

# Division of Substance Abuse and Mental Health



## *“A Wise Investment”*



“Candyland Dream”

BY CAMILLE HOUSTON

A member of the DSAMH-sponsored Youth Action Council

Annual Report 2009

# DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

## 2009 Annual Report

Cover art by:

CAMILLE HOUSTON

Camille is a member of the DSAMH-sponsored Youth Action Council  
(Read more about Camille on the DSAMH  
Initiatives divider in this report.)

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State of Utah

GARY R. HERBERT  
*Governor*GREG BELL  
*Lieutenant Governor*

## DEPARTMENT OF HUMAN SERVICES

LISA-MICHELE CHURCH  
*Executive Director*

## DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

MARK I. PAYNE  
*Director*

December 2009

We are proud to release the DSAMH Annual Report for 2009. We hope the report will be helpful as you review how and what services are being provided throughout the state.

We have chosen “A Wise Investment” as the theme for this year’s report. With the recent economic downturn and possible cuts in services, we want to emphasize that funds invested in providing services to those in need of mental health and substance abuse treatment will result in greater financial returns due to increased productivity, lower net costs of illness and care, and a better quality of life for Utah’s individuals and communities.

Due to the infusion of federal stimulus money this year, the budget reductions of the 2009 legislative session did not initially have a widespread effect on statewide services. However, we are aware that there is an enormous gap between the need for treatment and the resources available, and anticipate the gap will increase as the stimulus funding runs out. We are working with other agencies to make sure services will still be accessible to those in need and will use our funds to reach as many as possible. We are committed to being totally accountable for all funds received in our division.

DSAMH has made it a priority to streamline its processes and improve efficiency. One example is the substance abuse justice plan model that we are pursuing to consolidate all justice programs (i.e., DORA, drug courts, etc.) to make sure they are meeting local needs. We are also excited about the results of the wellness initiative set in place last year in the state’s mental health centers. We are already seeing great dividends in the lives of many suffering with mental illness, as service providers have focused more on overall health and well-being with a greater expectation for recovery.

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

We appreciate your support as we work to increase accessibility for Utahns who are in need of prevention and treatment services in substance abuse and mental health.

Sincerely,

Mark I. Payne, LCSW  
Director

## **A Tribute to Prior State Board of Substance Abuse and Mental Health**

As a result of House Bill 306, the State Board of Substance Abuse and Mental Health no longer has statutory authority to operate and therefore has been dissolved. The bill eliminated funding for the Department of Human Services' policy boards, as well as repealed the statute that authorized the boards. H.B. 306 was drafted in response to budget reductions during the 2009 legislative session. Consequently, all Board duties and responsibilities are now under the auspices of the Division of Substance Abuse and Mental Health.

We would like to honor the members of the State Board of Substance Abuse and Mental Health for their tireless efforts during their years of service on the State Board. Board members played a major role in working to develop policies to assure that substance abuse and mental health services were provided throughout the state. We thank these committed, dedicated men and women for all they have done for these vulnerable populations and for the service they have given to all Utahns.



**PAULA BELL, CHAIR**



**DARRYL WAGNER, R.PH., VICE-CHAIR**



**MICHAEL CROOKSTON, M.D.**



**NORA B STEPHENS, M.S.**



**JAMES C. ASHWORTH, M.D.**



**JOLEEN G. MEREDITH**



**LOUIS H. CALLISTER**

## Introduction to Annual Report

The respected anthropologist Margaret Mead believed that our value as individuals and our success as a society could be measured by the compassion we show for the vulnerable. The following pages reflect what the Utah Division of Substance Abuse and Mental Health (DSAMH) has invested toward improving the quality of life for the vulnerable populations of Utah. It is a wise investment, indeed. It is an investment that has returned great dividends in all segments of our society, because when you improve the quality of life for the vulnerable, the effects are far-reaching and the financial impact cannot be overlooked. In fact, according to the National Institute on Drug Abuse, savings from investing in substance abuse treatment can exceed costs by a 12 to 1 ratio.<sup>1</sup> And the World Health Organization estimates that, although mental disorders cost national economies several billion dollars annually in terms of expenditures incurred and loss of productivity, the cost of treatment is often completely offset by a reduction in the number of days of absenteeism and productivity lost while at work.<sup>2</sup>

Who, exactly, are the “vulnerable” that DSAMH serves?

The vulnerable are those struggling with mental health issues or with problems resulting from alcohol, tobacco or other drug use. The vulnerable are members of your family, your neighbors, those you go to school and church with, those you work with. The vulnerable population includes the homeless man as well as the business executive; the college professor as well as the struggling student; the young mother as well as the aging veteran. The vulnerable population cuts across all socio-economic strata and comes from all four corners of the state. DSAMH offers pre-

vention and treatment services for those among us who are struggling and for their families and caregivers.

This annual report is replete with numbers that substantiate the dollar amount of the investment (see pages 8 – 9) and statistics that back up DSAMH claims that treatment and prevention efforts work. Alcohol and other drug use, as documented in the 2009 SHARP (Student Health and Risk Prevention) Survey, is consistently going down among the state’s youth. Or check out the statistics for the Salt Lake County-implemented jail diversion program on page 47. When integrated mental health and substance abuse interventions are used with individuals involved in the criminal justice system, the outcomes have been very encouraging. You will also see the disheartening statistics showing the enormous gap in the need for services and the funds that are available (pages 67 – 68). But these are just numbers and numbers are easy to dismiss until you put a face on them.

DSAMH serves real people, not nameless, faceless statistics. Along with looking at the financial investment, we’re also looking at the dividends in terms of human and social capital. Rather than looking at inanimate numbers representing people who complete treatment, we’re looking at fathers who are off welfare and back supporting their families; mothers who regain custody of their children; parents who become role models to their children; youth who are able to look to the future with hope and confidence. So instead of just reporting bare numbers and statistics in this annual report, we have filled it with personal stories from real people in recovery from alcohol and drug abuse and real people suffering from mental illness who have found new purpose and hope for the future. You will find their stories spread throughout the book and on the divider pages. Some of the stories are about young people from the State Youth Action Council. They wrote and

<sup>1</sup> <http://csat.samhsa.gov/IDBSE/employee/Support-WorkersinRecovery-wpb10.pdf>.

<sup>2</sup> [http://www.who.int/mental\\_health/en/investing\\_in\\_mnh\\_final.pdf](http://www.who.int/mental_health/en/investing_in_mnh_final.pdf).

illustrated these stories about themselves, documenting their own struggles with mental illness. The resulting posters were exhibited in the Salt Lake Main Library for Children's Mental Health Awareness Day.

All of these personal stories offer hope to the many who are struggling. They are living proof that recovery is possible; that people can and do recover; and that treatment works. What we are doing at DSAMH is making a difference. And the stories highlight the fact that there is so much more to recovery than just abstinence from alcohol or drugs, and more than just an absence of symptoms. Recovery means finding joy in life, reaching one's full potential, and giving back to society. It's about quality of life.

The Initiatives that follow are areas DSAMH is focusing on to help bring about a better coordi-

nated and integrated service delivery system and to address the challenge set forth by Margaret Mead, all with the end goal of providing much-needed services for our vulnerable populations.

The Hope and Recovery graphic on the following page represents the principles that guide DSAMH decisions and activities.

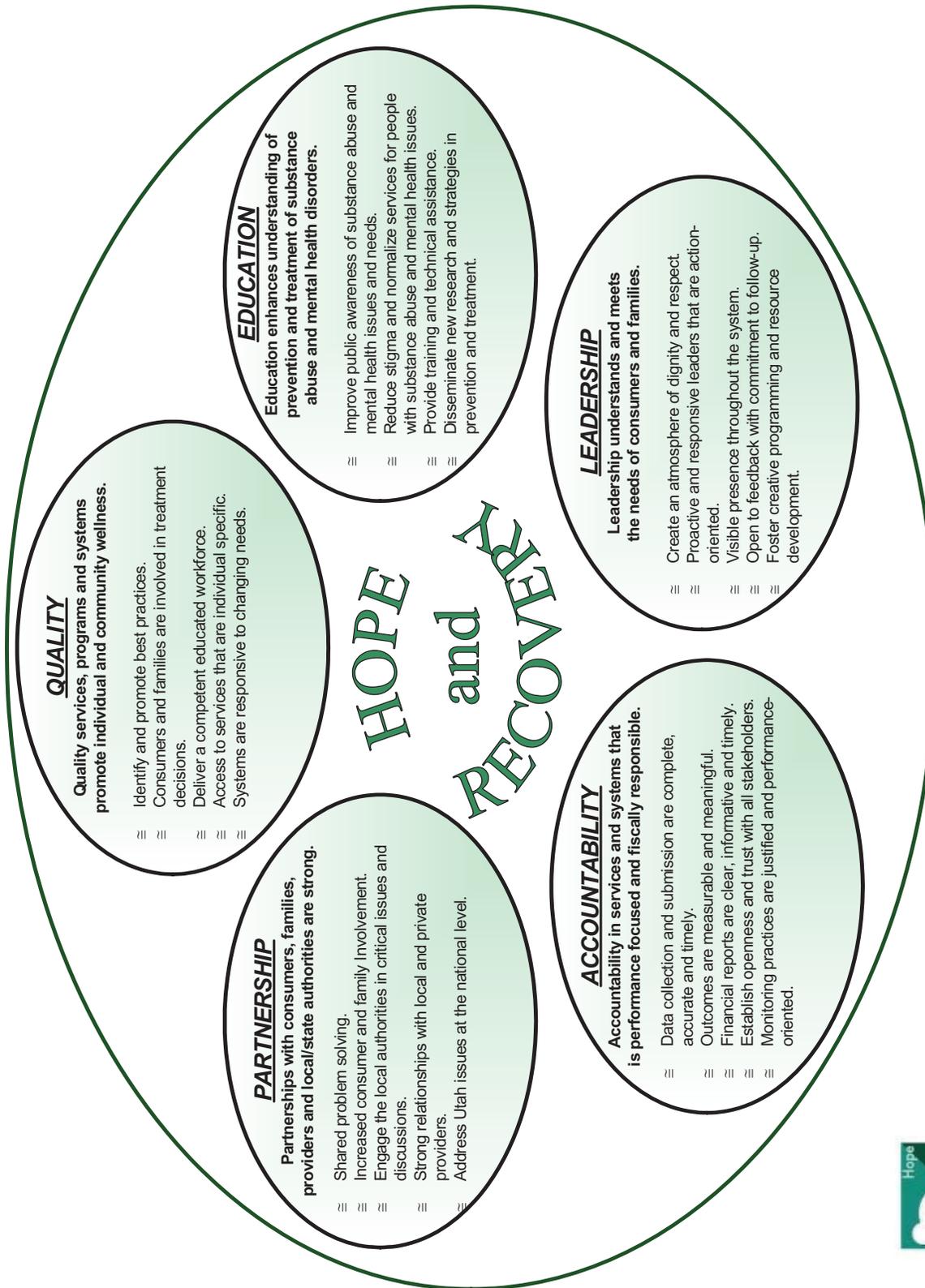
Fiscal year 2009 has been a year of challenges, a year of learning. We have learned that when systems change, people recover. We have learned that by investing in our most vulnerable, we are building stronger communities and more resilient individuals who are better able to cope with the stresses and strife that are part of everyday life. DSAMH is making a difference; and that is a wise investment, indeed.



Growing up in a poverty-ridden and abusive home, **Edna Kimball** carried a lot of "hurts, habits, and hang-ups" into adulthood. In her rebellious streak, her favorite line was "You can't stop me!" In her twenties she was doing drugs, drinking every day and deteriorating rapidly. She never expected to live to see the age of 30. But at age 36, after spending a night in jail, she was jobless, penniless, depressed, drunk, humiliated and utterly without hope . . . until she ended up in a 28-day recovery program. And that's when her life and new freedom really began.

"I am no longer held in bondage by alcohol or drugs. I am no longer held in bondage by low self-esteem. I am no longer held in bondage by shame. I started my process of healing through a 12-step program, and by the grace of God, I've been free from alcohol and illicit drugs for the past 28 years."

Now at age 64, having more than doubled her supposed life expectancy, Edna knows she's around for a reason. Her life has purpose and meaning as she and her husband have been involved for several years in a community outreach program called "Celebrate Recovery," a Christian-based 12-step program. With a new positive twist, her old line has taken on new meaning, "You can't stop me!"



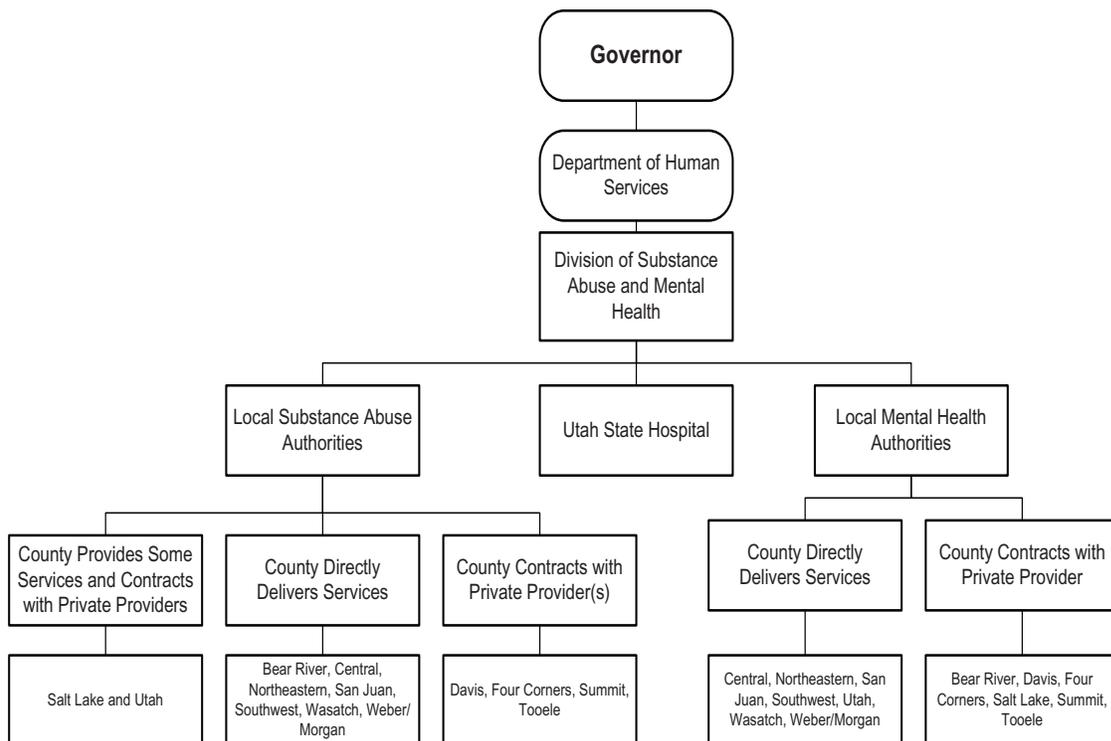
**Utah Division of  
Substance Abuse and Mental Health**

# About Utah’s Public Substance Abuse and Mental Health System

The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority in Utah. It is charged with ensuring that prevention and treatment services are available throughout the state. As part of the Utah Department of Human Services, 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. DSAMH provides oversight and policy direction to these local authorities.

DSAMH has the following responsibilities:

- Collect and disseminate information pertaining to substance abuse and mental health
- Develop, administer, and supervise comprehensive state substance abuse and mental health programs
- Provide direction over the Utah 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 prevention, substance abuse and mental health services
- Monitor and evaluate programs provided by local prevention, substance abuse, and mental health authorities, and examine expenditures of any local, State, and Federal funds



- Contract with local prevention, substance abuse and mental health authorities to provide or arrange for a comprehensive continuum of services in accordance with the local plan
- Contract with private and public entities for special statewide or non-clinical services
- Review and approve local prevention, substance abuse and mental health authority plans to assure a statewide comprehensive continuum of services
- Promote or conduct research on prevention, substance abuse and mental health issues and submit any recommendations for changes in policy and legislation to the Legislature and the Governor
- Withhold funds from local prevention, substance abuse and mental health authorities and public and private providers for contract noncompliance
- Coordinate with other state, county, nonprofit, and private entities to prevent duplication of services
- Monitor and assure compliance with State and Federal laws

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.

*“When we invest in services for individuals who are struggling, it has a ripple effect—first to the family and then to the community. We appreciate the support from the Division of Substance Abuse and Mental Health in funding critical programs that are building stronger, healthier individuals, and thus, stronger, healthier families and communities.”*

—Sherri Wittwer, Executive Director of the National Alliance on Mental Illness (NAMI Utah)

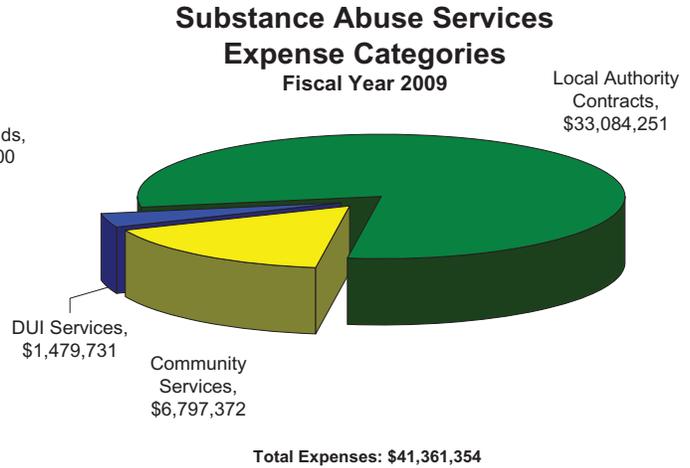
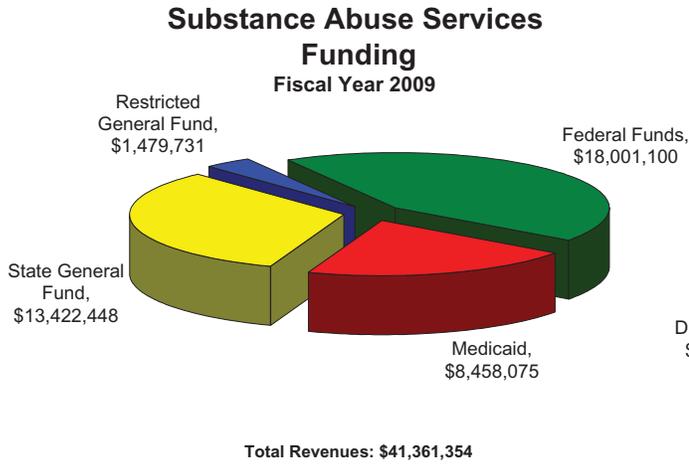
## Source of Funding and Category of Expenses

Prevention and treatment services in the state of Utah are funded by State general fund revenues, substance abuse and mental health block grant funds from the U.S. Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA), Medicaid, Medicare and various other local and Federal grant and contract monies. The majority of expenditures for DSAMH are directly related to contracts with the local authorities. DSAMH also has contracts for special statewide projects such as consulting, research, and education.

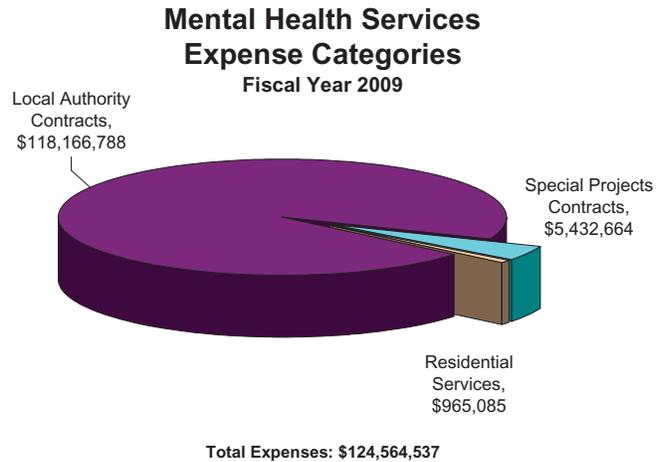
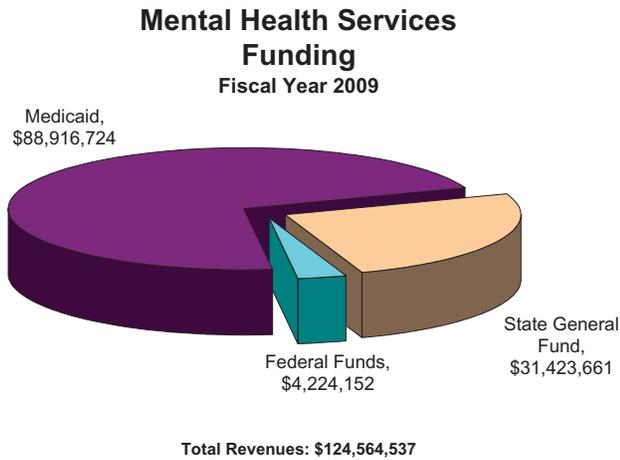
The local authorities are required by State statute to provide funding equal to at least 20% of the State funds allocated to them. However, some local authorities provide more than 20%. This source of funding is not reflected in the following charts because it is not disbursed by any State or Federal agency.

The following page provides a breakdown of the sources of funding and categories of expenses.

## Substance Abuse Services



## Mental Health Services

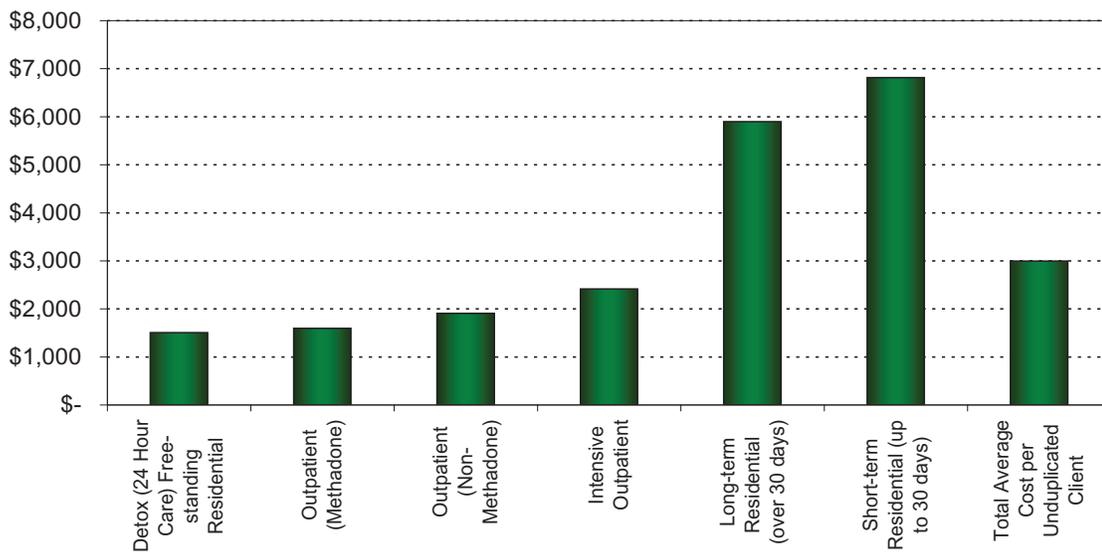


## Client Cost by Service Category

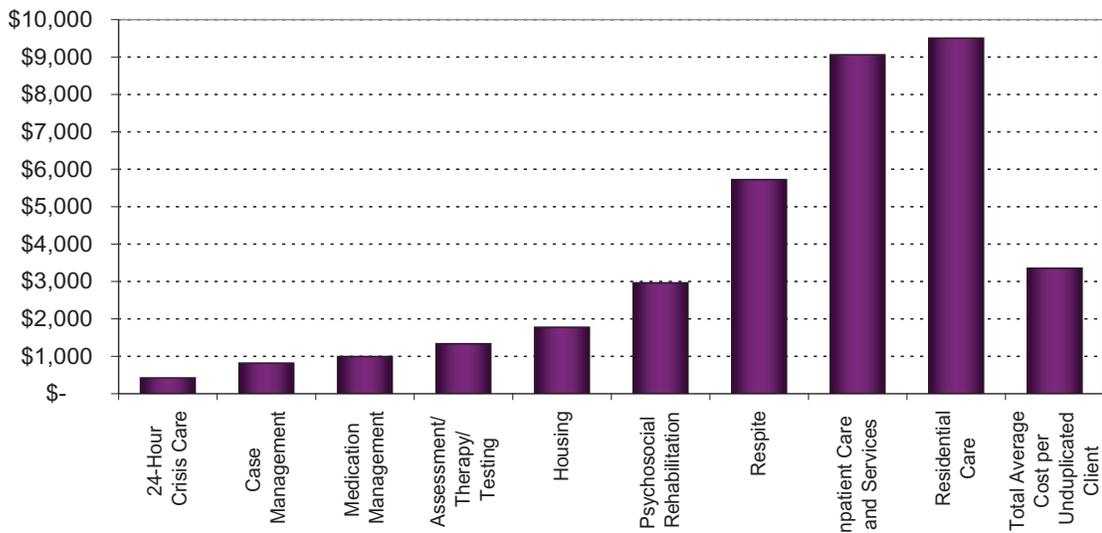
DSAMH requires the local authorities to submit year-end fiscal reports that describe local authority spending in specific categories. This fiscal information is then used to calculate a client cost by service category for both substance abuse and

mental health. In 2009, the statewide average cost for mental health services was \$3,355. For substance abuse services, the average client cost was \$2,994.

### Substance Abuse Client Cost by Service Category Fiscal Year 2009



### Mental Health Client Cost by Service Category Fiscal Year 2009







When people think of the words “mental illness” they think of a person who lives in an insane asylum or has some type of handicap and can no longer think logically.

There is some good news—recovery from mental illness is possible and I am living proof. I think I always knew something was wrong with me, but I did my best to act like others. Not a lot of luck there. I always knew I was not ordinary.

I was a wild child. I had trouble staying still and paying attention in class. I acted out and was just different. At age seven, it got even harder as I started hearing voices and seeing things. One hallucination terrified me so much that it's still engraved in my mind, as if I just saw it. I imagined a green lizard body with slimy nails and it walked toward me. It looked bigger than a dog.



As things got worse I began to think I was bad. I became suicidal. I told my parents I feared for my life. I was then put into a mental hospital and it was a long time before I could come out. It was not an insane asylum, it was way different. My stay was for protection from myself. It took years to find the perfect medication that would work on me.

Once I was a bit of a geek . . . big glasses, no figure, frizzy curly hair, and tall. Now I have a normal life. Now I have the right meds and this ugly duck turned into a swan. I have a loyal best friend who has stuck with me and has seen me at my worst. I have a loving family and talented art skills.



It wasn't simple, but I did it. I had the help of my God. I know it can be hard even without an illness, but life will break you to build your future. Though I am only 19 years old, I know it is through our hard times that we shine the brightest—trying hard not to be ordinary, but to be extraordinary!

### MY FAVORITES

- Sushi
- Sewing
- Seashores
- Fashion Designing
- Painting
- Drawing

*[Camille is a member of the DSAMH-sponsored Youth Action Council]*

# DSAMH Initiatives

## Utah's Wellness Initiative

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*. This initiative was put forth in response to a devastating national report,<sup>1</sup> which found that people with mental illness are dying 25 years earlier than the general population. This shocking revelation is made even more disconcerting because the figures have worsened so drastically. As recently as the '90s, people with mental illness were dying 15 years earlier than the general population. DSAMH is committed to changing this unacceptable condition by adopting what we have called the "Wellness Initiative."

In fiscal year 2009, DSAMH issued a directive requiring local mental health authorities to develop plans detailing how they will implement the following overall wellness activities:

- Monitoring weight
- Screening for diabetes
- Decreasing tobacco use
- Providing training for staff in recognizing health issues
- Implementing 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

### The System's Response

Centers across the state responded in precise and deliberate ways:

- In some areas new wellness coordinator positions were created to link between psychiatric and medical care.
- New protocols were initiated to include taking vital signs at each appointment for medication management.
- New lab protocols were added to include lipid profiles, liver function and diabetic screenings.
- American Psychiatric Association guidelines have been utilized for the use of anti-psychotic medications to prevent metabolic syndrome.
- Direct communication with consumers' primary care physicians was increased.
- Medical staff outreach efforts to consumers who miss appointments were increased.
- Staff-run wellness groups have been implemented in many areas.
- More centers are using an integrations model of care, bringing medical services

<sup>1</sup> [http://www.dsamh.utah.gov/docs/mortality-morbidity\\_nasmhpd.pdf](http://www.dsamh.utah.gov/docs/mortality-morbidity_nasmhpd.pdf)

into mental health settings and providing mental health services in health clinics.

- Primary health care doctors were consulted more frequently to provide mental health screening and treatment in the primary health care setting.
- Comprehensive education and treatment was implemented for obesity, nutrition, exercise, medication-adverse side effects and smoking cessation.
- Multiple centers have reported consumers and staff challenging each other to lose weight, stop smoking, increase exercise, and eat better.
- Reports from across the state have documented successful consumer efforts in losing weight, quitting smoking and sustaining non-smoking status.

These initiatives have literally changed the expectations of recovery for people with mental illness, as well as for their families and those who provide mental health services. The impact of the Wellness Initiative within the state's community mental health centers (CMHCs) has been remarkable, as evidenced by comments taken from people in treatment at these centers. Some of their stories are printed below, and other quotes and stories have been placed throughout the Annual Report.

---

**Geraldine**, a 55-year-old woman diagnosed with a bipolar disorder, was told by her physician that she was due for a stroke or a heart attack if she didn't lose weight. He also said she needed knee replacement surgery, but he wouldn't do it (no matter how much pain she was in) until she lost weight. That did it! She kicked right in and started going to a trainer at the gym and very quickly lost 100 lbs., going from a size 6X to XL. She has now had her knee surgery and is feeling much better.

Since losing the weight, she is able to hold her head high, rather than always looking down, with no eye contact. She smiles—a lot—and says she is genuinely happy. “Each day is a new day,” she says. She has new friends and new energy and is motivated to try new things. Her sleep has improved as well.

Geraldine uses the SAMHSA wellness books to help her take action. She reads them and does what they say. By following those guidelines, she says, “It made me realize I was worth it. For the first time in my life I knew I could take positive action myself.” She reads her recovery plan every day and goes to the books in a crisis rather than looking for outside help.

The books have also helped her with the depression she has lived with. She recognizes that she's making progress and, in her words: “I'm always changing and overcoming problems. I'm on top now!”

Her doctors have confidence in her physical abilities and, with their encouragement, she has started bicycling a mile a day on a stationary bike. She gets her weight and blood pressure checked regularly by the registered nurse (RN) on duty at the CMHC; and the staff and RN's coordinate regularly with her physicians to make sure she's getting her physical needs met as well as her mental health needs.

Her advice to others struggling with mental health issues: “You can get better but you have to be willing to do a lot of hard work to get there.”

---

**Angela** is a 67-year-old woman who has struggled with mental illness her entire life, and recently suffered a stroke. She is trying to quit smoking and gets lots of encouragement from the staff and her group members. Even though her gains have been small, each day has helped give her more self-esteem and helped her take better care of herself. She's also making a gradual

change from wheelchair to walker which makes her feel much better. She says, “The staff here work on the strengths that I do have to help me get stronger and better.”

Angela has adopted the center’s motto of “Get up, dress up, and show up.” It’s helped change her attitude on the days she doesn’t want to get out of bed.

---

**Martha**, at 59, has faced some devastating life experiences in recent years with the deaths of two of her children. She went into a deep depression and could no longer care for her grandchildren. She was also carrying extra weight and couldn’t even bend down to tie her shoes.

With encouragement from the staff at her treatment center, she started walking every day—first one mile a day and then two miles. She lost 28 lbs. and gained a healthier perspective on life. Taking this action step has helped her to feel better physically and emotionally and she is now able to

take care of herself again—and tie her shoes! She has suffered from both osteo- and rheumatoid arthritis, but since starting the walking routine, her symptoms have lessened so much that she has cut way back on her medications. She was also taking asthma medication every day of her life, but now only uses an inhaler for emergencies.

Martha walks as a tribute to her late daughter who was a walker. She was also inspired by a therapist at her center who modeled a healthy lifestyle and was in very good physical condition and encouraged the consumers at his center to do the same.

---

DSAMH intends to increase the life expectancy of people with serious mental illness by supporting collaboration between mental health and primary care. The DSAMH approach—an overall approach to recovery—involves a whole new look at what wellness and recovery is all about. And it’s making a difference.



**Chino Rodriguez** has lived a life of contrasts. As a former gang member, he spent more than ten years in prison. He is now free both literally and figuratively. He went from being lost in addiction to being found in recovery; from ignorance to spiritual wisdom; and from darkness into light. For 23 years, his life was about destruction, based on destroying everything around him. Now he spends his time building—building himself and others up. He even works in the field of construction—building sets on stage for entertainment events. Rather than use his strength to tear down as he did in the past, he now teaches the peaceful art of meditation. He also volunteers his time with several 12-step groups and participates with the Salvation Army to collect funds for the needy and homeless.

As a martial arts instructor, he’s worked on getting fit physically, but he says it’s much harder and much more important to get fit spiritually. It’s the spiritual fitness that keeps him in his recovery, going on twelve years now. He is constantly working at improving himself because, in his words, “When you’re not working on something, something’s working on you.” For Chino, recovery is a package deal—not just about stopping the use of drugs. “I have cleansed my mind, my body, and my life through everyday choices of higher living.”

## Recovery-Oriented Systems of Care

### Recovery Support

In 2009 DSAMH continued its move towards a Recovery-Oriented Systems of Care model that recognizes the need for long-term support in and out of the treatment system for people with Substance Use Disorders (SUDs). Moving to a care model similar to other chronic diseases acknowledges the chronic nature of SUDs and the need for long-term multi-agency support and assistance for people to succeed in maintaining their recovering lifestyle. DSAMH continued its contract with Utah Support Advocates for Recovery Awareness (USARA) as one way to improve the image of recovery in the state. USARA significantly expanded its membership and the services it provides to recovering individuals by making the CASE for Recovery statewide. (See their website at [www.u-sara.org](http://www.u-sara.org).)

DSAMH also worked with the local authorities on ways to expand their services to provide longer term care for individuals in treatment. The local authorities responded in creative ways and continue to work with DSAMH and other agen-

cies to provide recovery support services for individuals leaving their treatment programs. Expansion of after-care services, extensions of general outpatient treatment, increased referrals to 12-step programs, increased case management for clients preparing to discharge from the programs, expanded outreach of alumni groups and closer coordination with other agencies providing housing, employment, job training and other needed services are all examples of ways the local authorities have worked to improve their support for long-term recovery.

Additionally, DSAMH has spearheaded an effort to modify the Substance Abuse Practice Guidelines to more easily facilitate the move to a Recovery-Oriented System of Care as advocated by the Substance Abuse and Mental Health Services Administration (SAMHSA). This process will be a multi-year effort and will result in an expanded system of care that will provide support for individuals entering into recovery regardless of the way they enter into it.



In September, **Mary Jo McMillen** celebrated her 24 years in recovery with 49 other fellow recoverers in New York City. Mary Jo was the Utah delegate for the A&E-sponsored celebration commemorating the 20th anniversary of National Alcohol and Drug Addiction Recovery Month. Although the all-expense paid trip to New York was a thrill, it was nothing compared to the richness of life Mary Jo has experienced since putting her poly-substance dependency behind her.

Mary Jo had been addicted to alcohol, cocaine, marijuana, etc. since age 16, and in 1985, at the age of 24, she entered a residential treatment program. "Since 1985," says Mary Jo, "my life has been a gift and I am so grateful for all that recovery has brought into my life." Mary Jo's family were also affected by her recovery, as both her parents and her sister entered long-term recovery shortly afterward. Recovery also

had another positive effect on her life a few years later when she met her husband Shawn—also in recovery—while they were both working as counselors in a treatment program. They've now been married 18 years and have two teenage daughters who jokingly refer to Mary Jo and Shawn as "sober nerds"—a title Mary Jo is proud to claim. Both Mary Jo and Shawn now work at First Step House, a nonprofit treatment agency serving low and no-income individuals who are in need of treatment services.

Through the many contributions Mary Jo has made to the recovery community in Utah, she is passing the gift of recovery on to countless others. "My work in addiction treatment has been a most rewarding career for me," she says. "Even in spite of the tragic consequences I have witnessed as a result of addiction, there are many who do recover. I have a job that celebrates people and their success stories and I love it!"

## **Utah Support Advocates for Awareness (USARA)**

USARA is a grass-roots community breaking new ground in the field of addiction-related issues. They make a CASE for individuals and families in recovery. (CASE = Celebrate, Advocate, Support and Educate.) Following is a description of each of the CASE activities.

### **Celebrate**

USARA comes together to celebrate those in recovery, to give hope and demonstrate that recovery works.

They enthusiastically participate in National Recovery Month each September. (See Recovery Day 2009 review following this article.)

### **Advocate**

USARA is raising the voice of those in recovery that has been missing far too long from public policy debate.

- During the 2009 Legislative Session, USARA and its members/affiliates successfully campaigned to save funding for youth prevention programs and treatment programs slated to be cut. Specifically, thanks to the work of advocates and USARA, Synar compliance checks that were tied to tobacco prevention money were required to continue, thereby protecting over \$3 million in block grant funds that flow to prevention programs. In addition, their efforts ensured that the innovative Drug Offender Reform Act received funding of \$3.1 million, with the result that approximately 600 additional people will receive treatment for substance abuse issues who would previously not have been treated.
- USARA has a Social Responsibility and Advocacy Committee that meets monthly to discuss the needs of the recovery community in order to help shape legislative goals and activities.

- USARA's goal is to become the "go to" voice for legislators looking for information regarding recovery and recovery funding. They feel confident in saying that they have created a stronger, more unified voice for the individuals, families and organizations in the recovery community of Utah and will continue to pursue recovery success through the following 2010 legislative goals:

1. Continued funding of DORA and other similar programs
2. Changes to the current requirement of automatic six-month loss of drivers license for drug-related offenses and other regulations that create barriers to successful recovery outcomes
3. Pushing for proper usage of the alcohol/beer tax revenue for use on prevention and treatment services
4. Changes to the expungement process to encourage long-term recovery success
5. Continuing to promote voter education and registration among those in recovery
6. Holding a "Rally for Recovery" each year at the State Capitol to bring legislative awareness to recovery successes and continuing community needs

### **Support**

USARA develops programs serving the individual and family for the best outcome as well as encourages participation in established programs such as self-help, mutual aid, and 12-step.

- [www.U-SARA.org](http://www.U-SARA.org) offers updated lists of support group meetings and links to other substance abuse sites to broaden the range of options for families or

individuals looking for support in the recovery community.

- The USARA Family Awareness Program is in its third session now and it is becoming a valuable community resource for the loved ones of those struggling with addiction.
- USARA is currently pursuing the creation of a central Recovery Hub for those in recovery transitioning from treatment back into society. This facility will be patterned after the recovery center model developed by leaders in the recovery field in Connecticut (CCAR) and will provide innovative programs to maximize the potential of individuals and families involved in that process and provide programs for other addiction-related issues.

### Educate

USARA's goal is to educate the public in addressing the issues of addiction and the stigma surrounding people in recovery.

- Speakers Bureau Development and Speaker Training. USARA provides train-

ing for individuals to effectively share their story about the journey to recovery. Their speakers learn how to address the issues of substance abuse and deliver a message that helps decrease the public stigma regarding the recovery community. The training is offered quarterly. To date, USARA has trained over 100 individuals and maintains an active speaker database of over 80 people.

- U-SARA.org is being developed to provide an online video stream of speakers. The goal of the website content is to create a personal experience for those who visit the site, to educate and inspire them and to put a real face on the issue. USARA anticipates having this feature available by the end of 2009.
- Each year USARA works with DSAMH to promote the recovery track at June School. This year they were able to provide 30 scholarships and 64 people registered for the recovery track.



As a child, **Stephen Letendre** dreamed of becoming a cop. But by the time he landed a career in law enforcement he was heavily into his own self-destructive patterns of drug and alcohol abuse. When he was caught not only using, but also selling drugs, he was arrested and, of course, lost the career he loved. Still drinking and using drugs, he entered the field of social work, working with "at risk" youth, trying to teach others what he had failed to learn himself. He always found the most difficult cases to work with, thinking that if he focused on other bigger problems, he wouldn't have to worry about his own addictions. Eventually, the years of hypocrisy caught up with him and he landed in a treatment program in Pennsylvania that literally saved his life. That was more than 11 years ago and today he actually is able to teach others the lessons he has truly learned about surrendering and being totally honest. Today he has nothing to hide.

Stephen now owns a chemical dependency intervention and educational consulting business in Salt Lake City. Once again he is working with "at-risk" youth, but this time he is able to make a difference. He has earned the respect that is now shown to him, having served on the board of directors for USARA (Utah Support Advocates for Recovery Awareness), and on a citizen advisory committee to two Salt Lake County mayors, among other honors and awards. His words say it best: "I have been blessed with so much, too much to mention. I have the privilege of participating in my own recovery, my life, a life I never could have imagined, a life beyond words. A life helping others. Recovery is definitely the original 'Pay It Forward' program."

## Recovery Day

Each year USARA hosts local Recovery Day events across the state during September, which is National Recovery Month. They invite people in recovery and their families to come out and enjoy live music, food, and activities, bringing families and friends together to share as a community and support the fact that recovery works.

This year approximately 3,300 people participated and witnessed that recovery is possible. USARA is particularly excited that this year, for the first time, they were able to hold recovery events outside of Salt Lake City. With the help of volunteers and community partners, USARA held recovery events in Park City, Tooele and Provo, along with Salt Lake City. Each event included music, free food, fun activities, and information tables about various recovery resources available in the community. Seventy-three recovery-related organizations participated by sharing their expertise and knowledge with the community and to network the needs of those in—or looking for—recovery in their lives. Attendees also heard from a number of USARA-trained “recovery speakers.”

The Utah 5k Run for Recovery officially kicks off Salt Lake Recovery Day each year. The run/walk



is celebrated with prizes and each runner receives a “Run for Recovery” t-shirt that bears the names and logos of the sponsors. This year 220 people registered for the run and 170 completed the race. This was a big year for the race because it was the first year that USARA was able to secure a corporate sponsor (Reckitt-Benckiser). And they had more donated support than ever from local providers with the bands all donated and the Galivan Center at no charge.



Media coverage of Recovery Day was another great success this year. For years, USARA has struggled to promote Recovery Day in a substantial way through paid and earned media. This year through partnerships with Thomas Arts and Simmons Media, USARA was able to leverage a \$5,000 media buy into nearly \$15,000 worth of advertising on various radio stations. In addition, USARA representatives and volunteers appeared on both Channel 2 and Fox News 13 to promote Recovery Day as well as a front-page article in the *Deseret News*. Media interviews can be seen on the USARA website.

## Healthy Transitions Initiative for Youth—PASSAGE

Nineteen-year-old Camille Houston has a message for other struggling teens: “Recovery from mental illness is possible and I am living proof.” After years of grappling with the crippling effects of a mental disorder including months of hospitalization, Camille is now well on her way to responsible adulthood. Her healthy transition is, in large part, due to the help she received through the Partnership for Youth in Transition Initiative administered by DSAMH.

DSAMH now has another opportunity to provide youth-in-transition services in two counties—San Juan and Tooele—and will pay special attention to the diverse cultural groups within those communities, e.g., Native Americans and Hispanics. In October 2009, DSAMH received a five-year federal grant to implement Progressive Adulthood: Skills, Support, Advocacy, Growth, and Empowerment (PASSAGE). PASSAGE is the enhanced version of the previous initiative which offers a services and support network to young people with mental health needs during the transition to adulthood, a particularly critical juncture in their lives. It is anticipated that 380 young persons will receive transitional facilitation services from October 1, 2009, to September 30, 2014.

Core elements of the PASSAGE transitional facilitation services are:

- Providing transitional facilitators
- Availability of flexible funds
- Use of powerful family curriculum—*Growing Up without Growing Apart*
- Providing opportunities for youth development

**Transitional Facilitators**—San Juan and Tooele Counties will each receive grant funds to hire two full-time equivalent transitional facilitators. Transitional facilitators will assist young people in acquiring necessary skills and competency to

successfully transition into adulthood through an intervention style of coaching across five major transitional domains (employment, education, housing, community life, and personal well-being).

**Flexible Funds**—Flexible funds will be available to young people and their families to assist them in obtaining the necessary services or resources to facilitate a successful transition. With these funds, facilitators can address the specific transitioning needs of young people where no other traditional funding is available.

***Growing Up without Growing Apart* Family Curriculum**—The curriculum was written by a group of family members with transitional age youth. It provides family members a tool to help young people with serious mental health challenges negotiate the road to adulthood. It covers eight topics: 1) Taking Care of Yourself; 2) Person-Centered Planning; 3) Education; 4) Legal Issues; 5) Dreaming New Dreams/Loosening Up; 6) Developmental Milestones; 7) Transitional Timeline Checklist; and 8) Foster Children.

**Youth Development**—State and local youth councils will be formed to help the participants develop leadership and advocacy skills. Youth councils will participate in the annual National Children’s Mental Health Awareness Day campaign in May, and an annual Youth Leadership Conference will be organized to further focus on leadership and advocacy skills.

It is expected that PASSAGE will produce similar outcomes as the previous initiative. The anticipated outcomes include:

- improvement in mental health functioning
- improvement in academic performances and high school graduation
- increase in employment

- decrease in homelessness
- decrease in residential and in-patient psychiatric treatment
- decrease in juvenile/criminal justice involvement

These measurements will be significant because the transition initiative focuses not just on the mental disability, but looks at the whole person—as a student, a job-holder, a community member, and a family member.



My life has been quite the journey. I have been through boyfriends (my first and the break ups), my not so sweet 16, high school drama, and my graduation.

However none of these things were as terrible or as great a trial as what I have gone through having a mental illness. I have been diagnosed with several different disabilities and at this time I have Attention Deficit Disorder (A.D.D.) and Bipolar disorder.

When I was younger, I thought I was cursed and that no one knew or understood me. I have been placed in mental hospitals. I have been on tons of different medications. I had a few breakdowns. It was my “DARKEST HOUR.”

I thought that I would never be happy. I thought that this was how my life would always be. Then I found two resources—the National Alliance on Mental Illness (NAMI) and my Youth-in-Transition Groups.

In this group I found opportunities to share with others the stories and trials of mental illness. It cuts deep into my heart. I found out that there are other people who are enduring much harder things in their lives than I am. Through this experience I decided that I would change my life around and strive to live a better and happier life.

Today I am no longer on medication. I haven’t had any for over a year. For the past year I have held a job. My relationship with my parents and family has improved. I have gone back to church. I am making better friends and relationships. I have not relapsed in the past two years.

—Amanda, Member of the DSAMH-sponsored Youth Action Council

# Consumer and Family Involvement

## Overview

As mandated by the Mental Health Block Grant, DSAMH is required to convene a Mental Health Planning and Advisory Council with at least 50% participation by consumers and family members. When the State Board was dissolved in 2009 as a result of budget cuts, DSAMH shifted the board's responsibilities to the Mental Health Planning and Advisory Council.

Additionally, to ensure that the consumer's voice is heard, DSAMH has created the position of Consumer Affairs Manager to be a liaison to consumer organizations. The Consumer Affairs Manager also goes on monitoring visits to be sure the agencies DSAMH monitors are listening to their consumers.

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## NAMI Utah

NAMI is the National Alliance on Mental Illness. Their mission is to ensure the dignity and improve the lives of those who live with mental illness and their families through support, education and advocacy. To all who are suffering from mental illness and to their families and caregivers, NAMI spreads the message that treatment works, recovery is possible, there is hope, and you are not alone.

DSAMH contracts with NAMI Utah to provide services under the Federal Community Mental Health Services Block Grant.

NAMI Utah programs include:

**BRIDGES**—A 10-week class for those living with mental illness. Courses cover brain biology, symptoms, communication, building support, crisis planning, and recovery. This course is taught by trained individuals who can speak from personal experience. NAMI also provides BRIDGES classes in Utah's jails.

**Progression**—A 6-week education/support group for youth ages 16-21 who are living with mental health issues. It is a safe place to learn about illness, recovery, roadblocks, and valuable skills. Youth can talk to others who are dealing with similar issues.

**Connection**—A weekly recovery support group that is expanding in many cities throughout the country for adults with mental illness of any diagnosis.

**Family-to-Family**—A 12-week course for family members of people who have mental illnesses. Classes cover symptoms, medications, coping skills, recovery, advocacy and more. Classes are offered in English and Spanish and are taught by trained family members.

**NAMI Basics**—A 6-week course for parents and caregivers of children/adolescents with mental health issues. Classes cover symptoms, treatment, problem solving, crisis preparation, challenging behavior, record keeping and more.

**Family Support Groups** are available across the state for family members and friends looking for support from those who understand.

**Mentoring Program** provides those living with mental illness and their families a peer who can listen, empathize, and connect them to valuable education/support programs and other community resources.

**Hope for Tomorrow**—An education program offered to secondary schools with com-

ponents for students, teachers, and parents. The goals are to raise awareness of mental illness, erase stigma, and foster hope.

**Parents and Teachers as Allies** is a free 2-hour faculty in-service offered to all schools as a part of Hope for Tomorrow.

**Clergy and Provider Training** provides training to clergy members and professionals on mental illness from those who are living with it. Information includes suggestions on offering support, and resources available in the community.

**Artists' Project** encourages recovery and empowerment through self-expression, allowing artists with mental illness to display and market their art in the community.

**Hearts and Minds** is intended to raise awareness and provide information on diabetes, diet, exercise, and smoking, and includes a 13-minute inspirational video and a 26-page booklet. This course is for everyone.



My life has taken me down some difficult paths, but it has led me to the great place where I now am. I abused alcohol for years—and was not able to control it or to figure out why I depended on it so much. Luckily, I got into treatment for my alcoholism, but my life was still chaotic. Things were out of control and I was floundering. I lost a good job because I had become such a disruption in my workplace. Finally, after I was diagnosed with a bipolar disorder, I began to understand my symptoms better. I understood that I had been self-medicating with alcohol, trying to cover up or overcome my uncomfortable symptoms. And I used it to get me through the severe depressions that I suffered.

Getting on medication to control my bipolar symptoms made a world of difference to me. Then I found NAMI, and my life totally changed. After I started attending groups and classes there, they asked me to actually teach their classes. I was shocked! But I loved it. I realized that once you start giving back what you've been receiving, you get double in return. Soon I was appointed president of NAMI's Ogden affiliate, and started feeling self-esteem and self-worth that I had never experienced in my life. The next step was interviewing for the position of Consumer Affairs Manager at DSAMH and I got it. It has been a wonderful opportunity for me to help others who are experiencing the same difficulties I have had in my life.

—Roy Castelli, DSAMH Consumer Affairs Manager

## Utah Family Coalition

The Utah Family Coalition is a collaboration of NAMI-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, called family resource facilitators (FRFs), are located across the state. They provide help to other families and individuals faced with mental health issues, including education and access to needed community resources; gathering of those who can help (known as wraparound facilitation); and ultimately help-

ing each family develop a family voice. In this way they can positively impact not only their own treatment plans but can actively impact their local community mental health centers 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, which 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.”



## Adolescents Living with Mental Illness

The State Youth Action Council is an integral part of the Utah's Transformation of Child and Adolescent Network (UT CAN) project to improve the effectiveness of the children's mental health and substance abuse system in Utah. Youth Council members identified that stigma is something they have all struggled with. It is also one important factor in why many people, regardless of age, do not seek or receive the mental health and substance abuse services they need.

These young people chose to join hands with other young people around the country to bring more awareness to children's mental health issues. They wanted to bring their stories to the public's attention in conjunction with the National Children's Mental Health Awareness Day on

May 7. Nine young people wrote stories about themselves—their struggle with mental illness, the resilience they found within, their dreams, and their talents. They are artists, photographers, musicians, athletes, and just normal teenagers who like doing normal teenager stuff. Their stories were on exhibit in the Salt Lake Main Library; and Fox 13 TV station interviewed several of the youth and one parent on how mental illnesses impact families. The whole experience has been very empowering to these young people. They are now planning a bigger and better project to celebrate Children's Mental Health Awareness Day in May 2010. (NOTE: The stories written for the May 2009 celebration are included on the divider sheets and throughout the report.)



## School-Based Mental Health Services

One of the most exciting trends in mental health programs for children and youth is the growth of school-based treatment services. Substance abuse prevention has had a strong presence in Utah schools for years, and now the continuum of services has expanded to include mental health treatment. Providing services in schools is a consumer-friendly practice; it is convenient for families and it significantly reduces the stigma of seeking help for mental health problems.

Six of Utah's 13 local authority areas began providing school mental health services as a pilot project under DSAMH's UT CAN, a federal grant from SAMHSA; other areas instituted or increased services on their own. The services are implemented in both rural and urban settings; they are based on local data and needs and the joint planning efforts of local community mental health centers and local school districts. Because of this "tailoring" of services, Utah can boast a variety of forms statewide including: individual and group social skill development; individual

and group therapy; family therapy for parents and siblings; and referral to ancillary services in the community, where appropriate.

The early intervention which school-based services provide can decrease the severity of some mental illness, and can help ward off the dual diagnosis of substance abuse. Some of the positive outcomes associated with school mental health services are:

- Improved treatment outcomes
- Increased school attendance, performance, and graduation rates
- Decreased office disciplinary referrals and juvenile justice involvement

Utah will continue to emphasize the provision of mental health services in a school-based setting. A committee is currently designing a technical assistance manual in conjunction with the Utah State Office of Education in order to assist even more areas to implement this effective practice.

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### Client Quotes

*"I suffer from a mental health condition. I am very thankful for my therapist. She has been very kind and supportive to me in some very hard times. I am now in my first semester of grad school and I love it. I still have many hurdles to overcome, but I am very thankful for all that I have received as it has provided me a hand-up, not a handout."*

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## Mental Health Consumer Outreach Project

In fiscal year 2009, the DSAMH consumer affairs specialist continued a consumer outreach initiative begun in 2008, where he and a group of consumers visited and interviewed consumers across the state to gather feedback regarding any issues of concern. Small focus groups were conducted in places where people would feel comfortable to talk candidly. In general, consumers were asked questions about their current situation and unmet needs, including "How is your treatment going?" and "Do you have meaningful relationships?"

The group of reviewers highlighted the common responses to their questions in the bullet points below:

- One of the major concerns in most places was that Medicaid spend-down is neither consistent nor understood.
- More money is given to single adults receiving Social Security disability insurance than those who are married, which

leads some to divorce to increase their monthly income.

- In almost every group, the main topic of discussion was the participants' interest in getting a job. Most wanted to get a job but were frustrated with lack of transportation and fear about losing benefits by working.
- Housing is also a big concern statewide, specifically, trying to qualify, bureaucratic run-around, waiting period of one to three years, and background checks that might keep them from getting a place to live.
- Transportation is a problem with greatest impact in rural areas. Lack of funds and long distance travel make it difficult for clients to keep their appointments.
- Consumers want to enter the workforce, but there are very few competitive job opportunities outside of doing janitorial work for centers.
- Some of the consumers interviewed had a treatment plan but were never really involved in it, while others had set goals with their counselors and felt like they were a part of their plan.
- Many consumers interviewed had concerns about access to eye and dental care.

- Generally speaking, most are happy with their treatment services, but frustrated with issues regarding employment, transportation, and benefits eligibility.

**Summary.** This project began with a basic assumption that proved to be false. The assumption was that if consumers were asked by other consumers how things were going regarding their treatment and recovery, people would be comfortable to talk and share their concerns about treatment. The way it turned out, however, was that the outreach team had very few reports directly regarding treatment issues. Instead the issues listed above—getting a job, housing, fear of losing benefits, lack of transportation—were the universal concerns.

The message the outreach team received was that, generally, the consumers were satisfied with their treatment and felt like they were participating in their recovery. But they want to have meaningful activity in their lives and most have a strong desire to work. Barriers related to benefits and transportation are often overwhelming. People want to be active and involved in their community beyond “just going to the mental health center to receive treatment.”

#### *Client Quotes*

*“I have had a lot of problems staying on my medication. The staff at my community center remind me that a lot of people need medication just like me . . . I used to think that taking my medication made me abnormal, but I now realize the medication makes me closer to normal than I have ever been and I am grateful.”*

## Peer Support

Peer support is a structured method in which mental health consumers give help to others and is founded on the key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support for individuals with similar life experiences (e.g., parents who have lost children, individuals who have divorced, trauma survivors, or mental health consumers) has demonstrated tremendous success in helping individuals move through difficult stages in their lives to recovery.

Peer support should promote a culture of health and ability as opposed to a culture of illness and disability. The primary goal is to responsibly challenge the assumptions about mental illnesses and

at the same time to validate the individual—who they are and where they have come from. Peer support attempts to help individual consumers develop and achieve their own person-centered care—focused on recovery, wellness, community integration, employment, education and the attainment of life goals.

DSAMH continues to work with consumers, stakeholders, NAMI, Medicaid, the Department of Human Services' Office of Licensing, and the local mental health authorities to develop peer support certification and services as a critical component of the adult mental health service delivery system in the state.

### Client Quotes

*"My daughter and I are both consumers of mental health services in Utah. In December 2000 I gave up working as I could not hold a job for any length of time. I really felt useless and felt I was a failure at anything I attempted to do. My situation was further complicated by getting custody of my daughter in 2003 at age five. By the fourth grade, it was recommended that she needed some long-term inpatient treatment at the Utah State Hospital. I felt that I had failed as a father, but knew I'd exhausted all resources to help her on an outpatient basis. As my daughter's problems escalated, mine did as well. I had gone into a very deep depression (I suffer from bipolar and post traumatic stress disorders). I was a total wreck and was on the verge of being hospitalized myself, until my community mental health center stepped in with help for housing, utilities, medication, and increased therapy.*

*My therapist referred me to the Supported Employment Program as a way to get me up and moving again. I struggled at first but quickly began making progress as they were very helpful in supporting me. They helped me with transportation to see my daughter at the hospital, and with job skills, symptom management, early intervention, communication skills, conflict resolution skills and so much more. I learned how to advocate for myself and others with similar issues so they may have the opportunity to realize their dreams.*

*My daughter has been home from the State Hospital for a year-and-a-half now and is doing great. She is in the seventh grade and is a straight-A student. My biggest dream has now been realized. I have my family and we are doing great. I receive SSI benefits for my daughter and I am eligible to receive SSI benefits also, but I choose to work instead. I have been working a full-time job for two years now and require no on-going support for housing, bills or health care. I am a self-sufficient person. We still continue with mental health services, but they are becoming fewer and farther between.*

*I work in the Supported Employment Program now in the hope that I can mentor other consumers to be successful with their hopes and dreams. I volunteer for the Utah Parent Center so I may help other parents with children with disabilities."*

## Family Resource Facilitators

*Family Resource Facilitator Project—A Model for Strengthening Families and Building Communities*

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<sup>1</sup> to have at least one Family Resource Facilitator (FRF) at each of the 13 community mental health centers (CMHCs) throughout Utah.

FRFs are trained family members who develop working partnerships with the CMHC staff to represent family voice at service delivery, administration and policy levels. At no charge to families, FRFs provide: referrals to local resources and programs; advocacy for culturally appropriate services; links to information and support groups; and family wraparound facilitation. These services provide increased family involvement at all levels and improve outcomes for families and communities where they live.

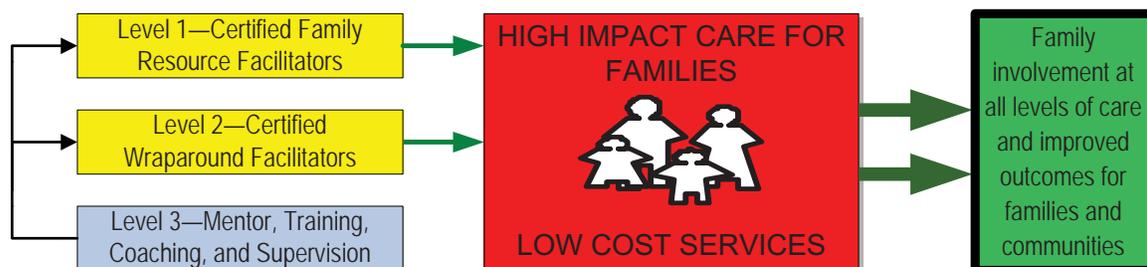
### Family Resource Facilitators:

- Are family members who have first-hand experience living with a child or loved one who has mental health challenges

<sup>1</sup> UFC Partners are Allies with Families (local chapter of the Federation for Families), NAMI-Utah, and New Frontiers for Families.

- Are trained in the Family Leadership Training curriculum
- Build community services and supports
- Link families to community-based services and formal and informal supports
- Are coached and mentored in wraparound facilitation to fidelity with the Wrap-around Fidelity Index
- Complete certification requirements as defined by the Utah Family Coalition and the Division of Substance Abuse and Mental Health
- Are accessible to all families in the community and trained in cultural competence
- Help families advocate for themselves and help families advocate for systems change
- **Help renew hope to families they serve!**

Family Resource Facilitators play a key role in developing a formalized, family-driven and child-centered public mental health system in the State of Utah. During the first two years of the program, FRFs have served over 1,000 families in their local communities through their education, advocacy, and facilitation efforts.





The thing that has kept **Steven Mickelson** going all these years could be boiled down to the golden rule. “Somebody gave me my life back,” he says. “And I needed to do that for others.”

Steven started drinking in his late teens “just to have fun and relax.” But as a binge drinker, this form of relaxation started causing problems for him. Even more problematic was the fact that he had become a police officer and he knew that if he didn’t stop drinking he might lose his job or end up in jail . . . or worse. So with the help of a good friend and mentor, he turned his life around.

As a police officer he observed the revolving door in jail—people would go in, come out, then go back in, which inspired him to help establish a drug court in Sevier County. He now serves on the drug court board. He is also active in all community and school prevention programs. His unique and outstanding program in Sevier County is directly involved with law enforcement, and other law enforcement agencies are learning from Steve so they can implement similar programs in their own areas.

To repay that “somebody” who helped turn his life around, Steve has become a friend and mentor to countless people he has encountered in his duties as sergeant and deputy sheriff in Sevier County. He doesn’t look at the people he picks up on DUIs as bad people. “They’re good people with a problem. We can help them. You can be a hard-nose or you can help them. We’ve chosen to help them.”

He wants people to know that there’s help out there. As he said it, “There are people who will bend over backwards to help.” And you can bet, it’ll be Steve Mickelson bending over backwards to help.

## Crisis Intervention Team

In 2001, DSAMH collaborated with the Salt Lake City Police Department and NAMI-Utah to provide a Crisis Intervention Team (CIT) academy where law enforcement officers are trained in tactics to effectively intervene in situations involving a person experiencing a mental health crisis. Crisis Intervention Team officers are volunteers from uniformed patrol divisions. These officers maintain their responsibilities as patrol officers, but become primary responding units in such incidents. The training provides officers with information in identifying characteristics of various mental disorders.

Along with a newfound empathetic approach, officers of this program are trained to provide a safer intervention for the person experiencing a mental health crisis, their family members, the community, and the officers themselves. In addition to classroom training, role-playing scenarios are provided and officers are given an opportunity to interact with patients at the Utah State Hospi-

tal. CIT is a statewide program that builds strong working partnerships between law enforcement agencies and the mental health resources they utilize. These partnerships bring law enforcement and mental health services together instead of working independently on mental health issues. The CIT program seeks to accomplish two major administrative goals:

- First, to establish a cadre of CIT law enforcement officers within all Utah jurisdictions. When a person is experiencing a mental health crisis, law enforcement officers are generally the first to respond and are tasked with de-escalating the situation. Training regarding mental health issues has previously been minimal for law enforcement officers. Without training, officers may have difficulty understanding why a person in crisis reacts as they do. Training gives the officers knowledge and understanding to empathetically deal

with a situation by utilizing de-escalating tactics and techniques.

- Second, to establish a system that includes law enforcement as a team member of mental health care. Once the officer has a situation controlled, it is paramount that a proper disposition be utilized to benefit the consumer as well as the community. The system established by the CIT program opens lines of communication with various agencies and resources. Instead of working independently, law enforcement teams with mental health resources to find more appropriate and long-term solutions.

### Training

Since 2001, 2,029 law enforcement and mental health staff representing 86 agencies have participated in these academies. In fiscal year 2009, 381 individuals from 60 agencies were certified as CIT officers. Trainings were held in 17 CIT academies in seven mental health center regions and three CIT academies for correction officers.

One of the academies, conducted by the Layton City Police Department in partnership with Davis Behavioral Health, began the CIT program in a new region. This brought the total regions that have the CIT program to 7 of the state's 11 regions.

The following areas conduct CIT academies and support the CIT program through partnerships. The partnerships formed include:

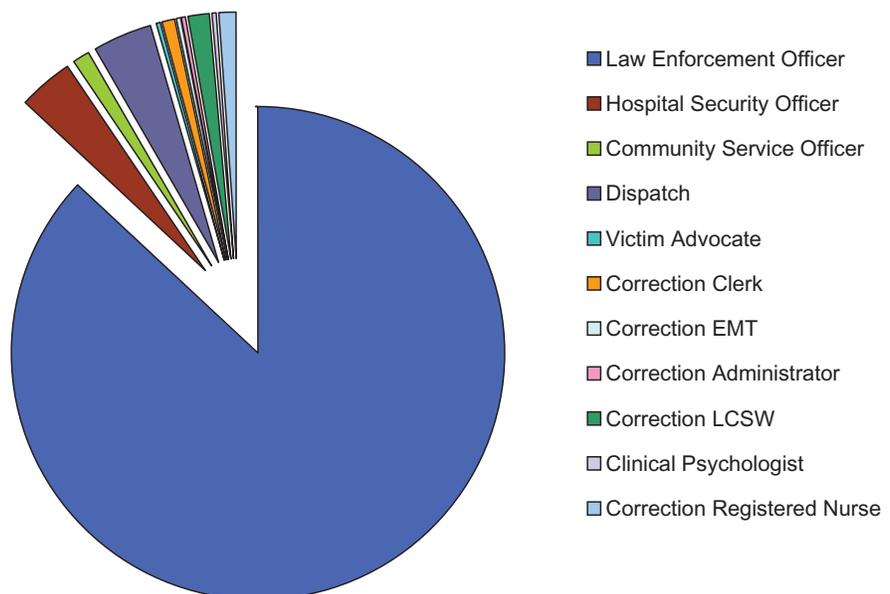
- Salt Lake City Police Department/Valley Mental Health

- St. George Police and Cedar City Police Departments/Southwest Center
- Orem City Police Department/Wasatch Mental Health
- Weber County Sheriff's Office/Weber Human Services
- Brigham City Police and Logan City Police Departments/Bear River Mental Health
- Wasatch County Sheriff's Office/Heber Valley Counseling
- Layton City Police Department/Davis Behavioral Health

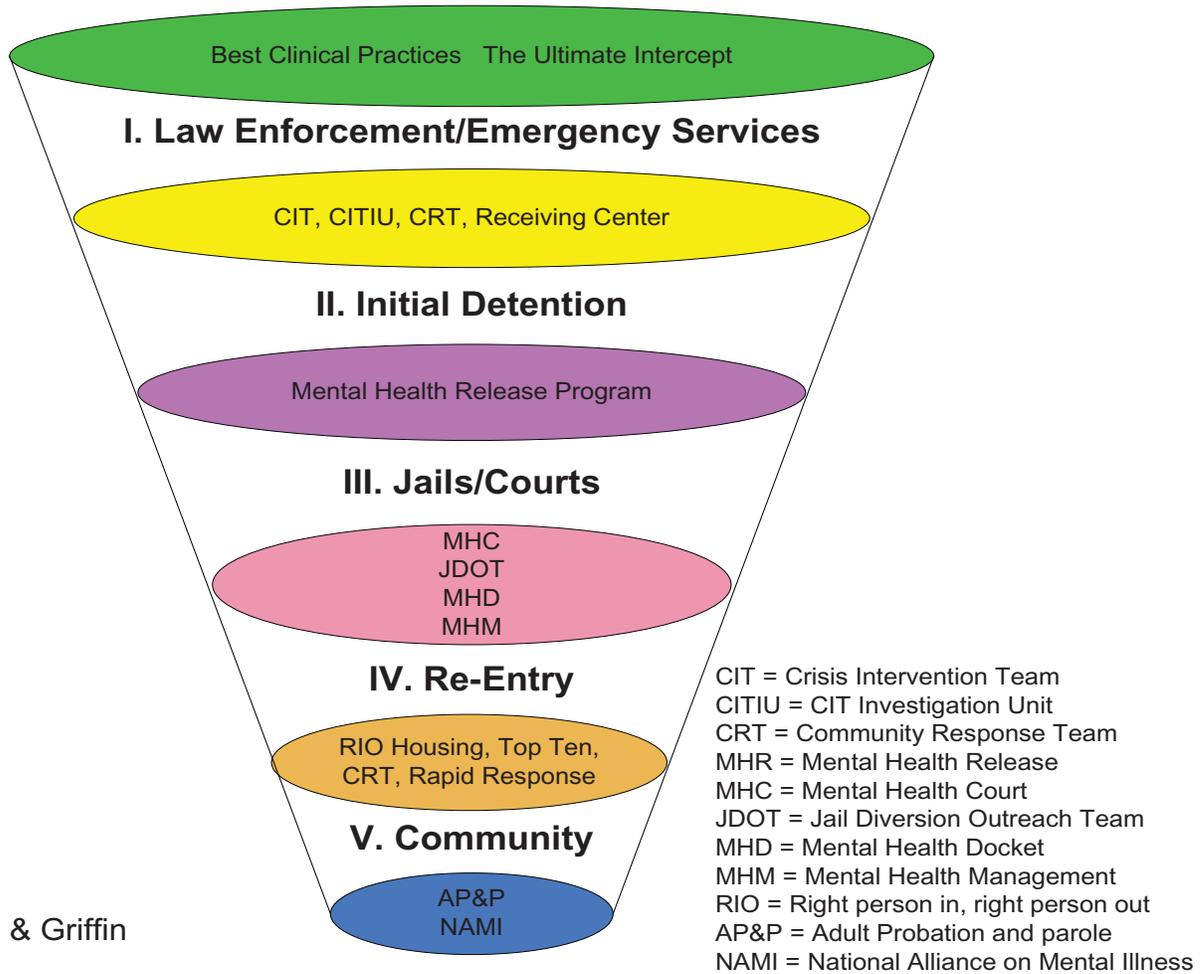
### Collaboration Efforts

The CIT program requires strong partnerships and dedicated collaboration efforts for success. In all regions, the initial partnership is formed between a law enforcement agency of the region and the region's mental health center. Both identify personnel from their respective agencies to become CIT regional coordinators. These regional coordinators work together with the support of the state program administrators to conduct CIT academies and develop the program. Often, other

Individuals certified during this period



# Sequential Intercepts



Munetz & Griffin

mental health services, as well as the entire criminal justice system, collaborate to find more permanent resolutions to situations involving mental health consumers called to the attention of law enforcement.

A sequential intercept model was developed by Mark Munetz, M.D., and Patricia Griffin, Ph.D., regarding different levels of where a person with mental illness could be intercepted, identified, and linked to services to prevent further penetration into the criminal justice system. Salt Lake County has worked diligently to fill gaps in the intercept model by developing programs at each level.

During fiscal year 2009, a presentation on Salt Lake County's model was given at the CIT National Conference. The Sequential Intercepts graphic was used in that presentation, depicting the various programs within the Salt Lake County model. As you will notice, CIT sits prominently in Intercept I.

## CIT for Youth

NAMI National's Child and Adolescent Action Center and CIT Technical Assistance Center are working together on a national initiative to promote CIT for Youth to respond to youth experiencing a psychiatric crisis or serious behaviors related to their mental illness in both school and community settings.

Building on the success of the adult CIT model, NAMI collected detailed information from existing CIT programs and identified the core components necessary for an effective CIT for Youth program. This information was compiled into a report titled, *Supporting Schools and Communities in Breaking the Prison Pipeline: A Guide to Emerging and Promising Crisis Intervention Programs for Youth*. This report provides the basis for the next step in NAMI's work on CIT for Youth program implementation in targeted communities in three states over the next two years. During the year of this report, Utah was identified by NAMI National as one of the three states.

NAMI National will work with strong NAMI state and local affiliate leaders and other key stakeholders in Illinois, Louisiana, and Utah to develop, implement, and sustain CIT for Youth. A minimum of two communities in each of these three states will be targeted for the implementation of the program. NAMI National will work with NAMI leaders in the selected communities to bring stakeholders together and create the steering committees needed for program implementation, sustainability and expansion.

The selected states were strategically chosen because 1) they have strong NAMI state organizations; 2) they have demonstrated a commitment to adult CIT programs; 3) they have established strong community partnerships between law enforcement, mental health systems, and schools; and 4) they are geographically diverse.

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In Utah, the two communities selected were Salt Lake City and St. George. Since the initial meetings with NAMI National, NAMI Utah, and CIT Utah, partners are beginning to be identified at the state level as well as the local levels. Meetings to help identify challenges, training curriculums, and policy issues have been conducted with Salt Lake City Police Department's and St. George Police Department's school resource officers. Steering committees are beginning to be formed at the state level and will be formed at the local levels for development and implementation.

### **Council of State Governments**

The Council of State Governments Justice Center has been funded by the Bureau of Justice Assistance to examine efforts in three states that are promoting and coordinating specialized police responses at a statewide level. This project will gather detailed information about state-level strategies and emerging approaches that may be replicated elsewhere. A publication summarizing these efforts will be widely disseminated.

In 2009, Utah was selected as one of the three states to be examined due to its strong CIT program. Many states have CIT programs in different regions, but do not have statewide coordination. Utah was one of the first to develop a statewide model in which training, testing, certification, and identifying insignias were formalized and made uniform throughout the state.



My name is James. My mental illness has helped me make some new friends. For me having a mental illness is just part of life.

I think it is important for other people to know how to help youth with mental illness. My grandma and grandpa always help me. Kids need good supports like their parents.

I hope to use the skills I am now learning to help others recover from mental illness. I feel good when I help other people.

I like playing my Xbox and watching TV. My favorite TV shows are about my heroes like “Batman” and “Superman.” I like them because they help people.

I am a big movie watcher too. I like playing with my friends and being outdoors. I am easy to get along with. There are some people who say that I am a peacemaker.

In my future, I want to be able to have a good job and support my family. Doing what is right is really important to me. I want to take care of my grandparents and further my education.

—James, Member of the DSAMH-sponsored Youth Action Council

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## Certification, Education, and Training

### Overview

Public understanding of substance abuse and mental health issues has grown tremendously in the past 50 years. However, individuals with substance use disorders are still too often seen as morally flawed. Mental illness is frequently perceived to be the result of some kind of personal weakness. There is still a long way to go in educating the public before the stigmas attached to these challenges will be eliminated. Along with educating the public, there is a continual need to offer training in the latest treatment methods to practitioners. Even individuals who work in the

field struggle to keep up with the rapidly emerging research on mental health and addiction. Treatment techniques proven in the clinical laboratory can take years to make their way into practice. To address these issues, DSAMH has developed a number of education and training initiatives to educate the general public, families, and practicing professionals. The Division also administers several certification programs to ensure the competency of professionals, to ensure integrity to program standards, and to ensure the quality and consistency of service delivery across the state.

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## Substance Abuse Fall Conference

In 2009, the 31<sup>st</sup> Annual Fall Substance Abuse Conference was held in conjunction with the National Association of Alcohol and Drug Addiction Counselors (NAADAC) in Salt Lake City, Utah, on August 18-22, 2009. The Division of Substance Abuse and Mental Health joined with NAADAC, the Association of Utah Substance Abuse Professionals, the Mountain West Addiction Transfer Technology Center, and the National Association of Lesbian and Gay Addiction Professionals in planning and presenting the conference. There were over 900 professionals from various fields throughout the United States attending the conference.

National keynote speakers included Westley Clark, director of the Center for Substance Abuse Treatment (CSAT); Timothy P. Condon, deputy director of the National Institute on Drug Abuse (NIDA); Benoit Denizet-Lewis, author of *America Anonymous: Eight Addicts in Search of a Life*; Stephanie Covington, well-known expert in gender responsive treatment; Carlo DiClementi, co-developer of the change model; Ray Daugherty, president of PRIME For Life; Jerry Moe, national director of children's programs at the Betty Ford Center; and Kevin McCauley, well-known local speaker and head of the Institute of Addiction Studies.

There were over 40 breakout sessions that addressed topics as diverse as equine therapy, ethical issues in substance abuse treatment, cultural sensitivity and awareness, clinical supervision, working with GLBT clients, addiction/trauma

connection, eating disorders, adolescent treatment, combating compassion fatigue, adolescent best practices and future trends in substance abuse treatment. The addition of the NAADAC sponsorship allowed this conference to be larger and longer than any of the previous fall conferences.

In addition to national awards presented by NAADAC, several local awards were presented this year: The Merlin F. Goode Prevention Services Award was presented to **Julie Spindler** for outstanding creativity and dedication in providing cutting-edge prevention services and for her leadership in guiding the community coalition in their prevention efforts. The Substance Abuse Treatment Award was presented to **Darin Carver** for his consistent commitment and outstanding professional and personal contributions towards improving substance abuse treatment services in Utah. The Stuart D. Wilkinson Excellence in Public Service Award was presented to **Gloria Boberg** for her demonstrated leadership and tireless efforts to increase the public awareness of the individual, family, and societal problems associated with substance abuse and for her leadership in energizing and expanding the Association of Utah Substance Abuse Professionals. And the Justice Award was presented to **Val Ellison** for his extraordinary service and dedication to improve the quality of life for individuals who are involved in the criminal justice system and are impacted by substance abuse issues.

## **Generations 2008 Mental Health Conference**

The annual Generations Mental Health Conference was held on April 1-2, 2009, at the Salt Palace Convention Center in Salt Lake City, Utah. Over 500 individuals attended, with 66% employed in the public mental health system and 34% in the private sector. The opening of the conference featured internationally known researcher and practitioner Dr. Joseph Parks, M.D., presenting his research titled, *Ending the Epidemic of Death in Persons with Mental Illness—What We Need to Do Now*. This presentation highlighted a recent study that found persons with major mental illness die an average of 25 years younger than the general population. Some of the original research included data from the state of Utah. The second day of the conference began with an educational and interactive presentation from Pulitzer Prize

winning author Eric Newhouse. Mr. Newhouse addressed current mental health issues related to returning combat veterans with an address titled, *America's Next Crisis: PTSD and TBI*. Approximately 100 active duty Utah National guard soldiers were invited to attend and participate. Representatives from the Federal Veterans Administration were on hand to connect attending soldiers directly with services.

During the two days of instruction, approximately 48 breakout sessions were held. Presenters included local and national experts. Topics ranged from *The Neuroscience of Major Depressive Disorders* to *Prescription Drug Abuse and Poisoning—Data and Mechanism of a Silent Epidemic*.

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### *Client Quotes*

*"After high school I tried very hard to obtain and keep a job. I was unable to hold down steady employment. I got extremely frustrated with life. I asked my parents to help me attend college. They told me I was too dumb to handle college. The clubhouse has helped me a lot because it has given me a lot of confidence. It has made me realize there are other people who struggle as much as I do. It has also given me the confidence that my parents didn't give me."*

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## **University of Utah School on Alcoholism and Other Drug Dependencies**

In June 2009, DSAMH, along with the University of Utah, co-sponsored the 58<sup>th</sup> 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 Justice, Dental, Drugs, Treatment and Rehabilitation, Education, Prevention and Youth Counseling, Employee Assistance and Human

Resource, Mining Industry, Nursing, Pharmacy, Physicians, Professional Treatment, Recovery Support, Relapse Prevention Counseling, Substance Abuse Overview and Current Issues, Vocational Rehabilitation, and Women's Treatment. Attendance this year exceeded 800 people and represented 42 states and three 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.



**Pat Correa** does not act or look her age. An exceptionally youthful 70-year-old, Pat has the vitality and enthusiasm for life of a much younger person. And even though years of smoking, drinking, drug use and over-eating generally take years off a life, Pat is living proof that recovery can be a fountain of youth. She is now “happy, joyous and free.”

Pat spent her childhood in foster homes and orphanages and learned to survive the insanity by feeding her addictions. As a teen she was into speed, diet pills and food, eventually adding alcohol and tobacco to her repertoire. She finally cracked at age 25—a divorced mother of six children, including one special-needs daughter. When nothing was working, she started working the 12 steps and they became her new way of life.

And, as she says, her life went from “rags to riches.” As she got better she stopped being bitter. She went back to school and got a bachelor’s and then a master’s degree in social services. Pat says she’s one of the “lucky ones that found recovery. It has changed the cycle of abuse and dysfunction in my family and has brought love, harmony and support. It enables me to serve with a purpose.”

Her motto is, “If you’ve got it, you’ll pass it on. And if you get it, you’ll serve.” Judging by this motto, Pat certainly gets it, as she’s spent the last 45 years serving. Along with serving continually in many capacities in her 12-step groups, she has also served four missions for her church, and is currently working with Habit for Humanity, helping families in need of homes.

## Utah Addiction Center

The Utah Addiction Center continues to work toward its mission of “preventing chemical addiction and improving patient care through research, clinical training, and education.” The staff at the Addiction Center divide their time among program/policy development at the local, state, and national levels; teaching and training within Utah and throughout the United States; and conducting both applied and clinical research on substance abuse addictions.

For the past several years, the Center staff have been actively involved in training medical residents, pharmacists, and other health care professionals in the recognition of substance abuse disorders. The program includes filmed “mock patient interviews,” online case studies, and valuable links to additional resources. The program has been so well received by the health care industry that the Center is now expanding its reach and offering similar resources to families who have been affected by substance abuse issues and would like to have a better understanding of the clinical elements and management of

associated problems. The Center will provide a filmed mock interaction that will allow families and friends to see “firsthand” how to talk to loved ones about substance abuse issues including denial, resistance, and treatment options. The mock interactions will also demonstrate how the friend or family member can develop insight into how drug abusers think, behave, and present their problems. The films will be available in DVD form and online at <http://healthcare.utah.edu/uac>.

The Center collaborated with the Utah Substance Abuse and Anti-Violence Coordinating Council to develop education and outreach to pregnant women regarding substances harmful during pregnancy. In addition, Drs. Hanson and Sullivan consulted with the State Health Department’s Prescription Drug Task Force to ensure that physicians are educated regarding substance abuse and drug overdose deaths.

Dr. Hanson served on the Prescription Drug Task Force to create the Utah Clinical Guidelines on

Prescribing Opioids for Treatment of Pain. The purpose of the guidelines is to educate both the public and clinicians about the appropriate use of opioids which will, if followed, significantly reduce deaths from misuse and abuse, but at the same time allow for the control of chronic pain with proper use of these medications.

Drs. Hanson and Sullivan served on the Pregnant and Parenting Women and Drug-Exposed Newborns Task Force. The committee worked to create H.B. 38: Education and Outreach Regarding Substances Harmful During Pregnancy. It is also working to create a Health Care Provider Survey to identify the reason health care providers do not ask patients about alcohol, tobacco, and other drug (ATOD) use during visits, what prevents them from discussing ATOD with patients, and what tools are needed to talk about ATOD. Lastly, the committee is continuing to organize the “Talk About It” campaign with government agencies as another means to disseminate information.

Drs. Hanson and Sullivan continue to provide training throughout Utah and the United States. The trainings are primarily directed toward individuals working within substance abuse prevention and treatment programs and related fields. The trainings have expanded beyond the neurobiology of addiction to include more specific applications regarding brain development, cognitive impairment related to addictions, and policy development. The Addiction Center is currently working closely with interested parties to address the issue of returning unused medications.

Through newsletters, dialogue with public officials, participation in policy development, training and research, the Addiction Center continues to provide a valuable link between the academic and direct service communities. Patient care and outcomes will be improved through increased collaboration.

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## ***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 valid for up to three years. The training focuses on teaching the server how to serve responsibly to

adults 21 and older, and instructors teach class participants techniques for dealing with 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 2009, more than 9,000 servers were trained.

## ***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 2009, over 10,000 sellers were trained in Utah. These efforts to reduce underage

alcohol consumption will continue through training and educating sales clerks, and educating 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.

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## ***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 for 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 2009, there were 15,683 DUI arrests, 386 more than the previous year. The average blood alcohol content was .14 and the highest was .43, 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 39% of all arrests. Approximately 67% of arrests were for a first DUI offense, 21% were for a second offense, 8% for a third offense and 4% for fourth or subsequent offense.



Halloween 1989 was a very scary day for **Deborah Stone**. Also one of the best days of her life. For the previous 20 years she hadn't gone a day without a drink, and was at that moment, quite literally, living on alcohol. She was afraid she'd be too drunk to take her kids out Trick or Treating and was haunted by the thought of missing out on those opportunities in her kids' lives. That's the day she called a friend and attended her first 12-step meeting. That's the day that changed her life.

Life has been a battle for Debby. But she's a fighter and she's not giving up. In January 2000 she went back to school so that she could help other struggling, recovering mothers like herself find the resources they need. During her first term, her daughter, Kelly, took her own life. Even through this excruciatingly painful time, Debby did not take a drink. She knew she had to take this tragedy and turn it into a positive so that Kelly would have a legacy. Six months later, Debby had to undergo surgery for two hip replacements. She did not take a drink. Shortly afterward, her father died and then her son was locked up. Still, she did not take a drink.

And still she has persisted with her education, maintaining a 4.0 GPA. She is now finishing up her practicum for her Ph.D. in counseling psychology. She has put her education and her background to work by serving in leadership positions in her 12-step group and by working in the Bridging the Gap program, as well as taking meetings in and sponsoring women in prison and in the metro jail. She says, "I have taken every crisis in the last two decades and turned them into positive experiences to help others. I pray that through Kelly's life and death, I can continue to give hope to others and that my example of perseverance and faith will remain Kelly's legacy."

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## ***Trauma Recovery and Empowerment Training***

DSAMH sponsored a 2½ day trauma training from January 12-14, 2009, for women's substance abuse treatment providers from the 13 local authorities, Utah State Hospital, Utah State Prison, substance abuse treatment providers in Salt Lake, Utah State representatives from the Division of Child and Family Services, Juvenile Justice Services and the Division of Substance Abuse and Mental Health. A total of 36 individuals participated in this training provided by Community Connections of Washington, D.C. The training covered the Trauma Recovery and Empowerment Model (TREM) and Trauma Recovery and Empowerment Profile (TREP), which are described below:

**The Trauma Recovery and Empowerment Model (TREM)** is a gender-based trauma model

designed to address issues of sexual, physical, and emotional abuse in the lives of women who have been economically and socially marginalized and for whom traditional recovery work has been unavailable and ineffective. This training prepares clinicians to implement the fully manualized, 20-session TREM approach to group work with women abuse survivors.

**The Trauma Recovery and Empowerment Profile (TREP)** is a rating instrument with 11 dimensions. Each dimension describes a skill that is central to coping effectively with the impact of emotional, physical and/or sexual abuse. Completed by a clinician who knows the consumer/survivor well, the TREP is designed to provide a summary of the consumer/survivor's recovery skills at a particular point in time.

The purpose of this training was to provide clinicians with skills to treat trauma survivors in the substance abuse treatment system. All participants received TREM and TREP manuals, participated in mock groups, received in-depth training, had opportunities to ask questions and engaged in discussions related to trauma issues. As a result of this training, the following treatment centers have implemented TREM and TREP in their programs:

- Four Corners Behavioral Health
- Odyssey House
- Southwest Behavioral Services

- Valley Mental Health–Summit County
- Utah County Division of Substance Abuse Services
- Heber Valley Counseling
- Weber Human Services

On December 10, 2009, a TREM and TREP Refresher Training was provided by Community Connections for women’s treatment providers in Utah. This training provides an overview of the TREM and TREP techniques and assists clinicians in following through with best practice standards in their programs.

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## ***Forensic and Designated Examiner Certification***

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, or not guilty by reason of insanity/diminished capacity, etc. Involuntary commitment to a local mental health authority requires an evaluation by a designated examiner.

DSAMH trains and contracts with mental health professionals to provide forensic evaluations for Utah courts. Basic requirements under this contract include:

- Various types of district court-ordered mental illness evaluations must be completed on adult defendants in the criminal justice system and written reports of evaluation findings must be prepared.
- Professionals should be prepared to testify at court proceedings as required.
- The evaluator must be familiar with and comply with applicable Utah law in conducting and reporting on evaluations and must focus on the relevant legal issues

pertaining to the particular type of evaluation ordered by the courts.

- Services are provided to adult defendants in the criminal justice system who have been court ordered to receive a mental illness evaluation.
- Evaluations may be performed in:
  - ◆ Community jails
  - ◆ Regional correctional facilities
  - ◆ The Utah State Hospital
  - ◆ Other institutional settings
  - ◆ The community

DSAMH also arranges training and certification for mental health professionals to provide designated examiner services. Basic requirements and a description of duties are as follows:

- Examiners must demonstrate a complete and thorough understanding of abnormal psychology and abnormal behavior.
- Examiners must demonstrate a fundamental and working knowledge of the mental health law. In particular, a thorough understanding of the conditions which must be met to warrant involuntary commitment.

- Examiners must be able to discriminate between abnormal behavior due to mental illness which poses a substantial likelihood of serious harm to self or others from those forms of abnormal behavior which do not represent such a threat.
- Examiners must be able to demonstrate a general knowledge of the court process and the conduct of commitment hearings.
- Examiners must demonstrate an ability to provide the court with a thorough and complete oral and written evaluation that addresses the standards and questions set forth in the law.

### Client Quotes

*"I suffer from depression and anxiety. In the past 10 months I have lost over 100 lbs. Before my weight loss, my feet hurt all the time and I was not able to walk very far. I am now able to stand a lot more, walk more and my knees don't hurt like they used to. I can climb stairs without getting winded. One of the best things about my weight loss is fitting into smaller clothes, and I feel more energetic and happier. I'm even taking up swimming and bike riding. The way to do this is part determination, part will and a whole lot of work. But it is worth it! I would recommend weight loss to anyone that wants to have a better life. It is working for me!"*

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## Case Management Certification

In order to ensure the quality of mental health case managers in Utah's public mental health system, DSAMH certifies both adult and child mental health case managers. In collaboration with Utah's Department of Community and Culture, DSAMH is in the process of revising the preferred practice guidelines for case management to include core competencies targeted to services for individuals who desire to live independently in the community. The collaborative approach seeks to improve the quality of care by providing a shared, unified approach for all service agencies.

During fiscal year 2009, there were 355 certified case managers in the public mental health system, which was comparable to fiscal year 2008. In fiscal year 2009 the Utah Public Mental Health System served 12,083 adults with serious and persistent mental illness (SPMI) and 5,349 youth with serious emotional disturbance (SED), in comparison to fiscal year 2008 when 11,397 adults with SPMI and 5,136 youth with SED were served in Utah.

## Disaster Crisis Counseling Certification

Current events continue to make emergency planning an urgent concern in Utah. DSAMH has been tasked with providing and/or coordinating crisis counseling resources for victims of any disaster which has been declared a “state of emergency” by the governor, or which has received a Presidential Disaster Declaration status.

DSAMH has developed curriculum and a certification program on crisis counseling for disaster and bioterrorism events and has held statewide trainings over the past year to help ensure that quality services are provided. This training has been successful in certifying 480 professionals

and paraprofessionals to assist in crisis counseling in the event of a disaster in our state.

The Crisis Counseling Program supports short-term interventions with individuals and groups experiencing psychological reactions to large-scale disasters. These interventions involve helping disaster survivors understand their current situation and reactions, reviewing their options, mitigating additional stress, promoting use of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies who may help survivors recover.

### Client Quotes

*“Our Family Resource Facilitator knows who to contact to get services and supports that my son needs so he doesn’t have to learn everything by himself like I did. The Family Resource Facilitator taught me how to say things at my IEP [Individualized Education Plan meeting with the school district] and taught me that I should speak up during that meeting.”*

## Family Resource Facilitator Certification

DSAMH and the Utah Family Coalition worked together to establish training and certification criteria for the Family Resource Facilitator (FRF) program.

There are three levels in the FRF certification process, each building on previous competencies. A Level I-certified FRF demonstrates competency in resource coordination, family advocacy and in providing information and support. Level II certification demonstrates competency in the wrap-around process, and with a Level III certification,

the FRF becomes a certified Family Mentor and FRF Trainer.

During 2009, ten Family Resource Facilitators obtained Level I certification and three additional people obtained all three levels and became certified Family Mentors. Efforts are being made to expand the FRF training and certification program to other child and family serving agencies in the Department of Human Services to help develop a common language and shared vision for family involvement across Human Services.

## PASRR Certification

In an effort to improve the efficiency and quality of PASRR evaluations, DSAMH has implemented required training for all PASRR evaluators, with 35 evaluators trained over the past year. PASRR training is based on State and Federal laws enacted to ensure that individuals with mental illnesses are being appropriately diagnosed before admittance into nursing homes. The train-

ing has resulted in improved evaluations for patients and increased compliance with the PASRR system. PASRR evaluator training will become increasingly necessary and valuable as Utah's senior population (65 and older) continues to swell dramatically, requiring a higher level of medical services for nursing facility placements.

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### Client Quotes

*"I came from a dysfunctional and very abusive family. I moved out for the first time at the age of 15. I got pregnant and married early in life. I was a battered wife, and as a result, I lost a set of twins from a beating. I knew I had to leave or I'd be killed. At that time I had two young children to care for. I finally ended up finding my community mental health center where I learned about making a life for myself. It wasn't easy, but it was the start of my life and getting an education. I first went to beauty college, but I knew I needed better money to supply my family and I was encouraged by a therapist to go back to school. I went to college—something I always thought I wasn't smart enough to do. I was surprised to find out how smart I really was.*

*College was not easy, nor the years leading up to it. I have and still do suffer from severe major depression. It was awful. When looking at my college transcripts I could tell you the times I was suffering with my mental illness and what was going on in my life. I never gave up though. Some of the things that happened during this time period were: my brother died of leukemia and while he was dying, my ex-husband took my kids to Oregon and I couldn't get them back for awhile because I had no money for an attorney. Worst of all, my youngest son died. I had become a social worker and when I finally got the job I worked so hard for with enough money and benefits to care for us in a decent manner, he was gone. I felt cheated, lost and could care less if I went to sleep and never woke up again. I was thinking of taking my whole bottle of pain medication and just going with my son. It was the worst fight of my life. I realized I was in trouble, my job was on the line, and my life was on the line. I went for help, but realized I had to help myself. I started to follow through on all the things I taught my clients and I began to feel better.*

*My journey with depression is not over. It is something I will have to work on all my life. But I can say that despite all that was against me—I made it. I became what I wanted to be. I have degrees in cosmetology, criminal justice and social work. Bottom line—I'm here; I'm alive and I sometimes know how hard it is for my clients. I'm a better person for what I've lived through. And a stronger person as well. It's not easy, but one can overcome many obstacles and make a decent life for themselves."*

# Justice Programs

## Overview

During fiscal year 2009, 76% of all people served through Utah's publicly funded substance abuse treatment services were involved in the justice system. Another 8,721 justice-involved individuals received publicly funded mental health treatment during this same time. Furthermore, national research indicates 54% of state prisoners and 64% of local jail inmates suffer from mental health problems,<sup>1</sup> 60% of arrestees test positive for at least one substance at the time of arrest<sup>2</sup> and 56% of state prisoners used drugs in the month before their offense.<sup>3</sup>

A recent national study found that 14.5% of male and 31% of female inmates admitted to jail have a serious mental illness.<sup>4</sup> DSAMH has found that estimates provided by county jail commanders across the state match, and oftentimes exceed, those cited in this study. DSAMH recognizes that there is a growing need for increased attention to be given to the provision of appropriate services for persons with mental illness who find them-

selves in the criminal justice system, and that there are gaps that need to be bridged. Several communities have already taken strides to help bridge those gaps. But this effort calls for the highest level of collaboration between multiple community agencies, i.e., law enforcement, corrections, mental health, hospitals, housing, consumer advocate groups, and others.

DSAMH understands that substance abuse, mental illness and crime are often interrelated. As a result, corrections, courts and treatment must work together to ensure these individuals enter and maintain recovery, which will ultimately reduce their strain on Utah's justice systems. The following are examples of the different ways in which DSAMH is working collaboratively with corrections and the courts for our common clients. Justice-involved individuals include:

- Individuals referred by the justice system
- Individuals involved with drug and mental health courts
- Individuals involved with Division of Child and Family Services
- Individuals on probation or parole
- Individuals arrested in past 30 days
- Individuals living in jail/prison

<sup>1</sup> Bureau of Justice Statistics, September 2006, NCJ 213600

<sup>2</sup> ADAM, 2007

<sup>3</sup> Bureau of Justice Statistics, October 2006, NCJ 213530

<sup>4</sup> (<http://ps.psychiatryonline.org/cgi/content/abstract/60/6/761>)

## Justice Services Plan

During the summer of 2009, DSAMH developed a working group of representatives from corrections, the courts, the Council on Criminal and Juvenile Justice, local substance abuse authorities and DSAMH staff to develop a plan for serving those involved with the justice systems in Utah who are receiving treatment through public funding. The goals of this plan are to reduce sub-

stance use and recidivism, enhance the physical, psychological, and/or social functioning of this population, and provide cost-effective, evidence-based treatment and supervision to the population.

The plan includes principles for treatment and supervision of the justice population based on more than 20 years of research on this popula-

tion regarding what works to reduce recidivism. The following includes the principles identified by the work group:

- All clients should be screened and assessed for risk to offend; and clinical needs and services should be matched to the specific level of risk and needs identified.
- Treatment needs to be of sufficient dosage/duration to affect behavior change.
- Treatment should be multi-dimensional rather than addressing addiction alone.
- Emphasis should be placed on the use of evidence-based practices (EBPs). EBPs are those practices which, based on research findings and expert or consensus opinion about available evidence, are expected to produce a specific clinical outcome.
- Treatment quality, including treatment fidelity and program integrity, should be consistently monitored.
- Measure progress.
- Treatment, supervising agencies and the criminal justice agency must make every effort to coordinate and communicate either by Memorandum of Understanding

or releases of information from every client.

- There should be a balance of incentives and sanctions.
- Recovery management strategies should be used across treatment and justice systems statewide.

Finally, the group developed recommendations for Utah's systems as a result of the plan. Some of these include:

- Establish the coordination and oversight of substance abuse treatment and supervision for all justice and criminally involved individuals in Utah.
- DSAMH, the courts, the Utah Department of Corrections and the Utah Board of Pardons and Parole should establish and adopt uniform standards for evaluation and treatment of justice and criminally involved individuals.

DSAMH has presented the plan to stakeholder groups/agencies and has received great support and feedback. As a result, DSAMH and partnering agencies will begin developing similar contracting language and monitoring schedules to better collaborate with agencies providing contracted services.

## Integrated Service Delivery System

### *Jail Diversion*

Salt Lake County has implemented the Jail Diversion Outreach Team (JDOT). This multidisciplinary team includes a social worker, case manager, nurse, peer mentors, and an Advance Psychiatric Registered Nurse to serve individuals who have been unsuccessful in mental health treatment in the past, are homeless, in poverty, and have cycled through the jail. This collaborative effort between mental health services, criminal justice services, the county jail, housing, and NAMI-Utah has been very successful in reducing participants' jail time.

The team works out of Valley Mental Health to provide in-home services to people who have multiple incarcerations and serious mental illness. The mental health services coordinators at the jail connect those appropriate for JDOT through their discharge planning process. The team provides intensive, community-based services to a minimum of 60 criminal-justice in-

involved persons with mental illness. Services emphasize integrated mental health and substance abuse interventions.

As part of the jail diversion services provided in Salt Lake County, JDOT is showing impressive outcomes in keeping individuals with serious and persistent mental illness out of the jail and in the community, with the goal of helping them to be contributing members of society. The following outcomes demonstrate the value of this intervention model:

	Pre JDOT	With JDOT
Total bookings for new offense	433	6
Total jail bed days	12,281	103
Average bookings/person	21	0.3
Average days in jail/person	585	5

### *School-Based Integrated Health Care*

School-based integrated health care combines the delivery of primary health care and behavioral health services in a school setting. This allows for the integration of academic, physical, and behavioral health resources and treatment to advance children's well-being and success. Intermountain Health Care, having previously established clinics in some local elementary schools, began a collaborative relationship with Valley Mental Health to add behavioral health services to the medical services already offered at Rose Park and Franklin Elementary Schools in the Salt Lake School District. This endeavor involved bringing together a number of partners

in addition to Intermountain and Valley Mental Health, including school personnel, the Salt Lake School District, Select Health, NAMI Utah, the Utah State Office of Education, and the Salt Lake City Police Department. The result is an integrated approach where school personnel, medical providers, mental health clinicians, and community partners work as a unified team to foster collaboration and maximize resources in providing services to children, youth, and their families. DSAMH applauds the current efforts to develop school-based integrated health programs and is supporting additional program development in this area.



**Ruby Lemoine** was that kid at the edge of the playground. The kid with no friends. The emotionally and sexually abused kid that had victim written all over her. Then at age 15 she discovered a whole new world—the world of alcohol and drugs. And suddenly she had friends, a social life, and even courage. But she also experienced bad relationships and a broken marriage. Eventually, nothing worked for her until she had a moment of clarity in 1994 and found recovery.

Through her associations with her 12-step group, she finally found the unconditional love she had always sought. Her recovery has truly given her all the things she thought she was getting from the drugs and alcohol—true, unconditional friends; a fulfilling social life; self-confidence; self-worth; self-esteem; and even the courage to leave her addiction days behind her. And this shy, quiet, unhappy little girl has turned into a popular public speaker with a fun-loving and vivacious personality. The new Ruby has the courage to take the hope and message of recovery inside treatment centers and jails as well as large-scale recovery events and conventions.

When her ex-husband, Mark, also found recovery they were able to reconcile and repair their relationship. By applying the 12 steps to all aspects of their life they've been able to build healthy, loving relationships within their family as they worked together, making sure that others know there is a better way of life than drugs and alcohol. Together they spread the word that recovery is possible and help is accessible to every person who is searching for a way to get sober.

Sadly, Mark was killed in a motorcycle accident in August 2009, but Ruby's been able to hold fast to the sobriety they had maintained together for so many years. She was gratified to receive a letter from a 22-year-old kid telling her how much Mark had influenced his life. This was particularly fulfilling to Ruby, knowing that her husband's life had truly made a difference for someone.

Her own enthusiastic words say it best: "Everything that the drugs and alcohol destroyed, recovery has given back to me along with things I had never even dreamed of. Recovery has become my life!"

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## Health HITECH, A New National Priority

In September of 2009, The Department of Health and Human Services, National Coordinator for Health Information Technology, released \$564 million in State Health Information Exchange Cooperative Agreement funding. This funding is part of the American Recovery and Reinvestment Act of 2009, specifically the Health Information Technology for Economic and Clinical Health (HITECH) Act. State health authorities may apply for this funding to further the use and exchange of electronic health information.

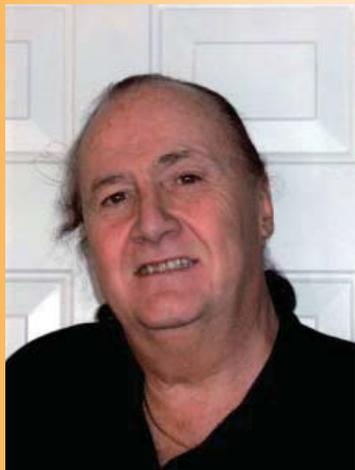
The Utah State Health Department has submitted an application for this funding and has designated the Utah Health Information Network (UHIN) as the designated entity. UHIN will work in partnership with HealthInsight, who will be applying to be a regional center. The Health HITECH Act will drive the specific goals of Health Information Exchange (HIE), which is planned to be completed by 2014. This act authorizes funding grants to states or their qualified designated entities to support health information exchange planning and implementation, Medicaid and Medicare incentive payments to providers that use electronic health record systems and can exchange data, and a requirement that the federal government adopt and use certified technology and standards in all its relevant agencies.

The applications are required to address coordination with Medicaid and Medicare as well as

other federally funded, state-based programs. The State Mental Health Data Infrastructure Grant (DIG) for Quality Improvement from SAMHSA is specifically listed as one of these state-based programs. DSAMH is the State mental health and substance abuse authority and is the grantee for this and other federally funded state-based programs. DSAMH has been invited to participate on the HIE Strategic Planning Group, to inform and coordinate specific needs of behavioral health care information. DSAMH has also submitted a letter of support to be included in Utah's application.

General wellness and integration with other health care providers is a top priority for our system as well. It is essential to recovery and to the general wellness of those we serve to be able to exchange consented health care records electronically. DSAMH will coordinate with the State health authority and their designated state-designated entity on this effort. Our goal is to ensure that specific standards for substance abuse and mental health records are included in the planning and operational phases of this project; and to the extent possible, ensure that existing and future technology investments for behavioral health care are considered as well.





When **Michael Dusoe** was a patient at Highland Ridge, a substance abuse and psychiatric hospital, he frequently said, “I could run a place like this!” Eventually, that is exactly what he did. Mike worked his way through every level in the organization from patient bed to national vice president. After leaving Highland Ridge, having since earned his master’s degree and Ph.D., he went on to open his own mental health clinic, where his experience with his clients has confirmed his profound belief that treatment works.

Knowing where Mike is now, it is hard to imagine what led to being admitted to Highland Ridge in the first place. But the truth is, as a teenager and into early adulthood, his addictions ran the full range, including alcohol, amphetamines, LSD, prescription pain meds, barbiturates, methamphetamines, heroin, and so on. And all the while he was actively engaged as a state trooper in Massachusetts, until he took a medical retirement at age 31. From there, things went from bad to worse, losing his first wife and family while adding new addictions along the way. He was in and out of treatment centers until finally finding success at Highland Ridge. What made the difference at Highland Ridge? Looking back, Mike realizes that they sincerely cared about him there and were not going to give up. And that’s where he discovered one of his most deeply held tenets which he has followed throughout his professional career: “Never, never give up on an addicted person!”

Mike participates in several 12-step groups as a sponsor and popular speaker and he sits on and has organized numerous community and volunteer boards. Among many other professional, educational and leadership positions he has held as an advocate for the recovery community, he has also taught in two graduate schools. In this capacity he has worked to train and encourage students (many in recovery) to move into the substance abuse counseling field through professional pathways.

Being around Mike, it’s hard not to catch his enthusiasm—he’s so passionate about his life’s work. “Don’t let people tell you that treatment doesn’t work!” he says. “It’s like trying to make me disappear . . . and I’m not leaving! I’m living proof that treatment works.”

# Substance Abuse Prevention

## Overview

The Utah Prevention System is centered on prevention coordinators from 13 local authority districts. These coordinators are responsible for planning, implementing, and evaluating prevention services in their area. Each local authority provides a comprehensive prevention plan for its area. This comprehensive plan is developed to address prevention needs while being vigilant in using prevention programs shown to be effective with the particular target audience.

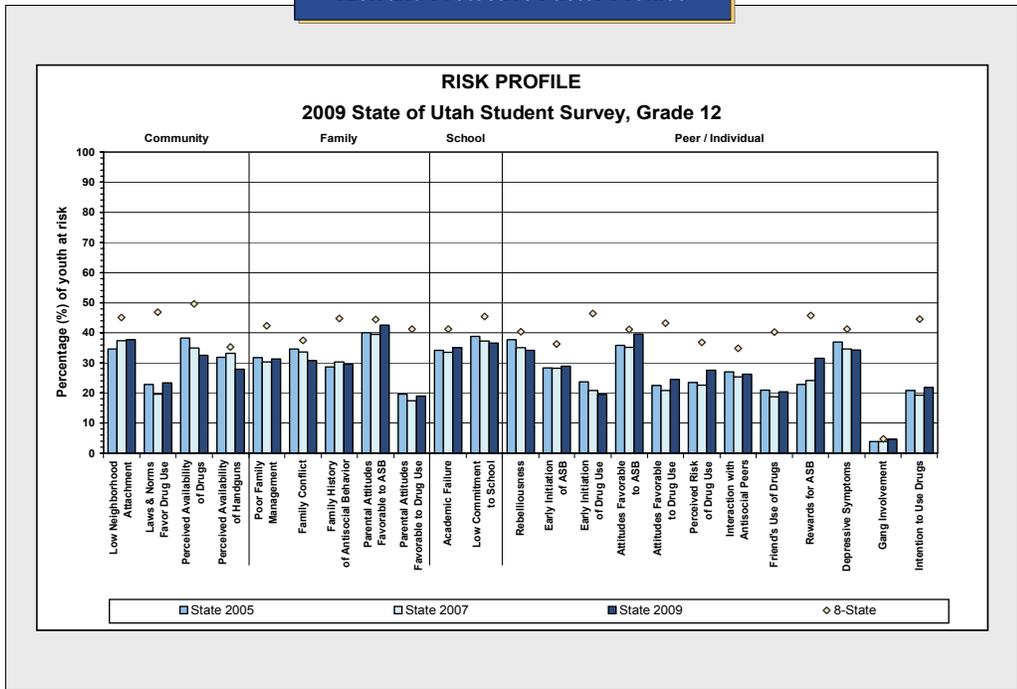
The local authority districts are required to have community level coalitions to help coordinate services and leverage resources. Utah's prevention system follows a strategic, science-based planning process called the Strategic Prevention Framework. The Strategic Prevention Framework (SPF), developed by the Federal Substance Abuse and Mental Health Services Administration, is utilized throughout Utah to ensure a culturally competent, effective, cost-efficient system is deployed. Communities throughout Utah utilize the five steps of the SPF, which are: 1) Assessing local needs; 2) Building capacity for services in local areas; 3) Making a plan based on



needs, strengths, and resources; 4) Implementation of evidence-based strategies; and 5) Evaluation of prevention services to ensure effective prevention work. By using the Strategic Prevention Framework, Utahns are assured that services in their area match their local needs, and factors that lead to costly problems are reduced.

Risk Factors	Community						Family				School		Peer/Individual					
	Community Laws & Norms Favorable Toward Drug Use, Firearms & Crime	Availability of Drugs & Firearms	Transitions & Mobility	Low Neighborhood Attachment	Community Disorganization	Extreme Economic & Social Development	Family History of the Problem Behavior	Family Conflict	Family Management Problems	Favorable Parent Attitudes & Involvement in the Problem Behavior	Academic Failure	Lack of Commitment to School	Early Initiation of Drug Use & Other Problem Behavior	Early & Persistent Antisocial Behavior	Alienation & Rebelliousness Friends Who Use Drugs & Engage in Problem Behaviors	Favorable Attitudes Toward Drug Use & Other Problem Behaviors	Gang Involvement	Constitutional Factors
Substance Abuse	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Delinquency	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teen Pregnancy						✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
School Drop-Out			✓			✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Violence	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

**Risk and Protective Factor Profiles**



protective factors buffer the impact of risk factors.

With the Strategic Prevention Framework, the goal is to increase a child's protective factors and decrease their risk factors. The prevention coordinators in each of the local areas have prioritized risk and protective factors that are based on their individual community's needs. By

Prevention needs are assessed using the Risk and Protective Factor Model developed by Drs. David Hawkins and Richard Catalano at the University of Washington. Using the medical model, the risk factors for substance abuse can be identified and mitigated in order to interrupt the development or progression of the addictive process. Similarly,

measuring their risk and protective factors, they can plan their programs and strategies to address their specific needs. For more detailed reports on how the local districts are meeting their prevention goals, please see the Local Authorities section in this report.

## Communities That Care (CTC)

SAMHSA'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 navigate the SPF in a scientifically proven manner. 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. In an effort to encourage communities to utilize CTC, DSAMH has provided incentives to small communities that commit to using CTC.



**KEY FINDINGS of CTC Study:**

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

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

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

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

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## Substance Abuse Prevention Specialist Training (SAPST)

All prevention specialists hired through the 13 local substance abuse authorities (LSAAs) throughout the state are encouraged to certify in the Substance Abuse Prevention Specialist Training (SAPST). The training modules include history, prevention science, planning, evaluation, human development, cultural context, media, and ethics. The 13 local prevention coordinators educate staff, coalition members and key leaders

in their communities on prevention science. The purpose of this training is to educate new prevention specialists throughout the state and present updated material to prevention specialists that have previously attended this training. The training is provided quarterly throughout the state. In fiscal year 2009, 40 new prevention workers were SAPST-trained in Utah.

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## Utah K-12 Prevention Dimensions Program

DSAMH collaborates with the Utah State Office of Education for implementation and evaluation of the Prevention Dimensions (PD) program. Prevention Dimensions is a statewide curriculum resource delivered by classroom teachers to students in Utah, kindergarten through 12<sup>th</sup> grade. It has been developed to help meet State Board of Education's core curriculum requirements. A cooperative evaluation effort between DSAMH and the State Office of Education allows an ongoing rigorous evaluation of Prevention Dimen-

sions. PD is listed on Substance Abuse and Mental Health Services Administrations as a Legacy Program.<sup>1</sup>

Prevention Dimensions objectives are based on increasing protective factors and decreasing risk factors while adhering to a no-use message for

<sup>1</sup> For details of legacy status, see [http://www.nrepp.samhsa.gov/legacy\\_fulldetails.asp?LEGACY\\_ID=1033](http://www.nrepp.samhsa.gov/legacy_fulldetails.asp?LEGACY_ID=1033).

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. In addition, PD also provides means for parents to get involved in preventing problems with their children by including them in homework assignments and providing prevention tools to be used in the home.

Prevention Dimensions 2009 highlights include the following:

- 1,283 individuals participated in Prevention Dimensions teacher trainings and received resource materials, bringing the cumulative number trained to 11,054. This represents a 29% increase in number of individuals trained over the previous year.
- A total of 36 teacher trainings were conducted during the year with teachers from 28 school districts and 2 charter schools participating.
- Approximately 42,128 4<sup>th</sup> grade “Mind Over Matter” music CDs and parent pamphlets were distributed statewide.
- A total of 30,970 students representing 57 schools in 24 school districts attended or participated in Steve James assemblies with an additional 27,960 parents or other family members attending parent evening concerts. Additionally, 24,080 participated in other community-based events or concerts.
- The average teacher teaches 2 lessons per month for an average of 49.7 minutes of instruction time. These figures represent slight reductions from the previous school year.



When **Stephanie Slack** says she has seen the worst of addiction and the best of recovery, she knows what she’s talking about. She began drinking at age 13, with drug experimentation following right along. She soon married and had five children and she blamed all of their problems on her abusive and alcoholic husband. Life was tough and she attempted suicide in 1988. But when she finally divorced her husband after 17 years, she realized that now she had no one to blame but herself. That did it. She went to her first 12-step meeting in 1990. That changed her life.

Unfortunately, that did not end her problems. By this time, her teenagers were all using, and they did not want a sober mother. It has taken years to repair the damage done, and through the 12 steps her relationships with her family are healing little by little. She has learned that the best thing she can do for her kids is just to listen to them. One way she is making amends to them is by being an available grandma, a role she relishes.

In 1994 she started working part-time in a treatment center, and by 1998 was working full-time as a licensed substance abuse therapist, where she has been ever since. “I love my job,” she says. “It’s the hardest job in the world, but I love seeing people change. It’s a beautiful thing to see people recover and begin to heal. Recovery has given me a life beyond my wildest dreams . . . I absolutely love my life!”

## Utah's State Epidemiology/Outcomes Workgroup (USEOW)

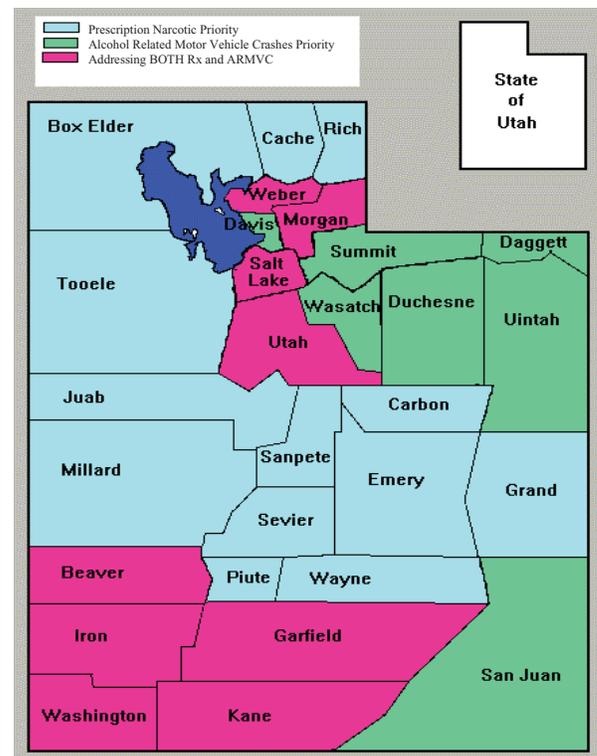
DSAMH has put into practice a State Epidemiology Workgroup made up of prevention, survey, and epidemiology experts to enable a system that will enhance the availability of assessment data. The primary task of the USEOW is to collect and interpret information in order to develop recommendations about the substance abuse priorities

for the State of Utah. As a result, prevention workers will be able to accurately accomplish step one of the SPF—assess their community's needs.

For more information visit [http://www.dsamh.utah.gov/docs/seow\\_final\\_epi\\_report\\_2007.pdf](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 from SAMHSA gives Utah \$2,093,000 per year for five years to: 1) prevent the onset and reduce the progression of substance abuse; 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 Utah's State Epidemiology/Outcomes Workgroup, the SPF staff identified two state-wide substance abuse-related priorities that this grant will address, 1) prescription drug abuse and 2) alcohol-related motor vehicle crashes. In 2007, data was used to determine the priorities for each LSAA.



## Utah Prevention Advisory Council (UPAC)

Negative behaviors including substance abuse, delinquency, teen pregnancy, school dropout, violence, and symptoms of depression and anxiety share the same risk and protective factors. Because these shared factors are addressed by other agencies, DSAMH coordinates its efforts among the Utah Prevention Advisory Council (UPAC).

UPAC is the foundation for collaboration between agencies with prevention interests. UPAC is made up of 28 people representing 26 public and private agencies and is administered by the Director of the Utah Substance Abuse and Anti-Violence Coordinating Council.

## Combating Underage Drinking

Utah supports a national underage drinking prevention effort organized by SAMHSA called Teach-Ins. Teach-Ins are conducted in fifth- and sixth-grade classrooms throughout the country. They are an excellent way for communities to deliver messages that build resistance skills among students and increase protective factors that help prevent underage alcohol use. Having multiple events across the nation during the same time frame helps focus media attention on this important public health issue. During Alcohol Awareness Month, 30 Utah communities signed up to conduct Teach-Ins.

During the Teach-Ins, prominent community leaders present a specially designed lesson plan to students. In Weber County, Weber Human Services prevention workers coordinated efforts between Weber State University athletes who taught the lessons throughout the county.

Underage drinking continues to be a leading public health problem in Utah. According to the 2009 Student Health and Risk Prevention Survey, alcohol is the most commonly abused substance among youth. In fact, while we have seen decreases over the last 20 years, there are still 17.1% of 12<sup>th</sup> graders drinking alcohol in the

past 30 days. In 2005, underage drinking cost the citizens of Utah \$266 million. Alcohol use among children and adolescents starts early and increases rapidly with age. Utah is in its fourth year of the “Parents Empowered” campaign, aimed at reducing underage drinking. The Utah Department of Alcoholic Beverage Control is the lead agency for the campaign and is working in partnership with other state agencies and organizations, including the following: Attorney General’s Office, Utah PTA, Department of Health, Department of Public Safety/Highway Patrol and Highway Safety Office, Division of Substance Abuse and Mental Health, Juvenile Court, State Office of Education, Mothers Against Drunk Driving (M.A.D.D.)/Utah Chapter, Utah Prevention Network, and Utah Substance Abuse and Anti-Violence Coordinating Council. According to a survey by R&R Partners, almost 59% of Utah parents are unaware that their children, some as young as 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. Parents need to know that parental disapproval is the number one reason kids don’t drink, and that neighborhoods can mobilize and make a difference.

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## System Review: Substance Abuse Prevention/Synar

In fiscal year 2009, the Center for Substance Abuse Prevention (CSAP) personnel examined the progress of DSAMH’s substance abuse prevention system and Synar program in improving the substance abuse indicators and outcomes measured by SAMHSA’s National Outcome Measures. The CSAP team made it clear they were glad to see that Utah has embraced the

Strategic Prevention Framework throughout the state. They commended DSAMH for their efforts in protecting the state’s youth from substance abuse and nicotine addiction and also encouraged them to change the contract language to assure cultural competency is assessed and monitored and that technical assistance is available to all local authorities throughout the state.

# Student Health and Risk Prevention Survey—Prevention in Utah Works!

The following is a representation from the Student Health and Risk Prevention Survey (SHARP)

available on our website at <http://www.dsamh.utah.gov/sharp.htm>.

## Even a Small Amount of Perceived Parental Acceptability Can Lead to Substance Use

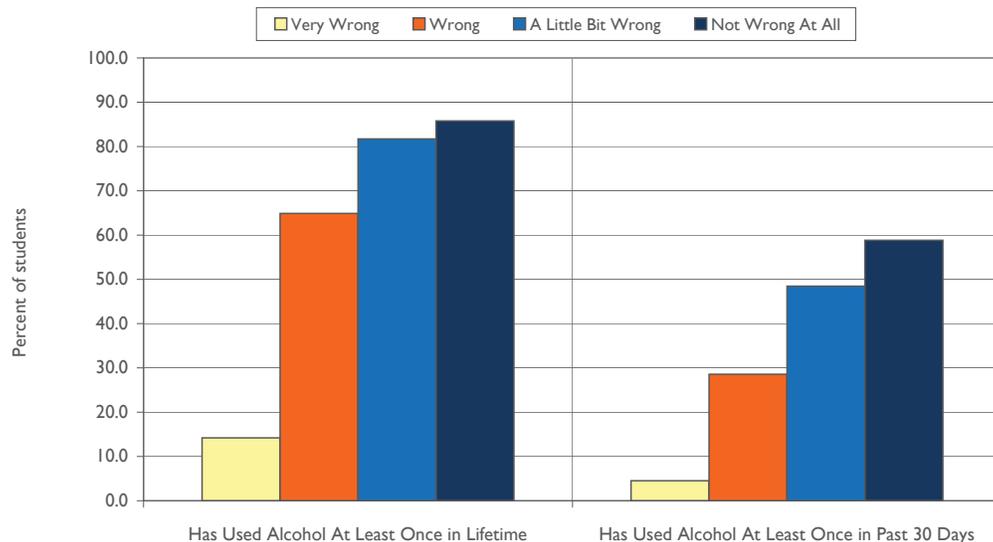
When parents have favorable attitudes toward drugs, they influence the attitudes and behavior of their children. For example, parental approval of moderate drinking, even under parental supervision, substantially increases the risk of the young person using alcohol. Further, in families where parents involve children in their own drug or alcohol behavior, for example, asking the child to light the parent’s cigarette or to get the parent a beer, there is an increased likelihood that their children will become drug users in adolescence.

In the Utah PNA Survey, students were asked how wrong their parents felt it was to drink beer, wine, or hard liquor regularly. As can be seen in following table, relatively few students

(14.5% lifetime, 5.3% 30-day) use alcohol when their parents think it is “Very Wrong” to use it. In contrast, when a student believes that his/her parents agree with use somewhat (i.e., the parent only believes that it is “Wrong,” not “Very Wrong”), alcohol use increases to 65.7% for lifetime use and 31.9% for 30-day use.

This table illustrates how even a small amount of perceived parental acceptability can lead to substance use. These results make a strong argument for the importance of parents having strong and clear standards and rules when it comes to ATOD use. Similar findings regarding marijuana and cigarette use can be viewed in the full SHARP report.

**Alcohol Use in Relation to Perceived Parental Acceptability (2009):**  
How wrong do your parents feel it would be for you to drink beer, wine, or hard liquor regularly?







**Natalie Gallegos'** parents put her in drug rehab for LSD at the age of 16. When she was released, she went back to high school and graduated with flying colors and a 4.0. Her life went well for the next seven years. Then being faced with the pressures of a busy wife and mother, she fell for methamphetamines and became the "super-woman" she had tried to be. She could finally accomplish all the tasks of motherhood and marriage. But it wasn't too long before all that came crashing down and she was at the most hopeless

stage of her life. She had lost the will to live and was facing jail, insanity or death. It was at that moment that she drew on the strength that had pulled her through the first time and she knew she could do it again. "My life has changed drastically over the last ten years. I have lived every moment aware of what it means to truly experience a life of recovery. I am a warrior of recovery and I am proud to say I have the will to fight this disease to keep my spirit free."

After getting into recovery again, she went back to school and got a bachelor's in criminal justice and a masters of social work. She is now working in a new project called Tranquility Home, a women and children's substance abuse treatment center. She is able to live her dreams while embracing the opportunity to empower women with the tools of recovery to overcome their addiction to drugs and alcohol.

She went from having no will to live to being absolutely and totally alive and heart-centered. Instead of turning to the counterfeit, Natalie now thrives on offering hope and encouragement to the women she works with. She gets her high from clean living and snowboarding, running and playing softball. "I work on self-care every day," she says, "so I am able to be the support to women that I needed when I was looking for help. My recovery experience is a gift to my family, my clients, my friends and most of all to myself. I am truly honored to share my recovery in hopes the suffering addict may hear a message that there is a better life than the one they are currently living."

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# Substance Abuse Treatment

## Overview

In the past decade, the knowledge base underlying substance abuse treatment has grown dramatically, as new research on the effect of drugs on the brain has opened new approaches to treatment, and as research on treatment methods and modalities has given us guidance as to how to provide treatment that is evidence-based, not just intuition-based. During the past decade new trends in drug use have challenged us, as have new drugs of abuse and new methods of using them. The characteristics of individuals using drugs have also changed and these changes continue to challenge the treatment system. In response to these challenges, DSAMH, in conjunction with the local authorities, has implemented a variety of evidence-based interventions to more effectively address the needs of the clients presenting for treatment. DSAMH continues to work to provide training and technical expertise to the local authorities in order to keep them current with the advances in the field. However, the need to expand the use of evidence-based practices and ensure that treatment methods keep pace with the

newest research continues to challenge DSAMH and the local authorities, especially in a time of shrinking resources.

## Continuum of Treatment Services

Addiction is a complex interaction of biological, social, genetic, and environmental factors. Given these multiple influences, there is no one treatment approach or intensity that is appropriate for everyone. Treatment should be science-based and individualized to meet the needs of those entering treatment, be they adolescent marijuana users, addicted pregnant women or chronic alcoholics. 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 table on the following page illustrates the continuum of substance abuse prevention and treatment services provided in Utah.



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

Function	Prevention/Intervention			Treatment		
	Universal	Selected	Indicated	Outpatient	Intensive Outpatient	Residential
Appropriate for	<ul style="list-style-type: none"> <li>General Population</li> </ul>	<ul style="list-style-type: none"> <li>At Risk</li> </ul>	<ul style="list-style-type: none"> <li>Using but does not meet DSM IV Diagnostic Criteria</li> </ul>	<ul style="list-style-type: none"> <li>DSM IV Diagnosis of Abuse or Dependence</li> </ul>	<ul style="list-style-type: none"> <li>Serious Abuse or Dependence</li> <li>DSM IV Diagnosis of Abuse or Dependence</li> </ul>	<ul style="list-style-type: none"> <li>Severe Abuse or Dependence</li> <li>DSM IV Diagnosis of Abuse or Dependence</li> </ul>
Identification Process	General Interest	Referral	SA Screening	ASI	ASI	ASI
Populations	<ul style="list-style-type: none"> <li>K-12 Students</li> <li>General Population</li> </ul>	<ul style="list-style-type: none"> <li>School Drop-outs, Truants, Children of Alcoholics, etc.</li> </ul>	<ul style="list-style-type: none"> <li>DUI Convictions, Drug Possession Charges, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate for general population, Criminal Justice Referrals including DUI when problem identified. Women and children, adolescents, poly drug abusers, meth-addicted, alcoholics, etc.</li> </ul>		
Program Methods	<ul style="list-style-type: none"> <li>Risk Protective Factor Model</li> <li>Prevention Dimensions</li> <li>Red Ribbon Week</li> </ul>	<ul style="list-style-type: none"> <li>Risk Protective Factor Model</li> </ul>	<ul style="list-style-type: none"> <li>Risk Protective Factor Model</li> <li>Education Intervention Program</li> </ul>	<ul style="list-style-type: none"> <li>Evidence-based, preferred practices, ASAM patient placement criteria</li> </ul>		

### Treatment Challenges and DSAMH's Response

Today there are significant issues facing the treatment system in Utah. Shrinking resources and competing demands; changing requirements for treatment staff qualification; increasing demand for outcomes to “justify” our programs; continued stigma and prejudice towards the substance using populations; and the need to move from our traditional treatment methods to more evidence-based practices are all daunting challenges that the treatment community must face.

In response to the challenges listed above, DSAMH focused on several areas during fiscal year 2009.

#### Updated Treatment Practice Guidelines.

In 2008 and 2009, DSAMH led a workgroup to update the Treatment Practice Guidelines that had not been updated since 2003. After numerous meetings and drafts, the updated

guidelines were approved in April 2009 and are available on our website.

**Increased Focus on Training.** Due to the increased challenges provided by special populations and the need for improved staff training, DSAMH worked to expand its training efforts across the spectrum. DSAMH sponsored the statewide trauma-related workshop, the University of Utah’s School on Alcoholism and Other Drugs, the Generations Conference, numerous trainings in local areas on specific treatment issues, and special training events scheduled through our collaborative committees. The opportunity to sponsor the annual NAADAC Conference enabled DSAMH to bring a wide variety of experts from outside the state to present at our conference. Of special note has been the emphasis on improving clinical supervision through involvement



**Mike Hicks'** turn-around came by way of a mysterious stranger. Hopelessly addicted to meth, he quit a great job, got kicked out of his apartment and watched his best friend get arrested and hauled away. He was finally at rock bottom and was sitting aimlessly on a bus bench when a man came up and asked where he was going. When he said he didn't know, the man said, "Then you're coming with me," and he proceeded to take him to a substance abuse clinic, where Mike stayed for 18 months, without ever seeing the stranger again.

He wasn't long into his stay before he started finding ways to serve and make the facility run more efficiently. Eventually, he began managing a halfway house for people with both mental illness and substance abuse issues. He got into case managing and found he had a knack for it because he understands what it's like for his clients. After all, he's been there. It's inspiring for him to see his clients make changes in their lives. Every day he sees people struggle . . . and succeed. And it takes him back to his own struggles. Even though his clients just want to get it over with, as he did ten years ago, he knows that each step along the way to recovery is a valuable step.

"Being sober means that I have my life back," Mike said. "I have my family back; I am self-sufficient and able to help others down the road to recovery." He sums it all up in three simple words: "I am alive."

with the Mountain West Region's Addiction Technology Transfer Center's (ATTC) Clinical Supervision courses and distribution of information through the State's clinical supervisor mailing list.

#### **Emphasis on Evidence-Based Practices.**

Because of the varied nature of the local authorities, DSAMH has not mandated that any one preferred practice be used across the state. However, DSAMH has encouraged the local authorities to expand their programs by adding evidence-based practices that make sense in their area, including:

- 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
- Seeking Safety
- Trauma Recovery and Empowerment Model

Also this year DSAMH began the development of a statewide Justice Services Plan that, when fully implemented, will provide a continuum of services for criminal justice clients based both on their need for treatment and their risk to re-offend.

#### **Improved Use of ASAM Placement Criteria and Individualized Treatment Planning.**

DSAMH has mandated the use of the American Society of Addiction Medicine's Patient Placement Criteria, 2<sup>nd</sup> revision (ASAM PPC 2R) since 2003. This year it has continued to expand and improve the use of the Client-Centered Treatment Planning and Individualized Treatment process that the ASAM PPC 2R facilitates. This expansion has challenged the local authorities to move past a "program" mind-set into a true "individualized treatment" approach.

**Expansion of Recovery Support Services.** As more and more research supports the evidence that addiction is a long-term chronic disease, much like diabetes, the recognition has grown that treatment must be long-term and based on a continuing care model, rather than on an acute 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 has worked, and will continue to work, to find 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 way DSAMH has worked to expand the support available for people in the substance abuse treatment system. Additionally, DSAMH has convened a planning group to address the many ways that a recovery-oriented system of care (ROSC) will affect the current treatment model.

**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 Issues Committee, the Drug Offender Reform Act (DORA) working group, the Justice Services Plan Workgroup, and the ROSC Planning Group, DSAMH has worked to improve the dialogue with treatment providers across the state.

**Increased Focus on Co-Occurring Disorders.** In 2008, DSAMH began focusing on the treatment of clients with co-occurring disorders, which has continued in 2009. During monitoring visits to the local authorities, the effectiveness of the mental health and substance abuse systems in dealing with clients with co-occurring disorders has been a key area of focus. An open discussion of what is working and not working in each area has been a special topic of discussion for both adolescent and adult teams during each monitoring visit. 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 (TEDS) and National Outcome Measures (NOMs) data is very important to DSAMH. Just as important is using the data collected to guide our future treatment decisions. DSAMH has produced a Substance Abuse Treatment Outcomes Scorecard for the past four years, and will continue to publish and use these tools to inform the stakeholders on how well these programs are doing.

## Utahns in Need of Substance Abuse Treatment

The results of the UTMB Synthetic Estimates of Needs for Utah and the 2009 SHARP Survey indicated:

- 4.7% of adults in Utah were classified as needing treatment for alcohol and/or drug dependence or abuse in 2009. This rate has stayed the same since 2005.
- 4.7% of Utah youth in the 6<sup>th</sup> through 12<sup>th</sup> grades are in need of treatment for drug and/or alcohol dependence or abuse, which is lower than the 2007 rate of 5.1%.
- The public substance abuse treatment system, at capacity, is currently serving approximately 18,001 individuals, or less than 20% of the current need.

- A combined total of approximately 79,858 adults and youth are in need of, but not receiving, substance abuse treatment services.

The percentage of adults and youth needing treatment by service district varies considerably. This reflects the challenges that each local authority must deal with. The following table demonstrates the actual number of adults and youth who need treatment, by district. The current capacity of each district, or the number who were actually served in fiscal year 2009, is also included to illustrate the unmet need. The same data is depicted on the following graphs.

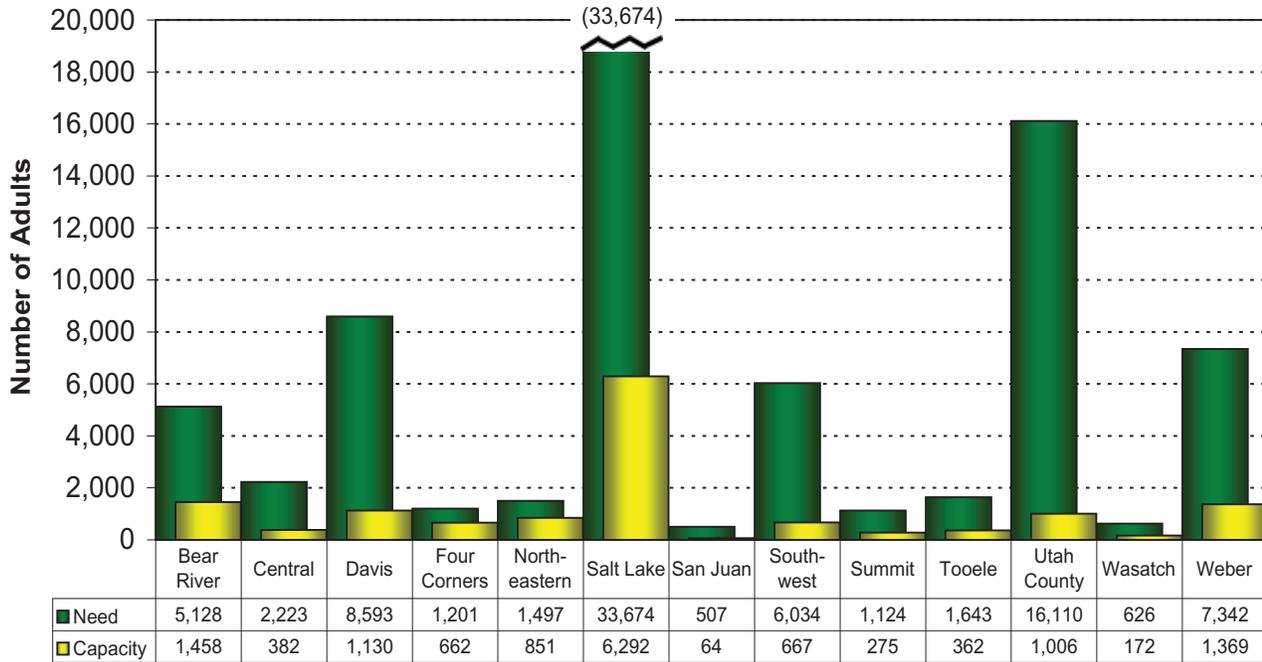
**Treatment Needs vs. Treatment Capacity**

	Adults (18 years+)			Youth (Under age 18)		
	% Need Treatment	# Need Treatment	Current Capacity	% Need Treatment	# Need Treatment	Current Capacity
<b>Bear River</b>	4.7%	5,128	1,458	2.5%	375	107
<b>Central</b>	4.6%	2,223	382	5.1%	378	81
<b>Davis</b>	4.4%	8,593	1,130	3.3%	964	60
<b>Four Corners</b>	4.2%	1,201	662	6.6%	234	69
<b>Northeastern</b>	4.6%	1,497	851	2.0%	92	57
<b>Salt Lake</b>	4.7%	33,674	6,292	7.1%	6,499	685
<b>San Juan</b>	5.1%	507	64	2.4%	44	14
<b>Southwest</b>	4.4%	6,034	667	4.6%	767	87
<b>Summit</b>	4.2%	1,124	275	6.5%	204	27
<b>Tooele</b>	4.5%	1,643	362	6.6%	387	58
<b>Utah County</b>	5.1%	16,110	1,006	1.9%	977	85
<b>Wasatch</b>	4.4%	626	172	6.1%	117	14
<b>Weber</b>	4.5%	7,342	1,369	4.3%	927	196
<b>State Totals</b>	4.7%	85,960*	16,467**	4.7%	11,899*	1,534**

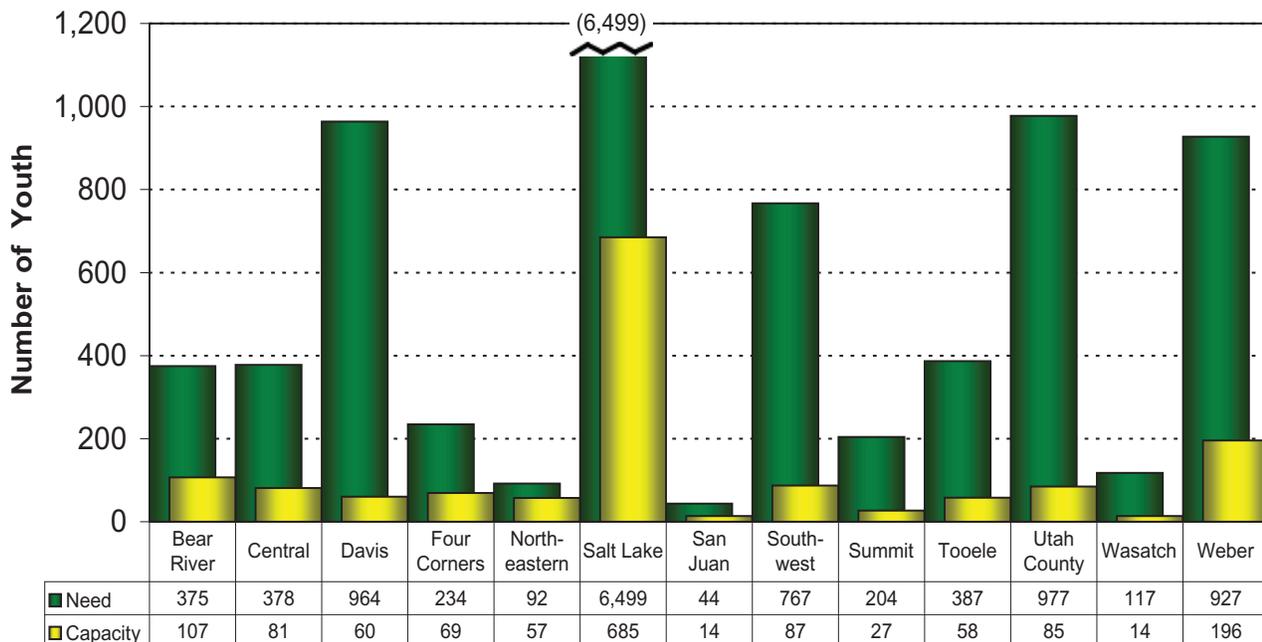
\*Because of rounding in the percentages, duplication of clients across Local Substance Abuse Authorities (LSAAs) and a small number of clients served in non-local authority contracts, LSAA totals do not add up to the unduplicated total of clients served statewide.

\*\*An additional 2,401 clients that were served by statewide contracts are reflected in the state total.

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



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



## Source of Data

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

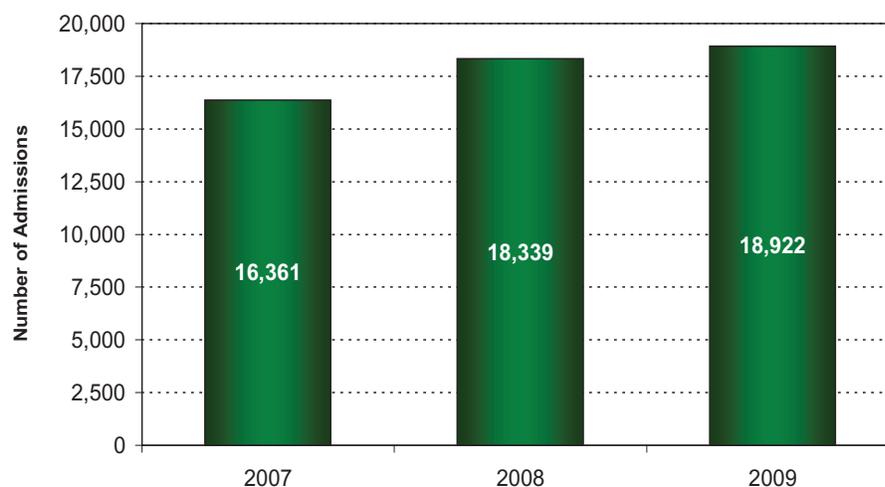
this data on a quarterly basis from the local substance abuse authorities (LSAAs). TEDS has been collected each year since 1991. This allows DSAMH to compare trend data based on treatment admissions over the past 10 years. Unless otherwise stated, the data in the following charts came from this source.

## Number of Treatment Admissions

While data has been collected over the past decade, in 2008 the local authorities and DSAMH approved new and more accurate reporting criteria for treatment admissions. However, the new system could only be computed for fiscal year 2007 and afterwards, resulting in the lack of comparable trend data before that time. The first

chart shows that the number of treatment admissions in fiscal year 2008 increased by 1,978, or 12% over fiscal year 2007, and again increased by 663, or just over 3% in fiscal year 2009. While the smaller increase in 2009 is disappointing, it is still encouraging in light of the general tightening of resources.

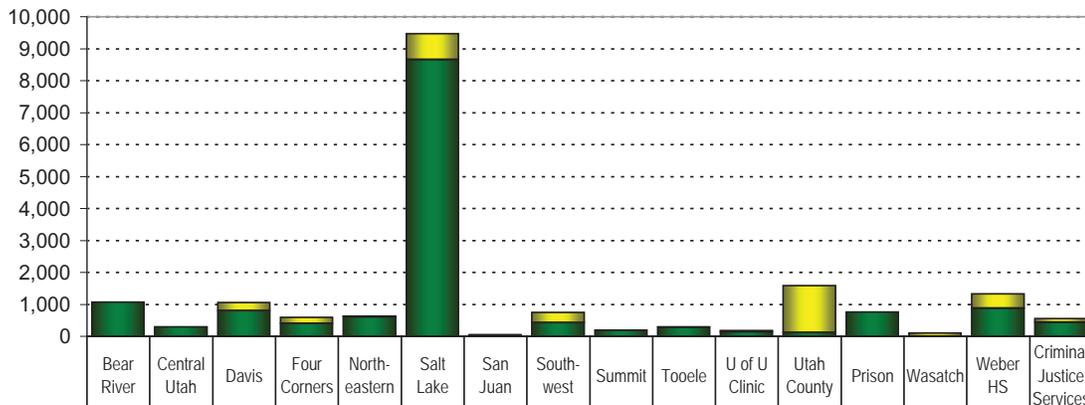
**Substance Abuse Initial and  
Transfer Admissions into Modalities  
Fiscal Years 2008 to 2009**



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 2009. Treatment admissions in Salt Lake County have risen to 57% of initial admissions and 50% of total admissions.

## Substance Abuse Treatment Admissions and Transfers in Utah by Local Authority Area Fiscal Year 2009



Transfer/Change in Modality	0	4	258	196	25	814	9	324	16	10	45	1472	0	93	460	108
Initial Admissions	1,066	291	796	397	608	8,653	44	428	175	283	141	121	764	4	873	444



**Cody Matheson** started using drugs and alcohol in the seventh grade and was in trouble with the law for the next 14 years. By 25, he was a two-time felon and was unemployable, homeless, and unwelcome in his family’s homes. But everything changed for him when his mother appeared at his court hearing, even though he’d asked her not to come. He couldn’t stand putting her in that position and vowed not to ever repeat that scenario.

After he cleaned up his life he started into college with the plan to become a history professor. But when he took a second job part-time in a treatment center just to get through college, he was hooked. He realized that’s where his heart was, and he became a licensed substance abuse counselor, where he’s been full-time for the last nine years. He loves what he’s doing. He loves to see his clients come back and tell him that they’ve applied what he taught them and they’re finding success.

In his own words: “My life began on June 6, 1998, when I got sober. I continue to grow and have struggles. Struggles that I can meet today without the need for drugs and with skills I learned in early recovery and continue to practice. Today I have a career that allows me to give back to suffering addicts like I was. I am married to a wonderful woman who has never seen me intoxicated . . . and, one day at a time, never will.”

## Primary Substance of Abuse

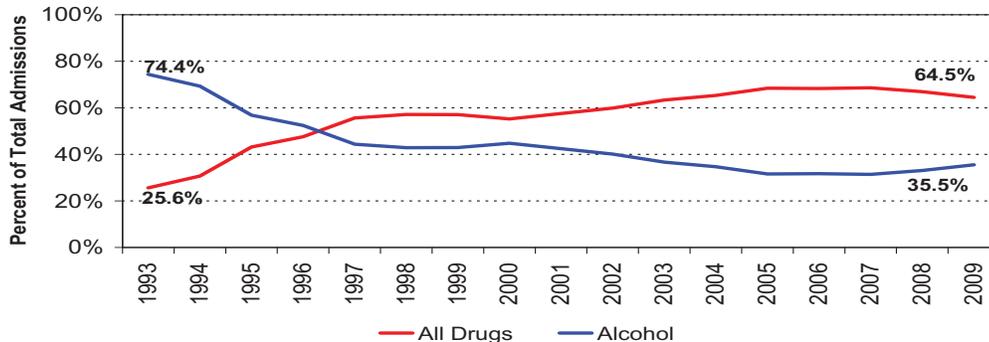
Trend data are invaluable in monitoring changing patterns in substance abuse treatment admissions. These patterns reflect underlying changes in sub-

stance abuse in the population, and have important implications for resource allocation and program planning.

From 1993 to 2007, treatment admissions for alcohol steadily declined or remained steady, while admissions for other drug use increased. In the past two years there has been a slight reversal

of that trend; however we still see admissions for all other drugs at a rate higher than admission rates for alcohol in 1995. Likewise, admissions for alcohol are slightly lower than those for other drugs in 1995.

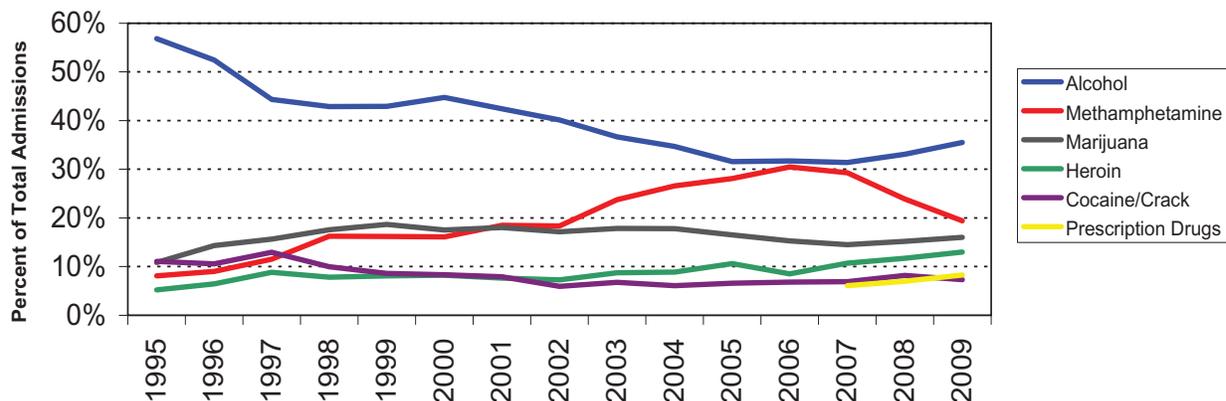
### Patient Admissions for Alcohol vs. Drug Dependence Fiscal Years 1993 to 2009



In 2009, 64.5% of treatment admissions were related to drug use, but alcohol remains the overall number one drug of choice. Of those admissions for other drugs, the top four drugs of choice are methamphetamine, marijuana, heroin and prescription drugs respectively. In 2009, prescription drugs passed cocaine/crack as the fourth highest illicit drug of choice. While methamphetamine

continues to be the most common drug of choice in treatment admissions for drug use, the number of admissions for methamphetamine has dropped by over a third in the past three years. Utah’s effort to target methamphetamine use through statewide campaigns such as “End Meth Now” and the Meth Task Force helped reduce the number of treatment admissions for methamphetamines.

### Top Drugs of Choice by Year Fiscal Year 1995 to Fiscal Year 2009



## Primary Substance by Gender

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 ad-

missions in 2009 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 be admitted into treatment for prescription drug use than men. Approximately 12.3% 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 of Abuse by Gender

Fiscal Year 2009

	Male	Male %	Female	Female %	Total
Alcohol	5,024	39.8%	1,691	26.8%	6,715
Cocaine/Crack	936	7.4%	437	6.9%	1,373
Marijuana/Hashish	2,322	18.4%	708	11.2%	3,030
Heroin	1,614	12.8%	850	13.5%	2,464
Other Opiates/Synthetics	287	2.3%	339	5.4%	626
Hallucinogens	18	0.1%	8	0.1%	26
Methamphetamine	1,909	15.1%	1,761	28.0%	3,670
Other Stimulants	29	0.2%	38	0.6%	67
Benzodiazepines	27	0.2%	54	0.9%	81
Tranquilizers/Sedatives	6	0.0%	29	0.5%	35
Inhalants	10	0.1%	5	0.1%	15
Oxycodone/Hydrocodone	406	3.2%	354	5.6%	760
Club Drugs	16	0.1%	8	0.1%	24
Over-the-Counter	11	0.1%	9	0.1%	20
Other	7	0.1%	7	0.1%	14
Unknown	0	0.0%	2	0.0%	2
<b>Total</b>	<b>12,622</b>	<b>100.0%</b>	<b>6,300</b>	<b>100.0%</b>	<b>18,922</b>

## Primary Substance by Age

Age plays a significant role in drug use preference. While alcohol has historically been the substance of choice for individuals over 45, in 2007 methamphetamine briefly eclipsed it as the drug of choice for individuals between 35 and 44. However, since 2008 alcohol has again become the primary drug of choice for that age group. Marijuana is preferred by those under 24, and alcohol and methamphetamine are the preferences for ages 25-34. From ages 18 to 24, alcohol and marijuana are the main drugs of choice. Under-

standing drug use preference among age groups assists treatment providers in targeting appropriate interventions towards each age group.

### Primary Substance of Abuse by Age Grouping

Fiscal Year 2009

	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	336	1,001	1,567	1,546	2,192	73	6,715
Cocaine/Crack	20	196	340	417	398	2	1,373
Marijuana/Hashish	965	1,153	579	203	129	1	3,030
Heroin	25	856	880	405	296	2	2,464
Other Opiates/Synthetics	13	121	276	114	100	2	626
Hallucinogens	1	10	7	3	5	0	26
Methamphetamine	17	687	1,549	924	493	0	3,670
Other Stimulants	2	13	26	18	8	0	67
Benzodiazepines	0	10	27	21	23	0	81
Tranquilizers/Sedatives	2	0	15	10	8	0	35
Inhalants	6	3	2	2	2	0	15
Oxycodone/Hydrocodone	4	172	380	118	85	1	760
Club Drugs	6	15	3	0	0	0	24
Over-the-Counter	3	5	5	6	1	0	20
Other	2	3	7	1	1	0	14
Unknown	0	0	1	0	1	0	2
<b>Total</b>	<b>1,402</b>	<b>4,245</b>	<b>5,664</b>	<b>3,788</b>	<b>3,742</b>	<b>81</b>	<b>18,922</b>

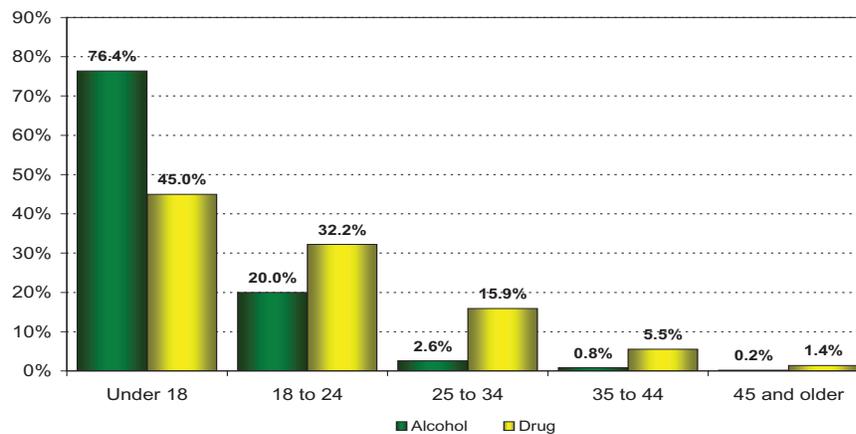
## Age of First Use of Alcohol or Other Drug

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

choice, 76% report they began using alcohol prior to the age of 18. Individuals seeking treatment primarily for drug use tend to begin their drug use at a later age, with 77% reporting first using substances under the age of 25.

Of the individuals who admitted to treatment in 2009, and identified alcohol as their substance of

**Age of First Use of Primary Substance of Abuse**  
Fiscal Year 2009

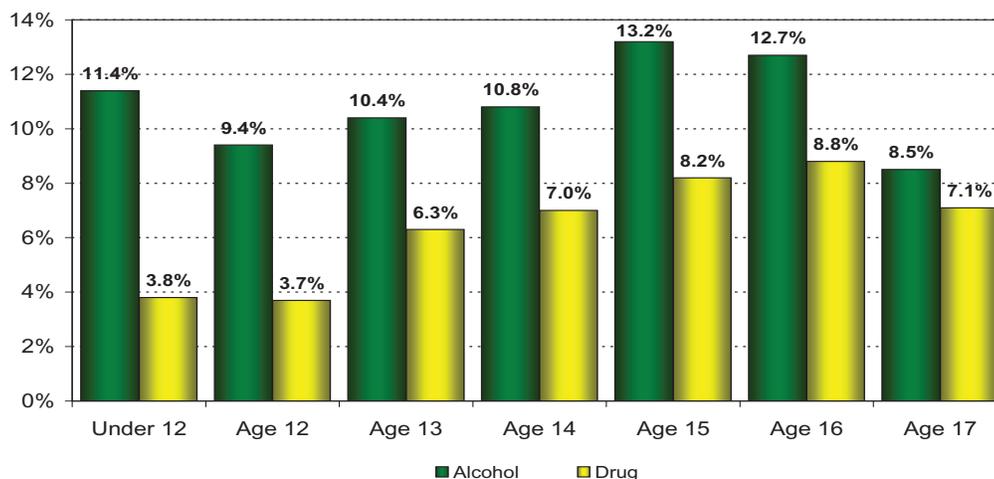


## Age of First Use of Primary Substance—Under 18

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

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

**Age of First Use of Primary Substance - Under 18**  
Fiscal Year 2009



## Multiple Drug Use

Using more than one drug/alcohol 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) drug use. The report of multiple drug use by clients at admission averages 39.3% across the state, ranging from 9.4% in San Juan County to 82.9% in Utah County. Typically, the more urban counties generally have higher rates of multiple drug use; however, Davis County at 13.7%, reports one of the lowest percentages. Tracking multiple drug use admissions helps providers tailor their treatment to the challenges that multiple drug use presents.

### Multiple Drug Use Fiscal Year 2009

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	169	15.9%
Central Utah	58	19.7%
Davis County	144	13.7%
Four Corners	183	30.9%
Northeastern	147	23.2%
Salt Lake County	3,208	33.9%
San Juan County	5	9.4%
Southwest Center	140	18.6%
Summit County	38	19.9%
Tooele County	69	23.5%
U of U Clinic	134	72.0%
Utah County	1,320	82.9%
Utah State Prison	568	74.3%
Wasatch County	55	56.7%
Weber HS	912	68.4%
Criminal Justice Services	285	51.6%
<b>Total</b>	<b>7,435</b>	<b>39.3%</b>

## Injection Drug Use

Injection drug use is a health risk. Injecting drug users are a priority population for receiving treatment because they are at greater risk of contracting and transmitting HIV/AIDS, tuberculosis and hepatitis B and C. This table indicates the number of clients who report intravenous needle use as the primary route of administration for any reported drug use in the past year. In 2009, 3,425 clients or 18.1% of the total number requesting services through the public treatment system, reported IV drug use as their primary route of administration. Utah State Prison reports the highest percentage of IV drug users at 38%, but Salt Lake County has more IV users than the rest of the state in total. As with multiple drug use, the preponderance of IV drug use (89.3%) is found in the more urban counties. Tracking trends in injection drug use assists in allocating and programming resources for this priority population.

### Admissions Reporting IV Injection Drug Use at Admission Fiscal Year 2009

	# Reporting Injection Drug Use at Admission	% of Total Admissions for Each Area
Bear River	39	3.7%
Central Utah	16	5.4%
Davis County	236	22.4%
Four Corners	60	10.1%
Northeastern	55	8.7%
Salt Lake County	1,813	19.2%
San Juan County	2	3.8%
Southwest Center	96	12.8%
Summit County	8	4.2%
Tooele County	11	3.8%
U of U Clinic	53	28.5%
Utah County	410	25.7%
Utah State Prison	290	38.0%
Wasatch County	6	6.2%
Weber HS	209	15.7%
Criminal Justice Services	121	21.9%
<b>Total</b>	<b>3,425</b>	<b>18.1%</b>

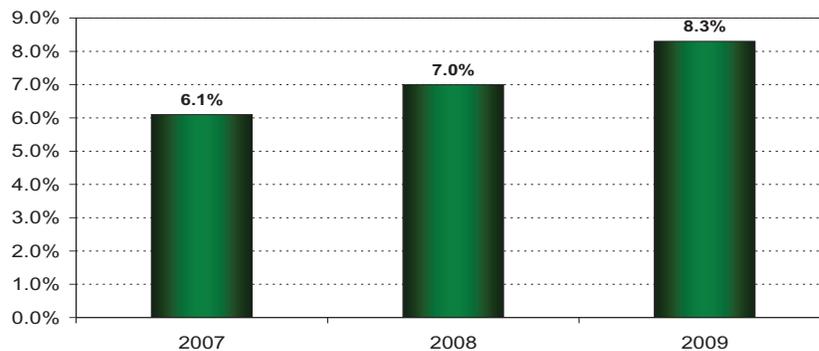
## Prescription Drug Abuse

Admissions to the public treatment system for prescription drug abuse have been rising for the past several years—from 5.0% in 2006 to 7.0% in 2008, and up to 8.3% in 2009, representing a 68% increase in three years. While the numbers remain relatively low, the rate of increase is of concern and the combination of drug categories that comprise the general category of prescription drugs has outstripped cocaine/crack as the fourth highest drug of choice at admission.

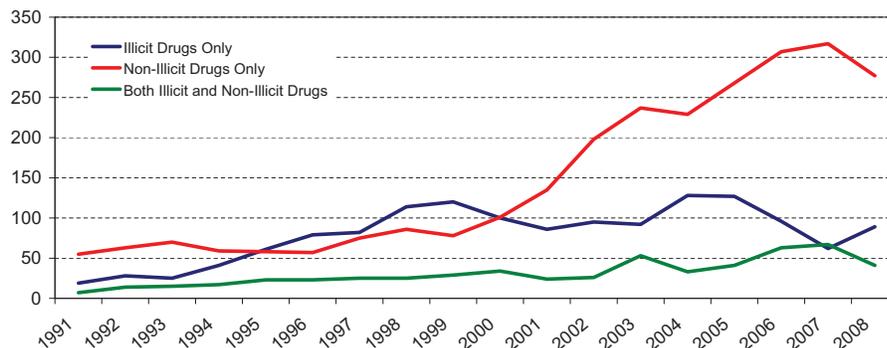
This increase appears to be partially due to the increase in oxycodone/hydrocodone admissions, which increased from 2.2% in 2006 to 3.8% in 2008, and to 4% in 2009, representing an 82% increase.

Of special concern is the high rate of prescription drug overdose deaths. In calendar year 2007, Utah had 317 deaths attributed to non-illicit drug overdoses, and while this number dropped to 277 in calendar year 2008, Utah is still significantly higher than the national average in the non-medical use of pain relievers. In 2006 Utah was the second highest 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 find ways to address this problem.

**Admission for Primary Drug—  
Prescription Drugs  
Fiscal Years 2007 to 2009**



**Number of Drug Poisoning Deaths by  
Drug Category and Year—Utah  
1991-2008**



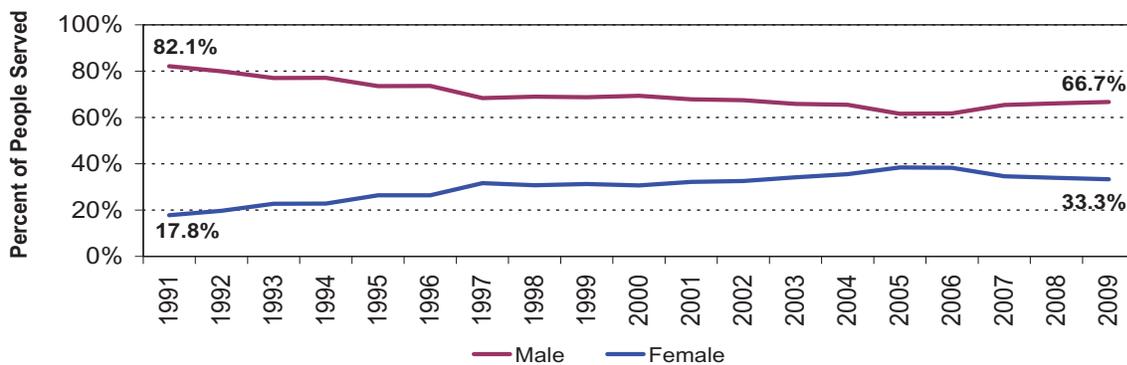
Utah Department of Health

## Admissions to Treatment by Gender

The table below shows the percentages of admissions by gender. As the data shows, there was a steady increase in the number of admissions for women from 1991 through 2005, and a 12.3% reduction from 2005 to 2009. There is some evidence that the decreased

use of methamphetamines among women (a 13% decrease from 2006 to 2009) explains the decrease of female admissions. This decrease corresponds to the increasing emphasis put on methamphetamines by programs such as the “End Meth Now” campaign.

**Gender of People in Substance Abuse Treatment Fiscal Years 1991 to 2009**



## Pregnant Women in Treatment

Information regarding pregnancy and current prenatal care, if applicable, is collected on all female clients entering the public treatment system. In fiscal year 2009, 5.7% of the women entering treatment (357 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 2009**

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	305	7	2.3%
Central Utah	115	8	7.0%
Davis County	389	26	6.7%
Four Corners	220	9	4.1%
Northeastern	218	12	5.5%
Salt Lake County	2,850	175	6.1%
San Juan County	13	1	7.7%
Southwest Center	273	13	4.8%
Summit County	62	3	4.8%
Tooele County	86	4	4.7%
U of U Clinic	73	4	5.5%
Utah County	693	39	5.6%
Utah State Prison	175	4	2.3%
Wasatch County	36	1	2.8%
Weber Human Services	581	46	7.9%
Criminal Justice Services	211	5	2.4%
<b>Total</b>	<b>6,300</b>	<b>357</b>	<b>5.7%</b>

## Clients with Dependent Children

Substance use disorders seriously impact an individual's physical, emotional, and social functioning. Not only does the individual with a substance abuse disorder suffer, but those living with the individual also suffer. Typically, the ones who suffer the most are the children. In addition, children with a parent who abuses alcohol and/or other drugs are at a higher risk of developing substance abuse problems themselves. The table below indicates the percentage of adult clients with dependent children and the average number of children in those households. The percentage of adult clients with dependent children in Utah is 42.8%. The average number of dependent children per household is 2.13.

The table also depicts the percentage of women entering treatment who have dependent children and the average number of children for those households. In contrast to 42.8% of all clients with children, over 59.2% of women who are admitted to treatment report having dependent children, and they report a higher number per family. Four counties report that over 71% of their female clients have dependent children.

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 in child care, transportation and case management services in order for their treatment to be successful. These requirements necessitate the treat-

ment program to provide a comprehensive set of wrap-around services. Appropriate treatment for adults with substance abuse disorders also includes the treatment of family members. Treatment providers throughout the state are tasked to address the emotional needs of all family members and provide services to children in households where parents or siblings are receiving treatment for substance use disorders.

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

**Clients with Dependent Children**  
Fiscal Year 2009

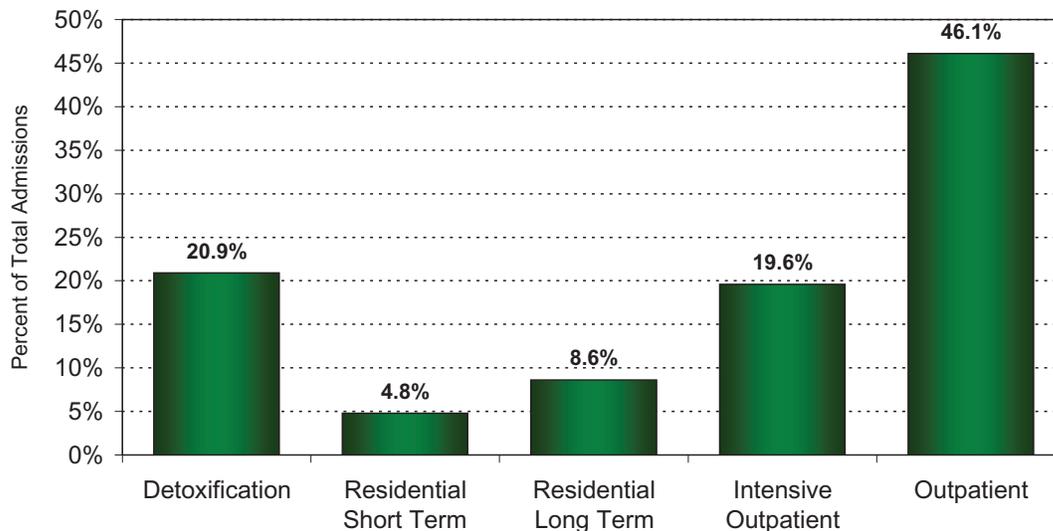
	Percent of all Clients with Children	Average Number of Children (of Clients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	33.2%	2.07	43.9%	1.99
Central Utah	39.6%	2.88	54.4%	2.66
Davis County	61.4%	2.30	79.2%	2.49
Four Corners	53.6%	2.30	67.7%	2.41
Northeastern	59.1%	2.42	69.3%	2.50
Salt Lake County	37.6%	2.00	54.7%	2.12
San Juan County	59.6%	2.32	75.0%	2.89
Southwest Center	49.3%	2.48	60.4%	2.73
Summit County	27.2%	2.21	38.7%	2.54
Tooele County	27.3%	1.89	29.1%	1.76
U of U Clinic	45.2%	2.07	39.7%	1.93
Utah County	56.7%	2.12	73.9%	2.25
Utah State Prison	33.9%	2.12	52.6%	2.41
Wasatch County	54.8%	1.96	71.4%	2.24
Weber Human Services	51.2%	2.22	66.4%	2.32
Criminal Justice Services	41.3%	1.85	47.4%	1.95
<b>Total</b>	<b>42.8%</b>	<b>2.13</b>	<b>59.2%</b>	<b>2.25</b>

## Service Type

Almost half of all treatment admissions are to outpatient treatment. As individuals successfully complete higher levels of care, such as detoxification, residential, and intensive outpatient, they are

transitioned to outpatient treatment for monitoring and maintenance which helps to explain the high number of outpatient admissions.

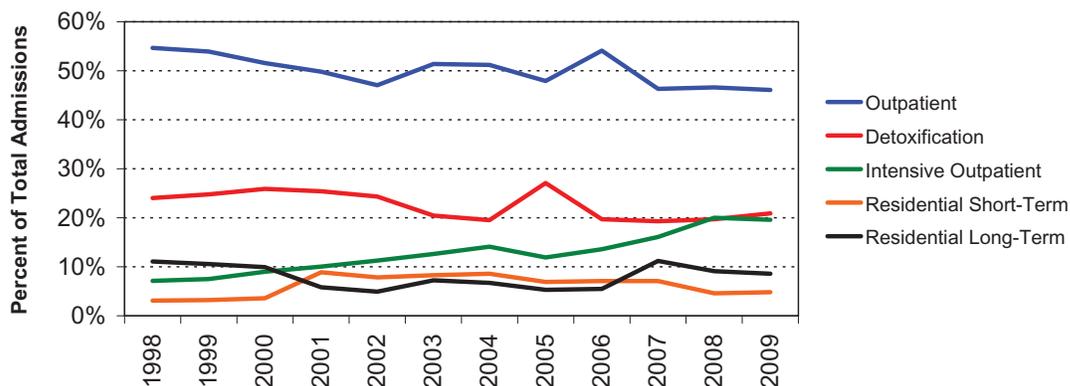
**Service Type at Admission**  
Fiscal Year 2009



**Trends in Service Types.** Admission to intensive outpatient treatment leveled off in 2009, probably due to the reduction in the Drug Offender Reform Act (DORA). With residential services becoming more expensive, and substance use becoming more severe, intensive outpatient treatment is an effective and less costly alternative to residen-

tial and detox services. The increasing availability of intensive outpatient funding, beginning in 2007 through programs such as DORA and the Women’s Treatment Initiative, helped reduce the number of long- and short-term residential admissions.

**Trends in Service Types**  
Fiscal Years 1998 to 2009



## 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.

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

DORA is based on the following concepts:

- Outcomes for felony offenders with substance abuse problems can be improved by providing them with appropriate treatment.
- Providing judges and Board of Pardons and Parole members with enhanced information about the treatment needs of offenders at the time of sentencing and release from prison will produce better treatment placements and smarter sentences.
- Closer collaboration between parole and probation agents and treatment providers will lead to higher rates of treatment and supervision completion for offenders.

Funds were allocated to DSAMH, the Department of Corrections, the Council on Criminal and Juvenile Justice, the Administrative Offices of the Courts, and the Board of Pardons and Parole to ensure these components were implemented accordingly. By appropriately matching the level of treatment and supervision to an offender's risk to re-offend and treatment needs, scarce resources can be better allocated to assure long-term benefits. The lower the risk to re-offend the less community supervision an offender requires; while a higher risk to re-offend requires more intensive community supervision. Likewise, offenders who

have a low need for substance abuse treatment should receive basic treatment services; while offenders with a high substance abuse treatment need should have access to multiple treatment services. As part of the justice and treatment continuums, DORA targets those offenders who are at medium to high risk to re-offend and who have high treatment needs.

Lessons learned from DORA:

- The foundations of DORA are sound (UCJC DORA Pilot Study).
- Having fewer days from conviction to probation start was associated with a greater likelihood of successful completion of probation.
- Completing a treatment admission during supervision was associated with a 7-11 times greater likelihood of successful completion of probation.
- Having parole officer contacts in the community was associated with over three times greater likelihood of successful completion of probation.
- DORA gets offenders into treatment and under supervision quickly after sentencing, which positively impacts successful completion.
- DORA creates collaborative relationships between supervising agents and treatment providers, which also positively impacts successful completion.
- DORA supports the completion of treatment.

### DORA Implementation

DORA was implemented as a pilot study in July 2005 and then implemented statewide in July of 2007. Due to statewide budget reductions, DORA was modified from a statewide implementation

to a six-county pilot in July of 2009. This pilot will focus on the effects of DORA with intensive community supervision versus increased communication between the treatment provider and the probation officer and regular supervision. Additionally, DORA will be limited to probationers only. The implementation plan for fiscal year 2010 is as follows:

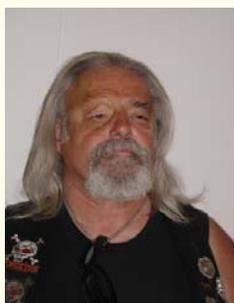
- DORA modified from statewide to a six-county pilot.
- Urban counties (Weber, Davis, Salt Lake, and Utah) have both DORA treatment and DORA intensive supervision.
- Rural counties (Cache and Washington/Iron) have DORA treatment and increased communication with supervising agents but do not have DORA specific agents providing intensive community supervision.
- An estimated 635 probationers will be served.
- The approximate cost per case per year is \$3,500.

### DORA Demographics 2009

Median age	30
Female	30.4%
Male	69.6%
Increased abstinence admit to discharge—Alcohol	17.7%
Increased abstinence admit to discharge—Drug	45.9%
Increased employment admit to discharge	59.5%
Decreased arrests admit to discharge	60.9%
DORA assessments	1,041
Separate offenders treated	1,288

### DORA’s Impact on Future Treatment

DORA will continue to be studied for its effectiveness and outcomes for several years. The lessons learned by both the criminal justice and treatment systems, as well as the cooperation at the local and policy levels, has led to changes which have greatly improved the cooperation and coordination of treatment and supervision services statewide.



**Kenny Rosenbaum**, a self-described “hippy biker dude,” started using drugs at age 13 and was in and out of jail for the next 36 years. But that life came to an abrupt halt the day his 7-year-old son said, “Dad, why can’t you stay out of jail long enough to be here for my birthday?” That did it. After his son’s sad question, Ken jumped on the judge’s option to take drug court instead of prison. The odds were against him, but Ken made the most of his opportunities and graduated from drug court in 2001.

Since that day in 1999 when he turned his life around, Kenny’s never missed a birthday celebration for his son. For obvious reasons, his heart is with the kids. He has been an advisor and mentor to K.O.P.I.R. Kids (Kids of Parents in Recovery). Sobriety has totally changed his relationships with his kids and family and he’s enjoying a life he never dreamed possible back in his using days.

Still a “hippy biker dude,” Kenny now spends full-time mentoring others in drug court as a volunteer through the Friends of Drug Court program, where he serves on the board of directors. He gives his number out to anyone in need and takes calls 24/7. It’s the service that keeps him in recovery. He says if it was a job, he wouldn’t do it. If it becomes a job, then it’s not fun. In his own words, “I took for so many years, there’s no way I’ll ever be able to pay it all back. This is my way of giving back.”

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## 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.

Since 1996, Utah's drug courts have increased from 2 to over 32 operating statewide today. The Department of Human Services through DSAMH, provides funding for 24 drug courts and 2 drug board programs.

### Drug Court Initiatives Fiscal Year 2009

DSAMH and the Administrative Offices of the Courts began integrating certification and contract monitoring visits during fiscal year 2009. Through this coordinated effort, drug courts

across the state became more focused on their day-to-day practices, ensuring participants' due process rights are maintained throughout their drug court experience.

### *In fiscal year 2009, 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 23% 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 94% compared to the national average of 40%.
- Utah's drug courts decreased the number of participants who were arrested from admission to discharge by 70% compared to the national average of 52%.





What I have learned about my mental illness is that I have gained a better understanding about the world around me. Nine years ago I found out I had a mental illness. Some people would say, "You're weird." I tell them, "it's not funny to laugh at someone that's different. Having mental illness is not something to laugh at." Befriend someone with a mental illness and you will gain a better understanding of what they experience.

There are people who understand what I am going through and who can relate to me. Having a mental illness isn't that bad. My friends accept me and understand about my mental illness. Everyone is different and I am glad to be different so I dare you to be different in your own way.



Since I have gotten older I can go to my appointments on my own. Someday I want to get a job and be independent. I want to find a job to work with animals. I like different kinds of animals. I like to hang out with them and play with them. I play soccer. I like bowling. I like going on camp outs, especially getting scared by skunks that come by. I really like this one song called, "War, what is it good for?"



### MY FAVORITES

- Soccer
- Riding my Bike
- Rollerblading
- Hanging out w/Friends

Having a mental illness has not stopped me from reaching my goals and dreams. No matter what people say or do that is not kind, I will never give up on my goals and dreams.

You can learn a lot about people like me and others who are dealing with their own challenges. It's ok to accept everybody. Please accept yourselves for who you are and not for what other people want you to be!

- Ash

*[Ashley is a member of the DSAMH-sponsored Youth Action Council]*

# Mental Health Treatment

## Overview

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 administrative direction of the Division of Substance Abuse and Mental Health (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
- 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 wrap-around 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 DSAMH. 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

*Client Quotes*

*“One year ago, I was in a bad place—a very angry, upset-all-the-time little girl. The nightmares were pretty bad, crying or yelling all the time. I was angry at everything. I was sent to a community health center to talk to a counselor. They knew what was wrong and why. The people there were great. I was put in a group with other girls. We could share our problems and work on them. They also gave our family a Family Resource Facilitator to help us. She was a guide and support person. All these people and my grandparents helped me. Today I have my self-esteem back. I am happy most of the time. They taught me to trust, to know that I am a good person and that I can do great things. I know if I need them again they will be there for me. They helped me turn my life around. The skills will help keep me on track through whatever comes at me.”*

## Treatment Information

### Diagnostic Data

The following tables describe the most common diagnoses 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 diagnoses require that mental health providers 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, which requires providers to have competence in the treatment of both conditions.

**Diagnosis of Mental Health Clients—18 years and older, by Mental Health Center**

Diagnosis	Bear River Mental Health	Central Utah Counseling	Davis Behavioral Health	Four Corners Behavioral Health	Northeastern Counseling Center	Salt Lake Co.—VMH	San Juan Counseling	Southwest Behavioral Health Center	Summit County—VMH	Tooele County—VMH	Utah Co.—Wasatch Mental Health	Wasatch Co.—Heber Valley Counseling	Weber Human Services	Statewide Adults
Mood Disorder	29.1%	24.9%	28.0%	23.0%	25.6%	23.1%	40.7%	28.1%	20.3%	27.0%	21.1%	17.3%	17.1%	23.2%
Substance Abuse	8.0%	5.8%	8.9%	30.1%	7.3%	23.5%	4.0%	2.0%	31.6%	28.8%	10.1%	13.8%	20.6%	18.0%
Anxiety Disorder	19.9%	18.8%	22.5%	12.7%	21.1%	14.4%	19.4%	8.9%	14.9%	16.9%	20.4%	20.4%	11.2%	16.1%
Personality Disorder	10.2%	10.7%	5.7%	7.0%	7.5%	10.7%	5.4%	11.4%	2.0%	6.6%	8.1%	4.3%	6.5%	8.6%
Schizophrenia and Other Psychotic	5.8%	9.9%	8.1%	3.8%	6.0%	8.9%	4.4%	10.6%	1.0%	2.7%	8.2%	3.3%	5.6%	7.3%
Cognitive Disorder	2.6%	1.9%	1.3%	1.4%	2.0%	1.7%	6.6%	3.7%	0.4%	0.5%	3.7%	0.4%	2.1%	2.1%
Attention Deficit	2.9%	1.7%	2.3%	1.4%	3.0%	1.9%	1.2%	0.4%	2.6%	3.1%	2.8%	1.5%	1.0%	2.0%
Adjustment Disorder	2.1%	1.7%	1.8%	1.6%	4.0%	1.0%	3.5%	6.1%	4.4%	1.6%	0.9%	3.2%	1.2%	1.6%
Impulse Disorders	1.0%	0.7%	0.6%	0.6%	2.2%	0.5%	0.9%	0.9%	0.6%	0.3%	1.3%	2.4%	0.4%	0.7%
Neglect or Abuse	0.3%	8.9%	0.5%	0.2%	1.6%	0.1%	0.5%	0.9%	0.1%	0.1%	1.5%	0.1%	0.5%	0.7%
Autism	0.8%	0.6%	0.7%	0.4%	0.4%	0.5%	0.9%	0.9%	0.2%	0.1%	0.9%	0.0%	0.2%	0.6%
Conduct Disorder	0.0%	0.0%	0.3%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.1%
Other	13.8%	11.0%	17.7%	14.5%	12.7%	6.4%	8.0%	22.4%	8.6%	3.5%	15.0%	23.4%	28.1%	13.3%
V Codes	3.6%	3.5%	1.6%	3.3%	6.6%	7.2%	4.4%	3.6%	13.5%	8.5%	5.9%	9.9%	5.3%	5.9%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

**Diagnosis of Mental Health Clients—17 years and younger, by Mental Health Center**

Diagnosis	Bear River Mental Health	Central Utah Counseling	Davis Behavioral Health	Four Corners Behavioral Health	Northeastern Counseling Center	Salt Lake Co.—VMH	San Juan Counseling	Southwest Behavioral Health Center	Summit County—VMH	Tooele County—VMH	Utah Co.—Wasatch Mental Health	Wasatch Co.—Heber Valley Counseling	Weber Human Services	Statewide Youth
Mood Disorder	15.7%	7.8%	15.3%	15.6%	13.9%	14.4%	19.6%	13.0%	17.8%	16.8%	10.7%	7.6%	11.6%	13.4%
Anxiety Disorder	14.2%	9.6%	11.1%	8.0%	15.0%	13.9%	17.0%	9.4%	12.9%	13.2%	13.0%	10.7%	9.4%	12.3%
Attention Deficit	11.3%	15.1%	13.2%	12.2%	11.1%	14.2%	18.7%	6.8%	9.3%	10.1%	10.0%	13.2%	8.4%	11.7%
Neglect or Abuse	7.7%	14.3%	13.0%	4.1%	10.9%	6.9%	3.0%	8.4%	1.9%	10.3%	9.0%	7.6%	11.3%	8.8%
Adjustment Disorder	11.5%	15.7%	5.1%	8.6%	11.7%	6.2%	13.5%	20.1%	10.6%	5.6%	6.2%	12.7%	5.3%	7.5%
Personality Disorder	0.8%	2.1%	1.8%	10.9%	2.9%	5.5%	0.0%	0.5%	12.9%	11.5%	2.0%	4.1%	10.3%	4.9%
Autism	2.6%	3.4%	3.5%	1.2%	2.0%	4.9%	5.7%	2.6%	1.1%	2.0%	4.6%	1.5%	4.4%	4.0%
Conduct Disorder	1.1%	2.2%	1.8%	1.1%	1.9%	2.1%	0.0%	1.8%	1.1%	2.9%	1.3%	2.5%	2.8%	1.9%
Cognitive Disorder	1.6%	1.0%	0.4%	1.1%	1.1%	1.1%	0.9%	1.5%	0.2%	0.8%	1.0%	0.0%	1.0%	1.0%
Schizophrenia and Other Psychotic	1.0%	0.8%	0.8%	0.2%	0.9%	0.7%	0.9%	0.2%	0.2%	0.1%	0.6%	0.0%	1.5%	0.7%
Impulse Disorders	1.7%	0.2%	0.7%	0.9%	1.1%	0.2%	1.7%	1.0%	0.4%	0.3%	0.8%	0.0%	0.3%	0.6%
Substance Abuse	0.1%	0.6%	0.2%	0.2%	0.3%	0.2%	0.4%	0.3%	0.0%	0.4%	0.2%	0.0%	0.1%	0.2%
Other	22.6%	20.9%	26.4%	25.0%	20.5%	22.1%	11.7%	27.3%	13.1%	18.0%	23.3%	21.4%	24.8%	23.1%
V Codes	8.2%	6.4%	6.6%	10.9%	6.9%	7.6%	7.0%	7.1%	18.4%	8.0%	17.2%	12.7%	8.6%	9.8%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

## Expected Payment Source

The following table identifies expected 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, Medi-

care, 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 2009

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	57.5%	0.5%	1.3%	1.1%	10.6%	2.0%	27.1%
Central	72.3%	9.7%	4.9%	1.0%	5.6%	5.6%	1.0%
Davis	60.5%	0.6%	11.8%	9.7%	6.2%	7.4%	3.9%
Four Corners	0.0%	0.1%	8.3%	48.3%	0.0%	0.0%	43.4%
Northeastern	38.3%	0.0%	25.5%	8.2%	3.3%	24.2%	0.5%
Salt Lake County—VMH	55.1%	16.8%	13.1%	11.7%	3.4%	0.0%	0.0%
San Juan	25.9%	0.6%	30.6%	20.3%	5.4%	10.4%	6.8%
Southwest	63.3%	3.3%	7.1%	11.4%	2.4%	0.8%	11.7%
Summit County—VMH	8.3%	45.0%	21.2%	24.2%	1.3%	0.0%	0.0%
Tooele County—VMH	30.4%	29.3%	20.3%	18.0%	2.0%	0.0%	0.0%
Utah County—Wasatch Mental Health	61.3%	32.4%	3.3%	0.0%	3.0%	0.0%	0.0%
Wasatch County—Heber Valley Counseling	20.6%	72.5%	7.0%	0.0%	0.0%	0.0%	0.0%
Weber	47.4%	42.0%	8.3%	0.0%	2.3%	0.0%	0.0%
<b>Statewide</b>	<b>50.3%</b>	<b>19.7%</b>	<b>10.6%</b>	<b>9.6%</b>	<b>3.6%</b>	<b>1.5%</b>	<b>4.7%</b>

## Service Penetration Rates

The following table 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 percent of its general population that received public mental health services.

### 2009 Mental Health Clients Penetration Rates

	2008 Population (Estimated)	Total Served	Penetration Rate
Bear River	163,836	2,656	1.6%
Central	71,592	988	1.4%
Davis	295,332	3,180	1.1%
Four Corners	39,648	1,960	4.9%
Northeastern	47,684	1,077	2.3%
Salt Lake County - Valley Mental Health	1,022,651	15,284	1.5%
San Juan	15,055	483	3.2%
Southwest	199,526	2,507	1.3%
Summit Co.—Valley Mental Health	36,100	1,039	2.9%
Tooele Co.—Valley Mental Health	56,941	1,982	3.5%
Utah Co.—Wasatch Mental Health	530,837	5,996	1.1%
Wasatch Co.—Heber Valley Counseling	21,066	345	1.6%
Weber	236,156	5,858	2.5%
<b>Statewide</b>	<b>2,736,424</b>	<b>42,416</b>	<b>1.6%</b>

Penetration rate is the percent of people in the general population who are receiving mental health services in each CMHC.

## Mental Health Courts

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.

Mental health courts require collaboration and consideration from practitioners in both the criminal justice and mental health fields. Mental health courts typically involve judges, prosecutors, defense attorneys, and other court personnel. The courts generally deal with nonviolent offenders who have been diagnosed with a mental illness or co-occurring mental health and substance abuse

disorders. The goal of a mental health court is to decrease the frequency of clients' contacts with the criminal justice system by providing courts with resources to improve clients' social functioning and link them to employment, housing, treatment, and support services.

There are currently two mental health courts in Salt Lake County for adults, one federal mental health court and one juvenile mental health court. There is also an adult mental health court in Utah County, one adult mental health court in Cache County and a juvenile mental health court serving Cache and Box Elder counties. For more information on mental health courts, please contact Kim Haws at (801) 323-9900 or kim@namiut.org.

### Client Quotes

*"I have suffered with mental illness and substance abuse most of my life. After coming to the clubhouse, I got the structure I need to help me solve my problems. I no longer use dangerous substances, drink alcohol or smoke cigarettes. The clubhouse has empowered me to do what's right for myself and has guided me through the process of finding the right medications for my illness. There have been short periods of time where I have felt sheer joy. I am on my way to a full recovery some day. I am looking forward to it!"*

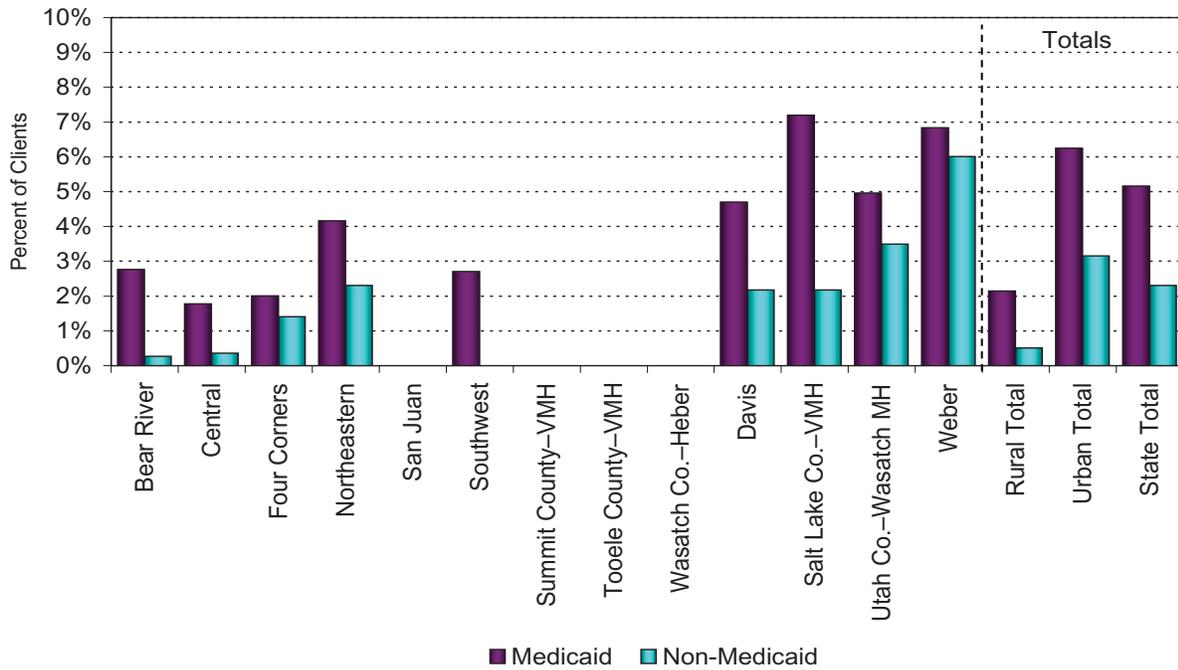
## Mandated Services Data by Local Provider

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 priorities (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 192.

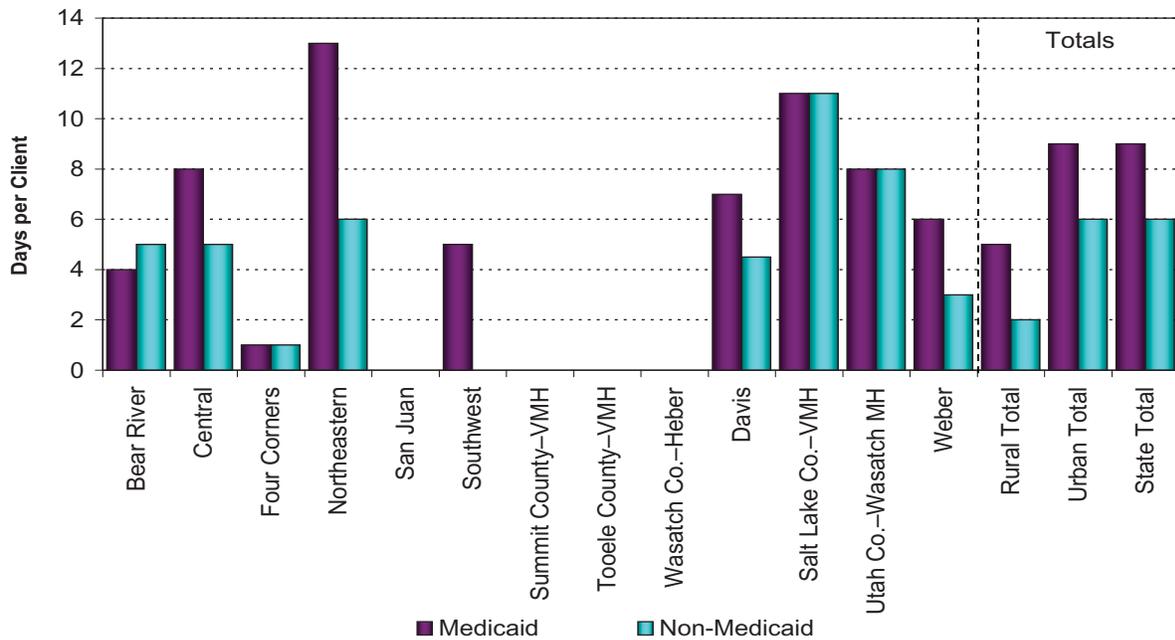
### Inpatient Utilization

Mental Health Clients  
Fiscal Year 2009

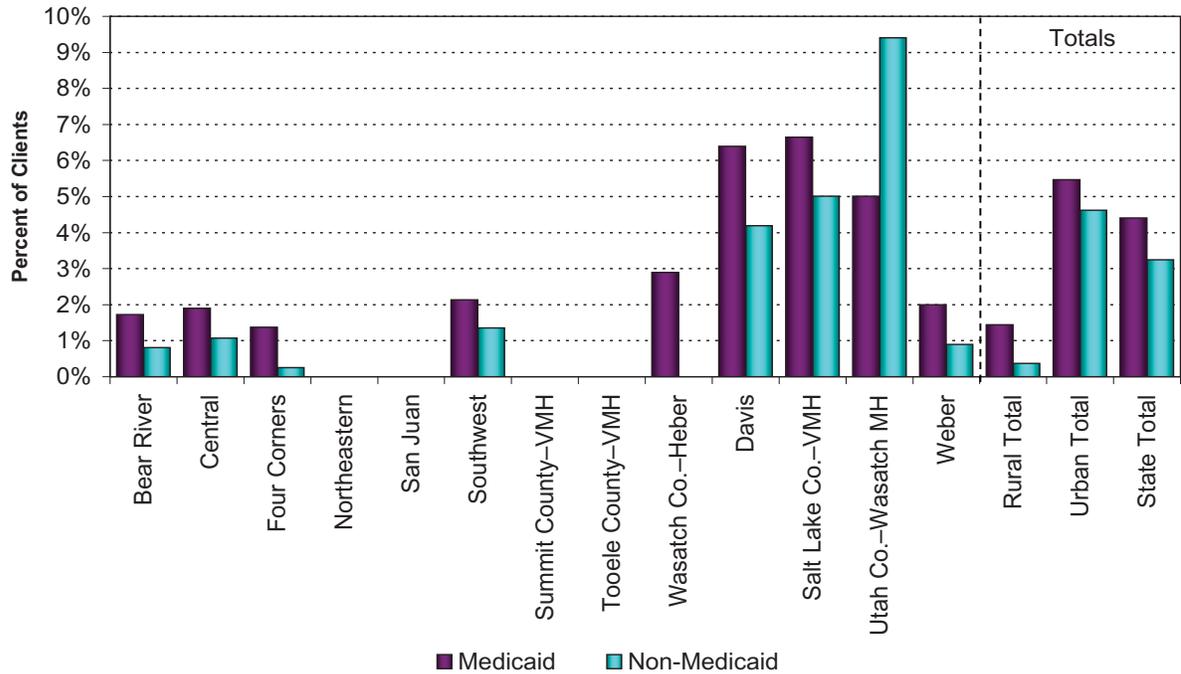


### Inpatient Median Length of Service

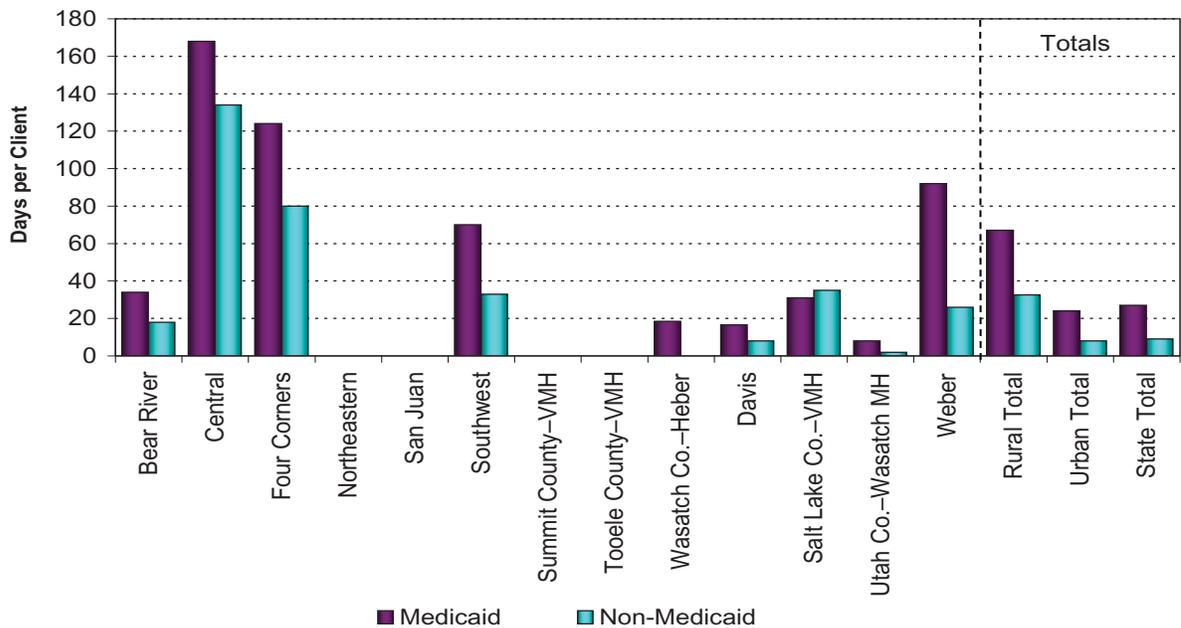
Mental Health Clients  
Fiscal Year 2009



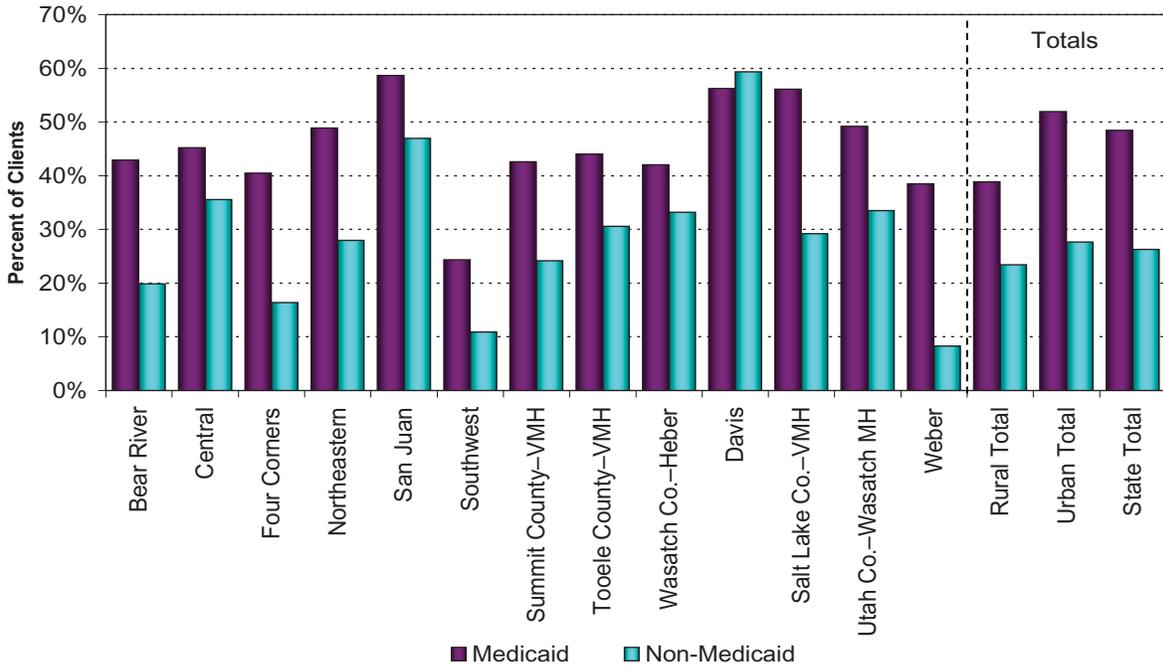
### Residential Utilization Mental Health Clients Fiscal Year 2009



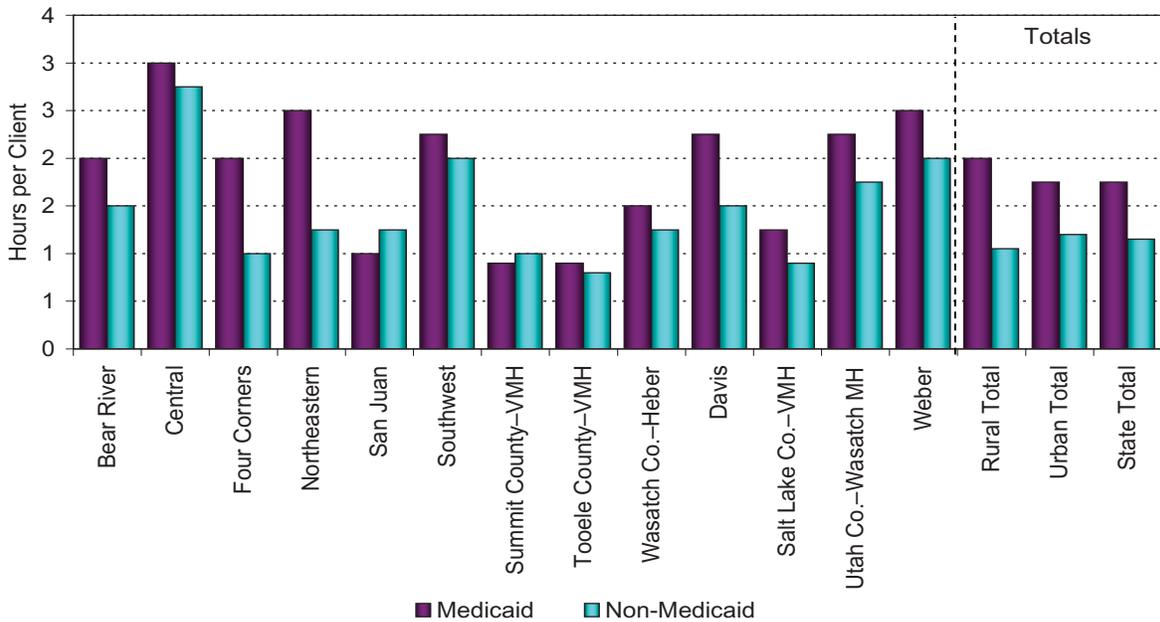
### Residential Median Length of Service Mental Health Clients Fiscal Year 2009



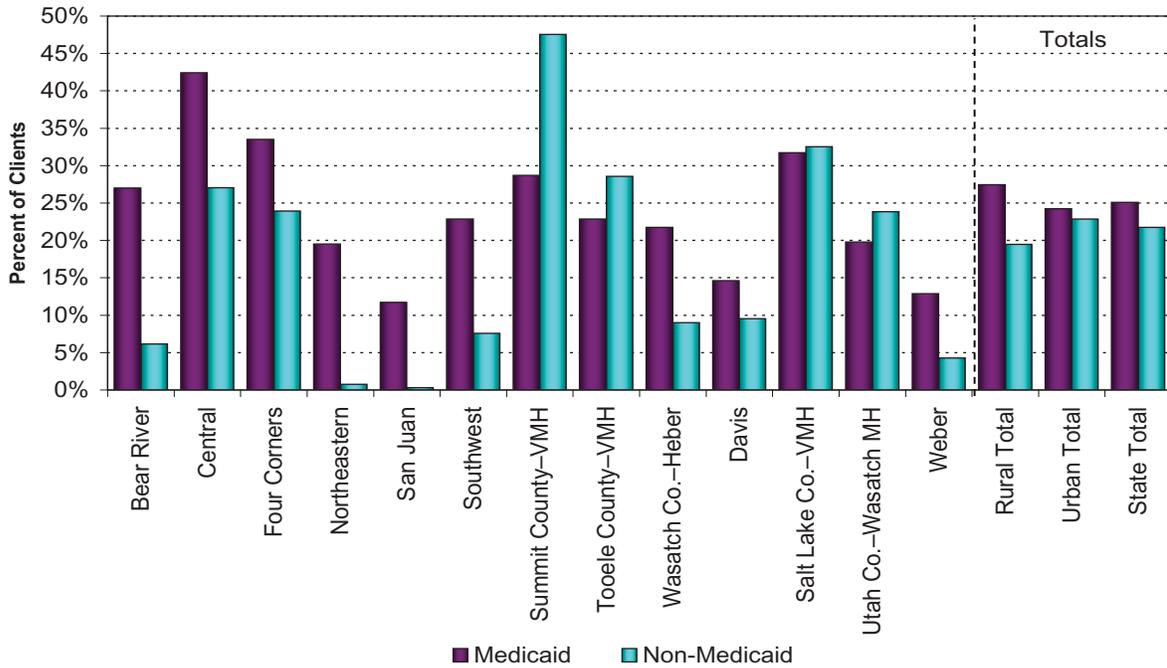
### Medication Management Utilization Mental Health Clients Fiscal Year 2009



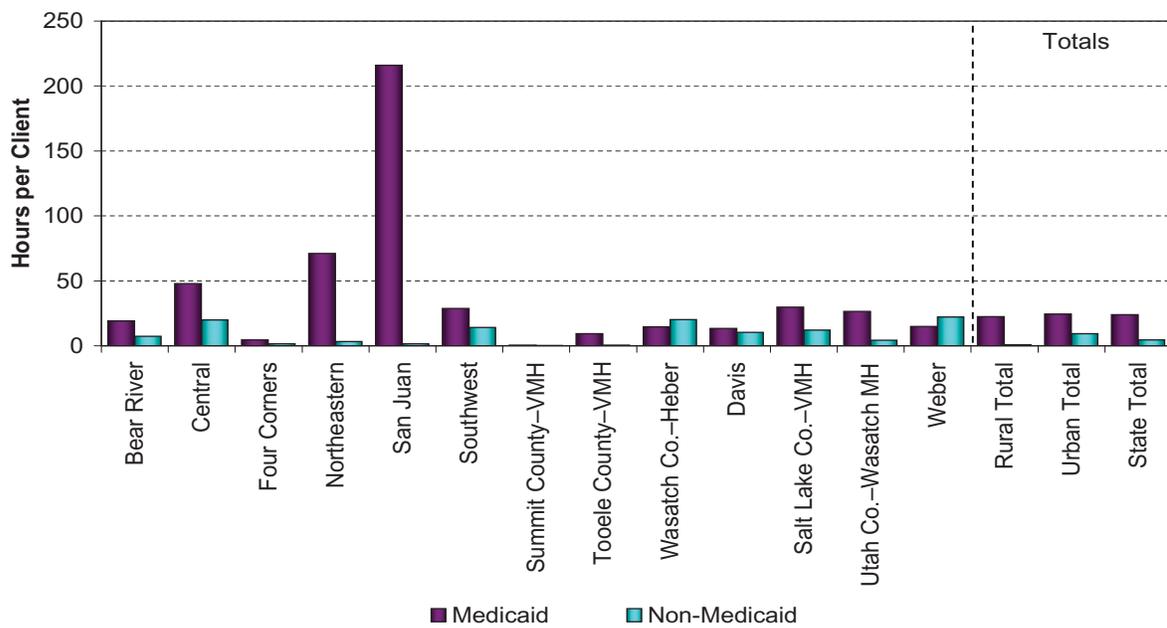
### Medication Management Median Length of Service Mental Health Clients Fiscal Year 2009



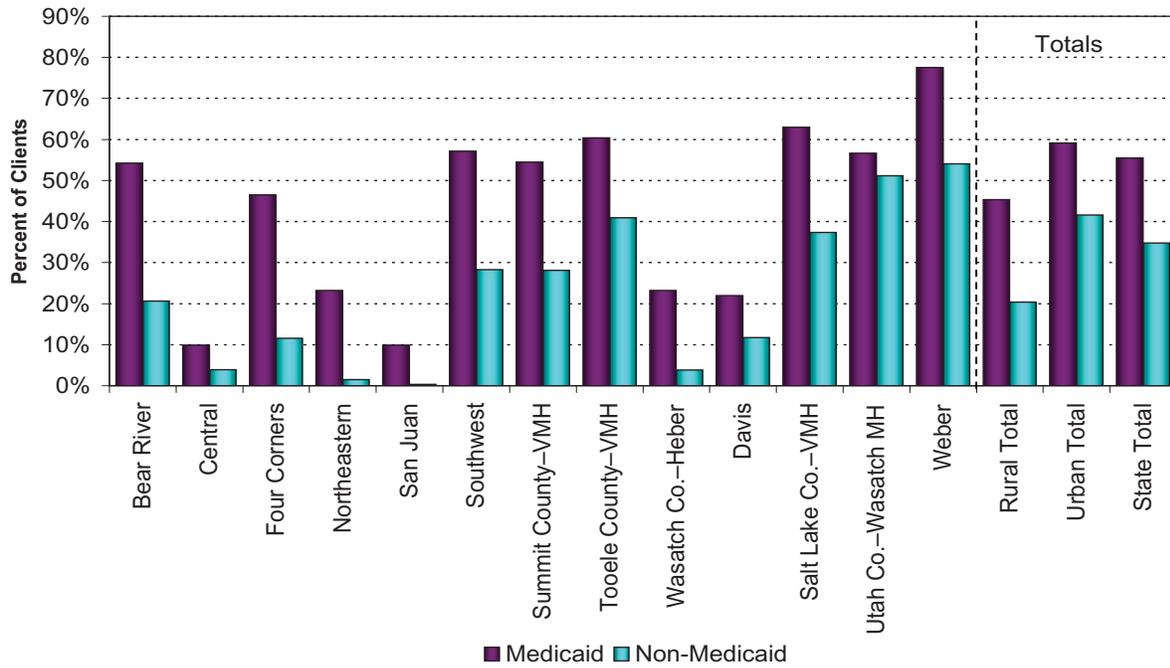
### Psychosocial Rehabilitation Utilization Mental Health Clients Fiscal Year 2009



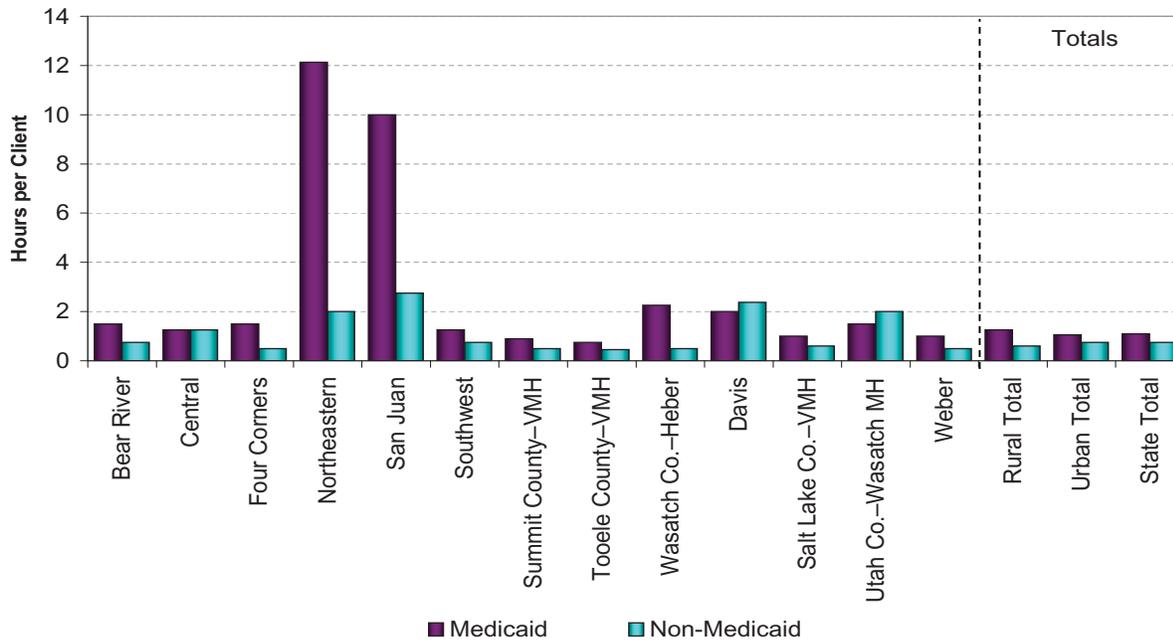
### Psychosocial Rehabilitation Median Length of Service Mental Health Clients Fiscal Year 2009



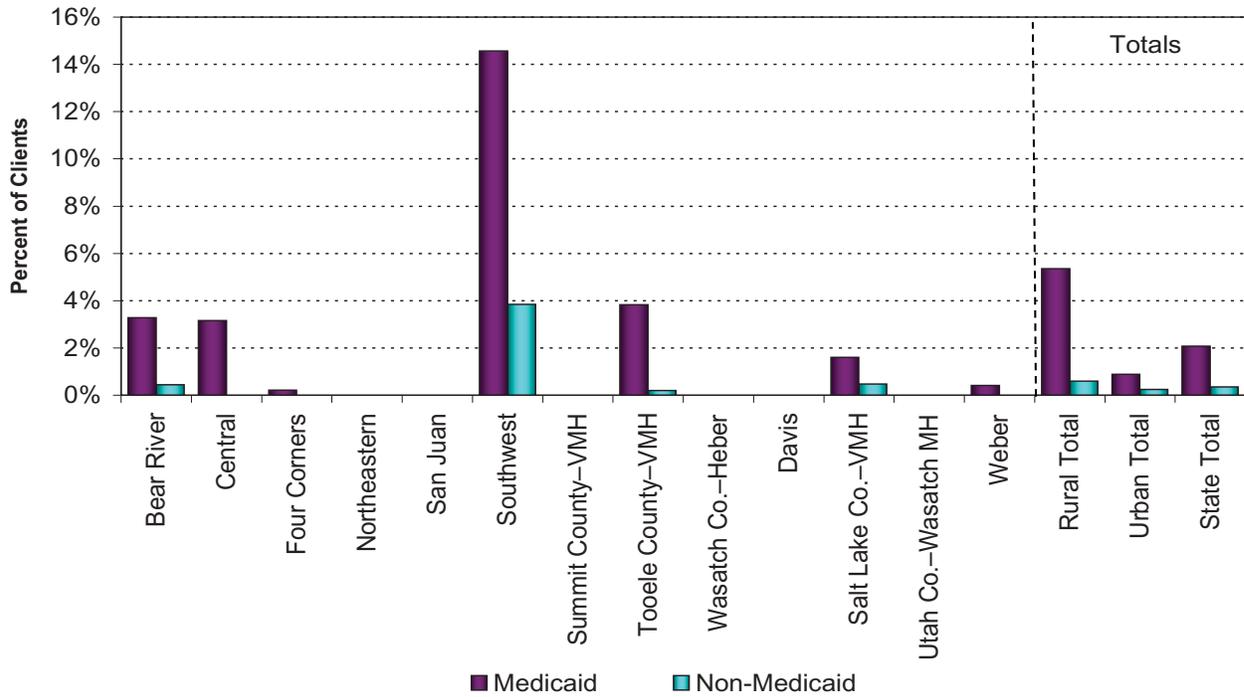
### Case Management Utilization Mental Health Clients Fiscal Year 2009



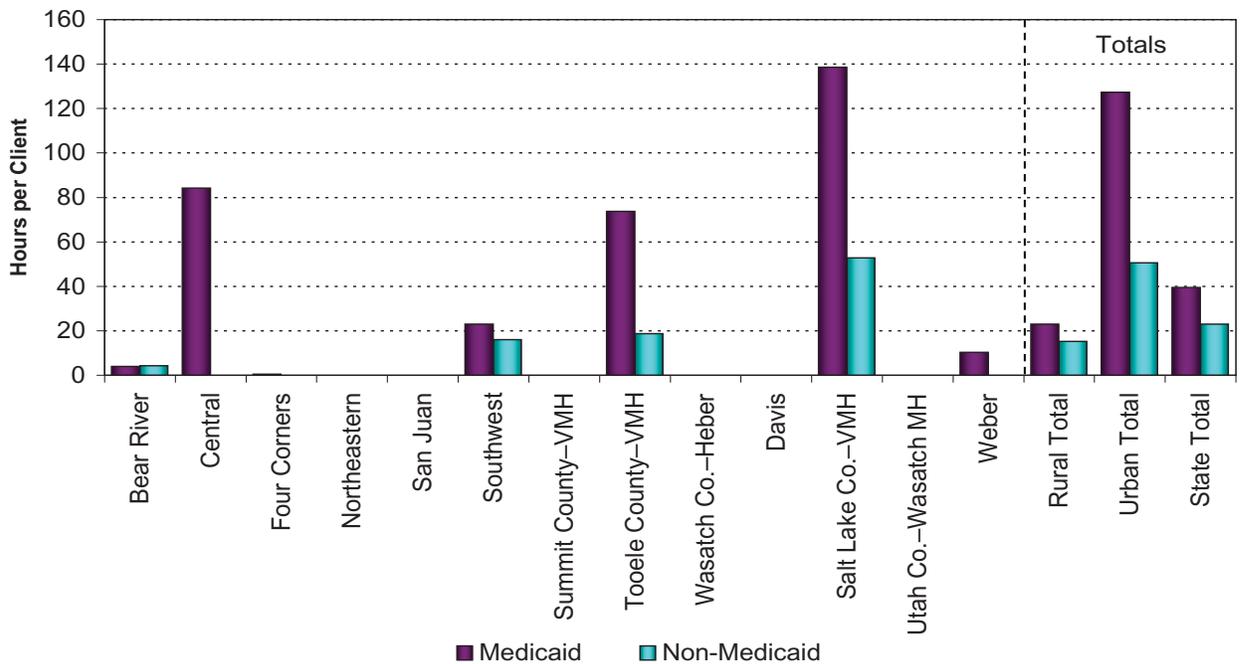
### Case Management Median Length of Service Mental Health Clients Fiscal Year 2009



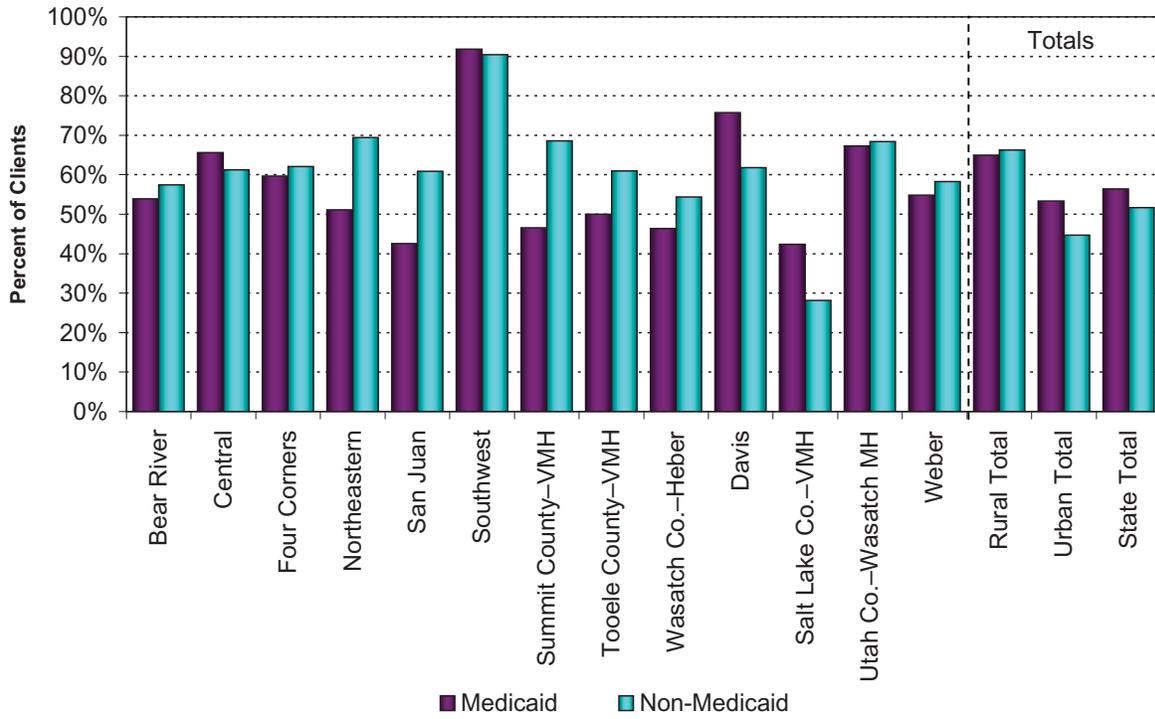
### Respite Utilization Mental Health Clients Fiscal Year 2009



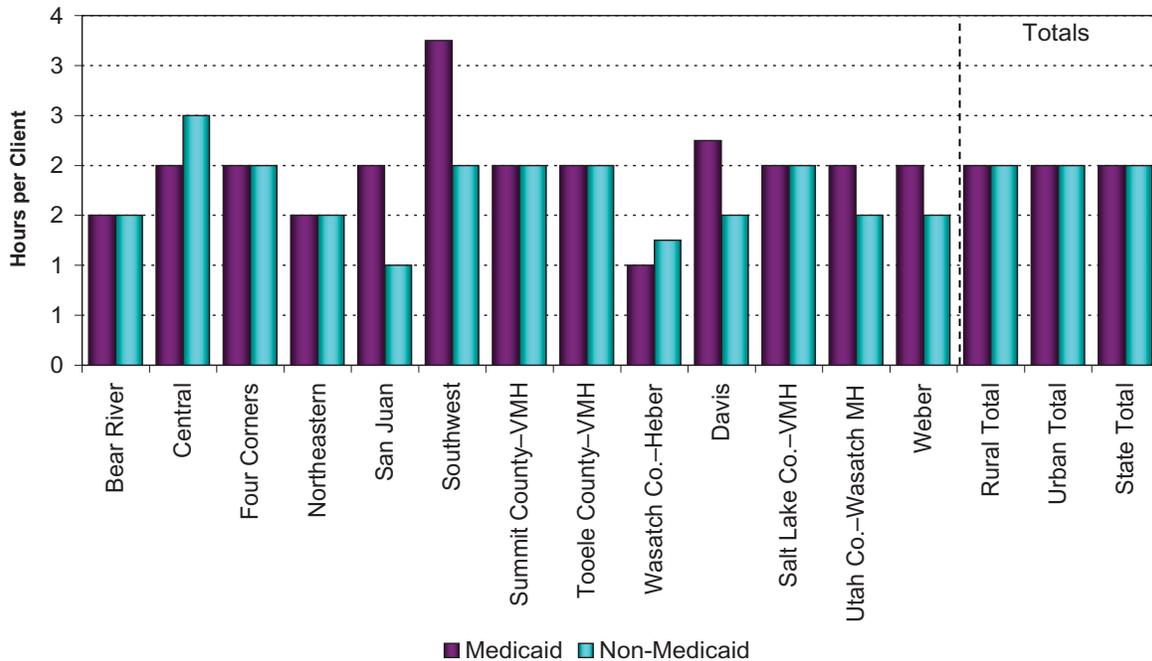
### Respite Median Length of Service Mental Health Clients Fiscal Year 2009



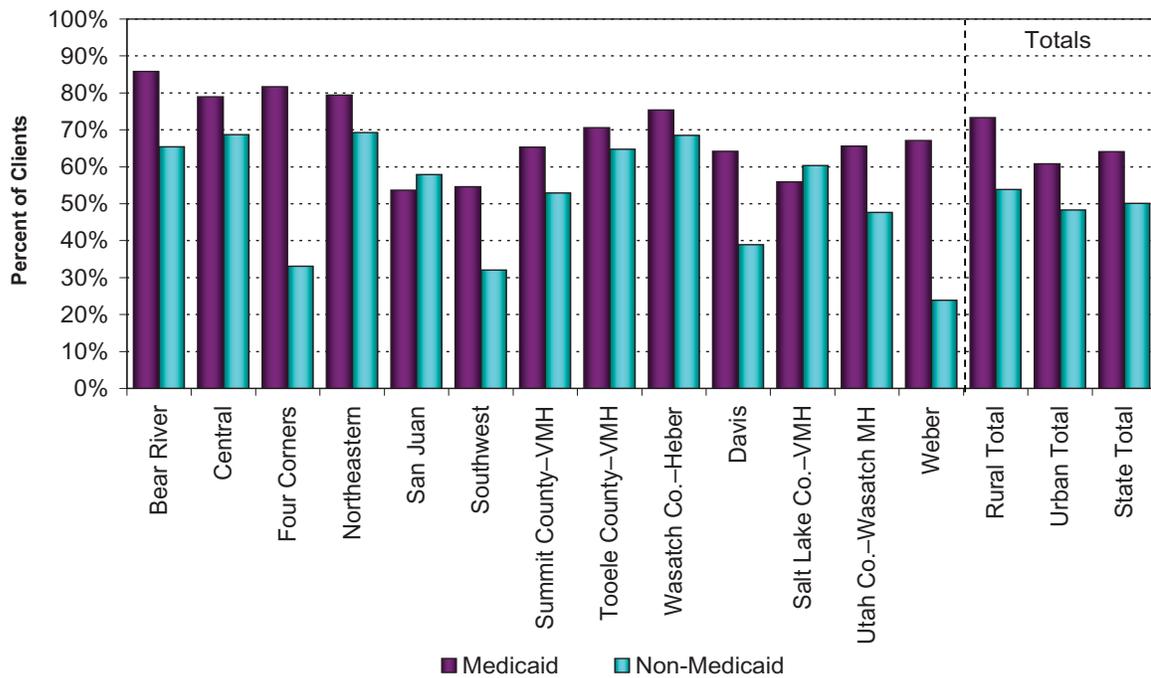
### Assessment/Evaluation Utilization Mental Health Clients Fiscal Year 2009



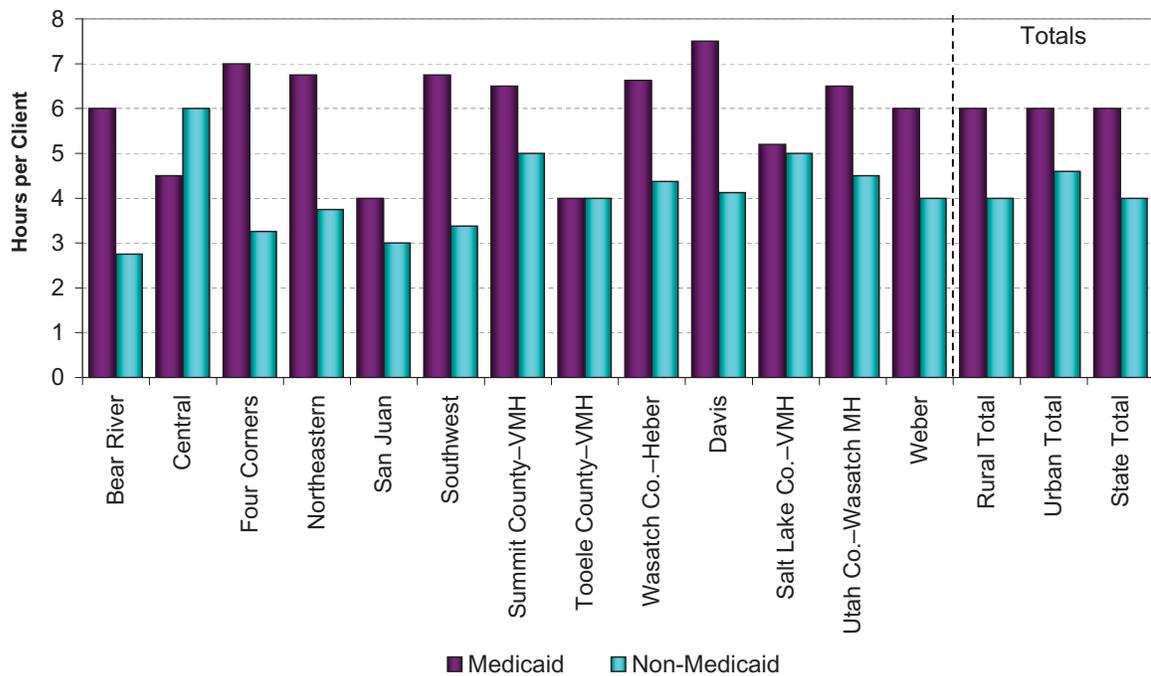
### Assessment/Evaluation Median Length of Service Mental Health Clients Fiscal Year 2009



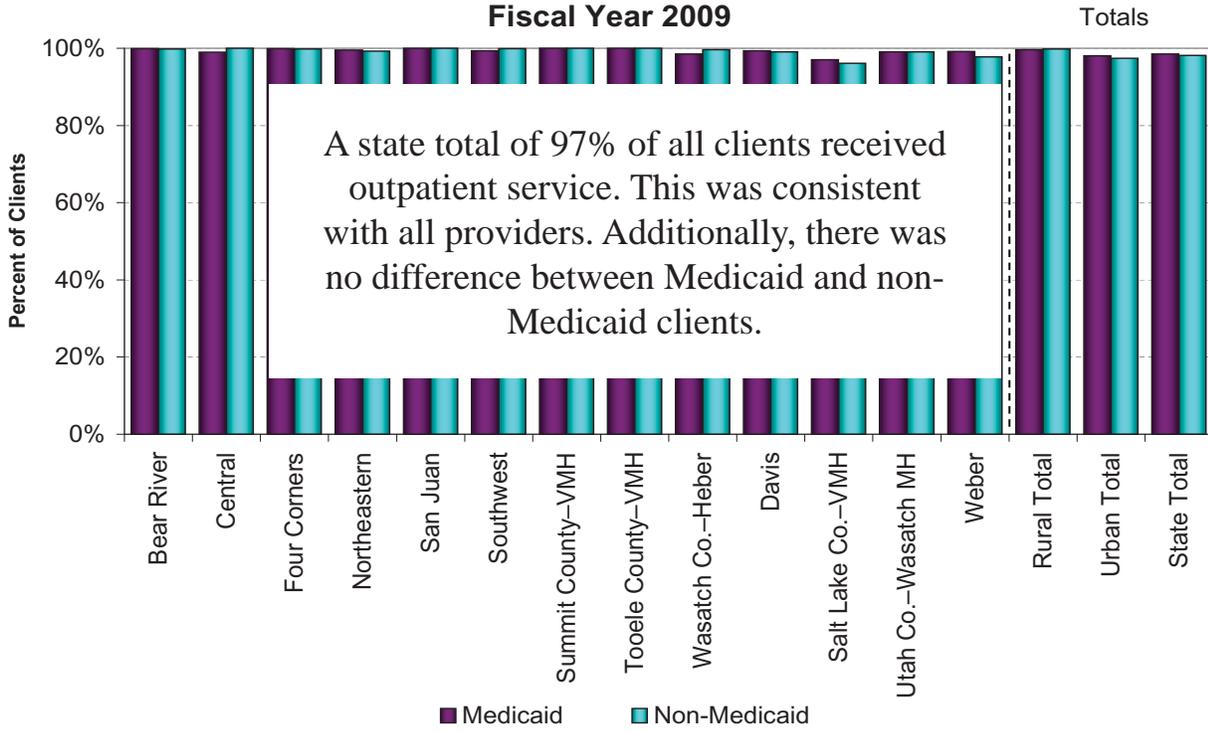
### Therapy Utilization Mental Health Clients Fiscal Year 2009



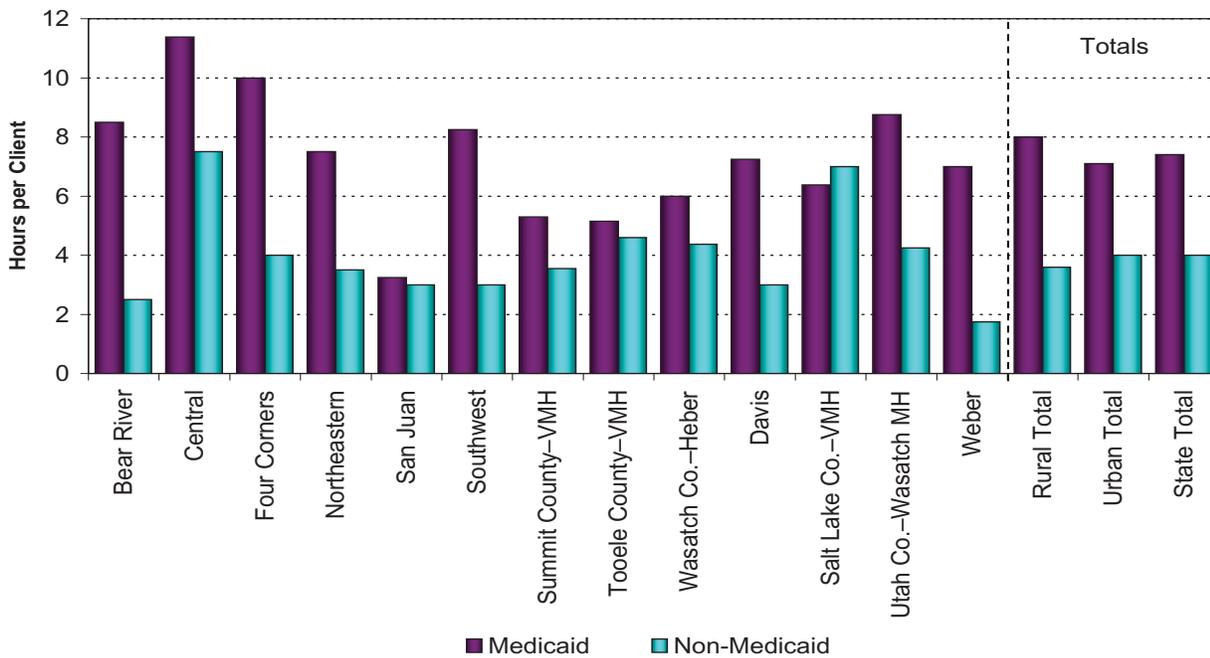
### Therapy Median Length of Service Mental Health Clients Fiscal Year 2009



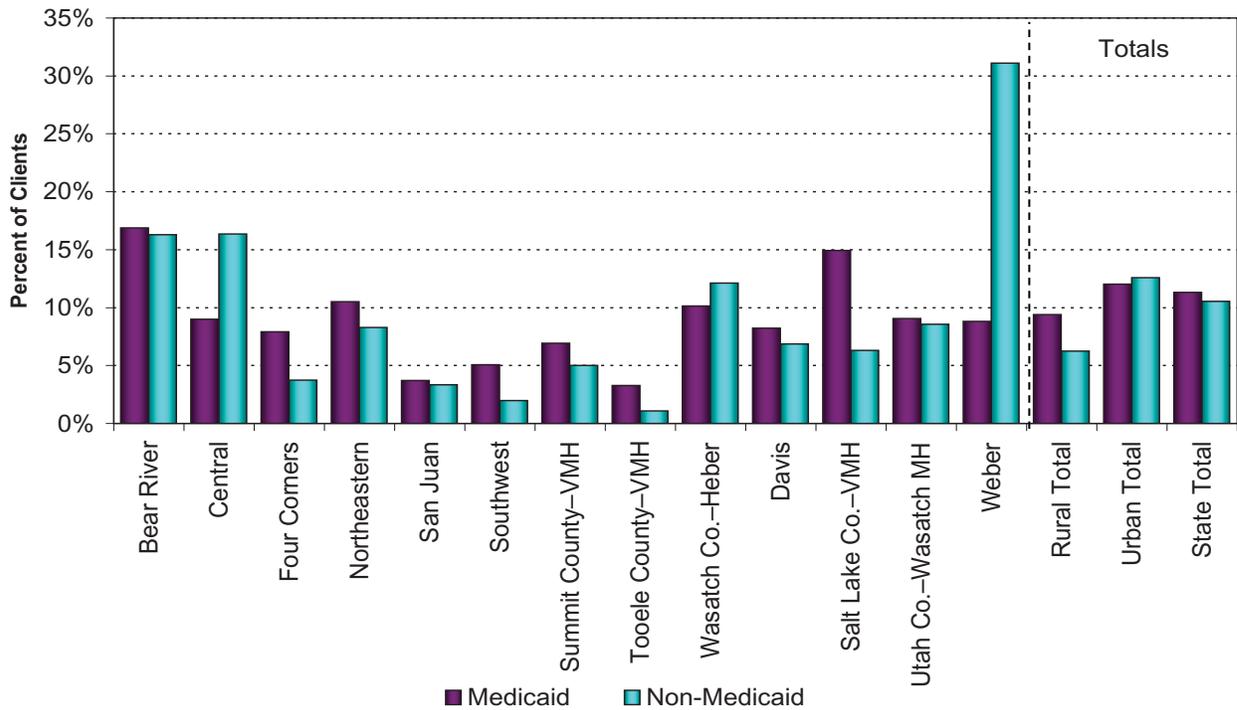
### Outpatient Utilization Mental Health Clients Fiscal Year 2009



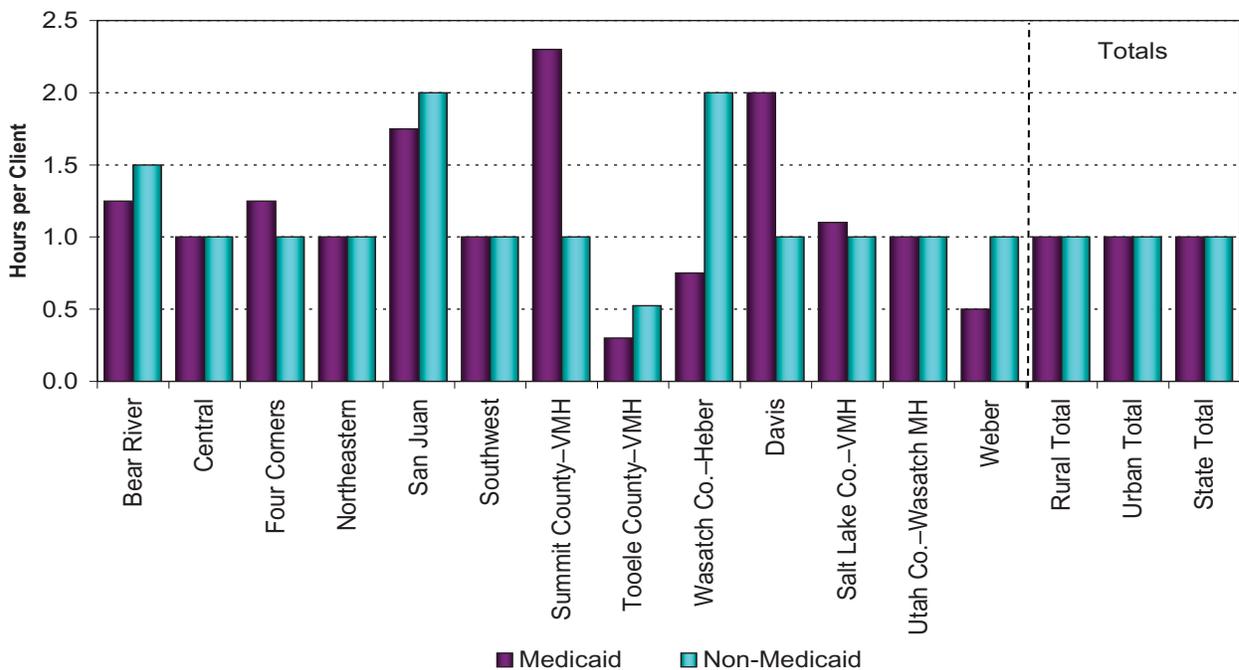
### Outpatient Median Length of Service Mental Health Clients Fiscal Year 2009



### Emergency Utilization Mental Health Clients Fiscal Year 2009



### Emergency Median Length of Service Mental Health Clients Fiscal Year 2009



*Client Quotes*

*“Since getting the help I needed for my mental health issues, I have been enjoying getting up in the morning and having a sense of purpose and not feeling like nothing matters outside of my bed. Every day with my daughter Mia is a treasure and a blessing. These days, our house has more play and laughter, rather than tears and silence. I’m happier and really looking forward to improving as well and following through with my goals towards my future. The things in my life seem less scary and more beautiful.”*

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## 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 (42 CFR 483.100-483.138). The PASRR program is required by Federal law and was enacted to insure that people with mental illnesses in Medicaid-funded nursing homes are being adequately diagnosed and treated; and to ensure that those with mental illnesses or developmental disabilities only (and no substantial physical problems), are not being warehoused in nursing homes; and to ensure 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, and provides an in-depth review of medical, social, and psychiatric history, as well as activities of daily living functioning. This comprehensive evaluation is funded by Medicaid, which is managed separately by DSAMH with no charge to the patient.

Over the past several years, in an effort to improve the efficiency and quality of PASRR evaluations,

DSAMH developed and implemented a HIPAA-compliant, web-based program that allows instant communication with nursing facilities and evaluators, greatly increasing the effectiveness of patient care. This instant link has sped up the communication process, getting results usually in less than two hours, rather than the old process that took several days.

In fiscal year 2009, DSAMH processed 2,004 PASRR evaluations in comparison to 1,830 in 2008. Last year Utah had fewer than 568 people with mental illness between the ages of 22 and 64 living in nursing homes, which is less than 11% of the total nursing home population.

According to the 2000 census, Utah has the sixth-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 along with the need for a higher level of medical services that require nursing facility placements. DSAMH’s ability to expedite the screening and evaluation process will take on greater value as the senior population increases, thus saving time and resources for the nursing facilities and, in the end, greatly benefiting Utah’s nursing facility patients.

## Olmstead (REDI System)

In July 1999, the Supreme Court issued the Olmstead v. L.C. decision. The Court's decision requires that all states have the ability to review and track the discharge status of clients in their mental health facilities and clearly challenges Federal, State, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective, community-based services.

DSAMH has received an Olmstead grant of \$20,000 for the past several years to serve clients with mental illnesses in the least restrictive setting possible. In response to the Olmstead grant, DSAMH has developed a HIPAA-compliant, web-based tracking system to document barriers and identify home and community-based services that are needed for clients discharged from Utah State Hospital (USH). The program has been named REDI (Readiness Evaluation and

Discharge Implementation). By identifying barriers and community needs, the REDI program is used to help prevent unnecessary institutional placements as well as help ensure that patients are not discharged to homelessness. The REDI program has proven successful in identifying and facilitating discharges for people who are ready for discharge. As demonstrated in fiscal year 2009, the REDI program was used to help facilitate discharges of 100 out of 159 adults with serious mental illness who were identified as having barriers to discharge.

DSAMH will continue to use this program as a monitoring tool toward ensuring that USH and the community mental health centers are actively working on a plan for people who are ready for discharge and who have barriers to discharge to live in the least restrictive environment.

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## Ten-Year Plan to End Chronic Homelessness

President Bush established a goal of ending chronic homelessness in 10 years and Utah's plan focusing on the chronically homeless was adopted March 2005. DSAMH is actively participating in working to help end chronic homelessness in Utah and alleviating the devastating impact that homelessness has on people with mental illness and substance abuse issues.

Utah's Vision Statement:

***“Every person will have access to safe, decent, affordable housing with the needed resources and support for self-sufficiency and well-being.”***

- People who are homeless are people first and have dreams.
- People with serious mental illness and/or co-occurring substance use disorders can and do recover.

- Homeless people should be given real choices in housing, treatment, and supportive services.
- Create hope—hopelessness breeds helplessness and despair.
- Be patient for change, but not results.

A survey and analysis of homelessness in Utah is conducted annually through the Utah State Department of Community and Culture. The most recent point-in-time homeless count was conducted January 2009 with the key results showing 15,525 homeless, which is an 8% increase from 2008 in the total homeless population. However, the 2009 total number of chronic homeless of 1,400 has decreased by 4.8% from last year's total chronic homeless count of 1,470.

Using a conservative figure of 25% of the total homeless population would indicate 3,881 home-

less people with mental illness statewide. Also, according to the January 2009 point-in-time count, 18.43% homeless individuals self-reported having a mental illness and 40% reported having substance abuse issues. The following chart shows the total homeless based on HUD-defined geographic areas of the state.

Chronic homelessness is the term used when an unaccompanied individual with a disabling condition has been homeless for a year or four times in three years.

Geographic Area	Total Homeless
Bear River Association of Government (BRAG) (Box Elder, Cache, and Rich Counties)	767
Carbon/Emery	410
Davis	645
Five County (Beaver, Garfield, Iron, Kane, and Washington Counties)	656
Grand	101
Mountainland (Summit, Wasatch, and Utah Counties)	447
Salt Lake	9,766
San Juan	109
Six County (Piute, Sevier, Juab, Wayne, Millard, and Sanpete Counties)	108
Tooele	86
Uintah Basin (Daggett, Duchesne, and Uintah Counties)	370
Weber (Weber and Morgan Counties)	2,060

Facts about chronic homeless:

- They are high consumers of homeless resources (at least 50% of homeless resources).
- They are high consumers of expensive community emergency services (emergency rooms, jails, etc.).
- 39% of chronic homeless live with mental illness.
- 30-35% of chronic homeless live with substance abuse disorders.

Utah has adopted the “Housing First” policy to first provide safe and affordable housing for an individual or family and then provide other services to them, including case management and support services. Utah has prepared a plan to end chronic homelessness by 2014, creating an environment to end—not manage—chronic homelessness, which includes improving access to mainstream resources, i.e., Social Security benefits, Medicaid, and food stamps. The plan also includes working to end chronic homelessness through effective discharge planning from public institutions and to increase the availability of affordable housing.

## Projects for Assistance in Transition from Homelessness (PATH)

The PATH program was created under the McKinney Act and is a formula grant program that funds the 50 states, District of Columbia, Puerto Rico, and four U.S. territories to support service delivery to individuals with serious mental illnesses, as well as individuals with co-occurring substance use disorders, who are homeless or at imminent risk of becoming homeless. The program is authorized under Section 521 et seq. of the Public Health Service and is administered by the Center for Mental Health Services,

a component of SAMHSA, within the U.S. Department of Health and Human Services. It is administered locally by DSAMH.

DSAMH currently receives \$482,000 in Federal PATH grant funds to deliver essential services, leverage significant State and local resources, and marshal a creative network of human service organizations to improve the mental health and well-being of this vulnerable population. The State of Utah uses PATH funds to provide outreach services to contact and engage people

who have not sought services and are the only dollars available for outreach services within the mental health system. PATH workers can often be found in alleyways, homeless camps, parks and emergency rooms, coordinating services

with law enforcement, health and other allied agencies.

It is estimated that PATH-funded services reached 1,150 individuals in fiscal year 2009, up from 971 in 2008.

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

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

Fiscal year 2009 is the fifth and final year of the project with a two-fold focus to: 1) continue with the implementation of the strategic plans, and 2) develop strategies to sustain and expand the infrastructure transformation activities. Some key activities included:

**My Portfolio.** 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 the 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 in developing 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.

**Sunrise to Sunset: Health and Wellness across the Lifespan.** The second annual conference for American Indian participants and staff of agencies serving American Indian clients was held August 12-13 in Cedar City with over 100 in attendance. Sessions focused on issues of particular concern to the American Indian population, such as obesity, diabetes, suicide, tribal substance abuse policies, pride in heritage as protection against adolescent problem behaviors, cancer, and tobacco.

**Youth Action Council.** Fifteen young people with mental health and/or substance abuse disorders participated in the Youth Action Council which met monthly. The Youth Action Council conducted a service project at the Homeless Youth Resource Center, and organized an exhibit at the Salt Lake Main Library highlighting the resiliency of young people with mental illness.

**California Brief Multicultural Competence Scale (CBMCS).** Four community mental health/substance abuse centers had staff members trained as local trainers on CBMCS, a research-based cultural competency training curriculum. The centers are Valley Mental Health, Weber Human Services, Central Utah Counseling Center, and Four Corners Community Behavioral Health Center. These local trainers will provide CBMCS training to staff at their centers.



I am looking forward to the future and what's in store for me!

When I was young I experienced some bad things in my life. I was in many foster homes, went to a residential facility, and later was adopted by a family.

I got into shoplifting and had a hard time in junior high and high school. My wonderful Grandma has always looked after me through my illness and hard times. I feel like she's the main reason I am alive today.

I got help from a mental health provider. I now live on my own in an apartment. I received a certificate in customer service training with a B average from a local college. I am so grateful to God. I have made so many friends and go to a great church. I have learned it is okay to be me. If I can overcome my illness, then so can others. It's not hopeless to live with an illness. I hope my life can be an inspiration to others. The message I want to send to others is . . . don't give up.

I am very happy. I have overcome the challenges in my life which has brought me to where I am today. I am a survivor. I admit I wanted to die several times. I even thought about how to die. Today, I am looking forward to the future and what's in store for me. My future looks bright. I have received help from so many people. I still have struggles but who doesn't?

There is a song that is my favorite by Francesca Battistelli called, "Free to Be Me". The words in the song say, "I've got a couple dents in my fender, I've gotta couple rips in my jeans...try to fit the pieces together." I can relate to those words. I feel there is hope and people can survive with a mental illness. There is hope even though it is hard. My journey has been good, bad, and pretty ugly; but I have pulled through. I guess you could say I am a survivor. Life has hit me with its best shot and damn it, I'm still here!

—Grace, Member of the DSAMH-sponsored Youth Action Council

**Consultation to Paiute Indian Tribe and Northwestern Band of Shoshone.** Holly Echo-Hawk, a nationally recognized consultant, provided technical consultation to the two American Indian tribes to increase their capacity to deliver quality, community-based children's mental health services.

**School- and College-Based Mental Health and Substance Abuse Services.** UTCAN 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. One method to sustain and expand the

current initiative is to develop an implementation manual and to organize a statewide Technical Assistance Team for School Behavioral Health. The TA Team will be comprised of members from the Utah State Office of Education, DSAMH, and local authority providers. They will assist new sites in implementing school-based behavioral health services following the process and protocol outlined in the implementation manual.

The preliminary evaluation results indicate that the school-based behavioral health services are effective. Outcomes included reduction in clinical symptoms, decreased stigma, decreased absences/tardies, improved grades, and fewer office disciplinary referrals.

Although the five-year UT CAN grant formally ended on September 30, 2009, most of the innovative pilot projects begun under its auspices have demonstrated effectiveness, and will be sustained by other funding such as State general funds, Mental Health Block Grant, and other local and State funding.

## Case Management

Case management is a mandated service in Utah, and all community mental health centers are responsible to provide case management in their local areas. Case management is one of the preferred methods of helping persons with mental illness live in the community, and it continues to be a central highlight of community mental health work in Utah.

Case management provides many critical functions, including 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 personal services and skill development services, as well as psychosocial rehab groups under the supervision of licensed mental health workers.



I was diagnosed with pervasive developmental disorder—experiencing anxiety and depression—at age 8. I was bullied and teased especially in elementary school. People judged me unfairly and treated me as if I couldn't do anything. But it's just an illness. You take medicine for it and you can be healed from the illness. By high school I gained more self-confidence. I'm not less of a person because I'm taking medicine for my illness. I want to make sure others with mental illnesses know that they can keep pushing forward, keep proving people wrong who judge them, and they shouldn't listen to anyone who puts them down. I'm learning to deal with stress and I've been able to accomplish many of my goals with the help of the "Reconnect" program at Valley Mental Health. I graduated from high school last year, I have a job in real estate and am interning at an investment company, and I'm preparing to serve a two-year mission for my church.

—Matthew, Member of the DSAMH-sponsored Youth Action Council

## 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.

## Counseling for Veterans and Their Families

Even though only 6% of Utahns are veterans, there are still approximately 161,000 veterans in Utah. When these men and women are in need of services, the State has an obligation to provide for them. The Utah Department of Veterans Affairs is the state agency that assists former and present members of the U.S. Armed Forces and their dependents in preparing claims for and securing compensation, hospitalization, education and vocational training, and other benefits or privileges to which they may be entitled under federal or state law or regulation by reason of their service in the military.

In 2007, the Utah Legislature appropriated \$270,000 to supplement currently available funds for the counseling needs of families of soldiers returning from Afghanistan or Iraq. In 2008, an additional \$100,000 was appropriated and the funds have been used to establish the Prevention

and Relationship Enhancement Program (PREP). The funds have been used to create a DVD about resources that are available to all returning veterans and their families. Additional services funded by PREP include:

- ♦ Reintegration training for community leaders, mental health providers, veterans and their families
- ♦ Training for mental health professionals on combat-specific mental health issues and challenges
- ♦ Advertising on billboards and TV spots about the availability of services

DSAMH serves on the Veterans and Family Counseling Committee to coordinate services across the state. The local community mental health centers provide services to veterans and their families upon request.

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### Client Quotes

*"I had dealt with alcoholism for several years before I finally got into treatment. After that hurdle, I was diagnosed as bipolar, and my wife and I were devastated. I started seeing a private doctor and was spending what seemed like a fortune. Eventually my cousin told me I could get the same services through the Veterans Administration and I started going there immediately. I found a wonderful psychiatrist and therapist there. They are more sensitive to my needs as a veteran than my other doctor had been. Also, I was amazed to find out all the services that are offered to veterans."*

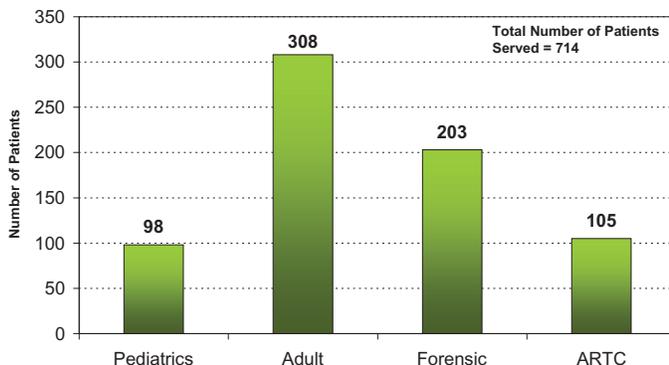
## Utah State Hospital

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 five-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

**Number of Patients Served**  
Fiscal Year 2009



- Acute treatment service for adult patients from rural centers (ARTC)

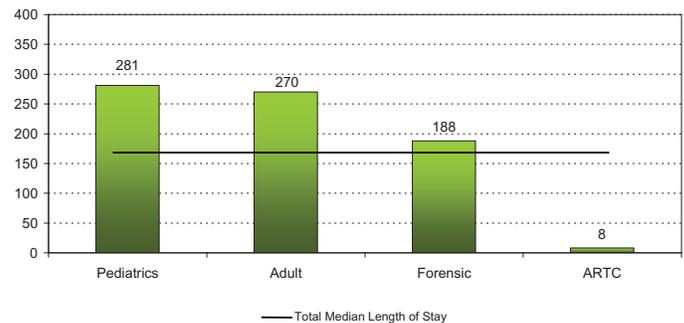
### Programs

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

### Length of Stay

The median length of stay at the USH is 166 days. The median discharged length of stay for adult patients with civil commitment is 270 days.

**Median Length of Stay in Days**  
Fiscal Year 2009



### Types of Disorders Treated

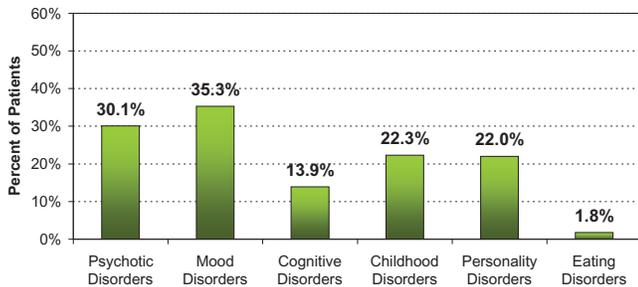
- Psychotic Disorders: schizophrenia, schizoaffective disorder, other psychotic disorders, and delusional disorders
- Mood Disorders: major depression, anxiety disorders, bipolar disorder, and dysthymia
- Childhood Disorders: developmental disorders, autism, attention deficit disorder, conduct disorder, 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 also had a substance abuse diagnosis.

**Percent of Patients with Major Psychiatric Diagnosis\***  
Fiscal Year 2009



\*Patients can have more than one diagnosis

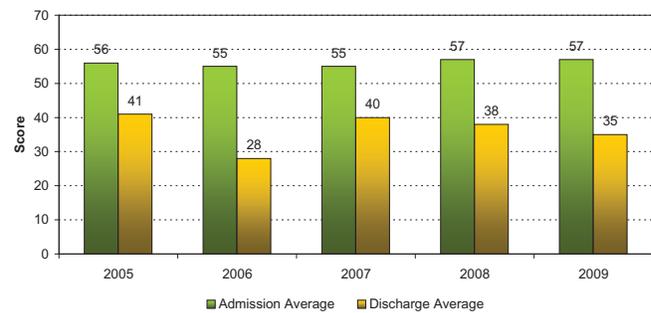
### Services Provided

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.

### 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 fiscal year 2009. Lower scores indicate a reduction of symptoms.

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

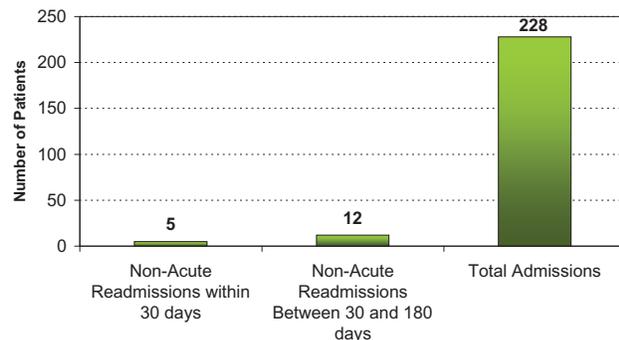


### Readmission

The USH admitted a total of 395 patients in fiscal year 2009. Of these admissions, 5 were non-acute readmissions within 30 days and 12 non-acute readmissions within 180 days.

The readmissions within 30 days are 1.26% of the total discharges in fiscal year 2009.

**Readmissions at the Utah State Hospital**  
Fiscal Year 2009





[Jon is a member of the DSAMH-sponsored Youth Action Council]

My name is Jon. I do not really know the ways my mental illness has affected me because I feel the same as everyone else.



I was in first grade when I found about my mental illness. My mom and dad explained it to me. I didn't really understand until a long time later.



I enjoy watching TV, my favorite show is "Survivor." I really like playing video games and playing basketball with my friends. I like to go running, biking, and like reading.

Having a mental illness does not make you stupid. I am easy to get along with and I am truthful about myself. I can make friends easily. My family gives the most support to me.

In my book bag, I have a paper listing the names of celebrities that have a mental illness. I got the list from school where we were learning about mental illnesses. Our teacher gave us each a packet. There were kids who were surprised at some of the names listed on the sheet.



\* Artwork created by Jon

I like being with other people who have the same problems as I do. I hear what has helped them to get on with their life. My favorite thing is finding ways to change weaknesses into strengths. A lot of famous people have done that and have been successful.

### MY FAVORITES

- WWE Wrestling
- Riding my bike
- Playing basketball
- Playing with my dog



# Treatment Outcomes and Consumer Satisfaction

# Treatment Outcomes

## Substance Abuse

DSAMH collected final discharge data on over 10,910 non-detox clients in fiscal year 2009. 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

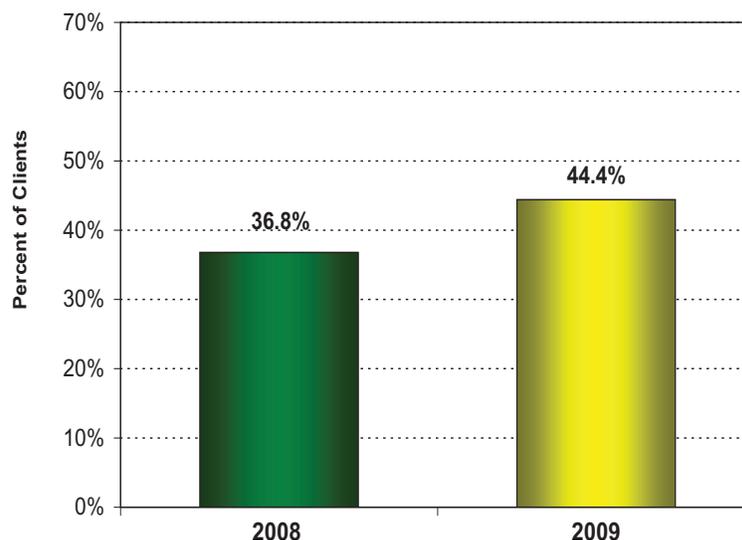
non-compliance). Clients who were discharged as a result of a transfer to another level of care are considered “successful.” The data does not include clients who were admitted only for detoxification services or who were receiving treatment from non-LSAA statewide providers. For all outcomes but treatment 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 year 2009 who successfully completed the entire treatment episode. Previous years showed the percentage who had completed each level of treatment, but in 2008

and 2009 DSAMH began measuring and reporting the percentage of people who had completed their entire treatment episode. As noted, there is a 20.6% increase in the percentages from 2008 to 2009.

**Percent of Clients Successfully  
Completing Treatment Episode**  
Fiscal Years 2008 - 2009

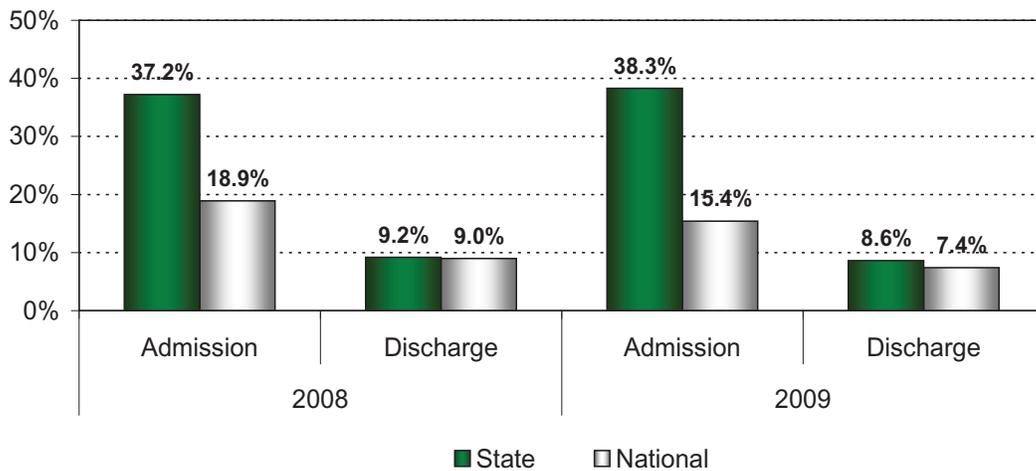


## Criminal Activity

Approximately 76% of clients who enter into the State’s treatment system are involved with the Criminal Justice System. Because of the relation between substance use and criminal justice involvement, reduction of criminal activity is an important goal for treatment and a good predictor of a client’s long-term success. It is therefore a solid measurement of treatment effectiveness.

Treatment in Utah continues to result in significant decreases in criminal activity and criminal justice involvement. In 2008 and 2009, Utah had higher criminal rates at admission than the national average, but the rates of criminal activity at discharge compare favorably to the national norm.

**Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment  
Fiscal Years 2008 - 2009**



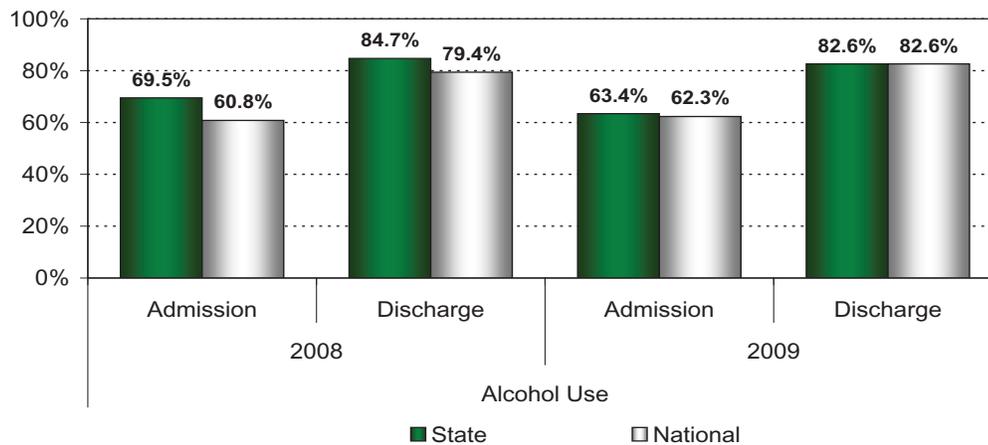
## Changes in Abstinence from Drug and Alcohol Use During Treatment

The following charts provide information about the changes in abstinence in alcohol and drug use patterns at admission and discharge. This data includes abstinence levels for clients in all treatment levels except detoxification. Substance use patterns are evaluated 30 days prior to the client entering a controlled environment, such as treat-

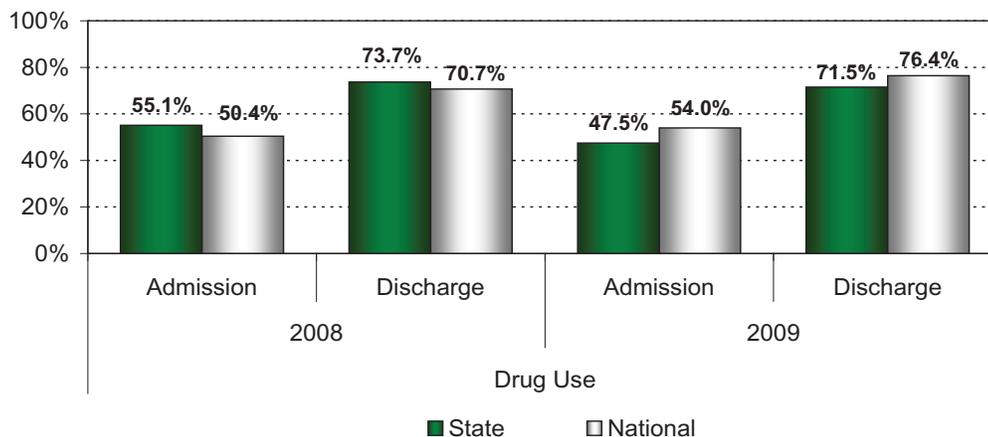
ment or jail, and again in the 30 days prior to their discharge.

As expected, the rate of abstinence increases during treatment. Utah's rates of abstinence from alcohol and drug use at admission and at discharge in 2009 are comparable to the national rates.

**Percent of Clients Reporting Abstinence from Alcohol Use Prior to Admission vs. Abstinence at Discharge  
Fiscal Years 2008 - 2009**



**Percent of Clients Reporting Abstinence from Drug Use Prior to Admission vs. Abstinence at Discharge  
Fiscal Years 2008 - 2009**



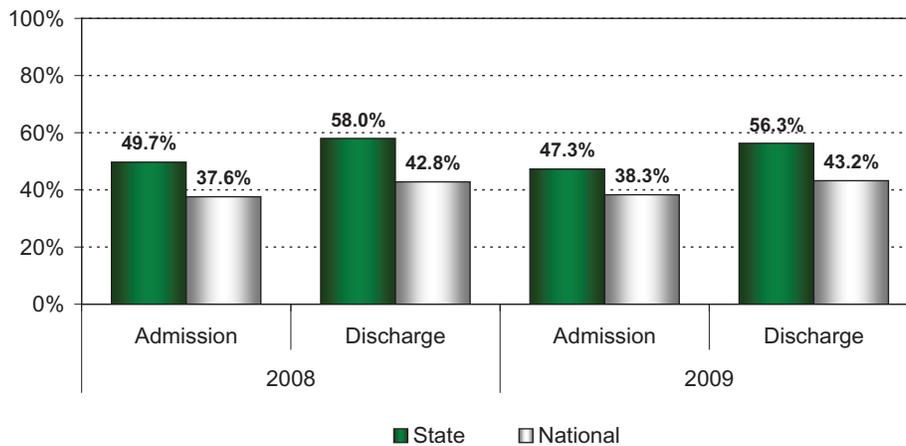
## Employment and Stable Housing

### Employment

Outcome 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

have higher rates of employment both at admission and at discharge in comparison to the rest of the nation. This is a significant area of improvement since 2005 when Utah trailed the national averages in those categories.

**Percent of Clients Who Are Employed**  
Fiscal Years 2008 - 2009

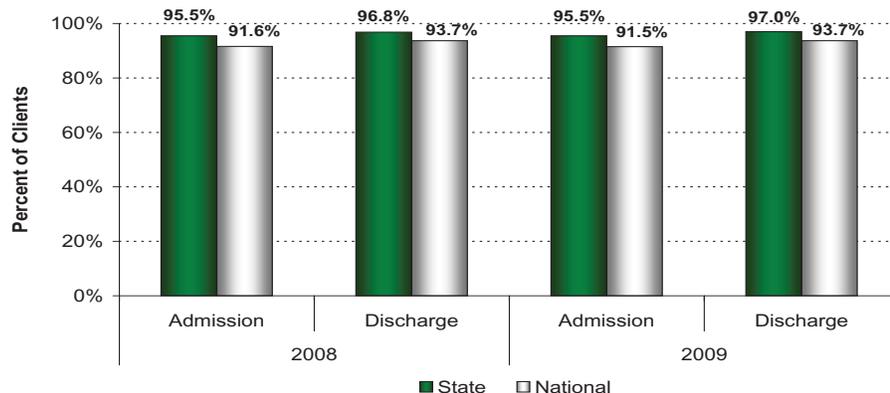


### Clients in Stable Housing

As shown in this chart, 95.5% of clients entering Utah’s public substance abuse treatment in 2008 and 2009 were in stable housing at the time of their admission to treatment. At discharge, 96.8% in 2008 and 97% in 2009 were in stable housing. Utah’s rate continues to be slightly above the national average. Stable housing is an important measure of successful treatment, as outcome studies have revealed that a stable living environment is a critical element in achieving long-term success in the reduction of substance abuse. At the same time, research has demonstrated that treatment is an important factor in helping the substance-abusing popu-

lation maintain more stable living environments. More and more treatment facilities are finding ways to deal with both issues simultaneously by providing increased transitional housing and post-treatment services.

**Percent of Clients in Stable Housing**  
Admission vs. Discharge  
Fiscal Years 2008 - 2009



## Mental Health

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

The behavioral health sciences have only recently been able to quantifiably measure the effectiveness of treatment. The Utah Public Mental Health system uses the Outcome Questionnaire (OQ) and Youth Outcome Questionnaire (YOQ), both scientifically valid instruments, to measure changes in people. These instruments have been

compared to measuring the vital signs of a person's mental health status. In fiscal year 2009, approximately 85% of people who received mental health services and participated in the OQ/YOQ program either stabilized or improved from the distress that brought them into services. More than 22% of the people were considered in recovery and functioning in a normal range.

There were 35% of the clients participating in the outcome survey for fiscal year 2009 which we consider a good response. We want to increase this participation to at least 50% of the clients to further validate the results.

### Statewide OQ Client Outcomes Report for Fiscal Year 2009

Provider	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River Mental Health	52%	20.56%	64.42%
Central Utah Counseling Center	58%	16.95%	66.95%
Davis Behavioral Health	16%	14.46%	69.48%
Four Corners CBH	34%	24.34%	62.55%
Northeastern Counseling Center	44%	23.91%	64.23%
Salt Lake County—VMH	29%	22.20%	61.78%
San Juan Counseling	20%	20.19%	67.31%
Southwest Behavioral Health	33%	23.48%	63.66%
Summit—VMH	1%	*	*
Tooele—VMH	3%	*	*
Utah Co.—Wasatch Mental Health	55%	24.10%	60.07%
Wasatch Co.—Heber Valley Counseling	1%	*	*
Weber Human Services	42%	24.39%	60.24%
<b>Statewide Totals</b>	<b>35%</b>	<b>22.58%</b>	<b>62.10%</b>

\*Outcome data for providers with less than 5% participating are not listed.

### Youth OQ Client Outcomes Report for Fiscal Year 2009

Provider	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River Mental Health	56%	23.96%	61.98%
Central Utah Counseling Center	46%	21.24%	62.18%
Davis Behavioral Health	14%	14.56%	65.82%
Four Corners CBH	36%	32.73%	58.18%
Northeastern Counseling Center	45%	24.75%	65.84%
Salt Lake County—VMH	34%	25.06%	58.45%
San Juan Counseling	15%	13.79%	68.97%
Southwest Behavioral Health	36%	26.85%	61.39%
Summit—VMH	1%	*	*
Tooele—VMH	5%	*	*
Utah Co.—Wasatch Mental Health	47%	38.10%	38.10%
Wasatch Co.—Heber Valley Counseling	2%	*	*
Weber Human Services	49%	27.37%	58.25%
<b>Statewide Youth Totals</b>	<b>38%</b>	<b>26.92%</b>	<b>58.40%</b>

### Statewide OQ Client Outcomes Report for Fiscal Year 2009

Provider	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River Mental Health	52%	20.56%	64.42%
Central Utah Counseling Center	58%	16.95%	66.95%
Davis Behavioral Health	16%	14.46%	69.48%
Four Corners CBH	34%	24.34%	62.55%
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Wasatch Co.—Heber Valley Counseling	1%	*	*
Weber Human Services	42%	24.39%	60.24%
<b>Statewide Totals</b>	<b>35%</b>	<b>22.58%</b>	<b>62.10%</b>

\*Outcome data for providers with less than 5% participating are not listed.

# Consumer Satisfaction

## Background

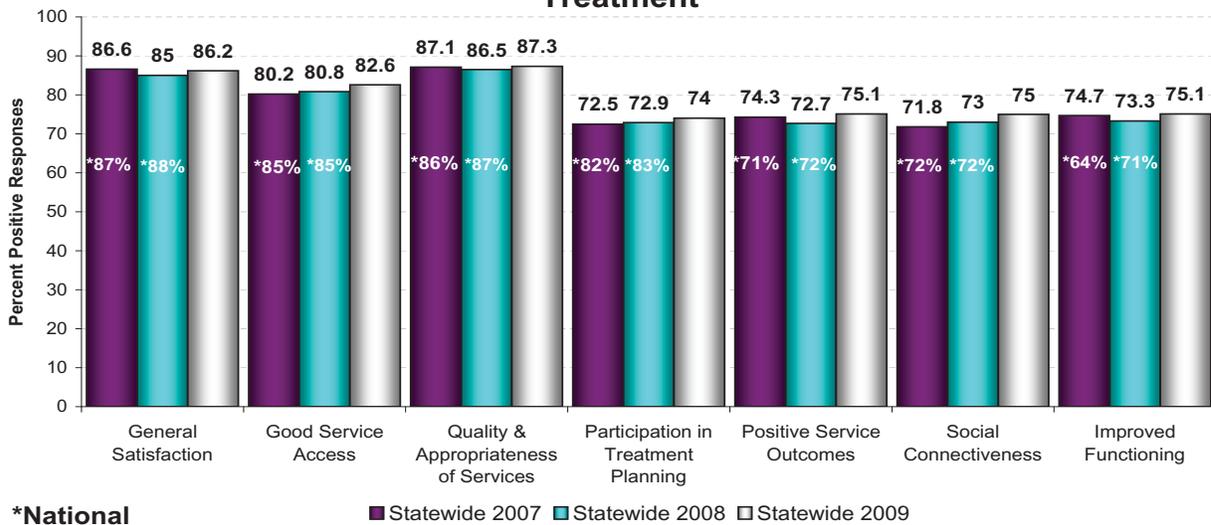
In 2004, DSAMH and Federal funding grants began to require that all providers conduct an annual survey on consumer satisfaction and treatment outcomes. DSAMH requires that the survey is administered to consumers of both substance abuse and mental health services, and that providers comply with administration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

and minimum sample rates. Below are the results of this survey for 2009.

For more information or a copy of the 2009 Consumer Satisfaction Survey Report go to [http://www.dsamh.utah.gov/consumer\\_satisfaction.html](http://www.dsamh.utah.gov/consumer_satisfaction.html).

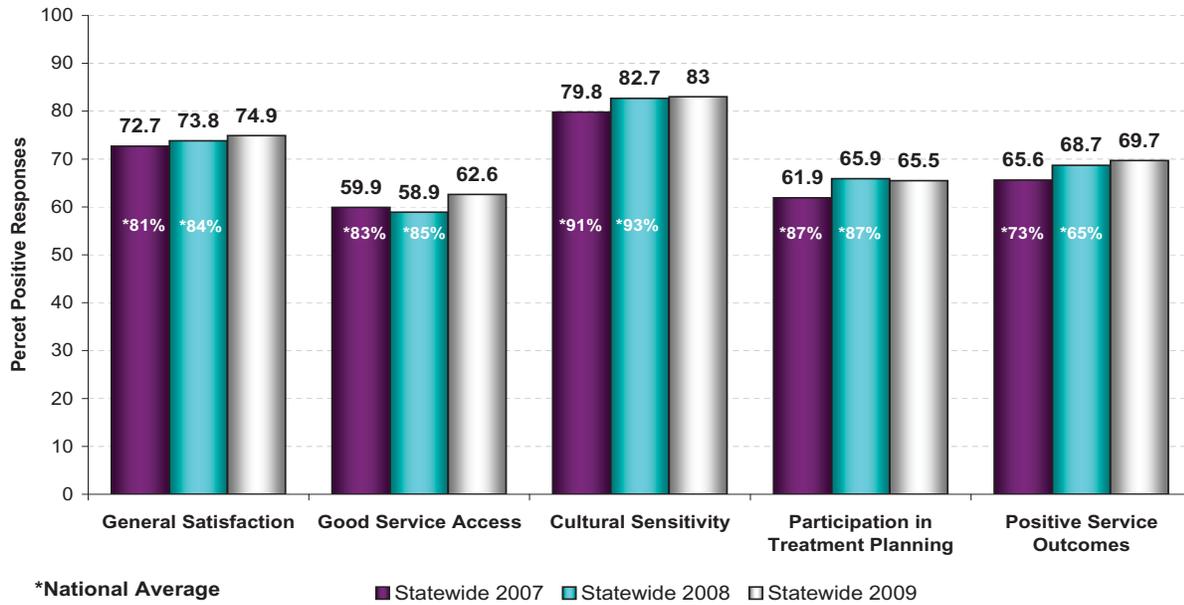
## Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)

Completed by Adults in Substance Abuse and Mental Health Treatment



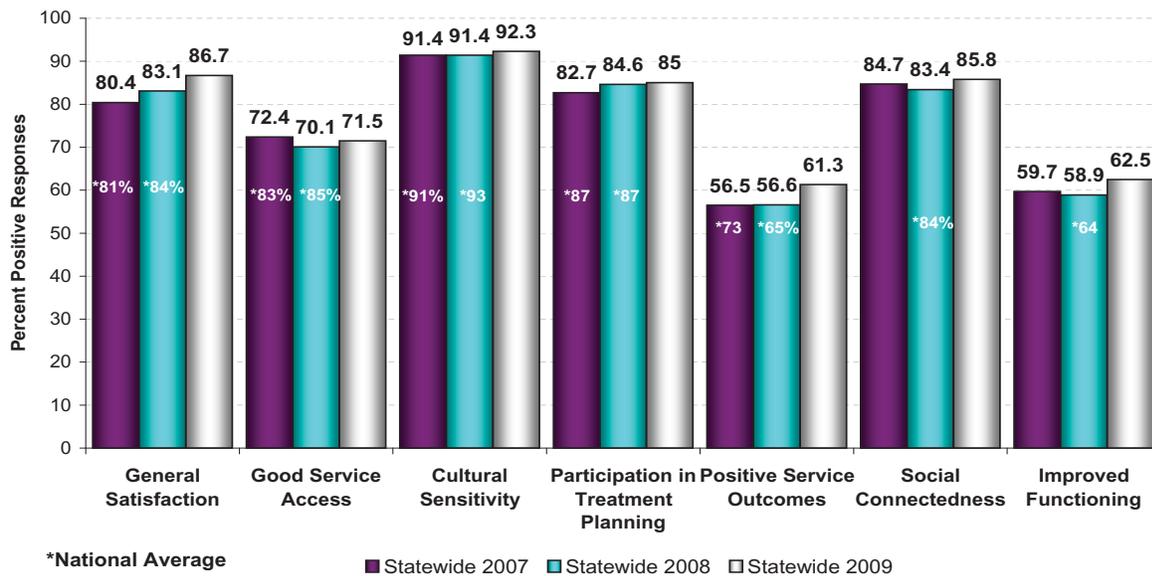
### Youth Consumer Satisfaction Survey Youth Services Survey (YSS)

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



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

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





When I was 8 years old, I was diagnosed with a bipolar disorder which has been tough for me to deal with. The mood swings are really hard. There are people who judge me even before they know me. My illness doesn't mean I'm a bad person. Some people tell me I do the things I do to get attention.



People considered me “crazy” because I have been hospitalized several times in my life. If I could change I would. Some of my friend's parents wouldn't let them play with me when I was growing up. I have had break ups with guys because their parents didn't approve of me. I hope one day people will just see me. When I take my medicines, I'm as normal as anyone else. I wonder how others would feel if:

- Their loved ones were being discriminated against?
- Could they even last a day in my shoes?
- How would they deal with being happy one minute and then depressed and irritable the next?
- How would they feel if they knew there is no cure for their illness?
- How would they feel if they had to take medicine for the rest of their life?
- How would they feel if people labeled them as “crazy,” “dangerous,” or even as an “attention seeker?”
- How would they feel if people talked about them in ways that made them wish they weren't here on this earth?

I want the stigma against people with mental illnesses to stop. If anyone took the time to actually get to know us, I think they would see we're not any of the stuff they seem to think we are. We are just a little different; but honestly.... if everyone in the world was the same, this place would be boring wouldn't it? Please think about how you make people with mental illness feel when you call them “crazy” or judge them.



### MY FAVORITES

- E-mailing my friends
- Dancing
- Singing
- Drawing
- Cooking



*[Anna is a member of the DSAMH-sponsored Youth Action Council]*

Who We Serve

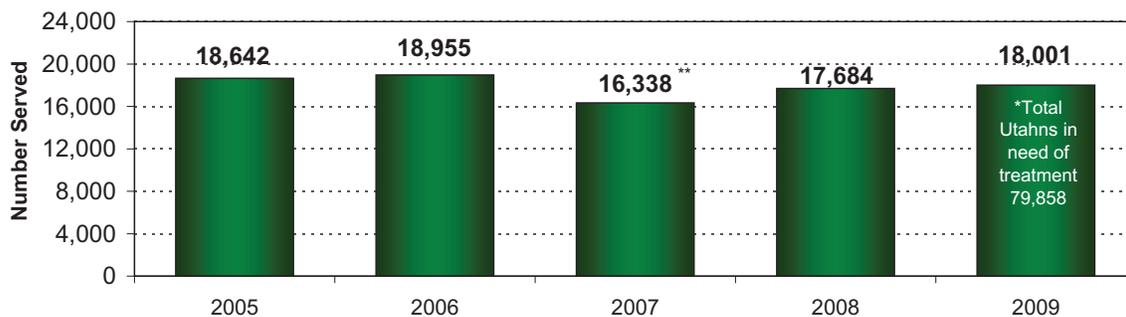
# Who We Serve

## Total Number Served

The following figures show the total number of individuals served in all publicly funded substance abuse treatment facilities for fiscal years 2005 through 2009. The same is depicted for individu-

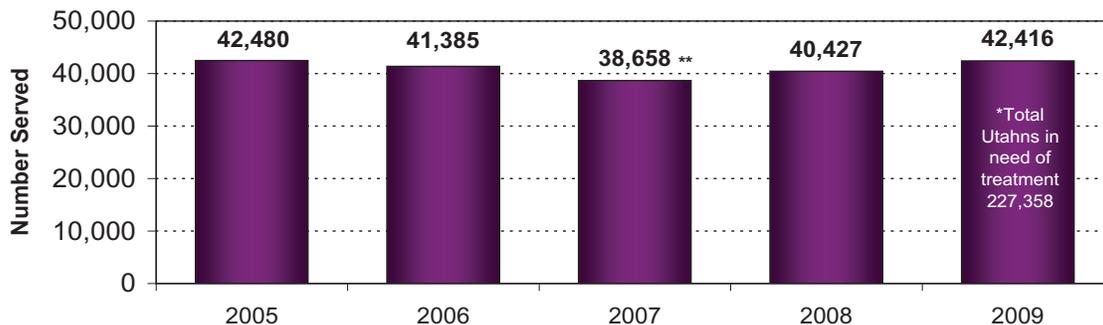
als being served within community mental health centers for fiscal year 2005 through fiscal year 2009.

### Total Number of Individuals Served in Substance Abuse Treatment Fiscal Years 2005 - 2009



\*Taken from the UTMB Synthetic Estimates of Needs for Utah and the 2009 SHARP Survey.

### Total Number of Individuals Served in Mental Health Services Fiscal Years 2005 - 2009



\*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://charles.holzer.com>.

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).

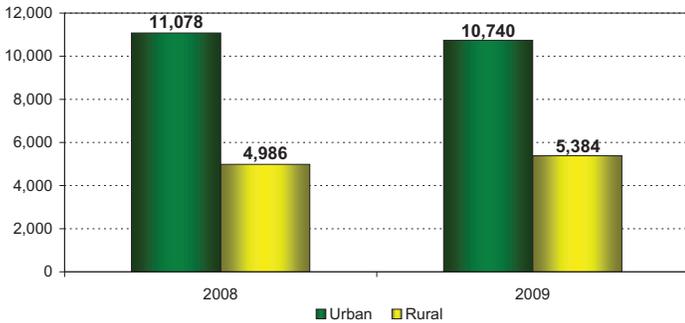
\*\*A unique client identification process was implemented in fiscal year 2007, which significantly reduced the duplication of unique clients served throughout the public substance abuse and mental health systems. As a result, the number of unique clients served in 2007 decreased, and cannot be compared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

## Urban and Rural Areas

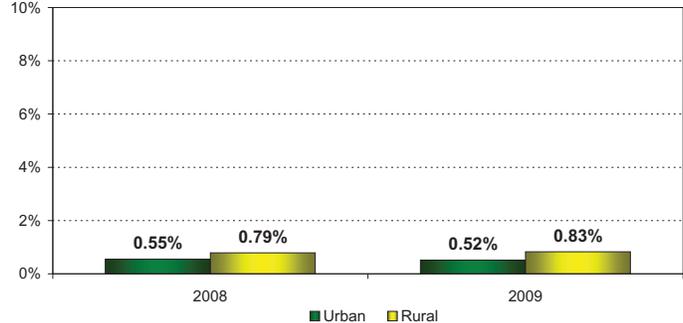
The following graphs show the total number of individuals served in urban and rural communities

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

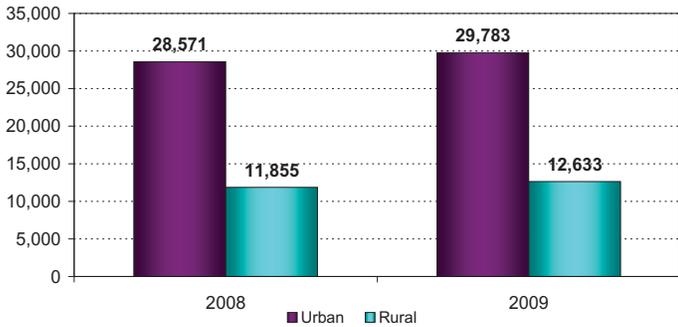
**Number of Individuals Served in Substance Abuse Services in Urban and Rural Communities**  
Fiscal Years 2008 - 2009



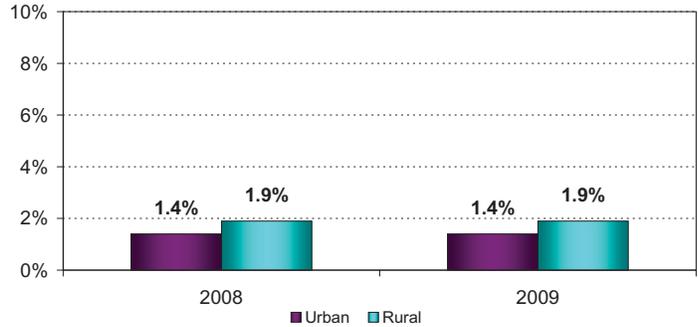
**Percent of Total Population Served in Substance Abuse Services in Urban and Rural Communities**  
Fiscal Years 2008 - 2009



**Number of Individuals Served in Mental Health Services in Urban and Rural Communities**  
Fiscal Years 2008 - 2009



**Percent of Total Population Served in Mental Health Services in Urban and Rural Communities**  
Fiscal Years 2008 - 2009



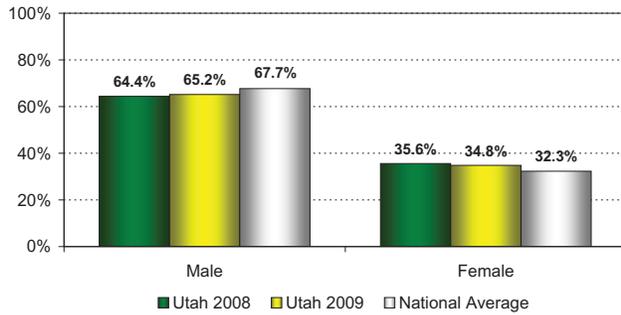
Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

## Gender and Age

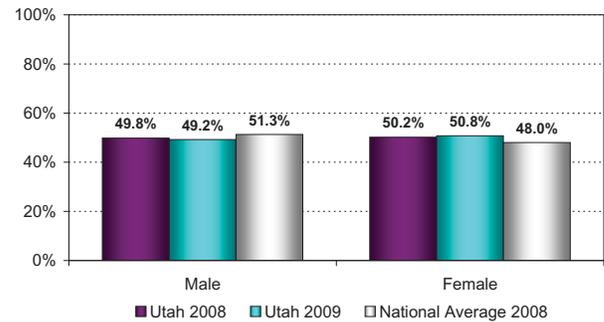
The following figures identify the distribution of services by gender and age for substance abuse and mental health services. There are significant dif-

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

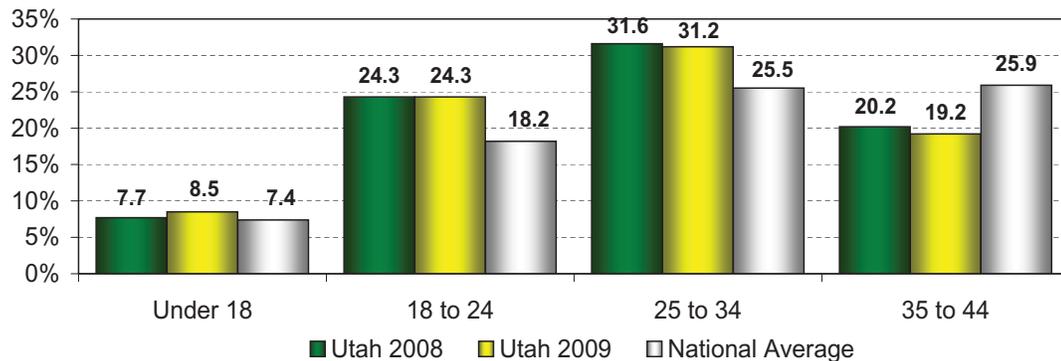
**Gender of People Served in Substance Abuse Services**  
Fiscal Years 2008 - 2009



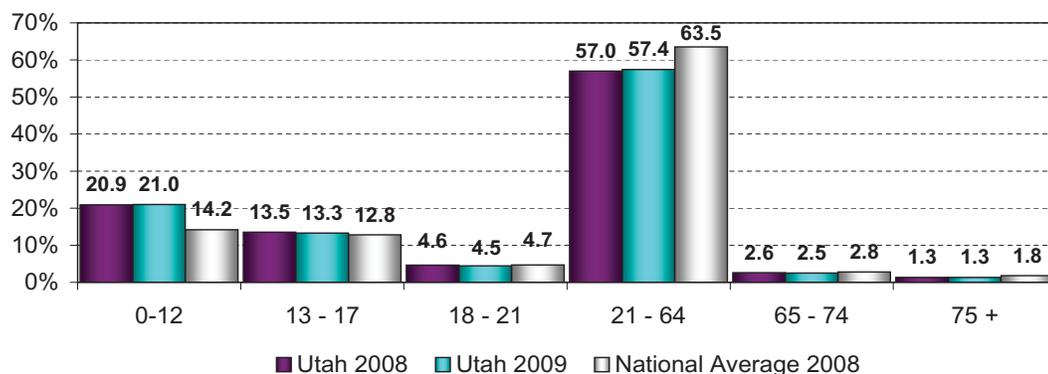
**Gender of People Served in Mental Health Services**  
Fiscal Years 2008 - 2009



**Age Grouping at Admission of People Served in Substance Abuse Services**  
Fiscal Years 2008 - 2009



**Age Grouping of People Served in Mental Health Services**  
Fiscal Years 2008 - 2009

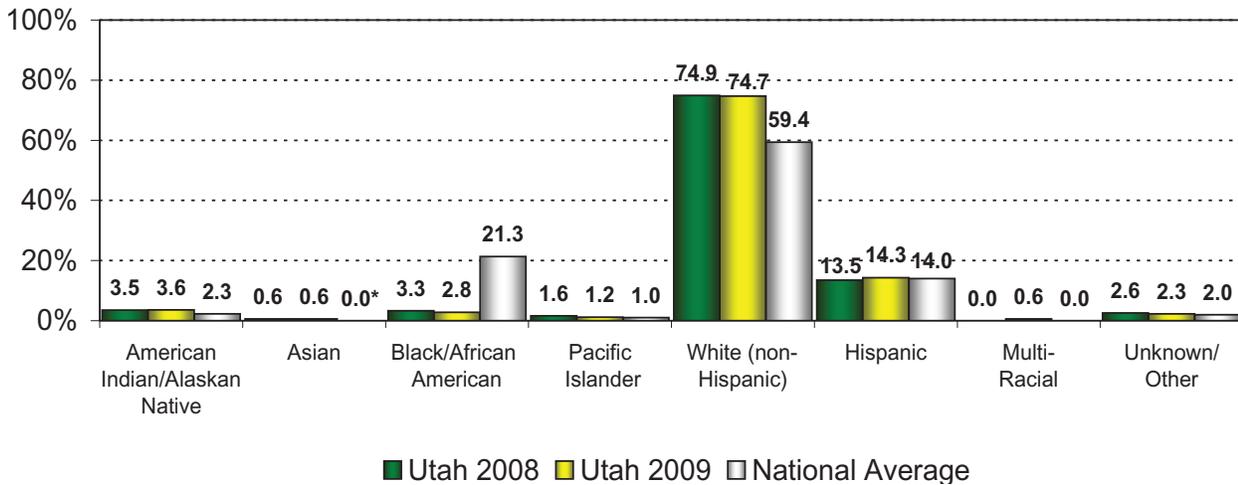


## Race and Ethnicity

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

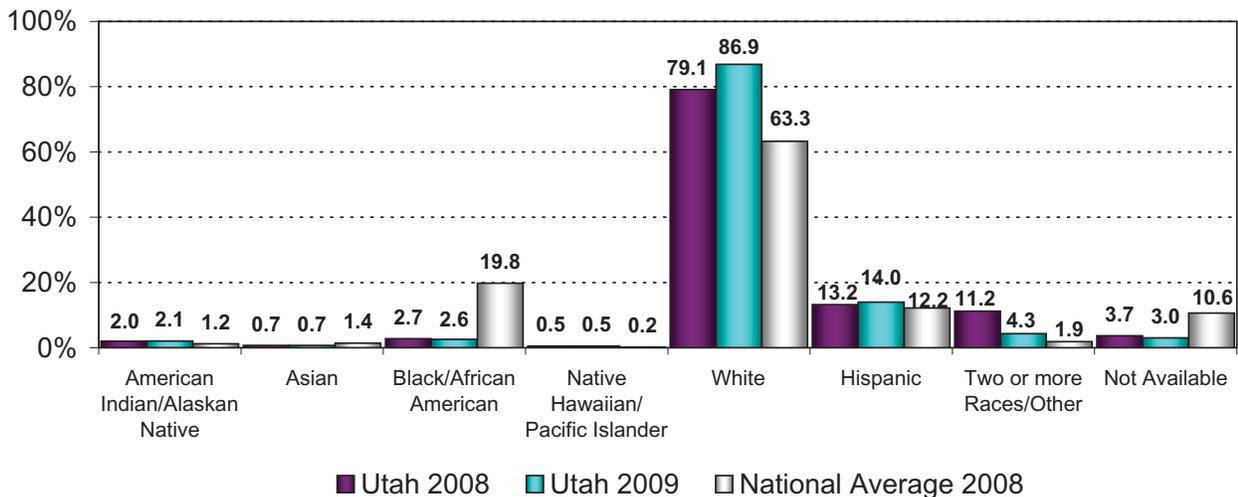
for clients receiving substance abuse or mental health services.

### Race/Ethnicity of People Served in Substance Abuse Services Fiscal Years 2008 - 2009



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

### Race/Ethnicity of People Served in Mental Health Service Fiscal Years 2008 - 2009

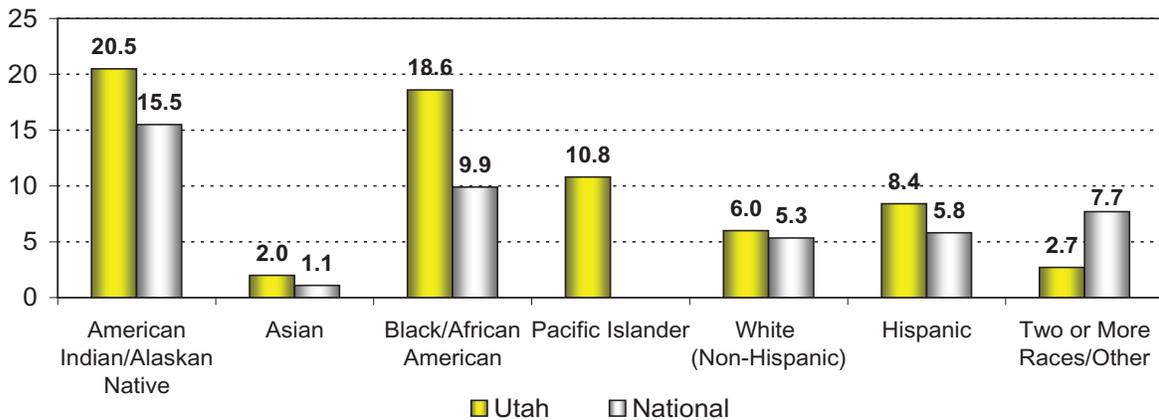


Note: More than one race/ethnicity may have been selected.

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

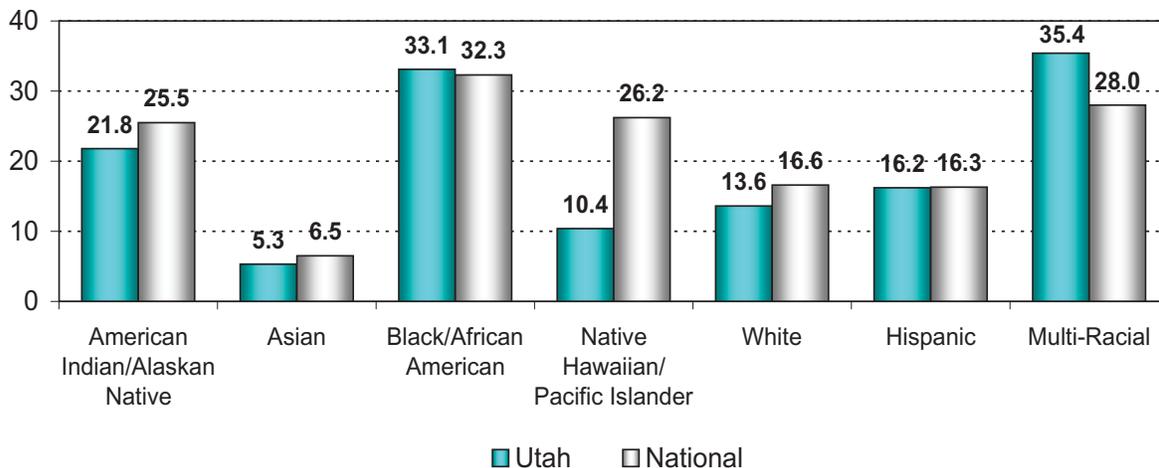
racial/ethnic groups. For example, for every 1,000 whites in Utah, 6 are receiving substance abuse treatment. For every 1,000 American Indians in Utah, 20.5 are receiving substance abuse services.

### Penetration of People in Substance Abuse Treatment Service per 1,000 Population by Race/Ethnicity Fiscal Year 2009



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 2009

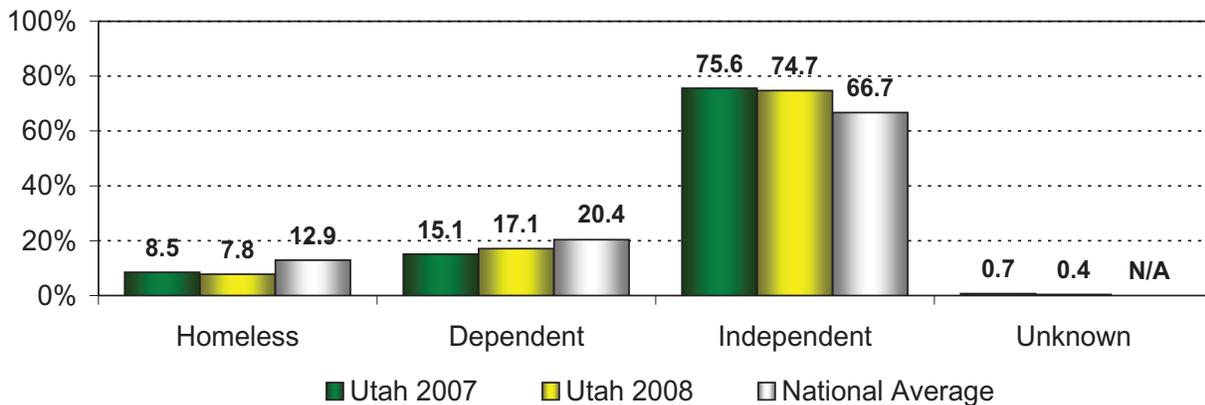


## Living Arrangement at Admission

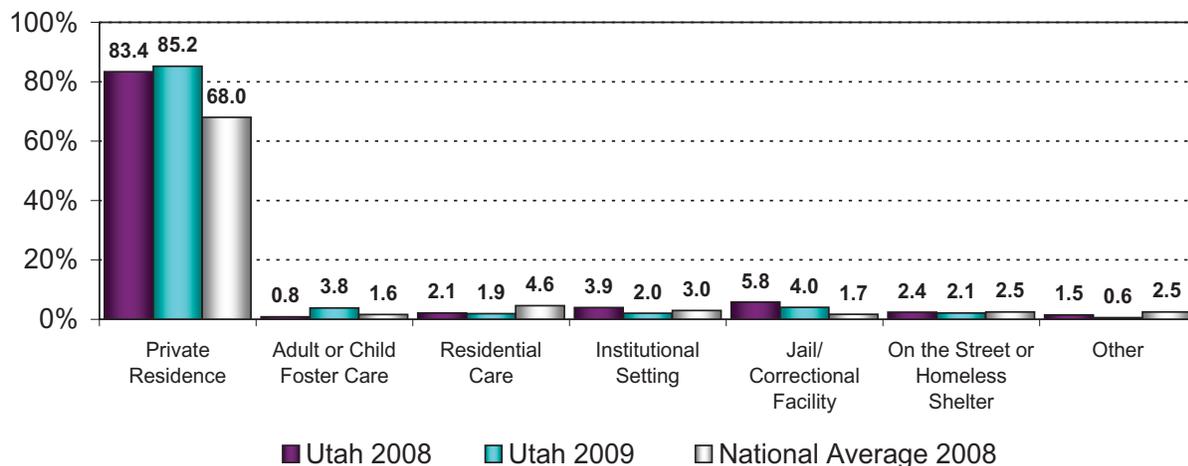
The following graphs depict clients' living arrangement at admission for substance abuse and mental health clients served in fiscal year 2009. By far, the majority of clients receiving substance abuse and mental health services are in

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 2008 - 2009



### Living Arrangement at Admission of Adults Served in Mental Health Services Fiscal Years 2008 - 2009

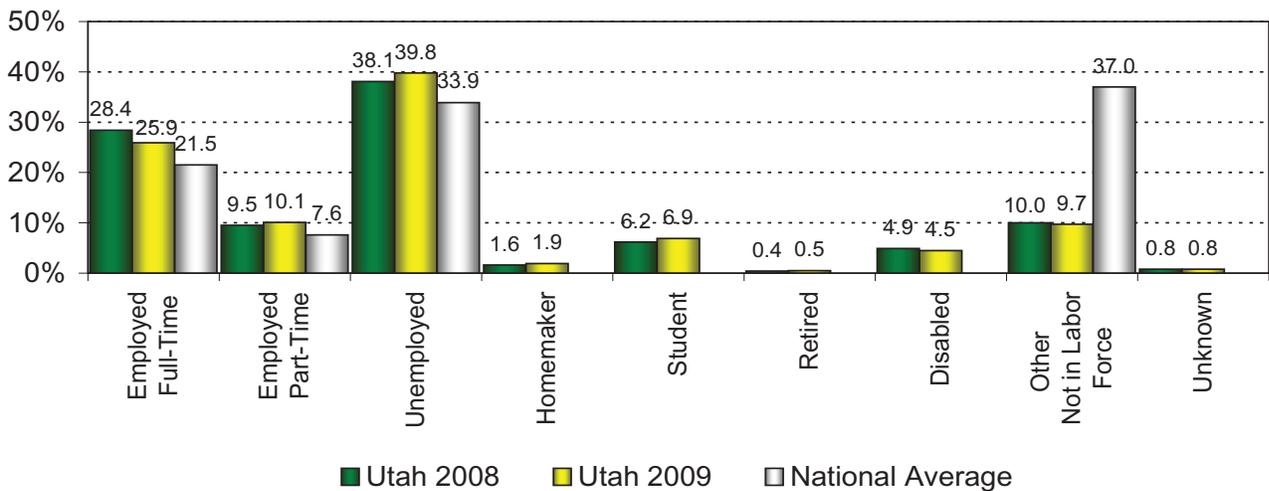


## Employment Status at Admission

The following graphs show the employment status at admission for substance abuse and mental health clients served in fiscal year 2009. The categories

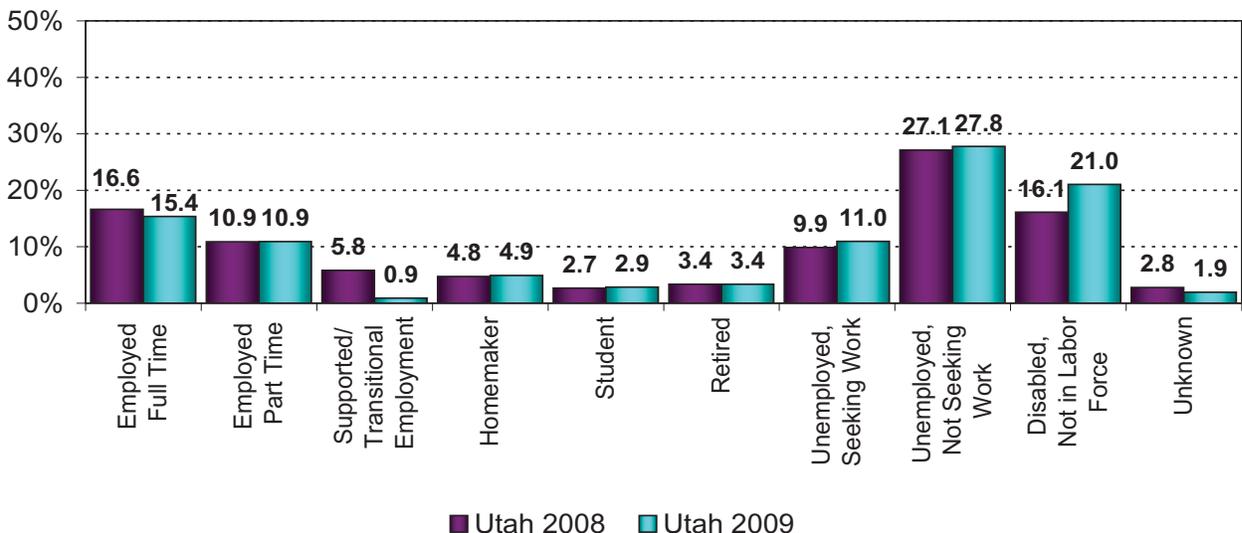
for mental health clients are different than those for substance abuse clients due to different reporting requirements.

### Employment Status at Admission for Individuals in Substance Abuse Services Fiscal Years 2008 - 2009



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

### Employment Status at Admission for Adults in Mental Health Services Fiscal Years 2008 - 2009



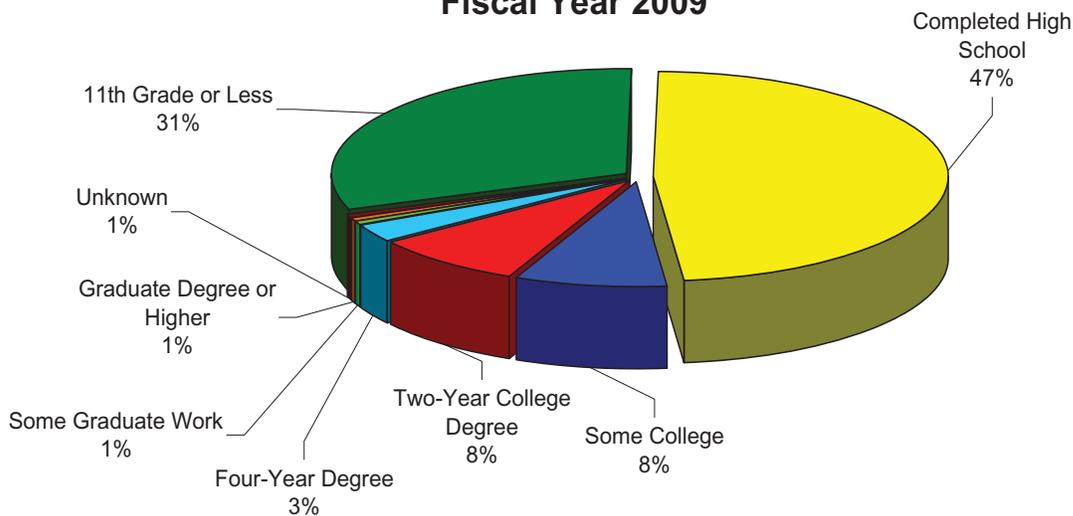
## Highest Education Level Completed at Admission

In fiscal year 2009, over 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.

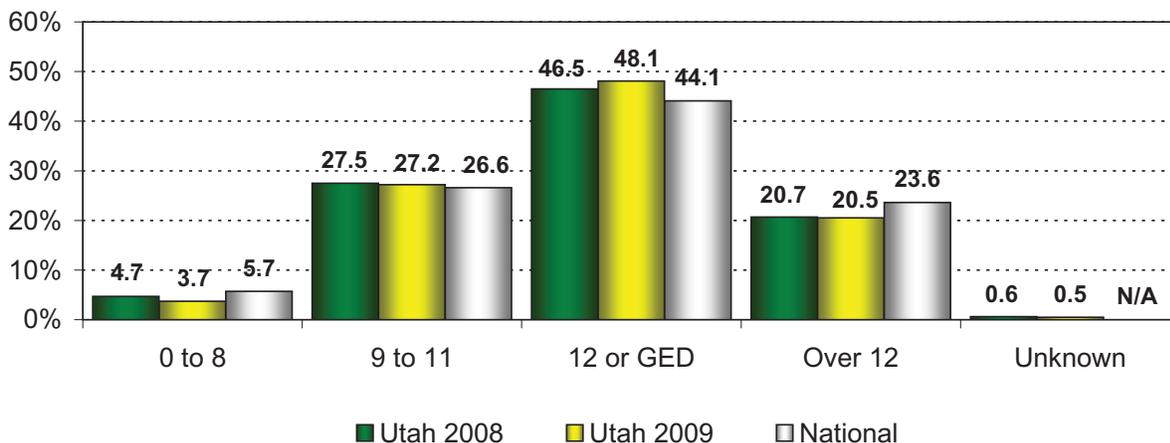
31% had not graduated from high school. This adds to challenge of treatment, as many of these individuals need education and job skills training in order to maintain a healthier lifestyle.

Additionally, 21% of the clients had received some type of college training prior to admission. Still,

### Highest Education Level at Admission for Individuals in Substance Abuse Services Fiscal Year 2009



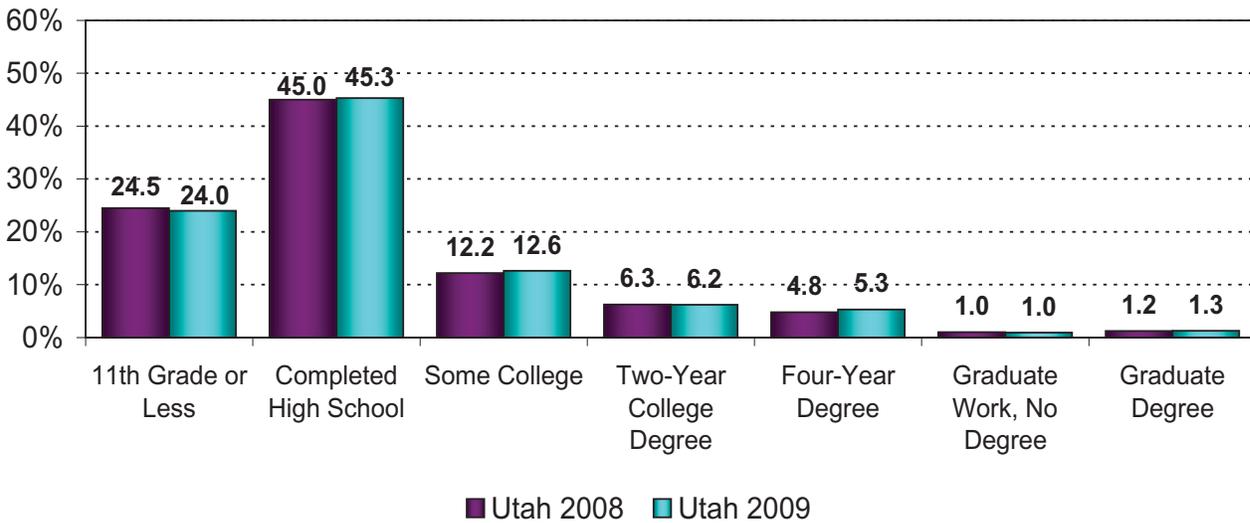
### Highest Education Level of Adults Served in Substance Abuse Services Fiscal Years 2008 - 2009



In fiscal year 2009, 72% 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,

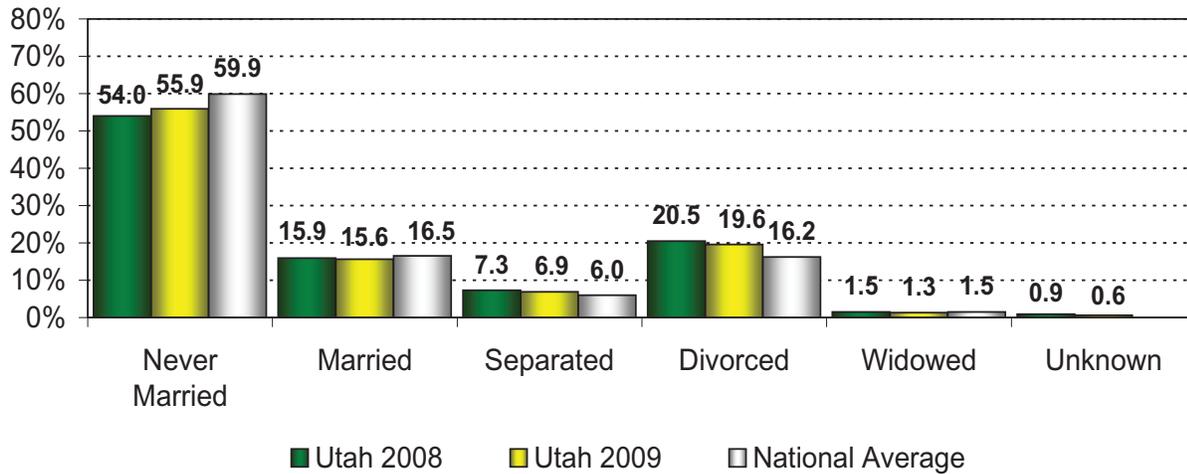
14% of the clients had received some type of college degree prior to admission. Still, 24% had not graduated from high school.

## Highest Education Level of Adults Served in Mental Health Services Fiscal Years 2008 - 2009



## Marital Status at Admission

### Marital Status of Individuals Served in Substance Abuse Services Fiscal Years 2008 - 2009



### Marital Status of Adults in Mental Health Services Fiscal Years 2008 - 2009

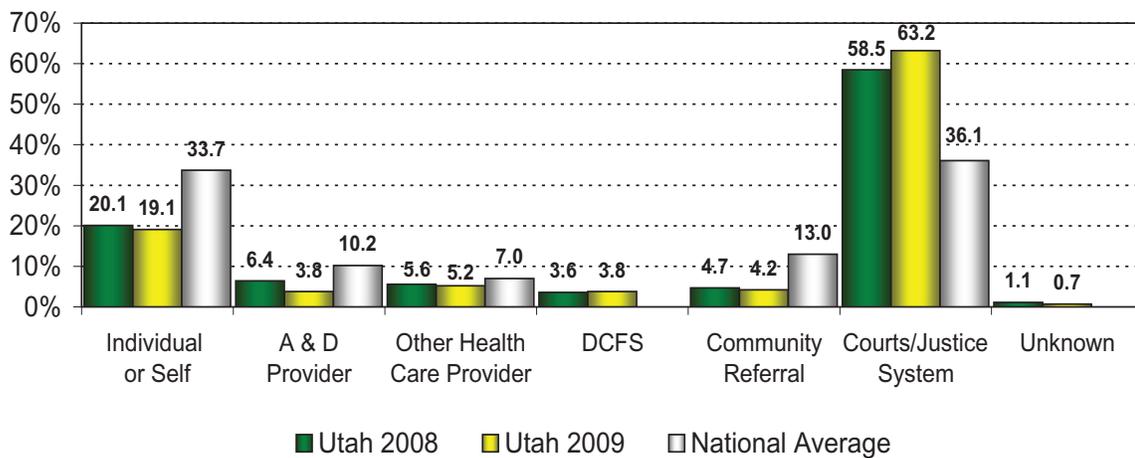


## Referral Source

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,

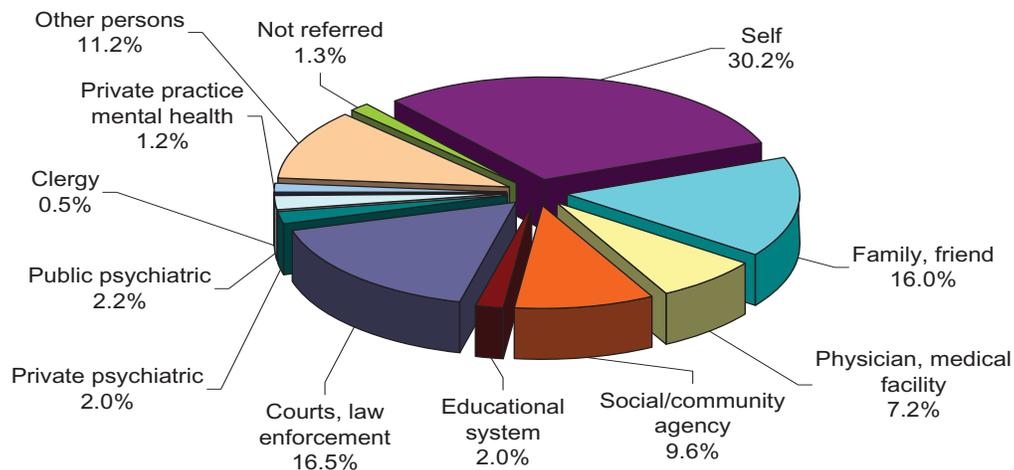
because the referral source can often continue to have a positive influence on the client's recovery. The graphs below detail referral sources for fiscal years 2008 and 2009 for substance abuse and fiscal year 2009 for mental health.

### Referral Source of Individuals in Substance Abuse Services Fiscal Years 2008 - 2009



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

### Referral Source of People Served in Mental Health Services Fiscal Year 2009







My name is Brent and I was born in Alaska. I have lived in different places from Colorado to Texas. At the age of three, I was diagnosed with Asperger's Syndrome. When I was eleven I lost my mom because of her addiction to alcohol. When I was almost thirteen I finally moved back to Alaska.



When I was eighteen, my dad died from a heart attack. The symptoms of my illness got worse. This past June mental health staff discovered that I went twenty years without counseling or medications.

### MY FAVORITES

- Skateboarding
- Hopping Fences
- Shopping
- Soda
- Watching TV
- Eating Tacos

In October I got into a fight with my aunt. I think it was because I wasn't taking my meds. I should have gotten help, but I didn't seek any. By November I had to be hospitalized for anxiety. After being there I was told I had a bipolar disorder and suffered a panic attack. I now have to take four types of medication to help keep me stable.

I was discharged from the hospital to a community mental health program. For two months now I have been living in HUD housing on my own, as a youth in transition. I am currently attending day treatment for my illness. I see a therapist every Wednesday.



The therapy groups I go to have helped me a lot. I have many friends and I am happy now. I love to skateboard, eat tacos, and watch my favorite TV shows: "Family Guy," "South Park," and "The Simpsons." Dr. Pepper is my all-time favorite soda.

I want to learn how to snowboard someday. In the future I would like to get a job in the "UPS World" delivering packages.

*[Brent is a member of the DSAMH-sponsored Youth Action Council]*

# Local Authorities Service Outcomes

## 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 provide data and graphs describing how each local authority provided services to its residents during fiscal year 2009 (July 1, 2008 to June 30, 2009).

There are four pages for each local authority: page one provides information on substance abuse prevention services; page two shows data and outcomes for the substance abuse provider; and pages three and four include information from the mental health provider.

# Bear River

Cache, Rich & Box Elder Counties



Population: 163,836



### Prioritized Risk Factors

- Family Conflict
- Parental Attitudes Favorable toward Problem Behaviors
- Attitudes Favorable to Problem Behavior

### Priority Protective Factors

Bear River's Prevention Plan addresses all protective factors by working to increase Skills, Opportunities, and Recognition among youth.

### All Stars

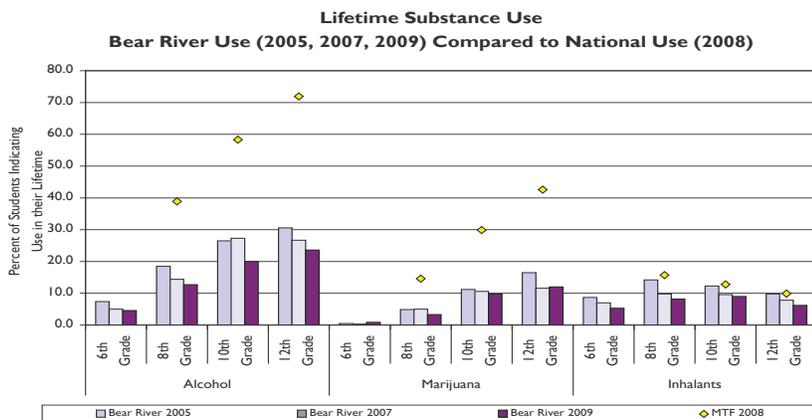
All Stars is a nationally recognized evidence-based curriculum designed to delay the onset of substance misuse and abuse, violence, and early sexual activity and promotes healthy goals and behaviors for their future.

In a recent report put out by the Substance Abuse and Mental Health Association's Center for Substance Abuse Prevention, All Stars topped the cost-benefit list for school-based prevention programs. This report demonstrates that for every dollar spent on All Stars, 32 dollars are saved long-term.

In the Bear River District, All Stars is focused on youth in grades 6-9. Health Department staff work with participating schools to identify classrooms and after-school clubs with youth for which this program will have the largest impact.

During fiscal year 2009, 41 students participated in the All Stars program. Based on the pre/post surveys, the students' attitudes toward substances were less favorable at the end of class, especially with alcohol.

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights



The 2009 Bear River SHARP report showed lifetime use rates for alcohol, marijuana, and inhalants went down among almost all grades. See the above graph.

### Reducing Alcohol Access to Minors

The Shoulder Tap Program is designed to reduce availability of alcohol to underage youth by targeting adults who supply alcohol for minors. Underage "decoys" approach adults outside stores and request that adults purchase alcohol for them. In partnership with the Cache County Sheriff's Office and the Logan City Police Department, the Bear River Health Department conducted three Shoulder Tap Operations in fiscal year 2009. During these operations 130 adults were approached by the youth, and 6 were arrested for "supplying alcohol to minors."

Shoulder Tap is more than enforcement of laws; it also includes an educational component through media outlets. Before, during, and often after the operation, a media blitz is implemented where community members are educated about the negative effects and illegality of supplying alcohol to minors.

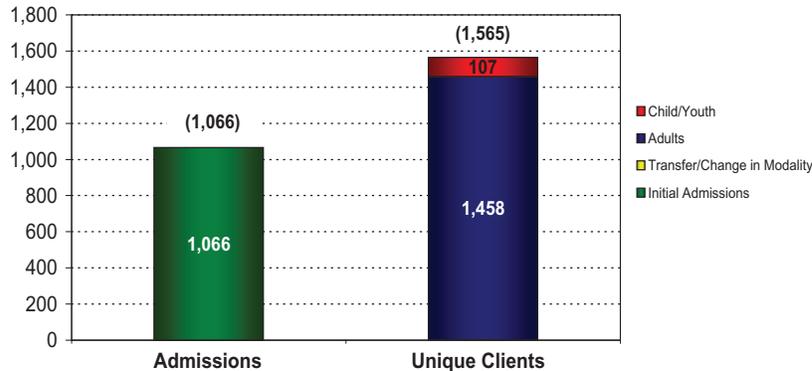
### Coalition-Guided Prevention

Bear River's substance abuse prevention plan is guided by the Northern Utah Substance Abuse Prevention Team, a community coalition comprised of 24 community members. NUSAPT has been overseeing prevention in Bear River for over 8 years which leads the way to effective grassroots prevention planning, reduces duplication of services, and allows for comprehensive program implementation.

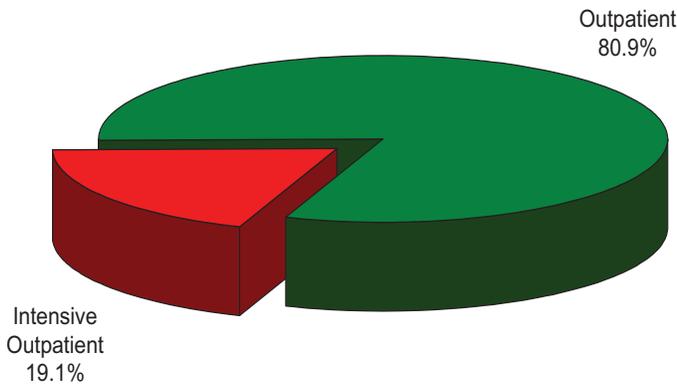
## Bear River Health Department— Substance Abuse

2008 Population	Total Served	Penetration Rate
163,836	1,565	1.0%

### Admissions into Modalities and Clients Served Fiscal Year 2009



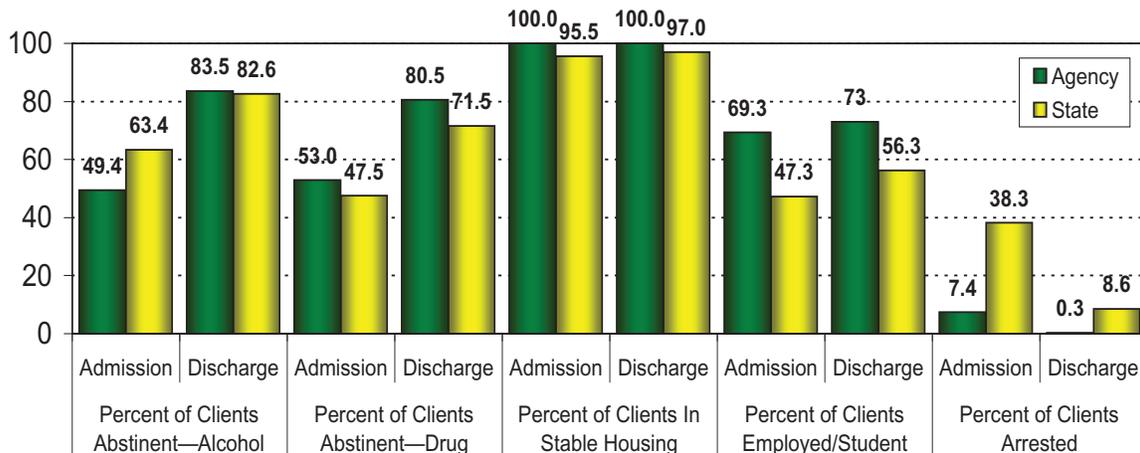
### Admission into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	410	138	548
Cocaine/Crack	3	3	6
Marijuana/Hashish	210	54	264
Heroin	20	2	22
Other Opiates/Synthetics	53	48	101
Hallucinogens	7	0	7
Methamphetamine	44	33	77
Other Stimulants	1	2	3
Benzodiazepines	2	7	9
Tranquilizers/Sedatives	3	5	8
Inhalants	0	0	0
Oxycodone	6	13	19
Club Drugs	1	0	1
Over-the-Counter	1	0	1
Other	0	0	0
Unknown	0	0	0
<b>Total</b>	<b>761</b>	<b>305</b>	<b>1066</b>

## Bear River Substance Abuse Outcome Measures Fiscal Year 2009



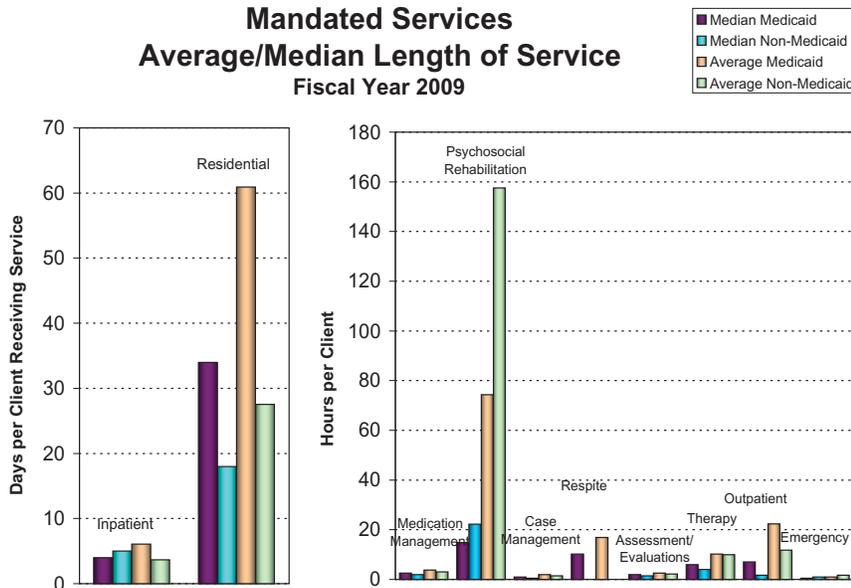
## Bear River Mental Health—Mental Health

Total Clients Served .....2,656  
 Adult .....1,735  
 Children/Youth.....921  
 Penetration Rate ..... 1.6%

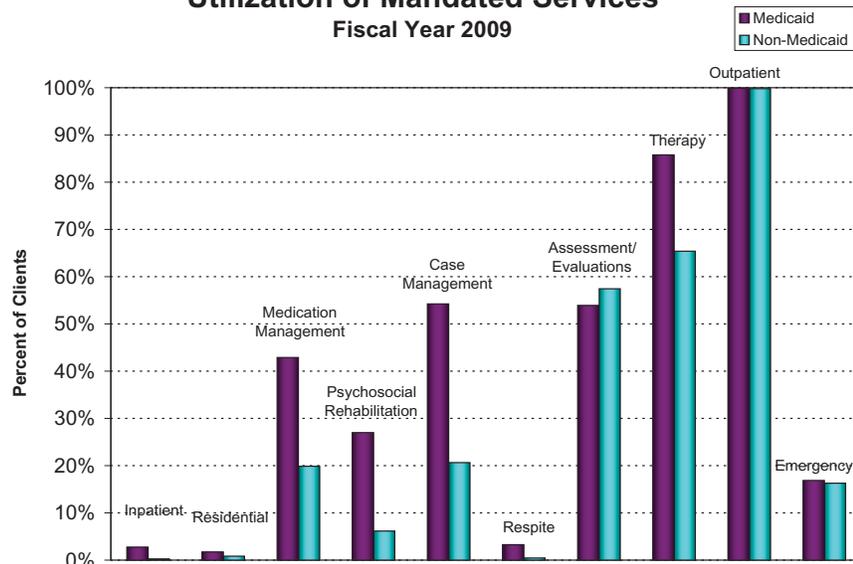
### Diagnosis

	Youth	Adult
Mood Disorders	296	1,401
Anxiety Disorders	269	958
Personality Disorders	1	490
Substance Abuse	15	388
Adjustment Disorders	217	101
Cognitive Disorders	30	124
Schizophrenia and Other Psychotic	18	280
Attention Deficit	214	139
Autism	50	40
Impulse Disorders	32	46
Neglect or Abuse	146	13
Conduct Disorders	20	2
Other	428	665
V Codes	155	173
<b>Total</b>	<b>1,891</b>	<b>4,820</b>

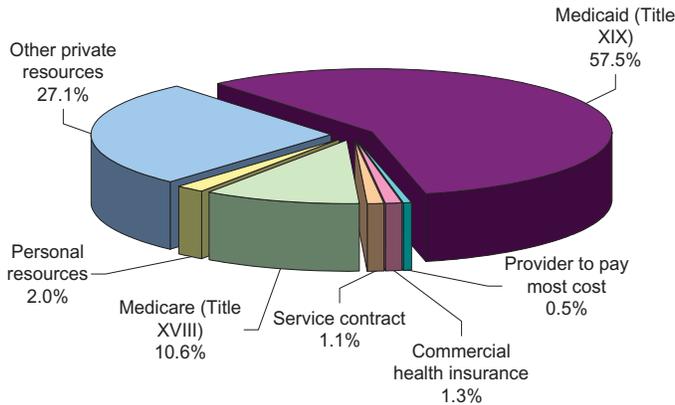
### Mandated Services Average/Median Length of Service Fiscal Year 2009



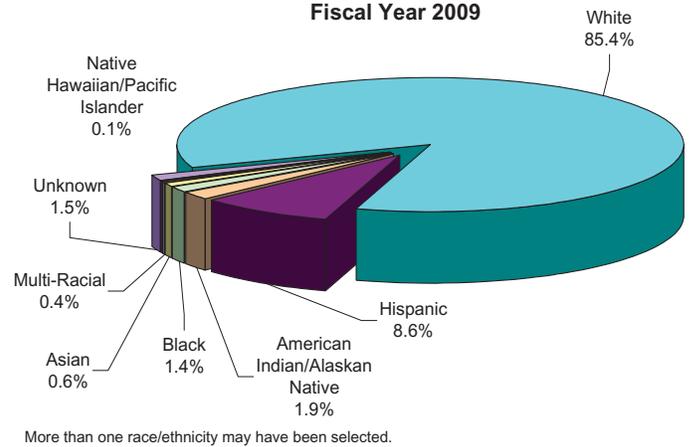
### Utilization of Mandated Services Fiscal Year 2009



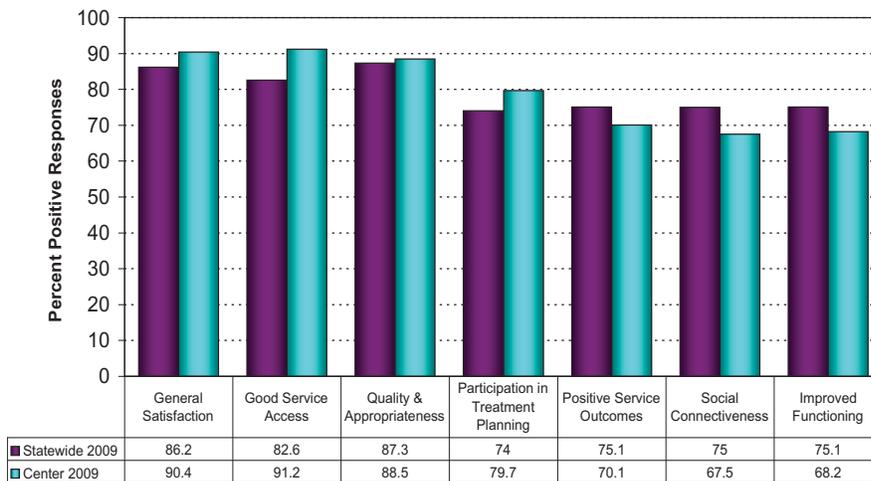
### Expected Payment Source At Admission Fiscal Year 2009



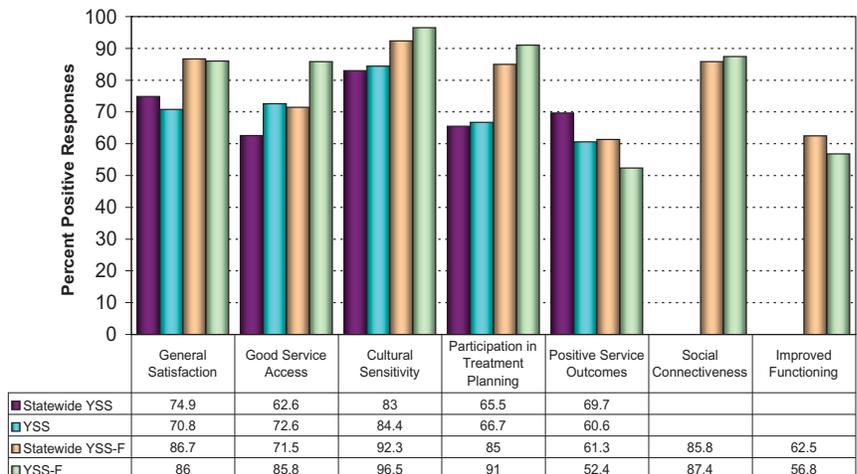
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



# Central Utah Counseling Center

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



Population: 71,592



### Prioritized Risk Factors

- Depressive Symptoms
- Parental Attitude Favorable to Antisocial Behaviors
- Low Commitment to School

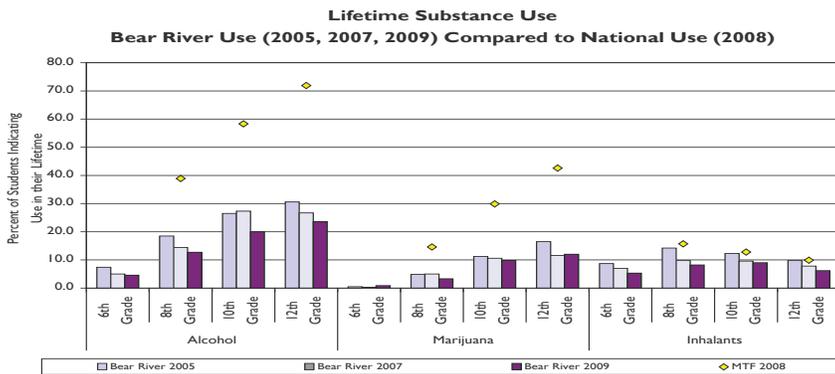
### Priority Protective Factors

- Rewards for Pro-Social Involvement
- Opportunities for Pro-Social Involvement in Community, School and Family

### Prevention Services Offered

- Social Marketing Media Campaigns:
  - ♦ Parents Empowered
  - ♦ Use Only As Directed
  - ♦ Clean Out the Cabinet
- Pamphlets and Materials Distribution
- Prevention Dimensions Training and Support
- Governing Youth Council
- Training and Support
- Parenting Classes
- EASY/SYNAR Compliance Checks
- Lifeskills Classes
- Prime For Life DUI Classes
- Seniors Safety Seminars
- Workforce ATOD Presentations
- Community Events/Presentations/Trainings
- Tutoring Program

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights



**Prevention Highlights:** Sevier Valley Substance Abuse Coalition (SVSAC) sponsored the 2<sup>nd</sup> Annual Conference held on Saturday, September 12, in Richfield. Workshops were offered for adults and youth to raise community awareness. Dr. Glen Hanson presented information on prescription narcotic abuse during the plenary session.

#### Governing Youth Council (GYC)

GYC students focus on safety, service, substance abuse prevention, and anti-violence issues. Projects included Town Hall Meetings on underage drinking.

#### After School Program

The Community First Coalition in Delta sponsors an after-school program which includes tutoring in English and Spanish, mentoring, skill-building, a hot meal and adult supervision, in a safe environment.

#### North Sanpete School District's 3<sup>rd</sup> Annual Prevention Night for Families

North Sanpete School District and community agencies sponsored the Prevention Night for Families. Local grade school students performed Prevention Dimensions musical numbers. Over 800 community members attended in spite of the blizzard!

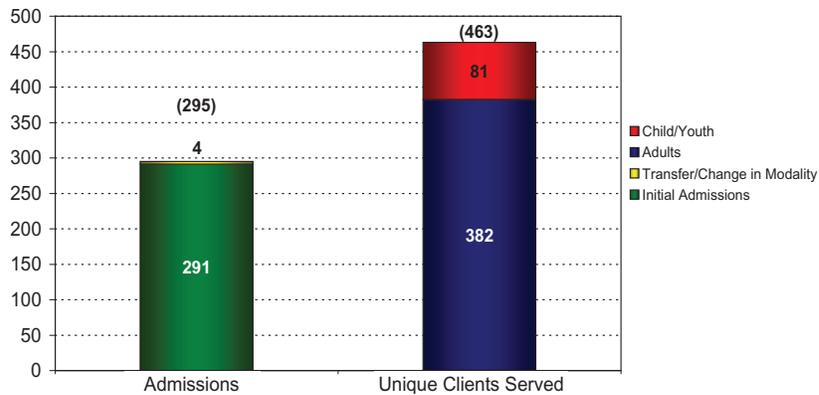
### Community Coalition Prevention

Central Utah Prevention is guided by the Strategic Prevention Framework (SPF) model and is supported by community coalitions focusing on research-based prevention strategies. Our partners include Millard County's Community First Coalition, Sanpete County Local Interagency Coalition, and Sevier Valley Substance Abuse Coalition. The Sevier Valley Substance Abuse Coalition recently applied for and received their 501(c)(3) status. All coalitions are working towards meeting federal standards. Central Utah Counseling Center provides SPF training to communities who would like to establish a coalition.

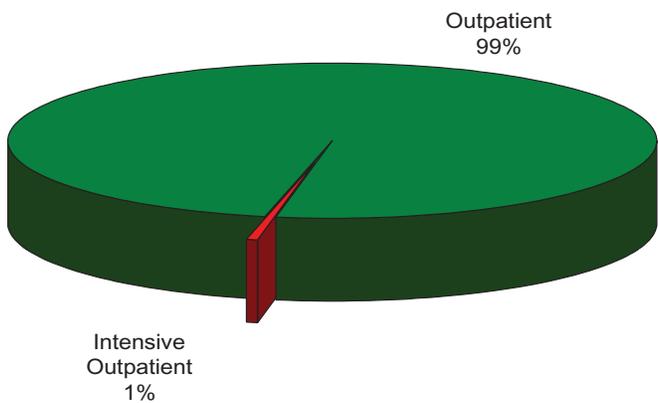
## Central Utah Counseling Center— Substance Abuse

2008 Population	Total Served	Penetration Rate
71,592	463	0.6%

### Admission into Modalities and Clients Served Fiscal Year 2009



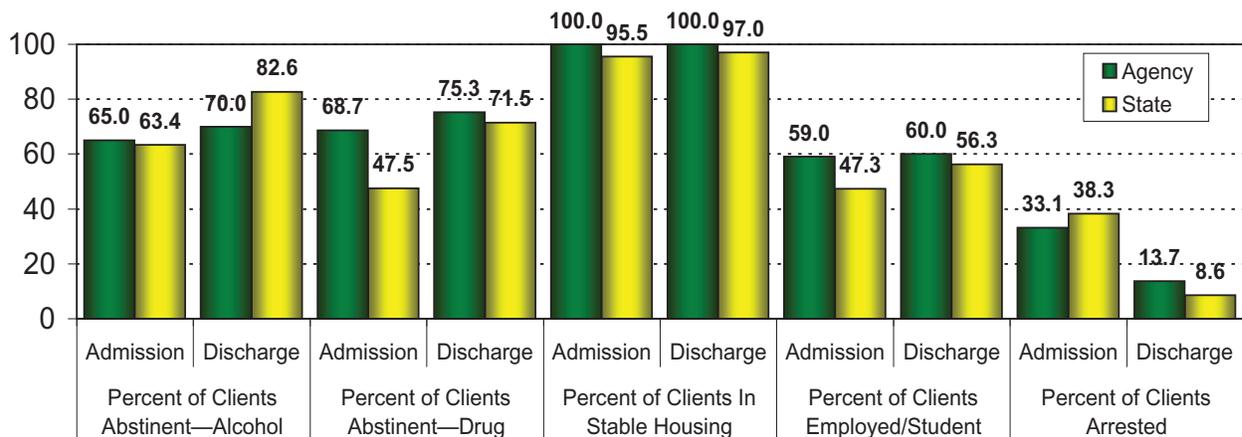
### Admission into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	87	48	135
Cocaine/Crack	3	4	7
Marijuana/Hashish	44	7	51
Heroin	6	4	10
Other Opiates/Synthetics	8	11	19
Hallucinogens	0	0	0
Methamphetamine	19	30	49
Other Stimulants	1	2	3
Benzodiazepines	1	3	4
Tranquilizers/Sedatives	0	0	0
Inhalants	2	5	7
Oxycodone	8	1	9
Club Drugs	0	0	0
Over-the-Counter	1	0	1
Other	0	0	0
Unkown	0	0	0
<b>Total</b>	<b>180</b>	<b>115</b>	<b>295</b>

## Central Utah Counseling Outcome Measures Fiscal Year 2009



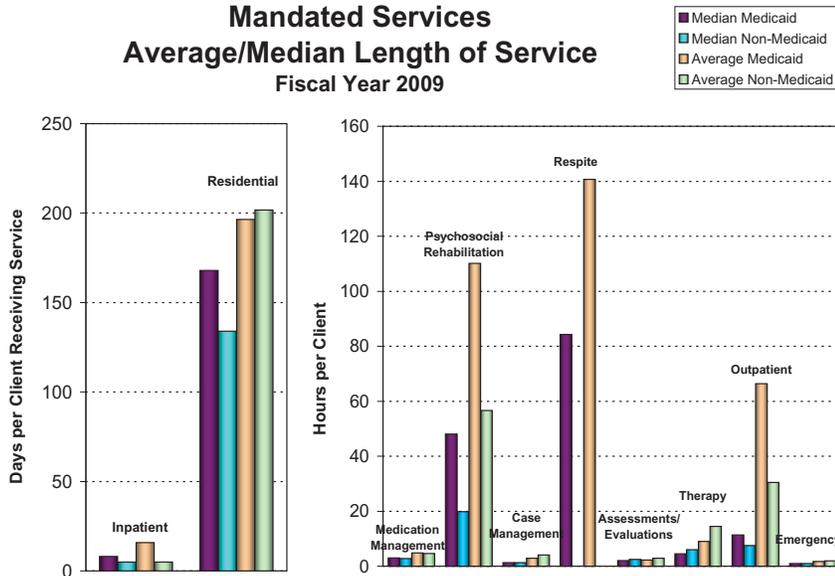
## Central Utah Counseling Center— Mental Health

Total Clients Served .....988  
 Adult .....603  
 Children/Youth .....385  
 Penetration Rate ..... 1.4%

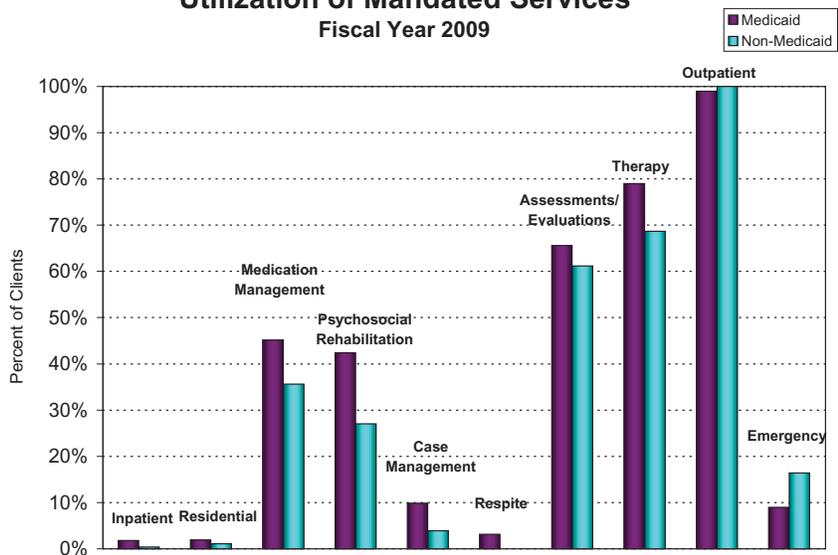
### Diagnosis

	Youth	Adult
Mood Disorders	69	402
Anxiety Disorders	85	303
Personality Disorders	5	173
Substance Abuse	19	94
Adjustment Disorders	140	27
Cognitive Disorders	9	30
Schizophrenia and Other Psychotic	7	159
Attention Deficit	134	28
Autism	30	9
Impulse Disorders	2	12
Neglect or Abuse	127	143
Conduct Disorders	20	0
Other	186	178
V Codes	57	56
<b>Total</b>	<b>890</b>	<b>1,614</b>

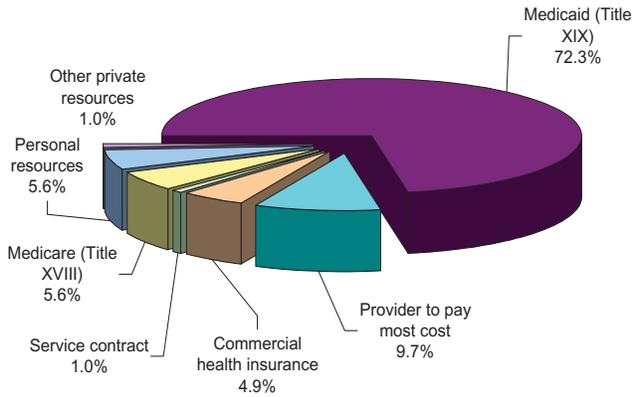
**Mandated Services  
Average/Median Length of Service  
Fiscal Year 2009**



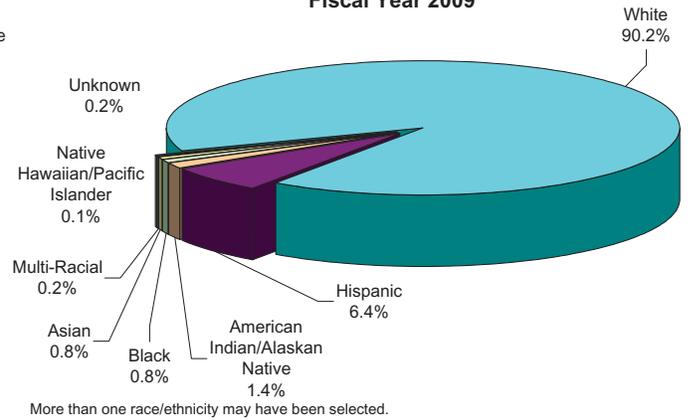
**Utilization of Mandated Services  
Fiscal Year 2009**



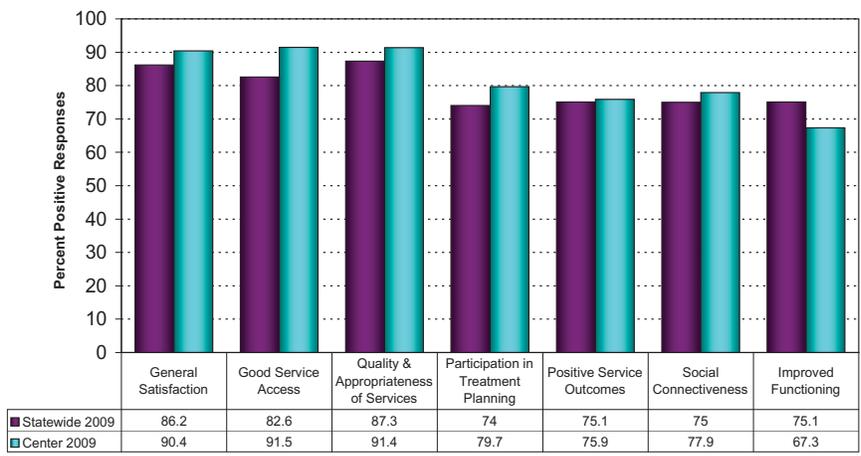
### Expected Payment Source At Admission Fiscal Year 2009



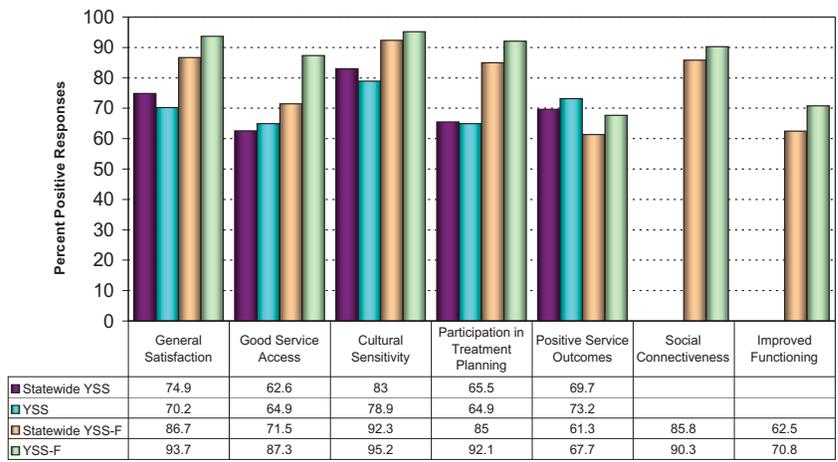
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009





**DAVIS BEHAVIORAL HEALTH INC**

Population: 295,332



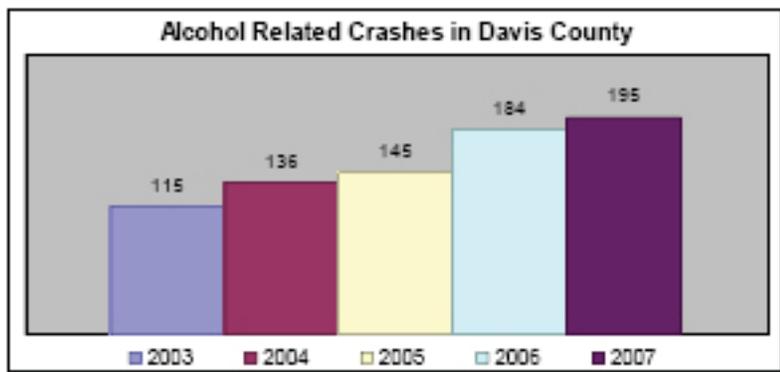
- Prioritized Risk Factors**
- Family Conflict
  - Poor Family Management
  - Low Commitment to school
  - Academic Failure
  - Depressive Symptoms

**Priority Protective Factors**

Davis' Prevention Plan addresses all protective factors by working to increase skills, opportunities, and recognition among children and youth.

**Prevention Programs in Davis County:**

- Prime for Life/DUI Classes
- Alcohol and Drug Intervention (ADI)
- Love and Logic Parenting Classes
- Davis Family Advocates
- Choices—Children of Substance Abusers
- Function Family Therapy
- Reconnecting Youth
- Vectors—Psychodrama
- Anger Management
  - ♦ Women
  - ♦ Men
  - ♦ Youth
  - ♦ Children
- Divorce Adjustment
- Prevention Dimensions
- Project Davis
- Strengthening Families



Source: Utah Department of Public Safety

Alcohol-related crashes are a serious concern in Davis County, with 195 alcohol-related crashes in 2007. That amounts to one alcohol-related crash every other day. Crash reports show alcohol-related crashes in Davis County climbing 70% over the past 5 years.



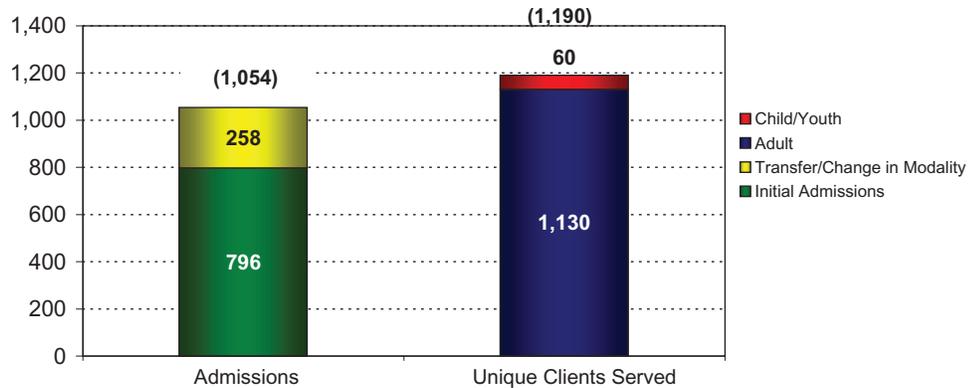
Davis Health Education and Law Enforcement Program (HELPS) is a coalition dedicated to making Davis County a healthy and safe place for families to live, work and play. Davis HELPS is working hard to reverse the increasing trend of alcohol-related crashes in Davis County by convincing residents of every age that drinking and driving is too much of a risk.

## Davis Behavioral Health— Substance Abuse

2008 Population	Total Served	Penetration Rate
295,332	1,190	0.4%

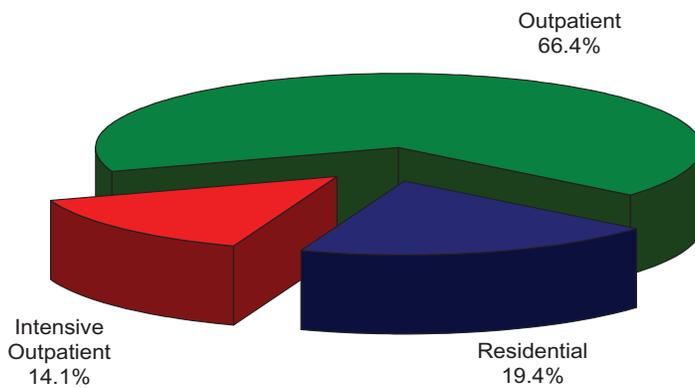
### Admissions into Modalities and Clients Served

Fiscal Year 2009



### Admissions into Modalities

Fiscal Year 2009

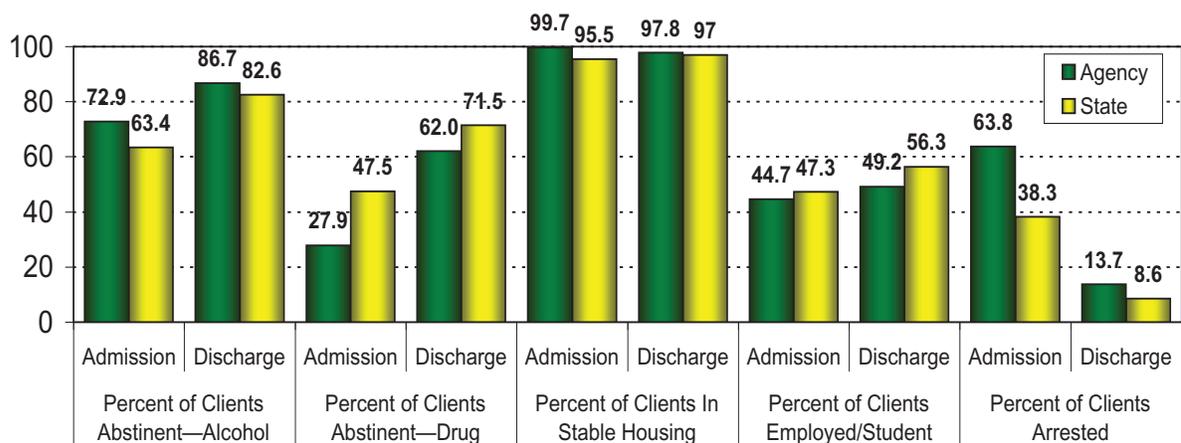


### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	158	89	247
Cocaine/Crack	54	16	70
Marijuana/Hashish	132	41	173
Heroin	89	20	109
Other Opiates/Synthetics	14	18	32
Hallucinogens	0	0	0
Methamphetamine	163	157	320
Other Stimulants	3	0	3
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	1	1
Inhalants	2	2	4
Oxycodone	48	44	92
Club Drugs	0	0	0
Over-the-Counter	2	0	2
Other	0	0	0
Unkown	0	0	0
<b>Total</b>	<b>665</b>	<b>389</b>	<b>1,054</b>

## Davis Behavioral Health Outcome Measures

Fiscal Year 2009



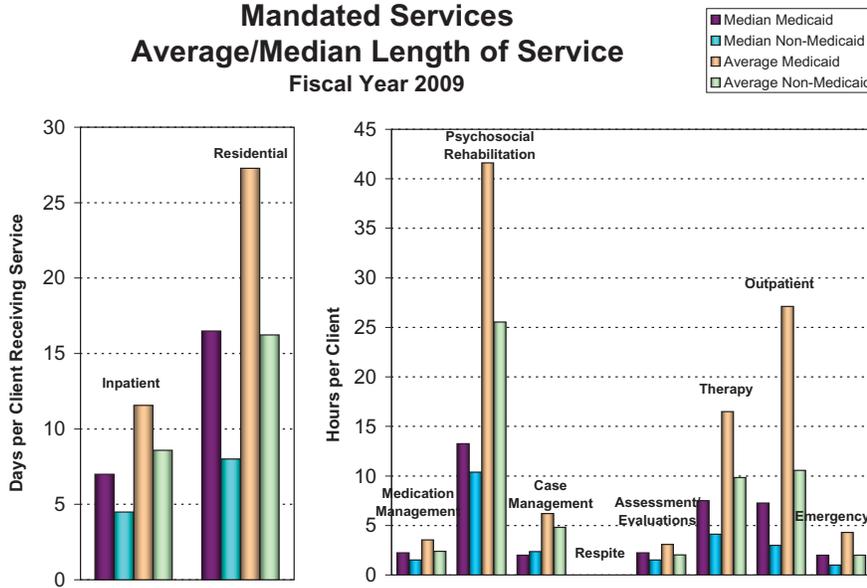
### Davis Behavioral Health—Mental Health

Total Clients Served.....3,180  
 Adult .....2,044  
 Children/Youth.....1,136  
 Penetration Rate..... 1.1%

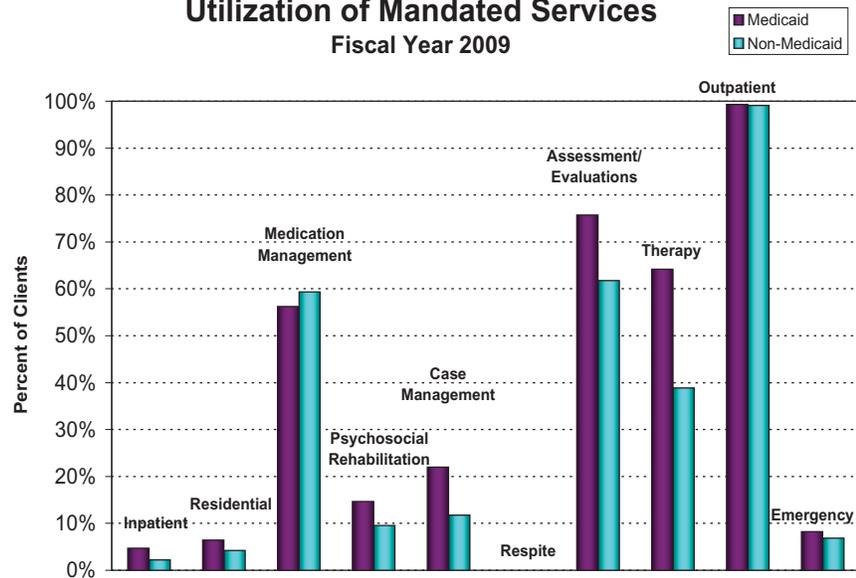
### Diagnosis

	Youth	Adult
Mood Disorders	512	1,560
Anxiety Disorders	371	1,253
Personality Disorders	8	319
Substance Abuse	61	497
Adjustment Disorders	172	102
Cognitive Disorders	15	71
Schizophrenia and Other Psychotic	26	454
Attention Deficit	441	129
Autism	117	40
Impulse Disorders	24	32
Neglect or Abuse	435	28
Conduct Disorders	61	15
Other	884	990
V Codes	220	89
<b>Total</b>	<b>3,347</b>	<b>5,579</b>

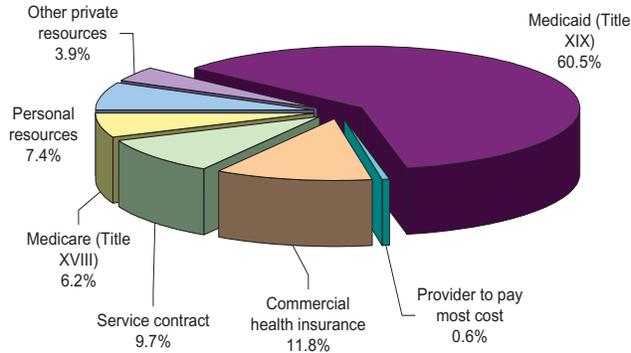
### Mandated Services Average/Median Length of Service Fiscal Year 2009



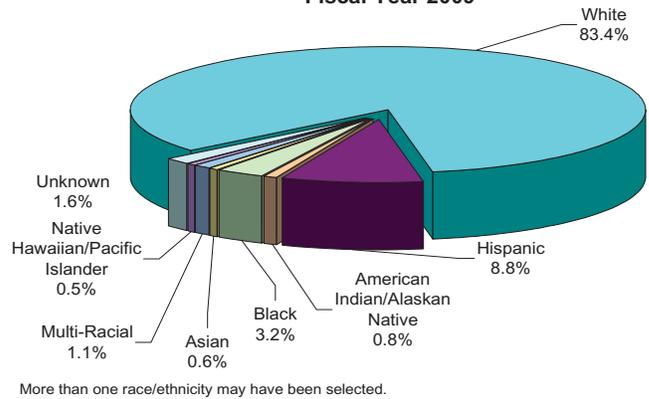
### Utilization of Mandated Services Fiscal Year 2009



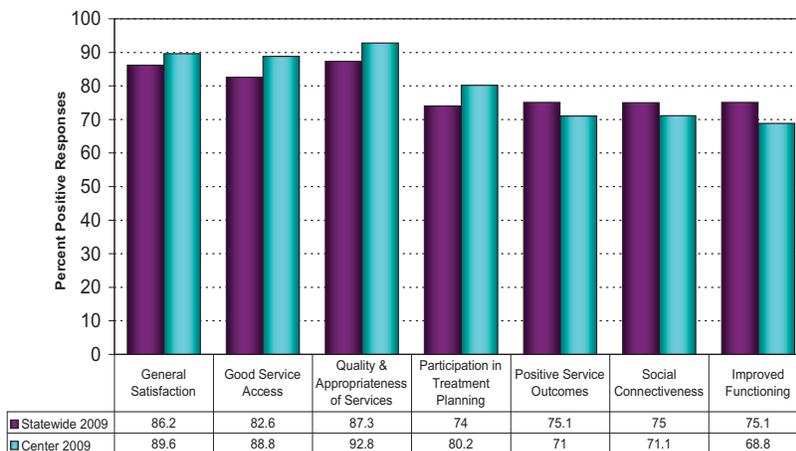
### Expected Payment Source At Admission Fiscal Year 2009



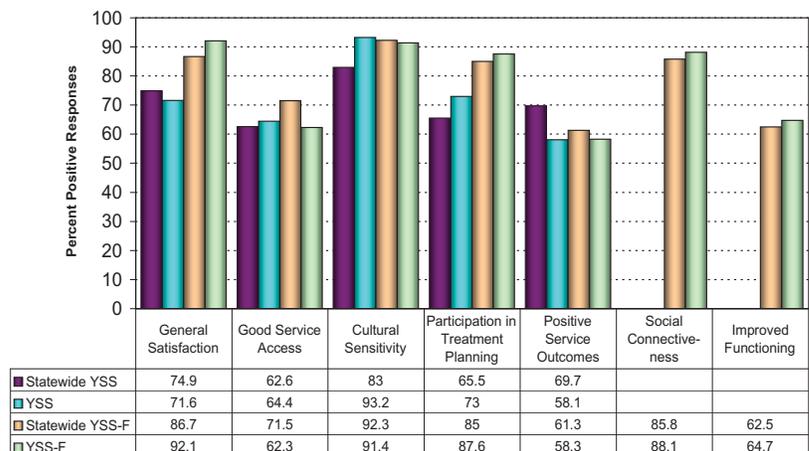
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



**Four Corners**  
Carbon, Emery & Grand Counties

**FCCBH**



**FOUR CORNERS  
COMMUNITY BEHAVIORAL  
HEALTH**

Population: 40,000



<p><b>Prioritized Risk Factors</b></p> <ul style="list-style-type: none"> <li>• Low Commitment to School</li> <li>• Expressed intention to use drugs</li> <li>• Laws and norms perceived as favorable to drug use</li> </ul>	<p><b>Priority Protective Factors</b></p> <ul style="list-style-type: none"> <li>• Opportunities for pro-social involvement</li> <li>• Rewards for pro-social involvement</li> </ul>
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**Funded Programs Addressing Four Corners Prioritized Factors:**

**Carbon County All Stars**  
Increase commitment to school and provide opportunities for pro-social involvement

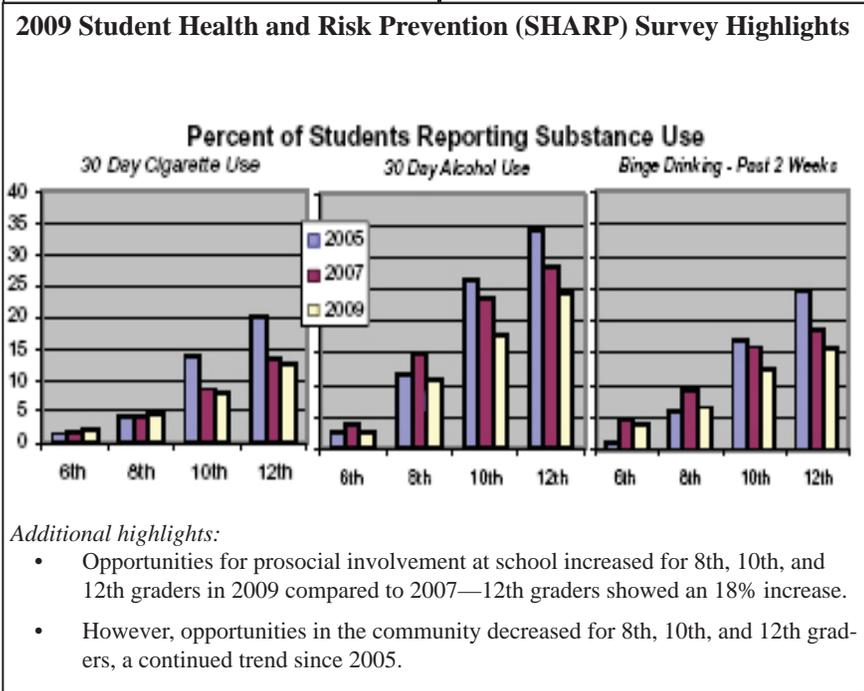
**Carbon County Boys & Girls Club**  
Academic tutoring and social skills to reduce intention to use drugs

**Emery County Governing Youth Council:** Reduce youth misperception towards ATOD. Increase commitment to school and provide opportunities for pro-social involvement.

**Carbon County Smart Leaders**  
Increase commitment to school and increase rewards and opportunities for pro-social involvement

**Grand County Life Skills Training**  
Reduce intention to use drugs and increase commitment to school

**Emery County Girls in Real Life Situations:** Reduce intention to use ATOD and increase commitment to school.



**PRIME for Life** is an evidence-based alcohol and drug prevention program for adults. It is designed to challenge common beliefs and attitudes that directly contribute to high-risk alcohol and drug use. PRIME for Life is also the State-mandated DUI education program. In FCCH district, PRIME for Life is offered as prevention programming in all three counties.

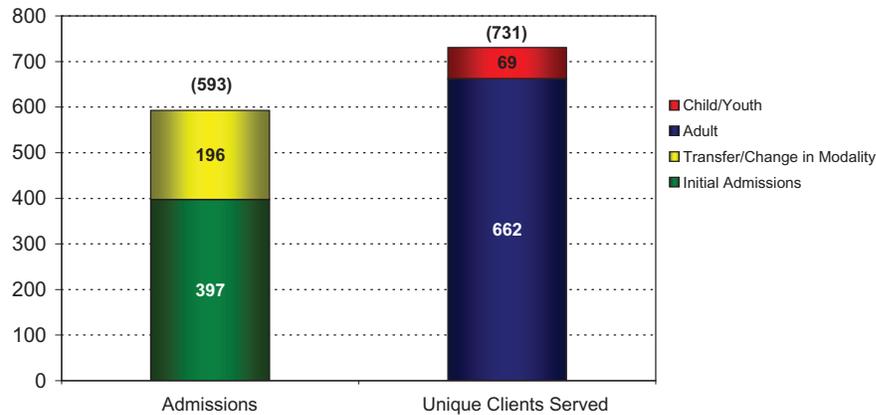
**Continuum of Care:** FCCBH provides a complete continuum of prevention services ranging from general Universal services to targeted Early Intervention.

**Community-Based Prevention:** With the Strategic Prevention Framework grant, FCCBH has identified high-risk communities within each county and is mobilizing them to address alcohol and drug related problems at the local level, including law enforcement, business, education, parents, clergy and families in recovery.

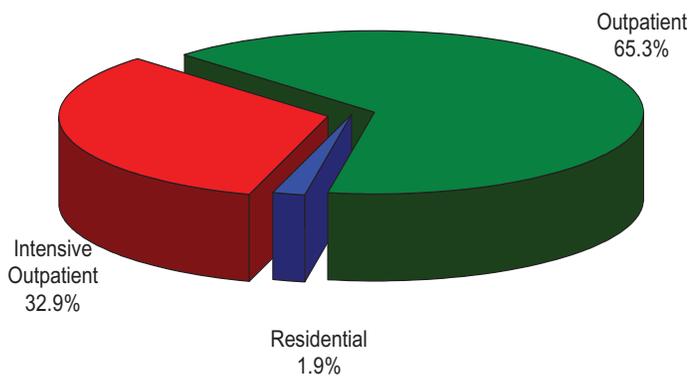
## Four Corners Community Behavioral Health—Substance Abuse

2008 Population	Total Served	Penetration Rate
39,648	731	1.8%

### Admissions into Modalities and Clients Served Fiscal Year 2009



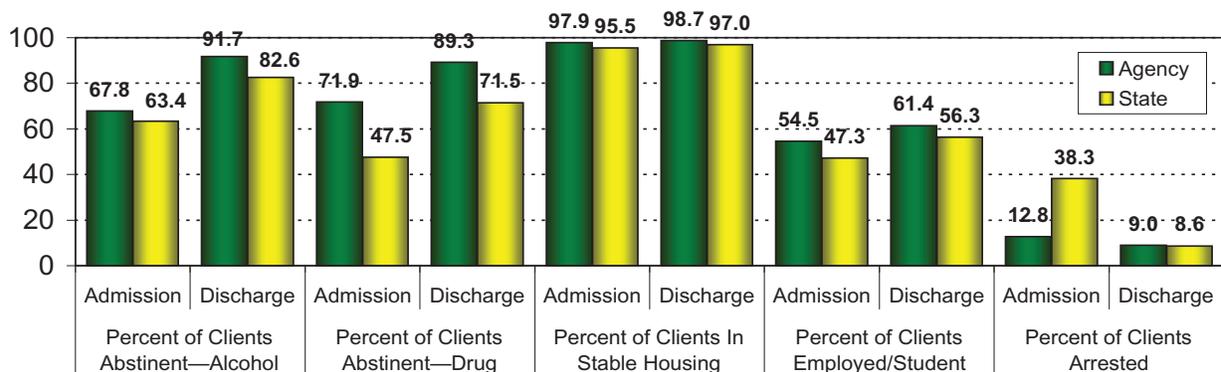
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	197	89	286
Cocaine/Crack	7	8	15
Marijuana/Hashish	88	26	114
Heroin	5	2	7
Other Opiates/Synthetics	13	30	43
Hallucinogens	0	2	2
Methamphetamine	55	56	111
Other Stimulants	2	0	2
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	1	1
Inhalants	1	0	1
Oxycodone	5	3	8
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	0	0	0
Unkown	0	2	2
<b>Total</b>	<b>373</b>	<b>220</b>	<b>593</b>

## Four Corners Community Behavioral Health Outcome Measures Fiscal Year 2009



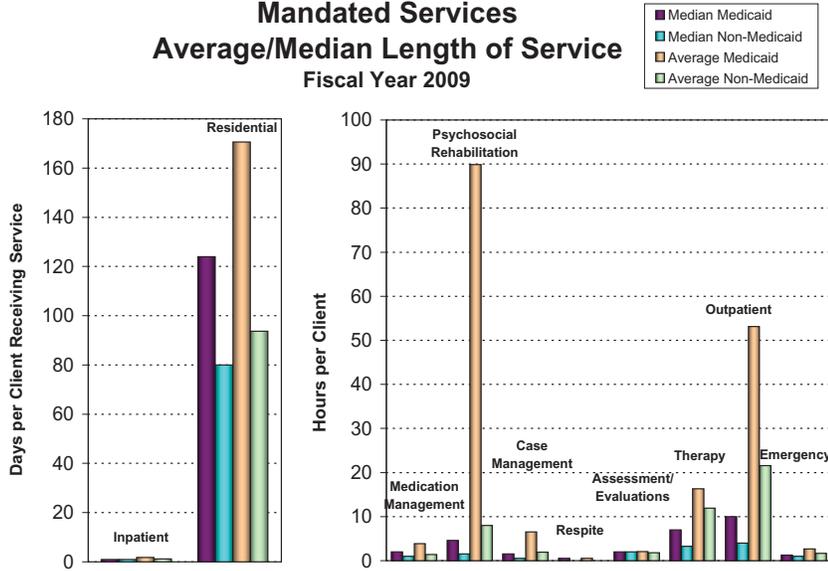
### Four Corners Community Behavioral Health—Mental Health

Total Clients Served ..... 1,960  
 Adult ..... 1,372  
 Children/Youth ..... 588  
 Penetration Rate ..... 4.9%

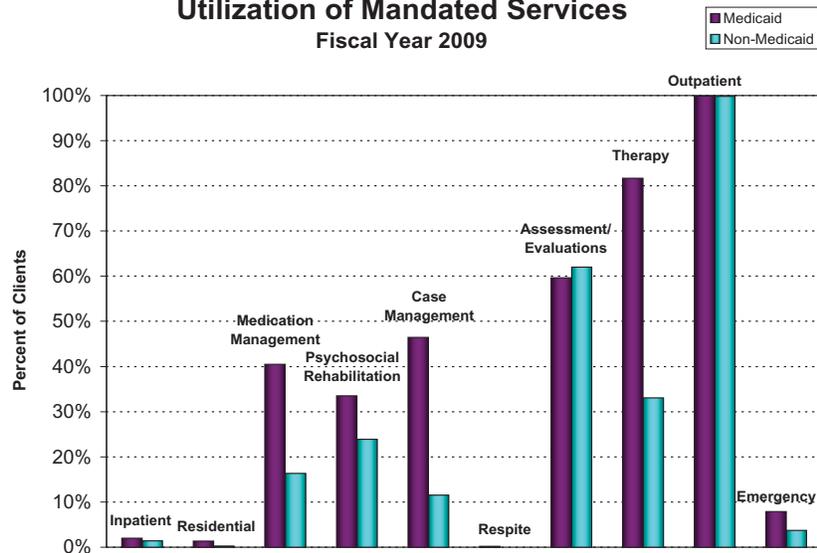
### Diagnosis

	Youth	Adult
Mood Disorders	204	724
Anxiety Disorders	104	401
Personality Disorders	2	220
Substance Abuse	143	948
Adjustment Disorders	112	50
Cognitive Disorders	14	44
Schizophrenia and Other Psychotic	3	120
Attention Deficit	159	43
Autism	16	12
Impulse Disorders	12	18
Neglect or Abuse	54	6
Conduct Disorders	15	0
Other	326	456
V Codes	142	104
<b>Total</b>	<b>1,306</b>	<b>3,146</b>

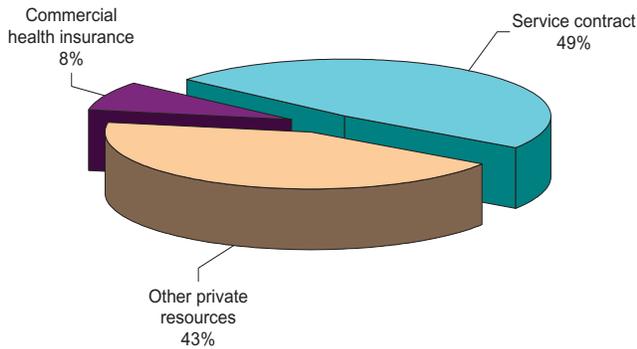
### Mandated Services Average/Median Length of Service Fiscal Year 2009



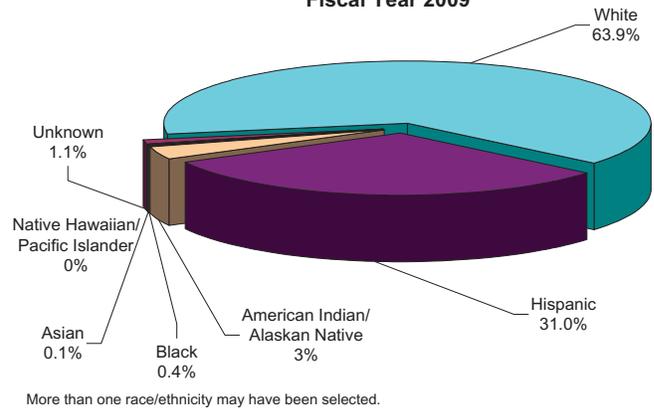
### Utilization of Mandated Services Fiscal Year 2009



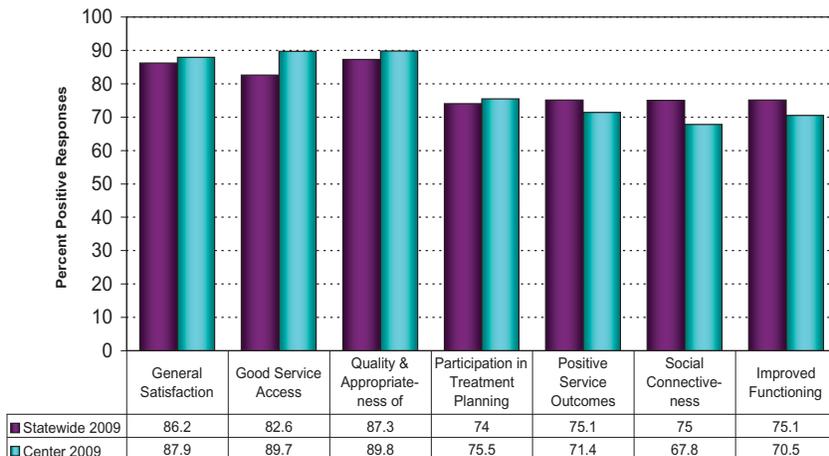
### Expected Payment Source At Admission Fiscal Year 2009



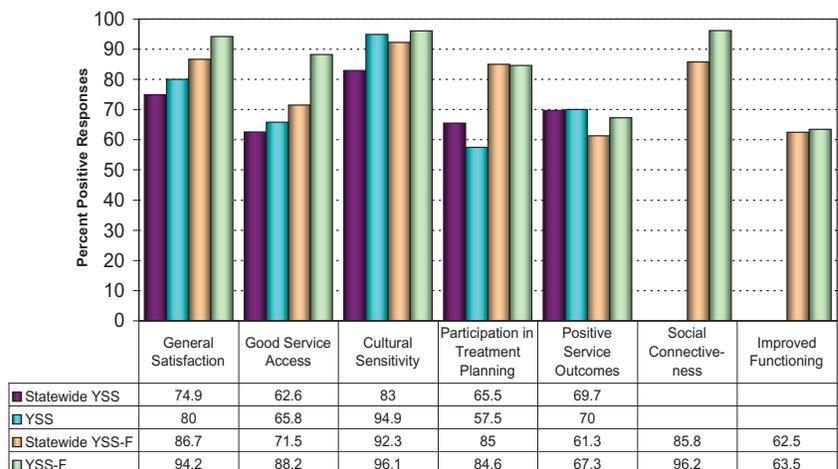
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



# Northeastern Counseling Center

Daggett, Duchesne & Uintah Counties



Population: 47,684



Proud supporter of Prevention Dimensions

- Prioritized Risk Factors**
- Availability
  - Attitudes Favorable to Problem Behavior
  - Parental Attitudes

- Priority Protective Factors**
- Opportunities for prosocial involvement
  - Recognition for involvement
  - Bonding

**Committed to Increased Awareness**

Presentations Include:

**Meth in the Industry**—Explains the addiction cycle and the attractiveness of meth to the oil industry.

**Methamphetamines in the Community**—Meth use affects our entire community including the user, families, place of work and our neighborhoods.

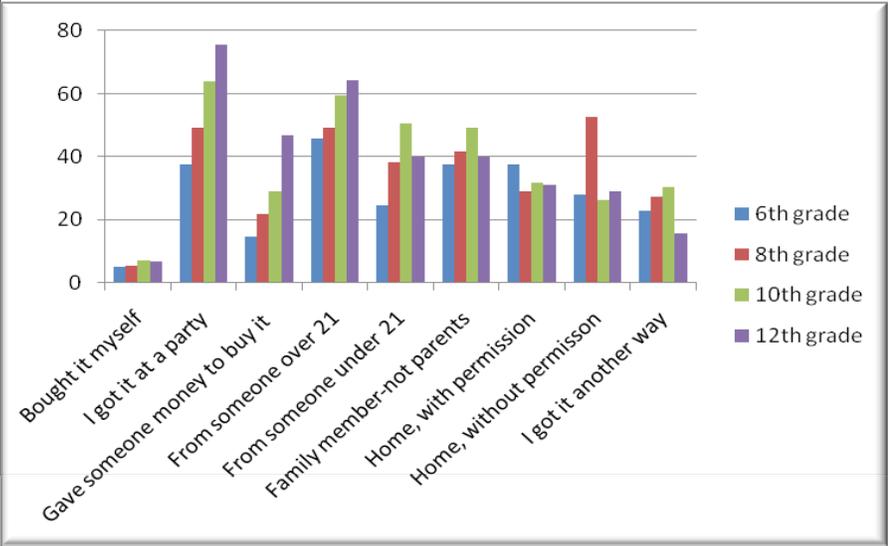
**Alcohol and the Teenage Brain**—Research shows that alcohol affects the teenage brain differently than the adult brain. Learn ways to reduce underage drinking.

**Prescription Drug Abuse/Misuse**—Defines abuse and shows ways prescription drugs are misused every day.

**Harmful Effects of Energy Drinks**—Learn the harmful effects of energy drinks. Presentation is adapted to age of audience.

\*\*\*Our prevention staff is eager to present prevention information to church groups, school health classes, community organizations, and health fairs.

**Sources and places of alcohol use**



**PRIME For Life** is an evidence-based alcohol and drug prevention program for people of all ages. It is designed to gently but powerfully challenge common beliefs and attitudes that directly contribute to high-risk alcohol and drug use. PRIME For Life is also the State-mandated DUI education program.

**PRIME Teens** is an evidence-based alcohol and drug prevention program for young adults, under 21. It is designed to gently but powerfully challenge common beliefs and attitudes that directly contribute to high-risk alcohol and drug use.

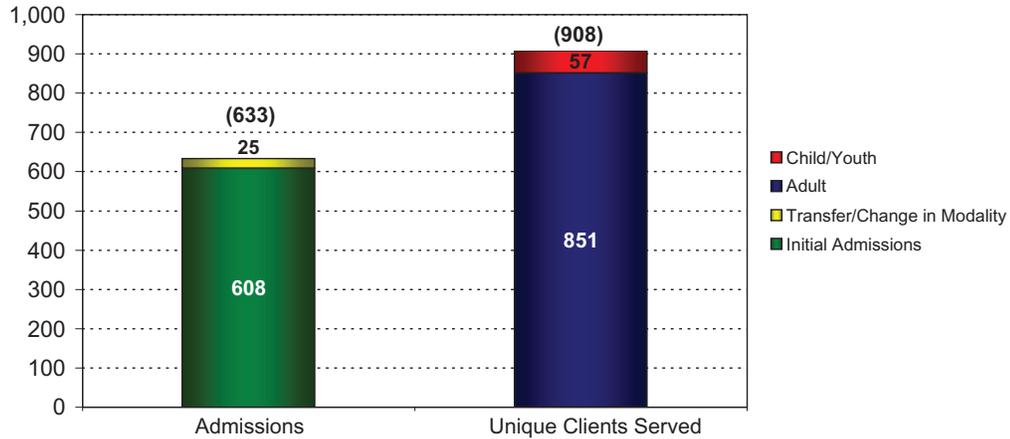
**SMART, SMART EASY** is offered in an effort to increase compliance in alcohol sales. SMART and SMART EASY are State-approved curriculum for on-premise and off-premise alcohol sales.

**Life Skills for Children of Addicted Parents** offer education and a safe and supportive environment for children of substance abusing parents, reducing isolation and enhancing protective factors.

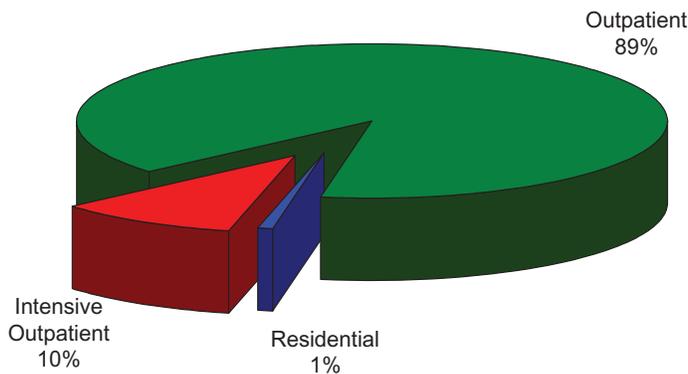
## Northeastern Counseling Center— Substance Abuse

2008 Population	Total Served	Penetration Rate
47,684	908	1.9%

### Admissions into Modalities and Clients Served Fiscal Year 2009



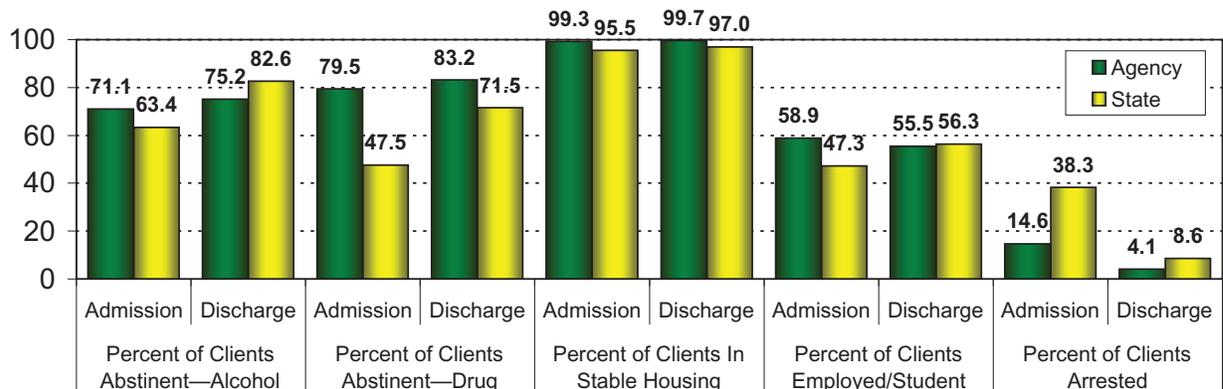
### Admission into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	215	99	314
Cocaine/Crack	8	6	14
Marijuana/Hashish	96	27	123
Heroin	3	1	4
Other Opiates/Synthetics	7	11	18
Hallucinogens	1	0	1
Methamphetamine	70	59	129
Other Stimulants	0	2	2
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	13	10	23
Club Drugs	1	0	1
Over-the-Counter	0	1	1
Other	1	0	1
Unkown	0	0	0
<b>Total</b>	<b>415</b>	<b>218</b>	<b>633</b>

## Northeastern Counseling Center Outcome Measures Fiscal Year 2009



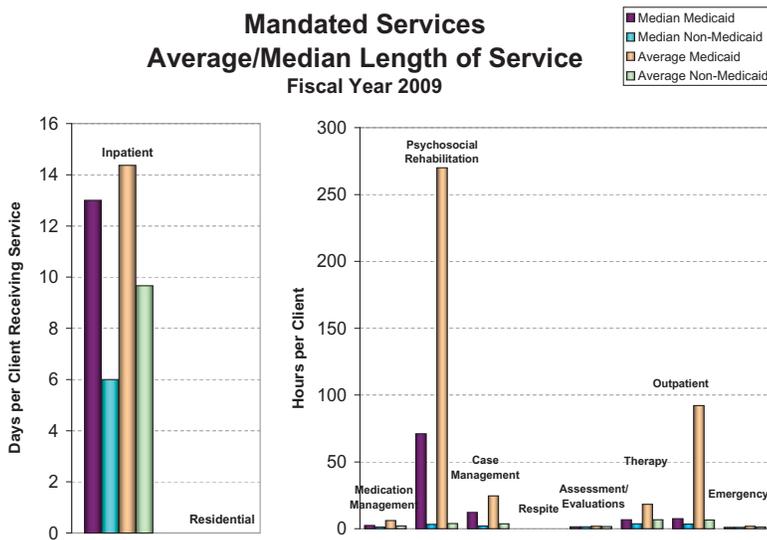
## Northeastern Counseling Center - Mental Health

Total Clients Served .....1,077  
 Adult .....696  
 Children/Youth.....381  
 Penetration Rate ..... 2.3%

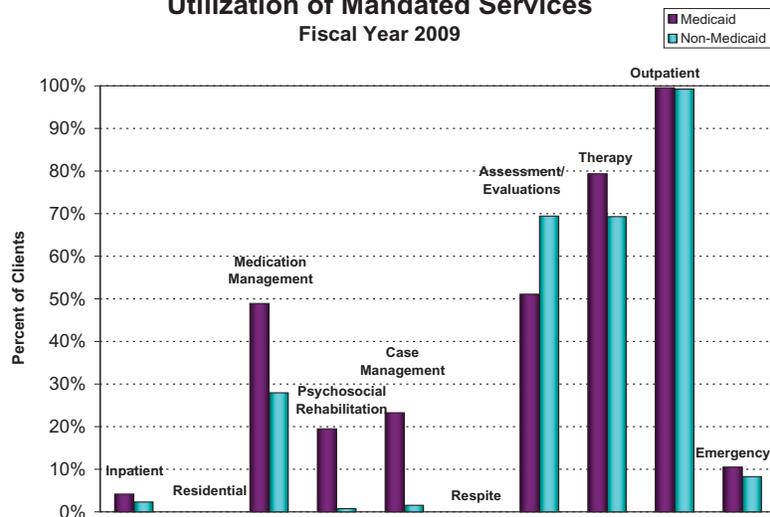
### Diagnosis

	Youth	Adult
Mood Disorders	105	452
Anxiety Disorders	113	373
Personality Disorders	2	132
Substance Abuse	22	129
Adjustment Disorders	88	71
Cognitive Disorders	8	36
Schizophrenia and Other Psychotic	7	106
Attention Deficit	84	53
Autism	15	7
Impulse Disorders	8	39
Neglect or Abuse	82	28
Conduct Disorders	14	0
Other	155	224
V Codes	52	116
<b>Total</b>	<b>755</b>	<b>1,766</b>

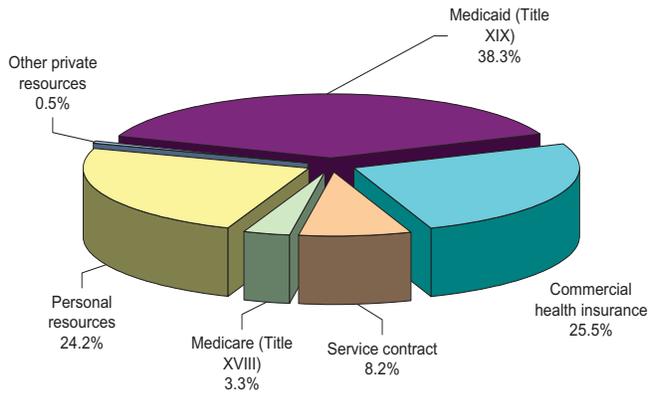
### Mandated Services Average/Median Length of Service Fiscal Year 2009



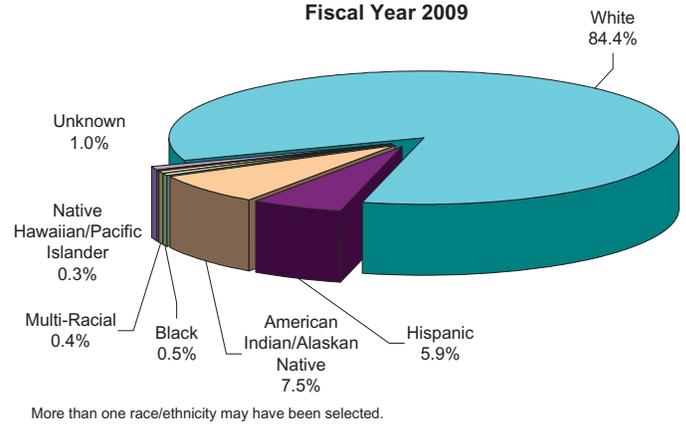
### Utilization of Mandated Services Fiscal Year 2009



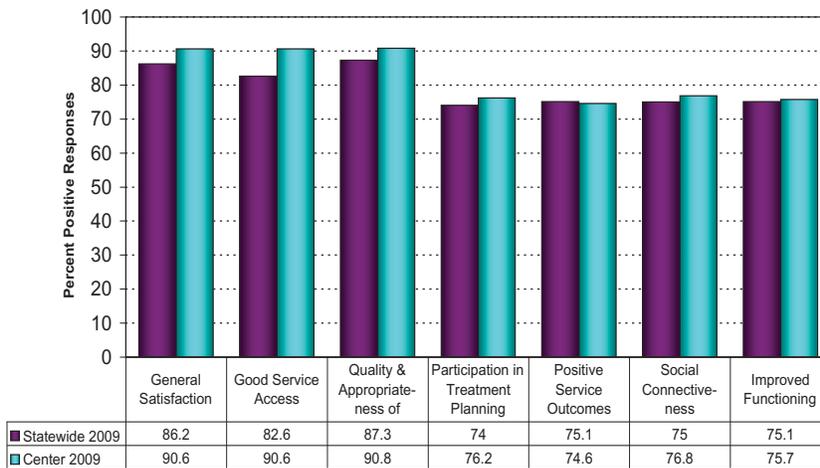
### Expected Payment Source At Admission Fiscal Year 2009



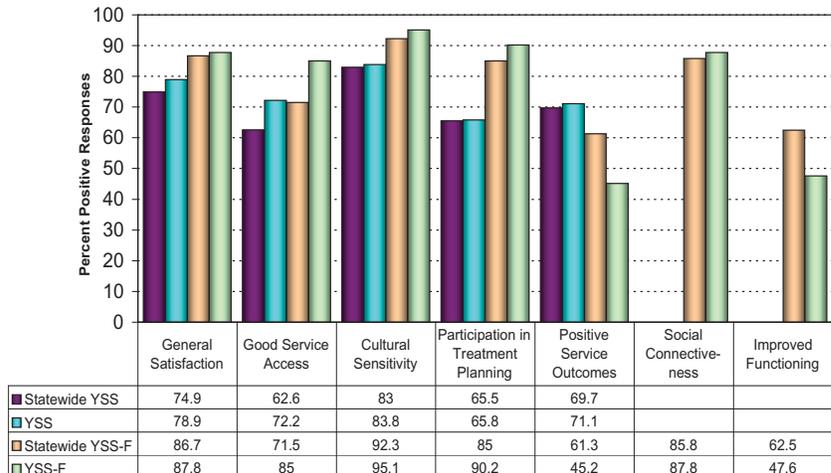
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



# Salt Lake County



Population: 1,030,519



### Prioritized Risk Factors

- Early Initiation of Use
- Attitudes Favorable to Problem Behavior
- Family Management

### Priority Protective Factors

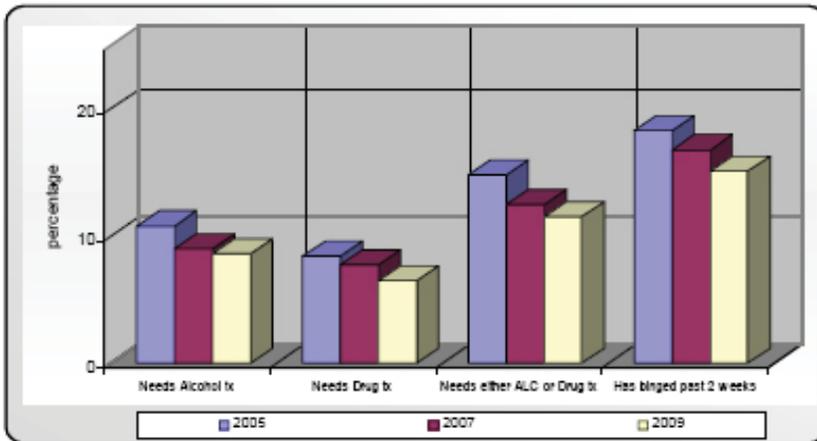
- Opportunities for prosocial involvement
- Recognition for involvement
- Bonding

Salt Lake County prevention services is a private-public partnership managed by the County and primarily provided by community-based businesses that are a part of the communities they serve.

### Some Funded Programs Addressing SLCo's Prioritized Factors:

- SLCo Aging
- Med checks
- Living Skills
- Asian Association of Utah
- Dare to Be You
- Family Crisis
- Academic Tutoring
- Social Skills
- Big Brother Big Sisters of SL
- Bonding—Mentoring
- Rewards
- Boys and Girls Club of Greater Salt Lake
- Smart Moves
- Centre de la Familia
- Nuevo Dia
- Parents as Teachers
- Children's Service Society
- Parenting
- Family Support
- Cornerstone Counseling Center
- Life Skills
- Families Plus
- Voices
- Living Skills
- SLCo Housing
- Parents as Teachers
- Too Good For Drugs
- Leadership/Resiliency
- Neighborhood Housing
- NeighborWorks
- Project Reality
- Parents Empowering Communities
- SPY HOP
- Vocational training
- Mentoring
- Valley Mental Health
- Parenting
- Pregnant Teen classes
- SLCo Youth Services
- Staying Connected with Your Teen
- Get Real About Violence
- Family Connections
- Youth Support Systems
- Taking Care of Me
- Strengthening Families

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights: 12<sup>th</sup> Grade - Decrease in Treatment Needs



**PRIME For Life** is an evidence-based alcohol and drug prevention program for adults. In Salt Lake County PRIME For Life is offered as prevention programming in the county jail. Last year 565 inmates completed the program.

**Continuum of Care:** Salt Lake County provides a complete continuum of prevention services ranging from general Universal services to Early Intervention and from prenatal services to working with aging populations.

**Community-Based Prevention:** With the Strategic Prevention Framework grant, Salt Lake County has identified high-risk communities within the county and is mobilizing them to address alcohol- and drug-related problems at the local level, including law enforcement, business, education, parents, clergy and families in recovery.

#### Examples of successful prevention services in Salt Lake County:

**GrandFamilies Program** earned "Model Program" status by the Justice Department.

**Boys and Girls Club of Salt Lake** was awarded best "After School Program" by Utah Family Magazine.

**YouthWorks**, with an 80% success rate last year, was certified as an "Effective" apprenticeship program by the Department of Labor.

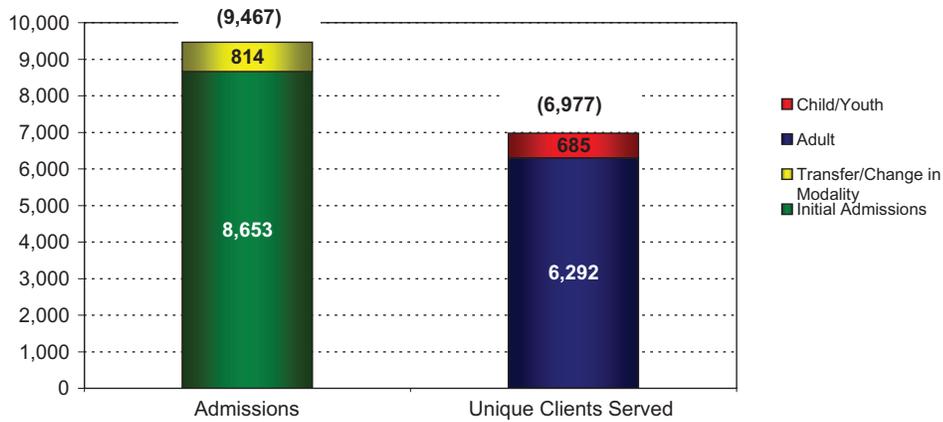
**Cornerstone's Living Skills Program** achieved an 83 percent success rate in improving behavior and positive relations with others among high risk youth.

**Big Brothers Big Sisters of Salt Lake** received "Gold Standard" for being in the top 24 programs in the country.

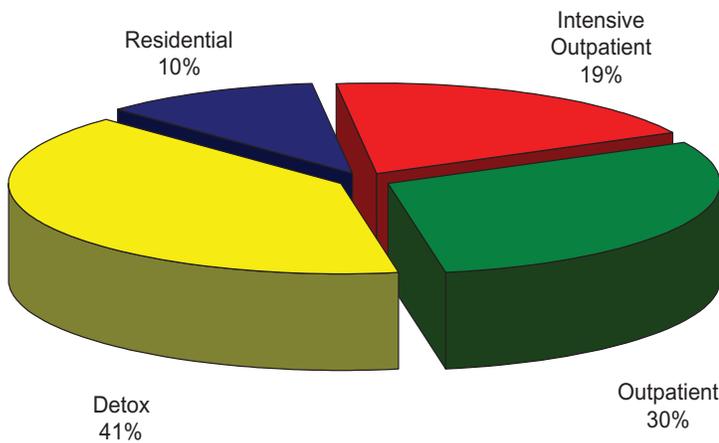
# Salt Lake County Division of Substance Abuse

2008 Population	Total Served	Penetration Rate
1,022,651	6,977	0.7%

## Admissions into Modalities and Clients Served Fiscal Year 2009



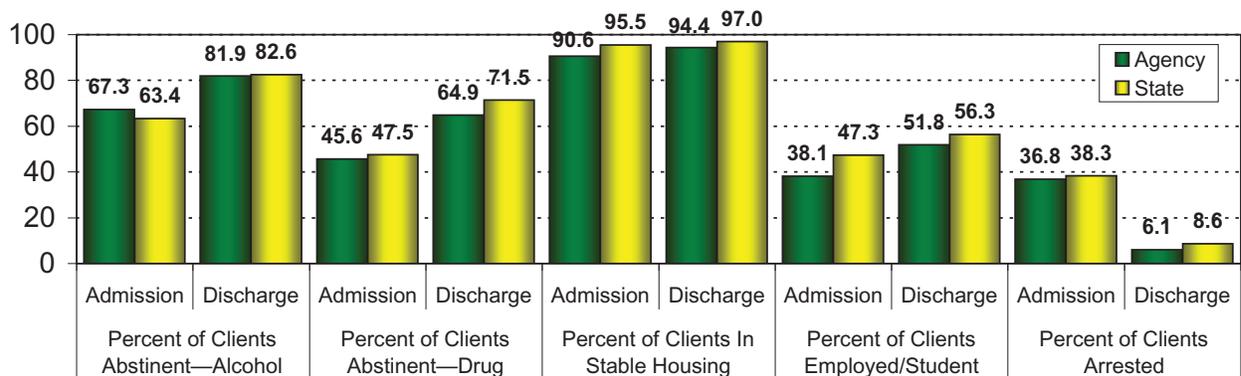
## Admissions into Modalities Fiscal Year 2009



## Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	2,884	737	3,621
Cocaine/Crack	644	275	919
Marijuana/Hashish	968	265	1,233
Heroin	1,016	526	1,542
Other Opiates/Synthetics	136	140	276
Hallucinogens	3	4	7
Methamphetamine	820	765	1,585
Other Stimulants	12	29	41
Benzodiazepines	13	13	26
Tranquilizers/Sedatives	3	14	17
Inhalants	3	1	4
Oxycodone	106	74	180
Club Drugs	6	4	10
Over-the-Counter	0	2	2
Other	3	1	4
Unkown	0	0	0
<b>Total</b>	<b>6,617</b>	<b>2,850</b>	<b>9,467</b>

## Salt Lake County Division of Substance Abuse Outcome Measures Fiscal Year 2009



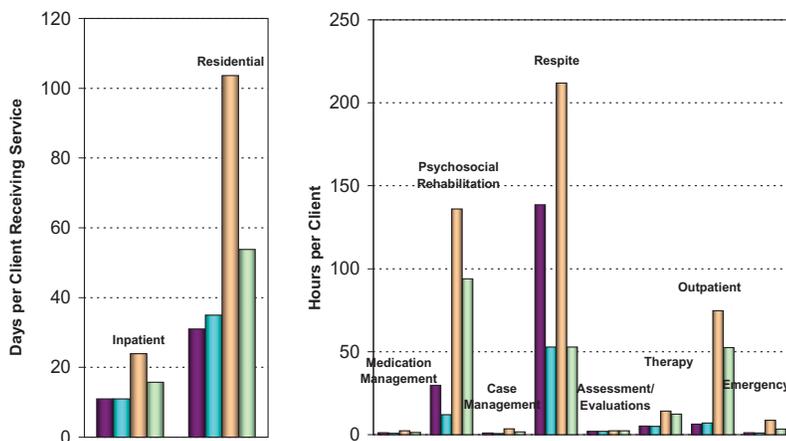
## Salt Lake County - Valley Mental Health

Total Clients Served.....15,284  
 Adult .....10,530  
 Children/Youth.....4,754  
 Penetration Rate ..... 1.5%

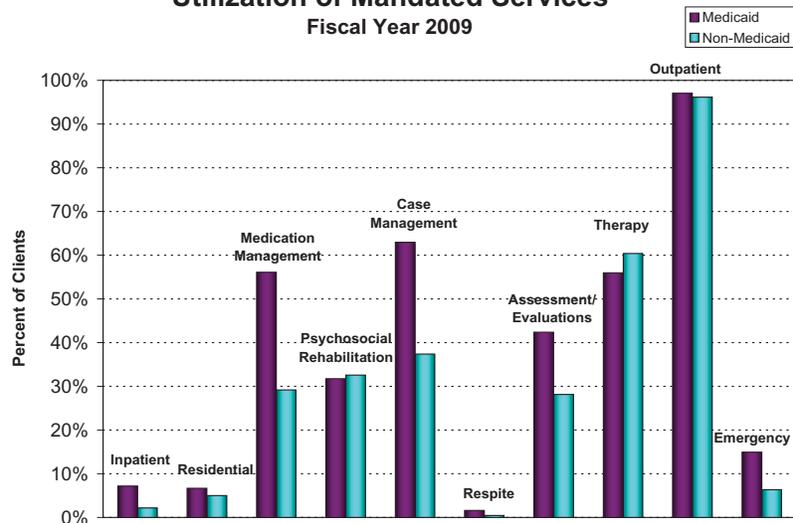
### Diagnosis

	Youth	Adult
Mood Disorders	1,601	5,865
Anxiety Disorders	1,537	3,663
Personality Disorders	22	2,713
Substance Abuse	615	5,970
Adjustment Disorders	682	251
Cognitive Disorders	117	431
Schizophrenia and Other Psychotic	80	2,260
Attention Deficit	1,577	494
Autism	548	136
Impulse Disorders	21	132
Neglect or Abuse	766	36
Conduct Disorders	231	21
Other	2,453	1,617
V Codes	838	1,830
<b>Total</b>	<b>11,088</b>	<b>25,419</b>

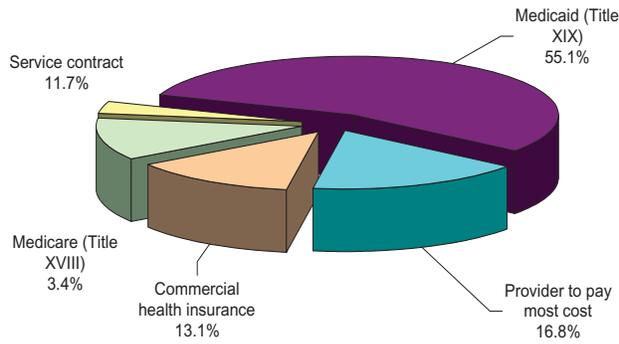
**Mandated Services  
 Average/Median Length of Service  
 Fiscal Year 2009**



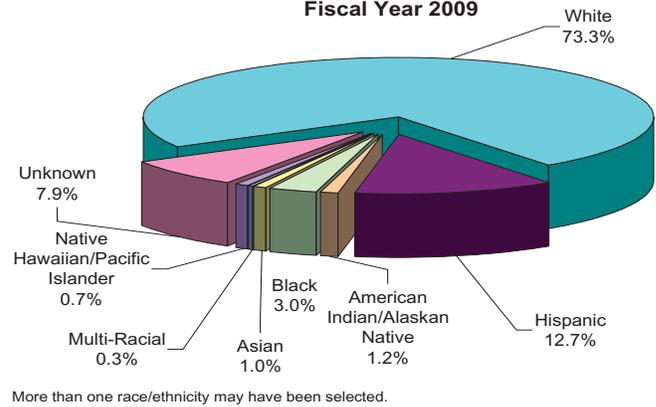
**Utilization of Mandated Services  
 Fiscal Year 2009**



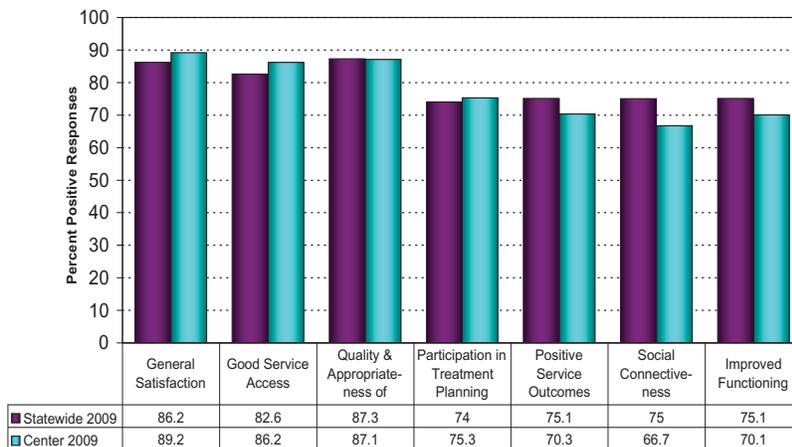
### Expected Payment Source At Admission Fiscal Year 2009



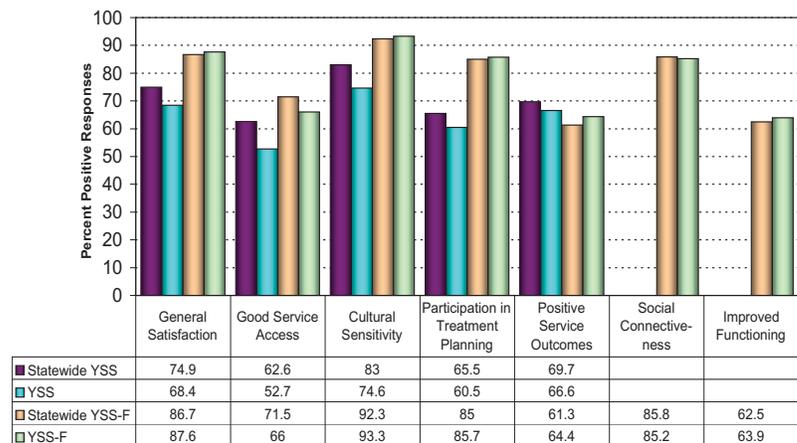
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



# San Juan County



Population: 14,413



### Prioritized Risk Factors

- Parental attitude favorable to anti-social behavior
- Academic failure
- Low commitment to school
- Depressive symptoms

### Priority Protective Factors

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

### Programs Addressing Risk Factors:

- Prevention Dimensions
- 6<sup>th</sup> Grade Orientation
- Post-Graduation Celebrations
- IPASS (Youth Referred from 7<sup>th</sup> District Juvenile Court)
- Synar Tobacco Checks
- Eliminate Alcohol Sales to Youth
- SPF-SIG Grant

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights

San Juan County  
Grade 8 Student Survey  
Life Time & 30 Day ATOD Use

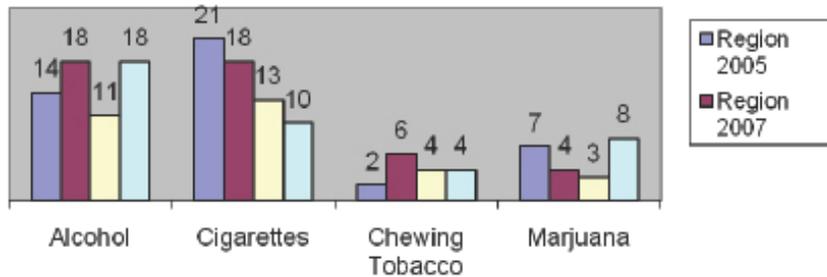


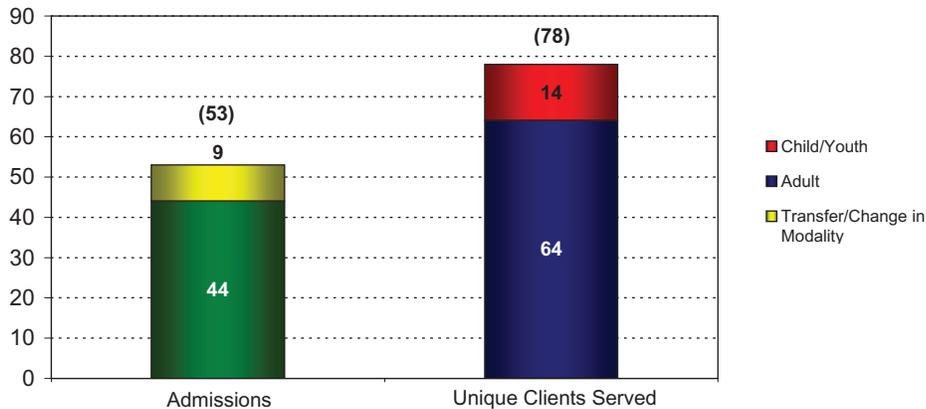
Table 5. Percentage of Students Who Used ATODs During the Past 30 Days

In the past 30 days, on how many occasions (if any) have you... (One or more occasions)	Grade 6				Grade 8				Grade 10				Grade 12	
	Region 2005	Region 2007	Region 2009	State 2009	Region 2005	Region 2007	Region 2009	State 2009	Region 2005	Region 2007	Region 2009	State 2009	Region 2009	State 2009
Alcohol had alcoholic beverages (beer, wine or hard liquor) to drink - more than just a few sips?	0.0	0.0	1.8	1.3	6.9	5.3	0.0	6.6	10.0	16.0	9.8	12.9	12.5	17.1
Cigarettes smoked cigarettes?	1.0	4.4	1.9	0.7	5.3	1.3	2.8	2.8	0.0	19.6	5.0	5.8	10.4	8.3
Chewing Tobacco used smokeless tobacco (chew, snuff, plug, dipping tobacco, chewing tobacco)?	2.1	1.0	2.8	0.5	0.0	2.6	2.8	1.3	0.0	4.0	3.8	2.9	6.2	3.7
Marjuana used marijuana (grass, pot) or hashish (hash, hash oil)?	1.0	0.0	0.9	0.4	3.4	2.6	1.9	3.2	7.5	4.1	2.5	7.4	4.2	8.0

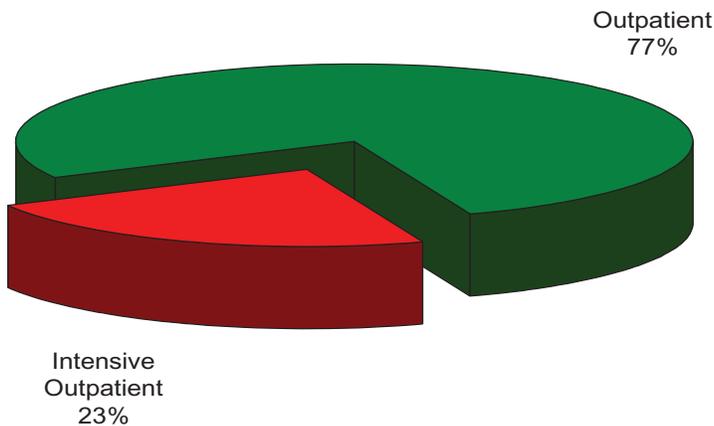
## San Juan Counseling - Substance Abuse

2008 Population	Total Served	Penetration Rate
15,055	78	0.5%

### Admissions into Modalities and Clients Served Fiscal Year 2009



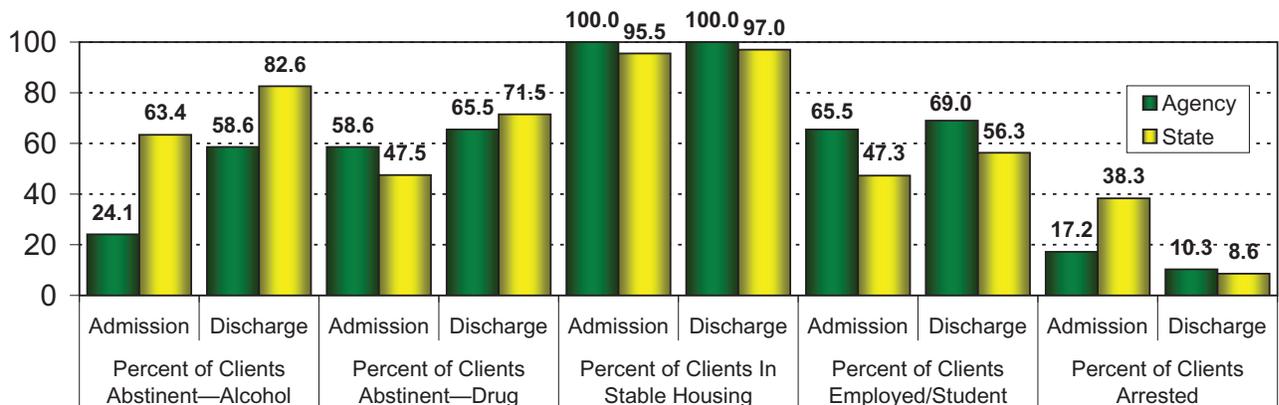
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	23	5	28
Cocaine/Crack	11	3	14
Marijuana/Hashish	0	0	0
Heroin	0	0	0
Other Opiates/Synthetics	0	1	1
Hallucinogens	0	0	0
Methamphetamine	3	4	7
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	3	0	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
<b>Total</b>	<b>40</b>	<b>13</b>	<b>53</b>

## San Juan Counseling Outcome Measures Fiscal Year 2009



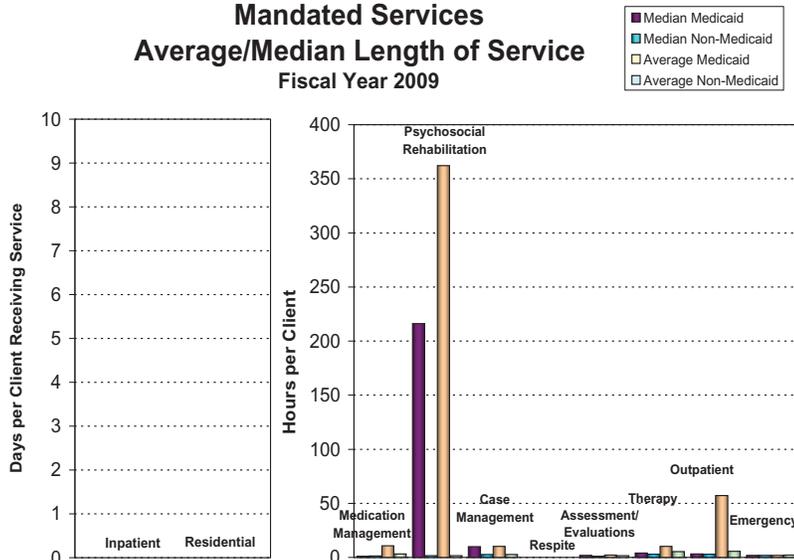
## San Juan Counseling - Mental Health

Total Clients Served .....483  
 Adult .....316  
 Children/Youth .....167  
 Penetration Rate ..... 3.2%

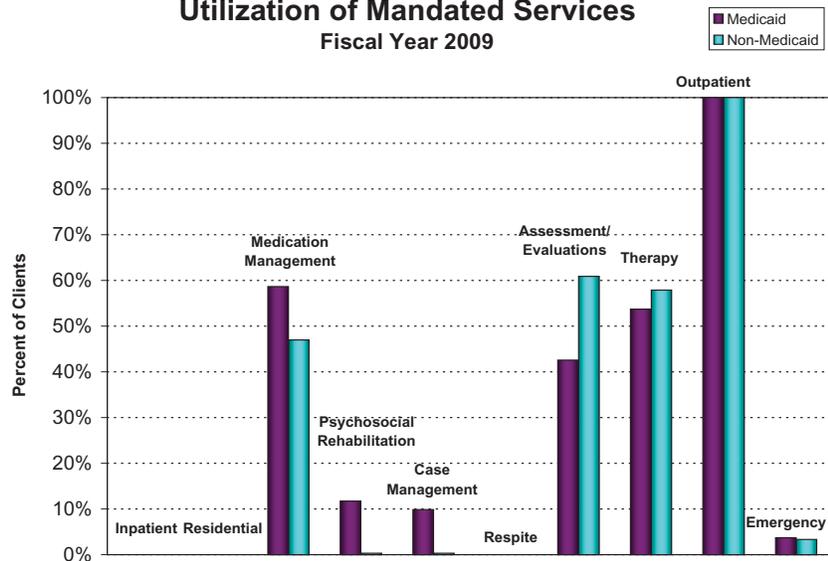
### Diagnosis

	Youth	Adult
Mood Disorders	45	174
Anxiety Disorders	39	83
Personality Disorders	1	23
Substance Abuse	0	17
Adjustment Disorders	31	15
Cognitive Disorders	2	28
Schizophrenia and Other Psychotic	2	19
Attention Deficit	43	5
Autism	13	4
Impulse Disorders	4	4
Neglect or Abuse	7	2
Conduct Disorders	0	0
Other	27	34
V Codes	16	19
<b>Total</b>	<b>230</b>	<b>427</b>

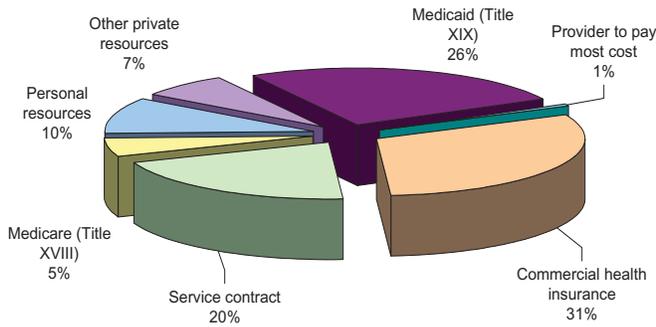
### Mandated Services Average/Median Length of Service Fiscal Year 2009



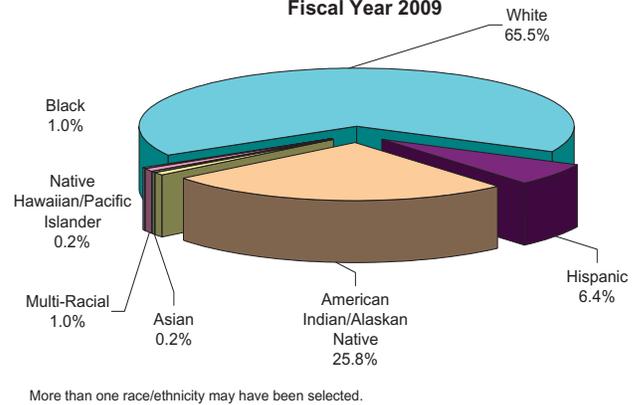
### Utilization of Mandated Services Fiscal Year 2009



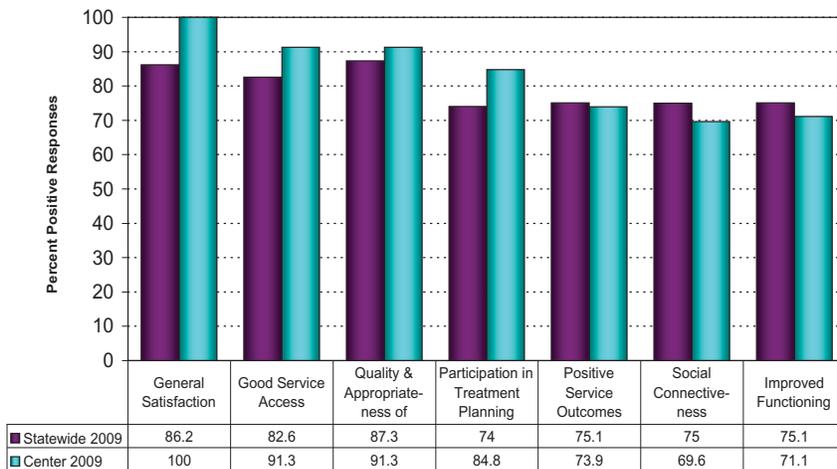
### Expected Payment Source At Admission Fiscal Year 2009



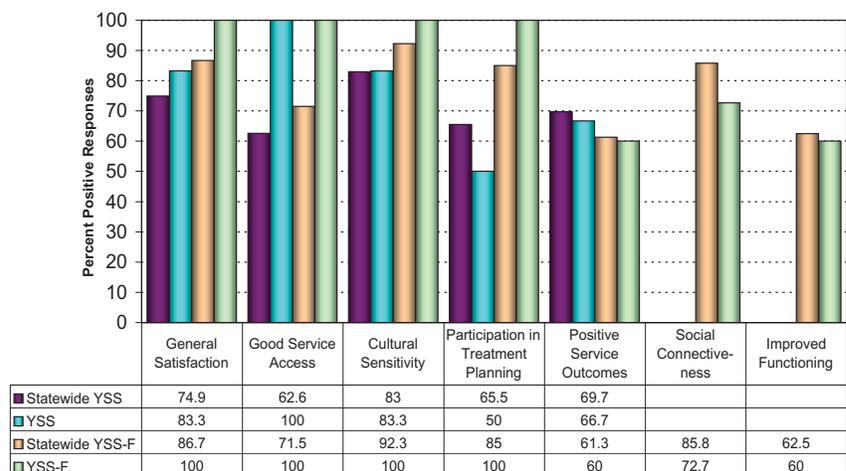
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



## Southwest Behavioral Health Center

Beaver, Garfield, Iron, Kane, and Washington Counties

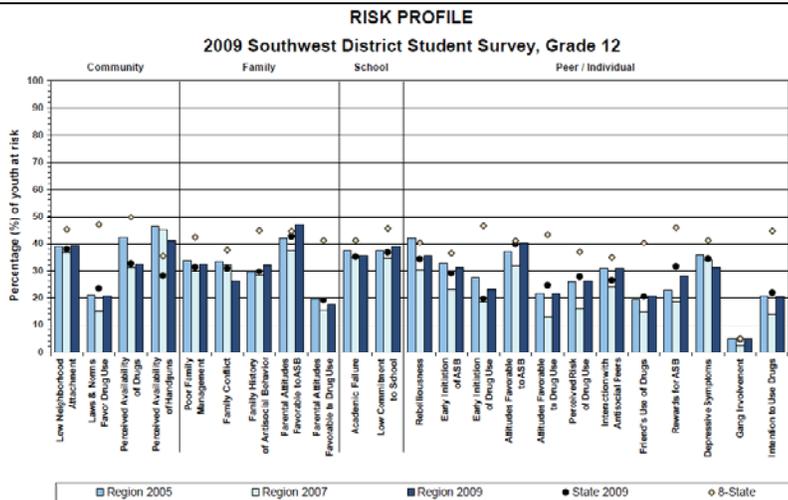


Population: 199,526



At Southwest Prevention, we strive to be proactive in promoting positive lifestyles. We focus on skill building for individuals, families, institutions and organizations. Our services are aimed to impact the general public and local school districts regarding such relevant issues as alcohol, drug and tobacco information, parenting skills, stress reduction techniques, building self esteem and life skills.

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights



### Student Assistance:

Currently, more than 600 youth in over 20 schools in the Southwest five-county area are enrolled in Student Assistance Programs. 88% of students in this program increased their grade point average and 85% decreased school absences by the end of their first year in the program. This number increased to 93% over four years.

### What's NEW with Southwest Prevention:

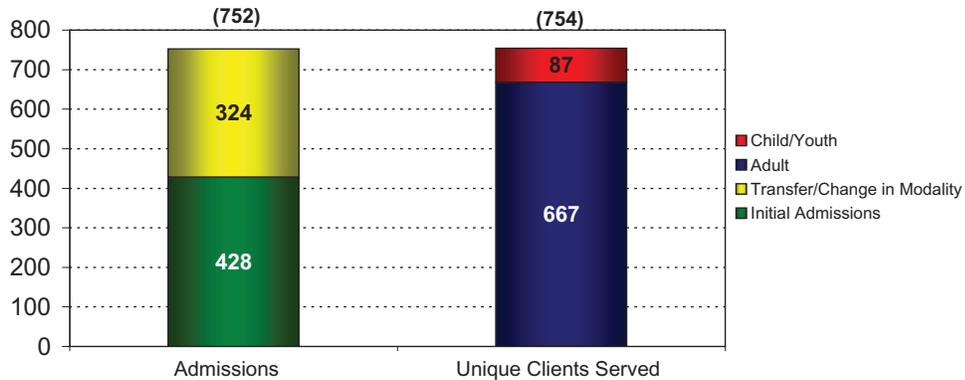
In 2008, Southwest Prevention conducted key community leader interviews that revealed a common sentiment that citizens have no resources available to them regarding substance abuse questions. In an effort to provide the communities with this information, Southwest Prevention (with the help of community prevention coalitions) has developed and launched a website: [WWW.SouthwestPrevention.com](http://WWW.SouthwestPrevention.com).

Evidence-based prevention programs can be cost effective. Current research shows that for each dollar invested in prevention services, a savings of up to \$10 in treatment for alcohol other substance abuse can be seen.

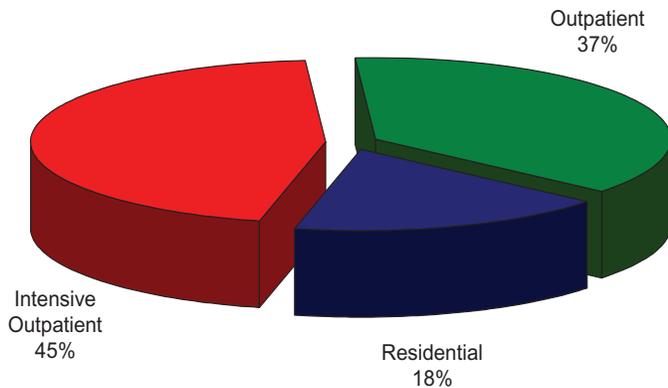
## Southwest Behavioral Health Center - Substance Abuse

2008 Population	Total Served	Penetration Rate
199,526	754	0.4%

### Admissions into Modalities and Clients Served Fiscal Year 2009



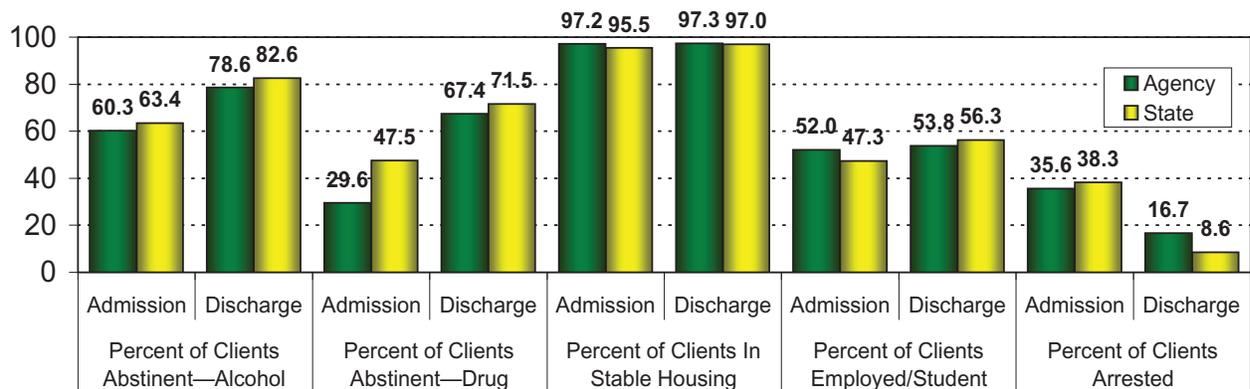
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	148	68	216
Cocaine/Crack	4	7	11
Marijuana/Hashish	107	37	144
Heroin	61	27	88
Other Opiates/Synthetics	18	8	26
Hallucinogens	0	1	1
Methamphetamine	92	87	179
Other Stimulants	2	0	2
Benzodiazepines	0	3	3
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	44	33	77
Club Drugs	0	0	0
Over-the-Counter	3	0	3
Other	0	1	1
Unkown	0	0	0
<b>Total</b>	<b>479</b>	<b>273</b>	<b>752</b>

## Southwest Behavioral Health Outcome Measures Fiscal Year 2009



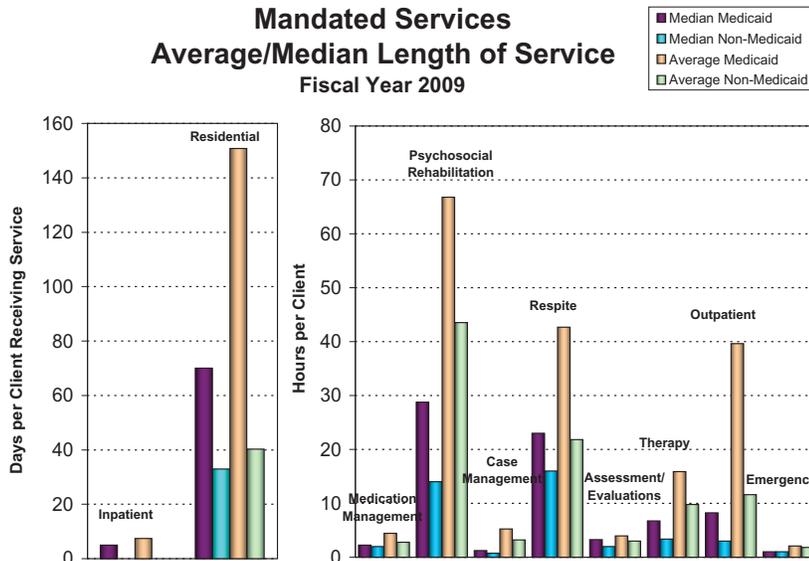
## Southwest Behavioral Health Center - Mental Health

Total Clients Served.....2,507  
 Adult .....1,212  
 Children/Youth.....1,295  
 Penetration Rate ..... 1.3%

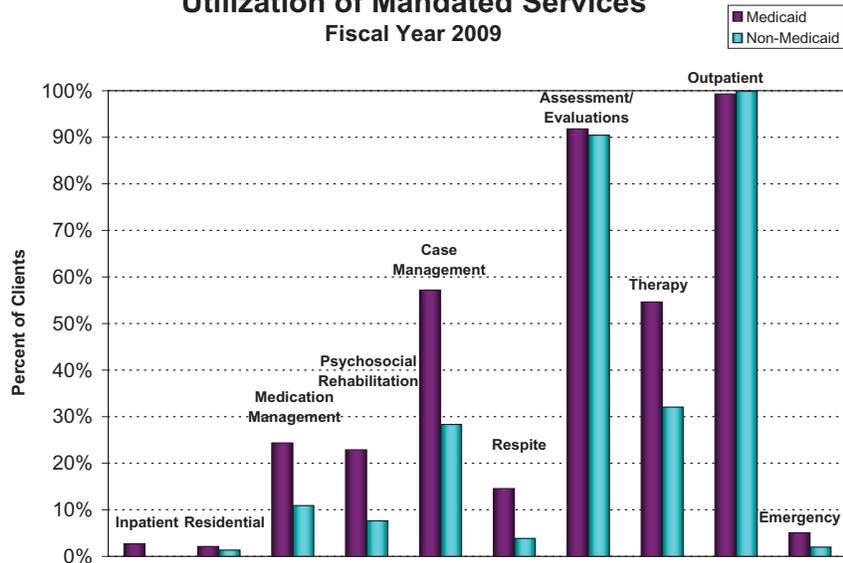
### Diagnosis

	Youth	Adult
Mood Disorders	214	627
Anxiety Disorders	154	198
Personality Disorders	5	255
Substance Abuse	8	44
Adjustment Disorders	330	137
Cognitive Disorders	25	82
Schizophrenia and Other Psychotic	3	237
Attention Deficit	112	9
Autism	42	19
Impulse Disorders	16	20
Neglect or Abuse	138	21
Conduct Disorders	30	1
Other	448	499
V Codes	117	80
<b>Total</b>	<b>1,642</b>	<b>2,229</b>

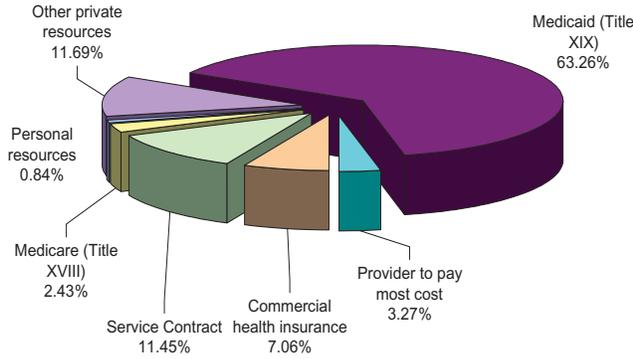
### Mandated Services Average/Median Length of Service Fiscal Year 2009



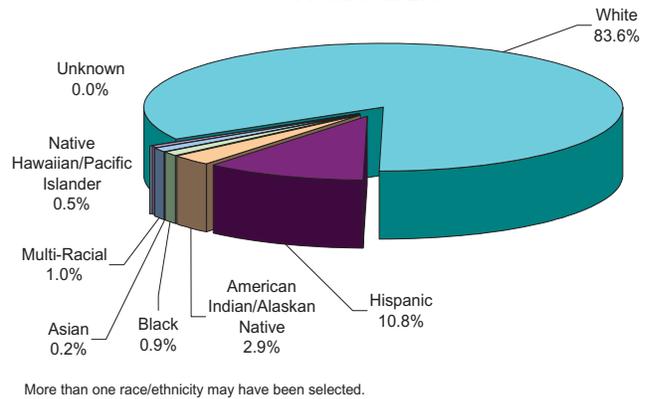
### Utilization of Mandated Services Fiscal Year 2009



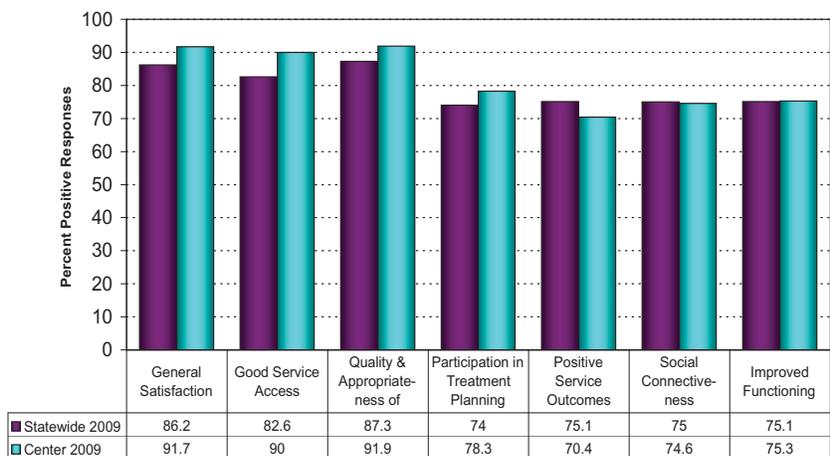
### Expected Payment Source At Admission Fiscal Year 2009



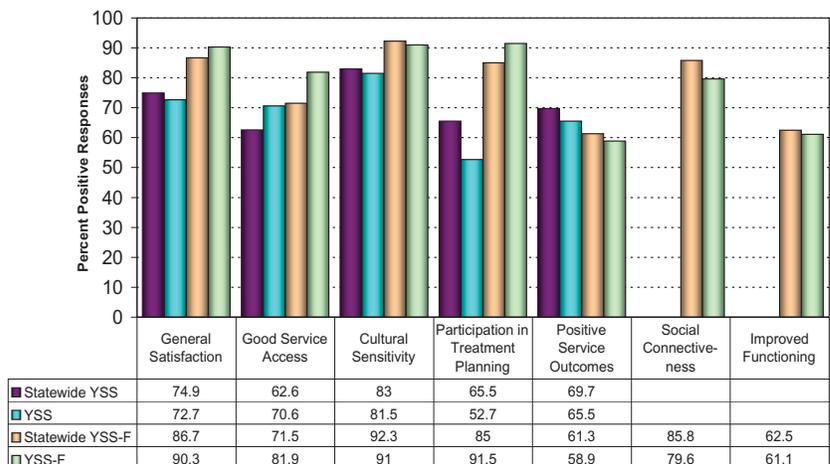
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



# Summit County

Park City, South Summit, North Summit



Population: 36,500



### Prioritized Risk Factors

- Laws and norms favorable to drug use
- Attitudes favorable to drug use
- Favorable parental attitudes towards drug use

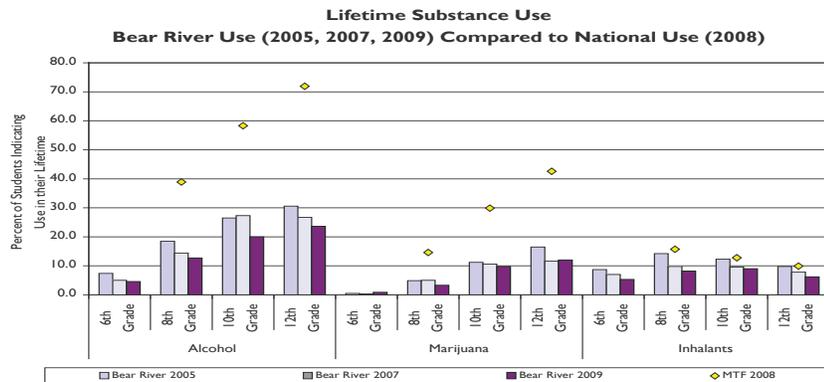
### Priority Protective Factors

- Opportunities for prosocial involvement
- Prosocial involvement

### Prevention Programs in Summit County:

- Prime for Life—DUI Classes in English and Spanish
- Parenting Classes
- Peer Leaders—South/North Summit High Schools
- Women’s Jail Group
- Ribbon Week
- TV Turn-Off Week
- Domestic Violence Coalition
- Sport/Activity Trading Cards w/drug-free message
- Latina Girl’s Groups
- Prevention Dimensions
- Parents Empowered promotions and events
- Town Hall Meetings
- 5<sup>th</sup> Grade Teach-Ins

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights



### Program Highlights:

- **Peer Leaders—South and North Summit High Schools**  
 Peer Leaders are a group of high school students that have been selected by their peers as people that they are comfortable confiding in. The Prevention Team, along with the Health Dept., provides monthly topics about current teen issues, including mental health and substance abuse. The Peer Leaders raise awareness in the elementary schools during Ribbon Week by providing anti-drug and alcohol messages.
- **Womens Jail Group**  
 Twice a week the women of the Summit County Jail meet as a group and discuss life skills education, prevention, recovery, etc. They are allowed during class time to crochet hats, blankets, scarves, etc. for the Peace House and the Children’s Justice Center.

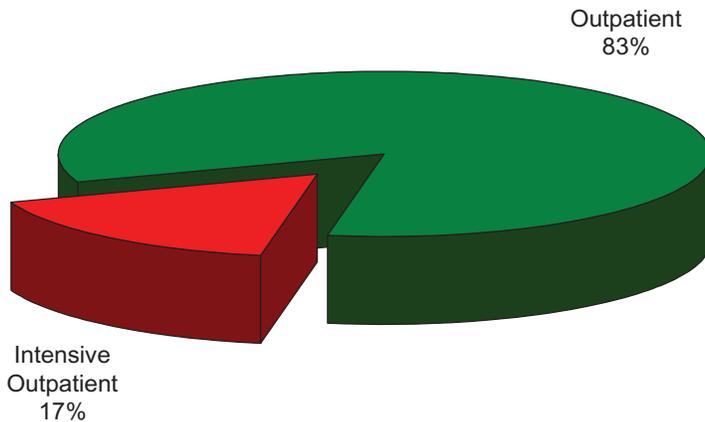
## Summit County - Valley Mental Health - Substance Abuse

2008 Population	Total Served	Penetration Rate
36,100	302	0.8%

### Admissions into Modalities and Clients Served Fiscal Year 2009



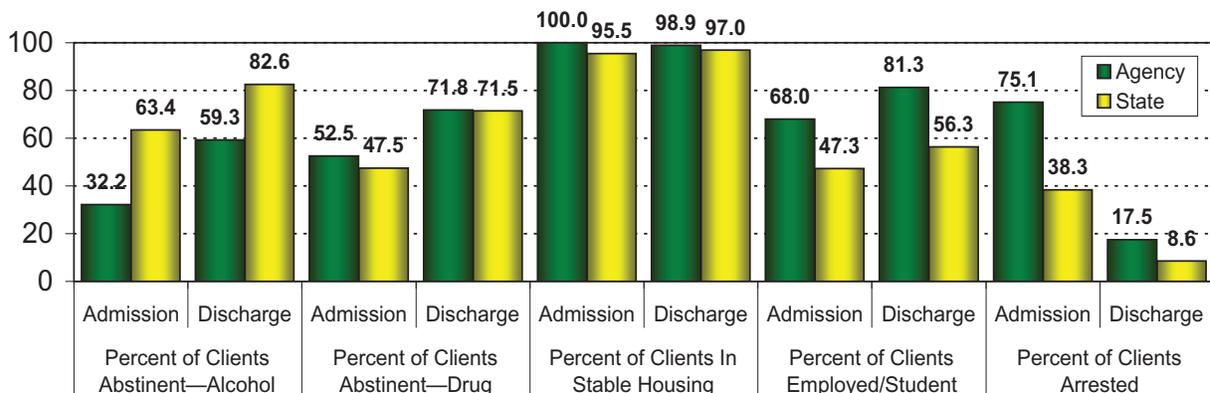
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	87	45	132
Cocaine/Crack	5	0	5
Marijuana/Hashish	25	8	33
Heroin	4	0	4
Other Opiates/Synthetics	4	1	5
Hallucinogens	0	0	0
Methamphetamine	1	5	6
Other Stimulants	1	1	2
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	1	0	1
Oxycodone	1	2	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unkown	0	0	0
<b>Total</b>	<b>129</b>	<b>62</b>	<b>191</b>

## Summit County—VMH Outcome Measures Fiscal Year 2009



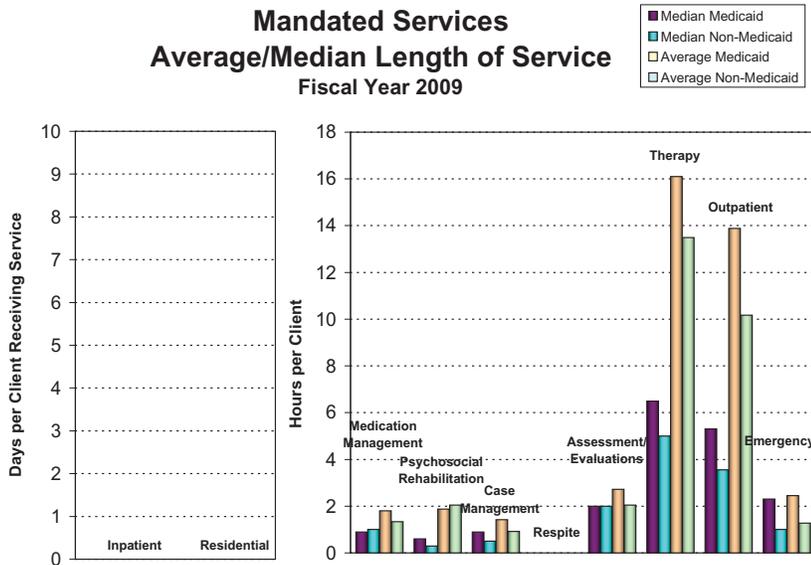
## Summit County - Valley Mental Health - Mental Health

Total Clients Served.....843  
 Adult .....661  
 Children/Youth.....182  
 Penetration Rate ..... 2.4%

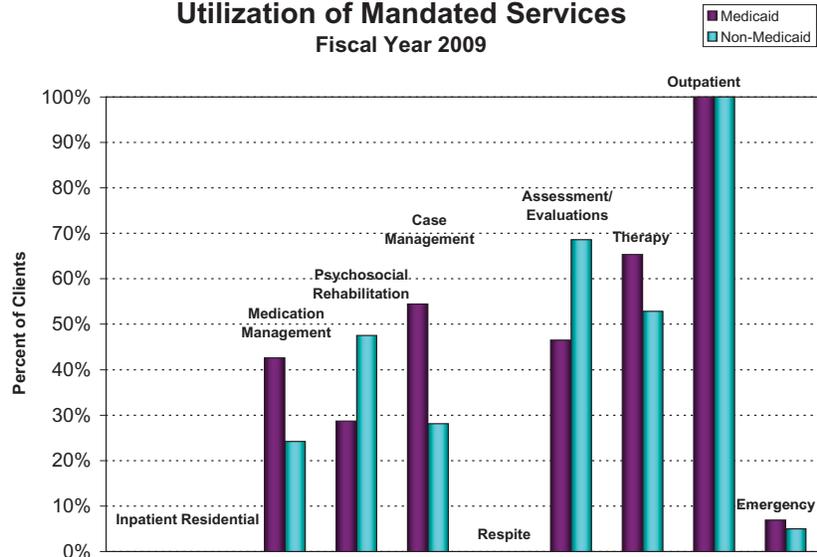
### Diagnosis

	Youth	Adult
Mood Disorders	94	331
Anxiety Disorders	68	242
Personality Disorders	0	32
Substance Abuse	68	514
Adjustment Disorders	56	71
Cognitive Disorders	1	7
Schizophrenia and Other Psychotic	1	16
Attention Deficit	49	42
Autism	6	3
Impulse Disorders	2	9
Neglect or Abuse	10	2
Conduct Disorders	6	0
Other	69	140
V Codes	97	219
<b>Total</b>	<b>527</b>	<b>1,628</b>

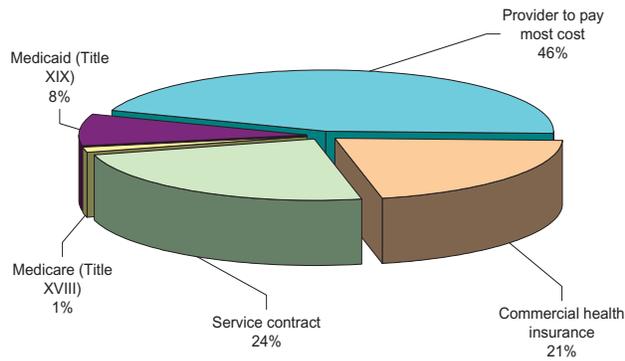
### Mandated Services Average/Median Length of Service Fiscal Year 2009



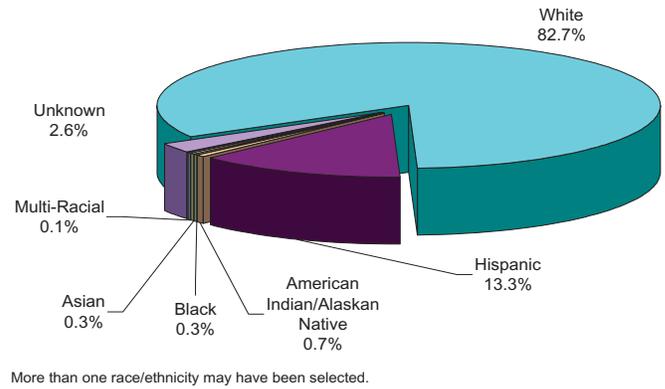
### Utilization of Mandated Services Fiscal Year 2009



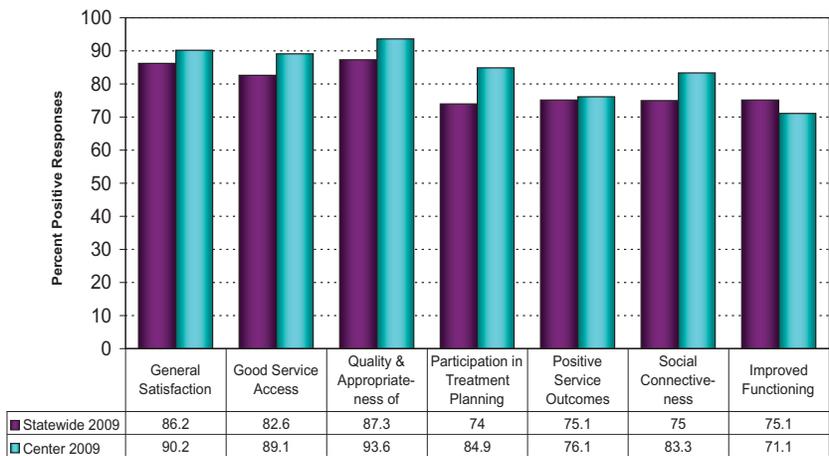
### Expected Payment Source At Admission Fiscal Year 2009



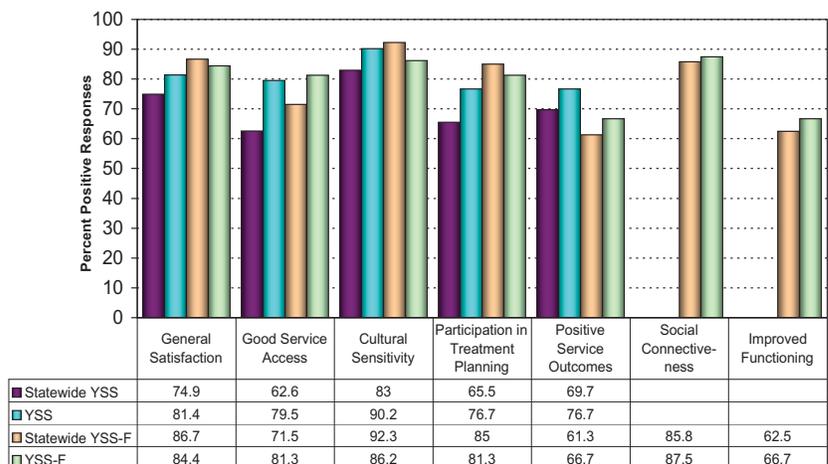
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



# Tooele County



Population: 60,000

## Tooele Interagency Prevention Professionals

### Mission Statement

Through collaborative programming and networking, provide the citizens of Tooele County the support, guidance, and resources to improve their quality of life by being drug free, healthy, and contributing members of society.

### Vision Statement

We empower the citizens of Tooele County to make informed decisions regarding health, relationships, careers, and the pursuit of their goals.

Provide oversight of all prevention programs and services throughout Tooele County, ensuring prevention programming is using best practices and guiding principles.



### Prioritized Risk Factors

- Interaction with Antisocial Peer
- Academic Failure
- Attitudes Favorable to Drug Use
- Low Neighborhood Attachment

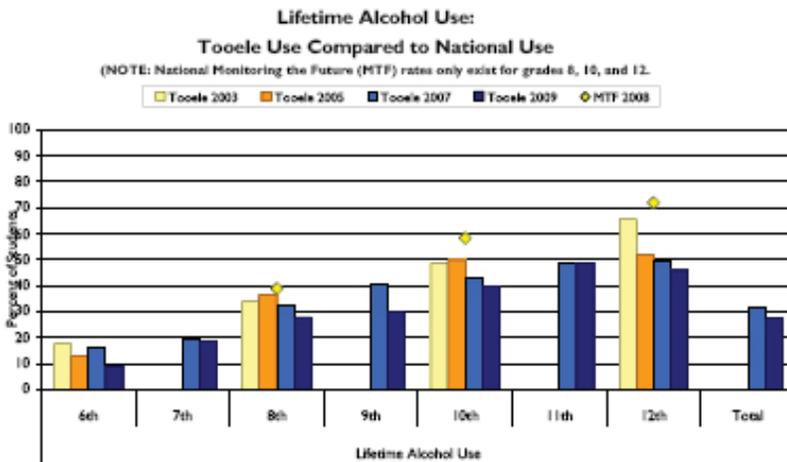
### Priority Protective Factors

- School Opportunities and Rewards for Prosocial Involvement
- Family Attachment
- Social Skills

### VMH Prevention Program Highlights

- Prevention Dimensions
- Healthy Life Skills Classes
- Young Mothers
- Tooele County Summit
- Tutoring Program
- PRIME For Life DUI Course
- Teen Alcohol and Drug School (TADS)
- Youth PAC Team (Prevention Advocacy Coalition)
- Presentations and Public Awareness
- SPF/SIG Grant to reduce prescription drug use and abuse

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights



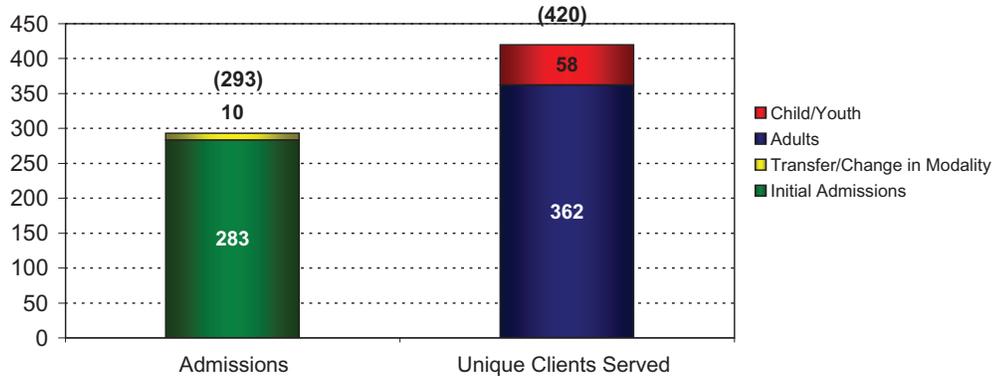
Tooele County recognizes that underage drinking has become a growing problem throughout Utah and that underage drinking hurts everyone. With the awareness that it is a community problem that requires a community solution, and it all starts with perceptions about underage drinking, Tooele County has an underage drinking prevention campaign, MostDont.org. If you ask teenagers in Tooele schools how many kids drink, the students will tell you “a lot.” They’ll tell you that most teenagers, especially in high school, have at least tried alcohol. But the fact is they’re wrong!

Research shows that seven out of 10 teenagers in Tooele County have never tried alcohol. Teenagers in Tooele think they are under incredible peer pressure to drink. But in reality, that pressure doesn’t exist. The campaign’s objective is to let teens know the truth about who is and who isn’t drinking. It’s designed to let kids know that they’re normal if they don’t drink. Additionally, for those who are drinking, it informs them of the potential harmful effects of their decision. A 13-year-old who begins drinking has almost a 50% chance of becoming an alcoholic, versus just a 7% chance for a 21-year-old. And it contributes to drug use, violence, truancy, suicide and more. Unlike other campaigns, MostDont.org is aimed directly at teens and pre-teens. Valley Mental Health is a proud partner with the Tooele County School District in making this campaign a success!!

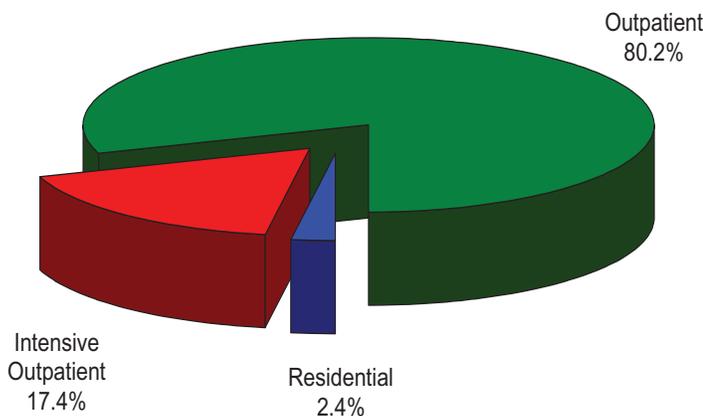
## Tooele County - Valley Mental Health - Substance Abuse

2008 Population	Total Served	Penetration Rate
56,941	420	0.7%

### Admissions into Modalities and Clients Served Fiscal Year 2009



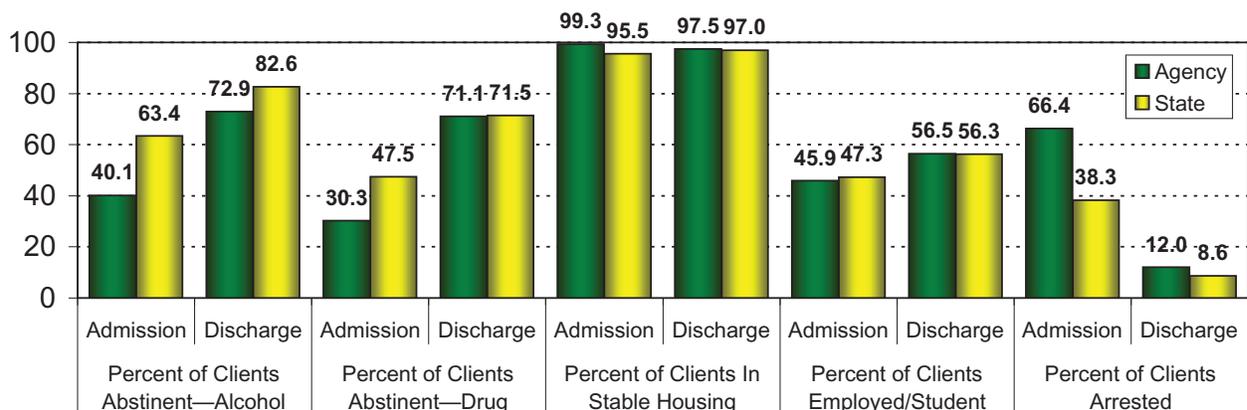
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	104	35	139
Cocaine/Crack	7	1	8
Marijuana/Hashish	62	19	81
Heroin	9	7	16
Other Opiates/Synthetics	3	5	8
Hallucinogens	1	0	1
Methamphetamine	13	14	27
Other Stimulants	2	0	2
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	5	4	9
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	0	1
Unkown	0	0	0
<b>Total</b>	<b>207</b>	<b>86</b>	<b>293</b>

## Tooele County—VMH Outcome Measures Fiscal Year 2009



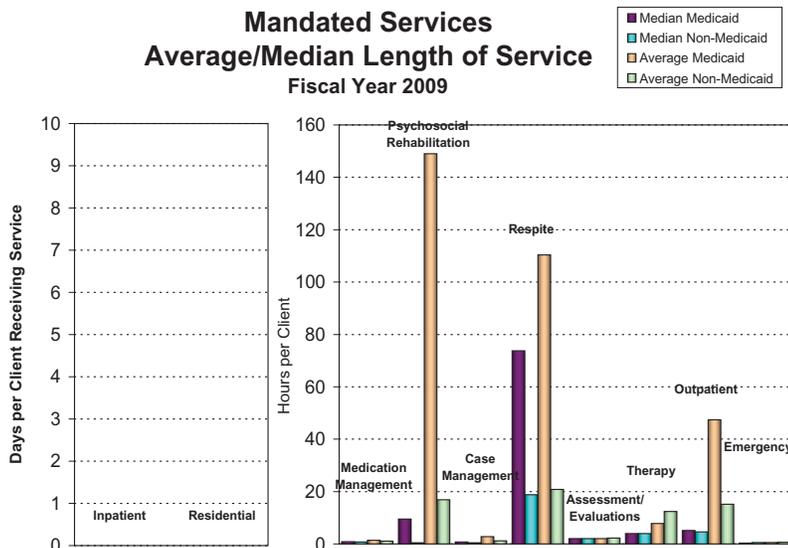
## Tooele County - Valley Mental Health - Mental Health

Total Clients Served.....1,982  
 Adult .....1,427  
 Children/Youth.....555  
 Penetration Rate ..... 3.5%

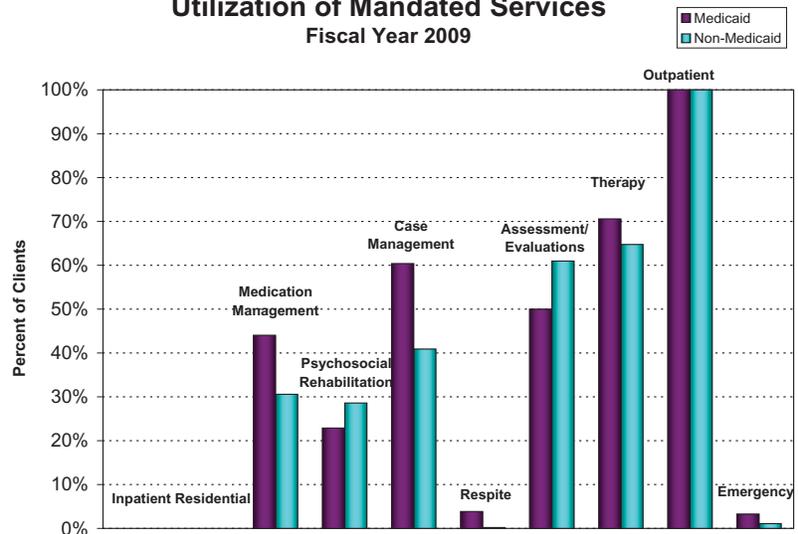
### Diagnosis

	Youth	Adult
Mood Disorders	230	837
Anxiety Disorders	181	524
Personality Disorders	5	206
Substance Abuse	158	894
Adjustment Disorders	76	50
Cognitive Disorders	11	15
Schizophrenia and Other Psychotic	1	84
Attention Deficit	138	97
Autism	28	4
Impulse Disorders	4	9
Neglect or Abuse	141	3
Conduct Disorders	40	4
Other	247	108
V Codes	109	265
<b>Total</b>	<b>1,369</b>	<b>3,100</b>

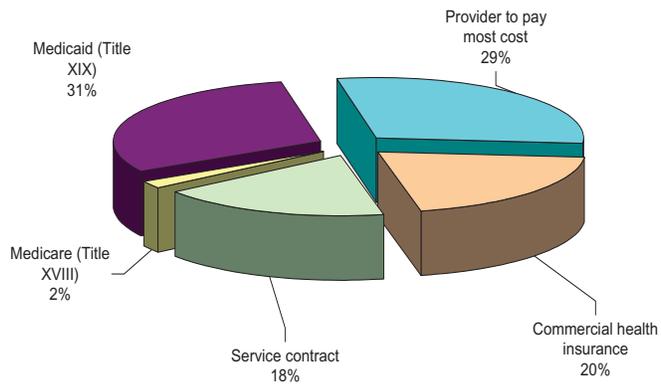
### Mandated Services Average/Median Length of Service Fiscal Year 2009



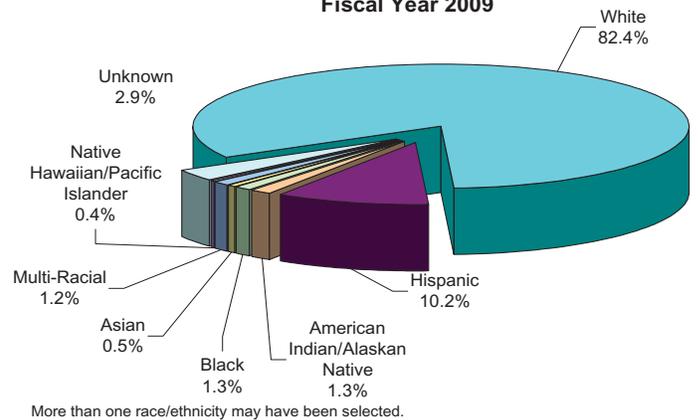
### Utilization of Mandated Services Fiscal Year 2009



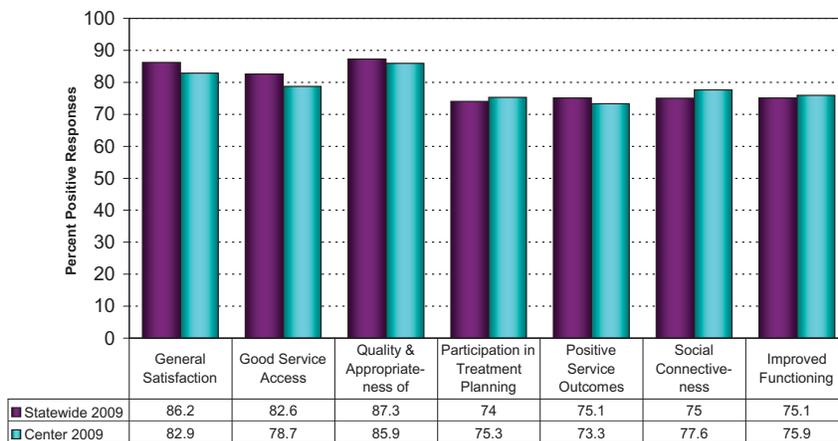
### Expected Payment Source At Admission Fiscal Year 2009



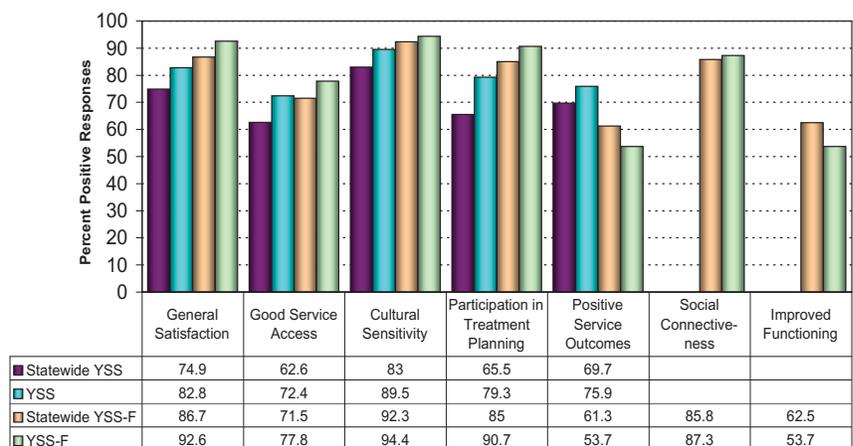
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



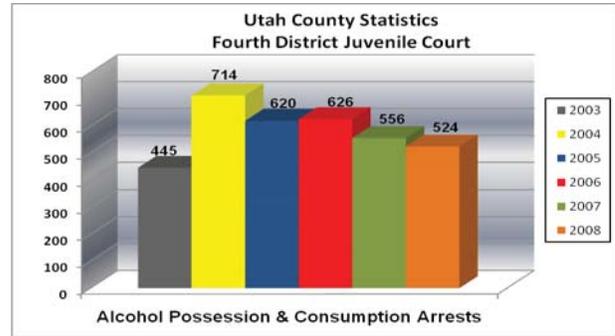
### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



Utah County  
Division of Substance Abuse



Population: 530,837



Utah County Division of Substance Abuse implemented the EASY program in 2004. Since that time, we have seen a reduction from 714 alcohol possession/consumption arrests to 524 arrests. A comprehensive approach of the Parents Empowered campaign, training, compliance checks, reduced availability to youth and support by the state and communities in Utah County are directly related to the reduction—an overall reduction of 27% or 190 arrests in 4 years.

**Prioritized Risk Factors**

- Low commitment to school
- Family conflict
- Parent attitudes favorable towards antisocial behaviors

**Priority Protective Factors**

- School rewards and opportunities for prosocial involvement
- Family rewards for prosocial involvement

Utah County prevention services collaborate with non-profit groups, school districts and local cities to help address the prevention needs of the community.

**Funded Programs Addressing Utah County's Prioritized Factors:**

**Big Brother Big Sisters**

Bonding—Mentoring Rewards

**Boys and Girls Club of Provo**

Smart Moves

**Utah State Extensions**

4H Afterschool Programs

**Communities That Care**

Risk and Protective Factor Model

**Alpine School District**

Prevention Dimensions  
Love and Logic  
Student Assistance

**Provo School District**

Prevention Dimensions  
Student Assistance

**Nebo School District**

Prevention Dimensions  
Love and Logic  
Student Assistance

**Wasatch Mental Health**

Vantage Point

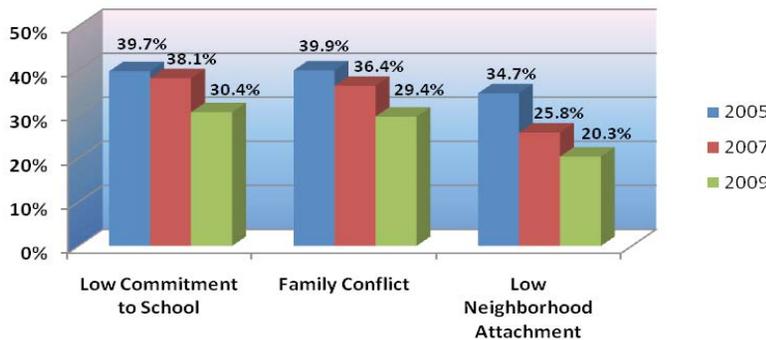
**Utah County**

PRI-Under 21  
PRI-Adult  
EASY Trainings, Compliance Checks  
Community Presentations  
Utah Valley Youth Council  
Community Mobilization  
SMART Coalition  
Parents Empowered Campaign

**2009 Student Health and Risk Prevention (SHARP) Survey Highlights**

This graph represents the age group of students that were initially in 6<sup>th</sup> grade in 2005 and now in 10<sup>th</sup> grade. The research indicates an average 30.4% decline in risk over the last four years for this age group.

**10th Grade Risk Factors**



**Interaction with Pro-Social Peers increased 15.9% during the same time period.**

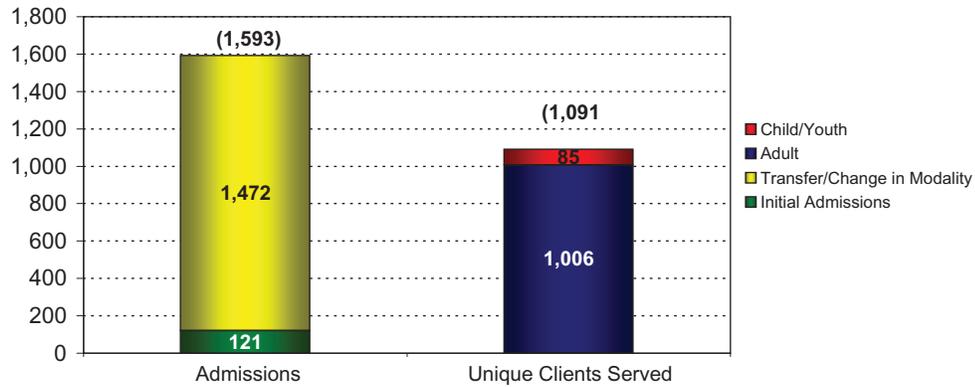
Utah County Division of Substance Abuse Prevention implements evidence-based prevention programs, practices and policy changes based on individual and community needs. Our goal is to help reduce costs in each community by developing comprehensive prevention plans based on their unique needs and characteristics through the Communities That Care Model (CTC). The cost benefit of substance abuse prevention to each Utah County community can be up to \$36 in savings for every \$1 invested.

(The Substance Abuse Prevention Dollars and Cents: A Cost Benefits Analysis, <http://www.samhsa.gov>)

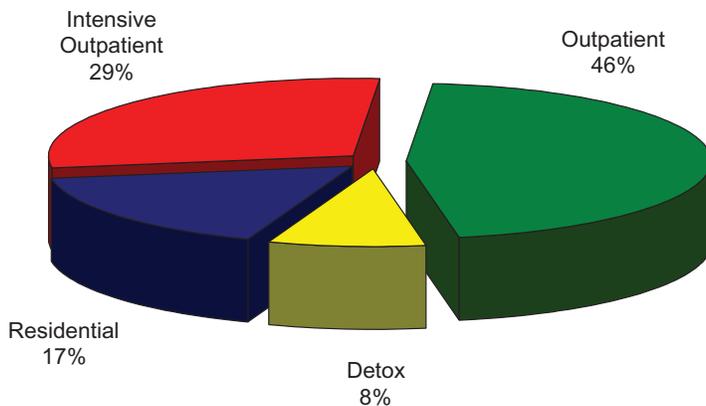
## Utah County Division of Substance Abuse

2008 Population	Total Served	Penetration Rate
530,837	1,091	0.2%

### Admissions into Modalities and Clients Served Fiscal Year 2009



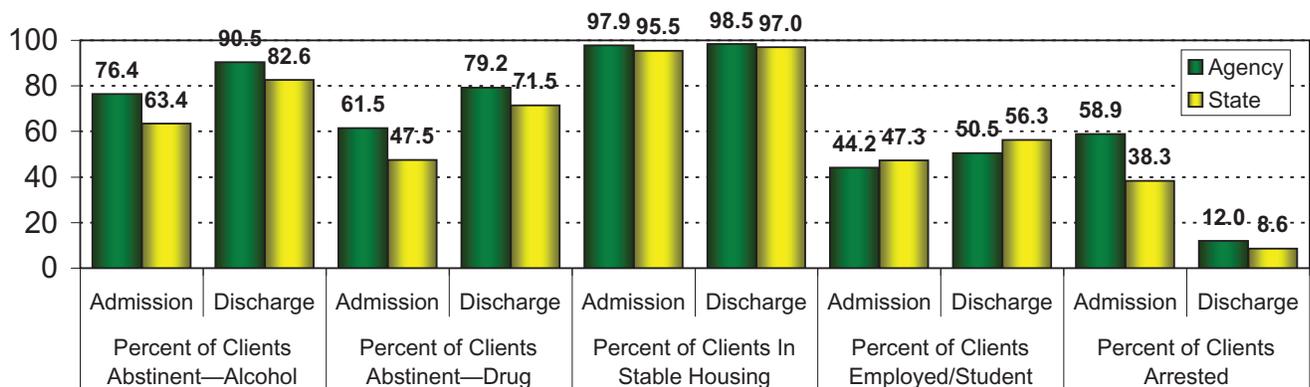
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	256	136	392
Cocaine/Crack	27	32	59
Marijuana/Hashish	162	60	222
Heroin	198	151	349
Other Opiates/Synthetics	5	16	21
Hallucinogens	5	0	5
Methamphetamine	136	172	308
Other Stimulants	4	0	4
Benzodiazepines	9	15	24
Tranquilizers/Sedatives	0	3	3
Inhalants	0	0	0
Oxycodone	94	103	197
Club Drugs	3	0	3
Over-the-Counter	0	3	3
Other	1	2	3
Unkown	0	0	0
<b>Total</b>	<b>900</b>	<b>693</b>	<b>1,593</b>

## Utah County Division of Substance Abuse Outcome Measures Fiscal Year 2009



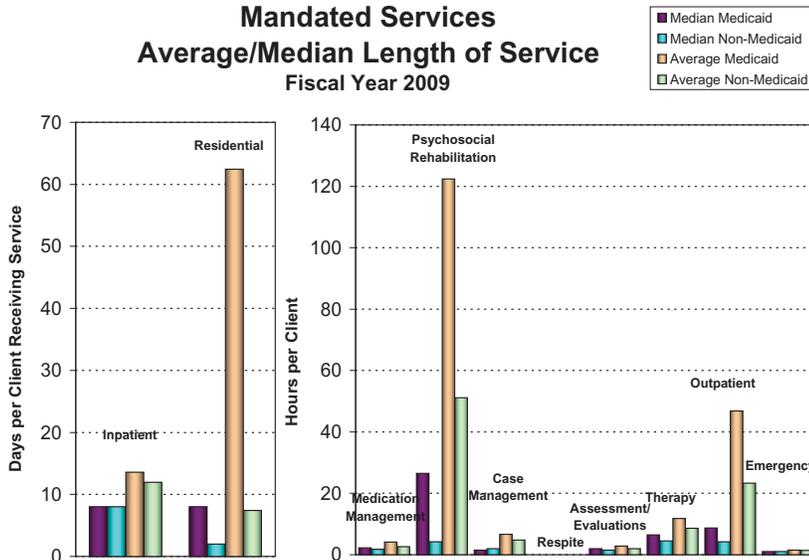
## Utah County - Wasatch Mental Health

Total Clients Served .....5,996  
 Adult .....3,222  
 Children/Youth.....2,774  
 Penetration Rate ..... 1.1%

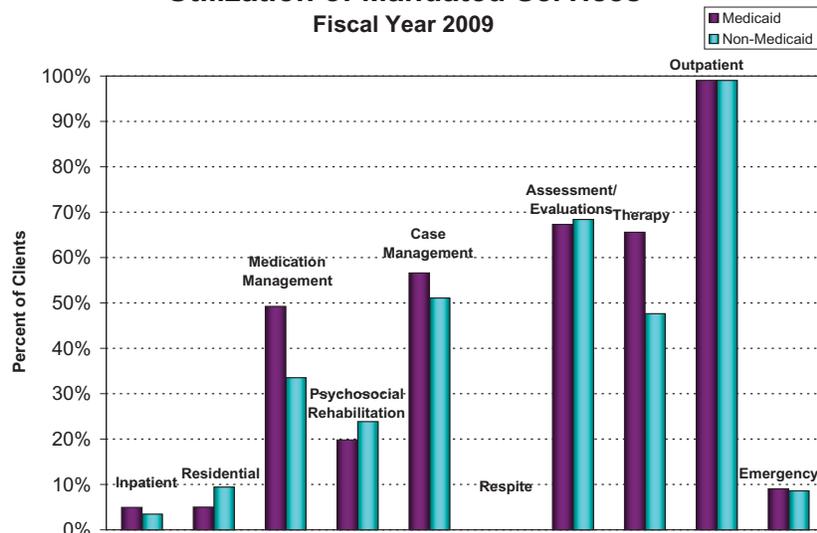
### Diagnosis

	Youth	Adult
Mood Disorders	730	2,145
Anxiety Disorders	887	2,073
Personality Disorders	15	828
Substance Abuse	133	1,032
Adjustment Disorders	423	94
Cognitive Disorders	69	374
Schizophrenia and Other Psychotic	41	833
Attention Deficit	681	281
Autism	316	94
Impulse Disorders	55	134
Neglect or Abuse	612	154
Conduct Disorders	87	8
Other	1,585	1,524
V Codes	1,174	600
<b>Total</b>	<b>6,808</b>	<b>10,174</b>

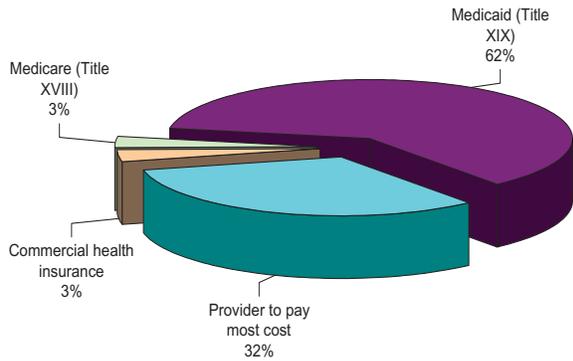
### Mandated Services Average/Median Length of Service Fiscal Year 2009



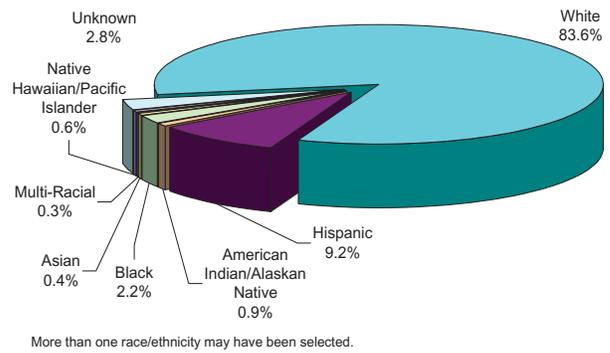
### Utilization of Mandated Services Fiscal Year 2009



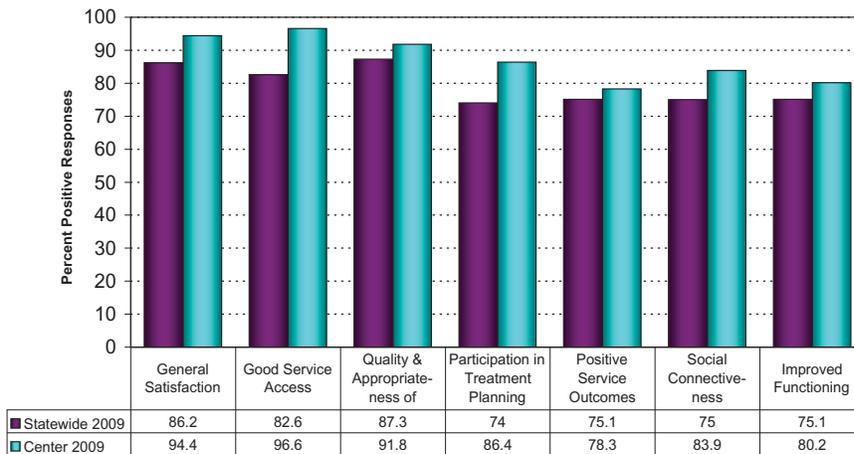
### Expected Payment Source At Admission Fiscal Year 2009



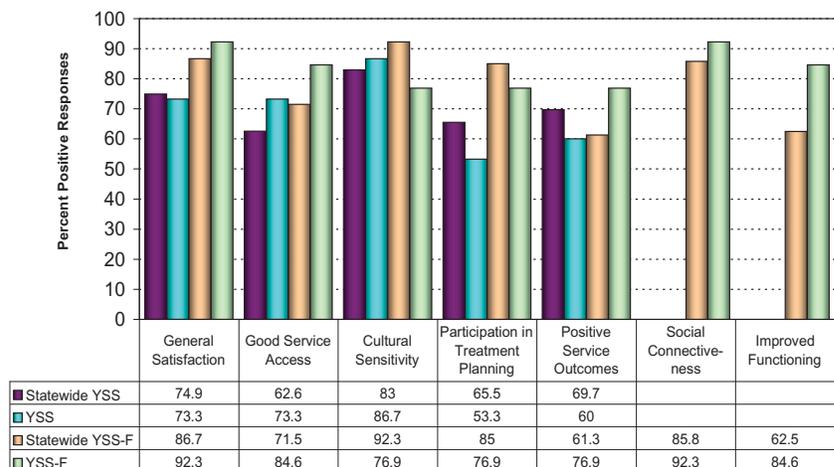
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009



Wasatch County  
Heber Valley Counseling



Population: 22,845



**Prioritized Risk Factors**

- Parental and Youth Attitudes Favorable toward Problem Behaviors
- Intent To Use Drugs
- Perceived Availability of Drugs

**Priority Protective Factors**

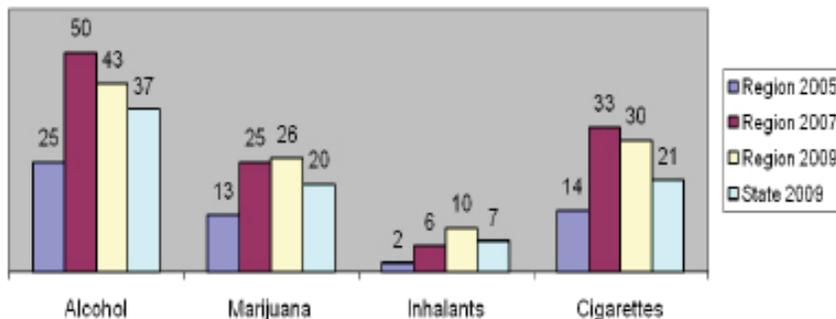
Heber Valley Counseling’s Prevention Plan addresses all protective factors by working to increase skills, opportunities, and recognition among youth.

**Prevention Programs in Wasatch County**

- GYC Peer Leader Group
- Issues Community Conference
- Parents Empowered Underage Drinking Campaign
- Prevention Dimensions Teacher Training
- Prime For Life DUI Classes
- Prime For Life Under 21 Classes
- Project Graduation All-Night Alcohol and Drug Free Party
- Raising Responsible Children Parenting Classes

**2009 Student Health and Risk Prevention (SHARP) Survey Highlights**

Wasatch County  
Lifetime ATOD Use by 12th Grade



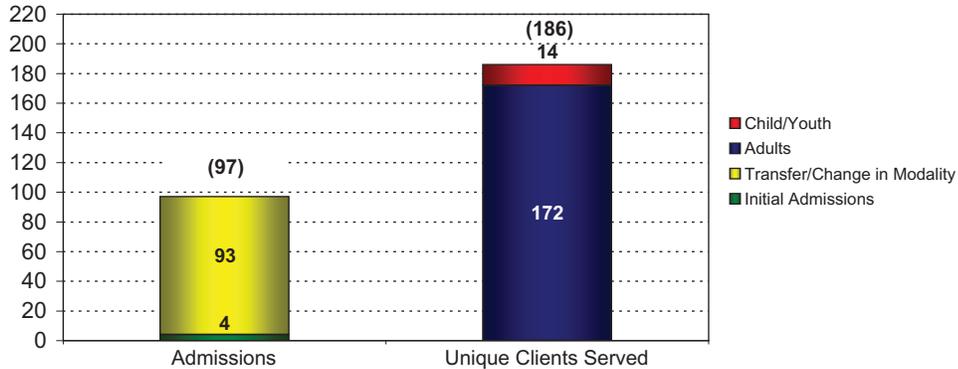
**Teen AOD Class**—An alcohol and drug prevention program for young adults. It is designed to challenge common beliefs and attitudes that directly contribute to high-risk alcohol and drug use. Attendee’s are juvenile court and school referred.

**Raising Responsible Children Parenting Class**—A nine week session focusing on increasing self esteem, self control, respect, and affection while decreasing criticism and anger among family members. The course is open to the community as well as court and DCFS referrals. Classes and childcare are free of charge to provide the opportunity for all to participate regardless of ability to pay.

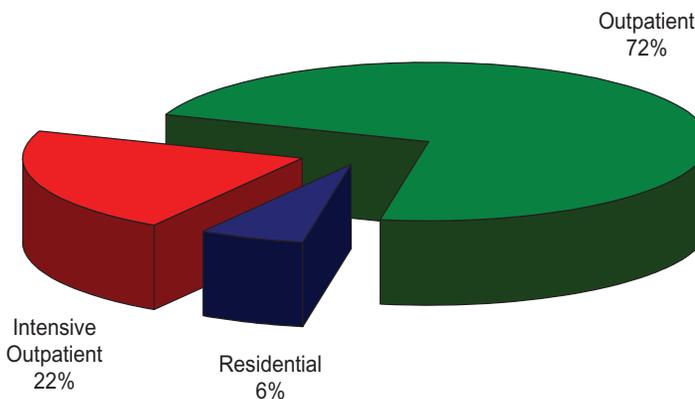
## Wasatch County - Heber Valley Counseling - Substance Abuse

2008 Population	Total Served	Penetration Rate
21,066	186	0.9%

### Admissions into Modalities and Clients Served Fiscal Year 2009



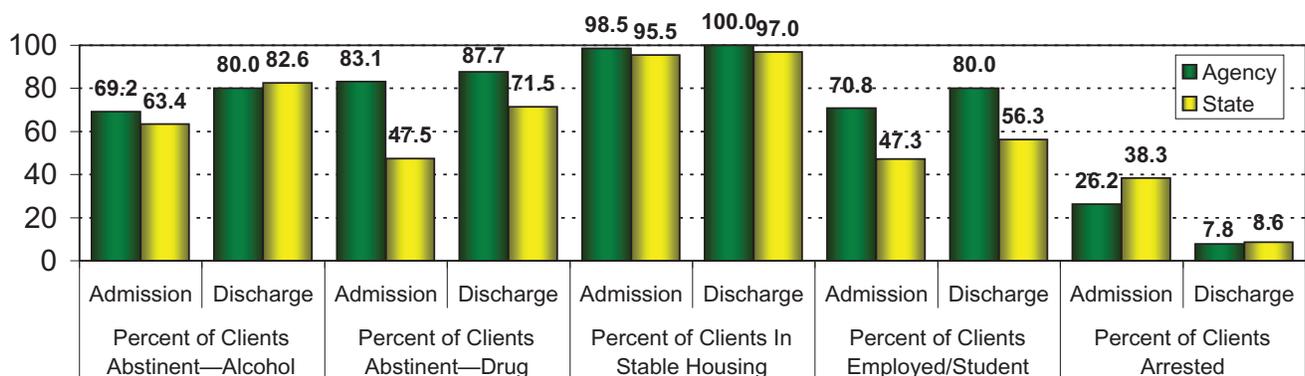
### Admissions into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	34	20	54
Cocaine/Crack	2	0	2
Marijuana/Hashish	15	2	17
Heroin	0	1	1
Other Opiates/Synthetics	0	0	0
Hallucinogens	0	0	0
Methamphetamine	4	5	9
Other Stimulants	0	0	0
Benzodiazepines	0	2	2
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	6	5	11
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	0	0	0
Unkown	0	0	0
<b>Total</b>	<b>61</b>	<b>36</b>	<b>97</b>

## Wasatch Co.—Heber Valley Counseling Outcome Measures Fiscal Year 2009



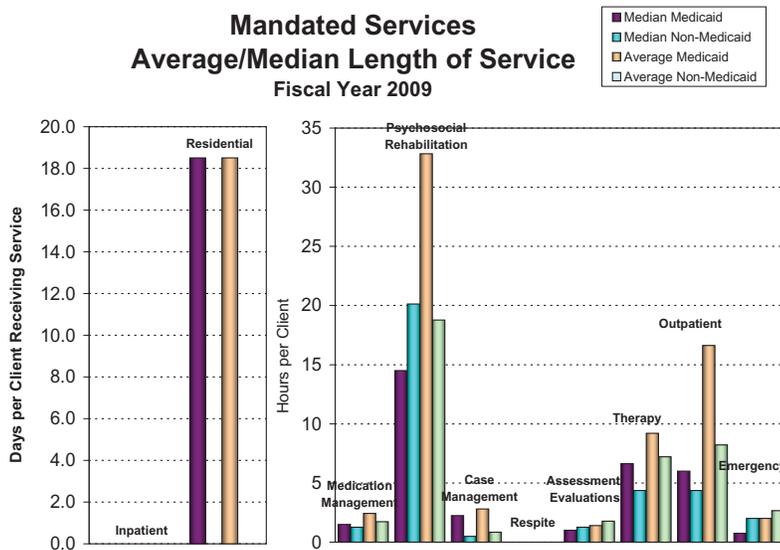
## Wasatch County - Heber Valley Counseling - Mental Health

Total Clients Served .....345  
 Adult .....248  
 Children/Youth .....97  
 Penetration Rate ..... 1.6%

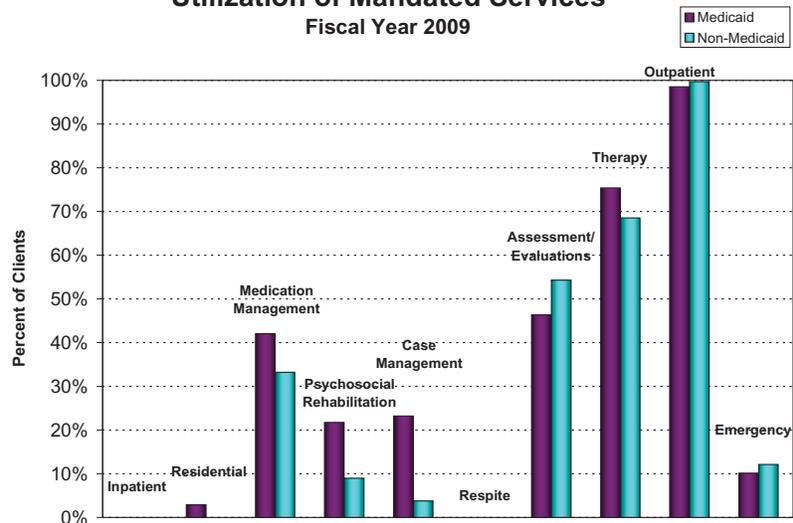
### Diagnosis

	Youth	Adult
Mood Disorders	15	130
Anxiety Disorders	21	153
Personality Disorders	0	32
Substance Abuse	8	104
Adjustment Disorders	25	24
Cognitive Disorders	0	3
Schizophrenia and Other Psychotic	0	25
Attention Deficit	26	11
Autism	3	0
Impulse Disorders	0	18
Neglect or Abuse	15	1
Conduct Disorders	5	0
Other	54	176
V Codes	25	74
<b>Total</b>	<b>197</b>	<b>751</b>

### Mandated Services Average/Median Length of Service Fiscal Year 2009

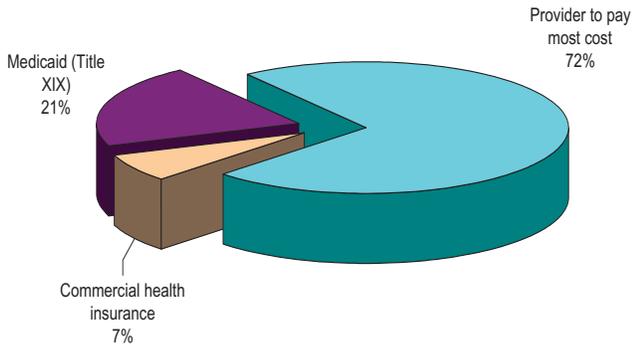


### Utilization of Mandated Services Fiscal Year 2009



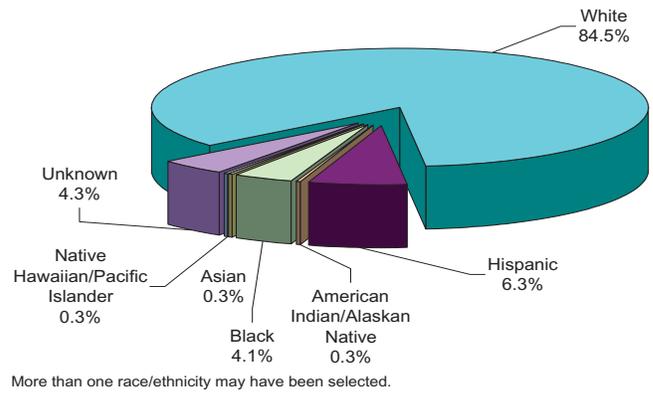
### Expected Payment Source At Admission

Fiscal Year 2009



### Race/Ethnicity

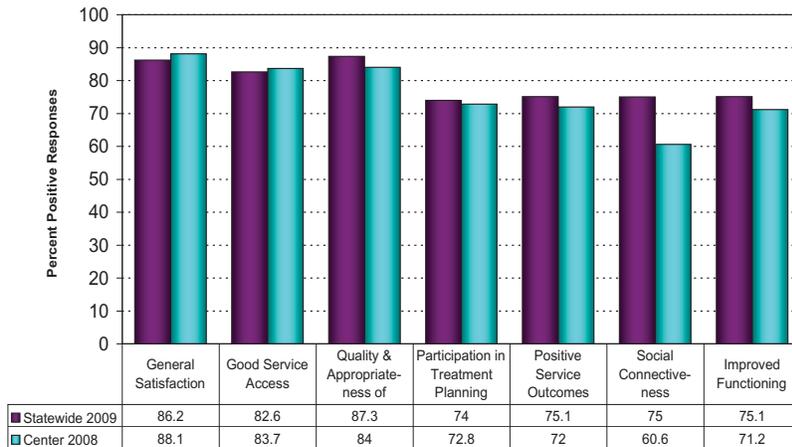
Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health

#### Statistics Improvement Program (MHSIP)

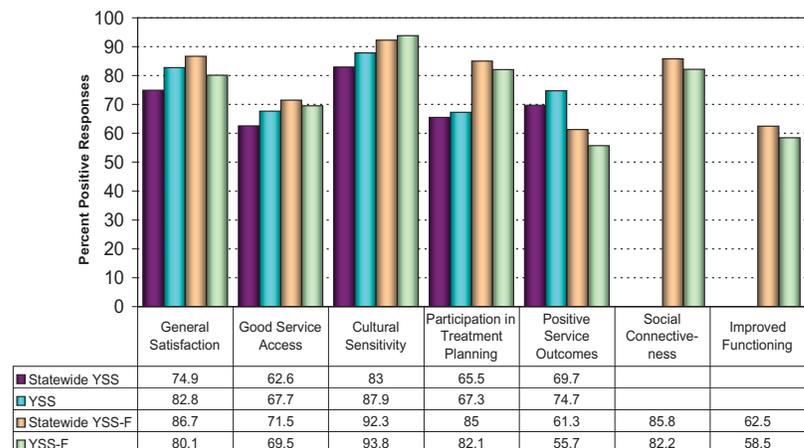
2009



### Youth Consumer Satisfaction Surveys

#### (YSS and YSS-F)

2009



## Weber Human Services Weber and Morgan Counties

Weber Human Services  
**PREVENTION**



Population: 236,156



### Prioritized Risk Factors

- Favorable attitudes toward anti-social behavior
- Norms and attitudes favorable towards substance use
- Family management
- Perceived risk of harm associated with substance use

### Priority Protective Factors

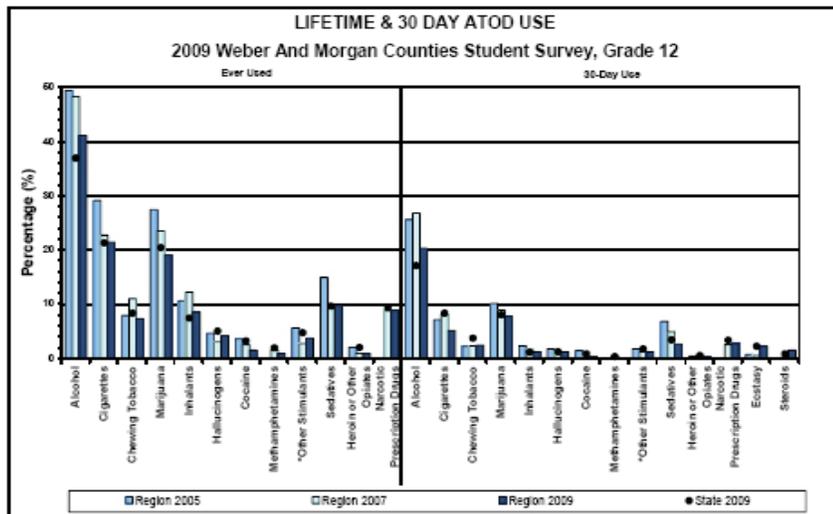
- Bonding
- Involvement in pro-social activities

Weber Human Services Prevention Team provides educational information, specialized trainings, presentations and other services that promote healthy life skills to help prevent substance use.

### Programs Offered

- Alcohol Screening
- All Stars
- Cammi Awards
- Coalition of Resources Meeting
- Community Awareness Presentations
- Guiding Good Choices (also in Spanish)
- High-Risk Skill Building
- High-Risk Support Groups
- In-Classroom Presentations
- Local Prevention Networking
- Pamphlet and Other Material Distribution
- Parent and Teen Alternative Program
- Parenting Wisely (also in Spanish)
- Peer Leadership Training and Support
- Prevention Dimensions Training
- Prevention Screening
- Prime Under 21
- School-Age Alternative Programs
- Senior Citizen Education
- Statewide Prevention Planning
- Tutoring Program
- Youth Council
- Youth in Custody

### 2009 Student Health and Risk Prevention (SHARP) Survey Highlights



### GROWING UP STRONG

Growing Up Strong for grades 1 and 2 is a special program designed to emphasize mental wellness, enhance self-esteem and teach skills to prevent substance use.

Children receive guidance and practice in such areas as taking responsibility, expressing feelings, learning coping skills, resisting peer pressure and other related healthy life skills.

Parent handouts are sent home each week to inform parents of what was discussed in group and ways to reinforce the concepts at home.

The groups are facilitated by staff members and volunteers who have been trained in the program.

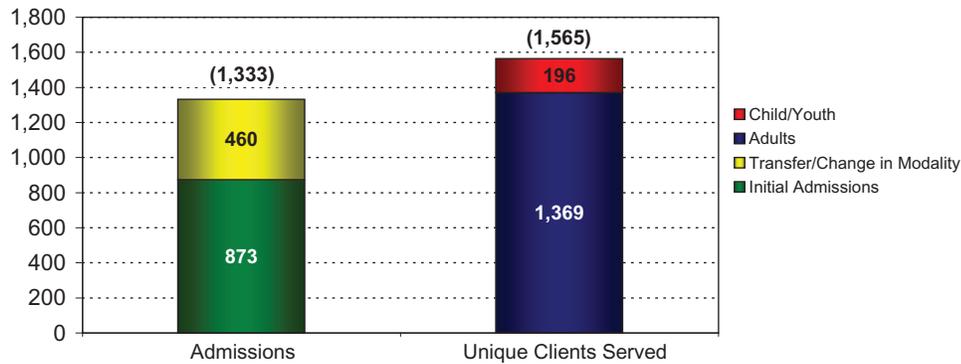
The program runs 1 hour per week for 10 weeks during school hours.

A graduation ceremony is held upon completion of the program for peers, parents and other family members to attend.

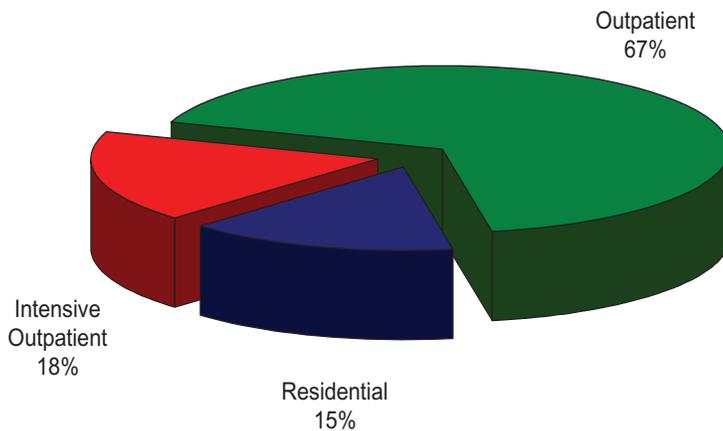
## Weber Human Services - Substance Abuse

2008 Population	Total Served	Penetration Rate
236,156	1,565	0.7%

### Admissions into Modalities and Clients Served Fiscal Year 2009



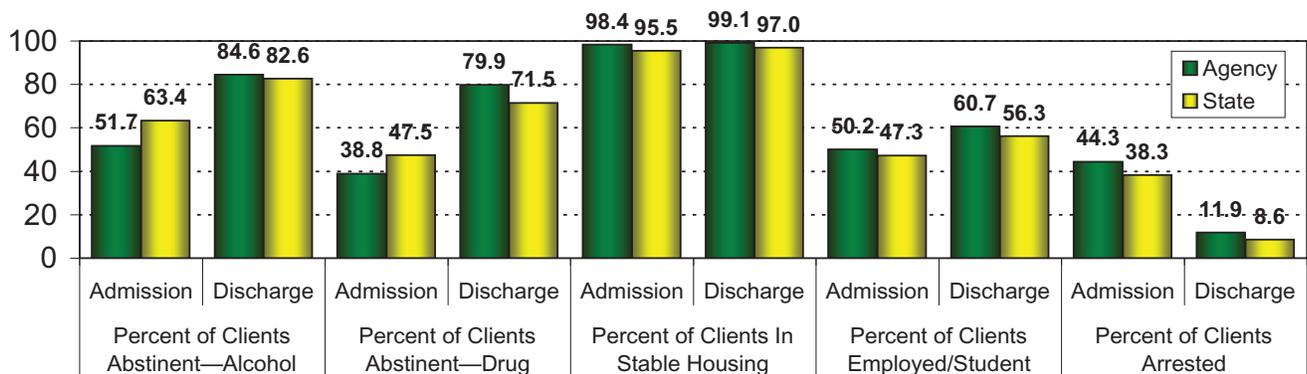
### Admission into Modalities Fiscal Year 2009



### Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	245	134	379
Cocaine/Crack	37	44	81
Marijuana/Hashish	220	112	332
Heroin	42	27	69
Other Opiates/Synthetics	1	6	7
Hallucinogens	1	1	2
Methamphetamine	164	204	368
Other Stimulants	0	0	0
Benzodiazepines	2	7	9
Tranquilizers/Sedatives	0	1	1
Inhalants	1	2	3
Oxycodone	35	38	73
Club Drugs	1	2	3
Over-the-Counter	3	1	4
Other	0	2	2
Unkown	0	0	0
<b>Total</b>	<b>752</b>	<b>581</b>	<b>1,333</b>

## Weber Human Services Outcome Measures Fiscal Year 2009



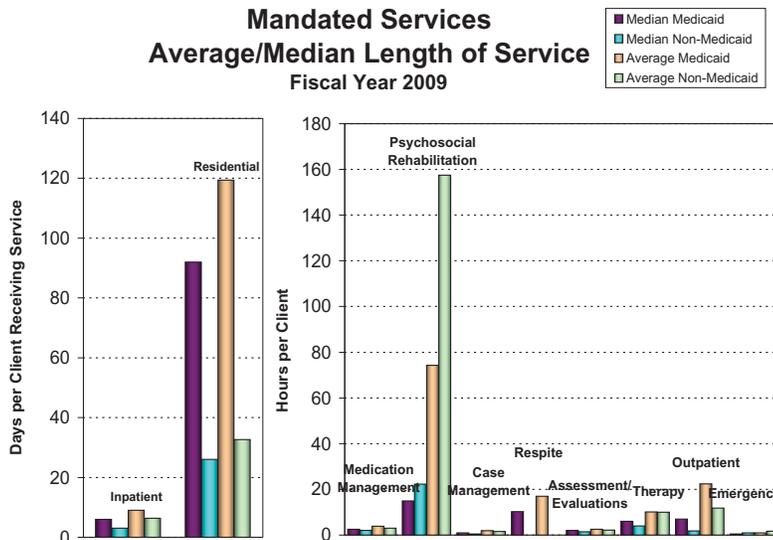
## Weber Human Services - Mental Health

Total Clients Served .....5,858  
 Adult .....4,243  
 Children/Youth.....1,615  
 Penetration Rate ..... 2.5%

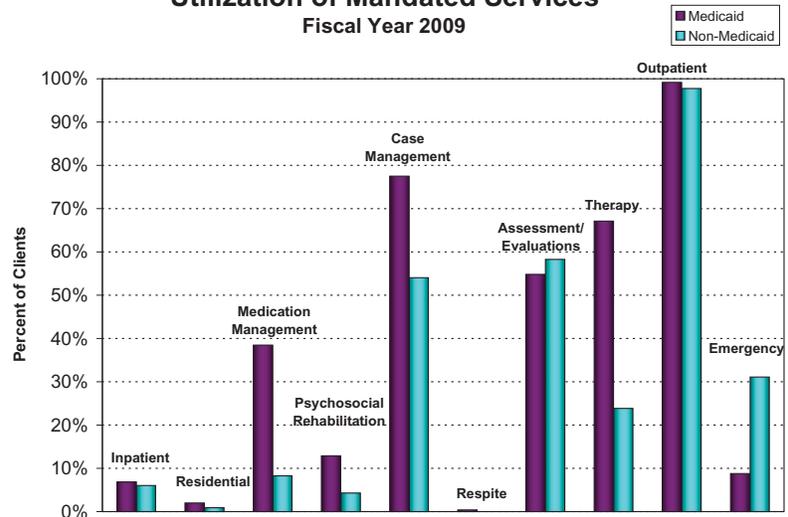
### Diagnosis

	Youth	Adult
Mood Disorders	494	1,651
Anxiety Disorders	401	1,081
Personality Disorders	5	629
Substance Abuse	437	1,989
Adjustment Disorders	226	114
Cognitive Disorders	44	205
Schizophrenia and Other Psychotic	65	543
Attention Deficit	358	98
Autism	187	23
Impulse Disorders	14	38
Neglect or Abuse	482	47
Conduct Disorders	118	9
Other	1,053	2,710
V Codes	366	508
<b>Total</b>	<b>4,250</b>	<b>9,645</b>

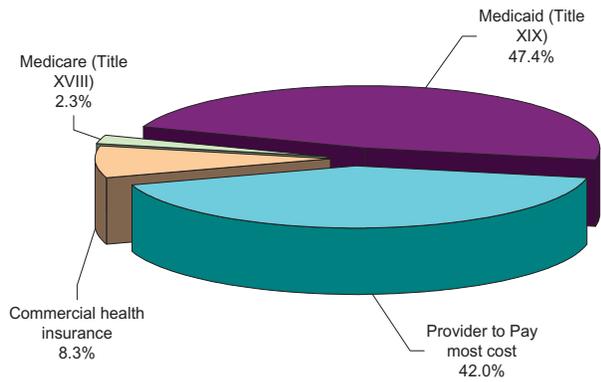
### Mandated Services Average/Median Length of Service Fiscal Year 2009



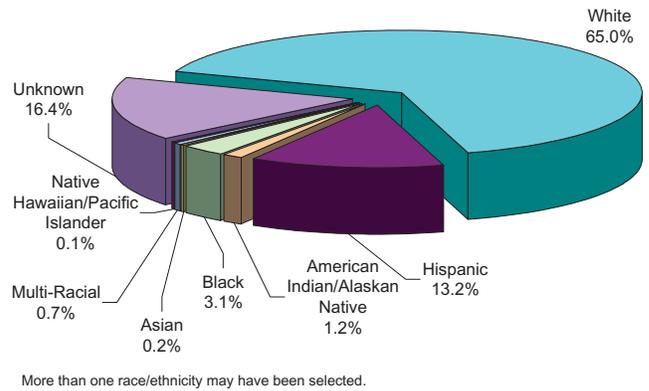
### Utilization of Mandated Services Fiscal Year 2009



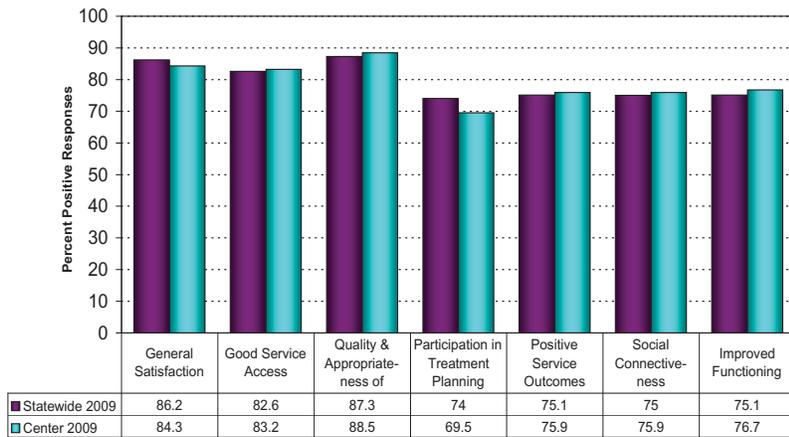
### Expected Payment Source at Admission Fiscal Year 2009



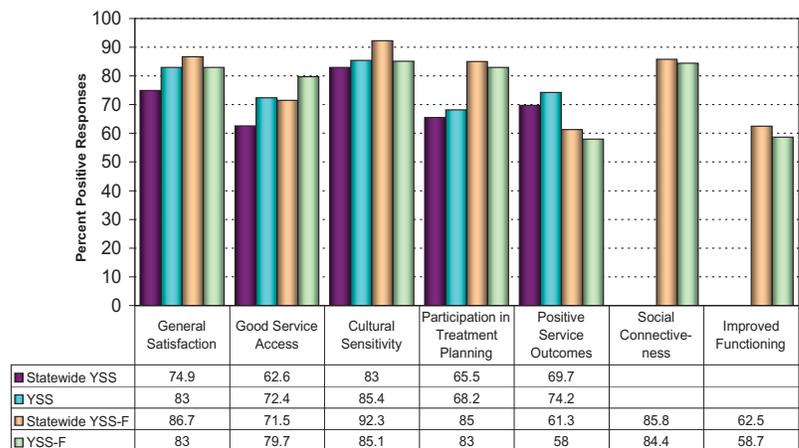
### Race/Ethnicity Fiscal Year 2009



### Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2009



### Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2009







When I was young, I suffered abuse and neglect from my father. I ended up in foster care. He refused to give up his parental rights so it took five years until I was able to get adopted by a family. I felt lucky because families usually want babies.



The trauma from my early childhood was a lot and I had to take medication prescribed by doctors who treated me for Post Traumatic Stress Disorder (PTSD). At that time I also began attending therapy to help me.

I did well for a while, but when I got older my body started to change. My changing hormones effected how the medicine worked and that made it difficult to maintain a stable mood. At fifteen, I ran away from home. My parents were worried and I was placed in a program for five months. The therapy groups I went to taught me ways to deal with my mood swings.



I went home and for months I did well, but then winter came. As the seasons changed from fall to winter and my moods changed also. I fell apart again. I wanted to overdose. What a stupid, stupid thing to do. I ended up in the hospital in a mental health ward. Changes were made in my meds and they seemed to work. I was released to my parents and did well for almost a year.

Winter came again. I got into a mess and overdosed. This time they didn't think I would ever wake up, but I did. It was decided that I needed to go to the state mental hospital where I stayed for nine months. My life changed.



I learned new coping skills to deal with my mood changes and developed new ways to look at life. I smile a lot now. I have hope. I have goals and dreams. I know with all the power I have, I will live!

Trying to take your life is not a wise idea. You are probably chuckling as you read this because you know it's not a good idea, but when you are very depressed you don't think. This is my story. It's not very detailed, but I want to pass along a message to whoever reads this.

*Smile. Life is a beautiful thing. Out of everything that could go wrong, look at it with a smile and you will succeed!*

*[Michelle is a member of the DSAMH-sponsored Youth Action Council]*

# RESOURCES

## List of Abbreviations

AP&P—Adult Probation and Parole	OTP—Outpatient Treatment Program
ASAM—American Society of Addiction Medicine	PASRR—Pre-admission Screening and Residential Review
ASI—Addiction Severity Index	PTSD—Post Traumatic Stress Disorder
ATOD—Alcohol, Tobacco, and Other Drugs	REDI—Readiness Evaluation and Discharge Implementation Program
BAC—Blood Alcohol Content	SAMHSA—Substance Abuse and Mental Health Services Administration (Federal)
BPRS—Brief Psychiatric Rating Scale	SAPT—Substance Abuse Prevention and Treatment Block Grant
CMHC—Community Mental Health Center	SED—Serious Emotional Disturbance
CMS—Center for Medicaid and Medicare Services	SHARP—Student Health and Risk Prevention
CSAP—Center for Substance Abuse Prevention	SMD—Serious Emotional Disturbance
CSAT—Center for Substance Abuse Treatment	SMI—Serious Mental Illness
CYF—Children, Youth, and Families	SPF—Strategic Prevention Framework
DCFS—Division of Child and Family Services	SPMI—Seriously and Persistently Mentally Ill
DHS—Department of Human Services	SUDs—Substance Use Disorders
DORA—Drug Offender Reform Act	TBI—Traumatic Brain Injury
DSAMH—Division of Substance Abuse and Mental Health	TEDS—Treatment Episode Data Set
DUI—Driving Under the Influence	UAC—Utah Addiction Center
E.A.S.Y—Eliminate Alcohol Sales to Youth	UBHC—Utah Behavioral Healthcare Committee
FRF—Family Resource Facilitator	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 Medicaid/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.

<b>Medicaid/Non-Medicaid Client Counts</b>			
<b>Mental Health Center</b>	<b>Medicaid</b>	<b>Non-Medicaid</b>	<b>Both Medicaid and Non-Medicaid</b>
Bear River Mental Health	1,538	920	198
Central Utah Counseling	707	198	83
Four Corners Behavioral Health	756	1,011	193
Northeastern Counseling	426	621	30
San Juan	153	321	9
Southwest	1,546	770	191
Summit County–VMH	80	938	21
Tooele County–VMH	522	1,278	182
Wasatch Co.–Heber Valley Counseling	56	276	13
Davis Behavioral Health	1,987	1,054	139
Salt Lake Co.–VMH	7,502	6,027	1,755
Utah Co.–Wasatch Mental Health	3,359	2,084	553
Weber Human Services	2,397	2,949	512
Rural	5,578	6,196	859
Urban	14,951	11,946	2,886
Statewide Total	20,529	18,142	3,745

# Contact Information

## Single State Authority

Mark I. Payne, Director  
 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

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## **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

### 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  
 Office: (435) 462-2416

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### Davis County

County: Davis

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

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

### 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 and Mental Health Administrative Agency:***

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

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**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:***

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

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**Summit County**

County: Summit

***Substance Abuse and Mental Health Provider***

***Agency:***

Debra Falvo, President/Executive Director  
Margaret Tan, Acting County 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, County Program Manager  
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

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**Weber**

Counties: Weber and Morgan

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

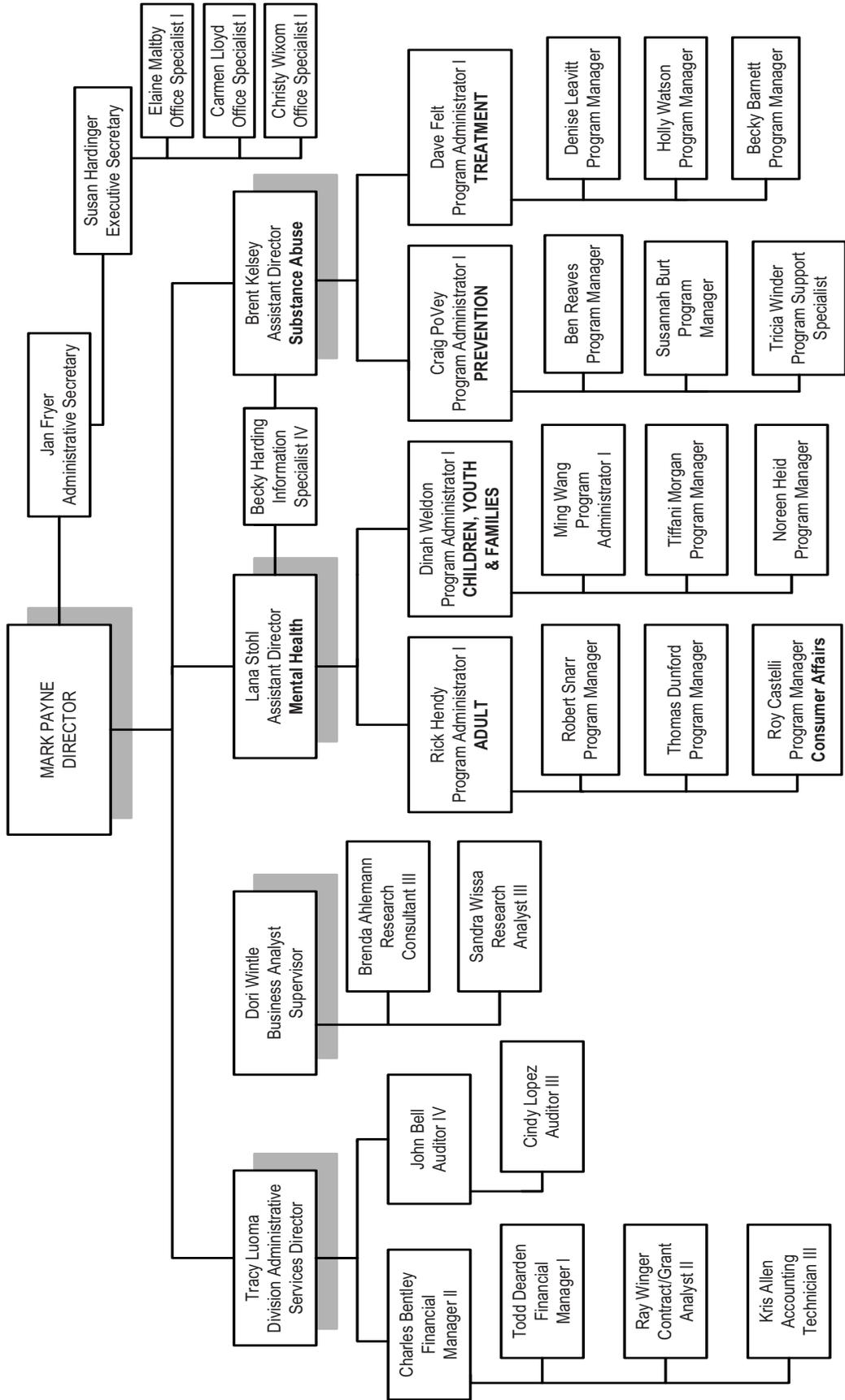
Kevin Eastman, Executive Director  
Weber Human Services  
237 26th Street  
Ogden, UT 84401  
Office: (801) 625-3771

**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

November 2009





Division of Substance Abuse  
and Mental Health  
195 North 1950 West  
Salt Lake City, UT 84116  
(801) 538-3939  
[dsamh.utah.gov](http://dsamh.utah.gov)

