate action by the provider and consumer. Ownership in the plan (and outcomes) by consumers, highlight the difference between traditional treatment plans and person-centered planning. Also, symptom reduction is the overarching goal of traditional treatment planning whereas symptom reduction is only a part of the person-centered plan; thus making the attainment of housing, employment, relationships, and other critical issues the focus of recovery efforts.

DSAMH plans to implement person-centered planning through a three step process. First, training will be provided by Dr. Adams to a select group of staff from all 13 community mental health centers. An assessment of further training in the general workforce will be assessed and provided as needed. Second, a uniform person-centered planning recovery plan will be developed and offered to the community mental health centers as a template for organizing recovery plans. Finally, fiscal year 2008 site visits will focus on reviews of treatment plans that are assessed against person-centered planning principles.

Benefits of Person-Centered Planning

- Move the system forward in the recovery movement
- Satisfies Center for Medicaid and Medicare Services (CMS)
- Compatible with the Futures Report or the Utah Recovery Plan

- Can be used in Substance Abuse Treatment as well as Mental Health as a shared model in the system
- Empowers individuals to direct recovery/treatment efforts in achieving their own goals

Strength-Based Treatment

In recent decades, human services disciplines have moved from implementing medical treatment models that view people with a mental illness, as having problems that require “compliance” and a need to be “controlled” or “stabilized.” Recovery from mental illness was not considered possible. We now know that recovery is possible through a strength-based approach that focuses on a person-centered planning process which places the consumer’s hopes and dreams foremost in the recovery process. Despite difficult circumstances and challenging issues, each person has strengths and in troubling times, it is our assets, not our deficits, which give us the momentum to climb onward. People working toward recovery build their lives on resources and choices, not on pathology. Strengths are a family’s source of power, will, character, purpose, values, and toughness that give them the capability of generating a reaction of effect and change.

Strength-based service delivery is incorporated into the person-centered plan and begins with what an individual wants and chooses to do. Professionals and other team members partner with the consumer to develop desired outcomes and a plan of action to reach those outcomes. The consumer (including children, youth, and family members) is perceived as an active participant in changing his or her life with shared decision making, and client defined outcomes based on the client’s strengths and available supports. Strengths are the building blocks in the achievement of goals and tasks.

Innovative Provider Programs Serving the Unfunded Gap

“Help for the Unfunded, A Creative Legislative Response”

The 2007 Legislature granted \$2.7 million (ongoing) to DSAMH to be used for innovative, evidence based and cost effective ways to provide mental health services to residents who were without adequate insurance. The specific intent of this funding is to serve 2,700 people who otherwise are not able to access the public mental health system.

DSAMH’s guiding principles for this initiative have been creativity and accountability; therefore, DSAMH requested local mental health authorities to submit proposals demonstrating these principles. Funds were not awarded until the proposals were reviewed and determined to meet the intent of the legislative action. Plans were returned for revision when they did not demonstrate legislative intent.

The outcome of this process resulted in new programs and services relevant to this population and the unique needs in their communities. The following is a brief summary of services to be provided:

- Weber Human Services will develop a pilot project in which it will provide treatment to Spanish speaking females. This plan includes the placement of a Spanish speaking worker in the Midtown clinic, which is a federally qualified health clinic. Another portion of the award will be used to develop a recovery clinic and school-based early intervention services that are coordinated with the UT CAN project.

- Valley Mental Health Tooele will develop a resource recovery clinic that focuses on inmates who are released from jail, and place a bilingual counselor in Wendover.
- Valley Mental Health Salt Lake will provide universal screen and referral services. Develop a voucher type system where \$1,000 worth of services are offered to the consumer who chooses from a menu of treatment options. This provides an opportunity for family and religious organizations to maximize the money they have available to provided this level of care.
- Bear River Mental Health will develop a school-based program using two clinicians who will be placed in four public schools.
- Northeastern Counseling also plans to develop a school-based program by placing part-time therapists in middle and junior high schools. It will also provide community reentry services for consumers who are ready to leave inpatient care.
- Four Corners Community Behavioral Health will collaborate with three federally qualified health clinics to develop an integrations model in their catchment area. This plan includes the placement of therapists in the identified clinics with the intent to provide onsite care. A wellness clinic will also be developed to provide peer counseling, advocacy, and case management.
- Central Utah Counseling will increase emergency services, assessments, case management, and medication management. It will also provide individual and group therapy, and community reentry services.
- Wasatch Mental Health will increase access to the wellness recovery clinic through reduction in percent of poverty required for services and possibly opening the clinic at a second site.
- Southwest center will create a universal screening (any resident seeking services will be screened) process. It will also develop an integrations model with the Doctor's Free Clinic in St. George.
- Heber Valley Counseling will provide school-based care, individual therapy, skills development, and group therapy.
- Valley Mental Health Summit will provide a school-based service that includes assessments, screenings, and treatment planning that focuses on 8th and 9th graders.
- San Juan Mental Health will increase access in remote sections of the county through sharing of resources with the Utah Navajo Health Systems clinic.
- Davis Behavioral Health will collaborate with other community agencies to increase access.

All of these programs/proposals will provide services to individuals who previously would not have access to public mental health treatment.

EndMethNow.org (Governor's Methamphetamine Campaign)

In January 2006, Governor Huntsman and the *Utah Association of Counties* formed *The Utah Methamphetamine Joint Task Force* to comprehensively consider and address the methamphetamine problem in Utah. The Task Force consists of state and county representatives who have had a direct connection to the methamphetamine problem and other interested members of the community. With the support of Governor Huntsman and the Utah Association of Counties, the Utah Methamphetamine Joint Task Force came forward with legislative recommendations to ad-

dress methamphetamine. Below is a summary of the Task Force's Legislative accomplishments:

- S.B. 50 – Drug Offenders Reform Act (Sen. Chris Butters) – PASSED

This bill appropriates \$8 million for fiscal year 2008 and \$9 million for fiscal year 2009 to expand screening, assessment, and treatment services for felony offenders with substance abuse problems statewide.

- S.B. 112 – Methamphetamine Precursor Access – Amendments (Sen. Chris Butters) – PASSED

This bill codifies the provisions of the federal Combat Meth Act into Utah law, including reducing the amount of products containing ephedrine and pseudoephedrine that may be legally possessed at one time, requiring that these products not be sold over-the-counter, and requiring retailers to keep a log of the sales of these products.

- H.B. 91 – Commission on Criminal and Juvenile Justice Funding (Rep. Brad Dee) – PASSED

This bill creates a new restricted account, the "Law Enforcement Operations Account," to be funded with collections from the criminal surcharge. The funds in the account will be appropriated annually to CCJJ (Commission on Criminal and Juvenile Justice), which will award grants to law enforcement and other appropriate agencies for law enforcement operations and programs related to reducing illegal drug activity and related crime including education, prevention, treatment, research, and control. The first priority for grants will be Utah's multi-jurisdictional Drug and Crime Task Forces. It is also the Governor's recommendation that the Methamphetamine Task Force receive \$600,000 from this account for its priority initiatives. H.B. 91 appropriates \$2,370,000 to CCJJ for fiscal years 2007-08.

In addition to the bills listed above, the Task Force was also instrumental in securing new resources to combat Methamphetamine. Below is a list of appropriations recommended by the Task Force and appropriated by the Utah State Legislature:

- \$8 million fiscal year 2008/\$9 million fiscal year 2009 to expand DORA statewide (S.B. 50/ongoing)
- \$5,026,300 (includes Medicaid) for substance abuse treatment on demand for women and children (ongoing)
- \$2 million for a Utah Methamphetamine Public Awareness Campaign (one-time)
- \$1.5 million for multi-jurisdictional Drug and Crime Task Forces (H.B. 91/ongoing)
- \$2 million for statewide expansion of Drug Courts (\$1 million ongoing and \$1 million one-time)
- \$1.7 million for the Underage Drinking Prevention Media Campaign (ongoing)
- \$600,000 for Utah Methamphetamine Joint Task Force priority initiatives (H.B. 91/ongoing)

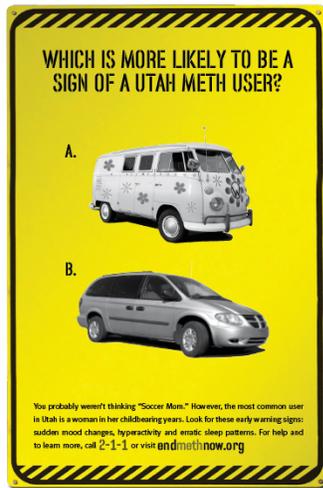


"Addiction is not relegated to the small minority most citizens think of as 'drug users,'" said

Lisa-Michele Church, Executive Director of Human Services and co-chairperson of the Utah Methamphetamine Joint Task Force. "On the contrary, meth use cuts across a wide segment of Utah society." To raise public awareness of the consequences of methamphetamine use, The Governor's Task Force lunched the "End Meth Now" campaign. This campaign is designed to reveal the true face of meth addiction in Utah - and to educate citizens on what they can do to take action as part of the solution."

The \$2 million campaign, End Meth Now, includes television, radio, and print advertisements and a comprehensive web site (www.endmethnow.org)

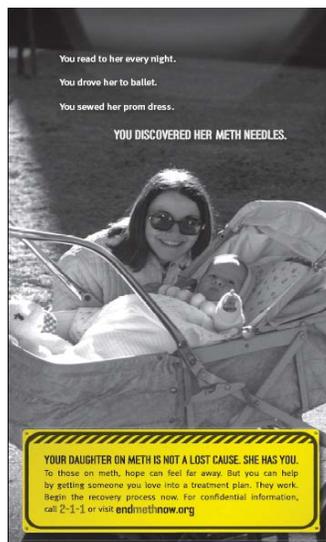
now.org), as well as a media outreach effort focusing on educating citizens on the facts of meth use and addiction, helping them to identify the warning signs of meth use and informing them how they can obtain help for themselves, their loved ones or their families.



In addition, the campaign provides materials and assistance to county administrators and

treatment professionals across Utah that allows them to take the campaign message directly to the citizens in their local communities.

Since the launch of the End Meth Now campaign in September, residents across Utah have started a conversation about Meth use and how it impacts our neighbors, friends, family, and communities statewide. Thousands of Utahns have taken the time to visit the campaign website, www.endmethnow.org, to learn how Meth impacts our state and what they can do to help themselves or a loved one who might be using Meth.



The chart below provides information on website usage from September 24, 2007–January 6, 2008:

Site Usage	
Total pages viewed	43,501
Total visits to the site	10,473
Absolute Unique Visitors	9,011
Average Page views per visit	4.15 pages
Time on Site	3 minutes 29 seconds

The campaign will run through fiscal year 2008 and will include a wide variety of activities as well as locally organized events. Some of the events that have already occurred or are planned for the upcoming year include: Meth and Families All-Day Workshops and the Launch of the www.endmethnow.org website.

Parents Empowered Prevention Public Awareness Campaign



The Parents Empowered statewide media campaign celebrates its 2nd year in continuing its mission to eliminate underage drinking in Utah. Working synergistically with the Eliminating Alcohol Sales to Youth Program (see page 124), the Parent’s Empowered Campaign works by providing skills and resources to help parents take action to keep their child alcohol-free. Parents Empowered is marshaling the skills and resources of all affected agencies and parties to alert and empower parents, strengthen families, change the social norm, and eliminate underage drinking and the resulting consequences in Utah.

Because research shows parent’s are the strongest protection against alcohol and other substance

abuse, the campaign stresses the need for parents to set clear rules and expectations and monitor those rules regularly. The advertising agency that is directing this project, R & R Partners, has used several creative ways to reinforce the message to parents including a website, advertisements on TV, radio, and billboards as well as utilizing text messaging between parents and teens.

Ten Facts You Need to Know About Underage Drinking

1. The brain goes through dynamic change during adolescence (age 12-21) and alcohol can seriously damage long- and short-term growth processes. (American Medical Association Fact Sheet, 2003)
2. 40% of kids who begin drinking before the age of 15 will become alcohol dependant. (Grant, BF and Dawson, DA. Journal of Substance Abuse 9: 103-110. 1997)
3. More than 67% of young people who start drinking before the age of 15 will try an illicit drug. They are 22 times more likely to use marijuana, and 50 times more likely to use cocaine. (SAMHSA 2005 “Start Talking before they start drinking”)
4. Youth report that alcohol is easy to obtain. (Institute of Medicine 2004)
5. 59% of Utah parents are unaware that sixth graders are drinking. (Pre-media Parental Survey R&R Partners, July 2006)
6. A national survey shows that 31% of the youth who reported being drunk last year were believed to be non-drinkers by their parents. (Pre-media Parental Survey R&R Partners, July 2006)
7. Research shows parental disapproval of underage drinking is the #1 reason youth choose not to drink.

8. 45% of Utah Parents don’t believe they are the #1 influence. (Pre-media Parental Survey R&R Partners, July 2006)
9. Alcohol kills more young people than all other illegal drugs combined.
10. Research shows that addiction begins (and can be prevented) in adolescence:

“A child who gets through age 21 without smoking, abusing alcohol or using illegal drugs is virtually certain never to do so.” (Joseph Califano, The National Center on Addiction and Substance Abuse at Columbia University, 2006)

Women in Treatment

Between 1991 and 2006, there was a 170% increase in the number of women who entered the public treatment system. This information and indicators from other data demonstrated an increased need for specific women’s treatment services. In 2007, the State Legislature appropriated \$2.53 million to achieve that expansion for this targeted population.

The proposed expansion was two fold. The first intent was to allocate \$827,442 to establish two new facilities located in the southern and northern part of the state that would increase the number of treatment beds available for women and/or women with children. The contracts to provide the two residential treatment facilities were awarded to Southwest Behavioral Health Center and Weber Human Services.

The second intent was to allocate \$1,556,511 to expand the availability and range of treatment services across the state for women and women with children. The distribution of these funds went to Local Substance Abuse Authorities. The funds are to be utilized in establishing a full continuum of services ranging from long-term residential treatment to outpatient treatments for women; and to enhance outreach and collaborative efforts with the Division of Child and Family Services (DCFS). A portion of the award was

structured as an incentive allocation to encourage creative and innovative treatment programming for this targeted population. An estimated additional 600 women in Utah will receive services from these funds.

Drug Offender Reform Act (DORA)

The Drug Offender Reform Act (DORA) is an innovative and collaborative approach to dealing with offenders with drug addictions. Offenders who are potential clients undergo a community risk screening by Adult Probation and Parole (AP&P) as well as a clinical assessment of their need for substance abuse treatment. Information from both the clinical and AP&P assessments are then shared with Judges before sentencing, and Judges then have the choice of imposing prison time, mandating treatment, or both. If treatment is mandated, Adult Probation and Parole officers provide supervision specifically designed to reinforce that treatment.

The DORA pilot program was initiated in 2005 when the Legislature appropriated funds for a pilot project in Salt Lake County. The purpose of the pilot program was to determine if providing substance abuse screening, assessment, and treatment of services to felony offenders would reduce recidivism and reduce the cost of treating and/or incarcerating offenders with drug addictions. The University of Utah Graduate School of Social Work was tasked to conduct a professional and independent review of this program. In 2006, the last two years of the DORA pilot program were funded in the amount of \$918,000.

During the 2007 legislative session, the initial impact that the DORA program had made in Salt Lake County led the Legislature to expand the program statewide, despite the fact that the pilot program data was not yet complete. At that time the Legislature appropriated \$8 million total for the program in fiscal year 2008 with \$9 million budgeted for fiscal year 2009.

Families Initiative

In 2007, DSAMH's Children, Youth and Families team continued to demonstrate its initiative to integrate family involvement in all levels of care. This year, DSAMH, the Children's Center, and the Utah Family Coalition, joined together to implement a system that would ensure the beginning of a formalized family-driven/youth guided public mental health system throughout the state.

The goals of implementation are three-fold:

1. Ensure that the community mental health system is able to provide community based assessment, treatment, education and care coordination to children (and their families) from birth through age five.
2. Ensure that the family voice is cultivated and respected throughout the system to work in partnership to provide access and quality treatment for Utah's children and their families.
3. Develop resources for families who are underinsured or have no funding.

Each participating community mental health center has designated an early childhood mental health clinician to assess and treat children (and their families) from birth to five. These clinicians will receive clinical training and consultation from Doug Goldsmith and Dr. Kristina Hindert from the Children's Center. In addition, some of the mental health centers are developing community-wide projects that will strengthen care coordination and treatment access in their local settings.

In addition, Family Resource Facilitators (FRFs) will be hired at each community mental health center. This is a fundamental step to ensure that family involvement is present at all levels of care. The FRFs are being trained in core competencies that will give them the skills they need to implement the following tasks:

1. Act as a Resource Coordinator to provide local resource information to any family requesting assistance.
2. As a Family Advocate/Advisor they will develop working partnership with CMHS staff to represent the family voice at the service delivery, administration, and policy levels.
3. Develop a local Family Support and Information Group to provide information and support if and when no other resources are available.
4. Family Wrap-around Facilitation. Work with families and youth who have complex needs to build a plan that incorporates both formal supports (e.g. mental health/substance abuse treatment, educational assistance, juvenile court engagement etc.) and informal supports (family members, Boy Scouts, clergy, etc.) that will help the child and his/her family exit the mental health system to live full and productive lives.

The development of a formalized family-driven youth guided public mental health system will empower families, promote recovery, and enable communities to work together in addressing the concerns of children and families with complex issues.

FRF CORE COMPETENCIES

A core competency is fundamental knowledge, ability, or expertise in a specific subject area or skill set.

- Human Growth and Development
- Systems of Care Expertise
- Family Support Skills
- Basic Knowledge of Laws and Policy
- Cultural Competence
- Communication Skills
- Organizational Skills
- Presentation Skills
- Advocacy Skills
- Confidentiality
- Professional, Ethical Behavior

State Suicide Prevention Plan

During fiscal year 2007, DSAMH used federal block grant funds to create a statewide suicide prevention plan through a contract with NAMI-Utah. The suicide prevention plan has now been released and covers both adult and children's issues. It is the Utah's first comprehensive Suicide Prevention Plan. Efforts in the past have focused on youth suicide, but this plan encompasses all ages and culturally diverse groups. The Suicide Prevention Council consisting of advocate groups, experts in suicide prevention, schools, the Veteran's Administration, family members, and minority groups developed the plan. The plan will be used as a "blueprint" to target funding, develop legislation and focus efforts using evidence-based practices.

Recommendations are stated in the following goals:

- Goal 1: Promote awareness that suicide is a preventable public health problem.
- Goal 2: Develop broad-based support for suicide prevention.
- Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.
- Goal 4: Develop and implement suicide prevention programs.
- Goal 5: Promote efforts to reduce access to lethal means and methods of self harm.
- Goal 6: Implement training for reporting on suicide and recognition of at risk behavior and delivery of effective treatment.
- Goal 7: Develop and promote effective clinical and professional practices.
- Goal 8: Improve access to and community linkages with mental health and substance abuse services.

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

Goal 10: Promote and support research on suicide and suicide prevention.

Veterans and Their Families

Counseling for Families and Veterans

H.B. 407, Counseling for Families and Veterans, sponsored by Rep. Tim Cosgrove was passed during the 2006 legislative session with a one-time appropriation of \$210,000.

The funds were allocated to the Division of Substance Abuse and Mental Health. Rep. Tim Cosgrove chaired a committee, which consisted of all branches of the military, veterans, family organizations, various veterans' affairs and benefits organizations, employment organizations, religious organizations and included a research component. Between 20 and 30 individuals attended the meetings. Meetings began in March 2006 and were held at least monthly through August 2007. The focus of the committee was on Utah soldiers returning from Iraq and Afghanistan.

One of the major benefits of the meetings was the cross training that occurred regarding the many services and programs already available to the veterans and their families. Many committee members were not aware of the resources provided by other agencies. The various agencies are now coordinating a variety of activities and programs as well as resources because of the information shared in the meetings.

A survey, conducted by a graduate student, was funded to try and identify why, with so many resources already available, veterans and their families were not taking advantage of those re-

sources. The survey indicated that service members lacked awareness concerning eligibility and availability of the many programs and resources available. Educating the service member and their family about available resources became a key issue. The committee approved using resources to fund a media campaign to educate veterans and their families concerning existing resources. The Utah Division of Veteran's Affairs (Now the Department of Veteran's Affairs) developed a media campaign mainly utilizing a series of TV and radio spots. The campaign directed veterans and family members to toll free telephone number and the Veteran's Affairs web site. Calls to the toll free number doubled during the campaign and the website had 6,000 hits in December alone. A number of veterans were referred for immediate counseling.

A major concern of returning veterans and their spouse was re-establishing strong marriages after returning from deployment. The committee reviewed various approaches to prevent marital problems and enhance relationships. One model, which has a strong research base, is PREP (Prevention and Relationship Enhancement Program). It is considered the best developed marriage enrichment program in the country. This program provides couples with a two-night stay in a hotel and an intensive series of workshops during the weekend. It has been highly successful and the committee decided to send 400 couples to this program and 100 singles to a similar program. The Utah Army National Guard paid for the cost of materials and the instructors for the workshops. Slots to attend the PREP workshops were given to all branches of the military, including the Army Reserve, Air Reserve, Marines, Air Guard, and Naval Reserve.

Post Traumatic Stress Disorder (PTSD) was also a major concern of the committee. The committee learned that the Veteran's Administration has a team of experts in working with and treating veterans with PTSD. The VA volunteered to have

team members train public and private counselors and members of the clergy in recognizing and treating PTSD. This team trained groups throughout Southern Utah in preparation of the return of the 222nd Field Artillery Battalion Utah National Guard. This training was considered highly successful and continues to be available upon request for any area of the state.

Telehealth

Utah has come a long way in telehealth since the Utah Department of Health, the Center for Public Service Communications, and then Governor Michael O. Leavitt co-hosted the first major “*National Conference on Telemedicine and Health Informatics: Issues for Consideration at a State and Local Level*,” on September 17-20, 1995. Over the years, a lot has been accomplished in providing physical health care via telehealth. In 2007, DSAMH spearheaded a project to expand telehealth care into the mental health and substance abuse arena. We now have telehealth capability at all rural/frontier regions. It is common knowledge that rural/frontier regions face geographic disparities in accessing mental health and substance abuse care. The challenges they

face include transportation problems, inconvenient locations, inclement weather making traveling dangerous, provider shortage, and lack of training programs. In 2007, DSAMH provided funding for 10 Community Mental Health/Substance Abuse Centers to purchase videoconferencing equipment for telehealth at 28 sites. These sites are Roosevelt, Vernal, Duchesne, Blanding, Price, Emery, Moab, Nephi, Mt. Pleasant, Ephraim, Richfield, Loa, Delta, Fillmore, Junction, Logan, Brigham, Tremonton, Rich County, Milford, Hurricane, Tooele, Park City, Coalville, Kamas, Wendover, Salt Lake City, and Heber City. With the telehealth capability, consumers in these communities can now have better access to clinical care (especially psychiatric care), monitoring and follow-up services, and attending meetings to coordinate treatment planning/delivery/discharge. It’s more convenient for providers to attend meetings and training programs. DSAMH is very excited about the prospect of telehealth and believes that it can help bring recovery-focused services into rural/frontier communities through better access to clinical care, monitoring, and assisting consumers in managing their own mental health and substance abuse challenges.



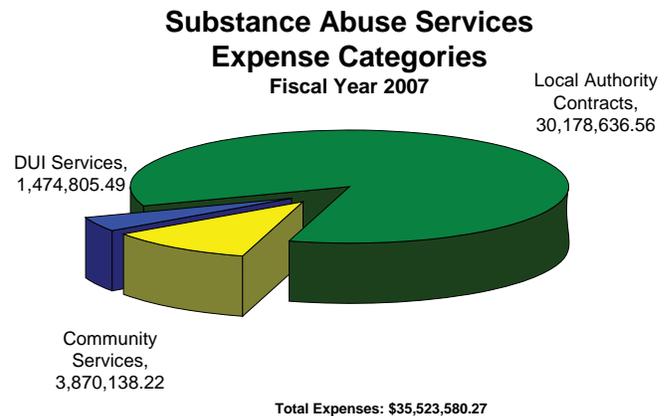
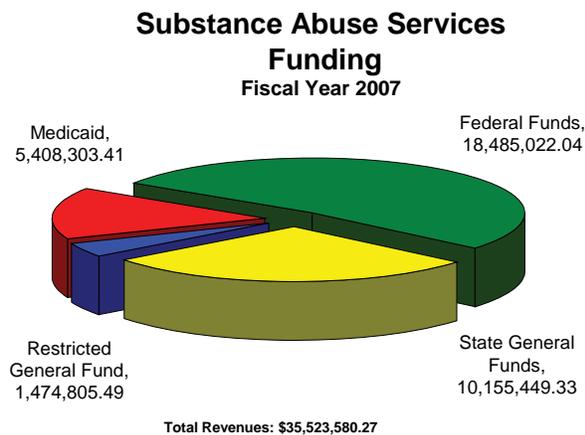
Source of Funding and Category of Expenses

State statute requires the local authorities to provide mental health and substance abuse services. Therefore, the majority of all funding and expenditures are through the local authorities as seen in the charts below.

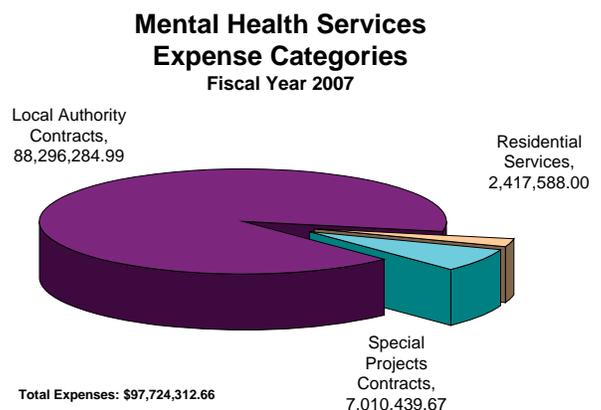
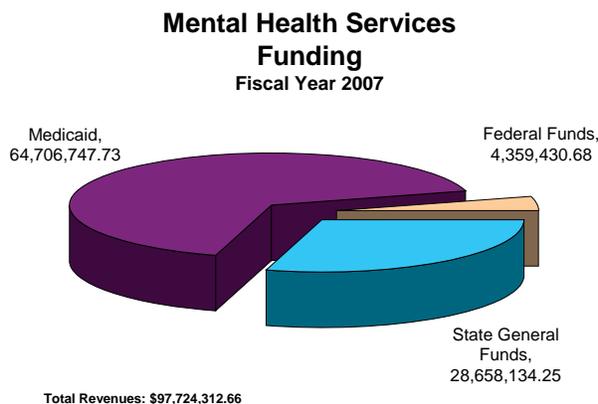
aid and Federal funds. The majority of State and Federal funds are allocated to the local authorities through a mandated funding formula and contracted out. The Medicaid dollars are collected directly by the local authorities through the State of Utah, Department of Health.

DSAMH's funding sources consist of State general funds, State restricted general funds, Medic-

Substance Abuse Services



Mental Health Services



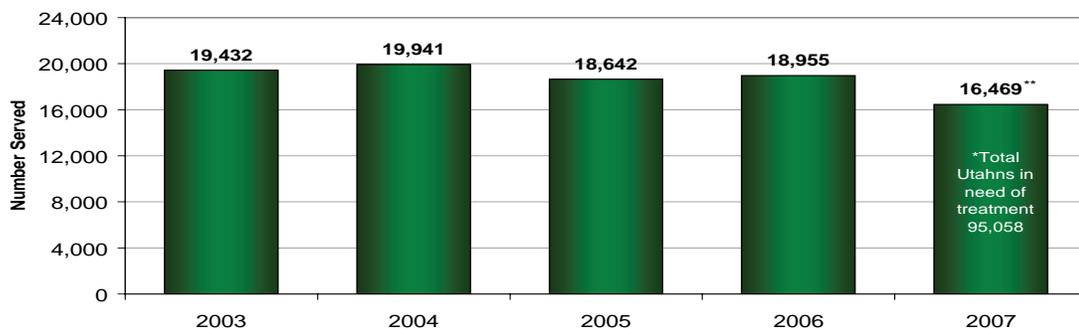
Who Do We Serve

Total Number Served

The following figures show the total number of individuals served in all publicly funded substance abuse treatment facilities for fiscal years 2003 through 2007. The same is depicted for individuals in service within community mental health centers for fiscal year 2003 through fiscal year 2007. A unique client identification process was

implemented in fiscal year 2007, which significantly reduced the duplication of unique clients served throughout the public mental health and substance abuse systems. As a result, the number of unique clients served has decreased, and can not be compared to prior fiscal years for the purpose of identifying a trend in treatment capacity or need.

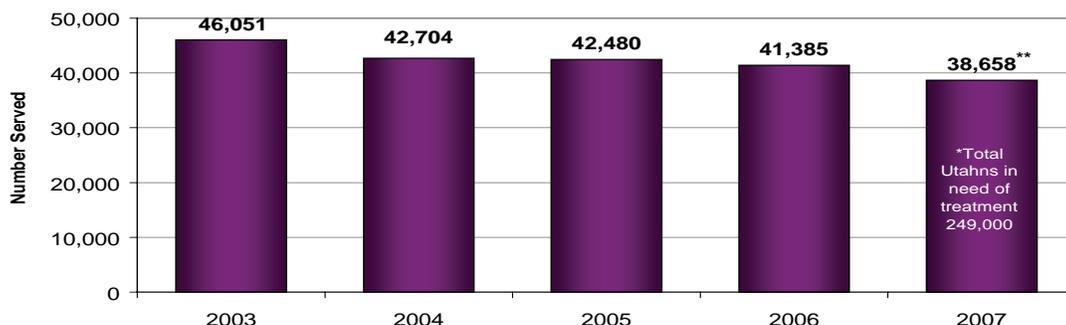
**Total Number of Individuals Served in Substance Abuse Treatment
Fiscal Years 2003 - 2007**



*Taken from the 2005 State Substance Abuse Treatment Needs Assessment Survey and the 2007 SHARP Survey.

**A unique client identification process was implemented in fiscal year 07, which significantly reduced the duplication of unique clients served throughout the public substance abuse and mental health systems. As a result, the number of unique clients served has decreased, and can not be compared to prior fiscal years for the purpose of identifying a trend in treatment capacity or need.

**Total Number of Individuals Served in Mental Health Services
Fiscal Years 2003 - 2007**



*2007 Utahns Ages 12+ in need of MH treatment = 249,000 based on 2006 NSDUH National Survey.

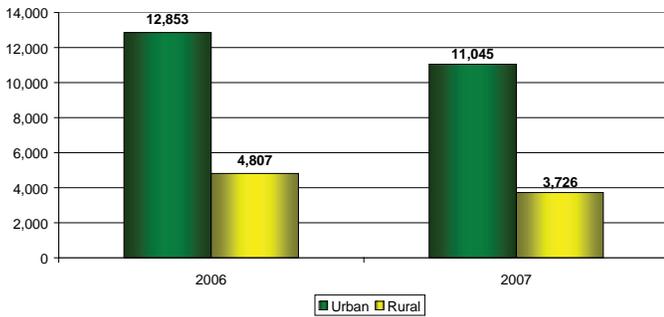
**A unique client identification process was implemented in fiscal year 07, which significantly reduced the duplication of unique clients served throughout the public substance abuse and mental health systems. As a result, the number of unique clients served has decreased, and can not be compared to prior fiscal years for the purpose of identifying a trend in treatment capacity or need.

Urban and Rural Areas

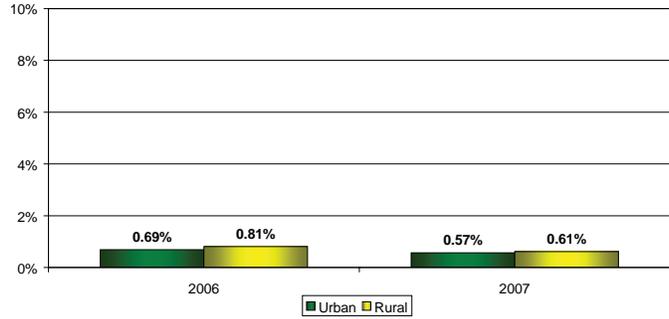
The following graphs show the total number of individuals served in urban and rural communities

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

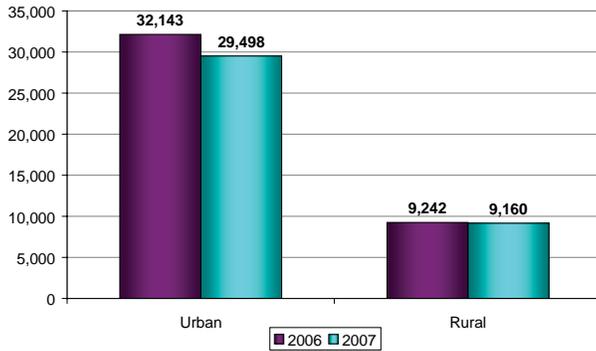
Number of Individuals Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2006 - 2007



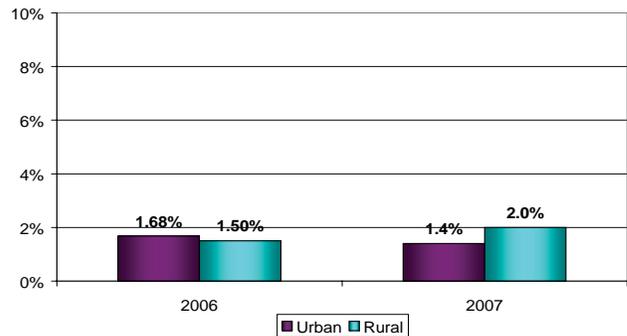
Percent of Total Population Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2006 - 2007



Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2006 - 2007



Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2006 - 2007



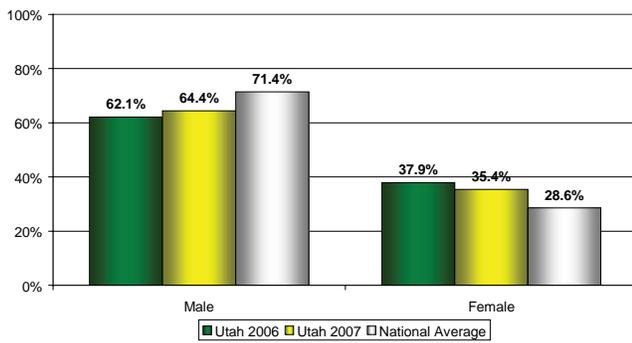
Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

Gender and Age

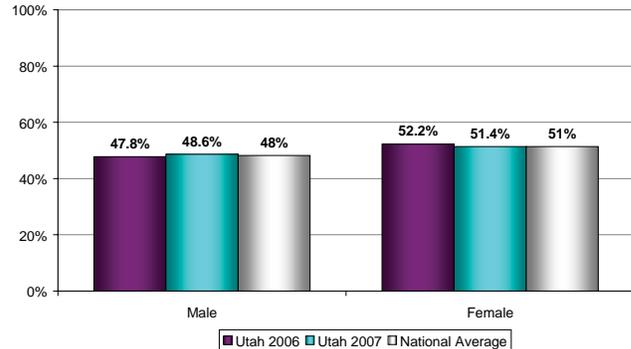
The following figures show the distribution of services by gender and age for Substance Abuse and Mental Health services. There are significant

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

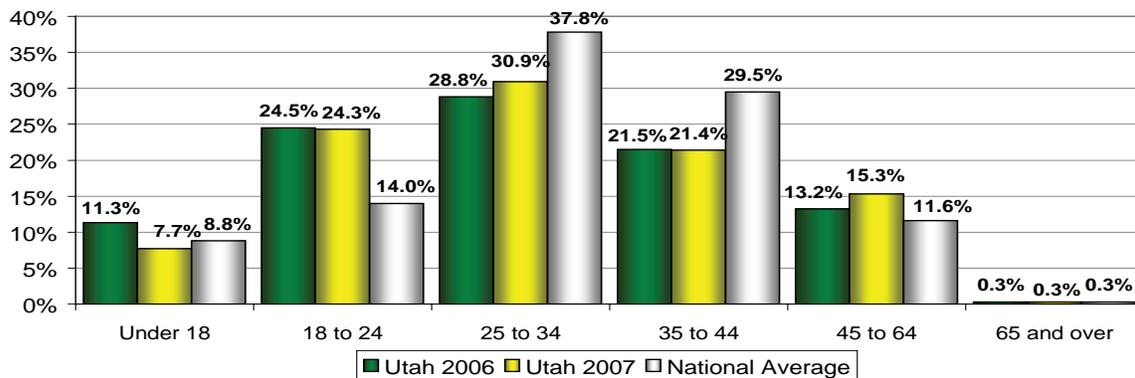
**Gender of People Served in Substance Abuse Services
Fiscal Years 2006 - 2007**



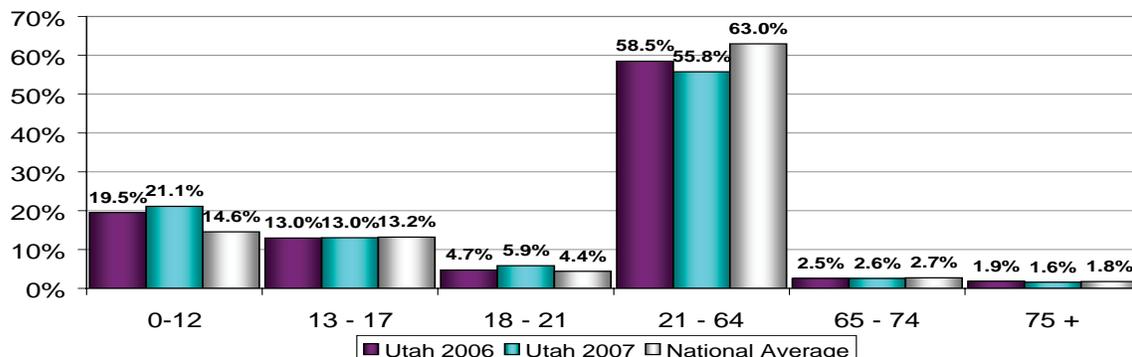
**Gender of People Served in Mental Health Services
Fiscal Years 2006 - 2007**



**Age Grouping at Admission of People Served in Substance Abuse Services
Fiscal Years 2006 - 2007**



**Age Grouping of People Served in Mental Health Services
Fiscal Years 2006 - 2007**

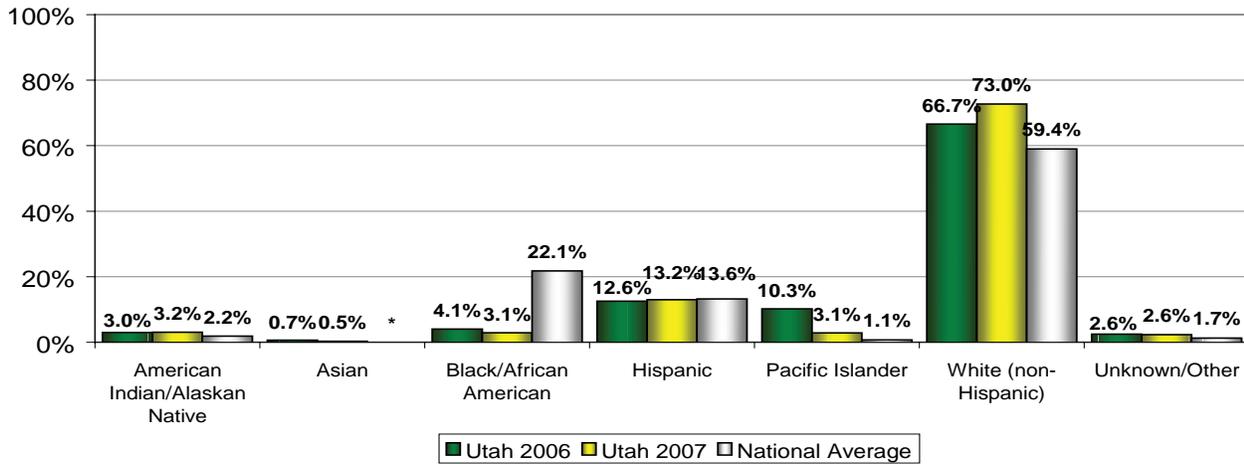


Race and Ethnicity

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

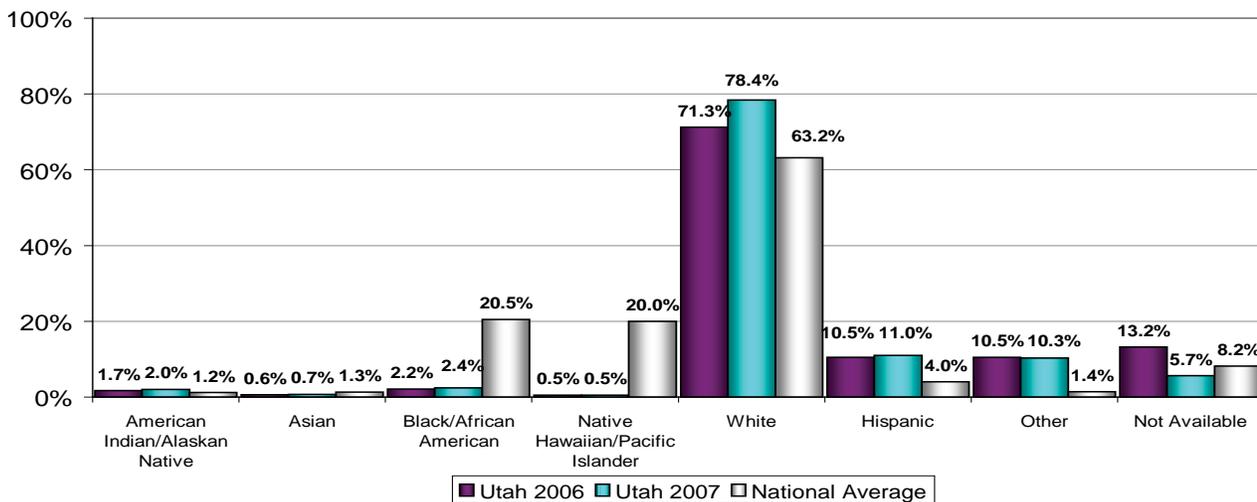
health services. More detailed data on ethnicity categories are available for substance abuse clients than mental health clients.

Race/Ethnicity of People Served in Substance Abuse Services Fiscal Years 2006 - 2007



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

Race/Ethnicity of People Served in Mental Health Service Fiscal Years 2006 and 2007



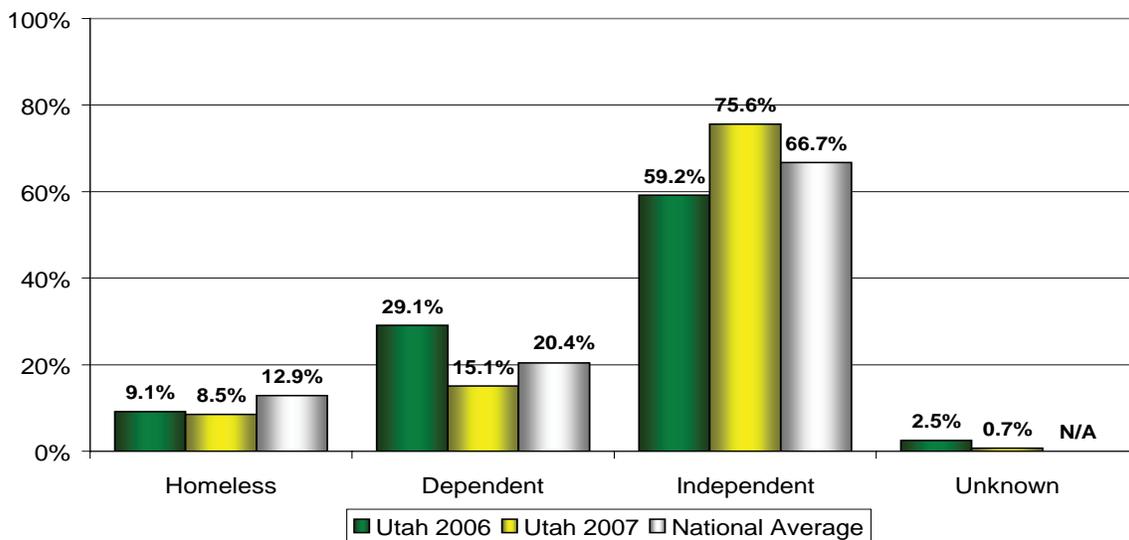
Note: More than one race/ethnicity may have been selected.

Living Arrangement at Admission

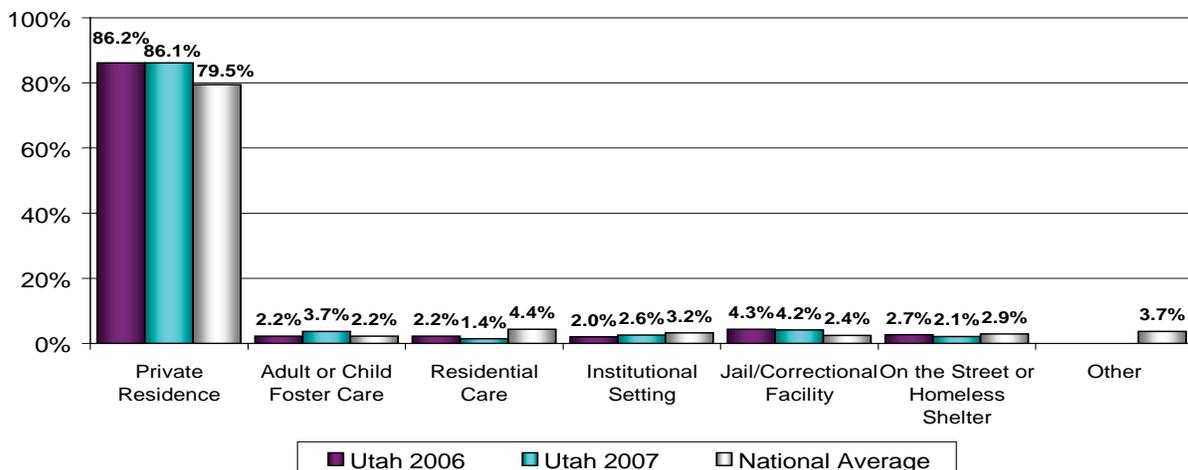
The following graphs depict the living arrangement at admission for substance abuse and mental health clients served in fiscal year 2007. By far, the majority of clients receiving substance abuse and mental health services are independent

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 2006 - 2007



Living Arrangement at Admission of Adults Served in Mental Health Services Fiscal Years 2006 - 2007

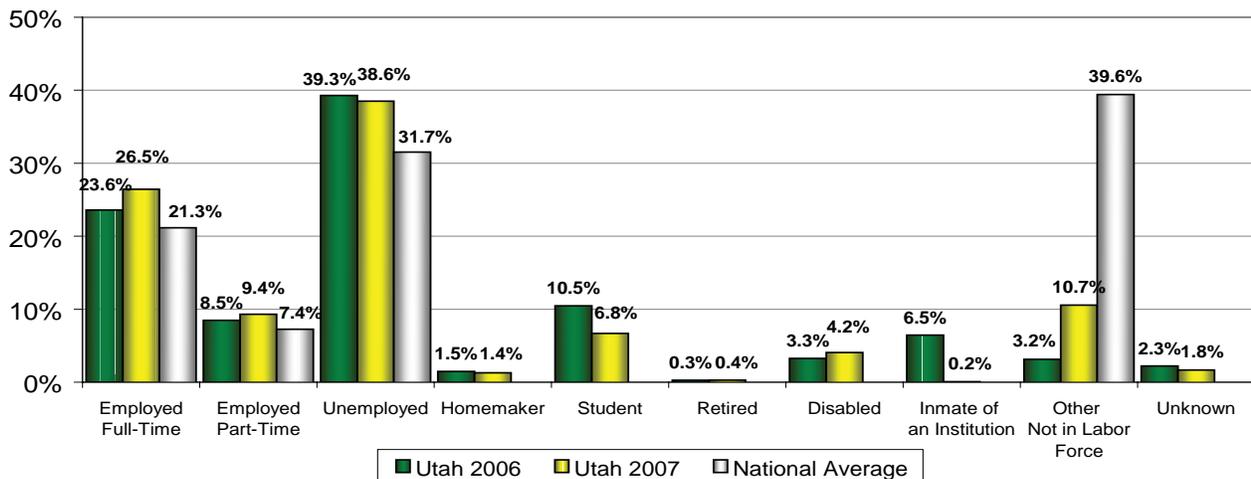


Employment Status at Admission

The following graphs show the employment status at admission for substance abuse and mental health clients served in fiscal year 2007. The categories

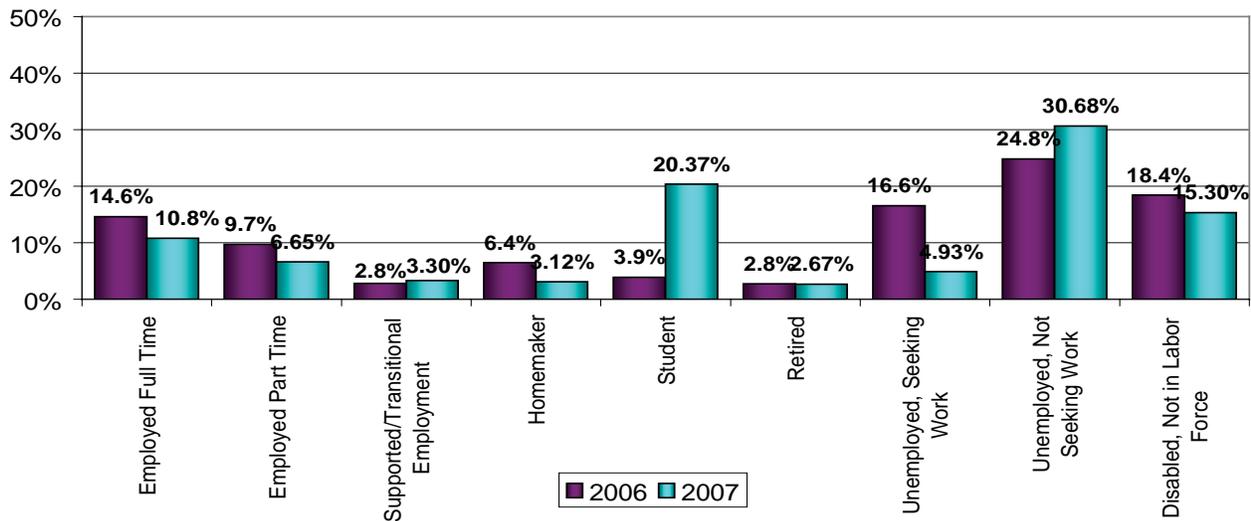
for mental health clients are different than those for substance abuse clients.

Employment Status at Admission for Individuals in Substance Abuse Services Fiscal Years 2006 - 2007



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 2006 - 2007

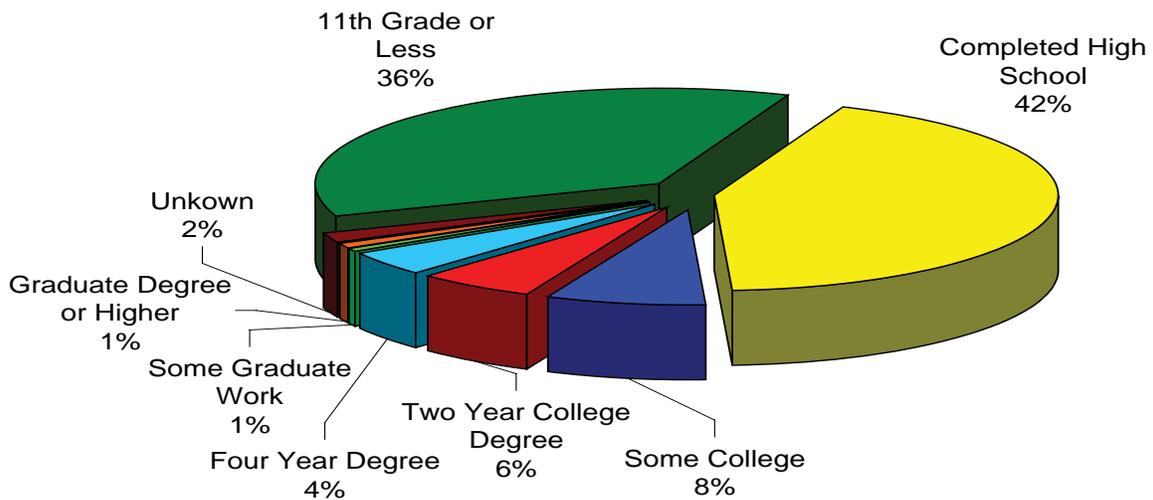


Highest Education Level Completed at Admission

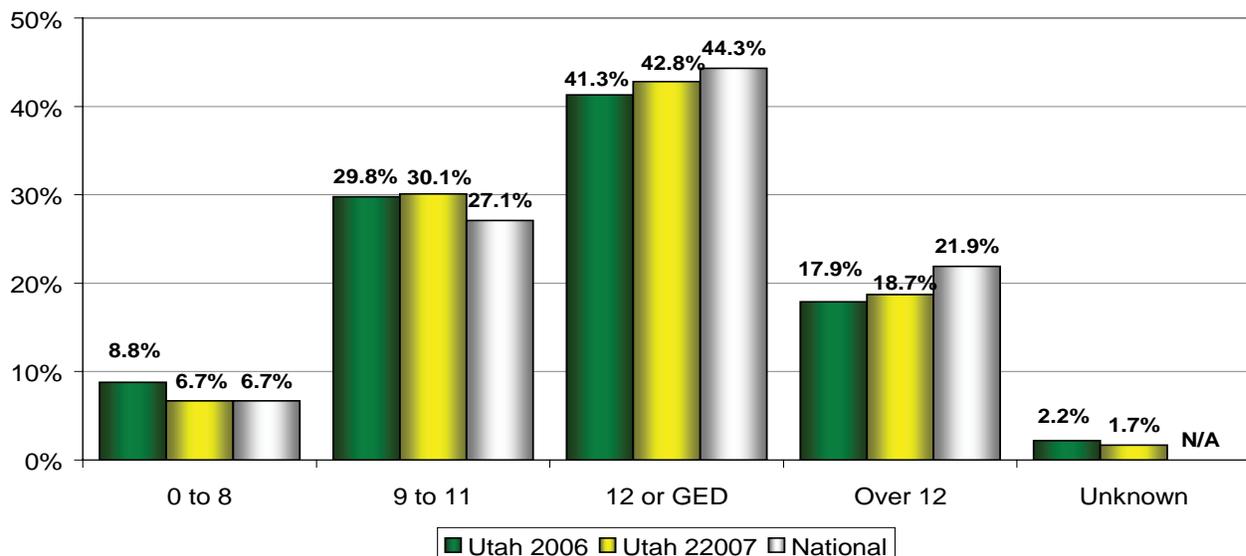
In fiscal year 2007, 62% of adults in substance abuse treatment statewide completed at least high school, which included those clients who had attended some college or technical training.

Additionally, 19% of the clients had received some type of college training prior to admission. Still, over 36% had not graduated from high school.

**Education Level at Admission for Individuals in Substance Abuse Services
Fiscal Year 2007**



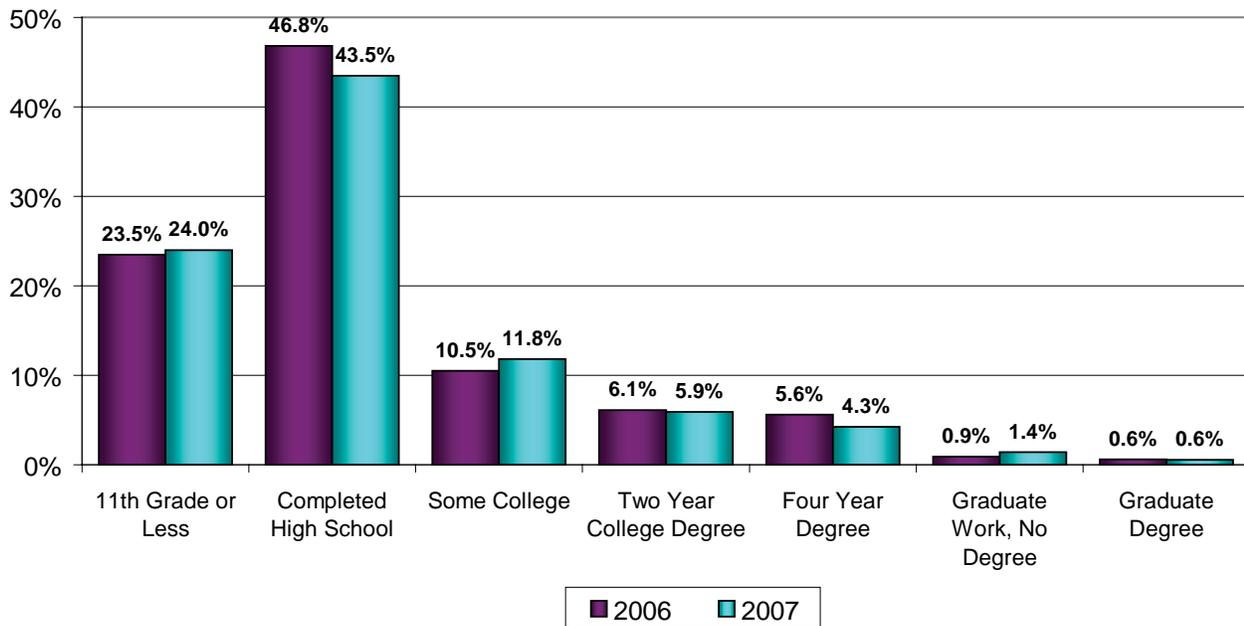
**Highest Education Level of Adults Served in Substance Abuse Services
Fiscal Years 2006 - 2007**



In fiscal year 2007, 45% 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,

16% of the clients had received some type of college degree prior to admission. Still, over 48% had not graduated from high school.

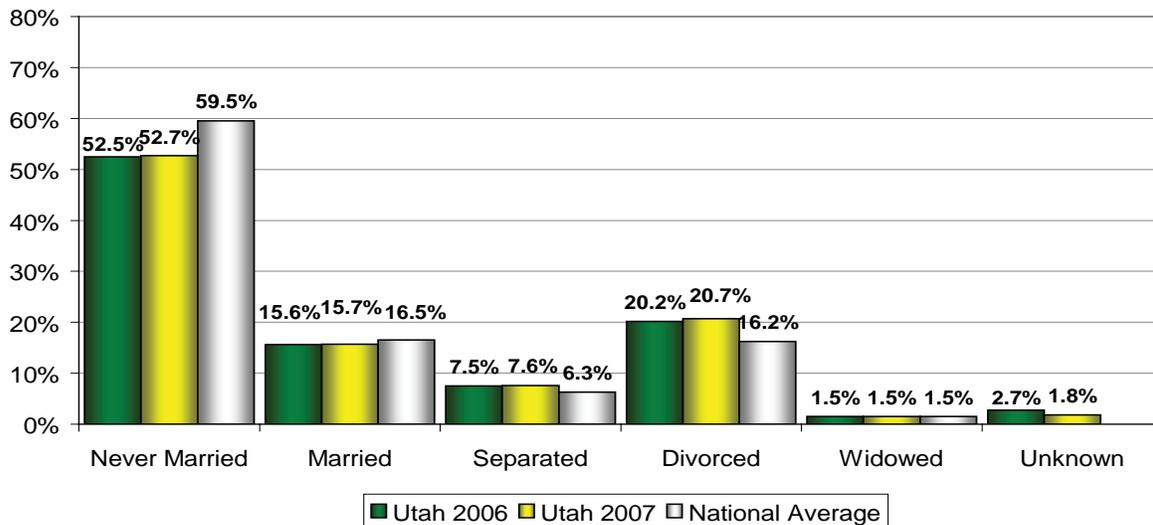
Highest Education Level of Adults Served in Mental Health Services Fiscal Years 2006 - 2007



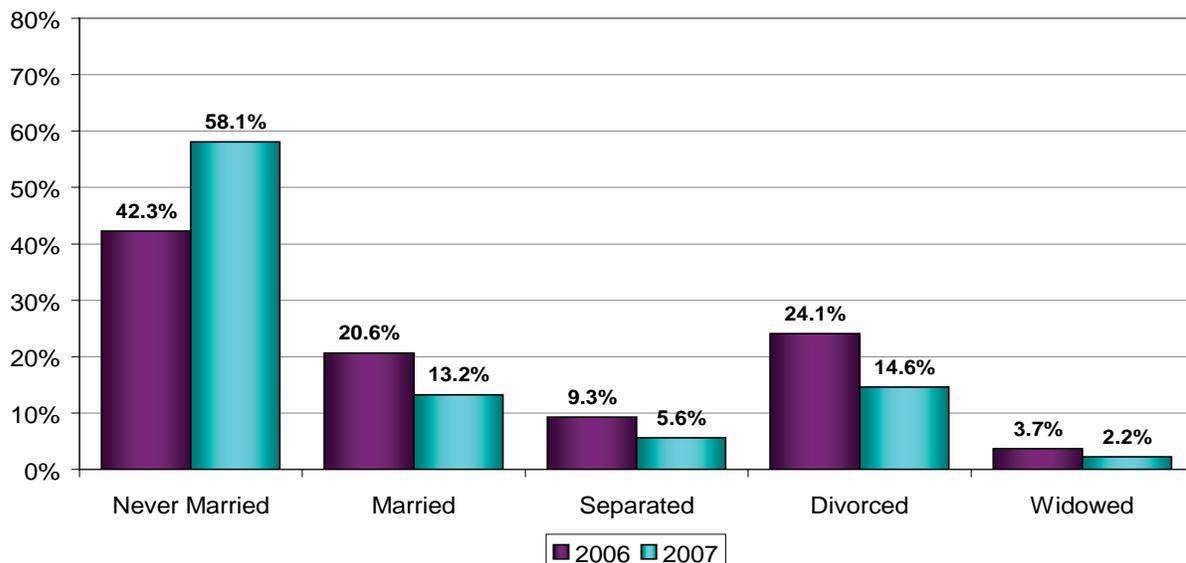
Marital Status at Admission

The following graphs show the marital status at admission for substance abuse and mental health clients served in fiscal year 2007.

Marital Status of Individuals Served in Substance Abuse Services Fiscal Years 2006 - 2007



Marital Status of Adults in Mental Health Services Fiscal Years 2006 - 2007

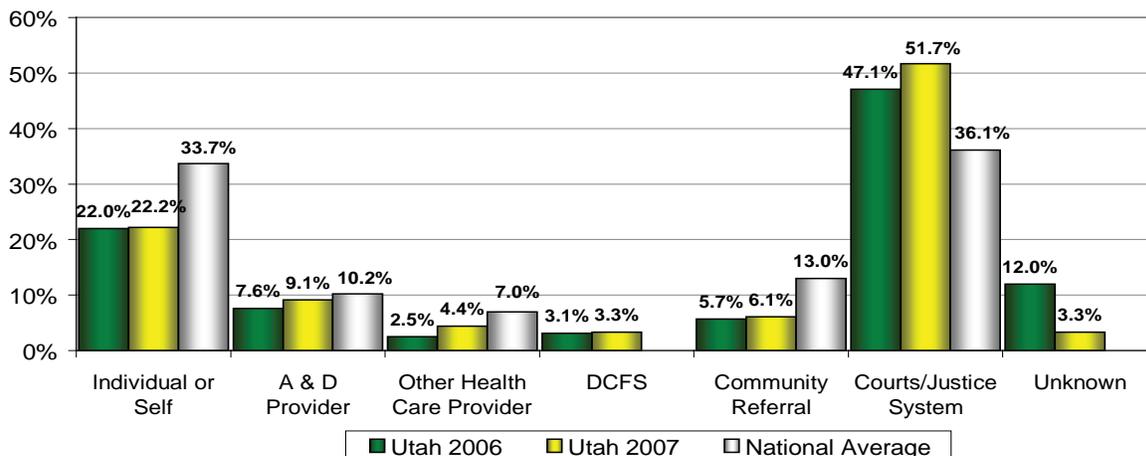


Referral Source

The individual or organization that has referred a client 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 client stay in treatment once there; the “referral

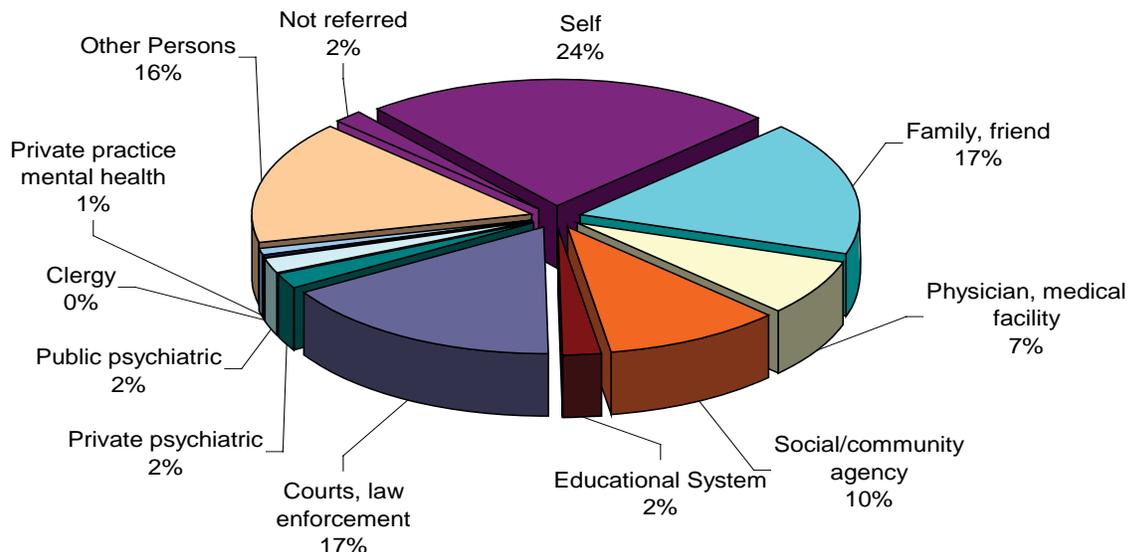
source” can continue to have a positive influence on the clients’s recovery. The graphs below show the detailed referral sources for fiscal years 2006 through 2007 for substance abuse and fiscal year 2007 for mental health.

Referral Source of Individuals in Substance Abuse Services Fiscal Years 2006 - 2007



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

Referral Source of People Served in Mental Health Services Fiscal Year 2007



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 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. Each survey contains five measured domains.

1. General Satisfaction
2. Good Service Access
3. Quality & 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 the Division. 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	2007
MHSIP	3,568	3,473	3,692	4,669
YSS	N/A	675	825	977
YSS-F	N/A	536	823	1,211

Results

The percentage of individuals reporting positive responses for all scales in the MHSIP survey did not significantly change from 2004 to 2007. In all, more than 70% reported positive responses in all scales.

The YSS survey, completed by youth, has declined in all domains from 2006 and are below the national average in all domains.

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.

All domains reported by the youth (YSS) and 4 of the 5 domains reported by parent or guardian of youth (YSS-F) are below the national average.

Recommendations

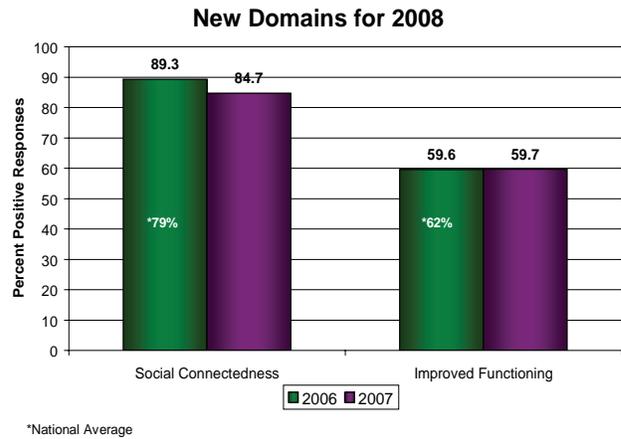
The Division takes the results of these surveys seriously and will use the results to improve services by taking the following actions:

- Set a minimum sample rate of 5%.
- Establish a target performance standard to meet or exceed the national average for MHSIP and the statewide average for YSS and YSS-F.

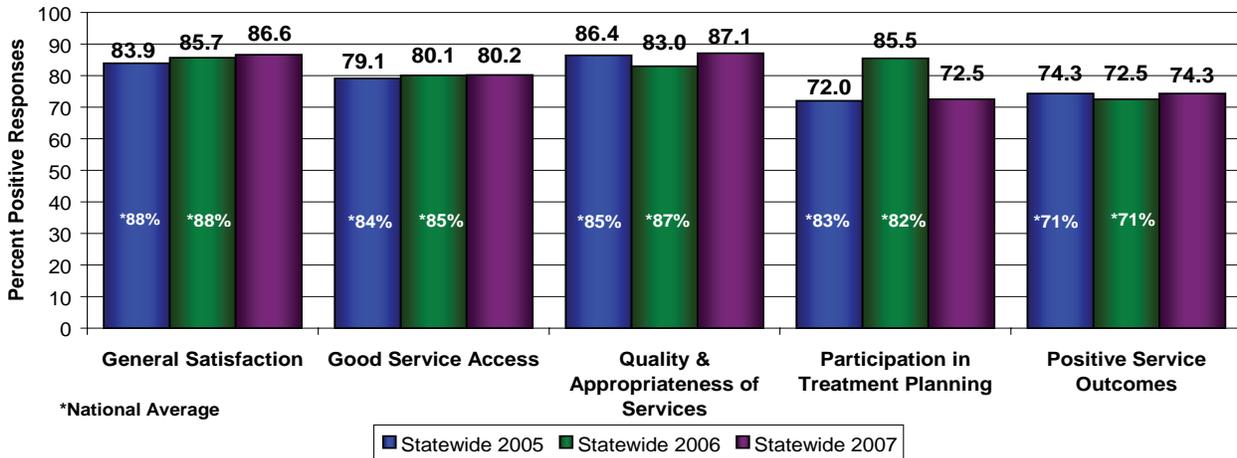
- The Division will include survey results and sample rates in monitoring reviews and will use that information to assess the quality of services and to help agencies improve.
- The results of the surveys will be reported to Local Authorities and Providers as a part of the Division’s Balanced Scorecard, along with trends and ideas for improvement.
- The Division 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.
- The Division will review sample rates and survey administration with the 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 the Division.

New Domains for 2008

For the past two years additional questions have been piloted for two additional domains on the MHSIP and YSS-F surveys. These additional domains are: Social Connectedness and Improved Functioning. Improved Functioning included some of the questions from the Outcomes domain. We have collected information on these domains on the YSS-F for the past two years and have found the following: while Improved Functioning has stayed the same, Social Connectedness has decreased in the last year by about 5%. Next year these domains will be reported in Consumer Satisfaction Survey Scorecard.

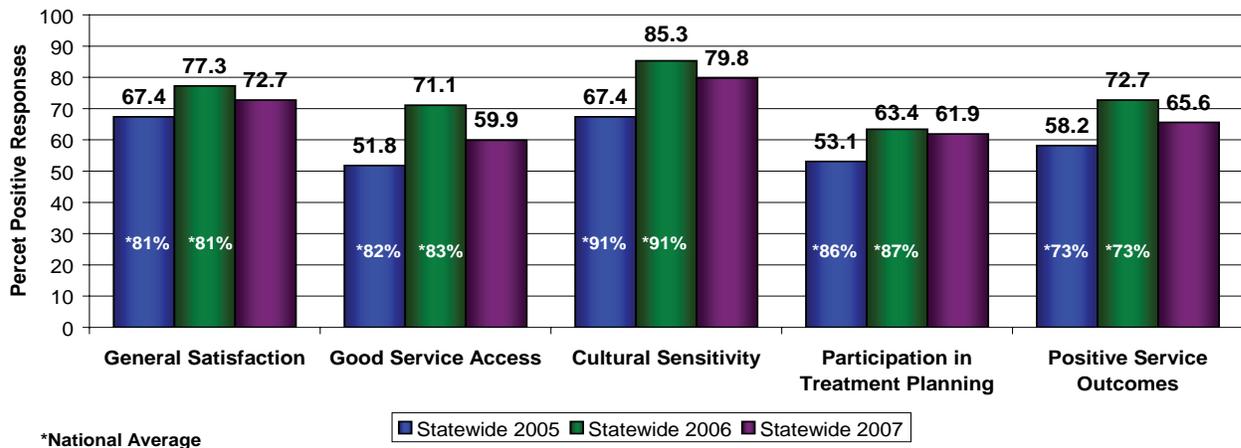


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) Completed by Adults in Substance Abuse and Mental Health Treatment



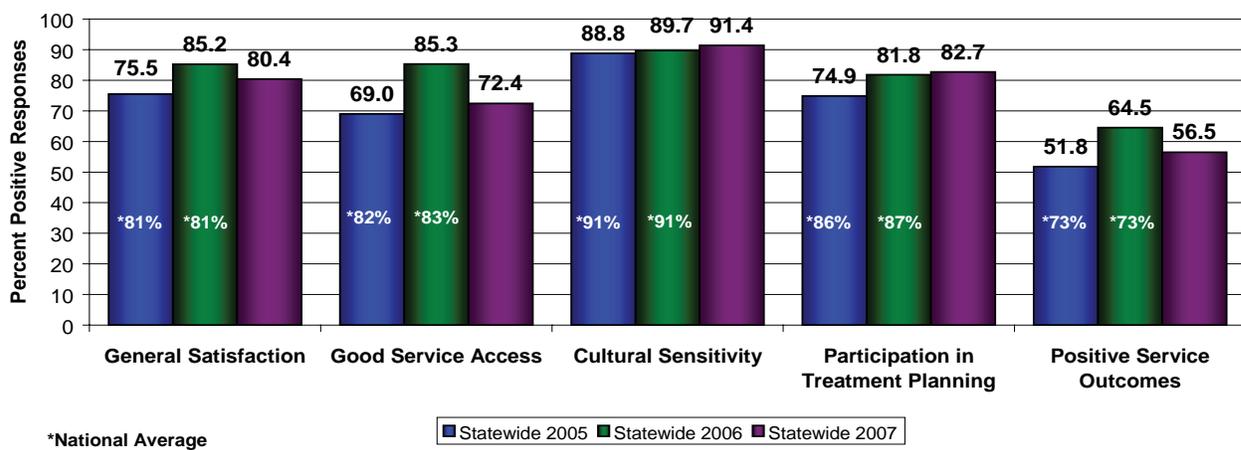
Youth Consumer Satisfaction Survey Youth Services Survey (YSS)

Completed by Youth (ages 12 to 17) 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



Substance Abuse Prevention

Overview

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. 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. 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 its 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.

The Utah Prevention System is centered on prevention coordinators from 13 Local Authority Districts. These coordinators are responsible for planning, implementing, and evaluating prevention services in their area. The Local Authority Districts are required to have community level coalitions to help coordinate services and leverage resources. Utah's prevention system follows a strategic, science-based planning process.

Statewide prevention initiatives include the Utah Prevention Advisory Council, Eliminating Alcohol Sales to Youth Program, Parents Empowered media campaign, Governor Huntsman's Meth Task Force, Prevention Dimensions, and a prevention workforce development plan that includes prevention specialist training and community coalition building training.

Local Service Highlight

Southwest Behavioral Health Center partnered with schools in its area to develop a Student Assistance Program. Evaluation of this program has shown that participants in the program increase school attendance, grade point average, and reduce risk factors for substance abuse. The program is currently being evaluated and is taking place in a "Service to Science Academy" where Southwest's prevention staff can leverage resources needed to move this program into a best practice status. One middle school, with a class of 32 Student Assistance participants, reduced their annual school absences from 394 to 153.

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. While most school-based prevention programs are an addition to school curriculum requirements, the Prevention Dimensions program has been developed to help

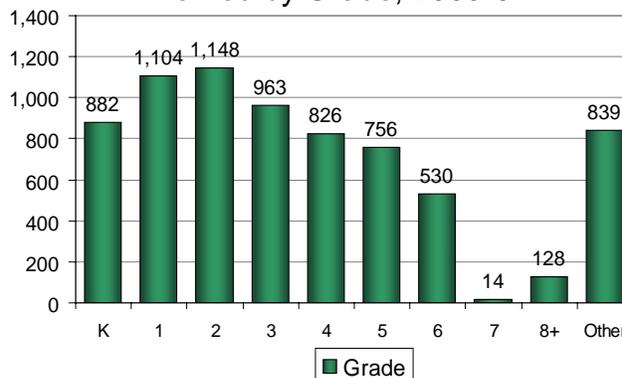
meet core curriculum needs. The Prevention Dimensions program was first started in 1982 with curriculum enhancements taking place in 1992 and 2003. The lesson objectives are based on increasing protective factors and decreasing risk factors while adhering to a no-use message for alcohol, tobacco, marijuana, inhalants, and other drugs. Prevention Dimensions builds life skills, delivers knowledge about alcohol, tobacco, and other drugs (ATOD), and provides opportunities for students to participate in prevention activities. Prevention Dimensions also provides means for parents to get involved in preventing problems with their children by including them in homework assignments and providing prevention tools to be used in the home. Foremost among these materials are the supplemental musical CDs produced by Steve James Productions. While specific songs on these CDs are used effectively to supplement age-appropriate lessons, the power of this music component is extended not only to students, but also to families and the community at large. Steve James continues to be very active throughout the state promoting assemblies and Prevention Dimensions parent night concerts in elementary schools. During the 2006-07 school year, these community outreach activities were extended to 41 schools in 14 school districts.



Based on its history and positive outcomes Prevention Dimensions received a U.S. Department of Health and Human Services Exemplary Program award and was accorded “promising program” status. A cooperative effort between

DSAMH and the State Office of Education allows an ongoing rigorous evaluation of Prevention Dimensions. Currently listed on Substance Abuse and Mental Health Services Administrations as a Legacy Program, Prevention Dimensions’s current evaluation outcomes support its status of a best practice program.

Cumulative Number of Teachers Trained by Grade, 2003-07



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

The goal of the SIG-E project was to change the way prevention is implemented at the campus and local levels. Specifically, prevention planning should be based on data compiled during regular needs assessments; redundancies and gaps in services should be minimized through regular resource assessments; and program effectiveness should be maximized through the use of science-based programs and regular outcome evaluations. The evaluation analysis indicates that the SIG-E project was successful in meeting that goal.

SHARP (Student Health and Risk Prevention) Survey 2007

The SHARP Survey is a bi-annual survey that is a collaborative effort by the DSAMH, the Utah State Office of Education, and the Utah Depart-

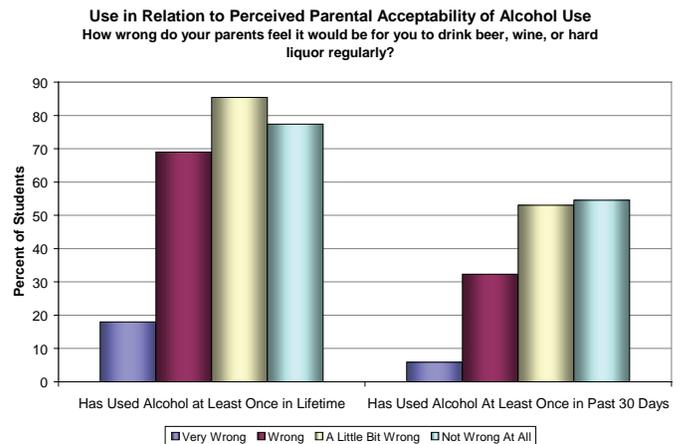
ment of Health. The survey combines three instruments: the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS), and the Prevention Needs Assessment Survey (PNA). Data obtained through the surveys are utilized to identify key risk and protective factors for substance abuse, consumption rates, and identify levels of anti social behavior in Utah's 6th, 8th, 10th, and 12th graders. More than 46,000 students were surveyed in the 2007 administration. Survey information helps communities identify local needs which in turn allow the selection of science-based, tested and proven effective prevention programs. The SHARP state report as well as regional reports can be found at dsamh.utah.gov/sharp.htm.

Highlights of the 2007 SHARP Survey

New to the survey this year are questions about steroid use, methamphetamine use, prescription drug abuse, and gambling.

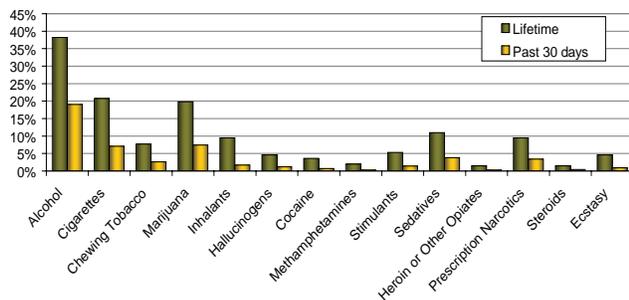
While in most cases, Utah's students use substances at a rate far less than their national counterparts, Utah's teens meet or exceed national rates in inhalant abuse and prescription narcotic abuse rates.

Parents have an influence over their student's use of alcohol. The survey revealed that parents that set clear rules and expectations about no under-age drinking had children with significantly lower use rates than parents that did not use a clear "no use" message.

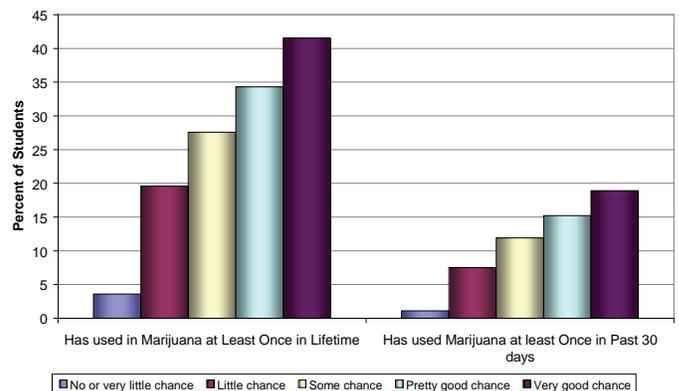


The survey also points out the importance of peer influence on a teens decision to use alcohol or other drugs. The next graph shows a dramatic difference in use rates for youth based on whether they think their friends will think Marijuana is "cool."

12th Graders who Used ATOD's Lifetime vs. Past 30 Days



Marijuana Use in Relation to Perceived Peer Acceptability
What are your chances you would be seen as cool if you smoked marijuana?



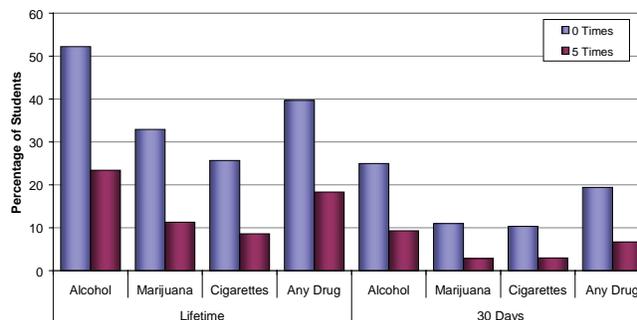
Substance Abuse and Mental Health

One tool parents can use to help protect their children from poor decision and negative consequences is to have family dinner. The SHARP survey supports other surveys done throughout the nation that show strong correlations between the number of dinners per week and alcohol and other drugs use rates. Families that have dinner five times a week provide more protective factors, less risk factors, and less consumption of alcohol.

The charts below show why prevention of underage drinking remains a top priority in DSAMH's prevention efforts.

For more information on the 2007 SHARP survey see dsamh.utah.gov/sharp.htm.

Substance Abuse by the Percentage Reporting the Average Number of Times They Eat Dinner With Their Family in a Week



30-Day Alcohol USERS

County	6th Grade			8th Grade			10th Grade			12th Grade		
	2003	2005	2007	2003	2005	2007	2003	2005	2007	2003	2005	2007
Bear River District	0.0	1.6	1.2	5.1	6.5	5.1	13.8	11.1	13.5	18.7	13.7	9.0
Central Utah	1.3	0.6	2.1	12.0	6.5	6.4	20.7	11.6	12.7	27.1	15.9	13.3
Davis County	1.8	1.5	1.3	7.0	6.6	6.4	13.8	14.0	11.3	16.7	15.2	15.1
Four Corners	0.0	2.6	4.1	13.6	11.7	15.1	43.8	26.4	23.6	35.0	34.2	28.5
Northeastern District	2.5	3.9	2.3	10.2	10.6	12.7	10.9	19.8	15.1	-	24.8	18.9
Salt Lake County	2.6	2.7	2.3	12.0	11.6	10.2	17.4	18.9	19.9	22.7	27.2	25.2
San Juan County	5.9	0.0	0.0	9.4	6.9	5.3	9.5	10.0	16.0	-	-	-
Southwest District	2.3	1.9	1.3	5.6	7.1	6.5	14.8	11.5	12.7	22.5	21.1	11.9
Summit County	1.6	5.5	3.4	13.6	16.6	20.0	21.4	42.1	35.8	63.2	42.1	48.0
Tooele County	3.7	2.9	5.0	12.1	18.0	13.3	29.9	26.0	24.5	44.2	29.1	26.1
Utah County	1.2	0.7	0.7	4.5	4.7	4.1	7.7	7.3	6.9	16.5	8.1	8.1
Wasatch County	2.0	1.5	1.4	8.7	6.6	11.3	12.7	6.9	9.5	27.7	8.9	23.4
Weber/Morgan Counties	1.6	3.1	2.2	11.0	14.1	16.0	16.3	23.0	23.0	27.3	25.6	26.8
Statewide Average	5.4	2.6	1.8	5.4	9.3	8.7	17.2	15.7	15.9	17.2	20.5	19.0
National MTF*				19.7	17.1	15.9	35.4	33.2	33.4	47.5	47.0	44.4

*Monitoring the Future

LIFETIME Alcohol USERS

County	6th Grade			8th Grade			10th Grade			12th Grade		
	2003	2005	2007	2003	2005	2007	2003	2005	2007	2003	2005	2007
Bear River District	4.8	7.4	5.0	14.8	18.5	14.4	27.4	26.5	27.3	27.2	30.6	26.7
Central Utah	9.2	10.3	9.2	22.8	22.2	20.0	42.6	33.6	30.9	52.5	38.9	31.0
Davis County	9.6	9.7	8.3	19.6	18.3	19.2	30.1	30.5	25.7	36.6	31.4	31.7
Four Corners	20.0	11.9	16.2	44.4	32.9	33.8	68.2	52.0	52.5	58.5	56.7	51.2
Northeastern District	16.7	12.6	9.9	27.9	25.0	30.0	41.8	43.7	33.4	-	44.9	48.7
Salt Lake County	16.9	16.0	16.7	29.8	30.4	27.0	36.7	42.0	41.3	45.5	48.9	46.9
San Juan County	10.1	3.1	2.4	25.0	13.8	18.4	38.1	22.5	38.0	-	-	-
Southwest District	12.0	9.2	9.1	18.9	19.9	19.7	37.8	28.7	33.0	50.0	43.4	33.8
Summit County	14.5	16.4	14.6	32.2	40.5	39.0	44.0	57.5	62.9	70.0	63.6	77.2
Tooele County	17.4	12.8	16.5	34.0	36.4	32.4	48.4	49.9	43.2	65.5	51.7	49.5
Utah County	10.1	7.0	5.0	14.9	14.0	14.7	22.1	20.0	22.1	37.9	21.1	20.2
Wasatch County	12.2	10.3	6.9	26.6	21.3	27.0	28.5	26.3	27.0	51.3	25.0	50.0
Weber/Morgan Counties	18.4	17.1	12.2	24.7	33.4	34.0	34.0	49.4	47.4	55.0	49.4	48.3
Statewide Average	13.1	12.3	11.3	21.9	24.5	23.2	35.0	35.3	35.0	43.7	40.0	38.2
National MTF*				45.6	41.0	38.9	66.0	63.2	61.7	76.6	75.1	72.2

*Monitoring the Future

Higher Education Needs Assessment Survey

During spring of 2007, DSAMH conducted a third statewide survey of college students called the Utah Higher Education Health Behavior Survey; the 2007 survey was completed by a total of 8,384 students attending the nine Utah public institutions of higher education. The survey has several objectives: assessing the prevalence of ATOD use on Utah campuses; measuring the need for substance abuse treatment by college students; measuring the need for mental health treatment by college students; measuring the levels of selected risk factors for substance abuse; to gain information about health and safety issues facing college students; and to measure students' perception of substance abuse prevention and policies on campus. A comparison of the results from 2003 to 2007 reveals that the use rates for most substances are fairly similar across the three survey periods. One class of drugs, heroin and other opiates, appears to be increasing over time for lifetime and past year use (this is a relatively low-use drug compared to tobacco, alcohol, and marijuana). Lifetime use of several other drugs appears to be decreasing over time. For example, lifetime use of stimulants, ecstasy, and other club drugs has decreased.

- 10.9% had 5+ drinks in one sitting in the past 2 weeks (called high-risk or binge drinking)
- More female students (24.6%) have had alcohol in the past 30 days than males (18.7%)
- 70.5% of students under age 21 report it is very easy or sort of easy to get alcohol
- 31.5% do not know whether their campus has drug or alcohol policies
- 19.3% have had a hangover in the past year
- 7.0% have driven under the influence in the past year
- 8.7% have been in an argument or fight after ATOD use in the past year

Positive findings from the survey:

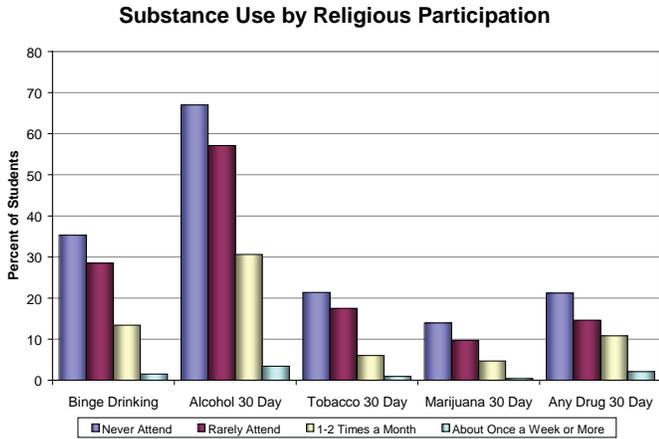
- 57.3% have never had more than a sip of alcohol, 70.1% have not had more than a sip of alcohol in the past year, and 78.1% have not had more than a sip of alcohol in the past 30 days
- 75.9% have never tried marijuana, 92.2% have not had marijuana in the past year, and 96.1% have not had marijuana in the past 30 days

Areas of concern that were revealed from the survey results:

- 32.7% of females and 25.1% of males need mental health treatment
- 10.7% have seriously considered attempting suicide in the past year
- 1.5% have actually attempted suicide in the past year
- 12.4% have regretted their actions after ATOD use in the past year
- 7.3% need alcohol or drug treatment

Treatment Needs by Participant Characteristics

	Number of Participants in Category	Need for Alcohol Treatment	Need for Drug Treatment	Need for Alcohol or Drug Treatment	Need for Mental Health Treatment
Total Percent	8,384	6.3	2.5	7.3	29.4
Gender					
Male	3,757	5.8	2.9	6.9	25.1
Female	4,490	6.9	2.2	7.8	32.7
Academic Year					
Freshman	1,972	7.1	3.2	8.0	31.5
Sophomore	2,298	6.3	3.2	7.6	30.6
Junior	1,962	6.0	2.0	7.0	27.6
Senior	1,520	6.3	1.7	6.9	26.6
Age					
24 and Younger	5,424	6.6	2.6	7.5	28.9
25 and Older	2,704	6.0	2.5	7.3	30.7
Marital Status					
Single	4,990	7.8	3.2	8.9	31.0
Married	2,652	2.5	0.9	3.0	23.3
Separated, Divorced, Widow	340	8.0	1.8	8.3	46.3
Cohabiting	278	14.5	7.9	19.1	34.2
Housing					
Houses/Apartments/etc.	7,481	6.2	2.5	7.2	29.3
Residence Hall	519	7.2	2.5	8.0	29.7
Approved Housing	123	4.9	2.4	6.5	29.0
Fraternity or Sorority	31	19.4	3.2	22.6	30.8
Other	93	12.1	3.3	14.3	32.0



- Religious attendance and preference strongly correlate with ATOD use
- International students have higher rates of drinking (including high-risk drinking) and smoking, but lower rates of drug abuse than other students
- Part-time students use alcohol (including high risk drinking) and cigarettes more than full-time students

- 71.4% have never tried any illegal drug, 86.6% have not had any illegal drugs in the past year, 92.8% have not had any illegal drugs in the past 30 days
- 32.3% believe that campus alcohol and drug policies are enforced
- 71.1% have never smoked a cigarette. 93.6% have not smoked in the past 30 days

Other key findings:

- Grade Point Average (GPA) correlates with ATOD use and need for mental health treatment
 - 8.6% have experienced memory loss after ATOD use in the past year
 - 8.6% have missed a class after ATOD use in the past year
 - 6.4% have had poor academic test or project performance after ATOD use

ATOD Use by Participant Characteristics - Weighted Sample

	Number of Participants in Category	Binge Drinking	Alcohol 30 Day	Cigarette 30-Day	Marijuana 30-Day	Any Drug 30-Day
Total Percent	8,220	10.9	21.6	6.4	3.9	7.2
Gender						
Male	3,740	11.6	18.7	6.4	4.4	7.4
Female	4,480	10.4	24.6	6.5	3.5	6.9
Academic Year						
Freshman	1,964	10.2	19.4	6.7	4.5	7.4
Sophomore	2,291	11.3	21.6	7	4	6.8
Junior	1,960	11.4	21.1	6	4.4	7.7
Senior	1,517	9.8	23.1	5.3	3	7.6
Age						
24 and Younger	5,408	10.4	19.1	5.1	4.1	6.9
Older than 24	2,695	11.7	27.6	8.9	3.5	7.8
Student Status						
Full-Time	5,898	10	18.9	5.6	3.8	6.9
Part-Time	2,247	13	29.3	8.6	4.4	8
Residency While In School						
On-Campus	1,068	10.6	19.2	4.5	3.5	6.1
Off-Campus	6,991	10.8	22.1	6.8	4.1	7.3
Permanent Residence						
In-State	7,547	10.4	21.3	6.2	3.7	6.8
Other U.S. State	557	15.3	27.1	7.7	7.6	12.1
Country Other than USA	124	16.9	31.7	10.7	1.6	4.1
Employment						
Not Employed	1,819	11.3	21.7	7	4.8	8.3
Full-Time	2,540	13.5	28.5	8.4	3.7	7.9
Part-Time	3,866	9.1	17.8	4.9	3.6	6.1
Relationship Status						
Single	4,975	12.1	21.5	6.6	4.7	8.1
Country other than USA	2,647	5.7	15.7	4	1.3	3.5
Separated, Divorced, or Widowed	340	15.9	33.3	11.8	2.7	9.2
Cohabiting	277	31	74	20.9	15.7	22.4
Housing						
Houses or apartment	7,466	10.4	21.6	6.4	3.8	7.1
Residence Hall	519	13.5	23.6	6	4.6	7
Approved Housing	123	12.2	19.7	6.6	4.9	8.3
Fraternity or Sorority	31	48.4	67.9	13.8	6.9	14.8
Other	93	15.1	26.1	8.9	5.5	10.6
GPA						
A	3,460	9.3	20.4	5.9	3.4	6.3
B	3,899	11.1	22.1	6	4.1	7.3
C	741	16.9	27.1	11.8	5.3	10.7
D or F	42	14.3	23.8	7.1	7.1	12.2
Religious Attendance						
Never Attend	1,126	35.3	67	21.4	13.9	21.2
Rarely Attend	1,183	28.5	57.1	17.5	9.7	14.6
1-2 Times a Month	636	13.4	30.6	6	4.7	10.8
About Once a Week or More	5,291	1.5	3.4	0.9	0.4	2.1
Religious Preference						
Catholic	318	33.3	65.6	18.6	6.4	11
LDS	6,042	3.9	7.3	2.2	1.3	3.6
Protestant	326	22.1	50.8	13.4	8.3	12.2
Other	595	27.1	57.2	17.6	11.8	17.8
No preference	944	33.7	67.3	20.2	13	19.8

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 DSAMH. During fiscal year 2007, local health departments and local law enforcement conducted more than 5,000 compliance checks to ensure that tobacco outlets are following Utah laws that prohibit tobacco sales to underage youth.

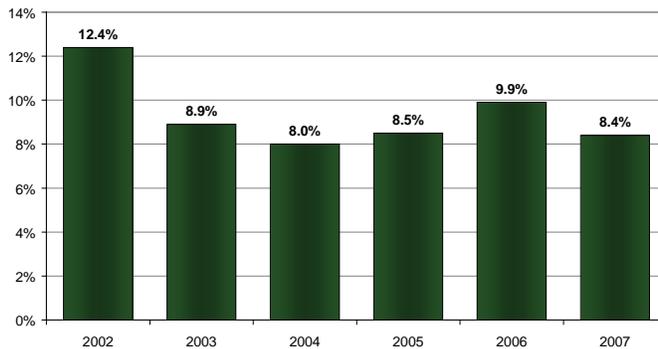
Utah's State Epidemiology/ Outcomes Workgroup (USEOW)

DSAMH has implemented a State Epidemiology Workgroup made up of prevention experts, survey experts, and epidemiology experts to enable a system that will enhance the availability of data related to substance abuse consumption and consequences. The primary task of the USEOW is to collect and interpret data in order to develop recommendations about the substance abuse priorities for the State of Utah. As a result, prevention workers will be able to accurately assess their community's needs and apply effective prevention activities. The USEOW has developed 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.

The USEOW has collated state data and compared it to national measures. As a result of this effort, an epidemiological profile was developed that presents 28 indicators of substance use consequences and 24 indicators of substance use estimates for youth and adult populations in the state.

For the Epidemiology Report see http://www.dsamh.utah.gov/docs/seow_final_epi_report_2007.pdf.

Percentage of Outlets Found in Violation
Federal Fiscal Years 2002 - 2007



Compliance Checks & Use Rates

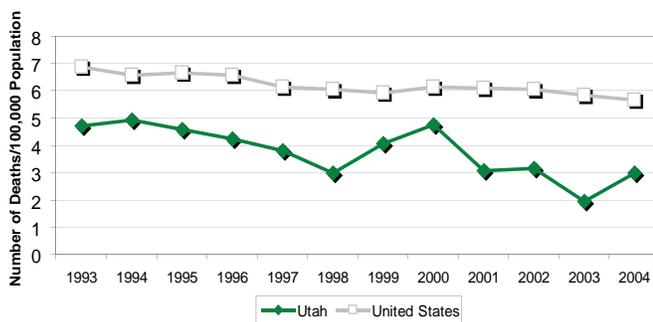
Area	Percentage of non-compliant sales	12th grade, used cigarettes in lifetime	12th grade, used cigarettes in past 30 days
Summit	3.2	44.8	26
Wasatch	7.8	33.3	14.1
Northeastern	14.7	34.8	11.8
Tooele	10	25.7	10.5
Salt Lake County	9.4	24.2	8.2
Weber-Morgan	7	22.7	8.1
Southeastern (Four Corners and San Juan)	7.9	FC 36.1 SJ 36.0	FC 13.3 SJ 19.6
Davis	14.3	17.9	6.8
Southwestern	5.2	18.4	5.8
Central	6.8	21.2	5
Bear River	5.5	11.8	4.1
Utah County	6.5	12.6	2.8
Utah State Average	8.3	20.7	7.1

Strategic Prevention Framework (SPF) Grant

In October 2006, DSAMH was awarded a Strategic Prevention Framework Grant. The grant, from the Federal Substance Abuse and Mental Health Services Administration, gives Utah \$2,093,000 per year for five years to 1) prevent the onset and reduce the progression of substance abuse, including childhood and underage drink-

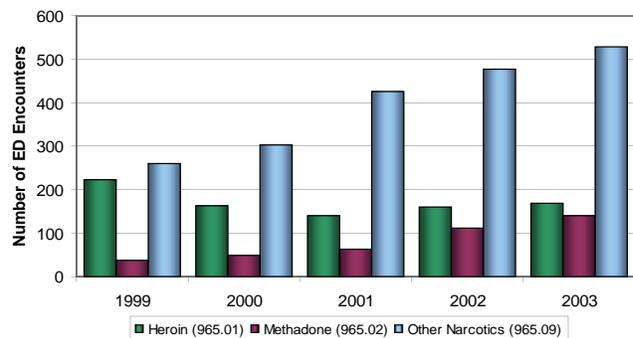
ing; 2) reduce substance abuse-related problems in communities; and 3) build prevention capacity and infrastructure at the State and community levels. Using data collected by the Utah State Epidemiology/Outcomes Workgroup, the SPF staff identified two statewide substance abuse related priorities that this grant will address, 1) Prescription Drug Abuse and 2) Alcohol Related Motor Vehicle Crashes.

Alcohol Related Motor Vehicle Fatalities



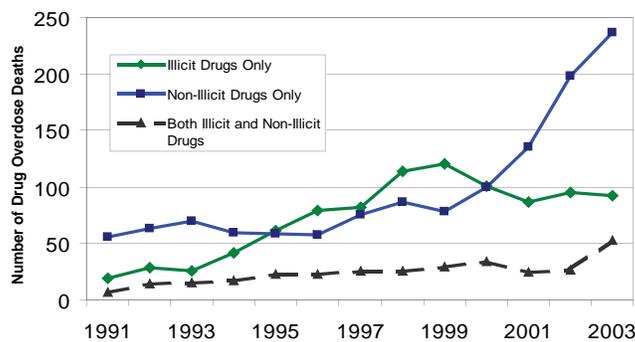
National Highway Traffic Safety Administration, 2004 Fatality Analysis Reporting System (FARS) 2003. Department of Transportation.

Emergency Department Encounters for Narcotics Overdose, 1999 - 2003



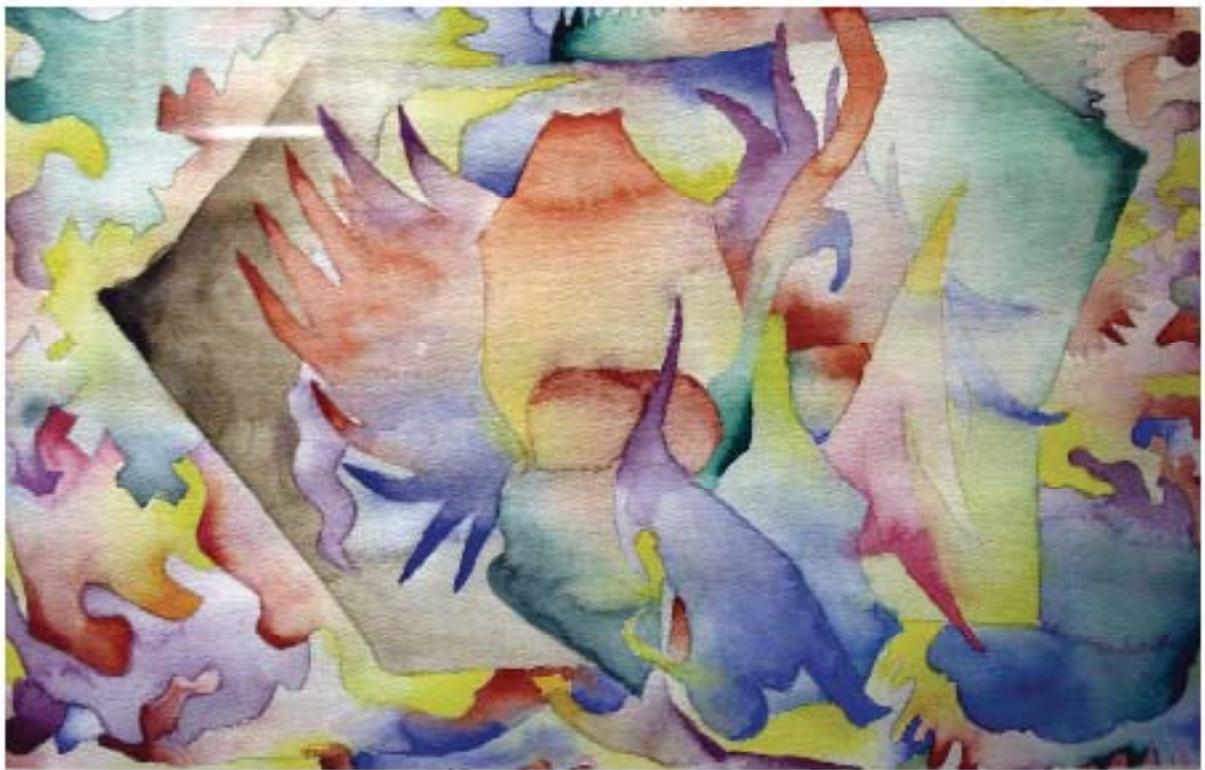
Bureau of Emergency Medical Services, Utah Department of Health.

Number of Drug Poisoning Deaths by Drug Category and Year Utah 1991 - 2003



Utah Medical Examiner Database, Office of the State Medical Examiner, Utah Department of Health.

SUBSTANCE ABUSE TREATMENT



Substance Abuse Treatment

System Overview

Treatment for substance abuse and dependence disorders has changed dramatically over the past several years. The drugs of abuse and the client characteristics have changed. 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 routinely screened. 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 a licensed mental health therapist 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, determine the appropriate level of care, and establish a baseline for determining progress. In addition to a clinical interview, DSAMH requires

that adults complete the Addiction Severity Index (ASI). 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, and 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 to 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, and assistance in helping clients to develop 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 programs 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 abrupt 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, genetic, and environmental factors. 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. Research shows 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

Methamphetamine affects can last up to six months for just one use, and the drug can do greater damage to a person’s physical, behavioral and thinking functions than many other illicit drugs or alcohol. For this reason, a longer episode of treatment is necessary for methamphetamine addiction. Women have a variety of complex issues and should have (1) gender specific services; (2) family focused treatment, (3) child care and housing, and (4) other supportive services that will promote long term sobriety.

- Individuals with co-occurring mental illness disorder (COD)

Services for clients with COD, especially those with more serious mental disorders, must be tailored to individual needs and functioning. For example, SPMI (seriously and persistently mentally ill) clients with substance abuse disorders typically require life long services due to the nature of their disorder.

- Individuals in the Criminal Justice System

The length of time an individual remains in a drug abuse treatment program is an important indicator of treatment effectiveness. Several studies support longer treatment episodes (i.e. at least a year) for individuals in the criminal justice system. 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 treatment 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		
	Universal	Selected	Indicated	Outpatient	Intensive Outpatient	Residential
Program Level						
Appropriate for	• General Population	• At Risk	• Using but does not meet DSM IV Diagnostic Criteria	• DSM IV Diagnosis of Abuse or Dependence	• Serious Abuse or Dependence • DSM IV Diagnosis of Abuse or Dependence	• Severe Abuse or Dependence • DSM IV Diagnosis of Abuse or Dependence
Identification Process	• General Interests	• Referral	• SA Screening	• ASI	• ASI	• ASI
Populations	• K-12 Students • General Population	• School Drop-outs, Truants, Children of Alcoholics, etc.	• DUI Convictions, Drug Possession Charges, etc.	• 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	• Risk Protective Factor Model • Prevention Dimensions • Red Ribbon Week	• Risk Protective Factor Model	• Risk Protective Factor Model • Education Intervention Program	• 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 2007 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%.
- 5.1% 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 16,469 individuals, or less than 20% of the current need.

- A combined total of approximately 95,058 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 2007, is also included to illustrate the unmet need. The same data is depicted on the following graphs.

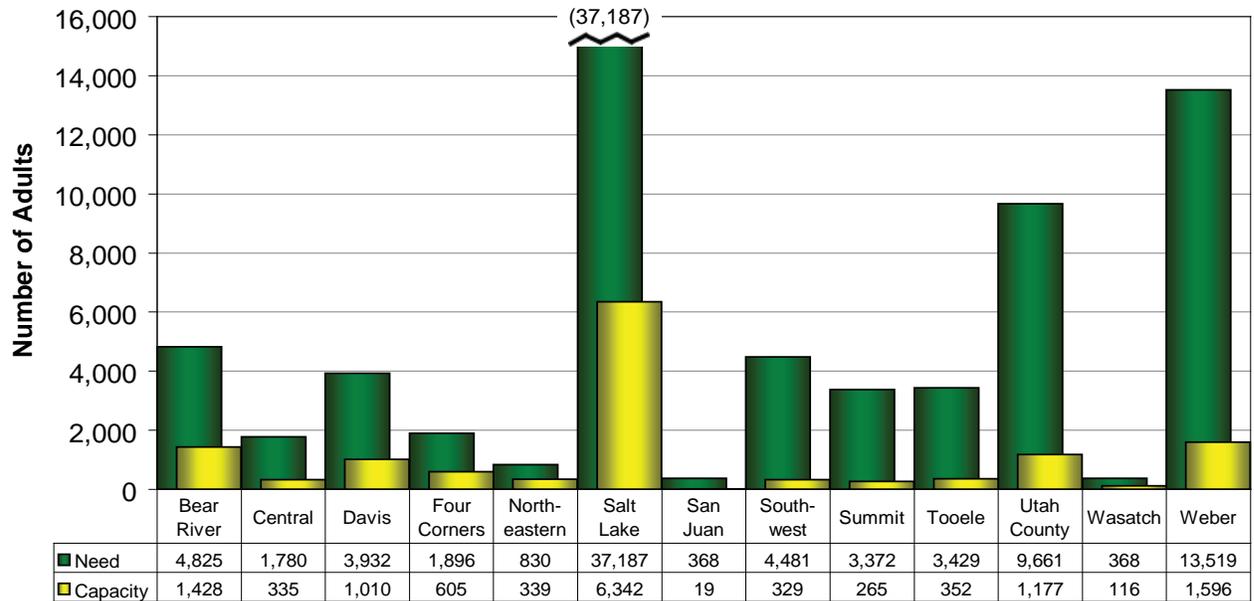
Treatment Needs Vs. Treatment Capacity

	Adults (18 years+)			Youth (Under age 18)		
	% Need Treatment	# Need Treatment	Current Capacity	% Need Treatment	# Need Treatment	Current Capacity
Bear River	4.8%	4,825	1,428	3.4%	475	83
Central	3.7%	1,780	335	4.0%	306	45
Davis	2.1%	3,932	1,010	3.9%	1,133	27
Four Corners	6.6%	1,896	605	5.8%	217	90
Northeastern	2.7%	830	339	5.5%	256	23
Salt Lake	5.4%	37,187	6,342	6.7%	5,926	605
San Juan	3.9%	368	19	9.5%	177	0
Southwest	3.4%	4,481	329	4.0%	643	20
Summit	12.9%	3,372	265	14.6%	482	40
Tooele	9.5%	3,429	352	3.4%	185	52
Utah County	3.2%	9,661	1,177	3.2%	1,465	88
Wasatch	2.6%	368	116	3.7%	73	4
Weber	8.7%	13,519	1,596	6.2%	1,279	200
State Totals	4.7%	82,667*	15,198**	5.1%	12,391*	1,271**

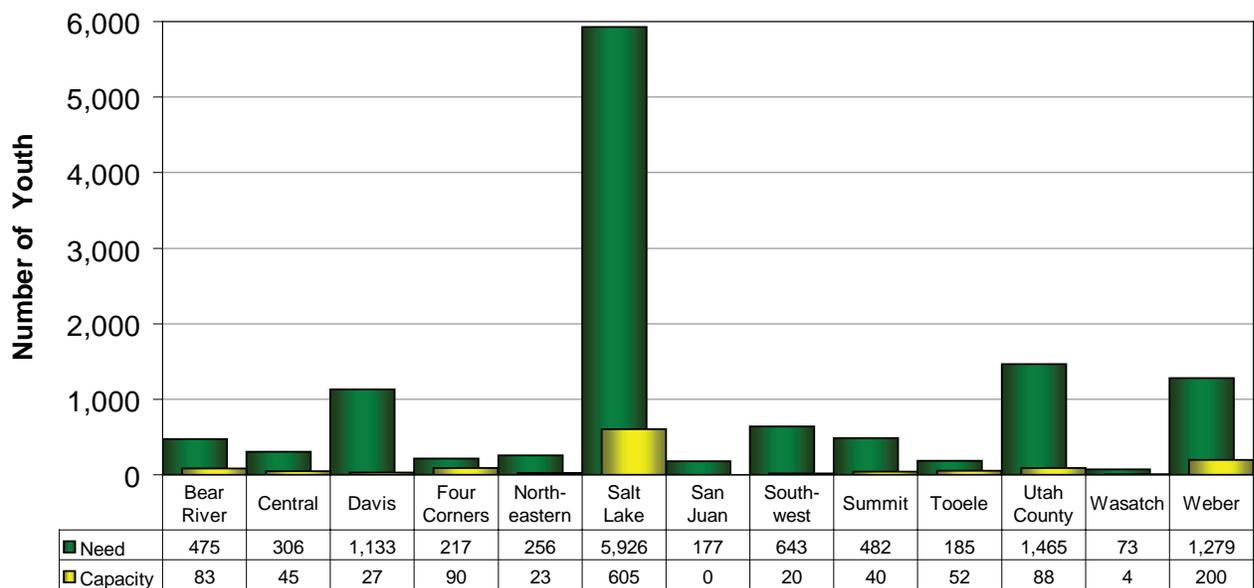
*because of rounding in the percentages, Local Authorities totals do not exactly add to the State total.

** an additional 1,668 clients that were served by statewide contracts at the U of U Clinic (411) and the Utah State Prison (1,257) are reflected in the State total.

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



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



Number of Treatment Admissions

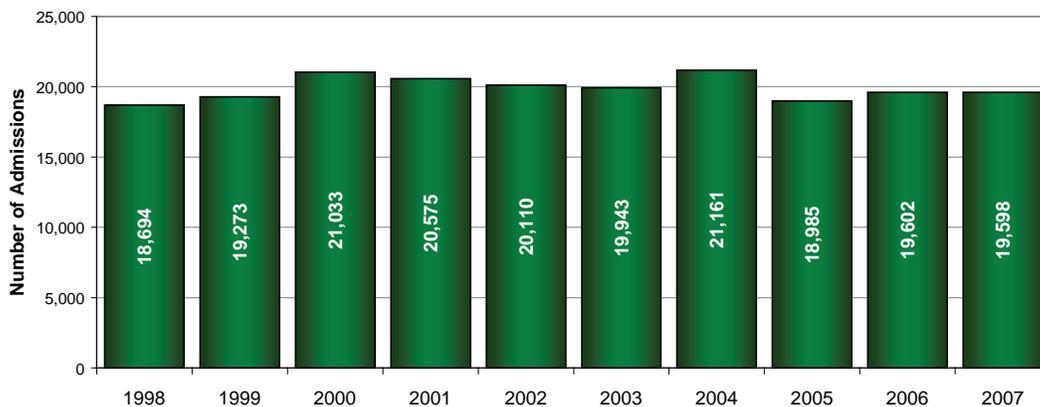
The Federal government requires that each state collect demographic and treatment data on all clients admitted into any publicly-funded substance abuse treatment facility. This data is called the Treatment Episode Data Set (TEDS). TEDS is the source that DSAMH uses for treatment admission numbers and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

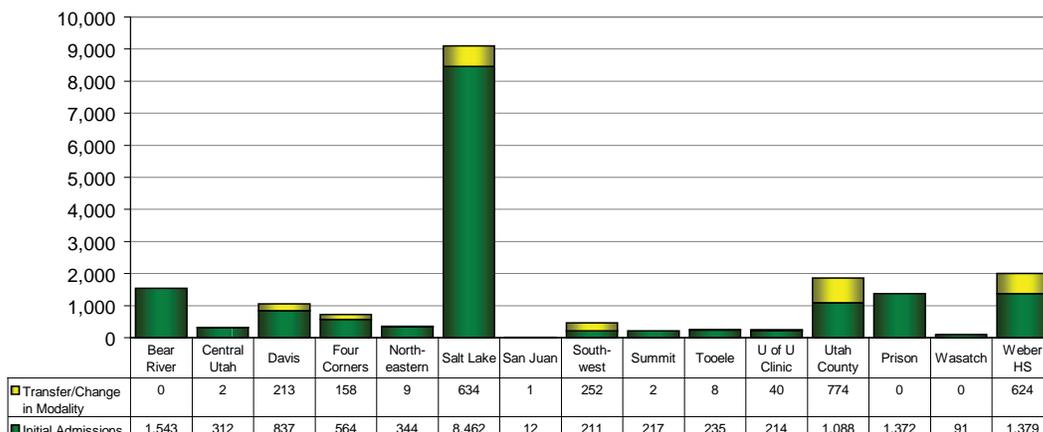
based on treatment admissions over the past 10 years. The first chart shows that data and shows that the number of treatment admissions has remained relatively constant over the past decade.

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 2007. Treatment admissions in Salt Lake County account for over 46% of all admissions. This is a decrease from fiscal year 2006 when Salt Lake County served 55% of all treatment admissions.

Substance Abuse Initial and Transfer Admissions into Modalities
Fiscal Year 1998 to Fiscal Year 2007



Substance Abuse Treatment Admissions and Transfers in Utah by Local Authority Area
Fiscal Year 2007

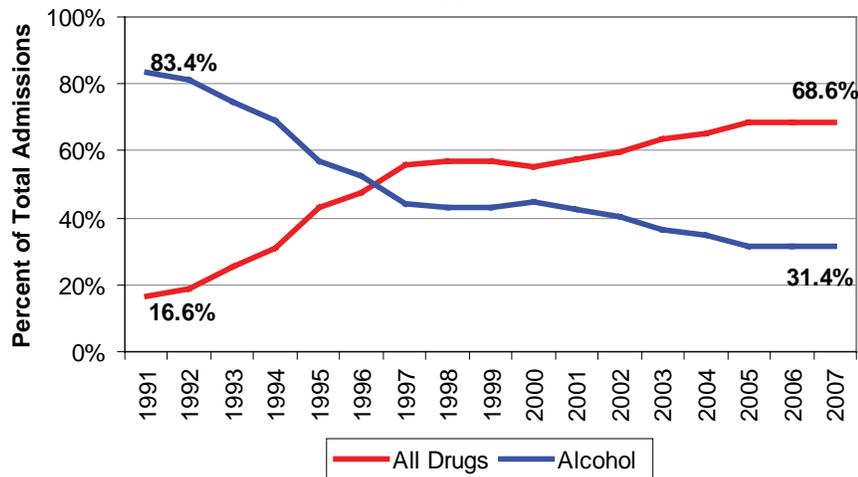


Primary Substance of Abuse

In 1991, 83% of Utah clients came into treatment for help with alcohol dependence; in fiscal year 2007 that percentage fell to 31%. During the

same period, the percentage of clients entering treatment for illicit drug abuse/dependence has risen from 17% in 1991 to 69% in 2007.

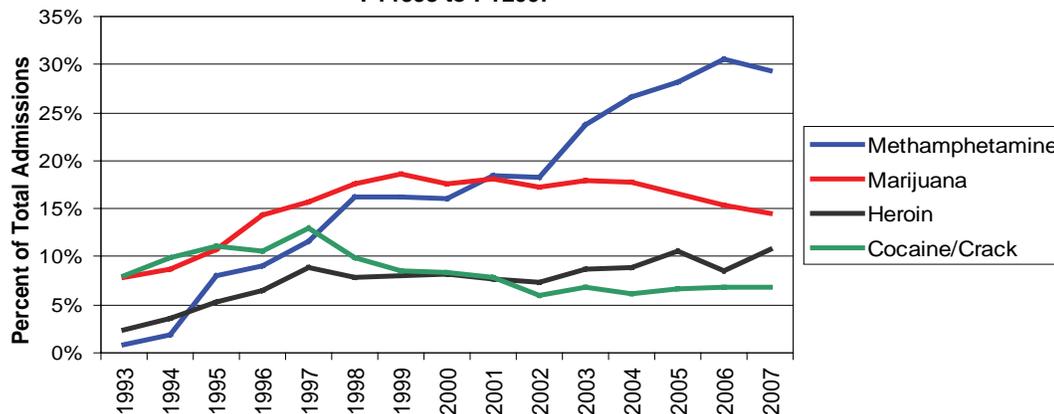
**Patient Admissions for Alcohol vs. Drug Dependence
FY1991 to FY2007**



Over 61% 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 1992, cocaine was the most common illicit drug used. Today, methamphetamine is 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. While heroin use has spiked somewhat during fiscal year 2007, use of heroin and cocaine has remained fairly constant over the past 10 years.

**Top Four Illicit Drugs of Choice by Year (Excluding Alcohol)
FY1993 to FY2007**



The next table lists the primary substance used by clients, by gender, as reported at admission to treatment. As this table illustrates, the primary drug of choice differs between the male and female treatment populations.

Alcohol continues to be the primary substance of abuse for men, followed by methamphetamine.

The primary substance of abuse for women remains methamphetamine, followed by alcohol. These two drugs make up almost 60% of admissions for men and over 62% for women. Heroin and marijuana each represent 10% of admissions for women, while marijuana is the third choice for men (16.6% of admissions).

Primary Substance by Gender
FY2007

	Male	Male %	Female	Female %	Total
Alcohol	4,576	35.7%	1,557	23.0%	6,133
Cocaine/Crack	897	7.0%	457	6.7%	1,354
Marijuana/Hashish	2,134	16.6%	694	10.2%	2,828
Heroin	1,419	11.1%	680	10.0%	2,099
Other Opiates/Synthetics	236	1.8%	306	4.5%	542
Hallucinogens	23	0.2%	8	0.1%	31
Methamphetamine	3,064	23.9%	2,660	39.2%	5,724
Other Stimulants	36	0.3%	39	0.6%	75
Benzodiazepines	20	0.2%	53	0.8%	73
Tranquilizers/Sedatives	3	0.0%	19	0.3%	22
Inhalants	9	0.1%	5	0.1%	14
Oxycodone/Hydrocodone	313	2.4%	245	3.6%	558
Club Drugs	16	0.1%	11	0.2%	27
Over-the-Counter	21	0.2%	8	0.1%	29
Other	17	0.1%	3	0.0%	20
Unknown	33	0.3%	36	0.5%	69
Total:	12,817	100.0%	6,781	100.0%	19,599

The table below shows the primary substance of abuse by age grouping. Marijuana continues to be the primary drug of abuse for clients under 18 with methamphetamine the choice of clients 18-24

and 25-34. Methamphetamine use has increased to statistical parity with alcohol in the 35 to 44 age group. Alcohol remains the primary drug of choice for individuals over the age of 44.

Primary Substance of Abuse by Age Grouping
FY2007

	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	401	1,159	1,345	1,492	1,698	38	6,133
Cocaine/Crack	17	198	349	491	294	5	1,354
Marijuana/Hashish	761	1,015	632	253	166	1	2,828
Heroin	20	648	670	409	347	5	2,099
Other Opiates/Synthetics	6	88	231	115	100	2	542
Hallucinogens	3	10	11	6	1	0	31
Methamphetamine	68	1,194	2,457	1,435	565	5	5,724
Other Stimulants	3	17	23	17	14	1	75
Benzodiazepines	3	13	20	14	22	1	73
Tranquilizers/Sedatives	0	5	6	4	7	0	22
Inhalants	8	3	3	0	0	0	14
Oxycodone/Hydrocodone	6	155	262	84	49	2	558
Club Drugs	10	14	3	0	0	0	27
Over-the-Counter	10	9	5	4	1	0	29
Other	0	3	5	6	6	0	20
Unknown	10	13	22	16	8	0	69
Total:	1,326	4,544	6,044	4,346	3,278	60	19,598

Age of First Use of Alcohol or Other Drug

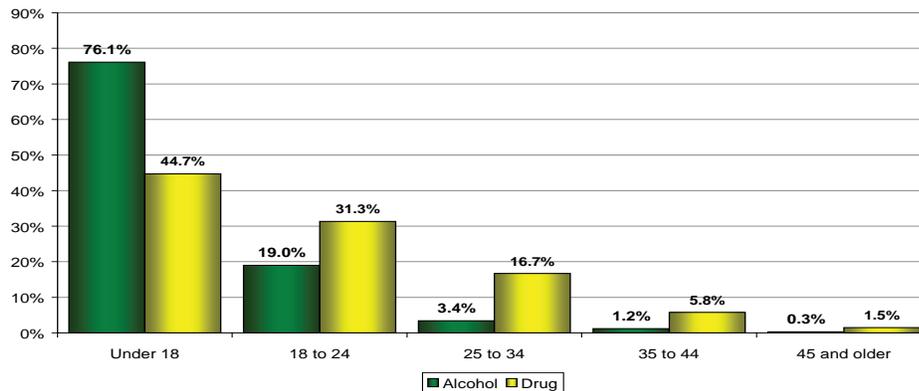
DSAMH tracks data on age of first use for alcohol and illicit drugs. Knowledge about early onset of substance use or abuse can help target prevention and intervention services. Understanding age of first use can also help treatment providers develop effective wellness strategies for their clients.

As the following graphs illustrate, most use begins in the 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. Over 50% report their first use before they are 16. An additional 20% report their first use of alcohol in their early adult years (18 to 25), with significant decreases in the following years.

Illicit drug use also begins in the early teenage years with 45% of the youth reporting the use of illicit substances prior to age 18. Another 31% of those clients report beginning use of illicit substances in their early adult years (18-25).

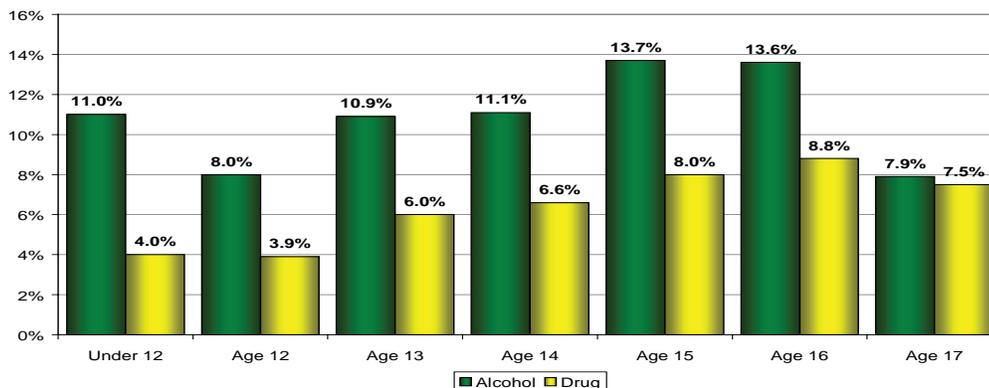
Age of First Use of Primary Substance of Abuse
Fiscal Year 2007



The use of alcohol and illicit drugs begins at an early age. Of youth admitted to the public treatment system, 11% 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 ages 12 through 16. At age 17, beginning use of alcohol drops significantly, while beginning use of illicit drugs only slightly decreases.

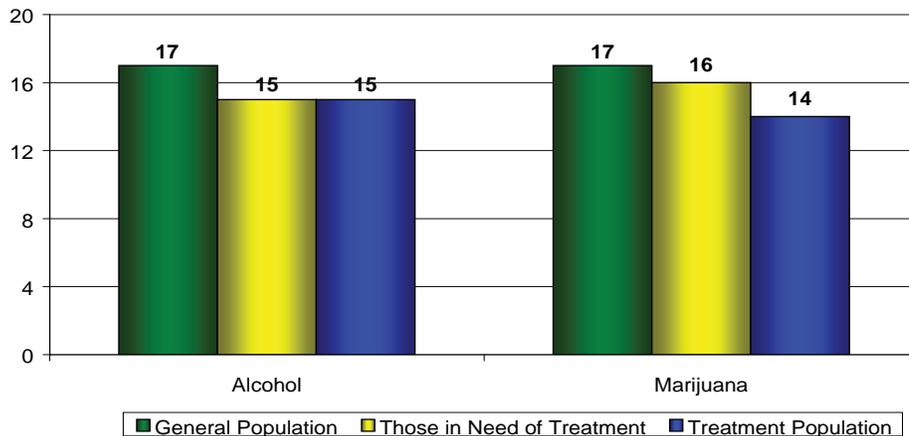
Age of First Use of Primary Substance - Under 18
Fiscal Year 2007



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**

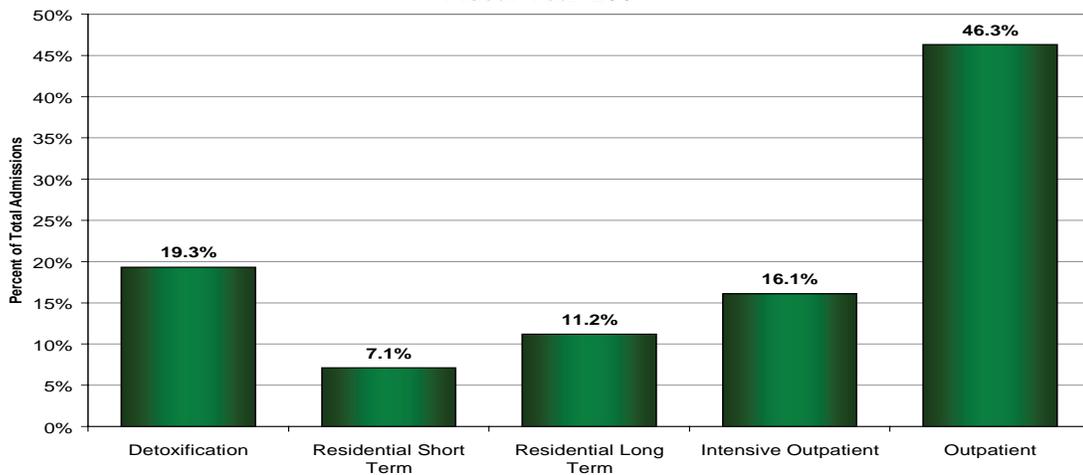


Service Type

The graph below depicts the service type for client entering treatment in fiscal year 2007. Placement in a treatment modality is based on a client's individual needs, the severity of their situation and the availability of the different modalities. Outpatient services remain the most widely used

service modality, followed by detoxification services. Statewide, admissions for residential services remain under 20% of total admissions due to the high cost and limited availability of those services.

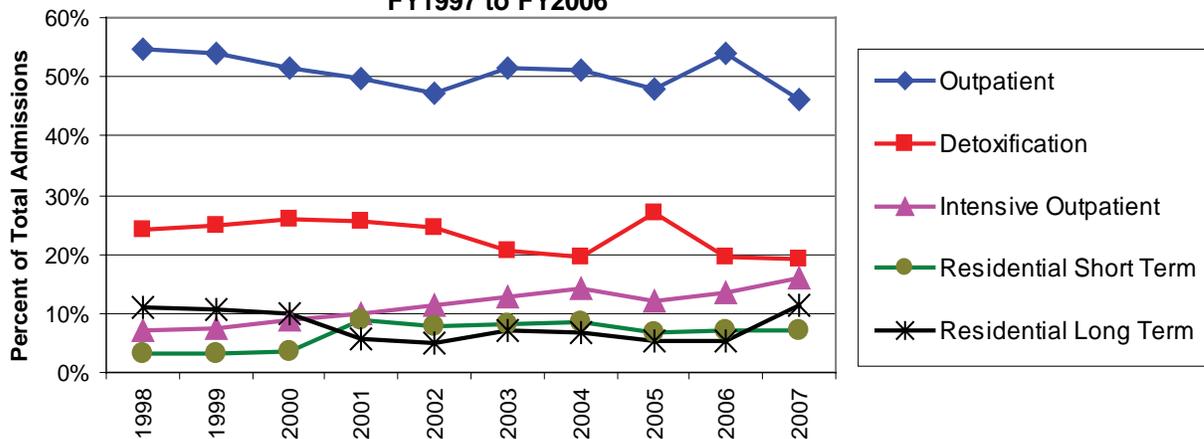
Service Type at Admission
Fiscal Year 2007



As the graph below indicates, the provision for all levels of service has remained relatively stable over the past 10 years. Admissions for intensive outpatient and long term residential services

increased this year, with general outpatient services decreasing. Detoxification and short term residential services remained constant from 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 57.9% across the State,

ranging from 16.4% in Davis County to 90.1% 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
FY2007**

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	686	44.5%
Central Utah	133	42.4%
Davis County	172	16.4%
Four Corners	358	49.6%
Northeastern	186	52.7%
Salt Lake County	4,803	52.8%
San Juan County	5	38.5%
Southwest Center	158	34.1%
Summit County	88	40.2%
Tooele County	86	35.4%
U of U Clinic	214	84.3%
Utah County	1,678	90.1%
Utah State Prison	1,229	89.6%
Wasatch County	68	74.7%
Weber HS	1,482	74.0%
Total:	11,346	57.9%

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's 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. There were 3,901 clients requesting services through the public treatment system that reported IV drug use as their primary route of administration. Salt Lake County reported the highest number of IV drug users at 2,072 while the Utah State Prison reports the highest percentage at 39.7%. Individuals reporting IV drug use increased 2.2% over the previous year.

**Clients Reporting Injecting
Drug Use at Admission
FY2007**

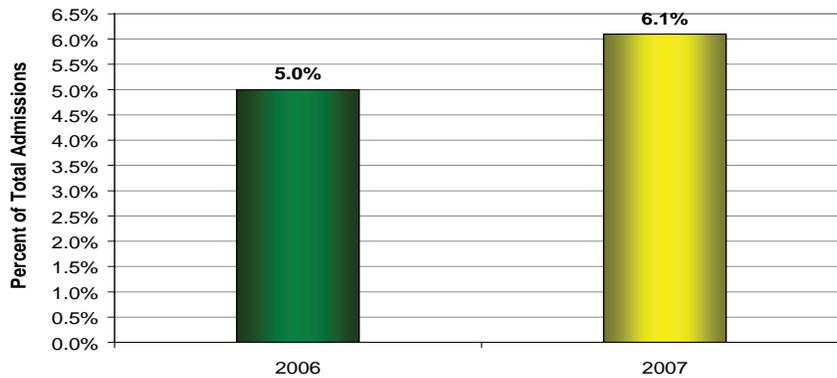
	# Reporting Injecting Drug Use at Admission	% of Total Admissions for Each Area
Bear River	55	3.6%
Central Utah	22	7.0%
Davis County	223	21.2%
Four Corners	54	7.5%
Northeastern	30	8.5%
Salt Lake County	2,072	22.8%
San Juan County	0	0.0%
Southwest Center	80	17.3%
Summit County	10	4.6%
Tooele County	17	7.0%
U of U Clinic	80	31.5%
Utah County	452	24.3%
Utah State Prison	545	39.7%
Wasatch County	3	3.3%
Weber HS	258	12.9%
Total:	3,901	19.9%

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 2007, only 6.1% of the total admissions to the public treatment system were due to prescription

drug abuse, up slightly from 5.0% in fiscal year 2006. This increase appears to be due to the increased use of opiates, which correlates with the increase in treatment admissions for heroin.

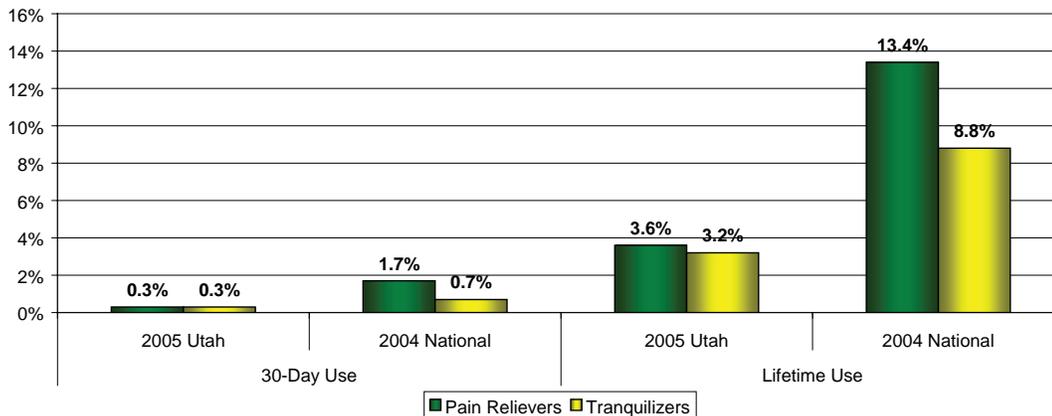
**Admissions for Primary Drug - Prescription Drugs
Fiscal Years 2006 - 2007**



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% Utahans report misuse of Pain Relievers (Oxycodone, Percocet, Vicodin etc.) within the last 30 days compared to 1.7% nationally. Utah's report lifetime misuse of 3.6% as compared to

13.4% nationally. Utah's report 0.3% misuse of tranquilizers (Xanax, Valium, etc.) within the last 30 days and 3.2% report lifetime misuse. These figures are again lower than the national averages of misuse for tranquilizers of 0.7% within the last 30 days and 8.8% lifetime misuse.

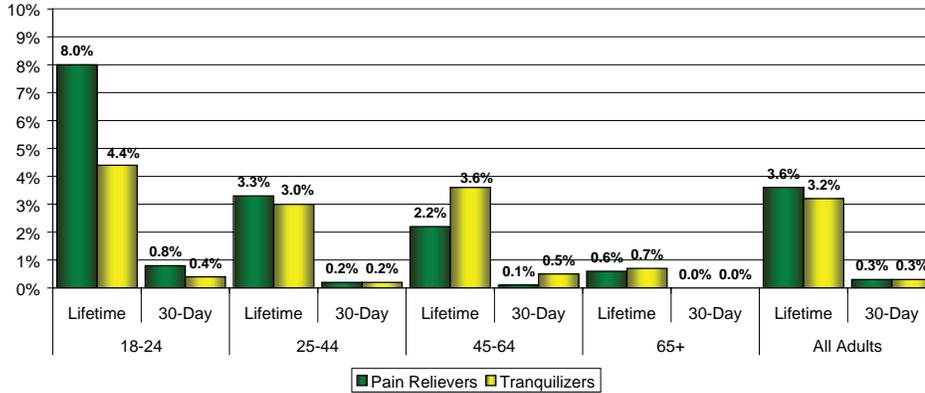
**Adults that Reported Misusing Prescription Drugs
2005**



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



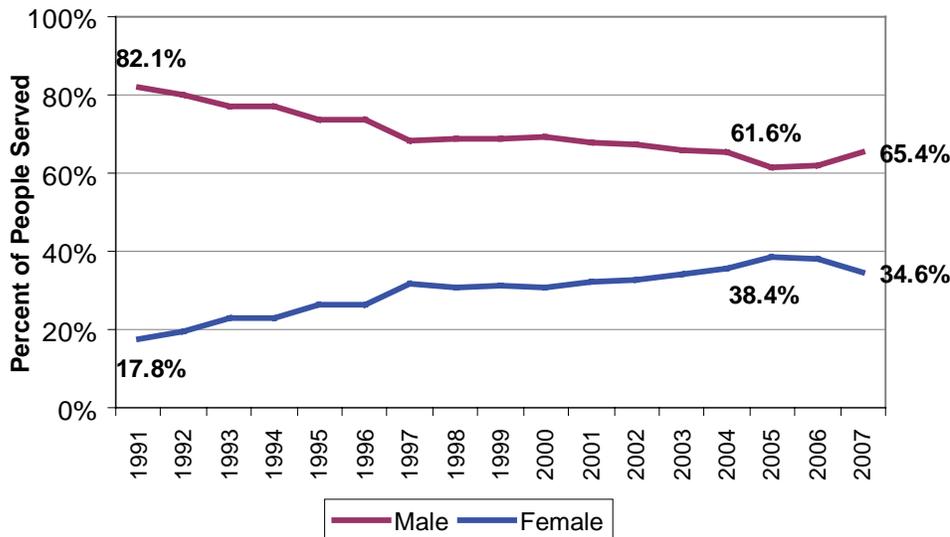
Note: Data from 2005 Utah Substance Abuse Treatment Needs Survey

Admissions to Treatment By Gender

The table below shows the percentages of admissions by gender. As the data shows, there has been a steady increase in the number of admissions

for women during the past 10 years. However, in fiscal year 2007, there was close to a 10% decrease in admissions for women.

Gender of People in Substance Abuse Treatment FY1991 to FY2007



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 6.2% of the women entering treatment (408 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 2007

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	456	25	5.5%
Central Utah	93	6	6.5%
Davis County	324	33	10.2%
Four Corners	270	7	2.6%
Northeastern	93	5	5.4%
Salt Lake County	3,118	197	6.3%
San Juan County	5	2	40.0%
Southwest Center	188	18	9.6%
Summit County	55	2	3.6%
Tooele County	82	3	3.7%
U of U Clinic	88	1	1.1%
Utah County	770	53	6.9%
Utah State Prison	258	8	3.1%
Wasatch County	11	1	9.1%
Weber Human Services	783	47	6.0%
Total:	6,594	408	6.2%

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. Typically, the ones who suffer the most are the children. 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 43.6%. The average number of dependent children per household is 2.19. San Juan County and Southwest Counseling report the highest percentage of clients with dependent children, with both reporting that 65% or more of their clients have dependent children. Southwest Counseling reports the highest number of children per family at 2.60.

The table also depicts the percentage of women entering treatment who have dependent number of children and the average number of children for those households. Southwest Counseling and San Juan County also have the highest percentages

of women with dependent children at 79.1% and 100%, while Southwest Counseling and Central Utah report the highest average number of dependent children at 2.63 and 2.48.

Appropriate treatment for adults with substance abuse disorders includes the treatment of family

members. Treatment providers throughout the State are tasked to 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 2007**

	Percent of all Patients with Children	Average Number of Children (of Patients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	34.6%	2.08	45.4%	1.99
Central Utah	46.3%	2.34	49.5%	2.48
Davis County	55.0%	2.24	68.6%	2.32
Four Corners	47.6%	2.23	64.8%	2.28
Northeastern	57.2%	2.49	67.7%	2.27
Salt Lake County	41.0%	2.12	56.3%	2.12
San Juan County	69.2%	1.56	100.0%	2.00
Southwest Center	65.0%	2.60	75.1%	2.63
Summit County	28.2%	2.20	25.0%	2.00
Tooele County	29.3%	1.94	35.4%	1.90
U of U Clinic	49.2%	2.26	58.0%	2.25
Utah County	53.4%	2.34	69.6%	2.40
Utah State Prison	36.7%	2.04	51.9%	2.24
Wasatch County	50.5%	2.20	73.7%	2.29
Weber Human Services	46.0%	2.18	57.3%	2.31
Total:	43.6%	2.19	58.1%	2.22

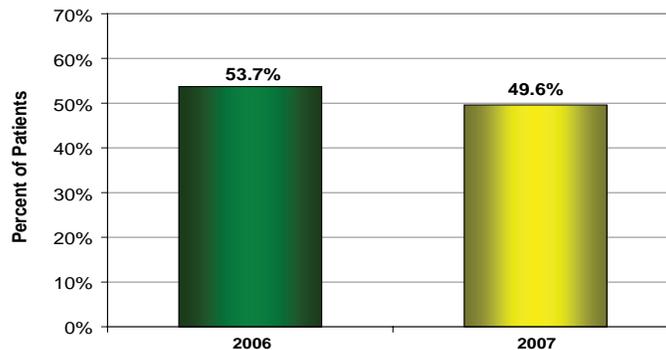
Treatment Outcomes

DSAMH collected discharge data on over 9,509 non-detox clients in fiscal year 2007. The analyses in this section include 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 considered a successful discharge. The data does not include

clients who were admitted only for detoxification services.

The following graph depicts the percentage of clients discharged in fiscal year 2007 who successfully completed treatment. Of the clients entering treatment 49.67% successfully completed their treatment objectives. The data from 2007 continues the slightly downward trend in completion percentages from previous years.

Percentage of Clients Successfully Completing Treatment Modality
Fiscal Years 2006-2007

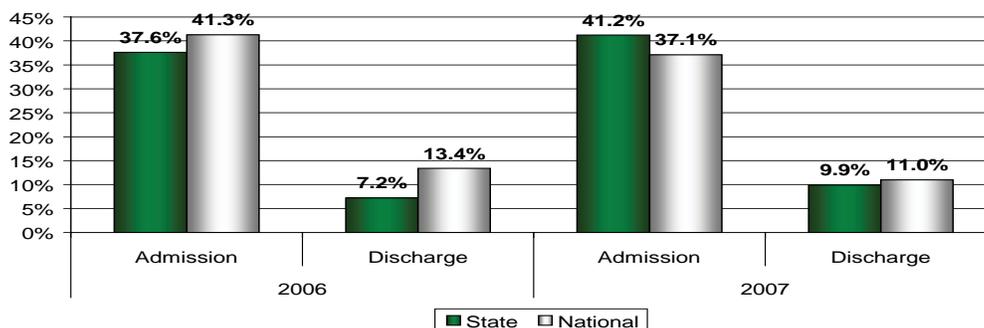


Criminal Activity

In fiscal year 2007, during the 30 days prior to being admitted to treatment services, 41.2% of clients reported they had been arrested. Once admitted to treatment, only 9.9% reported further

criminal arrests. For clients in treatment in Utah, arrests during their treatment episode were less than the national average of 11.0%.

Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment
Fiscal Years 2006 - 2007



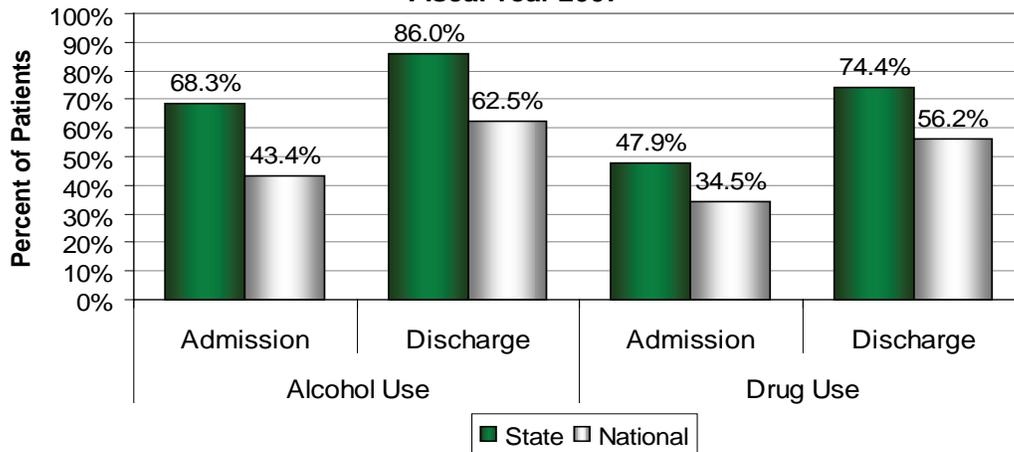
Note: 2006 numbers are based on 6 month arrests and 2007 numbers are based on 30 days.

Changes in Abstinence from Drug and Alcohol Use During Treatment

The following chart provides information about the changes in abstinence in both alcohol and drug use substance use patterns at admission and discharge. This data includes abstinence levels for 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, the rate of abstinence increases sharply during treatment, with an increase of abstinence from alcohol increasing 17.7% and abstinence from drug use increasing 26.5%. Utah's rates of abstinence both at admission and at discharge are significantly higher than the national averages.

Percent of Clients Reporting Abstinence Prior to Admission vs. Abstinence at Discharge
Fiscal Year 2007



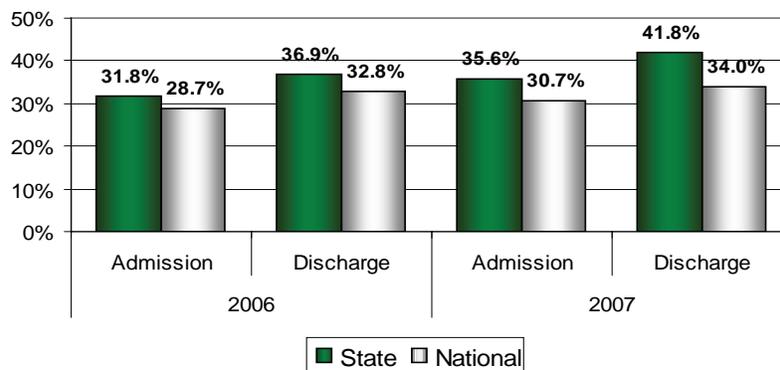
Employment and Living Arrangement

Percentage of Clients Employed

The employment status of a client struggling with a substance use disorder is a key element for successful recovery. Outcome research has consistently found that clients who are in school or are employed have much higher treatment suc-

cess 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 2007, 35.6% were employed at admission and 41.8% were employed at discharge. This compares favorably to national averages of 30.7% and 34.0% respectively.

Percentage of Clients Who Are Employed
Fiscal Years 2006 - 2007

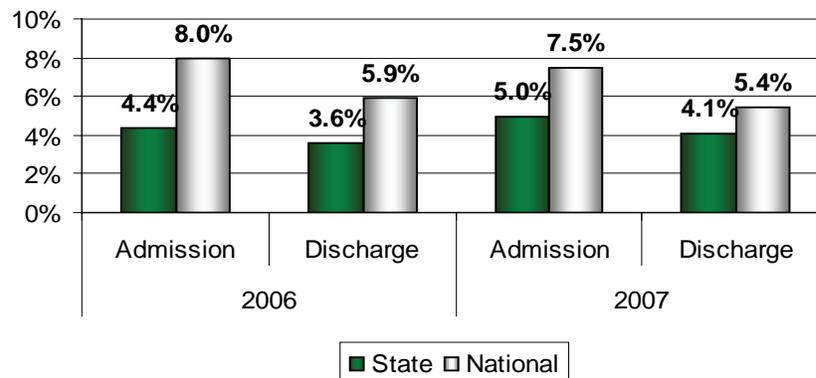


Percentages of Clients Who are Homeless

As shown in this chart, 5.0% of clients entering Utah’s public substance abuse treatment in fiscal year 2007 were homeless at the time of their admission to treatment as compared to 7.5% nationally. At discharge, Utah’s homeless rate is 4.1%, compared to the national average of 5.4%.

Outcome studies have revealed that a stable living environment is a critical element in achieving long-term successful results in the reduction of substance abuse. Research has demonstrated that treatment is an important factor in helping the substance abusing population enter more stable living environments. As the data shows, providers across Utah assist clients in establishing a more stable living situation during their treatment episode.

Percentage of Clients Who are Homeless
Fiscal Years 2006 - 2007



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, and DORA strive to decrease substance use, enhance public safety, and reduce recidivism by providing individualized services for the justice population.

Drug Court

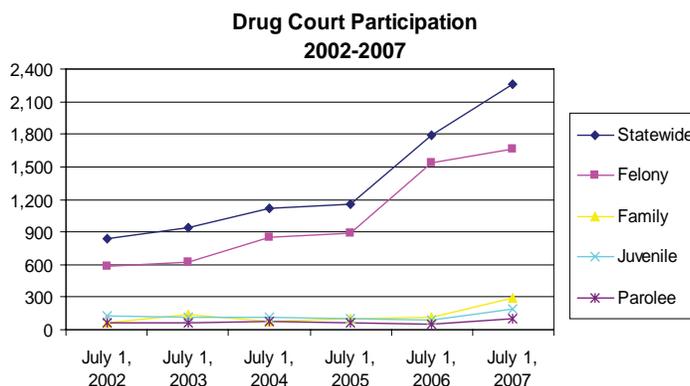
Drug Courts and Drug Boards offer nonviolent, drug abusing offenders' intensive court-supervised drug treatment as an alternative to jail or prison. DHS provides funding for 23 Drug Court and 2 Drug Board programs.

Caseload Growth

In response to the cycle of criminal recidivism common among drug offenders, local jurisdictions began in the mid 1990s to create Drug Courts in Utah. In 1996, two Drug Courts existed in Utah. Currently in 2007, 32 Drug Courts are 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. The following chart shows Drug Court participation 2001-2007.

What Do Drug Courts Require of Participants?

Drug Court participants undergo long-term, judicially monitored treatment and counseling, and must appear before the 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.



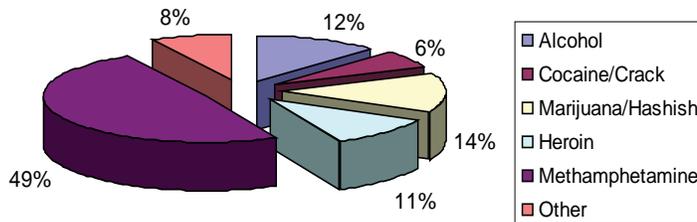
Are Drug Courts Effective?

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. The capital costs of building a prison cell can be as much as \$80,000. 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 #1 illicit drug of choice for clients admitted to the public sub-

stance abuse treatment system surpassing marijuana and accounting for approximately 29% of all treatment admissions. At admission 49% of Drug Court participants report that methamphetamine is their drug of choice.

**Primary Drug of Choice for Drug Court
Participants Statewide
Fiscal Year 2007**



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 425 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

- Almost 7,300 Utahns have participated, or are currently participating in a Drug Court
- Over 4,400 Utahns have graduated from a Drug Court
- 64% of participants graduate from Drug Court compared to approximately 50% of the general treatment population complete treatment successfully
- Participants are involved an average of 425 days (Graduates = 475, Unsuccessful or terminated participants = 333)

Decreases Substance Use

- 95% of all participants that complete Drug Court report abstinence of alcohol at discharge and 82% report abstinence of drugs at discharge

Increases Employment Rates

- Statewide, between admission and discharge, employment rates for Adult Drug Court participants increased 14%, which is above the National Average of 11%

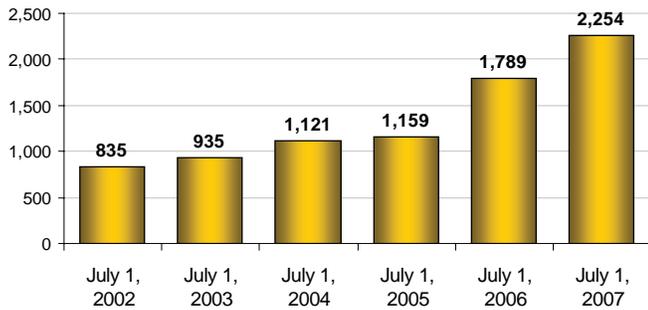
Reduces Recidivism

- 30 days prior to involvement, participants report an average of 2.3 arrests
- 85% of participants report zero arrests while in Drug Court

Statewide Drug Court Statistics

Overall, participation in Drug Court is growing. Since 2002, participation has tripled.

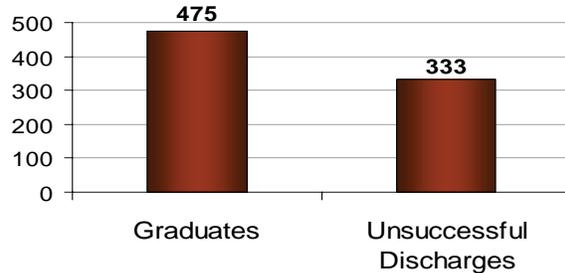
State Totals - Drug Courts
Participants Receiving Services as of:



Sixty-four 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, this result is outstanding.

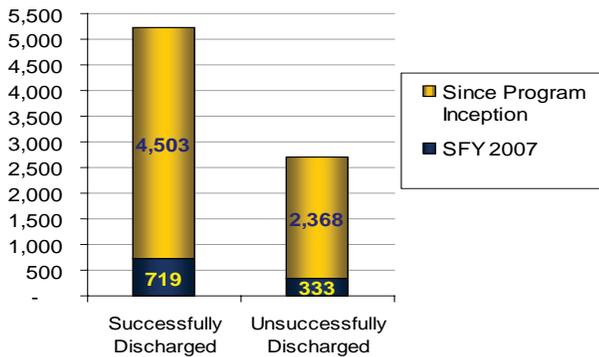
Drug Court retains offenders in treatment. The research suggests that retention is the most critical factor in successful outcomes (Marlowe, DeMatteo, & Festinger, 2003).

Treatment Retention
Days in Treatment for Drug Court Participants

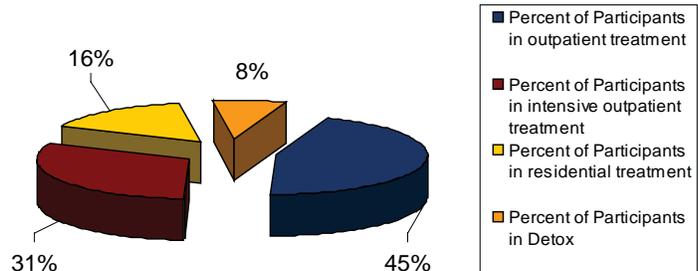


Forty-five percent of participants are treated at the outpatient level. In traditional programs, offenders are often placed at higher levels of care due to concerns about public safety. This can be five times as expensive as outpatient care.

State Drug Court Discharges



State Total Drug Courts - Level of Care as of July 1, 2007



Utah Drug Courts

There are currently over 30 Drug Courts and 2 Drug Board programs throughout the state; at this time DHS provides funding for 23 drug courts and 2 drug board programs. All of the courts are listed separately below, the courts that are provided funding from DHS are indicated with an * before the court.

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. These crimes 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
- Offenders must be in the country legally

Utah has 18 functioning Adult Felony Drug Courts, located in *Box Elder, *Cache, *Carbon, *Davis, *Emery, *Iron, Juab, Millard, *Salt Lake, *San Juan, Sanpete, *Sevier, Tooele, *Uintah, *Utah, *Wasatch, *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 Court 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. Seven Family/Dependency Drug Courts operate in Utah. These programs are located in *Carbon, *Grand, *Emery (combined with Felony Drug Court), *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: Six 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. The Misdemeanor Drug Courts are found in Salt Lake County, Holladay, Davis County, Clearfield City, Taylorsville City, and Riverdale City.

Independent Evaluations

The general effectiveness of Drug Courts on reducing recidivism has been consistently estab-

lished 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. Studies consistently show lower recidivism for Drug Court graduates than nondrug court comparison groups and lower recidivism for Drug Court graduates than non-successful clients.

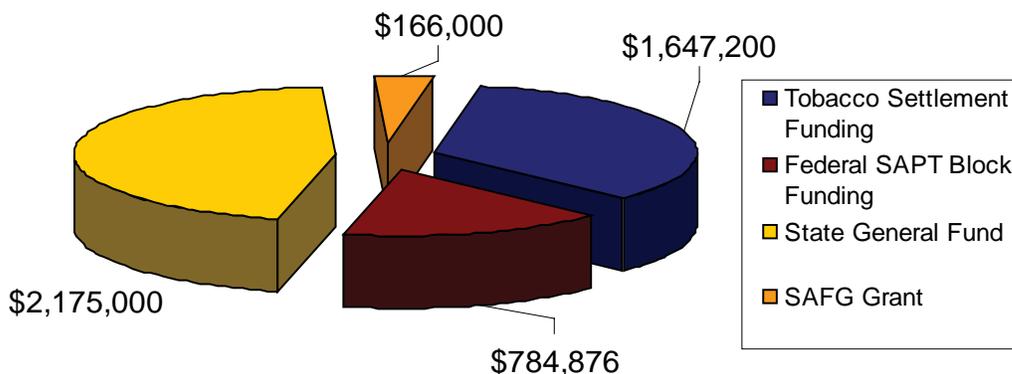
Appropriations

Senate Bill 15, Use of Tobacco Settlement Revenues, passed during the 2000 Legislative General Session. This bill 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 2007 Legislative session, \$2,000,000 of State General Funds was allocated to drug courts. With these additional funds five new courts were started and six expansions and six enhancements began throughout the state in Drug Courts that already existed. A summary of DHS funding for Drug Court is found in the chart on the following page.

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

Drug Court Funding: Federal, State, and Local



The charts below shows DHS funding for each Drug Court for 2007:

Drug Court Funding	2002	2003	2004	2005	2006	2007	2008
Tobacco Settlement Funding	\$1,647,200	\$1,647,200	\$1,647,200	\$1,647,200	\$1,647,200	\$1,647,200	\$1,647,200
Federal SAPT Block Funding	\$247,884	\$247,884	\$729,136	\$799,136	\$799,136	\$898,588	\$784,876
State General Fund	\$0	\$0	\$0	\$0	\$0	\$435,000	\$2,175,000
SAFG Grant	\$0	\$0	\$0	\$0	\$0	\$75,000	\$166,000
Total Funding	\$1,895,084	\$1,895,084	\$2,376,336	\$2,446,336	\$2,446,336	\$3,055,788	\$4,773,076

UTAH DRUG COURT FUNDING BY DRUG COURT MODEL								
MODEL	DRUG COURT	2002	2003	2004	2005	2006	2007	2008
FELONY	Box Elder First District Drug Court	125,000	125,000	125,000	125,000	125,000	131,250	150,000
	Cache County Felony Drug Court	-	-	-	-	-	-	131,250
	Carbon County Felony Drug Court	-	-	-	-	-	95,831	149,989
	Davis County Felony Drug Court	250,000	250,000	250,000	250,000	250,000	275,500	275,500
	Emery County Drug Court (Dual Model)	160,000	160,000	160,000	160,000	160,000	149,998	149,998
	Iron County Felony Drug Court	-	-	-	-	-	-	75,000
	Salt Lake County Felony Drug Court	250,000	250,000	250,000	250,000	250,000	292,500	642,500
	San Juan Felony Drug Court	-	-	-	-	-	-	85,137
	Sevier County Felony Drug Court	64,064	64,064	64,064	64,064	64,064	68,250	68,250
	Uintah County / Eighth District Drug Court	120,000	120,000	120,000	120,000	120,000	126,000	126,000
	Utah County Adult Felony Drug Court	200,000	200,000	200,000	200,000	200,000	250,000	390,000
	Wasatch County Felony Drug Court	-	-	36,000	36,000	36,000	43,200	118,200
	Washington County Felony Drug Court	46,870	46,870	50,000	120,000	120,000	192,000	192,000
	Weber County Felony Drug Court	41,250	41,250	250,000	250,000	250,000	292,500	378,500
	Total	1,257,184	1,257,184	1,505,064	1,575,064	1,575,064	1,917,029	2,932,324
FAMILY / DEPENDENCY	Carbon County Dependency Drug Court	-	-	-	-	-	-	150,000
	Fourth District Dependency Drug Court	75,000	75,000	125,000	125,000	125,000	137,500	137,500
	Grand County Family Drug Court	-	-	40,000	40,000	40,000	75,900	138,962
	Third District Dependency Drug Court	105,000	105,000	105,000	105,000	105,000	136,500	187,000
	Weber Child Protection Drug Court	-	-	80,000	80,000	80,000	124,000	139,000
Total	180,000	180,000	350,000	350,000	350,000	473,900	752,462	
JUVENILE	Third District Juvenile Drug Court	75,000	75,000	63,372	63,372	63,372	69,709	112,709
	Tooele County Juvenile Drug Court	32,000	32,000	32,000	32,000	32,000	32,000	32,000
	Utah County Juvenile Drug Court	-	-	75,000	75,000	75,000	86,250	216,250
	Weber Juvenile Drug Court	-	-	-	-	-	126,000	210,431
Total	107,000	107,000	170,372	170,372	170,372	313,959	571,390	
	Drug Board	350,900	350,900	350,900	350,900	350,900	350,900	350,900
	Training/QA							166,000
	STATE TOTAL	1,895,084	1,895,084	2,376,336	2,446,336	2,446,336	3,055,788	4,773,076

Recovery Day

Utah’s Annual Recovery Day “Saving Lives, Saving Dollars,” was held on September 15, 2007 at the Gallivan Center in Salt Lake City. This yearly event is held in conjunction with the National Alcohol and Drug Addiction Month every September. 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.

Utah Governor Jon M. Huntsman signed a proclamation designating September 15, 2007 as Utah’s 6th Annual Drug and Alcohol Recovery Day. This special event provided members of the recovery community—their friends, families, and allies, an opportunity to put a face on recovery from addi-

tion so that others in Utah can be motivated to get the help they need.

The day started with a 5K “Run for Recovery” hosted by the Utah Alcoholism Foundation which began at the east side of the state capital and ended at the Gallivan Center. Al and the Aces Band, Mama’s Temple Choir, and the Odyssey House Choir provided entertainment during the event which hosted over 500 people. Other activities included children’s crafts, games, prizes, free giveaways, family activities, free food and drinks.

In addition, over 30 exhibitors from community organizations, groups, and providers set up displays and distributed information about their programming. K. Erik Jergensen (Salt Lake City Council Representative District 3), and Pat Flemming (Salt

Lake County Substance Abuse) spoke along with members from the SARA Utah (Substance Abuse Recovery Alliance) during the day. The Sober Riders rode in on their motorcycles in a mini-parade showing support for recovery. People enjoyed the events and SAMHSA representative Roxanne ran in the 5K and spent the day at the event.

The Salt Lake County Substance Abuse, SARA Utah, Odyssey House, Volunteers of America, Utah Alcoholism Foundation, First Step House, and the Haven were instrumental in the planning and production of Recovery Day.



MENTAL HEALTH TREATMENT



Mental Health Treatment

System Overview

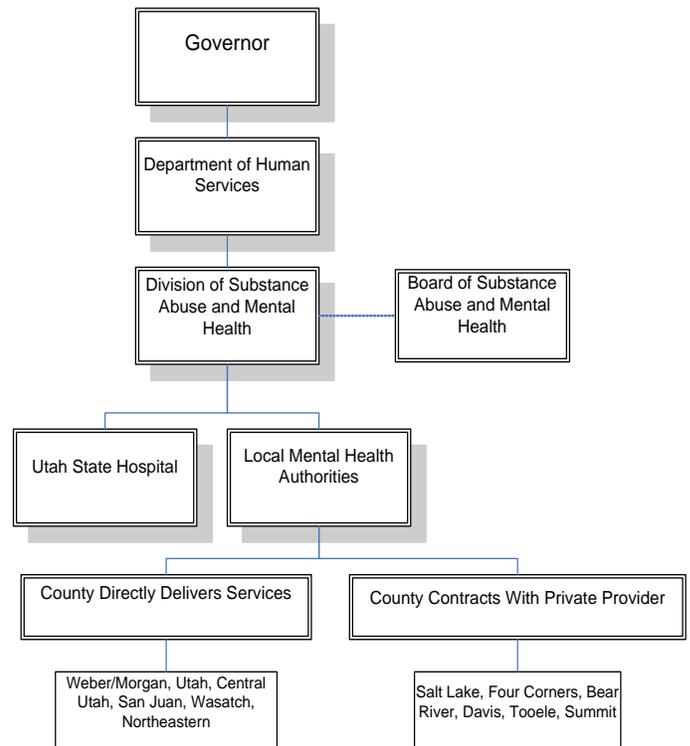
State Division of Substance Abuse and Mental Health (DSAMH)

DSAMH is authorized under Utah State Code Annotated §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 DSAMH
- 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 §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 DSAMH.

A local authority contracts with a community mental health center; the centers are the service providers of the system. Counties set the priorities to meet local needs, but must submit a plan to DSAMH describing what services they will pro-

vide 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 20 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 Information

DSAMH has established “Recovery In a System of Care” as a model of treatment to reach the 38,658 clients currently being served by community mental health centers (CMHC).

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 1.5% of the general population.

Mental Health Clients Penetration Rates

	Suicide Deaths per 100,000 Population	2006 Population (Estimated)	Total Served	Penetration Rate
Bear River	14.4	147,899	2,620	1.8%
Cental	23.3	69,537	931	1.3%
Davis	13.4	276,259	2,886	1.0%
Four Corners	25.2*	39,166	1,816	4.6%
Northeastern	22.0	44,603	995	2.2%
San Juan	25.2*	14,265	411	2.9%
Southwest	15.9	184,216	2,469	1.3%
Valley Mental Health - Salt Lake	15.4	978,701	13,736	1.4%
Valley Mental Health - Summit	10.6	35,469	856	2.4%
Valley Mental Health - Tooele	10.5	53,552	1,642	3.1%
Wasatch County - Heber Valley Counseling	16.4	20,255	205	1.0%
Wasatch Mental Health	12.7	464,760	4,948	1.1%
Weber	19.4	221,381	5,706	2.6%
Statewide	15.4	2,550,063	38,658	1.5%

*Southeastern portion of the state combined.

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	Central	Davis	Four Corners	Heber Valley	North-eastern	San Juan	South-west	Summit	Tooele	Valley	Wasatch	Weber	Statewide <18 yrs
Substance Abuse	0.4%	0.3%	0.9%	10.1%	2.6%	0.3%	0.0%	1.1%	25.6%	13.5%	5.8%	0.6%	5.5%	4.1%
Schizophrenia	0.1%	0.5%	0.6%	0.2%	0.0%	0.3%	0.0%	0.3%	0.0%	0.4%	0.6%	0.2%	0.5%	0.4%
Depressive Disorders	16.4%	7.9%	19.6%	19.2%	5.3%	17.6%	35.7%	12.7%	17.3%	15.6%	16.6%	6.9%	9.8%	14.2%
Conduct Disorder	1.0%	1.8%	0.9%	0.9%	0.0%	0.6%	0.0%	0.9%	0.0%	0.6%	1.0%	0.9%	0.7%	0.9%
Attention Deficit	14.3%	22.3%	14.4%	18.8%	7.9%	12.2%	20.2%	12.5%	8.9%	17.6%	20.4%	8.7%	7.3%	15.0%
Oppositional Defiant Disorder	6.1%	6.8%	5.8%	9.8%	2.6%	4.8%	0.0%	4.7%	5.4%	7.1%	7.3%	4.2%	9.4%	6.5%
Other Childhood	12.2%	5.5%	8.5%	6.9%	5.3%	6.3%	3.1%	6.5%	5.4%	2.5%	5.3%	7.3%	6.5%	6.6%
Mental Retardation	1.9%	3.1%	1.9%	1.4%	0.0%	1.8%	3.1%	3.4%	0.6%	2.5%	7.8%	5.9%	5.7%	5.1%
Alzheimers and Organic Brain	0.5%	0.5%	0.0%	0.2%	0.0%	0.6%	0.8%	0.2%	0.0%	0.0%	0.3%	0.2%	0.4%	0.3%
Anxiety Disorders	13.5%	9.9%	12.0%	7.8%	2.6%	19.7%	20.2%	9.8%	6.0%	15.6%	13.4%	10.4%	8.0%	11.8%
Personality Disorders	0.0%	0.3%	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Abuse	2.8%	8.4%	6.9%	4.1%	0.0%	8.7%	2.3%	11.2%	3.6%	11.0%	5.7%	10.8%	16.9%	8.3%
Diagnosis Deferred	7.7%	0.3%	0.0%	0.9%	60.5%	0.3%	0.0%	1.4%	0.0%	0.0%	0.0%	11.9%	7.0%	3.5%
Sexual/Gender Disorders	0.1%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	0.2%	0.1%
Adjustment Disorders	18.6%	28.5%	21.4%	8.7%	10.5%	20.3%	11.6%	21.1%	16.7%	3.9%	7.7%	10.7%	10.2%	12.5%
Other	1.6%	1.3%	4.4%	1.2%	0.0%	1.5%	1.6%	2.7%	1.2%	1.9%	1.0%	1.0%	1.5%	1.6%
Bipolar	1.7%	1.0%	1.3%	2.1%	0.0%	2.7%	0.0%	0.4%	0.0%	0.6%	0.6%	0.7%	0.5%	0.8%
V Codes	1.2%	1.6%	1.1%	7.3%	2.6%	2.4%	1.6%	11.0%	9.5%	7.3%	6.4%	19.3%	10.2%	8.4%
Total	100.0%													

Diagnosis of MH Clients 18 years and older, by MH Center														
	Bear River	Central	Davis	Four Corners	Heber Valley	North-eastern	San Juan	South-west	Summit	Tooele	Valley	Wasatch	Weber	Statewide >18 yrs
Substance Abuse	2.3%	2.1%	3.0%	40.7%	3.7%	2.8%	2.2%	2.0%	48.8%	33.3%	30.4%	11.4%	17.3%	20.7%
Schizophrenia	11.6%	24.5%	17.5%	10.1%	11.1%	10.9%	6.8%	19.3%	1.5%	4.6%	17.1%	12.3%	7.6%	13.5%
Depressive Disorders	39.2%	42.8%	40.5%	26.1%	18.5%	45.2%	54.0%	36.7%	21.8%	36.1%	28.4%	24.9%	13.2%	28.9%
Conduct Disorder	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%
Attention Deficit	1.4%	0.2%	1.7%	0.6%	0.7%	2.2%	1.1%	1.5%	1.6%	1.5%	0.9%	3.9%	1.9%	1.5%
Oppositional Defiant Disorder	0.0%	0.2%	0.4%	0.3%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
Other Childhood	0.6%	0.0%	0.4%	0.3%	0.0%	0.8%	0.4%	0.2%	0.7%	0.3%	0.2%	2.3%	0.4%	0.5%
Mental Retardation	1.0%	0.8%	1.0%	0.3%	0.0%	0.2%	0.0%	1.4%	0.1%	0.5%	0.7%	1.4%	0.4%	0.7%
Alzheimers and Organic Brain	1.7%	0.2%	1.2%	1.1%	1.5%	2.0%	9.4%	3.1%	0.6%	1.2%	1.4%	2.9%	1.4%	1.7%
Anxiety Disorders	14.5%	13.9%	12.9%	7.2%	6.7%	17.1%	16.5%	10.5%	9.2%	6.9%	6.2%	16.7%	12.7%	10.2%
Personality Disorders	0.2%	0.4%	0.2%	0.1%	0.0%	0.2%	0.4%	0.1%	0.1%	0.3%	0.0%	0.1%	0.0%	0.1%
Abuse	0.4%	1.7%	0.4%	0.2%	2.2%	1.6%	0.7%	2.5%	3.2%	1.8%	1.8%	4.1%	2.6%	1.9%
Diagnosis Deferred	11.3%	0.8%	0.0%	0.2%	43.7%	0.2%	0.0%	0.6%	0.0%	0.0%	0.0%	7.5%	31.2%	6.3%
Sexual/Gender Disorders	0.1%	0.4%	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.4%	0.3%	0.1%
Adjustment Disorders	3.6%	2.7%	6.1%	1.8%	1.5%	5.0%	1.1%	8.6%	6.7%	2.5%	1.1%	1.8%	1.7%	2.5%
Other	1.3%	1.3%	0.8%	1.4%	0.7%	2.8%	2.5%	1.6%	0.0%	0.3%	0.9%	4.0%	1.1%	1.4%
Bipolar	9.0%	7.6%	13.3%	7.2%	6.7%	7.5%	4.3%	8.9%	1.3%	4.6%	6.8%	4.0%	3.5%	6.5%
V Codes	1.9%	0.6%	0.8%	2.3%	3.0%	1.9%	0.7%	2.9%	4.0%	6.1%	4.0%	2.2%	4.5%	3.3%
Total	100.0%													

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

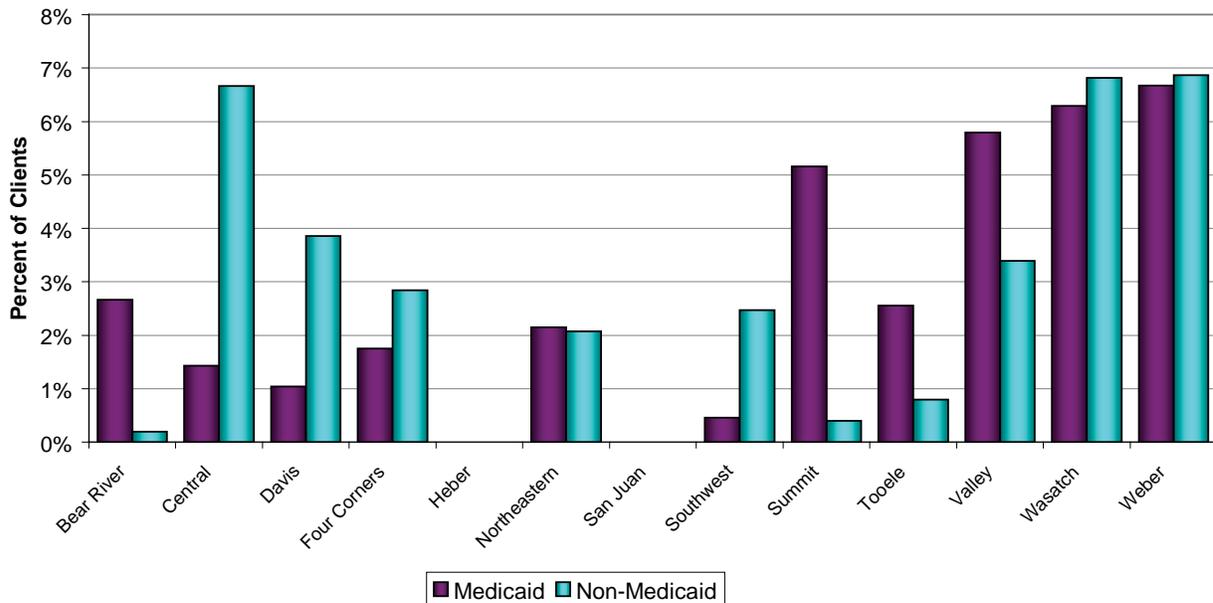
1. Treatment is individualized (youth guided/family driven),
2. Treatment occurs in the least restrictive setting (community-based whenever possible), and
3. Treatment is culturally competent, coordinated and utilizes natural supports.

One of the tools 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.

Mandated Services Data by Local Provider

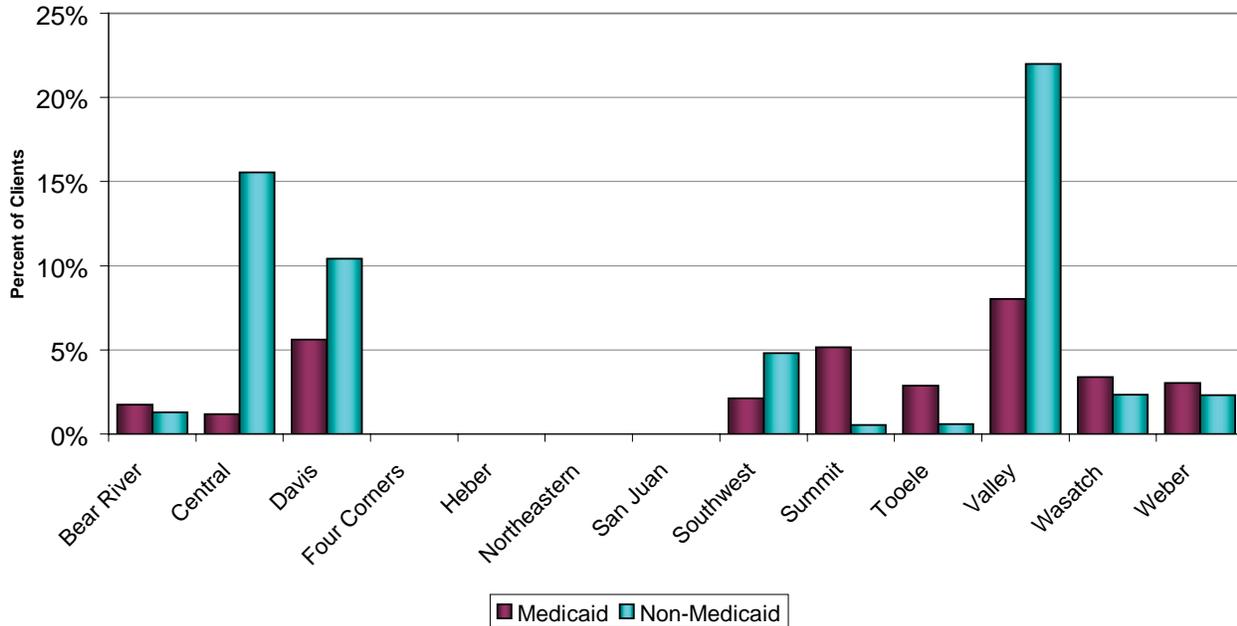
Percent of Clients Receiving Inpatient Services

Mental Health Clients
Fiscal Year 2007

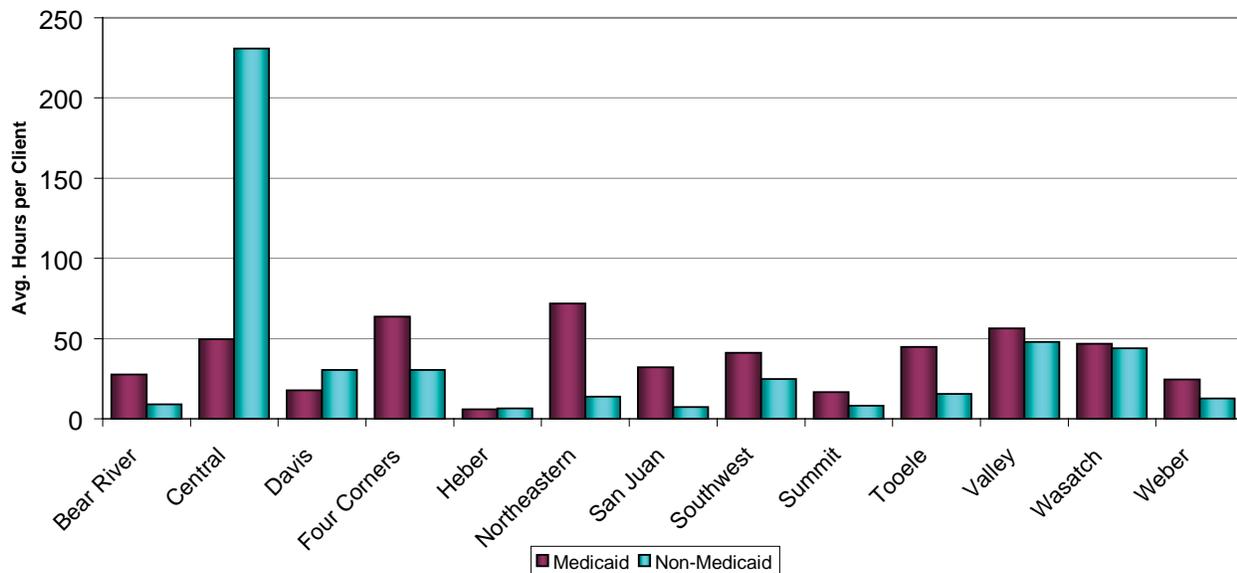


Percent of Clients Receiving Residential Services

Mental Health Clients
Fiscal Year 2007

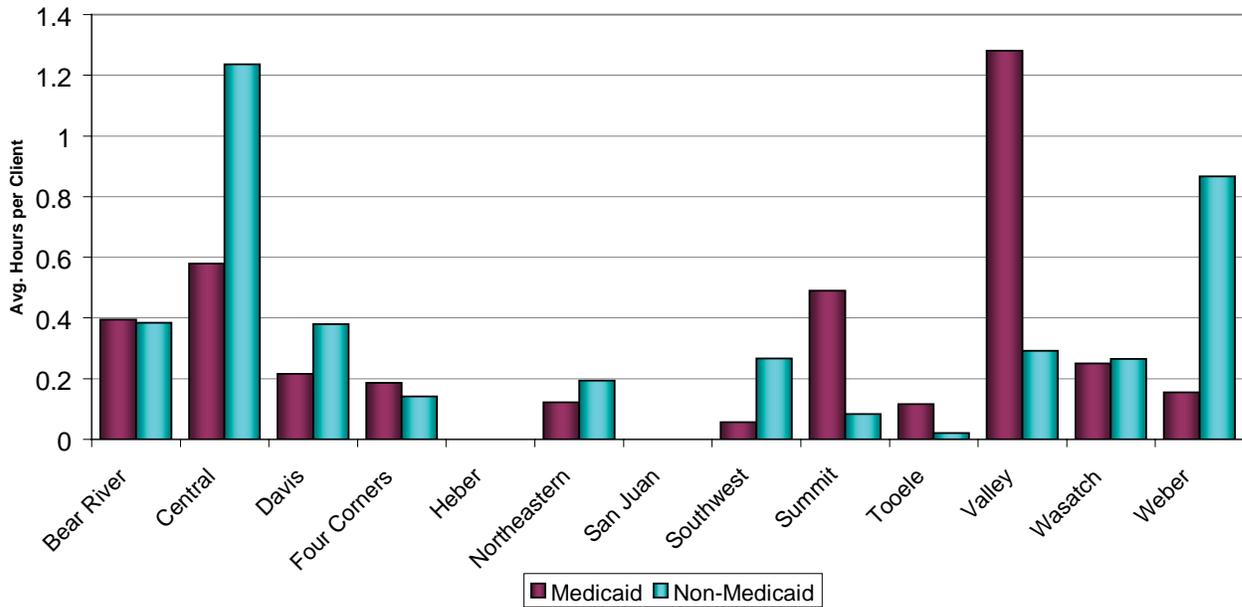


Outpatient Mental Health Clients Fiscal Year 2007



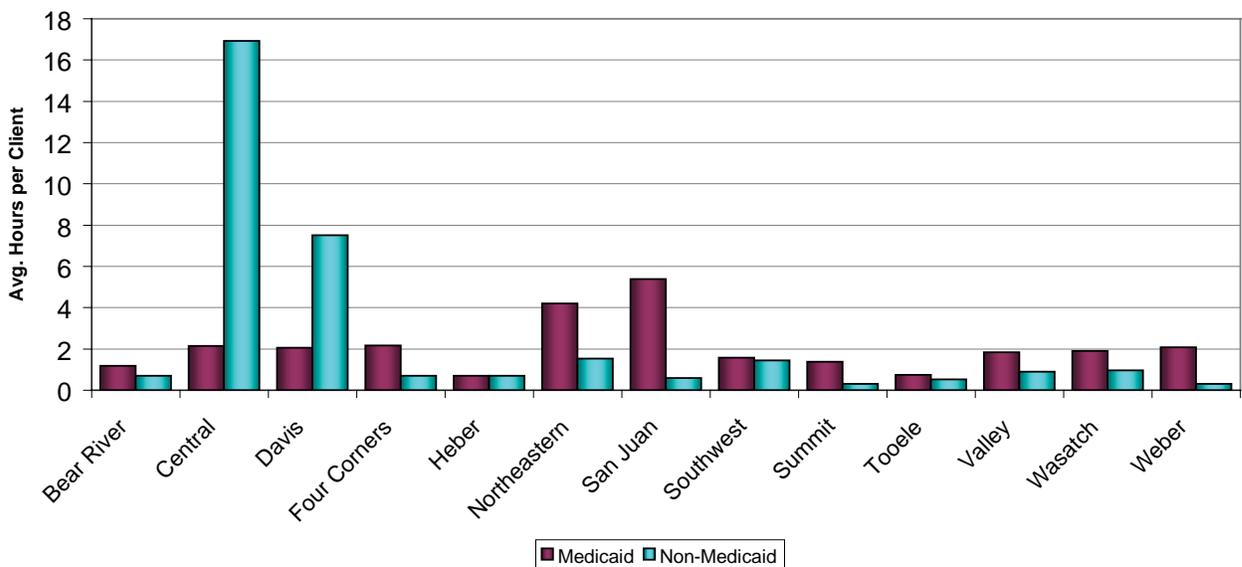
Note: Total outpatient hours for Medicaid and Non-Medicaid service divided by the corresponding total number of Medicaid and Non-Medicaid clients for each center.

Emergency Mental Health Clients Fiscal Year 2007



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.

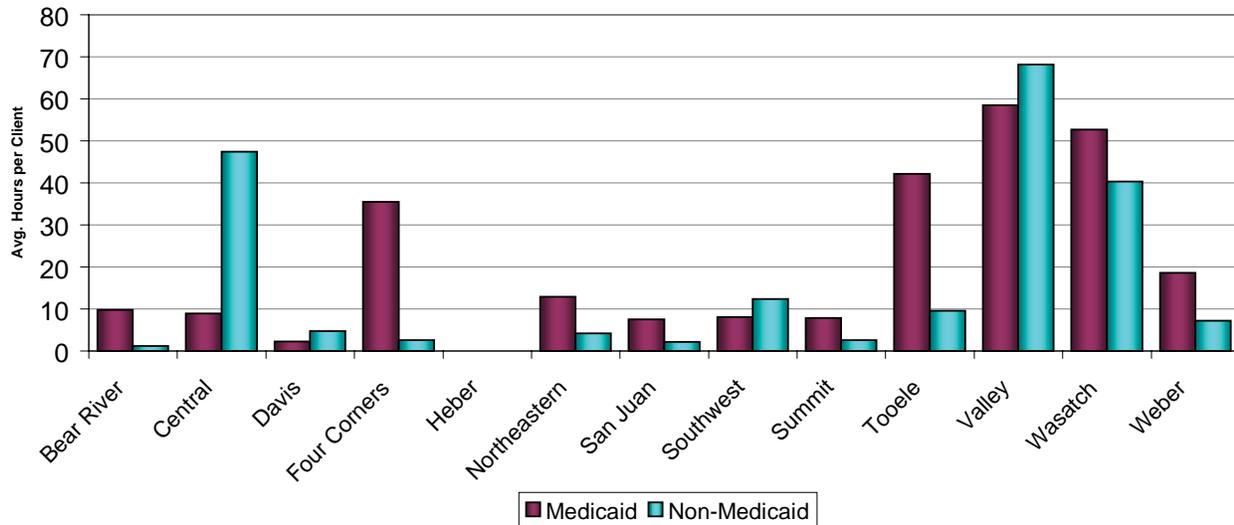
Medication Management Mental Health Clients Fiscal Year 2007



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

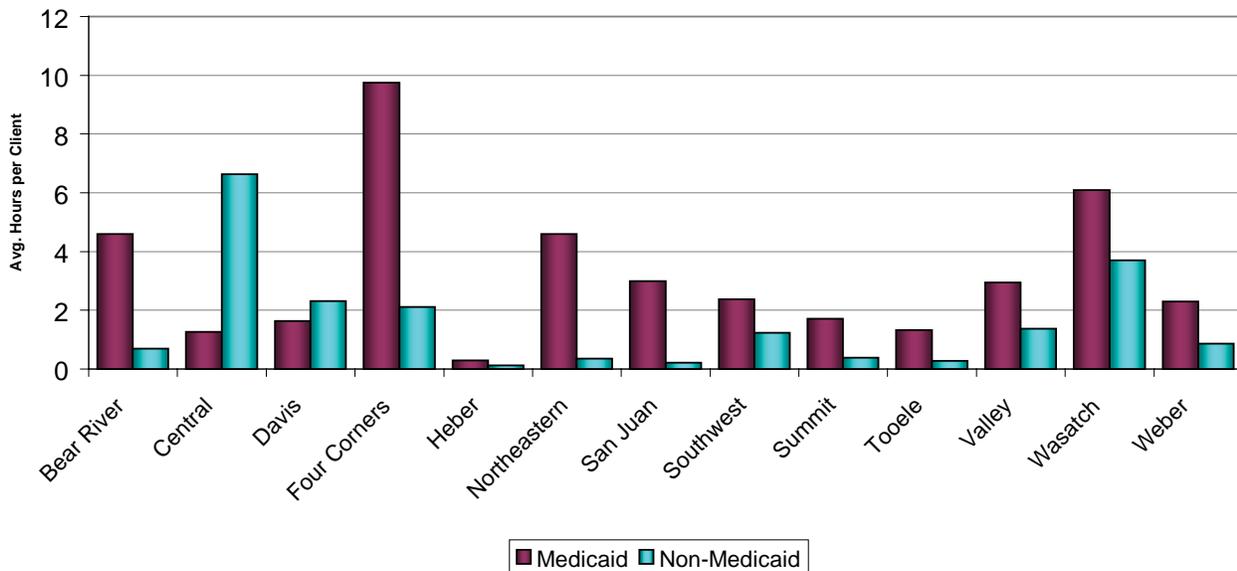
Mental Health Clients
Fiscal Year 2007



Note: The total sum of 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.

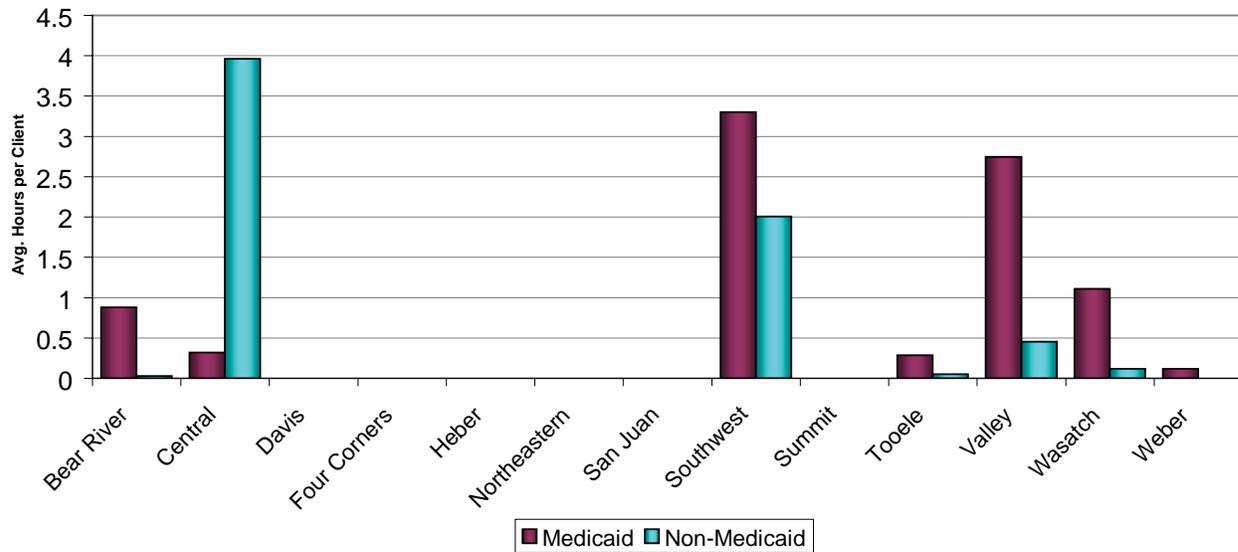
Case Management

Mental Health Clients
Fiscal Year 2007



Note: The total sum of 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 2007



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

Mental Health Center	Medicaid	Non-Medicaid	Total
Bear River	1,612	1,008	2,620
Central	841	90	931
Davis	1,926	960	2,886
Four Corners	971	845	1,816
Heber	46	159	205
Northeastern	512	483	995
San Juan	132	279	411
Southwest	1,741	729	2,470
Summit	97	756	853
Tooele	626	1,008	1,634
Valley	9,081	4,835	13,916
Wasatch	3,877	1,071	4,948
Weber	3,072	2,635	5,707
	24,534	14,858	39,392
This is a duplicated count between centers			

This is the N= that was used to calculate the percentages of all tables where mandated programs are divided by Medicaid, non-Medicaid clients. Medicaid clients are those with at least one service event paid by Medicaid.

CMHCs are accepting clients from various funding sources. While over 75% of clients receive funding through Medicaid or another

funding source, 23% of clients served have absolutely no funding.

The Expected Payment Sources of Clients Admitted into Mental health Centers
Fiscal Year 2007

Mental Health Center	Medicaid (Title XIX)	Unfunded Provider to pay most cost	Commercial Health Insurance	Service Contract	Medicare (Title XVIII)	Personal Resources	Other
Bear River	50%	1%	1%	0%	16%	2%	30%
Central	88%	3%	1%	0%	3%	4%	1%
Davis	61%	1%	12%	3%	7%	10%	5%
Four Corners	0%	0%	9%	53%	0%	0%	38%
Heber Valley	26%	0%	7%	8%	3%	47%	9%
Northeastern	47%	1%	18%	0%	5%	28%	1%
San Juan	27%	1%	35%	0%	7%	19%	10%
Southwest	67%	11%	9%	1%	4%	3%	6%
Summit	10%	64%	19%	5%	3%	0%	0%
Tooele	33%	43%	22%	1%	2%	0%	0%
Valley	55%	33%	7%	2%	4%	0%	0%
Wasatch	70%	15%	3%	7%	3%	2%	0%
Weber	51%	39%	9%	0%	2%	0%	0%
Statewide	53%	23%	8%	5%	4%	2%	5%

Pre-Admission Screening/ Resident Review (PASRR)

The PASRR Program is required by federal statute and regulations and the State’s Medicaid plan that DSAMH administer the Program. The PASRR program comprises the process of screening and determining whether individuals meet nursing facility (NF) criteria and/or require specialized mental health services and provides an in-depth review of medical, social, and psychiatric history, as well as Activities of Daily Living (ADL) functioning. 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.

In an effort to improve the efficiency of PASRR evaluations, DSAMH implemented a new web-based program in October 2006. The web-based

PASRR Program has helped alleviate the hospitals and NF staff concerns over placement delays and prevent unnecessary institutional placements and duplicate PASRR evaluations.

In fiscal year 2006 DSAMH processed 1,623 PASRR evaluations and in fiscal year 2007 DSAMH processed 1,671 PASRR evaluations. According to the 2000 Census 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.

Olmstead (REDI System)

In July 1999, the Supreme Court issued the *Olmstead v. L.C.* decision. The Court's decision clearly challenges federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services. DSAMH with input from mental health stakeholders has created a plan for continuing efforts to serve individuals with mental illnesses in the least restrictive setting possible. This year DSAMH has developed and implemented a tracking system: the Readiness Evaluation and Discharge Implementation Program (REDI) to document when people are ready for discharge from the Utah State Hospital (USH). The REDI program will alert DSAMH when people are ready for discharge, identifies any barriers and identifies what home and community based services are needed for people to be successful in the community. The REDI program is a web-based system, which is used as an assistant in the discharge process and shows trends and issues, tracks patient transfers and improves communications between the USH and the local Community Mental Health Centers (CMHC's). DSAMH is now using this program as a monitoring tool toward ensuring that the USH and the CMHC's are actively working on a plan to live in the least restrictive environment for people who are ready for discharge.

Ten Year Plan to End Chronic Homelessness

The DSAMH has been actively working toward President Bush's national initiative 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 there have been ten Local Homeless Coordinating Committees (LHCC) formed across the state chaired by a local political leader

and membership to include a broad coalition of interested partners from government, social service agencies, and the business community. Each LHCC is tasked with preparing their own plan to end homelessness and solve problems related to homelessness within their geographic region. Each of the areas has identified a pilot project related to the highest need in their respective region that range from housing projects for the chronically homeless, housing "throwaway" youth, and wraparound services for victims of domestic violence. DSAMH is working with the Public Substance Abuse and Mental Health system to collaborate and actively participate with the LHCC to implement this plan and alleviate the devastating impact chronic homelessness has on people with a mental illness and/or a co-occurring substance abuse disorder. Using a nationally accepted figure between 20 to 25% of the homeless population have a severe or persistent mental illness and of the homeless population up to 50% may have a co-occurring substance abuse disorder (National Resource Center on Homelessness and Mental Illness, 2001). Key strategies include identifying policy and system issues that may result in complication in accessing services as well as working to resolve difficulties and collaborate efforts in order to provide the needed supportive services, including case management, education and training, and effective treatment. In 2006 an estimated 15,000 people were homeless, of that approximately 2,000 are chronically homeless. The updated numbers for 2007 are 13,425 total homeless and 1,530 chronically homeless.

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

In 2005, the Utah Division of Substance Abuse and Mental Health 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 account-

able 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.

In 2006 and 2007, the project focused on strategic planning at the state and local levels. State transformation plans address several focus areas: financing/system integration, clinical practice, technology/data, cultural competency, and American Indian issues. There are 13 local transformation plans, each addresses focus areas that are identified as critical needs for that particular local community. Local focus areas include school-based behavioral health services, wraparound services, community awareness campaign, adolescent substance abuse treatment services, inter-agency collaboration, suicide prevention project, etc.

Several major achievements from 2007 include:

1. Kathy Reynolds, a consultant from Michigan, provided training and consultation on how to integrate behavioral health care into the primary care setting. Stakeholders from state and local agencies were invited and attended the training. With the training and consultation, we now have a process and standard for promoting and implementing integrated care. The next step is to select pilot site(s) to implement the integrated model.
2. We collaborated with the Utah State Office of Education to implement school-based mental health and substance abuse services in five local planning districts: Bear River, Davis, Heber, Northeastern, and Weber.
3. DHS accepted the recommendations from the American Indian Workgroup to establish a Departmental Tribal Consultation Policy with the seven tribal governments in Utah and to establish the “DHS Tribal and Indian Issues Committee” to provide input on human service issues.

4. The Financing/System Integration Workgroup developed a comprehensive finance map of how children’s mental health and substance abuse services are funded. Consultants were brought in to discuss strategies to collaborate funding for children’s services.
5. Many local planning districts have been able to braid funding from various funding sources to implement local transformation plans.
6. The State Youth Council adapted the “BRIDGES” curriculum (a peer-to-peer 10-week recovery course for adults) to develop the “Progression” curriculum for young people between the ages of 15 and 21 who are dealing with mental health issues. Fourteen youth are trained to be trainers on the curriculum and will train other youth about recovery from mental illness.
7. Salt Lake Community College and Snow College provided gatekeeper training and peer mentor services to improve college students’ behavioral health and well being.

Case Management

Case Management is a mandated service in Utah and in most other states, and community mental health centers are responsible for case management in their local areas. 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. Case management continues to be a central highlight of community mental health work, both in teams and individually working with consumers to achieve their goals. 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. This year the Utah Public Mental Health System served 11,866 adults with serious mental illness and provided 192,123 individual services and served 5,087 youth with serious and emotional disturbance, and provided 50,428 individualized services.

Mental Health Art Exhibit / Contest

In 2007 the Department of Human Services held its first Mental Health art contest. The theme was “This has meaning in my life because.” The goal was to have at least 60 entries by August. Thanks to the interest and effort of all the consumers and the mental health facilities throughout the State

the total was more than doubled, a total of 123 entry’s, and because of the large number of art work, entries were divided into three categories: Adult, Youth, and Utah State Hospital. An open house was held for the public to come and vote on the art. Then the artwork was judged by a panel and online voting. The winners were announced during an award ceremony and Lisa-Michele Church was there to hand out the awards.

There are not any words that could explain the joy and happiness on the faces of those who participated. Especially one young artist named Amber, who walked away with most of the awards.

Pictures of artwork from this contest are included on the front cover and throughout this report.

LOCAL AUTHORITIES

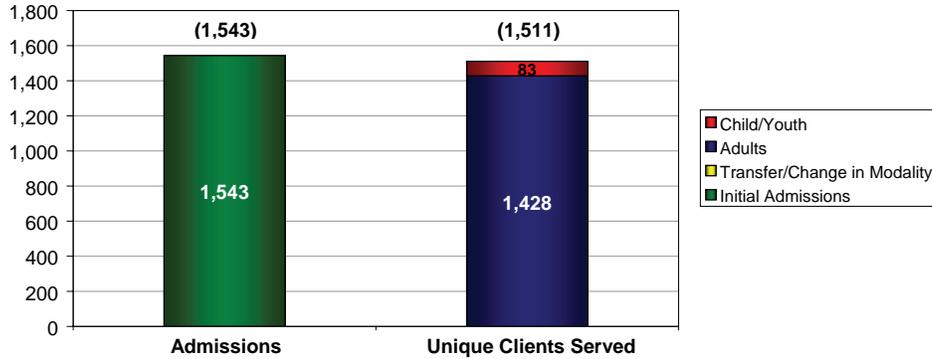


Substance Abuse and Mental Health Statistics by Local Provider

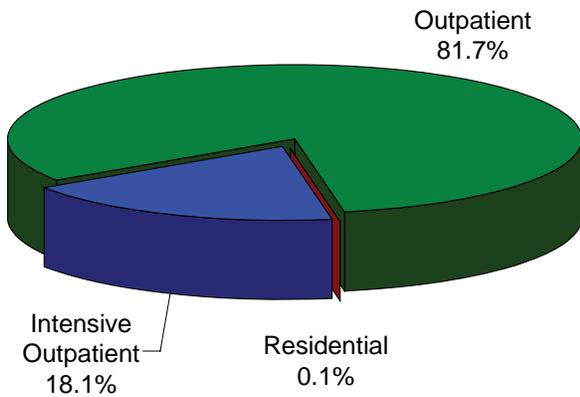
Bear River Substance Abuse

2006 Population	Total Served	Penetration Rate
147,899	1,511	1.0%

Admissions into Modalities and Clients Served Fiscal Year 2007



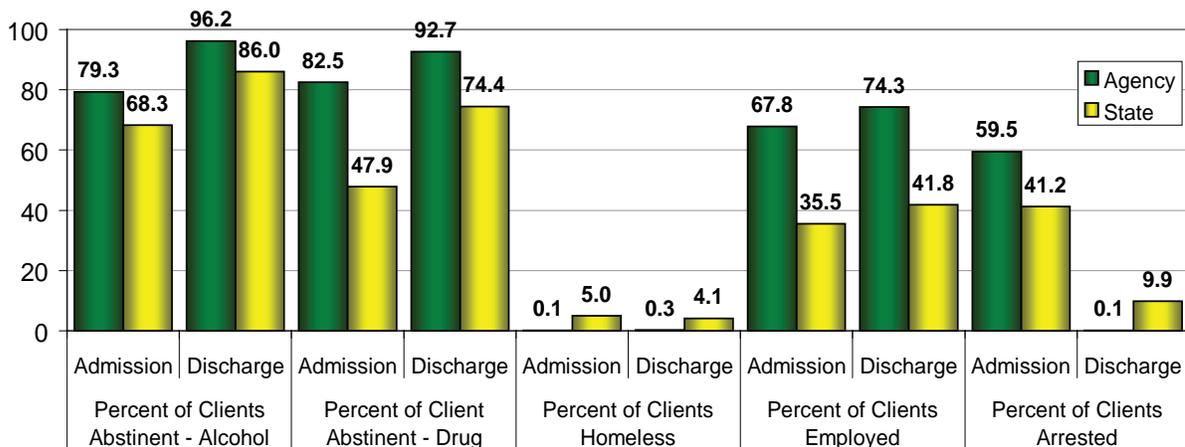
Admission into Modalities Fiscal Year 2007



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	586	216	802
Cocaine/Crack	16	9	25
Marijuana/Hashish	265	44	309
Heroin	8	1	9
Other Opiates/Synthetics	30	28	58
Hallucinogens	2	0	2
Methamphetamine	159	130	289
Other Stimulants	1	1	2
Benzodiazepines	0	2	2
Tranquilizers/Sedatives	0	4	4
Inhalants	1	1	2
Oxycodone	17	17	34
Club Drugs	2	3	5
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	1,087	456	1,543

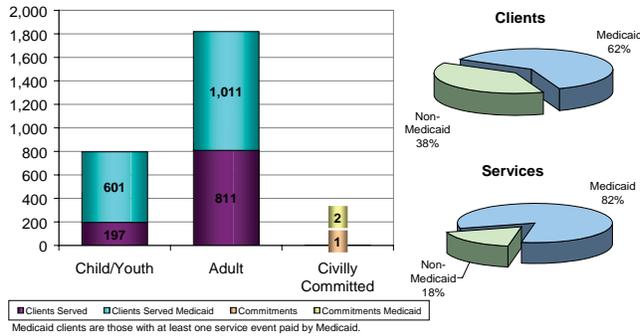
Bear River Substance Abuse Outcome Measures Fiscal Year 2007



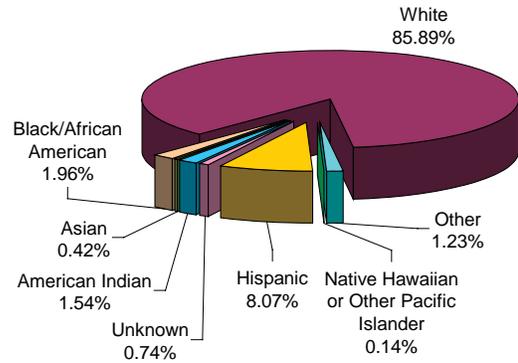
Bear River Mental Health

2006 Population	Total Served	Percentage
147,899	2,620	1.8%

Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007

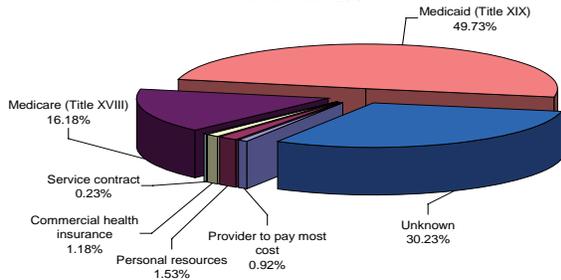


Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

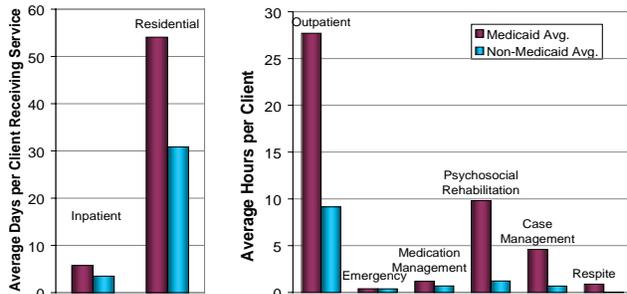
Expected Payment Source At Admission
Fiscal Year 2007



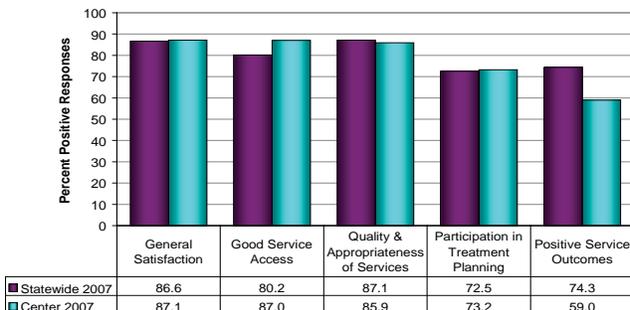
Primary Diagnosis at Admission

	Youth	Adult
Substance Abuse	14	248
Schizophrenia	4	230
Depressive Disorders	196	944
Conduct Disorder	13	
Attention Deficit	188	105
Oppositional Defiant Disorder	81	
Other Childhood	149	45
Mental Retardation	61	108
Alzheimers & Organic Brain Disorders	5	61
Anxiety Disorders	174	706
Personality Disorders	4	503
Abuse	143	51
Diagnosis Deferred	163	517
Sexual/Gender Disorders	1	10
Adjustment Disorders	177	91
Other V Codes	688	703
Other	27	61
Bipolar	16	171
Total	2104	4554

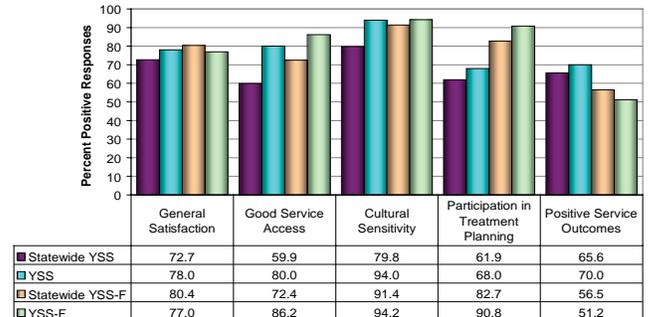
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



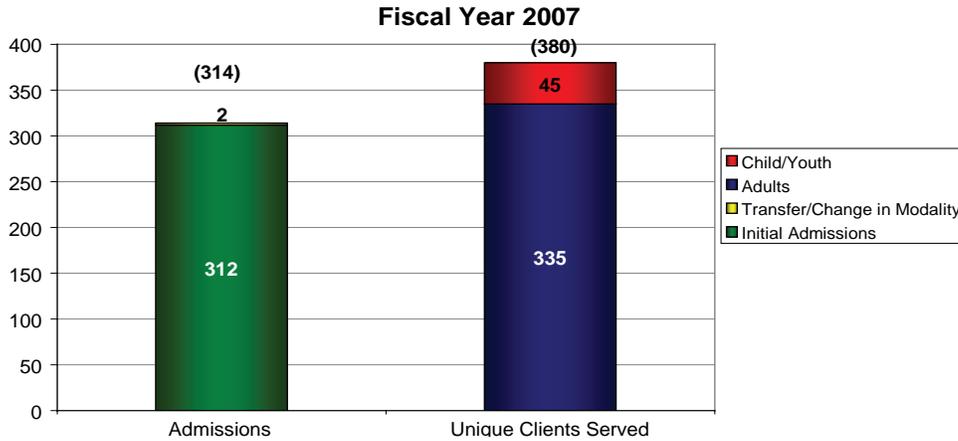
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



Central Utah Counseling Center - Substance Abuse

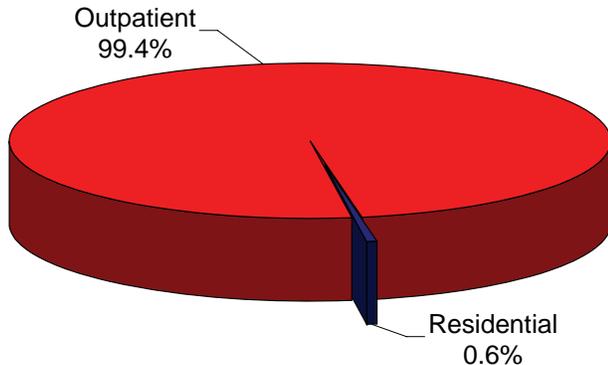
2006 Population	Total Served	Penetration Rate
69,537	380	0.5%

Admission into Modalities and Clients Served



Admission into Modalities

Fiscal Year 2007

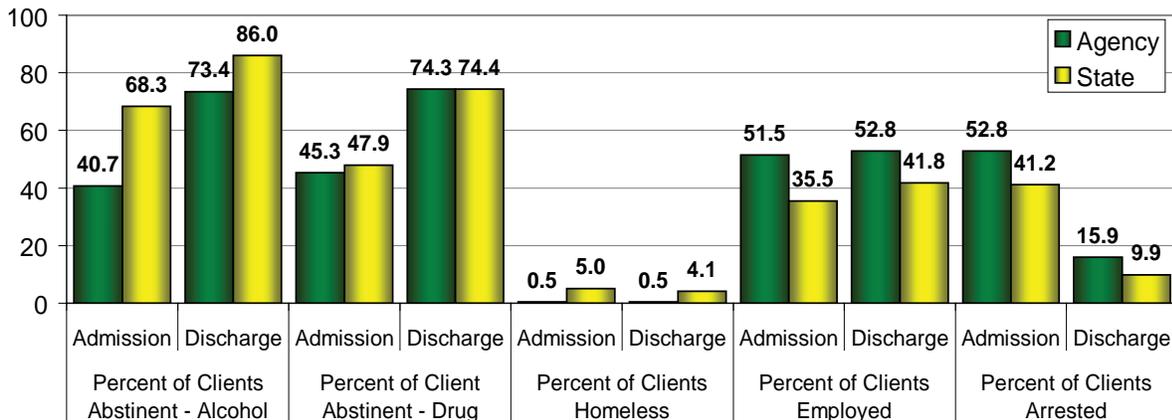


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	74	42	116
Cocaine/Crack	2	3	5
Marijuana/Hashish	44	21	65
Heroin	3	5	8
Other Opiates/Synthetics	5	4	9
Hallucinogens	0	0	0
Methamphetamine	43	30	73
Other Stimulants	1	0	1
Benzodiazepines	0	2	2
Tranquilizers/Sedatives	0	0	0
Inhalants	1	0	1
Oxycodone	5	4	9
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	0	0	0
Unkown	9	15	24
Total	187	127	314

Central Utah Counseling Outcome Measures

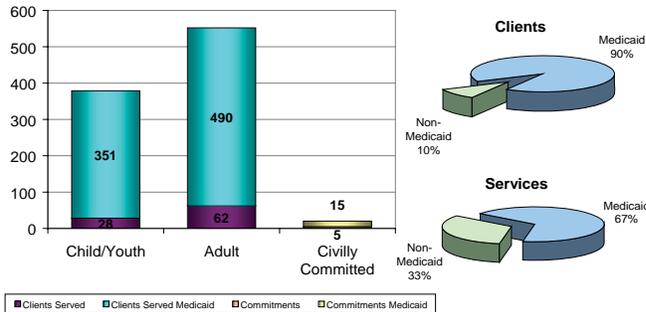
Fiscal Year 2007



Central Utah Counseling Center - Mental Health

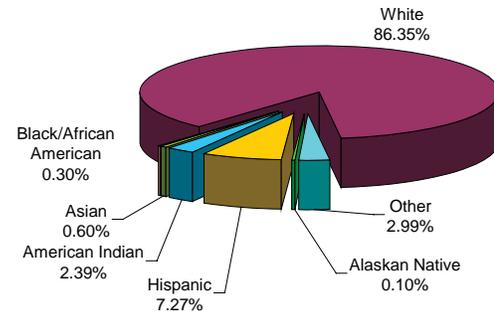
2006 Population	Total Served	Percentage
69,537	931	1.3%

Clients Served, Commitments and Medicaid Percentages
Fiscal Year 2007



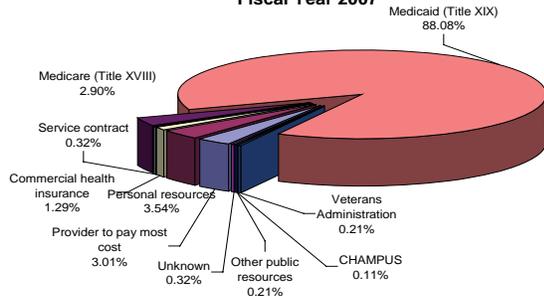
Medicaid clients are those with at least one service event paid by Medicaid.

Race/Ethnicity
Fiscal Year 2007

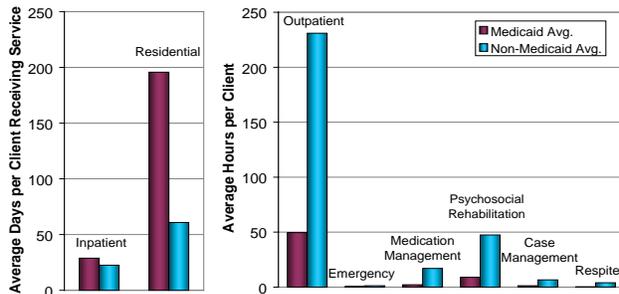


More than one race/ethnicity may have been selected.

Expected Payment Source At Admission
Fiscal Year 2007



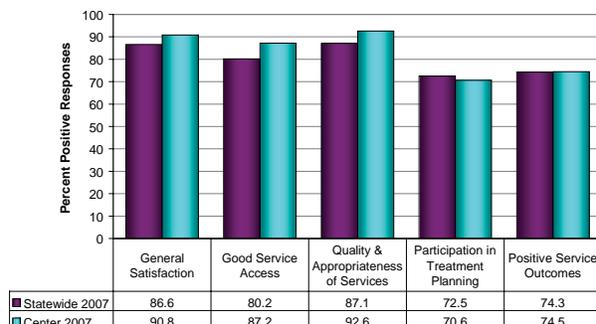
Mandated Services
Fiscal Year 2007



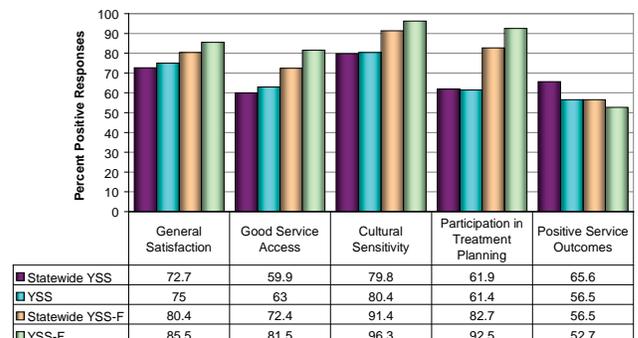
Diagnosis at Admission

	Youth	Adult
Substance Abuse	8	56
Schizophrenia	4	147
Depressive Disorders	52	258
Conduct Disorder	12	
Attention Deficit	128	14
Oppositional Defiant Disorder	50	1
Other Childhood	35	8
Mental Retardation	27	38
Alzheimers & Organic Brain Disorders	2	7
Anxiety Disorders	58	230
Personality Disorders	3	170
Abuse	99	148
Diagnosis Deferred	24	73
Sexual/Gender Disorders		2
Adjustment Disorders	128	20
Other V Codes	286	179
Other	5	15
Bipolar	6	42
Total	927	1,408

Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
Fiscal Year 2007



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



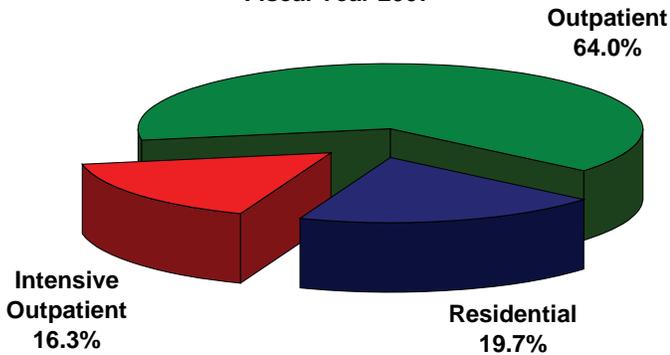
Davis Behavioral Health - Substance Abuse

2006 Population	Total Served	Penetration Rate
276,259	1,037	0.4%

Admissions into Modalities and Clients Served Fiscal Year 2007



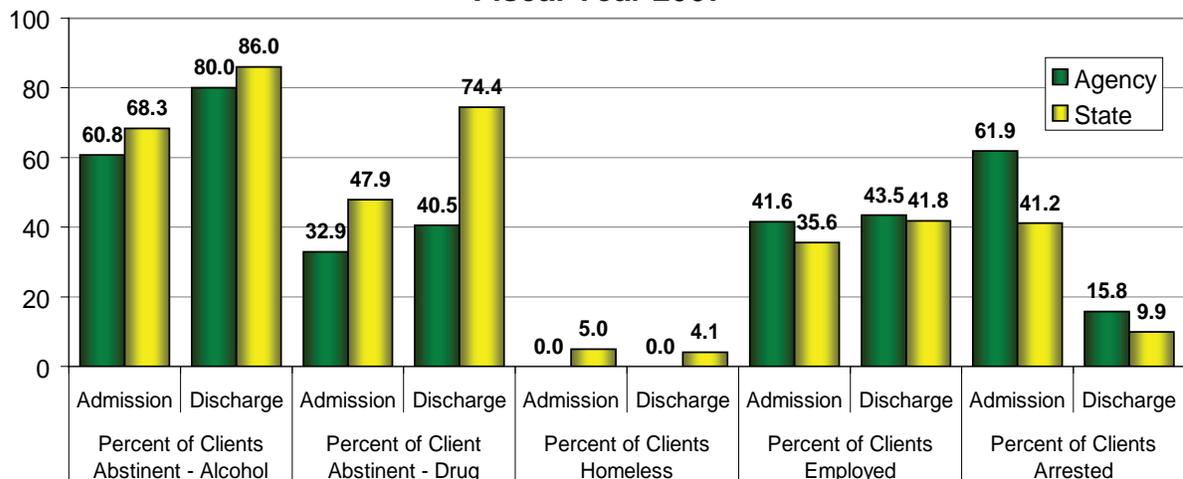
Admissions into Modalities Fiscal Year 2007



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	132	66	198
Cocaine/Crack	48	26	74
Marijuana/Hashish	96	27	123
Heroin	50	23	73
Other Opiates/Synthetics	14	19	33
Hallucinogens	1	1	2
Methamphetamine	276	172	448
Other Stimulants	4	2	6
Benzodiazepines	2	0	2
Tranquilizers/Sedatives	1	0	1
Inhalants	0	0	0
Oxycodone	45	25	70
Club Drugs	1	0	1
Over-the-Counter	2	1	3
Other	0	0	0
Unkown	9	7	16
Total	681	369	1050

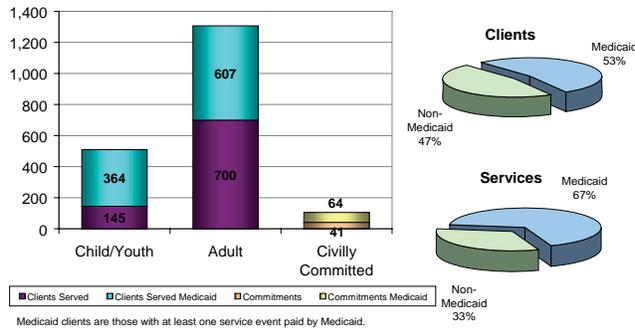
Davis Behavioral Health Outcome Measures Fiscal Year 2007



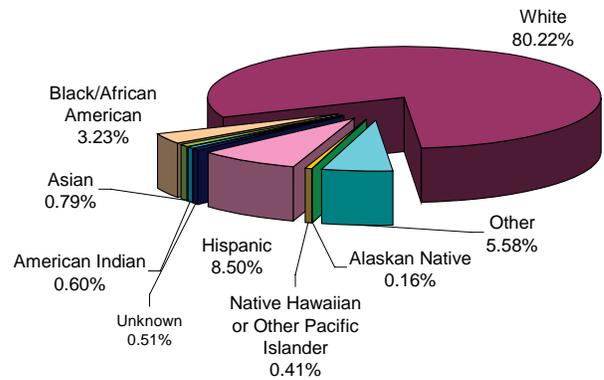
Davis Behavioral Health - Mental Health

2006 Population	Total Served	Percentage
276,259	2,886	1.0%

Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007

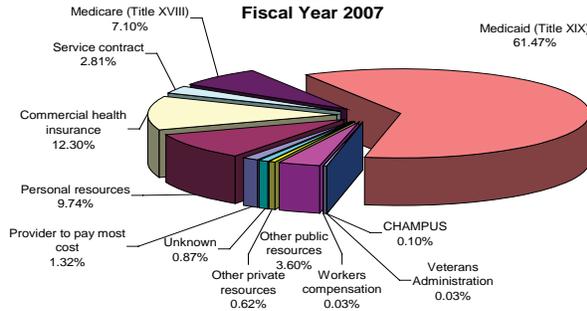


Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

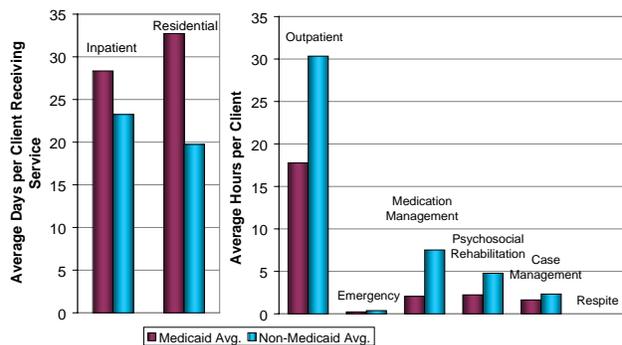
Expected Payment Source At Admission
Fiscal Year 2007



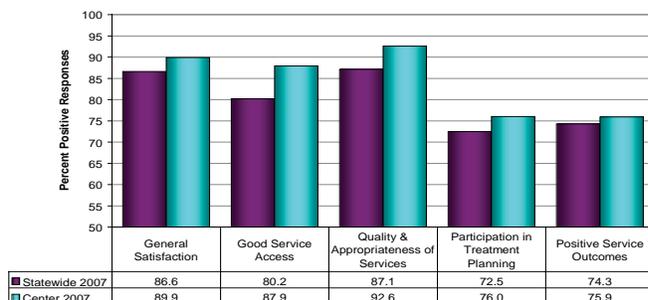
Diagnosis at Admission

	Youth	Adult
Substance Abuse	89	213
Schizophrenia	12	354
Depressive Disorders	325	847
Conduct Disorder	16	2
Attention Deficit	321	79
Oppositional Defiant Disorder	132	10
Other Childhood	168	29
Mental Retardation	93	94
Alzheimers & Organic Brain Disorders	4	31
Anxiety Disorders	253	598
Personality Disorders	11	305
Abuse	383	87
Diagnosis Deferred	177	617
Sexual/Gender Disorders		3
Adjustment Disorders	270	110
Other V Codes	1,037	592
Other	83	46
Bipolar	22	250
Total	3,396	4,267

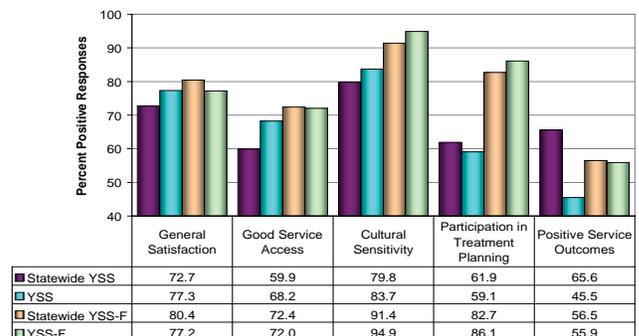
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



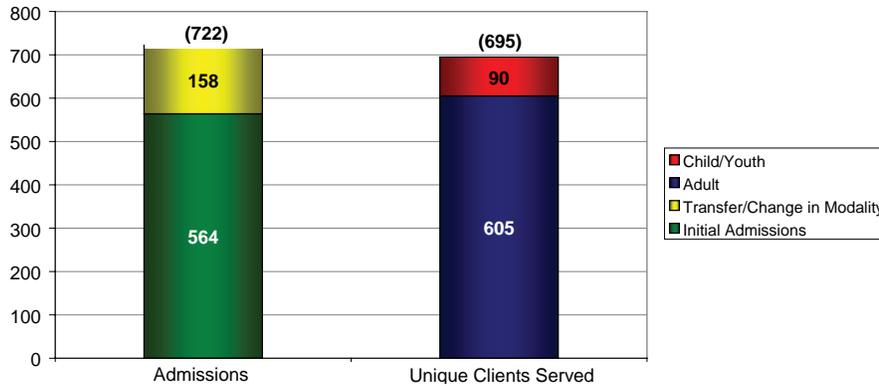
Youth Satisfaction Survey
2007



Four Corners Community Behavioral Health - Substance Abuse

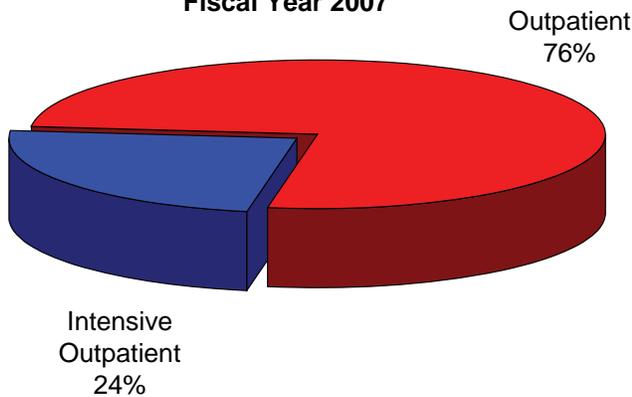
2006 Population	Total Served	Penetration Rate
39,166	695	1.8%

Admissions into Modalities and Clients Served
Fiscal Year 2007



Admissions into Modalities

Fiscal Year 2007

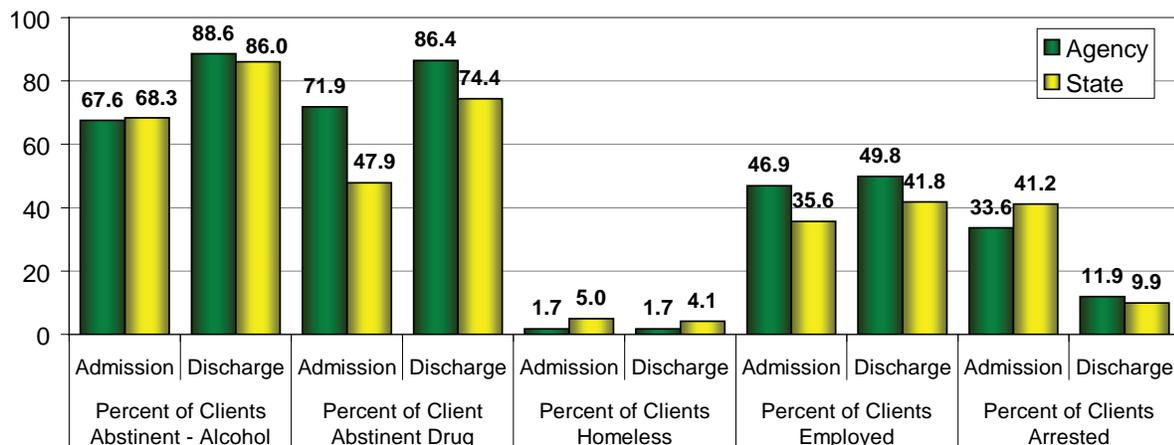


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	236	109	345
Cocaine/Crack	1	2	3
Marijuana/Hashish	106	49	155
Heroin	8	3	11
Other Opiates/Synthetics	23	27	50
Hallucinogens	1	0	1
Methamphetamine	74	75	149
Other Stimulants	0	1	1
Benzodiazepines	1	2	3
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	1	2
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	1	2
Unkown	0	0	0
Total	452	270	722

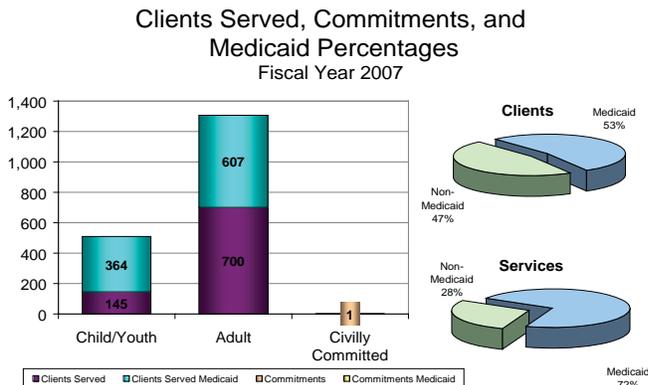
Four Corners Community Behavioral Health Outcome Measures

Fiscal Year 2007

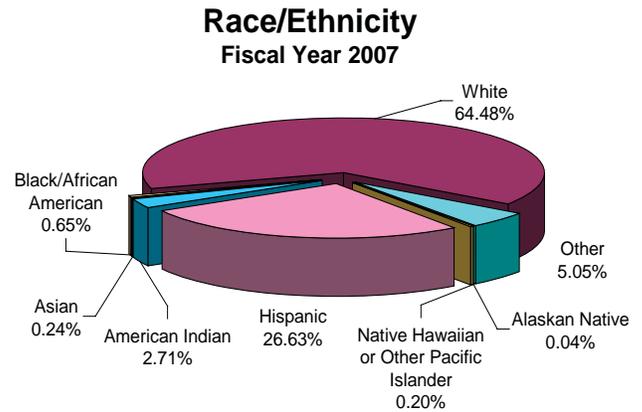


Four Corners Community Behavioral Health - Mental Health

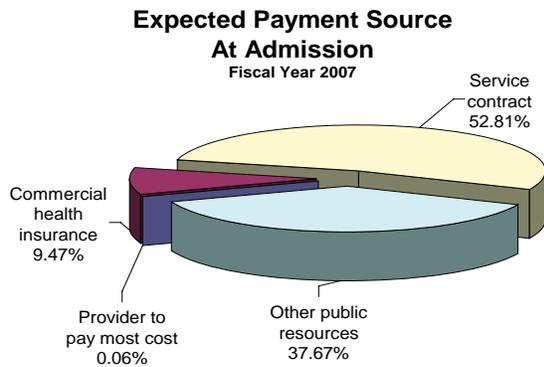
2006 Population	Total Served	Percentage
39,166	1,816	4.6%



Medicaid clients are those with at least one service event paid by Medicaid.

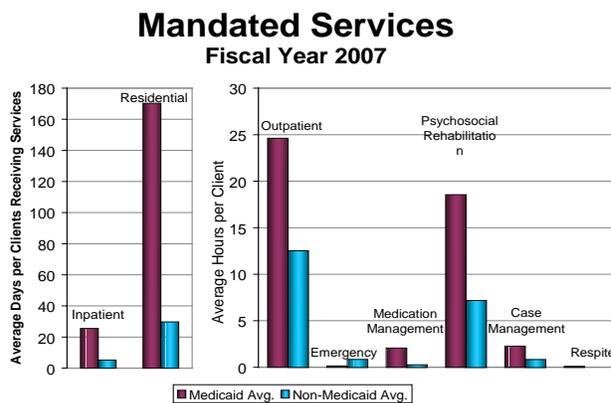


More than one race/ethnicity may have been selected.

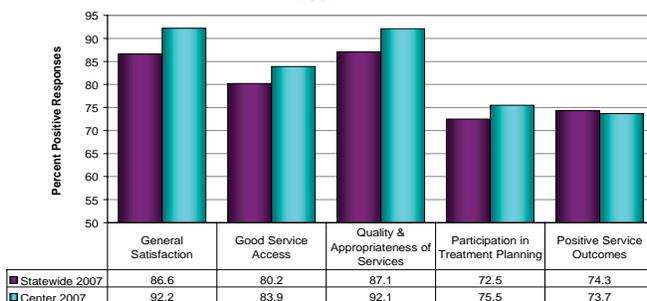


Diagnoses at Admission

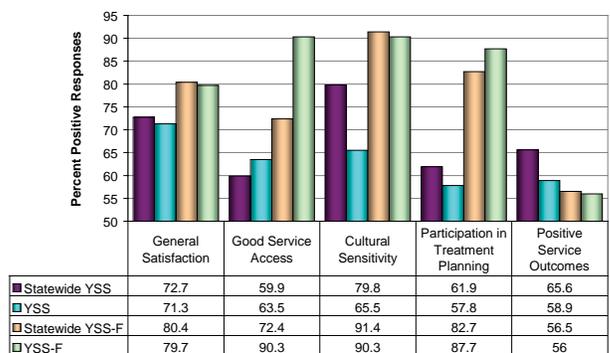
	Youth	Adult
Substance Abuse	120	768
Schizophrenia	1	142
Depressive Disorders	165	440
Conduct Disorder	7	1
Attention Deficit	163	17
Oppositional Defiant Disorder	103	5
Other Childhood	59	11
Mental Retardation	42	28
Alzheimers & Organic Brain Disorders	1	24
Anxiety Disorders	69	237
Personality Disorders	5	191
Abuse	62	17
Diagnosis Deferred	126	401
Sexual/Gender Disorders	2	2
Adjustment Disorders	54	29
Other V Codes	425	426
Other	13	30
Bipolar	17	97
Total	1,434	2,866



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2007



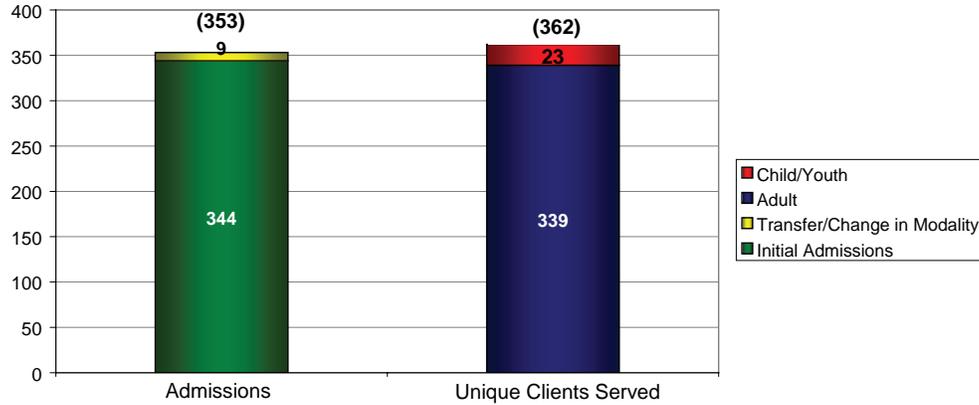
Youth Satisfaction Survey



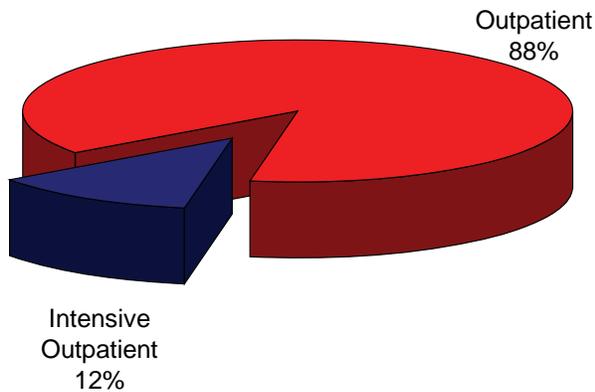
**Northeastern Counseling Center
Substance Abuse**

2006 Population	Total Served	Penetration Rate
44,603	362	0.8%

**Admissions into Modalities and Clients Served
Fiscal Year 2007**



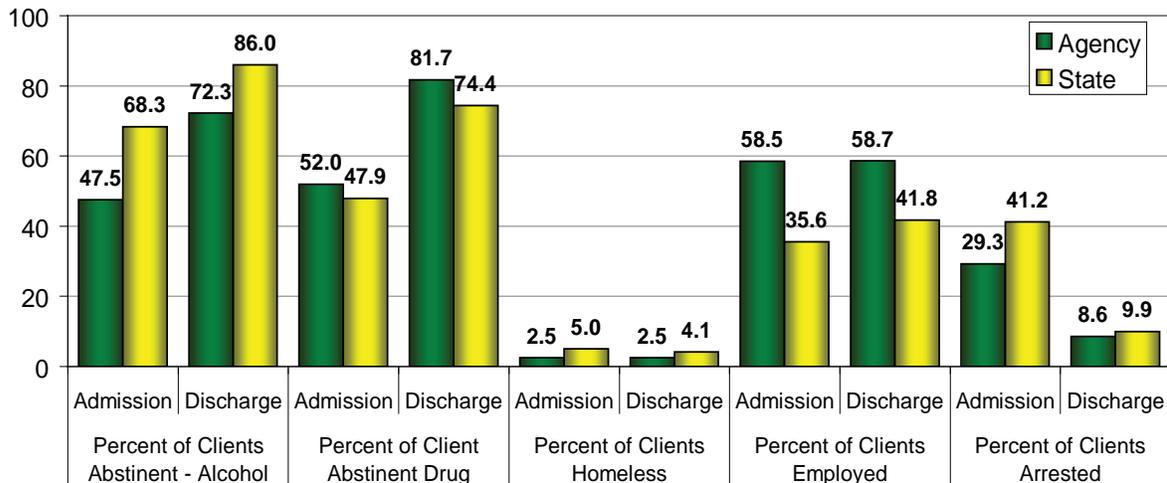
**Admission into Modalities
Fiscal Year 2007**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	122	37	159
Cocaine/Crack	3	1	4
Marijuana/Hashish	36	15	51
Heroin	0	0	0
Other Opiates/Synthetics	3	2	5
Hallucinogens	0	0	0
Methamphetamine	81	41	122
Other Stimulants	2	0	2
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	1	1
Other	0	0	0
Unknown	3	2	5
Total	253	100	353

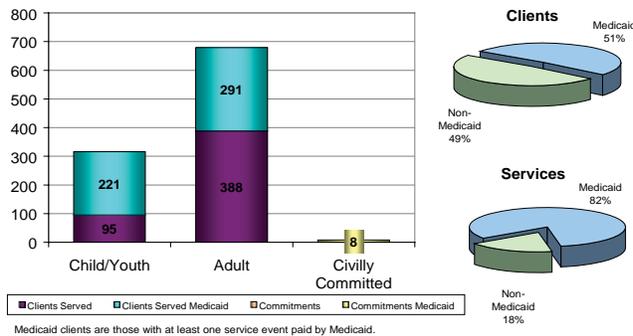
**Northeastern Counseling Center
Outcome Measures
Fiscal Year 2007**



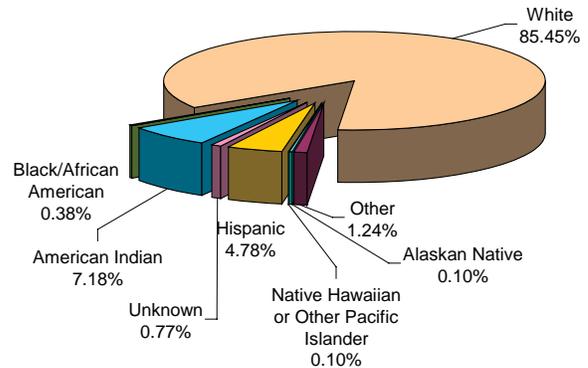
Northeastern Counseling Center Mental Health

2006 Population	Total Served	Percentage
44,603	995	2.2%

Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007

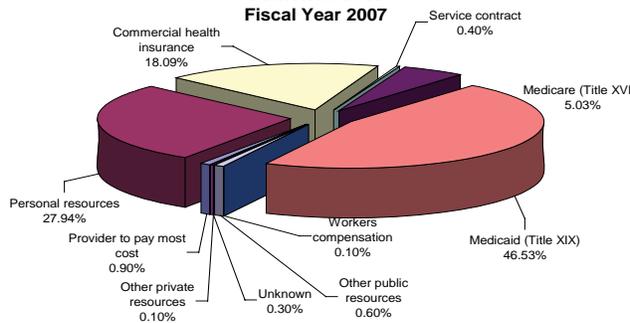


Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

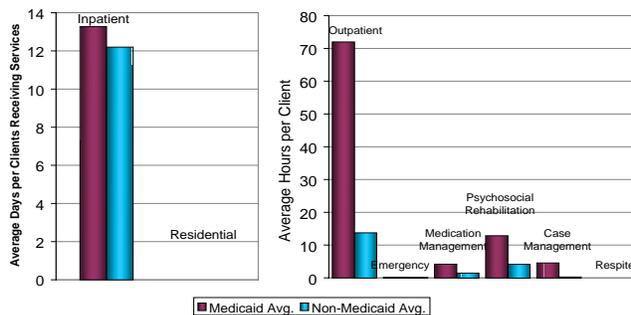
Expected Payment Source At Admission
Fiscal Year 2007



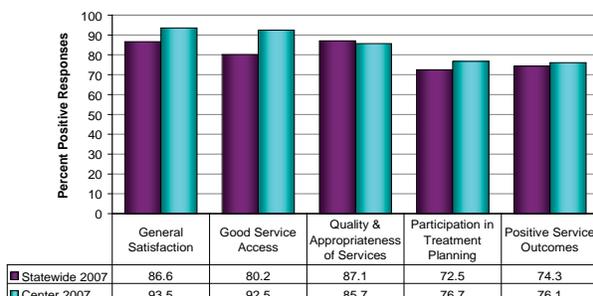
Diagnoses at Admission

	Youth	Adult
Substance Abuse	11	88
Schizophrenia	2	92
Depressive Disorders	87	363
Conduct Disorder	4	
Attention Deficit	70	40
Oppositional Defiant Disorder	33	
Other Childhood	42	12
Mental Retardation	39	45
Alzheimers & Organic Brain Disorders	3	26
Anxiety Disorders	105	327
Personality Disorders	1	151
Abuse	127	75
Diagnosis Deferred	39	184
Sexual/Gender Disorders		1
Adjustment Disorders	79	43
Other V Codes	307	313
Other	14	39
Bipolar	15	61
Total	978	1,860

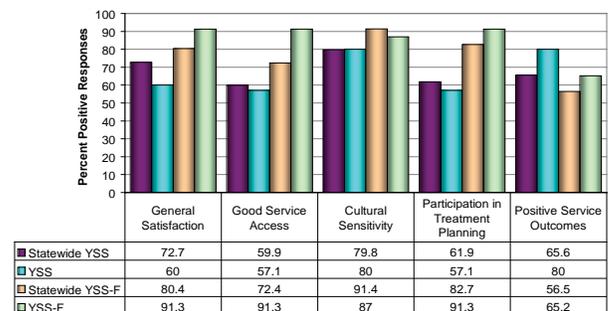
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



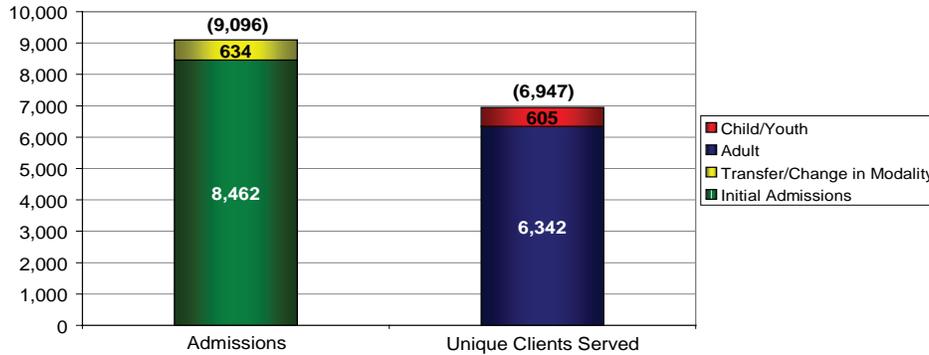
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



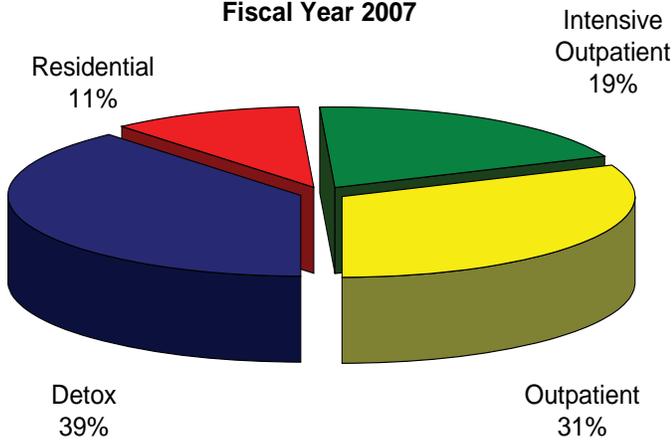
Salt Lake County Division of Substance Abuse

2006 Population	Total Served	Penetration Rate
978,701	6,947	0.7%

**Admissions into Modalities and Clients Served
Fiscal Year 2007**



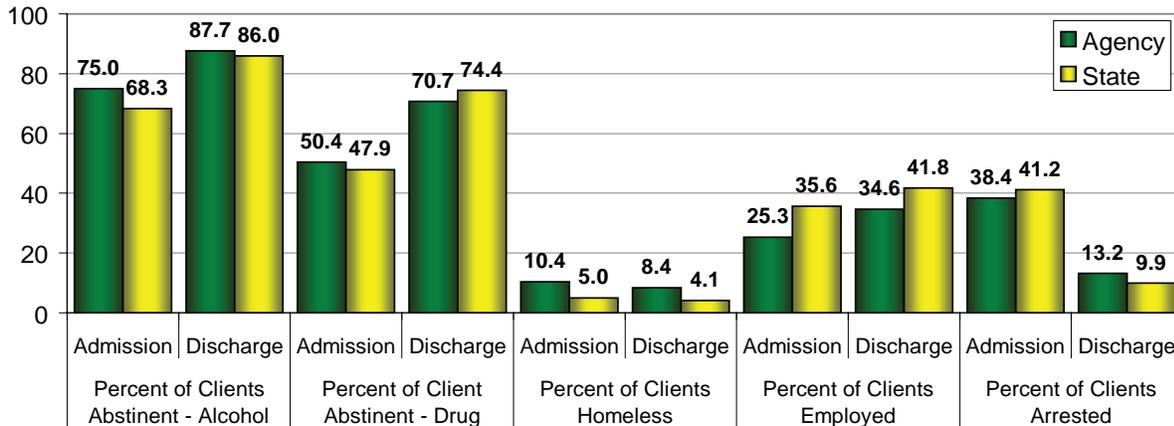
**Admissions into Modalities
Fiscal Year 2007**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	2,124	584	2,708
Cocaine/Crack	605	296	901
Marijuana/Hashish	740	253	993
Heroin	996	487	1,483
Other Opiates/Synthetics	127	157	284
Hallucinogens	11	4	15
Methamphetamine	1,172	1,267	2,439
Other Stimulants	15	14	29
Benzodiazepines	8	17	25
Tranquilizers/Sedatives	0	5	5
Inhalants	3	0	3
Oxycodone	80	80	160
Club Drugs	7	6	13
Over-the-Counter	16	3	19
Other	6	2	8
Unkown	3	8	11
Total	5,913	3,183	9,096

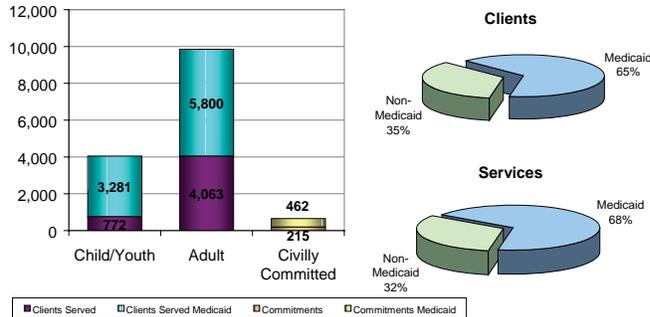
**Salt Lake County Division of Substance Abuse
Outcome Measures
Fiscal Year 2007**



Valley Mental Health - Salt Lake

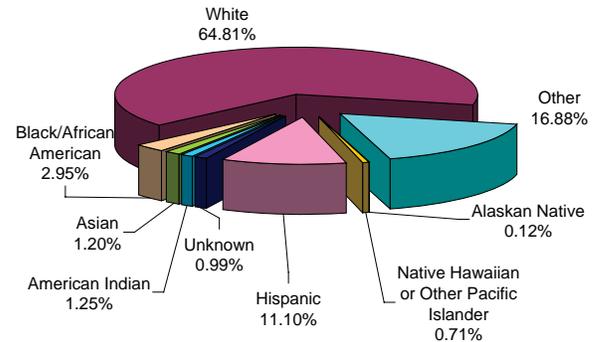
2006 Population	Total Served	Percentage
978,701	13,736	1.4%

Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007



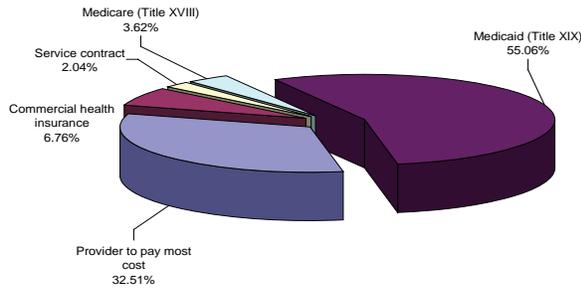
Medicaid clients are those at least service event paid by Medicaid.

Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

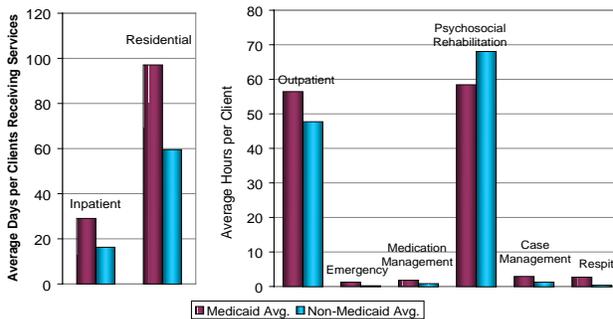
Expected Payment Source At Admission
Fiscal Year 2007



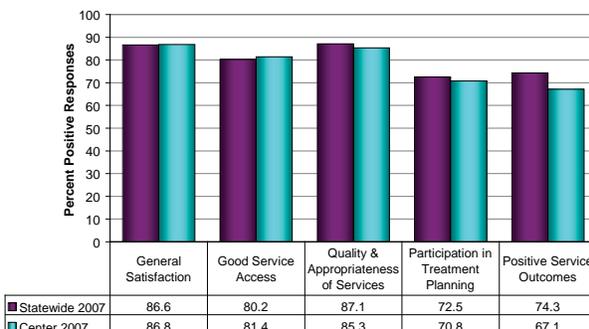
Diagnoses at Admission

	Youth	Adult
Substance Abuse	513	4,705
Schizophrenia	38	1,949
Depressive Disorders	1,114	3,723
Conduct Disorder	97	8
Attention Deficit	1,283	281
Opositional Defiant Disorder	797	13
Other Childhood	410	77
Mental Retardation	514	388
Alzheimers & Organic Brain Disorders	17	222
Anxiety Disorders	967	1,907
Personality Disorders	9	2,200
Abuse	679	332
Diagnosis Deferred		8
Sexual/Gender Disorders	4	18
Adjustment Disorders	456	160
Other V Codes	571	1,254
Other	88	154
Bipolar	39	748
Total	7,596	18,147

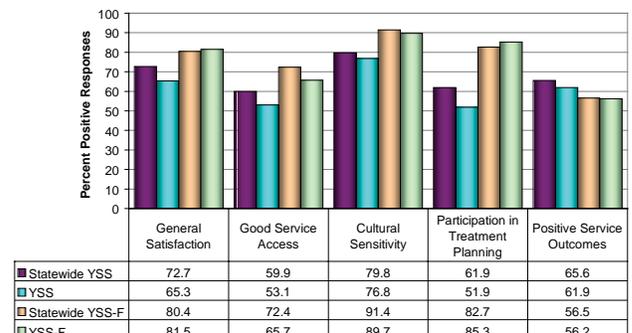
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



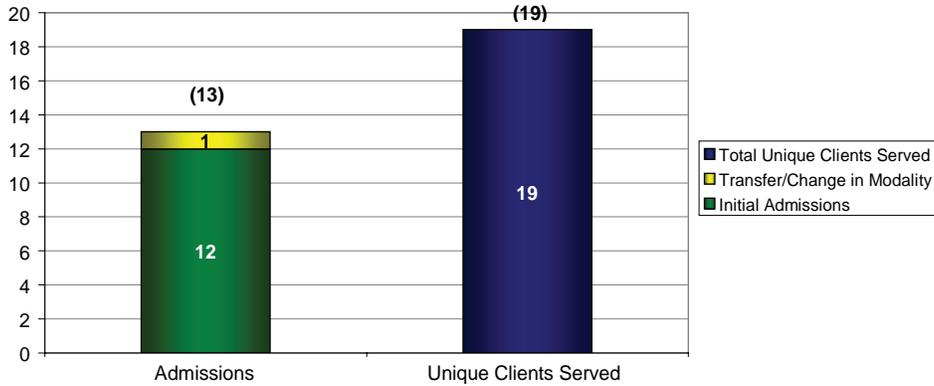
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



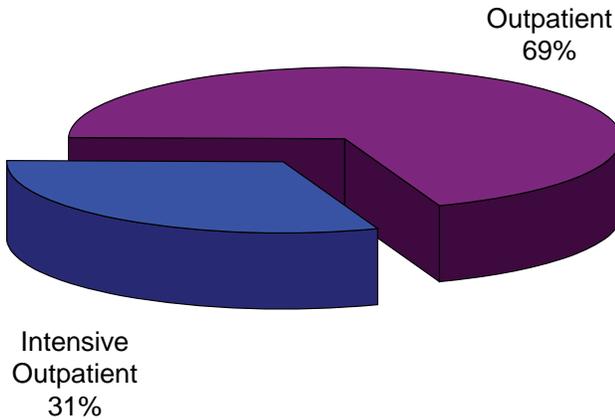
San Juan Counseling - Substance Abuse

2006 Population	Total Served	Penetration Rate
14,265	19	0.1%

Admissions into Modalities and Clients Served Fiscal Year 2007



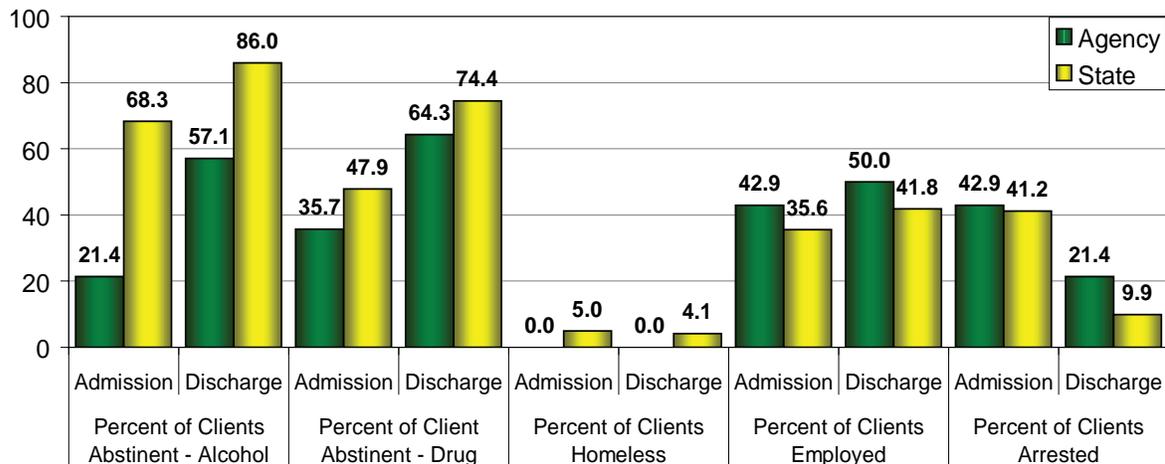
Admissions into Modalities Fiscal Year 2007



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	7	3	10
Cocaine/Crack	0	0	0
Marijuana/Hashish	0	0	0
Heroin	0	0	0
Other Opiates/Synthetics	0	0	0
Hallucinogens	0	0	0
Methamphetamine	1	2	3
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
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
Unkown	0	0	0
Total	8	5	13

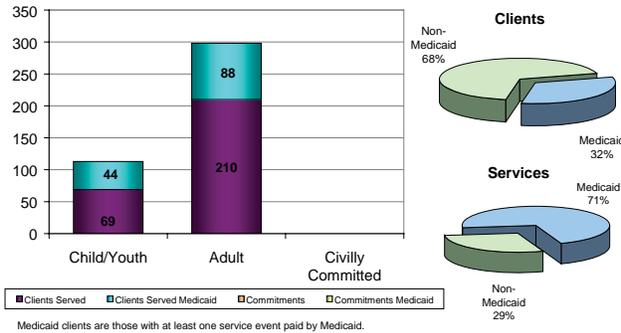
San Juan Counseling Outcome Measures Fiscal Year 2007



San Juan Counseling - Mental Health

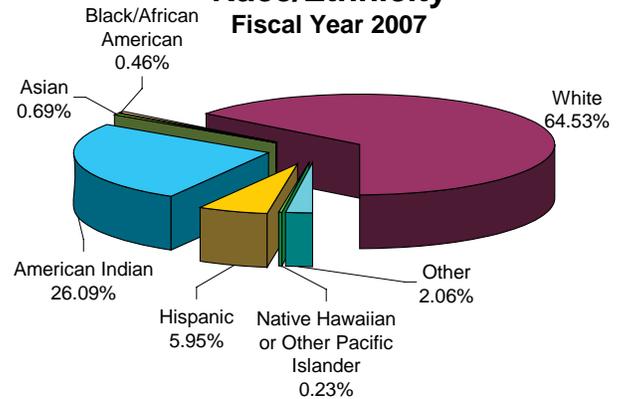
2006 Population	Total Served	Percentage
14,265	411	2.9%

Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007



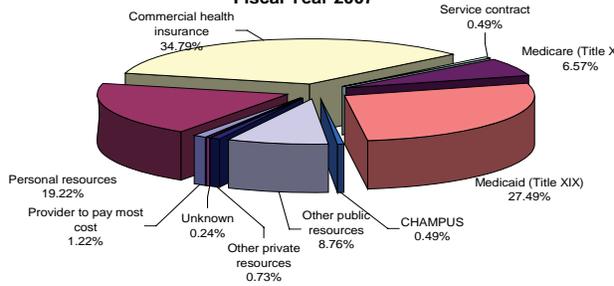
Medicaid clients are those with at least one service event paid by Medicaid.

Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

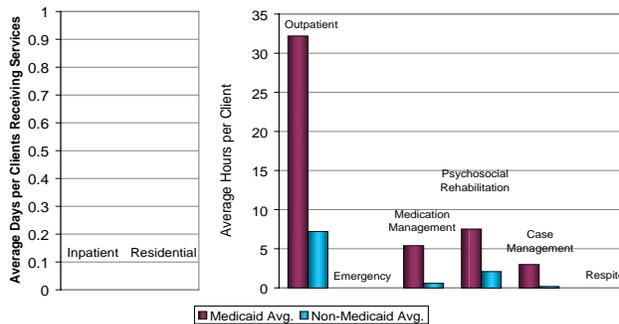
Expected Payment Source At Admission
Fiscal Year 2007



Diagnoses at Admission

	Youth	Adult
Substance Abuse	12	1
Schizophrenia	19	
Depressive Disorders	164	51
Conduct Disorder		
Attention Deficit	6	32
Oppositional Defiant Disorder		
Other Childhood	2	7
Mental Retardation	5	10
Alzheimers & Organic Brain Disorders	28	1
Anxiety Disorders	63	37
Personality Disorders	30	1
Abuse	9	7
Diagnosis Deferred	25	3
Sexual/Gender Disorders		
Adjustment Disorders	3	16
Other V Codes	114	95
Other	7	3
Bipolar	12	
Total	499	264

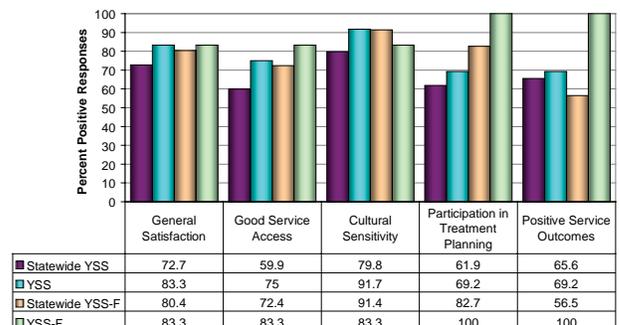
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



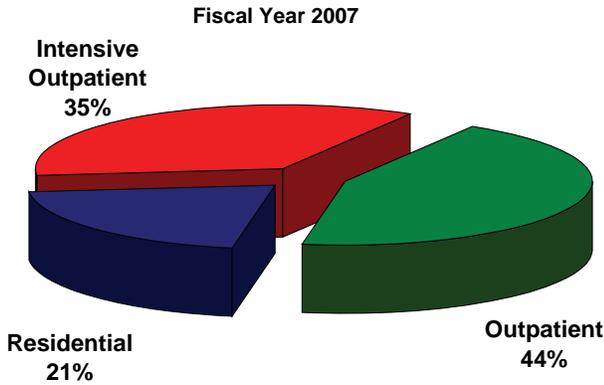
Southwest Behavioral Health Center - Substance Abuse

2006 Population	Total Served	Penetration Rate
184,216	349	0.2%

Admissions into Modalities and Clients Served Fiscal Year 2007



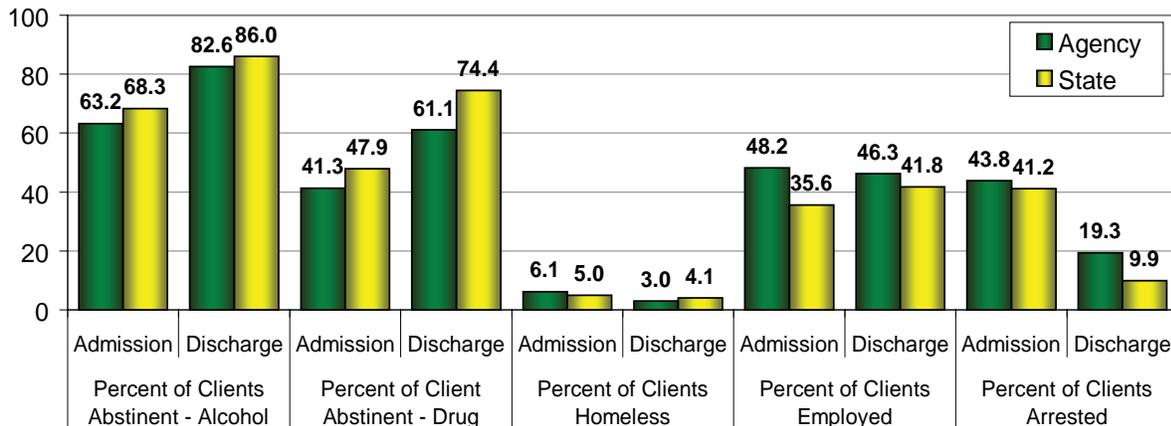
Admissions into Modalities Fiscal Year 2007



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	68	47	115
Cocaine/Crack	4	0	4
Marijuana/Hashish	44	29	73
Heroin	20	1	21
Other Opiates/Synthetics	4	4	8
Hallucinogens	0	0	0
Methamphetamine	94	108	202
Other Stimulants	0	2	2
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	0	0
Inhalants	2	0	2
Oxycodone	16	12	28
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	6	1	7
Total	258	205	463

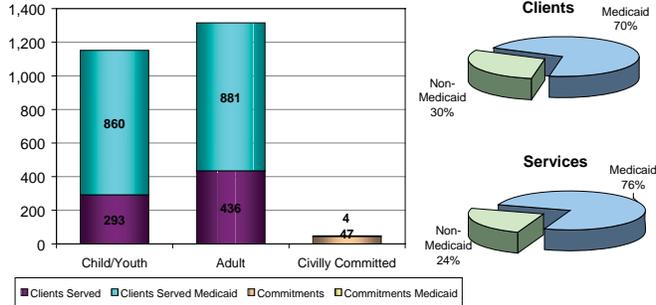
Southwest Behavioral Health Outcome Measures Fiscal Year 2007



Southwest Behavioral Health Center - Mental Health

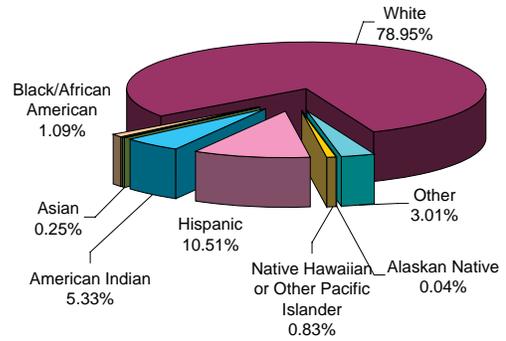
2006 Population	Total Served	Percentage
184,216	2,469	1.3%

Clients Served, Civil Commitments, and Medicaid Percentages Fiscal Year 2007



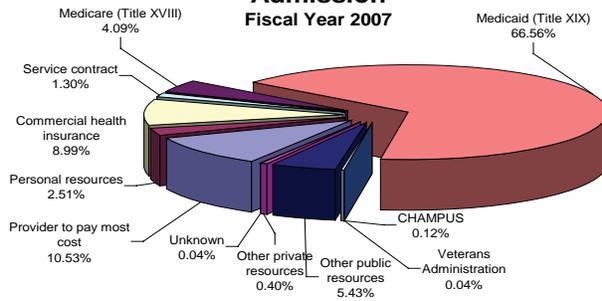
Medicaid clients are those clients with at least one service event paid by Medicaid.

Race/Ethnicity Fiscal Year 2007

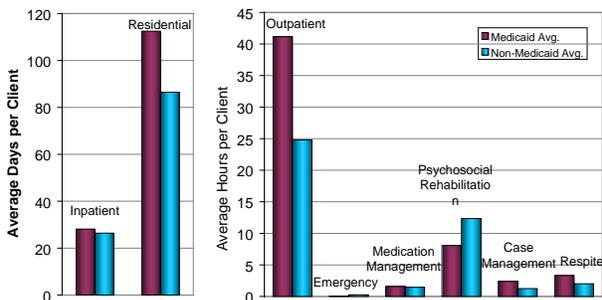


More than one race/ethnicity may have been selected.

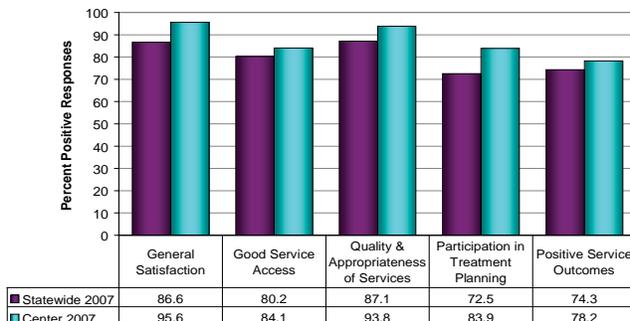
Expected Payment Source At Admission Fiscal Year 2007



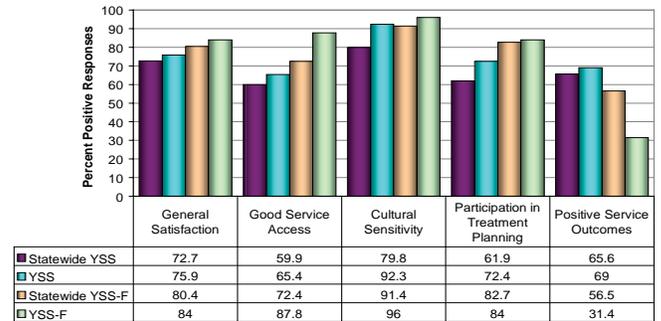
Mandated Services Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2007



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2007



Summit County - VMH - Substance Abuse

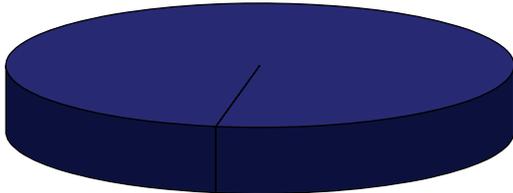
2006 Population	Total Served	Penetration Rate
35,469	305	0.9%

Admissions into Modalities and Clients Served Fiscal Year 2007



Admissions into Modalities Fiscal Year 2007

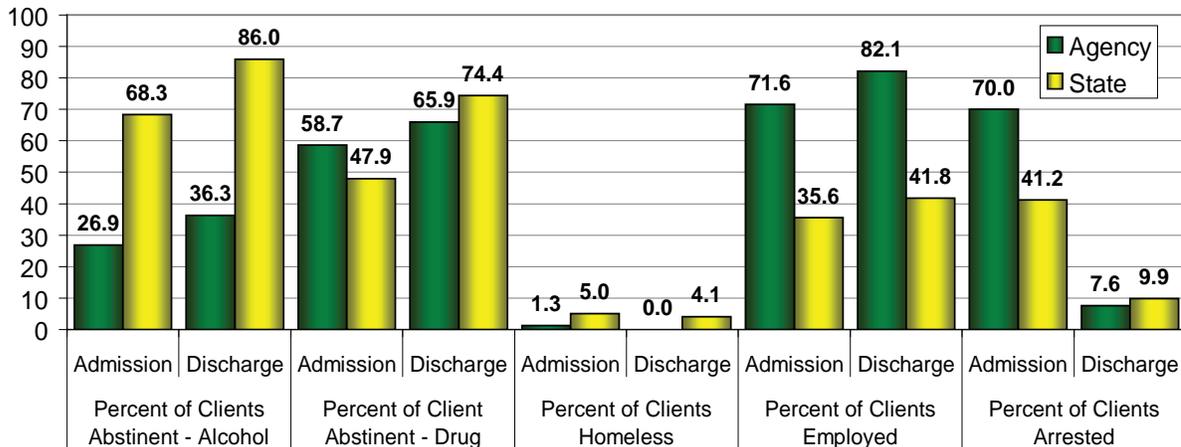
Outpatient
100%



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	91	40	131
Cocaine/Crack	9	6	15
Marijuana/Hashish	36	7	43
Heroin	3	1	4
Other Opiates/Synthetics	0	1	1
Hallucinogens	0	1	1
Methamphetamine	10	8	18
Other Stimulants	0	1	1
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	1	1	2
Inhalants	0	0	0
Oxycodone	1	0	1
Club Drugs	1	0	1
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	153	66	219

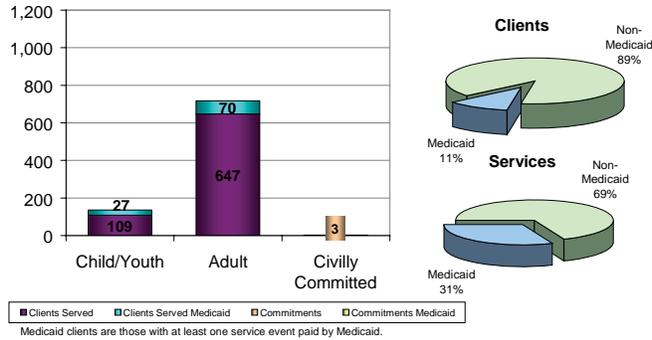
Summit County - VMH Outcome Measures Fiscal Year 2007



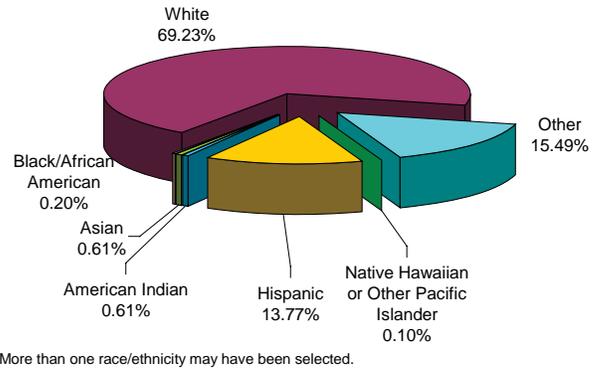
Summit County - VMH - Mental Health

2006 Population	Total Served	Percentage
35,469	856	2.4%

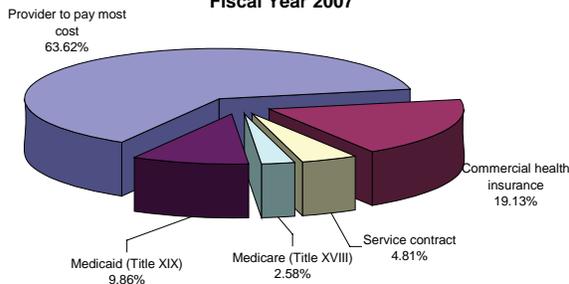
Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007



Race/Ethnicity
Fiscal Year 2007



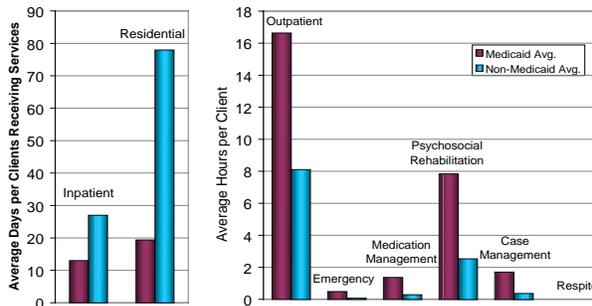
Expected Payment Source At Admission
Fiscal Year 2007



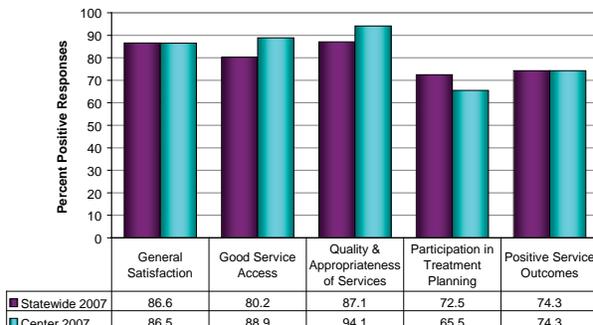
Diagnoses at Admission

	Youth	Adult
Substance Abuse	52	427
Schizophrenia		11
Depressive Disorders	42	224
Conduct Disorder	1	
Attention Deficit	19	30
Oppositional Defiant Disorder	15	
Other Childhood	14	12
Mental Retardation	3	7
Alzheimers & Organic Brain Disorders		5
Anxiety Disorders	19	130
Personality Disorders	1	13
Abuse	9	41
Diagnosis Deferred		
Sexual/Gender Disorders		2
Adjustment Disorders	39	56
Other V Codes	42	51
Other	5	5
Bipolar		12
Total	261	1,026

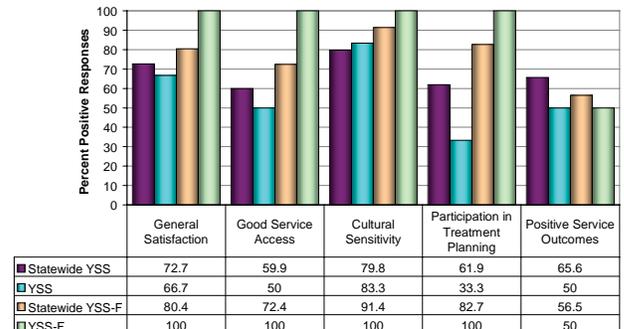
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



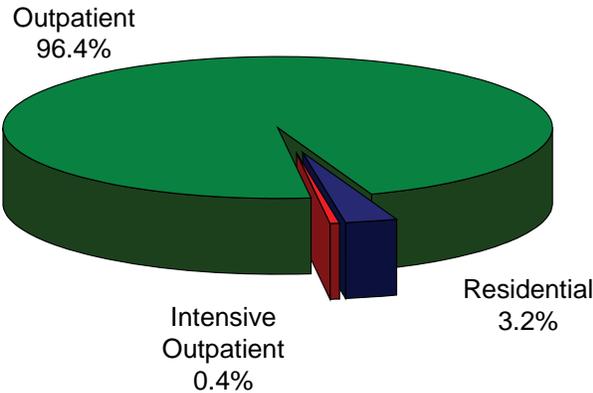
Tooele County - VMH - Substance Abuse

2006 Population	Total Served	Penetration Rate
53,552	327	0.6%

**Admissions into Modalities and Clients Served
Fiscal Year 2007**



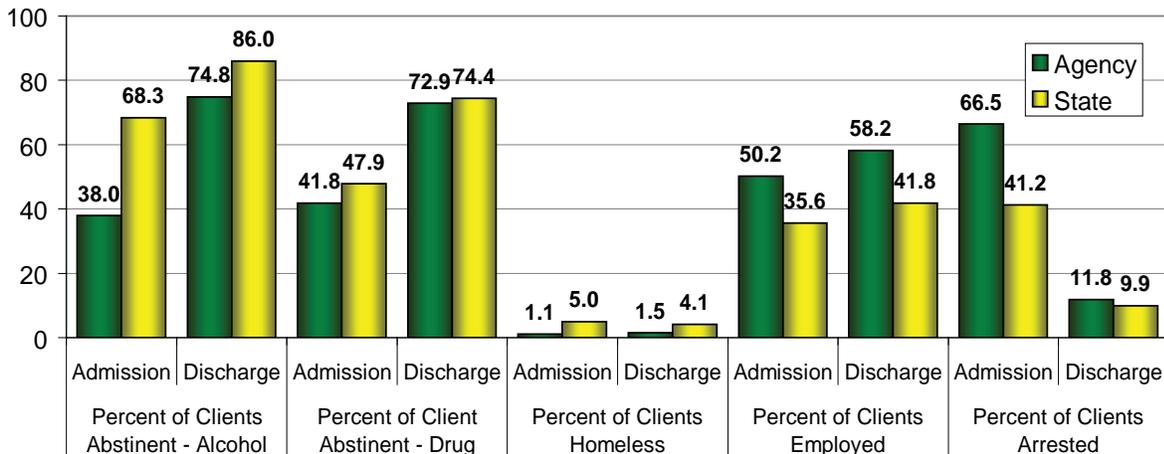
**Admissions into Modalities
Fiscal Year 2007**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	92	40	132
Cocaine/Crack	5	3	8
Marijuana/Hashish	33	11	44
Heroin	7	2	9
Other Opiates/Synthetics	2	0	2
Hallucinogens	0	0	0
Methamphetamine	19	20	39
Other Stimulants	0	1	1
Benzodiazepines	1	1	2
Tranquilizers/Sedatives	0	0	0
Inhalants	1	2	3
Oxycodone	1	2	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	161	82	243

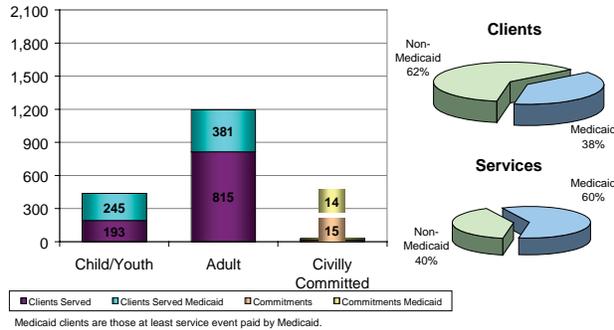
**Tooele - VMH Outcome Measures
Fiscal Year 2007**



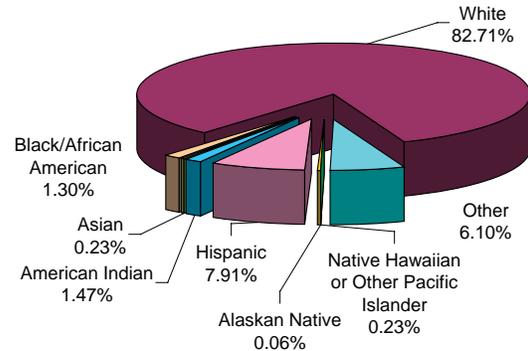
Tooele County - VMH - Mental Health

2006 Population	Total Served	Percentage
53,552	1,642	3.1%

Clients Served, Medicaid Percentages, and Commitment Status
Fiscal Year 2007

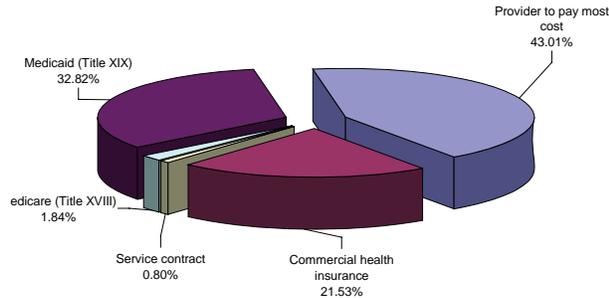


Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

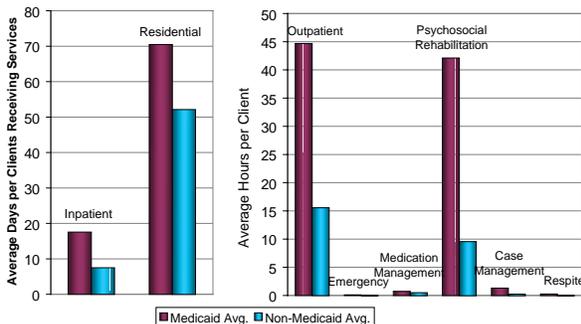
Expected Payment Source At Admission
Fiscal Year 2007



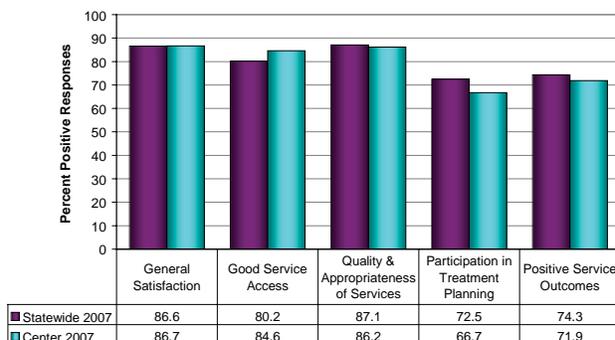
Diagnoses at Admission

	Youth	Adult
Substance Abuse	88	567
Schizophrenia	2	60
Depressive Disorders	136	552
Conduct Disorder	9	2
Attention Deficit	115	64
Oppositional Defiant Disorder	68	1
Other Childhood	33	7
Mental Retardation	31	19
Alzheimers & Organic Brain Disorders		24
Anxiety Disorders	123	259
Personality Disorders	1	69
Abuse	107	39
Diagnosis Deferred		
Sexual/Gender Disorders		2
Adjustment Disorders	23	34
Other V Codes	104	144
Other	14	7
Bipolar	5	57
Total	859	1,907

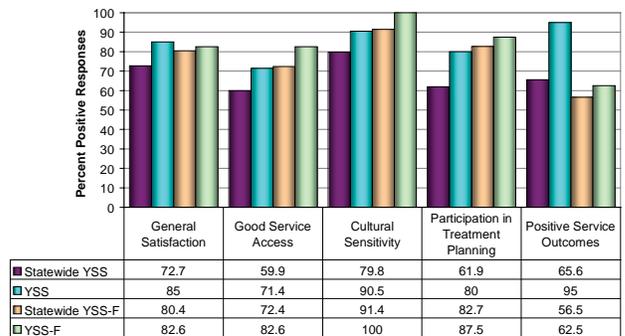
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2007



Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2007



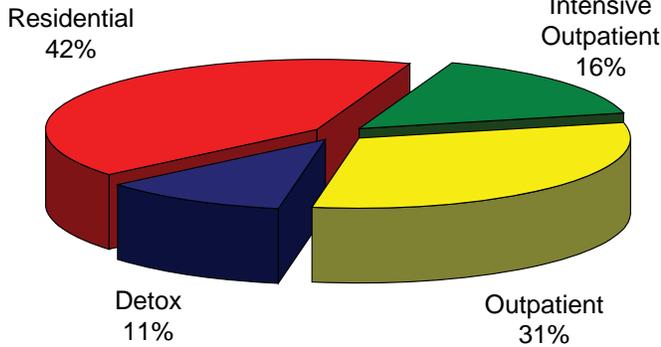
Utah County Division of Substance Abuse

2006 Population	Total Served	Penetration Rate
464,760	1,265	0.3%

Admissions into Modalities and Clients Served Fiscal Year 2007



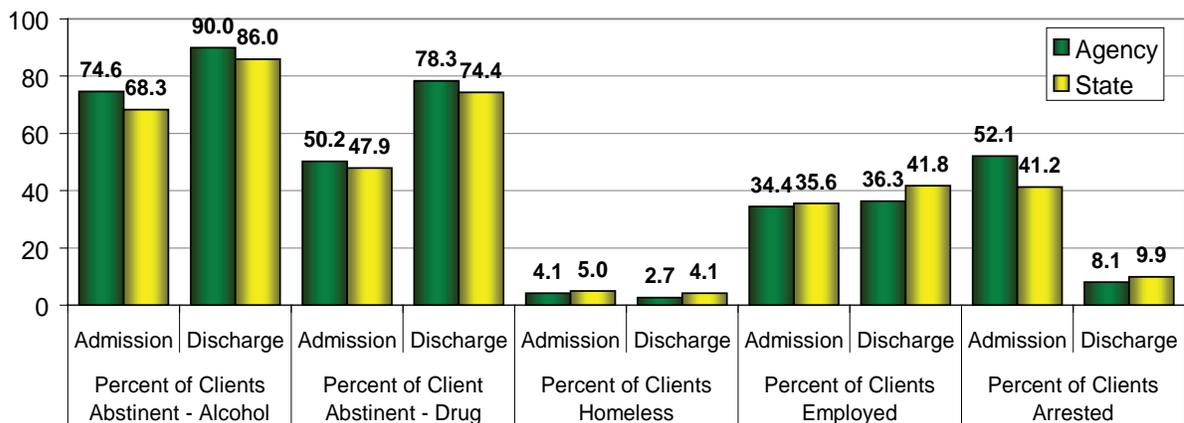
Admissions into Modalities Fiscal Year 2007



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	310	124	434
Cocaine/Crack	29	31	60
Marijuana/Hashish	219	75	294
Heroin	210	125	335
Other Opiates/Synthetics	13	24	37
Hallucinogens	6	1	7
Methamphetamine	196	294	490
Other Stimulants	2	3	5
Benzodiazepines	4	17	21
Tranquilizers/Sedatives	0	5	5
Inhalants	1	0	1
Oxycodone	93	67	160
Club Drugs	4	1	5
Over-the-Counter	2	0	2
Other	0	0	0
Unkown	3	3	6
Total	1,092	770	1,862

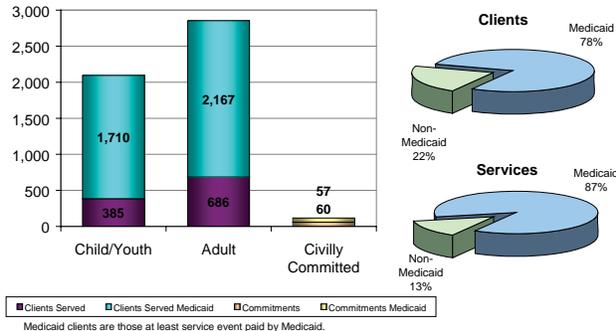
Utah County Division of Substance Abuse Outcome Measures Fiscal Year 2007



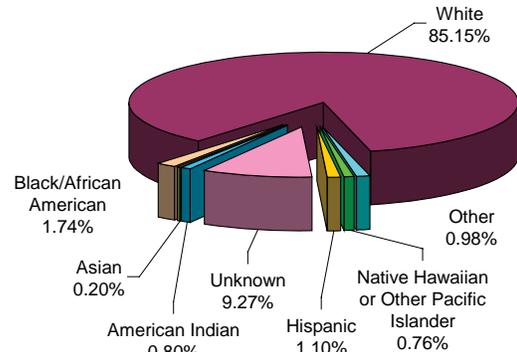
Wasatch Mental Health

2006 Population	Total Served	Percentage
464,760	4,948	1.1%

Clients Served, Medicaid Percentages, and Commitment Status
Fiscal Year 2007

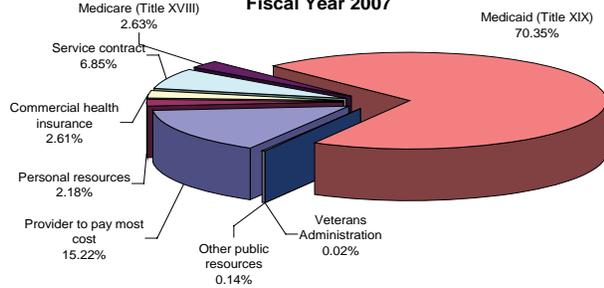


Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

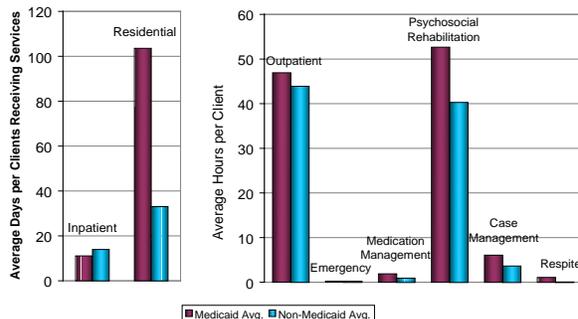
Expected Payment Source At Admission
Fiscal Year 2007



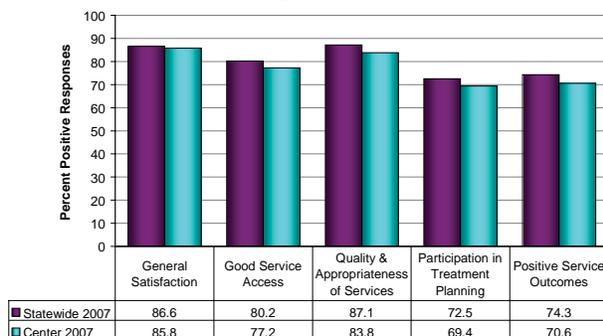
Diagnoses at Admission

	Youth	Adult
Substance Abuse	27	480
Schizophrenia	10	589
Depressive Disorders	267	1,072
Conduct Disorder	29	
Attention Deficit	375	170
Oppositional Defiant Disorder	160	
Other Childhood	217	103
Mental Retardation	229	222
Alzheimers & Organic Brain Disorders	7	95
Anxiety Disorders	405	776
Personality Disorders	10	437
Abuse	318	148
Diagnosis Deferred	353	416
Sexual/Gender Disorders	4	16
Adjustment Disorders	272	54
Other V Codes	1,305	852
Other	50	155
Bipolar	47	203
Total	4,085	5,788

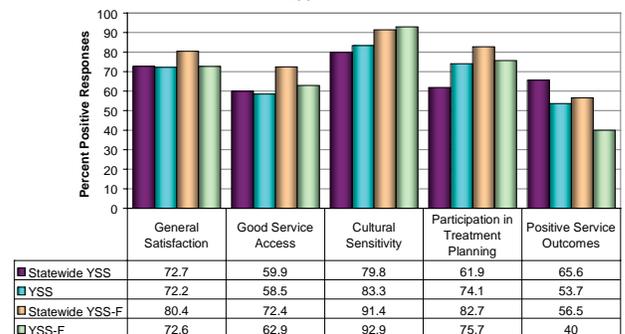
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2007



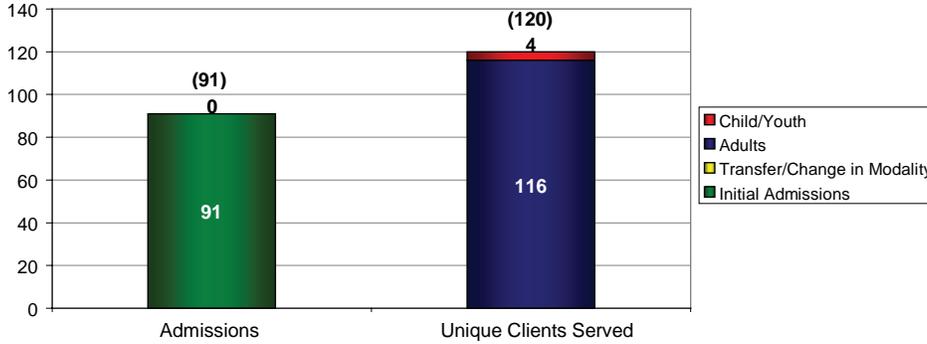
Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2007



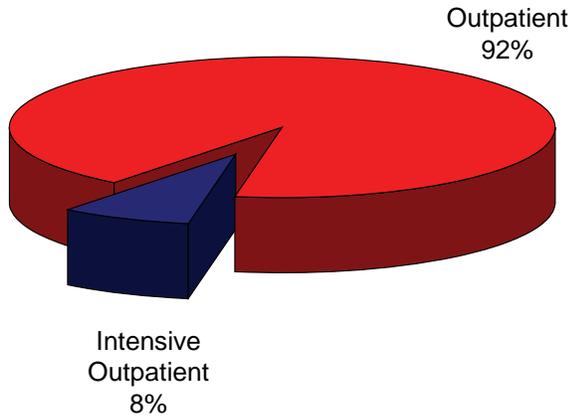
**Wasatch County - Heber Valley
Counseling - Substance Abuse**

2006 Population	Total Served	Penetration Rate
20,255	120	0.6%

**Admissions into Modalities and Clients Served
Fiscal Year 2007**



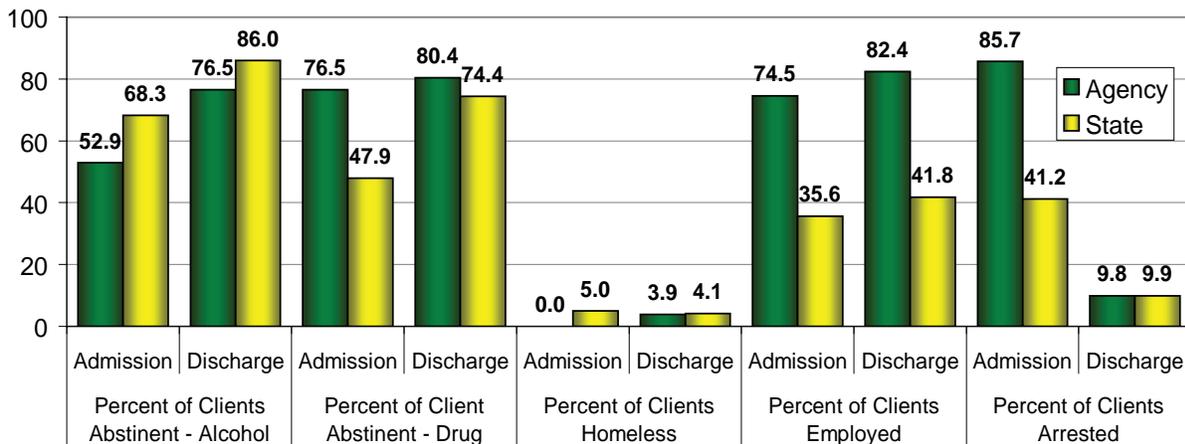
**Admissions into Modalities
Fiscal Year 2007**



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	38	5	43
Cocaine/Crack	4	0	4
Marijuana/Hashish	18	4	22
Heroin	2	2	4
Other Opiates/Synthetics	2	1	3
Hallucinogens	0	0	0
Methamphetamine	5	2	7
Other Stimulants	1	0	1
Benzodiazepines	1	2	3
Tranquilizers/Sedatives	0	1	1
Inhalants	0	1	1
Oxycodone	1	1	2
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	72	19	91

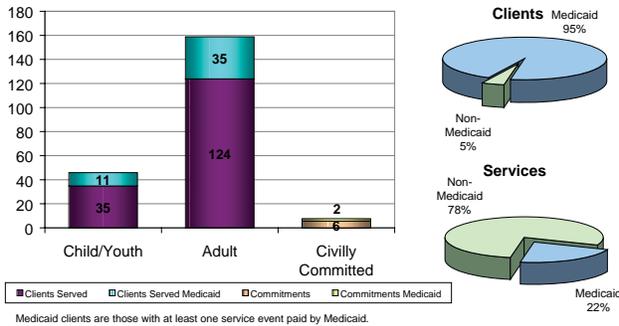
**Wasatch County - Heber Valley Counseling
Outcome Measures
Fiscal Year 2007**



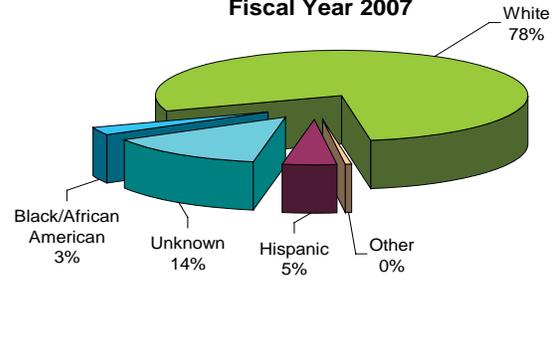
Wasatch County - Heber Valley Counseling - Mental Health

2006 Population	Total Served	Percentage
20,255	205	1.0%

Clients Served, Commitments and Medicaid Percentages
Fiscal Year 2007

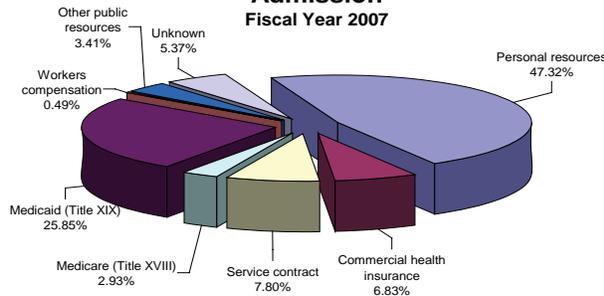


Race/Ethnicity
Fiscal Year 2007



More than one race/ethnicity may have been selected.

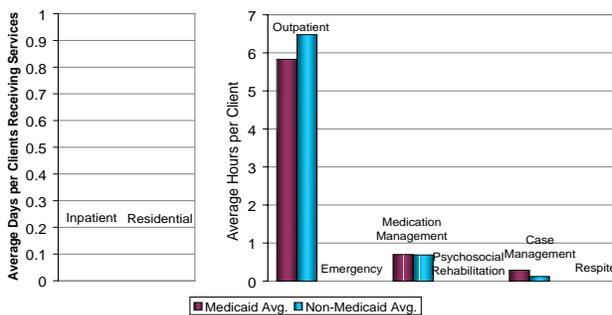
Expected Payment Source At Admission
Fiscal Year 2007



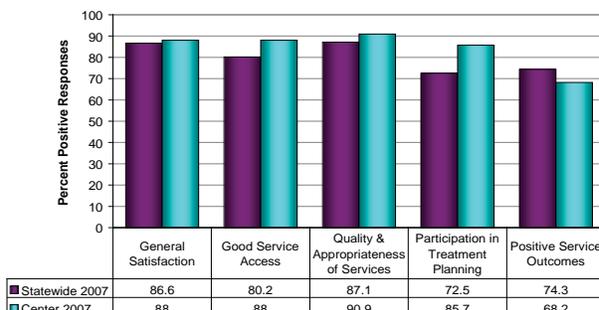
Diagnoses at Admission

	Youth	Adult
Substance Abuse	1	13
Schizophrenia		16
Depressive Disorders	4	31
Conduct Disorder		
Attention Deficit	4	2
Opositional Defiant Disorder	4	
Other Childhood	3	1
Mental Retardation	1	3
Alzheimers & Organic Brain Disorders		2
Anxiety Disorders	1	19
Personality Disorders		16
Abuse	1	6
Diagnosis Deferred	23	75
Sexual/Gender Disorders		
Adjustment Disorders	4	2
Other V Codes	12	25
Other		1
Bipolar		11
Total	58	223

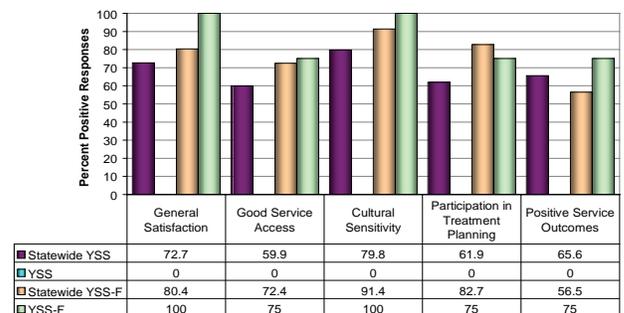
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



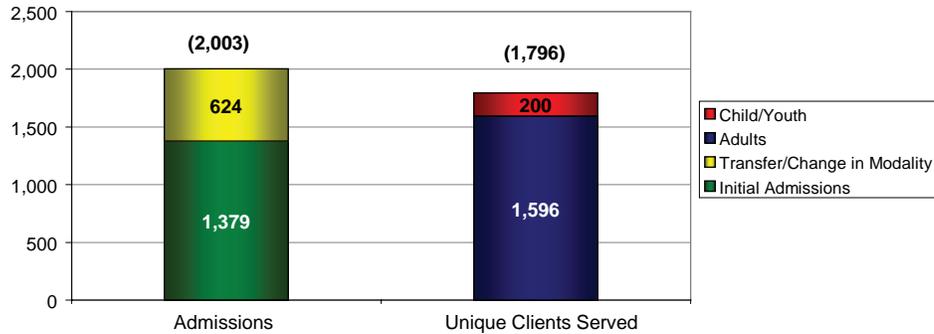
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



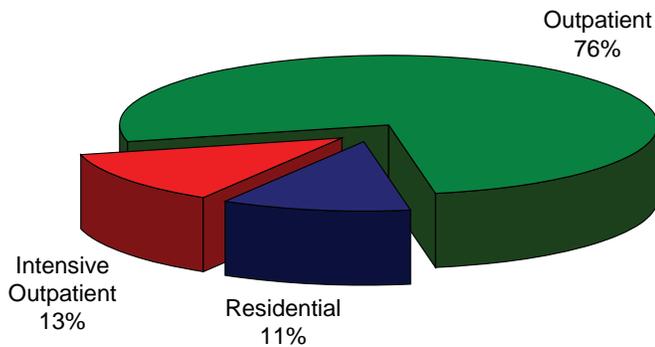
Weber Human Services - Substance Abuse

2006 Population	Total Served	Penetration Rate
221,381	1,796	0.8%

Admissions into Modalities and Clients Served Fiscal Year 2007



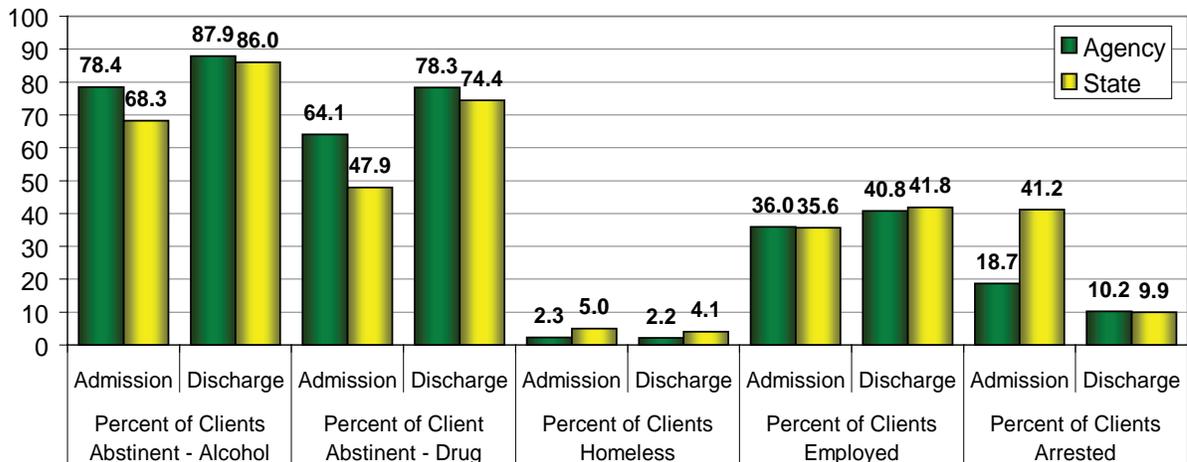
Admission into Modalities Fiscal Year 2007



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	433	193	626
Cocaine/Crack	44	43	87
Marijuana/Hashish	262	132	394
Heroin	20	9	29
Other Opiates/Synthetics	8	21	29
Hallucinogens	0	1	1
Methamphetamine	414	339	753
Other Stimulants	4	1	5
Benzodiazepines	1	7	8
Tranquilizers/Sedatives	1	3	4
Inhalants	0	1	1
Oxycodone	32	30	62
Club Drugs	1	1	2
Over-the-Counter	0	2	2
Other	0	0	0
Unkown	0	0	0
Total	1,220	783	2,003

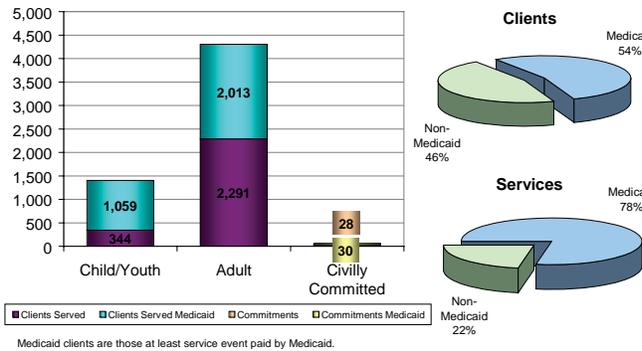
Weber Human Services Outcome Measures Fiscal Year 2007



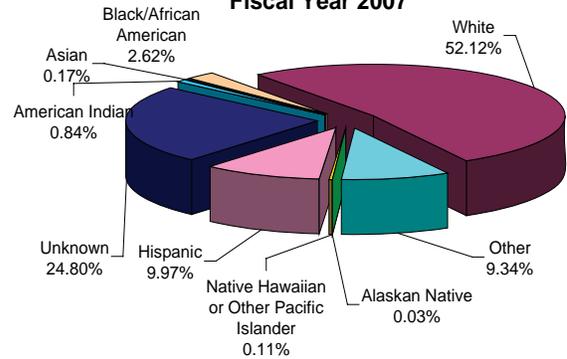
Weber Human Services - Mental Health

2006 Population	Total Served	Percentage
221,381	5,706	2.6%

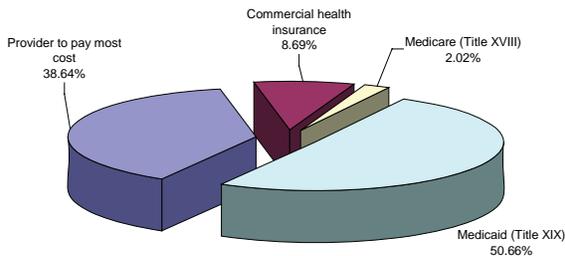
Clients Served, Commitments, and Medicaid Percentages
Fiscal Year 2007



Race/Ethnicity
Fiscal Year 2007



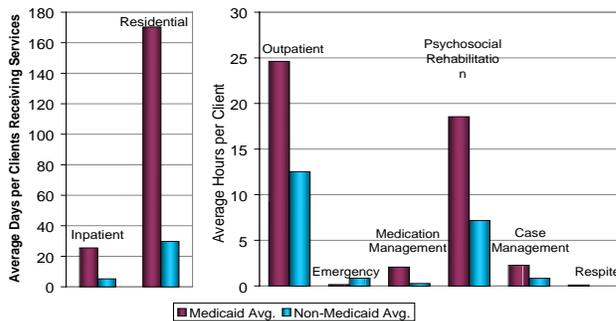
Expected Payment Source At Admission
Fiscal Year 2007



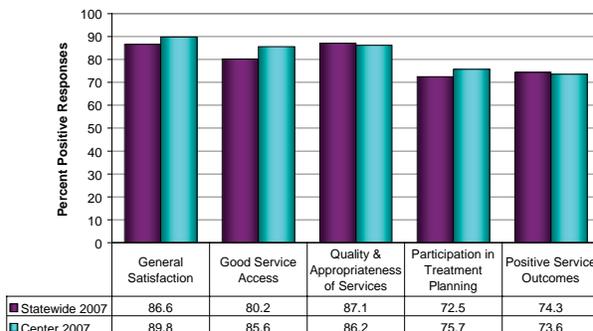
Diagnoses at Admission

	Youth	Adult
Substance Abuse	260	1,253
Schizophrenia	25	450
Depressive Disorders	317	824
Conduct Disorder	31	5
Attention Deficit	289	120
Oppositional Defiant Disorder	246	9
Other Childhood	152	28
Mental Retardation	148	142
Alzheimers & Organic Brain Disorders	15	74
Anxiety Disorders	269	803
Personality Disorders	12	592
Abuse	387	160
Diagnosis Deferred	291	1,766
Sexual/Gender Disorders	3	11
Adjustment Disorders	198	92
Other V Codes	1,155	1,049
Other	62	71
Bipolar	21	235
Total	3,881	7,684

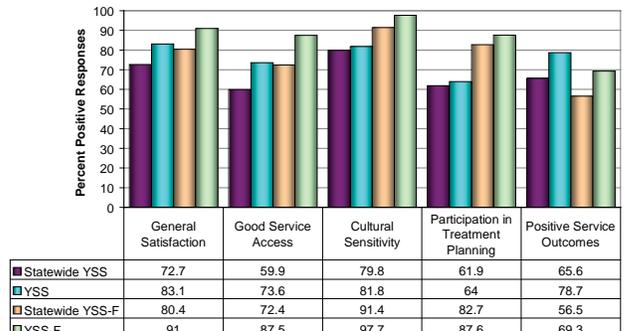
Mandated Services
Fiscal Year 2007



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2007



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2007



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 359 patients (including a 5 bed acute unit). 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)

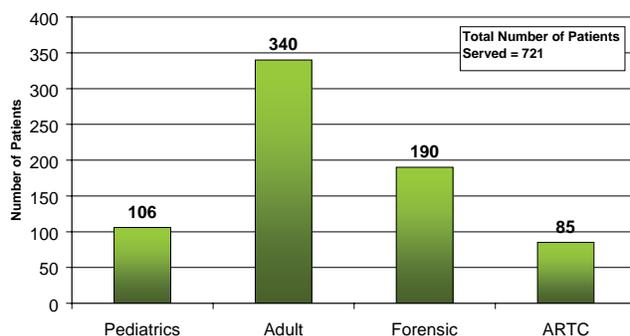
Programs

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

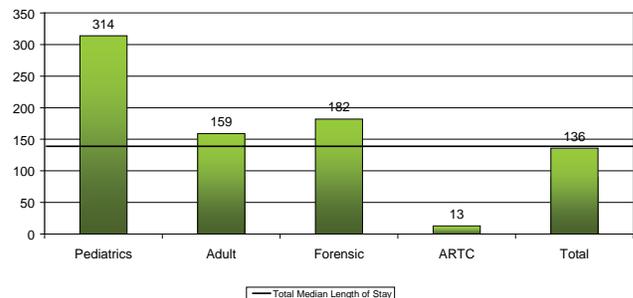
Length of Stay

The median length of stay for the Utah State Hospital is 136 days. The median length of stay for adult patients with civil commitment is higher, at 169 days.

Number of Patients Served
Fiscal Year 2007



Median Length of Stay in Days
Fiscal Year 2007

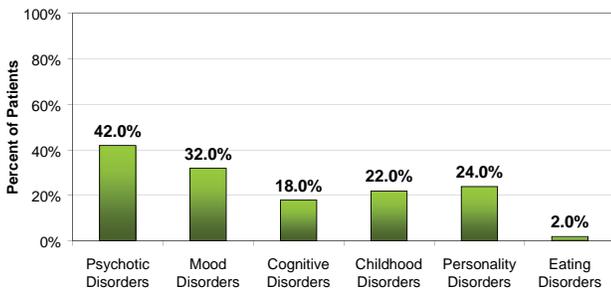


Types of Disorders Treated

- Psychotic Disorders: schizophrenia, schizoaffective disorder, other psychotic disorders, and delusional disorders
- Mood Disorders: major depression, anxiety disorders, bipolar disorder, and dysthymia

- Childhood Disorders: developmental disorders, autism, attention deficit disorder, conduct disorder, separation anxiety, and attachment disorder
- Cognitive Disorders: primary degenerative dementia, mental disorders due to general medical conditions, and mental retardation
- Eating Disorders
- Personality Disorders: borderline, antisocial, paranoid, and narcissistic disorders. These are often a secondary diagnosis.

Percent of Patients With Major Psychiatric Diagnosis**
Fiscal Year 2007



**Patients can have more than one diagnosis

37% of the patients treated also had a Substance Abuse diagnosis

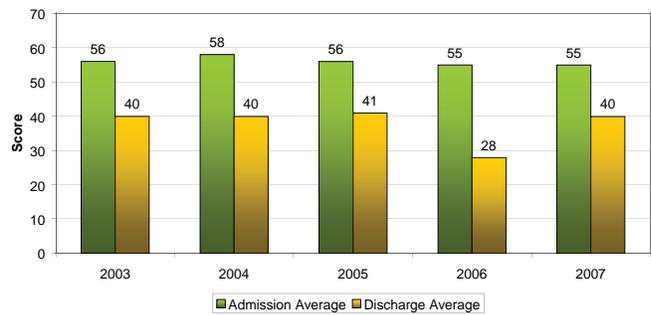
Services Provided

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

Assessment

In order to assess patient progress, the 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 Hospital continued to show a decrease in BPRS scores from admission to discharge in the 2007 fiscal year.

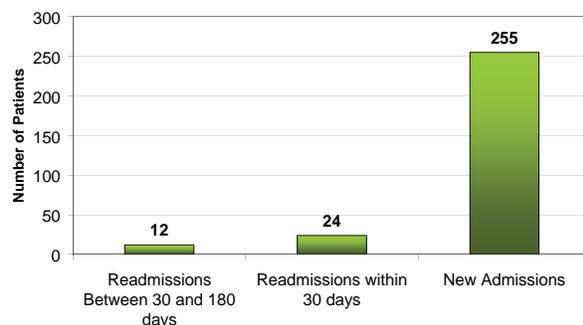
Average Symptom Levels of Patient Discharged Compared to Their Admission Symptom Levels as Measured by their Brief Psychiatric Scale



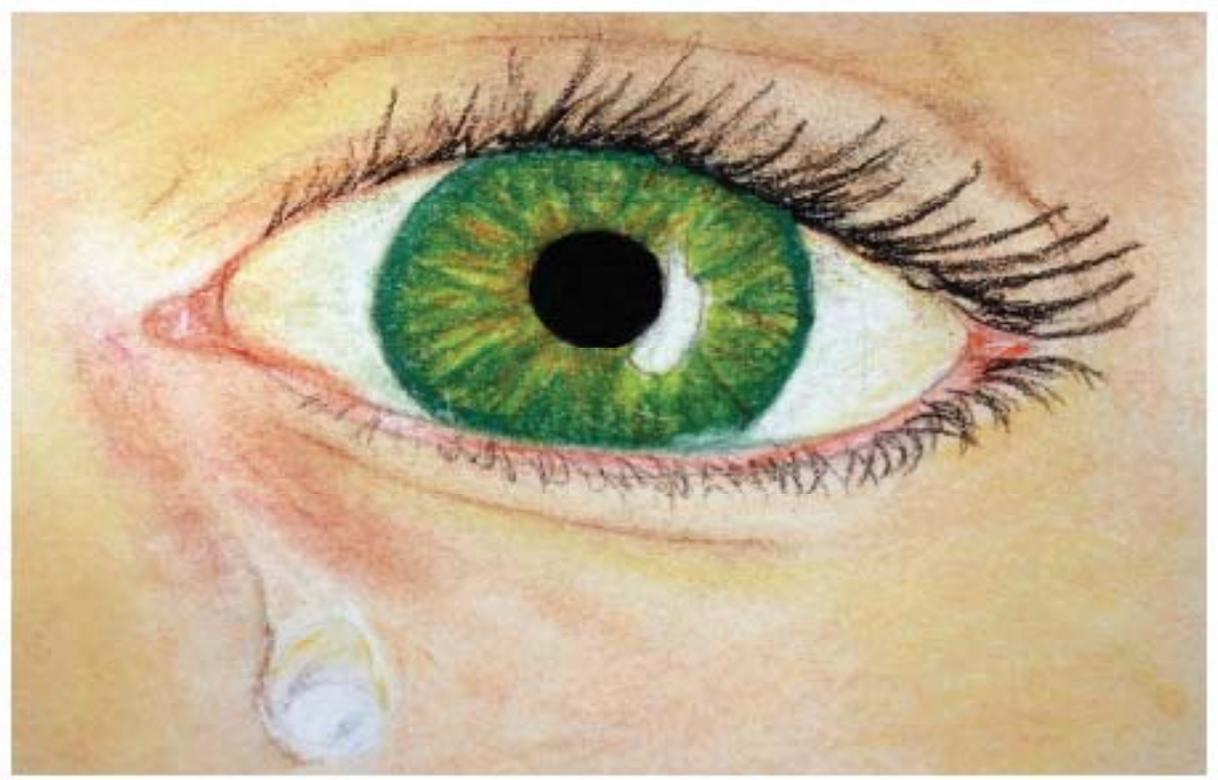
Readmission

The hospital admitted a total of 430 patients in the 2007 fiscal year. Of these admissions, 12 were prior patients who had been discharged from the hospital within the past 30 days. 24 of these admissions had been discharged from the hospital between 30 and 180 days from the current admission. There were 255 other patients admitted to the hospital.

Readmissions at the Utah State Hospital
Fiscal Year 2007



EDUCATION AND TRAINING

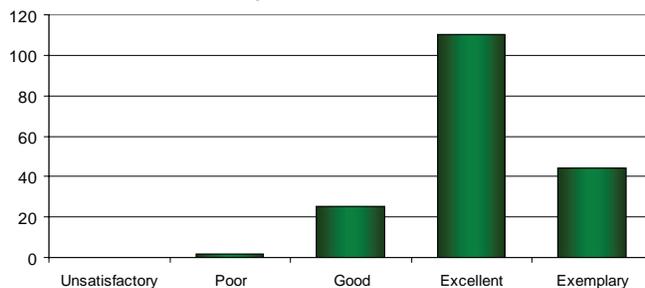


Education and Training

Substance Abuse Fall Conference

The 29th Annual Fall Substance Abuse Conference was held in St. George, Utah, September 26-28, 2007. The Division of Substance Abuse and Mental Health (DSAMH), the Utah State Board of Substance Abuse and Mental Health, Mountain West ATTC, Weber Human Services Foundation, and Reckitt Benckiser Healthcare sponsored the conference. There were over 500 professionals 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 Women and Addiction: A Gender Responsive Approach (Dr. Stephanie Covington), Prevention: Shaken & Stirred (Ray Daugherty & Michelle Ellison), Bridges out of Poverty: Strategies for Professionals & Communities (Terie Dreussi Smith), Deadly Persuasion: Advertising & Addiction Part II: The Saga Continues (Jean Kilbourne). Breakout sessions were offered throughout the conference and included seminars on Taking Care of “Housing First,” Latest Research and Prevention Strategies on Energy Drinks, DORA – A Criminal Justice Perspective, Prescription Drug Abuse, The Role of Recovery Community Organizations, Drug Testing of Bio-

logical Specimens, and Training and Engaging Peer Leaders: Tips, Trips and Traps in Building a Successful Peer Leadership Program.

Six distinguished awards were presented this year: the Merlin F. Goode Prevention Services Award was presented to Pat Bird; the Leon PoVey Lifetime Achievement Award was presented to Paul Thorpe; the Justice Award was presented to the Honorable Steven L. Hansen; the Utah Behavioral Health Network Award was presented to Senator D. Chris Buttars; the Dr. Stuart D. Wilkinson Excellence in Public Service Award was presented to Harold L. Morrill; and the Treatment Award was presented to Glen R. Lambert.

Generations 2007 Mental Health Conference

The Generations 2007 Conference was held on April 19-20, 2007 at the Hilton Salt Lake City Center. The theme for the conference was, “Navigating Through Behavioral/Mental Health and Substance Abuse in Public and Private Practices.”

This was the first year that the annual state mental health conference collaborated and merged with “The Generations” Conference of private practitioners and agencies. This change provided synergy and enthusiasm to the conference providing improved quality and attendance. Additionally, it allows DSAMH to focus on important and critical issues that need to be addressed both locally and nationally.

The conference included many highly-renowned national speakers and provided quality workshops sessions. Participants were able to gain knowledge on the latest knowledge of behavioral

health and substance abuse issues in order to develop and implement effective prevention and intervention/treatment programs and strategies in communities, and in individual practices and programs, both public and private.

There were over 560 individuals that attended the conference, which is an increase of over 100 from previous years. This number includes attendees from seven other states in the nation.

The University of Utah School on Alcoholism and Other Drug Dependencies

This June, DSAMH co-sponsored the 56th 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. All 50 states, the District of Columbia, and 18 countries were represented at this year's school. The tracks for the School include Residential Treatment, Criminal and Juvenile Justice, Professional Treatment, Women's Treatment, Pharmacy, Nursing, Mining Industry, Drugs: Treatment and Rehabilitation 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 2007, the Utah Addiction Center pursued its goals within each of its pri-

mary 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 include Salt Lake County Council, National METH Awareness Day, NIDA Blending Conference, Drug Endangered Children Conference, Matsu Unified School District, 3rd District Juvenile Court, Annual Fall Conference, Utah Public Health Association, Utah Bar Association, and the National Conference on Methamphetamines.

The Center was granted a \$100K contract with DSAMH to implement a training curriculum for physicians. The Center has collaborated with representatives from pediatrics, family practice, and rehabilitation medicine to create 24 case studies that focus on the identification, assessment, and referral of substance abuse patients. In addition the Center has created online training materials titled *How to Approach Addicted Patients*, *the Incidence and Prevalence of Substance Abuse*, and *Substance Abuse Dependence in Women*. The Center is currently filming "mock patient interviews" that demonstrate the correct way for physicians to assess and refer patients with substance abuse issues. All curriculum materials are available to physicians, residents, and community members on the UAC (Utah Association of Counties) training website.

The Center has increased its newsletter circulation to just under 1,000 copies to community members and public officials. In addition, Prevention and Treatment Work Group Committees continue to meet quarterly and are currently focused on the incidence and prevalence of substance abuse in Utah schools. In addition, the groups are collaborating with Utah's State Epidemiological Outcome Workgroup to gather data, analyze it, and package it in a way that is useful to substance abuse prevention professional throughout the state.

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 fiscal year 2007, DSAMH recertified nine providers to conduct these seminars. These providers trained over 10,000 servers across the state.

DSAMH oversees the certification of education 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.)

As of the end of fiscal year 2007, 139 providers have been certified to conduct Off Premise Alcohol Training and Education Seminars, and 716 trainers have conducted seminars across the state, certifying over 31,000 store clerks and supervisors in techniques that facilitate the elimination of alcohol sales to underage youth.

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. Addition-

ally, 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.

Efforts to protect youth and the community will continue through media campaigns, training of sales clerks, the parentsempowered.org website, and other prevention and treatment initiatives.

Driving Under the Influence (DUI) Education and Training Seminar

According to the 5th Annual DUI report to the Utah Legislature, in fiscal year 2007, there were 14,658 DUI arrests, 520 more than in fiscal year 2006. The majority of the arrests, 80%, 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 25 and 36 accounted for 37% 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 2007, there were 253 instructors certified to teach the PRIME for Life curriculum. 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 has developed a Crisis Counseling Program (CCP) and has trained a cadre of crisis counselors for victims of a disaster throughout the Utah Public Mental Health System including both private and non-profit providers. This year Utah experienced a significant crisis with the Salt Lake City Trolley Square shooting in February when an 18-year-old gunman randomly opened fire on unsuspecting shoppers, killing five people and wounding four other people. As twenty-four hour crisis care and services is a mandated responsibility of the local mental health authority, Valley Mental Health in Salt Lake County was quick to respond and provide Crisis Counseling Services. Valley Mental Health informed the media of their crisis services and phone numbers and within the first 48 hours they received over 300 phone calls from media, callers wanting information and from those in distress. In addition to providing the telephone crisis counseling Valley Mental Health provided extensive interviews for the media both locally and nationally and provided crisis counseling services to the public who experienced the shooting, including the Trolley Square management and employees.

DSAMH has also facilitated crisis counseling for the Hurricane Katrina evacuees that re-located to Utah. Working with Calvary Baptist Church and multiple community partners including the local Community Mental Health Centers, the Red Cross, the Utah Psychological Association, and

the Utah State Hospital to meet the major needs of evacuees with the stress of relocation include acculturation, adjusting to Utah's weather, and coping with multiple losses in a new area far away from family and friends and those who have not yet been able to address the psychological and/or emotional trauma of loss and relocation. The CCP trains providers on the basic standards and preferred practices for crisis counseling with a certification process to promote, and support the practice of crisis counseling in behavioral health-care.

This year DSAMH re-certified over 200 crisis counselors and have approximately 500 certified crisis counselors for disaster response statewide. This 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.

VOICES OF CONSUMERS



Voices of Consumers

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.

The Recovery Network has developed the following mission statement: The Mission of 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.

The Network Recovery is meeting regularly and June 15, 2007 hosted the first Annual outing with a barbecue and a Christmas Party is being planned for December.

The Utah Mental Health Recovery Network has had the privilege of training at the state capital on advocacy by some of the legislators and is looking forward to advocating on different issues. Some of the issues the Recovery Network anticipates are looking into ways to help the underfunded and under insured and a statewide Mental Health Court System, such as the ones in Salt Lake and Provo.

Utah Family Coalition

What is the Utah Family Coalition (UFC)?

The Coalition currently consists of three family organizations: Allies with Families, New Frontiers for Families, and NAMI - Utah (National Alliance on Mental Illness) that work together to support children and their families with mental health and substance abuse issues.

What is the UFC Vision?

To assist families and youth to have access to mental health and substance abuse services; and to develop a meaningful, educated, and authentic voice for policy and advocacy.

What is the UFC 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 UFC has been actively involved in defining, educating and supporting Utah families to understand family involvement. The following are examples of local community supports built by UFC members: Support and information groups directed by local communities; after school programs tailored to the needs of children and youth with complex needs to help them remain in school; parenting classes; strengthening marriage classes; respite programs and skills development groups; and wraparound facilitation to utilize a team approach that is child and family centered and focused on keeping children and youth in their homes.

What is “family involvement?”

Consistent with “System of Care” values, the Utah Family Coalition has defined family involvement in the mental health/substance abuse system as family-driven and child focused. This means that families have a primary decision-making role in the care of their own children as well as in the policies and procedures governing care for all children in their community, state, tribe, territory and nation. In effective systems of care, families and youth are partners at policy making, management and services levels of the system along with other key stakeholders. Effective systems of care support families and youth in tangible ways which enable and empower them as system builders. We teach each partner how to build community services and support one child and one family at a time, always looking for ways to build on what is already working in the community.

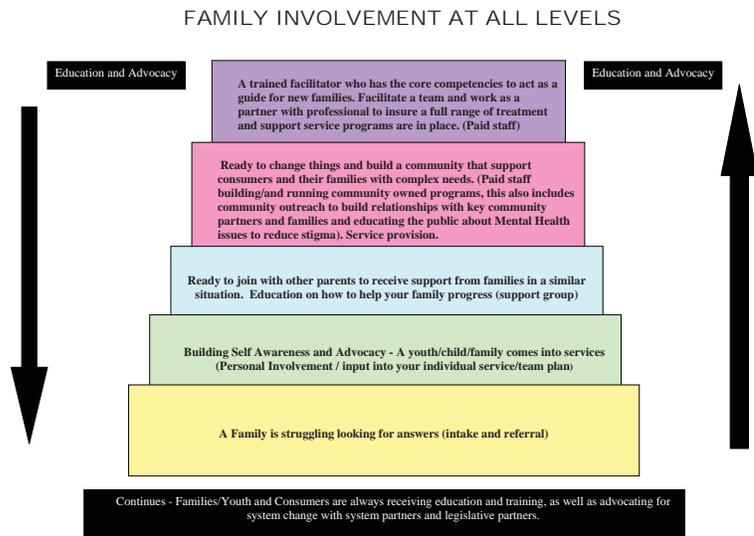
Family involvement in the mental health system is described as families becoming educated and understanding how they can be a force for change. When there is family involvement at all levels in the mental health/substance abuse system everyone benefits. Families become part of the solution not only for their own challenges, but also for other families. Families can provide a needed voice to the mental health/substance abuse system on how to provide services and supports that truly meet the needs of children/youth and families.

The UFC understands family involvement in the community as families becoming part of the solution to supporting children and youth with complex needs in their local community. Families speak out to help improve the mental health system, they become involved in their child’s treatment, and act as a family voice on local committees, and advisory boards that influence services. Families provide peer to peer support to new families. Families who receive support

become families who are ready to give back by becoming involved in or chairing a local support group.

What are some ways that families can become involved?

Family might be involved at 5 different system levels:



Who will assist the families in their involvement?

The UFC is working to develop a strong family mentoring component that will become an integral part of the public mental health and substance abuse service delivery system by providing technical assistance, training, coaching and mentoring to the Family Resource Facilitators (FRFs) at local Community Mental Health Centers (CMHC) across the state, and at the State Hospital. We are implementing this important work by using our experience to develop a competent family-based workforce, mentoring new FRFs as they gain new skills and learn the core competencies shown on page 8 of this report. These skills are necessary to support and strengthen family involvement (family voice) at all levels of care.

The UFC is supporting the FRF to successfully accomplish the following:

- Mastery of all the Family Core Competencies
- Community resource mapping, information gathering and skills in linking families to community resources
- Wrap-around family facilitation
- Development of or linkage to locally-based family information and support group targeting families/caregivers of children with behavioral health needs
- Development of skills necessary to participate in CMHC clinical staff/team meetings and/or other advisory meetings representing family voice and modeling team building, strength-based strategies.
- In conjunction with an early childhood therapist, provide individual support and mentoring for families with children ages birth to five who have complex needs.

RESOURCES



RESOURCES

List of Abbreviations

ADL - Activities of Daily Living	NSDUH - National Survey on Drug Use and Health
AP & P - Adult Probation and Parole	OMT - Opioid Maintenance Therapy
ASAM - American Society of Addiction Medicine	OTP - Outpatient Treatment Program
ASI - Addiction Severity Index	PASRR – Pre-admission Screening and Residential Review
ATOD - Alcohol, Tobacco, and Other Drugs	PNA - Prevention Needs Assessment Survey
BAC - Blood alcohol content	PPC - Patient Placement Criteria
BPRS - Brief Psychiatric Rating Scale	PREP - Prevention and Relationship Enhancement Program
CCP - Crisis Counseling Program	PSTD - Post Traumatic Stress Disorder
CIT - Crisis Intervention Team	REDI - Readiness Evaluation and Discharge Implementation Program
CMHC - Community Mental Health Centers	SAFG Grant - State Asset Forfeiture Grant
CMS - Center for Medicaid and Medicare Services	SAMHSA - Substance Abuse and Mental Health Services Administration (Federal)
CSAP - Center for Substance Abuse Prevention	SAMHSA - Substance Abuse and Mental Health Services Administration
CSAT - Center for Substance Abuse Treatment	SAPT - Substance Abuse Prevention and Treatment Block Grant
CYF - Children, Youth, and Families	SARA Utah - Substance Abuse Recovery Alliance of Utah
DCFS - Division of Child and Family Services	SED - Seriously Emotionally Disturbed
DHS - Department of Human Services	SHARP - Student Health and Risk Prevention
DORA - Drug Offenders Reform Act	SIG-E - State Incentive Enhancement Grant
DSAMH - Division of Substance Abuse and Mental Health	SMI - Serious Mental Illness
DUI - Driving while under the influence	SPD – Serious Psychological Distress
E.A.S.Y – Eliminate Alcohol Sales to Youth	SPF – Strategic Prevention Framework
FRF - Family Resource Facilitators	SPMI - Seriously and Persistently Mentally Ill
GAO - Government Accountability Office	TEDS - Treatment Episode Data Set
GPA - Grade Point Average	UBHN – Utah Behavioral Health Network
IOP = Intensive Outpatient	UFC – Utah Family Coalition
IV - Intravenous	USEOW – Utah’s State Epidemiology Outcomes Workgroup
LHCC - Local Homeless Coordinating Committees	USH - Utah State Hospital
LMHA - Local Mental Health Authorities	UT CAN - Utah’s Transformation of Child and Adolescent Network
LOS – Length of Stay	VA - Veterans Administration
LSAA - Local Substance Abuse Authorities	YRBS - Your Risk Behavior Survey
Meth - Methamphetamine	YTS - Youth Tobacco Survey
MH - Mental Health	
MHSIP - Mental Health Statistical Improvement Program	
NAMI – National Alliance on Mental Illness	
NF - Nursing Facility	

Contact Information

Single State Authority

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Bear River

Counties: Box Elder, Cache, and Rich

Substance Abuse Provider Agency:
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Bear River Health Department
Substance Abuse Program
655 East 1300 North
Logan, UT 84341
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Mental Health Provider Agency:
C. Reed Ernstrom, President/CEO
90 East 200 North
Logan, UT 84321
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Central Utah

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

Substance Abuse and Mental Health Provider
Agency:
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255 West Main St.
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Davis County

Counties: Davis

Substance Abuse and Mental Health Provider
Agency:
Maureen Womack, CEO/Director
Davis Behavioral Health
934 S. Main
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Office: (801) 544-0585

Four Corners

Counties: Carbon, Emery, and Grand

Substance Abuse and Mental Health Provider
Agency:
Jan Bodily, LCSW, Director
Four Corners Community Behavioral Health
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Northeastern

Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider

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Salt Lake County

Counties: Salt Lake

Substance Abuse Administrative Agency:

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Salt Lake County
Division of Substance Abuse Services
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Salt Lake City, UT 84190-2250
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Mental Health Provider Agency:

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President/Executive Director
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San Juan County

Counties: San Juan

Substance Abuse and Mental Health Provider

Agency:

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Southwest

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

Substance Abuse and Mental Health Provider

Agency:

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Summit County

Counties: Summit

Substance Abuse and Mental Health Provider

Agency:

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President/Executive Director
Merrilee Buchanan, LCSW, Area
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Park City, UT 84060-7322
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Tooele County

Counties: Tooele

Substance Abuse and Mental Health Provider

Agency:

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President/Executive Director
Doug Thomas, LCSW, Unit Director
Valley Mental Health, Tooele County
100 South 1000 West
Tooele, UT 84074
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Utah County

Counties: Utah

Substance Abuse Provider Agency:
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Utah County Division of Substance Abuse
151 South University Ave. Ste 3200
Provo, UT 84606
Office: (801) 851-7127

Mental Health Provider Agency:
Juergen Korbanka, PhD., Executive Director
Wasatch Mental Health
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Wasatch County

Counties: Wasatch

Substance Abuse and Mental Health Provider
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Weber

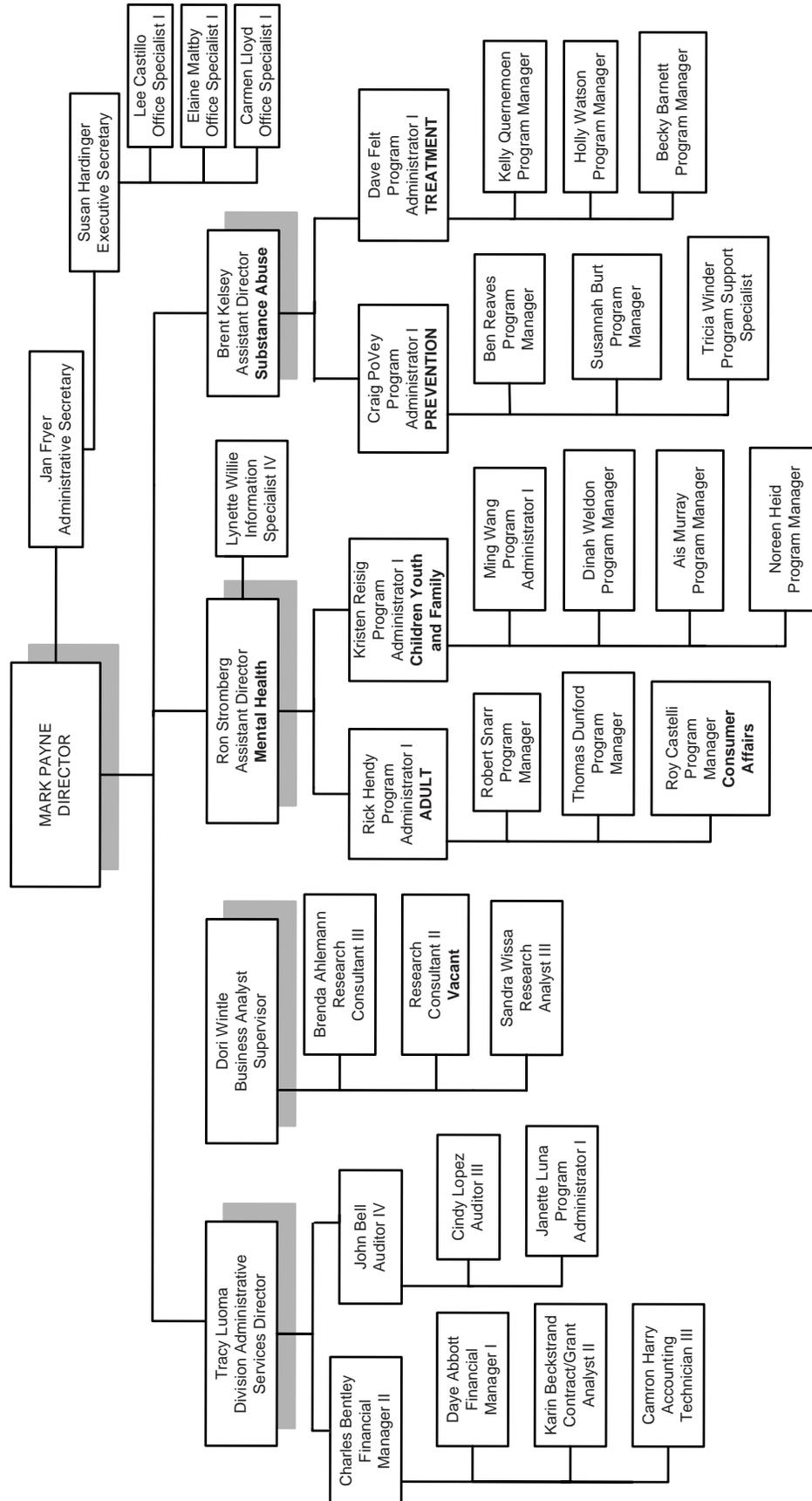
Counties: Weber and Morgan

Substance Abuse and Mental Health Provider
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Local Authorities/Local Providers

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Utah Division of Substance Abuse and Mental Health
January, 2008





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