

A Culture of Wellness

Annual Report



2008

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2008
Annual Report

Front Cover art:
Kenny Davis, *Homage to Beethoven*, 1993,
Commissioned by
the Utah Public Art Program
Located at
The Utah State Hospital

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December 2008

On behalf of the Utah State Board of Substance Abuse and Mental Health, it is my pleasure to present you with DSAMH's 2008 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 throughout the State and in individual communities. We also invite you to take an active role in making your community stronger and healthier.

The State Board supports DSAMH's theme of "Creating a Culture of Wellness" throughout the State. 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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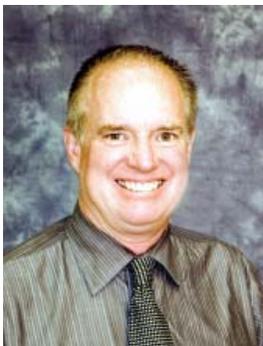


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Thirty-year mental health advocate; Co-chair of a fund raising committee and former Board Member of Alliance House; Former chair of the Mental Health section of The Governor's Coalition for People with Disabilities; Legislative activist; mental health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

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Member, Davis Hospital Board of Trustees; Former Chair, Utah Prevention Advisory Council; Former Co-chair, Governor's Council on DUI; Former Member, Utah House of Representatives; Supervisor, Davis Hospital Volunteer Auxiliary.



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Division of Substance Abuse and Mental Health

MARK I. PAYNE
Director



December 2008



We are proud to release DSAMH's Annual Report for fiscal year 2008. We hope the report will be helpful as you review the services being provided throughout the state.

DSAMH works hard to promote Hope and Recovery in every local community. A recent report, *Morbidity and Mortality in People with Serious Mental Illness*, released by the Medical Directors Council of the National Association of State Mental Health Program Directors, shows that people with serious mental illnesses are now dying 25 years earlier than the general population. This year's report theme is "A Culture of Wellness," and we are dedicated to promote this vision in new and innovative ways.

DSAMH looks forward this year in developing a plan for children's mental health services, which will identify gaps and strengths in the existing treatment system, with a strategy to provide a comprehensive system of care. We will also look at expanding specialty courts (drug court and mental health court) throughout the state. We will work to strengthen the standards and methods of these courts as we share the positive outcomes that they produce. We will continue to work towards enhancing substance abuse treatment services for women by increasing the availability and effectiveness of those services. Additionally, training in cultural competency has been an emphasis of DSAMH this year.

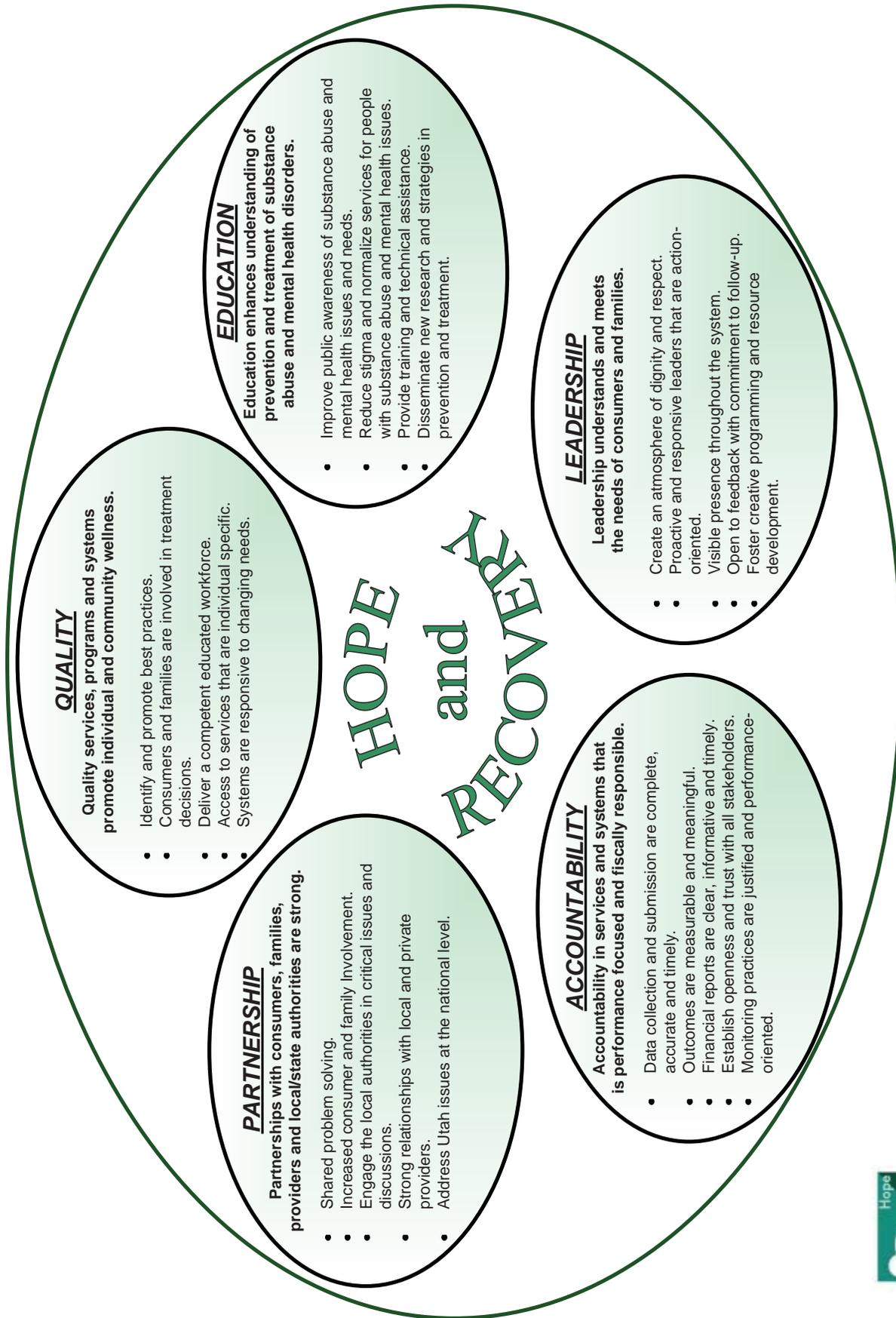
I want to thank the many dedicated staff members who have contributed to this report and work hard to constantly improve our statewide system of care. We thank all of the advocates and volunteers who make a difference in the lives of the people and communities we serve.

We ask you to join us 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



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 approximately 44% for substance abuse and mental health combined.

Website

The DSAMH website (dsamh.utah.gov) contains 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 Healthcare Committee (UBHC) and the Network of Care.



Utah County Felony Drug Court Graduation convened at the Historic Utah County Courthouse in Provo, Utah with the Honorable Judge James Taylor presiding.

Statewide Initiatives

Report on Statewide Initiatives

Utah's Wellness Initiative

In 2006, the National Administration of State Mental Health Program Directors issued the report "Morbidity and Mortality in people With Serious Mental Illness (SMI)."¹ Utah was one of the original eight states that participated in the study. On May 3, 2007, this report was presented as headline news in *USA Today*. The article brought to light the fact that adults with serious mental illness who are treated in public mental health systems die about 25 years earlier than Americans overall. This gap has widened since the earlier 1990s when major mental disorders decreased the life span by only 10 to 15 years. In 2008, the SMI population became 1.2 to 4.9 times more likely to die early.

Actual causes of death are similar to those in the general population. Complicating factors such as the mental illness itself, medications, and modifiable risk factors accelerate the propensity for:

- Cardiovascular disease
- Diabetes (including related conditions such as kidney failure)
- Respiratory disease including pneumonia influenza
- Infectious disease including HIV and AIDS
- Obesity due to medications known as second generation "atypical" antipsychotic

¹ *Morbidity and Mortality in People with Serious Mental Illness*, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 66 Canal Center Plaza, Suite 302, Alexandria VA 22314 VA 22314, 703-739-9333, www.nasmhpd.org.

Mental illness in and of itself may contribute to higher death rates in ways such as a paranoid ideation causing fear of accessing care or disorganized thinking causing difficulty in following medical recommendations. Psychiatric symptoms themselves may mask underlying medical illnesses.

Medications used to treat mental illness have been identified as contributing factors in higher death rates:

- Psychotropic medication—may mask and/or contribute to symptoms of medical illness.
- Polypharmacy (the uses of several types of medications)—identified as a risk factor for sudden death.
- The second generation antipsychotic medications—have become more highly associated with weight gain, diabetes, dyslipidemia, insulin resistance, and metabolic syndrome. The terms "metabolic syndrome," "insulin resistance syndrome," and "syndrome X" are now used specifically to define a constellation of abnormalities that are associated with increased risk for the development of type 2 diabetes and atherosclerotic vascular disease (e.g. heart disease and stroke).

Modifiable risk factors contributing to the higher death rates include:

- Smoking (Smoking prevalence is among the highest for people with mental illness, 75% of individuals with either addictions

or mental illness smoke cigarettes as compared with 23% of the general population.)

- Alcohol consumption
- Poor nutrition/obesity
- Lack of exercise
- High risk sexual behavior
- IV drug use

Also, people with mental illness are exposed to other vulnerabilities due to higher rates of:

- Residence in group care facilities and homeless shelters (Exposure to tuberculosis and other infectious diseases and fewer opportunities to modify individual nutritional practices.)
- Homelessness
- Victimization/trauma
- Unemployment
- Poverty
- Incarceration
- Social isolation
- Limited access to medical care

Dr. Joseph Parks, the lead researcher in this study has often suggested that recovery from mental illness may be a long process, and that it is a shame that people are dying just as they are beginning to enjoy life.

The Division of Substance Abuse and Mental Health (DSAMH) Response

DSAMH has adopted a guiding principle that **WELLNESS IS AN INTEGRAL PART OF RECOVERY; AND MENTAL HEALTH TREATMENT MUST INCLUDE A FOCUS ON PHYSICAL HEALTH.** In fiscal year 2009, DSAMH issued a directive requiring Local Mental Health Authorities to demonstrate in their area

plans how they, at a minimum, will implement the following overall wellness issues activities:

- Monitoring weight
- Screening for diabetes
- Decreasing tobacco use
- Providing training for staff in recognizing health issues
- The adoption of policies to ensure integration of mental health and physical health care
- Providing information to consumers on physical health concerns and ways to improve their physical health
- Incorporating wellness into individual person-centered plans
- Improving prevention, screening, and treatment in context of better access to health care
- Identifying a specific practitioner to be the responsible party to ensure that each person's medical health care needs are being addressed

In August of 2008, DSAMH sponsored a training featuring Dr. Parks. This event was attended by 200 public mental health provider staff, public and private medical staff, and the Veteran's Administration and was carried as a lead news story on one of the local television stations.

DSAMH will be monitoring wellness initiatives in the community mental health centers during fiscal year 2009.

DSAMH intends to increase the life expectancy of people with serious mental illness by supporting collaboration between mental health and primary care. In addition, DSAMH will actively monitor research that supports methods to decrease the morbidity rate in persons affected by mental illness. **DSAMH will spearhead a state-wide initiative that will call on all health care providers, consumers, families, and advocates**

to sign a pledge to help reduce the morbidity rate by 10 years within the next 10 years.

Innovative Provider Programs Serving the Unfunded

“Help for the Unfunded, A Creative Legislative Response”

The 2007 Legislature granted \$2.7 million (ongoing) to the Division of Substance Abuse and Mental Health 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.

The public mental system responded with creative and innovative programs which served over 3,400 consumers who were uninsured or under insured and lacked adequate funding to receive mental health services. These consumers were able to receive low cost, time limited services such as assessment, screening and referral, medication management, group therapy, and school-based services for children.

Treatment Services for Women

Between 1991 and 2006, the number of women who entered the public substance abuse treatment system increased by 170%. This growth strained existing resources and created a need to modify existing services to better meet the unique needs of women. In response to this need, the Legislature appropriated \$2.45 million to expand treatment services for women.

Research tells us that women come to treatment for different reasons and respond differently than men. The vast majority of women entering treatment

have dependent children. Nearly three-quarters of women in treatment are mothers and often the sole guardian of their children. In Utah parental drug use is one of the leading causes of involvement in the child welfare system. The Division of Child and Family Services (DCFS) reports that 59% of closed cases, where a child was removed from the home, involved parental substance abuse. Compared to men, women entering treatment are more likely to be in poverty and they are less likely than men to have graduated from high school, be employed, or have sufficient supportive social networks. The National Institute on Drug Abuse has also found that males and females tend to return to drug use for different reasons. For men relapse is more likely to be associated with anxiety and positive feelings. Women are more likely to relapse because of depression and negative feelings. Women are also more likely to have multiple psychosocial problems, including mental illness, a history of trauma and abuse, and involvement in abusive relationships. Effective treatment requires providers to address these issues.

The Local Substance Abuse Authorities (LSAA) have successfully implemented new and innovative programming for women with the funds allocated by the Legislature. An allocation of \$827,442 was used specifically for treatment expansion. Southwest Behavioral Health Center and Weber Human Services expanded residential treatment services increasing the number of treatment beds available for women and women with children.

Center	2007 Admissions	2008 Admissions	2008 Percentage of 2007
Bear River	285	318	111.58%
Central	79	112	141.77%
Davis	268	338	126.12%
Four Corners	219	266	121.46%
Heber	19	30	157.89%
Northeastern	79	180	227.85%
Salt Lake	2,757	2,803	101.67%
San Juan	3	5	166.67%
Southwest	134	238	177.61%
Summit	48	27	56.25%
Tooele	78	86	110.26%
Utah County	770	623	80.91%
Weber	562	659	117.26%
Total	5,301	5,685	107.24%

The remaining \$1,623,158 was allocated to the 13 LSAAs to expand the availability and range of treatment services for women and women with children across the state. The funds were to be used to expand the continuum of services ranging from long-term residential to standard outpatient treatments for women.

The graph on the previous page outlines the total number of women served by the local authorities from 2007 to 2008:

Outcome data gathered for women’s treatment services in fiscal year 2008:

- 15.8% increase in alcohol abstinence (87% were abstinent at discharge)
- 44.2% increase in drug abstinence (73.1% were abstinent at discharge)
- 23% increase in employment/school attendance
- 75.9% decrease in arrests
- 42.6% decrease in homelessness

Drug Offender Reform Act (DORA)

DORA was developed to expand offender access to treatment, provide for smarter sentencing by judges, create a seamless transition for offenders re-entering the community from prison, and provide for increased community supervision. The legislation appropriated \$8 million total for treatment and supervision for fiscal year 2008. The Department of Human Services was allocated \$4,850,000 for assessment and treatment to drug offenders statewide.

DORA funding became available on July 1, 2007, and represented a significant

increase in treatment dollars across Utah. Funding from this legislative initial startup was contingent not only on offenders qualifying for these services but also on increasing provider and Adult Probation and Parole (AP&P) capacity. This increase included hiring treatment professionals across the state to provide treatment services. While offenders began receiving treatment and assessment under this legislation on July 1, 2007, most areas across the state were not staffed to capacity until December of 2007.

DORA Admissions and Expenditures:

It was anticipated the \$4,850,000 would treat approximately 1,100 offenders at an average cost per case of \$4,200. In fiscal year 2008 over 1,300 assessments were conducted across the state by the Local Substance Abuse Authorities (LSAA) and 845 drug offenders were admitted to treatment at an average cost per case of \$3,285 statewide. The Division of Substance Abuse and Mental Health (DSAMH) expects the average cost per case to change during fiscal year 2009 to reflect a higher number of DORA clients receiving services for an entire fiscal year.

DORA Funding:

During the fall 2008 Special Legislative Session all DORA funds that were not spent in fiscal year 2008 were cut from the budget as well as \$773,000

Drug Offender Reform Act Fiscal Year 2008 Admissions and Expenditures										
Local Authority:	FY08 Contract Amount	FY08 Amount Billed	FY08 Assessments Conducted	FY08 Unduplicated Clients Served	FY08 Total Treatment Admissions	FY08 Admissions to Detox	FY08 Admissions to Residential	FY08 Admissions to IOP	FY08 Admissions to OP	FY08 Cost Per Case
Bear River (Box Elder, Cache, Rich)	\$241,829.00	\$115,579.47	71	54	54	0	0	7	47	\$2,056.85
Weber Human Services (Weber & Morgan)	\$648,499.00	\$522,991.71	174	110	168	0	62	28	78	\$4,740.00
Davis Behavioral Health (Davis)	\$493,515.00	\$294,932.06	121	106	139	0	21	35	83	\$2,782.38
Salt Lake County Substance Abuse Services (Salt Lake)	\$1,803,394.00	\$718,549.00	638	285	426	4	113	125	184	\$2,323.89
Valley Mental Health (Tooele)	\$98,843.00	\$56,261.61	14	14	15	0	1	8	6	\$4,018.69
Valley Mental Health (Summit)	\$50,000.00	\$25,000.00	7	7	7	0	0	0	7	\$3,571.43
Heber Valley (Wasatch)	\$50,000.00	\$37,480.00	3	5	4	0	0	1	3	\$7,496.00
Utah County Substance Abuse Services (Utah)	\$569,178.00	\$532,293.00	97	85	148	2	15	91	40	\$6,262.27
(Juab, Millard, Piute, Sanpete, Sevier, Wayne)	\$163,422.00	\$144,353.00	37	36	40	0	0	2	38	\$4,009.81
(Beaver, Garfield, Iron, Kane, Washington)	\$360,364.00	\$227,466.00	149	91	121	0	23	58	40	\$2,418.93
Four Corners Counseling Center (Carbon, Emery, Grand)	\$97,060.00	\$24,503.00	29	29	44	0	0	18	26	\$844.93
San Juan Counseling (San Juan)	\$50,000.00	\$4,741.89	4	3	3	0	0	1	2	\$1,492.20
Northeastern Counseling Center (Daggett, Duchesne, Uintah)	\$125,139.00	\$71,977.21	23	20	22	0	0	5	17	\$3,585.60
Statewide	\$4,751,243.00	\$2,776,127.95	1367	845	1191	6	235	379	571	\$3,285.36

of the base fiscal year 2009 budget. Contracts with the LSAs are being amended to reflect this decrease to each of their budgets. The following chart details each LSA's funding distribution for fiscal year 2008 as well as the changes to their current years' budget amounts. The new allocation amount includes approximately \$126,000 of DSAMH administrative budget which was given to the local authorities to decrease the impact of this budget cut as much as possible.

Local Authority	FY 2008 Contract Amt	FY 2009 Orig Allocation	FY 2009 New Allocation
Bear River	241,829	277,216	242,916
Weber	648,499	732,241	641,640
Salt Lake	1,803,394	2,024,878	1,774,336
Davis	493,515	555,258	486,556
Tooele	98,843	108,004	94,641
Wasatch	50,000	50,000	50,988
Utah	569,178	655,103	574,047
Summit	50,000	55,815	51,325
Six Counties	163,422	184,024	161,254
Southwest	360,364	413,613	362,436
Uintah	125,139	143,185	125,469
Four Corners	97,060	108,963	95,481
San Juan	50,000	50,000	50,511
TOTAL	4,751,243	5,358,300	4,711,600

How Offenders Access Treatment:

DORA allows for smarter sentencing for drug offenders in the community as well as seamless transition for drug offenders being released back into the community from corrections.

Smart Sentencing: Upon conviction and prior to sentencing, certain drug offenders are screened by AP&P and then assessed for substance abuse treatment needs by the LSAA. Recommendations from the screening and assessment process are delivered to the judge and included in the pre-sentence report. By including the screening and assessment information in the pre-sentence report, judges are able to structure sentencing and probation requirements to include clinically appropriate treatment.

Re-Entry: For drug offenders returning to the community from prison, DORA provides for screening and assessment within the corrections

setting. Upon completion of the screening and assessment, clinically appropriate treatment services are recommended and the assessment and recommendations are sent to the LSAA.

Community Treatment: Once an offender has been recommended for treatment under DORA, and is returned to the community, the AP&P agent and LSAA work closely together to monitor the offenders progress in treatment. An initial "hand-off" is conducted for each offender. The "hand-off" consists of the AP&P agent taking the offender to the treatment provider for the first treatment session. The offender, AP&P agent, and treatment provider meet together to review expectations of treatment program and to discuss initial treatment requirements. The AP&P agent and the treatment provider then meet together frequently to review each case and update each other on the offender's progress.

Collaboration:

This legislation requires the LSAs to establish local planning groups to develop and plan for the local implementation of DORA. Utah's 13 LSAs each established local planning and implementation committees comprised of the presiding judge or trial court administrator, the regional AP&P director and the LSAA. Many local planning groups included representatives from law enforcement as well as prosecuting attorneys and public defenders. All 13 LSAs submitted a written plan to DSAMH and the Utah Substance Abuse and Anti-Violence Council for approval.

These local planning and implementation committees met over the year to review their plans, address local implementation concerns, and increase communication and collaboration among each of the stakeholders.

The Graduate School of Social Work at the University of Utah has conducted the professional and independent studies on this pilot project and released the results on November 1, 2008. For detailed results please visit: http://www.law.utah.edu/_studyfiles/98/98.pdf.

Mental Health Treatment Outcome Initiative

Does Mental Health Treatment Work? Do People Get Better?

For the first time in Utah public mental health history, the Division of Substance Abuse and Mental Health is able to answer YES to these questions in a scientific and an objective manner.

The table below (OQ45 adult measure only) describes the change in suffering associated with symptoms of mental illness in consumers receiving public mental health services: 38% of the consumers demonstrated a reduction in symptoms while in treatment, 48% reported moderate change with their symptoms, and only 13% experienced an increase in symptoms.

People entering mental health services suffer from chronic and long enduring conditions, therefore, maintaining the current level of functioning is an incredible achievement. Remarkably, these outcomes show 86% of the people maintain or improve their functioning while in treatment. This suggests, from a functional point of view, people have been able to maintain marriages, attend school, keep employment, parent their children, and live and interact in their communities.

Mental Health Courts

Mental Health Courts are a relatively new concept based on the successful use of specialty Drug Courts. A high percentage of jail and prison inmates have a mental illness and are typically held in jails and prisons for much longer periods than other offenders. These mentally ill inmates are often vulnerable and become victims of assault or intimidation by other inmates.

Mental health courts divert arrested mentally ill persons away from the criminal justice system and into court monitored treatment programs. Mental health courts are cost effective and have shown promising outcomes as opposed to incarceration. Only three counties in Utah currently have mental health courts, with several other counties showing interest in creating a mental health court.

The Mental Health Initiative, sponsored by the Commission on Criminal and Juvenile Justice, consists of experts from the courts, law enforcement, mental health, prosecutors, defense attorneys and advocates, is working to develop a mental health court model for use statewide. The model will allow courts to gradually move from an initial “start-up” court to a fully functional court. Additional funding will be required to implement the fully functional mental health court

Agency Name	Intake and Most Recent OQ45 Scores*Scores		OQ45 Change Metrics		
	Avg Valid Intake Score	Avg Recent Score	Significant Symptom Reduction	Moderate Symptom Change	Significant Symptom Deterioration
Bear River Mental Health	87.21	78.28	39.20%	45.90%	14.90%
Davis Behavioral Health	89.52	81.31	36.60%	46.20%	17.20%
Four Corners CBH	80.63	73.12	34.10%	51.10%	14.80%
San Juan Counseling	81.91	69.71	37.70%	57.10%	5.20%
Southwest Behavioral Health	86.59	81.49	27.60%	56.20%	16.20%
Valley Mental Health (SLC)	81.81	73.40	36.90%	49.50%	13.60%
Valley Mental Health (Summit)	84.71	69.10	44.20%	50.00%	5.80%
Valley Mental Health (Tooele)	87.72	80.57	32.90%	55.10%	12.00%
Wasatch Mental Health	86.75	76.41	41.00%	44.30%	14.70%
Weber Human Services	79.20	67.61	41.50%	46.10%	12.40%
Total	82.97	73.70	38.30%	48.00%	13.70%

* Higher scores indicate increased symptoms.

model. This initiative, while in the beginning stages, shows great promise in the both holding mentally ill offenders accountable and protecting the public, while providing treatment with long lasting positive effects.

Family Resource Facilitators

The Division of Substance Abuse and Mental Health (DSAMH) is committed to the principles of recovery, systems of care, and full integration of family involvement at all levels of service and policy delivery. To promote these principles, DSAMH partnered with the Utah Family Coalition (UFC)² and The Children's Center. By braiding legislative, block grant, and federal grant funds we built a program that would: 1) have at least one Family Resource Facilitator (FRF); and 2) at least one clinician trained in assessing and treating children ages birth to five at each of the 13 community mental health centers (CMHC) throughout Utah.

The UFC is responsible for training and mentoring each FRF; The Children's Center is responsible for training and providing clinical consultation to each early childhood clinician; and DSAMH is responsible for administration, coordination, and implementation. In year two of the project, DSAMH and each CMHC will share the FRF costs, and DSAMH will continue to pay the costs of the UFC.

The primary job components of each FRF are:

- Resource Coordination. Provide local resource information to any family requesting assistance.
- Family Advocate / Advisor. Develop working partnership with CMHC staff, to

represent the family voice at the service delivery, administration, and policy levels.

- Develop local Family Support & Information Group. This group will provide information and support to all families regardless of funding.
- Family Wrap-around Facilitation. Work with families and youth who have complex needs to build a plan that incorporates necessary formal supports (e.g., mental health/substance abuse treatment, educational assistance, juvenile court engagement, etc.) and informal supports (family members, Boy Scouts, clergy, etc.) to help the child and his/her family exit the mental health system and live full and productive lives.

Family Resource Facilitation: A Youth's Perspective

"My name is Bobby. I'm 14 years old. I live in a small town in southern Utah. I was in 7th grade and I was getting into trouble at school and in town. I seemed to always find the wrong people to do things with and made the wrong choices. My dad died when I was just 6 years old and my mom didn't take it very well. She had a tough time taking care of herself let alone my older brother and me.

I was in major trouble with the law, school, and my mom. I was sent to detention on a 30 day hold then to Observation & Assessment. I was there for 45 days. I was able to do some school work but I didn't finish 7th grade. The school suspended me for a year. It was terrible. I couldn't wait to get out. I missed my room, my mom, my friends, and my freedom. I was even crying a couple of times. But, I thought, that won't help. I was really sad and depressed. I wanted to just get out and get home. Once I got home I had to go to court and was put on house arrest. It was better but the judge was very angry with me. I

² UFC Partners are Allies with Families (local chapter of the Federation for Families), NAMI-Utah, and New Frontiers for Families.

was glad to be home, but school was almost out. I was really missing school and my friends.

I had to go to the Southwest Behavioral Health Center to meet with the therapist. I talked to her about my anger and hopelessness. Meeting with her was very helpful to me. She was helping me to work through all the feelings I had and what things I needed to do to make my life better. She and I were really concerned about my having to repeat 7th grade. She suggested I get a Family Resource Facilitator who worked with me so that I could finish all the requirements for completing 7th grade. It was a lot of work and I had to spend my whole summer working at it. My Family Facilitator helped me form a team made up of my mom, probation officer, my therapist, school counselor, and the facilitator. With this team we talked about my successes and the setbacks as well. I had to get special permission from the school board to get into school early. I went into 8th grade in September. This was only a few weeks after my classmates but five months before I was supposed to be let back to school. I have continued with this positive thinking. I meet with my therapist only once a month now. I still meet with my family facilitator just about every day. I can talk with her and she helps me with my school work and assists me to make better choices in my life.

With my facilitator's encouragement, I was able to volunteer at the local Pow Wow. At that event I saw a lot of Native Americans and began to think of my heritage. My mother and I were invited by New Frontiers for Families to visit the Goshute Reservation and reconnect with my aunts and cousins. It was very strange for my mother and me. My mother is Goshute but she was adopted. She had never met this part of her family before. It was good to see where my heritage is. I made friends with one of the organizers of the Pow Wow and this gentleman has become my friend and a member of my team. He has taken me fishing and I have done some work for him. He has

also invited me to go with him to volunteer in Arizona at the Navajo Reservation.

My brother is home now and I understand how I need to make the proper choices for myself. I hope to be off of probation in June. I will pass 8th grade. Best of all I know that I will have a successful future. I can see a future. I can feel that my positive choices are what help to make me become a better person. I know that the support and assistance of my therapist, the New Frontiers Family Facilitator, and my mom have all helped to make these successes possible. I thank them."

Family Resource Facilitation: Family Facilitators' Perspectives

"When I started working with one of my families they had few supports and no income. Since being involved with an FRF they now have a phone, gas to their house, clothes for the whole family, backpacks for the kids, mental health treatment for the youngest child, an IEP (Individualized Education Plan) and respite care for another child, and a job for the father (even though he had a criminal record). Through the dad's job the family now has several social supports and they are no longer in danger of losing their housing. The family still has struggles, but they are more independent and successful in taking care of their family's needs."

"I have helped a family avoid having their 10 year old son placed into state custody when his therapist referred his case to Division of Child and Family Services (DCFS). We facilitated a wraparound plan for this child and his family which incorporated help from many informal supports, got him enrolled in a charter school, and found a therapist who could do Functional Family Therapy, who is local and who accepts their insurance."

“Family Facilitation was able to help another family whose 16 year old boy had been in and out of the juvenile justice system for 4 years for a variety of offenses including truancy, shoplifting, assault, and most recently an alcohol charge. The court’s patience had run out and the judge ordered a state multi-agency committee meeting to discuss placing the boy in the custody of DCFS for purposes of more intensive interventions than those that have been tried already. The parent was allowed to have a voice at that meeting, which was unprecedented for this committee. I was able to help the family come up with a plan to present to the judge and the judge allowed the family to proceed with their plan, commended them for taking a proactive role in the process and suspended DCFS custody pending the family following through with their plans as presented in court.”

“I have been working with a family who tried unsuccessfully to get their daughter to go to school. The school police officer had talked to her along with the principal and counselor. She would agree to do what she needed to do but then would not follow through. I found a resource for this family to get involved with a program through youth services to help get the child back on track as far as school issues go.”

“Family Resource Facilitation helped a young man, 16 years old, who was having troubles at home, in school, and with juvenile court. We started the wraparound process with him and his family by involving the school, juvenile court, DCFS, mental health, the FRF, members of his family, and a friend. After a couple of months, the client indicated that he was interested in conducting his own family team meeting. I worked with him in developing a meeting agenda and developing phone skills that he used in contacting his team members about his upcoming family team meeting. The first meeting he conducted, I sat be-

side him and assisted him in what to say and do. The second month I sat a little ways away and assisted him. As the months went on I was able to sit further away and provide less assistance. The last time he had a team meeting, I sat across the room and he conducted his own family team meeting. He felt ten feet tall and bullet proof and he and his team resolved his struggles and he was able to move out of the area.”

American Indian Initiative

The Utah Transformation of Child and Adolescent Network (UT CAN) has focused on mental health and substance abuse services available to American Indian/Alaskan Native children and adolescents living in Utah. In 2005, UT CAN established an American Indian Workgroup (AIWG) that included representatives from tribal behavioral health systems/organizations who have met on a monthly basis to address their specific needs.

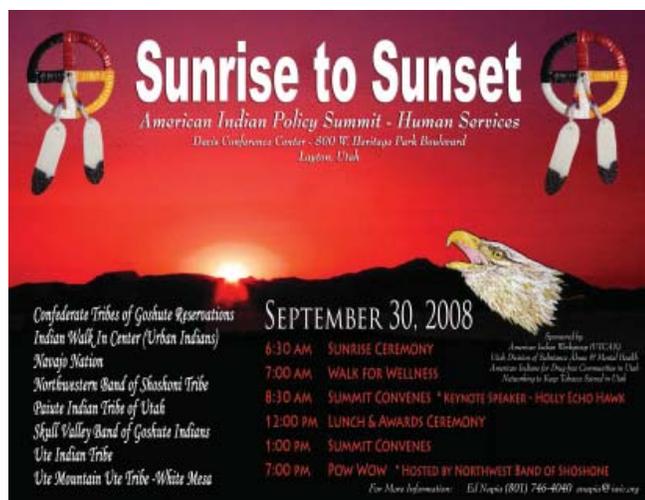
AIWG’s strongest recommendation was to establish a formal tribal consultation policy. In 2008, AIWG presented the idea to Lisa-Michele Church, Executive Director, Department of Human Services (DHS) who fully supported the recommendation. A new Indian Human Services Liaison for the DHS was assigned to act as the primary point of contact on issues relating to American Indian/Alaskan Natives living in Utah.

A tribal consultation agreement was presented to the tribal governments and Indian Walk-In Center. Part of the agreement included the establishment of a DHS Tribal and Indian Issues Committee to provide input about human services issues as they relate to American Indian/Alaskan Native populations. Each tribe appoints an official designated representative to participate in these ongoing committee meetings.

On September 24, 2008, the consultation agreement was signed between the seven federally recognized Indian tribes of Utah, the Indian Walk In Center, the Department of Human Services, and

the State of Utah. The signing of the agreement was a historical event bringing recognition of the government-to-government relationship that exists between Indian Tribes and the State of Utah. The hope is for these entities to engage in open and meaningful consultation to identify human services needs and priorities.

Rupert Steele (Chairman of the Confederate Tribes of Goshute Reservations) said, “American Indians are citizens of Utah. We are equal in our responsibility to find solutions. Our [tribal] human services agencies have the same goals and objectives to help our communities.”



UT CAN’s AIWG hosted “Sunrise to Sunset” American Indian Policy Summit on September 30, 2008, at the Davis Conference Center in Layton, Utah. The overall goal of the summit was to foster a mutual understanding that everyone shares equal partnership in the solution-finding process to improve human services for American Indian people residing in Utah. Several highlights of the conference included:

1. A video called “Sunrise to Sunset” was created as a tool to give a brief overview of the American Indian tribes in Utah and shared the signing of the Consultation Agreement. The film is currently uploaded onto the DHS Diversity web site for viewing by the 5,000 employees of DHS.

2. Representatives from DHS (leadership of each Division) attended the day long event which included facilitated panel discussion related to the delivery of human services to American Indians residing in Utah. The closing session of the summit entailed a summary response from each of the agencies about the information they learned and what commitments their agency would be making in improving relationships with the tribal entities.
3. Native American cultural value based teachings (sunrise ceremony, video interviews, medicine wheel concepts, and Pow Wow) were incorporated in the summit to broaden understanding how these aspects relate to the Native American people.

In all 172 people attended the summit, and a Pow Wow (Native American Dancing Event) was open to the general public.

Treatment for Youth

The Division of Substance Abuse and Mental Health (DSAMH) is committed to improving services for youth in Utah. Providing effective treatment services for adolescents is critical and the consequences for not doing so are devastating for youth, families, and communities. According to a national in-depth survey:

“Drug and alcohol abuse and dependence are the most prevalent causes of adolescent morbidity and mortality in the United States. Effective, accessible treatment for adolescents with substance abuse problems is urgently needed.”³

A recent national survey identified nine principles that promote effective services for adolescents.

³ “The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs,” Rosalind Branningan, MPH; Bruce R. Schackman, Ph.D; Mathea Falco, JD; Robert B. Millman, MD, reprinted Arch Pediatric Adolescent Med/Vol 158, Sept. 2004.

DSAMH recommends that these be the guiding principles for programs serving youth.

- ◆ **Assessment and Treatment Matching:** *Programs should conduct comprehensive assessments that cover psychiatric, psychological and medical problems, learning disabilities, family functioning and other aspects of the adolescent's life.*
- ◆ **Comprehensive, Integrated Treatment Approach:** *Program services should address all aspects of an adolescent's life.*
- ◆ **Family Involvement in Treatment:** *Research shows that involving parents in the adolescent's drug treatment produces better outcomes.*
- ◆ **Developmentally Appropriate Program:** *Activities and materials should reflect the developmental difference between adults and adolescents.*
- ◆ **Engaging and Retaining Teens in Treatment:** *Treatment programs should build a climate of trust between the adolescent and the therapist.*
- ◆ **Qualified Staff:** *Staff should be trained in adolescent development, co-occurring mental disorders, substance abuse and addiction.*
- ◆ **Gender and Cultural Competence:** *Programs should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.*
- ◆ **Continuing Care:** *Programs should include relapse prevention training, after-care plans, referrals to community resources and follow-up.*
- ◆ **Treatment Outcomes:** *Rigorous evaluation is required to measure success, target resources and improve treatment services.*

Providing specialized services to youth and their families is critical. Utah has a need for increasing

and improving services for youth, which can be accomplished through creative methods.

Statewide Needs Assessment for Community Mental Health Services

Currently, Utah relies on national data to describe the amount of mental illness that exists in the state's population. The Division of Substance Abuse and Mental Health (DSAMH) believes that Utah specific data needs to be collected to develop a sustainable strategic plan. It believes a strategic plan based on Utah specific scientific research will aid in appropriately prioritizing services and developing funding strategies for present and future need.

In May of 2008, DSAMH entered into a contract with the University of Utah's School of Social Work that has commissioned a prevalence and needs assessment in all areas of public mental health. The prevalence study includes the general public and targeted populations such as jails, older adults, homeless individuals, emergency departments, inpatient hospitals, and consumers currently receiving services in the public mental health system. This comprehensive needs assessment will analyze:

- gaps in services
- service capacities (i.e. does the state have enough acute care beds)
- priority populations
- outcome measures

DSAMH anticipates the formal needs assessment will be completed July of 2009.

Counseling for Veterans and Their Families

It is estimated that approximately 13,000 Utah service members have been deployed during Op-

eration Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). The majority of these Utah service members are in the Army National Guard, Air National Guard, and Army Ready Reserve. The disproportionate representation of rural Americans serving in the military is an issue for Utah. Utah has 25 of its 29 counties that are considered rural. The lack of mental health services is particularly problematic for the rural combat veteran. There are approximately 160,000 veterans in Utah.

Utah veterans have faced re-adjustment problems that have lead to interactions with law enforcement, particularly around driving, conduct, domestic violence, or substance use issues. Tragically, the suicide rate for Utah OEF/OIF veterans exceeds expected rates. In some of these cases, overdoses on medications prescribed for chronic pain from combat injuries have been involved. Soldiers have also had difficulty in their efforts to return to school or employment due to Post Traumatic Stress Disorder (PTSD)/traumatic brain injury (TBI) symptoms. Other soldiers have developed substance abuse dependencies. Frustratingly, many Utah veterans have not made use of the existing services for providing assistance.

The Utah Veterans and Families Counseling committee has been created to assist veterans and their families to receive the assistance they need. Because of the progressive work being done by this committee, they were selected as one of only ten states to send a ten member team to Washington D.C. to attend the National Policy Academy on Returning Veterans and Their Families. The team developed a comprehensive plan for Utah which will be implemented in Utah, and as a model for other states, to assure that Utah veterans are receiving the services they need to be successful.

Telehealth

In 2007, the Division of Substance Abuse and Mental Health (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 ten 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 is 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.

The Walk for Wellness is to raise awareness about the human services issues facing the American Indian people of Utah.



Confederate Tribes of Goshute Reservations
Indian Walk In Center (Urban Indians)
Navajo Nation
Northwestern Band of Shoshoni Tribe
Palute Indian Tribe of Utah
Skull Valley Band of Goshute Indians
Ute Indian Tribe
Ute Mountain Ute Tribe - White Mesa
State of Utah Department of Human Services
American Indian Workgroup (UTCAN)

Walk for Wellness

Join in the Walk to Support Healthy Communities in Utah



Tuesday, September 30, 2008

**Walk begins @ 7:00 am at the
Davis Conference Center**

800 West Heritage Park Boulevard in Layton, Utah



"Walk for Wellness" held on Tuesday, September 30 in conjunction with the 2008 Utah Fall Conference on Substance Abuse

Federal Review of Services Source of Funding & Category of Expenses

Federal Review of Substance Abuse and Mental Health Systems

Substance Abuse Block Grant Review

In March 2008, a team from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) conducted a five day technical review of the State's administration of the Substance Abuse Prevention and Treatment (SAPT) Block Grant. The team examined policies and procedures, contracts with and guidance to the Local Substance Abuse Authorities, and supervisory activities in regards to the SAPT Block Grant. As part of the review, they visited an urban (Salt Lake County) and a rural (Tooele County) local authority to track the processes from the state level to the user of services. In Salt Lake County, they reviewed procedures at Project Reality's methadone treatment program, House of Hope's women's treatment program, and Odyssey House's adolescent treatment program. Their comments about the quality of treatment were complimentary and recognized the wide range of services available. The State received special praise for its performance-based management capacity. Throughout the technical review, discussions on the SAPT Block Grant requirements and their implementation were used to expand CSAT's understanding of the State's challenges and its response. The visit also produced several offers to assist the Division of Substance Abuse and Mental Health in improving its current procedures.

Mental Health Block Grant Review

On June 19, 2008, the Division of Substance Abuse and Mental Health (DSAMH) completed a three day review of the Federal Mental Health Block Grant. The review was performed by federal experts in the fields of block grant finance, adult mental health, children and youth mental health services, and mental health planning councils. This panel of experts was also joined by Utah's mental health block grant project manager. The review included a meeting with the Utah Mental Health Block Grant Planning and Advisory Council and a site visit at Wasatch Mental Health. Overall, the review went very well with the review team stating that there were no compliance findings. The reviewers were impressed with the commitment of the planning council members and provided a glowing report on Wasatch Mental Health's programming. Adult mental health was complemented on several fronts including an overall vision of future need in the state. Childrens mental health received high praise for their planning process and the implementation of family resource facilitators. Utah's financial use of the block grant and documentation of federal requirements were unchallenged and DSAMH's annual report was held up as an exemplary document for disseminating information in a reasonable and useful manner. The team also provided some helpful process improvement opportunities.

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

UT CAN had a federal site visit on March 13-14, 2008, to learn about Utah progress in accomplishing the grant goals, to identify challenges and technical assistance needs, and to enhance efforts sustain system reforms. Site visitors interviewed a large number of key stakeholders who provided important input. Site visit respondents indicate that the project has made significant implementation progress. Some key accomplishments include:

1. Successful collaboration, partnership, and shared vision among cross-state department and state agency-to-local districts.
2. Formation and organization of the Steering Committee and the seven workgroups.
3. Creation of a full time position, Adolescent Substance Abuse Treatment Program Manager, through the recommendation of the Financing/System Integration workgroup.
4. Implementation of approved local plans in local planning districts
5. Acceptance and implementation of key recommendations of the American Indian Workgroup to the Utah Department of Human Services (DHS), including the Consultation Policy and "DHS Tribal & Indian Issues Committee."

Some key recommendations include:

1. Using the data from its financial map to identify gaps, overlaps, and opportunities to blend funds and to consolidate services. There also may be opportunities to use joint contracts across agencies.

2. Developing a concerted effort to address systems integration of mental health and substance abuse services.
3. Addressing workforce issues through the identification of core competencies in mental health, substance abuse, and co-occurring problems.
4. Expanding how family and youth voices change systems. Additionally, it is important to have a family- and youth-driven data collection process to document the outcomes and impact of these efforts.
5. Continuing with cultural competency training, and considering using the expanding telehealth system to make current training curricula more available.

Projects for Assistance in Transition from Homelessness (PATH) Program Review

The Center for Mental Health Services (CMHS) contracted with AFYA, Inc., to conduct a site visit in Utah to monitor the administration and operation of the PATH program. The Utah site visit was conducted August 5-6, 2008, by Gigi Belanger, Public Health Advisor, CMHS/Homeless Programs Branch, and Sarah Andre, Advocates for Human Potential. The site visit included meetings with the State PATH Contact, Robert Snarr, and three staff at the State level—Mark Payne, Director; Ron Stromberg, Associate Director; and Rick Hendy, Program Administrator. The team also met with local providers in Salt Lake City and Provo, Utah. Observations from the site visit were collected and organized using five voluntary performance goals approved by CMHS in September 2003. This methodology allows teams to examine the performance of the State and its contracted providers in a comprehensive and standardized way, and offers the opportunity to discuss best practices within PATH. Overall the

review reports the Utah PATH program is managed well and demonstrated exemplary knowledge of the program, provides best practices, and is an excellent example of partnership at the state and local levels to ensure that people who are homeless receive the services they need to maintain stable housing. Recommendations included

encouragement to state level staff to take on a mentor role for PATH staff in other states. Also, that local staff may benefit from additional training on providing trauma-informed services and to ensure that clients are tracked when they transition to mainstream services.

Source of State and Federal Funding and Category of Expenses

The Division of Substance Abuse and Mental Health's (DSAMH) funding sources consist of State general funds, State restricted general funds, and Federal funds. A key funding source that is not included in DSAMH's budget, but is critical to the system, is Medicaid. Medicaid is disbursed through the Department of Health and collected directly by the local authorities. We have included Medicaid in the charts below to reflect a more accurate picture of the critical state and federal funding sources within the mental health and substance abuse system.

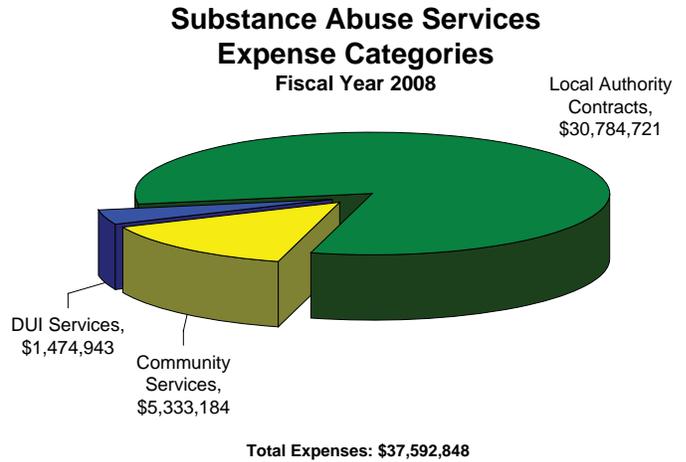
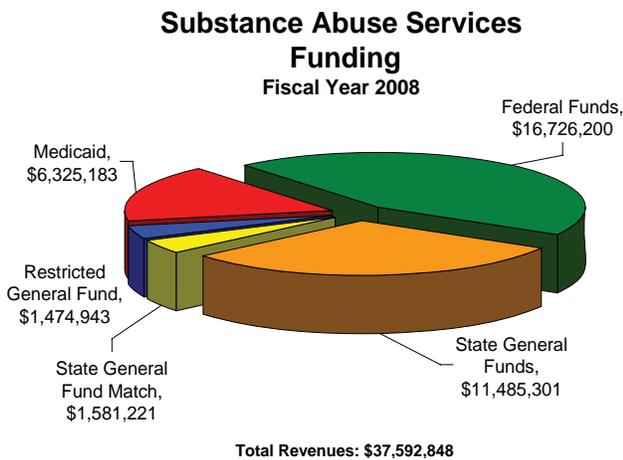
The local authorities are required by State statute to provide funding equal to at least twenty percent

of the state funds allocated to them. However, some local authorities provide more than twenty percent. This source of funding is not reflected in the charts below since it is not funding that is disbursed by any state or federal agency.

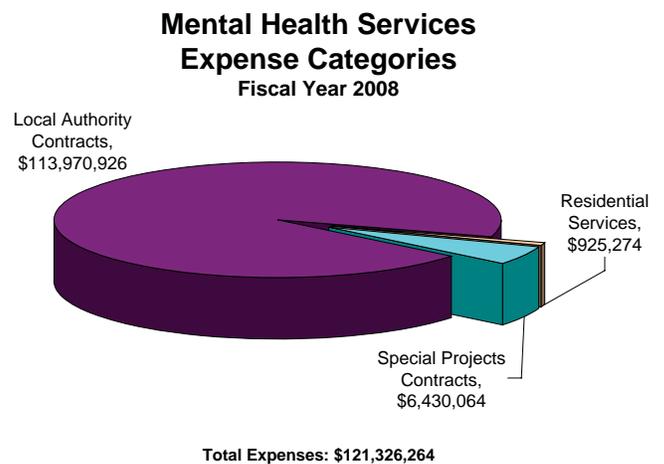
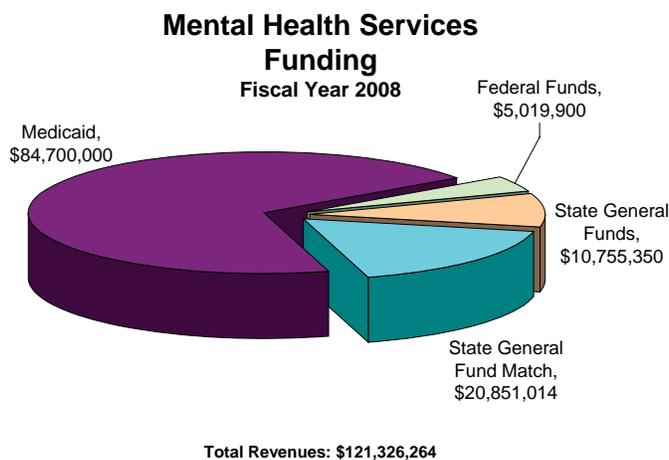
The majority of expenditures for DSAMH are directly related to the contracts with the local authorities. DSAMH also has contracts for special statewide projects such as consulting, research, and education.

See funding and expense charts on the following page.

Substance Abuse Services



Mental Health Services





DHS American Indian Summit pre-conference held in conjunction with the 2008 Utah Fall Conference on Substance Abuse

Who do we serve? Consumer Satisfaction

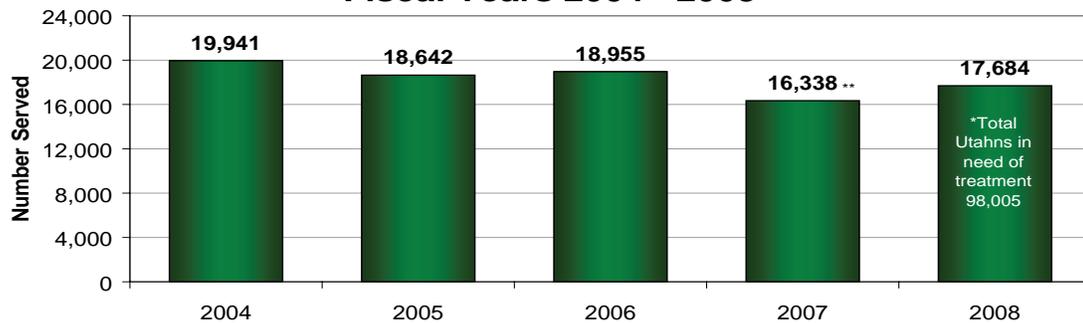
Who Do We Serve

Total Number Served

The following figures show the total number of individuals served in all publicly funded substance abuse treatment facilities for fiscal years 2004 through 2008. The same is depicted for individuals in service within community mental health centers for fiscal year 2004 through fiscal year 2008. A unique client identification process was imple-

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

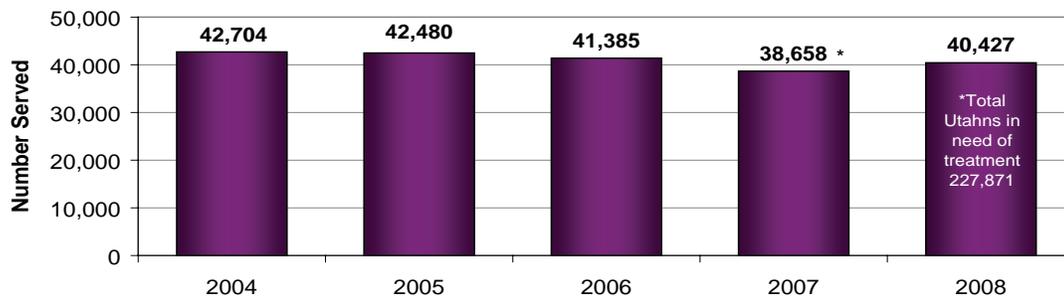
Total Number of Individuals Served in Substance Abuse Treatment Fiscal Years 2004 - 2008



*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 cannot 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 2004 - 2008



**Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric epidemiological Surveys and the U.S. Census 2007 Population Estimate), from <http://psy.utmb.edu/estimation/estimation.htm>

Note: These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2007, using the MHM 3 broad definition. The MHM3 definition requires a current or chronic disorder and a disability duration of at least 30 days, and is comparable to Seriously Mentally Disturbed (SMD). For children and adolescents, the estimates use poverty levels to assign rates of Serious Emotional Disturbance (SED).

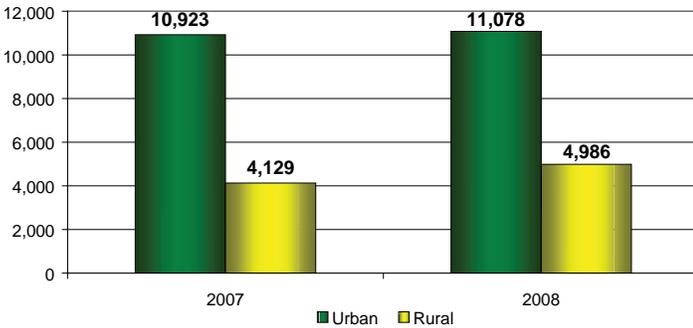
**A unique client identification process was implemented in fiscal year 2007, which significantly reduced the duplication of unique clients served throughout the public substance abuse and mental health systems. As a result, the number of unique clients served in 2007 decreased, and cannot be compared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

Urban and Rural Areas

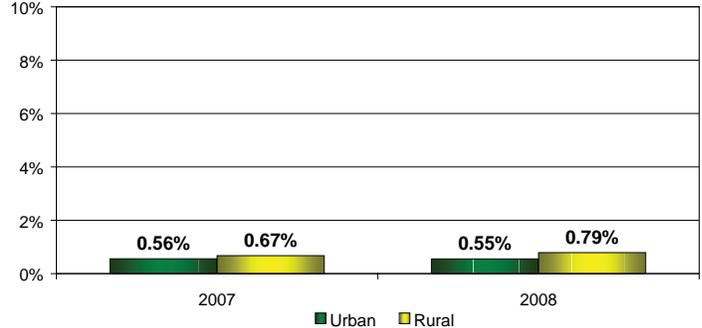
The following graphs show the total number of individuals served in urban and rural communities

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

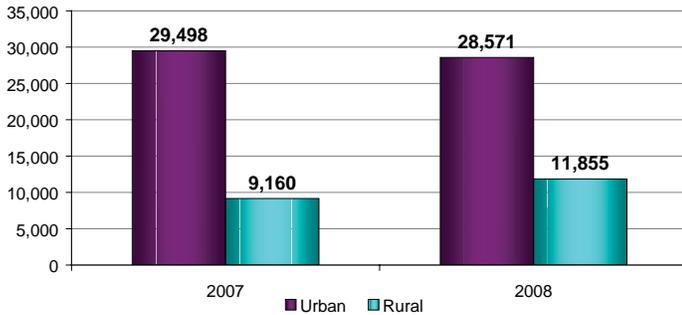
**Number of Individuals Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2007 - 2008**



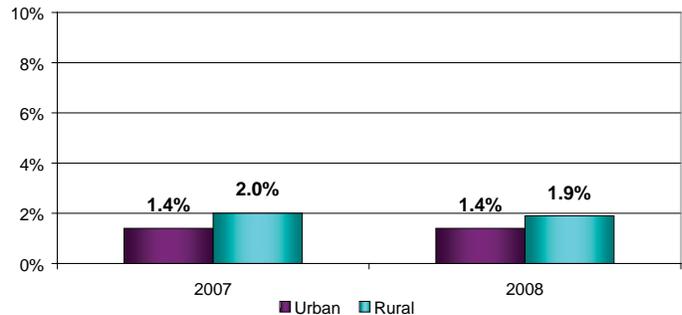
**Percent of Total Population Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2007 - 2008**



**Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2007 - 2008**



**Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2007 - 2008**



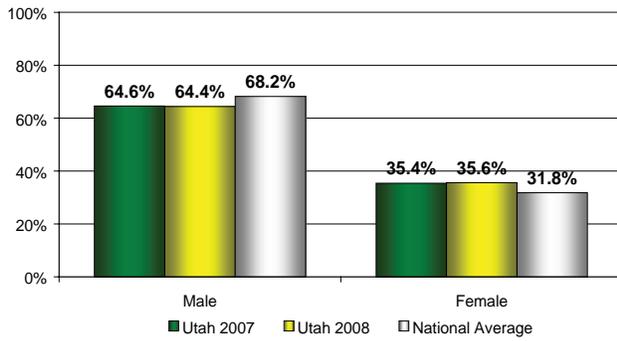
Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

Gender and Age

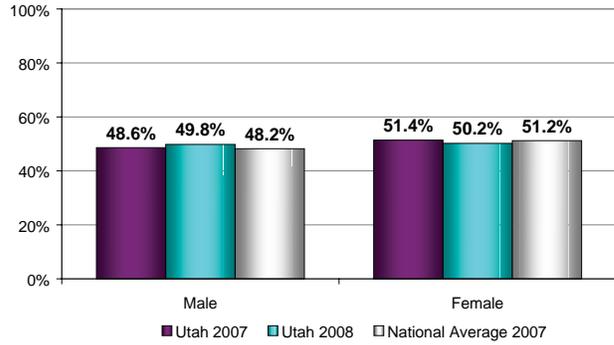
The following figures identify the distribution of services by gender and age for substance abuse and mental health services. There are significant dif-

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

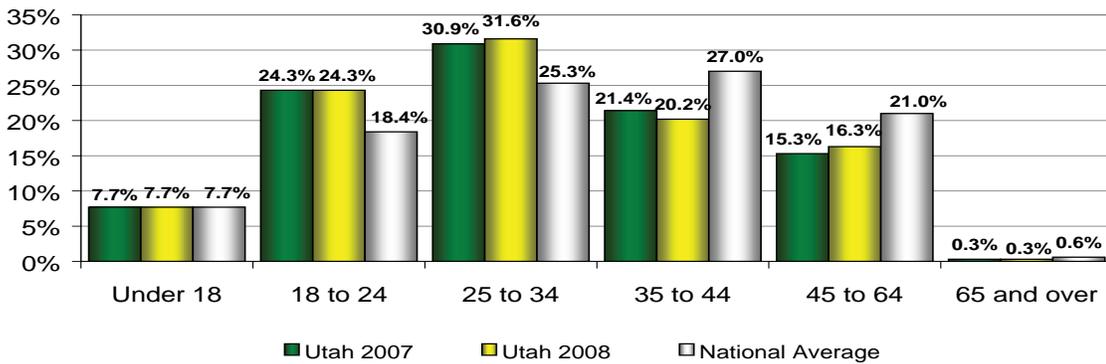
Gender of People Served in Substance Abuse Services
Fiscal Years 2007 - 2008



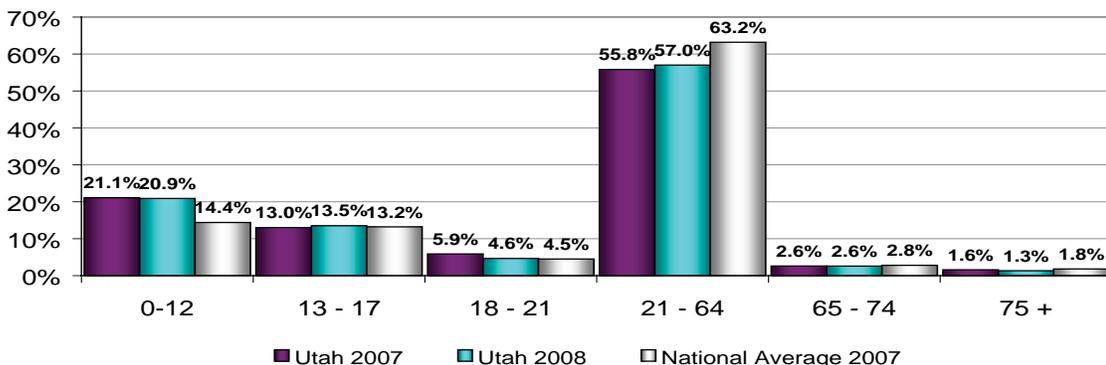
Gender of People Served in Mental Health Services
Fiscal Years 2007 - 2008



Age Grouping at Admission of People Served in Substance Abuse Services
Fiscal Years 2007 - 2008



Age Grouping of People Served in Mental Health Services
Fiscal Years 2007 - 2008

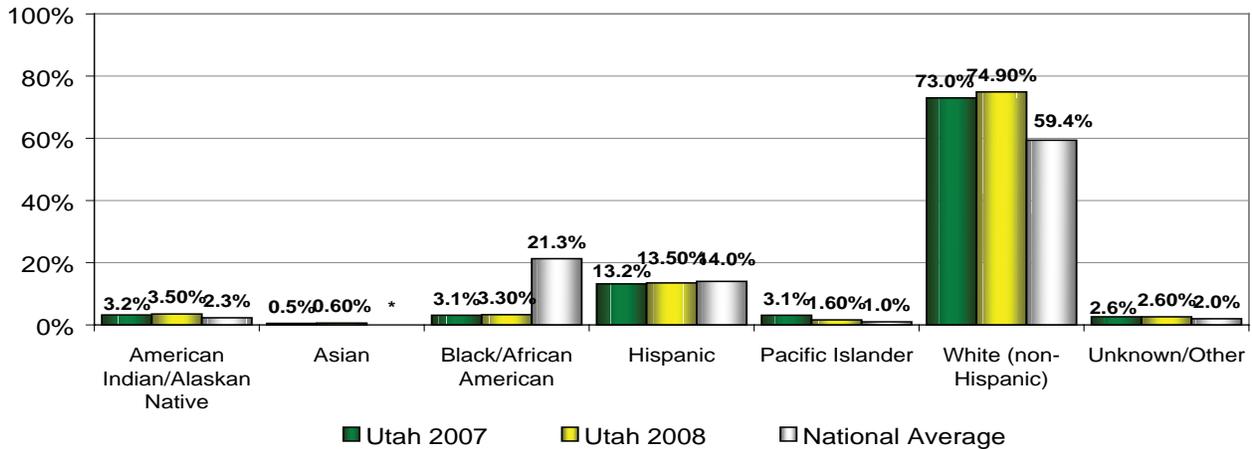


Race and Ethnicity

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

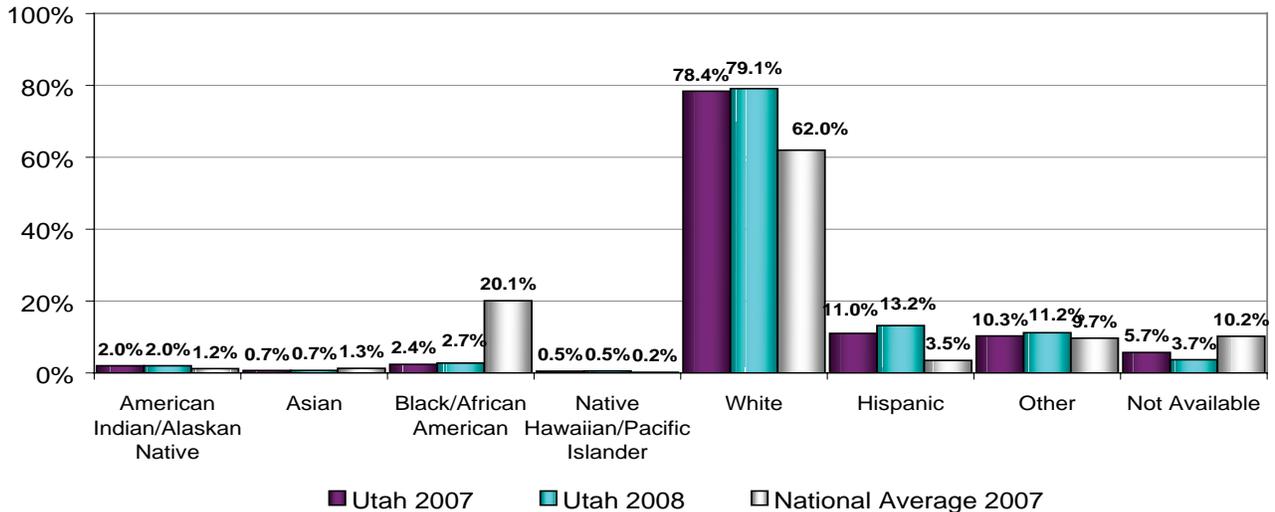
the clients receiving substance abuse or mental health services.

Race/Ethnicity of People Served in Substance Abuse Services Fiscal Years 2007 - 2008



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

Race/Ethnicity of People Served in Mental Health Service Fiscal Years 2007 and 2008

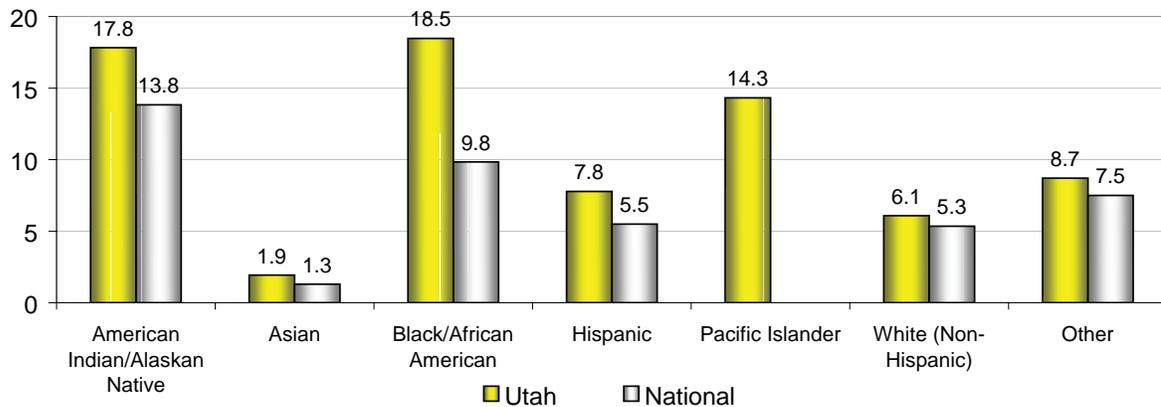


Note: More than one race/ethnicity may have been selected.

The graphs below show the penetration of substance abuse and mental health services by race/ethnicity. These graphs compare the rates that people are seeking services and account for the widely differing numbers of people in those

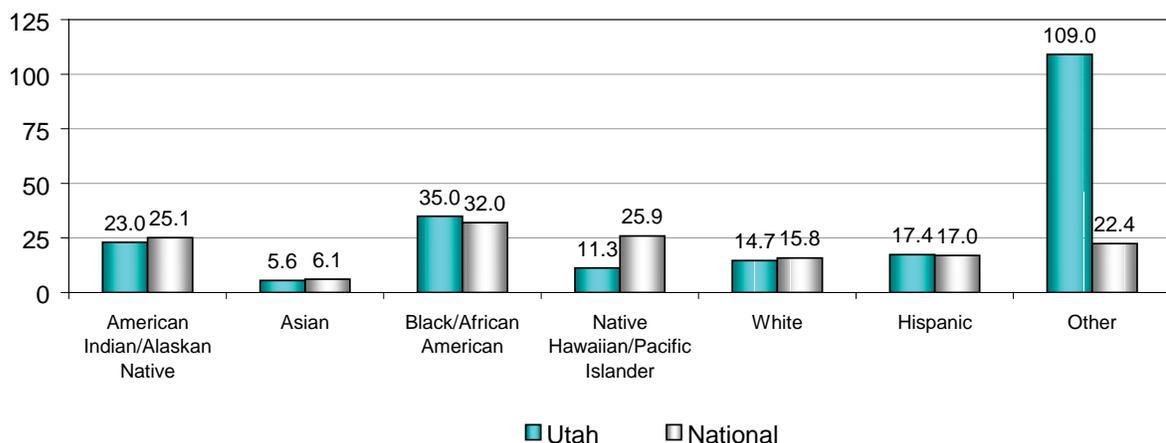
racial/ethnic groups. For example, for every 1,000 whites in Utah, 6.1 are receiving substance abuse treatment. For every 1,000 Americans Indians in Utah, 17.8 are receiving substance abuse services.

Penetration of People in Substance Abuse Treatment Service per 1,000 Population by Race/Ethnicity Fiscal Year 2008



Note: Pacific Islander and Asian reported together in National Averages

Penetration of People in Mental Health Treatment per 1,000 Population by Race/Ethnicity Fiscal Year 2008

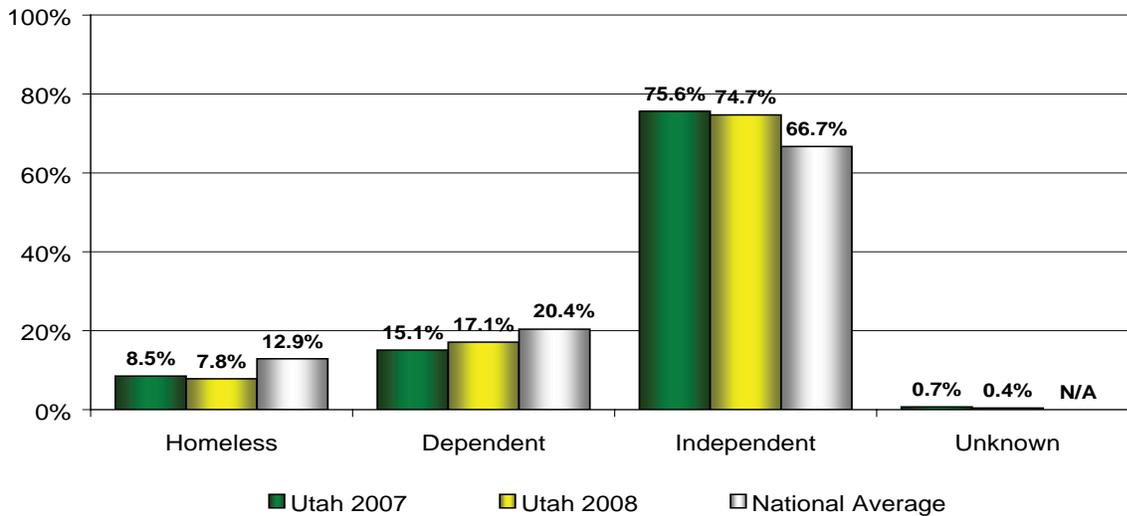


Living Arrangement at Admission

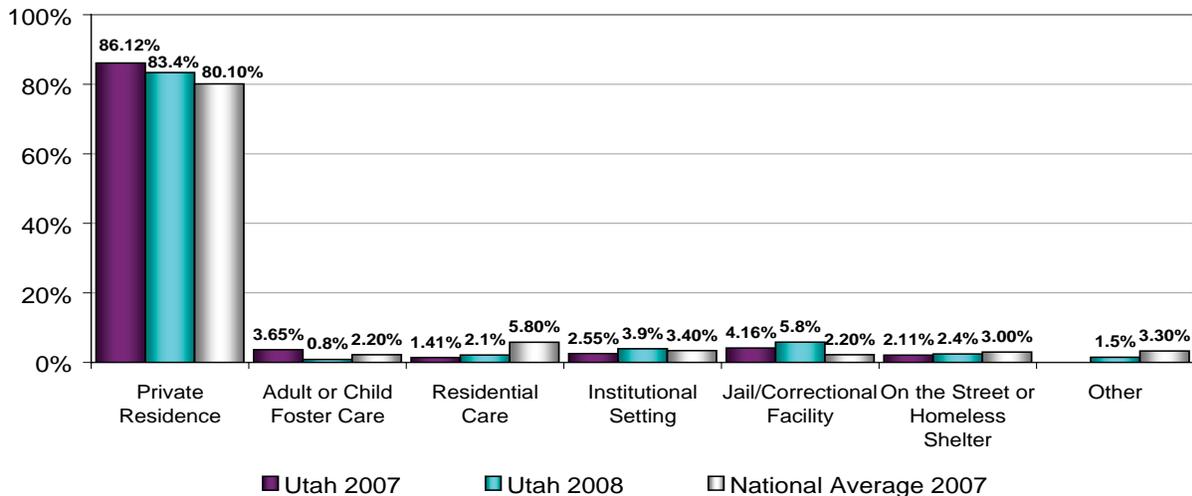
The following graphs depict clients living arrangement at admission for substance abuse and mental health clients served in fiscal year 2008. By far, the majority of clients receiving substance abuse and mental health services are in independent living

situations at the time they enter treatment. Due to reporting requirements 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 2007 - 2008



Living Arrangement at Admission of Adults Served in Mental Health Services Fiscal Years 2007 - 2008

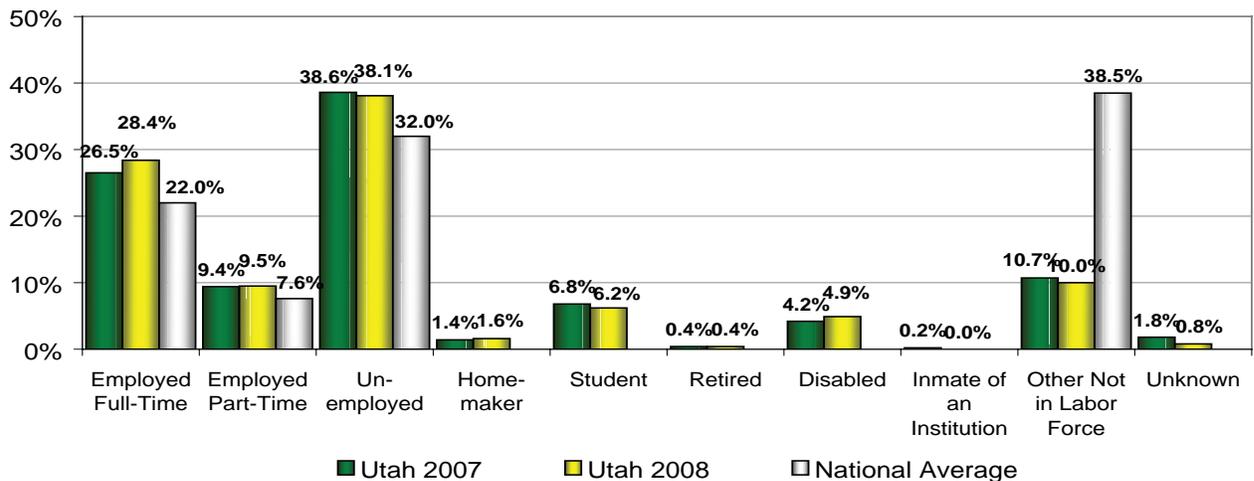


Employment Status at Admission

The following graphs show the employment status at admission for substance abuse and mental health clients served in fiscal year 2008. The categories

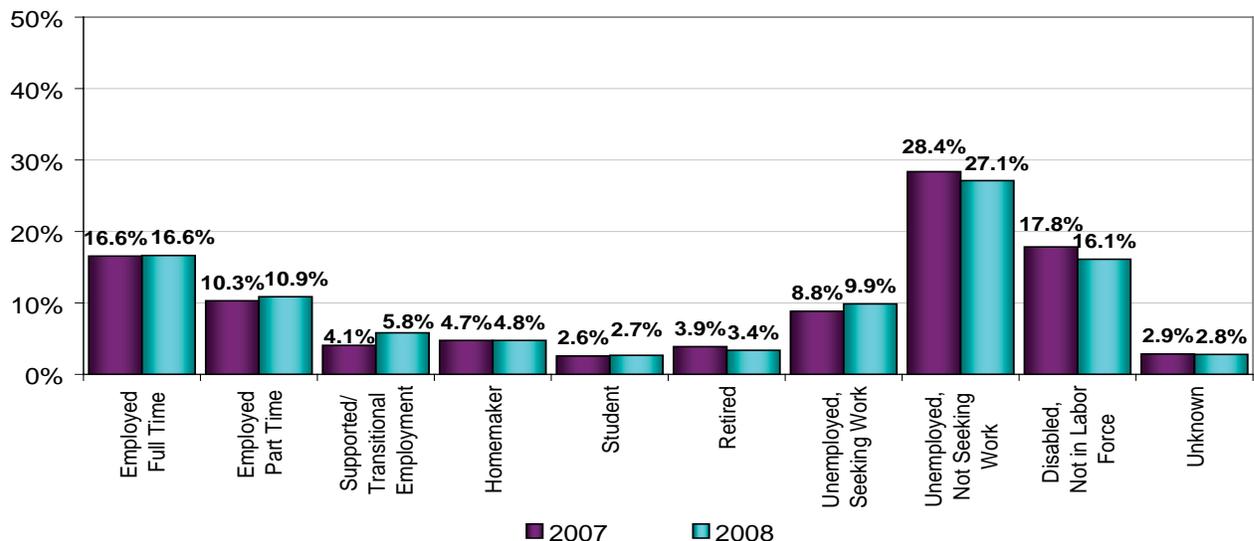
for mental health clients are different than those for substance abuse clients.

Employment Status at Admission for Individuals in Substance Abuse Services Fiscal Years 2007 - 2008



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 2007 - 2008

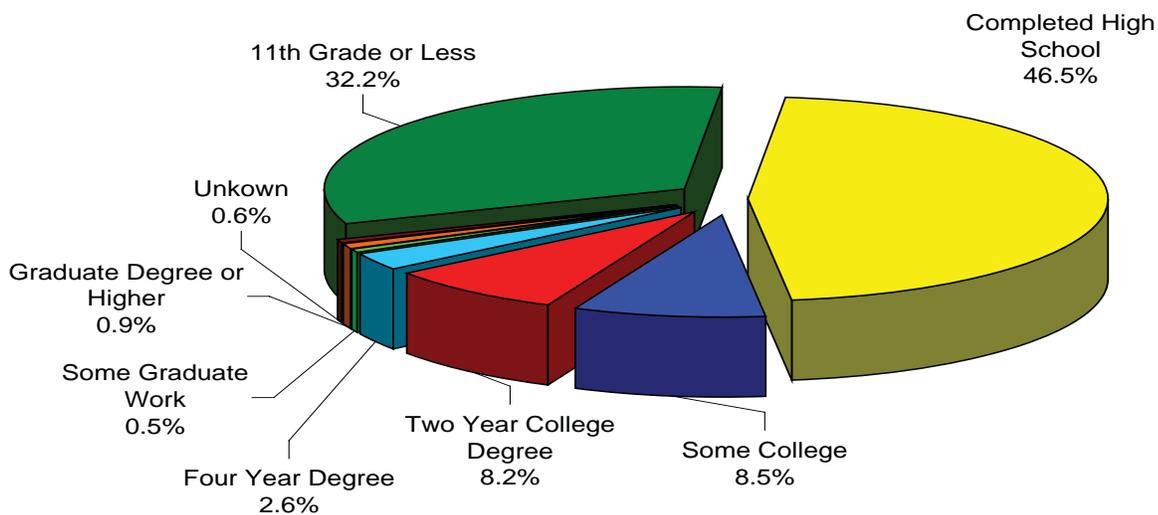


Highest Education Level Completed at Admission

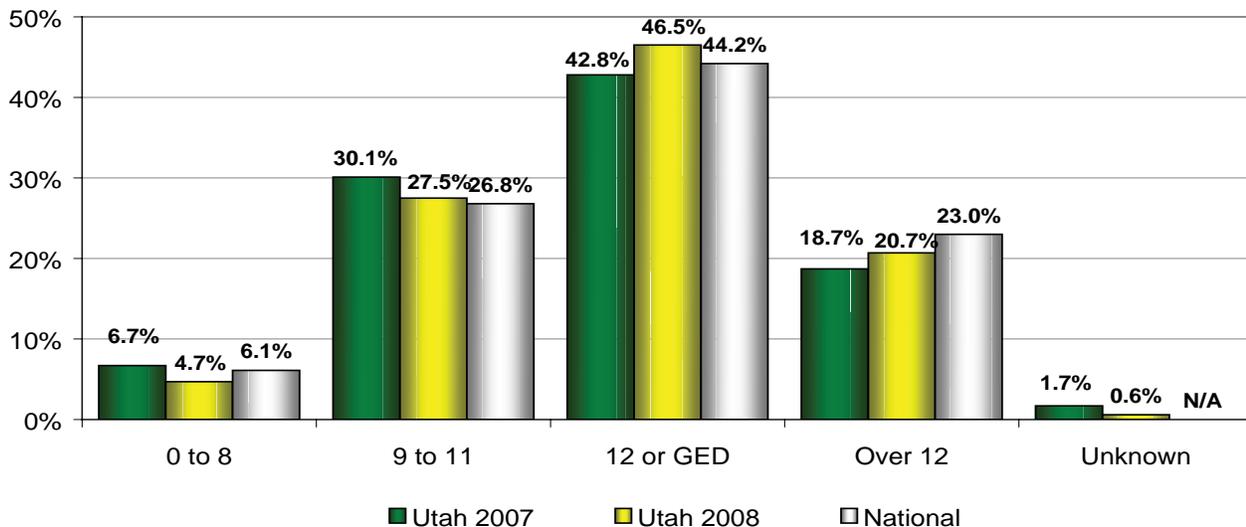
In fiscal year 2008, 68% of adults in substance abuse treatment statewide completed at least high school, which included those clients who had attended some college or technical training.

Additionally, 21% of the clients had received some type of college training prior to admission. Still, 32% had not graduated from high school.

Education Level at Admission for Adults in Substance Abuse Services Fiscal Year 2008



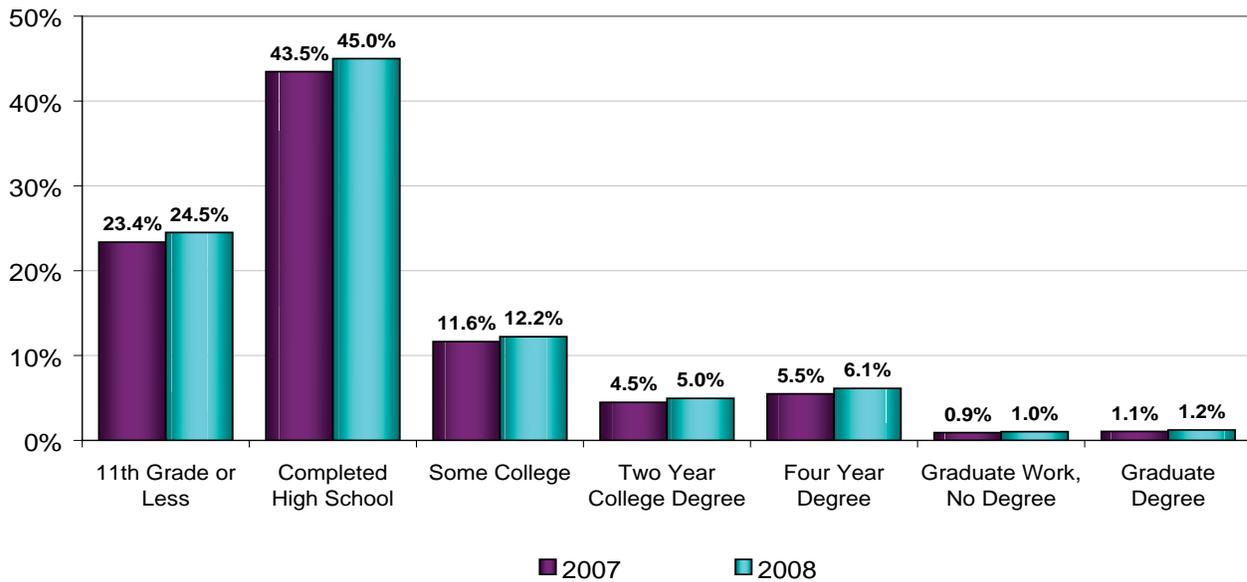
Highest Education Level of Adults Served in Substance Abuse Services Fiscal Years 2007 - 2008



In fiscal year 2008, 71% 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,

26% of the clients had received some type of college degree prior to admission. Still, over 24% had not graduated from high school.

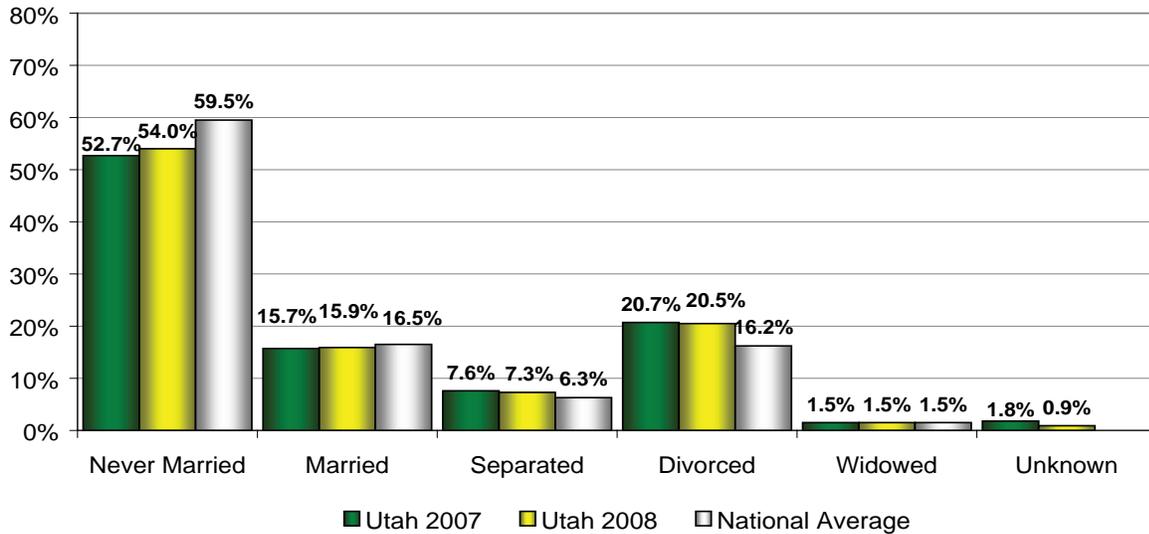
Highest Education Level of Adults Served in Mental Health Services Fiscal Years 2007 - 2008



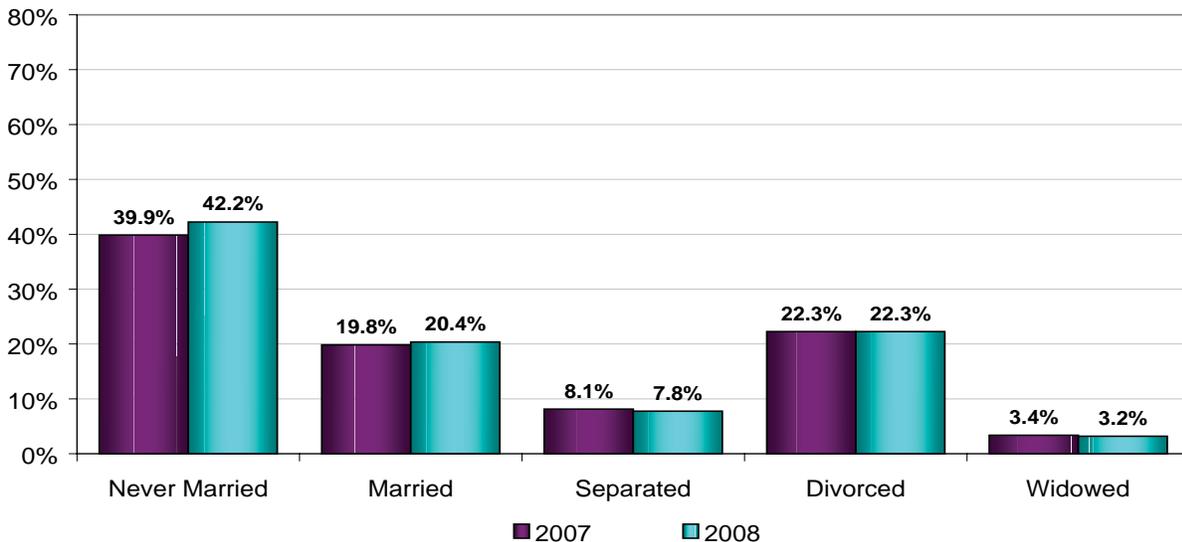
Marital Status at Admission

The following graphs show the marital status of clients at admission for substance abuse and mental health clients served in fiscal year 2008.

Marital Status of Individuals Served in Substance Abuse Services Fiscal Years 2007 - 2008



Marital Status of Adults in Mental Health Services Fiscal Years 2007 - 2008

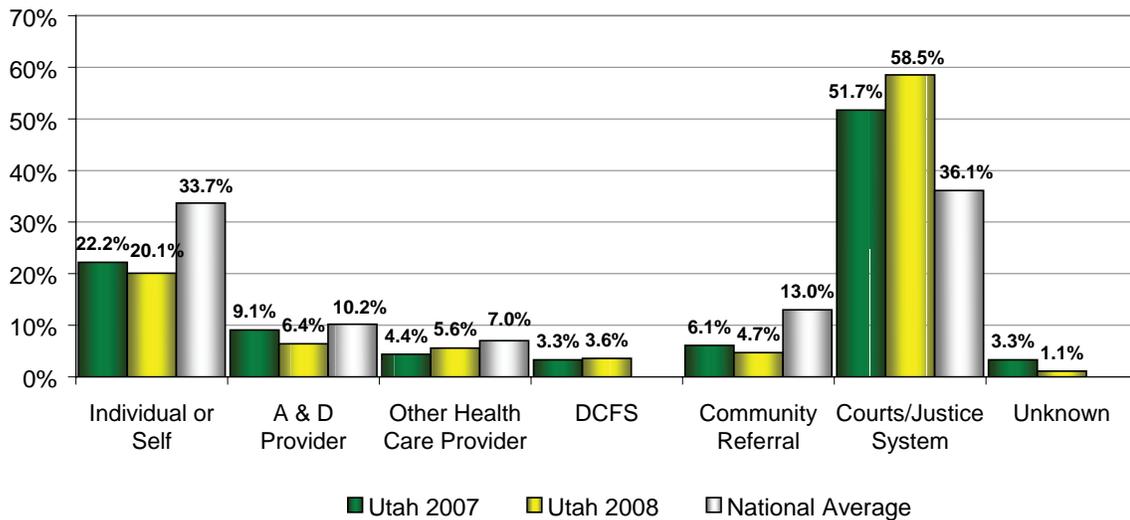


Referral Source

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

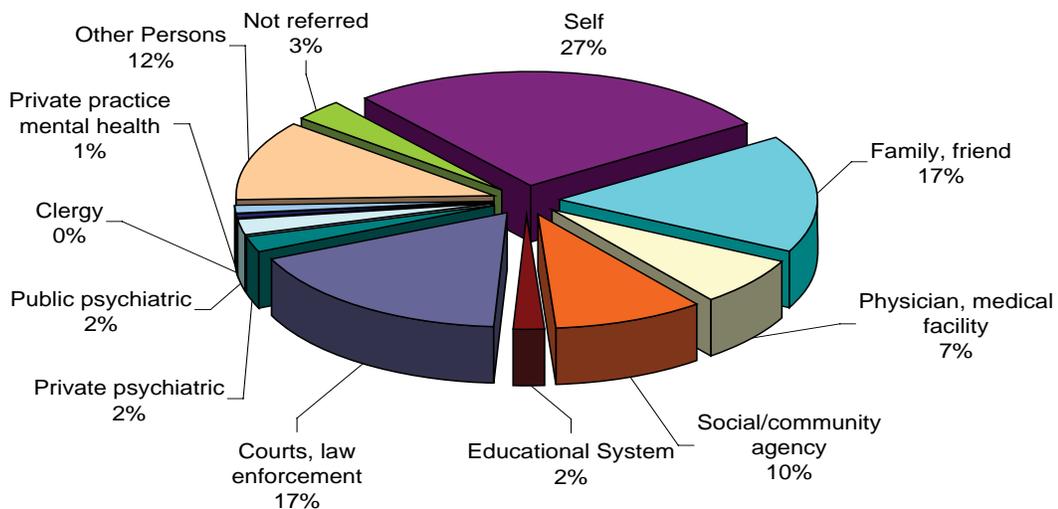
“referral source” can continue to have a positive influence on the clients’s recovery. The graphs below detail the referral sources for fiscal years 2007 and 2008 for substance abuse and fiscal year 2008 for mental health.

Referral Source of Individuals in Substance Abuse Services Fiscal Years 2007 - 2008



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

Referral Source of People Served in Mental Health Services Fiscal Year 2008



Consumer Satisfaction

Background

In 2004, the Division of Substance Abuse and Mental Health (DSAMH) and federal funding grants, began to require that all providers conduct an annual survey on consumer satisfaction and treatment outcomes. DSAMH requires that the survey is administered to consumers of both substance abuse and mental health services, and that providers comply with administration requirements and minimum sample rates. Below are the results of this survey for 2008, along with recommendations

Recommendations

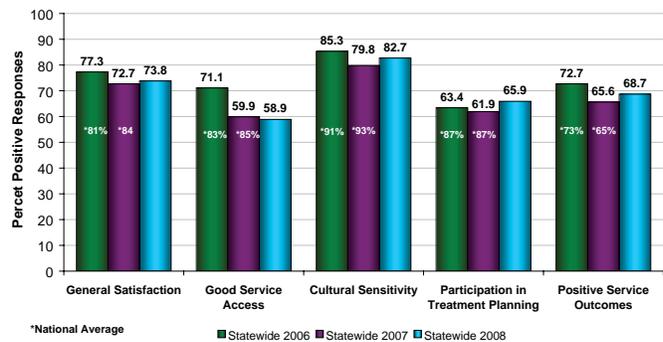
DSAMH takes the results of these surveys seriously and will use the results to improve services by taking the following actions:

- Establish a target performance standard to meet or exceed the national average for MHSIP and the statewide average for YSS and YSS-F.
- DSAMH will include survey results and sample rates in monitoring reviews and will use that information to assess the quality of services and to help agencies improve.

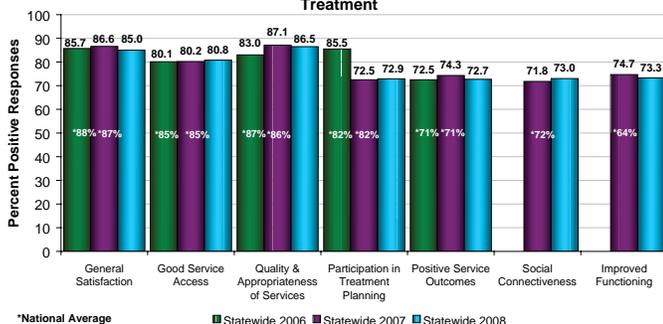
- The results of the surveys will be reported to local authorities and providers as a part of the DSAMH’s Scorecard, along with trends and ideas for improvement.
- DSAMH will work with clinical representatives in the community serving adults to continue with efforts to improve the involvement in treatment planning to meet or exceed the national average.

For more information or a copy of the 2008 Consumer Satisfaction Survey Report go to http://www.dsamh.utah.gov/consumer_satisfaction.html.

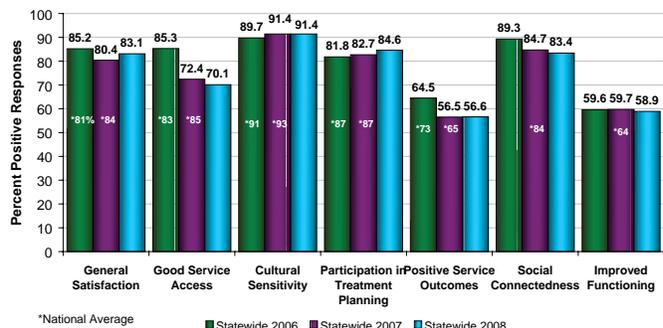
**Youth Consumer Satisfaction Survey
Youth Services Survey (YSS)**
Completed by Youth (ages 12 to 17) in Substance Abuse and Mental Health Treatment



**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-F)**
Completed by Parent or Guardian of Youth in Substance Abuse and Mental Health Treatment





Substance Abuse Prevention

Governing Youth Council Conference held at Snow College-Richfield Campus

Substance Abuse Prevention

Overview

The Risk and Protective Factor Model developed by Dr. David Hawkins and Dr. Richard Catalano at the University of Washington is the foundation for building, developing, and guiding Utah’s prevention services. As is found in medical models, substance abuse risk factors can be identified and mitigated in an effort to interrupt the development or progression of the addictive process. Similarly, protective factors buffer the impact of risk factors. To determine which prevention services to implement in a particular community, a community profile of the risk and protective factors is created, utilizing data from various sources, including periodic surveys and archival indicators. Upon identification of the risk and protective factors community, local planning bodies select prevention programs targeted to reduce risk and enhance the protective factors identified in the community profile.

Each local authority is responsible to provide a comprehensive prevention plan for its area. This plan must address prevention needs across the life span and use prevention programs shown to be effective for the identified target audience.

Utah’s prevention system is headed by the Division of Substance Abuse and Mental Health (DSAMH) and centered on prevention coordinators from 13 local authorities. These coordinators are responsible for planning, implementing, and evaluating prevention services in their area. Local authorities are required to have community level coalitions to help coordinate services and leverage

resources. Utah’s prevention system is built upon a strategic, science-based planning process.

Statewide prevention initiatives include: the Utah Prevention Advisory Council, Eliminating Alcohol Sales to Youth Program (E.A.S.Y.), Parents Empowered Media Campaign, Governor Huntsman’s Methamphetamine Task Force, Prevention

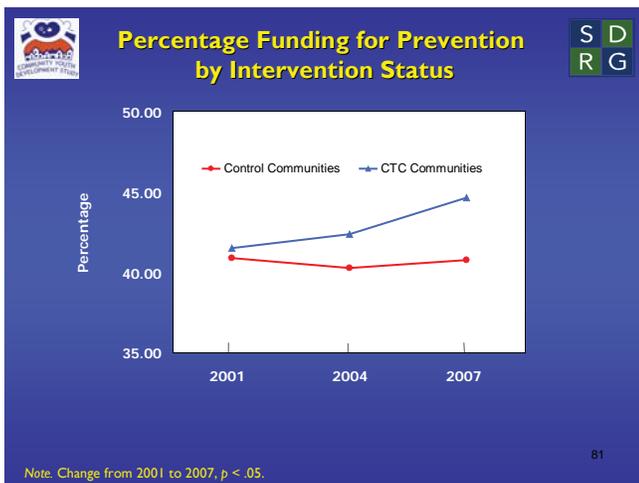
<i>Communities That Care</i>	Adolescent Problem Behaviors					
	Substance Abuse (Alcohol, Tobacco & Other Drugs)	Delinquency	Teen Pregnancy	School Drop Out	Violence	Depression and Anxiety
Risk Factors						
<i>Community</i>						
Availability of Drugs	✓				✓	
Availability of Firearms		✓			✓	
Community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

Dimensions, and a prevention workforce development plan that includes prevention specialist training.

Communities That Care (CTC)

The National Substance Abuse and Mental Health Administration’s “Communities That Care” program is a complete package of training and support services delivered by professionals in the field of prevention science to help communities develop an integrated approach to: (1) increase the positive development of behaviors in children and youth; and (2) decrease problem behaviors related to, or associated with, substance abuse including delinquency, teen pregnancy, school dropout, and violence. In June of 2008, the University of Washington concluded a research project conducted in Utah on the CTC program. Results of the study encouraged DSAMH to promote CTC throughout the state. Research shows communities that use CTC will experience reduced risk factors, increased protective factors, and increased funding for prevention services

To encourage local communities to use CTC,



DSAMH hosted a training for trainers where 12 people were trained and certified as CTC trainers. DSAMH has also negotiated with the University of Washington to provide ongoing technical assistance and consulting.

“Communities That Care” Flies in Tooele

In 2002, Tooele County received a grant to implement a community mobilization program that included the community’s key leaders in their prevention planning. Valley Mental Health–Tooele utilized this grant money efficiently and engaged government agencies as well as private businesses in their prevention activities. In 2004, Tooele City received additional grant money to implement the CTC prevention system. Using Valley



Local business participate in a breakfast fundraiser for Communities that Care in Tooele

Mental Health–Tooele’s community mobilization work as a catalyst, Tooele City formed a prevention coalition, Tooele Interagency Prevention Professionals (TIPP), that included the Mayor, City Council Members, and prevention agencies and citizens from the private sector.

Four years later, TIPP continues to drive the CTC process in its area, and its efforts are showing success. Compared to 2002, Tooele has seen a reduction in problem behaviors among their youth including substance abuse, property damage, suspensions from school, and shoplifting. In addition, TIPP has secured local resources to implement evidence based prevention programs such as the Mayor’s Community Youth Program and the “SOAR” program which helps kids bond to their community by providing skills, opportunities, and recognition to the kids in Tooele.

Utah K-12 Prevention Dimensions Programs

DSAMH collaborates with the Utah State Office of Education for implementation and evaluation of the Prevention Dimensions Program. The Prevention Dimensions Program is a statewide curriculum delivered by classroom teachers to Utah's students, kindergarten through 12th grade. While most school-based prevention programs are delivered in addition to school curriculum requirements, the Prevention Dimensions program

Number of School Staff Trained in Prevention Dimensions Fiscal Year 2008	
TRAININGS	NUMBER TRAINED
Ogden	31
Sevier	21
Tintic	17
Jordan (Summit Academy)	47
Tooele	52
Jordan	60
Davis	39
Box Elder	26
Logan/Cache	36
Granite / Salt Lake/ Jordan	61
Alpine/Nebo/Provo	50
Granite /Salt Lake / Murray	22
Iron / Garfield	29
Alpine / Nebo / Provo	72
North & South Sanpete	22
Weber / Morgan	33
Carbon / Emery	31
Salt Lake / Granite	74
Ogden / Weber / Morgan	31
Granite (Lakeview Charter)	38
Washington	46
Garfield	15
Granite / Salt Lake	8
Wasatch/Summit / Park City	15
Granite	34
Rich	8
Washington	29
Davis	40
TOTAL = 28	TOTAL = 987

was developed to meet core curriculum requirements in addition to prevention curriculum. The Prevention Dimensions program first started in 1982 with curriculum enhancements taking place in 1992 and 2003. The State Office of Education owns Prevention Dimensions, and therefore, it can easily be altered to meet ongoing educational and developmental needs. For example, to meet the needs of the Governor's End Meth Now campaign, Prevention Dimensions developers used recent research to develop a lesson specific to methamphetamine.

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, and provides opportunities for students to participate in prevention activities.

Prevention Dimensions also provides a 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 musical component is extended not only to students, but also to families and the community at large.

Steve James is very active throughout the state promoting Prevention Dimensions through assemblies and parent night concerts. During the 2007-2008 school year, these community outreach activities reached over 18,000 students at school assemblies and over 27,000 people at community Prevention Dimensions concerts. These assemblies and concerts set the stage for local efforts to impact peer and social norms related to substance abuse.

The cooperative effort between DSAMH and the State Office of Education allows for ongoing rigorous evaluation of Prevention Dimensions. Prevention Dimensions is listed on Substance Abuse and Mental Health Services Administrations as a Legacy Program (for details of legacy status, see http://www.nrepp.samhsa.gov/legacy_fulldetails.asp?LEGACY_ID=1033).

Utah's State Epidemiology/ Outcomes Workshop (USEOW)

DSAMH has put into practice a State Epidemiology Workgroup made up of prevention, survey, and epidemiology experts to systematically enhance the availability of data related to substance abuse consumption and consequences. The primary task of the USEOW is to collect and interpret data and develop recommendations of substance abuse priorities for Utah. As a result, prevention workers will be able to accurately assess their community's needs and apply effective prevention activities. USEOW has developed a process for accumulating data, interpreting it, and sharing the data in a way that allows the prevention network the ability to examine critical components of prevention data, i.e., trends, consumption rates, and consequences.

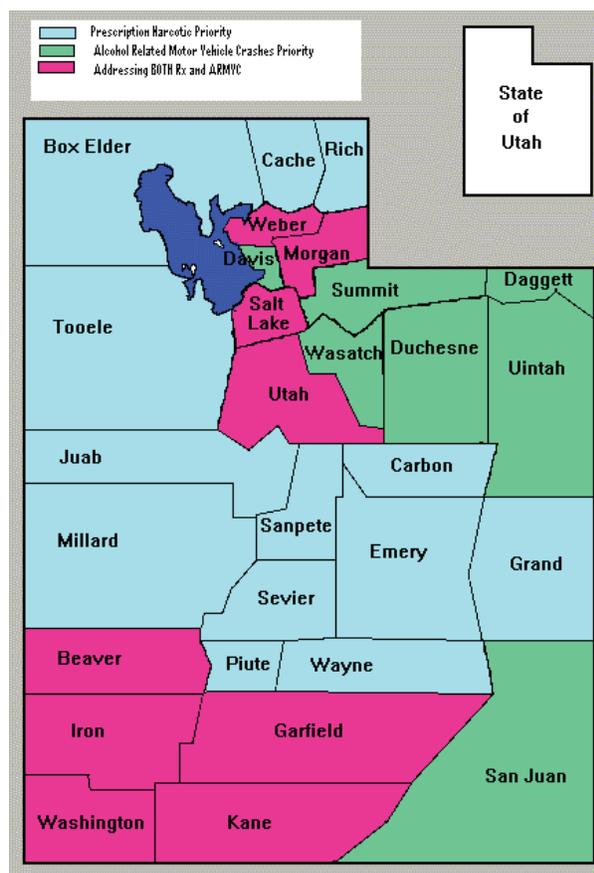
USEOW collated state data and compared it to national measures. This effort resulted in the development of an epidemiological profile that presents 28 indicators of substance use consequences and 24 indicators of substance use estimates for youth and adult populations in the state.

The Epidemiology Report can be viewed at http://www.dsamh.utah.gov/docs/seow_final_epi_report_2007.pdf.

Strategic Prevention Framework (SPF) Grant

In October 2006, DSAMH was awarded a Strategic Prevention Framework Grant. The grant,

awarded by the Federal Substance Abuse and Mental Health Services Administration, gives Utah \$1,930,00 per year for five years to: 1) prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; 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 USEOW, SPF staff identified two statewide substance abuse related priorities to be addressed by this grant: 1) Prescription Drug Abuse, and 2) Alcohol Related Motor Vehicle Crashes. In 2007, data was used to determine the priorities for each Local Substance Abuse Authority. See following map:



Collaborative Efforts

Research shows that several negative behaviors exhibited by youth share the same risk factors. These negative behaviors include substance abuse, delinquency, teen pregnancy, school drop-

out, violence, and symptoms of depression and anxiety. Because these shared negative outcomes are addressed by other agencies, DSAMH has coordinated its prevention efforts. Partners in prevention efforts include the National Alliance of Mental Illness, Division of Child and Family Services, and the Utah Behavioral Healthcare Committee's Futures Project.

The Utah Prevention Advisory Council (UPAC) is the foundation for collaboration between agencies with prevention interests. UPAC is made up of 28 individuals representing 26 agencies and is administered by the Director of the Utah Substance Abuse and Anti-Violence Coordinating Council.

Town Hall Meetings

Underage drinking continues to be a leading public health problem in Utah. Alcohol use threatens the safe and healthy development of more young people than any other substance—even more than tobacco and illicit drugs! Throughout the nation in 2006, on an average day, 7,970 teens drank alcohol for the first time, a much higher number than teens who begin smoking or trying illicit drugs. Alcohol use among children and adolescents starts early and increases rapidly with age. According to a recent survey (R&R Partners) almost 59% of Utah parents are unaware that sixth graders are drinking. Parents are shocked to learn that in another study, 1 in 10 fourth graders had consumed more than a sip of alcohol.

As part of a national effort to help communities in their efforts to stop underage drinking, a series of Town Hall Meetings took place across Utah during the week of March 31–April 4, 2008. Utah's Town Hall Meetings were designed to increase understanding and awareness of underage drinking and its consequences, and encourage individuals, families, and communities to address the problem. Parents need to know that parental disapproval is the #1 reason kids don't drink, and that neighborhoods can mobilize and make a difference. Over 80% of Utah's counties par-

ticipated in Town Hall Meetings this year. Some counties had multiple meetings and there were town hall meetings in communities such as Asian Affairs at the Office of Ethnic Affairs.

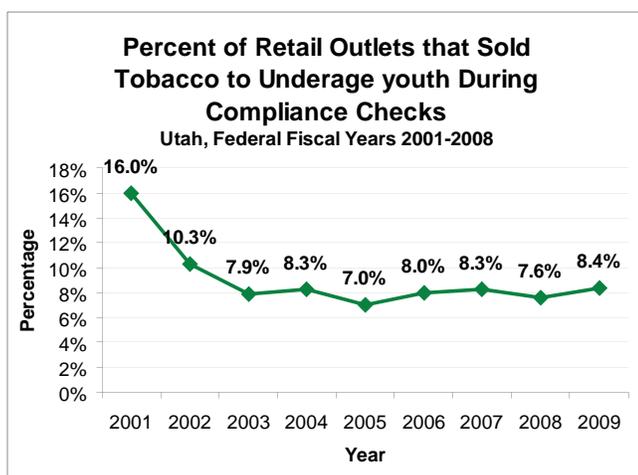
Cedar City was the first city to hold a town hall meeting this year and set a high standard by attracting nearly 900 participants. In Ogden, town hall organizers joined forces with local business and used the new "Solomon Center" activity center to help attract participants. Utah County utilized their local Youth Leadership Group to deliver the message and provide information to parents, while Green River, Utah, engaged Bikers Against Child Abuse to help convey the no underage drinking message. Brigham City found success in using local businesses, representatives from city government, and youth groups to provide a wealth of information about how their city could combat the illegal use of alcohol. The Salt Lake City Mayor's Coalition on Substance Abuse collaborated with the schools. Using the Prevention Dimensions substance abuse prevention program, the coalition provided a concert where elementary age students sang to a large audience about the benefits of staying healthy and avoiding underage alcohol use.

The Town Hall Meetings were supported and sponsored by: DSAMH, Department of Alcohol Beverage Control, Parents Empowered, Mothers Against Drunk Drivers (MADD), Governing Youth Council, Local Substance Abuse Authorities, Office of Ethnic Affairs, and Drug Free Community Grantees throughout Utah and the Substance Abuse and Mental Health Services Administration.

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 sale to minors' rate of not greater than 20%. In a collaborative effort between the Department of Health and DSAMH, Utah has effectively decreased the number of tobacco sales to minors and has a violation rate lower than 10%. 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. Since 2001, illegal tobacco sales to underage youth during compliance checks declined 53% to 8.4%.



Declines in Utah smoking since Master Settlement Agreement (MSA) funds were allocated to the Tobacco Prevention and Control Program¹:

- 17% decline in rate of adult smokers (1999-2007)
- 34% decline in rate of youth smokers (1999-2007)
- 28% decline in rate of pregnant smokers (1999-2007)
- 70% decline in rate of children exposed to smoking in their homes (2001-2007)

¹ Reference: <http://www.tobaccofreeutah.org/tpcpfy08report.pdf>

Local Area Program Highlights

The Bear River Health Department (BRHD) implemented *Family Works* as a way of reaching parents with tools and information to keep their kids alcohol and drug free. The *Family Works* program is an adaptation of the Nicasa Parent Project which is a nationally recognized program rated effective by the Office of Juvenile Justice and Delinquency Prevention. By collaborating with local businesses, BRHD was able to reach 229 families. The classes are held during lunch hours and are held at the place of business.

Why hold the classes at the work site during the lunch period?

- It is easy and convenient to attend. Parents do not have to spend another evening away from their youth to attend the class.
- Builds networks for support and encouragement between co-workers.
- Is offered free of charge as a company benefit. Not only do parents get the information they want and need, but they also feel the company cares about them and their families.
- Does not interrupt the business day by distracting from the work time.

In the spring of 2008, *Family Works* was evaluated by Utah State University. Results showed that parents attending the classes had a decrease in family conflict, an increase in bonding between parent and child, and better stress management skills. After attending the *Family Works* classes, parents showed a less favorable attitude towards drug use. The results were favorable enough to submit for publication in the American Journal of Health Education.



Substance Abuse Treatment

The Parents Empowered Prevention Team met on a weekly basis to develop new plans with a goal of eliminating underage drinking in Utah through a successful creative mass media campaign.

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 both changed, and these changes have resulted in clients with a wider and more difficult array of issues. In response to these changes, the treatment field has developed a variety of evidence-based interventions to effectively address the needs of the clients presenting for treatment.

Treatment Services Are On A Continuum

Addiction is a complex interaction of biological, social, genetic, and environmental factors. Given these multiple influences, there is no one treatment approach or intensity of care that is appropriate for everyone. Treatment should be research-based and

individualized to meet the needs of those entering treatment. In Utah, treatment services range from early intervention to long term opioid replacement treatment therapies. Clients are matched to the level and type of treatment that is most appropriate for them.

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

Treatment Challenges and the Division of Substance Abuse and Mental Health's (DSAMH) Response

Today, there are significant challenges facing the treatment system in Utah. Shrinking resources and competing demands; changing requirements for treatment staff qualification; increasing demand for outcomes to demonstrate our program's effectiveness; continued stigma and prejudice towards



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

Function	Prevention/Intervention			Treatment		
Program Level	Universal	Selected	Indicated	Outpatient	Intensive Outpatient	Residential
Appropriate for	<ul style="list-style-type: none"> General Population 	<ul style="list-style-type: none"> At Risk 	<ul style="list-style-type: none"> Using but does not meet DSM IV Diagnostic Criteria 	<ul style="list-style-type: none"> DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Serious Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Severe Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence
Identification Process	<ul style="list-style-type: none"> General Interests 	<ul style="list-style-type: none"> Referral 	<ul style="list-style-type: none"> SA Screening 	<ul style="list-style-type: none"> ASI 	<ul style="list-style-type: none"> ASI 	<ul style="list-style-type: none"> ASI
Populations	<ul style="list-style-type: none"> K-12 Students General Population 	<ul style="list-style-type: none"> School Drop-outs, Truants, Children of Alcoholics, etc. 	<ul style="list-style-type: none"> DUI Convictions, Drug Possession Charges, etc. 	<ul style="list-style-type: none"> Appropriate for general population, Criminal Justice referrals including DUI when problem identified. Women and Children, Adolescents, poly drug abusers, Methamphetamine addicted, alcoholics, etc. 		
Program Methods	<ul style="list-style-type: none"> Risk Protective Factor Model Prevention Dimensions Red Ribbon Week 	<ul style="list-style-type: none"> Risk Protective Factor Model 	<ul style="list-style-type: none"> Risk Protective Factor Model Education Intervention Program 	<ul style="list-style-type: none"> Evidenced Based, Preferred Practices, ASAM Patient Placement Criteria 		

the substance using populations; and the need to move from our traditional treatment methods to more evidenced based practices are all daunting issues that the treatment community must face.

In response to the challenges listed above, DSAMH focused on several areas during fiscal year 2008.

Increased Focus on Training: Due to the need for improved staff training, DSAMH worked to expand its training efforts across the spectrum. DSAMH sponsored the statewide Drug Court Conference, the University of Utah's School on Alcoholism and Other Drugs, Fall Substance Abuse Conference, numerous trainings at local authorities on specific treatment issues, and special training events scheduled through our collaborative committees. Of special note has been the emphasis on improving clinical supervision through involvement with the Mountain West Region's Addiction Technology Transfer Center's (ATTC) Clinical Supervision courses.

Emphasis on Evidenced Based Practices: Because of the varied nature of the local authorities, DSAMH has not mandated any one preferred practice to be used across the State. However, DSAMH has encouraged the local authorities to add evidenced based practices that "make sense" in their area. "Motivational interviewing"; "medication assisted therapies" using vivitrol, suboxone, and methadone; "matrix model" intensive outpatient programs; "A Woman's Path to Recovery"; "Moral Reconciliation Therapy"; "Contingency Management"; and "Seeking Safety" have all been implemented in at least one area of the State.

Implementations of New Standards: This year DSAMH established a new and more challenging set of criteria for Drug Courts and adolescent treatment. In cooperation with the Administrative Office of the Courts and the Department of Corrections, DSAMH used a contract proposal process that significantly

shifted the focus of the State's Drug Courts based on the most current research.

Adolescent treatment standards were also updated, based on research presented at the Fall Substance Abuse Conference.

Improved Use of ASAM Placement Criteria and Individualized Treatment Planning: DSAMH mandated the use of the American Society of Addiction Medicine's Patient Placement Criteria, 2nd revision (ASAM PPC 2R) in 2003. This year it has worked to expand use of the client centered treatment planning and individualized treatment process that the ASAM PPC 2R facilitates. This expansion challenges the local authorities to move past a "program" mind set into a more "individualized" treatment approach.

Expansion of Recovery Support Services: Research shows that addiction is a long-term chronic disease and therefore treatment must be long term and based on a continuing care model. The need for linkage to long term aftercare, self help groups, ongoing monitoring and routine "recovery check ups" has become all too apparent. DSAMH will continue to identify ways to facilitate this shift in treatment focus. The initial support and funding of Utah's Support Advocates for Recovery Awareness (USARA) (formerly Substance Abuse Recovery Alliance, SARA), has been one method DSAMH has used to expand the support available for people in recovery from substance abuse disorders.

Expanded collaboration and cooperation with providers: During the past year DSAMH has worked to expand its collaboration and cooperation with various provider networks. Through chairing the Opioid Treatment Provider's Committee, the Women's Treatment Provider's Network, and the Drug Offender's Reform Act (DORA) working group, DSAMH has worked to improve communication with treatment providers across the state.

Increased focus on Co-occurring Disorders:

In fiscal year 2008, DSAMH increased the focus on the treatment of clients with co-occurring disorders. During monitoring visits to the local authorities, the effectiveness of the mental health and substance abuse system in treating clients with co-occurring disorders has been a key area of interest. This assessment of our current status will be used to guide us in future planning and training activities.

Focus on Outcomes: Collection of Treatment Episode Data Set and National Outcome Measures data is very important to DSAMH. The data is used to guide our treatment decisions. DSAMH has published a Substance Abuse Treatment Outcomes Scorecard for the past four years. This year we have developed Women's and Adolescent Treatment Scorecards. DSAMH will use these tools to better inform consumers.

Utahns in Need of Substance Abuse Treatment

The results of the 2005 State Substance Abuse Treatment Needs Assessment Survey and the 2007 Student Health and Risk Prevention (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 17,684 individuals, or less than 19% of the current need.

- A combined total of approximately 98,005 adults and youth are in need of, but not receiving, substance abuse treatment services.

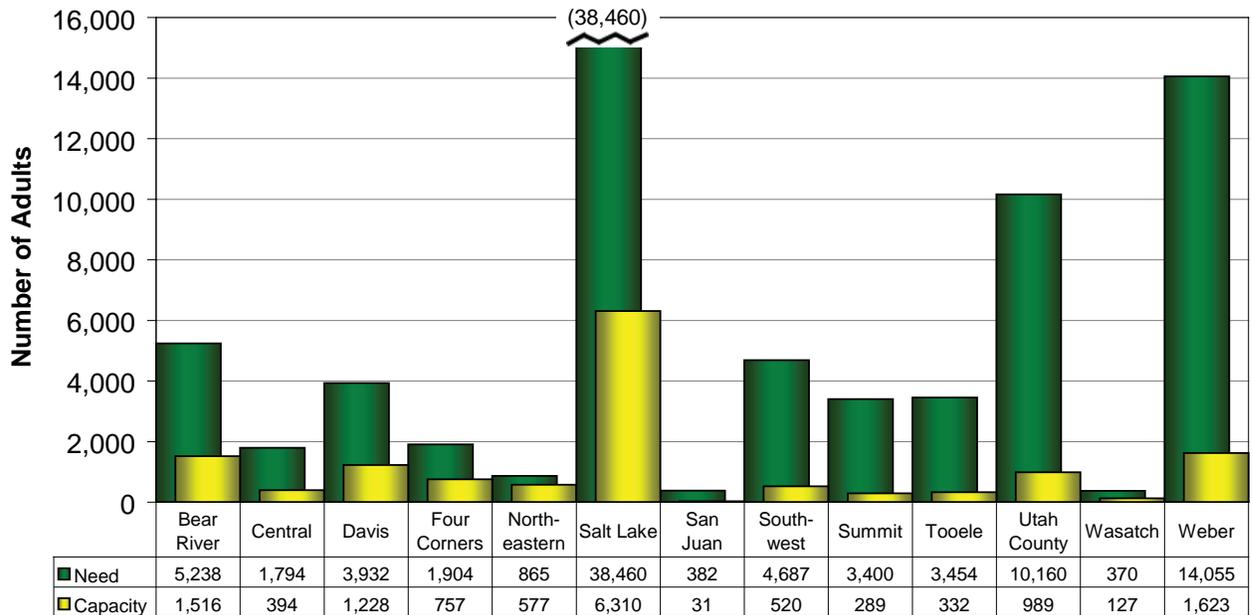
The percentage of adults and youth needing treatment by service area varies considerably. This reflects the unique challenges faced by each local authority. The following table demonstrates the actual number of adults and youth who need treatment, by area. The current capacity of each area, or the number who were actually served in fiscal year 2008, is included to illustrate the unmet need. The same data is depicted on the following graphs.

Treatment Needs vs. Treatment Capacity

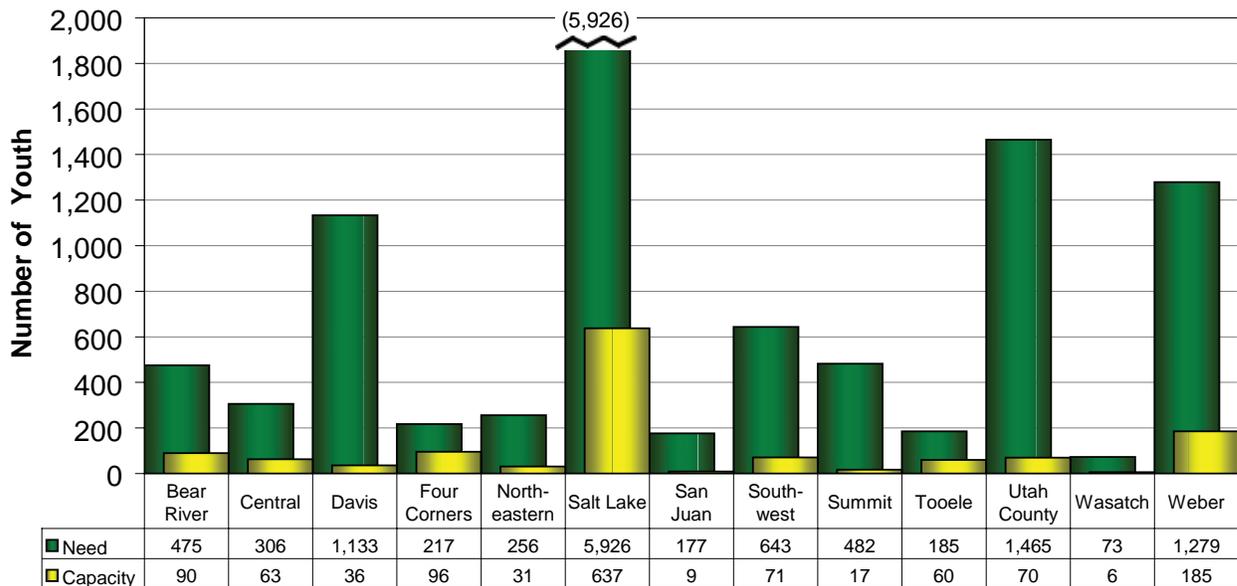
	Adults (18 years+)			Youth (12-17)		
	% Need Treatment	Need	Capacity	% Need Treatment	Need	Capacity
Bear River	4.8%	5,238	1,516	3.4%	475	90
Central	3.7%	1,794	394	4.0%	306	63
Davis	2.1%	3,932	1,228	3.9%	1,133	36
Four Corners	6.6%	1,904	757	5.8%	217	96
Northeastern	2.7%	865	577	5.5%	256	31
Salt Lake	5.4%	38,460	6,310	6.7%	5,926	637
San Juan	3.9%	382	31	9.5%	177	9
Southwest	3.4%	4,687	520	4.0%	643	71
Summit	12.9%	3,400	289	14.6%	482	17
Tooele	9.5%	3,454	332	3.4%	185	60
Utah County	3.2%	10,160	989	3.2%	1,465	70
Wasatch	2.6%	370	127	3.7%	73	6
Weber	8.7%	14,055	1,623	6.2%	1,279	185
State Totals*	4.7%	85,614	16,320	5.1%	12,391	1,364

*because of rounding in the percentages, duplication of clients across Local Substance Abuse Authorities (LSAA) and a small number of clients served in non-local authority contracts, LSAA's totals do not add to 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



Source of Data

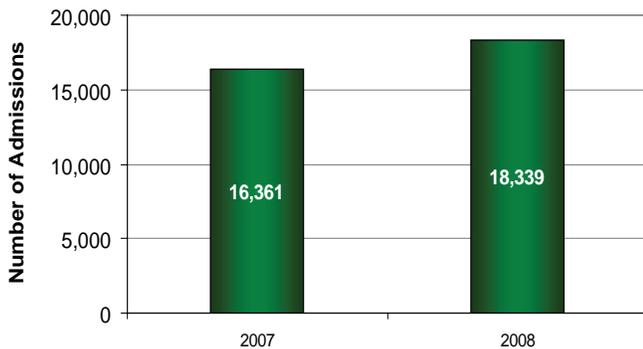
The Federal government requires each state to collect demographic and treatment data on all clients admitted into any publicly-funded substance abuse treatment facility. This data is called the Treatment Episode Data Set (TEDS). TEDS is the source DSAMH uses to identify treatment admission numbers and characteristics of clients entering treatment. Local Substance Abuse Authorities (LSAAs) submit this data quarterly. TEDS has been collected each year

since 1991. Unless otherwise stated, the data in the following charts is derived from this source.

Number of Treatment Admissions

While data has been collected over the past decade, in 2008 DSAMH adopted a more accurate reporting criteria for treatment admissions. Due to the new reporting criteria, trend data for admissions is only available from 2007 forward.

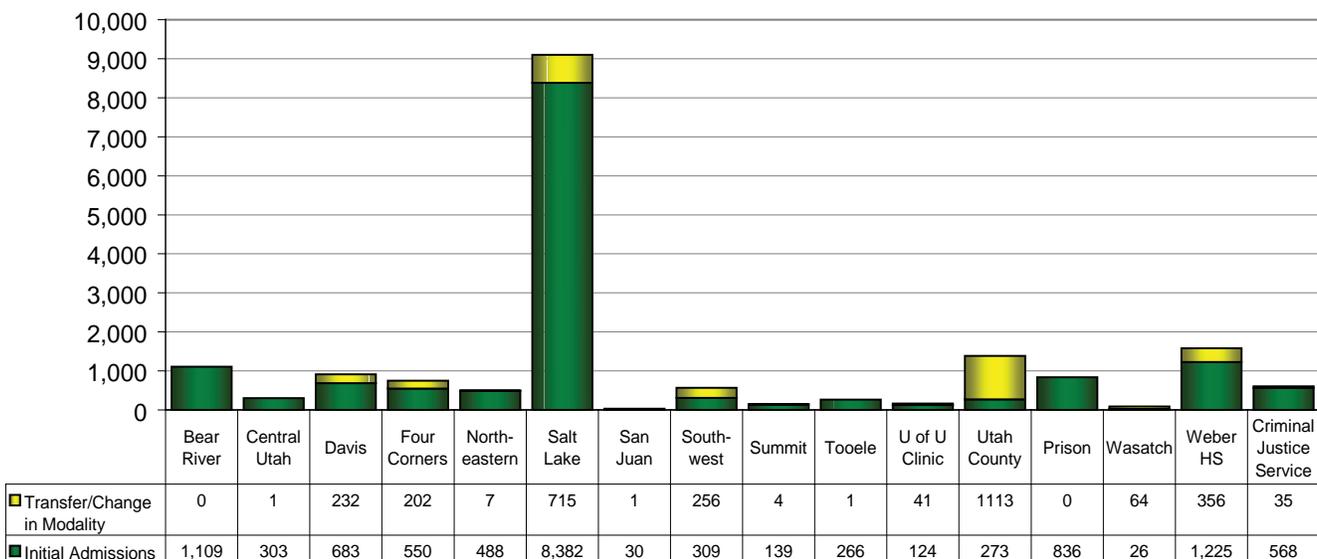
Substance Abuse Initial and Transfer Admissions into Modalities
Fiscal Years 2007 to 2008



The first chart below shows that the number of treatment admissions in fiscal year 2008 increased by 1,978, or 12% over fiscal year 2007.

The second chart shows the number of admissions and transfers to each local authority, the University of Utah Clinic and the Utah State Prison in fiscal year 2008. Treatment admissions in Salt Lake County continue to account for approximately 46% of all treatment admissions.

Substance Abuse Treatment Admissions and Transfers in Utah by Local Authority Area
Fiscal Year 2008

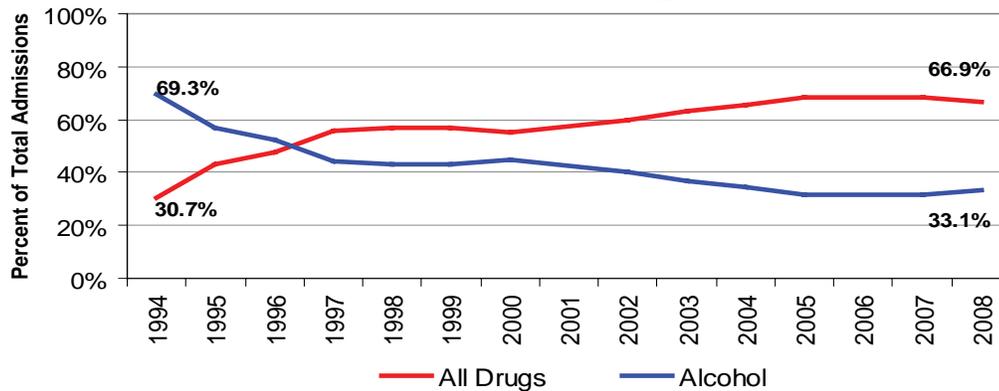


Primary Substance of Abuse

Trend data are invaluable in monitoring changing patterns of substance abuse treatment admissions. These patterns reflect underlying changes in substance abuse across the treatment population, and have important implications for resource allocation and program planning.

Since 1994, treatment admissions for alcohol have steadily declined while admissions for other drugs of abuse have increased. Today we see admissions for all other drugs at a rate comparable to admission rates for alcohol in 1994 and admissions for alcohol comparable to those for other drugs in 1994.

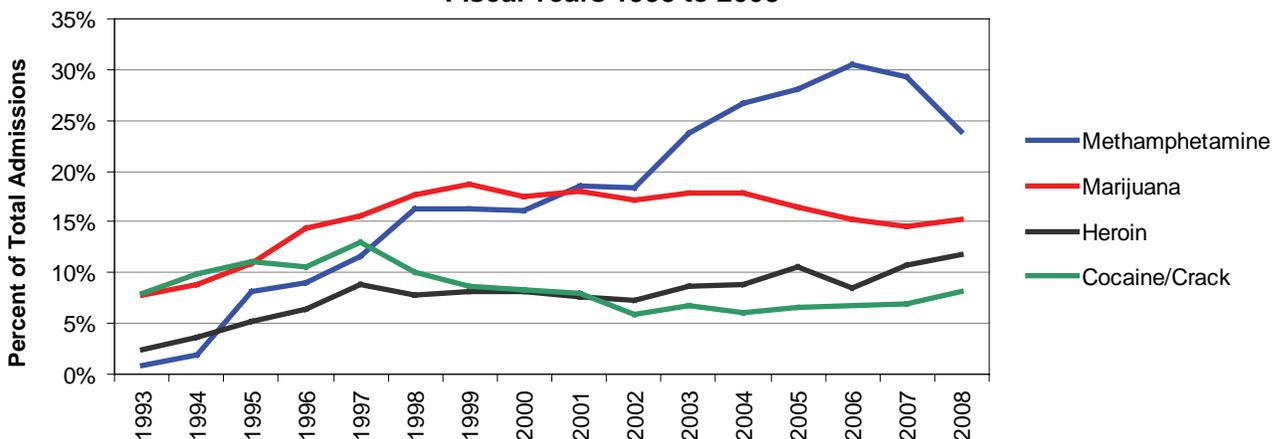
**Patient Admissions for Alcohol vs. Drug Dependence
Fiscal Years 1994 to 2008**



In 2008, 66.9% of treatment admissions were related to drug use. Of those admissions, the top four drugs of choice were methamphetamine, marijuana, heroin, and cocaine/crack respectively. While methamphetamine continues to be the most common drug of choice in treatment admissions for drug use, the number of admissions for meth-

amphetamine has dropped significantly over the past two years. Utah has made a concerted effort to target methamphetamine use through statewide campaigns such as “End Meth Now” and the Meth Task Force. These initiatives helped play a part in reducing the number of treatment admissions for methamphetamines.

**Top Four Illicit Drugs of Choice by Year (Excluding Alcohol)
Fiscal Years 1993 to 2008**



A number of studies indicate women are less likely to enter treatment than men. Utah’s data reflects this, showing approximately 1/3 of treatment admissions in 2008 were women. Other differences include drugs of choice. While men report their primary drug of choice is alcohol, women are more likely to enter treatment for methamphetamine use. Women in Utah are also more likely to admit

to treatment for prescription drug use than men. Approximately 11.5% of women reported their primary drug of choice as a prescription based substance in contrast to men who reported it in 5% of cases. Utah treatment providers have responded to these gender differences by offering gender specific treatment curriculum targeted to address specific needs for women and men.

**Primary Substance by Gender
Fiscal Year 2008**

	Male	Male %	Female	Female %	Total
Alcohol	4,595	37.9%	1,482	23.8%	6,077
Cocaine/Crack	995	8.2%	504	8.1%	1,499
Marijuana/Hashish	2,099	17.3%	696	11.2%	2,795
Heroin	1,461	12.1%	687	11.0%	2,148
Other Opiates/Synthetics	209	1.7%	269	4.3%	478
Hallucinogens	16	0.1%	6	0.1%	22
Methamphetamine	2,293	18.9%	2,098	33.7%	4,391
Other Stimulants	31	0.3%	32	0.5%	63
Benzodiazepines	24	0.2%	41	0.7%	65
Tranquilizers/Sedatives	4	0.0%	18	0.3%	22
Inhalants	15	0.1%	9	0.1%	24
Oxycodone/Hydrocodone	356	2.9%	356	5.7%	712
Club Drugs	8	0.1%	7	0.1%	15
Over-the-Counter	3	0.0%	6	0.1%	9
Other	10	0.1%	7	0.1%	17
Unknown	2	0.0%	0	0.0%	2
Total:	12,121	100.0%	6,218	100.0%	18,339

Age plays a significant role in drug use preference. While alcohol is the substance of choice for individuals 35 and older, marijuana is preferred among adolescents, and methamphetamine is the

preference for those ages 25-34. Understanding drug use preference among age groups assists treatment providers in targeting interventions towards those drugs of choice.

**Primary Substance of Abuse by Age Grouping
Fiscal Year 2008**

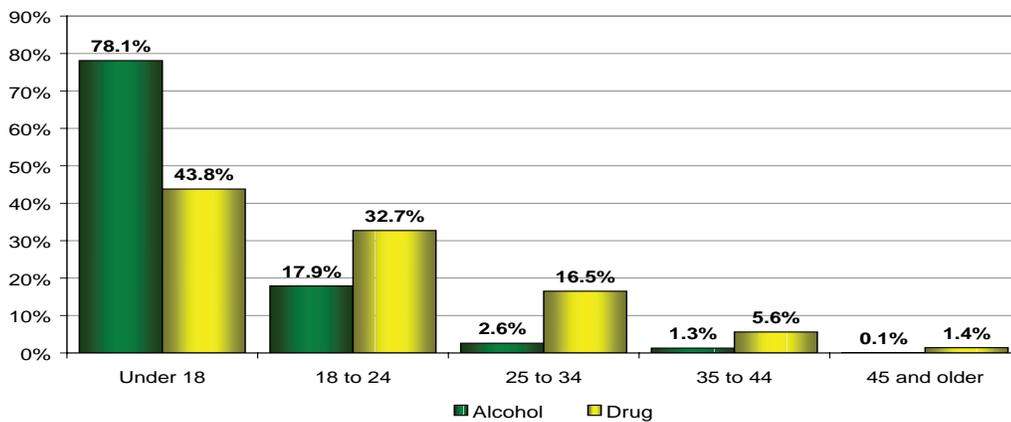
	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	329	1,038	1,479	1,401	1,791	0	6,038
Cocaine/Crack	8	226	411	487	365	39	1,536
Marijuana/Hashish	826	1,005	592	209	163	2	2,797
Heroin	18	682	724	369	351	0	2,144
Other Opiates/Synthetics	3	88	210	91	85	4	481
Hallucinogens	0	10	6	3	3	1	23
Methamphetamine	23	862	1,930	1,082	493	0	4,390
Other Stimulants	0	19	24	9	10	1	63
Benzodiazepines	1	13	28	13	9	1	65
Tranquilizers/Sedatives	1	0	13	2	5	1	22
Inhalants	9	9	4	2	0	1	25
Oxycodone/Hydrocodone	4	150	363	111	81	0	709
Club Drugs	1	9	3	0	2	3	18
Over-the-Counter	1	1	1	3	3	0	9
Other	3	4	4	1	5	0	17
Unknown	0	0	1	0	1	0	2
Total:	1,227	4,116	5,793	3,783	3,367	53	18,339

Age of First Use of Alcohol or Other Drug

Knowledge about early onset of substance use or abuse can help target prevention and intervention services. Understanding age of first use can also assist treatment providers develop effective wellness strategies for their clients.

Of the individuals who admitted to treatment in 2008, and identified alcohol as their substance of choice, 78% report they began using alcohol prior to the age of 18. Individuals seeking treatment primarily for drug use typically begin their drug use at a later age with 77% reported first using substances under the age of 25.

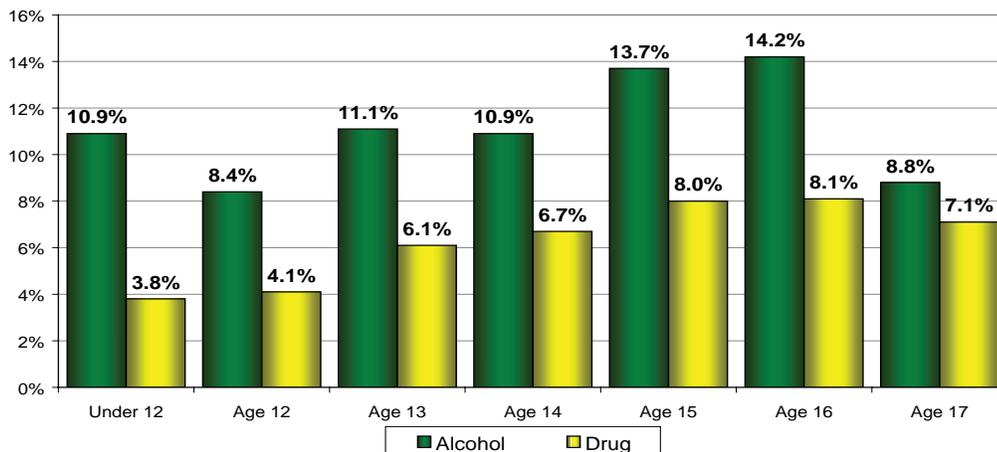
**Age of First Use of Primary Substance of Abuse
Fiscal Year 2008**



Of the individuals who reported using their primary substance under the age of 18, the following chart further breaks down age of first use. For

alcohol, age of first use peaks at age 16 and for other drugs age of first use occurs between 15 and 16 years old.

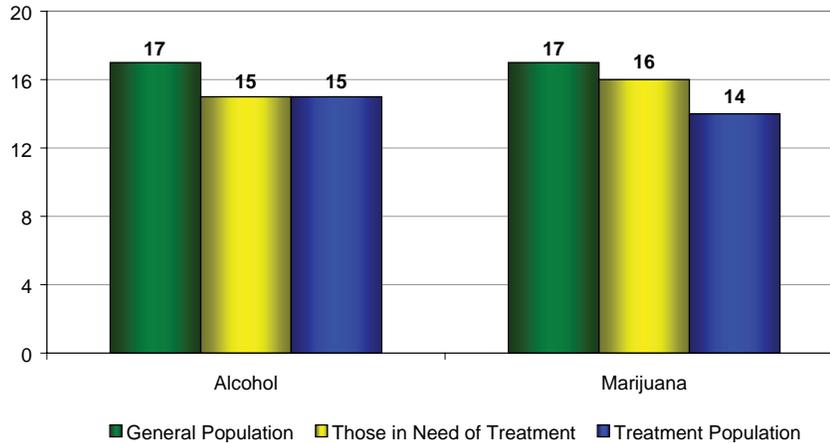
**Age of First Use of Primary Substance - Under 18
Fiscal Year 2008**



As this graph indicates, the age of first use for alcohol and marijuana 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**



Multiple Drug Use

Using more than one drug places the client at greater risk for negative drug interactions, overdoses, psychiatric problems, and complications during the treatment process. 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 40.9% across the State, ranging from 13.3% in Summit County to 80.9% in Utah County. Close examination shows that the more urban counties (Salt Lake including Criminal Justice Services, Utah, Davis, and Weber) generally have much higher rates of multiple drug use, comprising 88.2% of the total admissions for multiple drug use to the local authorities. Tracking multiple drug use admissions helps providers tailor their treatment to the needs specific to multiple drug users.

Multiple Drug Use Fiscal Year 2008

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	198	17.9%
Central Utah	60	19.7%
Davis County	124	13.6%
Four Corners	188	25.0%
Northeastern	126	25.5%
Salt Lake County	3,436	37.8%
San Juan County	6	19.4%
Southwest Center	93	16.5%
Summit County	19	13.3%
Tooele County	63	23.6%
U of U Clinic	113	68.5%
Utah County	1,121	80.9%
Utah State Prison	621	74.3%
Wasatch County	53	58.9%
Weber HS	1,040	65.8%
Criminal Justice Services	240	39.8%
Total:	7,501	40.9%

Injecting Drug Use

Injecting drug users are a priority population to receive substance abuse treatment due to many related health risks. Their method of use puts them at greater risk of contracting and transmitting HIV/AIDS, tuberculosis, and hepatitis B and C. This table indicates the number of clients who report intravenous needle use as the primary route of administration for any reported drug use in the past year. A total of 3,347 clients requesting services through the public treatment system reported IV drug use as their primary route of administration, a decrease from 2007. Salt Lake County reported the highest number of IV drug users at 1,920 while the Utah State Prison reports the highest percentage at 39.4%. As with multiple drug use, the preponderance of the IV drug use (88.6%) is found in the more urban counties. Tracking trends in injecting drug use assists in allocating and programming resources for this priority population.

Patients Reporting IV Injecting Drug Use at Admission Fiscal Year 2008

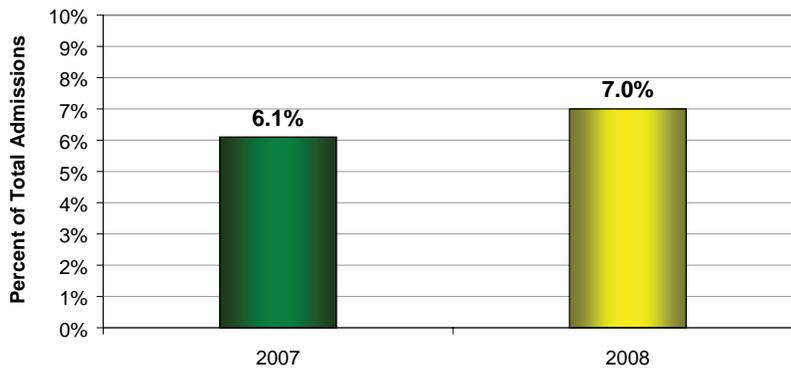
	# Reporting Injecting Drug Use at Admission	% of Total Admissions for Each Area
Bear River	31	2.8%
Central Utah	18	5.9%
Davis County	212	23.2%
Four Corners	55	7.3%
Northeastern	38	7.7%
Salt Lake County	1,920	21.1%
San Juan County	0	0.0%
Southwest Center	67	11.9%
Summit County	3	2.1%
Tooele County	17	6.4%
U of U Clinic	43	26.1%
Utah County	321	23.2%
Utah State Prison	329	39.4%
Wasatch County	5	5.6%
Weber HS	183	11.6%
Criminal Justice Services	105	17.4%
Total:	3,347	18.3%

Prescription Drug Abuse

Admissions to the public treatment system for prescription drug abuse have risen for the past two years. Admissions for prescription drug abuse rose from 5.0% in 2006 to 7.0% in 2008, a 40% increase. While the numbers remain

relatively low, the rate of increase is concerning. This increase appears to be partially due to the increase in oxycodone/hydrocodone admissions, which rose from 2.2% in 2006 to 3.8% in 2008, a 42% increase.

**Admissions for Primary Drug—
Prescription Drugs
Fiscal Years 2007 - 2008**

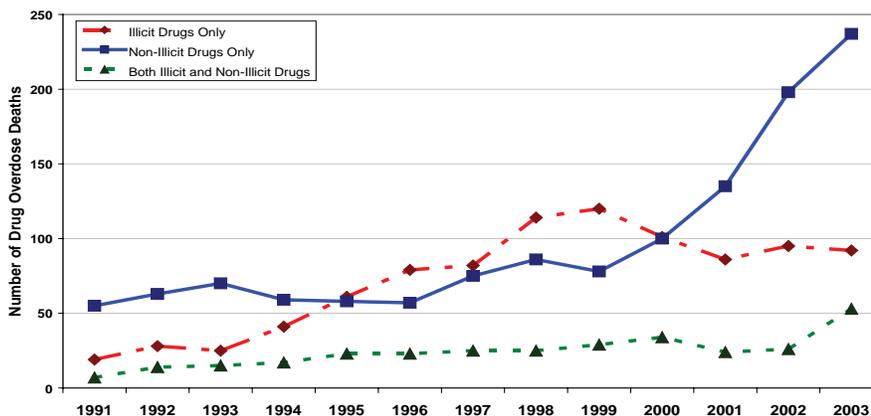


Of special concern is the high rate of prescription drug overdose deaths. In 2007, Utah had 317 deaths attributed to non-illicit drug overdoses, which is significantly higher than the national average in the non-medical use of pain relievers. In 2006, Utah was the second highest state in the nation for individuals over 26, and fourth highest for individuals over 12 in the non-medical use of pain relievers. DSAMH is working closely with

the Department of Health and other state and local agencies to address this problem.

As a part of this collaboration, one of the projects was to develop educational materials for the public to use spreading the message Prescription Pain Medicines “Use Only as Directed” which can be obtained by visiting www.useonlyasdirected.org.

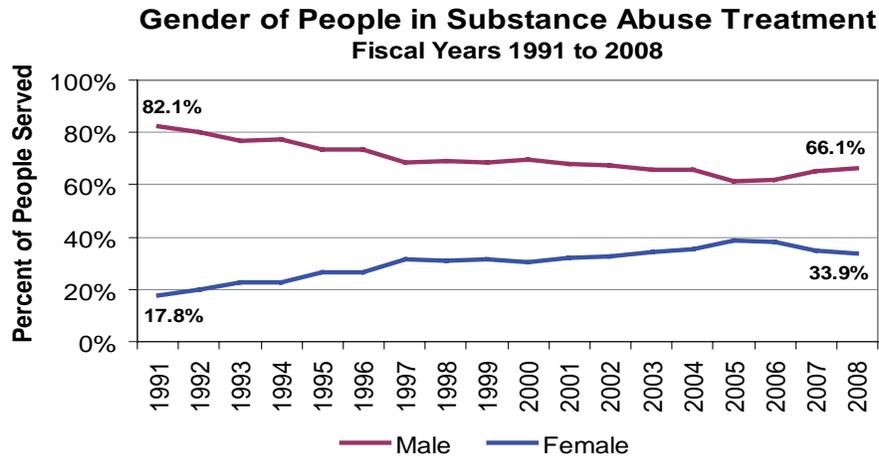
**Number of Drug Poisoning Deaths
by Drug Category and Year
Utah 1991-2003**



Admissions to Treatment By Gender

The table below shows the percentages of admissions by gender. There was a steady increase in the number of admissions for women from 1998 through 2005, and an 11.7% reduction from 2005 to the present. Treatment admission data shows a

steady decrease of methamphetamine use among women (41% in 2006, 39.2% in 2007 and 33.7% in 2008) which may help explain the decrease of female admissions.



Pregnant Women in Treatment

Pregnancy and information regarding current prenatal care, if applicable, is collected on all female clients entering the public treatment system. In fiscal year 2008, 5.4% of the women entering treatment (336 women) were pregnant at the time of their admission. This information aids providers 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. State and Federal statutes require treatment providers to admit pregnant women into

care within 14 days of their first contact with the treatment provider.

**Pregnancy at Admission
Fiscal Year 2008**

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	318	14	4.4%
Central Utah	112	10	8.9%
Davis County	338	12	3.6%
Four Corners	266	10	3.8%
Northeastern	180	6	3.3%
Salt Lake County	2,803	170	6.1%
San Juan County	5	1	20.0%
Southwest Center	238	16	6.7%
Summit County	27	1	3.7%
Tooele County	86	5	5.8%
U of U Clinic	60	3	5.0%
Utah County	623	28	4.5%
Utah State Prison	241	7	2.9%
Wasatch County	30	3	10.0%
Weber Human Services	659	39	5.9%
Criminal Justice Services	232	11	4.7%
Total:	6,218	336	5.4%

Clients with Dependent Children

Substance use disorders seriously impact an individual’s physical, emotional, and social functioning. Not only does the individual with the substance use disorder suffer but those living with the individual also suffer. Typically, those 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. The percentage of adult clients with dependent children in Utah is 43%. The average number of dependent children per household is 2.16. In 2008, 16,320 individuals were treated in the public substance abuse system. Based on these figures over, 15,000 children in Utah have a parent receiving treatment services.

Research shows that women have increased need for treatment regarding relationships, sexual and physical abuse, vocational skills, networking, and parenting. They need longer treatment stays and more support with child care, transportation,

and case management services in order for their treatment to be successful. These requirements necessitate treatment programs to provide a comprehensive set of wrap around services. Appropriate treatment for adults with substance abuse disorders also includes the involvement 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.

Pregnant women and women with dependent children are priorities for the public treatment system. The Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires 20% to be set aside for Women’s Treatment, and the Utah Legislature has passed a special General Fund appropriation specifically for the treatment of women and their dependent children. DSAMH closely tracks the use of these special funds to ensure that quality treatment is provided to this priority population.

**Clients with Dependent Children
Fiscal Year 2008**

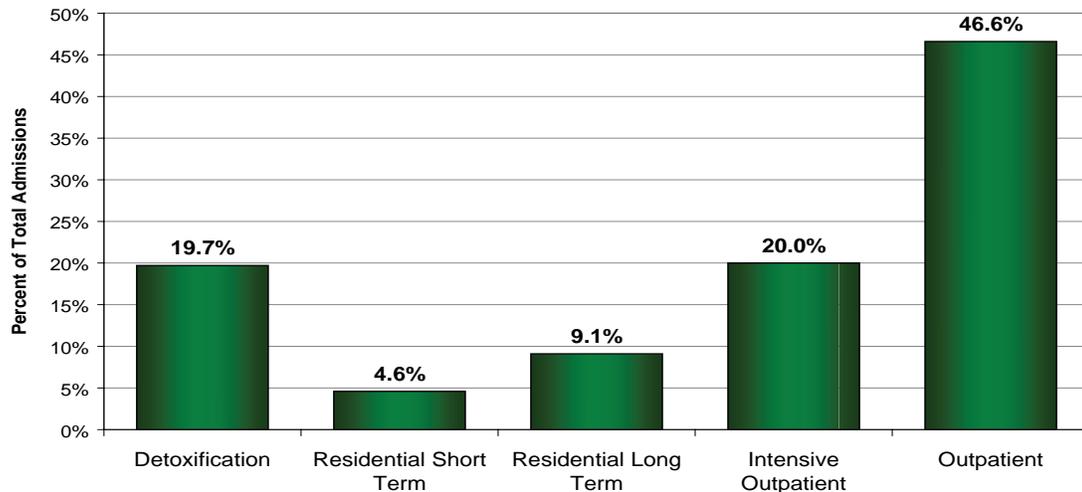
	Percent of all Patients with Children	Average Number of Children (of Patients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	33.5%	2.08	41.2%	2.12
Central Utah	48.8%	2.37	59.8%	2.54
Davis County	65.6%	2.38	78.3%	2.45
Four Corners	51.5%	2.34	63.2%	2.52
Northeastern	56.6%	2.49	71.0%	2.60
Salt Lake County	38.6%	2.08	54.7%	2.11
San Juan County	30.0%	2.22	75.0%	2.67
Southwest Center	53.0%	2.34	68.4%	2.48
Summit County	30.8%	1.89	40.7%	1.36
Tooele County	33.3%	1.97	36.0%	2.00
U of U Clinic	43.6%	2.00	55.0%	2.03
Utah County	54.3%	2.15	60.3%	2.18
Utah State Prison	34.9%	2.15	46.1%	2.17
Wasatch County	44.9%	2.29	55.6%	2.33
Weber Human Services	47.7%	2.19	63.4%	2.37
Criminal Justice Services	42.0%	1.91	52.2%	2.02
Total:	43.0%	2.16	58.4%	2.23

Service Type

The graph below represents the percent of admissions to each treatment level during fiscal year 2008. Almost half of all treatment admissions are to outpatient treatment. As individuals successfully complete more intensive levels of care,

such as detoxification, residential, and intensive outpatient they are often transitioned to outpatient treatment for monitoring and maintenance. This may help account for the high number of outpatient admissions.

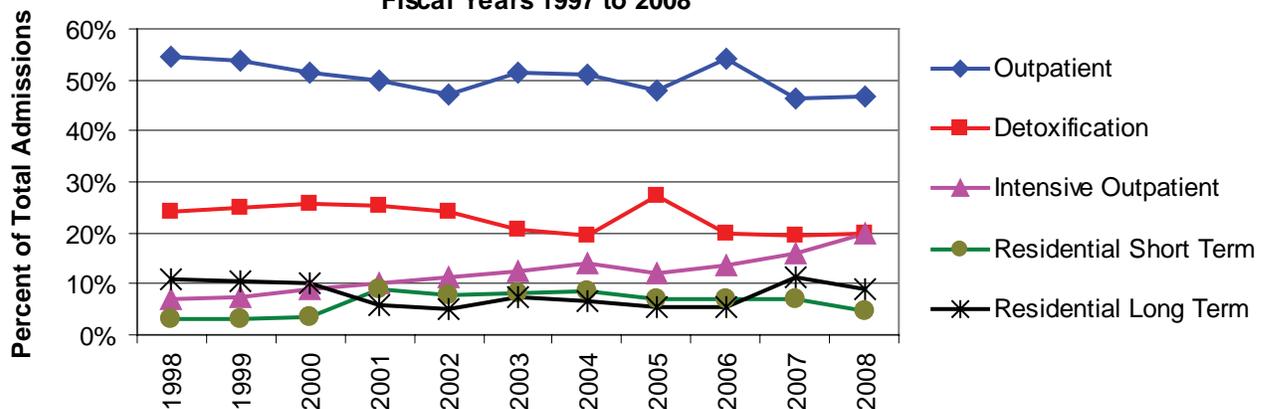
**Service Type at Admission
Fiscal Year 2008**



Admission to intensive outpatient treatment continues to rise as more providers are now offering this level of care. With residential services becoming more expensive, and substance use becoming

more severe, intensive outpatient treatment can be an effective and less costly alternative to residential and detox services.

**Trends in Service Types
Fiscal Years 1997 to 2008**



Treatment Outcomes

DSAMH collected final discharge data on over 9,192 non-detox clients in fiscal year 2008. These are clients who were discharged from treatment and were not re-admitted into any treatment within 30 days after discharge. This section includes data of clients who were discharged successfully (completed the objectives of their treatment plan), and of clients who were discharged unsuccessfully (left treatment against professional advice or were involuntarily discharged by the provider due to

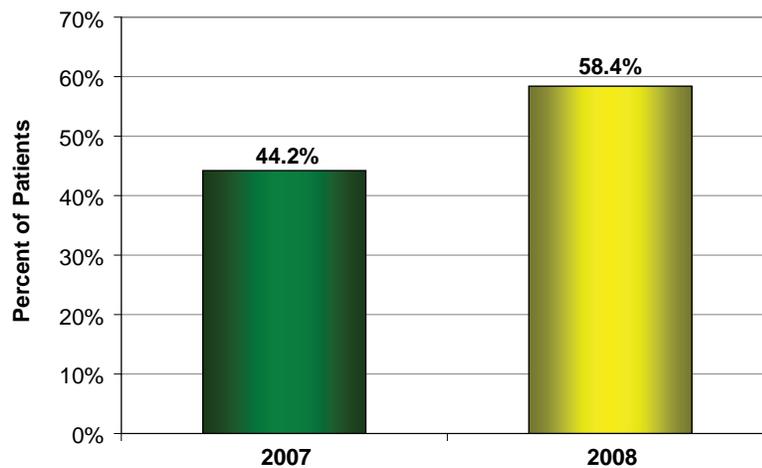
non-compliance). Clients who were discharged as a result of a transfer to another level of care are considered “successful.” The data does not include clients who were admitted only for detoxification services or who were receiving treatment from non-LSAA statewide providers. For all outcomes but treatment completion, numbers are based on complete treatment episode, rather than a single treatment modality.

Discharge

The following graph depicts the percentage of clients discharged in fiscal years 2007 and 2008 who successfully completed treatment. As you can see in 2008 there is a 14.2% increase in the number of clients successfully completing their treatment

objectives in the modality or being transferred to another level of care. The data from 2008 reverses a slightly downward trend in completion percentages from previous years.

Percentage of Clients Successfully Completing Treatment Modality
Fiscal Years 2007 - 2008

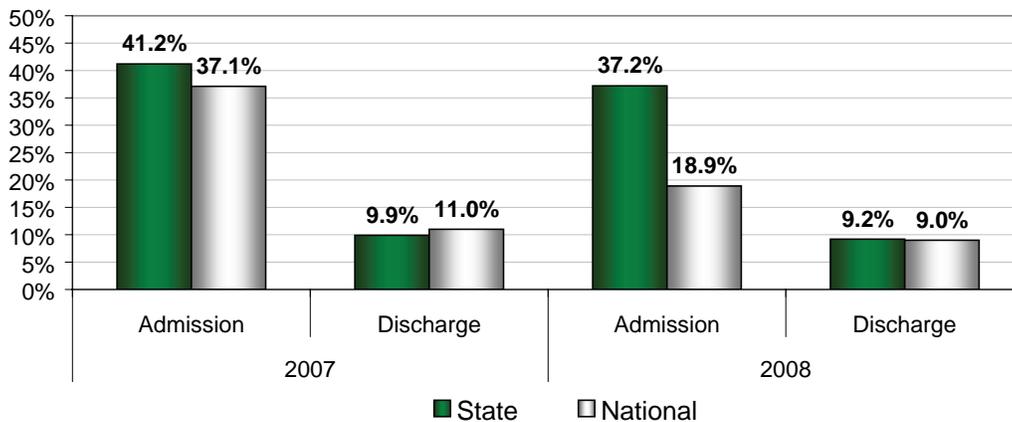


Criminal Activity

Criminal activity and substance abuse go hand in hand. Involvement in the criminal justice system is a factor that leads to many of our clients' entry into treatment. Therefore, reduction of criminal activity is a solid measurement of treatment effectiveness. Treatment in Utah continues to

result in significant decreases in criminal activity. In 2007 and 2008, Utah had higher criminal rates at admission than the national average, but the rates of criminal activity at discharge compare favorably to the national average.

**Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment
Fiscal Years 2007 - 2008**



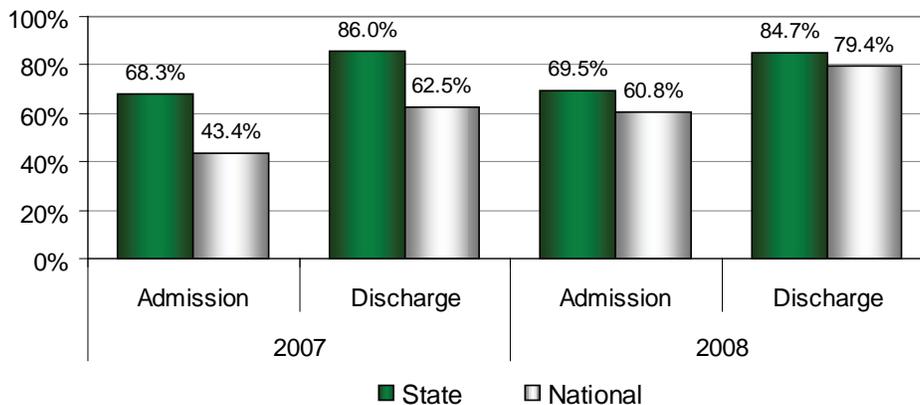
Changes in Abstinence from Drug and Alcohol Use During Treatment

The following charts show change in abstinence in alcohol and drug use 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.

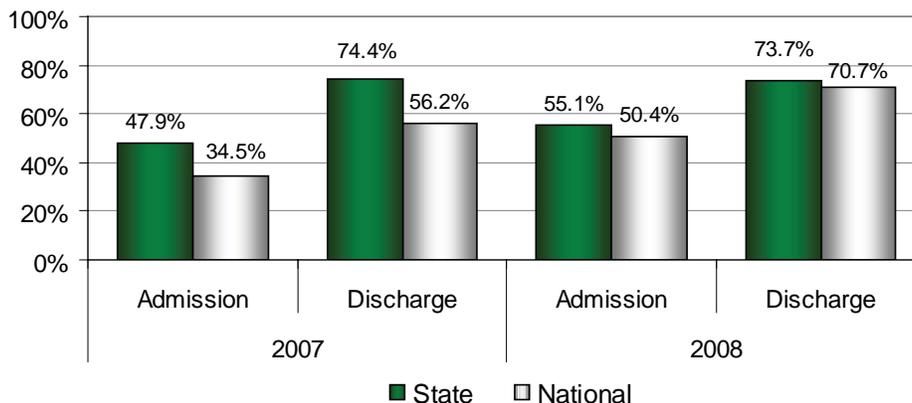
As expected, the rate of abstinence increases during treatment, with the rate of abstinence

from alcohol increasing 15.2% and abstinence from drug use increasing 18.2% over the course of treatment. Utah's rates of abstinence both at admission and at discharge are higher than the national averages, however, the national rates show a higher rate of increase. As demonstrated in these graphs, treatment is an effective tool for reducing substance use.

Percent of Clients Reporting Abstinence from Alcohol Use Prior to Admission vs. Abstinence at Discharge
Fiscal Years 2007 - 2008



Percent of Clients Reporting Abstinence from Drug Use Prior to Admission vs. Abstinence at Discharge
Fiscal Years 2007 - 2008



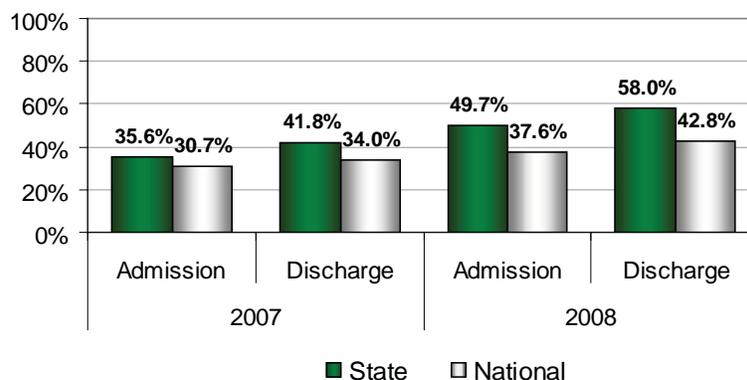
Employment and Living Arrangement

Employment

Employment is a key element for successful recovery. Research has consistently found that clients who are in school or are employed have much higher treatment success rates than those clients who are unemployed. Consequently, treatment providers work with clients to improve their

employability. As the chart shows, Utah continues to increase its lead over the national average for the percentage of clients who are employed or in school both at admission and at discharge. This is a significant area of improvement since 2005 when Utah trailed the national averages in those categories.

Percentage of Clients Who Are Employed
Fiscal Years 2007 - 2008

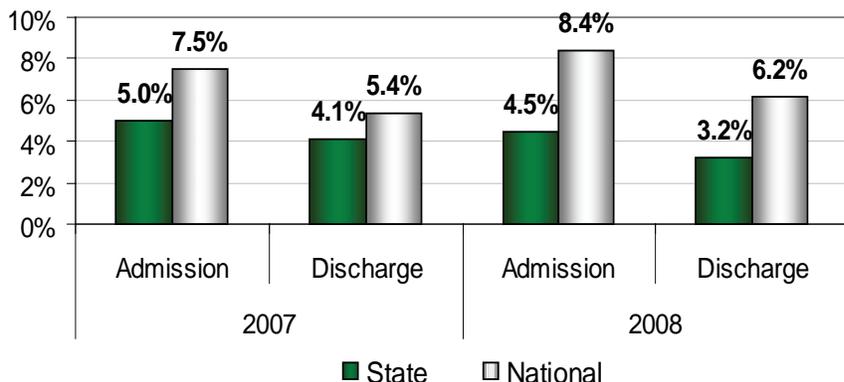


Homelessness

As shown in this chart, 4.5% of clients entering Utah's public substance abuse treatment in fiscal year 2008 were homeless at the time of their admission as compared to 8.4% nationally. At discharge, Utah's homeless rate was 3.2%, compared to the national average of 6.2%. While Utah's homelessness has decreased since 2007, the national averages increased in that same time. This decrease is encouraging, as it reverses a three year trend of increases in both admission and discharge. Reduction of homelessness is an important measure of successful treatment, as outcome studies have revealed that a stable living environment is a critical element in achieving long-term success in the reduction of substance abuse. At the same time,

research has demonstrated that treatment is an important factor in helping the substance abusing population maintain more stable living environments. Housing authorities and treatment facilities are working to find ways to deal with both issues simultaneously.

Percentage of Clients Who are Homeless
Fiscal Years 2007 - 2008



Justice Programs

Substance use and abuse has a significant impact on criminality in Utah. The Utah Department of Corrections reports approximately 70% of Utah's inmates have a drug or alcohol problem. Substance abuse treatment significantly reduces the likelihood that these offenders will commit new crimes; however, only about one third of those who need treatment are able to access it.

Research suggests that when substance abuse treatment and criminal justice personnel work closely together, the outcomes for substance abusing offenders are improved more so than with treatment or supervision alone. Through this coordinated effort substance abusing offenders commit fewer crimes than their counterparts, remain drug and alcohol free longer, become employed at a higher rate and give back to their communities at a higher rate than their counterparts who do not receive these coordinated efforts.

DSAMH and Utah's LSAAAs work closely with our criminal justice partners across the State to provide appropriate treatment services to these targeted individuals. The following is a description of activities and programs throughout Utah providing coordinated services to substance abusing offenders during fiscal year 2008.

Utah's Drug Courts and Drug Boards

Drug Courts and Drug Boards, through the coordinated effort of the judiciary, prosecution, legal defense, probation, law enforcement, social services and the treatment community, offer non-violent, drug abusing offenders intensive court-supervised drug treatment as an alternative to jail or prison. These intensive services are provided through coordination among the participating agencies to those individuals identified at high risk for recidivism and in high need of substance abuse treatment services. Successful completion of Drug Court results in dropped charges, vacated or reduced sentences, or rescinded probation.

Over the past 12 years, Utah's Drug Courts have increased from 2, in 1996, to over 32 operating statewide today. The Department of Human Services (DHS) through DSAMH, provides funding for 24 Drug Courts and 2 Drug Board Programs.

Drug Court Initiatives In Fiscal Year 2008:

In response to the increased number of Drug Courts, and research on Drug Court Effectiveness, Utah's Drug Courts have moved from targeting low risk offenders to more focused eligibility criteria on higher risk individuals. During the fall of 2007, the DSAMH and the Administrative Office of the Courts (AOC) sponsored a statewide Drug Court training. Key team members of each Drug Court across the State attended. During this conference, DSAMH and the AOC requested each Drug Court begin targeting those individuals whose substance abuse and criminal activity may be more serious and pose a greater threat to society.

During the spring of 2008, DSAMH, in coordination with the AOC, released a Request for Application (RFA) for all DHS Drug Court funding for fiscal year 2009. This RFA focused on Drug Court Adherence to best practices including: The 10 Key Components identified by the National Association of Drug Court Professionals for Felony Drug Courts, the Characteristics of Family/Dependency Drug Courts identified by the Center for Substance Abuse Treatment, Bureau of Justice Assistance for Family Dependency Drug Courts, and the Strategies used by a Juvenile (Youth) Drug Court identified by the Bureau of Justice Assistance for Juvenile Drug Courts.

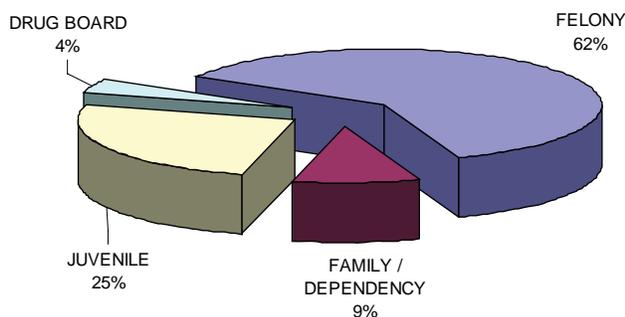
In Fiscal Year 2008 Utah's Drug Courts Show:

- 64% of participants graduated from Drug Court compared to approximately 39% of the general treatment population who completed treatment
- Utah's Drug Courts increased employment rates from admission to discharge

by 19% which is above the national average of a 14% increase

- Utah's Drug Courts decreased the number of participants using drugs, from admission to discharge, by 58% compared to the national average of 40%
- Utah's Drug Courts decreased the number of participants who were arrested from admission to discharge by 72% compared to the national average of 52%

Clients Served by Court Type Fiscal Year 2008



Utah's Drug Offender Reform Act (DORA)

The Drug Offender Reform Act (DORA) is an innovative and collaborative approach to sentencing, treatment, supervision, and re-entry of drug offenders in Utah. The purpose of DORA is to provide for the screening, assessment and, if warranted, treatment of drug offenders. It additionally provides for an increased level of community supervision provided by Adult Probation and Parole (AP&P).

DORA was developed on the following premise: Smarter Sentencing + Smarter Treatment = Better Outcomes and Safer Neighborhoods.

During the 2007 Legislative Session, S.B. 50 was entered and passed. This legislation provided for the statewide implementation of DORA and appropriated \$8 million total for the program in fiscal year 2008. Of that, \$4,850,000 was allocated for substance abuse treatment for qualifying of-

fenders. During fiscal year 2008, a total of 1,367 assessments were completed by local authorities and 845 clients were served in treatment. For further detail on the DORA program see page 6 of this report.

Local Responses to Substance Abusing Offenders

Utah Code Ann. §17-43-201 requires LSAA's to include provisions for services, either directly or by contract, for adults, youth, and children (including those incarcerated in a county jail or other county correctional facility). Each year DSAMH requires each LSAA to submit a plan for providing these services in their counties.

Across Utah, LSAA's provide for coordinated assessment and treatment of substance abusing offenders during their incarceration in local county jails. Assessments and/or crisis services are available to county jails across the State. Regular groups focused on substance abuse education are held for inmates by 7 of the 13 LSAA's. Additionally, in Salt Lake County, Weber County, and Davis County intensive substance abuse treatment services are offered to offenders in county jails.

Treatment in the Prison

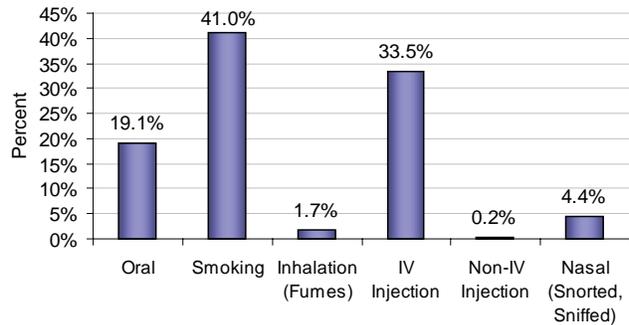
Since 1983, DSAMH has provided funding for substance abuse treatment within the prison setting utilizing a Therapeutic Community (TC) Model. In 2008, the Utah Department of Corrections reported 836 admissions to the TCs funded by DSAMH. Of those admissions 47% reported methamphetamine as their drug of choice. Admission records show that 89% of offenders treated in the TCs reported using substances on a daily basis in the 30 days prior to their incarceration, with 34% reporting intravenous needle use as their typical route of administration.

The primary goal of a TC is to foster individual change and positive growth. This is accomplished by changing an individual's life style through a community of concerned people working together to help themselves and each other. Being part

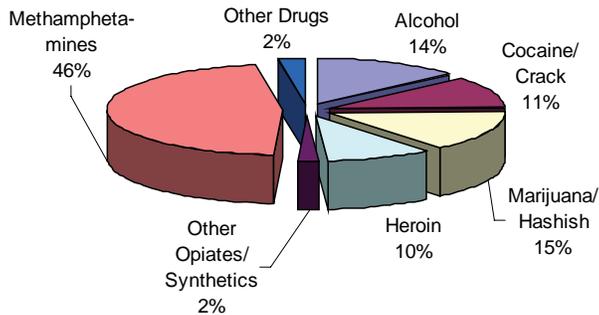
of something greater than oneself is an especially important factor in facilitating positive growth.

Offenders who participate in TCs typically began their drug abuse, criminality, and incarceration as teens; have dysfunctional, abusive, and criminogenic families; have little formal education; have inadequate work skills and experience; do not “buy in” to mainstream morality; and have few skills and resources with which to take responsibility for their lives and those of their children. TCs act to habilitate offenders, providing them not only with substance abuse treatment but also

**Route of Administration
Primary Substance**
Fiscal Year 2008



**Primary Substance Prison
TC Admissions**
Fiscal Year 2008



with skills to go back into the community at large as a productive member of society. Research shows that offenders who participate in TCs stay in the community, without re-offending, longer than those who do not participate in TCs. It also shows that fewer return to state custody after participating in a TC than those who do not participate in TCs.

Recovery Day

Utah's Annual Recovery Day "Real Voices, Real People" was held on September 20th, 2008 at the Gallivan Center in Salt Lake City. This event is held every September in conjunction with the National Alcohol and Drug Addiction Month. This 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.

This event provided members of the recovery community, their friends, families, and allies an opportunity to put a face to recovery from substance abuse and to motivate other Utahns to seek help.



The day started with a 5K "Run for Recovery" hosted by the Utah Support Advocates for Recovery Awareness (USARA). Over 100 individuals participated in the race. Beginning at the Gallivan Center, runners made their way to Memory Grove and returned back down State Street to the Gallivan Center. Local rock bands Nazty Habit, Al and the Aces, and acoustic wonder John Connors provided music and entertainment during the event. This year was the largest turnout ever for Recovery Day with an estimated 1,300 people in



attendance. Other activities included children's crafts, games, prizes, giveaways, family activities, and free food.

In addition, 65 exhibitors from community organizations, groups, and treatment providers set up displays and distributed information regarding their programming. Salt Lake County Mayor Peter Coroon (shown above) spoke to the crowd as did members of USARA during the day. The Sober Riders rode their motorcycles in a mini-parade to show support for recovery.

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





Mental Health

On May 03, 2007, *USA Today* reported that adults with serious mental illness who are treated in the public mental health systems die about 25 years earlier than Americans overall. In August 2008, DSAMH sponsored a one-day training featuring Dr. Joseph Parks, a lead researcher of the study. Over 200 public and private health providers from across Utah attended the training.

Mental Health Treatment

System Overview

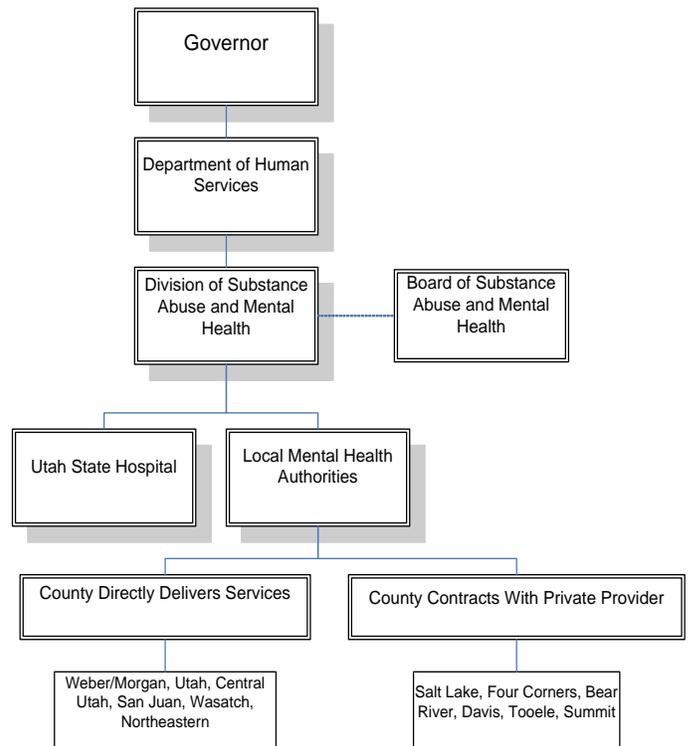
State Division of Substance Abuse and Mental Health (DSAMH)

DSAMH is authorized under Utah State Code Annotated §62A-15-103 as the substance abuse and mental health authority for the State. As the statewide mental health authority, 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 (generally the governing body of a county) is given the responsibility to provide mental health services to their citizens. They do this under the policy direction of the State Board of Substance Abuse and Mental Health and under the administrative direction of DSAMH.

If a local authority contracts with a community mental health center (CMHC), CMHCs are the service providers of the system. Counties set the priorities to meet local needs and submit a plan to DSAMH describing what services they will provide with the state, federal, and county money.

They are required by statute to provide at a minimum the following services:

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

Additional services provided by many of the mental health centers are important. Some of these include:

- Supported employment
- Community-based wraparound services
- Family Resource Facilitation
- Clubhouses
- Consumer drop-in centers
- Forensic evaluation
- Nursing home and hospital alternatives
- Consumer and family education

State and federal funds are allocated to a county or group of counties based on a formula established by the board. Counties may deliver services in a variety of ways that meet the needs of citizens in their catchment area. Counties must provide at least a 20% county match to any state funds. However, a number of counties provide

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

Currently, there are 13 CMHCs providing services to 29 counties. Most counties have joined

with one or more other counties to provide mental health treatment for their residents. The following chart shows the counties served by each CMHC.

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

Treatment Information

Diagnostic Data

The tables below describe the most common diagnosis treated in the public mental health system. The diagnostic process is complex and often a consumer may have more than one diagnosis. Each diagnostic category listed may have several subsets, i.e., anxiety disorders include—generalized anxiety, post traumatic stress, panic disorder etc.

The wide variety of diagnosis require that mental health providers to have expertise in many areas. Co-occurring is a term that refers to this situation of a consumer having more than one diagnosis. One of the most common co-occurring incidents is that of mental illness and substance abuse. This requires providers to have competence in the treatment of both conditions.

Diagnosis of Mental Health Clients 17 years and younger, by Mental Health Center														
	Bear River	Central	Davis	Four Corners	North-eastern	Salt Lake–VMH	San Juan	South-west	Summit–VMH	Tooele–VMH	Utah Co.–Wasatch MH	Wasatch Co.–Heber Valley	Weber	Statewide Adults
Mood Disorders	10.2%	5.7%	10.7%	13.6%	11.2%	13.5%	19.7%	7.9%	16.6%	14.2%	6.9%	12.5%	10.6%	10.5%
Attention Deficit	7.9%	12.3%	10.9%	9.7%	7.0%	13.7%	13.1%	5.2%	7.5%	11.9%	6.9%	9.8%	6.9%	9.4%
Anxiety Disorders	8.8%	5.5%	7.3%	5.1%	11.0%	12.2%	9.2%	5.3%	8.7%	10.3%	8.7%	12.0%	0.0%	8.9%
Neglect or Abuse	4.8%	13.8%	12.5%	3.6%	8.5%	6.1%	3.2%	4.8%	1.9%	9.5%	6.5%	8.2%	9.5%	7.3%
Adjustment Disorders	8.9%	13.0%	6.3%	4.5%	7.7%	4.9%	8.9%	13.2%	7.5%	4.5%	4.8%	3.8%	0.0%	6.1%
Substance Abuse	0.5%	1.0%	1.8%	9.9%	1.4%	5.5%	0.3%	0.3%	8.2%	13.6%	1.5%	7.6%	7.0%	4.0%
Autism	1.5%	1.5%	2.0%	1.0%	1.2%	4.4%	4.1%	1.3%	1.2%	1.7%	3.2%	2.2%	4.5%	2.8%
Conduct Disorders	1.0%	2.0%	0.0%	0.7%	1.3%	1.9%	0.0%	1.3%	1.2%	3.2%	0.8%	0.0%	2.1%	1.5%
Cognitive Disorders	1.3%	0.9%	2.1%	0.9%	1.5%	0.9%	1.6%	1.0%	0.5%	1.0%	0.9%	0.0%	1.4%	0.9%
Schizophrenia and Other	0.4%	0.8%	0.6%	0.2%	0.5%	0.8%	0.0%	0.0%	0.5%	0.1%	0.4%	0.0%	1.7%	0.6%
Impulse Disorders	1.0%	0.0%	0.6%	0.5%	0.9%	0.1%	1.6%	0.7%	0.5%	0.3%	0.6%	0.0%	0.3%	0.5%
Personality Disorders	0.1%	0.3%	0.3%	0.2%	0.0%	0.2%	1.0%	0.5%	0.2%	0.4%	0.3%	1.1%	0.1%	0.3%
Other	20.2%	14.1%	17.3%	19.7%	12.4%	18.4%	10.5%	13.1%	13.8%	15.7%	17.1%	14.1%	21.5%	17.4%
V Codes	33.5%	29.1%	27.5%	30.3%	35.4%	17.4%	26.8%	45.4%	31.9%	13.7%	41.4%	28.8%	34.5%	29.9%
Total	100.0%	100.0%	100.0%	100.0%										

Diagnosis of Mental Health Clients 18 years and older, by Mental Health Center														
	Bear River	Central	Davis	Four Corners	North-eastern	Salt Lake–VMH	San Juan	South-west	Summit–VMH	Tooele–VMH	Utah Co.–Wasatch MH	Wasatch Co.–Heber Valley	Weber	Statewide Adults
Mood Disorders	24.3%	22.4%	26.4%	20.0%	23.0%	22.8%	35.3%	22.6%	18.3%	28.0%	18.9%	18.9%	15.4%	21.3%
Anxiety Disorders	17.2%	16.2%	17.4%	9.6%	17.0%	12.2%	15.0%	6.1%	11.7%	15.0%	15.9%	18.3%	11.1%	13.0%
Substance Abuse	6.3%	5.2%	6.8%	25.4%	5.7%	25.4%	4.2%	1.4%	32.5%	25.8%	9.6%	9.8%	17.0%	17.2%
Personality Disorders	9.5%	10.1%	5.7%	7.0%	8.2%	10.9%	4.8%	8.7%	1.5%	5.1%	7.9%	6.2%	7.4%	8.4%
Schizophrenia and Other	5.1%	10.0%	8.0%	4.6%	5.6%	9.2%	5.6%	9.6%	1.2%	3.1%	8.3%	3.7%	7.7%	7.2%
Cognitive Disorders	2.1%	2.1%	1.6%	1.5%	2.3%	1.6%	5.0%	3.7%	0.4%	0.7%	3.5%	0.8%	2.2%	2.0%
Attention Deficit	2.0%	1.7%	2.0%	0.8%	1.9%	1.5%	1.2%	0.6%	2.2%	5.1%	2.3%	0.8%	1.3%	1.7%
Adjustment Disorders	1.6%	1.2%	1.9%	0.9%	2.0%	1.0%	1.8%	4.8%	3.2%	1.7%	0.9%	1.0%	1.0%	1.4%
Impulse Disorders	0.8%	0.7%	0.6%	0.5%	1.7%	0.5%	1.8%	0.5%	0.2%	0.2%	1.3%	0.2%	0.4%	0.6%
Autism	0.6%	0.3%	0.6%	0.3%	0.3%	0.5%	0.4%	0.8%	0.3%	0.4%	0.8%	0.0%	0.3%	0.5%
Neglect or Abuse	0.3%	7.5%	0.6%	0.1%	1.8%	0.1%	0.0%	0.7%	0.1%	0.2%	0.8%	0.4%	0.6%	0.5%
Conduct Disorders	0.1%	0.1%	0.2%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%	0.1%
Other	16.3%	10.0%	16.4%	11.8%	11.5%	3.4%	7.2%	19.5%	6.6%	3.1%	12.7%	23.7%	16.7%	11.6%
V Codes	13.8%	12.5%	11.7%	17.5%	18.9%	10.9%	17.8%	20.8%	21.6%	11.6%	17.0%	16.2%	18.7%	14.5%
Total	100.0%	100.0%	100.0%	100.0%										

Expected Payment Source Chart

The following table identifies payment sources at the time of admission. Medicaid pays for 50% of the services received at the community mental health centers statewide. The cost of doing business would not be complete without funding through other various sources such as matching funds from counties, self pay, Medicare, federal

grants, and private insurances. This funding formula helps to illustrate the importance of funding from all possible sources. Ultimately, this complex mix of funding streams allows centers to function in their mandate as community mental health centers.

The Expected Payment Sources of Clients Admitted Into Mental Health Centers
Fiscal Year 2008

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	53.3%	0.7%	1.5%	0.1%	6.9%	1.4%	36.0%
Central	80.1%	7.2%	2.2%	0.8%	4.1%	4.8%	0.7%
Davis	60.8%	0.4%	10.4%	10.4%	6.0%	8.0%	4.0%
Four Corners	0.0%	0.0%	9.3%	47.6%	0.0%	0.0%	43.1%
Northeastern	46.5%	0.8%	21.2%	4.0%	4.9%	22.2%	0.4%
Salt Lake County - VMH	53.3%	27.9%	12.8%	2.4%	3.5%	0.0%	0.0%
San Juan	27.4%	1.8%	37.2%	10.1%	5.7%	11.6%	6.3%
Southwest	62.7%	9.2%	8.3%	4.1%	3.1%	3.3%	9.3%
Summit County - VMH	9.0%	67.1%	20.2%	2.4%	1.3%	0.0%	0.0%
Tooele County - VMH	30.0%	43.6%	22.7%	1.4%	2.3%	0.0%	0.0%
Utah County - Wasatch Mental Health	60.1%	33.7%	3.1%	0.0%	3.1%	0.0%	0.0%
Wasatch County - Heber Valley Counseling	21.3%	69.3%	9.4%	0.0%	0.0%	0.0%	0.0%
Weber	46.7%	41.7%	9.4%	0.0%	2.1%	0.0%	0.0%
Statewide	50.0%	24.6%	10.4%	4.5%	3.4%	1.6%	5.5%

Service Penetration Rates

The table below identifies the total population living in the catchment area of each mental health center. The second column is an actual account of how many people received services.

The penetration rate refers to the per cent of its general population that received public mental health services.

2008 Mental Health Clients Penetration Rates

	2007 Population (Estimated)	Total Served	Penetration Rate
Bear River	158,827	2,692	1.7%
Central	69,760	945	1.4%
Davis	288,146	2,985	1.0%
Four Corners	39,056	2,059	5.3%
Northeastern	46,185	853	1.8%
Salt Lake County - Valley Mental Health	1,009,518	14,548	1.4%
San Juan	14,484	457	3.2%
Southwest	194,459	2,860	1.5%
Summit County - Valley Mental Health	35,541	843	2.4%
Tooele County - Valley Mental Health	54,914	1,715	3.1%
Utah County - Wasatch Mental Health	483,702	5,716	1.2%
Wasatch County - Heber Valley Counseling	20,535	244	1.2%
Weber	230,203	5,738	2.5%
Statewide	2,645,330	40,427	1.5%

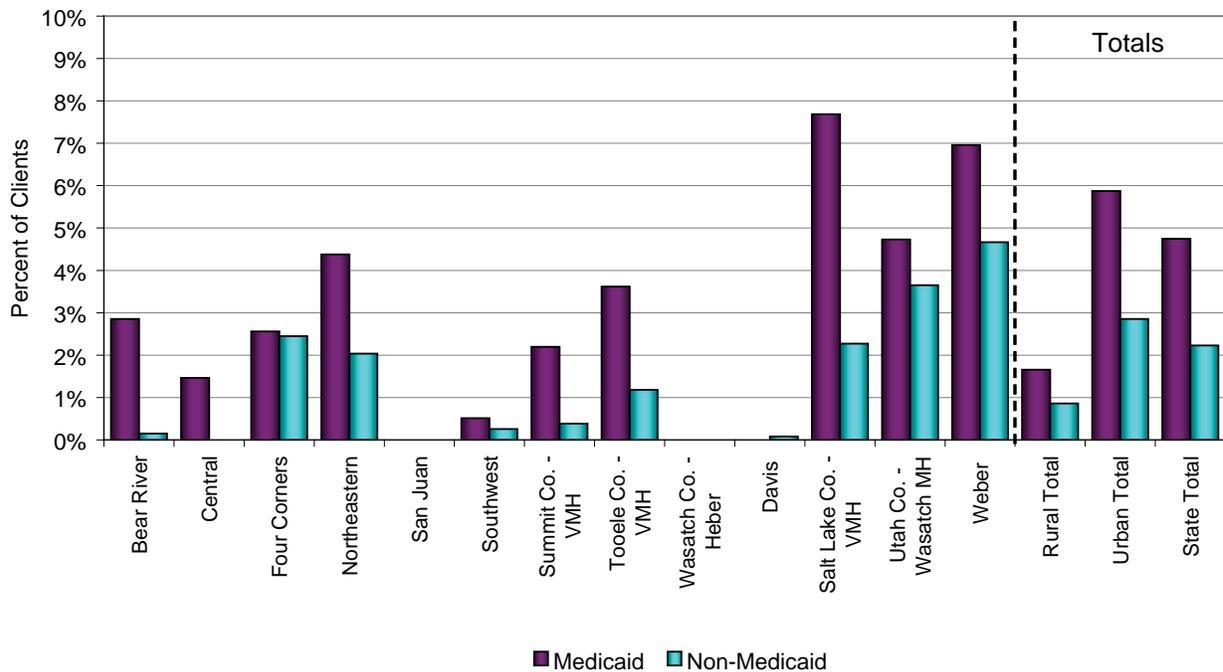
Mandated Services Data by Local Provider

DSAMH monitors the following statutorily mandated services for quality of care. Services provided to families and consumers in the mental health system are captured in these service areas. The following tables illustrate the service priori-

ties (based on utilization and median length of service) for each of the 13 CMHCs. The N= for the utilization charts can be found on page 142

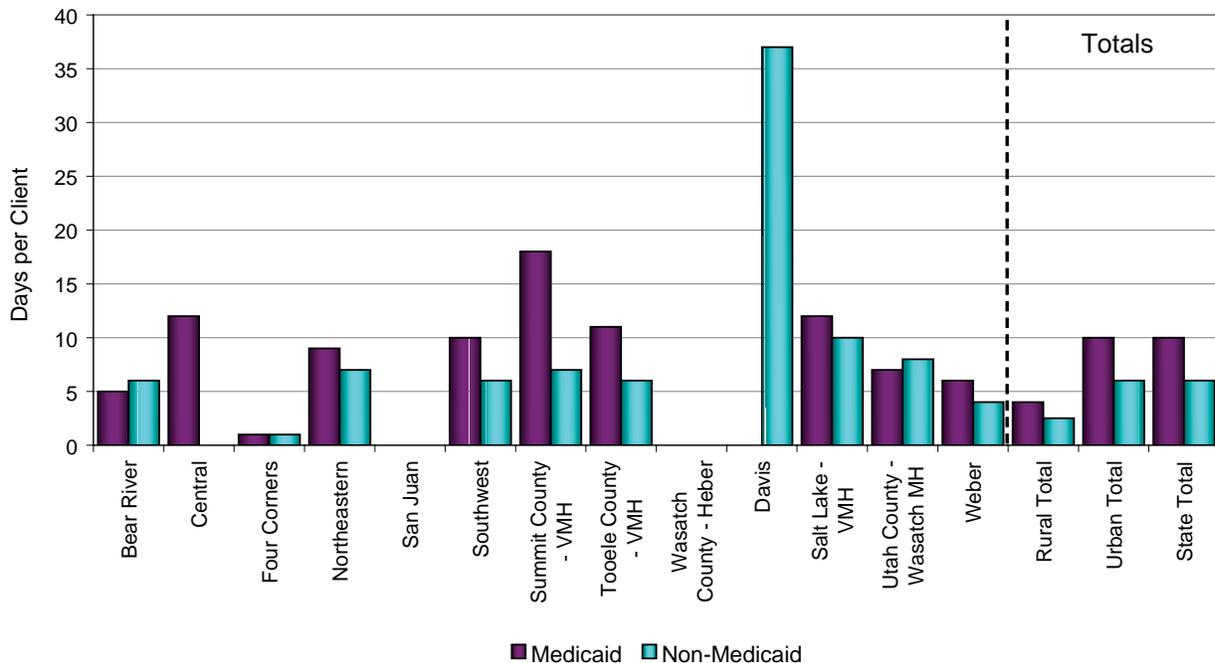
Inpatient Utilization

Mental Health Clients
Fiscal Year 2008



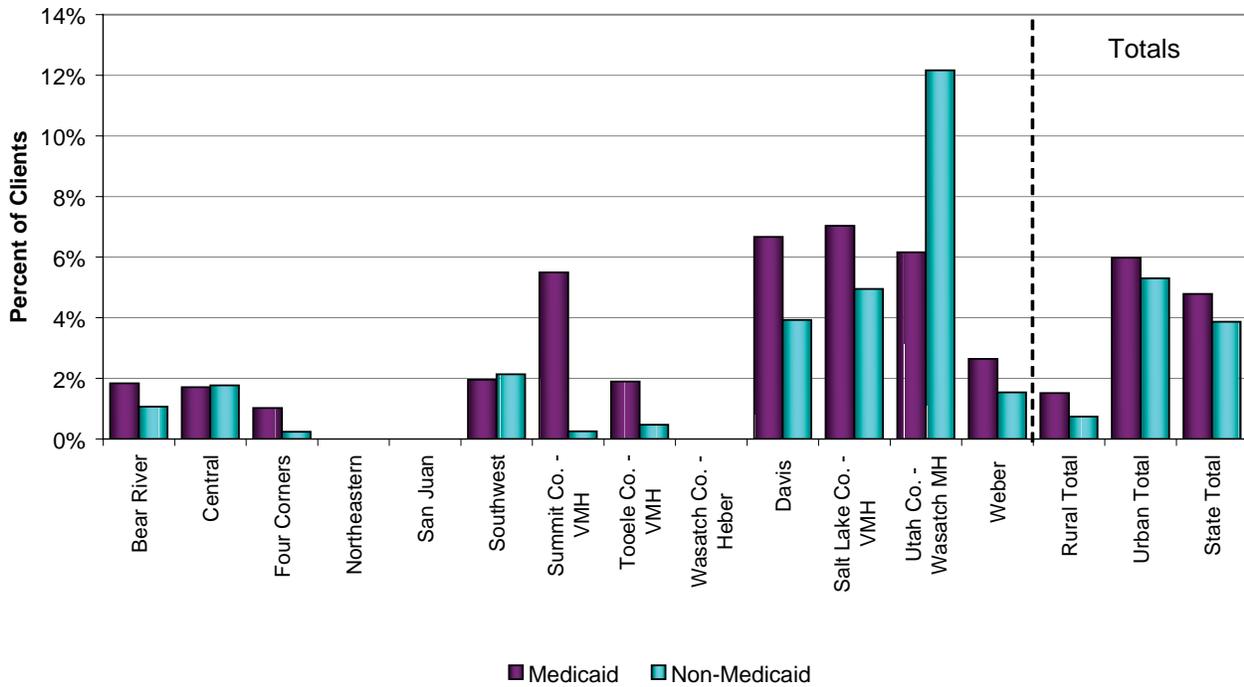
Inpatient Median Length of Service

Mental Health Clients
Fiscal Year 2008



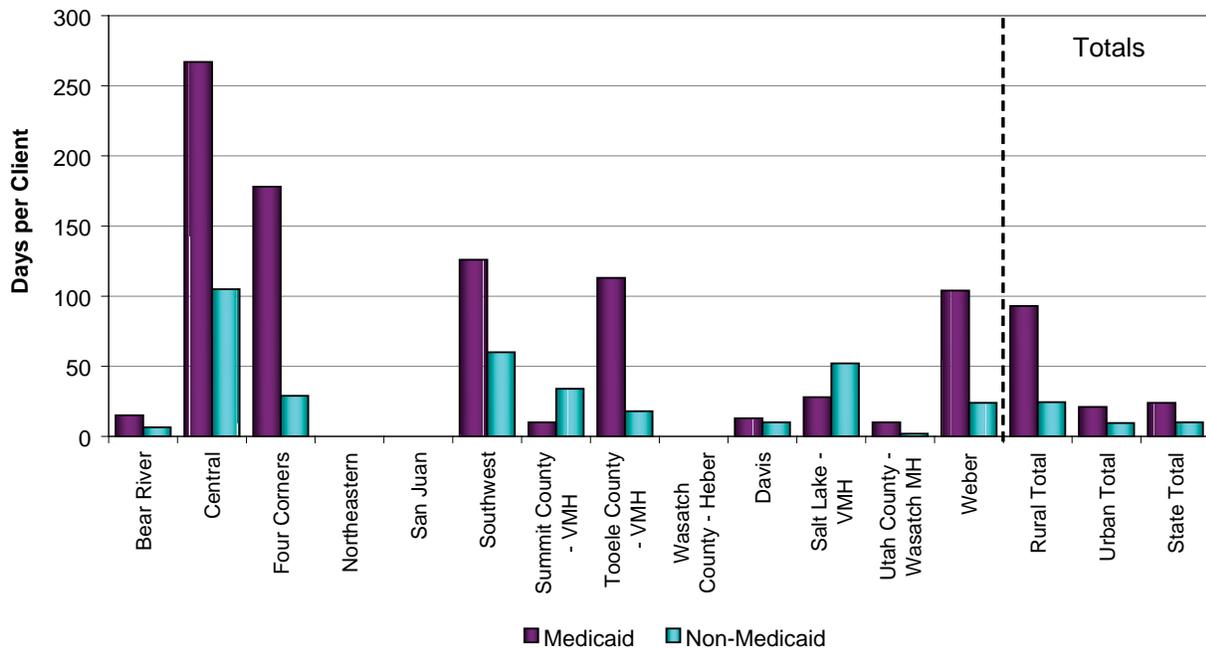
Residential Utilization

Mental Health Clients
Fiscal Year 2008



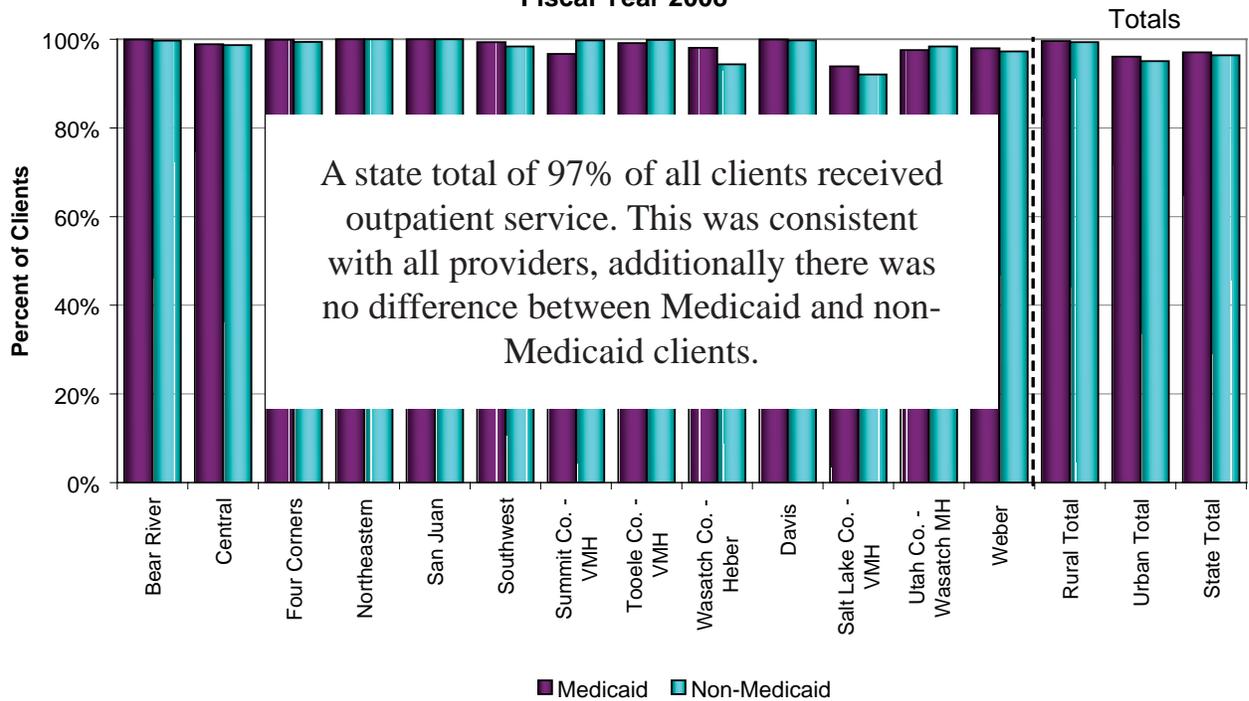
Residential Median Length of Service

Mental Health Clients
Fiscal Year 2008



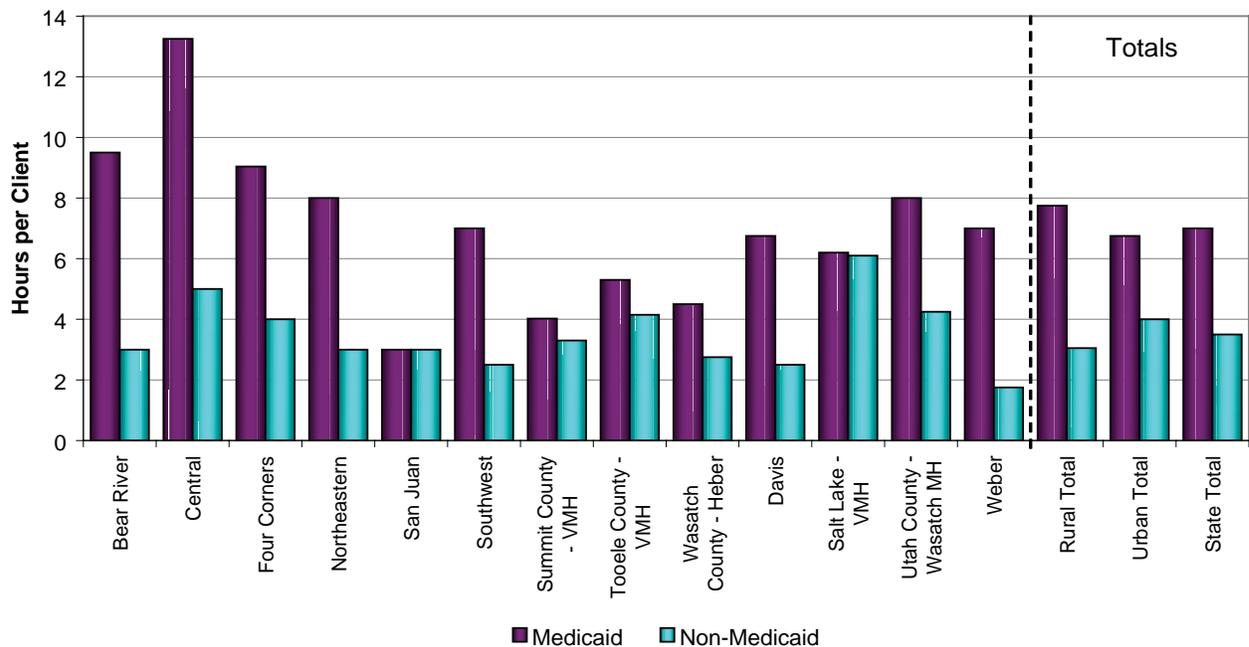
Outpatient Utilization

Mental Health Clients
Fiscal Year 2008

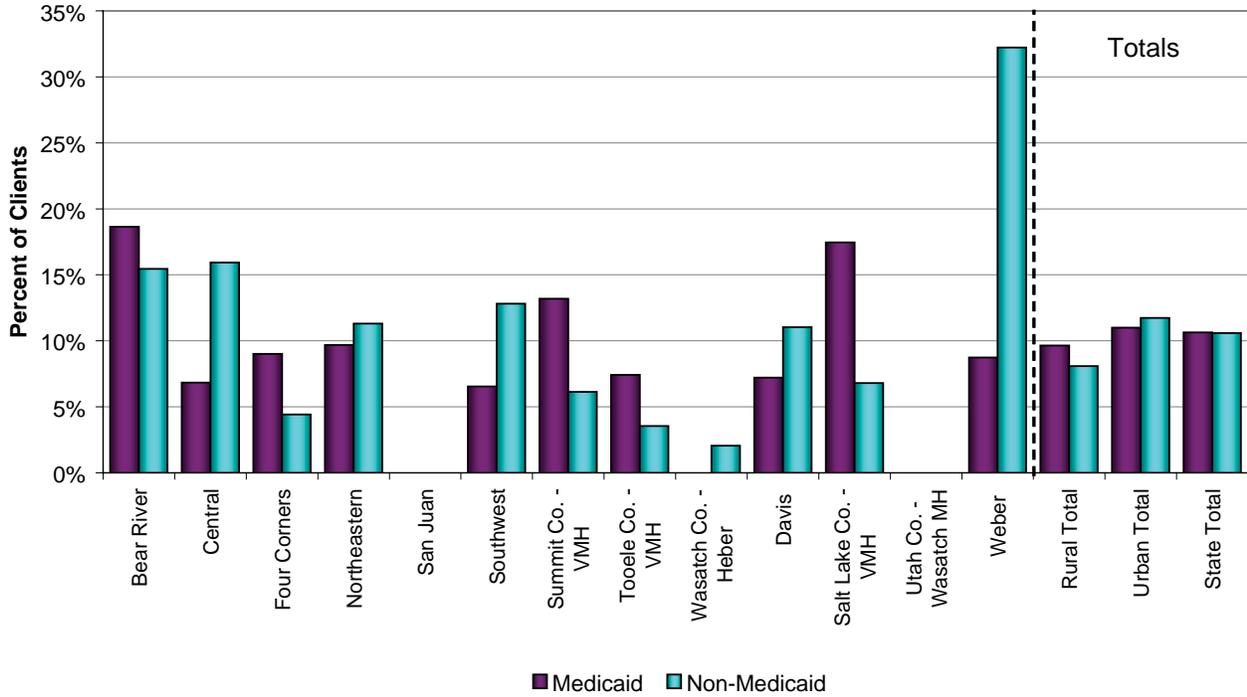


Outpatient Median Length of Service

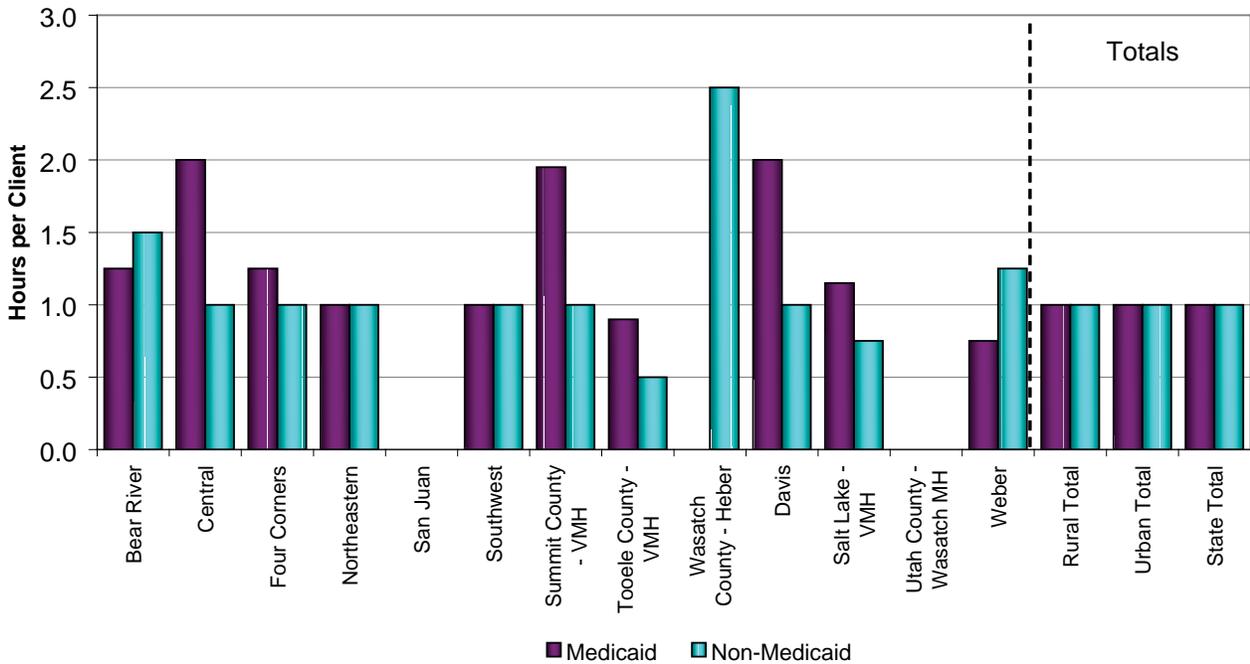
Mental Health Clients
Fiscal Year 2008



Emergency Utilization Mental Health Clients Fiscal Year 2008

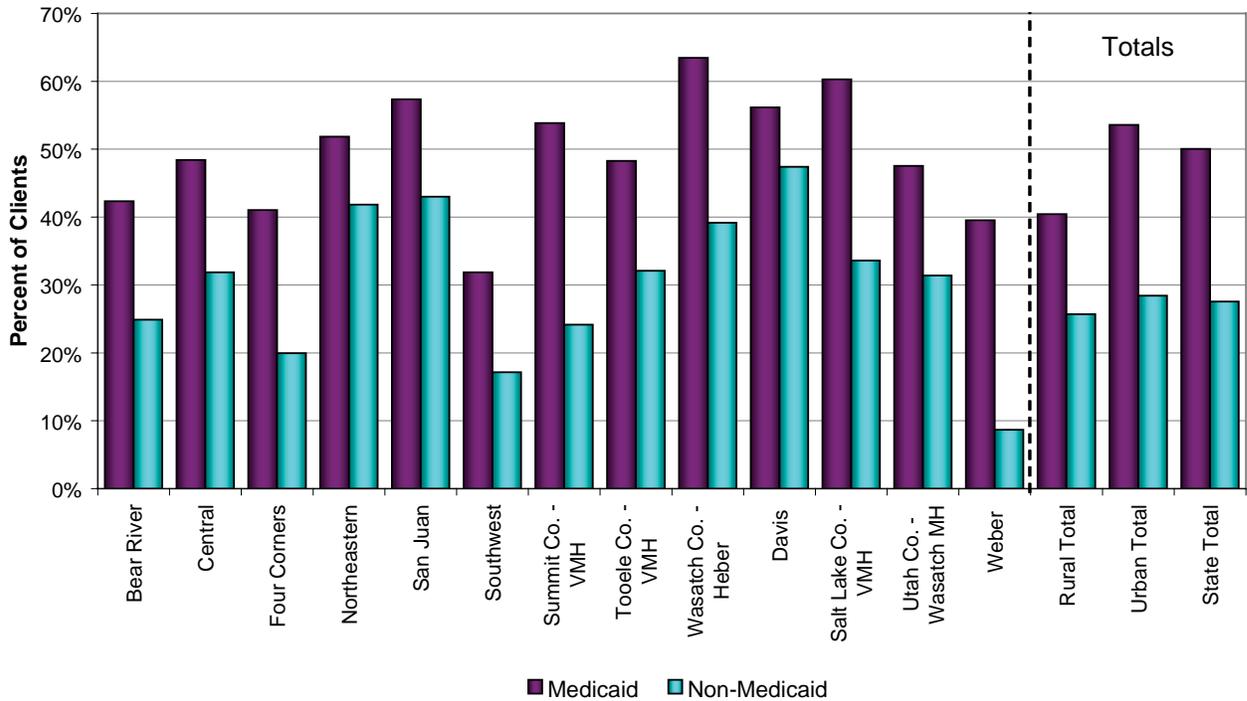


Emergency Median Length of Service Mental Health Clients Fiscal Year 2008



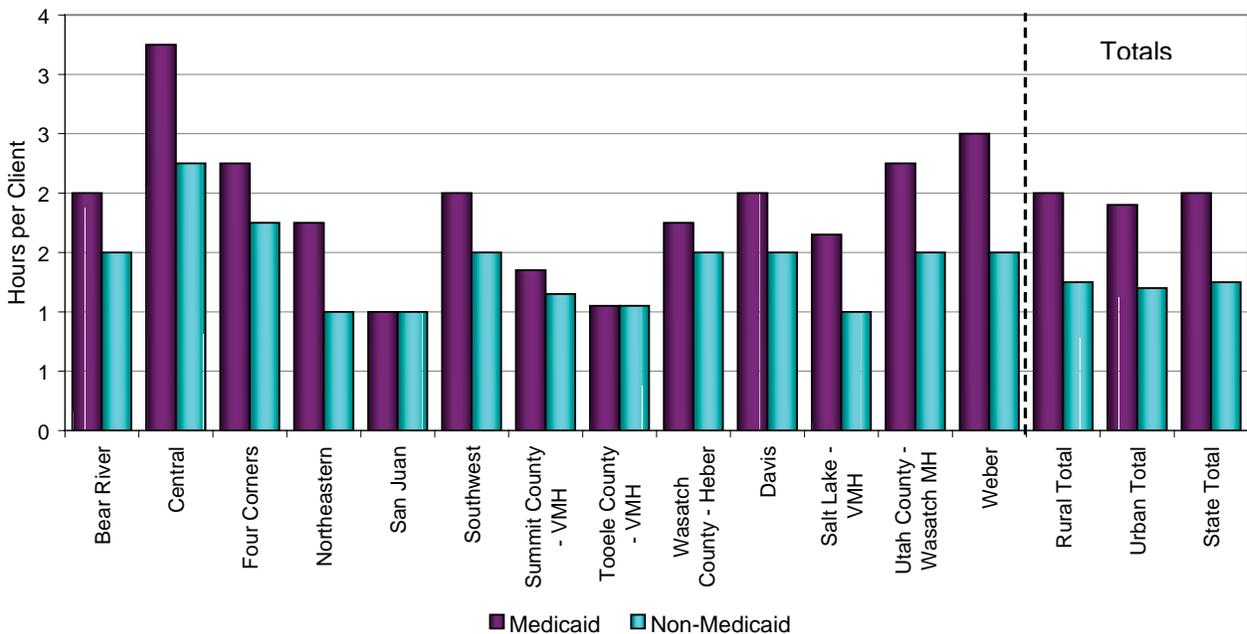
Medication Management Utilization

Mental Health Clients
Fiscal Year 2008



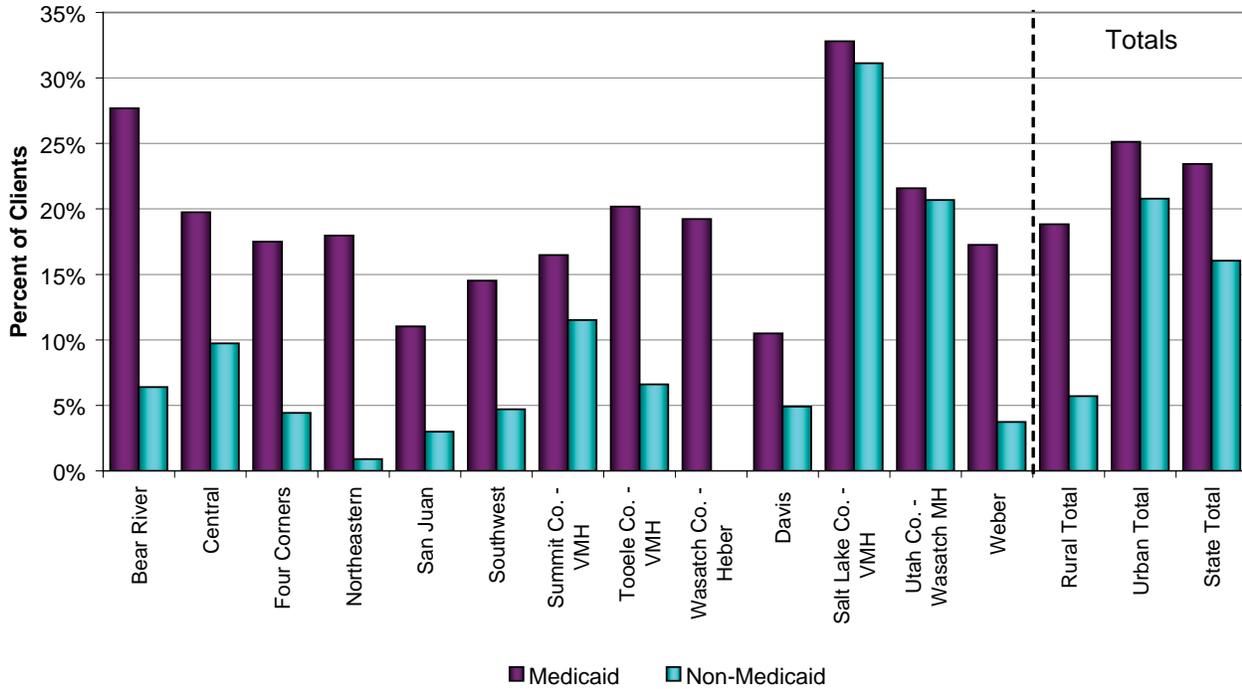
Medication Management Median Length of Service

Mental Health Clients
Fiscal Year 2008



Psychosocial Rehabilitation Utilization

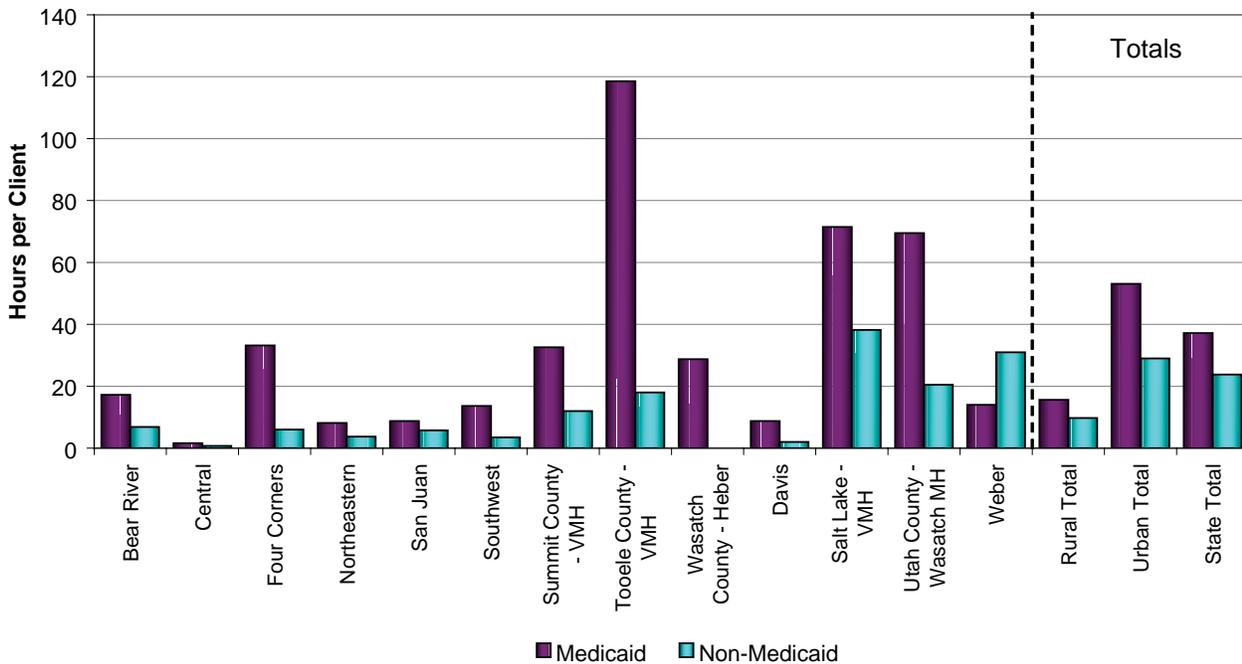
Mental Health Clients
Fiscal Year 2008



Psychosocial Rehabilitation

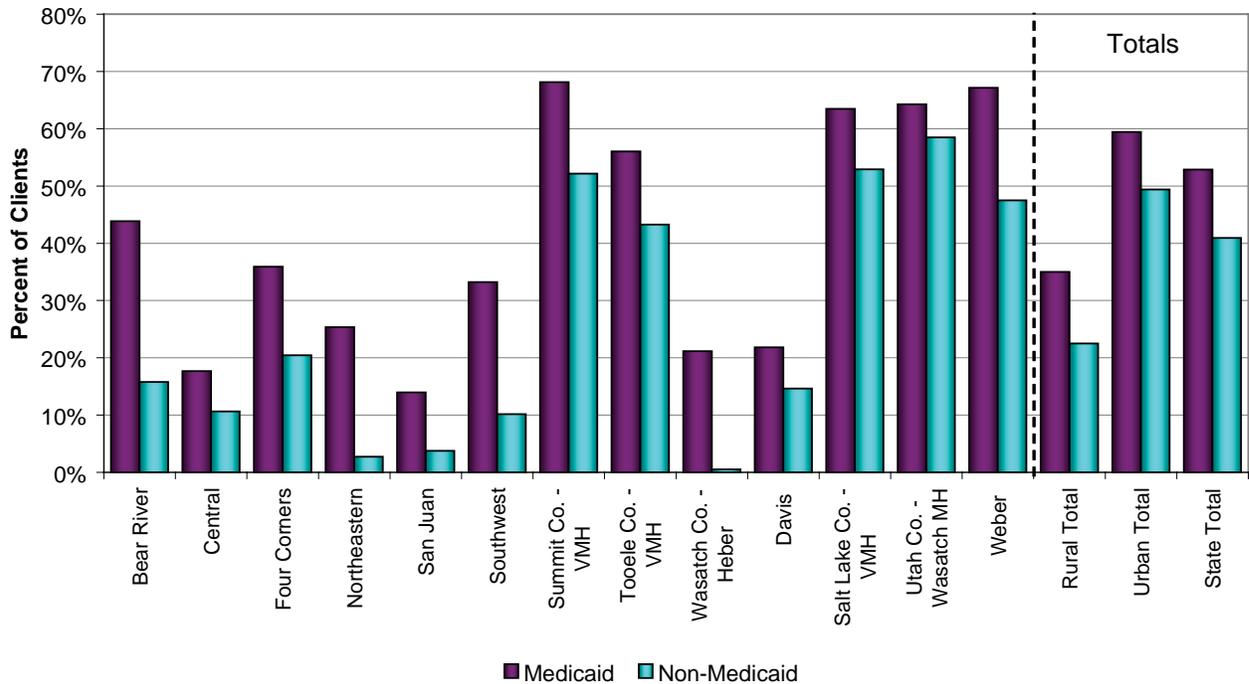
Median Length of Service

Mental Health Clients
Fiscal Year 2008



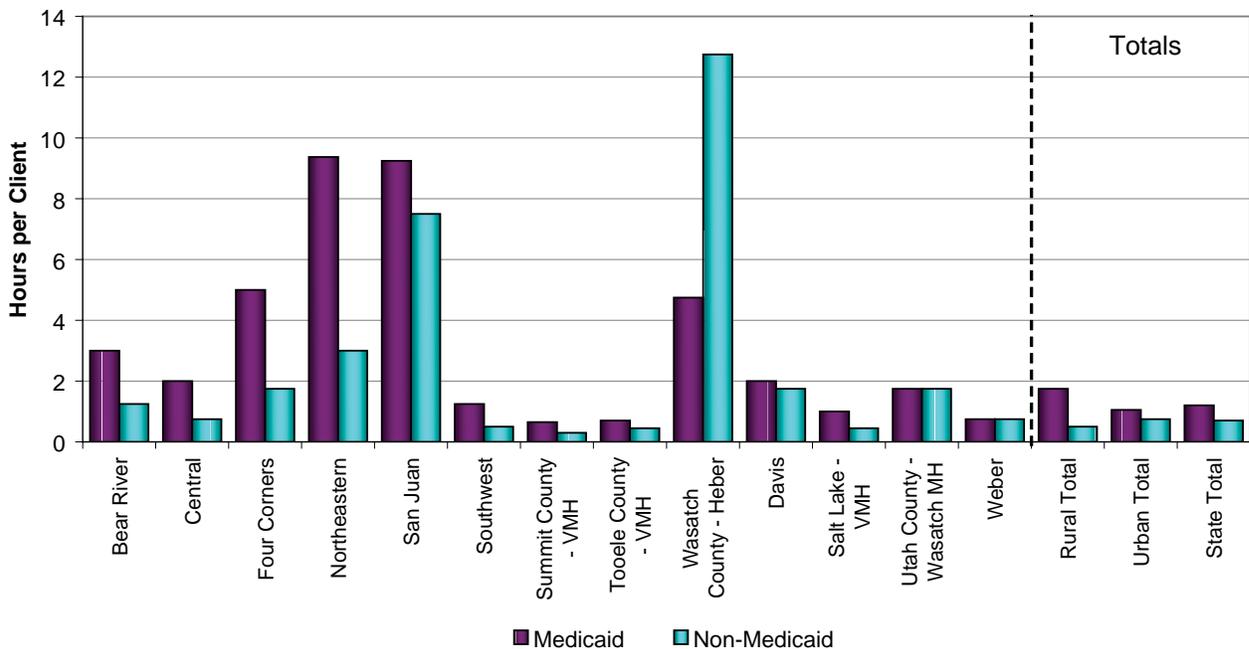
Case Management Utilization

Mental Health Clients
Fiscal Year 2008

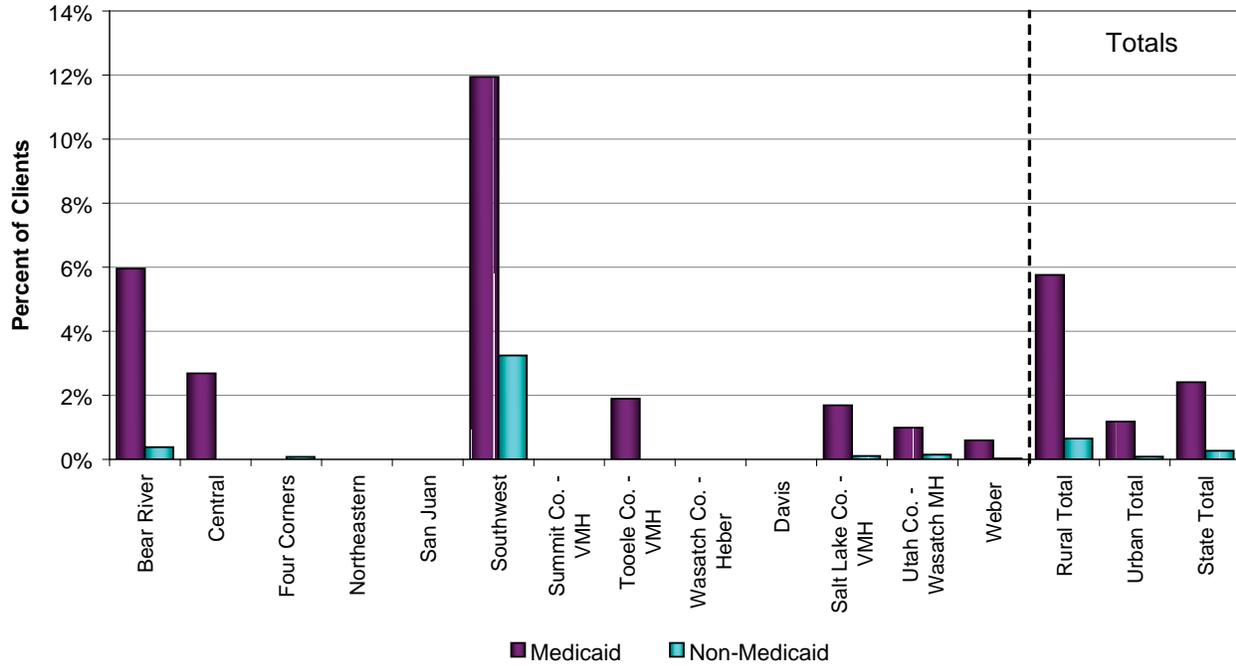


Case Management Median Length of Service

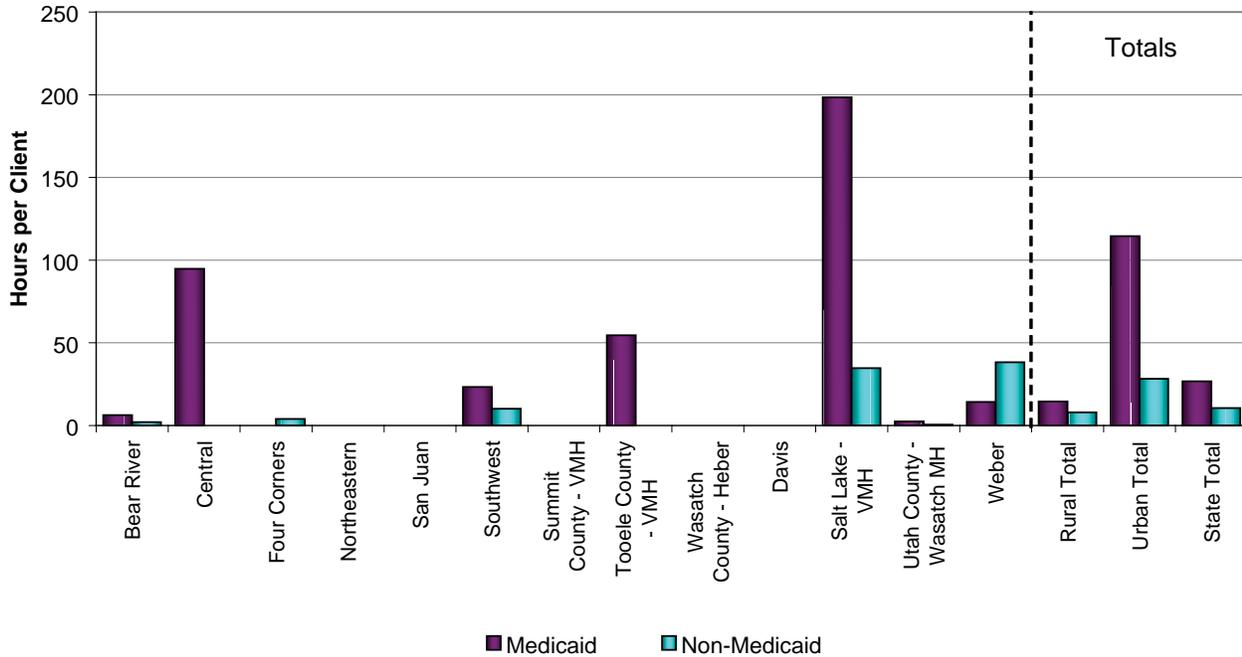
Mental Health Clients
Fiscal Year 2008



Respite Utilization Mental Health Clients Fiscal Year 2008



Respite Median Length of Service Mental Health Clients Fiscal Year 2008



Pre-Admission Screening/ Resident Review (PASRR)

PASRR is a system that aids in the treatment and review process for individuals in Medicaid Certified Nursing Facilities, and is part of the Federal Omnibus Budget Reconciliation Act. The rules regarding the PASRR process are found in the Code of Federal Regulations Part 483, Subpart C, Volume 57, No. 230. The PASRR Program is required by federal statute and the federal law was enacted for three purposes:

- To insure that people with mental illnesses in Medicaid-funded nursing homes are being adequately diagnosed and treated;
- To insure that those with mental illness or a developmental disability only (and no substantial physical problems), are not being warehoused in nursing homes; and
- To insure that the federal government is not paying for long-term care of the mentally ill or developmentally disabled in nursing homes.

The PASRR program comprises the process of screening and determining whether individuals meet nursing facility criteria and/or require specialized mental health services. This comprehensive evaluation provides an in-depth review of medical, social, and psychiatric history, as well as activities of daily living functioning. The evaluation is funded by state and federal money, which is managed separately by State mental health and developmental disability authorities. There is no charge to the patient.

To improve the efficiency of the PASRR evaluations, DSAMH implemented a new web-based program that allows instant communication with nursing facilities and evaluators via e-mail. The communication process of typing information, copying, and mailing once took days to complete. The process now is completed in a matter of minutes or hours through this new “instant” link. This has assured the proper level of care

for patients, and improved accessibility to services by utilizing a secure web-based system. Also, this has allowed for accessing information anywhere, anytime, and always ensures that no patient information can be accessed by an unauthorized person.

PASRR genuinely benefits our Utah citizens by alleviating the hospital and nursing facility concerns over placement delays and prevents unnecessary institutional placements. It truly making a difference in the lives of those around us.

In fiscal year 2008, DSAMH processed 1,830 PASRR evaluations in comparison to fiscal year 2007 of 1,671. 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. Prior to the *Olmstead* decision, DSAMH had prioritized community-based services and supports to serve individuals with mental illnesses in the least restrictive setting possible. Over the past year, DSAMH developed and implemented a tracking system to facilitate discharge from the Utah State Hospital (USH) for people with barriers to discharge. The Readiness Evaluation and Discharge Implementation Program (REDI) identifies barriers and what home and community-based services are needed for people to discharge successfully from the USH. By identifying barriers and community needs, the REDI program is used to help prevent unnecessary in-

stitutional placements and provides CMHCs improved and secure accessibility to patient information. DSAMH is also using this program as a monitoring tool to ensure that USH and CMHCs are actively working on a plan for people who are ready for discharge to live in the least restrictive environment. The REDI program has proven successful in identifying discharges for individuals. In fiscal year 2008, the REDI program was used to help facilitate discharge of 200 adults with mental illness from USH that were identified as having barriers to discharge, out of a total of 278 people.

Ten Year Plan to End Chronic Homelessness

DSAMH continues to actively work towards achieving Utah's initiative to end chronic homelessness by 2014 and work on alleviating the devastating impacts that homelessness has on people with mental illness and substance abuse issues.

A survey of homelessness is conducted annually through the Utah Department of Community and Culture. It was determined that on any given night, about 3,000 persons in Utah are homeless. In January 2008, the homeless count was completed and the results showed a total of about 15,786 homeless persons. Previously 1,728 chronically homeless people were reported, but the current report showed there were only 1,470 chronically homeless people, indicating a dramatic 15% decrease in the total number of persons who are chronically homeless. This finding gives support that the Ten Year Plan to end chronic homelessness is working. The current estimate indicates that about 50% of Utah's chronically homeless suffer with mental illness and/or substance abuse addictions. However, applying a conservative figure of 25% to the current total population of homeless people would indicate that there are 3,959 homeless people with mental illness statewide.

Individuals who are chronically homeless comprise a small percentage of the homeless, however, they use more than half of the resources for the total homeless population. The "Housing First" approach was created to remedy the problem. The idea is to provide safe and affordable housing first, then provide case management and support services to work on issues of addiction, mental illness, and job training. Since the beginning of the Ten Year Plan, over 260 chronically homeless people have moved off the streets into apartments. By next year, the goal is to have more than 500 people into affordable housing. The Housing First model not only improves the quality of lives of the people, but it also shows that housing is more cost effective at \$3,000 a month compared to a cost of \$22,000 a month on the street, which includes emergency medical and criminal justice services.

DSAMH is working with the public substance abuse and mental health system to collaborate with the local homeless coordinating committees. Key strategies include identifying policy and system issues that may result in complications in accessing services, as well as working to resolve difficulties by coordinating efforts in order to provide the needed supportive services, education and training, and effective treatment.

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

UT CAN is a federally funded program to develop an accountable, child and youth mental health and substance abuse system. The program delivers effective, coordinated, culturally competent, and community-based services through personal networking, agency collaboration, and active family/youth involvement.

In 2008, the project focused on implementing the strategic plans developed at the state and lo-

cal levels during the first two years. Some key implementation activities included:

1. DSAMH contracts with Holly Echo-Hawk, a nationally recognized consultant, to assist three American Indian tribes (Northwestern Band of Shoshone, Paiute Indian Tribe of Utah and Confederated Tribes of Goshute Indian) to increase their capacity to deliver quality, community-based children's mental health services.
2. The Cultural Competency Advisory Council invited Dr. Vivian Jackson, from Georgetown University, to provide training and facilitated discussion on developing a culturally competent system.
3. Sheila Pires, author of the *Building Systems of Care: A Primer* and two co-trainers provided statewide training on developing systems of care. Approximately 100 people, including 20 family members, attended the training.
4. DSAMH hired a youth coordinator who works directly with youth on a state and local level to provide input on developing genuine youth-guided systems of care. The coordinator also provides training to local providers on how to incorporate meaningful youth involvement to achieve youth-guided care.
5. Approximately 25 young people attended a two-day YOUTH CAN Academy which focused on experiential exercises for self discovery, leadership, and advocacy skills.
6. UT CAN is piloting an innovative process to reduce the redundancy of the assessment process many families and youth experience. The new process utilizes an assessment template called "My Portfolio" which contains information

written and owned by youth and their family. They have an opportunity to include any information that they believe is critical for a comprehensive understanding of their mental health and substance abuse challenges. This allows youth and their families to control if, when, and how they will share the information with providers. This tool engages youth and their families to be involved early on in treatment. The process begins with a Family Resource Facilitator collaborating with a clinician to assist youth and their families to develop their own "My Portfolio." One of the goals in utilizing this process is to help reduce the time spent on assessment and to improve the accuracy of the assessment reflecting the input of youth and families.

7. Kathy Reynolds, a consultant from Michigan, provided training and consultation regarding the integration of behavioral health care into the primary care setting. UT CAN collaborated funding with Salt Lake County to have two sites piloting the integrated model. These two sites are the South Main Health Clinic in Salt Lake City and the Midvale Family Health Clinic in Midvale.

Another major initiative is the school- and college-based mental health and substance abuse services. UT CAN collaborates with the Utah State Office of Education to implement school-based services in six local planning districts: Bear River, Davis, Heber Valley, Northeastern, Weber, and Utah County. Additionally, Snow College and Salt Lake Community College piloted mental health, substance abuse, and suicide prevention services on college campuses. School- and college-based services have been well received by local communities. These communities have developed or are developing plans to tap into other local funding to sustain and expand the services. UT CAN is promoting the expansion of statewide

school- and college-based services. A conference was organized to share lessons learned from pilot studies and encourage other communities to adopt an integrated model.

UT CAN School Provision

One of the most exciting initiatives to emerge under UT CAN is the provision of behavioral health services in schools. Each local authority was provided a small amount of seed money (\$30,000) to develop a pilot project based on the specific needs in their area. In six areas, UT CAN Local Project Leaders collaborated with their schools to design expanded school-based services for high-risk students. These innovative services include:

- Brief, social-skill building lessons during the lunchtime recess. (Bear River)
- Traditional group, individual, and family therapy at two high-risk schools. A community learning center developed cooperatively by community mental health center, school district, and county government. In addition to mental health services, the center provides consumers with "1-Stop Shopping": entrée to a variety of other government services in one central location that is easily accessible by public transportation. (Davis)
- Combating a high client no-show rate at the community mental health center by providing individual therapy sessions during established after school program. (Heber)
- Outreach to American Indian community by providing services in schools with high enrollment of Ute Tribe students. (North-eastern)
- Peer helper/suicide prevention program. (Wasatch Mental Health)
- Building on school-year services by offering group therapy sessions over the summer. (Weber)

In August 2008, these programs began offering services for the second consecutive school year. Preliminary evaluation demonstrates good outcomes including reduction in clinical symptoms, decreased stigma, decreased absences/tardies, improved grades, and fewer office disciplinary referrals.

Case Management

Case Management is a mandated service in Utah, and CMHCs are responsible to provide case management in their local areas. Case management provides six critical functions: connecting with the consumer, planning for services, linking consumers with services, linking family members with services, monitoring service provision, and advocating for consumer rights. Case managers also provide skill development services, and personal services, as well as psychosocial rehab groups. 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 has worked on improving the quality of case managers through a certification process that has proven to be successful. 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. In fiscal year 2008, DSAMH certified 57 new adult case managers and 21 new children's case managers with a total of 355 case managers throughout the public mental health system. In fiscal year 2008, the Utah public mental health system served 11,397 adults with serious and persistent mental illness and served 5,136 youth with serious emotional disturbance.

Autism Services

Due to the frequent co-occurrence of autism with other psychiatric disorders and the positive impact of early intervention on children with autism, DSAMH contracts with four local authorities to provide services primarily for preschool age children with autism, and their families.

Services may include evaluations (psychiatric evaluation, developmental assessment and other assessments as indicated), psychiatric services,

medication management, case management, mental health preschool, transition planning, parent education, and skill development for siblings.

Services are available in nine counties and are provided by Valley Mental Health (The Carmen B. Pingree School for Children with Autism), Wasatch Mental Health (GIANT Steps), Weber Human Services (The Northern Utah Autism Program), and the Southwest Educational Development Center.

Local Authorities



Governing Youth Council made posters as a service project for a statewide conference.

Substance Abuse and Mental Health Statistics by Local Provider

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.

Local authorities are responsible for providing a full continuum of services to their residents from prevention services to residential treatment to hospitalization. Additionally, they submit data regularly to DSAMH detailing the number and types of services they are providing and some basic information about the people they are

serving. This data helps to inform DSAMH, and Utah citizens, regarding the services provided by the local authorities and provides information regarding how well local authorities are doing in providing services.

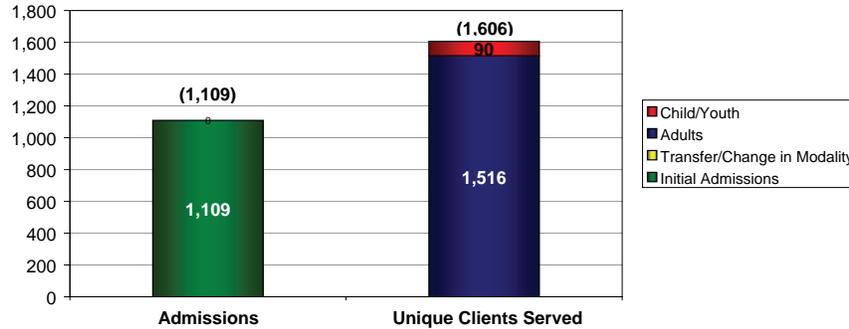
The following pages provides data and graphs describing how each local authority provided services to its residents during fiscal year 2008 (July 1, 2007 to June 30, 2008).

There are two pages for each local authority, on the left side is the **substance abuse provider and data** and on the right the **mental health provider and data**.

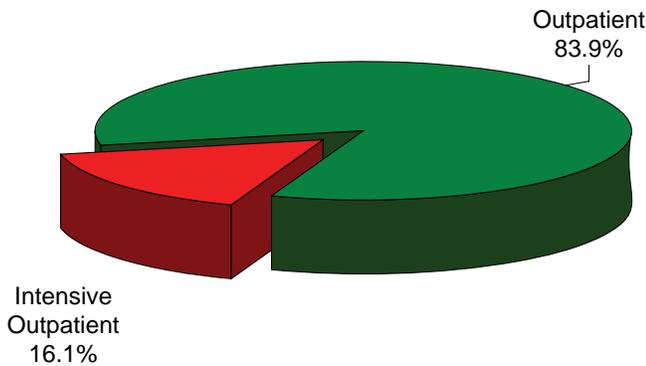
Bear River Health Department - Substance Abuse

2007 Population	Total Served	Penetration Rate
158,827	1,606	1.0%

Admissions into Modalities and Clients Served
Fiscal Year 2008



Admission into Modalities
Fiscal Year 2008

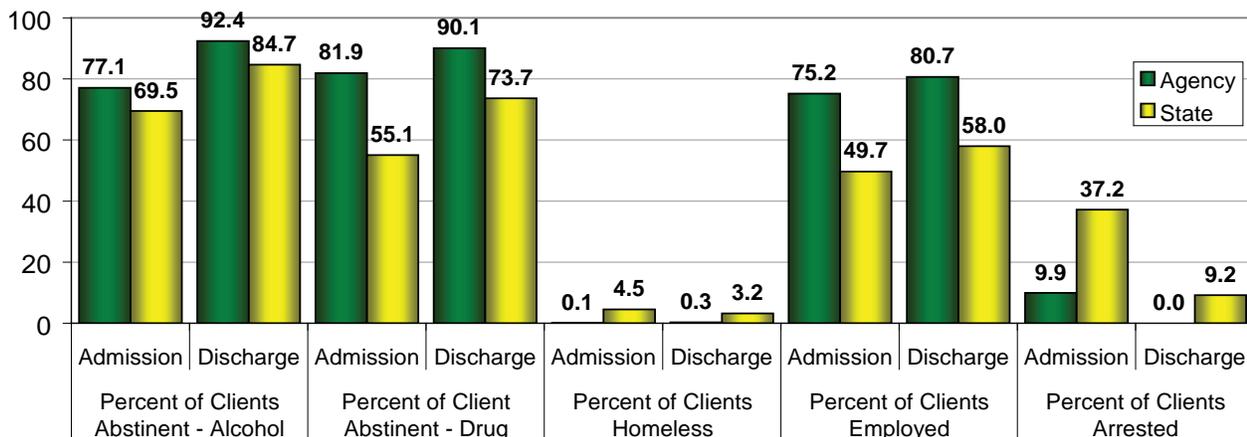


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	420	127	547
Cocaine/Crack	17	4	21
Marijuana/Hashish	214	53	267
Heroin	10	4	14
Other Opiates/Synthetics	21	29	50
Hallucinogens	5	0	5
Methamphetamine	77	73	150
Other Stimulants	3	3	6
Benzodiazepines	2	1	3
Tranquilizers/Sedatives	1	1	2
Inhalants	2	1	3
Oxycodone	15	22	37
Club Drugs	2	0	2
Over-the-Counter	0	0	0
Other	2	0	2
Unkown	0	0	0
Total	791	318	1109

Bear River Substance Abuse Outcome Measures

Fiscal Year 2008



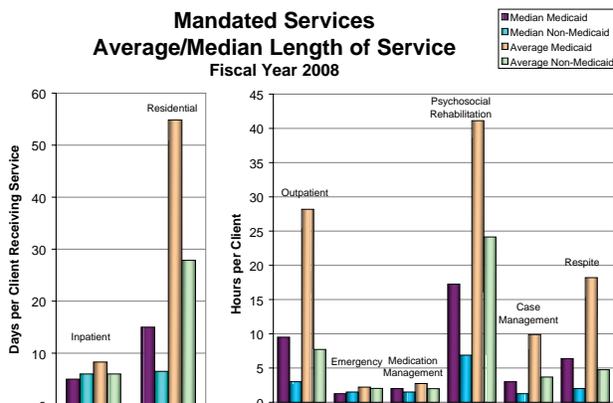
Bear River Mental Health - Mental Health

Total Clients Served2,692
 Adult1,765
 Children/Youth927
 Penetration Rate 1.7%

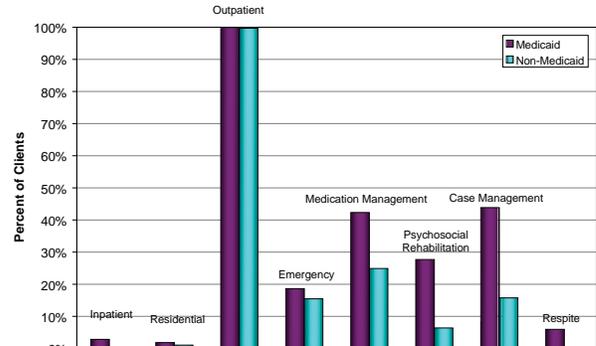
Diagnosis

	Youth	Adult
Mood Disorders	262	1,302
Anxiety Disorders	228	921
Personality Disorders	2	512
Substance Abuse	13	338
Adjustment Disorders	229	85
Cognitive Disorders	33	110
Schizophrenia and Other Psychotic	10	275
Attention Deficit	203	108
Autism	38	31
Impulse Disorders	26	44
Neglect or Abuse	125	16
Conduct Disorders	25	4
Other	520	877
V Codes	865	741
Total	2,579	5,364

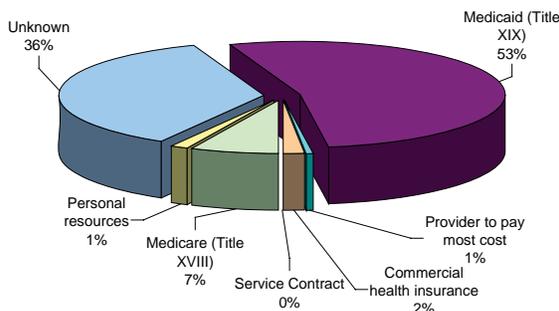
Mandated Services
Average/Median Length of Service
Fiscal Year 2008



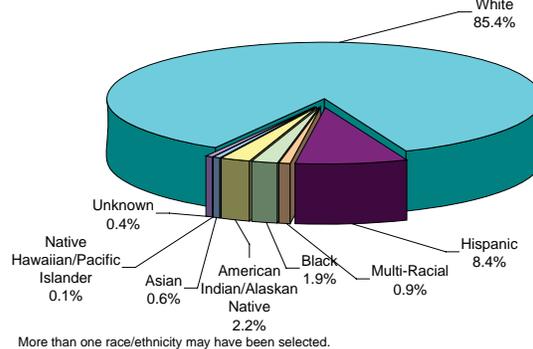
Utilization of Mandated Services
Fiscal Year 2008



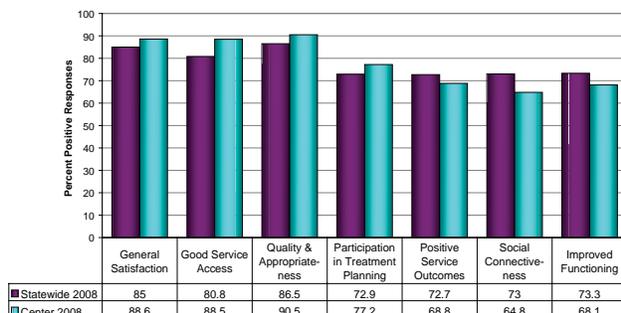
Expected Payment Source At Admission
Fiscal Year 2008



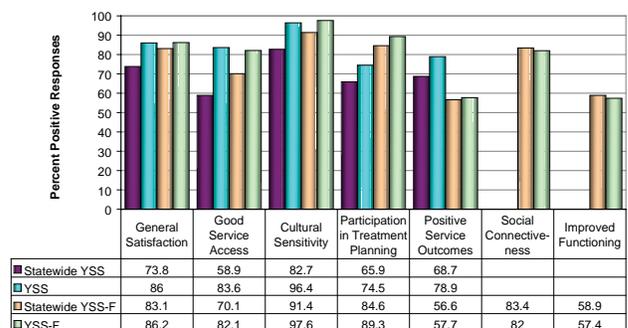
Race/Ethnicity
Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2008



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2008

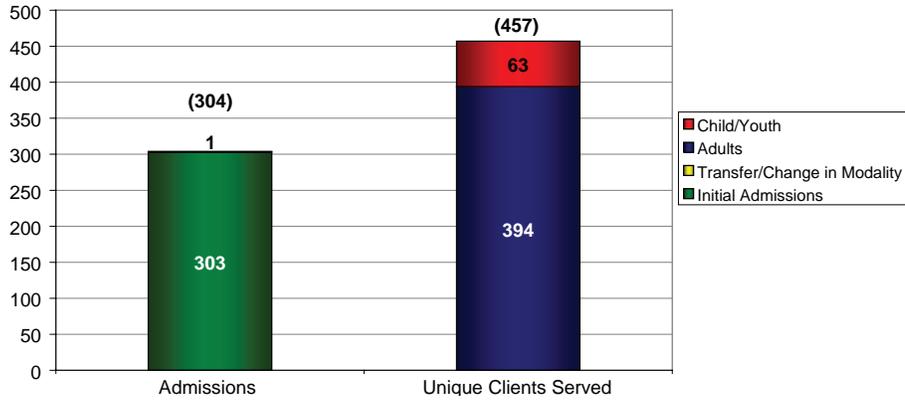


Central Utah Counseling Center - Substance Abuse

2007 Population	Total Served	Penetration Rate
69,760	457	0.7%

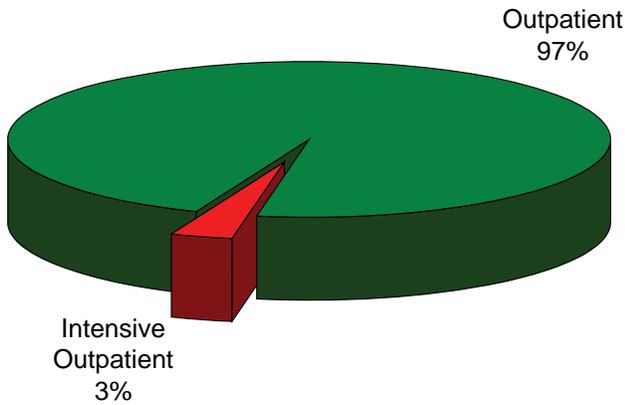
Admission into Modalities and Clients Served

Fiscal Year 2008



Admission into Modalities

Fiscal Year 2008

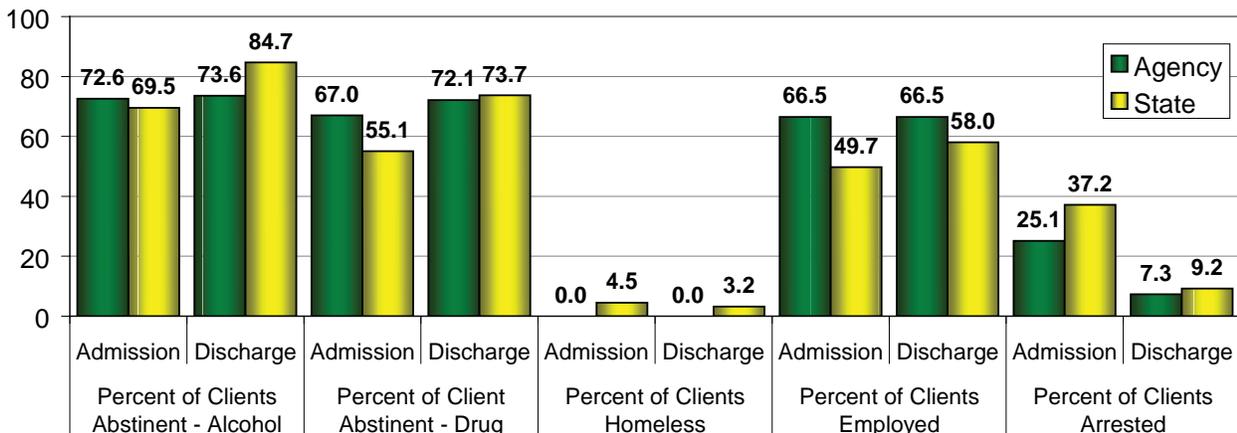


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	77	40	117
Cocaine/Crack	1	4	5
Marijuana/Hashish	58	15	73
Heroin	6	1	7
Other Opiates/Synthetics	2	8	10
Hallucinogens	0	0	0
Methamphetamine	32	31	63
Other Stimulants	1	1	2
Benzodiazepines	1	1	2
Tranquilizers/Sedatives	0	1	1
Inhalants	2	0	2
Oxycodone	11	10	21
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	0	1
Unkown	0	0	0
Total	192	112	304

Central Utah Counseling Outcome Measures

Fiscal Year 2008



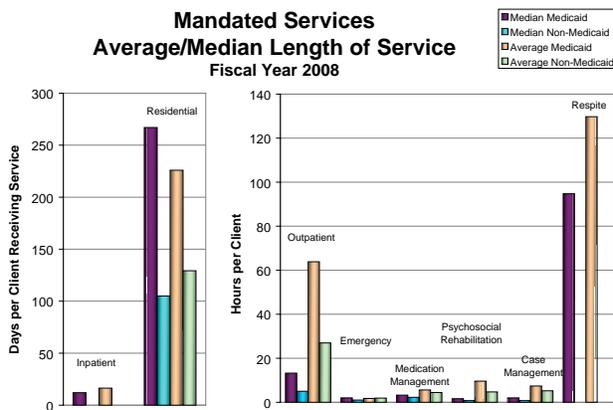
Central Utah Counseling Center - Mental Health

Total Clients Served945
 Adult555
 Children/Youth.....390
 Penetration Rate 1.4%

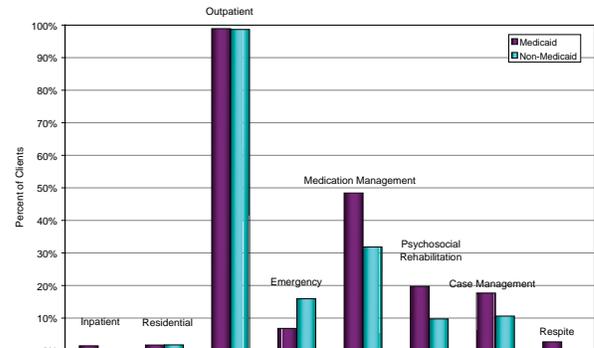
Diagnosis

	Youth	Adult
Mood Disorders	60	360
Anxiety Disorders	58	261
Personality Disorders	3	163
Substance Abuse	10	83
Adjustment Disorders	136	20
Cognitive Disorders	9	33
Schizophrenia and Other Psychotic	8	161
Attention Deficit	129	28
Autism	16	5
Impulse Disorders	0	12
Neglect or Abuse	145	120
Conduct Disorders	21	1
Other	148	160
V Codes	305	201
Total	1,048	1,608

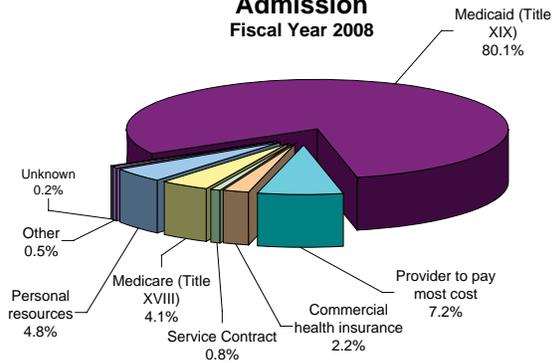
Mandated Services
Average/Median Length of Service
Fiscal Year 2008



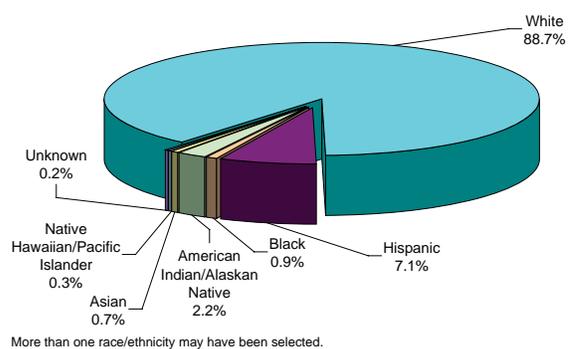
Utilization of Mandated Services
Fiscal Year 2008



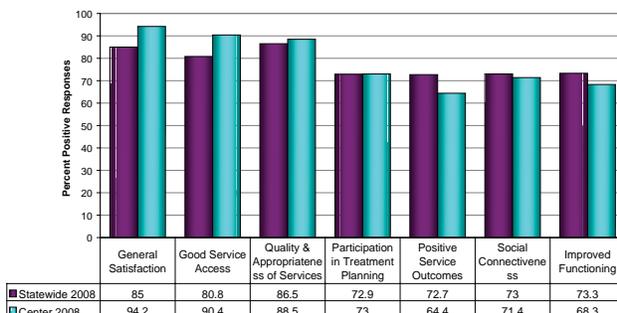
Expected Payment Source At Admission
Fiscal Year 2008



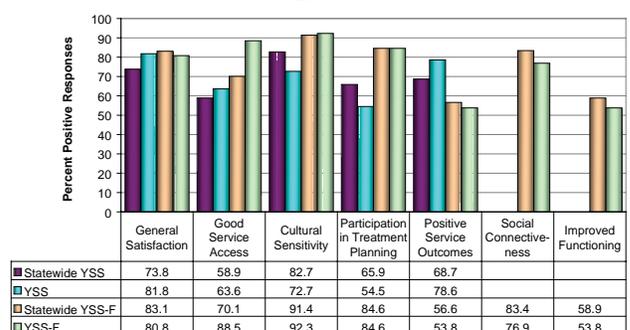
Race/Ethnicity
Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2008



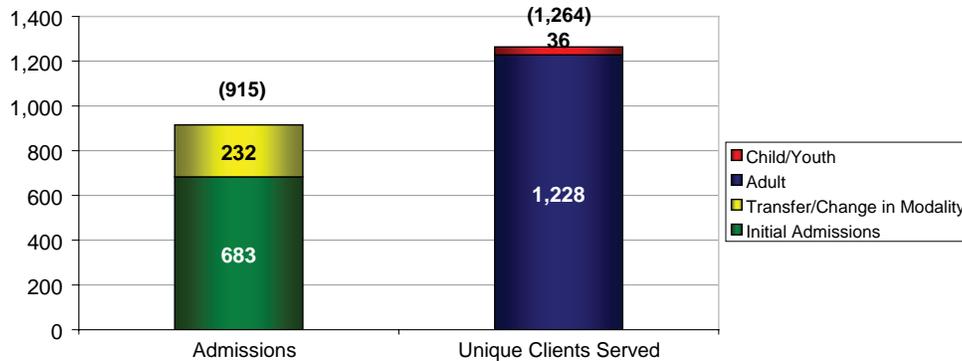
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2008



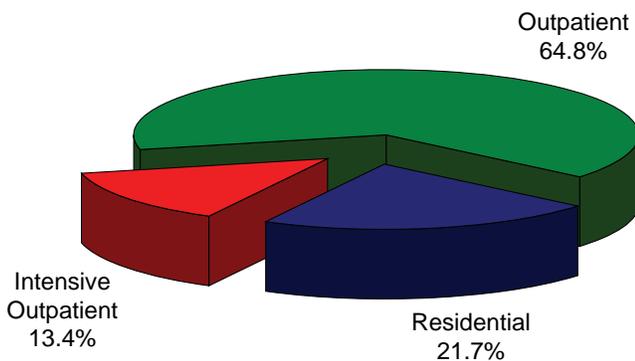
Davis Behavioral Health - Substance Abuse

2007 Population	Total Served	Penetration Rate
288,146	1,264	0.4%

Admissions into Modalities and Clients Served Fiscal Year 2008



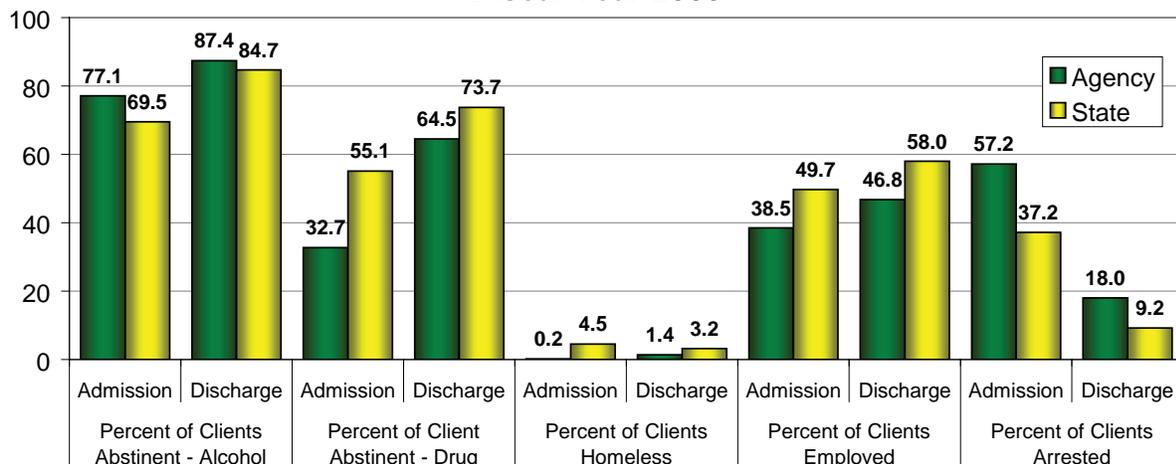
Admissions into Modalities Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	138	63	201
Cocaine/Crack	36	23	59
Marijuana/Hashish	94	31	125
Heroin	70	24	94
Other Opiates/Synthetics	15	12	27
Hallucinogens	1	0	1
Methamphetamine	185	144	329
Other Stimulants	0	1	1
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	1	2	3
Inhalants	1	0	1
Oxycodone	34	36	70
Club Drugs	0	0	0
Over-the-Counter	1	0	1
Other	1	1	2
Unkown	0	0	0
Total	577	338	915

Davis Behavioral Health Outcome Measures Fiscal Year 2008



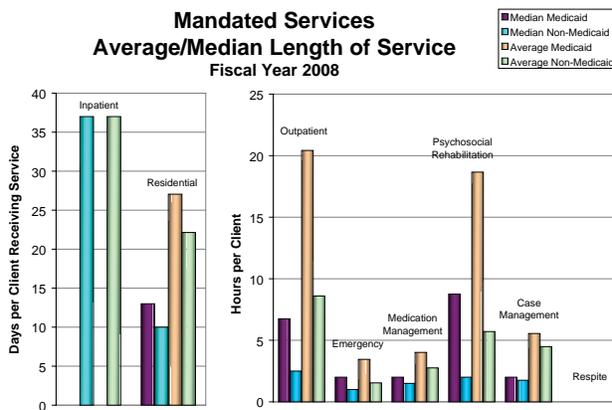
Davis Behavioral Health - Mental Health

Total Clients Served2,985
 Adult1,866
 Children/Youth1,119
 Penetration Rate 1.0%

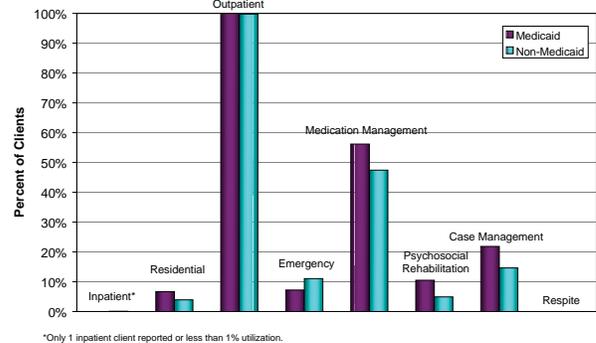
Diagnosis

	Youth	Adult
Mood Disorders	410	1,397
Anxiety Disorders	280	922
Personality Disorders	11	302
Substance Abuse	68	362
Adjustment Disorders	242	100
Cognitive Disorders	79	87
Schizophrenia and Other Psychotic	24	421
Attention Deficit	414	105
Autism	77	32
Impulse Disorders	22	31
Neglect or Abuse	477	32
Conduct Disorders	0	12
Other	661	867
V Codes	1,049	617
Total	3,814	5,287

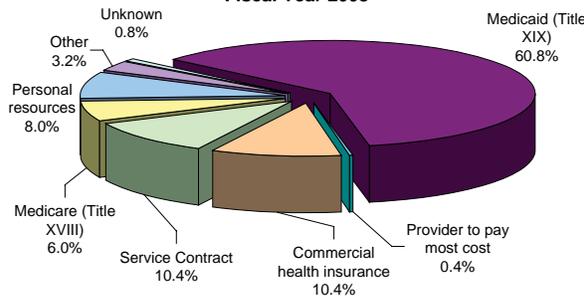
Mandated Services
 Average/Median Length of Service
 Fiscal Year 2008



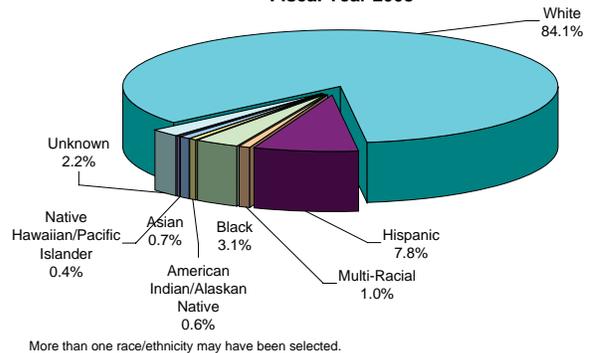
Utilization of Mandated Services
 Fiscal Year 2008



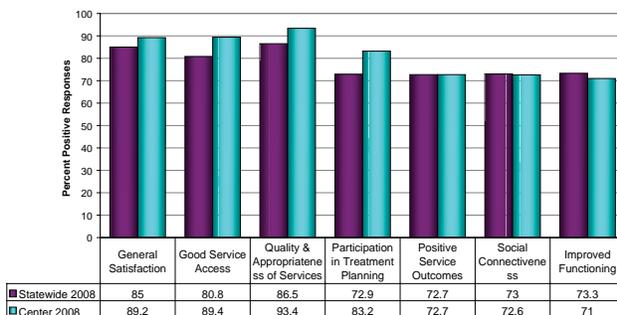
Expected Payment Source At Admission
 Fiscal Year 2008



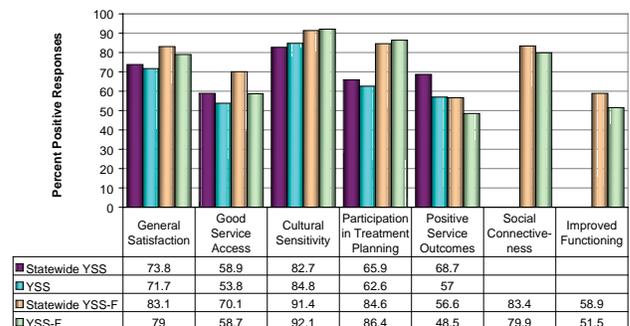
Race/Ethnicity
 Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2008



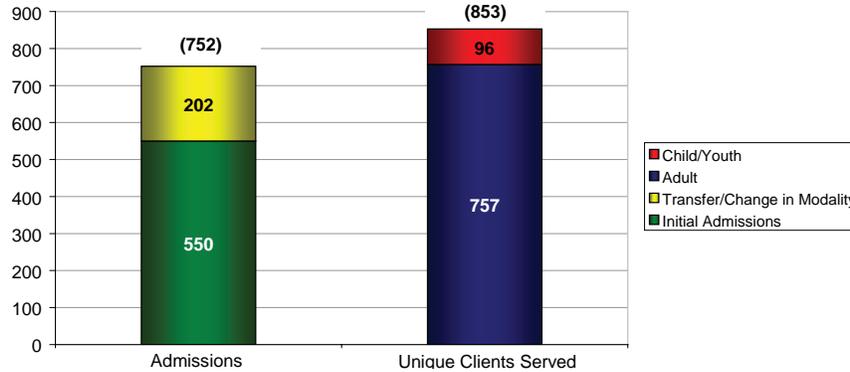
Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2008



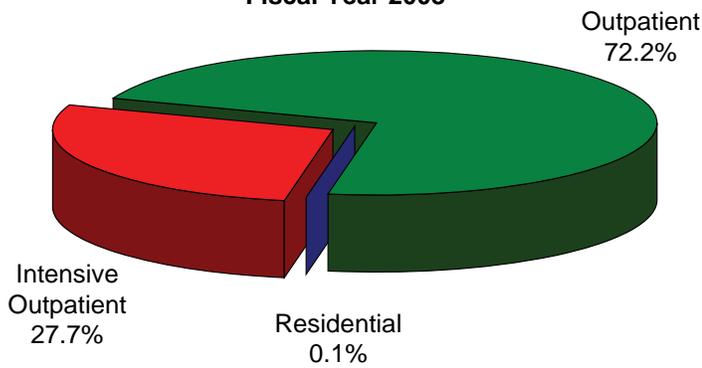
Four Corners Community Behavioral Health - Substance Abuse

2007 Population	Total Served	Penetration Rate
39,056	853	2.2%

Admissions into Modalities and Clients Served
Fiscal Year 2008



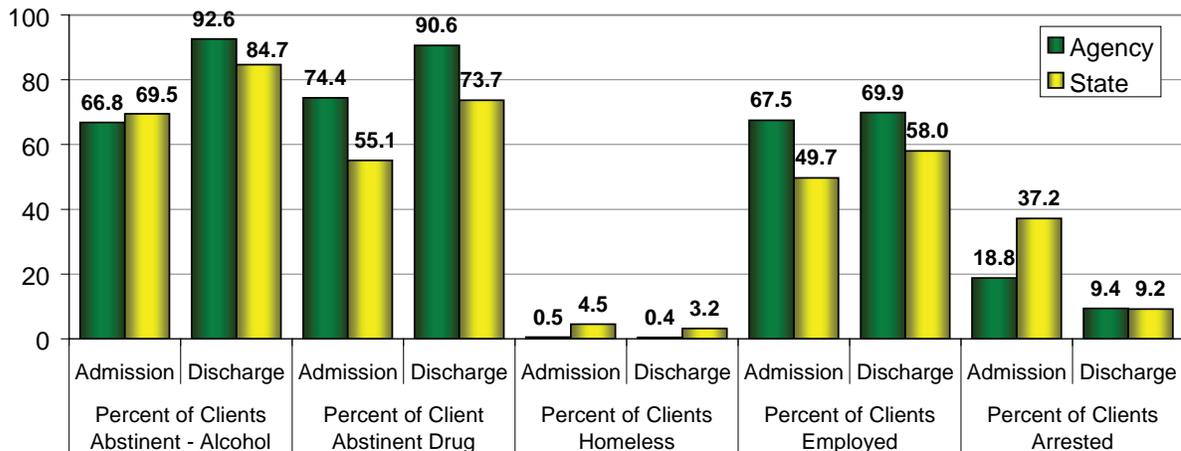
Admissions into Modalities
Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	273	109	382
Cocaine/Crack	3	4	7
Marijuana/Hashish	101	52	153
Heroin	5	3	8
Other Opiates/Synthetics	23	29	52
Hallucinogens	0	2	2
Methamphetamine	74	58	132
Other Stimulants	0	0	0
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	0	0
Inhalants	0	4	4
Oxycodone	4	4	8
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	3	0	3
Unkown	0	0	0
Total	486	266	752

Four Corners Community Behavioral Health Outcome Measures Fiscal Year 2008



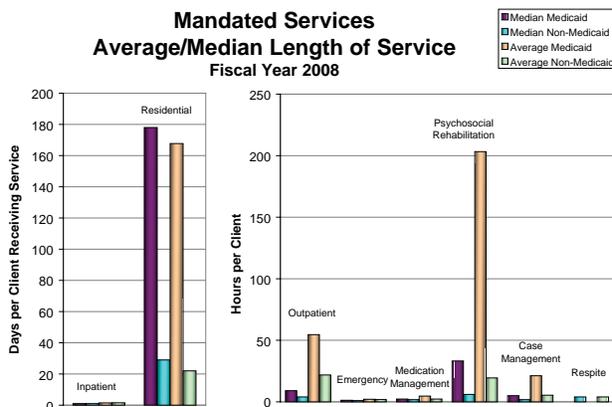
Four Corners Community Behavioral Health - Mental Health

Total Clients Served.....2,059
 Adult1,464
 Children/Youth.....595
 Penetration Rate 5.3%

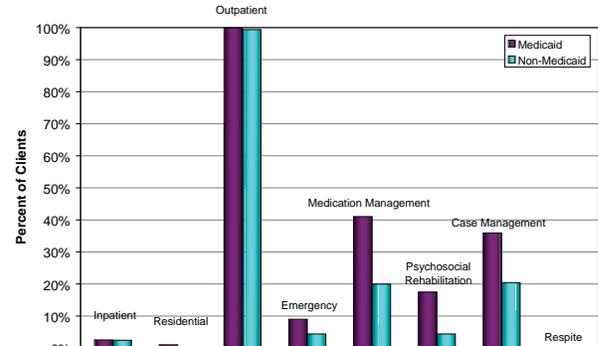
Diagnosis

	Youth	Adult
Mood Disorders	301	999
Anxiety Disorders	114	477
Personality Disorders	4	348
Substance Abuse	220	1,266
Adjustment Disorders	100	47
Cognitive Disorders	21	73
Schizophrenia and Other Psychotic	5	227
Attention Deficit	216	39
Autism	22	15
Impulse Disorders	10	24
Neglect or Abuse	80	6
Conduct Disorders	16	2
Other	436	588
V Codes	672	875
Total	2,217	4,986

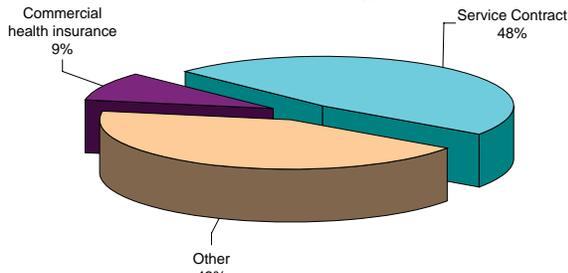
Mandated Services Average/Median Length of Service Fiscal Year 2008



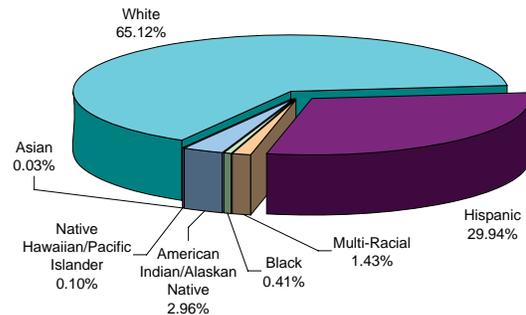
Utilization of Mandated Services Fiscal Year 2008



Expected Payment Source At Admission Fiscal Year 2008

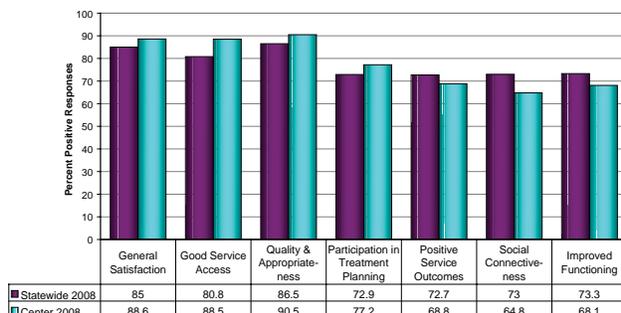


Race/Ethnicity Fiscal Year 2008

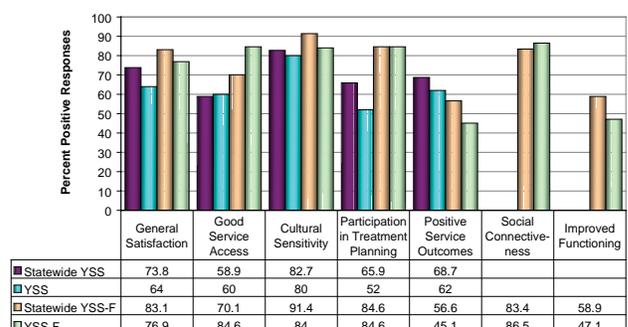


More than one race/ethnicity may have been selected.

Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2008



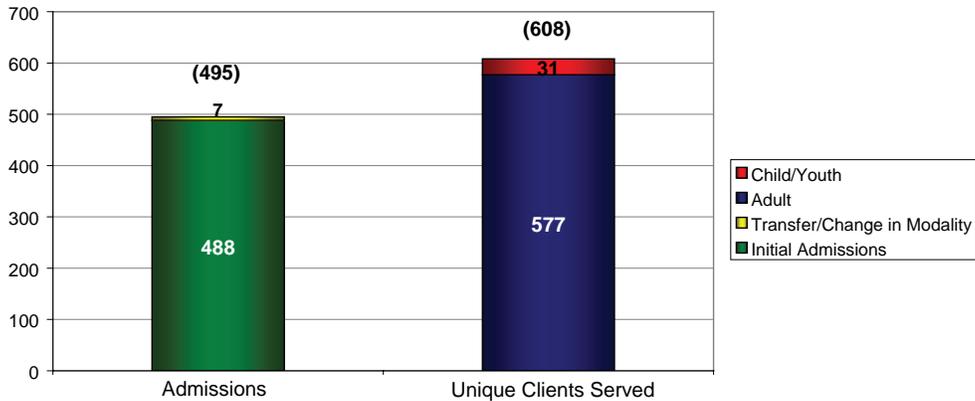
Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2008



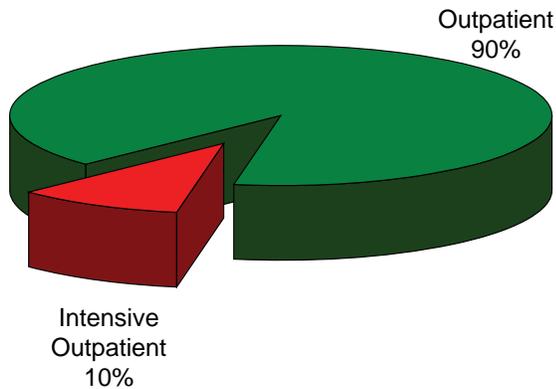
Northeastern Counseling Center - Substance Abuse

2007 Population	Total Served	Penetration Rate
46,185	608	1.3%

Admissions into Modalities and Clients Served Fiscal Year 2008



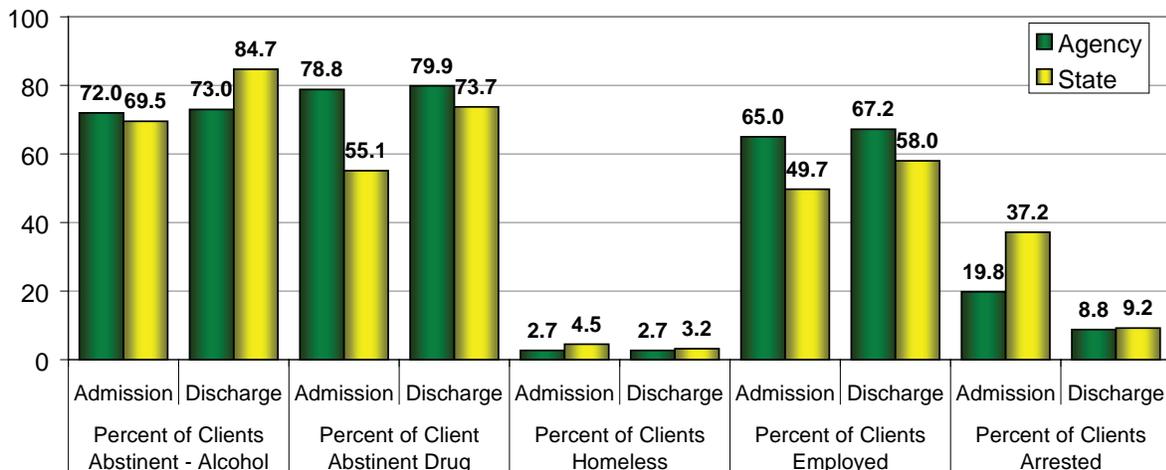
Admission into Modalities Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	181	78	259
Cocaine/Crack	5	5	10
Marijuana/Hashish	47	20	67
Heroin	4	2	6
Other Opiates/Synthetics	5	9	14
Hallucinogens	0	1	1
Methamphetamine	58	55	113
Other Stimulants	2	0	2
Benzodiazepines	0	2	2
Tranquilizers/Sedatives	0	2	2
Inhalants	0	1	1
Oxycodone	11	5	16
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	2	0	2
Total	315	180	495

Northeastern Counseling Center Outcome Measures Fiscal Year 2008



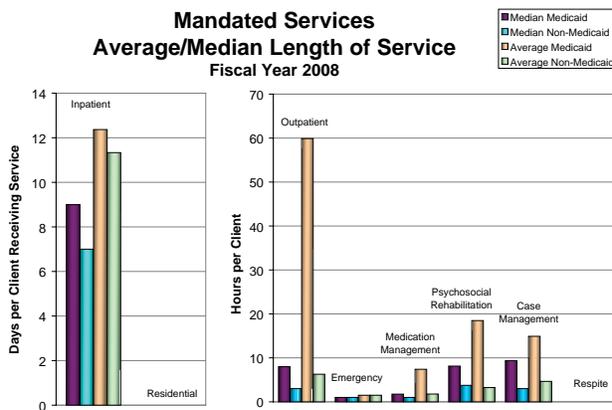
Northeastern Counseling Center - Mental Health

Total Clients Served853
 Adult554
 Children/Youth299
 Penetration Rate 1.8%

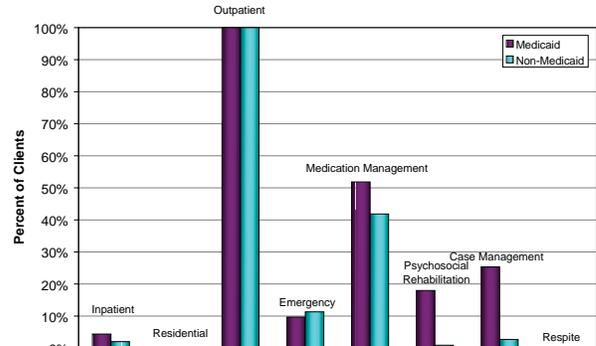
Diagnosis

	Youth	Adult
Mood Disorders	106	402
Anxiety Disorders	104	296
Personality Disorders	0	144
Substance Abuse	13	99
Adjustment Disorders	73	35
Cognitive Disorders	14	40
Schizophrenia and Other Psychotic	5	97
Attention Deficit	66	33
Autism	11	6
Impulse Disorders	9	30
Neglect or Abuse	81	32
Conduct Disorders	12	1
Other	118	201
V Codes	336	330
Total	948	1,746

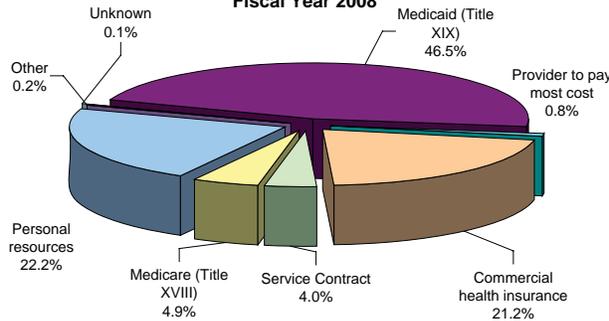
Mandated Services
Average/Median Length of Service
Fiscal Year 2008



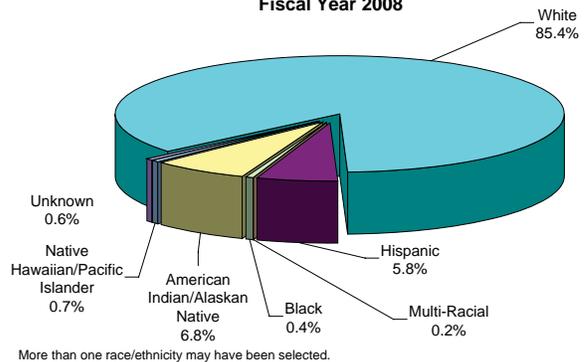
Utilization of Mandated Services
Fiscal Year 2008



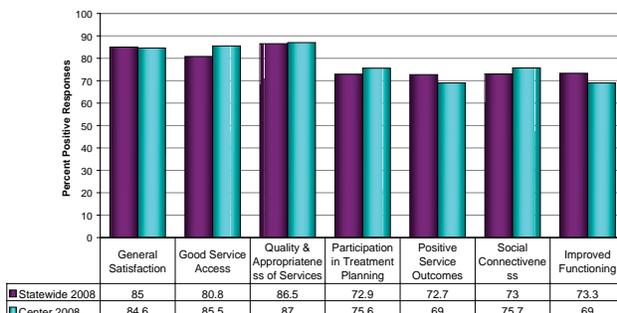
Expected Payment Source At Admission
Fiscal Year 2008



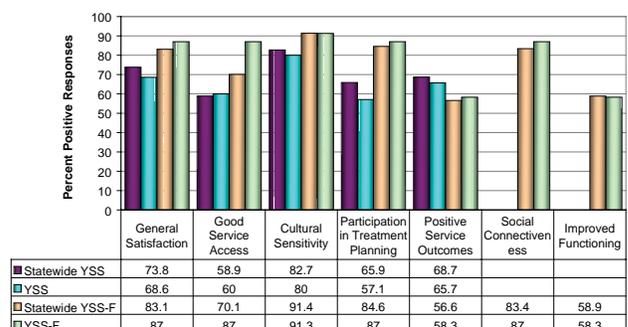
Race/Ethnicity
Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2008



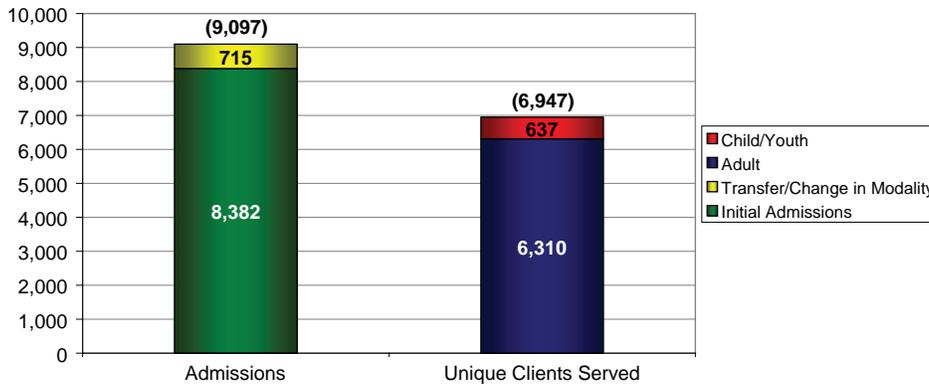
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2008



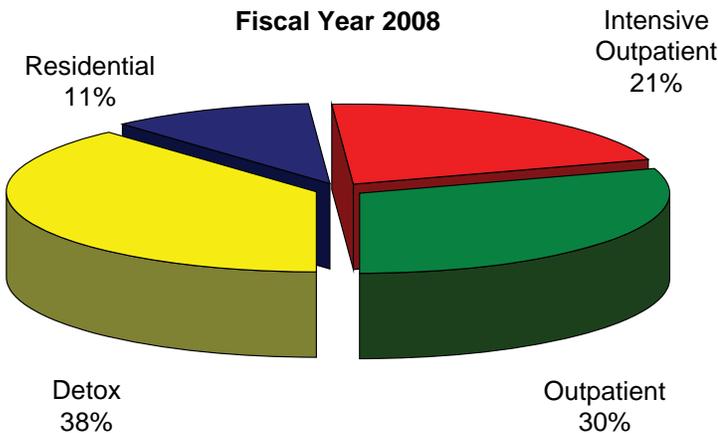
Salt Lake County Division of Substance Abuse

2007 Population	Total Served	Penetration Rate
1,009,518	6,947	0.7%

Admissions into Modalities and Clients Served Fiscal Year 2008



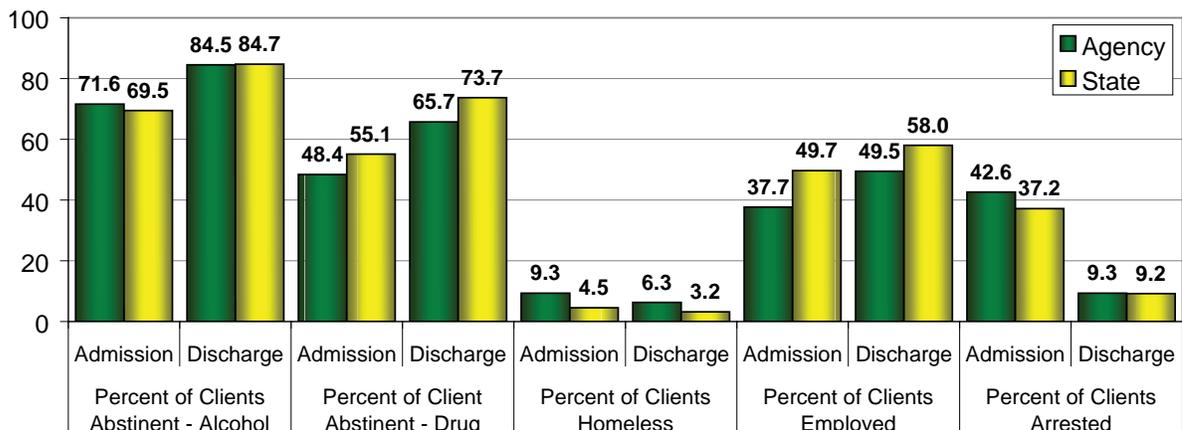
Admissions into Modalities Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	2,510	572	3,082
Cocaine/Crack	694	320	1,014
Marijuana/Hashish	865	271	1,136
Heroin	1,018	463	1,481
Other Opiates/Synthetics	85	108	193
Hallucinogens	5	2	7
Methamphetamine	988	923	1,911
Other Stimulants	14	22	36
Benzodiazepines	11	11	22
Tranquilizers/Sedatives	1	3	4
Inhalants	8	1	9
Oxycodone	92	98	190
Club Drugs	2	4	6
Over-the-Counter	1	1	2
Other	0	4	4
Unkown	0	0	0
Total	6,294	2,803	9,097

Salt Lake County Division of Substance Abuse Outcome Measures Fiscal Year 2008

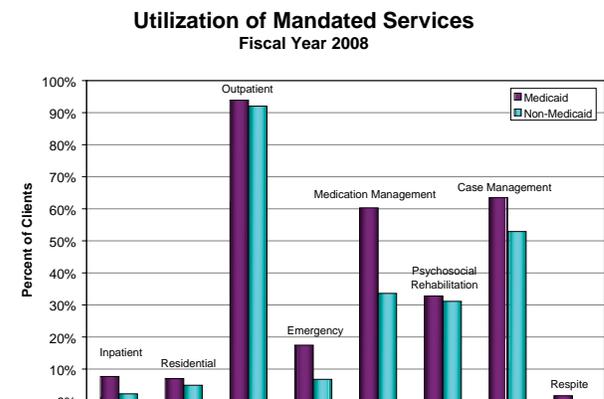
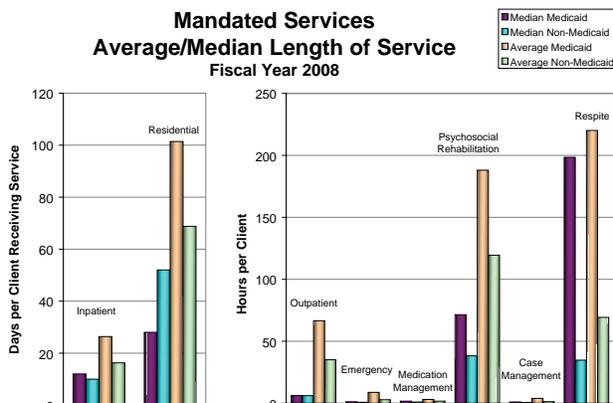


Salt Lake County - Valley Mental Health

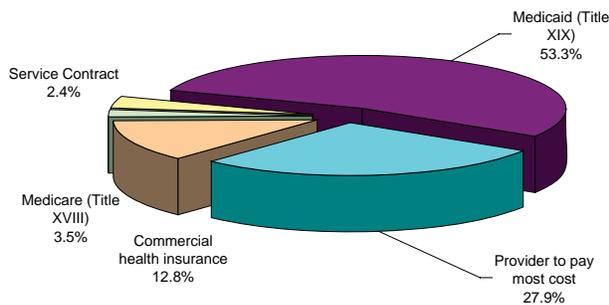
Total Clients Served.....14,547
 Adult10,082
 Children/Youth.....4,465
 Penetration Rate 1.4%

Diagnosis

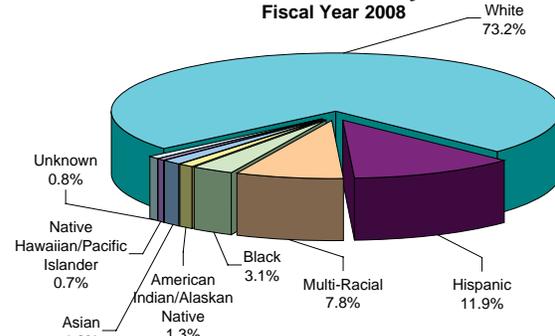
	Youth	Adult
Mood Disorders	1,436	5,343
Anxiety Disorders	1,298	2,849
Personality Disorders	19	2,562
Substance Abuse	587	5,938
Adjustment Disorders	526	239
Cognitive Disorders	101	367
Schizophrenia and Other Psychotic	80	2,145
Attention Deficit	1,463	361
Autism	469	117
Impulse Disorders	15	110
Neglect or Abuse	651	27
Conduct Disorders	204	11
Other	1,963	800
V Codes	1,853	2,541
Total	10,665	23,410



Expected Payment Source At Admission Fiscal Year 2008

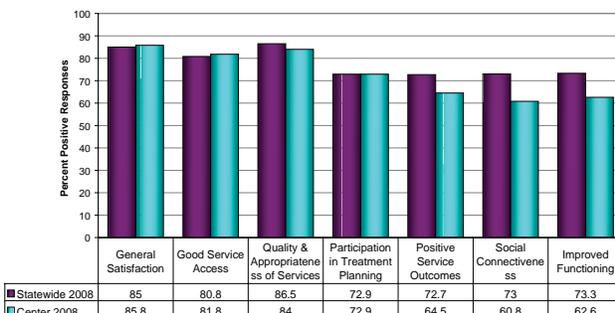


Race/Ethnicity Fiscal Year 2008

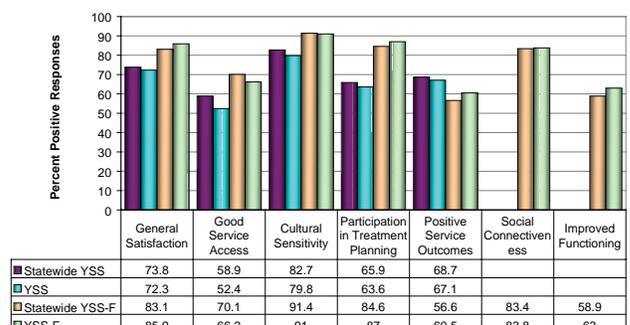


More than one race/ethnicity may have been selected.

Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2008



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2008



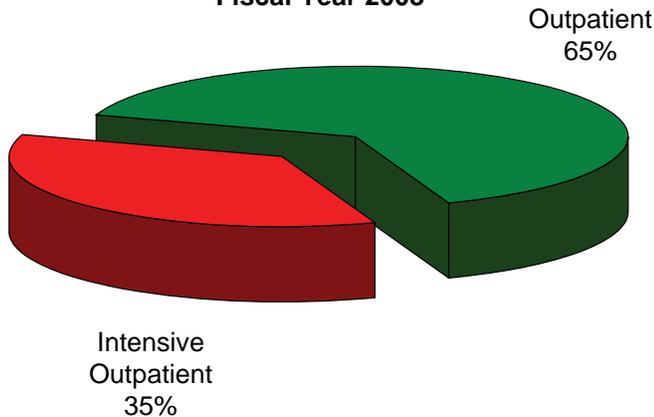
San Juan Counseling - Substance Abuse

2007 Population	Total Served	Penetration Rate
14,484	40	0.3%

Admissions into Modalities and Clients Served
Fiscal Year 2008



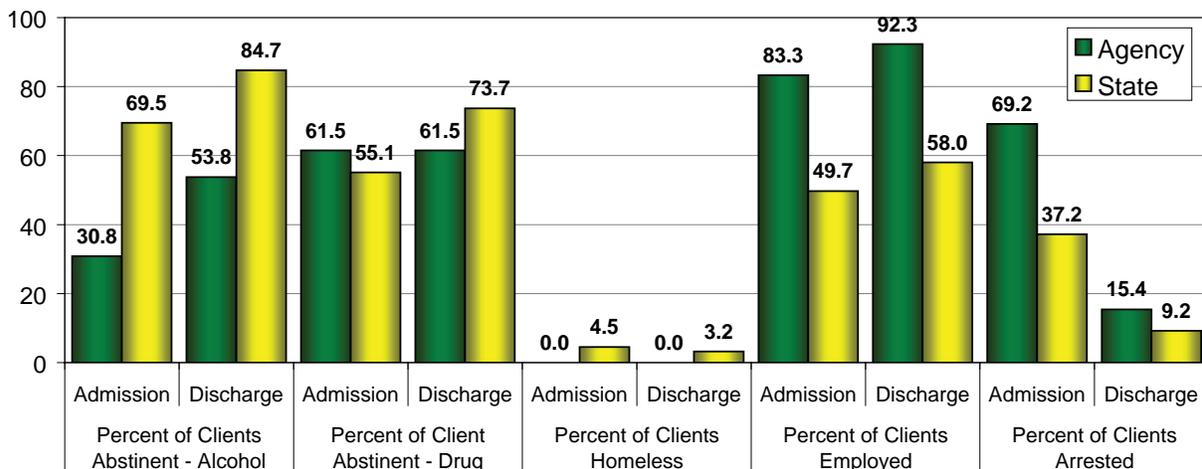
Admissions into Modalities
Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	14	3	17
Cocaine/Crack	0	0	0
Marijuana/Hashish	8	1	9
Heroin	0	0	0
Other Opiates/Synthetics	0	0	0
Hallucinogens	0	0	0
Methamphetamine	3	1	4
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	0	1
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	26	5	31

San Juan Counseling Outcome Measures
Fiscal Year 2008



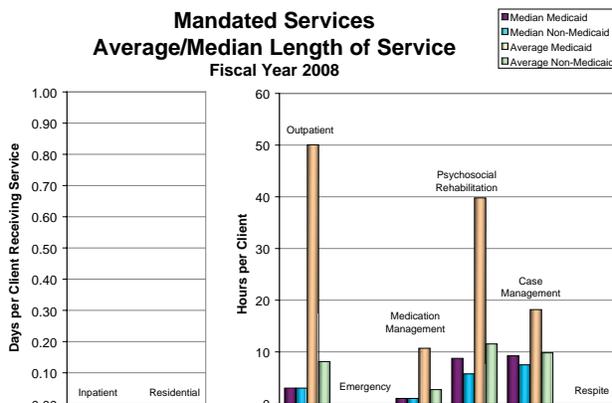
San Juan Counseling - Mental Health

Total Clients Served457
 Adult310
 Children/Youth147
 Penetration Rate 3.2%

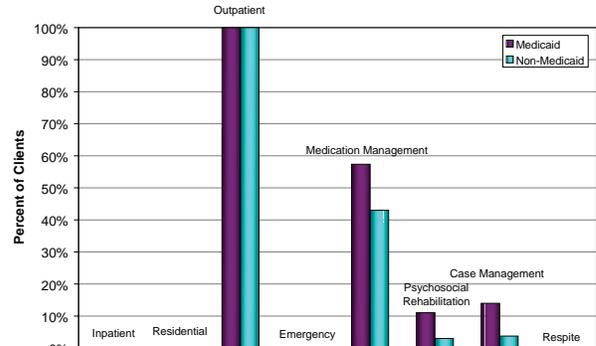
Diagnosis

	Youth	Adult
Mood Disorders	62	177
Anxiety Disorders	29	75
Personality Disorders	3	24
Substance Abuse	1	21
Adjustment Disorders	28	9
Cognitive Disorders	5	25
Schizophrenia and Other Psychotic	0	28
Attention Deficit	41	6
Autism	13	2
Impulse Disorders	5	9
Neglect or Abuse	10	0
Conduct Disorders	0	0
Other	33	36
V Codes	84	89
Total	314	501

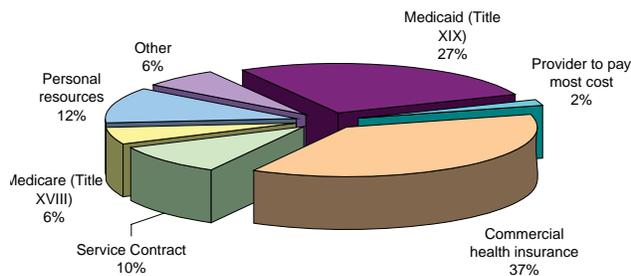
Mandated Services
 Average/Median Length of Service
 Fiscal Year 2008



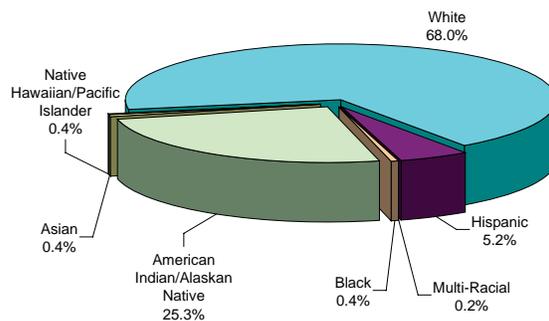
Utilization of Mandated Services
 Fiscal Year 2008



Expected Payment Source At Admission
 Fiscal Year 2008

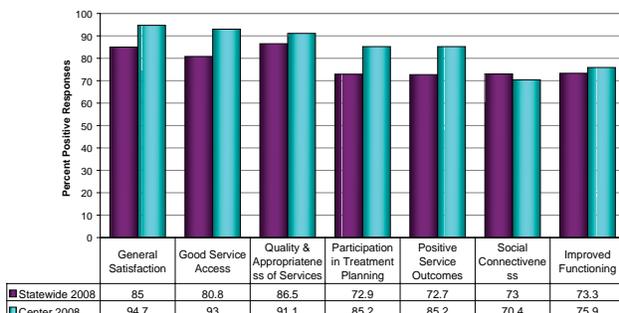


Race/Ethnicity
 Fiscal Year 2008

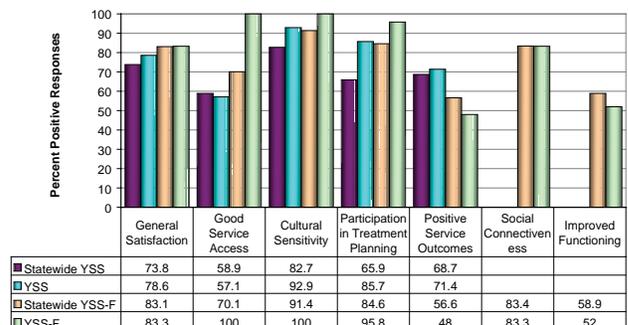


More than one race/ethnicity may have been selected.

Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
 2008



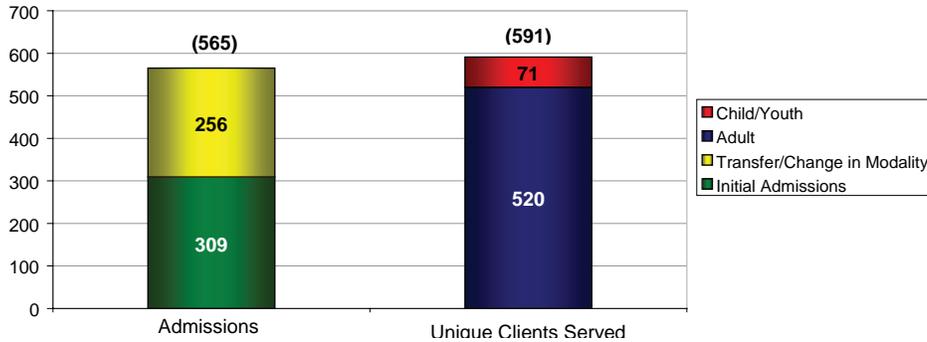
Youth Consumer Satisfaction Surveys (YSS and YSS-F)
 2008



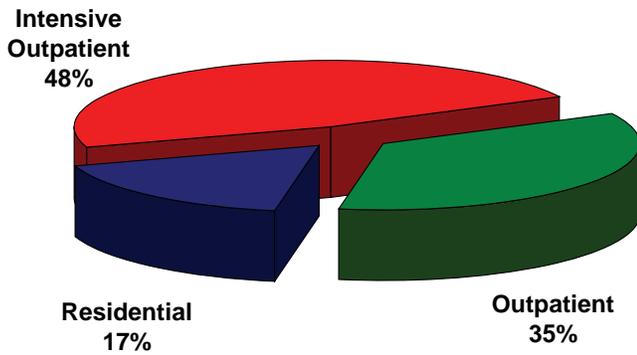
Southwest Behavioral Health Center - Substance Abuse

2007 Population	Total Served	Penetration Rate
194,459	591	0.3%

Admissions into Modalities and Clients Served Fiscal Year 2008



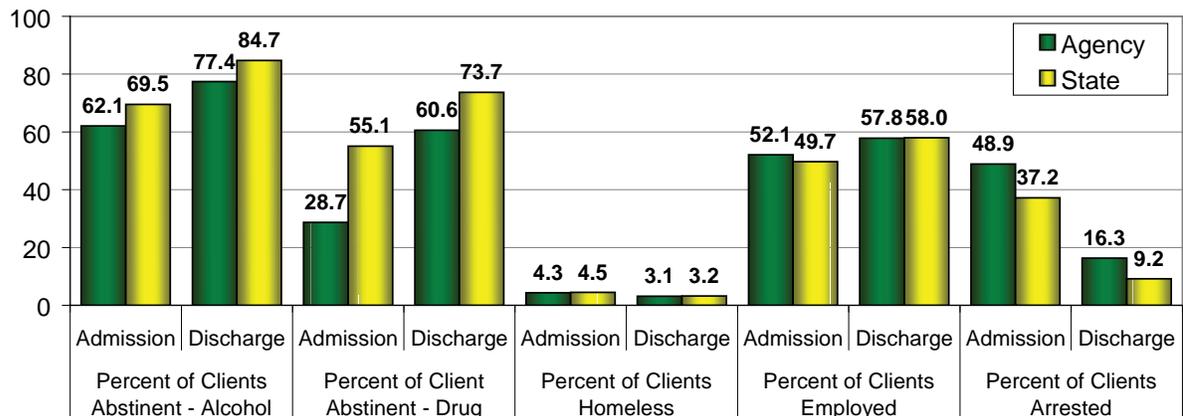
Admissions into Modalities Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	97	73	170
Cocaine/Crack	5	0	5
Marijuana/Hashish	84	23	107
Heroin	15	13	28
Other Opiates/Synthetics	13	13	26
Hallucinogens	0	0	0
Methamphetamine	87	102	189
Other Stimulants	1	0	1
Benzodiazepines	3	5	8
Tranquilizers/Sedatives	1	0	1
Inhalants	0	0	0
Oxycodone	20	8	28
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	1	2
Unkown	0	0	0
Total	327	238	565

Southwest Behavioral Health Outcome Measures Fiscal Year 2008



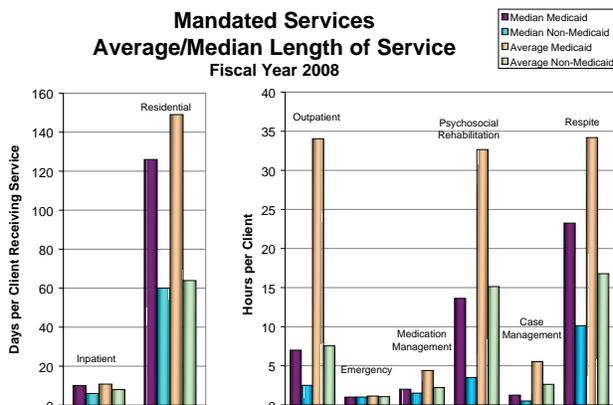
Southwest Behavioral Health Center - Mental Health

Total Clients Served2,860
 Adult1,490
 Children/Youth1,370
 Penetration Rate 1.5%

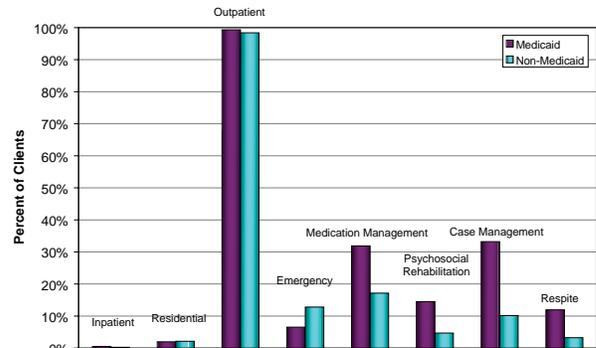
Diagnosis

	Youth	Adult
Mood Disorders	203	577
Anxiety Disorders	136	156
Personality Disorders	12	222
Substance Abuse	7	35
Adjustment Disorders	336	122
Cognitive Disorders	25	95
Schizophrenia and Other Psychotic	1	245
Attention Deficit	134	16
Autism	33	21
Impulse Disorders	17	14
Neglect or Abuse	123	18
Conduct Disorders	32	0
Other	335	498
V Codes	1,160	530
Total	2,554	2,549

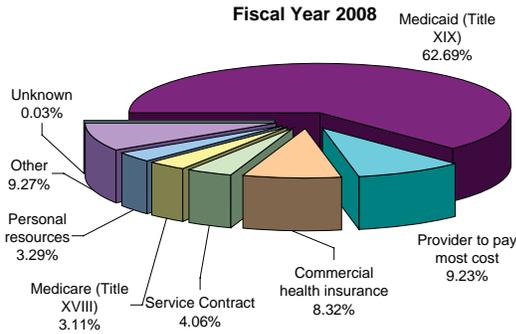
Mandated Services
Average/Median Length of Service
Fiscal Year 2008



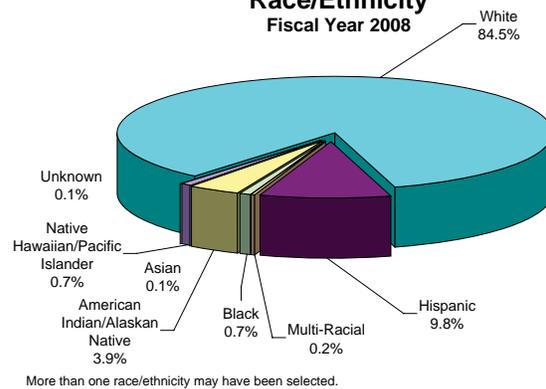
Utilization of Mandated Services
Fiscal Year 2008



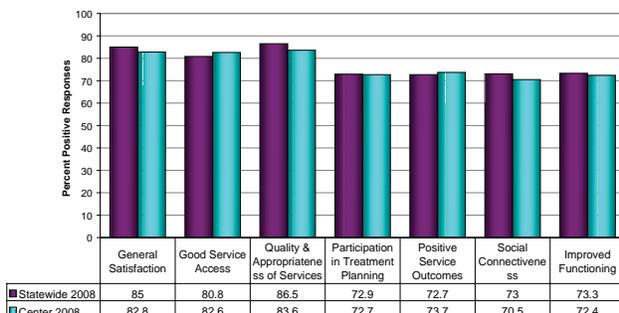
Expected Payment Source At Admission
Fiscal Year 2008



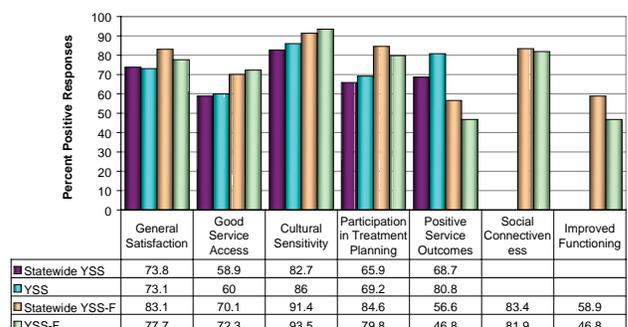
Race/Ethnicity
Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2008



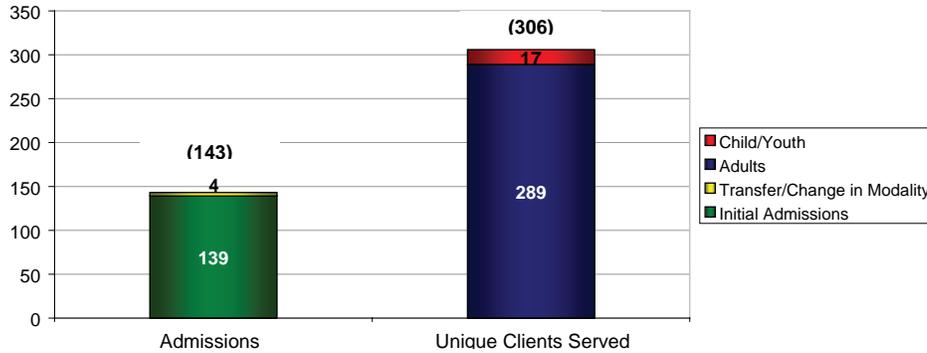
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2008



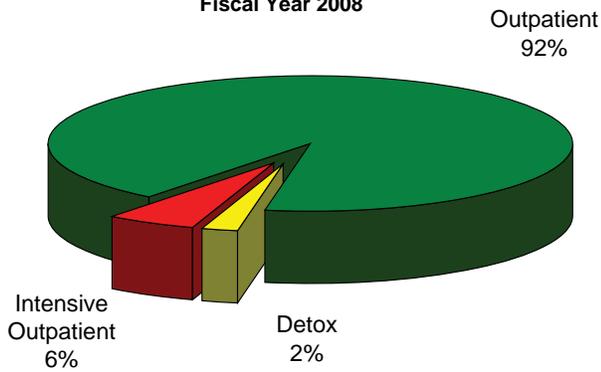
Summit County - Valley Mental Health - Substance Abuse

2007 Population	Total Served	Penetration Rate
35,541	306	0.9%

Admissions into Modalities and Clients Served Fiscal Year 2008



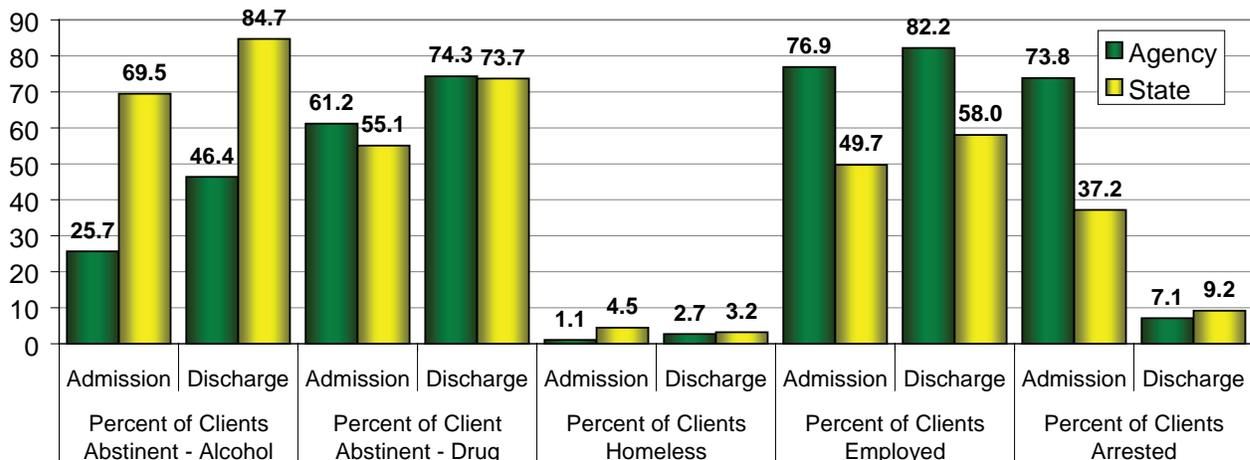
Admissions into Modalities Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	87	19	106
Cocaine/Crack	5	0	5
Marijuana/Hashish	15	4	19
Heroin	0	0	0
Other Opiates/Synthetics	4	0	4
Hallucinogens	0	0	0
Methamphetamine	4	4	8
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	1	0	1
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	116	27	143

Summit County - VMH Outcome Measures Fiscal Year 2008



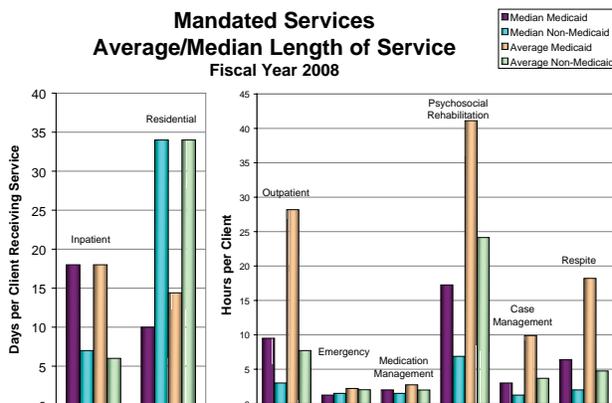
Summit County - Valley Mental Health - Mental Health

Total Clients Served.....843
 Adult661
 Children/Youth.....182
 Penetration Rate 2.4%

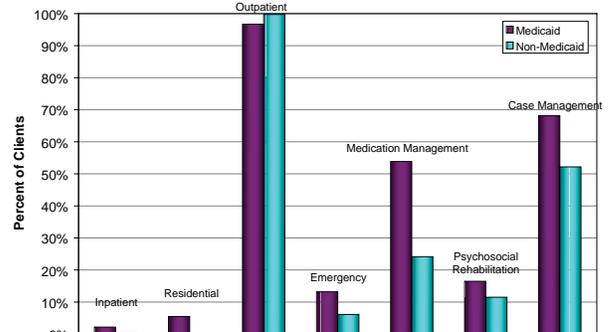
Diagnosis

	Youth	Adult
Mood Disorders	71	250
Anxiety Disorders	37	159
Personality Disorders	1	21
Substance Abuse	35	443
Adjustment Disorders	32	44
Cognitive Disorders	2	6
Schizophrenia and Other Psychotic	2	17
Attention Deficit	32	30
Autism	5	4
Impulse Disorders	2	3
Neglect or Abuse	8	2
Conduct Disorders	5	1
Other	59	90
V Codes	136	294
Total	427	1,364

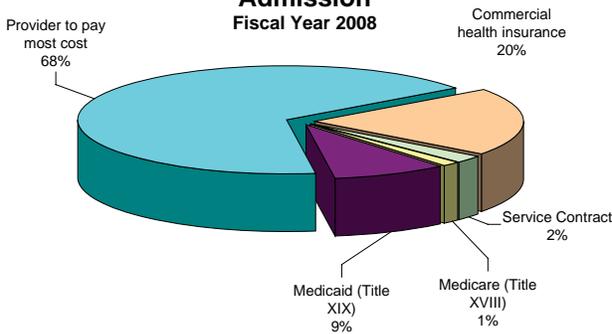
Mandated Services
Average/Median Length of Service
Fiscal Year 2008



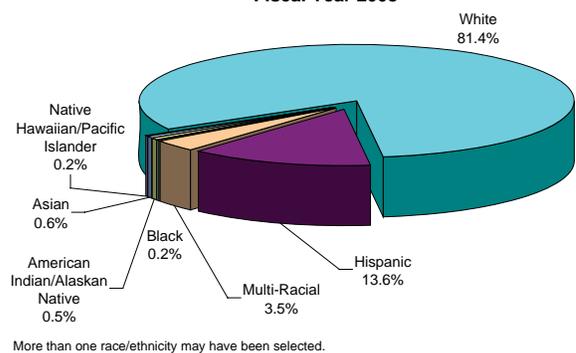
Utilization of Mandated Services
Fiscal Year 2008



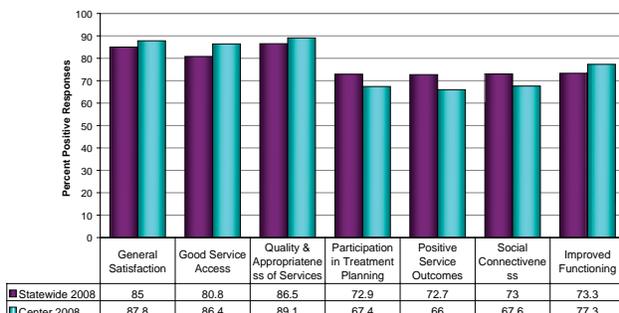
Expected Payment Source At Admission
Fiscal Year 2008



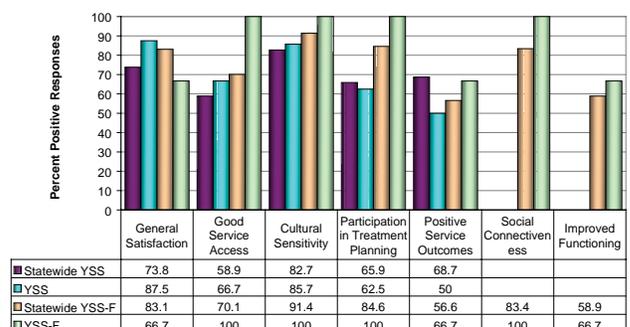
Race/Ethnicity
Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2008



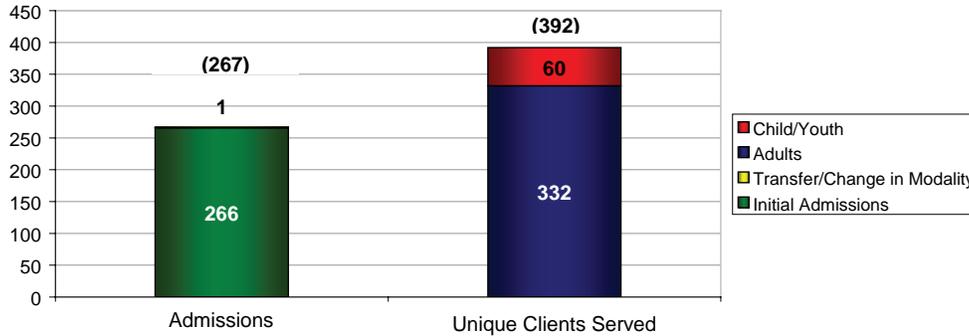
Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2008



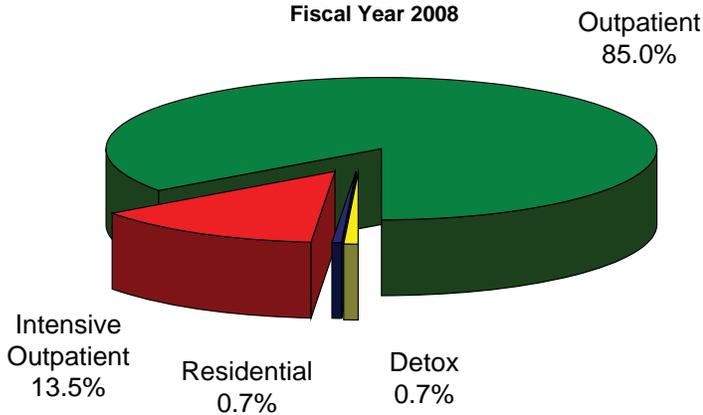
Tooele County - Valley Mental Health - Substance Abuse

2007 Population	Total Served	Penetration Rate
54,914	392	0.7%

Admissions into Modalities and Clients Served Fiscal Year 2008



Admissions into Modalities Fiscal Year 2008

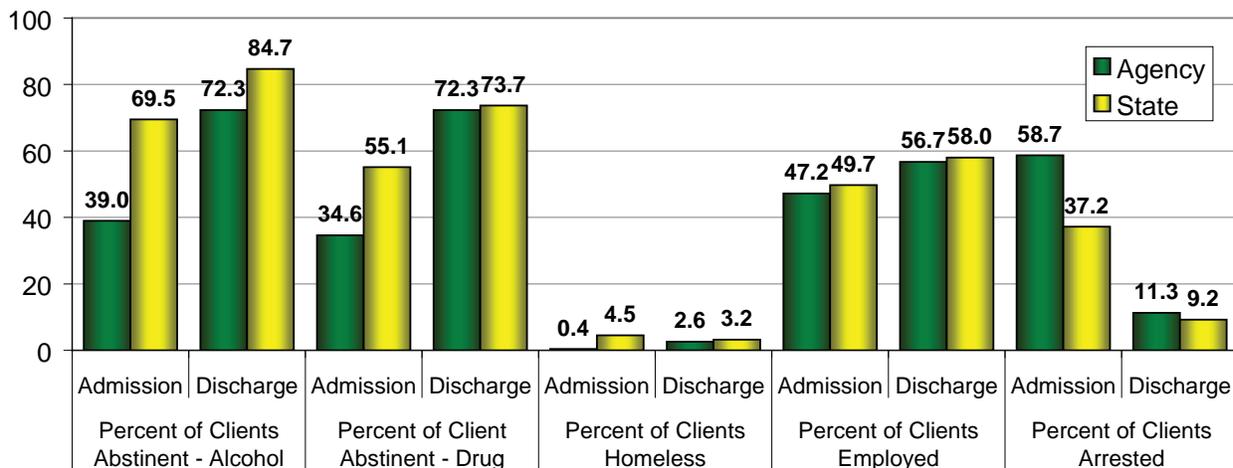


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	89	29	118
Cocaine/Crack	5	3	8
Marijuana/Hashish	48	13	61
Heroin	8	4	12
Other Opiates/Synthetics	3	2	5
Hallucinogens	0	0	0
Methamphetamine	23	28	51
Other Stimulants	1	0	1
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	0	2	2
Inhalants	0	1	1
Oxycodone	3	4	7
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
Total	181	86	267

Tooele - VMH Outcome Measures

Fiscal Year 2008



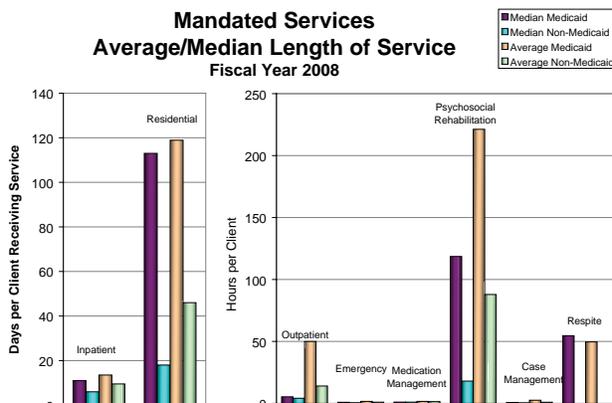
Tooele County - Valley Mental Health - Mental Health

Total Clients Served1,715
 Adult1,216
 Children/Youth499
 Penetration Rate 3.1%

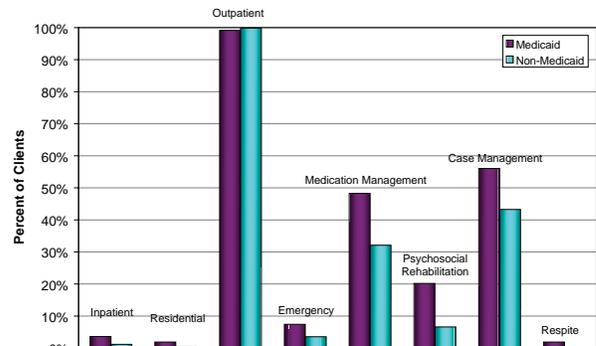
Diagnosis

	Youth	Adult
Mood Disorders	162	728
Anxiety Disorders	117	391
Personality Disorders	5	134
Substance Abuse	155	671
Adjustment Disorders	51	43
Cognitive Disorders	11	18
Schizophrenia and Other Psychotic	1	81
Attention Deficit	136	132
Autism	19	10
Impulse Disorders	3	5
Neglect or Abuse	108	4
Conduct Disorders	36	2
Other	179	81
V Codes	156	302
Total	1,139	2,602

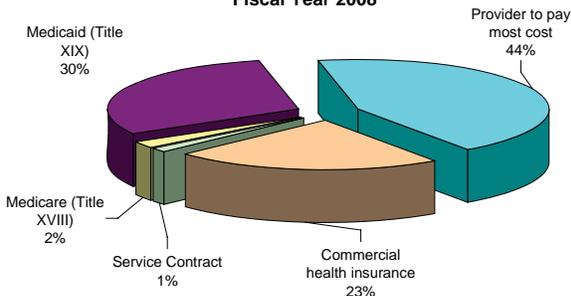
Mandated Services
Average/Median Length of Service
Fiscal Year 2008



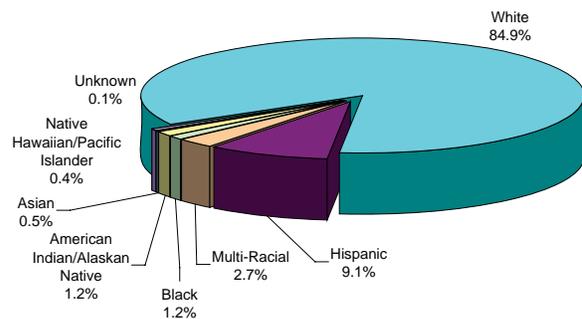
Utilization of Mandated Services
Fiscal Year 2008



Expected Payment Source At Admission
Fiscal Year 2008

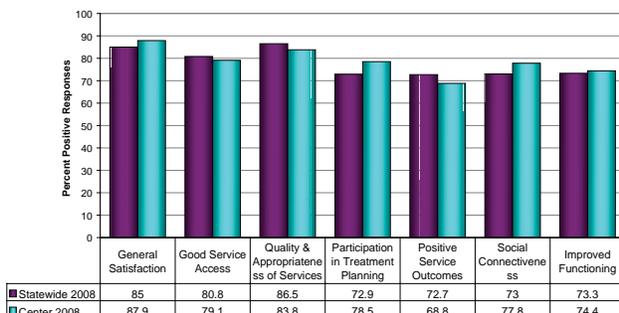


Race/Ethnicity
Fiscal Year 2008

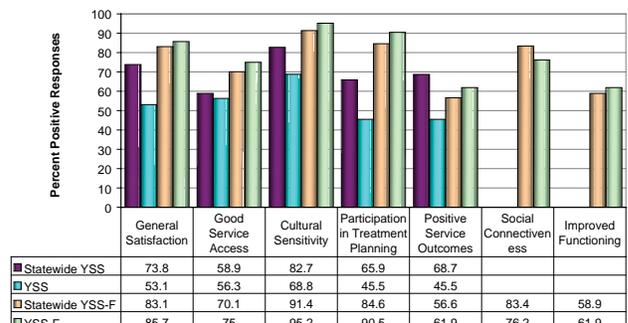


More than one race/ethnicity may have been selected.

Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2008



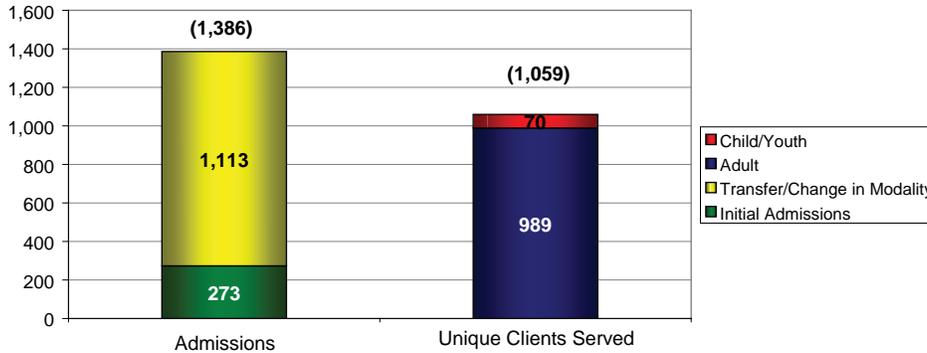
Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2008



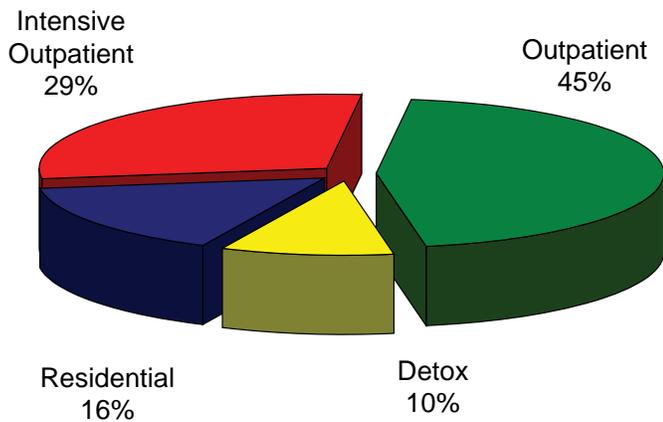
Utah County Division of Substance Abuse

2007 Population	Total Served	Penetration Rate
483,702	1,059	0.2%

Admissions into Modalities and Clients Served Fiscal Year 2008



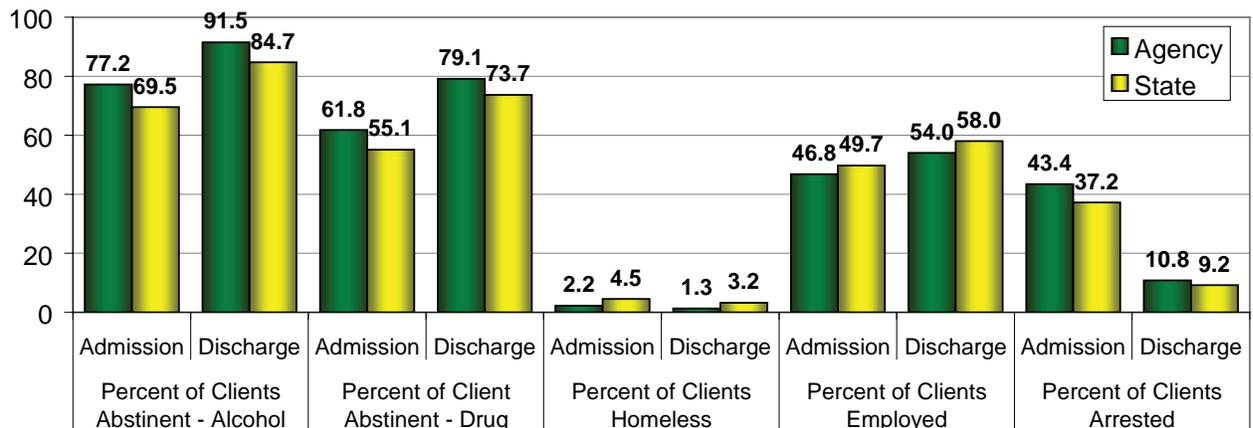
Admissions into Modalities Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	212	130	342
Cocaine/Crack	25	28	53
Marijuana/Hashish	129	54	183
Heroin	151	105	256
Other Opiates/Synthetics	3	11	14
Hallucinogens	3	0	3
Methamphetamine	134	185	319
Other Stimulants	1	0	1
Benzodiazepines	5	14	19
Tranquilizers/Sedatives	0	5	5
Inhalants	1	0	1
Oxycodone	99	87	186
Club Drugs	0	1	1
Over-the-Counter	0	2	2
Other	0	1	1
Unkown	0	0	0
Total	763	623	1,386

Utah County Division of Substance Abuse Outcome Measures Fiscal Year 2008



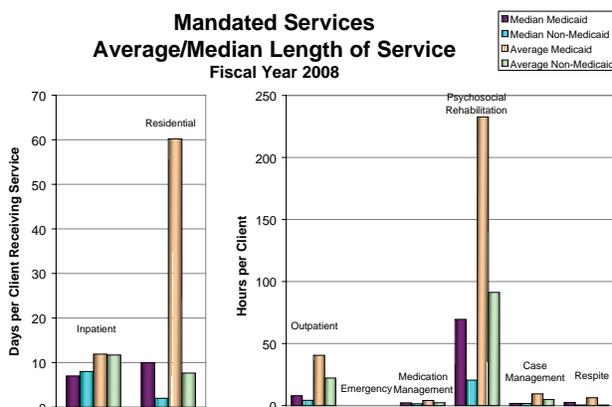
Utah County - Wasatch Mental Health

Total Clients Served.....5,716
 Adult2,944
 Children/Youth.....2,772
 Penetration Rate 1.2%

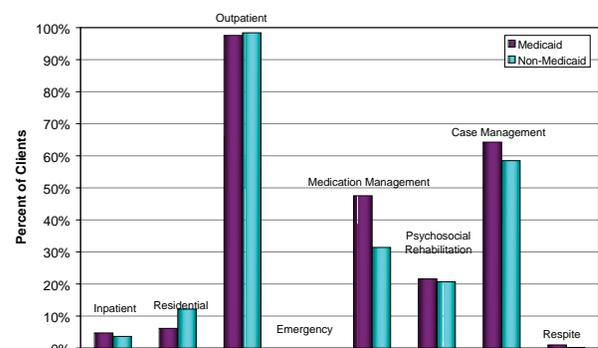
Diagnosis

	Youth	Adult
Mood Disorders	573	1,829
Anxiety Disorders	725	1,539
Personality Disorders	28	765
Substance Abuse	125	924
Adjustment Disorders	401	83
Cognitive Disorders	73	341
Schizophrenia and Other Psychotic	36	802
Attention Deficit	574	224
Autism	263	74
Impulse Disorders	49	123
Neglect or Abuse	545	75
Conduct Disorders	66	4
Other	1,423	1,230
V Codes	3,450	1,642
Total	8,331	9,655

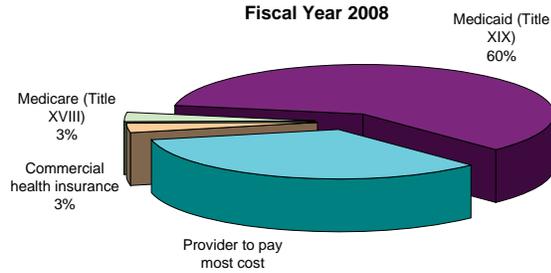
Mandated Services
 Average/Median Length of Service
 Fiscal Year 2008



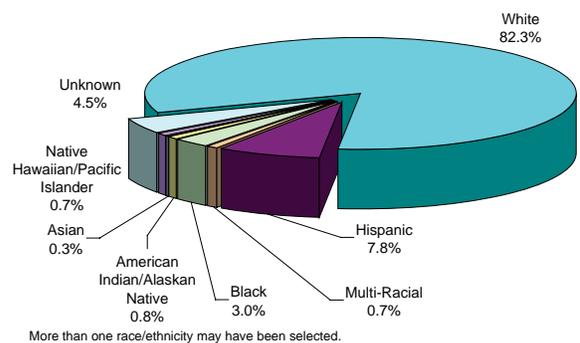
Utilization of Mandated Services
 Fiscal Year 2008



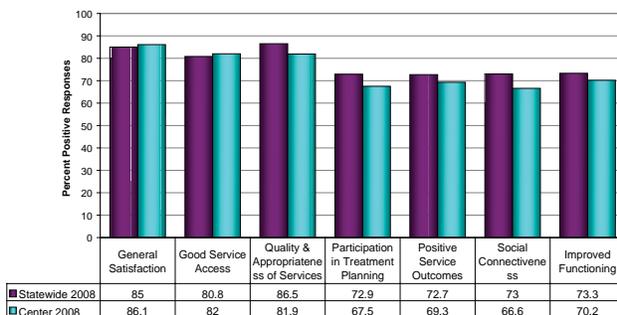
Expected Payment Source At Admission
 Fiscal Year 2008



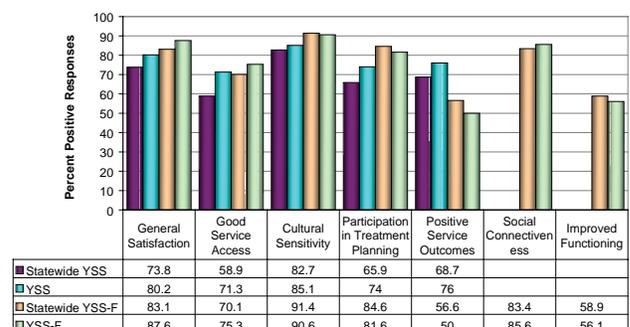
Race/Ethnicity
 Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
 2008



Youth Consumer Satisfaction Surveys (YSS and YSS-F)
 2008



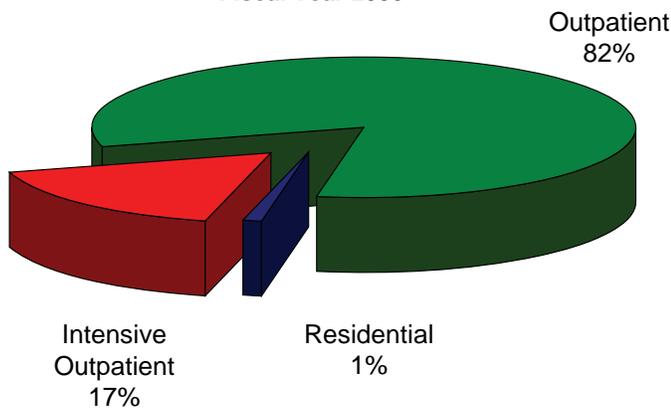
Wasatch County - Heber Valley Counseling - Substance Abuse

2007 Population	Total Served	Penetration Rate
20,535	133	0.6%

Admissions into Modalities and Clients Served
Fiscal Year 2008



Admissions into Modalities
Fiscal Year 2008

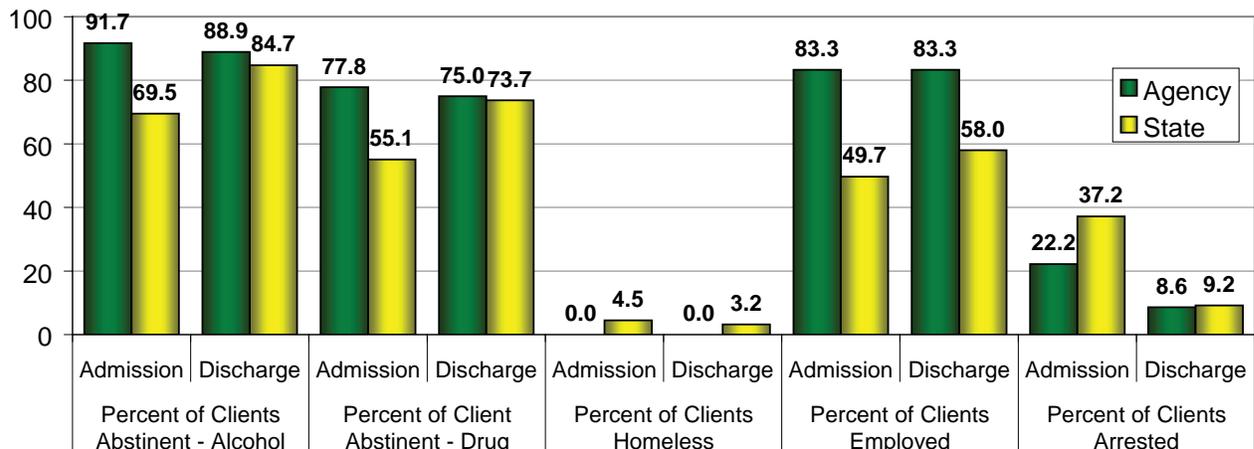


Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	24	9	33
Cocaine/Crack	5	1	6
Marijuana/Hashish	11	5	16
Heroin	3	5	8
Other Opiates/Synthetics	0	1	1
Hallucinogens	0	0	0
Methamphetamine	8	1	9
Other Stimulants	1	0	1
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	7	8	15
Club Drugs	1	0	1
Over-the-Counter	0	0	0
Other	0	0	0
Unknown	0	0	0
Total	60	30	90

Wasatch County - Heber Valley Counseling Outcome Measures

Fiscal Year 2008



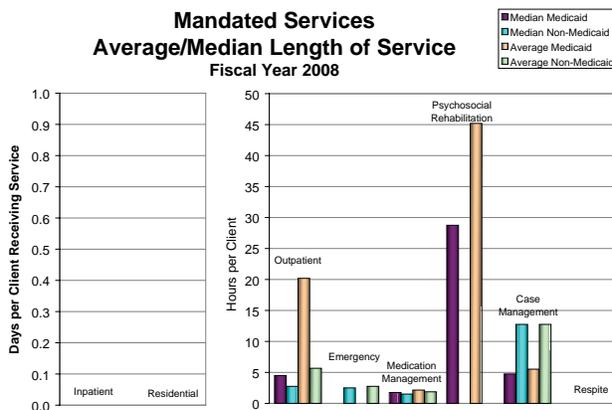
Wasatch County - Heber Valley Counseling - Mental Health

Total Clients Served 244
 Adult 177
 Children/Youth 67
 Penetration Rate 1.2%

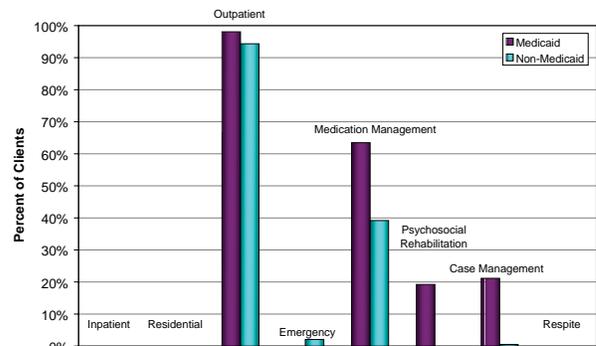
Diagnosis

	Youth	Adult
Mood Disorders	23	91
Anxiety Disorders	22	88
Personality Disorders	2	30
Substance Abuse	14	47
Adjustment Disorders	7	5
Cognitive Disorders	0	4
Schizophrenia and Other Psychotic	0	18
Attention Deficit	18	4
Autism	4	0
Impulse Disorders	0	1
Neglect or Abuse	15	2
Conduct Disorders	0	0
Other	26	114
V Codes	53	78
Total	184	482

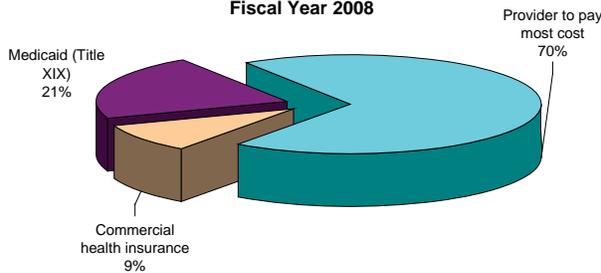
Mandated Services Average/Median Length of Service Fiscal Year 2008



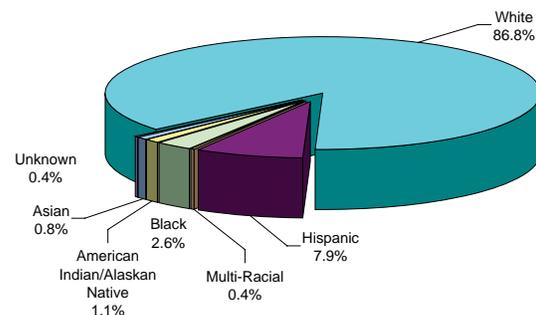
Utilization of Mandated Services Fiscal Year 2008



Expected Payment Source At Admission Fiscal Year 2008

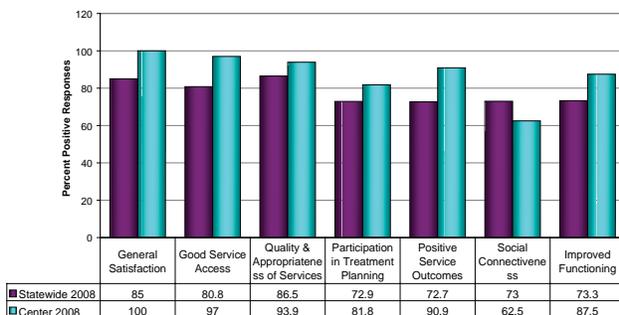


Race/Ethnicity Fiscal Year 2008

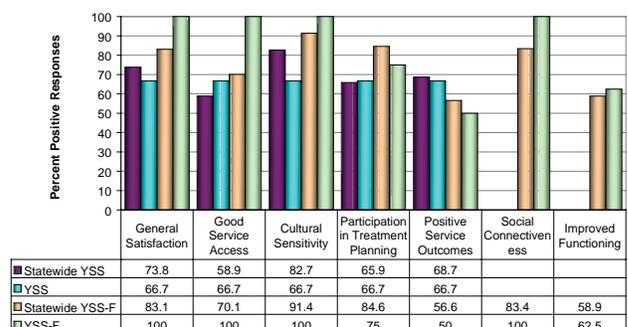


More than one race/ethnicity may have been selected.

Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2008



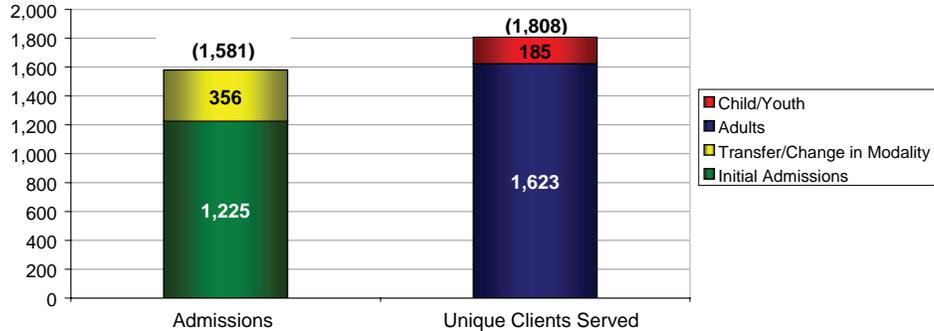
Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2008



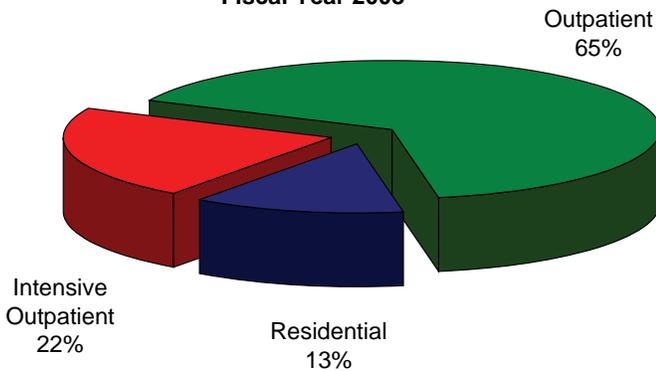
Weber Human Services - Substance Abuse

2007 Population	Total Served	Penetration Rate
230,203	1,808	0.8%

Admissions into Modalities and Clients Served
Fiscal Year 2008



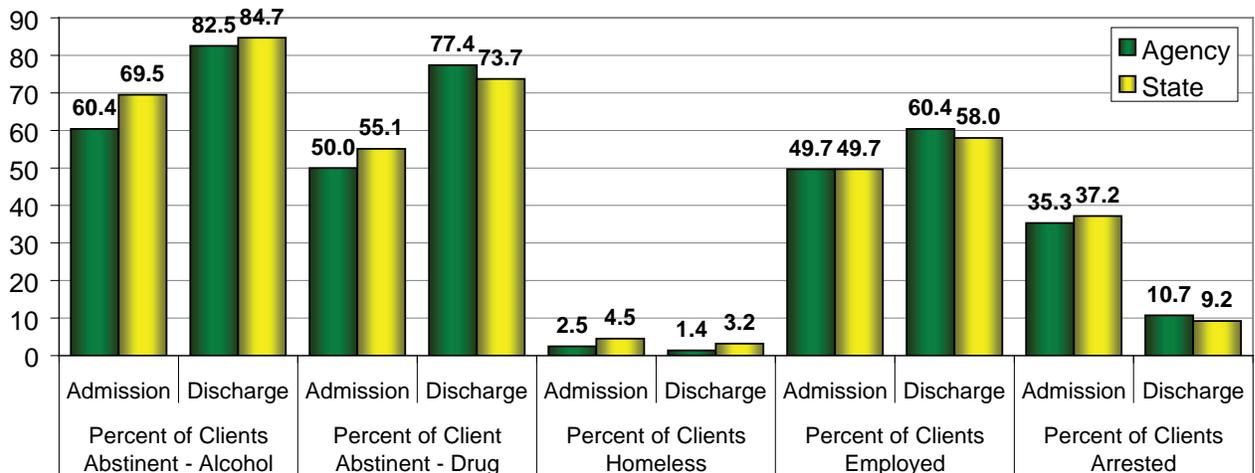
Admission into Modalities
Fiscal Year 2008



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	327	167	494
Cocaine/Crack	45	36	81
Marijuana/Hashish	226	104	330
Heroin	26	15	41
Other Opiates/Synthetics	8	10	18
Hallucinogens	1	1	2
Methamphetamine	243	249	492
Other Stimulants	4	3	7
Benzodiazepines	0	3	3
Tranquilizers/Sedatives	0	1	1
Inhalants	1	1	2
Oxycodone	39	64	103
Club Drugs	2	2	4
Over-the-Counter	0	3	3
Other	0	0	0
Unkown	0	0	0
Total	922	659	1,581

Weber Human Services Outcome Measures
Fiscal Year 2008



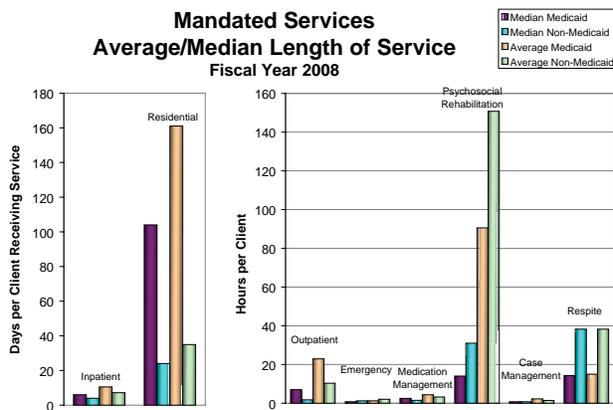
Weber Human Services - Mental Health

Total Clients Served5,738
 Adult4,166
 Children/Youth1,572
 Penetration Rate 2.5%

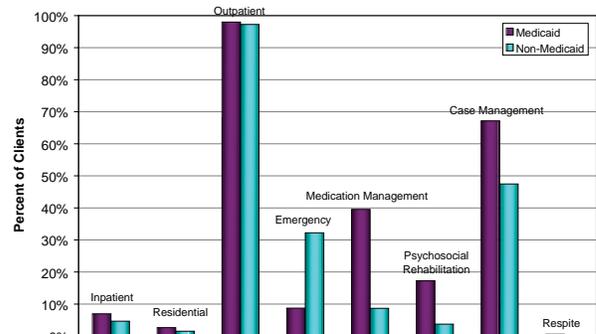
Diagnosis

	Youth	Adult
Mood Disorders	264	840
Anxiety Disorders	0	604
Personality Disorders	2	403
Substance Abuse	174	924
Adjustment Disorders	0	56
Cognitive Disorders	36	121
Schizophrenia and Other Psychotic	42	418
Attention Deficit	172	70
Autism	111	17
Impulse Disorders	7	24
Neglect or Abuse	237	33
Conduct Disorders	53	6
Other	536	910
V Codes	859	1,015
Total	2,493	5,441

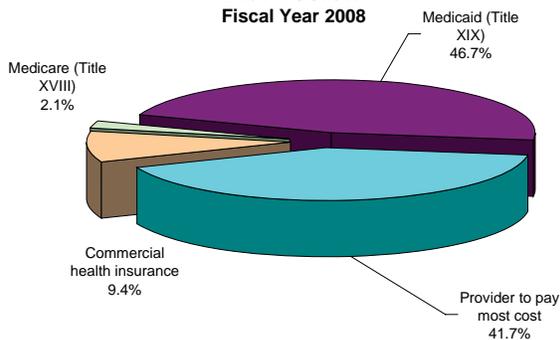
Mandated Services
 Average/Median Length of Service
 Fiscal Year 2008



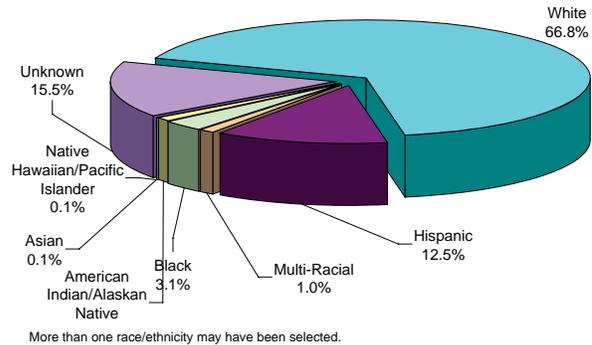
Utilization of Mandated Services
 Fiscal Year 2008



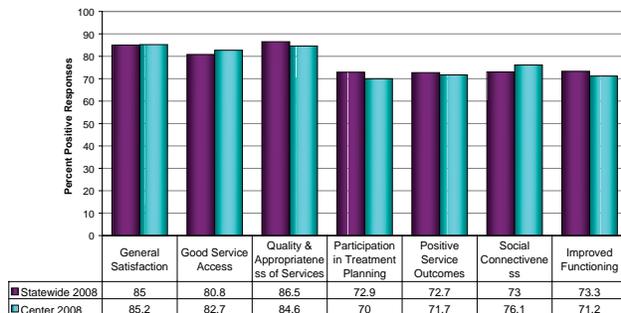
Expected Payment Source At Admission
 Fiscal Year 2008



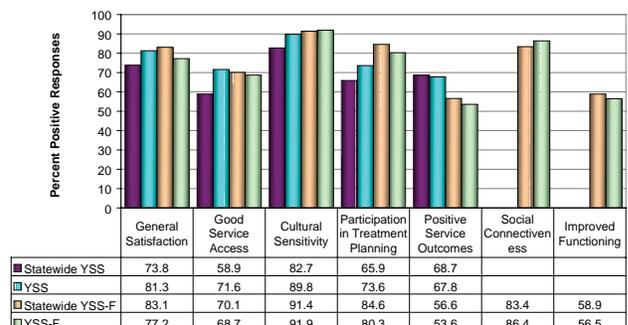
Race/Ethnicity
 Fiscal Year 2008



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2008



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2008





The Utah State Hospital held an open house for the museum. Dallas Earnshaw (USH Superintendent) was interviewed by various news outlets about the museum which features historical items relative to advances made in the treatment of mental illness in Utah. USH also has a treatment mall. Patients take courses in acquiring skills that will assist them towards individual recovery from mental illness.

Utah State Hospital

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 USH 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 13 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

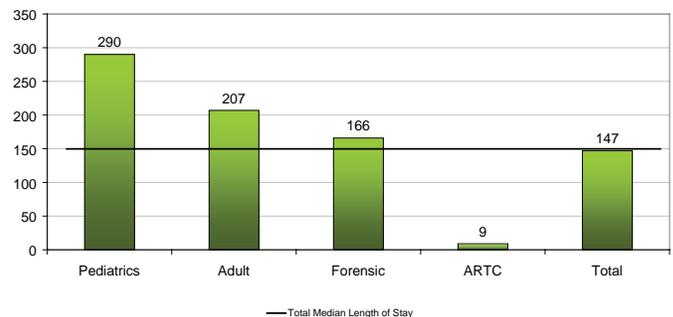
- Adult patients over 18 who have severe mental disorders (civil commitment)
- Children and youth (ages 6-18) who require intensive inpatient treatment
- Persons adjudicated and found guilty and mentally ill
- Persons found incompetent to proceed and need competency restoration or diminished capacity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

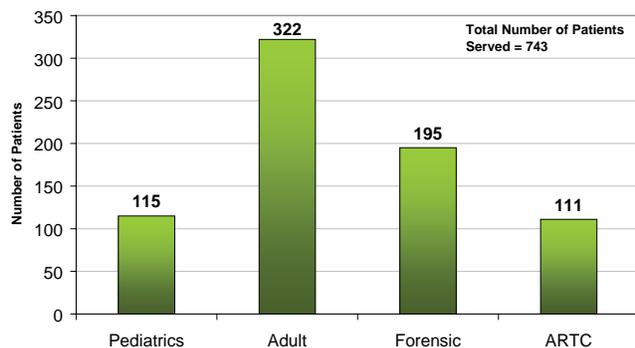
Programs

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

Median Length of Stay in Days
Fiscal Year 2008



Number of Patients Served
Fiscal Year 2008



Length of Stay

The median length of stay for USH is 147 days. The median length of stay for adult patients with civil commitment is higher, at 207 days.

Types of Disorders Treated

- Psychotic Disorders: schizophrenia, schizoaffective disorder, other psychotic disorders, and delusional disorders

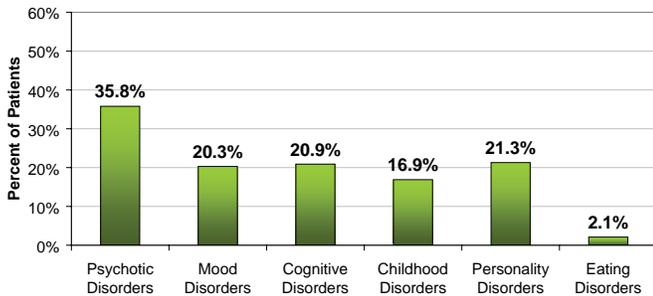
- Mood Disorders: major depression, anxiety disorders, bipolar disorder, and dysthymia
- Childhood Disorders: developmental disorders, autism, attention deficit disorder, conduct disorder, separation anxiety, and attachment disorder

Secondary Diagnoses

- 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

Additionally, 35% of the patients treated at USH

Percent of Patients With Major Psychiatric Diagnosis**
Fiscal Year 2008



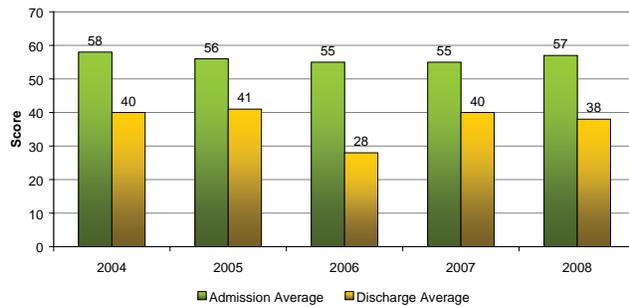
**Patients can have more than one diagnosis

also had a substance abuse diagnosis.

Services Provided

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

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



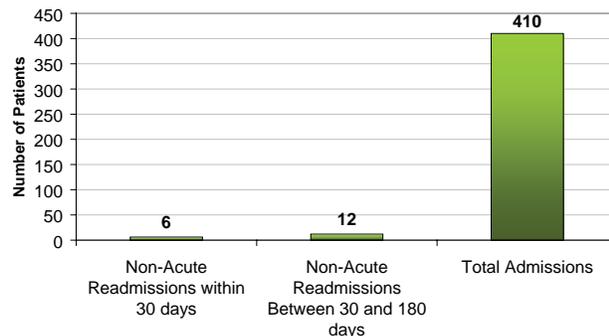
Assessment

In order to assess patient progress, USH uses the Brief Psychiatric Rating Scale (BPRS). The BPRS is a clinical measurement of patient symptoms. The scores from the BPRS indicate the level of improvement from admission to discharge. The patients at USH continued to show a decrease in BPRS scores from admission to discharge in the 2008 fiscal year.

Readmission

The USH admitted a total of 410 patients in the 2008 fiscal year. Of these admissions, 6 were non-acute readmissions within 30 days and 12 non-acute readmissions within 180 days.

Readmissions at the Utah State Hospital
Fiscal Year 2008



The readmissions within 30 days are 1.6% of the total discharges in fiscal year 2008.

Legislative Audit

The Utah State Hospital experienced a legislative audit between May 30 and November 1, 2007. The legislative audit findings are contained in a report to the Utah Legislature Number 2008-04 and were presented to the Auditor General in January 2008. The findings were very positive and included findings from a consultant hired by the auditing committee.

The audit states “The Utah State Hospital’s (State Hospital’s) quality of care is good overall. The State Hospital compared reasonably well within common performance measures, and our consultant believes the State Hospital’s quality of care is as good as, and in some cases, superior to that offered in other state hospitals. While quality of care is good, the availability of bed space varies by unit at the State Hospital. Demand for forensic beds exceeds availability, while pediatric beds appear to have excess capacity. The current number of adult beds appears sufficient.”

The audit made the following recommendations for improvements:

1. We recommend that State Hospital management review fiscal year 2007 elopements for unreasonable risk-taking by the treatment team or placement of a patient in preventable danger and take appropriate action.
2. We recommend that State Hospital management review our consultant’s report, identify those recommendations that will be adopted, and report accordingly during the 2009 General Session.
3. We recommend that the State Hospital enforce Utah Code Ann. §77-15-9(4), which requires counties to reimburse all expenses for patients who are retained in the State Hospital after being found competent to proceed.

4. We recommend that the State Hospital work with the courts through training or other means to reduce the waiting period between the hospital’s finding of competency and the competency hearing.
5. We recommend that the Department of Human Services consult with the Forensic Mental Health Coordinating Council to study whether competency alternatives to the State Hospital’s forensic unit can be developed for certain types of individuals found incompetent to stand trial.
6. We recommend that the Division of Substance Abuse and Mental Health consider using historical demand and usage for each center as a factor when allocating adult beds in the State Hospital.
7. We recommend the Division of Substance Abuse and Mental Health study the feasibility of providing a long-term care facility for the State of Utah.
8. We recommend that the Division of Substance Abuse and Mental Health finalize its policy concerning the appropriate placement of treatment for severely emotionally disturbed children.
9. We recommend that the State Hospital consider the demand for adolescent beds when finalizing the number of adolescent beds in the proposed new Pediatric Treatment facility.

The consultant, Dr. Joel Dvoskin, made several suggestions to the Hospital for Best Practices improvements. All of his suggestions as well as the recommendations of the legislative audit have been addressed and the hospital continues to focus on improving and providing quality patient care.

Education and Training



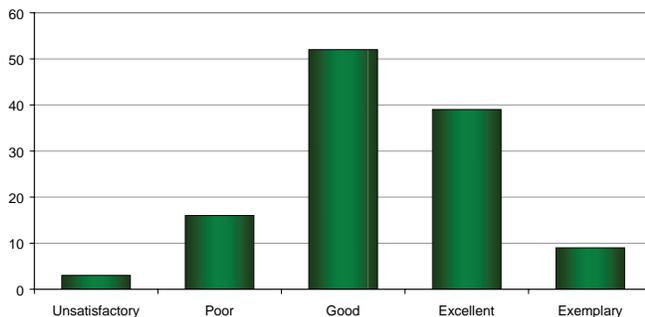
DSAMH's Utah Transformation of Child and Adolescent Network has focused on mental health and substance abuse services available to American Indian/Alaskan Native children and adolescents living in Utah. On September 24, 2008, a tribal consultation agreement was formally signed by Utah Governor Jon M. Huntsman Jr., the federally recognized Indian tribes of Utah, the Indian Walk In Center, and the Department of Human Services.

Education and Training

Substance Abuse Fall Conference

The 30th Annual Fall Substance Abuse Conference was held October 1-3, 2008, in Layton, Utah. 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. Over 570 professionals from various fields throughout the tri-state area attended.

Fall Substance Abuse Conference 2008
Overall Satisfaction with the Quality of
the Conference



National keynote speakers addressed current research and trends in substance abuse prevention and treatment. The following keynote presentations were delivered during the conference: *Community Program Clinician Practice of Motivational Interviewing* (Steve Martino, Ph.D); *Prescription Pain Killers: Steps to Achieving Zero Overdose Deaths* (Lynn R. Webster, M.D.); *The Road to Evidence Base: The Intersection of Evidence-Based Practices and Cultural Competence* (Holly Echo-Hawk); *Current Renaissance of Adolescent Treatment* (Michael Dennis, Ph.D); *Wired for Connection: How Empathy, Shame and*

Vulnerability Affect Helping and Healing (Brene Brown, Ph.D., L.M.S.W); and *The Moving Target of Addiction: Past, Present and ???* (Glen R. Hanson, Ph.D., D.D.S).

Breakout sessions were offered throughout the conference and included seminars on prevention, treatment, criminal justice and cultural competence. Examples of the array of presentations include: *Understanding Borderline Personality Disorder and Addiction* (Juergen Korbanka, Ph.D & Randy Huntington, L.C.S.W.); *Look Into My Crystal Ball: A Glimpse of the Prevention System in 2003* (Craig PoVey, L.C.S.W.); *GYC: A Statewide Youth Initiative* (Jamie Grosbeck and Sherry Paxton); *Community Readiness for Change and Impact on Program Building* (Holly Echo-Hawk); *Adult Probation & Parole 101* (Larry Evans, B.S., M.S.); *Women Offender Case Management Model* (Leslie Miller and Shannon Cox); and *Framework for Organizational Cultural and Linguistic Competence* (Vivian Jackson).

Two pre-conference sessions were held Tuesday, September 30, 2008, the American Indian Wellness and Prevention Conferences. The American Indian Wellness Conference began with a “Walk for Wellness” followed by the video premier of an American Indian historical. The event focused on collaborative and programmatic efforts in Utah and included various presentations by local and national speakers (Ed Napia, Holly Echo-Hawk, Nino Reyes, Donna Russell, Travis Parashonts, Lacey Harris, Monica Testhlikai, Robin Troxell, Rosemary Silversmith, Wade Moon, Shanda Wauneka, Lora Tom, and Elanor Tom). A Pow Wow concluded the day. The Prevention Conference included presentations provided by Art Brown, David Hawkins, and Verne Larsen. The Safe and Drug Free School Coordinators met and

a dinner was hosted by Parent's Empowered for the local substance abuse authorities and the Utah Addiction Center representatives.

Five distinguished awards were presented during the conference: the Merlin F. Goode Prevention Services Award was presented to Verne Larsen; the Leon PoVey Lifetime Achievement Award was presented to Douglas R. Wiese, LSAC; the Justice Award was presented to Mary Lou Emerson; the Dr. Stuart D. Wilkinson Excellence in Public Service Award was presented to Nora B Stephens; and The Treatment Award was presented to Carmen Negron.

Generations 2008 Mental Health Conference

The Generations 2008 conference was held on March 6-7, 2008 at the Hilton Salt Lake City Center. The conference theme was, "Behavioral Mental Health and Substance Abuse Treatment in Public and Private Practices."

The conference included several highly renowned national speakers and offered quality workshops. The latest information on behavioral health treatment was presented and discussed. This is the largest mental health conference in the state and continues to grow each year. Evaluations of the conference are consistently rated very high. There were 632 individuals who attended the conference from both the public and private mental health and substance abuse provider system. This was a 13% increase over last year.

The University of Utah School on Alcoholism and Other Drug Dependencies

In June 2008, DSAMH, along with the Utah Alcoholism Foundation and the University of Utah co-sponsored the 57th Annual University of Utah School on Alcoholism and Other Drug Dependencies. The School is recognized internationally and

continues to expand its scope to keep pace with advances in the knowledge of effective treatment of the health and social problems of alcoholism and other drug dependencies. This year the group sections included American Indian; Criminal and Juvenile Justice; Dental; Relapse Prevention; Physicians; Employee assistance and Human Resources; Education, Prevention and Youth Counseling; Women's Treatment; Pharmacy; Nursing; Mining Industry; and Vocational Rehabilitation. For the first time, a new group section addressing "Recovery support" was added, reflecting the increased focus on support outside of treatment. Attendance this year exceeded 950 people and represented 46 states and four countries. 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.

Utah Addiction Center

The Utah Addiction Center (UAC) is dedicated to the prevention of chemical addiction and improvement of patient care through research, education, and clinical training. DSAMH provides funding to support UAC's effort. The UAC staff work in the areas of: program/policy development at the local, state, and national levels; teaching and providing training within Utah and throughout the United States; and conducting both applied and clinical research on substance abuse addictions.

One of the areas that UAC has expanded services is the online health care training curriculum. Four "mock patient" scenarios are provided under the training section which were developed by physicians and substance abuse treatment professionals to demonstrate how to conduct brief screenings, interventions and referrals in primary care settings. These scenarios include: a physician dealing with an adolescent patient using marijuana; a pregnant drug seeker consumer; a chronic back pain patient; and a successfully employed attorney with an alcohol abuse problem. The "mock

scenarios” demonstrate the “incorrect” way to intervene with these patients and also shares the “correct” method to intervene. The UAC training website <http://healthcare.utah.edu/uac> provides curriculum materials available for download by health care professionals and community members.

Two UAC staff members, Dr. Glen Hanson and Dr. Sullivan continue to provide training throughout Utah and the United States to individuals working with the substance abuse prevention, treatment, and other related fields. These trainings include not only the neurobiology of addiction, but have expanded to include more specific applications regarding brain development, cognitive impairment related to addictions, and policy development. UAC also works closely with various entities to address the issue of returning unused medications.

The UAC publishes a newsletter that is distributed to the public, participates in policy development, provides training, and conducts research studies. Through these efforts UAC has become a valuable link between the academic and direct services communities to increase collaboration, patient care, and outcomes.

Beverage Server Training for On Premise Consumption

Utah State Statute and Administrative Rules require every person serving alcohol in a restaurant, private club, bar or tavern for “on premise” consumption, to complete alcohol training within 30 days of employment. Training certification is good up to three years. The training focuses on teaching the server responsible service to adults 21 and older, and instructors teach class participants techniques for dealing with an intoxicated or problem customers. Instructors also address

alternative means of transportation for getting customers home safely to protect them and the community. During fiscal year 2008, more than 9,000 servers were trained.

DSAMH oversees the certification of education providers, approval of the seminar curriculum and maintenance of the database of certified servers and instructors. Local and state law enforcement agencies and the Department of Alcohol Beverage Control regularly conduct operations to verify compliance with all alcohol laws.

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

The E.A.S.Y. law became effective July 1, 2006. The law seeks to stop the sale of alcohol to youth in grocery and convenience stores and requires every store employee who sells beer or directly supervises the sale of beer to complete training within 30 days of employment. The E.A.S.Y. law also authorizes local law enforcement to conduct up to four random alcohol sales compliance checks per store, per year, and provides money for state-wide media and education campaigns.

During fiscal year 2008, more than 11,000 sellers were trained in Utah. These efforts will continue through training and education of sales clerks, and education and motivating parents and other citizens.

During 2008, DSAMH launched an online payment system and database for those who train employees to sell alcohol. The new system allows for real time information and online payment of fees and allows prospective employers and law enforcement to verify a person’s training status. DSAMH has received very positive feedback on the new system and the streamlined process of data entry and payment of fees.

Driving Under the Influence (DUI) Education and Training Seminar

DSAMH is responsible, by statute, to promote or establish programs for the education and certification of DUI instructors. These instructors conduct education courses 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 and drug related injuries and deaths, the DUI Education Program attempts to eliminate alcohol and other drug-related traffic offenses by helping the offender examine the behavior which resulted in their arrest, implement behavior changes to cope with problems associated with alcohol and other drug use, and impress upon them the severity of the DUI offense.

DSAMH contracts with Prevention Research Institute to train instructors and provide all materials needed for DUI education. The specified program, PRIME For Life, is designed to gently and 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. PRIME For Life is based on the Lifestyle Risk Reduction Model which specifies three equally important, measurable, behavioral goals: increase abstinence for a lifetime, delay the age of first use of alcohol and reduce high-risk choices.

PRIME For Life is a 16-hour, research based, standardized curriculum. The persuasion-based teaching includes interactive presentations and small group discussions. Course participants use workbooks to complete a number of individual and group activities. More than a decade of program evaluation shows the curriculum changes attitudes and behaviors with first and multiple offenders.

In fiscal year 2008, there were 15,297 DUI arrests, compared with 14,658 during fiscal year 2007. The

average blood alcohol content (BAC) was .14 and the highest was .41, over five times the legal limit. Ten percent of the arrestees were under the legal drinking age of 21. DUI drivers between the ages of 25 and 36 accounted for 38% of all arrests.

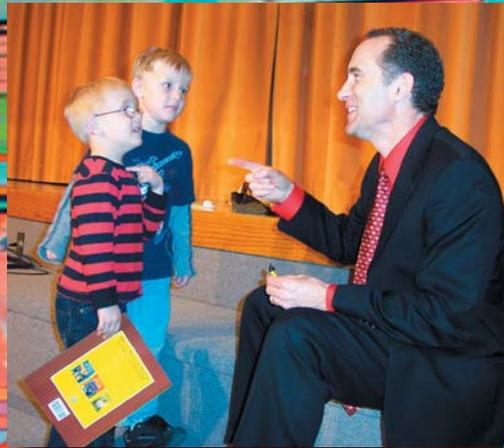
Forensic and Designated Examiner Training

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.

Fiscal Planning Training

On June 26-27, 2008, DSAMH sponsored a two-day technical assistance workshop on fiscal planning. The workshop was conducted by Leslie Schwalbe, a national expert on financing behavioral health care systems. Medicaid funding, performance based contracting, contract monitoring, and creative financing plans used in other states were discussed in depth with staff and local authority finance officers.

Recommendations were made to set short- and mid-term financial goals and to develop a new contract format and process which more accurately reflects the business model DSAMH uses to reimburse local mental health authorities. Development of a new contract is currently in process.



Over 30 town hall meetings were held statewide with the intent to decrease underage drinking. According to the 2007 SHARP data, approximately 23% of surveyed eighth graders have sampled alcohol. On March 10, 2008, Cedar City held the first of the scheduled Utah Town Hall Meetings on Underage Drinking with 950 people in attendance.

Voices of Consumers

Voices of Consumers

Utah Support Advocates for Awareness

The mission of Utah Support Advocates for Recovery Awareness (USARA) is to celebrate recovery, identify and advocate for needed services, and decrease stigma and discrimination by educating the public regarding the nature of substance abuse. USARA (formerly SARA-Utah) is a grass roots, community-based membership organization of individuals in recovery from alcohol and other drug addictions along with their families, friends, and community supporters. USARA was founded in 2005 and now has over 850 members.

USARA works to make the C.A.S.E. for recovery by doing the following:

CELEBRATING Recovery: We celebrate recovery by providing hope to others and demonstrating the power and reality of long-term recovery. We do this by sponsoring positive recovery support activities such as the Recovery Day Celebration each September. In 2008, over 1,300 people attended the event held at the Gallivan Center. More than 65 organizations, including counseling and treatment centers, helped sponsor and support the celebration. The free activities included children's games, arts and crafts, live music, food, and various awareness stations. In future years, USARA hopes to expand this celebration to other locations around the state.

ADVOCATING for those In Recovery: For many years, those most affected by alcohol and other drug problems have been absent from the public policy debate. USARA helps fill that void by working to pass legislation that supports Recovery. USARA represents the values and interests of Utah's recovery com-

munity and acts as a "recovery representative" to policymakers and leaders educating them about the importance of continued funding for recovery oriented organizations and treatment providers. This includes sponsoring an annual Rally for Recovery during Utah's legislative session. USARA also takes part in voter registration and this year registered nearly 300 voters, many first time voters.

SUPPORTING People in Recovery: USARA encourages participation in recovery support services such as self help/mutual aid/12 Step programs. USARA is working to establish Peer to Peer Recovery Support Services to aid clients coming out of treatment. In addition, USARA plans and promotes the Recovery Support Track of the University of Utah School on Alcoholism and other Drug Dependencies Conference each June.

EDUCATING the public about Recovery: In partnership with the telephone and information support service 2-1-1, USARA has developed a list of active support group meetings available around the Salt Lake Valley. This information is available on the USARA website (www.sarautah.org) or by calling 2-1-1. USARA has also established a Family Awareness Program to share the message that people can rise above addictions. Finally, USARA has developed a large network of qualified recovery speakers through the USARA Speakers Bureau. The Speakers Bureau provides training to individuals on sharing their recovery story effectively. Once they are trained, opportunities are provided for speakers to share their recovery stories with policymakers, others in recovery, and in some special cases the community at large.

Utah Family Coalition

The Utah Family Coalition is the joining of National Alliance on Mental Illness Utah, Allies with Families and New Frontiers for Families. Each is a strong organization with over 35 years of combined experience in providing education, support, advocacy, information and training to families and professionals in the mental health field.

The purpose of the Utah Family Coalition is to train family members whose lives have been affected by the mental illness of a young loved one. These trained individuals, Family Resource Facilitators (FRF), are located across the state. They provide help to other families and individuals faced with mental health issues. Through the peer support of the FRF, families and individuals are provided the help that they need. The help is designed to meet the needs of each family and can include: learning of, and access to needed

community resources; gathering of those who can help, known as wraparound facilitation; and ultimately helping each family to develop a family voice. In this way they can positively impact not only their own treatment plans but can actively impact the CMHC and their own community culture.

The Utah Family Coalition has developed standard competencies for the FRFs to master and has put in place a mentoring program to provide ongoing, on-site coaching. This insures that the local facilitators have the supports they need to be successful.

The Coalition members who act as mentors also provide training for staff at the local mental health centers as well as other community agencies. These trainings are designed to help all partners understand the importance of “family involvement at all levels” and “family voice.”



Resources

The American Indian Workgroup (UTCAN), Utah Division of Substance Abuse & Mental Health, and the Northwestern Band of Shoshoni Nation held a Social Pow Wow on Tuesday, September 30, 2008 at the Davis Convention Center as part of the "Sunrise to Sunset" American Indian Policy Summit. The Host Drum Group: White Lake Singers; Head Man: Winston Mason; Head Woman: Angela Crank; Master of Ceremonies: Nino Reyos; Elder/Cultural Advisor: Robert Taylor; Arena Director: Ben Yazzie; Pow Wow Coordinator: Lori Pacheco.

RESOURCES

List of Abbreviations

AP&P - Adult Probation and Parole	OEF/OIF - Operation Enduring Freedom/Operation Iraqi Freedom
ASAM - American Society of Addiction Medicine	OTP - Outpatient Treatment Program
ASI - Addiction Severity Index	PASRR – Pre-admission Screening and Residential Review
BAC - Blood alcohol content	PSTD - Post Traumatic Stress Disorder
BPRS - Brief Psychiatric Rating Scale	REDI - Readiness Evaluation and Discharge Implementation Program
CMHC - Community Mental Health Centers	SAMHSA - Substance Abuse and Mental Health Services Administration (Federal)
CMS - Center for Medicaid and Medicare Services	SAPT - Substance Abuse Prevention and Treatment Block Grant
CSAP - Center for Substance Abuse Prevention	SED - Seriously Emotionally Disturbed
CSAT - Center for Substance Abuse Treatment	SHARP - Student Health and Risk Prevention
CYF - Children, Youth, and Families	SMI - Serious Mental Illness
DCFS - Division of Child and Family Services	SPF – Strategic Prevention Framework
DHS - Department of Human Services	SPMI - Seriously and Persistently Mentally Ill
DORA - Drug Offenders Reform Act	TBI - Traumatic Brain Injury
DSAMH - Division of Substance Abuse and Mental Health	TEDS - Treatment Episode Data Set
DUI - Driving while under the influence	UAC - Utah Addiction Center
E.A.S.Y – Eliminate Alcohol Sales to Youth	UBHC – Utah Behavioral Healthcare Committee
FRF - Family Resource Facilitators	UFC – Utah Family Coalition
IEP - Individual Education Plan	USEOW – Utah’s State Epidemiology Outcomes Workgroup
IOP - Intensive Outpatient	USH - Utah State Hospital
IV - Intravenous	USARA - Utah Support Advocates for Recovery Awareness
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	
Meth - Methamphetamine	
MH - Mental Health	
MHSIP - Mental Health Statistical Improvement Program	
NAMI – National Alliance on Mental Illness	

Mental Health Reference Table

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

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

Medicaid/Non-Medicaid Client Counts			
Mental Health Center	Medicaid	Non-Medicaid	Both Medicaid and Non-Medicaid
Bear River	1379	1114	199
Central	719	125	101
Four Corners	792	1082	185
Northeastern	411	419	23
San Juan	57	321	79
Southwest	1689	918	253
Summit County - VMH	61	752	30
Tooele County - VMH	444	1135	136
Heber Valley Counseling	50	192	2
Davis	1762	975	248
Salt Lake - VMH	6969	5970	1608
Wasatch	3003	2079	634
Weber	2288	2863	587
Rural Total	5207	5807	942
Urban Total	13754	11704	3012
Statewide Total	18961	17511	3954

Contact Information

Single State Authority

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 Utah Division of Substance Abuse and Mental
 Health
 120 North 200 West, Suite 209
 Salt Lake City, UT 84103
 Office: (801) 538-3939
 Fax: (801) 538-9892
 dsamh.utah.gov

Utah State Hospital:

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

Local Authorities and Providers

Bear River

Counties: Box Elder, Cache, and Rich

Substance Abuse Provider Agency:

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

Mental Health Provider Agency:

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

Office: (435) 462-2416

Davis County

County: Davis

Substance Abuse and Mental Health Provider Agency:

Maureen Womack, CEO/Director
 Davis Behavioral Health
 934 S. Main
 Layton UT 84041
 Office: (801) 544-0585

Central Utah

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

Substance Abuse and Mental Health Provider Agency:

Brian Whipple, Executive Director
 Central Utah Counseling Center
 255 West Main St.
 Mt. Pleasant, UT 84647

Four Corners

Counties: Carbon, Emery, and Grand

Substance Abuse and Mental Health Provider Agency:

Jan Bodily, Director
 Four Corners Community Behavioral Health
 105 West 100 North
 P.O. Box 867
 Price, UT 84501
 Office: (435) 637-7200

Northeastern

Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider

Agency:

Kyle Snow, Director
Northeastern Counseling Center
1140 West 500 South
P.O. Box 1908
Vernal, UT 84078
Office: (435) 789-6300
Fax: (435) 789-6325

Salt Lake County

County: Salt Lake

Substance Abuse Administrative Agency:

Patrick Fleming, Director
Salt Lake County
Division of Substance Abuse Services
2001 South State Street #S2300
Salt Lake City, UT 84190-2250
Office: (801) 468-2009

Mental Health Provider Agency:

Debra Falvo, President/Executive Director
Valley Mental Health
5965 South 900 East #420
Salt Lake City, UT 84121
Office: (801) 263-7100

San Juan County

County: San Juan

Substance Abuse and Mental Health Provider

Agency:

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

Southwest

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

Substance Abuse and Mental Health Provider

Agency:

Paul Thorpe, Director
Southwest Behavioral Health Center
474 West 200 North, Suite 300
St. George, UT 84770
Office: (435) 634-5600

Summit County

County: Summit

Substance Abuse and Mental Health Provider

Agency:

Debra Falvo, President/Executive Director
Ozlen Kence, Program Manager
Valley Mental Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157

Tooele County

County: Tooele

Substance Abuse and Mental Health Provider

Agency:

Debra Falvo, President/Executive Director
Doug Thomas, Unit Director
Valley Mental Health, Tooele County
100 South 1000 West
Tooele, UT 84074
Office: (435) 843-3520

Utah County

County: Utah

Substance Abuse Provider Agency:

Richard Nance, Director
Utah County Division of Substance Abuse
151 South University Ave. Ste 3200
Provo, UT 84601
Office: (801) 851-7127

Mental Health Provider Agency:

Juergen Korbanka, Executive Director
Wasatch Mental Health
750 North 200 West, Suite 300
Provo, UT 84601
Office: (801) 852-4703

Wasatch County

County: Wasatch

Substance Abuse and Mental Health Provider Agency:

Dennis Hansen, Director
Heber Valley Counseling
55 South 500 East
Heber, UT 84032
Office: (435) 654-3003

Weber

Counties: Weber and Morgan

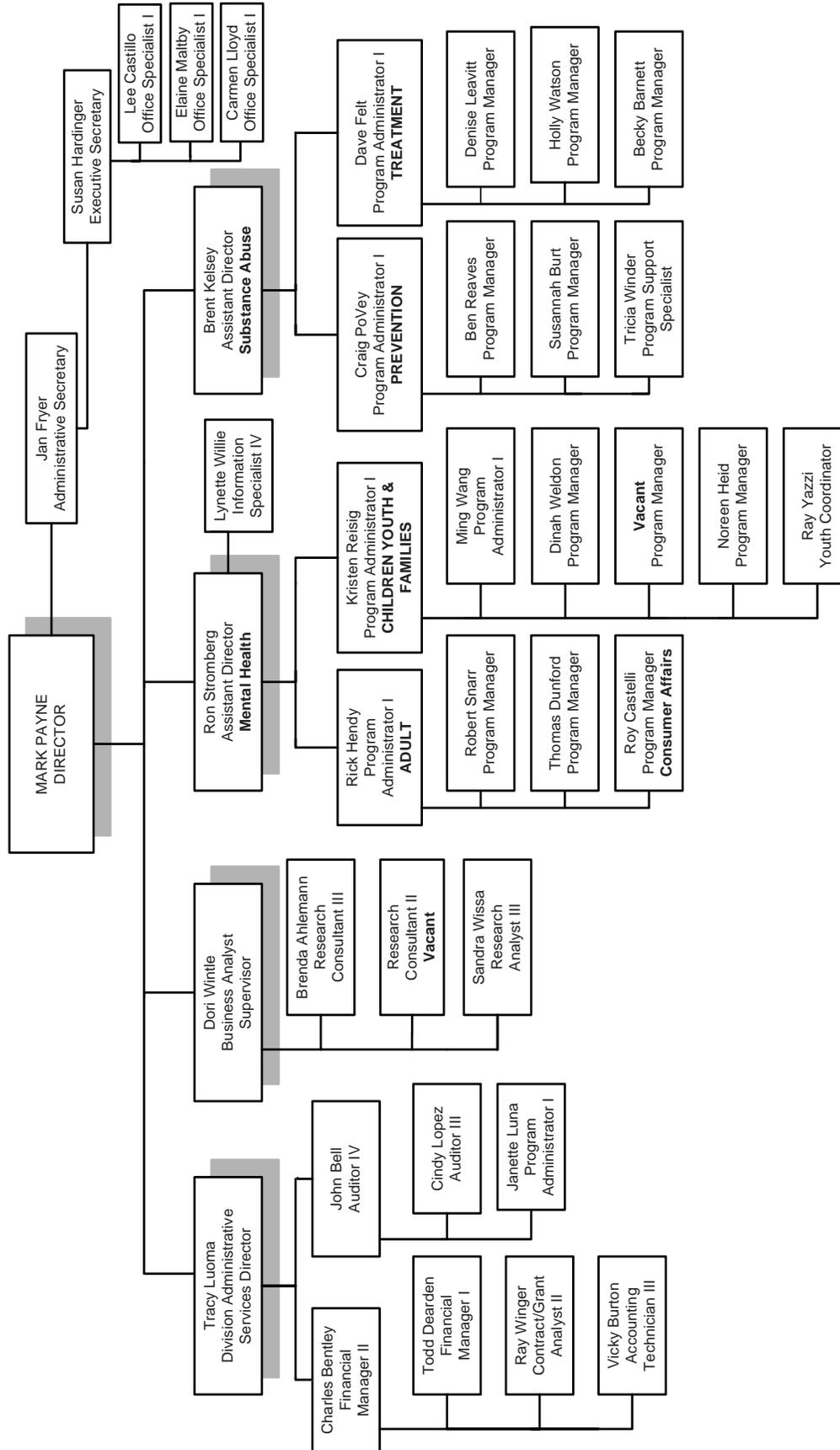
Substance Abuse and Mental Health Provider Agency:

Kevin Eastman, Executive Director
Weber Human Services
237 26th Street
Ogden, UT 84401
Office: (801) 625-3771

Local Authorities/Local Providers

Utah Association of Counties
Utah Behavioral Healthcare Committee
5397 S. Vine St.
Murray UT 84107
Office: (801) 265-1331

Utah Division of Substance Abuse and Mental Health
October 2008





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