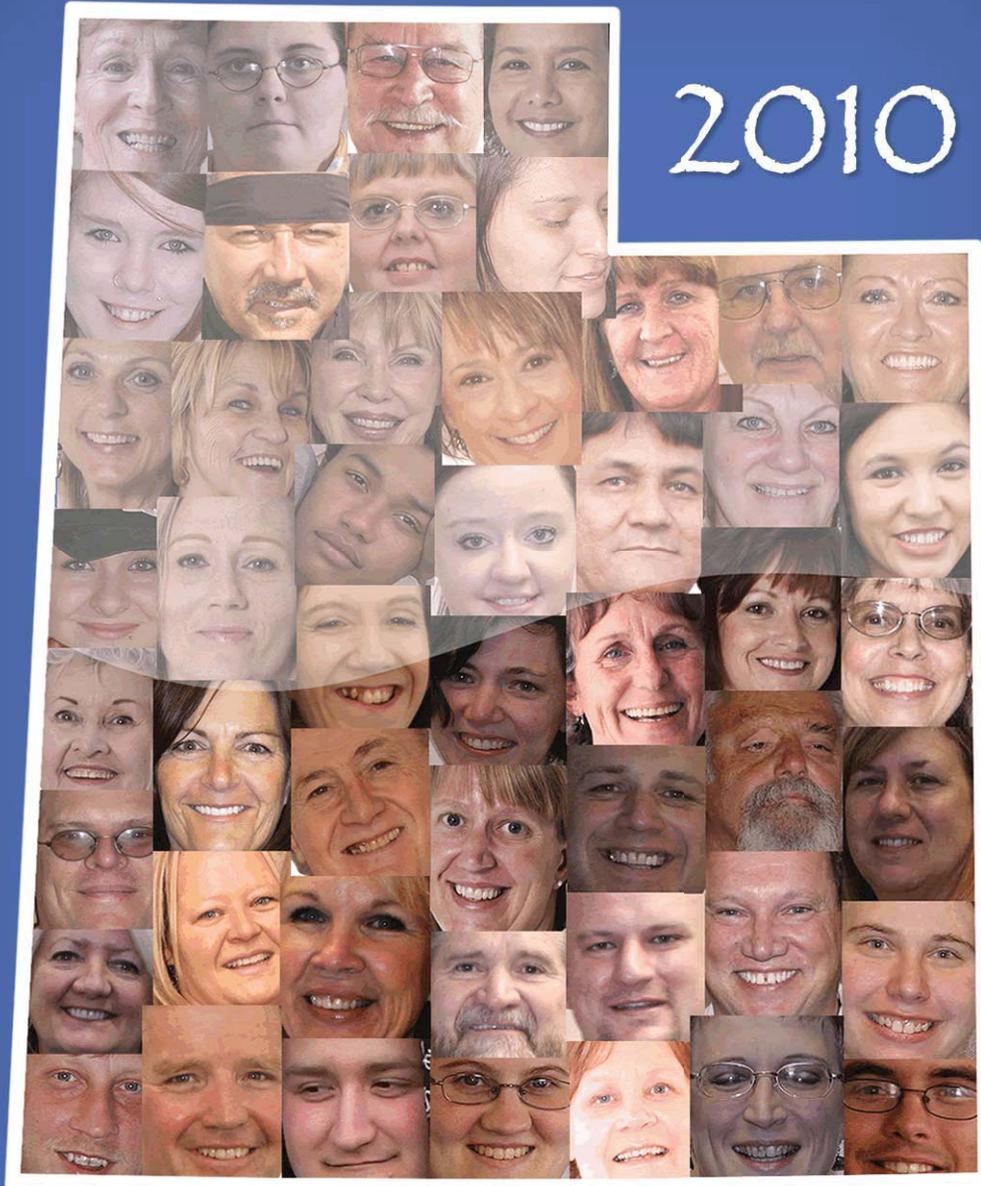


DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
ANNUAL REPORT



FACING RECOVERY
TOGETHER

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2010
Annual Report

Cover art by:

Rich Rayl
DHS Graphic Design

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

Revised 07/07/2011 v 1.6

TABLE OF CONTENTS

Introduction	1
Letter from the Director	1
Why We Exist	3
Utahns in Need of Substance Abuse Treatment	5
Utahns in Need of Mental Health Treatment	7
Who We Serve	9
Total Number Served	11
Urban and Rural Areas.....	12
Gender and Age.....	13
Race and Ethnicity	14
Living Arrangement at Admission	16
Employment Status at Admission	17
Highest Education Level Completed at Admission	18
Marital Status at Admission	19
Referral Source	20
What We Do	23
About Utah’s Public Substance Abuse and Mental Health System	25
Source of Funding and Category of Expenses	26
Leadership	29
Utah’s Wellness Initiative	31
Recovery Plus—Living Tobacco Free	31
Recovery Oriented Systems of Care	32
Quality	33
Trauma Recovery and Empowerment Model and Profile Training	35
Stephanie Covington’s “Helping Women Recover” Training	35
Peer Support Training.....	35
Quality Controls and Certifications.....	36
Accountability	39
Substance Abuse Outcomes	42
Criminal Activity	43
Changes in Abstinence from Drug and Alcohol Use During Treatment	44
Employment and Stable Housing	45
Mental Health Treatment Outcomes	47
Adult Outcome Questionnaires (OQ)/Youth Outcome Questionnaires (YOQ)	47
Consumer Satisfaction.....	49
Client Costs	51

Partnership	53
<i>Consumer and Family Partnerships</i>	55
Utah Family Coalition and Family Resource Facilitators.....	55
Allies with Families	55
National Alliance on Mental Illness (NAMI-Utah)	55
New Frontiers for Families	55
Utah Support Advocates for Recovery Awareness (USARA)	55
PASSAGES	56
School-Based Mental Health and Integrated Health Care Services	57
Autism Services	57
<i>Justice Partnerships</i>	57
Crisis Intervention Teams	57
Drug Offender Reform Act (DORA)	58
Drug Courts	59
Education	61
Substance Abuse Fall Conference	63
Generations 2009 Mental Health Conference	64
Critical Issues	64
University of Utah School on Alcoholism and Other Drug Dependencies	64
Utah Addiction Center	64
Substance Abuse Prevention Trainings	64
Substance Abuse Prevention	65
Prevention Works	67
Preventing Underage Drinking	68
Preventing the Abuse and Misuse of Prescription Drugs.....	68
The Risk and Protective Factor Model	68
Prevention Dimensions	69
Communities That Care	70
Substance Abuse Treatment	71
Substance Abuse Services Continuum.....	73
Source of Data	74
Number of Treatment Admissions	75
Primary Substance of Abuse	76
Primary Substance by Gender	77
Primary Substance by Age	77
Age of First Use of Alcohol or Other Drug	78
Age of First Use of Primary Substance of Abuse—Under 18	78
Multiple Drug Use	79
Injection Drug Use	80
Prescription Drug Abuse	81
Tobacco Use.....	82

Substance Abuse Treatment (continued)	
Admissions to Treatment by Gender	83
Pregnant Women in Treatment	83
Clients with Dependent Children.....	84
Service Type.....	85
Mental Health Treatment	87
Overview and Continuum of Services	89
Source of Data and Diagnostc Data.....	90
Expected Payment Sources	92
Service Penetration Rates	93
Mandated Services Data by Local Authority	94
Utah State Hospital	103
Local Authorities Service Outcomes	105
Substance Abuse and Mental Health Statistics by Local Authority.....	107
Bear River	108
Central Utah Counseling Center	112
Davis Behavioral Health.....	116
Four Corners Community Behavioral Health	120
Northeastern Counseling Center	124
Salt Lake County Behavioral Health Services	128
San Juan Counseling	132
Southwest Behavioral Health Center	136
Summit County	140
Tooele County.....	144
Utah County	148
Wasatch County	152
Weber Human Services	156
Resources	161
List of Abbreviations	163
Mental Health Reference Table	164
Contact Information	165
Division of Substance Abuse and Mental Health Organization Chart	168



State of Utah

GARY R. HERBERT
GovernorGREG BELL
Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

PALMER DePAULIS
Executive Director

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

LANA STOHL
Director

December 2010



We are proud to release the DSAMH Annual Report for 2010. We hope the report will be helpful to you and that it broadens your understanding of the public substance abuse and mental health system in Utah.

We have chosen “Facing Recovery Together” as the theme for this year’s report. We know that people can and do recover from mental illness and substance abuse. This vision and message of hope is shared among all the stakeholders in the recovery community. Together we can make a difference in the lives of those who suffer from the symptoms of mental illness and substance abuse disorders, and, as a result, build stronger and healthier communities.

We hope our vision of recovery shines through these pages as you see the faces and read the personal stories of our consumers—stories of recovery, achievement, and hopes and dreams fulfilled. We believe that putting a face on what we do can bring the message home and make it real. We are grateful to the courageous people who were willing to share their journeys and their challenges with us, in hopes of inspiring others and shining the light on what is possible when we face recovery together.

I appreciate the opportunity to lead the Division of Substance Abuse and Mental Health; however, I am mindful of the shoes I fill. Mark Payne, who was the director until his untimely passing in July 2010, was a great and visionary leader and will definitely be “a hard act to follow.” He was an outstanding example of knowledge, passion, and leadership and he exhibited an extraordinary commitment to public service and to the people of our state.

As I begin my tenure as director, I would like to reaffirm DSAMH’s commitment to the following key principles we adopted in 2005 under Mark’s leadership:

- Strengthen partnerships with consumers and families through a unified state, local, and federal effort;
- Provide quality programs that are outcome focused and centered on recovery;
- Monitor and evaluate programs provided by local authorities to ensure the highest level of standards and efficiencies are incorporated;
- Enhance education that will promote understanding and treatment of substance abuse and mental health disorders; and
- Demonstrate statewide leadership which meets the needs of consumers and families.

As we face recovery together, we will focus on prevention and treatment efforts for adults and youth and utilize the quality programs and services that are available throughout the system. We appreciate your support in our efforts to make a critical difference in the lives of those suffering with mental illness and substance abuse issues.

Sincerely,

Lana Stohl, MBA, LCSW
Director

Terri

Terri Duncan comes from a long line of alcoholics. Because her family moved every two years, she never felt like she fit in anywhere; but when she took her first drink at 14, Terri was sure she'd found the answer to all of her problems. "My first ten years of drinking were fun," she said. "The second ten years were sometimes fun and sometimes a nightmare. But the last ten years of drinking were just a nightmare."

Terri was married to an alcoholic and their marriage was tumultuous at best. Her final night of drinking came when she was trying to figure out a way to kill her husband. In a moment of clarity she was "struck sober," and realized that if she didn't stop doing what she was doing, she was going to die, go to jail, or maybe both. At that point she could see a light up ahead, and she knew it was a freight train heading straight for her. If she didn't turn around she would lose her family, her job and her home. That was her last drink.

If they'd told me to stand on my head in a corner and that would keep me sober, I would have done it willingly.

She found help in a 12-step program and was totally committed to following the program to the letter. "If they'd told me to stand on my head in a corner and that would keep me sober, I would have done it willingly." She has since taken this commitment to sobriety and turned it into helping other women who are struggling as she once did. Yearning for a way to help others through a Christian-based ministry, she has recently started a recovery ministry with her church called Break Free.



Why We Exist

Why We Exist

Utahns in Need of Substance Abuse Treatment

The results of the Synthetic Estimates of Needs for Utah¹ and the 2009 Student Health and Risk Prevention Survey indicated:

- 88,251 adults in Utah were classified as needing treatment for alcohol and/or drug dependence or abuse in 2010.
- 11,899 Utah youth in the 6th through 12th grades are in need of treatment for drug and/or alcohol dependence or abuse.
- The public substance abuse treatment system, at capacity, is currently serving approximately 16,976 individuals, or less than 17% of the current need.

- A combined total of approximately 83,174 adults and youth are in need of, but not receiving, substance abuse treatment services.

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 2010, is also included to illustrate the unmet need. The same data is depicted on the following graphs.

Treatment Needs vs. Treatment Capacity

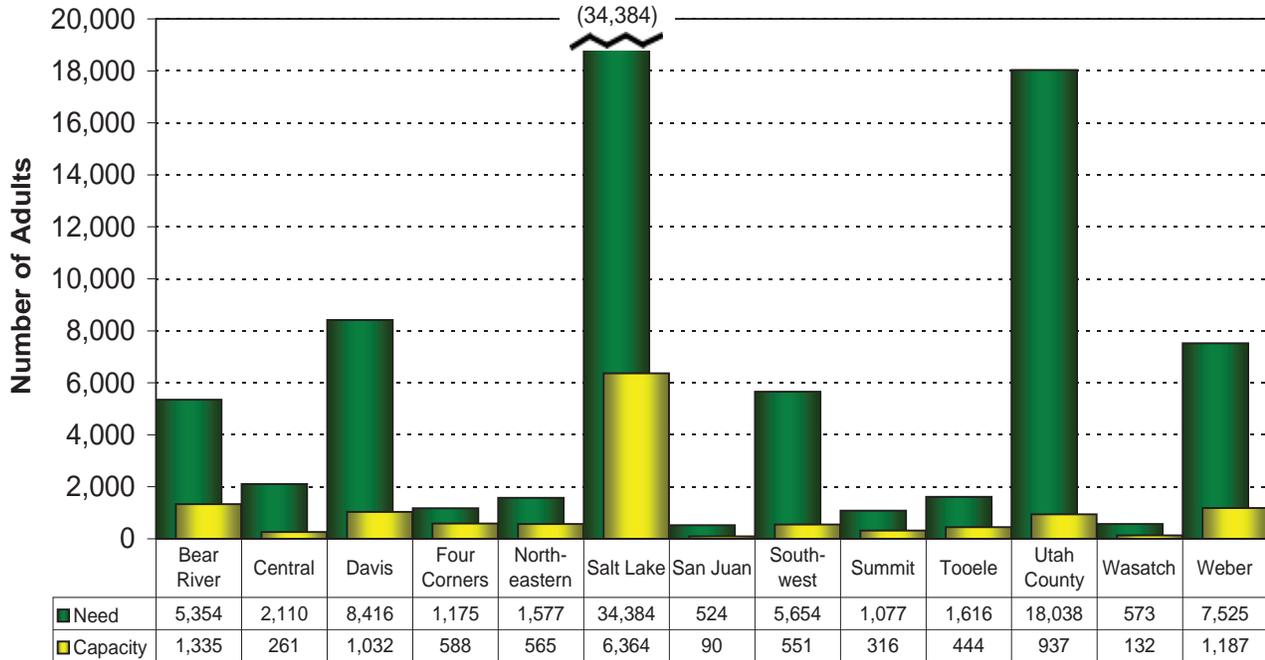
	Adults (18 years+)		Youth (Under age 18)	
	# Need Treatment	Current Capacity	# Need Treatment	Current Capacity
Bear River	5,354	1,335	375	88
Central	2,110	261	378	61
Davis	8,416	1,032	964	133
Four Corners	1,175	588	234	66
Northeastern	1,577	565	92	45
Salt Lake	34,384	6,364	6,499	665
San Juan	524	90	44	23
Southwest	5,654	551	767	85
Summit	1,077	316	204	19
Tooele	1,616	444	387	81
Utah County	18,038	937	977	38
Wasatch	573	132	117	20
Weber	7,525	1,187	927	181
State Totals	88,251*	15,480**	11,899*	1,496**

*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.

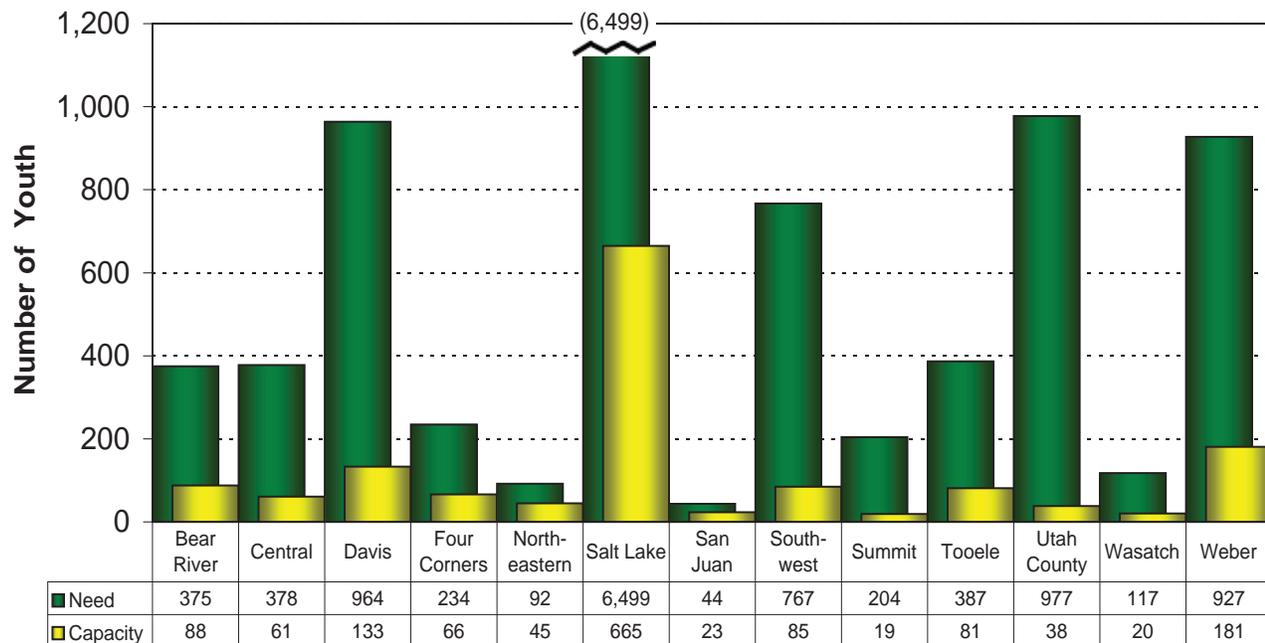
**An additional 2,159 clients that were served by statewide contracts are reflected in the state total.

¹ 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 2009 Population Estimate), from www.charles.holzer.com

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



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



Utahns in Need of Mental Health Services

The results of the 2009 Synthetic Estimates of Needs for Utah¹ indicate the following:

- 5.1% of adults in Utah were classified as needing treatment for mental health issues in 2010.
- 4.3% of Utah youth under age 18 were in need of treatment for mental health issues in 2010.
- The public mental health treatment system served approximately 43,662 individuals or less than 33% of the current need.
- A combined total of approximately 90,677 adults and children are in need of, but not receiving, mental health treatment services.

The percentage of adults and youth needing mental health treatment by service district varies considerably, which reflects the challenges that each local authority must deal with. Accessibility based on location, funding and other factors are still issues throughout different areas of the state. Stigma around mental health continues to be another factor why people do not seek services even though need exists. The following table demonstrates the actual number of adults and youth who need treatment by district. The current number in need of treatment in each district, and the number who were actually served in fiscal year 2010, is also included to illustrate the unmet need. The same data is depicted on the following graphs.

Treatment Needs vs. Clients Served

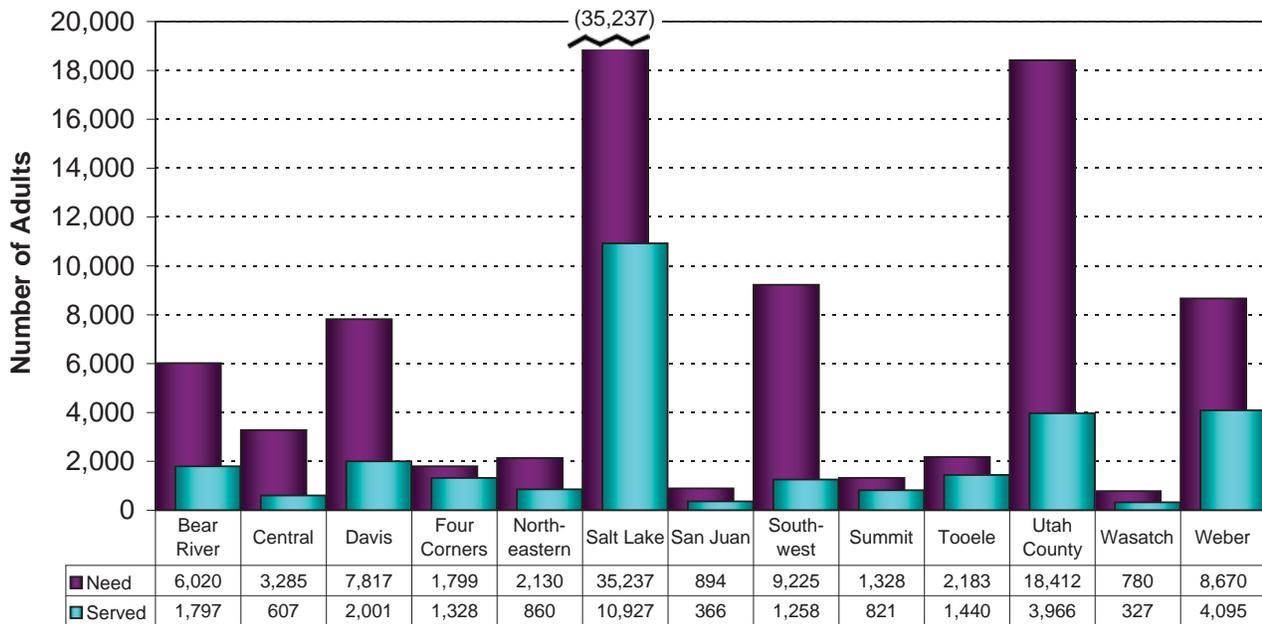
	Adults (18 years+)			Children/Youth (Under age 18)		
	% Need Treatment	# Need Treatment	# Served in FY2010	% Need Treatment	# Need Treatment	# Served in FY2010
Bear River	5.3%	6,020	1,797	4.6%	2,419	1,030
Central	6.7%	3,285	607	5.4%	1,261	376
Davis	3.9%	7,817	2,001	3.4%	3,425	1,253
Four Corners	6.1%	1,799	1,328	4.7%	519	553
Northeastern	6.3%	2,130	860	4.3%	717	442
Salt Lake	4.8%	35,237	10,927	4.2%	12,548	4,354
San Juan	8.9%	894	366	6.4%	319	170
Southwest	6.5%	9,225	1,258	5.4%	3,172	1,298
Summit	4.9%	1,328	821	4.1%	414	240
Tooele	5.8%	2,183	1,440	4.0%	825	470
Utah County	5.2%	18,412	3,966	4.2%	7,896	2,906
Wasatch	5.4%	780	327	3.8%	270	116
Weber	5.1%	8,670	4,095	4.4%	3,152	1,639
State Totals	5.1%	97,397*	29,147	4.3%	36,942*	14,515

*Because of rounding in the percentages and duplication of clients across Community Mental Health Centers (CMHC), CMHC totals do not add up to the unduplicated total of clients served statewide.

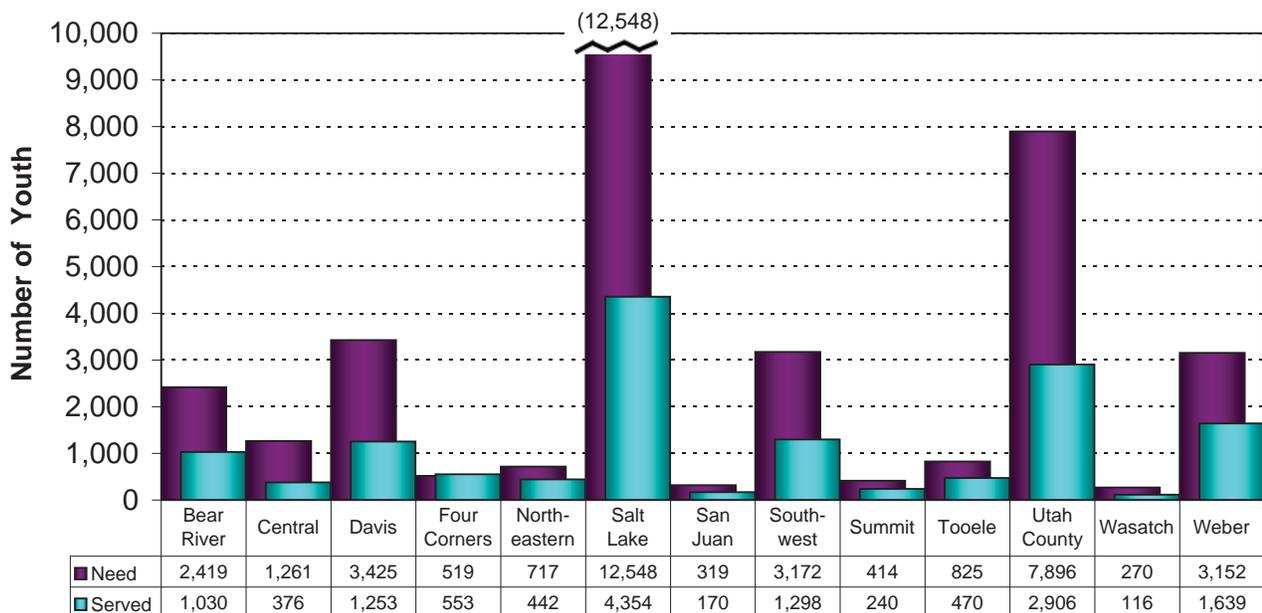
¹ Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimate), from www.charles.holzer.com

Note: These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition at 300% of poverty. 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).

Number of Adults Who Need Mental Health Treatment Compared to the Current Number of Clients Served



Number of Children/Youth Who Need Mental Health Treatment Compared to the Current Number of Clients Served



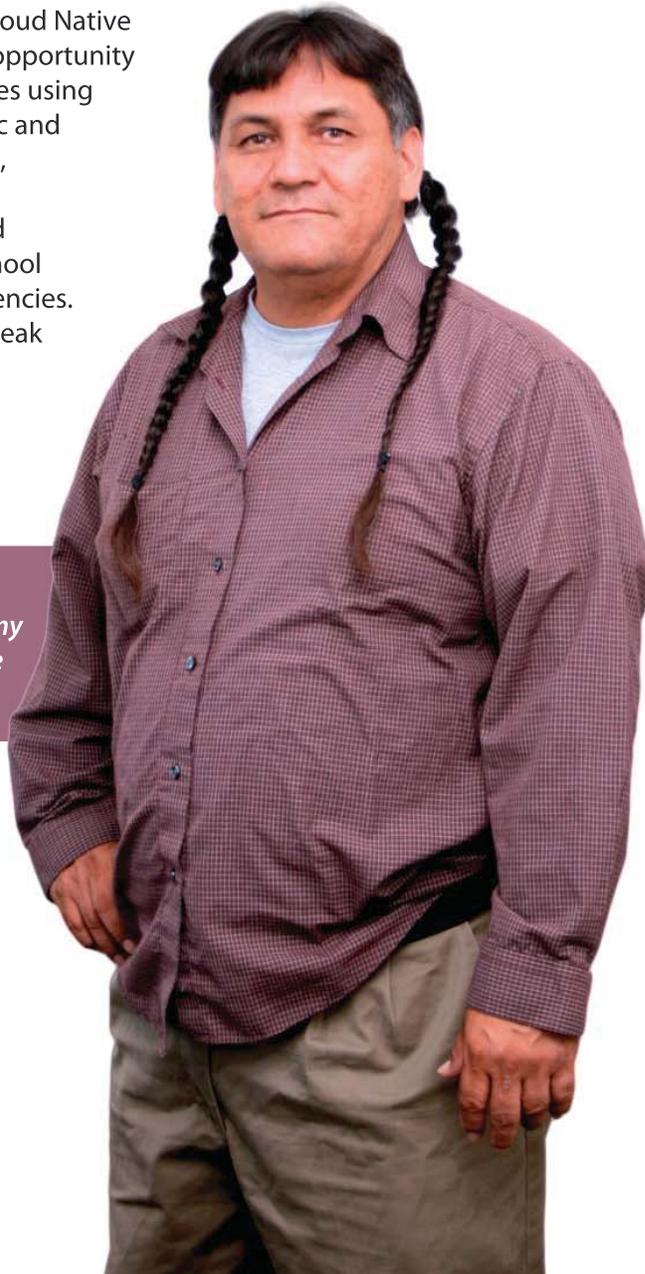
Nino

As the youngest of 11 children, Nino Reyos followed along in the family path of alcohol and drugs starting at the age of 13. Many years later, after taking the first critical steps into recovery, Nino wasn't able to be completely open with his family and friends because he was taunted and ridiculed for trying to "be white." He was told not to get too cocky because he'd be using again soon; but, fortunately, he was not overcome by these pressures. With sobriety, he was able to get a college degree—the only member of his family to do so—and he eventually graduated with a master's degree, and has since won back the respect of his family and friends.

"I could never have imagined being a proud Native American without my sobriety and the opportunity to live life to its fullest," Nino says. Besides using his degree to work in a methadone clinic and spending many hours mentoring others, Nino will be receiving a 20-year service award next year for his participation and leadership in the annual U of U June School on Alcoholism and Other Drug Dependencies. He is frequently called upon to MC or speak to Native American pow wows or youth groups and also conducts cultural programs in elementary schools.

I could never have imagined being a proud Native American without my sobriety and the opportunity to live life to its fullest.

Nino took up the Native American flute as a method of unwinding and staying healthy, but it has led to an enjoyable side career as a successful recording artist. His musical works have been recognized at the Grammy Awards and also the Native American Music Awards and he has performed all over the Western United States, as well as Japan, New Zealand and Sweden.



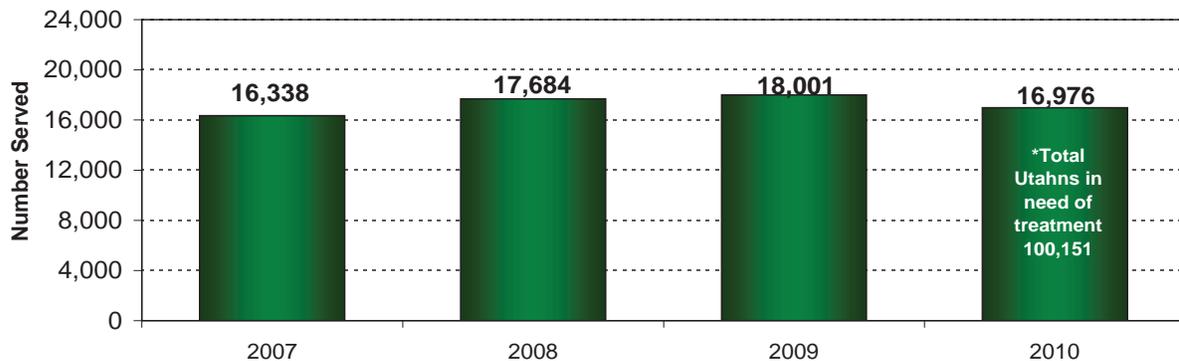
Who We Serve

Who We Serve

Total Number Served

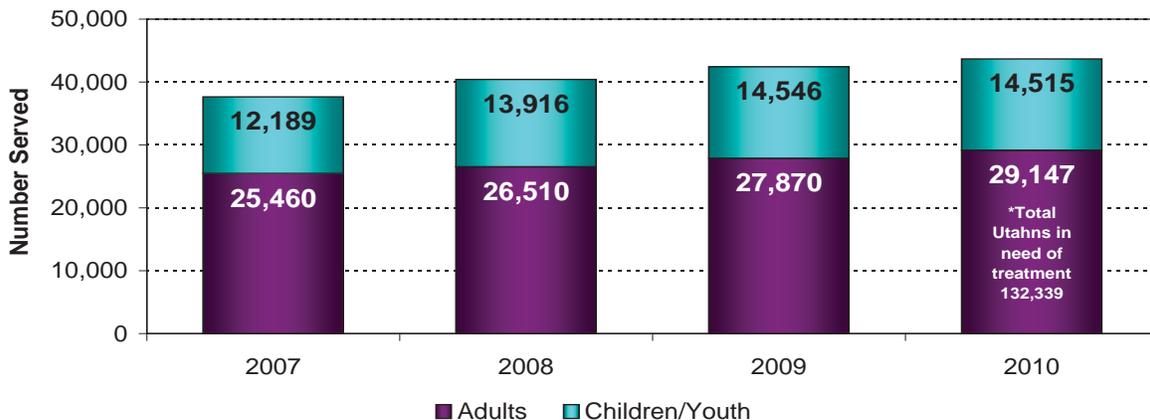
The following figures show the total number of individuals served in all publicly funded substance abuse treatment facilities and the total number served for adults and children/youth within community mental health centers for fiscal year 2007 through fiscal year 2010.

Total Number of Individuals Served in Substance Abuse Treatment Fiscal Years 2007 - 2010



*Taken from the 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 2009 Population Estimate), from <http://charles.holzer.com> and the 2009 SHARP Survey.

Total Number of Adults and Children/Youth Served in Mental Health Services Fiscal Years 2007 - 2010



*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 2009 Population Estimate), from <http://charles.holzer.com>.

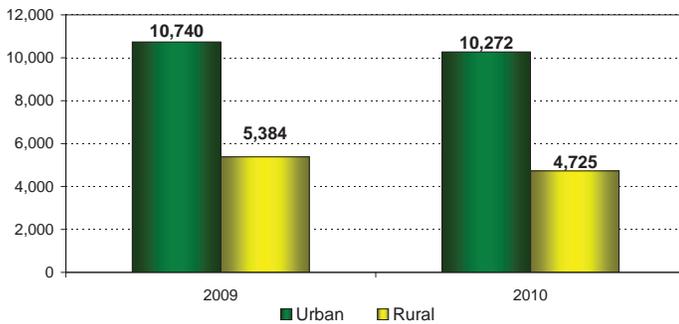
Note: These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition at 300% of poverty. The MHM3 definition requires a current or chronic disorder and a disability duration of at 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).

Urban and Rural Areas¹

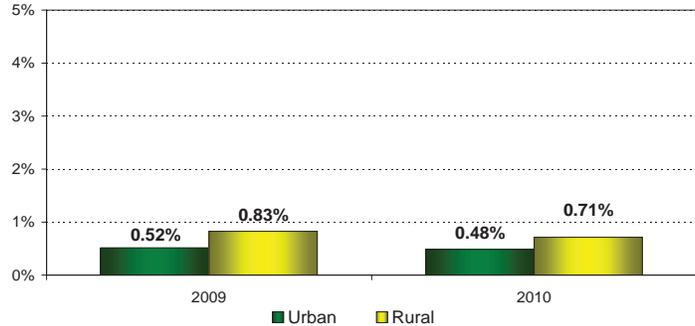
The following graphs show the total number of individuals served in urban and rural communities

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

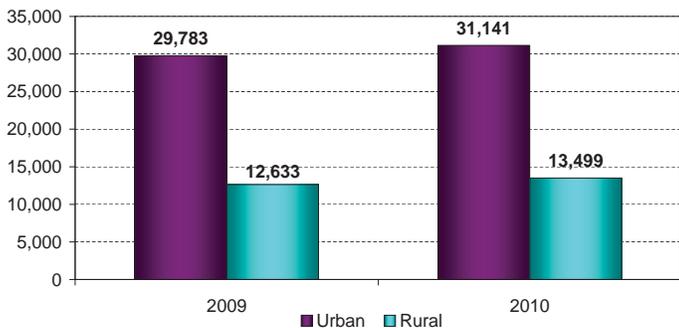
Number of Individuals Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2009 - 2010



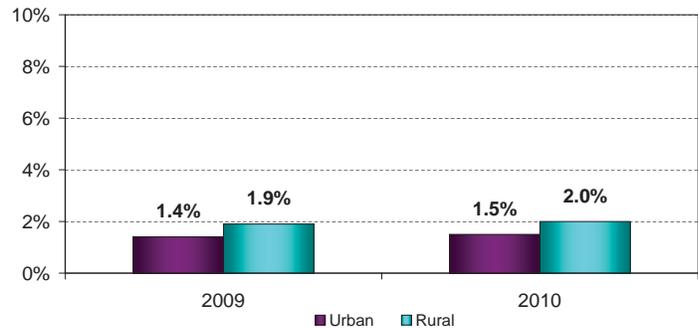
Percent of Total Population Served in Substance Abuse Services in Urban and Rural Communities
Fiscal Years 2009 - 2010



Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2009 - 2010



Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2009 - 2010



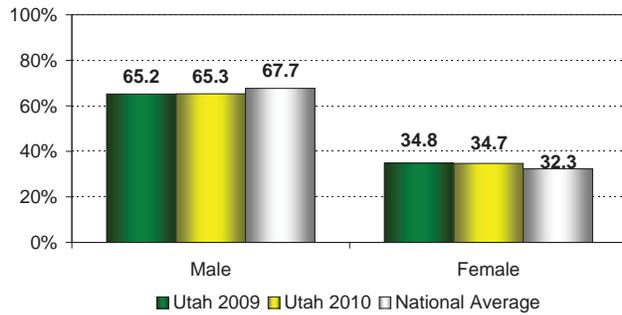
¹ Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

Gender and Age

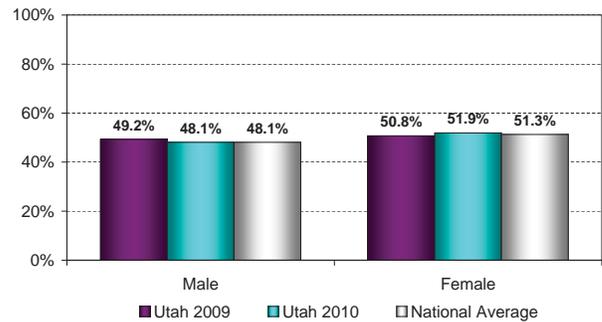
The following figures identify the distribution of services by gender and age for substance abuse and mental health services. There are significant dif-

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

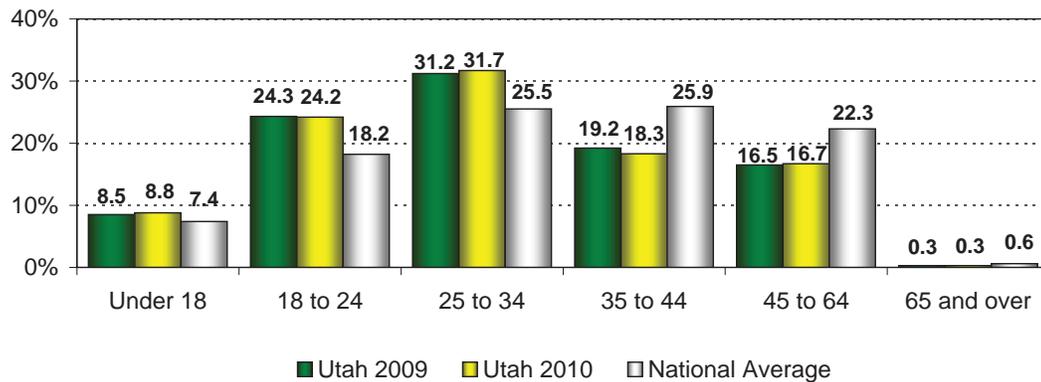
Gender of People Served in Substance Abuse Services
Fiscal Years 2009 - 2010



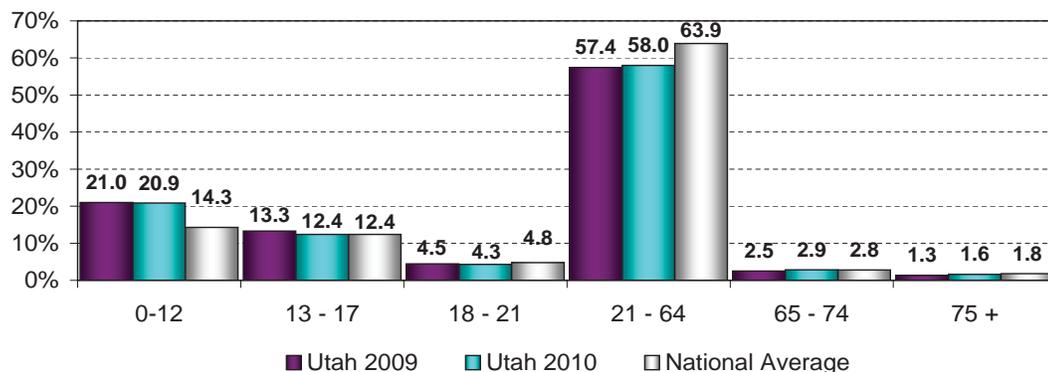
Gender of People Served in Mental Health Services
Fiscal Years 2009 - 2010



Age at Admission of People Served in Substance Abuse Services
Fiscal Years 2009 - 2010



Age of People Served in Mental Health Services
Fiscal Years 2009 - 2010

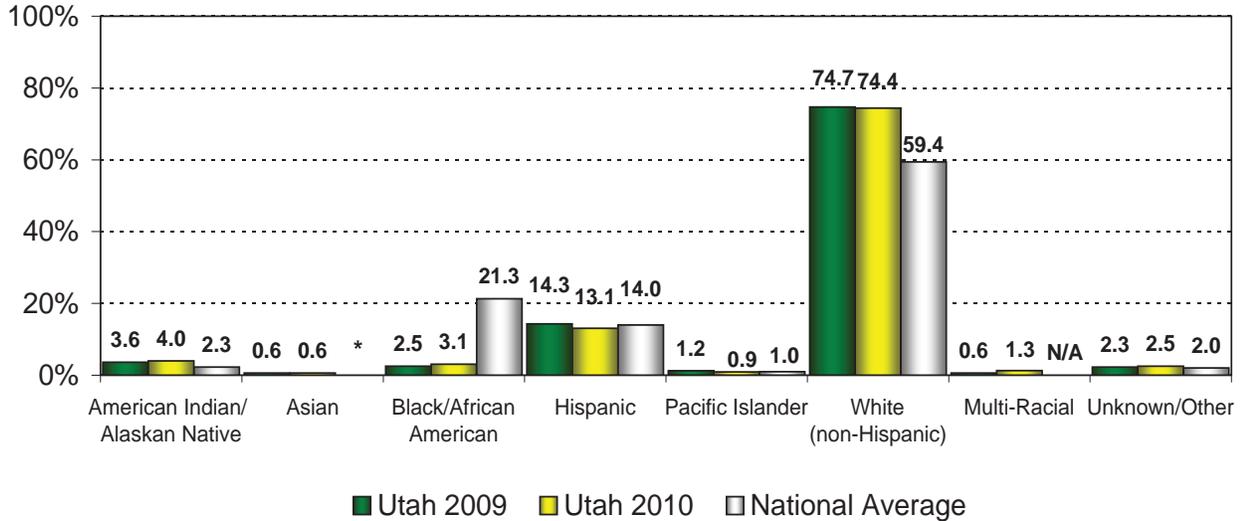


Race and Ethnicity

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

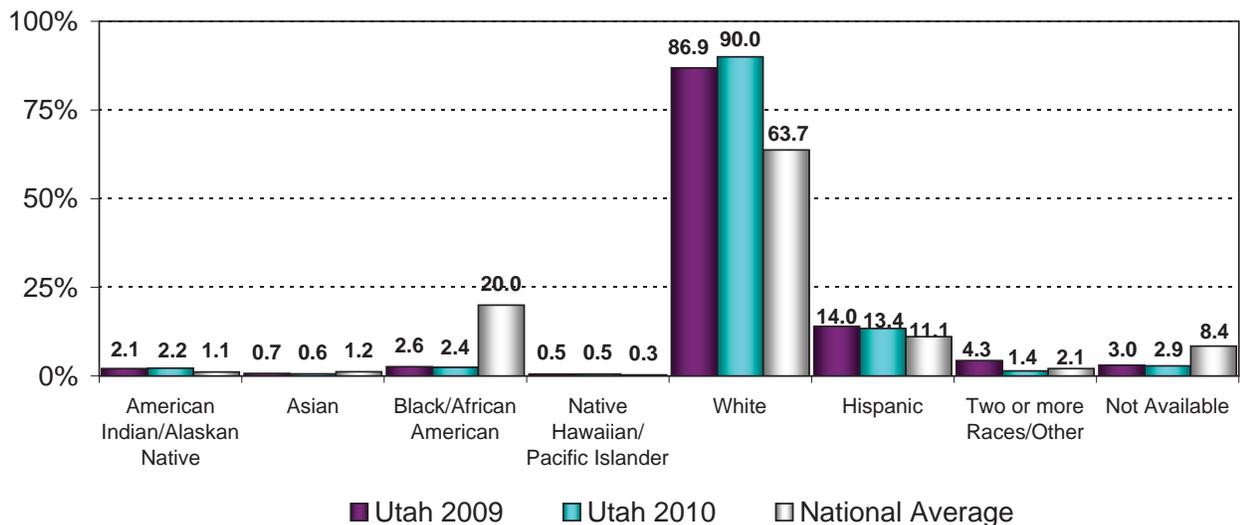
for clients receiving substance abuse or mental health services.

Race/Ethnicity of People Served in Substance Abuse Services Fiscal Years 2009 - 2010



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

Race/Ethnicity of People Served in Mental Health Service Fiscal Years 2009 - 2010

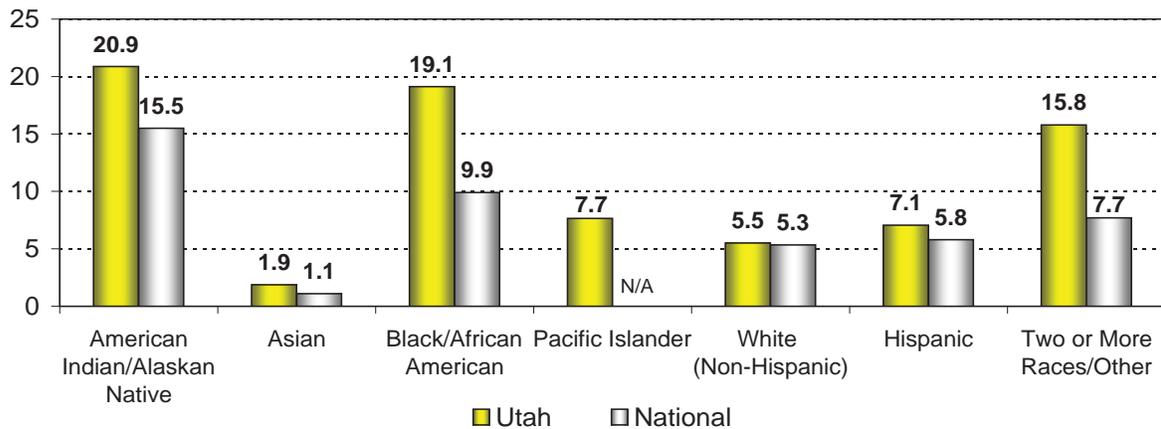


Note: More than one race/ethnicity may have been selected.

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

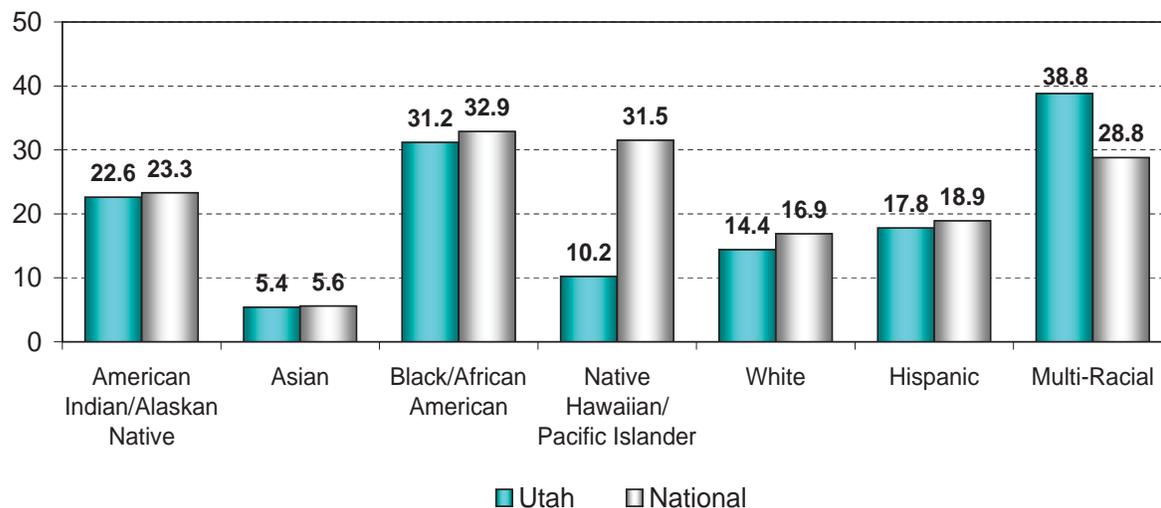
racial/ethnic groups. For example, for every 1,000 whites in Utah, 5.5 are receiving substance abuse treatment, however, for every 1,000 American Indians in Utah, 20.9 are receiving substance abuse services.

Penetration of People in Substance Abuse Treatment Service per 1,000 Population by Race/Ethnicity Fiscal Year 2010



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 2010

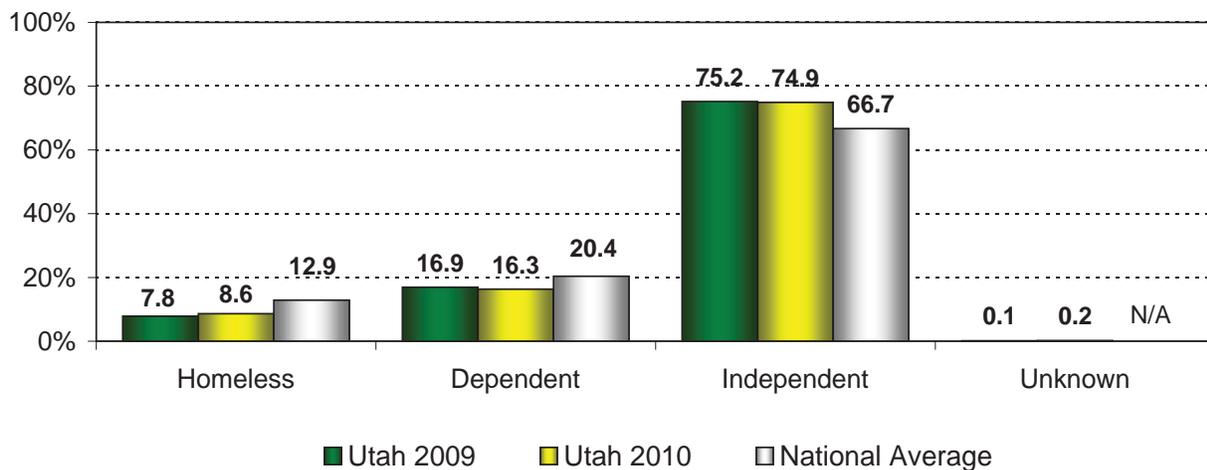


Living Arrangement at Admission

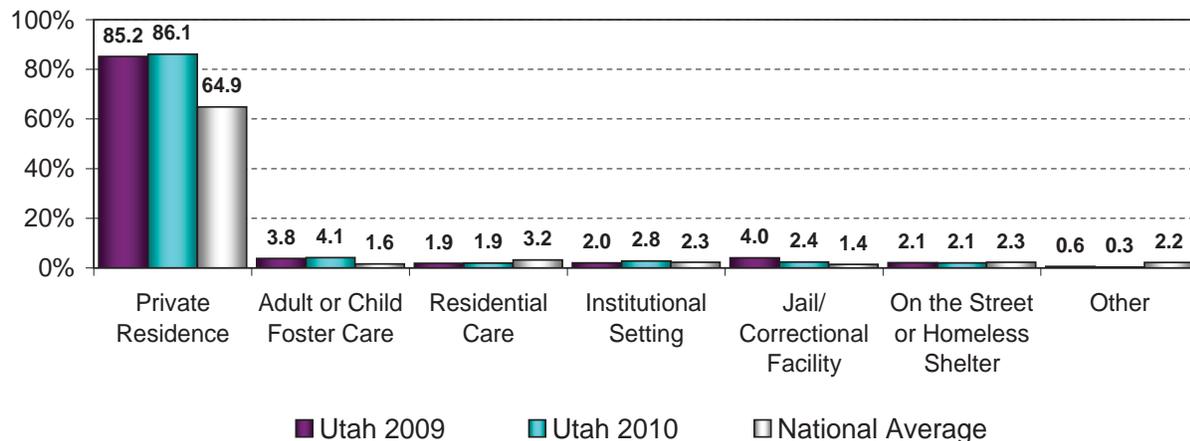
The following graphs depict clients' living arrangement at admission for substance abuse and mental health clients served in fiscal year 2009 and fiscal year 2010. By far, the majority of clients receiving substance abuse and mental

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 2009 - 2010



Living Arrangement at Admission of Adults Served in Mental Health Services Fiscal Years 2009 - 2010

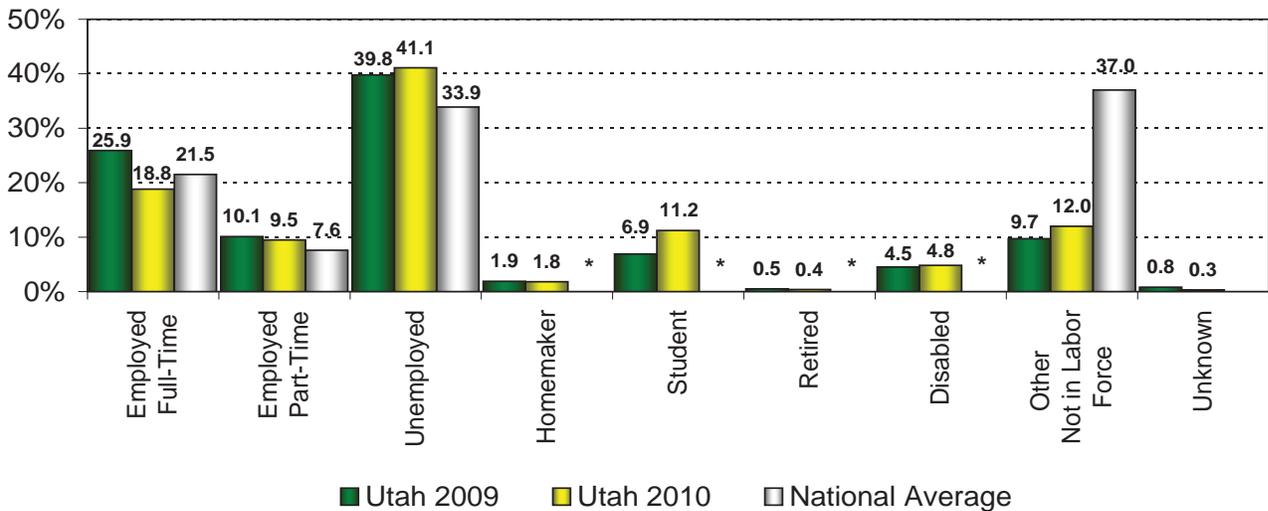


Employment Status at Admission

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

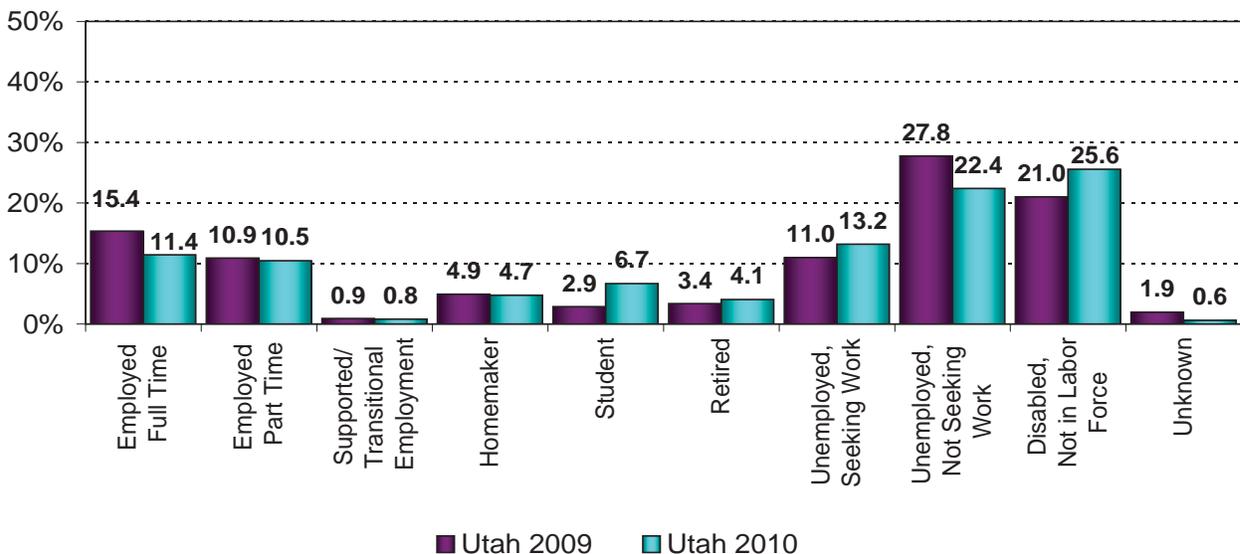
2010. The categories for mental health clients are different than those for substance abuse clients due to different reporting requirements.

Employment Status at Admission for Individuals in Substance Abuse Services Fiscal Years 2009 - 2010



*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 2009 - 2010



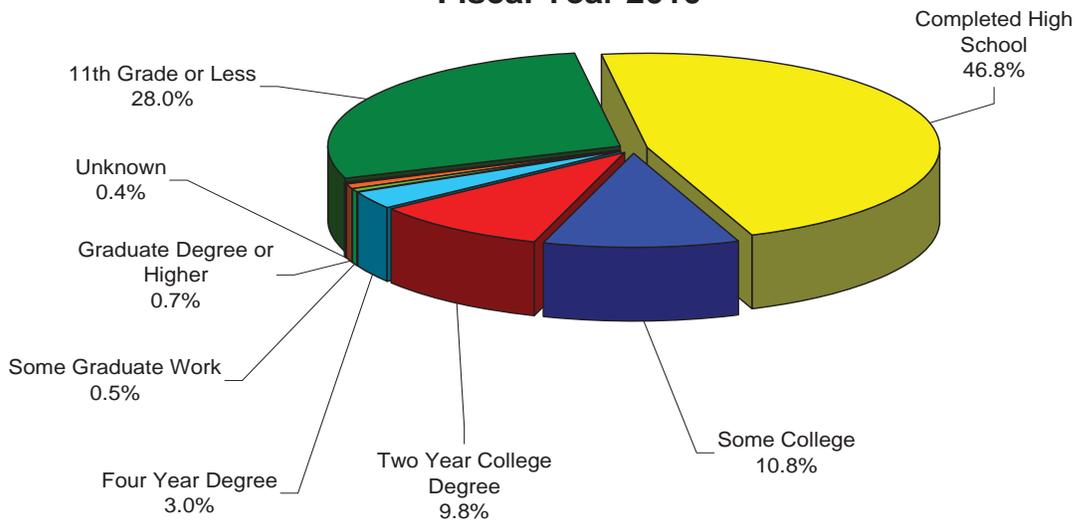
Highest Education Level Completed at Admission

In fiscal year 2010, over 71% of adults in substance abuse treatment statewide completed at least high school, which included those clients who had attended some college or technical training.

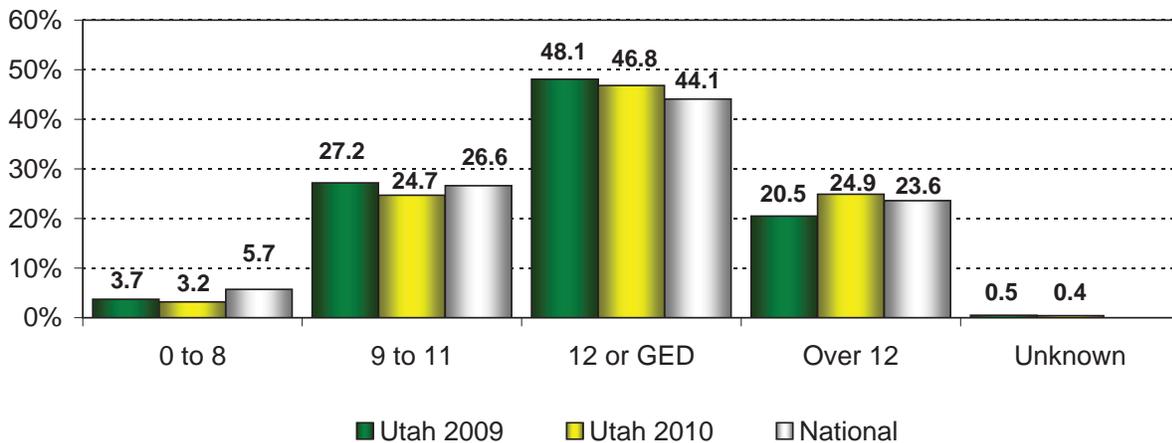
Additionally, almost 25% of the clients had received some type of college training prior to ad-

mission. Still, 28% had not graduated from high school. This adds to the challenge of treatment, as many of these individuals need education and job skills training in order to maintain a healthier lifestyle.

**Highest Education Level at Admission for Adults in Substance Abuse Services
Fiscal Year 2010**



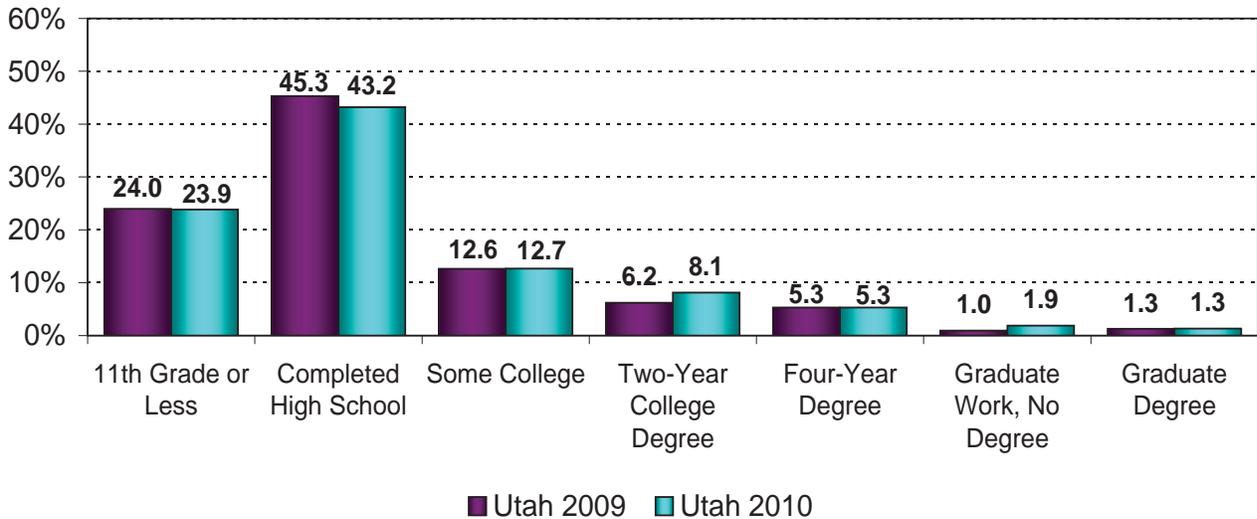
**Highest Education Level of Adults Served in Substance Abuse Services
Fiscal Years 2009 - 2010**



In fiscal year 2010, over 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, almost 17% 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 2009 - 2010



ABBIE'S STORY

Sometimes when I look back at what I've been through in my life, I'm amazed that I've done as well as I have. Besides being sexually molested by my step-grandfather, my mother's family totally turned on us when my sister and I told what he had been doing to us. That was hard on my parents. My dad started drinking again and my mother eventually became addicted to drugs. We lost our house, mom and dad split up, and my dad left us in a motel for nine months. We had to keep changing schools and I don't know how things could get worse, but then my mom went to jail. But jail actually turned out to be a good thing because it helped her get sober and back on track.

Although I almost dropped out of high school, I did end up graduating with a 3.6 GPA.

"The thing that motivated me the most to stay in school and stay in control of my life was watching my mom get clean and sober and turn her life around. Now I'm doing all I can to make her proud of me."

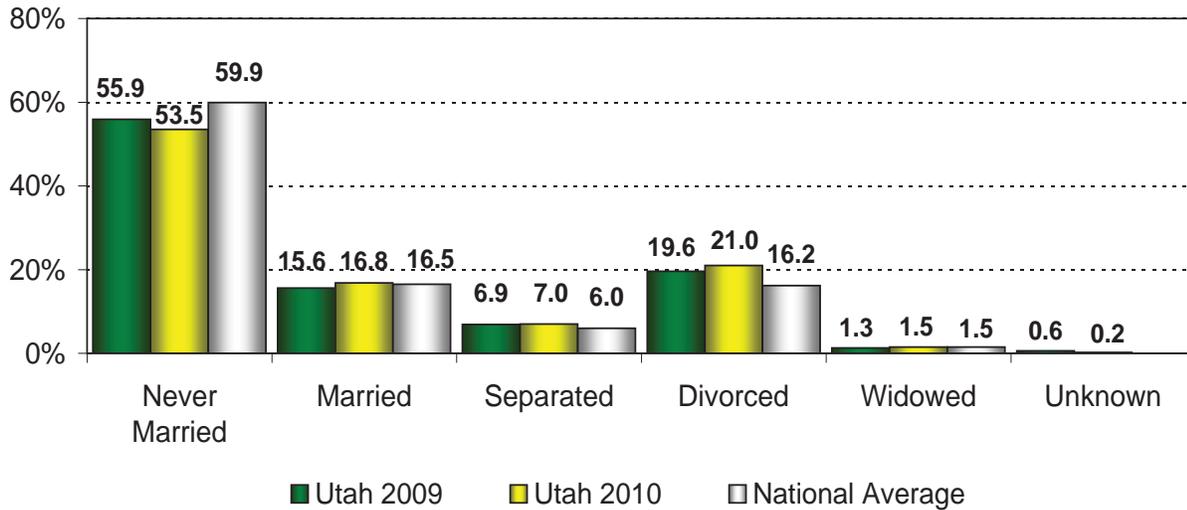
I've been getting help for my PTSD and depression, and I can honestly say things have never been better. I got a scholarship and am now attending Salt Lake Community College. I would like to become a substance abuse counselor. I've already had lots of

experience. I was one of the founders of a youth group called K.O.P.I.R. (kids of parents and people in recovery). We meet at least once a week and help each other through the tough times and we do a lot of service projects.

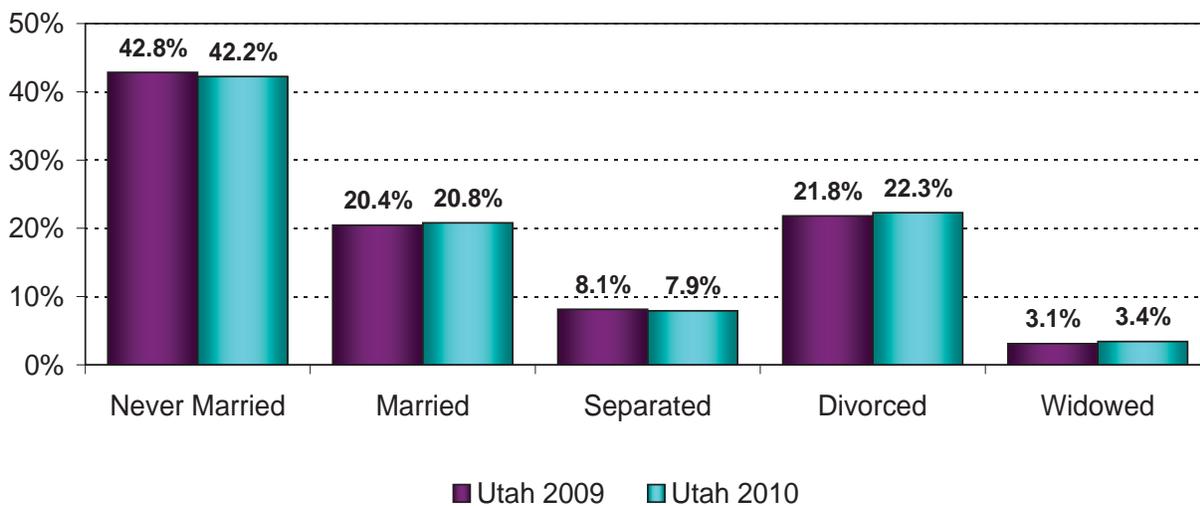


Marital Status at Admission

Marital Status of Adults Served in Substance Abuse Services Fiscal Years 2009 - 2010



Marital Status of Adults in Mental Health Services Fiscal Years 2009 - 2010

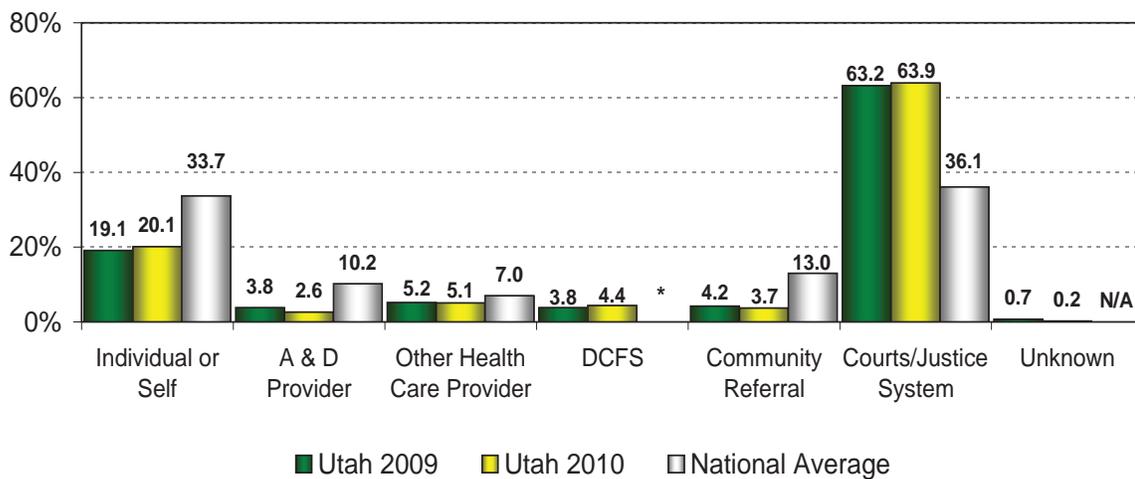


Referral Source

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,

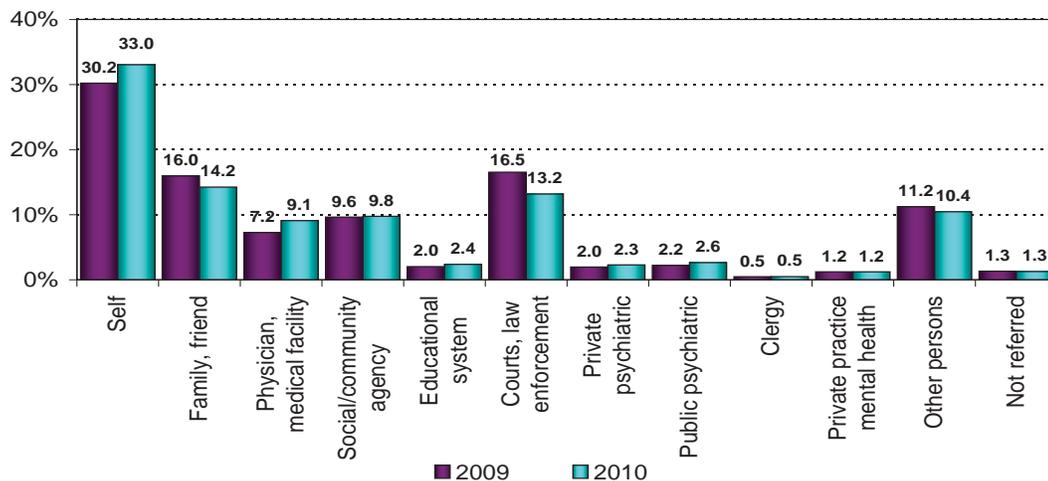
because the referral source can often continue to have a positive influence on the client’s recovery. The graphs below detail referral sources for fiscal years 2009 and 2010 for substance abuse and fiscal year 2010 for mental health.

Referral Source of Individuals in Substance Abuse Services Fiscal Years 2009 - 2010



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

Referral Source of People Served in Mental Health Services Fiscal Year 2009 - 2010



MARK'S STORY

As the child of a narcotics addict, Mark Van Wagoner suffered with opiate addiction since the age of 19. While on the surface living a respectable life, his private life was crumbling and he literally faced death and prison a few times in his journey. His turning point came when on the brink of losing everything—his wife, his children, his job, and possibly his life—he heard these words in a movie: “You gotta get busy living, or get busy dying.” He chose living and started down the difficult path to recovery.

Mark is a well-known local TV and radio personality, and even though he was warned professionally to “keep quiet” about his struggle with addiction, he and his family determined that if his example could result in just one other person finding recovery, the consequences to his work and status would be justified. He has since been an outspoken advocate for intervention and recovery—living proof that addiction reaches into every stratum of society, and also living proof that people can and do recover.

“My family and I agreed that if my example could result in just one other person finding recovery, the consequences to my work and status would be justified.”

Mark volunteers freely in the treatment and recovery community, and he and his wife have served a substance abuse recovery mission for their church. He is a frequent public speaker to doctors, pharmacists, legislators, and prison groups, volunteering his considerable talents to wiping out this plague. Because of his association with the media,

he has had many opportunities to speak about his recovery and his life-long challenge on television and radio as well as online. His life has been blessed by recovery as he has been able to keep his family together, send his five children to college, and live a meaningful and productive life.



Sheri

In 1986, Sheri Brandt had reached spiritual, emotional, physical and financial bankruptcy. After years of addiction and literally trying everything to stay clean and sober, she found herself in a dark bathroom, once again wondering how she could end her life of pain, despair and hopelessness . . . when, in fact, her addiction had been a slow suicide all along. "This time," she says, "I turned my eyes towards the heavens, and asked a power greater than myself to lead me to a better life." Within days, her life was uprooted and she ended up in treatment, peeling away the many layers of addiction and abuse.

Her recovery has been a lifetime commitment in every facet of her life. Not only has she remained clean and sober for 23 years, she has also over the last five years quit smoking, given up white refined sugars, processed foods, and salt, and has lost 75 lbs., 50 inches, and six dress sizes! She recently completed a 10K and she works out 4-5 times per week, doing cardio, weight training, yoga and pilates. She is applying the same principles she learned in addiction recovery to every part of her life—career, food, relationships.

In Sheri's words: "My recovery has encompassed an overall commitment to mind, body and spirit. The journey thus far has been painful, a struggle, a gift, a rebirth and transformation to personal inward and outward freedom."

My recovery has encompassed an overall commitment to mind, body and spirit. The journey thus far has been painful, a struggle, a gift, a rebirth and transformation to personal inward and outward freedom.

Sheri's recovery is not just based on her personal transformation; she has also focused her recovery on doing service work—giving back—mentoring others on their road to recovery, by living and working the steps; many, many hours of telephone calls; one-on-ones; hours of listening, praying and journaling.



What We Do

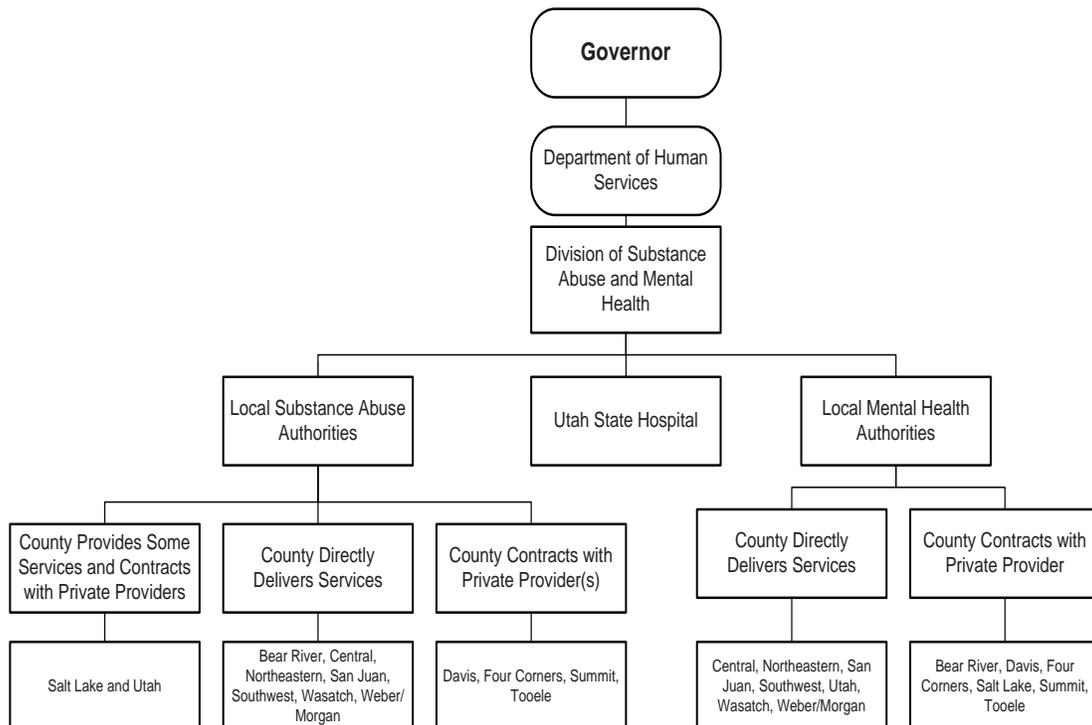
What We Do

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:

- 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
- Collect and disseminate information pertaining to substance abuse and mental health



- 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.

Source of Funding and Category of Expenses

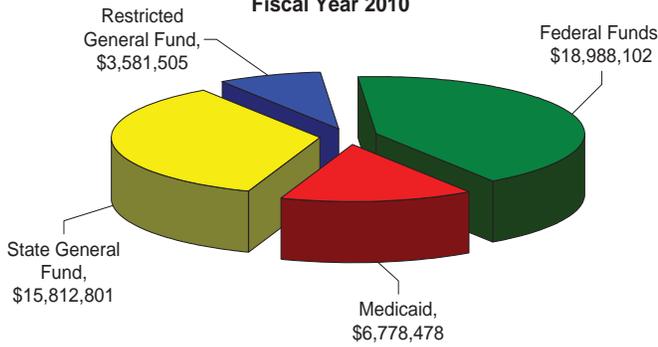
Prevention and treatment services in the state of Utah are funded by State general fund revenues, substance abuse and mental health block grant funds from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), Medicaid, Medicare, and various 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.

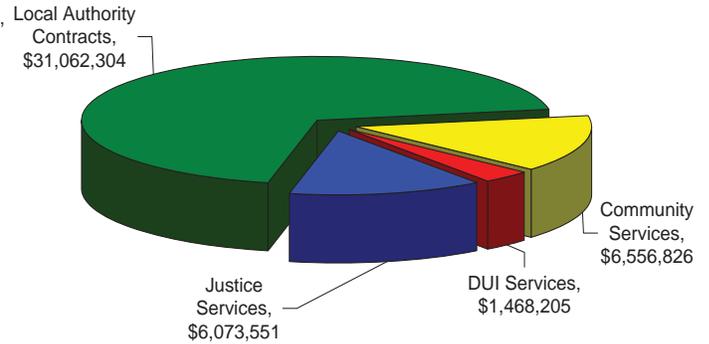
Substance Abuse Services

Community Substance Abuse Services Funding
Fiscal Year 2010



Total Revenues: \$45,160,886

Community Substance Abuse Services Expense Categories
Fiscal Year 2010

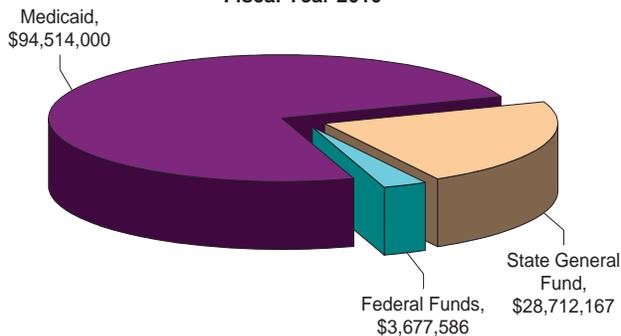


Total Expenses: \$45,160,886

The Substance Abuse figures above include Drug Court/Drug Board and DORA amounts, which have not been included previously due to the way they were originally appropriated.

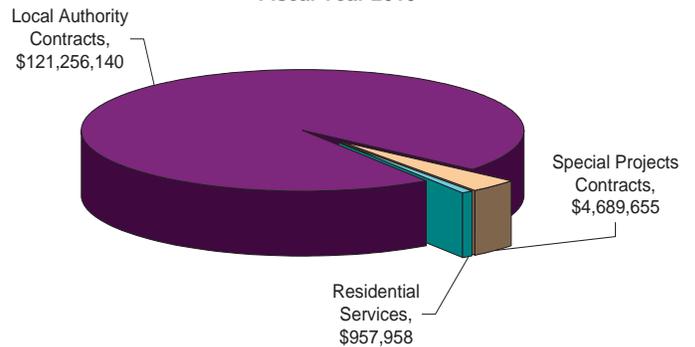
Mental Health Services

Community Mental Health Services Funding
Fiscal Year 2010



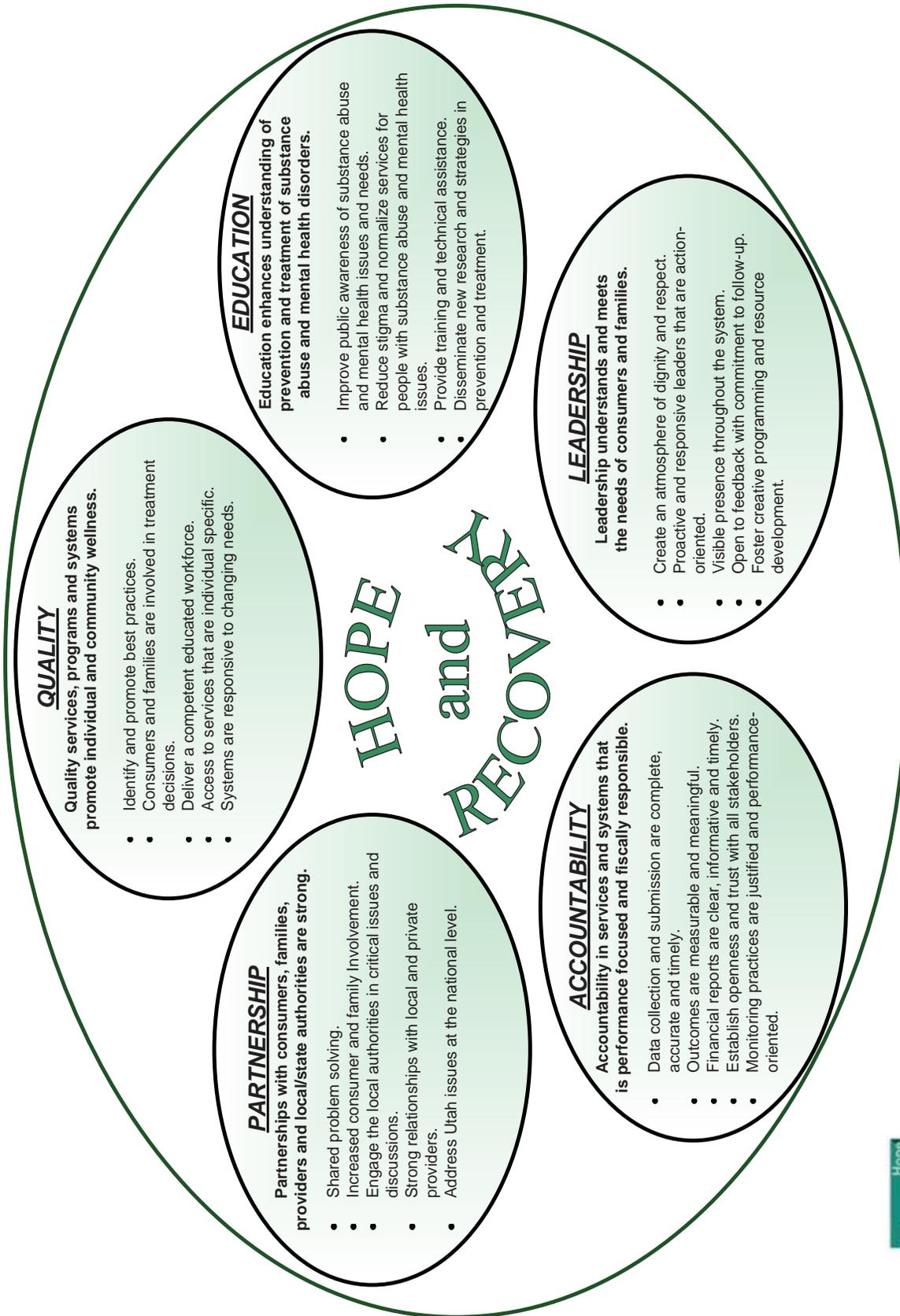
Total Revenues: \$126,903,753

Community Mental Health Services Expense Categories
Fiscal Year 2010



Total Expenses: \$126,903,753

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



Utah Division of
Substance Abuse and Mental Health

Dan

Although Daniel Murphy set out to be an altar boy, he grew up as the black sheep of his family. He first got drunk at 11 at one of his father's keg parties. He was impressed by the joviality and fun that always seemed to surround these gatherings, and he began participating early. As his disease progressed, he knew in his heart he was an alcoholic, but his problems did not slow him down. He went to radio school and landed a dream job on the radio in Los Angeles, but couldn't keep it because of the instability in his life. He didn't listen to anyone who tried to help because he had all the answers. With DUIs, lost jobs, wrecked cars, jail time, getting shot, barroom fights, he hated the way he lived and eventually had nothing and no one left . . . but a bottle. Finally when he could no longer stand the pain, his sober sister helped him into a treatment program.

Detox and treatment unfolded a lot of miracles in Dan's life and he realized that God must have had another plan for him. In Dan's words: "I have been given the freedom of recovery and the greatest reward for me is to see or hear from someone I was allowed to help along the way and know they are doing better. Money cannot buy those feelings. If you put money before helping others you miss the boat."

Dan has since been able to use the considerable talents he had accrued doing radio in Los Angeles to make a difference in the local recovery community.

If you put money before helping others you miss the boat.



He now produces and hosts a live two-hour talk show with the primary emphasis on finding solutions to drug and alcohol abuse and addictions. His show just celebrated 12 years of continuous broadcast on Fox News 1450.



Leadership

DSAMH has a long history of providing strong leadership on a state and national level. During fiscal year 2010, **Craig PoVey** (SA Prevention Program Administrator) has been serving as president of the National Prevention Network (NPN). On a regional level, **Rebecca Barnett** (SA Program Manager—Women, Youth and Family) serves as Region VIII representative for the National Association of State Alcohol/Drug Abuse Directors (NASADAD) Women's Services Network (WSN), while **David Felt** (SA Treatment Program Administrator) serves as secretary and regional representative of the National Treatment Network (NTN).

DSAMH also strives to understand and meet the needs of consumers and families. The programs highlighted below are just a few examples resulting from DSAMH's progressive and action-oriented leadership.

Wellness Initiative

Recent research indicates that people with serious mental illness die 25 years younger than

people without mental illness. DSAMH has set a wellness directive that guides policy and practice for Community Mental Health Centers to implement a clear set of wellness protocols that include monitoring weight; diabetic screening, education and self-management; increased use of labs; programming that incorporates diet, exercise and healthy choices; and enhanced communication between mental health providers and primary care physicians.

Recovery Plus

Because up to 80% of people with mental illness or substance use disorders use tobacco, DSAMH has set a directive that calls for a three-year initiative to assess, plan, and implement tobacco-free environments wherever public mental health and substance abuse services are provided. This project is a collaborative effort between DSAMH, the Utah Department of Health, local public behavioral health providers, and local health departments.

Recovery Oriented Systems of Care

DSAMH is committed to creating a Recovery Oriented System of Care. This model recognizes the need for long-term support for people with substance use disorders (SUDs). Moving to a care model similar to other chronic diseases acknowledges the benefits of long-term, assistance and support for people to succeed in maintaining their recovering lifestyle. DSAMH modified

its contract with Utah Support Advocates for Recovery Awareness (USARA) to provide additional recovery support functions, and continued to develop ways to expand support services. The Division applied for and received an Access to Recovery (ATR) grant. It is estimated that at least 40% of ATR services will be used for recovery support services.

SHANIN'S STORY

Shanin Rapp was born to a 14-year-old, drug-addicted mother who put her up for adoption. She was sexually and emotionally abused in her adoptive home, and had already started “sipping” alcohol by the age of 12. On her first time really drinking, she drank a fifth of vodka in less than 10 minutes and her heart stopped. Fortunately she was in school and was given CPR and was revived. That bad experience only served to spur her on to more drinking, and eventually being kicked out of her home at 17. Experimentation with drugs came next with no real consequences until she was introduced to freebase or crack cocaine and it was “love at first use.”

“I am a firm believer that anything is possible. I know the struggles of picking up the pieces, of rebuilding. Today my son and I have a beautiful relationship. I have no regrets.”

In two short years she destroyed everything that was dear to her. She willingly gave up her son to her sister so that she could run free, also losing her home, her marriage, and almost her life. Waking up from a four-days-long coma on her 30th

birthday in a strange hospital in Colorado, she realized that she didn't want to die. Choosing life meant getting help while she rebuilt her life and worked toward getting her son back. “I am a firm believer that anything is possible,” she says. “I know the struggles of picking up the pieces, of rebuilding. Today my son and I have a beautiful relationship. I have no regrets.”

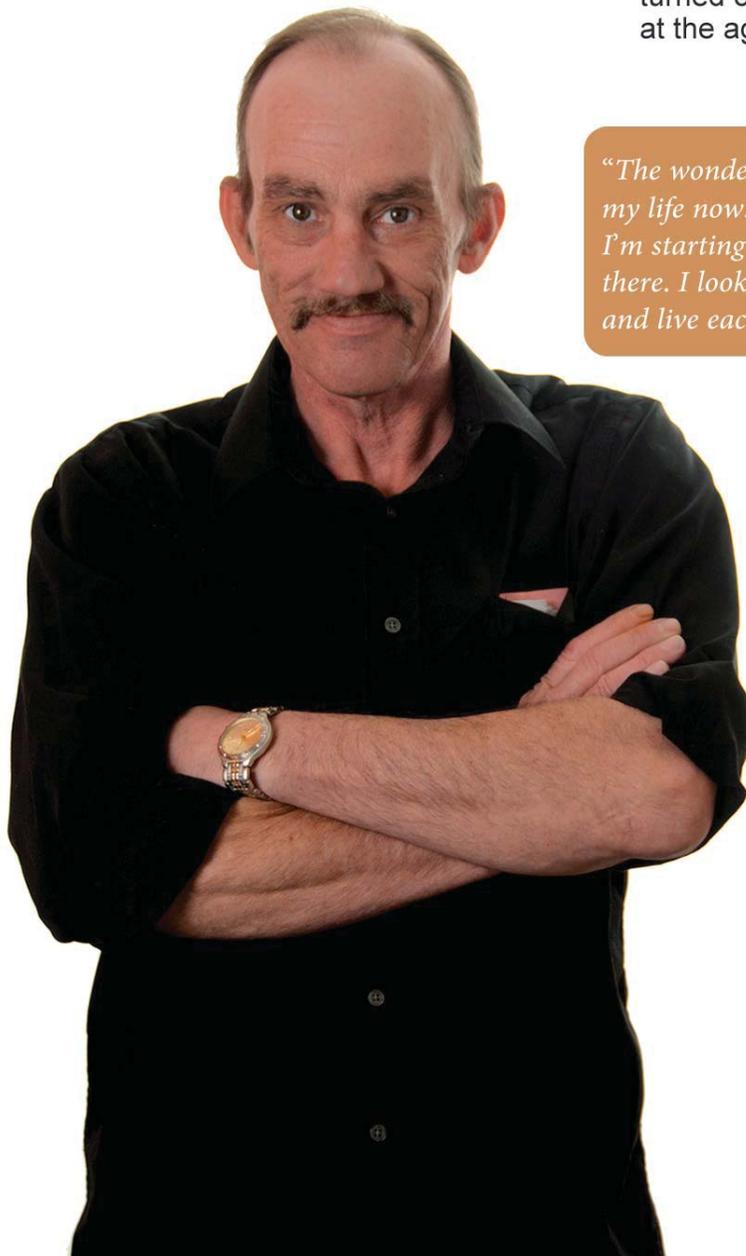
Shanin earned her LSAC and works in the adult felony drug court. She sits on many boards and committees within the local treatment and recovery community and works tirelessly to promote recovery in Utah. “I will always work in this field to help make treatment and recovery accessible, acceptable and understood.”



DAVID'S STORY

My first memory of an episode of mental illness was in about second grade when I had my first hallucination—just one of many which followed. Delusions ruled my teen years and my early twenties. I couldn't finish a four-year commitment in the Coast Guard because the stress of the job would trigger episodes, which resulted in seven courts martial and an early discharge. Through it all, no one offered—or suggested—psychological treatment.

Things got worse from there as I tried to cope by getting into cocaine, speed, pot, acid, heroin and anything I could find. I can't count how many times I hit bottom and started into five years of drug abuse treatment until finally a doctor saw the drug abuse for what it really was—self-medication. I got on the right meds and started doing well for the first time in my life. I can only wonder how my life would have turned out if I'd been diagnosed at the age of five instead of 35.



“The wonderful thing is how much I enjoy my life now. I’m a writer and an artist and I’m starting to get published here and there. I look forward to each and every day and live each day like it’s my last.”

Today I actively work on my recovery full-time. The wonderful thing is how much I enjoy my life now. I’m a writer and an artist and I’m starting to get published here and there. I look forward to each and every day and live each day like it’s my last. I don’t take anyone or anything for granted and I like to think I’m an asset to the recovery community.

Quality

Quality

DSAMH is required by statute to maintain the capability to consult and coordinate with Local Substance Abuse and Local Mental Health Authorities; to provide consultation and other assistance; to promote or conduct research on substance abuse and mental health issues; and to provide direction over public funds for substance abuse and mental health services. DSAMH is dedicated to ensuring the delivery of quality services, programs and systems that promote individual and community wellness throughout Utah by introducing dynamic, evidence-based practices to Utah clinicians, counselors and program administrators. Three examples of evidence-based trainings brought to Utah in fiscal year 2010 follow.

Trauma Recovery and Empowerment Model and Profile Training—37 trained/certified

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. The Trauma Recovery and Empowerment Profile (TREP) is designed to provide a summary of the consumer/survivor's recovery skills at a particular point in time.

In 2010, DSAMH sponsored a refresher and follow-up course for those already trained in the Recovery and Empowerment Model and the Empowerment Profile to review the core elements and principles of TREM and TREP.

Stephanie Covington's *Helping Women Recover* Training—75 trained/certified

In 2010, DSAMH sponsored a two-day workshop of Dr. Stephanie Covington's manualized

curriculum *Helping Women Recover: A Program for Treating Addiction*. This program offers a comprehensive treatment model that integrates theories of addiction, women's psychological development, and trauma. Designed to give counselors, clinicians, and program administrators a basic understanding of the current knowledge related to chemical dependency, the training focuses primarily on women's recovery. The emphasis is on the key issues of self, relationships, sexuality, spirituality, and the therapeutic techniques for dealing with these issues.

Peer Support Training—32 trained/certified

DSAMH is working with the Utah Health Department Medicaid office to submit a State Plan Amendment to add Peer Support Services as a Medicaid-reimbursable service. This is an exciting new service that is based on the belief that people with mental illness can recover and, with training and education, provide needed services to others. Peer support workers are uniquely qualified to share their stories of recovery, and to give others hope and understanding that treatment works and that recovery is possible. These services can be provided at various levels of intervention, including community living, discharge planning, supported employment and housing, and other traditional mental health services.

In 2010, DSAMH brought in Larry Fricks, one of the nation's leading experts in Peer Specialist Training and Certification, to provide this training and certification to 32 people who are now trained and ready to enter Utah's mental health services workforce.

Quality Controls and Certifications

To satisfy the goal of delivering a competent educated workforce, DSAMH trained, certified, or recertified a total of 29,509 participants in 2010 in the following programs:

Forensic and Designated Examiner—309 trained/certified

DSAMH provides training and certification for licensed mental health professionals as part of the qualification process to conduct forensic examinations or involuntary commitment evaluations.

Case Management—364 trained/certified

DSAMH provides case management training and certification for this mandated service, which connects the consumer with services and advocates for consumer rights to support community living.

Pre-Admission Screening Resident Review (PASRR)—38 trained/certified

PASRR is a federally mandated service which ensures that all individuals with mental illnesses entering nursing homes have a medical need that justifies this level of care and recommends mental health treatment as needed. DSAMH provides training and certification for licensed mental health professionals who provide PASRR evaluations.

Disaster Crisis Counseling—479 trained/certified

Crisis counseling training and certification is offered by DSAMH for volunteers who provide service to victims of traumatic events, including disasters, declared as a “state of emergency” by the governor, or which have received a Presidential Disaster Declaration status.

Crisis Intervention Teams—1,482 trained/certified

Crisis Intervention Teams are made up of police officers with specialized mental health training,

who respond to crisis calls that may involve a person with mental illness. Officers who volunteer to be part of these teams complete 40 hours of certification training, with required annual recertification, where officers learn about specific mental illnesses and effective de-escalation tactics. The preferred method of training takes place in the community with close collaboration between local law enforcement and mental health personnel. This model was implemented in Salt Lake City in 2001 and has since expanded to roughly two-thirds of the state. DSAMH supports efforts to implement this service throughout the entire state through a contract with the Salt Lake City Police Department.

Family Resource Facilitator Certification—25 trained/12 certified

FRF training and certification continued in 2010, with ten additional people becoming Certified Family Resource Facilitators and two additional individuals receiving Family Wraparound Facilitator certification. Requirements include participation in monthly trainings, on-site mentoring, 80% scores on evaluations, 100% scores on assignments, completion of documentation requirements, and a 152-hour supervised practicum.

Eliminate Alcohol Sales to Youth (EASY)—8,414 trained/certified

The EASY law, in effect since July 2006, 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. In 2010, more than 8,000 people were trained in Utah. DSAMH is responsible, by statute, to establish standards and certify program providers, and in this capacity DSAMH administers the Alcohol Training and Education Seminar Program. Every person who sells or furnishes alcoholic beverages to the public for off-premise consumption in the scope of that person’s employment must complete the program.

Beverage Server Training for On-Premise Consumption—10,667 trained/certified

Utah law requires every person serving alcohol in a restaurant, private club, bar or tavern, for **on-premise consumption** to complete an alcohol training and education seminar within **30 days of employment**. DSAMH establishes standards and certifies program providers. The Alcohol Server Training and Education Seminar, which is provided only by state-approved providers, focuses on topics such as:

- Teaching the server the effects of alcohol on the body and behavior
- Recognition of a problem drinker
- An overview of Utah’s alcohol laws
- How to deal with problem customers

- Discussion of alternative means of transportation for getting customers home safely to protect them and the community

Driving Under the Influence (DUI) Education and Training—7,590 trained/certified

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. DSAMH contracts with Prevention Research Institute to train instructors and provide all materials needed for DUI education. During 2010, 65 new instructors were trained and 125 were re-certified, who went on to teach the curriculum to 7,400 DUI offenders.

JAMES’ STORY

I’ve had some crazy experiences in my life. One time I jumped on the roof to get a shoe that belonged to one of my friends. Then I had to jump from the roof to a milk truck and then to the ground. My friends started calling me Spiderman after that.

“Lately it seems like I’ve been able to get through the hard things better and I don’t get in trouble as much. Another way I’ve changed is that I actually listen to people now instead of arguing all the time. But one thing that hasn’t changed is that I’ve always loved making people laugh.”

A more serious experience is what I remember of my life before I got adopted. Me and my dad were homeless most of the time. Once we were able to get an apartment for not too much money, but it had rats and mice. I had to learn how to use my reflexes to catch them. When we ran out of money we started to catch the mice to eat.

People also left food for us sometimes. We never saw the people, but I am glad they cared about me.

I’ve had ADHD and some other disorders since I was about five years old. These disorders made it hard for me in school because I couldn’t remember things very well. But lately it seems like I’ve been able to get through the hard things better and I don’t get in trouble as much. Another way I’ve changed is that I actually listen to people now instead of arguing all the time. But one thing that hasn’t changed is that I’ve always loved making people laugh.

I’ve been taking a welding class and I really enjoy doing metalwork. I also like to swim. I would like to use these two skills to become an underwater welder. I also like participating in the Youth Action Council because it gives me a chance to practice leadership skills.



EDITH'S STORY

My first encounter with mental health was at the age of 15. I was depressed and suicidal and had no idea why I felt so awful, nor what I could do to change my situation. What I did was move out on my own. I got pregnant and married early. I was a battered wife and I knew I had to leave with my children or I'd be killed.

Eventually I found a good therapist, vocational rehab and welfare. It wasn't easy but that was the start of my life and getting an education. I can't begin to say in this short space what heartaches I've been through with my children and the other situations that added to my depression. But even after becoming a social worker and spending my life helping others,



“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 still hit rock bottom last year and for a time couldn't even get out of bed. 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 . . . until I started to follow through on all the things I taught my clients. Then finally I began to feel better and was able to get back to work helping others.

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. I'm a better person for what I've lived through. And a stronger person as well.

Penny

Penny Keller was a straight-A student in accelerated classes in elementary school. After 6th grade, she started huffing, which led to marijuana, alcohol and pills and she did her first shot of heroin on her 15th birthday. Increasingly out of control, her risky lifestyle catapulted her into a world of rage, anger, depression and self-loathing. She medicated these feelings with alcohol, any drug available, and violent relationships.

Lost, twisted, desperate, terrified, unemployable, near death and weighing 79 pounds, she found recovery at 40. "There was just a little flicker of light inside me," she says. "I knew if the wind blew, it'd go out." Three months sober, she found a job at a plant nursery, the first job she'd ever kept for two straight years. Next move was to an animal sanctuary, then for the Forest Service as a wildlife tech, until she was given a chance as a substance abuse counselor even though she did not meet the educational requirements. She worked as an intern until becoming an LSAC, and now directs the substance abuse program for a small tribe of Native Americans. In her words: "It's like God said, 'Penny, first I'm going to let you work with my plants, then my animals, in my forest, then my children—before I will trust you to work with my beloved native people.'" That statement reflects Penny's deep commitment to her work and to these people who she loves.



It's like God said, "Penny, first I'm going to let you work with my plants, then my animals, in my forest, then my children—before I will trust you to work with my beloved native people."

She's now married to a wonderful man who has been sober for 24 years. They live a life beyond their wildest drunken dreams on the EZ Does It Ranch just outside of Kanab.



Accountability

By Statute, DSAMH is responsible to monitor and evaluate programs provided by local substance abuse authorities and local mental health authorities. DSAMH has developed performance metrics to ensure that local counties, or their contracted providers are accountable for public funds. Efficiency outcomes are derived from very detailed provider level scorecards. Our scorecards measure results of treatment, quality, cost, and impact within the community. Results are measured and compared to national standards

and statewide standards for rural and urban communities.

We use innovative research tools, technology, and data to monitor, fund, and improve services within the public behavioral healthcare system. This section provides a summary of only a portion of the measures we use to ensure that the highest level of clinical standards and efficiencies are incorporated.

RUSSELL AND RACHEL'S STORY

RUSSELL: I've been diagnosed with ADHD, ADD, OCD, Asperger's, mild Tourette's, depression, and bipolar disorder. I had a lot of problems growing up, and had suicidal thoughts until my parents sent me to Wasatch Canyons where I finally felt safe and made some good friends.

I love to study and research, and I've learned a lot about my disorders, especially Asperger's. With the knowledge I've gained, I've come to see my disability as an awareness, not a condition. Rachel and I went through the Youth Transition Group program before we got married and it's helped us a lot. One thing I'd tell others who are going through what I've been through is that it's important to recognize that no one can do it alone. We all need help and love from others.

RACHEL: I was raised by my grandparents because my mother has cerebral palsy and couldn't handle raising me. I have ADHD and depression, plus I've struggled with PTSD due to some very traumatic abuse I suffered as a child. With the help of my great therapist, and good family and friends, I've been able to develop some good coping skills, and have had my PTSD under control for a year-and-a-half now.

"One thing I'd tell others who are going through what I've been through is that it's important to recognize that no one can do it alone. We all need help and love from others."

Russell and I got married in 2008 and are now expecting our first child. I'm determined to study and learn all I can about raising a child so that our little girl won't have to go through what I went through. I missed out on parts of my childhood, and I'm looking forward to seeing it through her eyes. I really appreciated the transition class where we learned how to cook and budget and live on our own. With all that I've learned and all the changes I've made since getting help for my disorders, I'm ready to go out and face the world.



Substance Abuse Treatment Outcomes

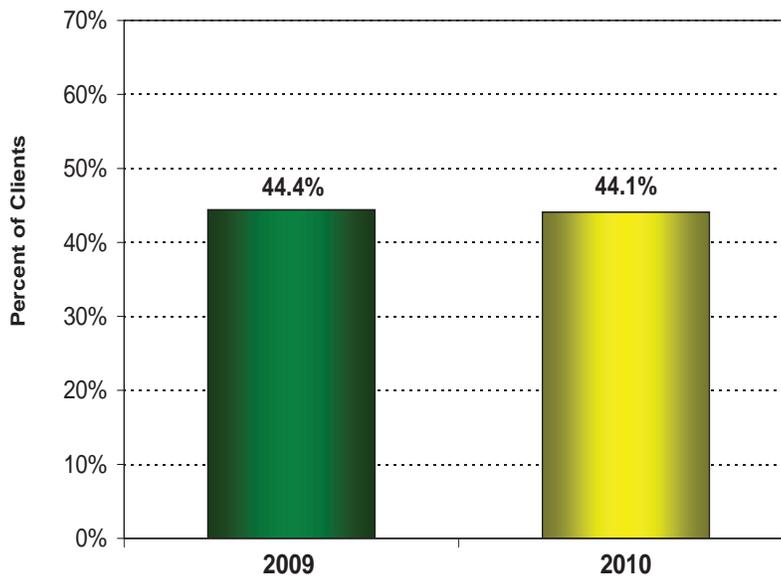
DSAMH collected final discharge data on over 10,048 non-detox clients in fiscal year 2010. These are clients discharged from treatment and not readmitted into any treatment within 30 days after discharge. This section includes data of clients who were discharged successfully (completed the objectives of their treatment plan), and of clients who were discharged unsuccessfully (left treatment against professional advice or were involuntarily discharged by the provider due to non-compliance). Clients discharged as a result of a transfer to another level of care are considered

“successful.” The data does not include clients admitted only for detoxification services or those 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 2010 who successfully completed the entire treatment episode.

Percent of Clients Successfully Completing Treatment Episode
Fiscal Years 2009 - 2010

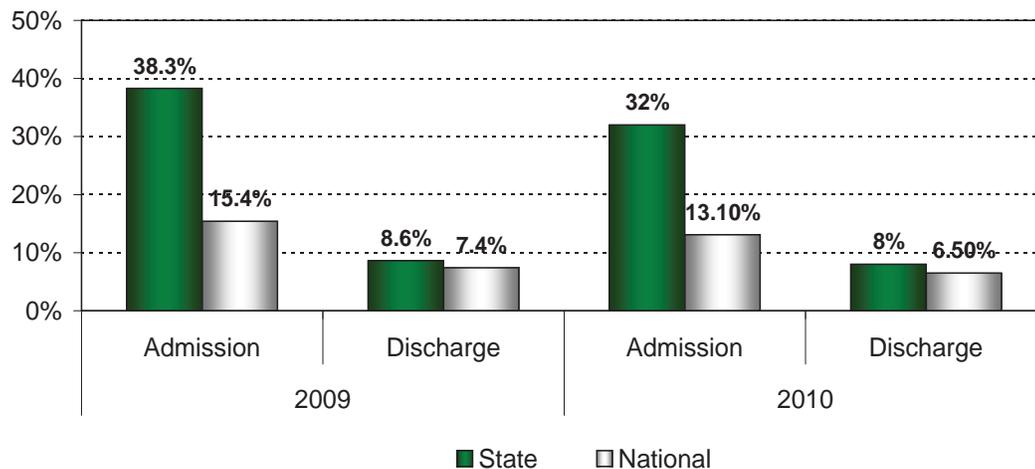


Criminal Activity

Approximately 76% of clients who enter into the State’s treatment system are involved with the Criminal Justice System. Reduction of criminal activity is an important goal for treatment and a good predictor of a client’s long-term success. 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 2009 and 2010, Utah had higher arrest rates at admission than the national average, but the arrest rates at discharge are comparable to the national norm.

Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment Fiscal Years 2009 - 2010



DEBBIE’S STORY

At age 32, everything Debbie Perry owned was stuffed into two Hefty garbage bags. She’d been evicted from her condo, the contents of her storage unit had been auctioned off, her truck had been repossessed, she’d lost her job, and she’d signed over custody of her son. For more than 15 years she’d been living a tumultuous and traumatic existence revolving around her own, and her family’s, substance abuse. When she was just 15, her mom died suddenly devastating the family, and Debbie had to take over raising her siblings as well as her alcoholic dad. She escaped by getting married at age 17 . . . to another alcoholic. She continued to use with increasing insanity, and her life was “lonely, dark, and full of desperation.”

I knew then that I wanted to live. I am grateful for my recovery and I am blessed. I am alive!

After many attempts to control her out of control behavior she had planned her own suicide when she experienced a rare moment of clarity and opened a phone book to Employment. By “accident” the book opened to Drug Abuse and she was on her way to recovery.

Service has been a huge part of Debbie’s recovery. She has an LSAC and also an associate’s degree in criminal justice. She works at a wonderful treatment center and takes the 12-step meetings into lock-down facilities.

“My son was 14 when I got clean,” says Debbie. “It took some time for him to be able to trust me. For so long, I was just a disappointment to him. He is proud of me today and that still makes me cry.”



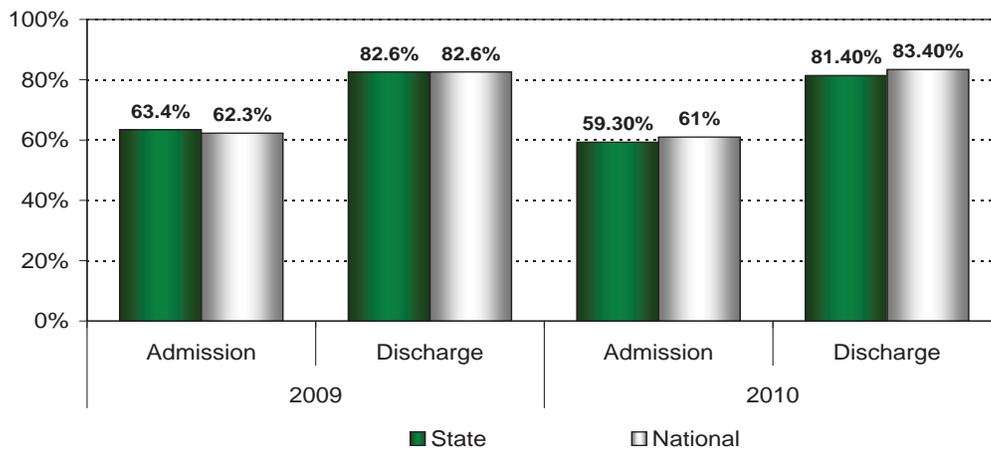
Changes in Abstinence from Drug and Alcohol Use During Treatment

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-

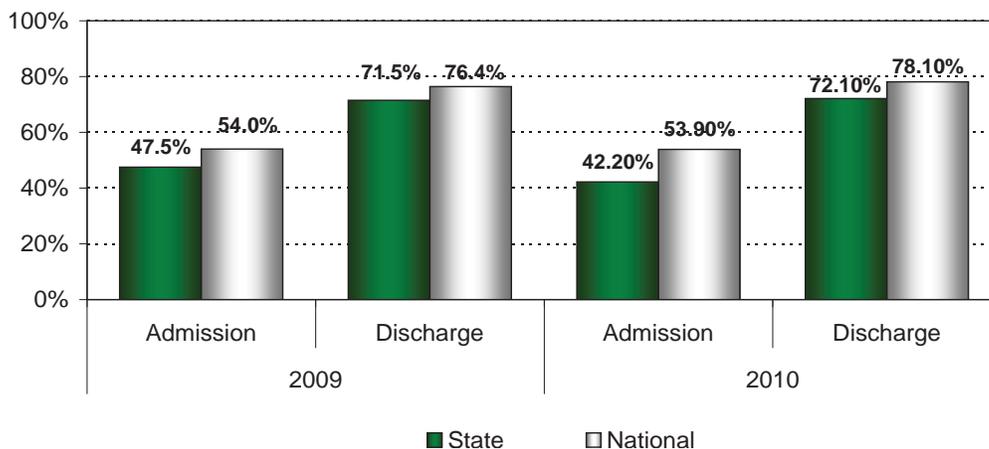
ment or jail, and again in the 30 days prior to their discharge.

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 2010 are comparable to the national rates.

Percent of Clients Reporting Abstinence from Alcohol Use Prior to Admission vs. Abstinence at Discharge
Fiscal Years 2009 - 2010



Percent of Clients Reporting Abstinence from Drug Use Prior to Admission vs. Abstinence at Discharge
Fiscal Years 2009 - 2010



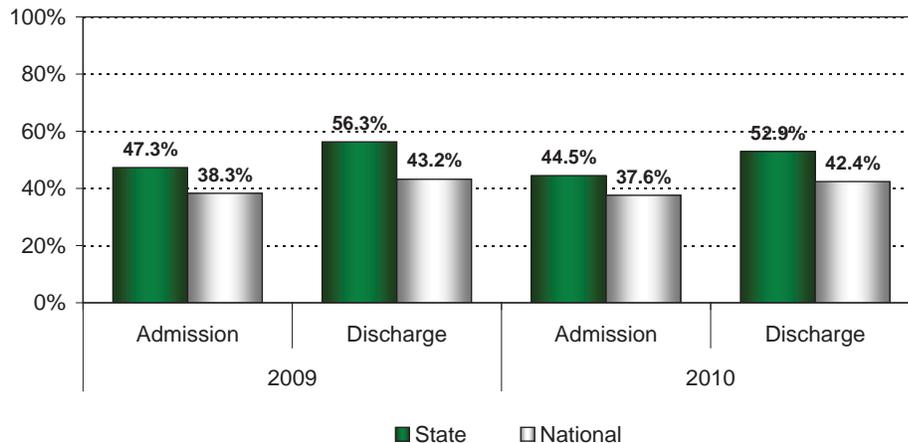
Employment and Stable Housing

Employment

Clients who are in school or are employed have much higher treatment success rates than those clients who are unemployed. Consequently, treatment providers work with clients to improve their employability. 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 2009 - 2010



MARSHA'S STORY

Marsha Stafford started her drinking career at the ripe old age of two. As the child of alcoholics they often gave her alcohol and thought it was funny to watch a drunk toddler. From the ages of 5 to 11, the family lived in a car at a park in Mesa, AZ, and instead of going to school, Marsha was taken to the “babysitter” every day—which was actually the town theater.

“I have a passion for life today that I didn’t know existed. I believe in miracles, in redemption, in people. You can climb mountains and overcome obstacles.”

When Marsha’s mother abandoned her at a trailer park at age 13, she was taken in by a neighbor family who were, themselves, alcoholics, but at least functional. She ended up in a relationship with her foster brother, and eventually married him. Along with the good, they went through a lot of bad times together as users, but are still married today and living a happy life together in recovery.

Marsha’s dysfunctional childhood led to an equally dysfunctional early adulthood characterized by addictions, lost opportunities, jail time, and financial disaster. But on the other side of the scale, her recovery has brought her more happiness and peace than she ever imagined possible. She wears a bracelet that says, “Expect Miracles,” and she has definitely seen a few in recent years as she has been able to recover not only from substance abuse, but also from financial ruin as well as relationship and emotional ruin. She now is a licensed private probation officer and also volunteers on a frequent basis, helping others get the help she was so freely given.

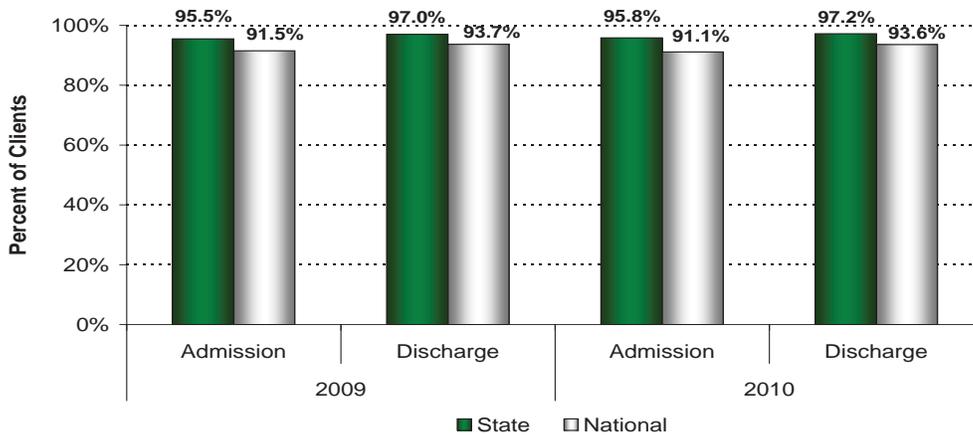


Clients in Stable Housing

As shown in this chart, 95.8% of clients entering Utah’s public substance abuse treatment in 2010 were in stable housing at the time of their admission to treatment. At discharge, 97.2% in 2010 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 population 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 2009 - 2010**



Mental Health Treatment Outcomes

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 2010, approximately 90% 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 23% of the people were considered in recovery and functioning in a normal range.

There were 46% of the clients participating in the outcome survey for fiscal year 2010 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 2010

Provider	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River Mental Health	48%	16.80%	66.56%
Central Utah Counseling Center	72%	23.71%	59.86%
Davis Behavioral Health	32%	17.97%	64.76%
Four Corners CBH	49%	26.86%	60.48%
Northeastern Counseling Center	47%	23.43%	62.09%
San Juan Counseling	9%	4.35%	76.09%
Southwest Behavioral Health	39%	25.98%	61.26%
Summit County—Valley Mental Health	23%	27.24%	60.57%
Tooele County—Valley Mental Health	38%	23.64%	60.73%
Salt Lake County—Valley Mental Health	39%	20.91%	62.17%
Utah Co.—Wasatch Mental Health	64%	25.42%	60.73%
Wasatch Co.—Heber Valley Counseling	35%	20.65%	67.74%
Weber Human Services	55%	25.75%	60.81%
Statewide totals	46%	22.97%	61.88%

Youth OQ Client Outcomes Report for Fiscal Year 2010

Provider	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River Mental Health	49%	18.18%	65.25%
Central Utah Counseling Center	68%	23.98%	55.28%
Davis Behavioral Health	57%	20.39%	61.96%
Four Corners CBH	61%	32.12%	57.51%
Northeastern Counseling Center	56%	25.35%	59.51%
San Juan Counseling	9%	14.29%	57.14%
Southwest Behavioral Health	44%	29.16%	60.15%
Summit County—Valley Mental Health	33%	24.69%	62.96%
Tooele County—Valley Mental Health	33%	23.21%	55.36%
Salt Lake County—Valley Mental Health	49%	22.89%	59.86%
Utah Co.—Wasatch Mental Health	69%	33.06%	54.35%
Wasatch Co.—Heber Valley Counseling	43%	29.41%	62.75%
Weber Human Services	63%	30.40%	56.38%
Statewide totals	55%	26.57%	58.47%

Adult OQ Client Outcomes Report for Fiscal Year 2010

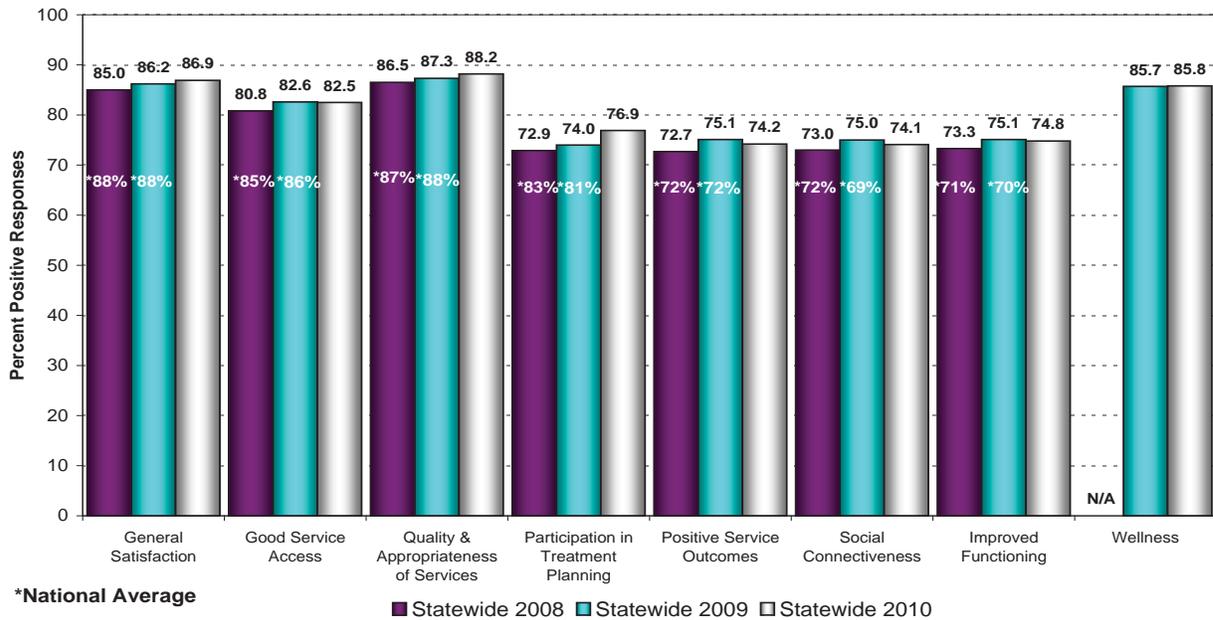
Provider	Percent of Clients Participating	Percent Recovered	Percent Improved/Stable
Bear River Mental Health	48%	15.93%	67.38%
Central Utah Counseling Center	74%	23.57%	62.33%
Davis Behavioral Health	20%	14.10%	69.23%
Four Corners CBH	45%	23.80%	62.20%
Northeastern Counseling Center	45%	22.02%	63.99%
San Juan Counseling	9%	0.00%	84.38%
Southwest Behavioral Health	35%	21.27%	62.90%
Summit County—Valley Mental Health	20%	28.48%	59.39%
Tooele County—Valley Mental Health	40%	23.77%	62.32%
Salt Lake County—Valley Mental Health	35%	19.68%	63.60%
Utah Co.—Wasatch Mental Health	62%	20.14%	65.13%
Wasatch Co.—Heber Valley Counseling	32%	16.35%	70.19%
Weber Human Services	52%	23.34%	63.11%
Statewide totals	42%	20.59%	64.13%

Consumer Satisfaction

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

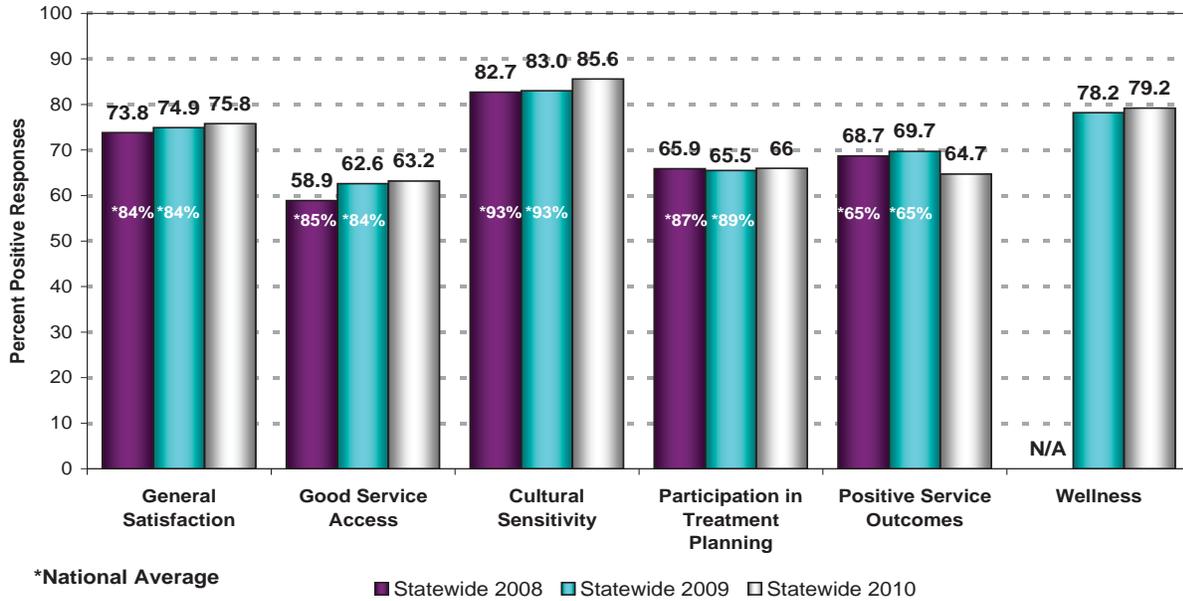
abuse and mental health services, and that providers comply with administration requirements and minimum sample rates. Below are the results of this survey for 2010.

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



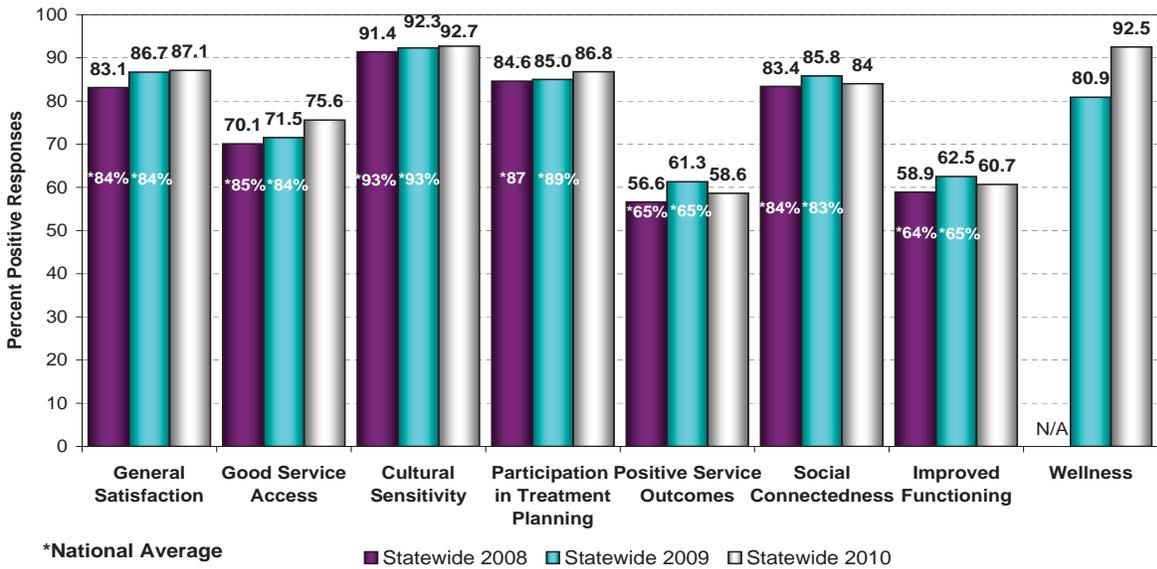
Youth Consumer Satisfaction Survey Youth Services Survey (YSS)

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

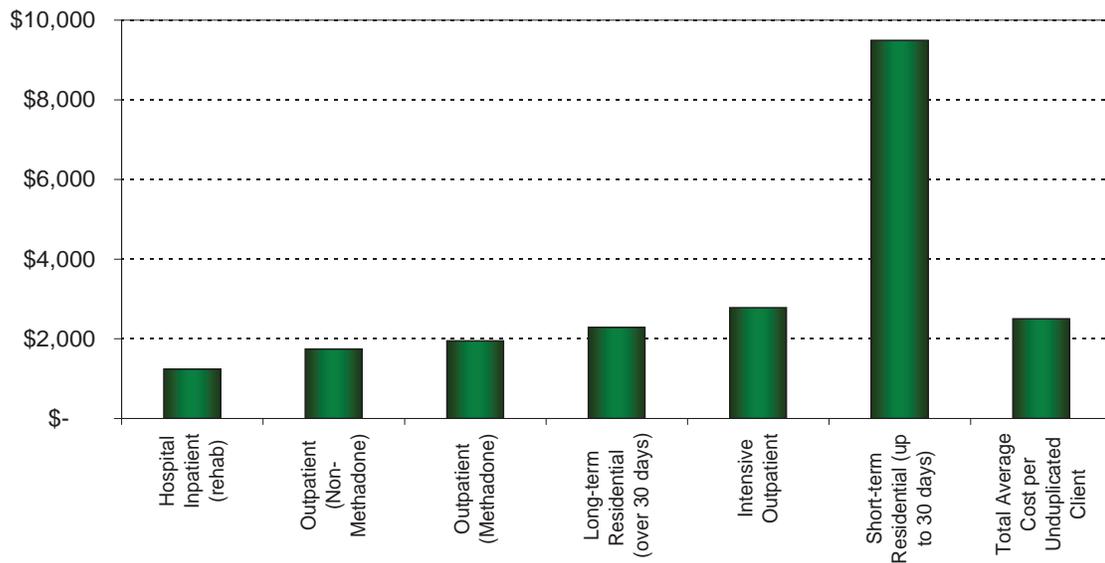


Client Cost by Service Category

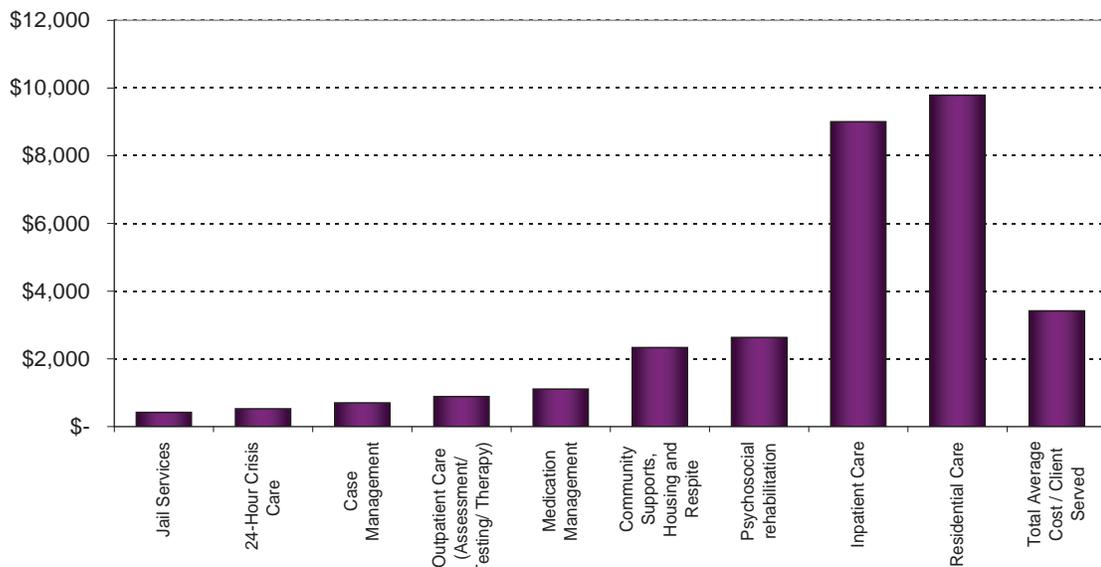
DSAMH requires the local authorities to submit year-end fiscal reports that describe local authority spending in specific categories. This fiscal information is then used to calculate a client cost by service category for both substance abuse and

mental health. In 2010, the statewide average cost for mental health services was \$3,418. For substance abuse services, the average client cost was \$2,499.

Substance Abuse Client Cost by Service Category Fiscal Year 2010



Mental Health Client Cost by Service Category Fiscal Year 2010



SHELLY'S STORY

When Shelly Marshall says that she is an intimate partner with the disease of addiction and likewise the program of recovery, she knows what she's talking about. In fact, you could say she literally wrote the book on recovery, as she is the author of *Day by Day*, the classic daily recovery meditation book which has sold more than two million copies over the last 20 years.

Shelly also knows the disease of addiction intimately as it completely devastated her entire family until their courageous alcoholic mother found 12-step sobriety in the late '60s, leading most of the family into recovery.

Shelly began her recovery at age 21, and went on to earn a BS in Human Services—Drugs/Alcohol, but she didn't stop there. She went on to found one of the first halfway houses for poly-drug abusers in Denver, then founded the Cortez Community Mission, a detox center for American Indians.

But for all her endeavors in recovery, personal tragedy from addiction was never far away. In 1988 she had to admit her daughter to a chemical dependency unit in Spokane. Having experienced addiction from every other angle, she now found herself the mother of an addicted child, but she didn't stop there. Seeing the low success rate in adolescent treatment centers, she knew something was wrong and devoted the next three years to finding what it was. She personally visited over 100 adolescent treatment centers and her research has been published in five peer-reviewed professional/scholarly journals.

“Alcoholism took absolutely everything from our family—our home, our jobs, and even our dignity. But recovery has given it all back, plus more than we ever imagined.”

Shelly's board memberships and vast public service—too numerous to list here—include working in Russia for the No to Alcoholism and Drug Addiction Foundation which earned her a position as NGO Representative to the United Nations.



Kenny

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 seven-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.

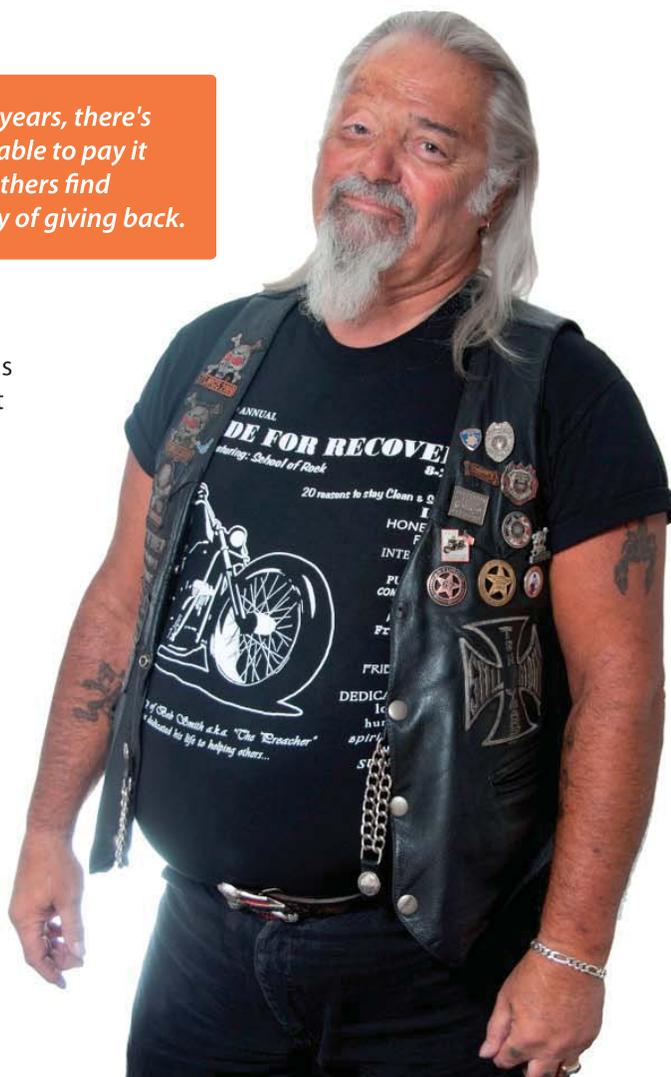
Since that day in 1999 when he turned his life around, Kenny’s never missed a birthday celebration for his son. For obvious reasons, his heart is with the kids and he has loved serving as an advisor and mentor to K.O.P.P.I.R. Kids (Kids of Parents and People in Recovery). Sobriety has totally changed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



I took for so many years, there's no way I'll ever be able to pay it all back. Helping others find recovery is my way of giving back.

Still a “hippy biker dude,” Kenny now mentors others in drug court as a volunteer through the Drug Court Alumni and Friends of Drug Court, where he serves on the board of directors. He gives his cell phone 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. Helping others find recovery is my way of giving back.”

I took for so many years, there’s no way I’ll ever be able to pay it all back. Helping others find recovery is my way of giving back.



Partnership

It is a principle goal of DSAMH to build strong relationships with local and private providers, along with consumers and families, in order to ensure the highest quality of treatment services for Utah's citizens. DSAMH looks for common ground to foster cooperation and support in meeting the challenges facing the treatment system, working cooperatively to benefit all citizens of the state.

Consumer/Family Partnerships

Utah Family Coalition and Family Resource Facilitators

DSAMH partnered with the Utah Family Coalition (Allies with Families, NAMI-Utah, and New Frontiers for Families) to provide Family Resource Facilitators (FRFs) across the state. FRFs are now present in all 13 community mental health centers statewide as well as plans for one at the Utah State Hospital. In 2010, the FRFs provided services to more than 1,400 families statewide with over 500 of those families receiving wraparound services. FRF training and certification continued in 2010, with 10 additional people becoming Certified Family Resource Facilitators and two additional individuals receiving Wraparound Family Resource Facilitator certification. Efforts are continuing to expand the FRF training and certification program to help develop a common language and shared vision for family involvement across Human Services.

Allies with Families

DSAMH contracts with Allies with Families to provide Family Resource and Wraparound Facilitation and to assist with transition to adulthood services. Allies with Families, the Utah Chapter of the Federation of Families for Children's Mental Health, offers practical support and resources for parents/caregivers and their children and youth with emotional, behavioral and mental health needs. Allies' network of resources and

personal experience provides effective strategies for families. Allies' mission is "Empowering families with voice, access and ownership, through education, training and advocacy."

NAMI-Utah

DSAMH contracts with the National Alliance on Mental Illness (NAMI-Utah) to provide the public with information and training on mental health, Family Resource and Wraparound Facilitation, and to assist with transition to adulthood services. NAMI's 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. These services are provided to family groups, consumer groups, clergy groups, public schools (primary to graduate), and private and public behavioral health agencies. To all those who serve and those 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.

New Frontiers for Families

DSAMH contracts with New Frontiers for Families to provide Family Resource and Wraparound Facilitation and to assist with transition to adulthood services. New Frontiers for Families subscribes to a system of core values and principles and utilizes the wraparound process to bring providers, educators, businesses, community leaders, and neighbors together in order to empower families to succeed at home, at school and in their communities by listening and working together to create services and supports that meet their needs.

Utah Support Advocates for Recovery Awareness (USARA)

USARA is a community-based membership organization of individuals in recovery from alcohol and other drug addiction, their families,

friends, and committed community supporters. USARA's mission is to support individuals and their families in all stages of recovery from alcohol and other drug problems. The organization works to celebrate recovery; identify and advocate for needed services related to substance misuse; infuse hope; and increase public awareness that long-term recovery is a reality.

USARA spearheaded Recovery Day events to celebrate individuals and families in recovery. This year there were five celebrations held: Salt Lake City, Provo, Ogden, Tooele, and St. George. Recovery Day is a free event that celebrates the success of people in recovery and provides information to the community about treatment and recovery support. Other initiatives of USARA include providing Family Support Services, Peer-to-Peer Recovery Support Services, Speakers Bureau and a "Rally for Recovery" at the state capitol.

PASSAGES

(Progressive Adulthood: Skills, Support, Advocacy, Growth, and Empowerment = Success)

PASSAGES has been implemented in San Juan and Tooele Counties to help young people with mental health conditions between the ages of 16 and 25 successfully transition into adulthood. The program started enrolling participants in February 2010, and as of September 30, 2010, over 80 young people have been enrolled in the program. Program participants have diverse characteristics—teen parents, homelessness, developmental disabilities, sexual orientation—all of which make their transitional process more challenging. Five have been discharged due to successful completion of the service plans.

An example of a participant who has been successfully discharged is Catherine, a 21-year-old who has suffered from major depression since

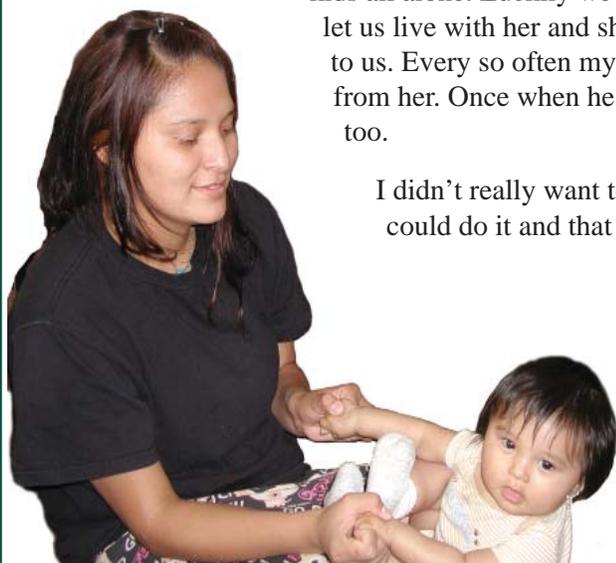
MALISHA'S STORY

My childhood was very hard. I was sexually molested as a child and my mother and father abused my brother and sister and me all the time we were growing up. My parents were always fighting and one day they split up and just left us kids all alone. Luckily we had an auntie who let us live with her and she was really nice to us. Every so often my dad would come back drunk and try to take us away from her. Once when he grabbed me, she tried to protect me and he beat her up too.

"I didn't really want to go to high school, but my auntie kept telling me I could do it. I want to be like my auntie and help kids who are struggling like she helped me."

I didn't really want to go to high school, but my auntie kept telling me I could do it and that I really needed to graduate. I didn't want to let her down, so I kept going. I want to be like my auntie and help kids who are struggling like she helped me.

Sometimes my mind just goes off and I get so depressed thinking about my life. I'm going to counseling now to help me get my mind straight. With the help I'm getting, it makes me want to go back to school so I can get a good job and make sure my son has a better childhood than I had.



2009. When she started the PASSAGES program, she was homeless, unemployed, and going into bankruptcy. Her hygiene and dental health were poor. Her husband had severe diabetes. The Transitional Facilitator at Tooele County used a strength-based approach and provided her with emotional support and concrete assistance in housing, employment, and finance management. After six months in the program, both she and her husband now have jobs with benefits with a combined income of \$45,000 a year. Both jobs offer medical benefits and they moved into an apartment. They received nutrition counseling and the husband's diabetes is now under control due to improved diet. Her hygiene improved greatly and she plans to take an online course to become a veterinary technician.

Five Transitional Facilitators have been hired for PASSAGES. Facilitators closely match with the race and linguistic diversity of the community. Among them, two speak fluent Spanish, one speaks Navajo, and two are American Indians. Three American Indian tribes (Navajo, White Mountain Utes, and Goshute) are fully engaged in the referral and service delivery process. Additionally, the program works closely with area high schools to establish school-based Youth-in-Transition services.

School-Based Mental Health and Integrated Health Programs

School-based mental health services were provided by the community mental health centers to approximately 1,900 children statewide in 2010, which represents a significant increase over the numbers served in school settings in 2009. To assist in the provision of school-based mental health services, DSAMH, in cooperation with the Utah State Office of Education, published *Utah's Behavioral Health Services Implementation Manual*.

Additionally, grants were awarded by DSAMH in 2010 to Davis Behavioral Health and Wasatch Mental Health for the establishment of school-

based integrated health programs. These programs involve the co-location of mental health services and a primary medicine clinic within a school setting. Their purpose is to integrate academic, physical, and behavioral health resources and treatment to advance children's well-being and success.

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 agencies 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.

Justice Partnerships

DSAMH understands that substance abuse, mental illness and crime are often interrelated. As a result, corrections, courts and treatment must work together. The following are examples of the different ways in which DSAMH is working collaboratively with the justice system and the courts to better serve our clients.

Crisis Intervention Teams

Crisis Intervention Teams are made up of police officers with specialized mental health training, who respond to crisis calls that may involve a person with mental illness. Officers who volunteer to be part of these teams complete 40 hours

of certification training, with annual recertification, where officers learn about specific mental illnesses and effective de-escalation tactics. The preferred method of training takes place in the community with close collaboration with local law enforcement and mental health personnel. This model was implemented in Salt Lake City in 2001 and has expanded to roughly two-thirds of the state. DSAMH supports efforts to implement this service throughout the entire state through a contract with the Salt Lake City Police Department.

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 Performance Measures Inventory				
Measure Title	Purpose of Measure / Measure Definition	Previous Value (FY 08)	Previous Value (FY 09)	Most Recent Value (FY 10)
Substance Use SA - Alcohol	Percent increase in abstinence from alcohol from admission to discharge	9.3%	17.7%	22.5%
Substance Use SA - Drug	Percent increase in abstinence from drugs from admission to discharge	32.3%	45.9%	61.6%
Employment SA	Percent increase in full/part-time employment from admission to discharge	21.9%	33.1%	55.0%
Decreased Homelessness SA	Percent decrease in homeless clients from admission to discharge.	11.4%	50.0%	56.3%
Criminal Justice SA	Percent decrease in clients arrested from 30 days prior to treatment to 30 days prior to discontinuation / discharge	46.9%	60.9%	75.7%
Treatment Retention	Percent of clients whose episode start to final discharge is 180 days or more	18.9%	50.8%	51.7%
Successful Completion	Percent of clients leaving treatment with a successful discharge	18.4%	52.6%	48.7%
Clients Served	Unduplicated number of clients served	814	1,288	759
Average Cost Per Case	Number of clients served in the fiscal year divided by the total dollars spent in the fiscal year.	\$3,417	\$2,768	\$2,757

Utah's Drug Courts

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

Over the past 12 years Utah's Drug Courts have increased from two, in 1996, to more than 32 operating statewide today. DSAMH provides funding for 29 Drug Courts. In addition, DSAMH and the Administrative Office of the Courts have worked together to develop a Drug Court certification and contract monitoring process.

Data collected in 2010 reflects the following significant outcomes:

- 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 25% which is above the statewide average of 19% and the national average of a 12.8% increase.
- Utah's Drug Courts decreased the number of participants using drugs, from admission to discharge, by 119% compared to the statewide average of 70.9% and the national average of 44.9%.
- Utah's Drug Courts decreased the number of participants who were arrested from admission to discharge by 70% compared to the national average of 50.4%.

RAY'S STORY

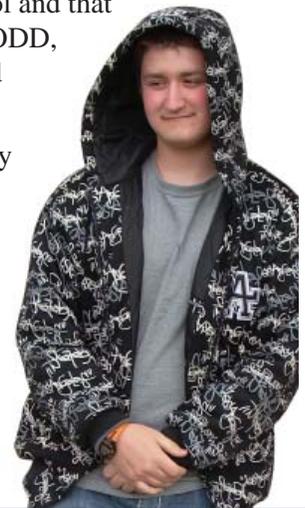
I've had a pretty positive attitude all of my life, but I have had some problems with Oppositional Defiant Disorder since I was about 13. What would happen is that I would just lose control and that made things pretty difficult for me. But since I've been getting treatment for my ODD, I've learned how to cope with it when the symptoms come up. It feels pretty good knowing that I've learned how to control it instead of acting on it.

"My life skills teacher relies on me a lot and asks me for help with the class. I'm glad I'm in the position to be of help to her instead of being the one needing help."

I've been able to learn and improve partly because I have a good support team and good family and friends. My life skills teacher relies on me a lot and asks me for help with the class. I'm glad I'm in

the position to be of help to her instead of being the one needing help.

I enjoy participating in the Youth Action Council and Boy Scouts. I also love football and working out and working with my hands. I'm looking forward to finishing school and getting a job.



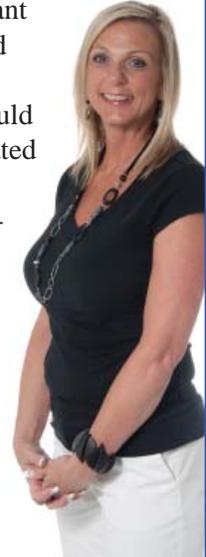
ANNETTE'S STORY

Both of Annette Robertson's parents are alcoholics, but they wanted Annette to be a "good girl." However, Annette realized while in high school that drugs and alcohol were magical for her—she truly believed when she was drinking that she fit in. She married early and they soon got involved in cocaine pretty heavily, then started dealing pot to pay for their partying. She smoked while she was pregnant and drank almost every day. "I hated myself for it," she says. "But I could not stop. I prayed

"I am so grateful I got to raise my girls in a crazy but sober home where I am trusted and loved. It has become my passion to help other struggling mothers become the kind of parent they were meant to be."

every night that I would not do it again, but every morning when I woke up I knew I would be there again." She loved her babies and hated herself. When her husband had a couple of surgeries, they added pain medication addiction to their list and things went from bad to worse.

It was easy for Annette to focus on her husband's problems while minimizing her own. She wanted everyone to think he was the problem and she was a good wife and mother; but she eventually reached the bottom of her rope and knew she could no longer go on living the way she had been—lying to everyone, neglecting her children, and dealing with guilt and shame for being the wife and mother she had become. When fear overwhelmed her, she sought help and has not had a drink or drug since 1989. "I am so grateful I got to raise my girls in a crazy but sober home where I am trusted and loved. It has become my passion to help other struggling mothers become the kind of parent they were meant to be."



RICHELLE'S STORY

Even as a small baby, I was different. I didn't like to be touched or held or cuddled. I was always throwing temper tantrums and not just during the terrible twos. The doctors knew I was developmentally delayed, but my parents didn't really know what was wrong with me until I was diagnosed at age ten with Asperger's Syndrome.

When you have Asperger's, it makes learning and going to school really hard, but I knew I couldn't give up. Asperger's also makes it hard to make and keep friends, and even carry on a conversation. But it has helped me to develop patience, with others and with myself. And it has made me much more understanding of other people's problems.

"I look at mental illness as a barricade on the road. It just means you must find an alternative way to reach your destination."

I consider myself unique rather than disabled. I want people to know me for the person I am, not just for my mental illness. I look at mental illness as a barricade on the road. It just means you must find an alternative way to reach your destination. I've just had to find different ways to succeed, especially in school and socially. But I actually view my mental illness as a gift because it has helped me recognize my talents. For example, I love art and I recently designed the logo for the Utah Division of Substance Abuse and Mental Health Youth Action Council.



My mental illness also made me try harder to graduate from high school. Since then I've been able to do all kinds of different jobs and I'm looking forward to going to college and getting a job working with kids or animals.



Education

Education

A primary goal of DSAMH is to improve public awareness of substance abuse and mental health issues with the hope of reducing stigma and normalizing services for people with substance abuse and mental health issues. Along with educating the public, there is a continual need to offer training in the latest treatment methods to practitioners. To address this goal, DSAMH co-sponsors a number of conferences and trainings each year 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. (See certification programs listed under Quality on page 36 of this report.)

DSAMH embraces this mandate to educate the public along with clinicians and practitioners. The total number of individuals trained or certified in DSAMH-sponsored programs for 2010 is over 33,350!

Some of the conferences and trainings that DSAMH participated in during 2010 are listed below.

DSAMH's annual **Substance Abuse Fall Conference** was held at the Dixie Conference Center in St. George, Utah, in September 2010. The conference attracted over 700 attendees who ranked it, on average, 4.3 out of 5 possible points.

National keynote speakers included **Frances M. Harding**, Director of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (SAMHSA,

BREE'S STORY

My family had lots of problems and I've pretty much had to take care of myself since I was nine years old. Even though I'm bipolar and have OCD and clinical depression, I'd been able to get by without help until during the course of one year my dad committed suicide, my mother attempted suicide, my boyfriend left me for my best friend, and I lost my place to live and had to move in with my sister and her family. Finally getting treatment for my disorders has made such a difference in my life, and it's helped me cope with all these problems.

"I know there are lots of people that feel like giving up. I want to tell them that I'm living proof that you can go through really hard things and still come out on top and have a good life."

My doctor and my therapist, and all the people at Valley Mental Health, have helped me totally turn my life around. I honestly don't know where I'd be right now if I didn't have them. They've given me hope. I'm trying really hard to catch up and graduate from high school with my class this year. Then I want to get back living on my own, go to college and become a veterinarian. I love animals and have a dog and two cats. I also love art and have won some awards for my paintings.

I know there are lots of people that feel like giving up. I want to tell them that I'm living proof that you can go through really hard things and still come out on top and have a good life.



CMHS); **Justice William Price**, Missouri State Courts, President of the National Association of Drug Court Professionals (NADCP); **Benjamin B. Tucker**, Deputy Director of State, Local and Tribal Affairs, White House Office of National Drug Control Policy (ONDCP); **Susan Storti**, Ph.D., R.N., CARN-AP, CAS of Synergy Enterprises, Inc.; and **Maureen McDonnell**, TASC-IL (Treatment Alternatives for Safe Communities).

The Leon PoVey Lifetime Achievement Award was given to **Patrick J. Fleming**, substance abuse director of the Salt Lake County Division of Behavioral Health Services. Pat has worked in human services for over 26 years in a variety of capacities. Other awards were given to **Doug Murakami** (Merlin F. Goode Prevention Services Award); **Charles W. Talcott** (Treatment Award); and **Don Leither** (Justice Award).

DSAMH co-sponsors two well-attended mental health conferences each year—the **Generations Conference** in April and **Critical Issues Facing Children and Adolescents** held in October. These two conferences trained 772 and 525 people respectively.

DSAMH also sponsors the **University of Utah School on Alcoholism and Other Drug Dependencies** which is held in June each year. 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. The School brought in 865 participants this year who had the option of

choosing between 16 different education tracks or disciplines.

In addition, DSAMH also supports the **Utah Addiction Center** in 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. The Center continues to train medical residents, pharmacists, and other health care professionals in the recognition of substance abuse disorders.

Addiction Center doctors, Glen Hanson and Barbara Sullivan, continue to provide training throughout Utah, the Intermountain West, and the United States. In 2010 their trainings reached 375 individuals. The trainings are directed toward translating research into clinical practice and increasing the conversation about addiction issues within our communities.

DSAMH’s **Substance Abuse Prevention** team also sponsors several trainings throughout the year as well as participating in the aforementioned conferences and trainings. For example, 500 individuals were trained in the **Prevention Dimensions (PD)** training. **The Substance Abuse Prevention Specialist Trainings (SAPST)** reached 57 people this year and **Communities That Care (CTC)** trained 50 individuals.

TOOELE COUNTY PREVENTION EFFORTS = SUCCESS!

Tooele County, under the direction of prevention coordinator Julie Spindler, has had a unique ability to bring the county's agencies together to work toward a common goal of promoting healthy lifestyles and supporting prevention efforts within the county. Through collaboration with their local coalition, Tooele Interagency Prevention Professionals (TIPP), more than 20 community prevention partners meet monthly to emphasize their mission: 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.

“In Tooele County, we are proud of how well each prevention agency works together for the betterment of our citizens. We know that through collaboration, we are making our county a much healthier place to live.”

— Julie Spindler, Tooele Prevention Coordinator

Tooele prevention partners have been able to document (through the Student Health and Risk Prevention Survey—SHARP) that substance use rates among Tooele students (grades 6-12) are going down, risk factors are decreasing and protective factors are increasing. Because of this strong community collaboration, and the usefulness of the SHARP Survey, almost \$2 million prevention dollars have been brought into Tooele County in the past two years. The following are a few highlights of TIPP's collaborative efforts:

- Federal grant to Reduce Alcohol Abuse awarded to Tooele School District—\$1.2 million
- Received grant for Tooele County Youth Services (JRC)—\$28,000
- Received grant for community collaboration with tobacco prevention (TCSD)—\$189,000
- Received grant for emergency preparedness—\$195,000



Members of Tooele Interagency Prevention Professionals (TIPP)

Substance Abuse Prevention

Prevention works.

You've heard the phrase "an ounce of prevention is worth a pound of cure," but in actual dollars and cents, the figures are even more thought-provoking. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), every \$1 invested in substance abuse prevention in the state of Utah can result in a \$36 savings in health care costs, law enforcement, other state-funded social and welfare services, and increased productivity.¹ Prevention serves a critical role in supporting healthy communities, families, and individuals.

Utah's prevention system follows a strategic, science-based planning process called the Strategic Prevention Framework (SPF). The SPF is utilized throughout Utah to ensure a culturally competent, effective, cost-efficient system is deployed. Communities throughout Utah utilize the five steps of the SPF, which are: 1) Assessing community needs; 2) Building capacity for services; 3) Making a plan based on needs, strengths, and resources; 4) Implementation of evidence-based strategies; and 5) Evaluation of prevention services to ensure effective prevention work. By using the Strategic Prevention Framework, Utahns are assured that services in their area match their local needs, and factors that lead to costly problems are addressed.

Paramount to a successful and sustainable prevention effort is a mobilized and organized com-



munity prevention coalition. DSAMH provides incentives to LSAs who utilize the Communities That Care system which has been scientifically proven to effectively run local coalitions and address local substance abuse issues.

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

By using the SPF, the DSAMH has determined that the statewide priorities for substance abuse prevention are first, to prevent underage drinking

¹ The Substance Abuse Prevention Dollars and Cents: A Cost Benefits Analysis, <http://www.samhsa.gov>.

and second, to prevent the abuse and misuse of prescription drugs. DSAMH has provided leadership, technical assistance, and additional funding to LSAAAs to address these priorities.

Preventing Underage Drinking. The first priority—to prevent underage drinking—was established because underage drinking continues to be a leading public health problem in Utah. According to the 2009 Student Health and Risk Prevention Survey (SHARP), 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 twelfth graders who reported drinking alcohol in the past 30 days. To relate this problem, once again, to dollars and cents, underage drinking cost the citizens of Utah \$324 million in 2007.²



Utah is now in its fifth year of the highly successful “Parents Empowered” campaign, aimed at reducing underage drinking. According to a survey by R&R Partners who administrate the campaign, almost 59% of Utah parents are unaware that their children, some as young as sixth graders, are drinking. They need to know that parental disapproval is the number one reason kids don’t drink, and that neighborhoods can mobilize and make a difference. For more information, visit www.parentsempowered.org.

² Miller, TR, Levy, DT, Spicer, RS, & Taylor, DM. (2006) Societal costs of underage drinking Journal of Studies on Alcohol, 67(4) 519-528.

Preventing the Abuse and Misuse of Prescription Drugs. In Utah, the illegal use of prescription drugs has reached epidemic proportions. Since 2000, the number of deaths due to overdose of pain medication has increased over 400%.³ In fact, more deaths were associated with overdose than with car crashes.⁴ Equally concerning, the abuse of prescription painkillers among teens now ranks second—only behind marijuana—as the nation’s most prevalent illegal drug problem. One in 10 twelfth graders reported having used



a prescription pain medication. For more information, visit www.useonlyasdirected.org.

The Risk and Protective Factor Model was adopted by the State of Utah’s Prevention Network to guide their prevention efforts. It is based on the simple premise that to prevent a problem from happening, we need to identify the factors that increase the risk for that problem developing, and then implement evidence-based practices, programs and policies to reduce the risk for the focus populations.

In the prevention field, the goal is to increase a child’s protective factors and decrease their risk factors. Each local authority has prioritized risk

³ November 2008 Utah Health Status Update.

⁴ U of U School of Medicine: http://health.utah.gov/opha/publications/hso/07Aug_uninskids.pdf.

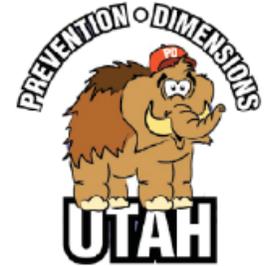
Risk Factors	Community					Family				School		Peer/Individual							
	Community Laws & Norms Favorable Toward Drug Use, Firearms & Crime	Availability of Drugs & Firearms	Transitions & Mobility	Low Neighborhood Attachment	Community Disorganization	Extreme Economic & Social Development	Family History of 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	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

and protective factors that are based on their individual community's needs. By measuring their risk and protective factors, they can plan their programs and strategies to address their specific needs. In the Local Authorities section, the Prevention Coordinators have listed their specific priorities and the programs they have implemented to meet those challenges. Two of the most widely implemented and most successful evidence-based programs implemented within Utah's Prevention Network are highlighted below.

Prevention Dimensions (PD) is a statewide curriculum resource delivered by trained classroom teachers to students in Utah, K-12. DSAMH collaborates with the Utah State Office of Ed-



ucation for implementation and evaluation of PD, to ensure it meets the State Board of Education's core curriculum requirements. The Prevention Dimension objectives are based on increasing protective factors and decreasing risk factors while adhering to a no-use message for alcohol, tobacco, marijuana, inhalants, and other drugs. PD builds life skills, delivers knowledge about alcohol, tobacco and other drugs, and provides opportunities for students to participate in prevention activities. 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.



PAMELA'S STORY

Pamela Higgins was a depressed teenager who found alcohol and other drugs as a solution to all of her problems. Coming from a family history of alcoholism, she learned that alcohol was the way to cope with problems. She married her high school sweetheart, also an alcoholic (also with a family history of alcoholism) and she was always surrounded by alcohol and other drugs.

“Because of recovery I was offered a scholarship for a college education and found myself pursuing a career in the field that gave me a life. I am over-paid in this field just by seeing others recover and become successful in their own lives.”

a tailspin of addiction, and Pam had to watch as her husband nearly drowned from his drinking, in order to cover up the pain of losing his father. Gradually, one by one, her in-laws were finding recovery and began dealing with the horrible event they had gone through. Pam held out for awhile. It took losing jobs, losing respect, and losing herself in the bottle for her to turn it around.

When she finally surrendered her addiction and got into recovery, she became a person she is proud of being. She's still married to her high school sweetheart—both in recovery—and their two daughters are proud of what they represent today. “Because of recovery I was offered a scholarship for a college education and found myself pursuing a career in the field that gave me a life. I am over-paid in this field just by seeing others recover and become successful in their own lives.”

As a result of substance abuse, her husband's family suffered through a very traumatic incident when her brother-in-law shot and killed his own kids and their grandfather, Pam's father-in-law. This sent the already-reeling family into





SAMHSA’s **Communities That Care (CTC)** 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 provides 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

CASSIE’S STORY

I was diagnosed with a mental illness when I was nine months old. I was mentally and developmentally delayed and my mother starting abusing me when I was just a baby. It wasn’t easy for my parents to hear that their child had a mental illness—but it was hard for me too.

“I can’t wait to go to my high school reunion to show everyone how I’ve succeeded. Nothing can stop me now.”

Kids always made fun of me at school and everyone told me I’d never be able to do anything in my life. People think that someone with a mental illness won’t be able to hold a job, or have a family, relationships and friends. But they can handle more if you give them a

chance. Just look at me now. I’m a good, hard worker and I’ve held the same job for a long time. I’m engaged to be married, and I’m so happy now because no one teases me anymore.

I want to go to college to become a resource teacher. I was always in resource, and I know I could help these kids. Also, I can’t wait to go to my high school reunion to show everyone how I’ve succeeded. Nothing can stop me now.



Charlotte

Charlotte Arendt had a family history of alcoholism (grandmother, father, mother, brothers, uncles, nieces and a nephew)—and she vowed early on NOT to follow down that path. But she was not taught how to resist, and eventually started drinking in high school. By the time she was married and had four children she realized she was exactly what she claimed she would never be. A physician told her she was too nice a person to be an alcoholic, then prescribed all sorts of mood-altering chemicals for her “anxiety.” Psychiatric counseling ended when she was told if she worked out her issues with her mother, she would not need to drink anymore.

Didn't work.

Finally she was introduced to a 12-step program and after many early relapses and 30-day residential treatment, she found success. She learned that the insanity of alcoholism is refusal to accept legitimate pain. She says, “I realized that not feeling pain also means not feeling joy, peace, and serenity, and that's too high a price to pay.”

I realized that not feeling pain also means not feeling joy, peace, and serenity, and that's too high a price to pay.

Charlotte recently lost her husband of 47 years. She is so grateful—thanks to the 12 steps—that he was able to live the last 35 years of his life with a sober and happy wife. The 12 steps have also blessed the lives of her children who grew up with the program as second nature.

Now as adults, they apply the 12-step principles in dealing with all sorts of issues.



Substance Abuse Treatment

In Utah, clients are matched to the appropriate level, type and intensity of services. The following table illustrates the continuum of substance abuse and treatment services provided in the state.



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

Function	Prevention/Intervention			Treatment			Recovery Support Services
Program Level	<i>Universal</i>	<i>Selected</i>	<i>Indicated</i>	<i>Outpatient</i>	<i>Intensive Outpatient</i>	<i>Residential</i>	<i>All levels depending on need for services</i>
Appropriate for	<ul style="list-style-type: none"> General Population 	<ul style="list-style-type: none"> At Risk 	<ul style="list-style-type: none"> Using but does not meet DSM IV Diagnostic Criteria 	<ul style="list-style-type: none"> DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Serious Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Severe Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Individuals needing support services outside of treatment in order to maintain their recovery
Identification Process	General Interest	Referral	SA Screening	ASI	ASI	ASI	RSS Screening
Populations	<ul style="list-style-type: none"> K-12 Students General Population 	<ul style="list-style-type: none"> School Dropouts, Truants, Children of Alcoholics, etc. 	<ul style="list-style-type: none"> DUI Convictions, Drug Possession Charges, etc. 	<ul style="list-style-type: none"> Appropriate for general population, Criminal Justice Referrals including DUI when problem identified. Women and children, adolescents, poly drug abusers, meth-addicted, alcoholics, etc. 			<ul style="list-style-type: none"> Appropriate for individuals struggling with SUDs who need RS services prior to, during, and after treatment services in order to initiate and/or sustain their recovery.
Program Methods	<ul style="list-style-type: none"> Risk Protective Factor Model Prevention Dimensions Red Ribbon Week 	<ul style="list-style-type: none"> Risk Protective Factor Model 	<ul style="list-style-type: none"> Risk Protective Factor Model Education Intervention Program 	<ul style="list-style-type: none"> Evidence-based, preferred practices, ASAM patient placement criteria 			<ul style="list-style-type: none"> RS Services include Peer to peer mentoring, recovery "Check ups," relapse prevention groups, housing and transportation services, education support, job counseling and training, and other services designed to support an individual in moving into and/or remaining in recovery.

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, which 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.

KAREN CARTER

Karen Carter's road to addiction began like many others with migraine headaches that were worsening due to stressful situations in her life. Taking prescription medications made her feel so much better and it wasn't long before she became addicted. "I had no idea," she says, "what lengths I would go to for my drug. I began going to different doctors, different pharmacies. I eventually maxed out every credit card we had and wrote bad checks. I ran to the mailbox to get the bills before my husband did. The financial crisis is what finally tipped my family off that there was a problem."

When she got into treatment, she found out how naïve she was about the world of drugs and soon realized that addiction touches many people in all walks of life. She was not the "typical addict." She was a married, church-going, middle-aged woman. They called her "Mrs. Brady on drugs." In treatment she could finally see the pain that addiction causes in so many lives.

"I love my job! When people are doing well in treatment it actually shows in their faces. It is so rewarding to see the positive changes in people's lives as they recover."

With all that she had learned in treatment, Karen wanted to go back to school with the goal of working in the field of substance abuse treatment. After getting her bachelor's degree she came full circle and began

working at Utah County Substance Abuse, the same place where she received her own residential treatment. She continued on to get her master's and is working towards being a licensed therapist. "I love my job! When people are doing well in treatment it actually shows in their faces. It is so rewarding to see the positive changes in people's lives as they recover."



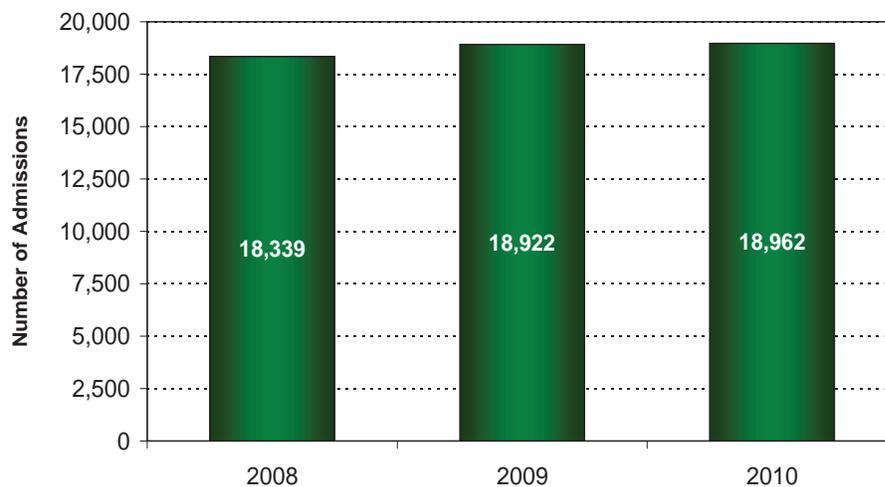
Number of Treatment Admissions

In 2010 total treatment admissions increased by only 40, less than one half of one percent.

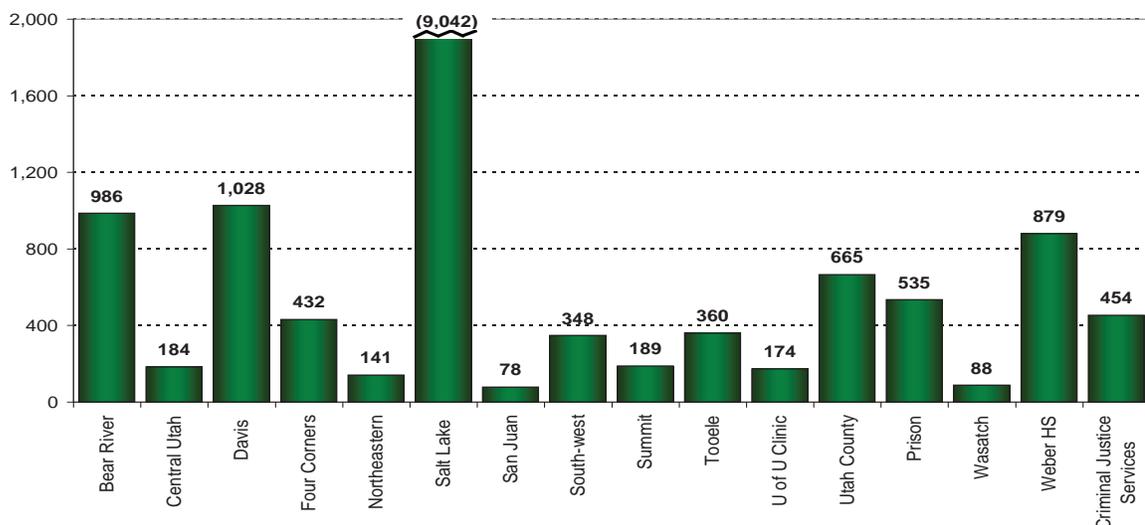
The second chart shows the number of admissions and transfers to each local authority, the University of Utah Clinic, and the Utah State

Prison in fiscal year 2010. Treatment admissions in Salt Lake County continue to increase as a percentage of total treatment in the state, increasing to 58% of initial admissions and 54.8% of total admissions.

Substance Abuse Initial and Transfer Admissions into Modalities Fiscal Years 2008 to 2010



Substance Abuse Treatment Admissions by Local Authority Area Fiscal Year 2010

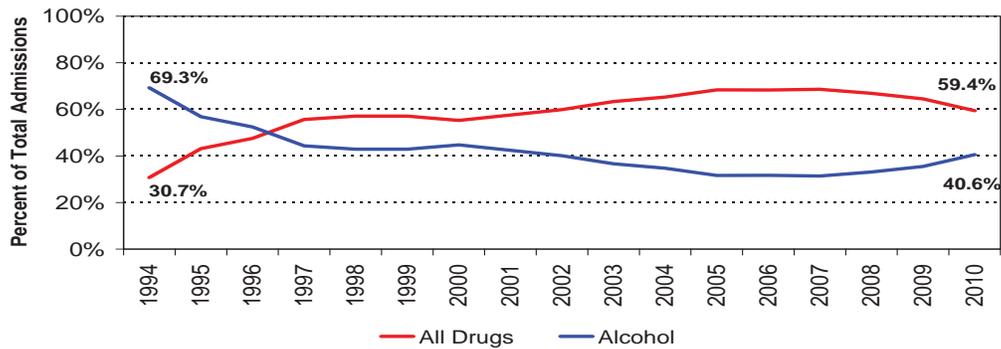


Primary Substance of Abuse

At admission, clients report their primary, secondary (if any), and tertiary (if any) drug use. From 1994 to 2007, treatment admission for alcohol steadily declined or remained steady, while admission for other drug use increased. There is now a three-year reversal of that trend, with admissions

for alcohol jumping from 35.5% in 2009 to 40.6% in 2010, reaching its highest level since 2002. This trend appears to be driven by an increase in alcohol admissions and a decrease in methamphetamine admissions.

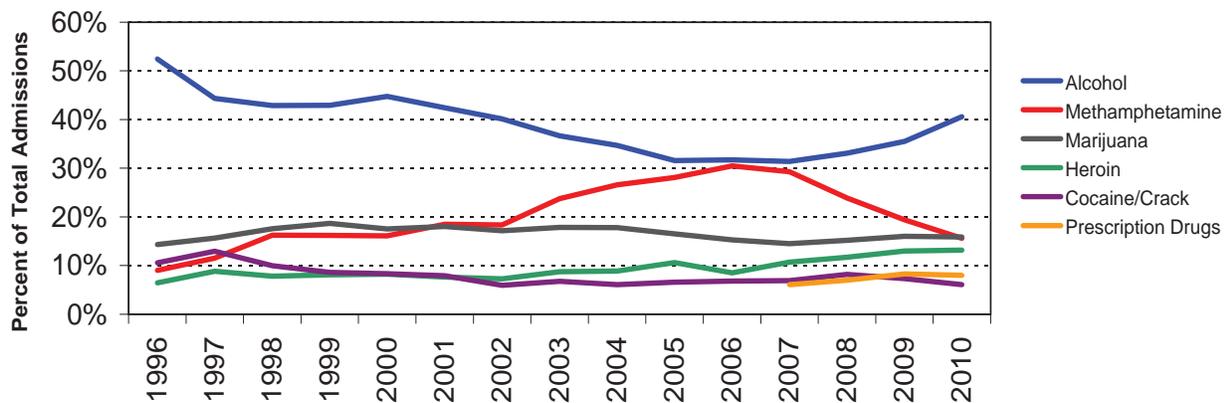
Patient Admissions for Alcohol vs. Drug Dependence
Fiscal Years 1994 to 2010



In 2010, alcohol remains the primary substance of abuse, with over 40% of clients reporting alcohol as their primary substance of abuse at admission. For the first time since 2002, marijuana admissions (15.9%) surpassed methamphetamine admissions

(15.6%). Following those two drugs are heroin and prescription drugs. Prescription drug admissions exceeded cocaine/crack admissions, which dropped to 6.1%, the lowest on record.

Top Drugs of Choice by Year
Fiscal Year 1996 to Fiscal Year 2010



Primary Substance by Gender

For the first time in many years, both men and women report their primary drug at admission is alcohol (44.2% and 39.8% respectively). Women's methamphetamine admissions dropped from 28% in fiscal year 2009 to 22% in 2010. Women in Utah are still more likely to be admitted into treatment for prescription drug use than men. Approximately 13.4% of women reported their primary drug at admission as a prescription-based substance in contrast to men who reported it in 5.9% of cases. Both genders' admissions for alcohol and prescription drugs increased in 2010, while their admissions for other drugs remained fairly stable.

	Male	Male %	Female	Female %	Total
Alcohol	5,759	44.2%	1,932	32.6%	7,691
Cocaine/Crack	785	6.0%	365	6.2%	1,150
Marijuana/Hashish	2,266	17.4%	752	12.7%	3,018
Heroin	1,751	13.4%	746	12.6%	2,497
Other Opiates/Synthetics	303	2.3%	313	5.3%	616
Hallucinogens	11	0.1%	4	0.1%	15
Methamphetamine	1,650	12.7%	1,314	22.2%	2,964
Other Stimulants	42	0.3%	26	0.4%	68
Benzodiazepines	43	0.3%	80	1.3%	123
Tranquilizers/Sedatives	12	0.1%	21	0.4%	33
Inhalants	10	0.1%	7	0.1%	17
Oxycodone/Hydrocodone	334	2.6%	325	5.5%	659
Club Drugs	23	0.2%	6	0.1%	29
Over-the-Counter	20	0.2%	20	0.3%	40
Other	16	0.1%	19	0.3%	35
Unknown	6	0.0%	1	0.0%	7
Total	13,031	100.0%	5,931	100.0%	18,962

Primary Substance by Age

Age plays a significant role in drug preference. While marijuana has historically been the substance of choice for those under 24, and alcohol for those over 24, in fiscal year 2010, alcohol surpassed marijuana as the number one cause of admissions for individuals 18 to 24 with 29.8%

of admissions being for alcohol and only 25.6% being for marijuana. This appears to be partially due to a decrease in admissions of methamphetamine users in this age group. Over all, alcohol continues to be the drug of choice for all other age groups entering treatment.

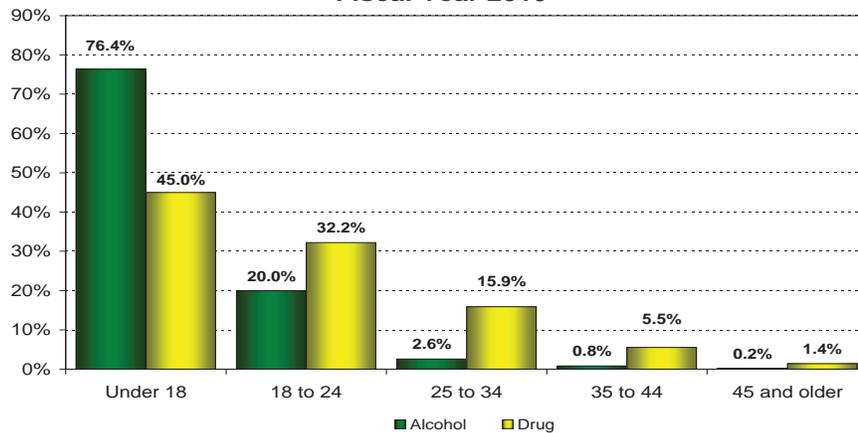
	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	326	1,227	1,880	1,712	2,510	36	7,691
Cocaine/Crack	6	190	328	302	322	2	1,150
Marijuana/Hashish	1,015	1,055	635	192	118	3	3,018
Heroin	16	837	1,001	344	294	5	2,497
Other Opiates/Synthetics	7	109	293	106	98	3	616
Hallucinogens	5	3	2	2	3	0	15
Methamphetamine	23	501	1,228	776	433	3	2,964
Other Stimulants	3	13	22	25	5	0	68
Benzodiazepines	3	18	58	26	18	0	123
Tranquilizers/Sedatives	2	6	6	4	15	0	33
Inhalants	6	5	1	5	0	0	17
Oxycodone/Hydrocodone	7	127	334	98	87	6	659
Club Drugs	10	16	3	0	0	0	29
Over-the-Counter	5	8	11	9	6	1	40
Other	12	7	4	3	9	0	35
Unknown	0	2	1	2	2	0	7
Total:	1,446	4,124	5,807	3,606	3,920	59	18,962

Age of First Use of Alcohol or Other Drug

Of the individuals who admitted to treatment in 2010 and identified alcohol as their substance of 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 32% reporting first using substances between ages 18 and 25.

**Age of First Use of Primary Substance of Abuse
Fiscal Year 2010**

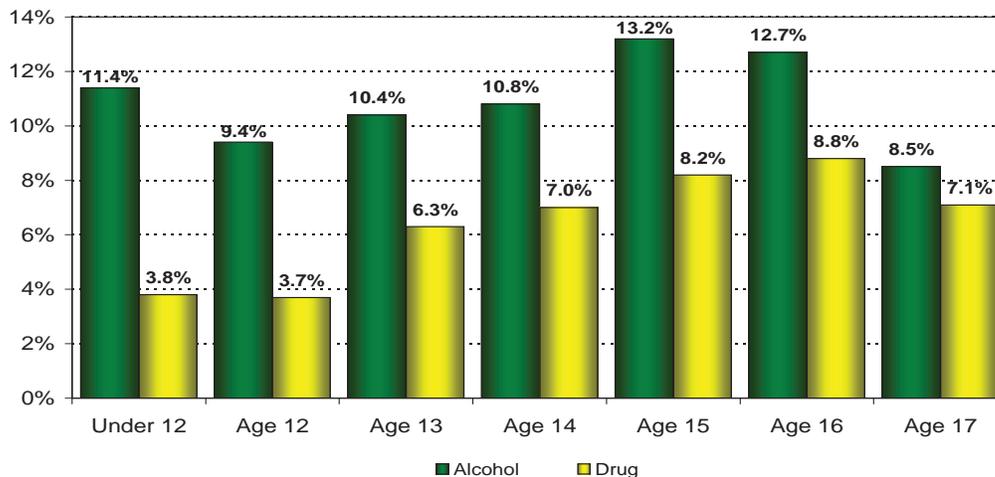


Age of First Use of Primary Substance—Under 18

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 2010**



Multiple Drug Use

Using more than one substance (drug or alcohol) places the client at greater risk for negative drug interactions, overdoses, psychiatric problems, and complications during the treatment process. 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 36.3% across the state, ranging from 7.4% in San Juan County to 73.8% in Utah County. What is encouraging about this data is the downward trend in multiple drug use at admission. In 2007, 57.9% reported multiple drug use, with Utah County reporting over 90% of their admissions. In 2008 the overall percentage had dropped to 40.9%; in 2009, to 39.3%; and then in 2010 to 36.3%, its current level. Outside of Salt Lake County, the mostly urban areas of the state showed significant decreases, with Utah County dropping 9.1 % and Weber County dropping 8.4%. Only Tooele, Bear River, and Northeastern showed an increase in 2010.

Multiple Drug Use Fiscal Year 2010

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	222	22.5%
Central Utah	36	19.5%
Davis County	130	10.6%
Four Corners	187	31.8%
Northeastern	94	26.5%
Salt Lake County	3,418	32.9%
San Juan County	6	7.4%
Southwest Center	97	15.2%
Summit County	33	16.3%
Tooele County	123	29.9%
U of U Clinic	112	59.3%
Utah County	912	73.8%
Utah State Prison	376	70.3%
Wasatch County	60	53.1%
Weber HS	736	60.0%
Criminal Justice Services	333	55.5%
Total:		36.3%

KRISTIN'S STORY

When Kristin turned 19 and moved out on her own, she used her newfound independence to rebel against the rules she'd lived under while growing up. She started smoking and drinking and found those two pastimes went hand in hand. One would automatically trigger the other. Though she would quit and start up again numerous times, the only thing that could keep her tobacco-free and sober was being pregnant. But shortly after giving birth, she would relapse back into her addictive behaviors.

“Before that point I didn’t care if I lived or died. But thinking of my children, I realized that I didn’t want them to see me smoking and think it was okay. And I knew I needed to live and be a good example for them.”

When she finally confessed her secret life of alcohol, other drugs and cigarettes to her father, he immediately got her into detox. She was surprised that while detoxing from alcohol and other drugs she was still allowed to smoke. Kristin knew intuitively she couldn't smoke and get well at the same time, so she was grateful to be taken to the Ark where you give up all harmful substances the day you walk in.

When Kristin finally gave up cigarettes and other addictive substances she realized that the only time she'd felt healthy and happy in her adult life—until now—was when she'd been pregnant and that was because she was cigarette-free and sober both times for her nine months of pregnancy. It was a good wake-up call for her to realize it wasn't the pregnancy that made her feel so good—it was her healthy lifestyle choices.



CHINO RODRIGUEZ

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.

“When you’re not working on something, something’s working on you.”

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. I have my family back. And as I walk in recovery, I have my morals back, my serenity, my peace of mind.”



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. The percentage of admissions for IV drug use has remained remarkably stable over the past four years. In 2010, 3,444 clients or 18.2% of the total number requesting services through the public treatment system, reported IV drug use as their primary route of administration. As with multiple drug use, the preponderance of IV drug use is found in the more urban counties.

Admissions Reporting IV Injection Drug Use at Admission

Fiscal Year 2010

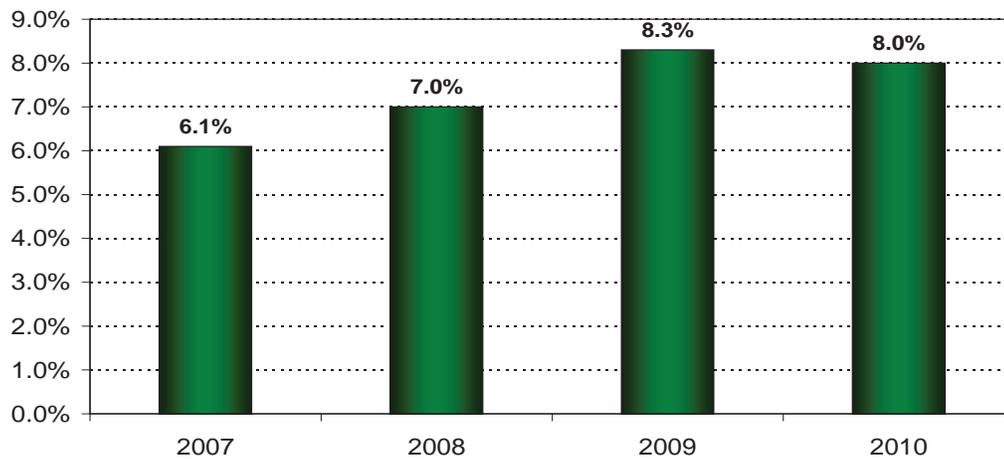
	# Reporting Injection Drug Use at Admission	% of Total Admissions for Each Area
Bear River	52	5.3%
Central Utah	14	7.6%
Davis County	294	24.1%
Four Corners	47	8.0%
Northeastern	33	9.3%
Salt Lake County	2,019	19.4%
San Juan County	3	3.7%
Southwest Center	100	1.6%
Summit County	4	2.0%
Tooie County	35	8.5%
U of U Clinic	43	22.8%
Utah County	299	24.2%
Utah State Prison	188	35.1%
Wasatch County	2	1.8%
Weber HS	144	11.7%
Criminal Justice Services	167	27.8%
Total:	3,444	18.2%

Prescription Drug Abuse

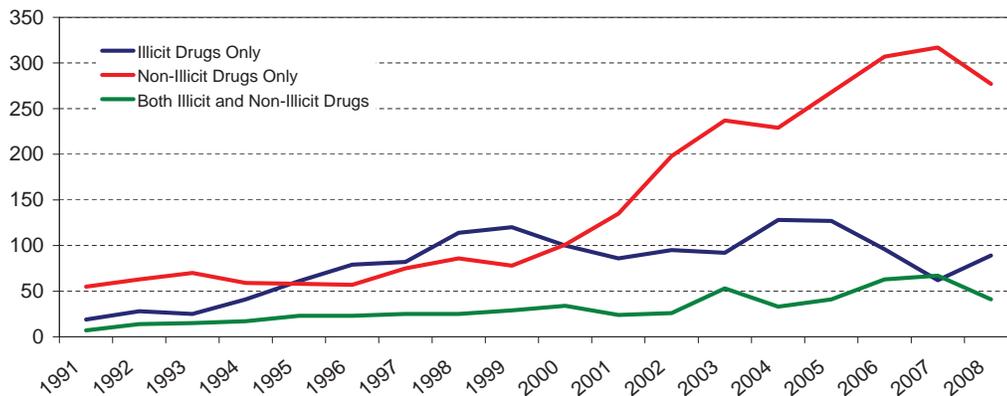
Admissions to the public treatment system for prescription drug abuse had been on the rise for the past three years—from 5.0% in 2006 to 8.3% in 2009, representing a 68% increase in three years. However, in 2010 the percentage of admissions dropped slightly to 8.0%.

Some of this decrease is due to the decrease in oxycodone/hydrocodone admissions from 2009 (4.0%) to 2010 (3.5%).

**Admission for Primary Drug—
Prescription Drugs
Fiscal Years 2007 to 2010**



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



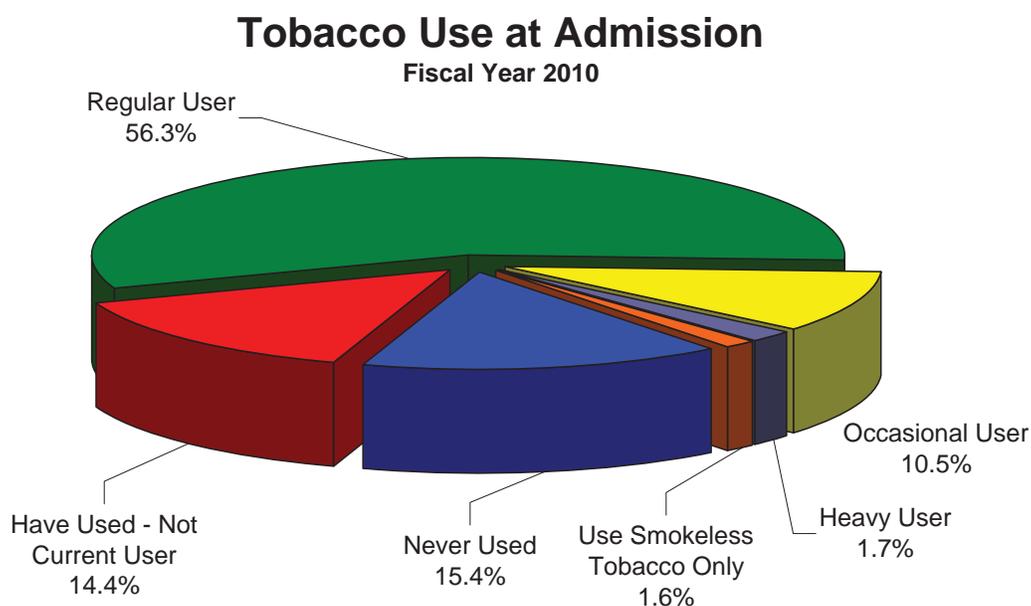
Utah Department of Health

Tobacco Use

The 2010 Report of the Surgeon General, *How Tobacco Smoke Causes Disease*, presents evidence on the mechanisms by which smoking causes disease and indicates that there is no risk-free level of exposure to tobacco smoke. This report investigated how and why smokers become addicted and documents how nicotine compares with heroin and cocaine in its hold on users and its effects on the brain. Tobacco-free campus

policies not only assist smokers in quitting, they also protect others from the harmful effects of secondhand smoke.

All substance abuse treatment clients are asked whether they use tobacco at admission. The chart below shows that over 84% of clients admitted to treatment in Utah have used tobacco in their lifetime.

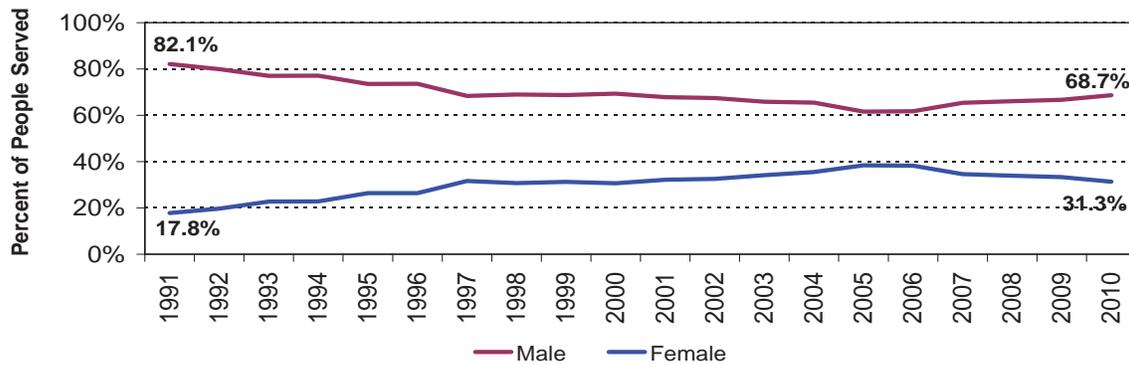


In fiscal year 2010, almost 70% of clients use some type of Tobacco at admission.

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 22.7% reduction from 2005 to 2010.

**Gender of People in Substance Abuse Treatment
Fiscal Years 1991 to 2010**



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 2010, 5.4% of the women entering treatment (319 women) were pregnant at the time of their admission. This is slightly down from 2009's 5.7%. Successful treatment planning 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 2010**

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	309	15	4.9%
Central Utah	85	6	7.1%
Davis County	418	12	2.9%
Four Corners	230	4	1.7%
Northeastern	142	10	7.0%
Salt Lake County	2,782	183	6.6%
San Juan County	24	1	4.2%
Southwest Center	261	14	5.4%
Summit County	62	3	4.8%
Tooele County	143	11	7.7%
U of U Clinic	67	1	1.5%
Utah County	549	27	4.9%
Utah State Prison	87	1	1.1%
Wasatch County	40	1	2.5%
Weber Human Services	551	27	4.9%
Criminal Justice Services	181	3	1.7%
Total:	5,931	319	5.4%

Clients with Dependent Children

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 41.3%. The average number of dependent children per household is 2.17.

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 41.3% of all clients with children, over 56.8% of women who are admitted to treatment report having dependent children, and

they report a higher number per family. Four counties report that over 70% of their female clients have dependent children.

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 2010**

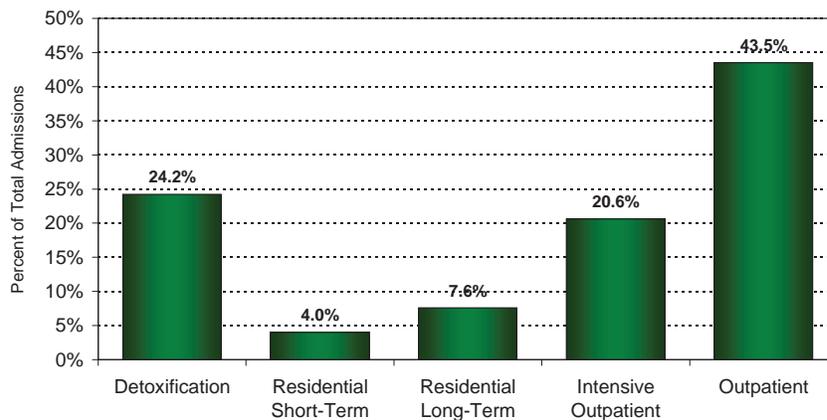
	Percent of all Clients with Children	Average Number of Children (of Clients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	31.6%	1.93	43.4%	1.79
Central Utah	47.3%	2.20	69.0%	2.19
Davis County	53.7%	2.33	71.8%	2.43
Four Corners	49.5%	2.31	70.0%	2.42
Northeastern	57.3%	2.38	70.2%	2.47
Salt Lake County	37.3%	2.10	54.6%	2.20
San Juan County	41.3%	3.18	47.8%	4.45
Southwest Center	54.1%	2.41	71.6%	2.59
Summit County	18.8%	2.13	25.8%	1.75
Tooele County	28.5%	1.80	35.7%	1.90
U of U Clinic	39.7%	2.03	35.8%	2.13
Utah County	57.9%	2.18	65.7%	2.07
Utah State Prison	39.6%	2.16	44.8%	2.51
Wasatch County	54.9%	2.48	45.0%	2.39
Weber Human Services	51.5%	2.32	57.6%	2.11
Criminal Justice Services	31.7%	1.95	40.9%	2.04
Total:	41.3%	2.17	56.8%	2.22

Service Type

In contrast to the earlier days of substance abuse treatment when almost all substance abuse treatment was residential, today over 64% of admissions to treatment are to outpatient and intensive outpatient treatment. Only 11.6% of admissions are for residential care. An expanded use of the ASAM Placement Criteria has helped place individuals in the level and intensity of care that they

need. Then, 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. With the expansion of Recovery Support Services, DSAMH hopes to expand the continuum of care even further.

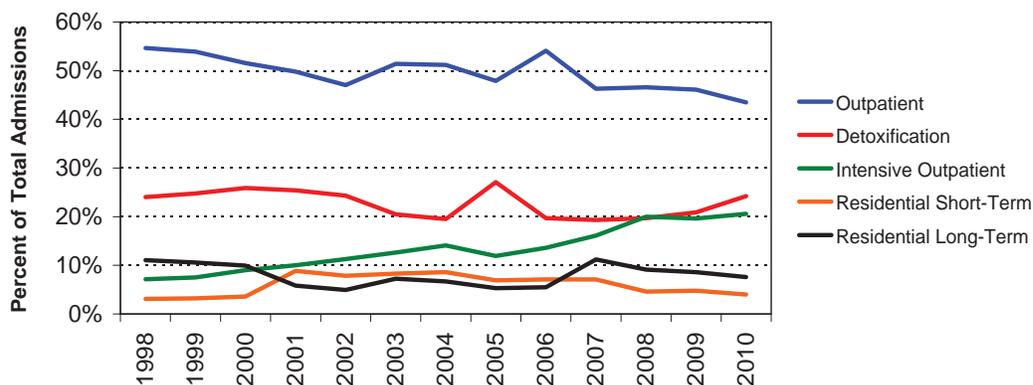
Service Type at Admission
Fiscal Year 2010



Trends in Service Types. Over the past five years there has been a slow but steady increase in intensive outpatient services from 11.9% in 2005 to 20.6% in 2010. Also during that period, long-term residential admissions have remained relatively stable, while short-term residential admissions have declined slightly. In 2006, admissions

to detoxification services declined sharply, but have risen slowly ever since. With the number of residential beds remaining relatively constant, and an increased number of overall admissions, the percentage of residential admissions has naturally declined in proportion to other admissions. Intensive outpatient services have a lower cost of

Trends in Service Types
Fiscal Years 1998 to 2010



of increasing capacity and have provided more intense services for those who are not able to enter residential treatment.

RANDY' STORY

Randy started smoking at age nine when he found a pack of cigarettes on the street. He soon added opiates to the nicotine and in the 46 years since then, he's pretty much done it all. And though he's now in his fourth time in residential rehab—this time at the Ark—he knows this time will be his last. This time no one tried to wean him off cigarettes, alcohol and pills, or get him to taper down. This time no one said he could get off nicotine later and he should just focus on his alcohol and other drug addictions first. This time he had to give it all up at once. And it worked! “If I can quit,” Randy says, “anybody can! I smoked or chewed for 46 years. How many people can beat that record . . . who are still alive to tell about it?”

“If I can quit, anybody can! I smoked or chewed for 46 years. How many people can beat that record . . . who are still alive to tell about it?”

A little surprising history here—there was a time when Randy would've fought to the death for his cigarettes but four years ago he was

actually able to give them up. He'd been “smoke-free” for four years when he checked himself into a hospital for detox. At the hospital, he was surprised to be given cigarettes along with “fresh air breaks” to smoke them eight times a day and he became addicted once again. How ironic is that?

From his personal experience with success, Randy agrees wholeheartedly with the Ark's philosophy that giving up cigarettes while in recovery for substance abuse is the smartest, most effective and long-lasting approach to recovery. “My true self is to smile and be happy,” Randy says with a big smile on his face. “It's so nice to actually be myself again.”



KELLY & ALEX'S STORY

I am a single father with disabilities trying to raise a daughter with disabilities. Life has been challenging to say the least. In 2000, I couldn't hold a job, I felt useless and felt I was a failure at everything I attempted.

Although my daughter Alex did not appear to have any problems early on, that all changed when she hit kindergarten. Alex was uncontrollable in the classroom and for the next seven years was in and out of hospitals, including several bouts at UNI (University of Utah Neuropsychiatric Institute), until it was recommended for her to be committed to the Utah State Hospital for extended treatment. I was devastated. Once again I felt like a failure and was also deteriorating mentally and physically. When it was determined I was suffering from Bipolar II and PTSD, and on the verge of being hospitalized myself, Davis Behavioral Health stepped in and provided me with help for my housing, utilities, medication and increased therapy.

And the happiest news is that Alex returned from USH happy and much improved. She's now finishing up seventh-grade (a transition that's often hard)—but she's a straight-A student with lots of friends, and loving life. My biggest dream has been realized. I have my family back together and we are doing great. I have been working a full-time job for two years and am completely self-sufficient. It is my hope to teach my daughter to be self-sufficient as there are so many rewards to realizing one's dreams.

My therapist recommended me to the Supported Employment Program through DBH as a way to get me up and moving again. To make a long and painful story short—that was the turning point in my life. I progressed quickly and graduated from the program in five months. I now manage the custodial division for DBH as a certified target case manager and certified job coach, helping people in the same situation I was once in.

"My biggest dream has been realized. I have my family back together and we are doing great. I have been working a full-time job for two years and am completely self-sufficient. It is my hope to teach my daughter to be self-sufficient as there are so many rewards to realizing one's dreams."



Mental Health Treatment

Overview

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

Continuum of Services

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

- 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

In addition, many of the local mental health centers also provide the following:

- **Supported employment** provides skills, support and coaching for individuals with disabilities such as mental illness to successfully re-enter the workforce.
- **Community Based Wraparound services** coordinate mental health needs, school, medical and other social services to support community living.
- **Family resource facilitation** is a model to strengthen and support families by developing partnerships with the community mental health centers and representing the family voice at service delivery, administration and policy levels.
- **Clubhouses** are a model of psycho-social rehabilitation where attendees are considered members and empowered to function in a work-ordered day.
- **Consumer drop-in centers** are places where consumers can receive support from other consumers to promote connectedness, social interaction, support and encouragement.

- **Forensic evaluations** are provided upon a judge's orders to determine an individual's competency to stand trial when he/she has been charged with a crime.
- **Nursing home and hospital alternatives** include community-based care, i.e., intense case management, outreach services, coordination with other entities such as home health, etc.

JENNIFER'S STORY

My mother is a LCSW, so she was able to recognize that I was having problems with depression even when I was only seven years old. I've been diagnosed with paranoia, major depression and anxiety and I spent four-and-a-half months in the State Hospital. After being released in 2000 I started into day treatment and became a member at Wasatch Clubhouse. The people at the clubhouse really made me feel comfortable, but my real turning point came when someone asked a math question that I was able to answer. People started coming to me when they had math questions and I even tutored one of the staff in math! That gave me such a boost of confidence and I really appreciated people needing and asking for my help.

"I'm off all assistance and am married and happy and healthy. I'm looking forward to finishing college and becoming a social worker."

This extra confidence gave me the courage I needed to start transitional employment. I have since gone on to get work entirely on my own. I am proud to speak out about my experiences and how far I've come. I want people to know that there is help available and not to give up and to make sure they take care of their physical and emotional well-being also. It's freeing to be able to talk to people and not have them look at me like I'm some kind of a freak. I'm off all assistance and am married and happy and healthy. I'm looking forward to finishing college and becoming a social worker.



Source of Data

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

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 Center	Davis Behavioral Health	Four Corners Community Behavioral Health	Northeastern Counseling Center	Salt Lake Co.—VMH	San Juan Counseling	Southwest Behavioral Health Center	Summit Co.—VMH	Tooele Co.—VMH	Utah Co.—Wasatch Mental Health	Wasatch Co.—Heber Valley Counseling	Weber Human Services	Statewide Adults
Mood Disorder	32.3%	26.2%	34.0%	27.0%	31.6%	28.2%	48.3%	37.4%	28.0%	30.2%	27.0%	22.9%	27.9%	29.1%
Anxiety	24.4%	21.9%	28.3%	17.2%	29.3%	19.3%	17.6%	14.2%	23.4%	22.3%	26.2%	34.5%	18.4%	21.8%
Substance Abuse	8.0%	7.3%	10.1%	35.4%	4.9%	20.5%	4.4%	4.2%	32.0%	27.9%	10.1%	26.1%	23.8%	17.6%
Personality Disorder	12.0%	11.4%	5.9%	8.0%	6.6%	13.1%	4.9%	15.7%	2.0%	9.0%	8.5%	5.2%	9.2%	10.4%
Schizophrenia and Other Psychotic	6.6%	8.7%	8.1%	3.8%	5.2%	8.5%	4.4%	10.6%	0.9%	2.6%	6.8%	3.8%	6.9%	7.1%
Attention Deficit	5.5%	2.4%	4.5%	2.0%	4.4%	3.0%	3.0%	0.9%	4.6%	3.1%	4.7%	2.5%	2.6%	3.5%
Cognitive Disorder	3.0%	2.5%	1.7%	1.6%	3.1%	2.6%	6.7%	3.4%	0.9%	0.7%	4.9%	0.7%	3.9%	2.9%
Adjustment Disorder	2.3%	2.0%	2.3%	2.0%	5.6%	1.5%	1.5%	8.5%	4.7%	1.5%	1.4%	1.2%	1.1%	2.0%
Neglect or Abuse	0.3%	13.5%	0.8%	0.2%	3.0%	0.2%	1.4%	1.6%	1.2%	0.8%	3.1%	0.5%	2.7%	1.5%
Impulse Control Disorders	1.3%	1.1%	0.7%	0.8%	2.6%	0.7%	1.4%	0.8%	0.6%	0.2%	1.6%	0.8%	0.9%	1.0%
Pervasive Developmental Disorders	1.1%	0.5%	0.9%	0.5%	0.5%	0.7%	1.2%	1.0%	0.3%	0.2%	1.1%	0.0%	0.4%	0.7%
Oppositional Defiant Disorder	0.2%	0.3%	0.2%	0.3%	0.2%	0.1%	0.0%	0.2%	0.0%	0.0%	0.2%	0.0%	0.3%	0.2%
Conduct Disorder	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.2%	0.1%
Other	3.0%	2.3%	2.4%	1.1%	3.1%	1.5%	2.3%	1.4%	1.1%	1.2%	4.1%	1.8%	1.4%	2.1%
V Codes	4.0%	3.1%	1.5%	3.1%	7.8%	8.4%	4.9%	4.6%	14.7%	12.5%	6.4%	12.0%	8.1%	7.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

Diagnosis	Bear River Mental Health	Central Utah Counseling Center	Davis Behavioral Health	Four Corners Community Behavioral Health	Northeastern Counseling Center	Salt Lake Co.—VMH	San Juan Counseling	Southwest Behavioral Health Center	Summit Co.—VMH	Tooele Co.—VMH	Utah Co.—Wasatch Mental Health	Wasatch Co.—Heber Valley Counseling	Weber Human Services	Statewide Children/Youth
Anxiety	18.3%	11.6%	17.2%	12.5%	15.4%	19.6%	17.2%	14.4%	20.4%	16.0%	17.3%	19.7%	13.2%	17.1%
Mood Disorder	20.3%	10.7%	16.9%	19.1%	16.5%	15.9%	23.4%	16.0%	22.5%	19.1%	15.1%	16.3%	13.8%	16.1%
Attention Deficit	16.5%	18.4%	17.6%	16.8%	15.8%	16.7%	26.6%	8.5%	16.7%	15.8%	15.1%	13.6%	13.7%	15.8%
Neglect or Abuse	7.7%	14.0%	14.2%	6.1%	14.1%	7.7%	2.6%	10.9%	1.9%	8.6%	12.8%	11.6%	14.7%	10.6%
Oppositional Defiant Disorder	4.9%	12.1%	6.8%	8.2%	5.7%	11.5%	8.2%	5.7%	6.6%	10.5%	8.2%	10.9%	10.1%	9.1%
Adjustment Disorder	12.6%	14.8%	5.1%	11.0%	10.0%	5.9%	19.3%	24.4%	12.4%	6.1%	7.4%	8.8%	5.5%	8.1%
Pervasive Developmental Disorders	2.3%	4.0%	4.2%	2.0%	3.5%	5.7%	2.6%	2.8%	1.9%	2.4%	6.2%	2.0%	5.6%	4.9%
Impulse Control Disorders	5.3%	3.1%	7.3%	3.5%	5.9%	4.0%	4.2%	11.3%	2.6%	3.2%	4.1%	2.7%	4.0%	4.8%
Substance Abuse	1.2%	1.6%	1.7%	10.5%	3.3%	4.4%	0.0%	1.0%	10.6%	11.8%	2.8%	7.5%	8.6%	4.4%
Conduct Disorder	0.9%	2.5%	1.2%	1.1%	1.0%	1.4%	0.0%	1.1%	1.9%	1.6%	2.0%	2.0%	1.7%	1.6%
Cognitive Disorder	2.3%	1.1%	0.7%	1.0%	1.2%	1.4%	1.0%	1.1%	0.3%	0.5%	1.5%	0.0%	1.9%	1.4%
Personality Disorder	0.2%	0.5%	0.2%	0.2%	0.3%	0.3%	0.0%	0.6%	0.0%	0.6%	0.2%	0.0%	0.3%	0.3%
Schizophrenia and Other Psychotic	0.3%	0.1%	0.1%	0.1%	0.8%	0.1%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.6%	0.2%
Other	7.3%	5.5%	6.8%	7.9%	6.3%	4.8%	2.8%	2.0%	2.4%	3.8%	7.5%	4.8%	6.2%	5.8%
V Codes	9.7%	7.1%	6.2%	14.5%	7.4%	7.6%	7.3%	9.1%	19.8%	10.5%	19.5%	9.5%	11.6%	11.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Expected Payment Source

The following table identifies expected payment sources at the time of admission. Medicaid pays for 55% 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 2010

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	60.4%	1.2%	3.6%	9.3%	5.5%	6.1%	13.9%
Central	76.7%	9.2%	2.8%	0.8%	5.3%	4.2%	1.0%
Davis	66.4%	0.5%	5.3%	10.4%	7.3%	7.0%	3.1%
Four Corners	0.0%	0.0%	2.1%	50.6%	0.0%	0.0%	47.4%
Northeastern	34.3%	0.1%	24.3%	7.2%	2.9%	31.2%	0.0%
Salt Lake County—VMH	57.6%	12.7%	8.7%	17.4%	3.6%	0.0%	0.0%
San Juan	25.7%	0.2%	31.3%	15.1%	5.0%	16.6%	6.0%
Southwest	68.0%	1.5%	5.9%	7.5%	2.4%	1.1%	13.6%
Summit County—VMH	9.8%	17.1%	24.7%	46.8%	1.6%	0.0%	0.0%
Tooele County—VMH	31.9%	12.3%	18.7%	35.0%	2.0%	0.0%	0.0%
Utah County—Wasatch Mental Health	68.3%	1.6%	0.9%	27.4%	1.7%	0.0%	0.0%
Wasatch County—Heber Valley Counseling	20.8%	60.7%	8.4%	10.2%	0.0%	0.0%	0.0%
Weber	58.6%	22.0%	3.7%	13.5%	2.2%	0.0%	0.0%
Statewide	55.1%	9.4%	7.2%	18.9%	3.2%	2.2%	4.0%

KELLIE'S STORY

I am from Utah, however, I lived out of state for a few years where I entered an extreme state of mental illness—mainly major depression; not my first bout, but it was indeed my longest set-back yet. Mostly my life was one of isolation, treatment, and latent psychosis. Returning to Utah, I was grateful to be given access to a vacant house. It was cold, the windows were covered with paper, and all I had was my cat, a mattress, my suitcases, and a referral to vocational rehab. It took me a few weeks to stop crying and to not be afraid to go outside.

“I am now in my third semester of grad school and I love it. Even though I still have many hurdles to overcome, I am so grateful for the progress I’ve made and the change from not daring to leave my house to now being a successful student, working, and giving back to the community.”

After a long and painful process, I mentioned to an associate that I hoped to get a master’s in vocational rehabilitation one day. She referred me to a program with an upcoming deadline and I started a whirlwind of activity to take the necessary



tests, make application, secure letters of reference, etc. I ended up scoring the highest score the department had seen on the Miller’s Analogy test which was a big boost to my self-confidence. I also received a scholarship.

I have many people to thank for the support I was given when I reached out for any services that were available to me. I am very thankful for all I received as it has provided me a hands-up, not a hand-out. Without this help I would not have survived the isolation, homelessness and hunger, the loss of self, self-worth and value, and I wouldn’t be here writing this today.

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.

2010 Mental Health Clients Penetration Rates

	2009 Population (Estimated)	Total Served	Penetration Rate
Bear River	167,331	2,827	1.7%
Cental	72,474	983	1.4%
Davis	300,827	3,254	1.1%
Four Corners	40,278	1,881	4.7%
Northeastern	50,425	1,302	2.6%
Salt Lake County - Valley Mental Health	1,034,989	15,281	1.5%
San Juan	15,049	536	3.6%
Southwest	200,246	2,556	1.3%
Summit Co.—Valley Mental Health	36,969	1,061	2.9%
Tooele Co.—Valley Mental Health	58,335	1,910	3.3%
Utah Co.—Wasatch Mental Health	545,307	6,872	1.3%
Wasatch Co.—Heber Valley Counseling	21,600	443	2.1%
Weber	240,742	5,734	2.4%
Statewide	2,784,572	43,662	1.6%

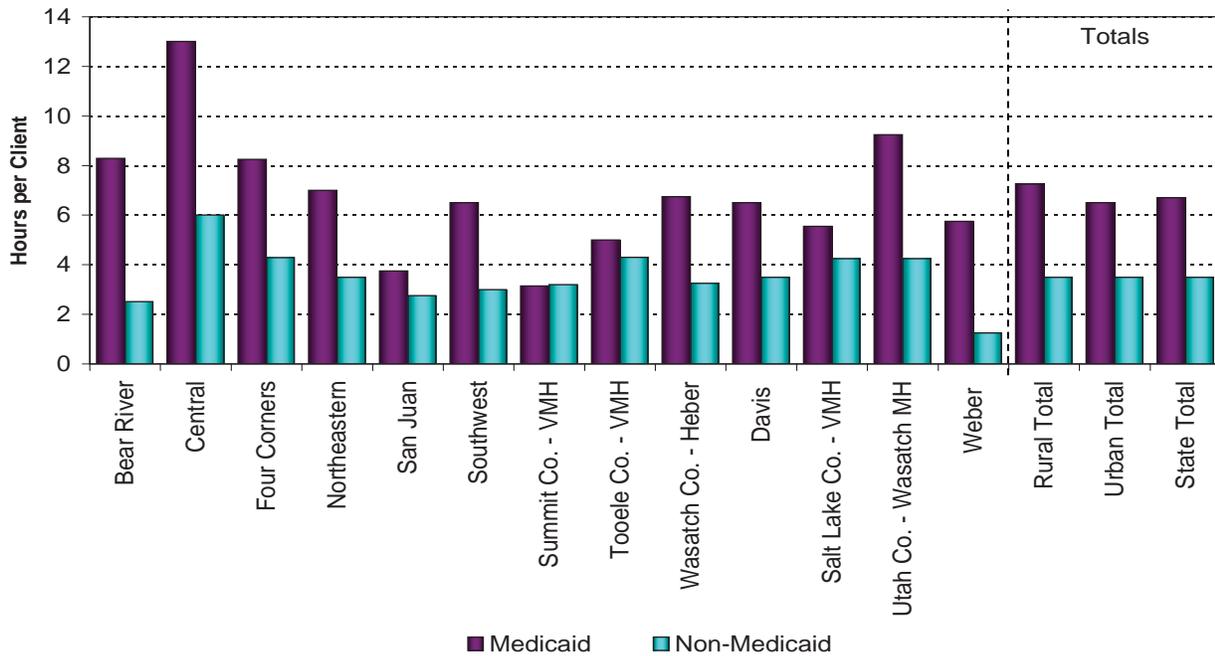
Penetration rate is the percent of people in the general population who are receiving mental health services in each CMHC.

Mandated Services Data by Local Authority

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

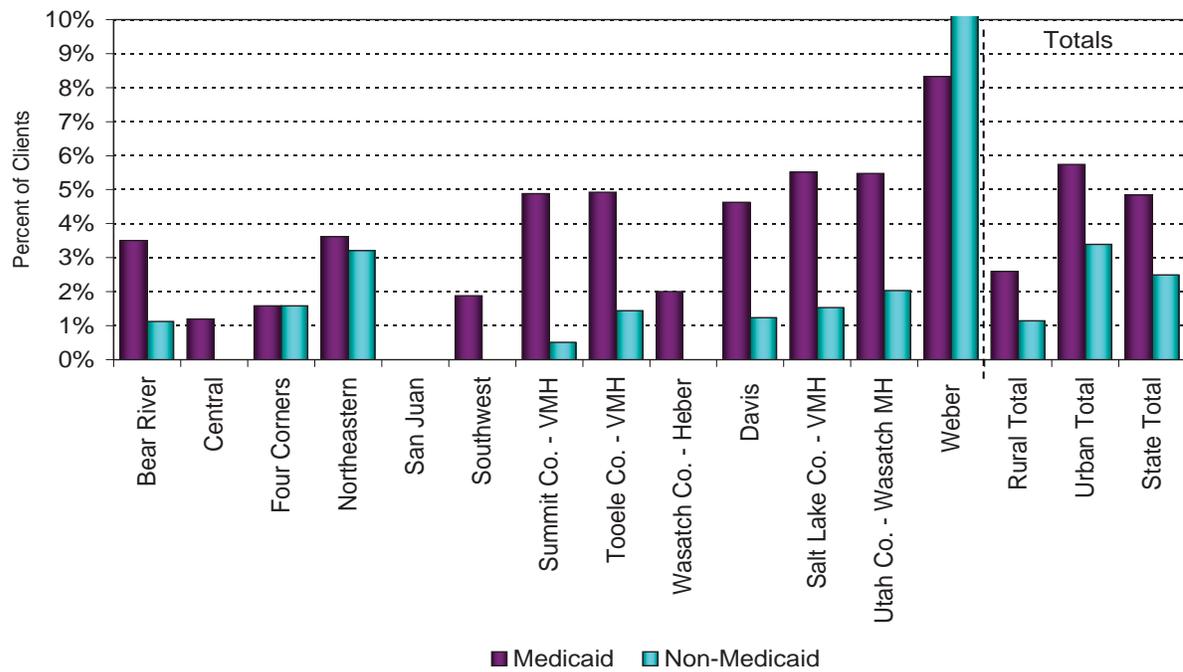
ties (based on utilization and median length of service) for each of the 13 CMHCs. The N= for the utilization charts can be found on page 164.

**Outpatient
Median Length of Service
Mental Health Clients
Fiscal Year 2010**



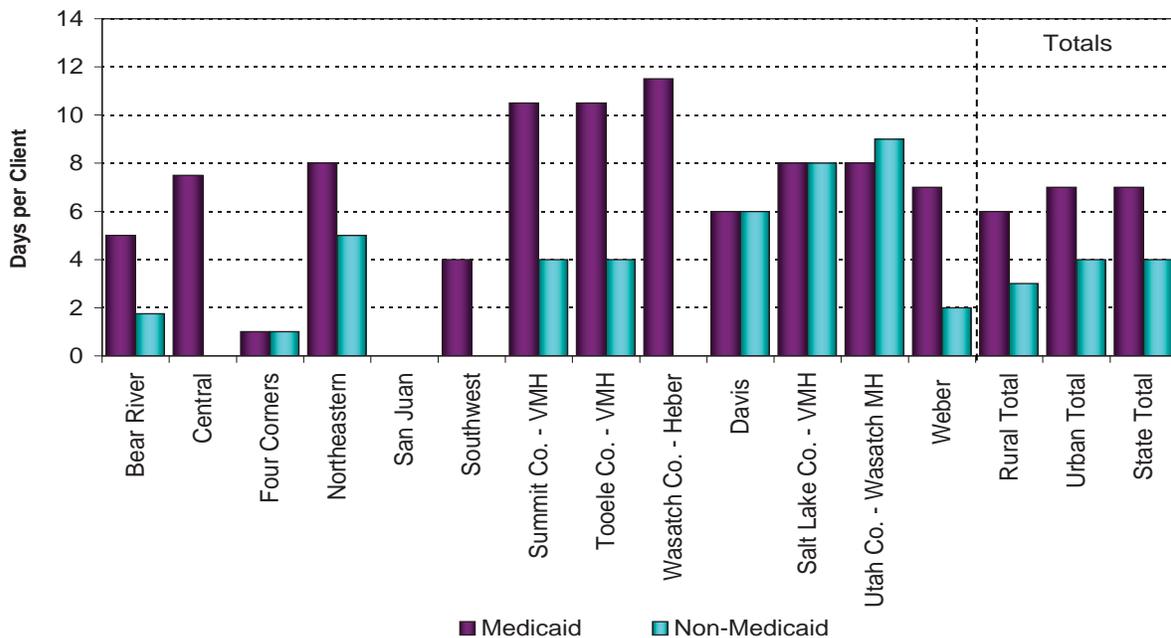
Inpatient Utilization

Mental Health Clients
Fiscal Year 2010

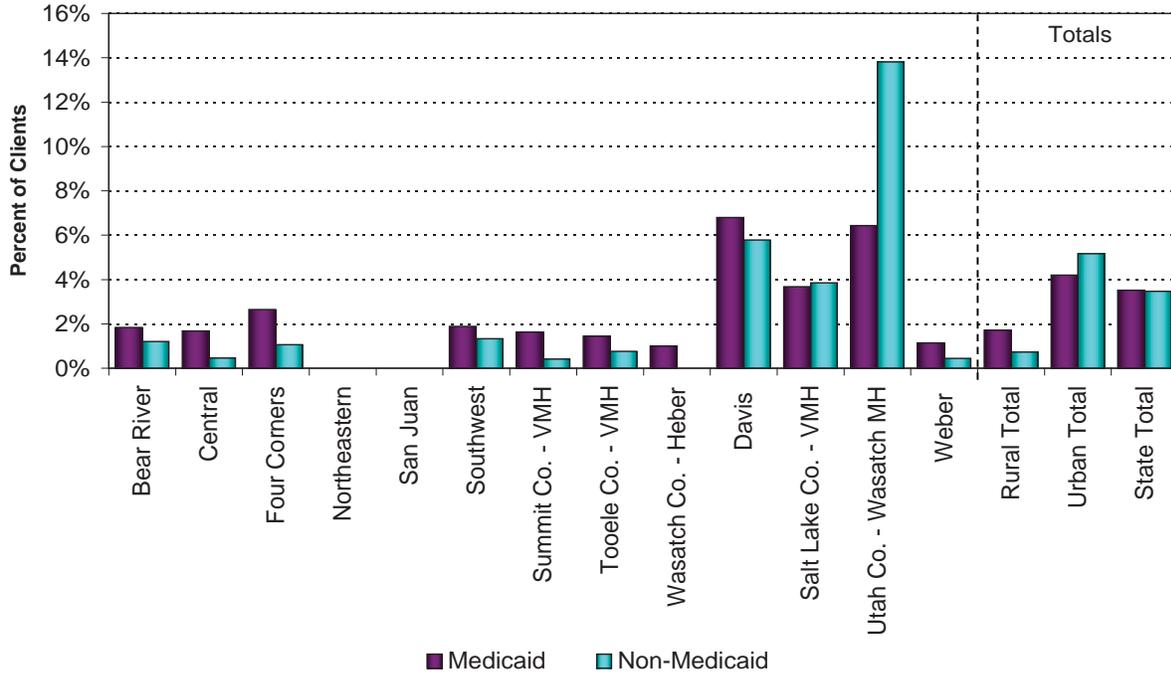


Inpatient Median Length of Service

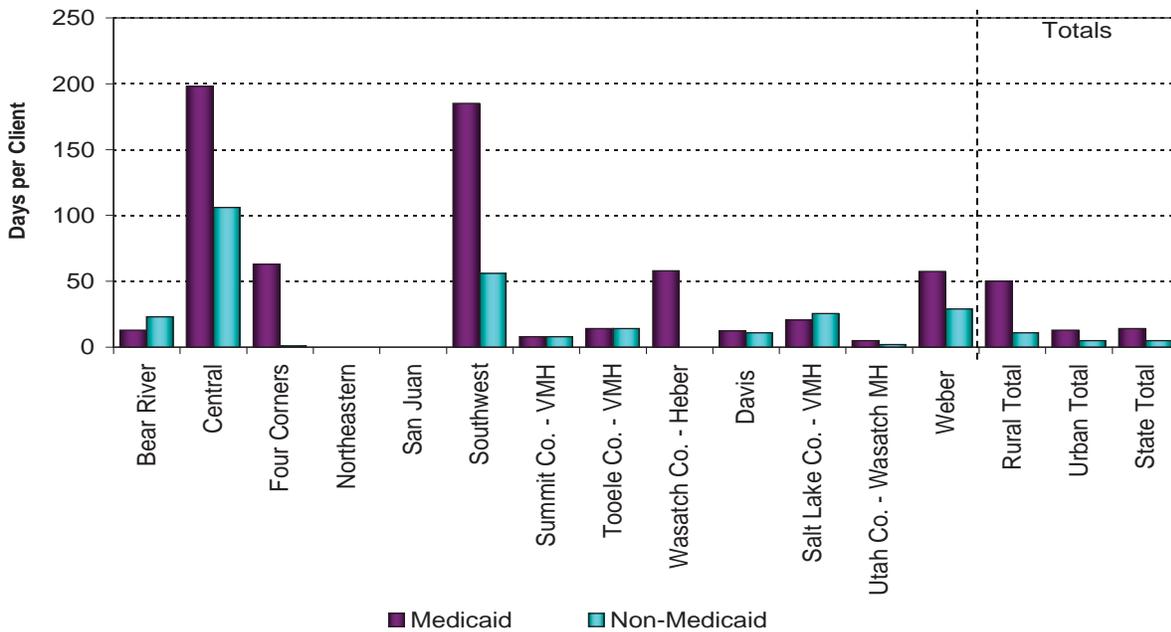
Mental Health Clients
Fiscal Year 2010



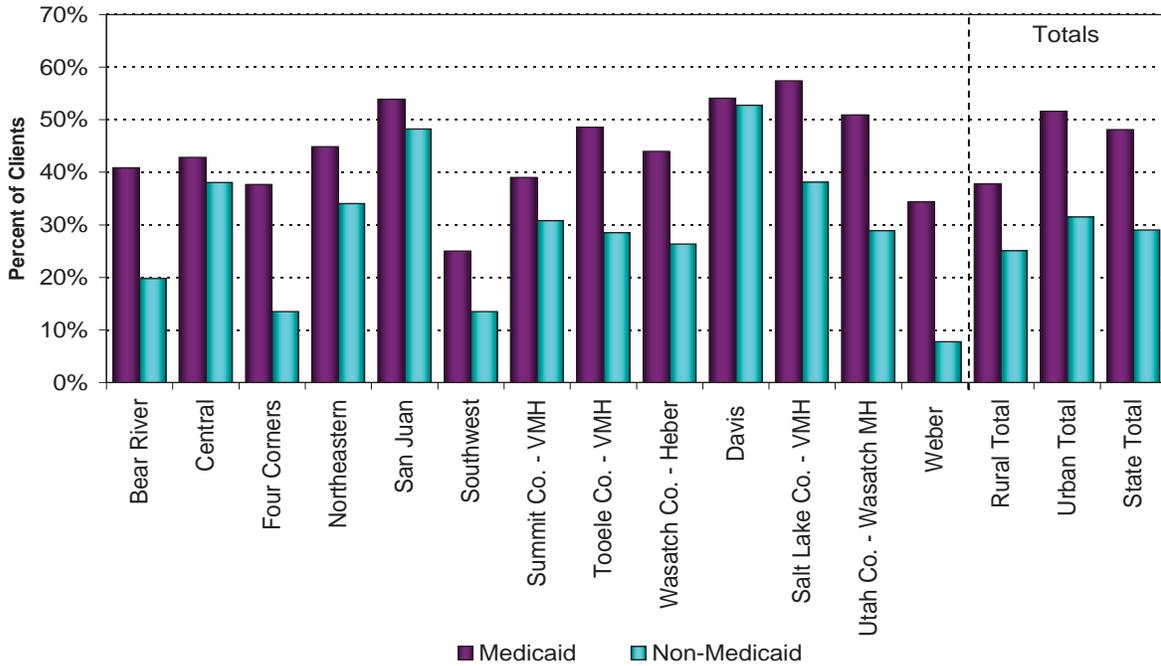
Residential Utilization Mental Health Clients Fiscal Year 2010



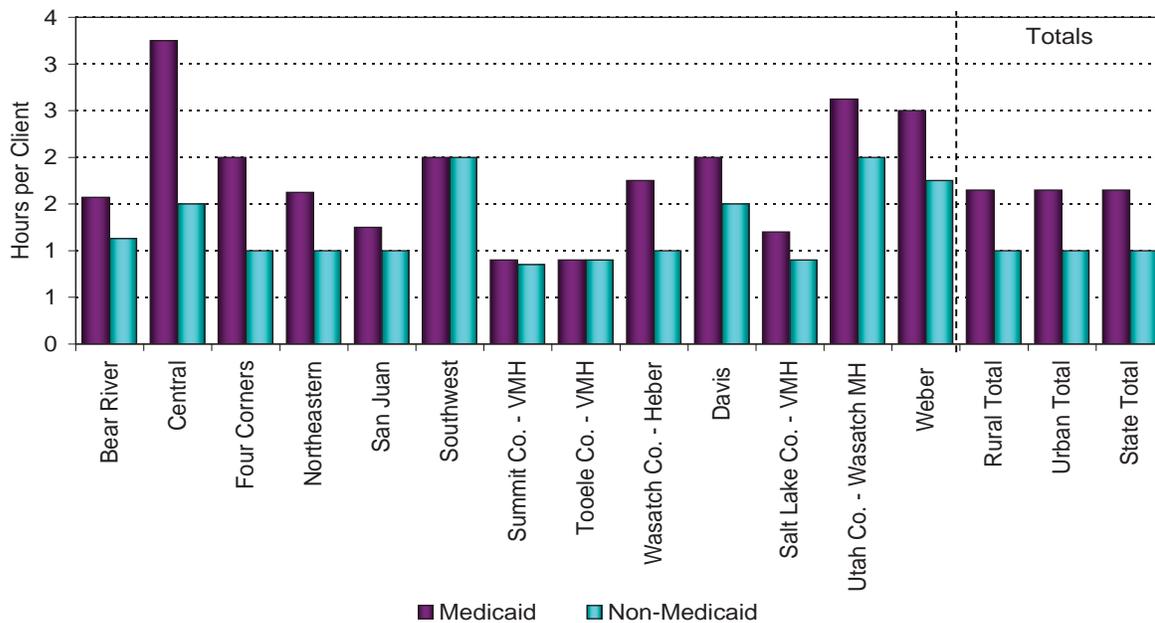
Residential Median Length of Service Mental Health Clients Fiscal Year 2010



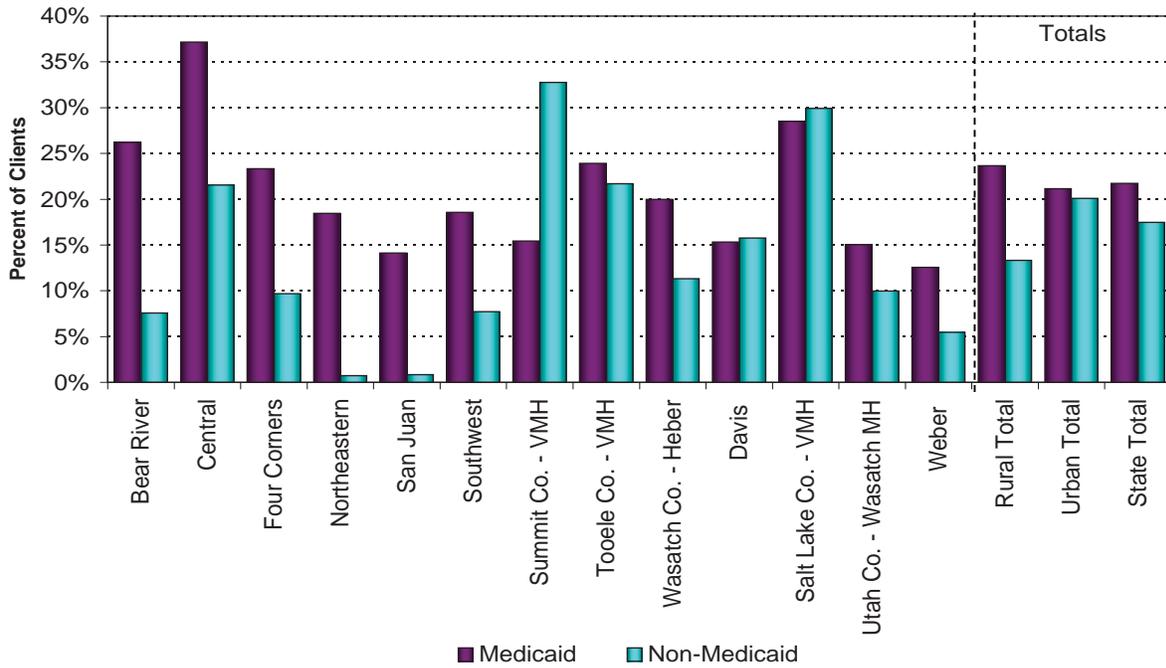
Medication Management Utilization Mental Health Clients Fiscal Year 2010



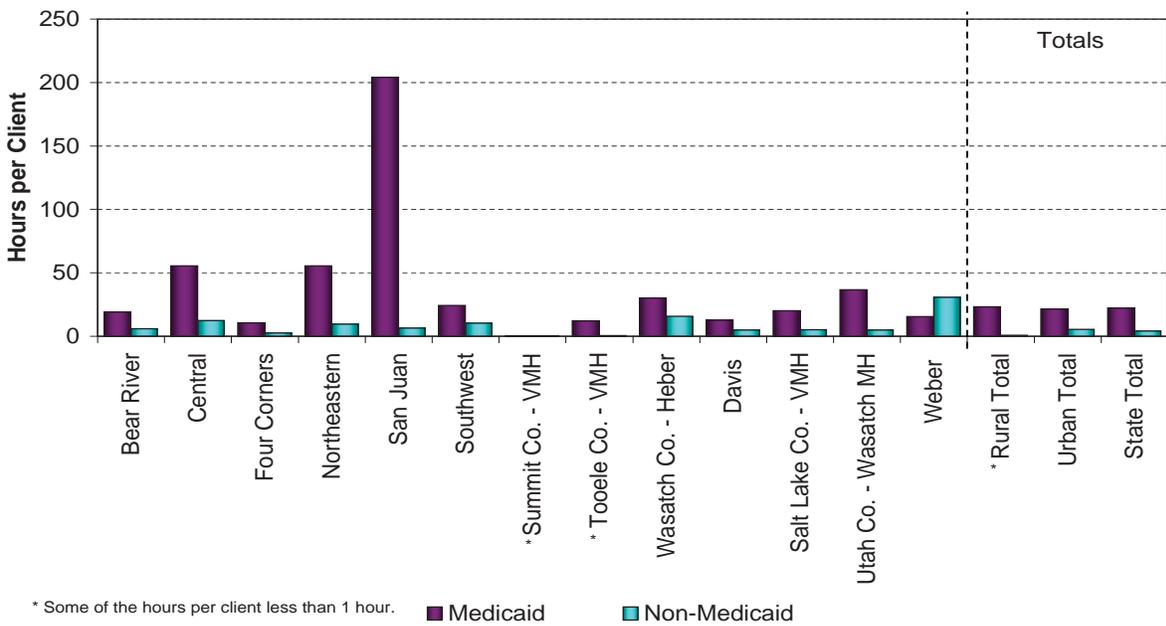
Medication Management Median Length of Service Mental Health Clients Fiscal Year 2010



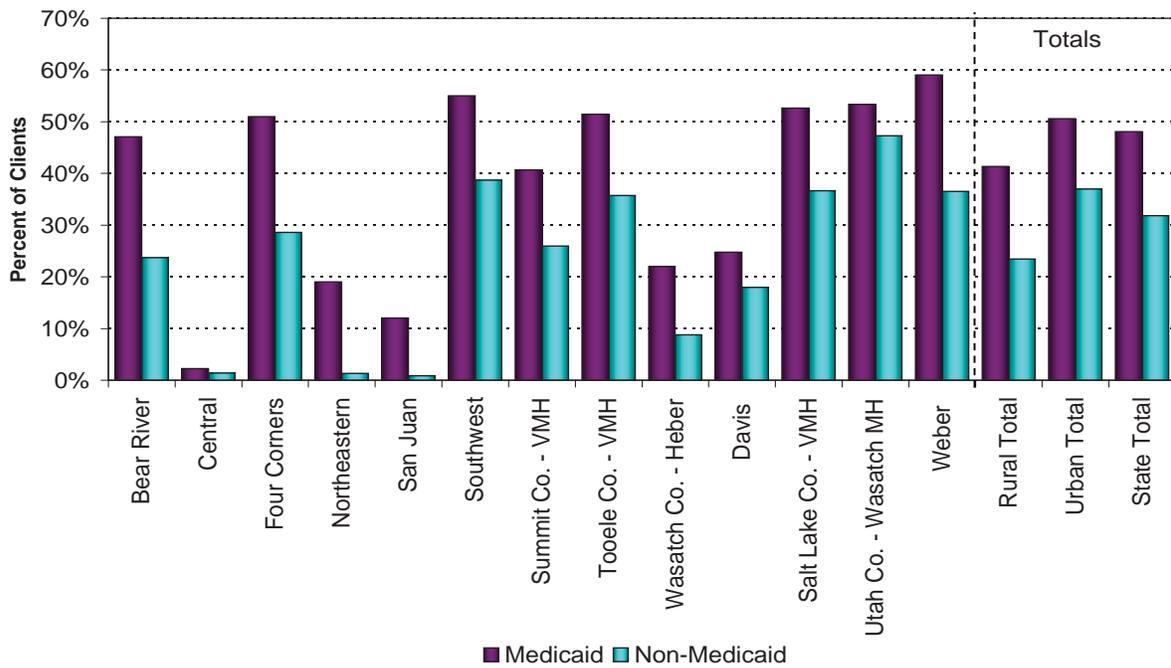
Psychosocial Rehabilitation Utilization Mental Health Clients Fiscal Year 2010



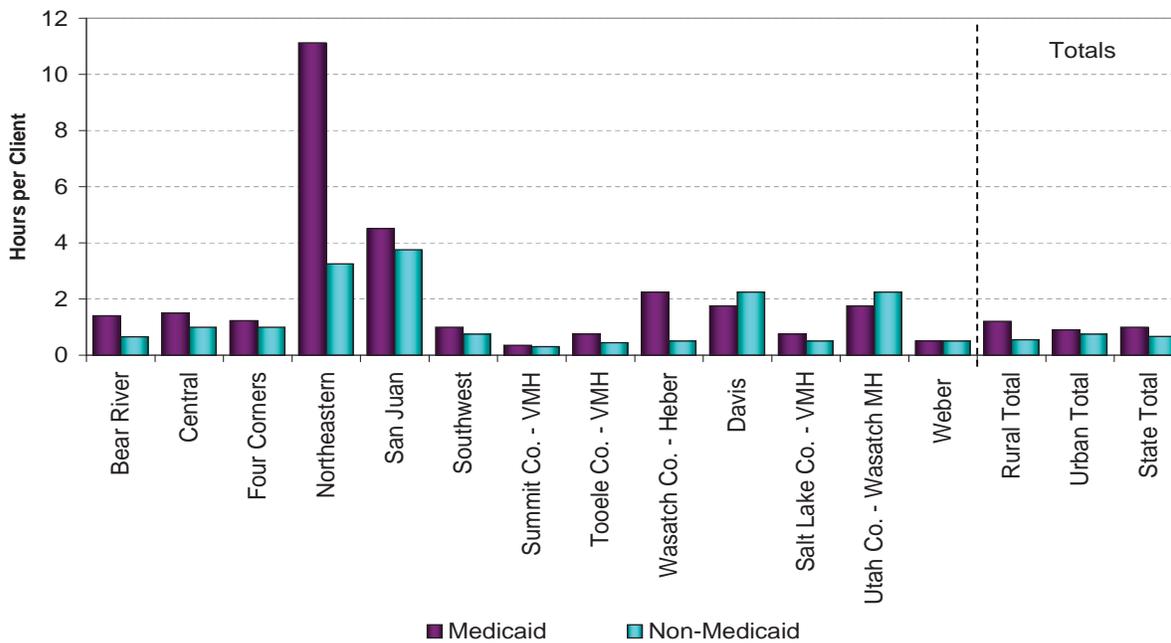
Psychosocial Rehabilitation Median Length of Service Mental Health Clients Fiscal Year 2010



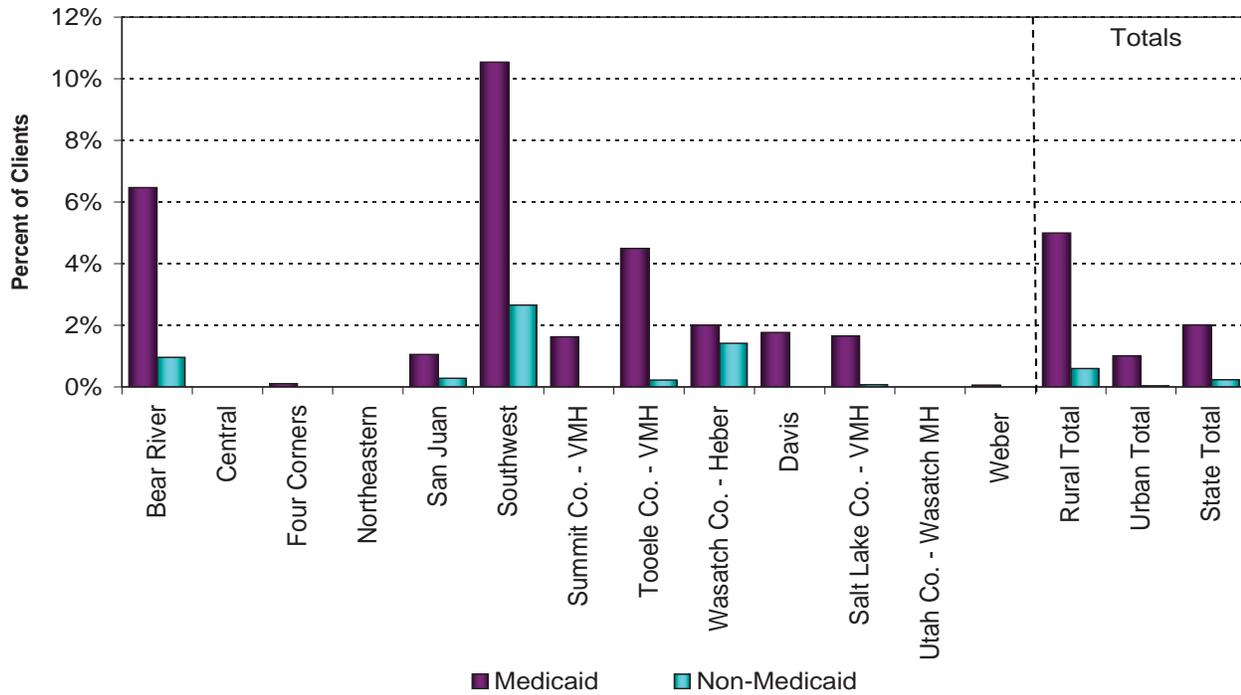
Case Management Utilization Mental Health Clients Fiscal Year 2010



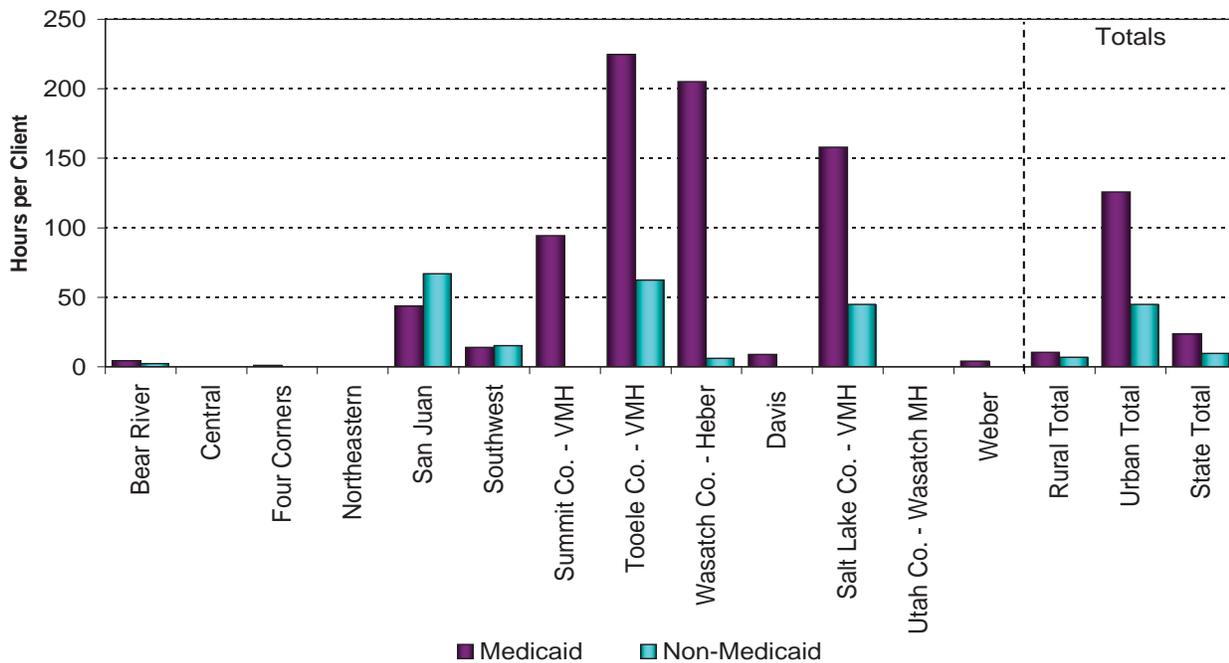
Case Management Median Length of Service Mental Health Clients Fiscal Year 2010



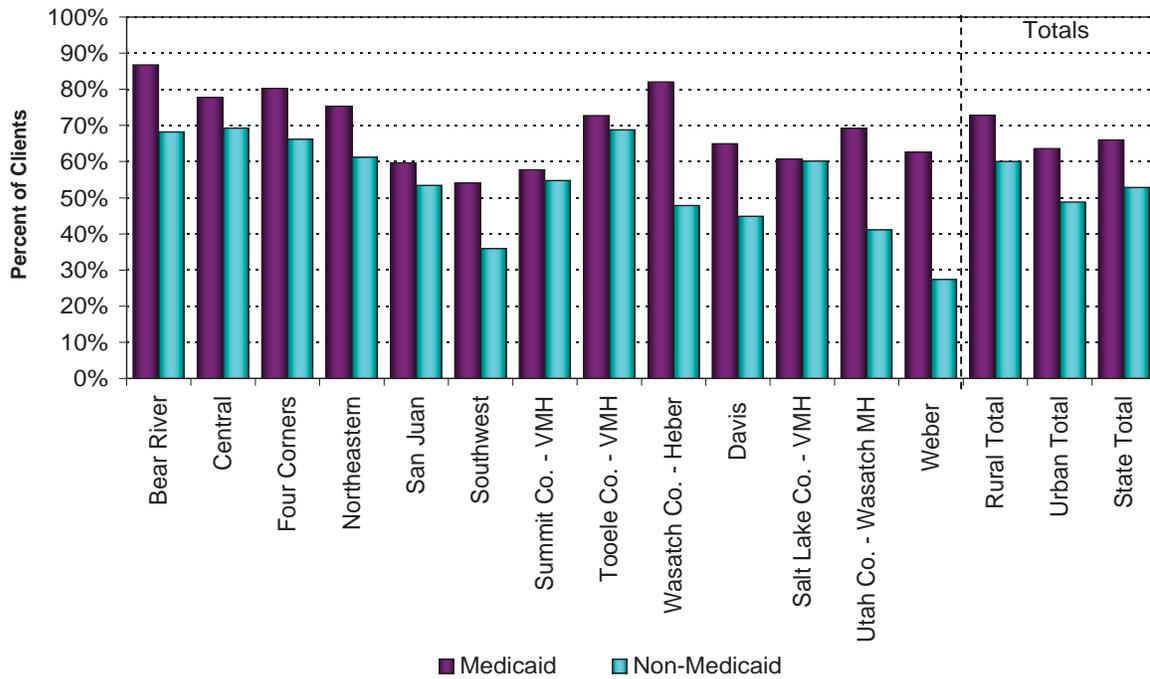
Respite Utilization Mental Health Clients Fiscal Year 2010



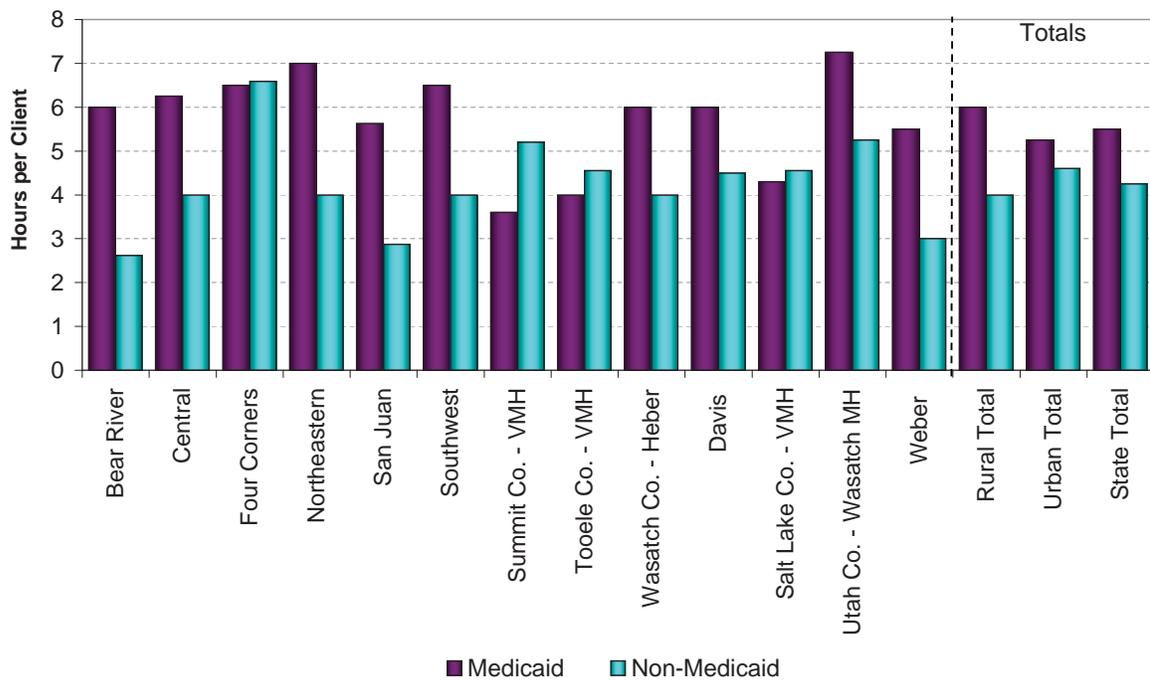
Respite Median Length of Service Mental Health Clients Fiscal Year 2010



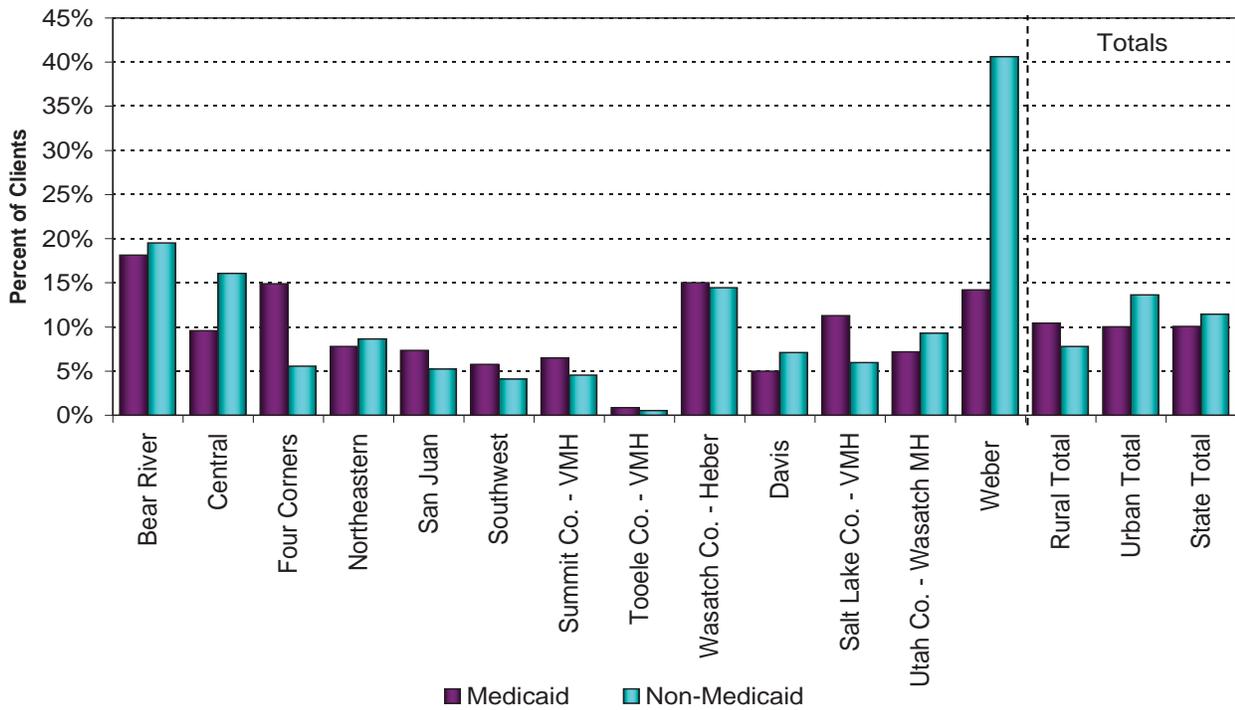
Therapy Utilization Mental Health Clients Fiscal Year 2010



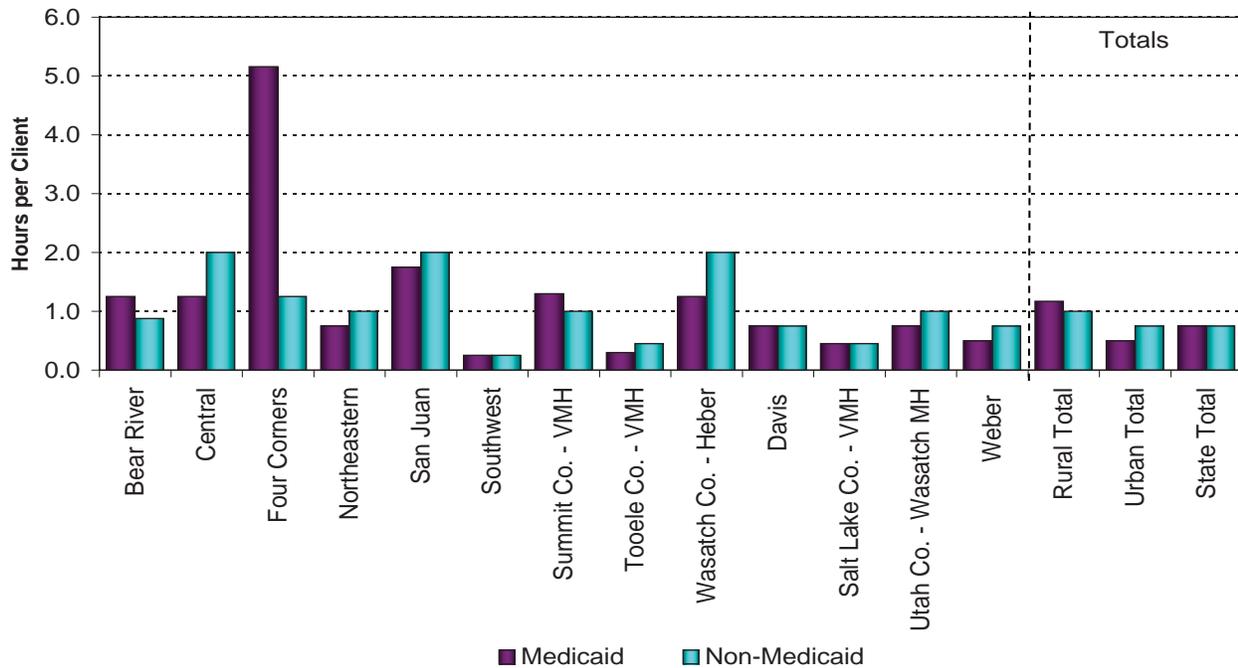
Therapy Median Length of Service Mental Health Clients Fiscal Year 2010



Emergency Utilization Mental Health Clients Fiscal Year 2010



Emergency Median Length of Service Mental Health Clients Fiscal Year 2010



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 adults who experience severe and persistent mental illness (SPMI) and children with severe emotional disturbance (SED). USH has the capacity to provide active psychiatric treatment services to 359 patients (including a five-bed acute unit). It serves all age groups and covers all geographic areas of the state. USH works with 13 mental health centers as part of its continuum of care. All adult and pediatric beds are allocated to the mental health centers based on population.

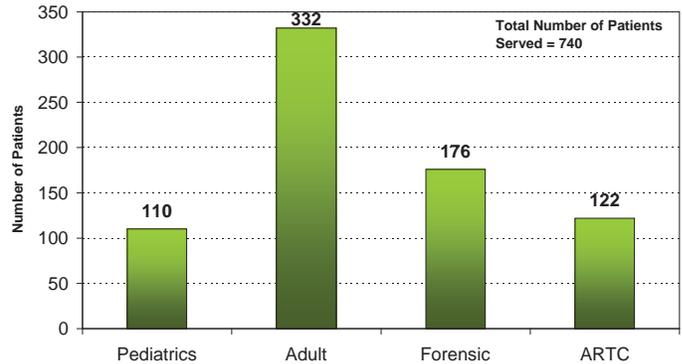
Major Client Groups at the Utah State Hospital

- Adult patients over 18 who have severe mental disorders (civil commitment)
- Children and youth (ages 6-18) who require intensive inpatient treatment
- Persons adjudicated and found guilty and mentally ill
- Persons found incompetent to proceed and need competency restoration or diminished capacity evaluations
- Persons who require guilty and mentally ill or diminished capacity evaluations
- Persons with mental health disorders who are in the custody of the Utah Department of Corrections
- Acute treatment service for adult patients from rural centers (ARTC)

Programs

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

Number of Patients Served
Fiscal Year 2010

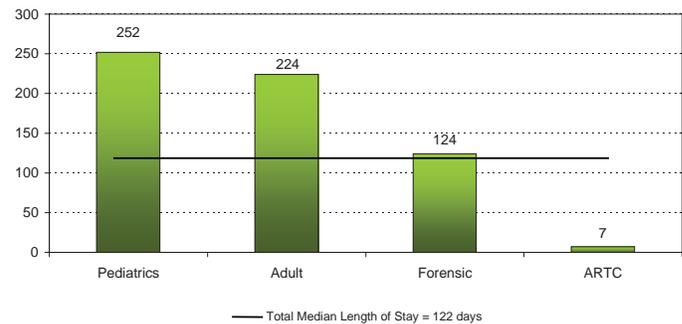


Forensic Unit (ages 18+)	100 Beds
--------------------------	----------

Length of Stay

The median length of stay at the USH is 122 days. The median discharged length of stay for adult patients with civil commitment is 224 days.

Median Length of Stay in Days
Fiscal Year 2010



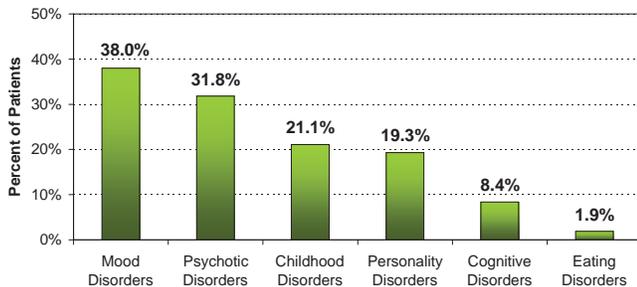
Types of Disorders Treated

- Psychotic Disorders: schizophrenia, schizoaffective disorder, other psychotic disorders, and delusional disorders
- Mood Disorders: major depression, anxiety disorders, bipolar disorder, and dysthymia
- Childhood Disorders: developmental disorders, autism, attention deficit disorder, conduct disorder, separation anxiety, and attachment disorder

- Cognitive Disorders: primary degenerative dementia, mental disorders due to general medical conditions, and mental retardation
- Eating Disorders
- Personality Disorders: borderline, antisocial, paranoid, and narcissistic disorders

Additionally, 31% of the patients treated at USH also had a substance abuse diagnosis.

Percent of Patients with Major Psychiatric Diagnosis*
Fiscal Year 2010



*Patients can have more than one diagnosis

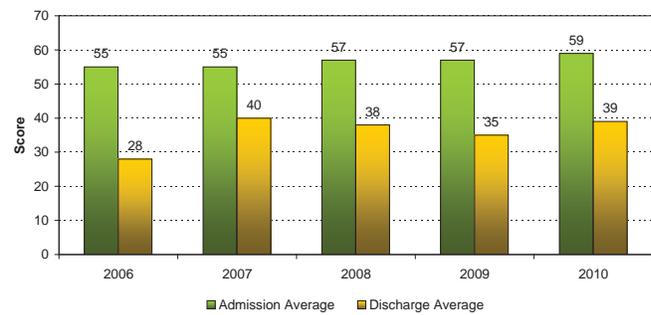
Services Provided

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). 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 2010. 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

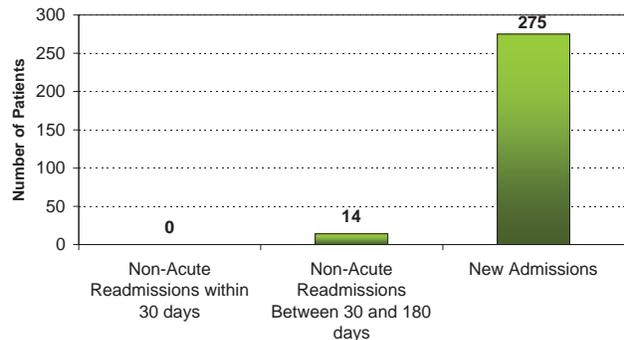


Readmission

USH admitted a total of 429 patients in fiscal year 2010. Of these admissions, there were no non-acute readmissions within 30 days and 14 non-acute readmissions within 180 days.

The readmissions within 30 days are 0% of the total discharges in fiscal year 2010.

Readmissions at the Utah State Hospital
Fiscal Year 2010



KAT'S STORY

All the time I was growing up on the reservation, and moving around a lot, I was in and out of jail, always in trouble, and drinking a lot. But once I got pregnant with Izaiah I knew I had to change.

It's been hard being a single mom and being homeless as I am right now, but when I think about giving up and possibly losing my son, I know I have to do whatever I can to keep him and to make things good for him.

Because I've been through so much, my friends are always coming to me for advice. I think I must have been sent here to have these experiences so I can turn around and help others who are going through tough times.

I'm going to therapy for my depression and to help me get some new opportunities like the Transition into Adulthood program. I've also been working in a daycare center at the college. I love knowing I'm helping these kids and teaching them something. My dream would be to go back to the reservation and start an after-school program so there will be something for the kids to do. I also want to teach the kids there about our Navajo culture so our traditions won't be lost.

"I think I must have been sent here to have these experiences so I can turn around and help others who are going through tough times."



Local Authorities

Local Authorities Service Outcomes

Substance Abuse and Mental Health Statistics by Local Authority

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

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

The following pages provide data and graphs describing how each local authority provided services to its residents during fiscal year 2010 (July 1, 2009 to June 30, 2010).

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

Bear River

Cache, Rich & Box Elder Counties



Population: 167,331

Substance Abuse Provider Agency:

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

Mental Health Provider Agency:

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

Bear River Substance Abuse—Prevention

Prioritized Risk Factors

- Family conflict
- Parental attitudes favorable toward problem behaviors
- Attitudes favorable to problem behavior

Prioritized Protective Factors

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

2010 Prevention Program Highlights

Environmental Changes

Alcohol Compliance Checks

- 40 stores were checked at least once
- Increased checks in Cache and Rich Counties

Early Intervention Services

First Offenders Class

- 6-week youth substance abuse prevention class

Minor in Possession Class

- 69 clients completed the 10-hour MIP class
- 11 classes held

Driving Under the Influence Class

- 77 clients completed the 16-hour DUI class
- 16 classes (11 English and 5 Spanish)

Women in Treatment Referrals

- 42 female substance abuse clients referred
- Clients with dependent children or pregnant
- Clients referred to services for themselves and their families; parenting classes, crisis nursery, housing assistance, employment, counseling for their children and more

School-Based Prevention

All Stars

- 7 All Stars courses taught in high-risk classrooms at 2 schools
- 102 students completed the 10-week course

Prevention Dimensions (PD) Support

- 9,662 students taught a PD lesson by BRHD
- Lessons taught during school and afterschool
- Additional PD lessons taught regularly by the teachers in their individual classrooms

Annual Teacher Trainings

- 79 new teachers trained
- 134 afterschool teachers trained

PTA Mini-Grants

- 18 PTAs participated
- 10,268 students received substance abuse prevention activities
- Substance Abuse Prevention Contacts
- 40 schools assigned prevention liaisons
- Liaisons monitor PD within their schools and disseminate prevention messages to faculty

Bear River Health Department—Substance Abuse

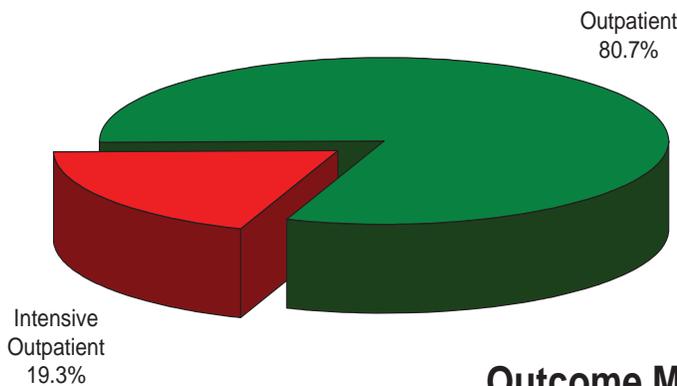
Total Clients Served.....1,423
 Adult1,335
 Youth.....88
 Penetration Rate..... 0.9%

Total Admissions.....986
 Initial Admissions986
 Transfers.....0

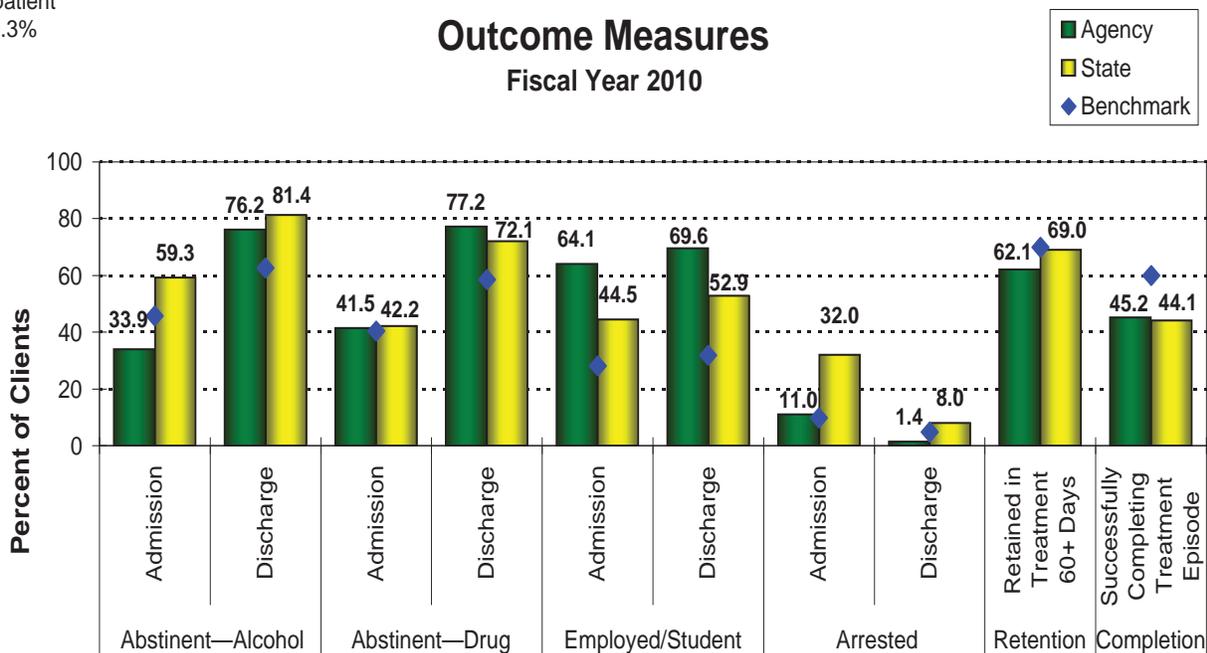
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	348	139	487
Cocaine/Crack	9	4	13
Marijuana/Hashish	182	57	239
Heroin	35	16	51
Other Opiates/Synthetics	29	35	64
Hallucinogens	1	1	2
Methamphetamine	45	29	74
Other Stimulants	4	3	7
Benzodiazepines	1	10	11
Tranquilizers/Sedatives	3	3	6
Inhalants	2	0	2
Oxycodone	11	11	22
Club Drugs	3	0	3
Over-the-Counter	3	1	4
Other	1	0	1
Total	677	309	986

Admission into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



Benchmark is 75% of the National Average.

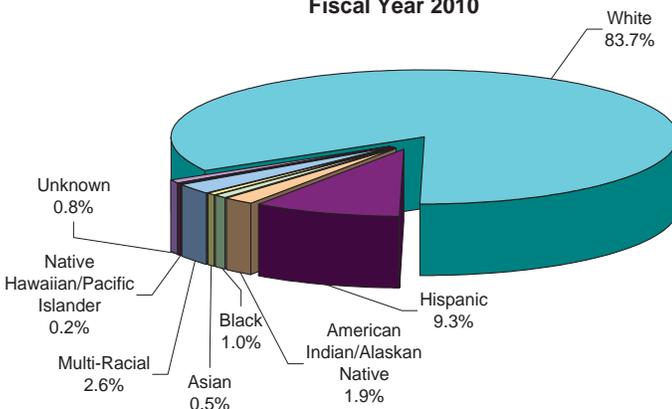
Bear River Mental Health—Mental Health

Total Clients Served.....2,827
 Adult1,797
 Youth.....1,030
 Penetration Rate 1.7%
 Civil Commitment39
 Unfunded Clients Served176

Diagnosis

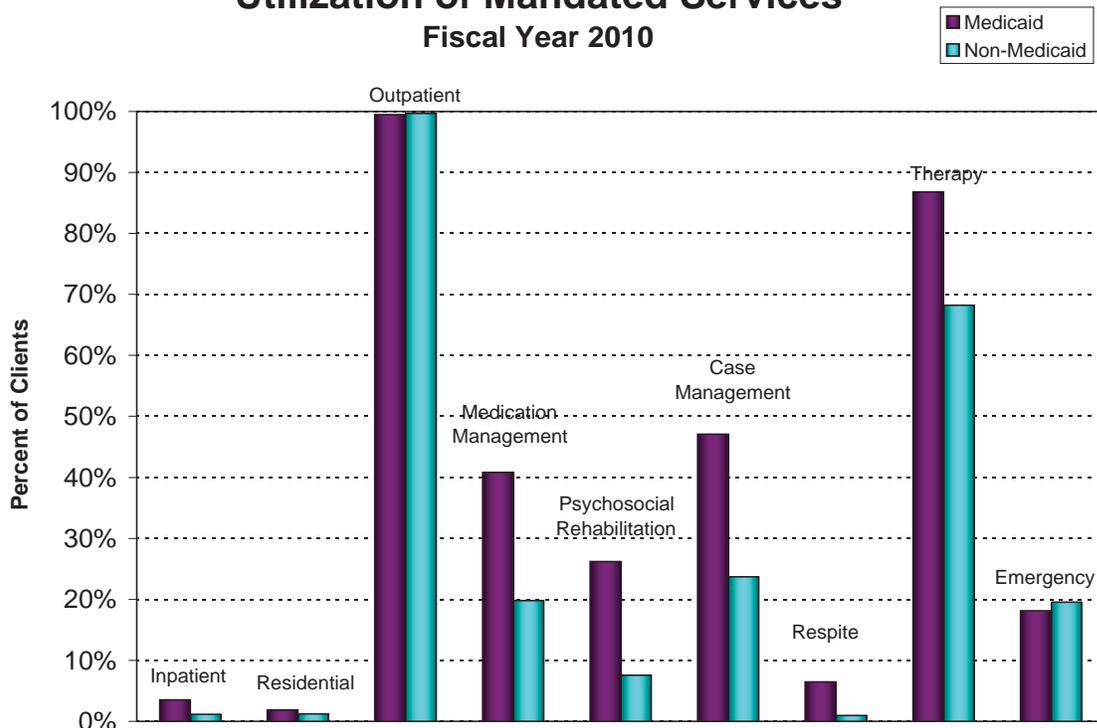
	Youth	Adult
Adjustment Disorder	218	100
Anxiety	316	1,079
Attention Deficit	285	244
Cognitive Disorder	39	134
Conduct Disorder	16	2
Impulse Control Disorders	91	58
Mood Disorder	350	1,427
Neglect or Abuse	133	14
Oppositional Defiant Disorder	84	7
Other	127	134
Personality Disorder	3	530
Pervasive Developmental Disorders	40	48
Schizophrenia and Other Psychotic	6	294
Substance Abuse	20	352
V Codes	168	175
Total	1,728	4,423

Race/Ethnicity Fiscal Year 2010



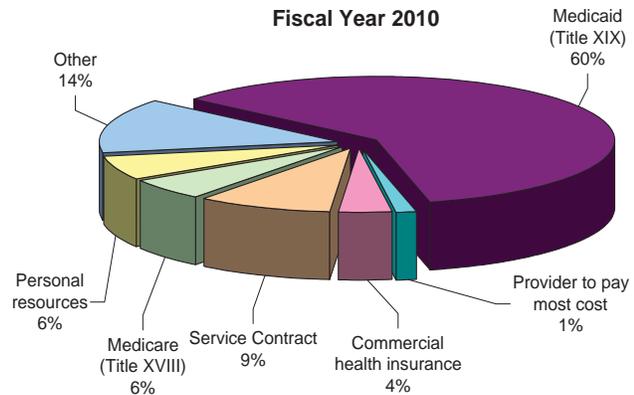
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

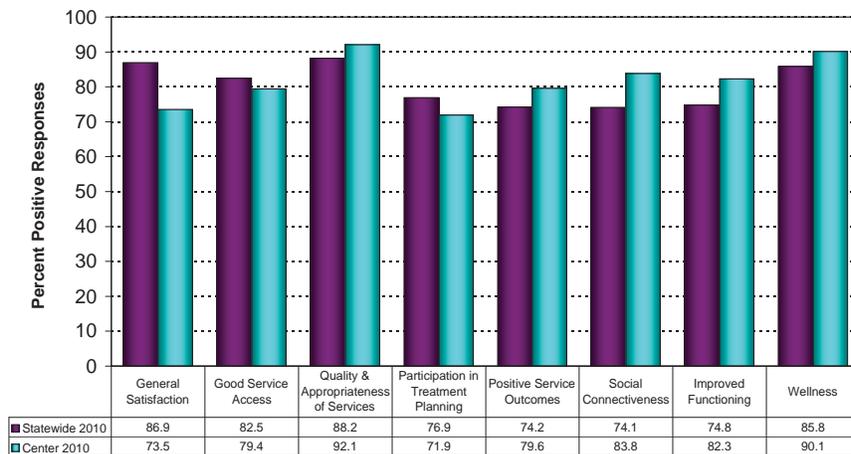


Bear River Mental Health—Mental Health (Continued)

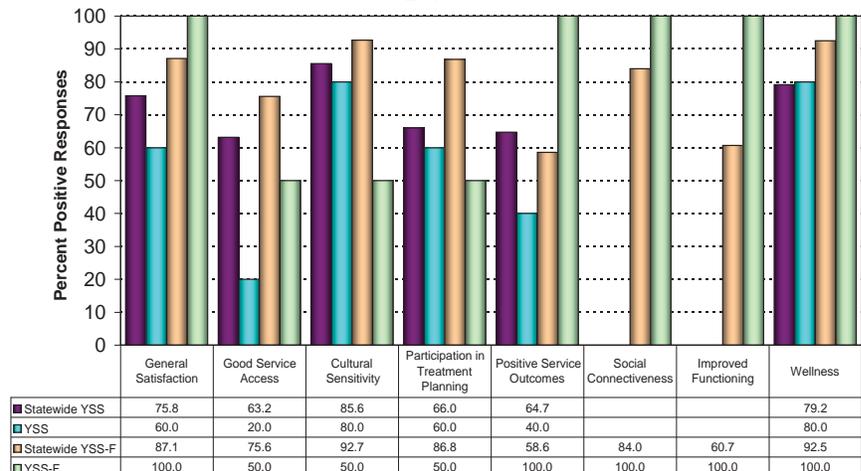
**Expected Payment Source At Admission
Fiscal Year 2010**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010**



Central Utah Counseling Center

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



Population: 72,474

Substance Abuse and Mental Health Provider

Agency:

Brian Whipple, Executive Director
Central Utah Counseling Center
152 North 400 West
Ephraim, UT 84647
Office: (435) 462-2416
www.cucc.us

Central Utah Substance Abuse—Prevention

Prioritized Risk Factors:

- Depressive symptoms
- Parental attitude favorable to antisocial behaviors
- Early initiation of antisocial behaviors

Prioritized Protective Factors

- Rewards for pro-social involvement
- Opportunities for pro-social involvement in community, school and family

2010 Prevention Program Highlights

3rd Annual KNOW MORE Conference

Sponsored by Sevier Valley Substance Abuse Coalition provided workshops to raise awareness for adults and youth, about prescription narcotic abuse, tobacco, and youth substance abuse.

4th Annual Prevention Night for Families

Sponsored by North Sanpete School District, GYC and community agencies. Over 500 community members attended.

Governing Youth Council (GYC)

Peer leaders in the six-county region continue to participate in opportunities and rewards for pro-social involvement by coordinating drug-free activities and life skills. GYC students strive to promote positive youth interaction and lifestyles in their school districts and communities. Semi-annual retreats provide opportunities for service and training in effective leadership skills.

After School Program

Provided by Community First's Coalition at the Delta Youth Activities Center—increased attendees with a new name and by moving closer to the middle school. They now offer tutoring in English and Spanish, 4-H mentoring, with an added focus on the arts and physical fitness. DYAC will be participating in the nationwide "Lights on After School Activity" to be held at the center October 28. The annual area clothing drive in August benefited hundreds.

CUCC Focus

Prevention of prescription abuse and overdose is the SPF focus in Central Utah. CUCC is providing training with Dr. Glen R. Hanson and DOPL to Medicaid prescribers, pharmacists, law enforcement, and the community. Together we are collaborating effects to reduce the alarming mortality and morbidity rates in Central Utah.

Central Utah Counseling Center—Substance Abuse

Total Clients Served.....322
 Adult261
 Youth.....61
 Penetration Rate..... 0.4%

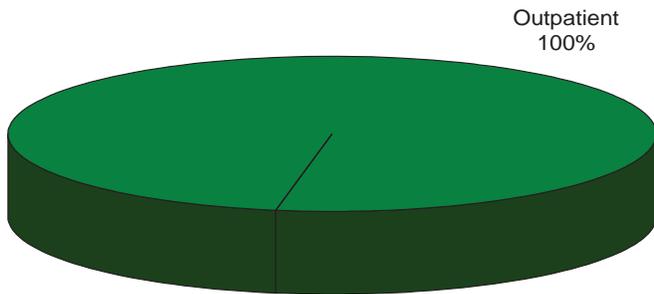
Total Admissions.....185
 Initial Admissions184
 Transfers.....1

Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	44	30	74
Cocaine/Crack	3	0	3
Marijuana/Hashish	27	12	39
Heroin	5	3	8
Other Opiates/Synthetics	3	9	12
Hallucinogens	0	0	0
Methamphetamine	8	14	22
Other Stimulants	0	1	1
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	1	1
Inhalants	2	2	4
Oxycodone	8	11	19
Club Drugs	0	1	1
Over-the-Counter	0	0	0
Other	0	1	1
Total	100	85	185

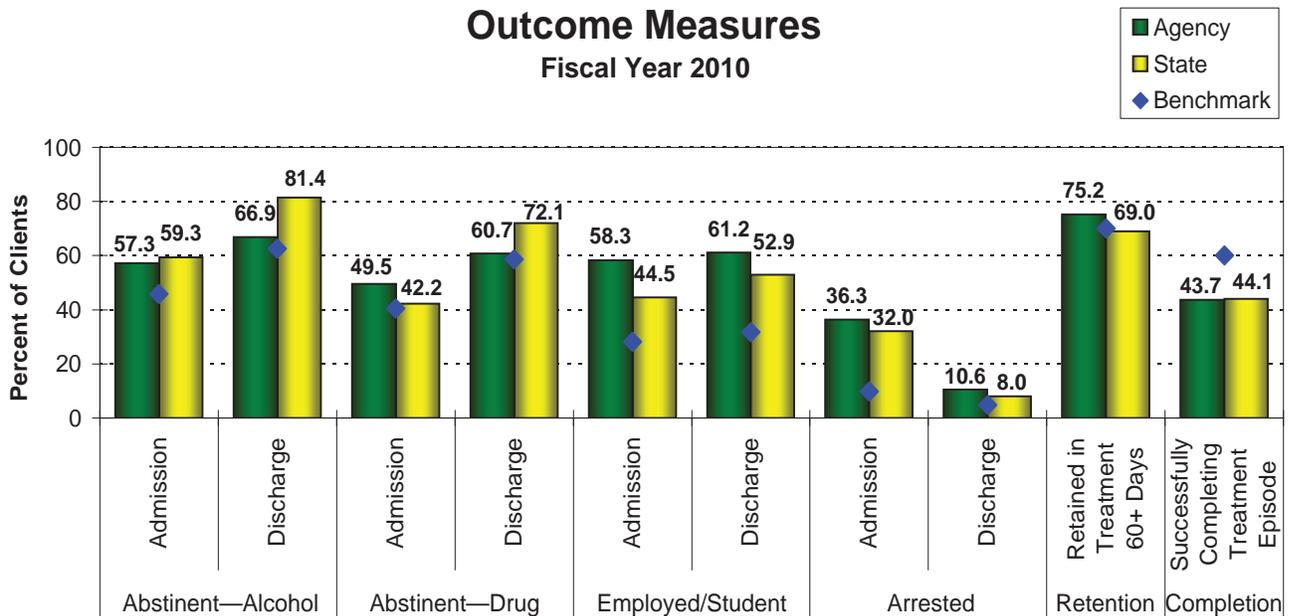
Admission into Modalities

Fiscal Year 2010



Outcome Measures

Fiscal Year 2010



Benchmark is 75% of the National Average.

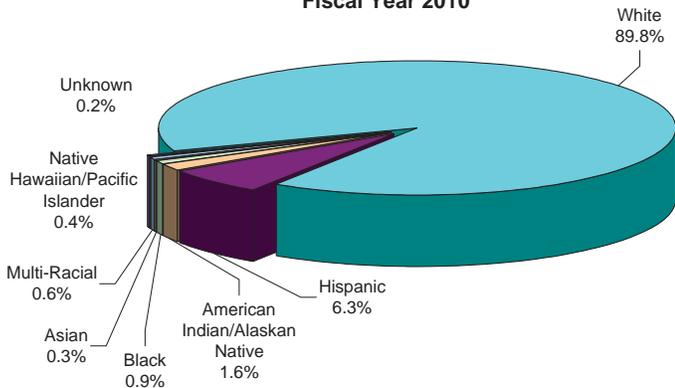
Central Utah Counseling Center—Mental Health

Total Clients Served983
 Adult607
 Youth376
 Penetration Rate 1.4%
 Civil Commitment12
 Unfunded Clients Served128

Diagnosis

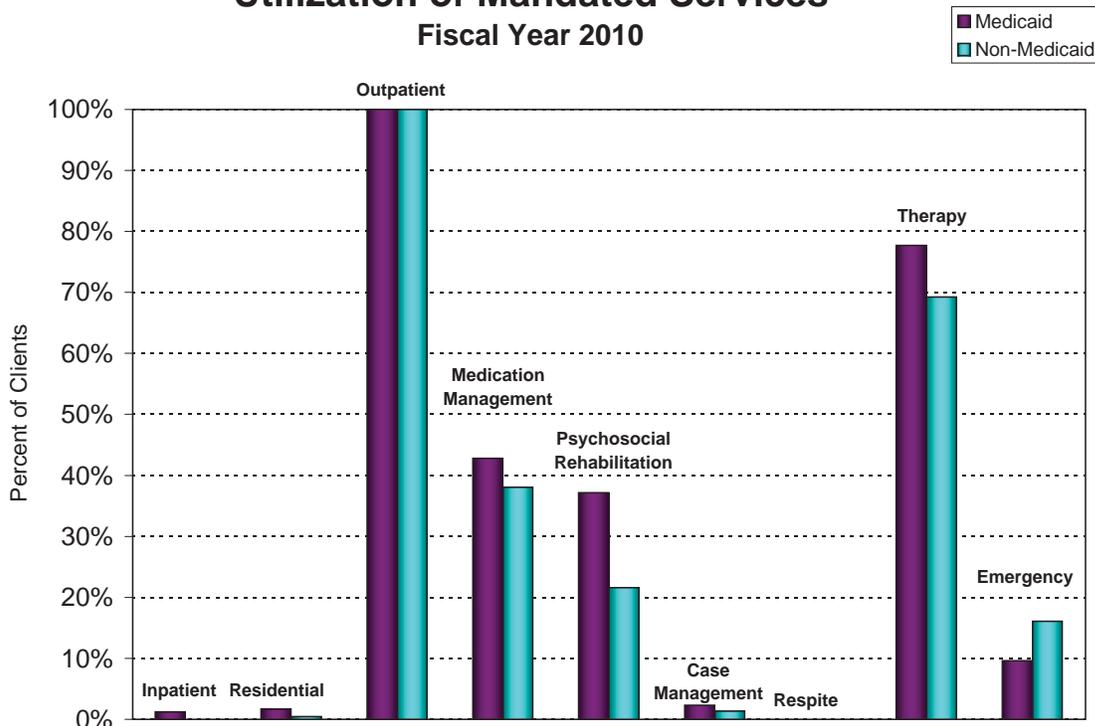
	Youth	Adult
Adjustment Disorder	111	30
Anxiety	87	330
Attention Deficit	138	36
Cognitive Disorder	8	37
Conduct Disorder	19	-
Impulse Control Disorders	23	16
Mood Disorder	80	395
Neglect or Abuse	105	203
Oppositional Defiant Disorder	91	5
Other	41	34
Personality Disorder	4	172
Pervasive Developmental Disorders	30	8
Schizophrenia and Other Psychotic	1	131
Substance Abuse	12	110
V Codes	53	46
Total	750	1,507

Race/Ethnicity Fiscal Year 2010



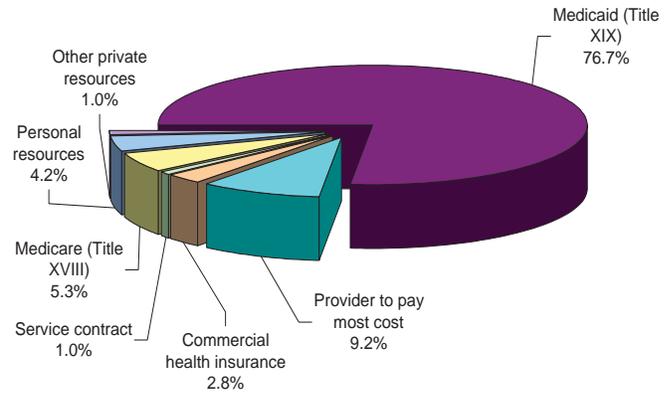
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

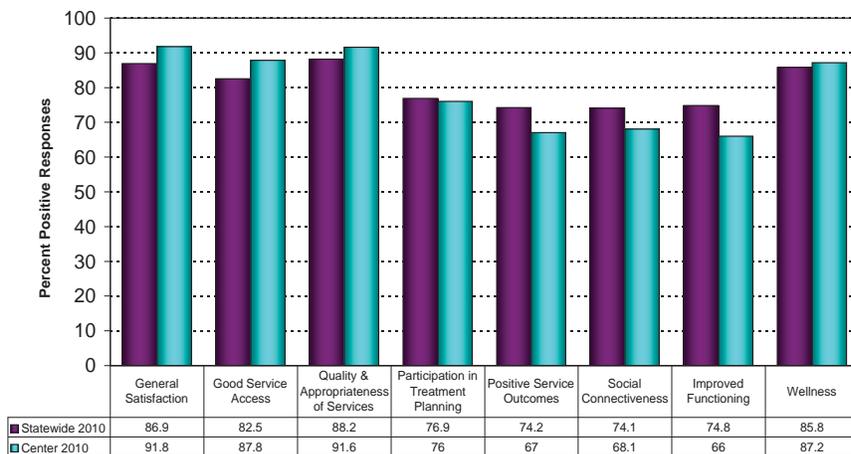


Central Utah Counseling Center—Mental Health (Continued)

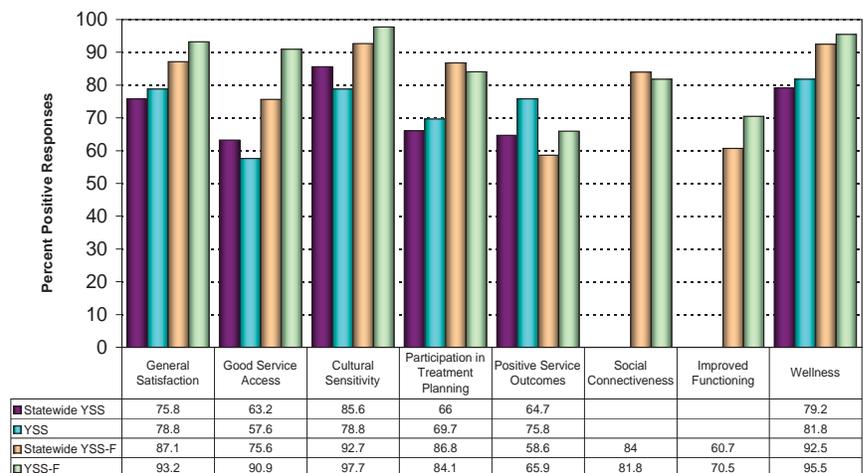
**Expected Payment Source At Admission
Fiscal Year 2010**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010**



Davis Behavioral Health

Davis County



DAVIS BEHAVIORAL HEALTH^{INC}

Population: 300,827

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
www.dbh.utah.org

Davis Substance Abuse—Prevention

Prioritized Risk Factors

- Family conflict
- Poor family management
- Low commitment to school
- Academic failure
- Depressive symptoms

Prioritized Protective Factors

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

2010 Prevention Program Highlights

Communities That Care

Leaders in Bountiful and Layton have joined together in a project called the Communities That Care prevention-planning system. The CTC system helps communities use prevention science research to enhance how communities, schools, families and youth groups operate to prevent youth behavior problems and promote healthy development. It provides a system that helps use money, efforts and energy efficiently and effectively, by using objective data from SHARP and other government resources to determine priorities, by implementation of programs that have been shown to work, and by giving tools to measure and track results. Bountiful and Layton Communities That Care teams are committed to building a safe, nurturing environment for all youth.

Prescription Drug Take Back Event

On Saturday, September 25, 2010, Davis HELPS, a coalition comprised of multiple community agencies, held its first countywide Prescription Drug Take Back event. Davis County residents turned in 654 lbs. of prescription drugs for safe and proper disposal. Davis Behavioral Health has worked with law enforcement agencies to increase the number of permanent prescription drug disposal bins from 3 to 12. Individuals may drop off any unused medication to any law enforcement agency in Davis County.

Davis Behavioral Health—Substance Abuse

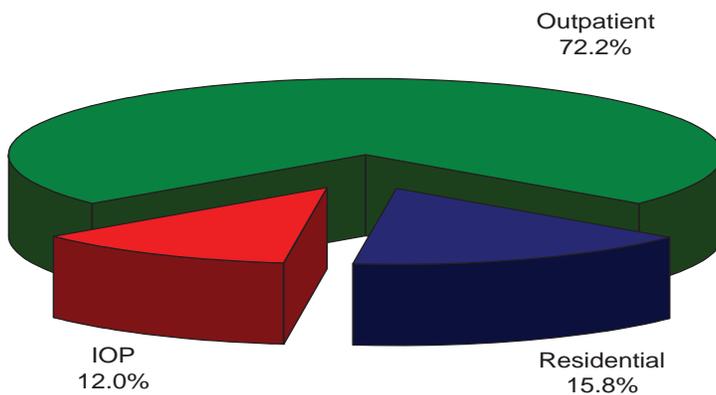
Total Clients Served1,165
 Adult1,032
 Youth133
 Penetration Rate 0.4%

Total Admissions1,221
 Initial Admissions1,028
 Transfers193

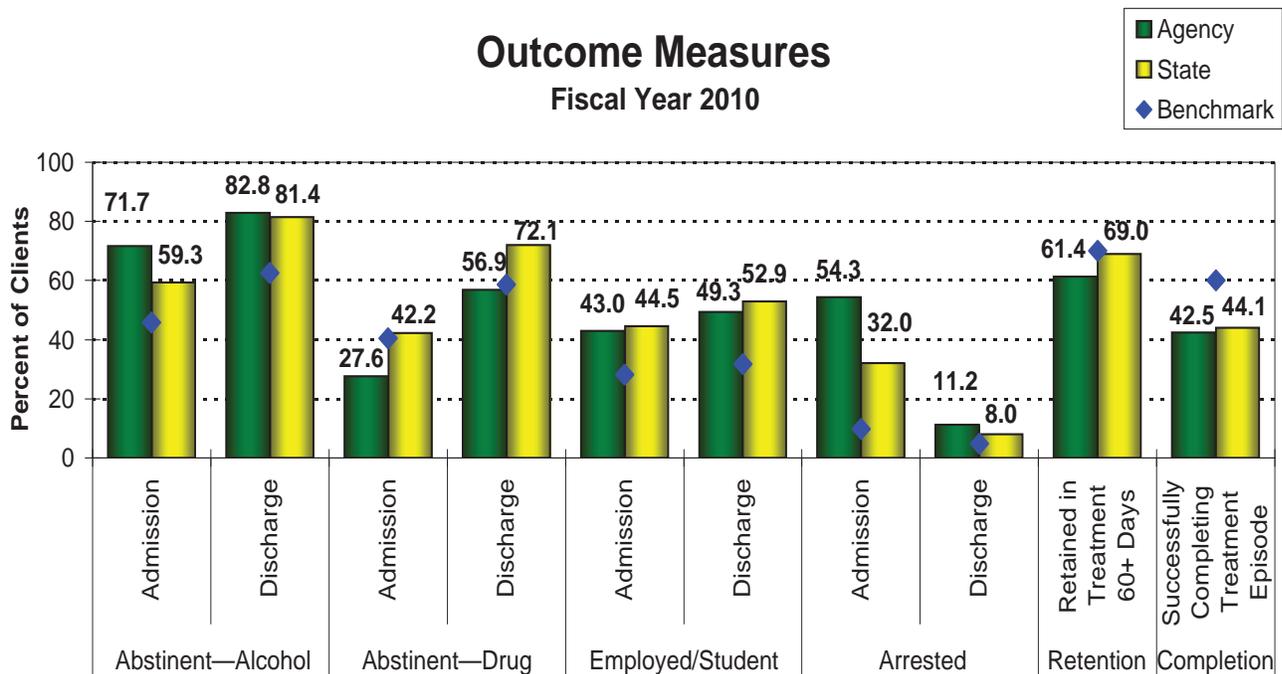
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	191	98	289
Cocaine/Crack	22	13	35
Marijuana/Hashish	210	67	277
Heroin	138	56	194
Other Opiates/Synthetics	21	15	36
Hallucinogens	0	1	1
Methamphetamine	158	127	285
Other Stimulants	4	0	4
Benzodiazepines	1	5	6
Tranquilizers/Sedatives	2	0	2
Inhalants	1	0	1
Oxycodone	50	34	84
Club Drugs	1	0	1
Over-the-Counter	3	1	4
Other	1	1	2
Total	803	418	1221

Admissions into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



Benchmark is 75% of the National Average.

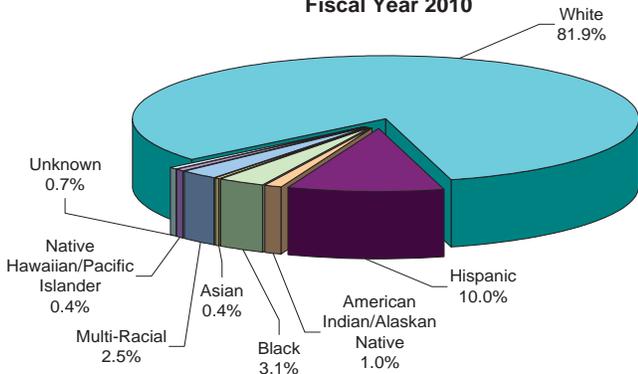
Davis Behavioral Health—Mental Health

Total Clients Served3,254
 Adult2,001
 Youth1,253
 Penetration Rate 1.1%
 Civil Commitment12
 Unfunded Clients Served470

Diagnosis

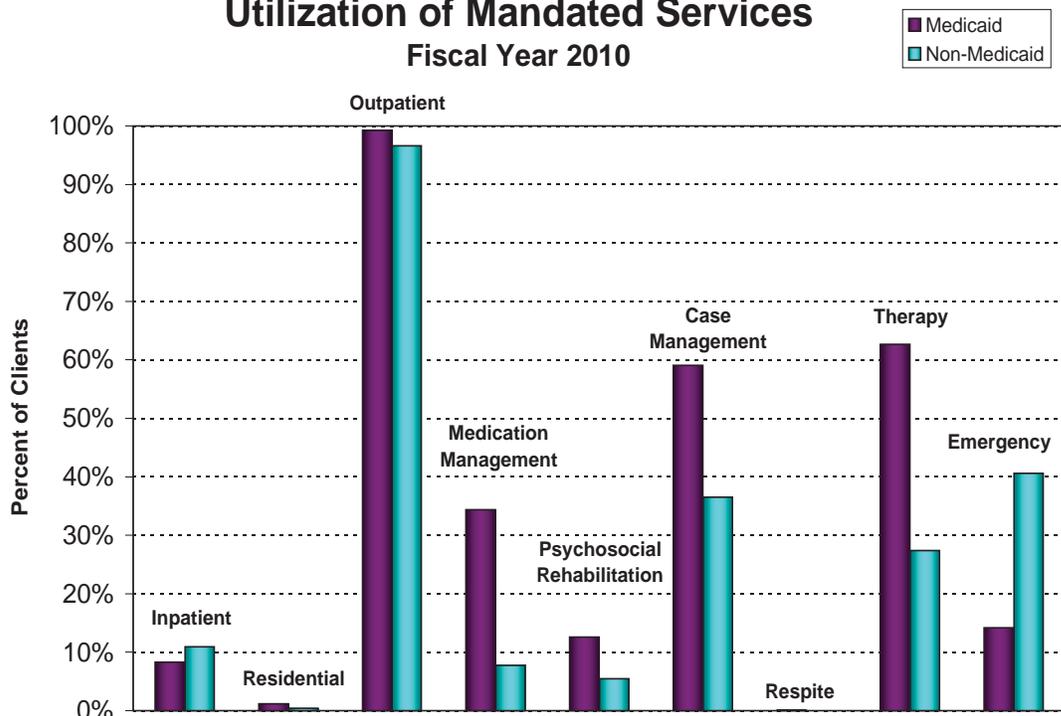
	Youth	Adult
Adjustment Disorder	160	103
Anxiety	541	1,252
Attention Deficit	552	200
Cognitive Disorder	21	76
Conduct Disorder	37	5
Impulse Control Disorders	231	31
Mood Disorder	531	1,504
Neglect or Abuse	445	37
Oppositional Defiant Disorder	215	8
Other	215	106
Personality Disorder	5	261
Pervasive Developmental Disorders	133	41
Schizophrenia and Other Psychotic	3	357
Substance Abuse	54	445
V Codes	195	68
Total	3,143	4,426

Race/Ethnicity Fiscal Year 2010



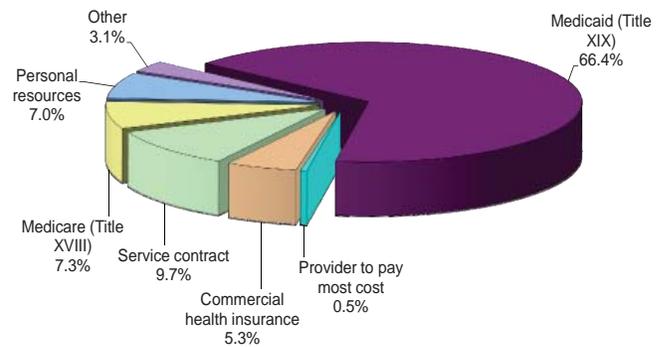
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

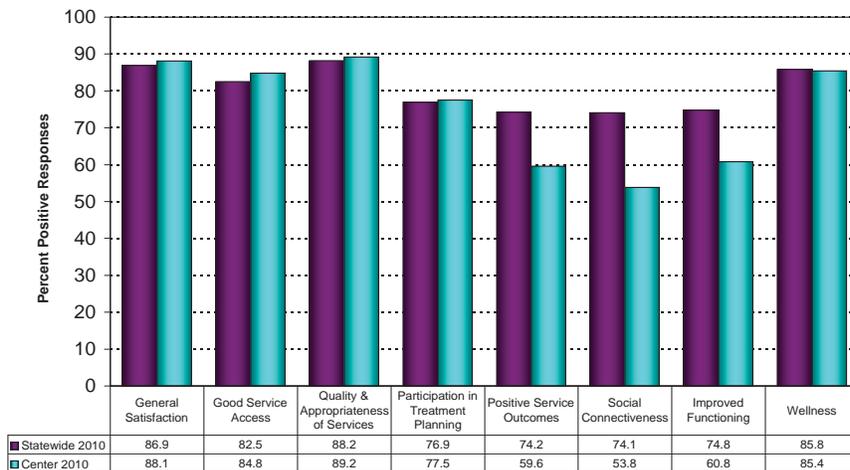


Davis Behavioral Health—Mental Health (Continued)

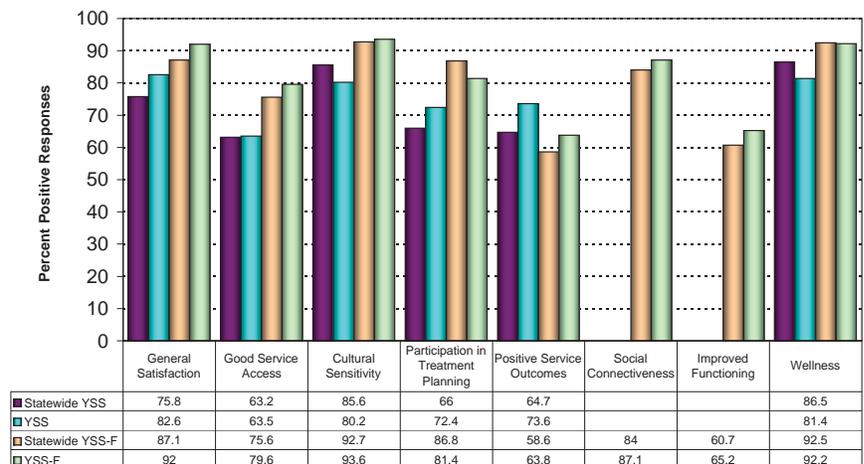
**Expected Payment Source At Admission
Fiscal Year 2010**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010**



Four Corners

Carbon, Emery & Grand Counties



Population: 40,278

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
www.fourcorners.ws

Four Corners Substance Abuse—Prevention

Prioritized Risk Factors

- Low commitment to school
- Expressed intention to use drugs
- Laws and norms perceived as favorable to drug use

Prioritized Protective Factors

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

2010 Prevention Program Highlights

Carbon County Life Skills Training (Botvin)

Reduce intention to use drugs and increase commitment to school.

Carbon, Grand Emery County Parents Empowered

Increase youth perception of laws and norms as unfavorable to drug use. Increase rewards for pro-social involvement.

Emery County Governing Youth Council

Reduce youth misperception towards ATOD. Increase commitment to school and provide opportunities for pro-social involvement.

Carbon, Grand, Emery Counties Community Planning

Increase number of and public awareness of laws and norms unfavorable to drug use.

Grand County Life Skills Training (Botvin)

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.

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.

PRIME for Life

In FCCBH district PRIME for Life is offered as prevention programming in all three counties.

Four Corners Community Behavioral Health—Substance Abuse

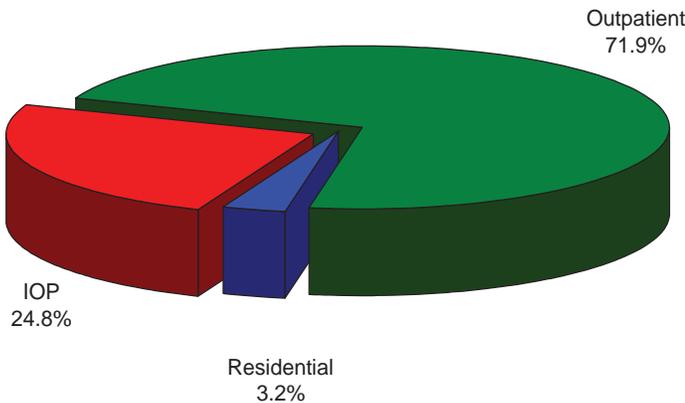
Total Clients Served.....654
 Adult588
 Youth.....66
 Penetration Rate..... 1.6%

Total Admissions.....588
 Initial Admissions432
 Transfers.....156

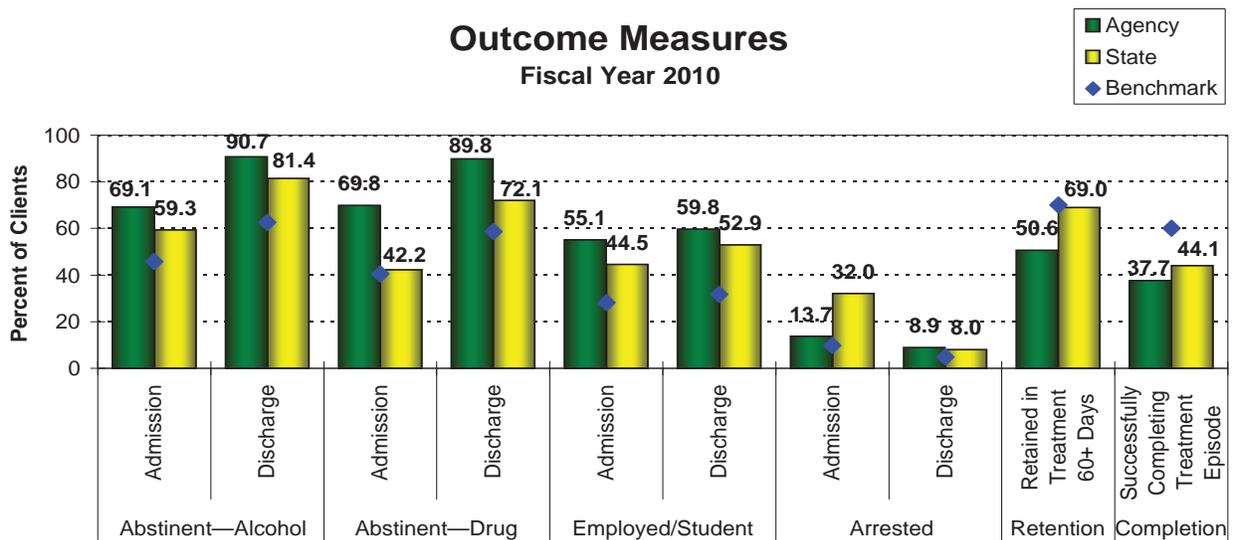
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	182	94	276
Cocaine/Crack	3	4	7
Marijuana/Hashish	93	28	121
Heroin	6	7	13
Other Opiates/Synthetics	28	21	49
Hallucinogens	1	0	1
Methamphetamine	36	56	92
Other Stimulants	0	3	3
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	1	1
Inhalants	0	1	1
Oxycodone	6	15	21
Club Drugs	2	0	2
Over-the-Counter	0	0	0
Other	1	0	1
Total	358	230	588

Admissions into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



Benchmark is 75% of the National Average.

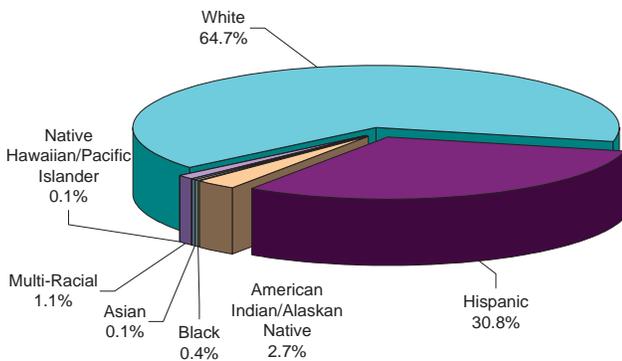
Four Corners Community Behavioral Health—Mental Health

Total Clients Served.....1,881
 Adult1,328
 Youth.....553
 Penetration Rate4.7%
 Civil Commitment0
 Unfunded Clients Served113

Diagnosis

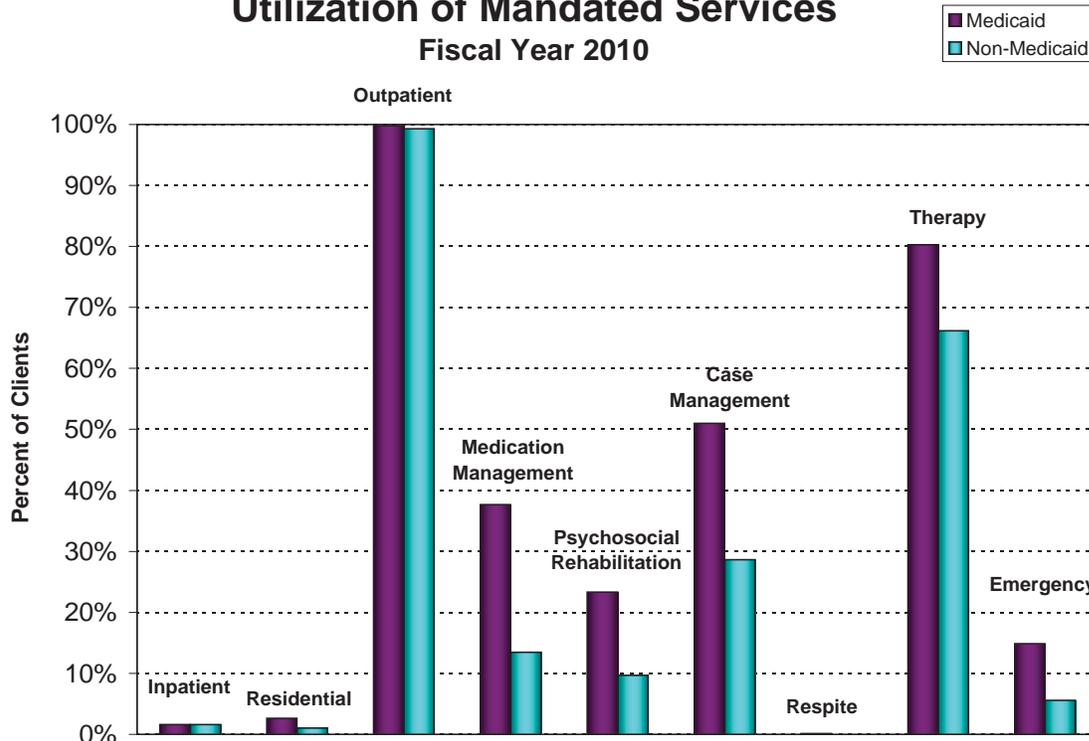
	Youth	Adult
Adjustment Disorder	134	66
Anxiety	152	563
Attention Deficit	204	65
Cognitive Disorder	12	51
Conduct Disorder	12	-
Impulse Control Disorders	42	27
Mood Disorder	232	884
Neglect or Abuse	74	8
Oppositional Defiant Disorder	100	10
Other	96	37
Personality Disorder	3	263
Pervasive Developmental Disorders	24	16
Schizophrenia and Other Psychotic	1	124
Substance Abuse	128	1,158
V Codes	176	101
Total	1,214	3,272

Race/Ethnicity Fiscal Year 2010



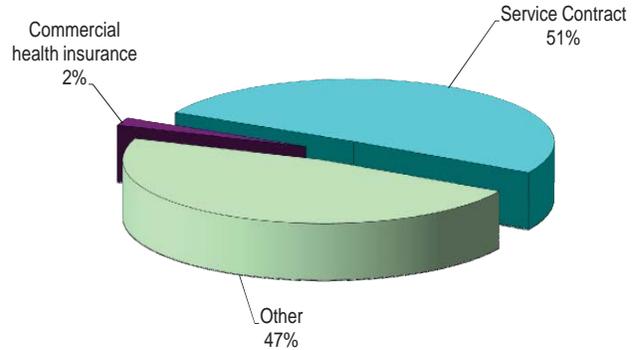
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

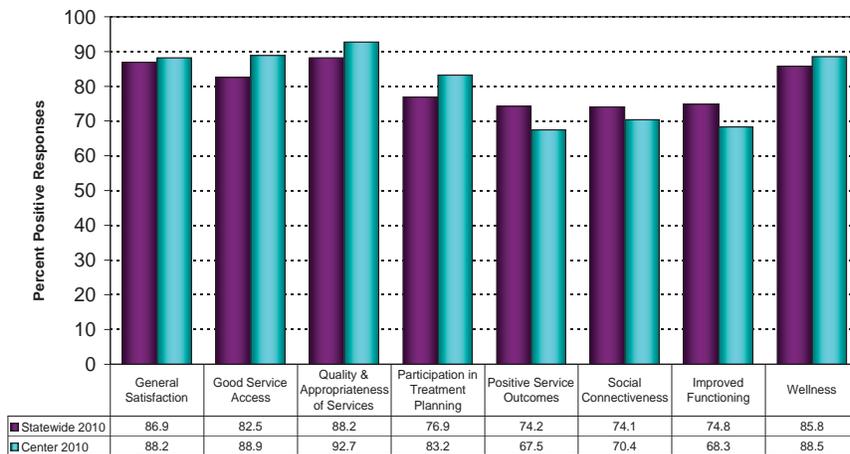


Four Corners Community Behavioral Health—Mental Health (Continued)

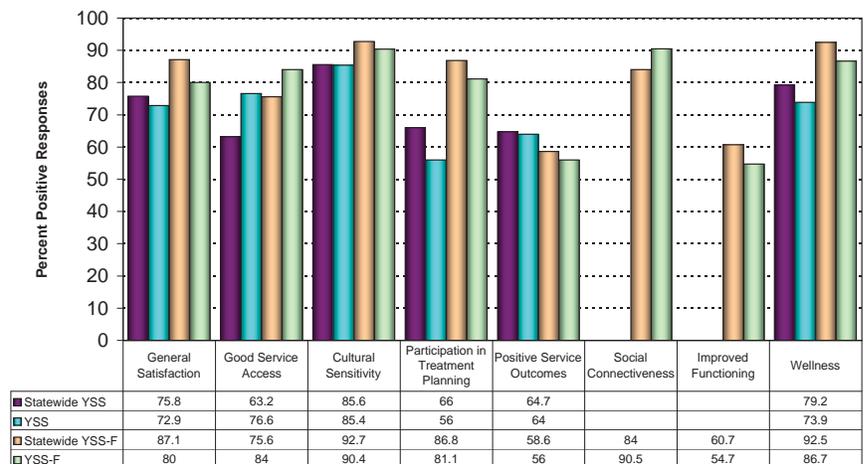
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



Northeastern Counseling Center Daggett, Duchesne, & Uintah Counties



Population: 50,425

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

Northeastern Substance Abuse—Prevention

Prioritized Risk Factors

- Availability
- Attitudes favorable to problem behavior
- Parental attitudes

Prioritized Protective Factors

- Opportunities for pro-social involvement
- Recognition for involvement
- Bonding

2010 Prevention Program Highlights

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.

PREVENTION ADVISORY COALITION was established to assess community needs and resources, utilize services offered and avoid duplication of local services available.

COMMITTED TO INCREASED AWARENESS

- ***Meth in the Industry*** explains the addiction cycle and the attractiveness of meth to the oil industry.
- ***Methamphetamines in the Community*** tells how 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.
- ***Huffing***—become familiar with signs to look for and the ways to address. Presentation is given to adults only.

Northeastern Counseling Center—Substance Abuse

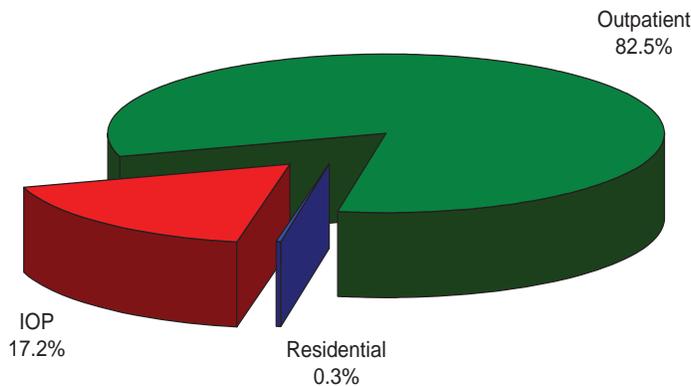
Total Clients Served.....610
 Adult565
 Youth.....45
 Penetration Rate 1.2%

Total Admissions.....355
 Initial Admissions141
 Transfers.....214

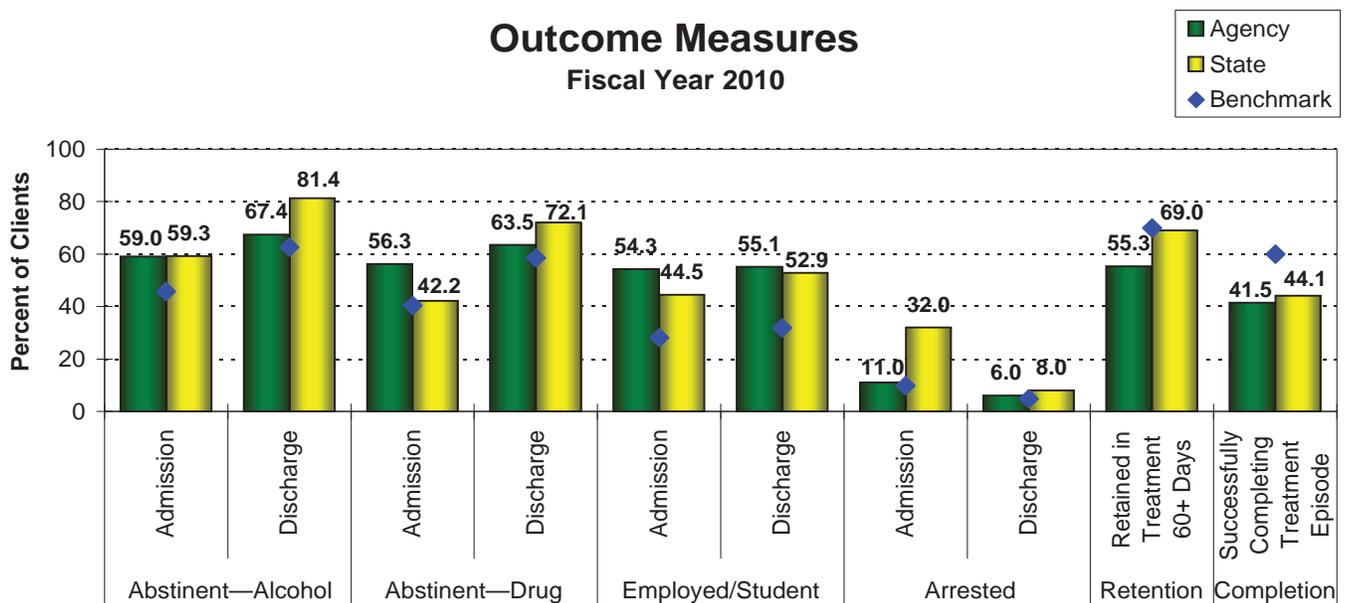
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	98	46	144
Cocaine/Crack	2	0	2
Marijuana/Hashish	46	30	76
Heroin	10	7	17
Other Opiates/Synthetics	9	11	20
Hallucinogens	0	0	0
Methamphetamine	30	36	66
Other Stimulants	0	1	1
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	1	1
Oxycodone	17	10	27
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	0	1
Total	213	142	355

Admission into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



Benchmark is 75% of the National Average.

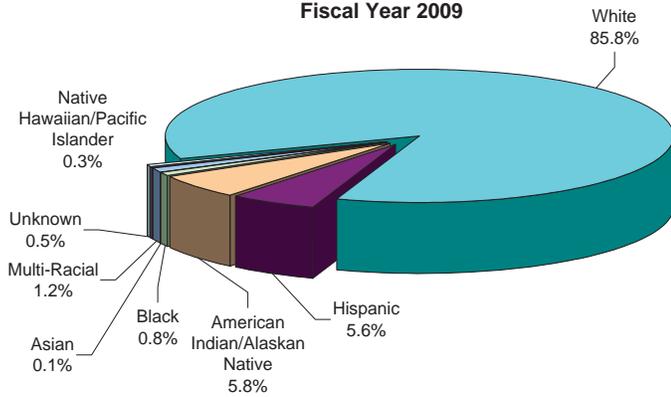
Northeastern Counseling Center—Mental Health

Total Clients Served1,302
 Adult860
 Youth442
 Penetration Rate 2.6%
 Civil Commitment 11
 Unfunded Clients Served423

Diagnosis

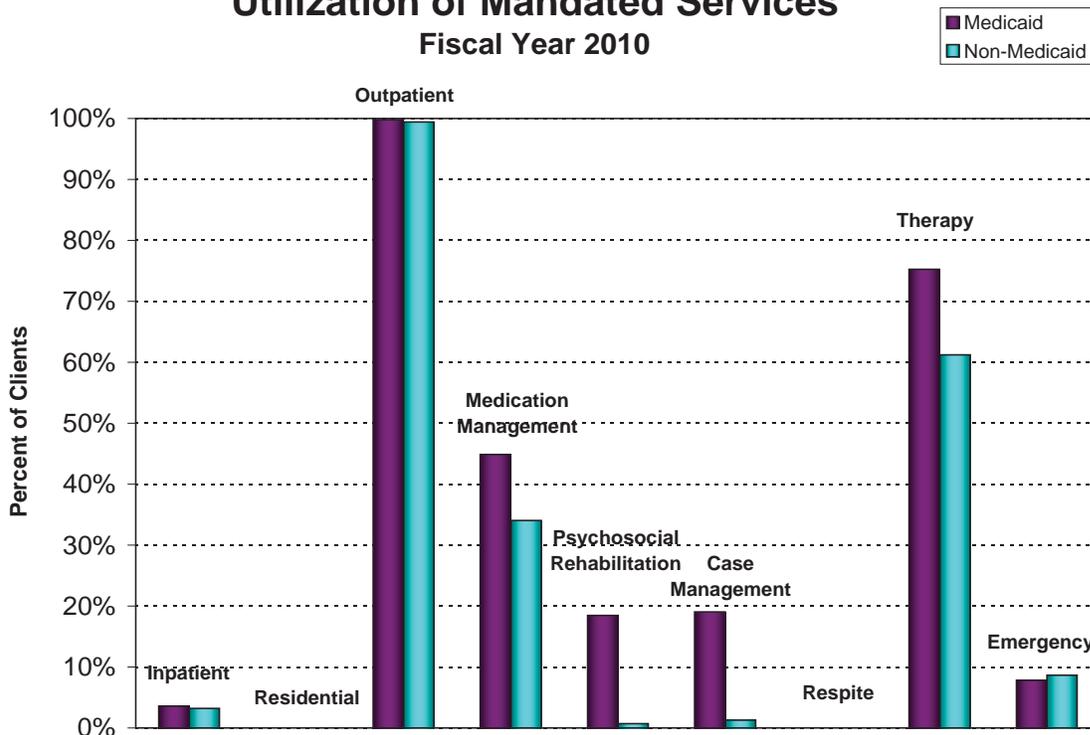
	Youth	Adult
Adjustment Disorder	77	98
Anxiety	118	515
Attention Deficit	121	77
Cognitive Disorder	9	54
Conduct Disorder	11	-
Impulse Control Disorders	45	46
Mood Disorder	127	556
Neglect or Abuse	108	52
Oppositional Defiant Disorder	44	4
Other	48	55
Personality Disorder	2	116
Pervasive Developmental Disorders	27	9
Schizophrenia and Other Psychotic	6	91
Substance Abuse	25	87
V Codes	57	137
Total	768	1,760

Race/Ethnicity Fiscal Year 2009



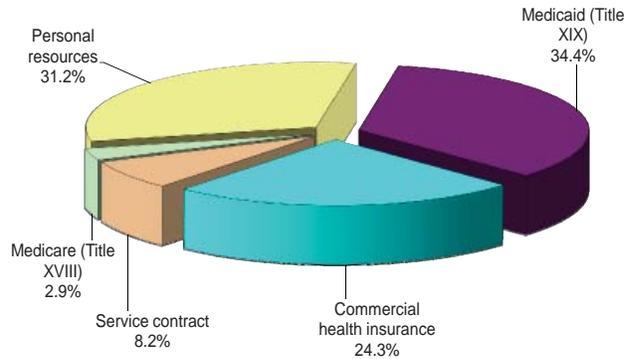
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

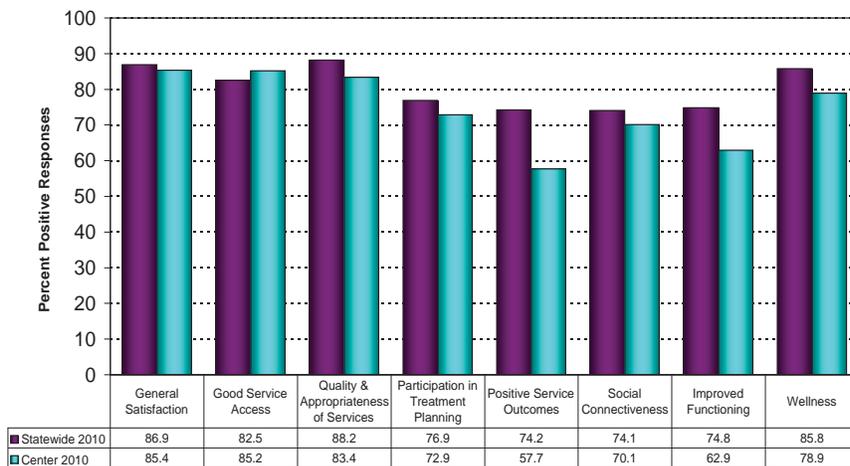


Northeastern Counseling Center—Mental Health (Continued)

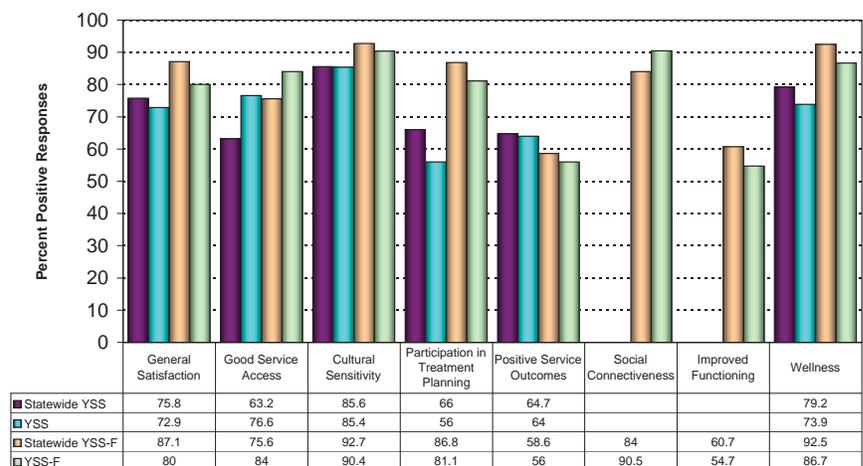
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



Salt Lake County



Population: 1,034,989

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
<http://www.slco.org/bydepartments/hs/behaviorH>

Salt Lake County Substance Abuse—Prevention

Prioritized Risk Factors

- Early initiation of use
- Attitudes favorable to problem behavior
- Family management

Prioritized Protective Factors

- Opportunities for pro-social involvement
- Recognition for involvement
- Bonding

2010 Prevention Program Highlights

Examples of Successful Prevention Services in SLCo

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% 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.

Examples of Funded Programs Addressing Salt Lake County’s Prioritized Factors

Asian Association of Utah

- Dare to Be You
- Family Crisis
- Academic Tutoring
- Social Skills

Centro de la Familia

- Nuevo Dia
- Parents as Teachers

SLCo Housing

- Parents as Teachers
- Too Good for Drugs
- Leadership/Resiliency

Project Reality

- Parents Empowering Communities

SPY HOP

- Vocational training
- Mentoring

SLCo Youth Services

- Staying Connected with Your Teen
- Get Real about Violence
- Family Connections

Salt Lake County Division of Substance Abuse

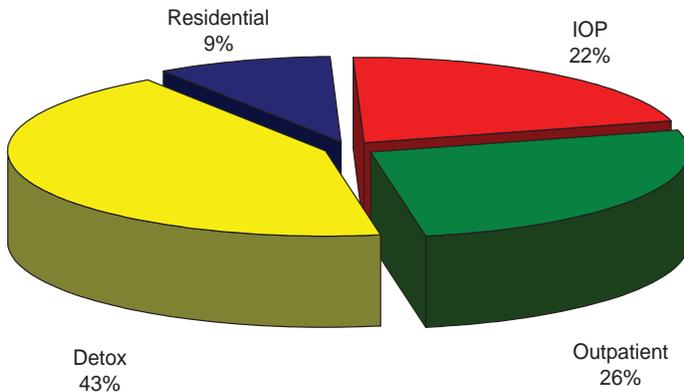
Total Clients Served.....7,029
 Adult6,364
 Youth.....665
 Penetration Rate..... 0.7%

Total Admissions.....10,394
 Initial Admissions9,042
 Transfers.....1,352

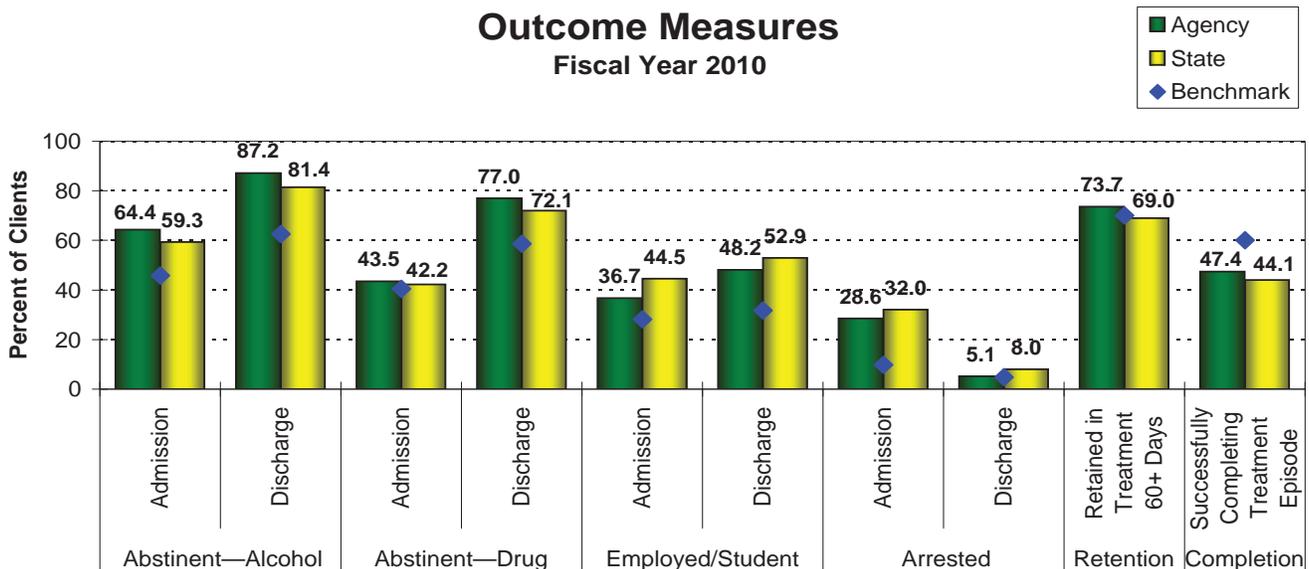
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	3,545	756	4,301
Cocaine/Crack	555	225	780
Marijuana/Hashish	1,051	329	1,380
Heroin	1,192	479	1,671
Other Opiates/Synthetics	149	153	302
Hallucinogens	8	1	9
Methamphetamine	927	670	1,597
Other Stimulants	23	17	40
Benzodiazepines	22	28	50
Tranquilizers/Sedatives	4	11	15
Inhalants	4	1	5
Oxycodone	111	103	214
Club Drugs	10	4	14
Over-the-Counter	8	3	11
Other	3	2	5
Total	7,612	2,782	10,394

Admissions into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



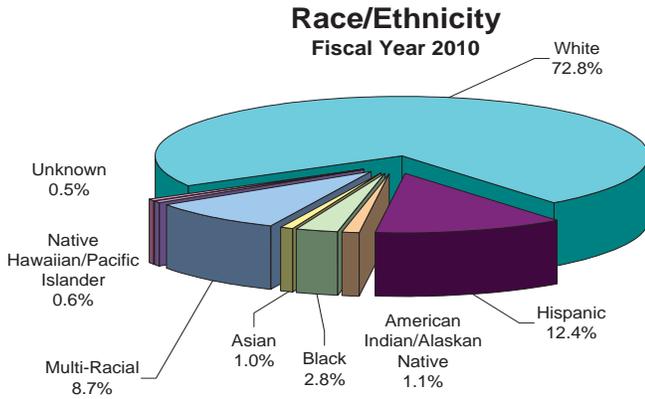
Benchmark is 75% of the National Average.

Salt Lake County—Valley Mental Health

Total Clients Served.....15,281
 Adult10,927
 Youth.....4,354
 Penetration Rate 1.5%
 Civil Commitment748
 Unfunded Clients Served1,876

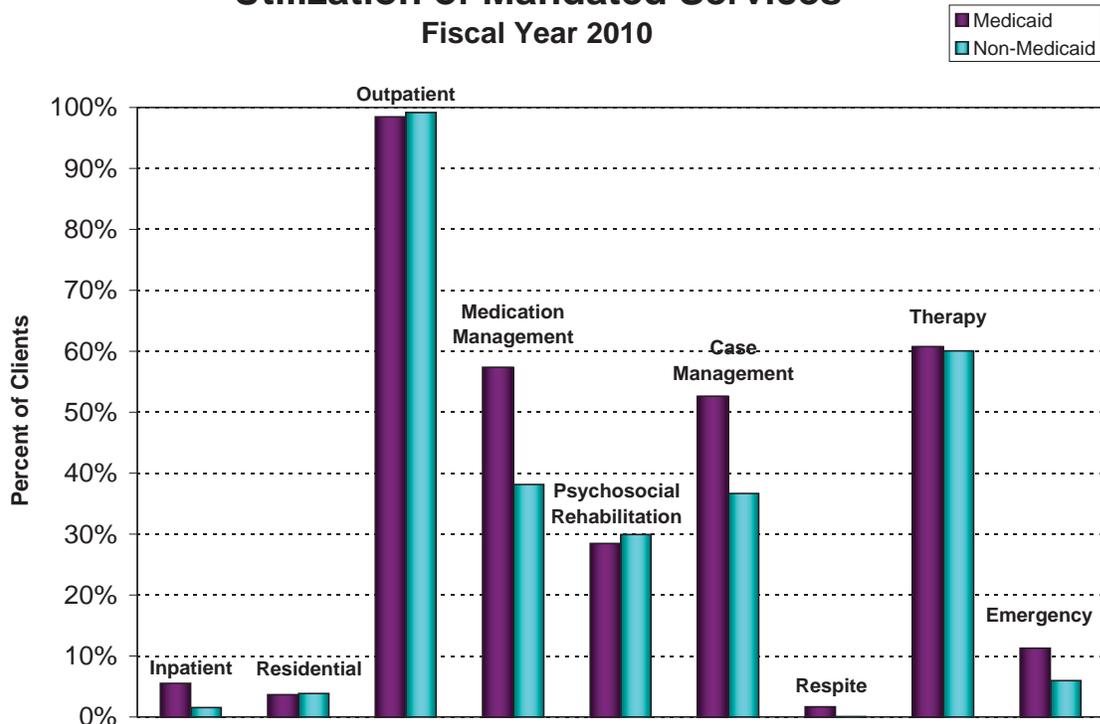
Diagnosis

	Youth	Adult
Adjustment Disorder	572	378
Anxiety	1,893	4,761
Attention Deficit	1,614	739
Cognitive Disorder	139	634
Conduct Disorder	177	11
Impulse Control Disorders	387	176
Mood Disorder	1,537	6,932
Neglect or Abuse	741	50
Oppositional Defiant Disorder	1,112	29
Other	463	371
Personality Disorder	25	3,224
Pervasive Developmental Disorders	552	164
Schizophrenia and Other Psychotic	10	2,089
Substance Abuse	422	5,052
V Codes	736	2,078
Total	9,644	24,610



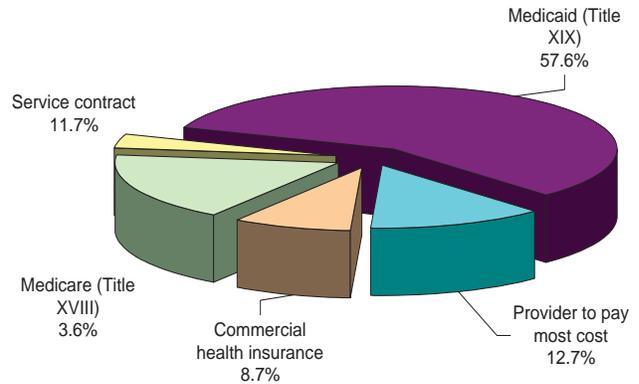
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

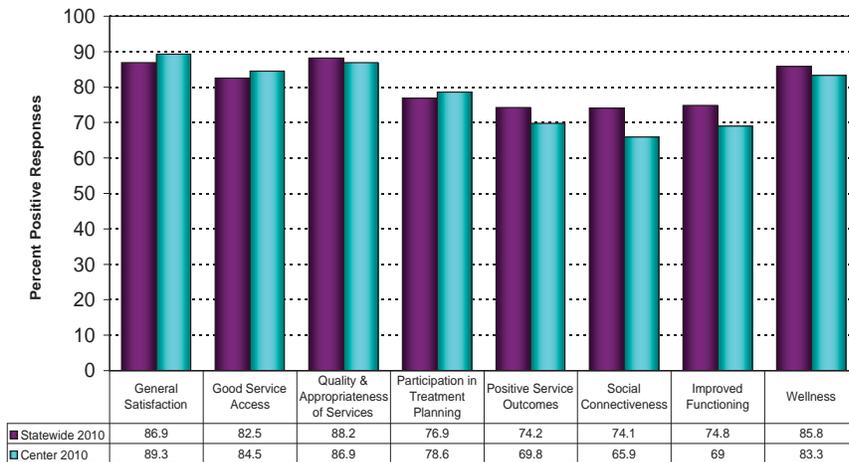


Salt Lake County—Valley Mental Health (Continued)

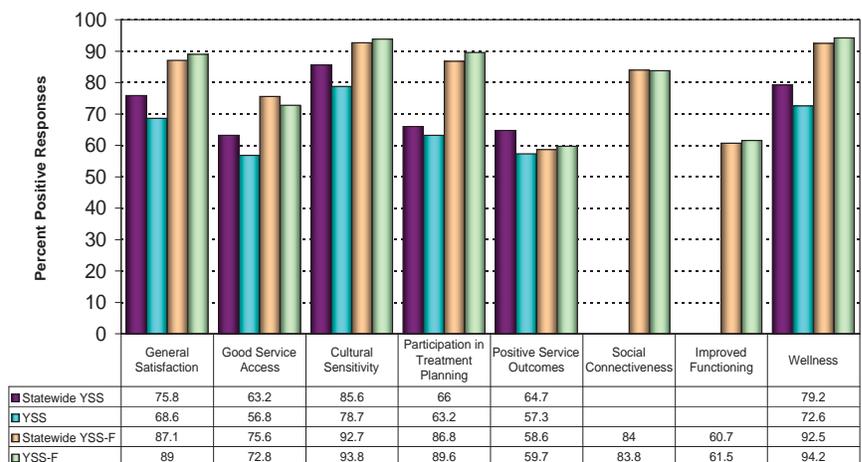
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



San Juan County



Population: 15,049

Substance Abuse and Mental Health Provider Agency:

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

San Juan Substance Abuse—Prevention

Prioritized Risk Factors

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

Prioritized Protective Factors

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

2010 Prevention Program Highlights

PREVENTION EFFORTS IN SAN JUAN COUNTY

- A strong prevention coalition up and running in Blanding with plans for expansion onto the reservation within the next year.
- An effective and efficient Systems of Care committee also in Blanding with plans for expansion in other towns.
- Collaboration with the school district and the PTA to do Prevention Dimensions and other prevention strategies.
- Collaboration with other grants to educate the community on risk issues
- Town Hall meetings
- Various surveys
- Prevention workshops, fairs, etc. to educate parents on Back to School Night.

San Juan Counseling—Substance Abuse

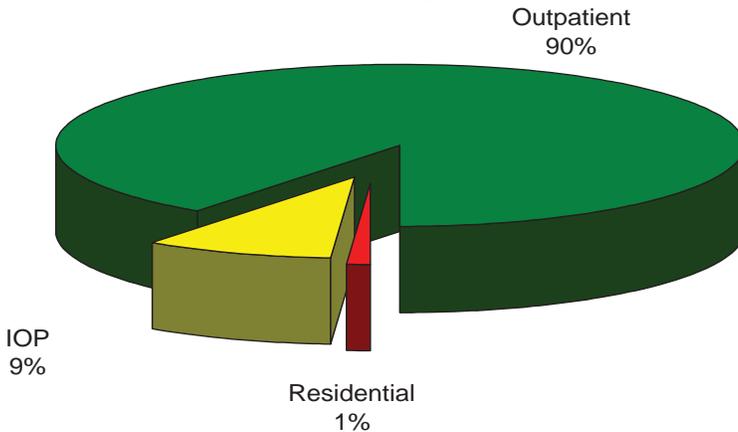
Total Clients Served113
 Adult90
 Youth23
 Penetration Rate 0.8%

Total Admissions81
 Initial Admissions78
 Transfers3

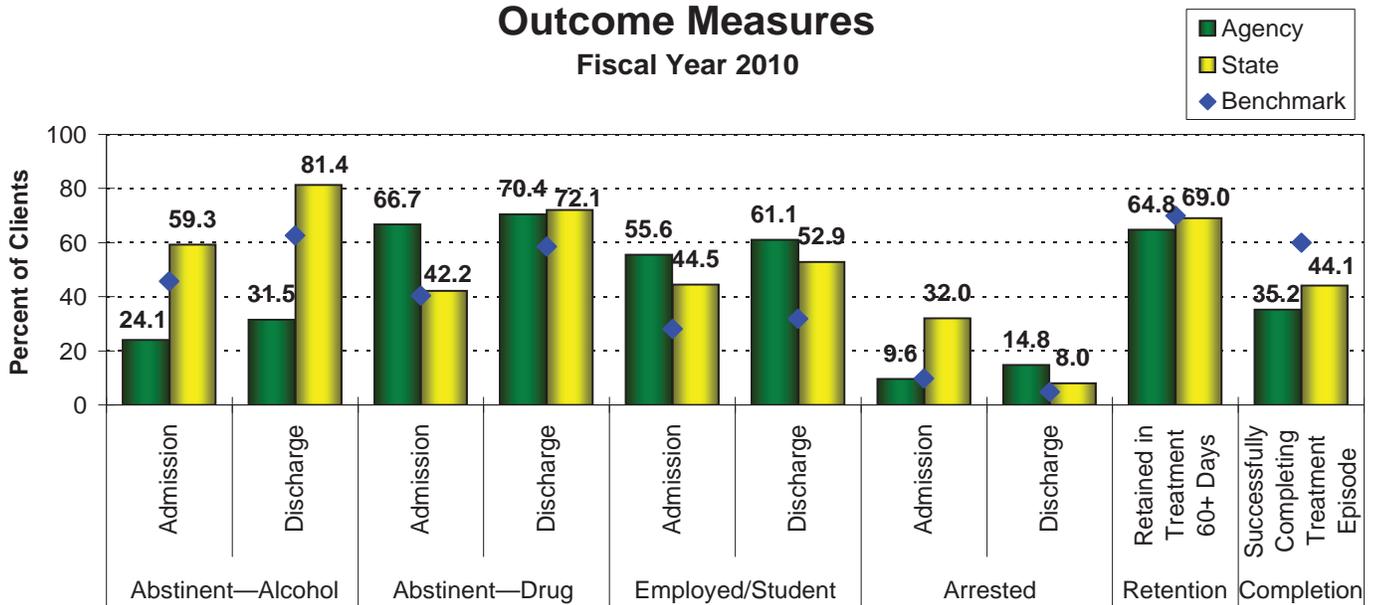
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	33	17	50
Cocaine/Crack	0	0	0
Marijuana/Hashish	19	3	22
Heroin	1	1	2
Other Opiates/Synthetics	1	0	1
Hallucinogens	0	0	0
Methamphetamine	3	1	4
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	0	1	1
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	1	1
Total	57	24	81

**Admissions into Modalities
Fiscal Year 2010**



**Outcome Measures
Fiscal Year 2010**



Benchmark is 75% of the National Average.

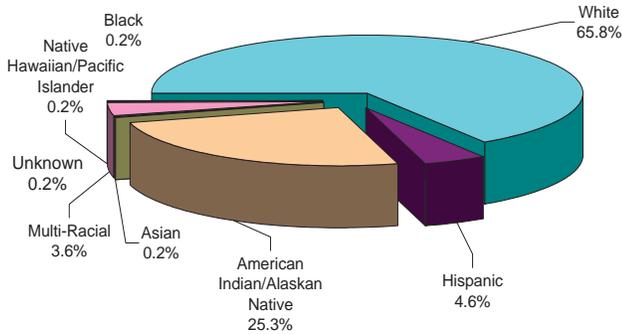
San Juan Counseling—Mental Health

Total Clients Served536
 Adult366
 Youth170
 Penetration Rate 3.6%
 Civil Commitment0
 Unfunded Clients Served143

Diagnosis

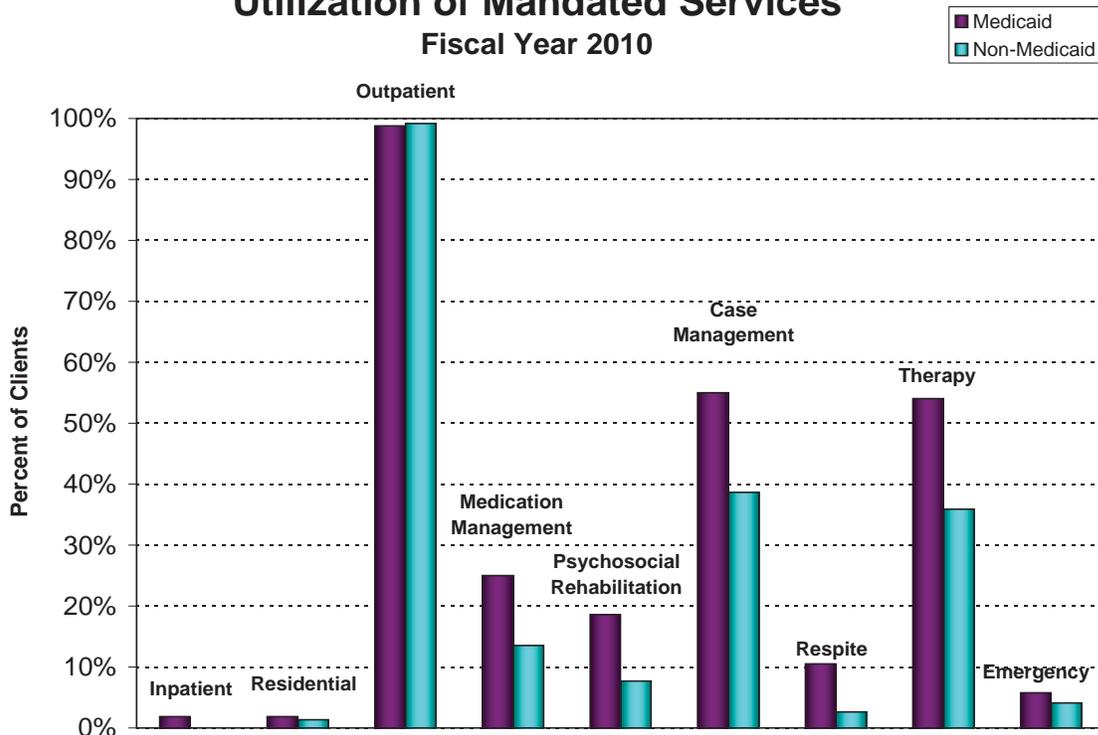
	Youth	Adult
Adjustment Disorder	37	19
Anxiety	33	76
Attention Deficit	51	13
Cognitive Disorder	2	29
Conduct Disorder	-	-
Impulse Control Disorders	8	6
Mood Disorder	45	208
Neglect or Abuse	5	6
Oppositional Defiant Disorder	1	-
Other	5	10
Personality Disorder	-	21
Pervasive Developmental Disorders	5	5
Schizophrenia and Other Psychotic	-	19
Substance Abuse	-	19
V Codes	14	21
Total	192	431

Race/Ethnicity Fiscal Year 2010



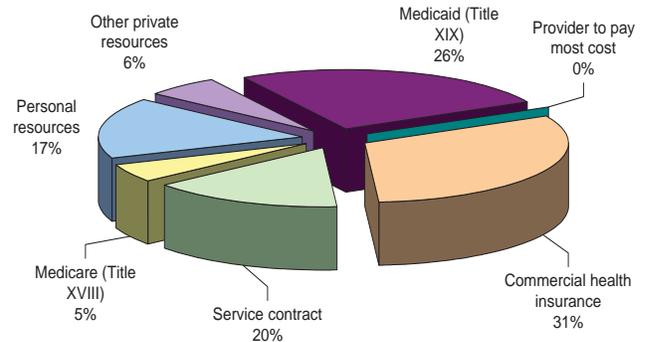
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

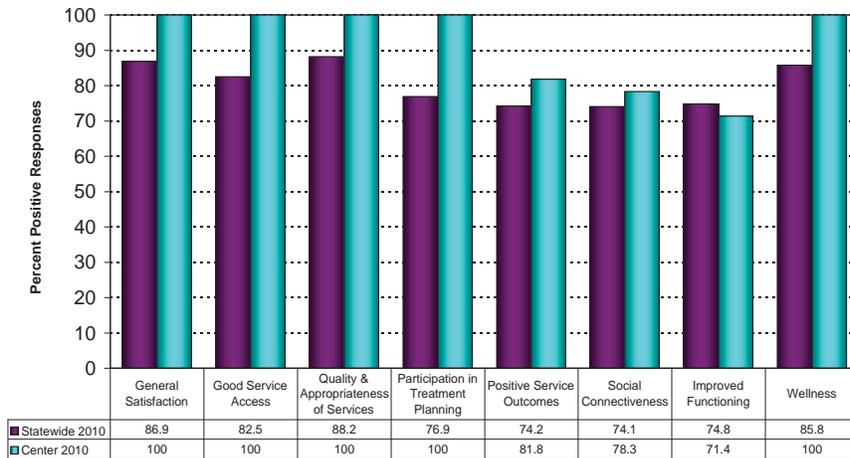


San Juan Counseling—Mental Health (Continued)

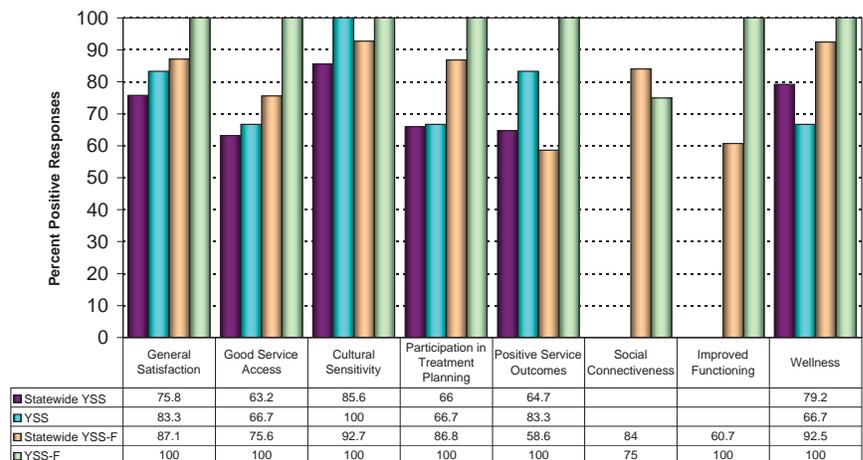
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



Southwest Behavioral Health Center

Beaver, Garfield, Iron, Kane, and Washington Counties



Population: 200,246

Substance Abuse and Mental Health Provider Agency:

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

Southwest Substance Abuse—Prevention

Prioritized Risk Factors

- Low neighborhood attachment
- Low commitment to school
- Poor family management
- Family conflict

Prioritized Protective Factors

- Peer and school rewards and opportunities for pro-social involvement
- Community, family and peer rewards for pro-social involvement

2010 Prevention Program Highlights

Research-Based Prevention

At Southwest Prevention, all of our services are guided by current and valid research. We collect data on all of the programs and services we provide, as well as current trends and risk and protective factors in the community. This allows us to assess our strategies and improve or change them if necessary.

Highlights from Southwest's Student Assistance Program—Personal Empowerment Program (PEP)

- 22% reported a more positive attitude towards school, teachers and education.
- Over 30% of students report more confidence in effectively dealing with peer pressure, making friends and changing their self image.
- Over 20% of students acknowledge more risk with anti-social behaviors (i.e., smoking, drinking alcohol, riding in a car with a drunk driver, using Rx meds to get high, etc.)
- Nearly 65% of students increased their GPA after one year in PEP.

Washington County Prevention Coalition

A primary focus at Southwest Prevention is the establishment, maintenance and capacity building of community coalitions. One of the most effective ways to create a population-level change on a community level is to involve key leaders, agencies and community members in a collaborative effort to reduce substance abuse. Therefore, over the past two years three community coalitions have been established and strengthened in an ongoing effort to create safer, healthier communities.

Southwest Prevention provides over 20 programs targeting our prioritized factors, including:

- Media campaigns
- Community outreach, technical support and collaboration with dozens of community service councils, committees and organizations
- School assistance programs, and much more

Southwest Behavioral Health Center—Substance Abuse

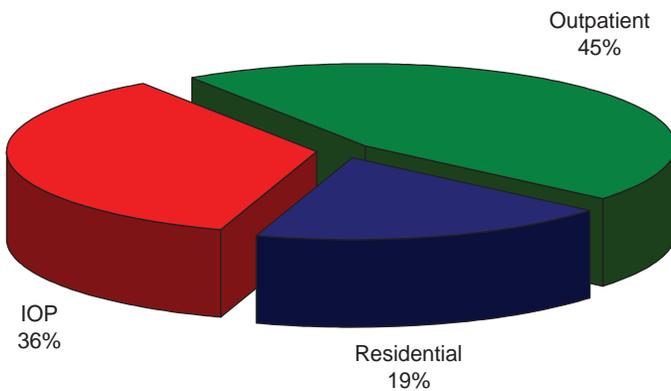
Total Clients Served.....636
 Adult551
 Youth.....85
 Penetration Rate 0.3%

Total Admissions.....640
 Initial Admissions348
 Transfers.....292

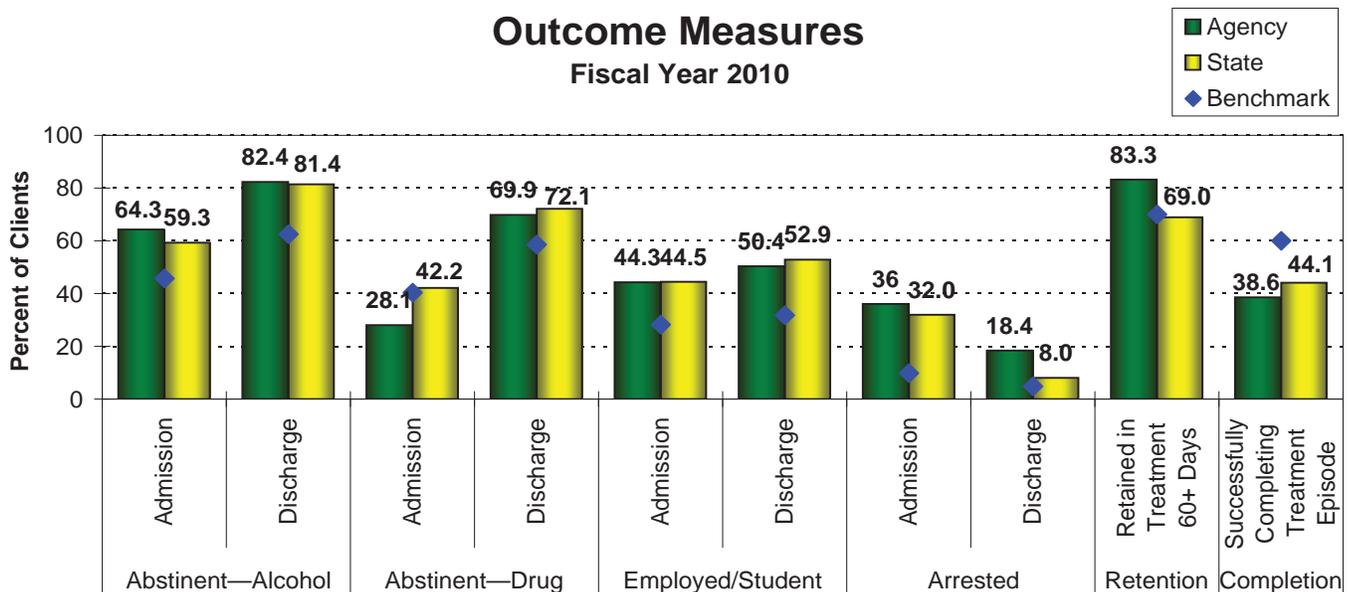
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	107	70	177
Cocaine/Crack	1	1	2
Marijuana/Hashish	94	28	122
Heroin	65	21	86
Other Opiates/Synthetics	3	6	9
Hallucinogens	0	1	1
Methamphetamine	63	96	159
Other Stimulants	2	1	3
Benzodiazepines	5	4	9
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	39	30	69
Club Drugs	0	0	0
Over-the-Counter	0	2	2
Other	0	0	0
Total	379	261	640

Admissions into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



Benchmark is 75% of the National Average.

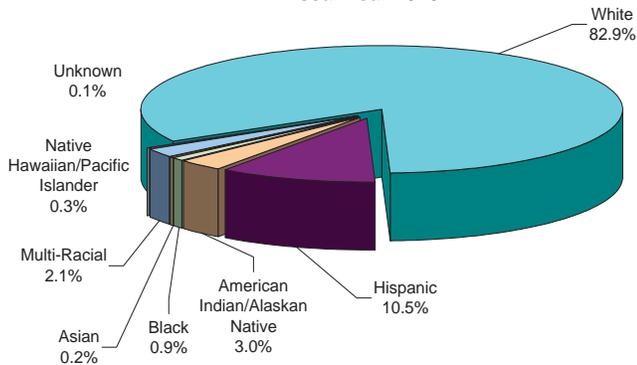
Southwest Behavioral Health Center—Mental Health

Total Clients Served.....2,556
 Adult1,258
 Youth.....1,298
 Penetration Rate 1.3%
 Civil Commitment41
 Unfunded Clients Served590

Diagnosis

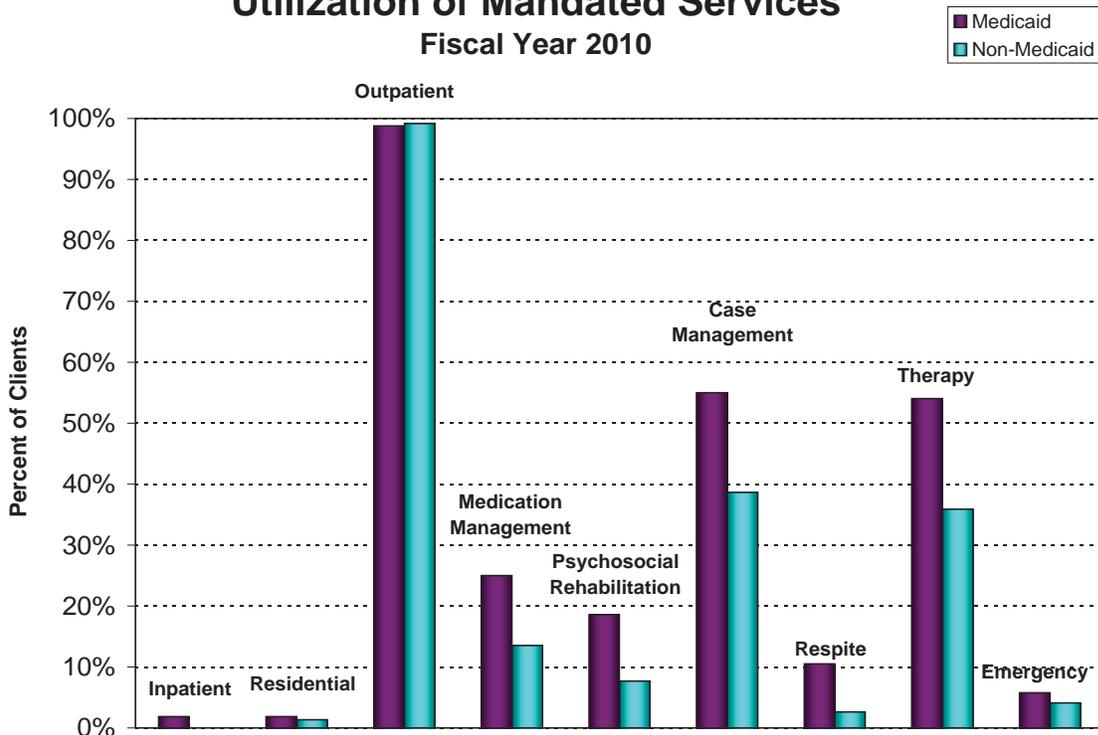
	Youth	Adult
Adjustment Disorder	344	153
Anxiety	203	255
Attention Deficit	120	16
Cognitive Disorder	15	62
Conduct Disorder	16	2
Impulse Control Disorders	159	14
Mood Disorder	225	673
Neglect or Abuse	154	28
Oppositional Defiant Disorder	81	3
Other	28	25
Personality Disorder	8	283
Pervasive Developmental Disorders	40	18
Schizophrenia and Other Psychotic	2	190
Substance Abuse	14	76
V Codes	128	82
Total	1,409	1,798

Race/Ethnicity Fiscal Year 2010



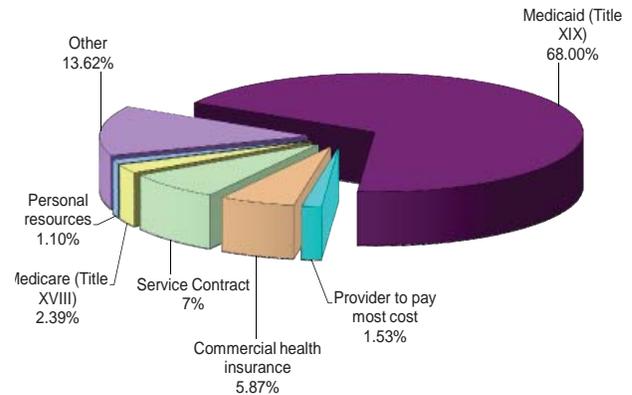
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

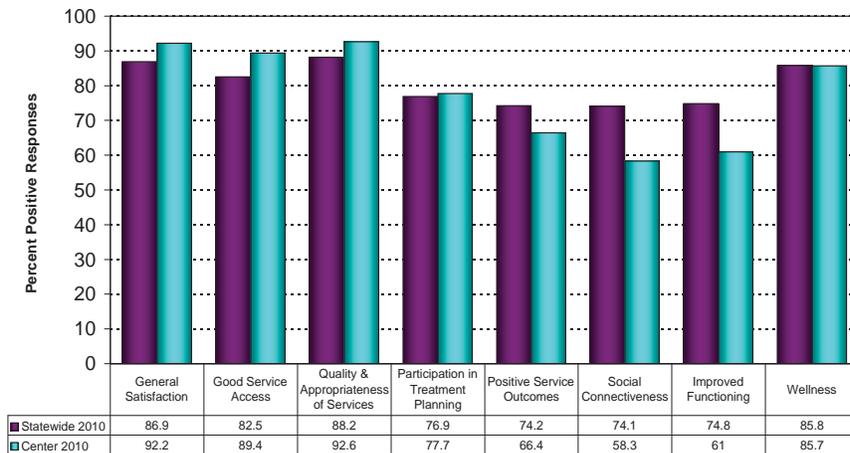


Southwest Behavioral Health Center—Mental Health (Continued)

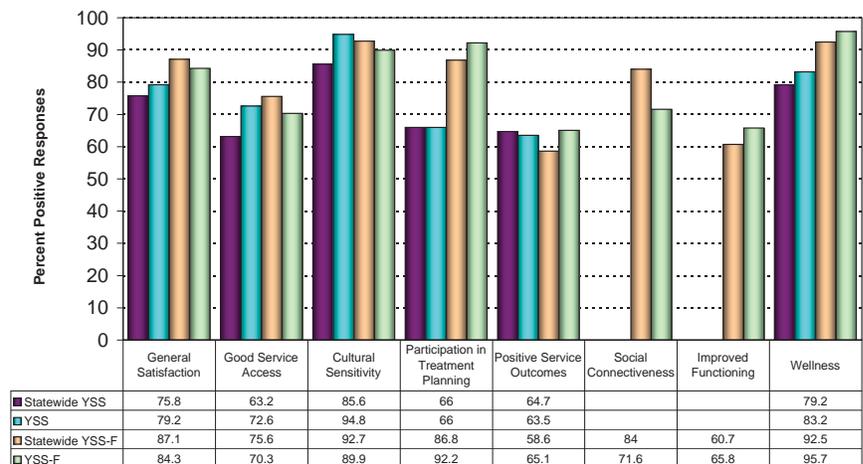
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



Summit County

Park City, South Summit, North Summit



Substance Abuse and Mental Health Provider Agency:

Debra Falvo, President/Executive Director
Thomas Roger Peay, County Program Manager
Valley Mental Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157
www.valleymentalhealth.org/summit_county

Population: 36,969

Summit Substance Abuse—Prevention

Prioritized Risk Factors

- Rewards for anti-social behavior
- Attitudes favorable to drug use
- Favorable parental attitudes towards drug use

Prioritized Protective Factors

- Opportunities for pro-social involvement
- Pro-social involvement
- Family attachment

2010 Prevention Program Highlights

Peer Leaders—South and North Summit High Schools

Peer Leaders are a group of high school students who have been selected by their peers as people that they are comfortable confiding in. The Prevention Team, along with the Health Department, provide monthly topics about current teen issues, including mental health and substance abuse issues. The Peer Leaders raise awareness in the elementary schools during Red Ribbon Week by providing anti-drug and alcohol messages.

Women's Jail Group

Twice a week the women inmates of the Summit County Jail meet as a group and discuss life skills, education, prevention, recovery, etc. During class time they are allowed to crochet hats, blankets, scarves, etc., for the Peace House and the Children's Justice Center.

Prevention Programs in Summit County

- PRIME for Life—English and Spanish
- Parenting Classes—English and Spanish
- Peer Leaders—South/North Summit High Schools
- Life Skills jail group
- Recovery jail group
- Friendship groups
- Independent living group
- Girls group
- Latina girls groups
- Prevention Dimensions training and support
- Parents Empowered promotions and events
- Town Hall meetings
- Prevention Awareness Coalition
- Summer teen group

Summit County - Valley Mental Health - Substance Abuse

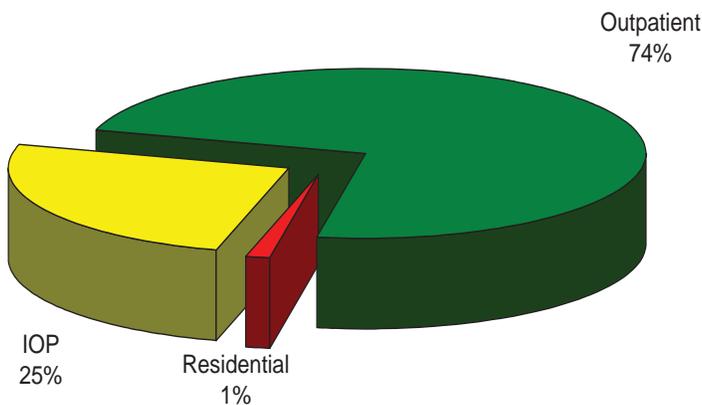
Total Clients Served.....335
 Adult316
 Youth.....19
 Penetration Rate.....0.9%

Total Admissions.....202
 Initial Admissions189
 Transfers.....13

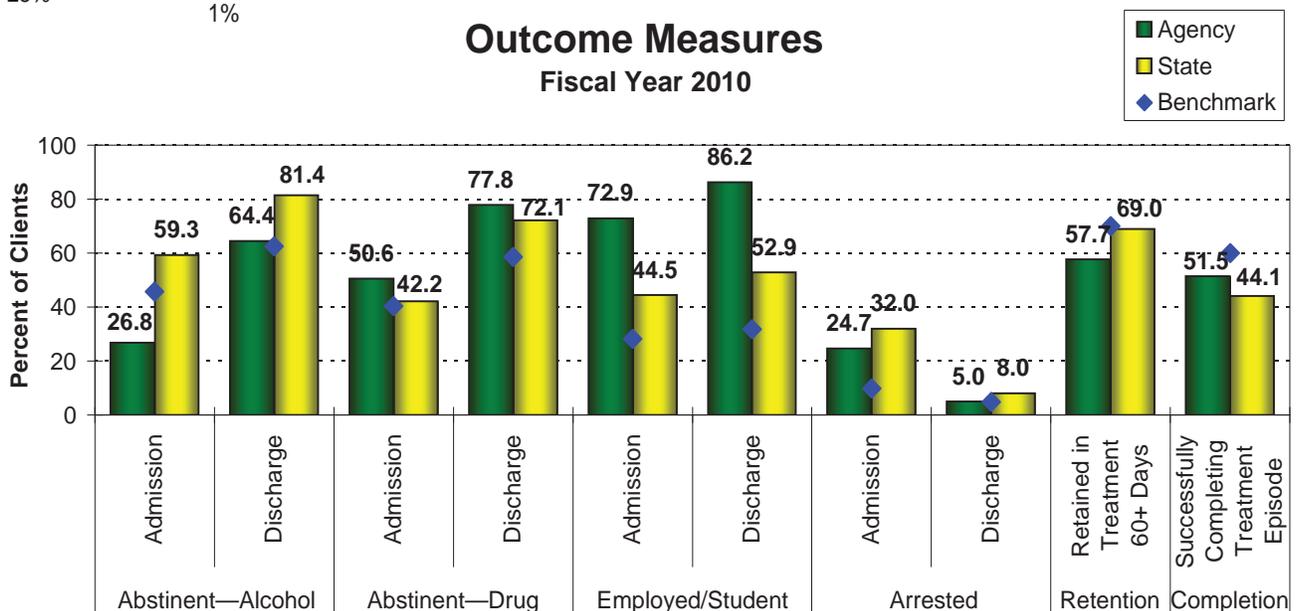
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	101	41	142
Cocaine/Crack	2	1	3
Marijuana/Hashish	26	6	32
Heroin	8	5	13
Other Opiates/Synthetics	1	2	3
Hallucinogens	0	0	0
Methamphetamine	0	2	2
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	5	7
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	140	62	202

Admissions into Modalities Fiscal Year 2010



Outcome Measures Fiscal Year 2010



Benchmark is 75% of the National Average.

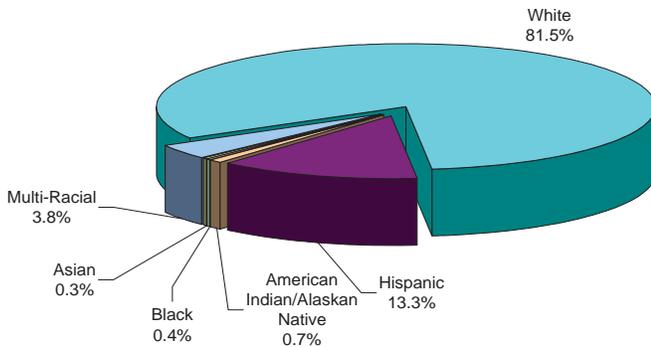
Summit County—Valley Mental Health—Mental Health

Total Clients Served1,061
 Adult821
 Youth240
 Penetration Rate 2.9%
 Civil Commitment9
 Unfunded Clients Served141

Diagnosis

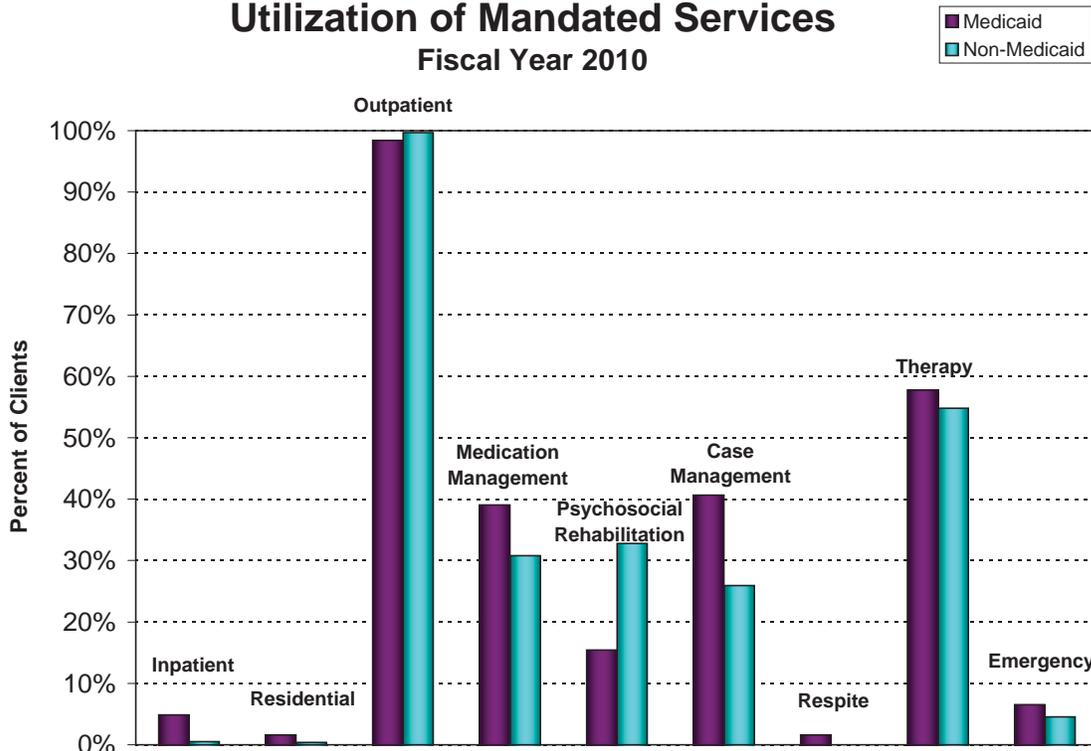
	Youth	Adult
Adjustment Disorder	47	67
Anxiety	77	332
Attention Deficit	63	65
Cognitive Disorder	1	13
Conduct Disorder	7	1
Impulse Control Disorders	10	9
Mood Disorder	85	397
Neglect or Abuse	7	17
Oppositional Defiant Disorder	25	-
Other	9	16
Personality Disorder	-	29
Pervasive Developmental Disorders	7	4
Schizophrenia and Other Psychotic	-	13
Substance Abuse	40	454
V Codes	75	209
Total	378	1,417

Race/Ethnicity Fiscal Year 2010



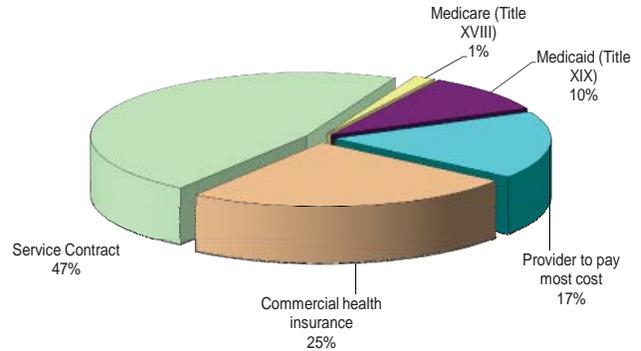
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

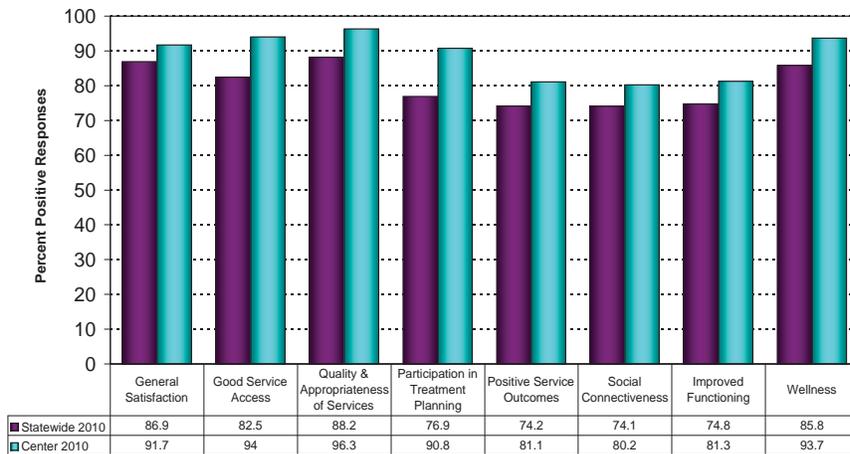


Summit County—Valley Mental Health—Mental Health (Continued)

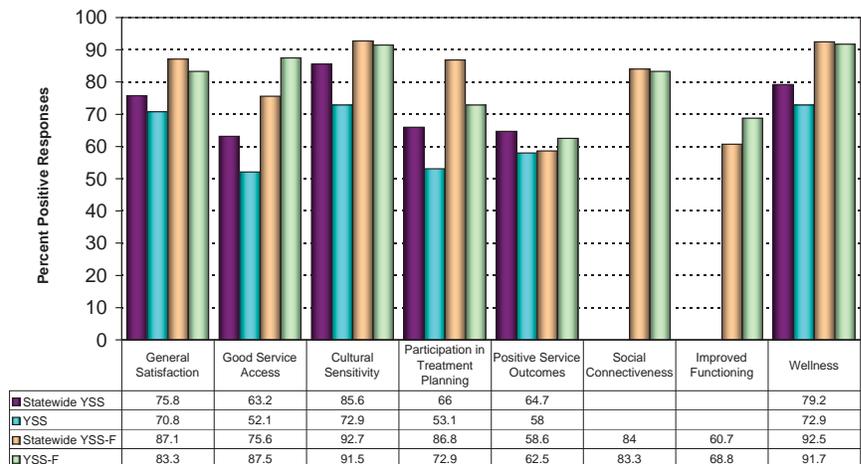
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2010



Tooele County



Population: 58,335

Substance Abuse and Mental Health Provider Agency:

Debra Falvo, President/Executive Director
Alex Gonzalez, County Program Manager
Valley Mental Health, Tooele County
100 South 1000 West
Tooele, UT 84074
Office: (435) 843-3520
www.valleymentalhealth.org/tooele_county

Tooele Substance Abuse—Prevention

Prioritized Risk Factors

- Interaction with antisocial peers
- Academic failure
- Attitudes favorable to drug use
- Low neighborhood attachment
- Rebelliousness

Prioritized Protective Factors

- School opportunities and rewards for pro-social involvement
- Family attachment
- Social skills

2010 Prevention Program Highlights

Prevention Programs Offered in Tooele

- Prevention Dimensions
- Healthy Life Skills Classes
- Young Mothers
- Community Coalition
- Tutoring Program
- PRIME for Life DUI Course
- Teen Alcohol and Drug School (TADS)
- Youth PAC Team (Prevention Advocacy Coalition)
- Presentations and Public Awareness
- Community Training Events
- Town Hall Meetings
- Teach-Ins
- Community Collaboration
- SPF/SIG Grant to reduce prescription drug use and abuse

Tooele Interagency Prevention Professionals (TIPP) is a coalition representing about 20 agencies from throughout Tooele County. TIPP assures implementation of best practices for prevention programs and services and promotes a coordinated effort to direct Tooele County prevention dollars.

Research shows that seven out of 10 teenagers in Tooele County have never tried alcohol. Yet teenagers in Tooele think they are under incredible peer pressure to drink. The perceptions individuals have can shape their behaviors, attitudes, and opinions and make those behaviors, attitudes and opinions seem “normal” or “typical.” The problem is that we often severely misperceive the typical behaviors or attitudes of our peers. For example, if people believe that the majority of their peers drink alcohol, then they are more likely to drink. Using social norming to inform people that the majority of their peers do not drink can potentially lead them to avoid drinking. Shifting those opinions by informing people that the majority of their peers are acting in a positive or healthy way can create an environment in which people actively strive to emulate what they believe is typical of their peers. VMH is a proud partner with the Tooele County School District in changing the perceptions of our youth!!

Tooele County—Valley Mental Health—Substance Abuse

Total Clients Served.....525
 Adult444
 Youth.....81
 Penetration Rate..... 0.9%

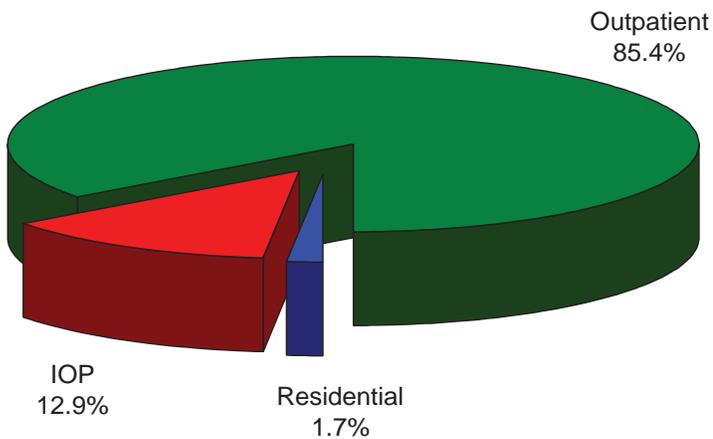
Total Admissions.....411
 Initial Admissions360
 Transfers.....51

Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	113	51	164
Cocaine/Crack	7	3	10
Marijuana/Hashish	74	25	99
Heroin	19	16	35
Other Opiates/Synthetics	6	10	16
Hallucinogens	0	0	0
Methamphetamine	37	31	68
Other Stimulants	2	0	2
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	1	1
Inhalants	0	0	0
Oxycodone	8	4	12
Club Drugs	1	0	1
Over-the-Counter	1	0	1
Other	0	1	1
Total	268	143	411

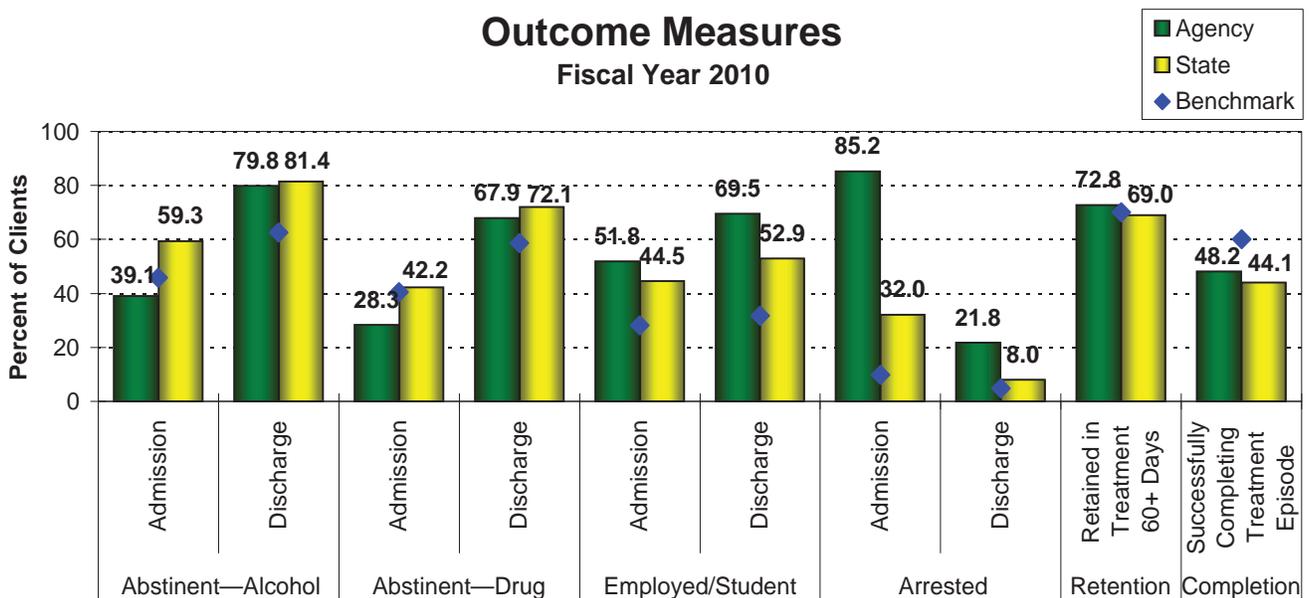
Admissions into Modalities

Fiscal Year 2010



Outcome Measures

Fiscal Year 2010



Benchmark is 75% of the National Average.

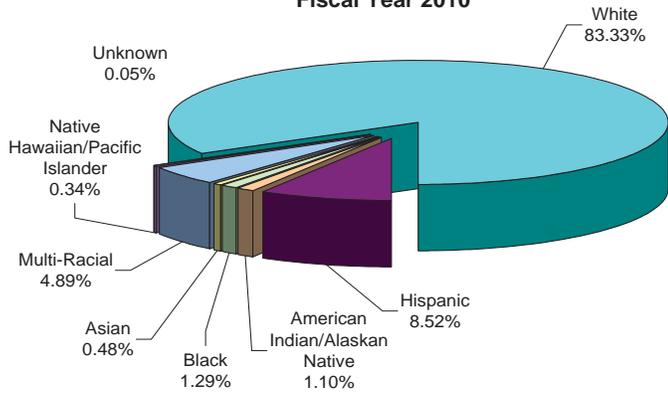
Tooele County—Valley Mental Health—Mental Health

Total Clients Served.....1,910
 Adult1,440
 Youth.....470
 Penetration Rate 3.3%
 Civil Commitment31
 Unfunded Clients Served96

Diagnosis

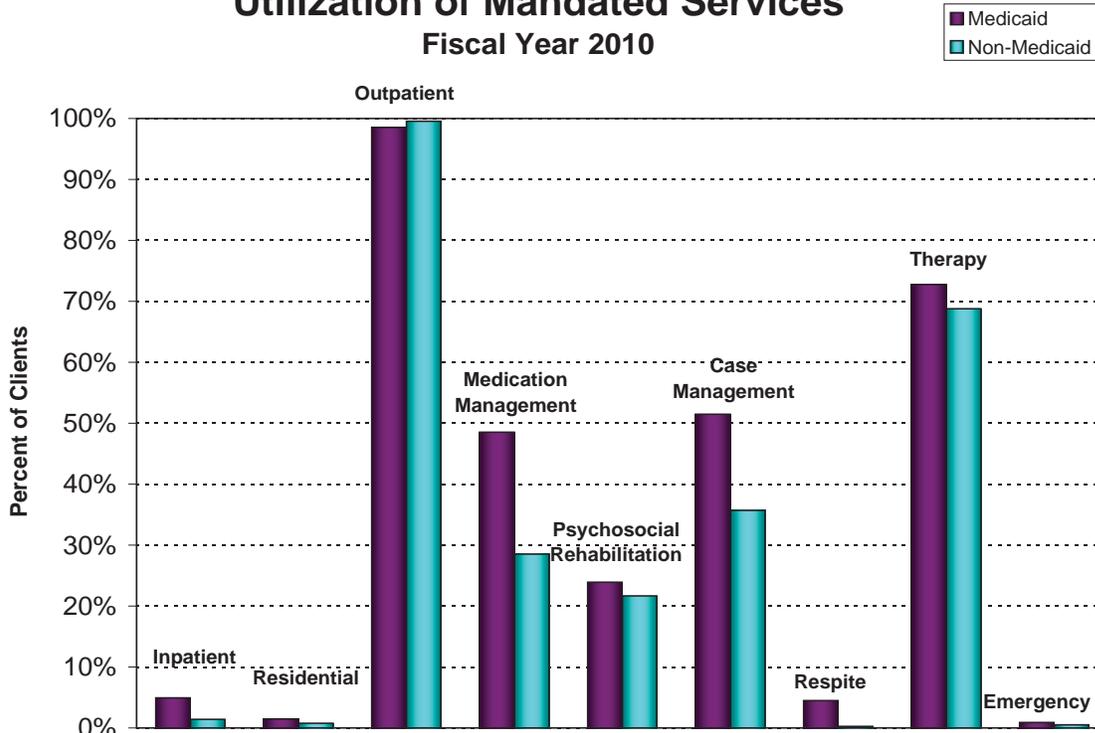
	Youth	Adult
Adjustment Disorder	60	44
Anxiety	157	648
Attention Deficit	155	91
Cognitive Disorder	5	21
Conduct Disorder	16	1
Impulse Control Disorders	31	7
Mood Disorder	187	878
Neglect or Abuse	84	23
Oppositional Defiant Disorder	103	-
Other	37	36
Personality Disorder	6	262
Pervasive Developmental Disorders	24	6
Schizophrenia and Other Psychotic	-	77
Substance Abuse	116	812
V Codes	103	362
Total	981	2,906

Race/Ethnicity Fiscal Year 2010



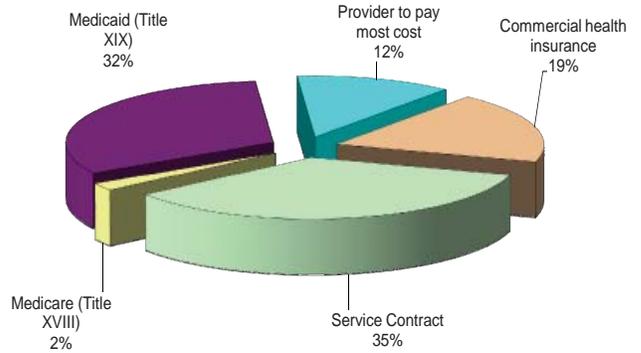
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

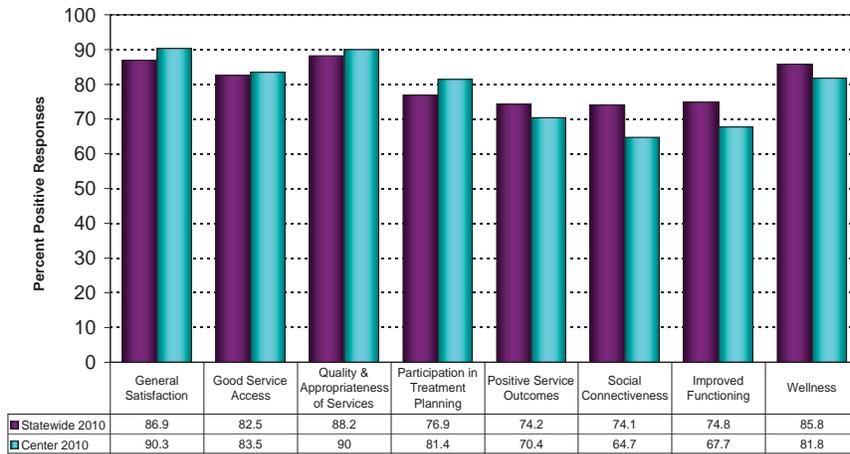


Tooele County—Valley Mental Health—Mental Health (Continued)

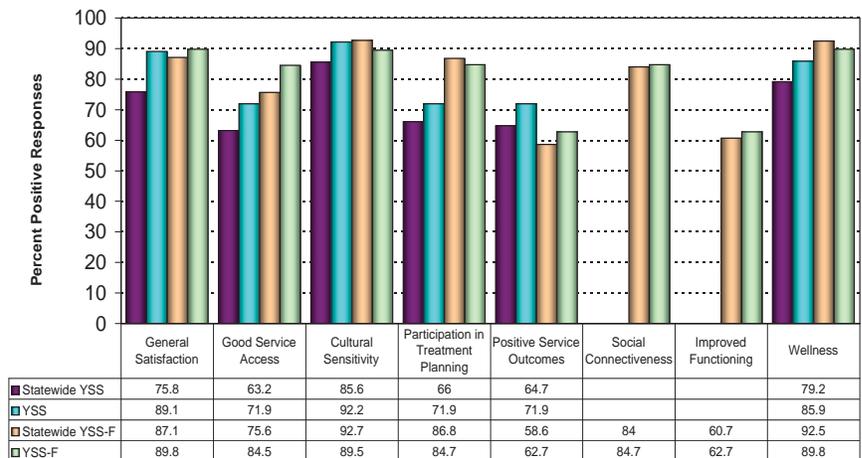
**Expected Payment Source At Admission
Fiscal Year 2010**



**Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010**



**Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010**



Utah County Division of Substance Abuse



Population: 545,307

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 www.utahcountyonline.org

Mental Health Provider Agency:

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

Utah County Substance Abuse—Prevention

Prioritized Risk Factors

- Low commitment to school
- Family conflict
- Parent attitudes favorable towards antisocial behaviors

Prioritized Protective Factors

- School rewards and opportunities for pro-social involvement
- Family rewards for pro-social involvement

2010 Prevention Program Highlights

CLEAN OUT YOUR MEDICINE CABINET

Take Back Event Results

- # of Rx pain pills collected—68,220
- # of other pills collected—84,510
- Lbs. of pharmaceuticals collected—1,161
- # of residents disposing of drugs—418

Utah County Division of Substance Abuse and the State Division of Substance Abuse have partnered with Springville, Saratoga Springs, and Eagle Mountain cities to implement a community research-based prevention model called Communities That Care.

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 (CTC) model.

The cost benefit of substance abuse prevention to each Utah County community can be up to \$36 in savings for every \$1 invested.¹

¹ Substance Abuse Prevention Dollars and Cents: A Cost Benefits Analysis, <http://www.samhsa.gov>

Utah County Division of Substance Abuse

Total Clients Served.....975
 Adult937
 Youth.....38
 Penetration Rate..... 0.2%

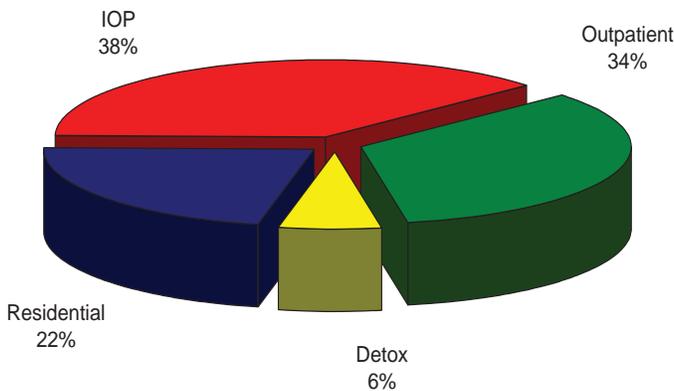
Total Admissions.....1,235
 Initial Admissions665
 Transfers.....570

Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	369	241	610
Cocaine/Crack	71	52	123
Marijuana/Hashish	79	50	129
Heroin	67	46	113
Other Opiates/Synthetics	8	20	28
Hallucinogens	1	0	1
Methamphetamine	40	49	89
Other Stimulants	3	1	4
Benzodiazepines	6	20	26
Tranquilizers/Sedatives	2	0	2
Inhalants	0	1	1
Oxycodone	30	56	86
Club Drugs	0	1	1
Over-the-Counter	3	6	9
Other	7	6	13
Total	686	549	1,235

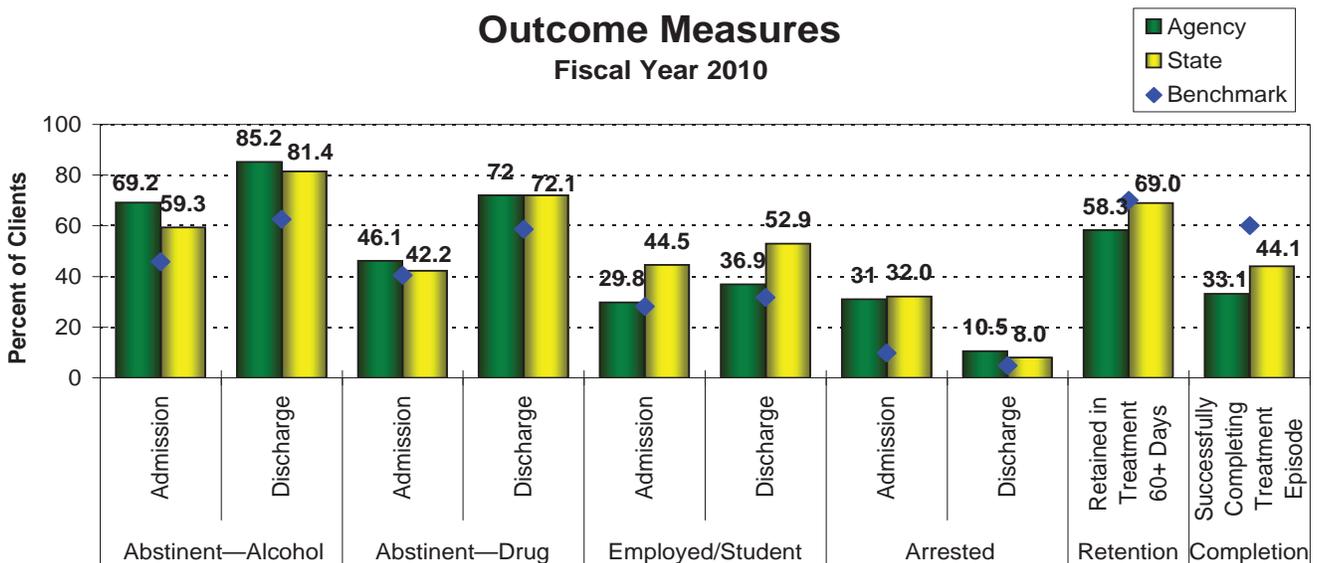
Admissions into Modalities

Fiscal Year 2010



Outcome Measures

Fiscal Year 2010



Benchmark is 75% of the National Average.

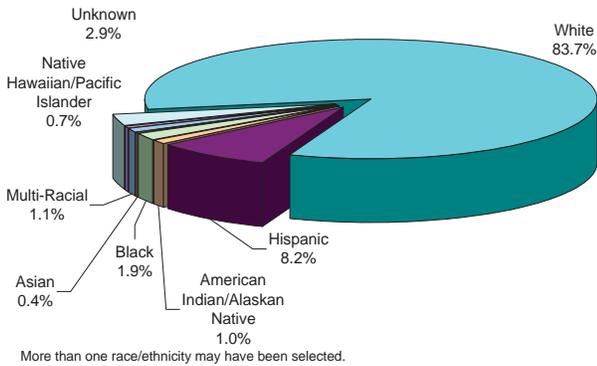
Utah County—Wasatch Mental Health

Total Clients Served6,872
 Adult3,966
 Youth2,906
 Penetration Rate 1.3%
 Civil Commitment185
 Unfunded Clients Served997

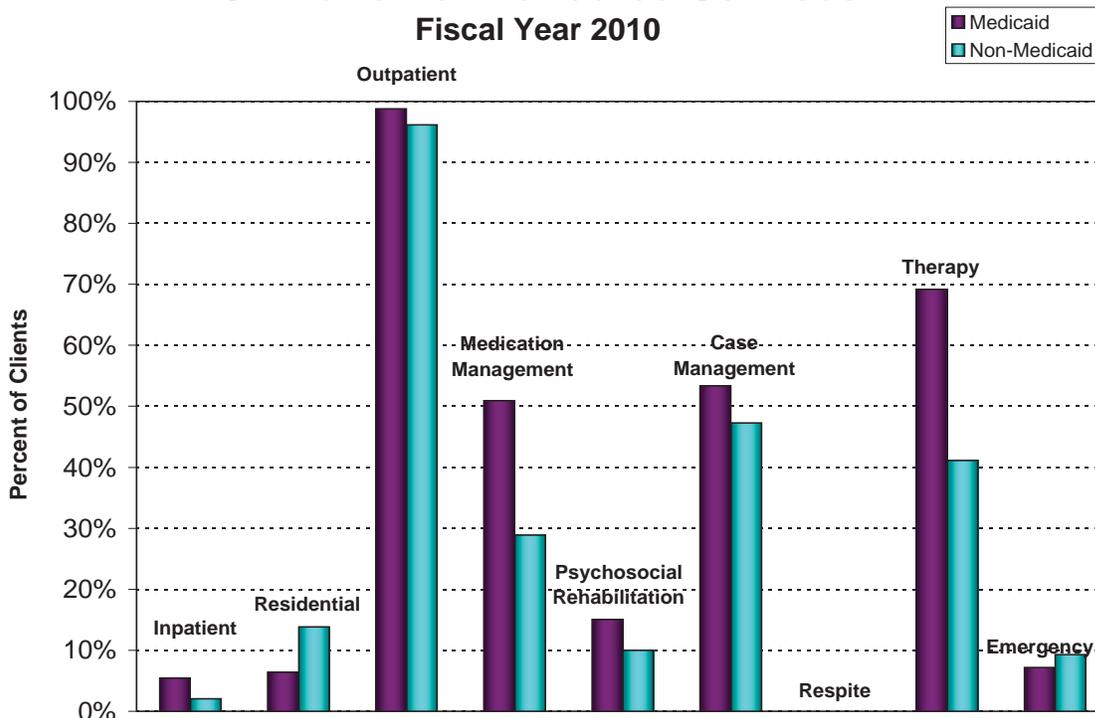
Diagnosis

	Youth	Adult
Adjustment Disorder	455	150
Anxiety	1,068	2,778
Attention Deficit	930	498
Cognitive Disorder	91	522
Conduct Disorder	96	9
Impulse Control Disorders	254	167
Mood Disorder	930	2,859
Neglect or Abuse	786	331
Oppositional Defiant Disorder	503	16
Other	462	432
Personality Disorder	15	903
Pervasive Developmental Disorders	382	121
Schizophrenia and Other Psychotic	14	728
Substance Abuse	175	1,070
V Codes	1,204	677
Total	6,161	10,584

Race/Ethnicity Fiscal Year 2010

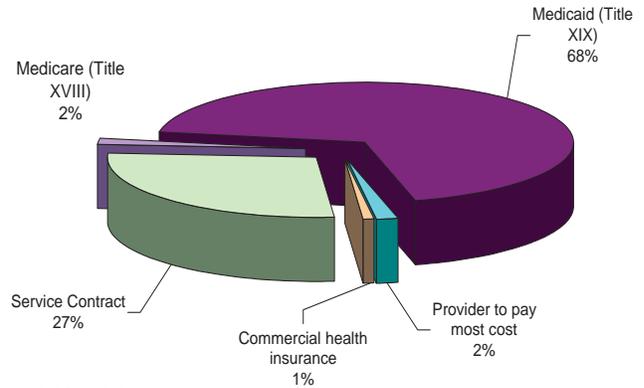


Utilization of Mandated Services Fiscal Year 2010

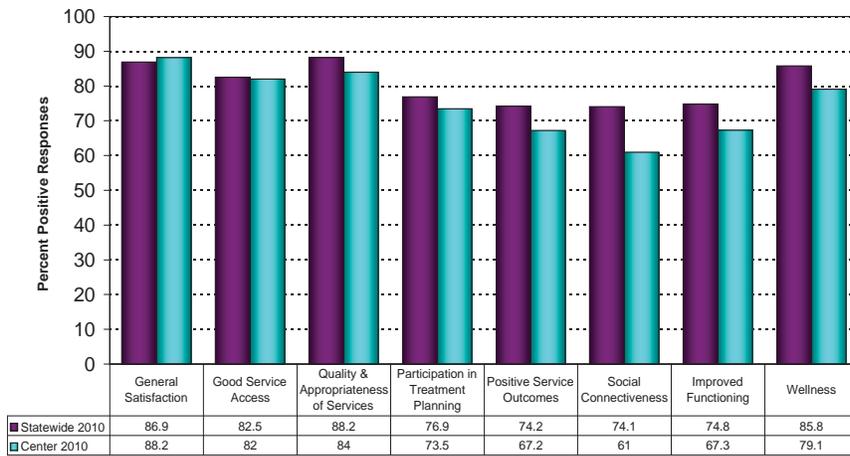


Utah County—Wasatch Mental Health (Continued)

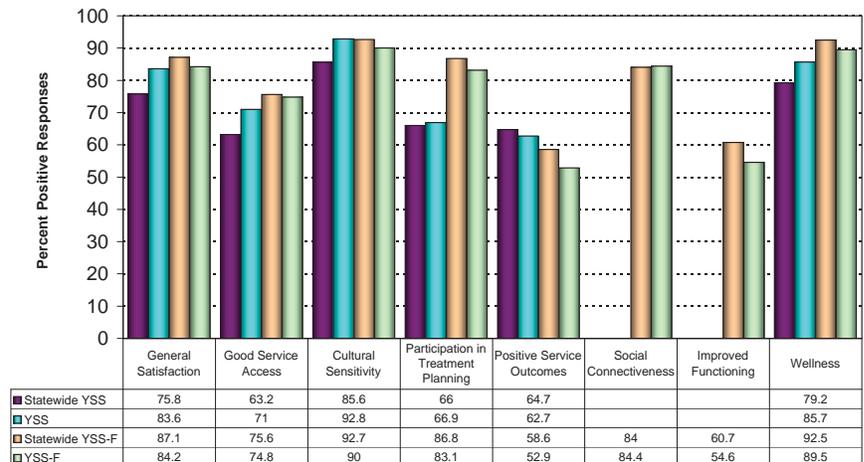
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



Wasatch County Heber Valley Counseling



Substance Abuse and Mental Health Provider Agency:

Dennis Hansen, Director
Heber Valley Counseling
55 South 500 East
Heber, UT 84032
Office: (435) 654-3003
www.co.wasatch.ut.us

Population: 21,600

Wasatch County Substance Abuse—Prevention

Prioritized Risk Factors

- Parental and youth attitudes favorable toward problem behaviors
- Intent to use drugs
- Perceived availability of drugs

Prioritized Protective Factors

Heber Valley Counseling's Prevention Plan addresses all protective factors by working to increase skills, opportunities, and recognition among youth.

2010 Prevention Program Highlights

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. Attendees are juvenile court and school referred.

Raising Responsible Children Parenting Class—A five-week session. The first four classes focus on increasing self esteem, self control, respect, and affection while decreasing criticism and anger among family members. On the last week of the program, developmental assets and risk and protective factors are discussed, giving parents knowledge to reduce the chances of their children making high-risk choices. The course is open to the community as well as court and DCFS referrals.

There's an A.P.P. for That! (Activities that Promote Prevention)

Together we can prevent underage drinking

Underage drinking has become an increasing problem in Wasatch County. Many youth feel there isn't anything to do but drink. Wasatch High School Health Coalition is addressing this perception by sponsoring monthly activities to create awareness of the many alternatives to drugs and alcohol that are available for youth in Wasatch County.

Some Prevention Programs Available in Wasatch County

- GYC Peer Leader Group
- Issues Community Conference
- Project Graduation All-Night Alcohol and Drug-Free Party
- Raising Responsible Children Parenting Class
- Prevention Dimensions Teacher Training
- PRIME for Life DUI (and Under 21) Classes
- WHS Prevention Coalition

Wasatch County—Heber Valley Counseling—Substance Abuse

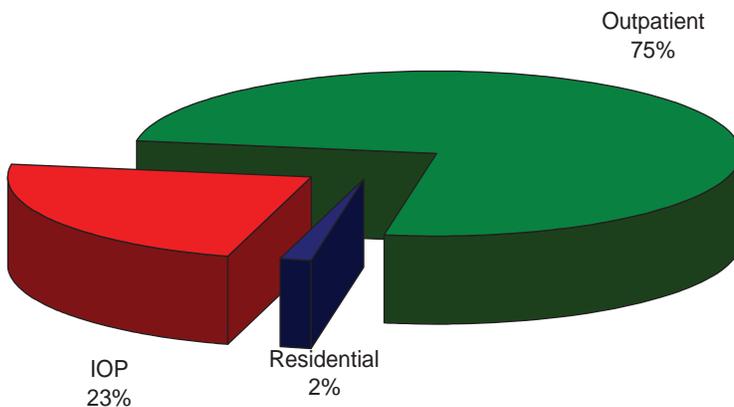
Total Clients Served.....152
 Adult132
 Youth.....20
 Penetration Rate.....0.7%

Total Admissions.....113
 Initial Admissions88
 Transfers.....25

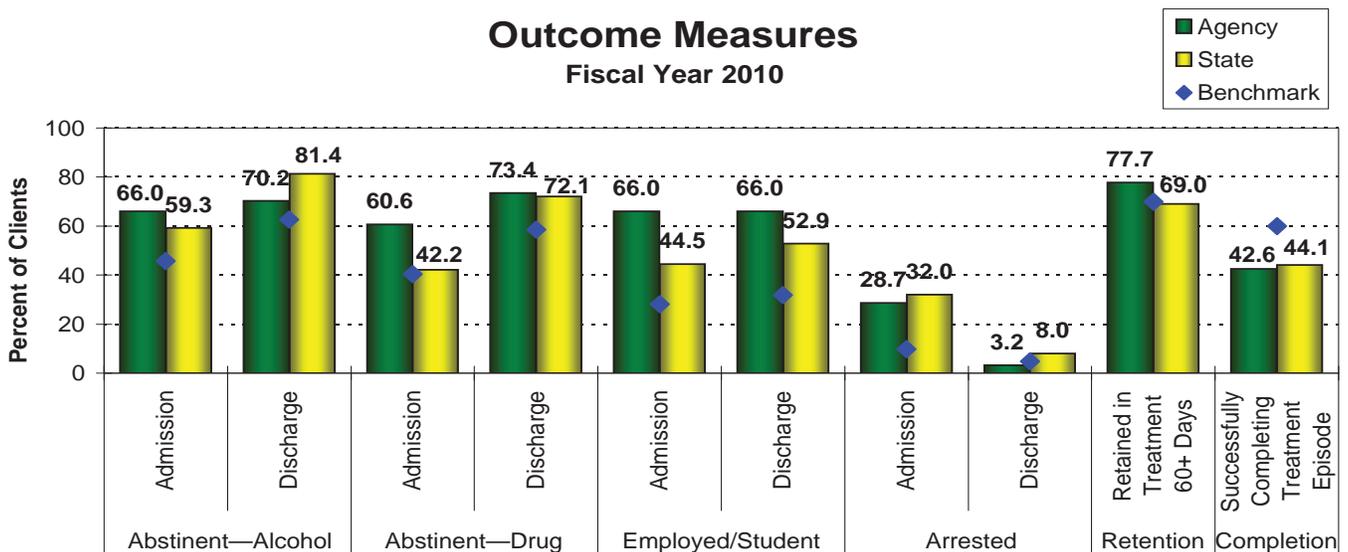
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	48	26	74
Cocaine/Crack	4	0	4
Marijuana/Hashish	11	2	13
Heroin	3	1	4
Other Opiates/Synthetics	0	2	2
Hallucinogens	0	0	0
Methamphetamine	3	3	6
Other Stimulants	0	0	0
Benzodiazepines	1	4	5
Tranquilizers/Sedatives	0	0	0
Inhalants	0	1	1
Oxycodone	2	1	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	0	1
Total	73	40	113

**Admissions into Modalities
Fiscal Year 2010**



**Outcome Measures
Fiscal Year 2010**



Benchmark is 75% of the National Average.

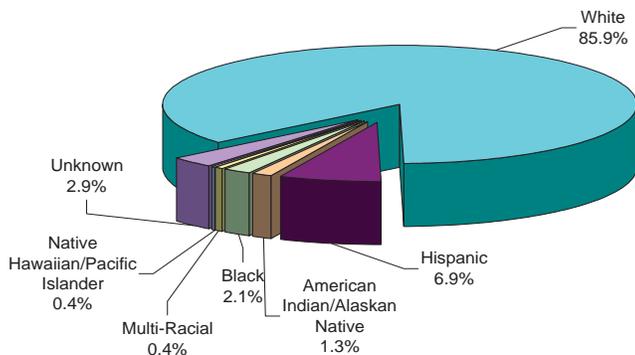
Wasatch County—Heber Valley Counseling—Mental Health

Total Clients Served.....443
 Adult327
 Youth.....116
 Penetration Rate 2.1%
 Civil Commitment4
 Unfunded Clients Served278

Diagnosis

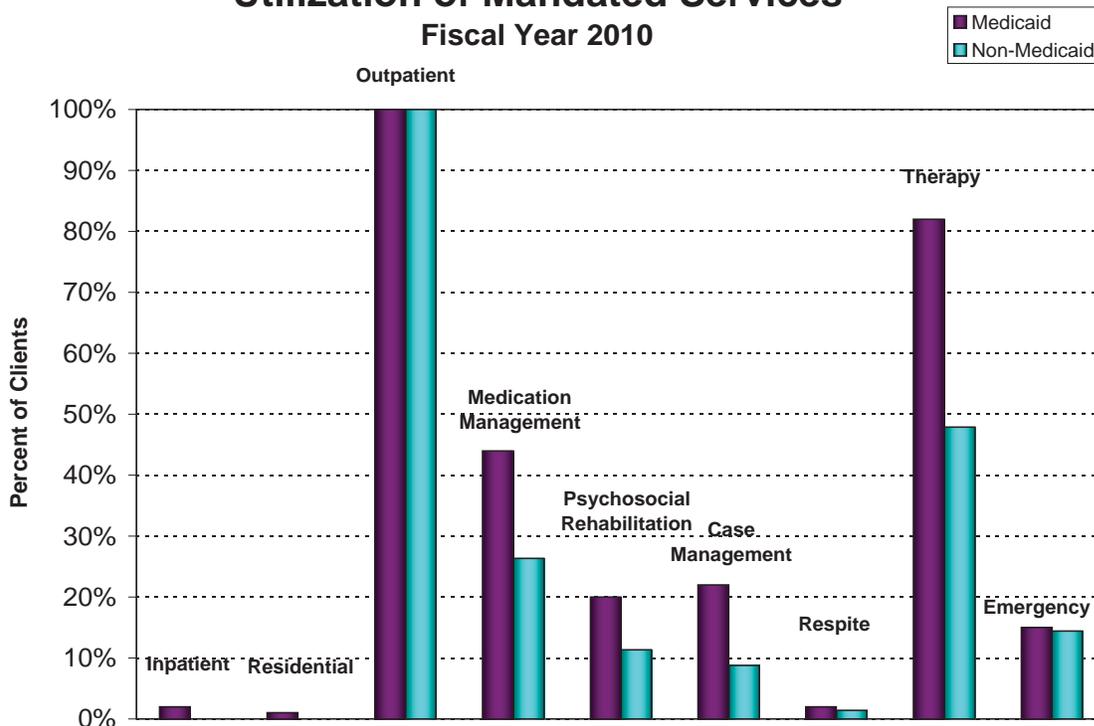
	Youth	Adult
Adjustment Disorder	13	9
Anxiety	29	253
Attention Deficit	20	18
Cognitive Disorder	-	5
Conduct Disorder	3	-
Impulse Control Disorders	4	6
Mood Disorder	24	168
Neglect or Abuse	17	4
Oppositional Defiant Disorder	16	-
Other	7	13
Personality Disorder	-	38
Pervasive Developmental Disorders	3	-
Schizophrenia and Other Psychotic	-	28
Substance Abuse	11	191
V Codes	14	88
Total	147	733

Race/Ethnicity Fiscal Year 2010



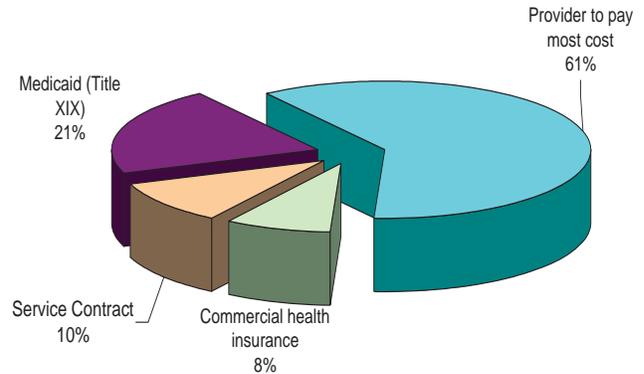
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

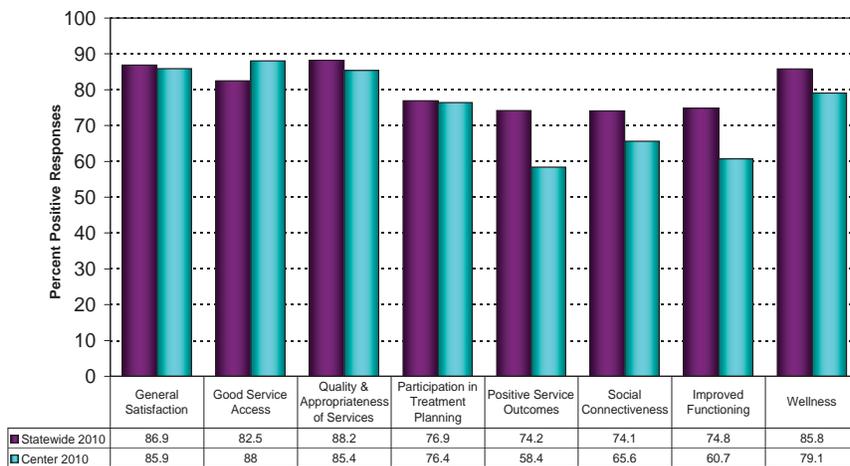


Wasatch County—Heber Valley Counseling—Mental Health (Continued)

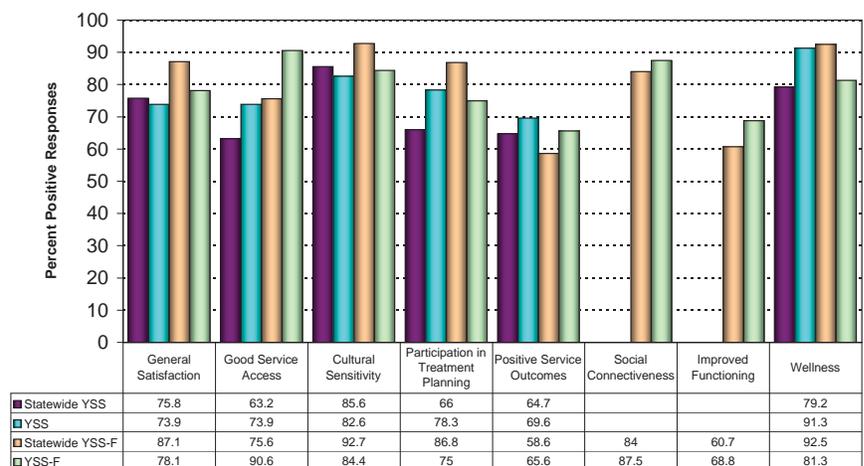
Expected Payment Source At Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



Weber Human Services Weber and Morgan Counties



Substance Abuse and Mental Health Provider Agency:

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

Population: 240,742

Weber Substance Abuse—Prevention

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

Prioritized Protective Factors

- Bonding
- Involvement in pro-social activities

2010 Prevention Program Highlights

The Governing Youth Council (GYC) is a local group of junior high and high school students that actively participate in local and statewide initiatives that promote positive youth lifestyles and provide solutions to issues facing today's youth.

What We Do:

- Promote an alcohol, tobacco and drug-free environment
- Coordinate and initiate local drug-free activities
- Serve as positive role models for peers in the community
- Educate and advocate for policy changes that affect youth
- Support statewide prevention efforts

Weber Human Services Prevention collaborates with local community agencies to provide educational information, specialized trainings, presentations and other services that promote healthy life skills to help prevent substance use. Some programs we offer are:

- Alcohol Screening
- All Stars
- Cammi Awards
- Coalition of Resources Board Meeting
- Guiding Good Choices (also in Spanish)
- High-Risk Skill Building
- High-Risk Support Groups
- Parent and Teen Alternative Program
- Parenting Wisely (also in Spanish)
- Peer Leadership Training and Support
- Prevention Dimensions Training
- PRIME Under 21

Weber Human Services—Substance Abuse

Total Clients Served.....1,368
 Adult1,187
 Youth.....181
 Penetration Rate..... 0.6%

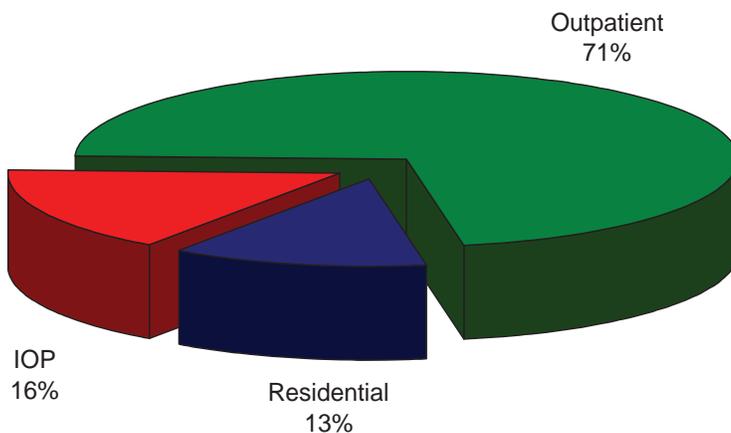
Total Admissions.....1,227
 Initial Admissions879
 Transfers.....348

Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	399	277	676
Cocaine/Crack	22	19	41
Marijuana/Hashish	132	78	210
Heroin	24	29	53
Other Opiates/Synthetics	1	8	9
Hallucinogens	0	0	0
Methamphetamine	56	85	141
Other Stimulants	2	0	2
Benzodiazepines	5	5	10
Tranquilizers/Sedatives	1	1	2
Inhalants	1	1	2
Oxycodone	19	34	53
Club Drugs	5	0	5
Over-the-Counter	2	7	9
Other	1	7	8
Total	676	552	1,228

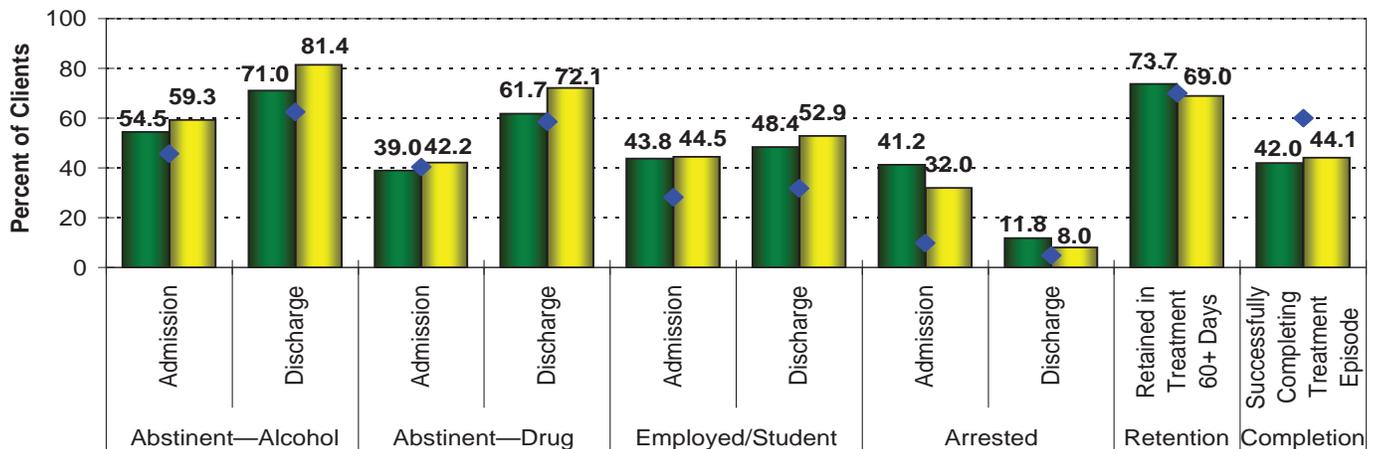
Admission into Modalities

Fiscal Year 2010



Outcome Measures

Fiscal Year 2010



Benchmark is 75% of the National Average.

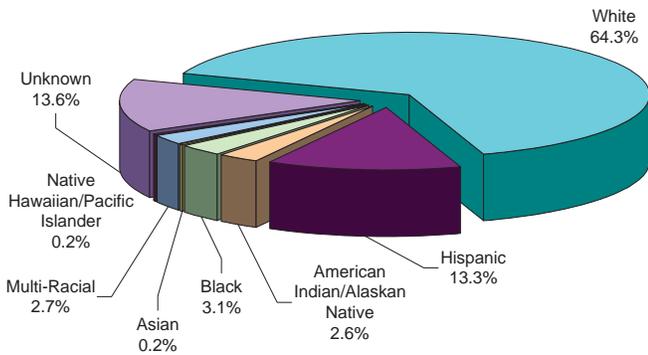
Weber Human Services—Mental Health

Total Clients Served5,734
 Adult4,095
 Youth1,639
 Penetration Rate 2.4%
 Civil Commitment279
 Unfunded Clients Served1,360

Diagnosis

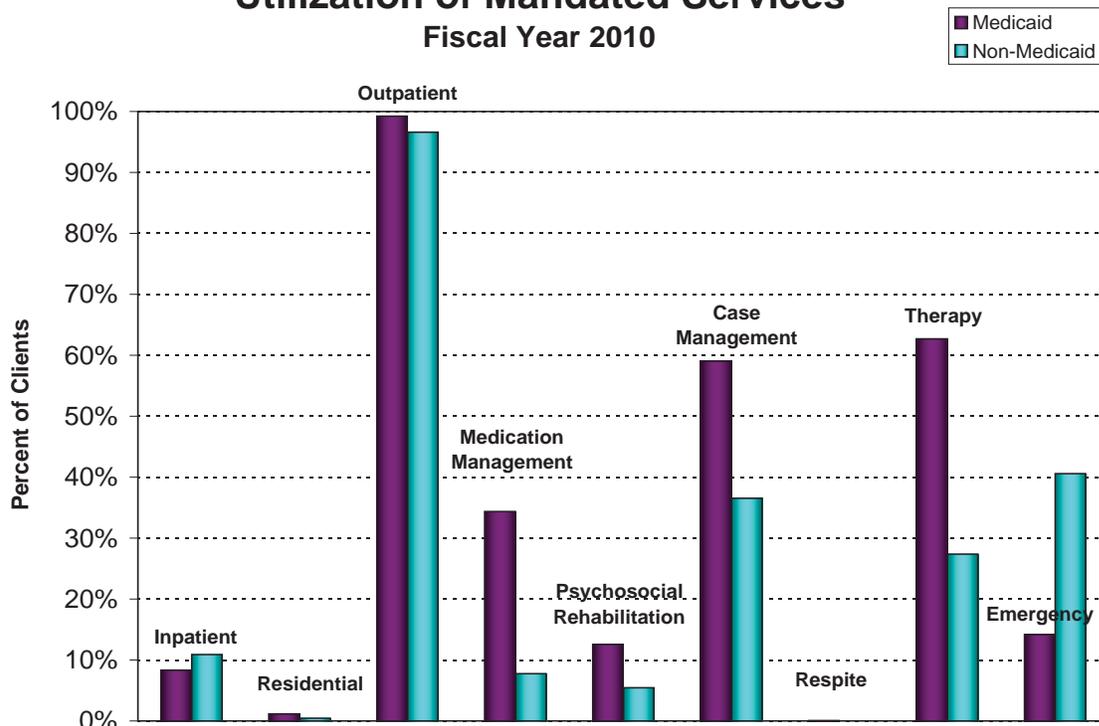
	Youth	Adult
Adjustment Disorder	194	69
Anxiety	464	1,106
Attention Deficit	484	158
Cognitive Disorder	68	237
Conduct Disorder	61	14
Impulse Control Disorders	142	57
Mood Disorder	487	1,678
Neglect or Abuse	519	163
Oppositional Defiant Disorder	355	19
Other	219	84
Personality Disorder	9	551
Pervasive Developmental Disorders	197	27
Schizophrenia and Other Psychotic	20	412
Substance Abuse	303	1,432
V Codes	409	484
Total	3,522	6,007

Race/Ethnicity Fiscal Year 2010



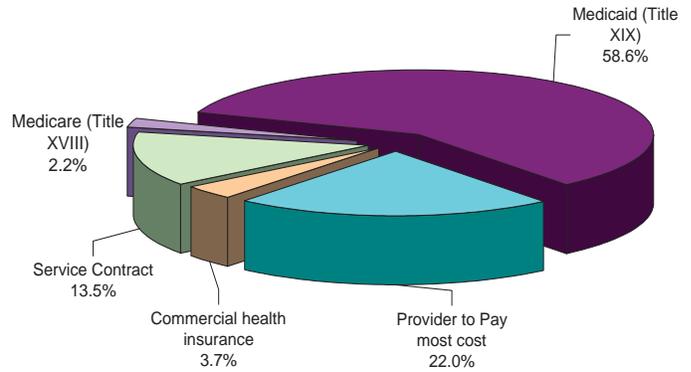
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2010

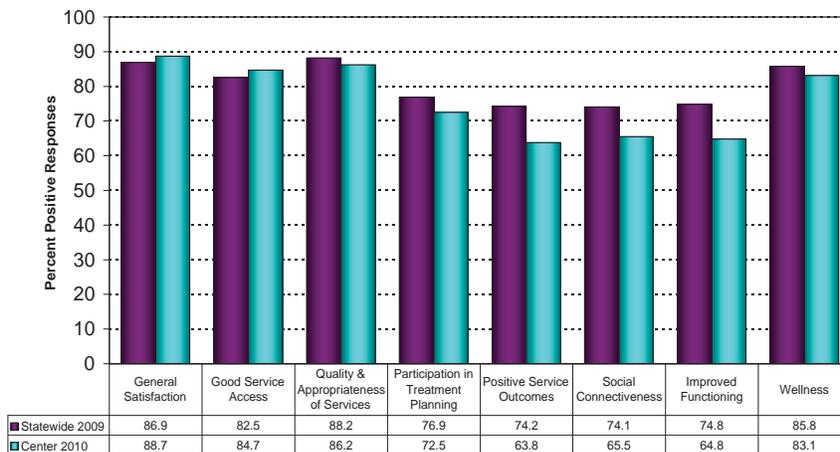


Weber Human Services—Mental Health (Continued)

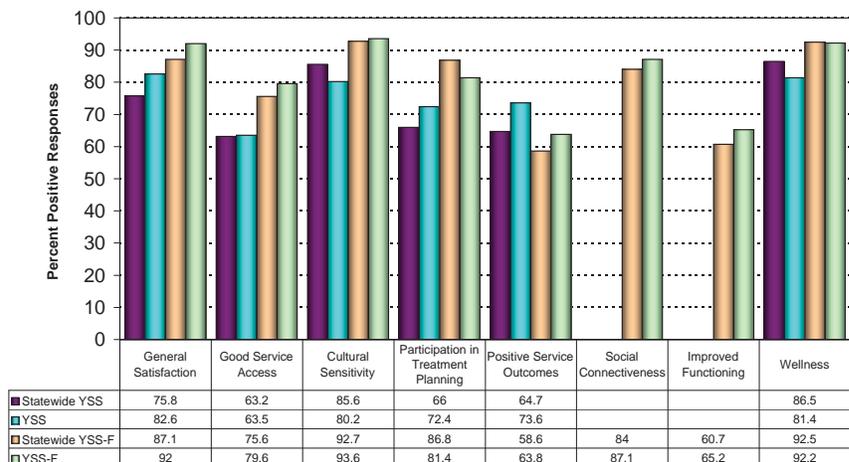
Expected Payment Source at Admission
Fiscal Year 2010



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2010



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2010



RICHARD'S STORY

I'm a very determined guy. When someone tells me I can't do something . . . well, just watch me. I've done many things I was told I'd never be able to do. Even though I was in special education as a child, and I grew up with bipolar disorder, depression, and intermittent explosive disorder, I started a business that lasted 22 years against all the odds. And when I said I wanted to be in movies—everyone just laughed at me—I moved to Utah and ended up being an extra in *Touched by an Angel* for eight seasons until the show was canceled.

I have a positive attitude and I'm optimistic about the future, but I have to admit that I've gone through some difficult times. I was teased and criticized as a child because I was different. I attempted suicide three times and I've been pretty upset and frustrated with life at times. But I've learned how to go on despite these difficulties. I'm satisfied with who I am because it is who I am. And I've learned to accept that. I don't really understand why I had to have these conditions, but I know I need to still try to be the best I can be.



After going through what I've gone through in my life, I really try to understand others who have problems. When I see other disabled people I know I can help them and show them ways to be happy with their lives. They just need to be patient. Changes will come but sometimes it takes awhile.

"I'm a very determined guy. When someone tells me I can't do something . . . well, just watch me. I've done many things I was told I'd never be able to do."

RESOURCES

List of Abbreviations

ARC—Access to Recovery	NPN—National Prevention Network
ASAM—American Society of Addiction Medicine	NTN—National Treatment Network
ASI—Addiction Severity Index	OTP—Outpatient Treatment Program
ATOD—Alcohol, Tobacco, and Other Drugs	PASRR—Pre-admission Screening and Residential Review
BPRS—Brief Psychiatric Rating Scale	PASSAGES—Progressive Adulthood: Skills, Support, Advocacy, Growth and Empowerment = Success
CMHC—Community Mental Health Center	PD—Prevention Dimensions
CMS—Center for Medicaid and Medicare Services	ROSC—Recovery Oriented Systems of Care
CSAP—Center for Substance Abuse Prevention	RSS—Recovery Support Services
CSAT—Center for Substance Abuse Treatment	SAMHSA—Substance Abuse and Mental Health Services Administration (Federal)
CTC—Communities that Care	SAPT—Substance Abuse Prevention and Treatment Block Grant
DCFS—Division of Child and Family Services	SA—Substance Abuse
DJJS—Division of Juvenile Justice Services	SED—Serious Emotional Disturbance
DORA—Drug Offender Reform Act	SHARP—Student Health and Risk Prevention
DSAMH—Division of Substance Abuse and Mental Health	SMI—Serious Mental Illness
DSPD—Division of People with Disabilities	SPF—Strategic Prevention Framework
DUI—Driving Under the Influence	SPMI—Serious and Persistent Mental Illness
E.A.S.Y—Eliminate Alcohol Sales to Youth	SUDs—Substance Use Disorders
FRF—Family Resource Facilitator	TEDS—Treatment Episode Data Set
IEP—Individual Education Plan	UAC—Utah Addiction Center
IOP—Intensive Outpatient Program	UBHC—Utah Behavioral Healthcare Committee
IV—Intravenous	UFC—Utah Family Coalition
LMHA—Local Mental Health Authorities	USARA—Utah Support Advocates for Recovery Awareness
LOS—Length of Stay	USEOW—Utah’s State Epidemiology Outcomes Workgroup
LSAA—Local Substance Abuse Authorities	USH—Utah State Hospital
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.

Medicaid/Non-Medicaid Client Counts			
Mental Health Center	Medicaid	Non-Medicaid	Both Medicaid and Non-Medicaid
Bear River Mental Health	1,583	973	271
Central Utah Counseling	765	149	69
Four Corners Behavioral Health	745	934	202
Northeastern Counseling	459	776	67
San Juan Counseling	173	345	18
Southwest Behavioral Health	1,726	697	133
Summit County—VMH	90	938	33
Tooele County—VMH	591	1,220	99
Wasatch Co.—Heber Valley Counseling	90	343	10
Davis Behavioral Health	2,200	813	241
Salt Lake County	8,689	5,281	1,311
Utah Co.—Wasatch Mental Health	4,513	2,033	326
Weber Human Services	3,212	2,238	284
Rural	6,200	6,353	895
Urban	18,370	10,259	2,133
Statewide Total	24,304	16,394	2,964

Contact Information

Single State Authority

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

Utah State Hospital

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

Local Authorities and Providers

Bear River

Counties: Box Elder, Cache, and Rich

Substance Abuse Provider Agency:

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

Mental Health Provider Agency:

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

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
www.dbhutah.org

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
 152 North 400 West
 Ephraim, UT 84647
 Office: (435) 462-2416
www.cucc.us

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
www.fourcorners.ws

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

San Juan County

County: San Juan

Substance Abuse and Mental Health Provider

Agency:

Jed Lyman, 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
www.swbehavioralhealth.com

Summit County

County: Summit

Substance Abuse and Mental Health Provider

Agency:

Debra Falvo, President/Executive Director
Thomas Roger Peay, County Program Manager
Valley Mental Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157
www.valleymentalhealth.org/summit_county

Tooele County

County: Tooele

Substance Abuse and Mental Health Provider

Agency:

Debra Falvo, President/Executive Director
Alex Gonzalez, County Program Manager
Valley Mental Health, Tooele County
100 South 1000 West
Tooele, UT 84074
Office: (435) 843-3520
www.valleymentalhealth.org/tooele_county

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
www.utahcountyonline.org

Mental Health Provider Agency:

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

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
www.co.wasatch.ut.us

Weber

Counties: Weber and Morgan

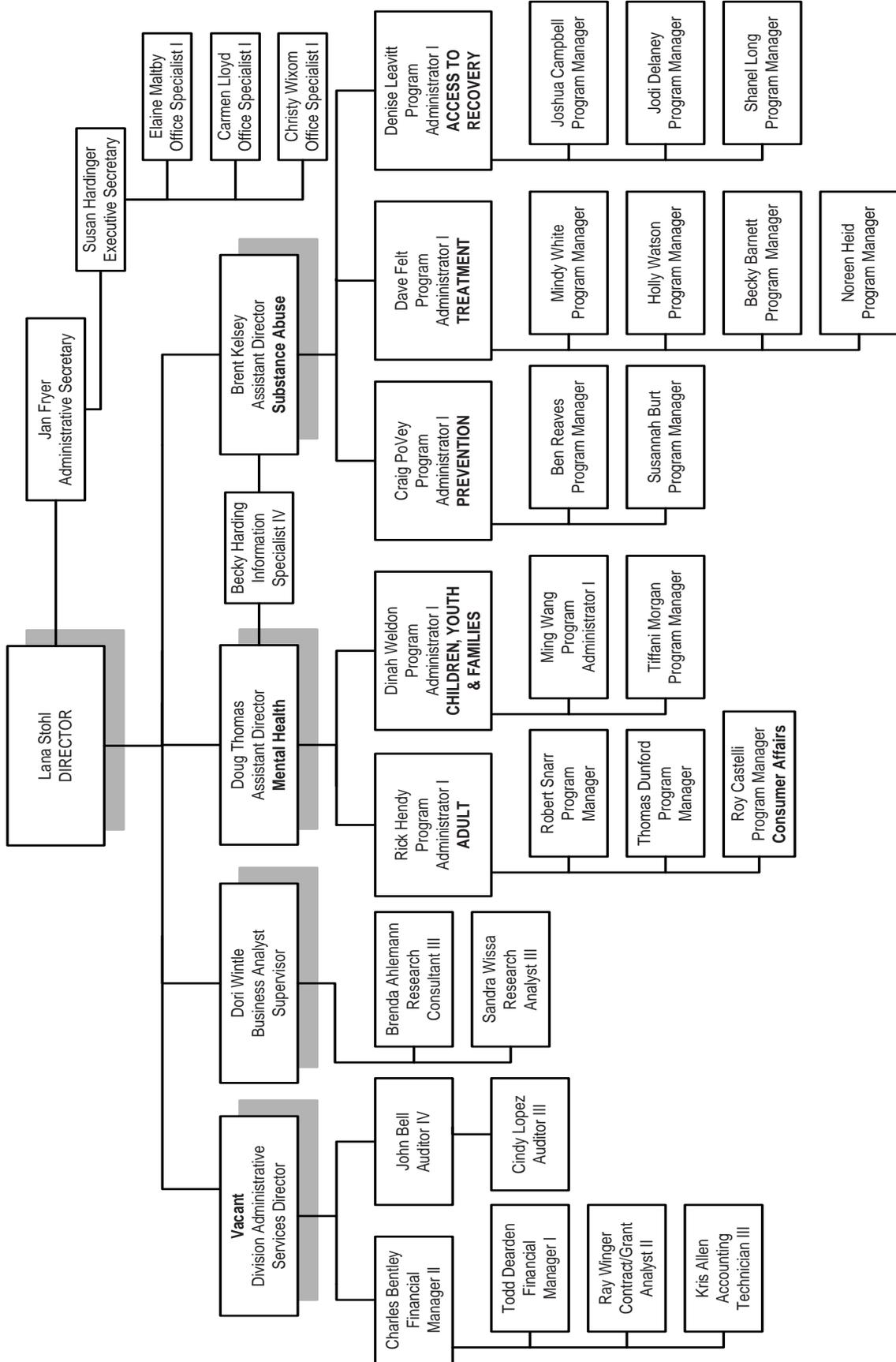
Substance Abuse and Mental Health Provider Agency:

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

Local Authorities/Local Providers

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

Utah Division of Substance Abuse and Mental Health
January 2011





Division of Substance Abuse
and Mental Health
195 North 1950 West
Salt Lake City, UT 84116
(801) 538-3939
dsamh.utah.gov

