DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

ANNUAL REPORT

2013

Hope • Health • Healing

UTAH DEPARTMENT OF HUMAN SERVICES • DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Division of Substance Abuse and Mental Health

2013
Annual Report

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and Mental Health
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State of Utah

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Governor

SPENCER J. COX
Lieutenant Governor

DEPARTMENT OF HUMAN SERVICES

ANN WILLIAMSON
Executive Director

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

DOUG THOMAS
Director

December 2013

Another year has passed and we are proud to release the Division of Substance Abuse and Mental Health Annual Report for 2013. We hope this report broadens your understanding of the important role that the public behavioral health system has in the lives of individuals and families in Utah.

We have chosen "Hope, Health, Healing" as the theme for this year's report. We know that prevention works, treatment is effective, that people can and do recover from mental health and substance use conditions and go on to live productive and meaningful lives in our communities. This vision and message of Hope is what we want to convey. Behavioral Health is essential to overall Health. Together we can make a difference for those among us who suffer from the symptoms of mental health or substance use disorders. The results of our efforts are stronger and healthier individuals, families, and communities in Utah.

Now is an exciting time to be in healthcare. The Mental Health Parity Act and the Affordable Care Act have opened the way for people to get their behavioral healthcare needs met in the same way as physical health. Over time, these programs should decrease stigma and increase understanding. We know the earlier people receive help, the better the outcomes people have, at less cost, with less disability. Our division has led the charge to increase access, adopt evidence-based practices, collaborate, and integrate towards a "System of Care" that meets the unique needs of each individual and family when and where they need help. In Utah's diverse and ever changing population, it is more important than ever to have a trauma informed approach that does no harm and encourages healing for those we serve.

As we continue to talk about healthcare reform I believe we need to continue to emphasize the following ongoing strategies:

- Focus on prevention and early intervention.
- Reduce Utah's rate of suicide.
- Develop a recovery-oriented system of care led by people in recovery that is trauma-informed and evidence-based.
- Strengthen the system of care for children and youth that is family-driven, youth-guided, community-based, and culturally and linguistically competent.
- Promote integrated programs that address an individual's substance use disorder, mental health and physical healthcare needs.

I want to personally thank the brave individuals reaching out to confront mental health and substance use disorders, facing their challenges to improve their individual situations. I also want to thank those who help facilitate this process; the many dedicated friends, family members and professionals, whose support is life-altering for so many. As we transform our system to make recovery a reality and build resilience in the face of life's daily challenges, individual lives will continue to improve, improving the very fabric of our families, neighborhoods, schools, and communities. We appreciate your support and hope this report broadens your understanding of our services, outcomes and those we serve.

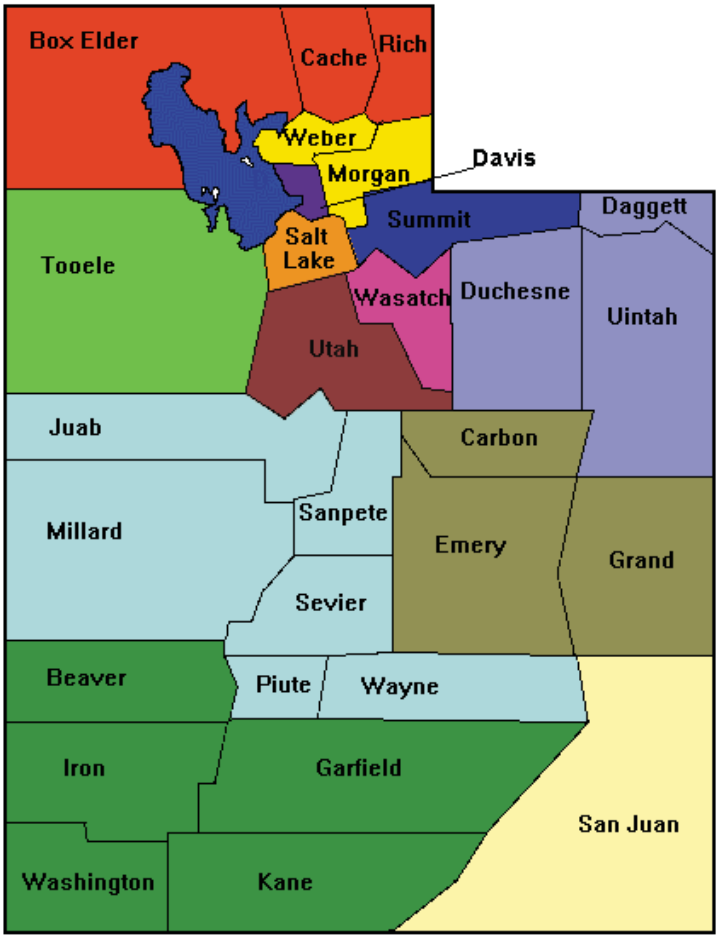
Sincerely,

Doug Thomas, LCSW
Director

About Utah's Public Substance Abuse and Mental Health System

This Annual Report summarizes the activities, accomplishments, and outcomes of Utah's public behavioral healthcare system. The theme of this year's report is "Hope, Health, Healing." Substance use disorders and mental illnesses are chronic diseases. However, prevention works, treatment is effective, and people recover.

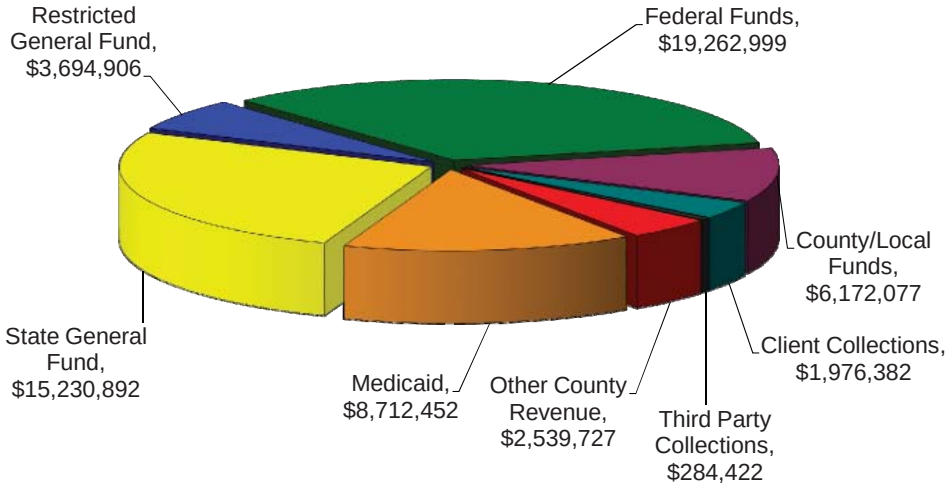
The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority in Utah. It is charged with ensuring a comprehensive continuum of mental health and substance use disorder services are available throughout the state. In addition, DSAMH is tasked with ensuring that public funds are spent appropriately. As part of the Utah Department of Human Services, DSAMH contracts with local county governments who are statutorily designated as local substance abuse authorities (LSAAs) and local mental health authorities (LMHAs) to provide prevention, treatment, and recovery services. DSAMH provides policy direction, monitoring, and oversight to local authorities and their contracted service providers.



Source of Funding

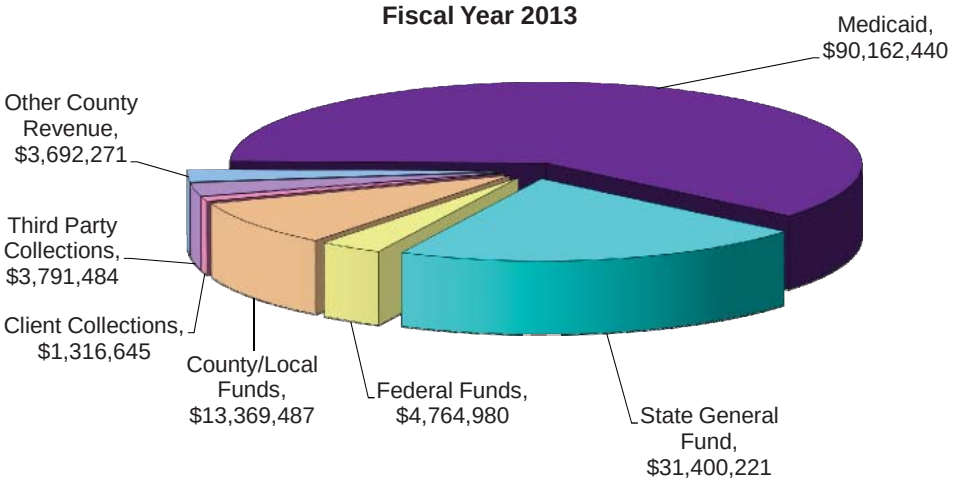
Funding for substance use disorder and mental health services comes from a variety of sources. State, county, and federal funds as well as private insurance and payments directly from clients are used to provide services. For mental health services, the primary funding source is Medicaid. For substance abuse services, the primary funding source is the Federal Substance Abuse Prevention Treatment (SAPT) block grant. Counties are required by State statute, to provide funding equal to at least 20% of the State contribution. The following provides a breakdown of the sources of funding for both mental health and substance use disorder services.

Community Substance Use Disorder Services Funding
Fiscal Year 2013



Total Revenues: $57,873,857

Community Mental Health Services Funding
Fiscal Year 2013



Total Revenues: $148,497,528

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

State Strategies

DSAMH focused on five strategies in 2013. These strategies provide a roadmap to move us forward in a rapidly changing healthcare environment. Each strategy is designed to improve health; provide hope and help individuals, families and communities; and heal.

The five strategies are:

1. Focus on prevention and early intervention.
2. Reduce Utah's rate of suicide.
3. Develop a recovery-oriented system of care led by people in recovery that is trauma-informed and evidence-based.
4. Strengthen the system of care for children and youth that is family-driven, youth-guided, community-based, and culturally and linguistically competent.
5. Promote integrated programs that address an individual's substance use disorder, mental health and physical healthcare needs.

The following provides greater detail about each of our chosen strategies.

Strategy One: Focus on prevention and early intervention

Mental and substance use disorders have a powerful effect on the health of individuals. They also significantly impact families, communities, economy, and public health. Mental and substance use disorders lead to disability, disease (e.g., diabetes, cardiovascular problems, cancer, etc.), and higher healthcare and socio-economic costs.[1] Below are some specific examples of the toll mental illness and substance use disorders have on individuals, families and communities:

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.[2]
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24—making the case that the long-term benefits are arguably greatest for prevention-based efforts that focus on children and youth.[3]
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.[4]
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.[5]
- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion, with an estimated 23.5 million Americans aged 12 and older needing treatment for substance use.[6]

Utah is not immune to the problems created by mental illness and substance use disorders. Utah-specific examples of these problems include:

- Utah is ranked eighth in the country on death due to suicide.[7]
- The number of students who consume alcohol with the permission of their parents is rising. Among Utah's 6th to 12th graders who reported alcohol use in 2011, 40.6%

[1] Substance Abuse and Mental Health Services Administration. (2011). Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014 Executive Summary and Introduction. HHS Publication No. (SMA) 11-4629 Summary. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[2] Ibid. p. 14

[3] Ibid.

[4] Ibid.

[5] Ibid

[6] Ibid.

[7] Substance Use Prevention and Beyond: Examples of Community Anti-Drug Coalitions that have Successfully Adopted Broader Health Promotion Missions and Projects, slide 10

reported they consumed alcohol "at home with parental permission." This is up from 34.4% in 2009.[8]

- Between 2009 and 2012, 1,476 Utah mothers (approximately 369 per year) were reported to have used illicit drugs.[9]
- Alcohol is the most commonly abused drug among youth.[10] Nearly one in three high school seniors, report having used alcohol in their lifetime. Fourteen percent of high school seniors report that they have used alcohol in the past thirty days.[11] Underage drinking costs Utah an estimated $400 million.
- Prescription drug abuse in Utah has reached epidemic proportions.[12] An average of 23 Utahns die as a result of prescription opoid use each month. Prescription opoid deaths now outnumber deaths from motor vehicle accidents.
- Almost 1 in 5 young people have one or more mental, emotional or behavioral disorders (MEB) that cause some level of impairment within a given year; however, fewer than 20% receive mental health services.[13]

Utah's prevention system follows a strategic, science-based planning process called the Strategic Prevention Framework (SPF). The SPF is used to ensure a culturally competent, effective, cost-efficient system. Communities work through a five step process to implement the SPF. The five steps are: (1) Assess community needs; (2) Build capacity for services; (3) Plan based on needs, strengths, and resources; (4) Implement evidence-based strategies; and (5) Evaluate the effectiveness of prevention services and activities. The SPF provides assurance that Utah prevention initiatives are effective, efficient, and address local needs. Additional information about Utah's substance use prevention efforts can be found on page 65 of this report.

The concept of mental health prevention is relatively new. However, the Institute of Medicine and the Center for Disease Control indicate that clear windows of opportunity are available to prevent mental, emotional, and behavioral disorders and related problems before they occur. The Affordable Care Act (ACA) also places a heavy focus on prevention and health promotion activities at the community, state, territorial, and tribal levels. The risk factors for both substance use disorders and mental illness are well established, with first symptoms typically preceding a disorder by 2 to 4 years. Prevention and early intervention can effectively reduce the development of mental, emotional, and behavioral disorders.

The onset of half of all lifetime mental illnesses takes place by age 14, and three-fourths by age 24. Almost 1 in 5 young people have one or more mental, emotional or behavioral disorders (MEB) that cause some level of impairment within a given year; however, fewer than 20% receive mental health services. MEB's are often not diagnosed until multiple problems exist. Adverse childhood experiences and their resulting MEB's are often not recognized until a person has dropped out of school, been hospitalized, entered the criminal justice system, or worse, has died from suicide.

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8 State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2011 Prevention Needs Assessment Survey Results, p. 40

9 Utah Department of Health. (July 2013). Utah Health Status Update: Neonatal Abstinence Syndrome. Retrieved from http://health.utah.gov/opha/publications/hsu/1307_NAS.pdf

10 (SHARP) 2011 Prevention Needs Assessment Survey Results

11 (SHARP) 2011 Prevention Needs Assessment Survey Results

12 www.useonlyasdirected.org

13 Centers for Disease Control and Prevention. Mental health surveillance among children – United States, 2005—2011. MMWR 2013;62(Suppl; May 16, 2013):1-35.

DSAMH estimates 24,760 children and youth were in need of and did not receive mental health treatment services in fiscal year 2013. This is in addition to the many other children and youth who could have benefited from mental health promotion (similar to health and wellness programs), mental illness prevention (addressing risk and protective factors), and early intervention services (for youth who are showing symptoms, but may not yet have a diagnosable illness). Early investment in mental health promotion, mental illness prevention and early intervention before symptoms become a disorder, offers the best opportunity for positive emotional, physical, and economic outcomes in our children, families, and communities.

Early Intervention

Three evidence-based programs that take advantage of this window of opportunity are: school-based behavioral health, Family Resource Facilitation with Wraparound to Fidelity, and mobile crisis teams.

School-Based Behavioral Health

In collaboration with the Utah State Office of Education, local mental health and substance abuse authorities partner with local schools in their area to provide school-based mental health services. Parent consent and involvement is integral for all school-based services. Services vary by school and may include individual, family, and group therapy; parent education; social skills and other skills development groups; Family Resource Facilitation and Wraparound; case management; and consultation services. Behavioral health services in schools promote healthy children and youth, and in turn increases academic success. School-based programs are accessible in 138 schools.

Family Resource Facilitation with Wraparound to Fidelity

Family Resource Facilitators (FRFs) work with families and youth who have complex needs to build a plan that incorporates both formal supports (e.g., mental health/substance abuse treatment, educational assistance, juvenile court engagement, etc.) and informal supports (family members, Boy Scouts, clergy, etc.). This process facilitates a partnership with all child service agencies involved with that child and family and facilitates coordination of service plans rather than having fractured or duplicated services. Additionally, many FRFs also partner with schools and community agencies by facilitating or participating in local interagency coordinating committees.

FRFs are trained, coached, and supervised by family mentors from NAMI Utah, Allies with Families and New Frontiers for Families. There are 38 certified FRFs statewide and Family Resource Facilitation and Wraparound services are accessible in 27 of the 29 Utah counties.

Mobile Crisis Teams

Access to crisis services increase the likelihood that families are linked to help before a tragedy occurs. Mobile crisis teams (MCT) help children and adolescents remain in their own home, school and community, and avoid out-of-home placements. MCT also help reduce police and juvenile justice involvement. MCT are now accessible in 4 of the 5 Utah counties that have a population over 125,000.

Common elements in each of Utah's youth mobile crisis teams include: 24-hour crisis line, mobile response, 2-person response, and a licensed therapist as part of the response team. Families may contact the MCT when their child or adolescent is experiencing a mental, emotional, or behavioral crisis. Mobile crisis services provide a licensed therapist who responds in person to a home, school or other community location. Services include therapeutic intervention and safety planning. Services may also include crisis respite and linking to community resources. When necessary, access to medication services may also be available.

Early intervention helps families access needed services during important developmental periods in their child's or adolescent's lives. Early intervention also supports and strengthens families and makes a positive, lasting impact in the lives of children and youth throughout the state.

Strategy Two: Reduce Utah's rate of suicide

Our second strategy to improve health, provide hope and healing is to work to reduce Utah's suicide rate. Suicide and suicidal behaviors are a growing concern in Utah and exact a heavy human and economic toll on individuals, families, and communities. Suicide impacts people from all socioeconomic backgrounds, all ages, and all racial and ethnic backgrounds. In Utah, 10 people per week lose their lives to suicide and 12 people are treated daily for suicide attempts.[14] Suicide is the 8th leading cause of death for Utahns and our state ranks 7th in the nation for suicide deaths.[15] Over the last decade the number of suicides in the U.S. has increased by 25%.[16] During the same time, suicides in Utah have increased by 46% almost doubling the previous year's suicide rate.[17] Research suggests that suicide is largely preventable. DSAMH is leading an effort to help communities understand that we all have a role to play in suicide prevention.

Suicide prevention is a priority nationally and locally. DSAMH established a goal of "zero suicides" in Utah. DSAMH co-chairs the Utah Suicide Prevention Coalition, and using the National Strategy for Suicide Prevention as a template revised the State Suicide Prevention Plan. They partnered with state agencies to examine and use suicide related data, formed public and private partnerships, worked with local coalitions to identify and implement suicide prevention strategies, and worked to improve clinical care related to suicide prevention statewide.

Solid partnerships within the public and private sector are critical. The Utah Suicide Prevention Coalition is dedicated to suicide prevention and membership includes: the Utah Department of Health, Veterans Administration, Hill Air Force Base, Utah Air and Army National Guard, law enforcement, local health departments, health care provider, behavioral health providers, suicide survivors, University of Utah researchers, Utah State Office of Education, legislators, mental health consumers, NAMI Utah, and other key stakeholders.

DSAMH, the Department of Health and the Utah Suicide Prevention Coalition created a Utah Suicide Prevention Plan. This comprehensive plan promotes the message that "Everyone has a Role to Play" in suicide prevention. The plan has nine goals with objectives and activities outlined to meet each goal. The goals are:

- Promote public awareness that suicide is a preventable public health problem
- Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts
- Improve the ability of all health providers and first responders to better support individuals at risk for suicide
- Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by helping professionals
- Increase access to health and behavioral health services, prevention programs, and other community resources

[14] Utah Department of Heath. Utah Suicide Facts. Retrieved from http://www.health.utah.gov/vipp/pdf/Suicide/SuicideInforgraphic.pdf

[15] Ibid.

[16] Ibid.

[17] Ibid.

- Develop policy to promote mental health, prevent mental illness, and eliminate suicide
- Promote efforts to reduce suicide by reducing access to lethal means
- Improve surveillance, data, research, and evaluation relevant to suicide prevention
- Provide care and support to those affected by suicide and implement community strategies to prevent contagion

Prevention by Design is a partnership between DSAMH, NAMI Utah, and local community coalitions that addresses statewide suicide deaths across the lifespan. Coalitions evaluate local data, identify local priorities and risk factors, then use this information to select and implement evidence-based strategies to prevent suicide and to promote mental and behavioral health. Programs such as Question, Persuade, Refer (QPR) Mental Health First Aid, Hope For Tomorrow, and Positive Action Program, are successfully used by coalitions to train and educate community members.

In 2013, the Utah State Legislature passed a law creating a suicide prevention coordinator position at DSAMH and at the Utah State Office of Education (USOE). Since then, DSAMH and USOE have been working together to further suicide prevention efforts statewide. Efforts involve providing training at professional conferences, including arranging for Melanie Puorto, Kelly Posner and David Covington, national suicide prevention experts, to present at Utah conferences. DSAMH and the Department of Health are partnering on a data sharing project to learn more about suicide deaths of individuals connected to the public mental health and substance use system in order to prevent future suicides. Suicide prevention is a top priority and DSAMH will continue to promote strategies to prevent suicide and to improve the mental health of all individuals and families in Utah.

Strategy Three: Develop a recovery-oriented system of care led by people in recovery that is trauma-informed and evidence-based

Substance use disorder and mental illness are diseases.[18] Far too often, treatment uses acute care interventions rather than a disease management approach. For many people seeking recovery, this has created a revolving door of multiple acute treatment episodes. Treatment needs to expand beyond acute care to reflect the chronic nature of both disorders and to develop a recovery oriented system of care, led by people in recovery, that is trauma informed and evidence based.

The Substance Abuse and Mental Health Services Agency (SAMHSA) found:

"Creating a recovery oriented systems of care requires a transformation of the entire system as it shifts to becoming responsive to meet the needs of individuals and families seeking services. To be effective, recovery oriented systems must infuse the language, culture, and spirit of recovery throughout their system of care. They have to develop values and principles that are shaped by individuals and families in recovery. These values and principles provide the foundation for systems that provide:

- *Accessible services that engage and retain people seeking recovery;*
- *A continuum of services rather than crisis-oriented care;*
- *Care that is age- and gender-appropriate and culturally competent; and*
- *Where possible, care in the person's community and home using natural supports."*[19]

[18] National Institute on Drug Abuse

[19] Kaplan, L. (2008). The Role of Recovery Support Services in Recovery-Oriented Systems of Care. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Services, Substance Abuse and Mental Health Services Administration. p. 3

DSAMH is committed to making this change. Contract requirements, practice guidelines, division directives and data requirements have been modified to ensure services are responsive to the needs of individuals and families. Initiatives such as peer support, Access To Recovery, trauma-informed care, supported employment and supported education are examples of DSAMH's commitment to this change.

Utah's Peer Support Services

Individuals who have experience with substance use disorder and mental illness can play an important role by helping others. Peers give encouragement, hope, assistance, guidance and understanding to those working to recovery. Peer support in Utah is provided by Certified Peer Support Specialists (CPSS) for adults and by Family Resource Facilitators (FRF) for children, youth, and families. Community partners have played a critical role in the development of peer support services in Utah. These partners include: Allies with Families, Empowerment Services, National Alliance on Mental Illness (NAMI) Utah, New Frontiers for Families, and Utah Support Advocates for Recovery Awareness (USARA).

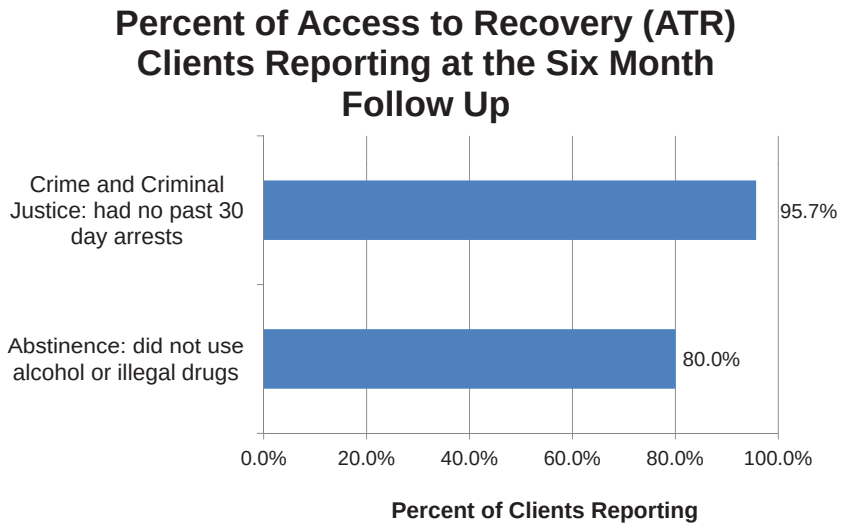
In the 2012 Legislative session, House Bill 496 authorized DSAMH to develop in rule the requirements for substance use disorder peer specialists. In December 2012, Administrative Rules R523-2 and 523-3 were finalized, establishing the Adult Peer Support Specialist Training and Certification, and Child/Family Peer Support Specialist Training and Certification programs. These rules establish the requirements to become a peer support specialist for both substance use disorder and mental health services or a child/family peer support specialist, and the role of the DSAMH in the training and certification.

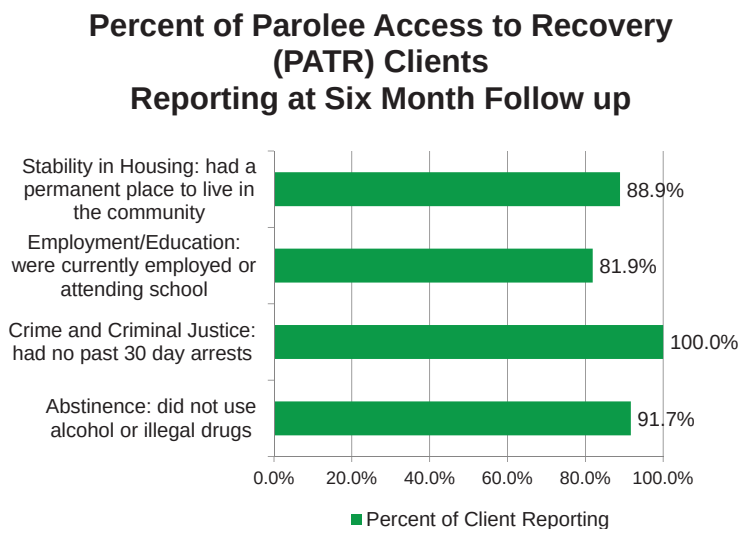
Currently, peers are employed in each of the local mental health authorities and in several other partner agencies. This opportunity strengthens the peers commitment to their own recovery, helps others recover, and over time, changes the culture of the agency and system in which they work.

Access to Recovery

Access to Recovery (ATR) allows individuals to find their own path to recovery. Individuals develop a personal recovery plan, choose the services and providers that they believe will be beneficial. Vouchers are provided to individuals and may be used for preventative services, treatment, or recovery support. Participation in ATR is not limited to those who have been in treatment. Some have, some have not.

ATR has significantly increased the service array. Vouchers can be used for bus passes, emergency housing, sober housing, GED testing, help securing state ID cards, child care, online recovery support, medication assisted recovery, and educational services. Case managers also help individuals identify other resources in the community not available through ATR.





Individuals participating in ATR have multiple needs. Navigating public resources can be overwhelming. ATR case managers provide direction, support and motivation. They also assist individuals develop their recovery plan and choose services and providers. Case managers maintain close contact and are available to resolve concerns or modify recovery plans as needed.

ATR is a success. Six months after entrance, 80% of surveyed participants are not using alcohol or drugs and 96% have had no arrests in the prior 30 days. In addition, participants are finding jobs, going to school, and finding a permanent place to live.

Since its inception ATR has served 6,846 individuals in Salt Lake, Utah, Weber, and Davis counties. The average cost per person for ATR services is $639. This compares favorably with the cost of serving an individual in the traditional system. In addition, as ATR provides supports such as housing and transportation it increases the likelihood that an individual attending traditional treatment will maintain services for a longer period of time.

In fiscal year 2013, ATR was expanded and began serving individuals paroling from state prisons. This program is called Parolee-Access to Recovery (PATR). Parolees, parole officers, and corrections administration agree this has filled a need within corrections for parolees entering back into the community with a history of substance use disorders. To date PATR has served 279 individuals with an average cost per parolee of $854.

PATR seems to be helping ease this transition to the community. Six months after starting PATR, 92% of respondents are not using alcohol or drugs, 100% have had no arrests in the 30 days prior, 82% were employed or attending school and 89% had a permanent place to live in the community.

Trauma-Informed Care

Most individuals with substance use disorders and mental illness are also dealing with trauma. Between 34% and 53% of people with a severe mental illness report childhood physical/sexual abuse.[20] A Center for Substance Abuse Treatment publication states that as many as two-thirds of women and men in treatment for substance abuse report experiencing childhood abuse or neglect.[21] Estimates of lifetime exposure to interpersonal violence in persons with severe mental illness are between 43% and 81%.[22] Child abuse, sexual assault, military combat, domestic violence, and a host of other violent incidents help shape the response of the people we serve. Adverse childhood experiences are strongly related to develop-

[20] Greenfield, S.F., Strakowski, S.M., Tohen, M., Batson, S.C., & Kolbrener, M.L. (1994). Childhood abuse in first episode psychosis. British J of Psychiatry, 164, 831-834. 2. Jacobson, A. & Herald, C. (1990). The relevance of childhood sexual abuse to adult psychiatric inpatient care. Hospital and Community Psychiatry, 41, 154-158.

[21] Center for Substance Abuse Treatment. Substance abuse treatment for persons with child abuse and neglect issues: TIP #36. DHHS Pub No. (SMA) 00-3357, 2000. Washington, DC:US Government Printing Office.

[22] Ibid

ment and prevalence of a wide range of health problems, including substance abuse and mental illness.[23] Neurodevelopment is altered by exposure to chronic stressful events. This disruption can impede a child's ability to cope with negative or disruptive emotions and contribute to emotional and cognitive impairment. Over time, and often during adolescence, children exposed to trauma adopt coping mechanisms, such as substance use. Eventually, this contributes to disease, disability and social problems, as well as premature mortality.

As part of a Department of Human Services (DHS) initiative to implement a trauma-informed approach in providing services, DSAMH hired Dr. Stephanie Covington to provide training on January 8-9, 2013, on trauma-informed care for DHS directors and managers. As a result of this training, DSAMH, along with the other DHS divisions, is developing and implementing a plan to incorporate a trauma-informed approach in its services, practices, policies, and procedures.

Trauma-informed care is one of the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) primary initiatives. They describe a program, organization or system that is trauma-informed as one that: (1) ***realizes*** the prevalence of trauma and taking a universal precautions position; (2) ***recognizes*** how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) ***responds*** by putting this knowledge into practice; and (4) ***resists retraumatization***.

DSAMH will continue in its efforts over the next several years to incorporate a trauma-informed approach in their services by changing policies and practices and providing training and technical assistance for the local authorities and community partners.

[23] Ibid

Supported Employment

Supported employment is an evidence-based practice that helps individuals with mental illness by helping them find a job and provides ongoing support to ensure success in the workplace. Valley Mental Health in Tooele County received funding from DSAMH to pilot supported employment services to young people with mental health conditions transitioning into adulthood.

Valley Mental Health in Tooele is approved to be Community Rehabilitation Provider which allows them to receive payments from Vocational Rehabilitation to support vocational rehabilitation eligible individuals in employments. It is also approved for the Ticket to Work program for the Social Security Administration, which allows it to receive additional funding for supporting people who receive Social Security Disability Insurance or Supplemental Security Income benefits in employment. In fiscal year 2013, the employment specialist met with 148 persons and placed at least 39 in meaningful employment.

Supported Education

Mental illness often begins when young people are still in school. Their educational accomplishments are impeded by the onset of the illness. This directly affects their abilities to obtain and maintain meaningful employment. Supported education, a promising practice, is similar to the supported employment in the philosophy and approach. It provides individualized support to people with psychiatric disabilities so they may succeed in their educational pursuits.

Many young people choose to enhance their education as a way to improve their outlook in adulthood. Through a Federal grant DSAMH provided funding to Valley Mental Health in Tooele County to implement the supported education program. In fiscal year 2013, the part-time education specialist worked with 50 individuals.

Six individuals completed secondary education (obtaining high school diploma or GED) and 35 enrolled into post secondary education (university or technical school/college).

Strategy Four: Develop a system of care for adolescents that is family-driven, youth-guided, community-based, and culturally and linguistically competent

The Department of Human Services is committed to a system of care for all children, youth and their families. It is our belief that the needs of children, youth, and families should guide the types and mix of services provided and should not be dependent on the referral source or available funding streams. The Department of Human Services and its Divisions of Substance Abuse and Mental Health, Child and Family Services, Juvenile Justice Services, and Services for People with Disabilities are committed to implementing the processes, cultural, and organizational changes needed to realize the values and improved outcomes resulting from a system of care approach.

In 2013, DSAMH received a one-year planning grant to develop a comprehensive statewide strategic plan for improving and expanding services using a system of care approach for children and youth, from birth to 21 years of age, and their families who have, or are at risk of developing, serious mental health conditions. A system of care provides effective, community-based services and supports organized into a coordinated network that build meaningful partnerships with families, children and youth and address cultural and linguistic needs to help them function better at home, in school, in their community, and throughout life.

A comprehensive strategic plan was developed by a statewide steering committee to improve, implement, expand, and sustain services and supports using a system of care approach throughout the state. This plan was shared with local community-based service systems and will be modified and adapted based on local needs and resources. As state agencies and local communities work together, we can ensure that children, youth, and their families receive effective, community based services using a system of care approach.

Strategy Five: Integration of mental health, substance use disorder and physical healthcare

Concerns over the quality, cost, and access to effective healthcare is driving healthcare reform discussions. There is growing recognition that behavioral health is essential to health and that some of our current problems are related to lack of access to effective behavioral healthcare.

- People with serious mental illness (SMI) are dying 25 years earlier than the general population.[24]
- Almost one-fourth of all adult stays in U.S. community hospitals involve mental or substance use disorders.[25]
- Mental disorders are the third most costly health condition behind only heart conditions and injury-related disorders.[26]

DSAMH recognizes that integration is a significant challenge. However, much work has been done to ensure access to integrated services. Implementation of healthcare reform, integration of physical health and behavioral health, Whole Health Action Management (WHAM) and Recovery Plus highlight our efforts to integrate care.

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[24] Mental Health: Research Findings: Program Brief. September 2009. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/factsheets/mental/mentalhth/index.html

[25] Ibid.

[26] Ibid.

Healthcare Reform

Enacted on March 23, 2010, the Patient Protection and Affordable Care Act (ACA) is expected to expand health care coverage to over 300,000 Utahns through the health insurance marketplace. The Governor has not made a decision on Medicaid expansion as of the printing of this report. Medicaid expansion would impact all adults below 138% of the federal poverty level, regardless of disability. Of this newly covered population, DSAMH estimates that approximately 20% will need behavioral health (mental health and/or substance use disorder) services. The ACA enacted a number of requirements to ensure that newly covered individuals would have better access to behavioral health services starting in 2014.

ACA requires all insurance plans selling coverage through a health insurance marketplace to cover a set of 10 essential health benefits (EHB). Included in the EHB is coverage for both mental health and substance use disorders. The law also builds upon the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (parity law), and requires mental health and substance use disorder services be covered on par or at parity with medical and surgical benefits. During fiscal year 2013, DSAMH worked to educate state policy makers and other stakeholders on parity law requirements.

Many of the people currently served by Utah's public behavioral health system are expected to gain access to health insurance as a result of the ACA, particularly if the state chooses to implement the optional Medicaid expansion program. A national report published by the National Association of State Mental Health Program Directors (NASMHPD, 2013) found:

- Nearly 40,500 adults who are uninsured in Utah (not covered by a public or private health insurance program) with a substance abuse disorder would be eligible for Health Insurance coverage through the Health Insurance Exchange, new Medicaid expansion program and the current Medicaid program.[27]
- Nearly 58,000 individuals who are uninsured in Utah (not covered by a public or private health insurance program) with a serious mental illness are eligible for health insurance coverage under the Health Insurance Exchange, new Medicaid expansion program and the current Medicaid program.[28]

Integration

Nationally and in Utah, the integration of behavioral and physical healthcare is being identified as part of the solution to our healthcare woes. House Bill 57, sponsored by Representative Dean Sanpei, and passed by the 2013 Utah Legislature, requires DSAMH to promote integrated programs that "address an individual's substance abuse, mental health, and physical health." It also requires local authorities (counties) to cooperate with DSAMH in the promotion of these integrated services. DSAMH is further tasked with ensuring that services delivered by local authority systems result in improved overall health and functioning. Finally, DSAMH must evaluate the effectiveness of these integrated programs in regards to their impact on emergency department utilization, jail and prison populations, the homeless population, and the child welfare system.

Integration across the state is varied. While some local authorities make referrals as needed for people to see primary care physicians, other local authorities are fully integrated with healthcare clinics on site.

In addition to reviewing local authority plans, DSAMH has been working with the Department

[27] Miller, J. E. & Maududi, N. (2013). NASMHPD Resource Management Guide: Impacts of Affordable Care Act on Coverage for Uninsured People with Behavioral Health Conditions. Retreived from http://www.nasmhpd.org/docs/State%20RMG%20Reports/UT%20Report.pdf

[28] Ibid.

of Health Medicaid staff to identify quality measures as well as ways to work together in a more integrated fashion. The Department of Health Medicaid program currently contracts with four Accountable Care Organizations (ACOs) to administer Medicaid to enrollees living along the Wasatch Front. The ACOs are charged with ensuring quality physical health services to Medicaid recipients, while the local authorities are charged with ensuring quality behavioral health services to Medicaid recipients. We have been working together collaboratively to bring the ACOs and local authorities together in an effort to provide a continuum of services for both an individual's physical and behavioral health. DSAMH and the local authorities have also developed a fruitful partnership with Federally Qualified Health Centers (FQHCs) in Utah. While there is still much to do, major steps have been taken to provide integrated services.

Whole Health Action Management

Whole Health Action Management (WHAM) is a training program offered to Certified Peer Support Specialists to enhance their work with individuals with behavioral health issues. The program is used to encourage increased resiliency, wellness, and self-management of health and behavioral health among people with mental health and substance use disorders.

This program helps individuals who are receiving services for their behavioral health disorders by enhancing their recovery using a "whole person" approach; the mental, physical, and spiritual health of an individual. These are broken up into 10 health and resiliency factors: stress management, healthy eating, physical activity, restful sleep, service to others, support networks, optimism based on positive expectations, cognitive skills to avoid negative thinking, spiritual beliefs and practices, and a sense of meaning and purpose.

The skills learned include developing a "whole health goal" and then utilizing weekly action plans to carry out reasonable steps to accomplish the individual's goal. Participants are also taught to participate in peer support groups to assist and encourage one another and to elicit the relaxation response to manage their stress, among others.

By focusing on all of these aspects of wellness, mainly mental, physical, and spiritual health, an individual in recovery is better suited to be successful in their many aspects of their life beyond the stabilization of their mental health and/or substance use disorder.

Recovery Plus

Tobacco use disproportionately impacts the health and well being of individuals with substance use disorder and mental illness. Nationally, within behavioral health treatment facilities, approximately 80-90% of people smoke cigarettes.[29] More alcoholics die of tobacco-related illness than alcohol-related problems.[30] Equally striking is that 44% of all cigarettes are consumed by individuals with addictions or mental health co-morbidities.[31] In Utah, DSAMH found that 9% of adults smoke yet 68% of individuals in treatment for substance use disorder smoke.

In 2010, DSAMH partnered with the Utah Department of Health to launch Recovery Plus. This initiative is a long-term project designed to improve the health and quality of life for individuals we serve by increasing the number

[29] Richter, K.P., Choi, W.S., and Alford, D.P. (2005). Smoking policies in U.S. outpatient drug treatment facilities. Nicotine and Tobacco Research, 7:475-480.

[30] Hurt, R.D., Offord, K.P., Vroghanm, I.T., Gomez-Dahl, L., Kottke, T.E., Morse, R.M., & Melton, J. (1996). Mortality following inpatient addictions treatment. Journal of the American Medical Association, 274(14), 1097-1103.

[31] Lasser, K., Boyd, J.W., Woolhandler, S., Himmelstein, D.U., McCormick, D., & Bor, D.H. (2000). Smoking and mental illness: A population-based prevalence study. Journal of the American Medical Association, 284(20), 2606-2610.

of individuals who live tobacco free while recovering from a mental health or substance use disorder. Initially supported by a federal stimulus grant from the Centers for Disease Control and Prevention, the project was designed to take three years to provide the local authorities time to assess their local needs, develop plans to tailor the initiative to their circumstances, implement the needed education, and then fully implement the program. The final implementation date for all of the local authorities was March 2013.

A key element of Recovery Plus is that use of tobacco will be identified early in each person's treatment, and that it will become part of their treatment record. Additionally, if a person expresses interest in becoming tobacco free, then support through counseling, education, and where appropriate and possible, medications will be provided.

While the initial planning and development phase of Recovery Plus was completed in 2013, full implementation will continue through 2013 and beyond. In 2013, DSAMH is monitoring each agency's implementation of tobacco free programming as part of its annual review. For additional information about Recovery Plus, visit: recoveryplus.utah.gov.

Education and Training

Utah's Peer Support Training and Certification

Certification is awarded by the Division of Substance Abuse and Mental Health (DSAMH) after participants complete a comprehensive 40-hour training program and by passing a written examination. Certified Peer Support Specialists (CPSSs) and Family Resource Facilitators (FRFs) receive ongoing weekly individual and/or group supervision by a licensed mental health therapist. FRFs receive additional training, coaching, and supervision for the provision of Wraparound services to ensure fidelity. In addition, CPSSs and FRFs must successfully complete 20 hours of continuing education each year in order to maintain certification.

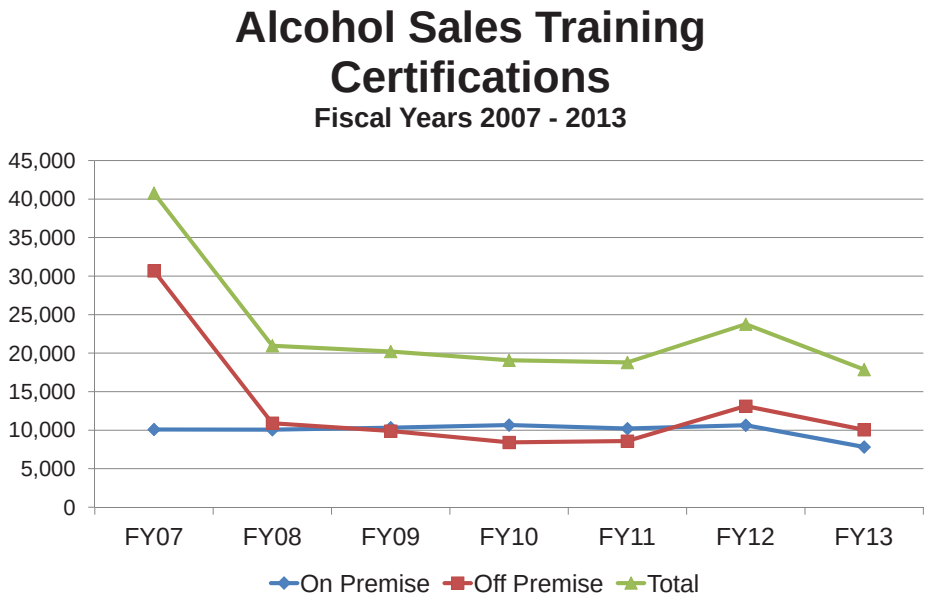
The 40-hour training program for CPSSs has been provided by the Appalachian Consulting Group, one of the nation's leading experts in peer specialist training and certification.

The 40-hour training program for FRFs has been provided by members of the Utah Family Coalition which is a partnership between Allies with Families, National Alliance on Mental Illness (NAMI) Utah, and New Frontiers for Families.

In 2013, there were 104 CPSSs with active certifications and there were 38 FRFs with active certifications.

On-Premise and Off-Premise Alcohol Sales Training Certification

DSAMH certifies providers that train people who sell beer and other alcoholic beverages in Utah. The graph below shows the numbers of people trained to sell beer in grocery and convenience stores (off-premise) and serve alcohol in bars, clubs and restaurants (on-premise). The jump in off-premise trainees in fiscal year 2012 represents the 5-year anniversary of the EASY law; all off-premise trainees must recertify at least every 5 years. During fiscal year 2013, 10,054 people were trained to sell beer for off-premise consumption and 7,818 people were trained to serve alcohol for on-premise consumption.



Driving Under the Influence (DUI) Education

DSAMH oversees the training of instructors who teach DUI Education classes. There are currently more than 200 certified DUI Instructors in Utah. These instructors use the *PRIME For Life* standardized DUI education program consisting of 16 hours of learning, self evaluation, and relevant group activities to help DUI offenders learn to make low-risk choices about alcohol and drug use. During fiscal year 2013, 7,579 people attended DUI Education classes.

PRIME for Life DUI education outcomes are measured every other year. A large percentage of participants in Utah who attended the *PRIME For Life* program in 2010-2011 reported positive reaction; 81% reported that the class helped them to decide to drink less, feel confident about doing so, and develop the needed skills to change behaviors.

Crisis Intervention Team–Utah

CIT training is designed to assist law enforcement officers to effectively respond to individuals experiencing a mental health crisis. The CIT officers learn to identify characteristics of various mental health disorders, and provide the safest intervention possible for the consumer, the community, and the officers. CIT officers gain an understanding of available options to assist in finding the best solution for the consumer and the community. Officers from uniformed patrol divisions volunteer to participate in the training.

The first Utah CIT academy was held in 2001. Each year, more agencies become part of the team and the team's cadre of officers continues to grow. CIT Utah has increased awareness about the importance of addressing mental health issues throughout the state. Mental health consumers and their families now ask for CIT officers when contacting law enforcement for assistance. CIT Utah Regional Coordinators are involved in developing other local programs to assist with the reduction of mental health consumer's involvement in the criminal justice system through local efforts with the local mental health authority and through statewide efforts with DSAMH.

During the last year, 15 CIT academies were conducted where 350 individuals from 73 different agencies became certified. This raised the state totals to 1,673 sworn CIT officers among 108 law enforcement agencies. The total for CIT training among non-sworn members of the law enforcement team rose to 213. Continuing education opportunities and trainings, including annual trainings in Salt Lake City and St. George during December 2012, allowed 563 CIT officers to maintain certifications.

Currently, 10 of Utah's 13 regions participate in the CIT Utah Program and conduct CIT academies. CIT Utah still continues to provide CIT Academies for correction officers through its partnership between the Salt Lake County Sheriff's Office, the Utah Department of Corrections, and the Salt Lake City Police Department.

CIT is recognized as a valuable and efficient statewide model. In 2012, the Utah State Legislature provided on-going funding for the program. The Salt Lake City Police Department, as the administrating agency for the CIT Utah program, continues to be one of six national learning sites for specialized police response. The Council of State Governments will provide support for law enforcement agencies throughout the nation to receive counsel and training from CIT Utah. In an attempt to strengthen national support of CIT programs, CIT Utah continues to be represented by a member of its administration as a Director of CIT International. CIT Utah raises awareness, increases understanding, and averts tragedies.

Peer/Consumer Conference

DSAMH in partnership with Empowerment Services held the 2nd State Peer/Consumer Conference at the Radisson Hotel in downtown Salt Lake City, Utah on September 13, 2013. This conference was for current or past consumers of mental health services.

The conference featured Leah Harris as the keynote speaker. She is a mother, psychiatric survivor, and artist/activist. She has spoken and written widely to promote human rights, dignity, healing, and self-determination at conferences including Alternatives, and the National Conference on Organized Resistance. She is the Communications and Development Coordinator at the National Empowerment Center.

There were nine break-out sessions with a variety of topics that are of interest to peers focusing on the principles of recovery and a model of person-centered care that values attention to the whole person where dignity and respect are the priority. Workshops were on a variety of topics from whole health to trauma informed care, and suicide prevention.

Critical Issues Facing Children and Adolescents Conference

The 16th Annual Critical Issues Facing Children and Adolescents Conference was held October 30-31, 2013, at the Salt Lake Hilton Center. The focus of this conference was on: (1) increasing awareness and knowledge of critical behavioral health issues facing youth; (2) providing effective prevention and intervention working tools to properly intervene with youth facing behavioral/mental health and/or substance use disorder issues; (3) developing strategies to more effectively promote healthy growth and development of youth; and (4) raising familiarity with current resources that will benefit programs and provide methods of navigating around existing gaps.

Generations Conference

The 2013 Generations Conference was held April 15-16, 2013, at the Salt Palace Convention Center. This conference provided the latest information and most effective practice techniques in the areas of addiction and behavioral health with specific programs designed for specialized areas such as family work, couples therapy, geriatrics, autism, and military individuals and families. This was the second year that the Utah Veterans and Families Summit was held in conjunction with Generations.

Seeking Safety Training

DSAMH sponsored the Seeking Safety Training, by Dr. Lisa Najavits May 1-2, 2013. Ms. Gabriela Grant, M.S. facilitated this training event. The goal of the training was to describe Seeking Safety, an evidence-based treatment for trauma and/or substance abuse. The training covered: (a) background on trauma and substance abuse (rates, presentation, models and stages of treatment, clinical challenges); and (b) implementation of Seeking Safety (overview, evidence base, demonstration of the model, adaptation to settings, frequently asked questions, fidelity monitoring, and clinician training). Assessment tools and community resources were also described. By the conclusion of the training, participants obtained the skills and tools to implement Seeking Safety in their setting. Approximately 100 treatment and prevention professionals attended this training from across Utah and a few representatives from Florida.

Utah Fall Substance Abuse Conference

The 35th Annual Utah Fall Substance Conference was held at the Dixie Convention Center in St. George, September 25-27, 2013. The primary focus of the conference this year was on trauma-informed care, which was addressed in several workshops and keynote presentations. Two outstanding presentations on trauma-informed care were provided by William Kellibrew and Tonier Cain from Federal Substance Abuse and Mental Health Services Administration. In addition, the prevention track incorporated “state-of-the art” live social media feeds from the audience on a projection screen during their session. The goal of this conference each year is to bring the most current information and tools for providers and community partners for substance use disorders. This conference was divided into three different

tracks: treatment, prevention, and justice/drug court. Over 860 professionals were registered for the conference this year.

University of Utah School on Alcoholism and Other Drug Dependencies

The 62nd Annual University of Utah School on Alcoholism and Other Drug Dependencies was held on June 16-21, 2013 at the University of Utah. This conference was divided into group sections to provide specialized information and techniques for working effectively with substance use disorders in various disciplines: (1) American Indian; (2) Dental; (3) Drugs: Treatment and Rehabilitation; (4) Education and Community Prevention; (5) Nursing; (6) Pharmacy; (7) Physicians; (8) Professional Treatment; (9) Recovery Support; (10) Relapse Prevention Counseling; (11) Substance Abuse Overview and Current Issues; and (12) Vocational Rehabilitation. As in years past, this conference was well attended by various professionals across Utah.

Statewide Drug Court Conference

DSAMH, in partnership with the Utah Administrative Office of the Courts (AOC), held the 4th Statewide Drug Court Conference on October 24 and 25, 2013. The conference is designed to ensure that Utah Drug Courts are using evidence-based best practices in their day-to-day operations.

More than 300 participants attended from every corner of the state. Drug court teams comprised of judges, prosecutors, defense attorneys, treatment providers, court coordinators, and law enforcement professionals were in attendance.

The two-day event featured a variety of learning opportunities related to topics such as:

- Adverse childhood experiences and entry into the prison pipeline
- Trauma informed care
- Health care reform and drug courts
- Updated utah drug court certification standards
- National drug court best practices

Community Outreach Efforts

DSAMH engages in hundreds of community outreach interactions each year to foster a better understanding of the symptoms, causes, treatment and prevention of substance use disorders and mental illness. In 2013, DSAMH staff and partners invested thousands of hours to educate, inform, and motivate stakeholders and constituents to dispel myths surrounding these important societal issues.

DSAMH staff members lead efforts in many areas to guide the strategic direction of the publicly funded prevention and treatment system. Some examples are:

- Mental Health First Aid
- Suicide Prevention–QPR
- Constituent problem solving and information requests
- Women’s health
- Mental Health Early Intervention
- Peer Support Specialist Certification
- Designated and Forensic Examiner Certification
- Fetal Alcohol Syndrome
- Communities That Care
- Trauma Informed Care
- Smoking Cessation

Partnerships

Individuals and Families

USARA

The Division of Substance Abuse and Mental Health (DSAMH) partners with Utah Support Advocates for Recovery Awareness (USARA), a non-profit recovery community organization made up of individuals who are in recovery from alcohol and drug use and addiction, family members, friends and allies in our community. USARA's services are primarily developed and run by peers in recovery and others whose lives have been impacted by substance use disorders.

During National Recovery Month, USARA hosted the 10th Annual Recovery Day Celebration in Salt Lake City and supported statewide celebrations in Park City, Provo, Tooele, Ogden, and St. George. The Recovery Day events involve a community collaboration of peers in recovery, volunteers, and organizations working together to host activities to raise awareness about substance use prevention, treatment, and recovery support. The primary goal is to bring a message of hope to the communities of Utah that individuals and families suffering from substance use and addiction can and do recover!

Throughout the year, USARA supports ongoing activities designed to reduce the negative stigma about people with addiction, and to educate the public that substance use and addiction is a public health issue. In February during the Utah legislative session, USARA hosts the Rally for Recovery at the State Capitol, where Utahns who are impacted by public policy and funding issues related to behavioral health needs can have a voice to advocate for changes needed in our system to provide greater support for persons with addiction. USARA is a contributing partner in the promotion of a film documentary called, "The Anonymous People" and is hosting screenings throughout Utah to encourage people in recovery to become involved in community outreach both personally and civically, participating on councils and committees in their local area.

For the past two years, USARA has operated a Recovery Community Center in Salt Lake County where individuals, families, and others can access assistance for recovery support services and resources. The direct services include a weekly Family Support Group, the Access to Recovery Program, Family Resource Facilitator Project and various peer run support meetings to include all paths to recovery. Over the next year, USARA will work to develop programs establishing statewide trainings for Recovery Peer Specialists who can provide ongoing support for persons seeking individual recovery support.

Allies with Families

DSAMH partners 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 National 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' mission is "Empowering families with voice, access and ownership, through education, training and advocacy."

NAMI-Utah

DSAMH partners 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 living with

a 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 partners 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.

Providers

Opioid Treatment Providers (OTPs)

One of the most researched evidence-based treatment practices for individuals addicted to opiates is Opioid Replacement Therapy (ORT) using medications such as methadone or buprenorphine.

ORT relieves the craving and fear of withdrawal that accompanies addiction to opioids and allows individuals to function normally. There are currently 12 OTP clinics offering methadone and buprenorphine therapy in Utah. DSAMH conducts quarterly meetings with all of the OTPs to coordinate services, ensure that they are provided current information and negotiate policies and procedures to provide the broadest range of services across the state. There are also a total of 147 Utah physicians that offer buprenorphine treatment in an office-based treatment model.

Accountable Care Organizations

In January 2013, the Department of Health's Division of Medicaid and Health Financing (DMHF) began contracting with four Accountable Care Organizations (ACOs) to administer Medicaid services to enrollees living across the Wasatch Front. The ACOs are charged with ensuring quality physical health services to Medicaid recipients. The current contracted ACOs are HealthChoice Utah, Healthy U, Molina, and SelectHealth Community Care. DSAMH came together with DMHF to begin developing quality measures for ACOs and local substance abuse and mental health authorities (local authorities) for their delivery of Medicaid services.

These meetings represented new discussions on collaboration between the divisions as well as the ACOs and local authorities. While both groups knew they served similar clients, it became clear that all could become more efficient in providing coordinated services to these individuals. Several efforts to better coordinate services are in the development phases and will be implemented throughout the course of this year. Two of these include coordinating services for restricted Medicaid recipients and providing daylong in-service meetings with ACOs and local authorities.

Approximately 800 Utah residents are currently on a restricted status within the Utah Medicaid population. Individuals are identified as restricted due to an excessively high use of Medicaid services. As a restricted individual on Medicaid, one is allowed to see only one primary care physician and can utilize only one pharmacy; however, emergency department visits are not restricted to this population. Once an individual is placed on a restriction their case is reviewed yearly to determine if they can be removed from the restriction status. A majority of individuals placed on a restricted status have behavioral health conditions such as substance use disorders and/or mental health diagnosis. Most of these individuals are not referred to the behavioral health system for services to treat their underlying diagnosis which created their high utilization of Medicaid services. However, when they are referred there is not a coordinated effort between the ACO and the local authority. DSAMH and DMHF are working with

the ACOs and local authorities to begin making more referrals into the local authority systems in an effort to deliver those services which will treat the underlying diagnosis, thereby decreasing the time an individual remains on restricted status.

With four local authorities and four ACOs there are multiple systems of care to navigate. Each has its own points of entry and individuals who oversee programs. DSAMH and DMHF are planning a daylong in-service for ACO and local authority management to meet for the first time. The in-service will include review of each system, keynote speaker on integration of health and behavioral health, and review of ways each system can better coordinate current services. This kick-off in-service will launch a series of meetings bringing together different staff within the ACO and local authority systems from front line staff to administrators.

Government

Schools

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.

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 Education for implementation and evaluation of PD to ensure it meets the State Board of Education's core curriculum requirements.

Health

Medicaid. DSAMH has a collaborative working relationship with the Division of Medicaid and Health Financing, Department of Health to address public policy and financing of mental health and substance abuse services in concert with local mental health and substance abuse authorities. DSAMH also provides the qualitative review for Medicaid.

Utah Department of Health, Bureau of Child Development. DSAMH partners with The Utah Department of Health, Bureau of Child Development (BCD) to further help young children obtain optimal health care and services. DSAMH takes part in the Interagency Coordinating Council for Infants and Toddlers with Special Needs to help at the systems level of care and to advocate for children birth to three years of age. DSAMH also partners with BCD for Early Childhood Utah to ensure that all Utah children are able to enter school healthy and ready to learn. Both of these partnerships foster the development of cross-service systems and interagency collaboration to further aid children in Utah.

Juvenile Competency. During the 2012 Legislative General Session, House Bill 0393 (H.B. 393) was passed and signed into law, effective on May 8, 2012. The legislation created Utah's first juvenile competency to proceed law. The law enacts standards and procedures for juvenile competency proceedings in the Juvenile Court, clarifies duties and responsibilities of the Department of Human Services (DHS) in regard to juvenile competency, and defines terms. As part of the requirements of H.B. 393, two divisions within DHS, DSAMH and the Division of Services for

People with Disabilities are now responsible to: 1) conduct juvenile competency evaluations; 2) prepare and implement a competency attainment plan when ordered by the Court; and 3) partner with the juvenile court and the Juvenile Justice Services.

Federal Government

One of the most important partners for DSAMH is the Substance Abuse and Mental Health Services Administration (SAMHSA). Through its many service centers, primarily the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention and the Center for Mental Health Services, SAMHSA provides ongoing funding, innovation grants, up-to-date research and information regarding new treatment trends and methods. A significant portion of Utah's Substance Abuse funding is provided through the Substance Abuse and Prevention Block Grant and the Access to Recovery Grant.

Another major source of funding for DSAMH is the Center for Medicaid and Medicare Services, which along with the Mental Health Block Grant provides the majority of funding for Mental Health Services in Utah.

These partnerships, along with information and research provided by other Federal agencies are critical for DSAMH to continue to provide effective behavioral health services to Utah.

Communities

Coalitions

Communities That Care. Communities That Care (CTC) helps community stakeholders and decision makers understand and apply information about issues in their community that are proven to make a difference in promoting healthy youth development. Specific issues include underage drinking, substance abuse, violence, delinquency, school dropout, and anxiety and depression.

In an effort to encourage communities to increase effectiveness by increasing partnerships and decrease isolated initiatives within their community, DSAMH provides incentives to communities in Utah that commit to using CTC.

Tribes

DSAMH continues to meet with the Tribal Indian Issues Committee (TIIC) at its bi-monthly meeting. Communication remains open on how DSAMH can collaborate with the state's nine tribes by participating in their prevention efforts to reduce the risk of substance abuse and mental illness among the Native American tribes. DSAMH is also engaged in planning and discussing ways to develop a shared purpose and mission for TIIC and participating in several of the Native American conferences and celebrations, such as the annual Native American Summit.

DSAMH also offered scholarships to the TIIC for the Utah Substance Abuse Fall Conference that has been an ongoing partnership to help maintain prevention, treatment, and justice tracks for traditional Native American breakouts and presentations. DSAMH maintains a willingness and commitment to work with the nine Utah tribes in collaborating resources to reduce substance abuse related issues within traditional practices as well as increasing community resources.

Accountability

Monitoring

By Statute, DSAMH is responsible to ensure that funds are used effectively to provide services across the State and services meet quality standards laid out in rule and in contract. To accomplish these goals, it conducts formal monitoring visits, as well as ongoing monitoring of the local authorities through reports and data collection.

Formal Monitoring Visits: Each year DSAMH publishes Division Directives that outlines specific targets and goals for the local authorities, and provides guidance for their area plans. The area plans outline the local authorities plan to provide services with the funds allocated during the coming year. When approved by DSAMH, this plan becomes a formal document that is used as the basis for the formal monitoring visit. The monitoring schedule is established as part of the division directive process and is known well in advance of the visit. Checklists and monitoring tools are provided at the beginning of the year and are used as a yardstick for each local authority's performance.

Well in advance of each site visit, DSAMH and the local authority agree on the time and place for the opening meeting where a review of the local authority's current status and accomplishments over the previous year are discussed. The site visits last from one to three days, depending on the location, size, and number of programs that need to be reviewed. A review of the local authorities performance on a variety of performance measures is conducted, along with a review of clinical records, visits to programs and interviews with clients and consumers. The activities and operations of the local authority are compared to its area plan, contract and division directive requirements, and best practice guidelines. Input from the interviews and other consumer and community partner information is included in the final assessment process. At the close of the visit an interim report is provided to the local authority with an emphasis on strengths and progress since the last visit. Areas needing improvement and any areas meeting the criteria for a finding are also discussed during the closing interview. (See http://www.dsamh.utah.gov/docs/Divison%20Directives_FY2014%20FINAL.pdf page 2-3)

Approximately two weeks after the site visit a formal report is drafted and after a thorough review, sent to the local authority for a formal comment process before it is finalized.

While the above discussion covers only the monitoring process for the local substance abuse and mental health authorities, a similar process is used to monitor the other contracts that DSAMH has with prevention, treatment, recovery support, and other providers of services. Each contracted provider is monitored to ensure the proper and effective use of state resources.

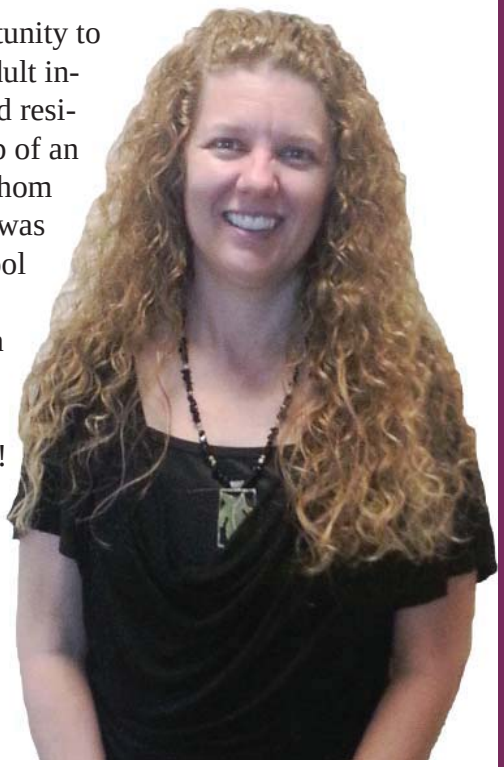
Ongoing Monitoring: DSAMH monitors the performance of its contracted agencies throughout the year through quarterly reviews of data submissions against area plan targets, quarterly reviews of outcome measures, monthly reviews of financial records and other reports, and reports received from individuals, families or agencies regarding DSAMH's provider agencies. The results of these informal monitoring processes are discussed with the agencies involved, and where necessary, a formal corrective action can be required.

Angi

I grew up in a tiny town in the middle of Utah. I was raised as an only child in the best family a kid could ask for. I often wonder if being the only child meant I had to take on all the roles of the children in a bigger family: hero, lost child, rebel, etc. I certainly played at least the hero and the rebel. I excelled in school and participated in extracurricular activities.

In the 7th grade I drank for the first time and loved the way it made me feel. I continued to drink on and off throughout middle school and high school, but avoided any negative consequences, mostly due to dumb luck. In college my use of alcohol escalated and I began using drugs as well. Toward the end of college, my use had caused serious problems in my life and I began to get arrested, with my last arrest several months after I graduated. I was facing possible prison time. I decided to enter residential treatment, more in hopes to get out of prison time, than to get help. While I was there I realized just how powerless I was over my use and how unmanageable my life had become. I became very involved in the recovery community and renewed a hope from my youth to become a counselor.

"There are many paths to recovery. Find the one that works for you."



I have had the opportunity to work in youth and adult intensive outpatient and residential. With the help of an amazing husband (whom I met in recovery), I was able to return to school and get my master's degree, while raising a beautiful daughter. Upon completion of graduate school I helped open a women and children's residential program. It has been the most rewarding work of my career! I also enjoy giving back to the recovery community by sitting as the chairperson for our local Recovery Day celebration.

Being in recovery doesn't mean I don't have any problems, it just means I have the tools to cope with them. My family, friends, camping, and hiking are a big part of my recovery. I also use yoga and meditation as a way to find balance and serenity in my life.

My hope is that by sharing my story, others will find the strength to confront their demons and find the peace that I enjoy.

Outcomes

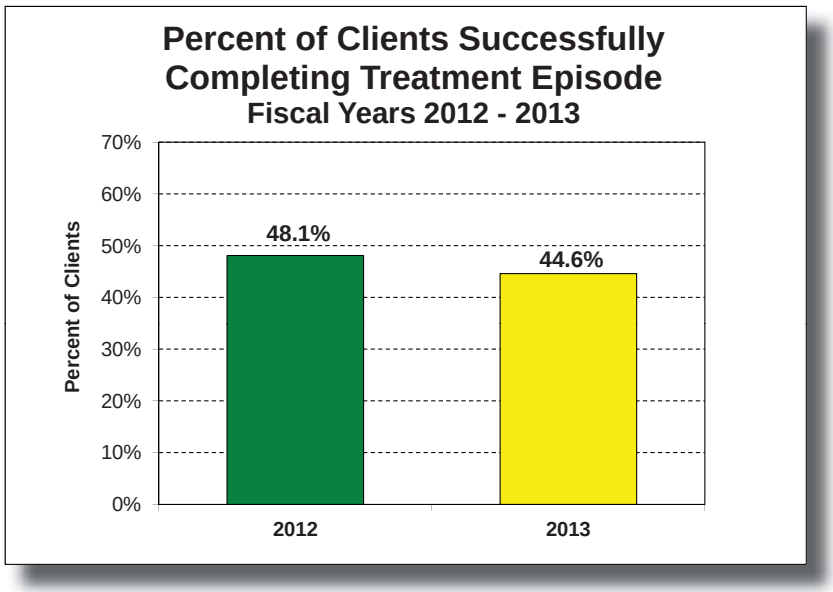
DSAMH monitors and evaluates programs provided by local substance abuse authorities (LSAAs) and their contracted providers. For a number of years, DSAMH has published detailed scorecards that measure and compare local authority providers with State and national standards. The scorecards are used to evaluate the quantity of services, cost, quality, client satisfaction, and outcomes. Innovative research tools, technology, and data are used to monitor, fund, and improve services within the public behavioral healthcare system. This section provides a summary of only a portion of the measures used to ensure that the highest level of clinical standards and efficiencies are incorporated.

Substance Use Disorder Treatment Outcomes

Substance abuse treatment outcomes are derived from data collected on each individual served. DSAMH collected final discharge data on 8,809 (non-detox) clients in fiscal year 2013. 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 noncompliance). Clients discharged as a result of a transfer to another level of care but not enrolled in that level are considered "unsuccessful." The data does not include clients admitted only for detoxification services or those receiving treatment from non-LSAA statewide providers. For all outcomes, numbers are based on completed treatment episode, rather than a single treatment modality.

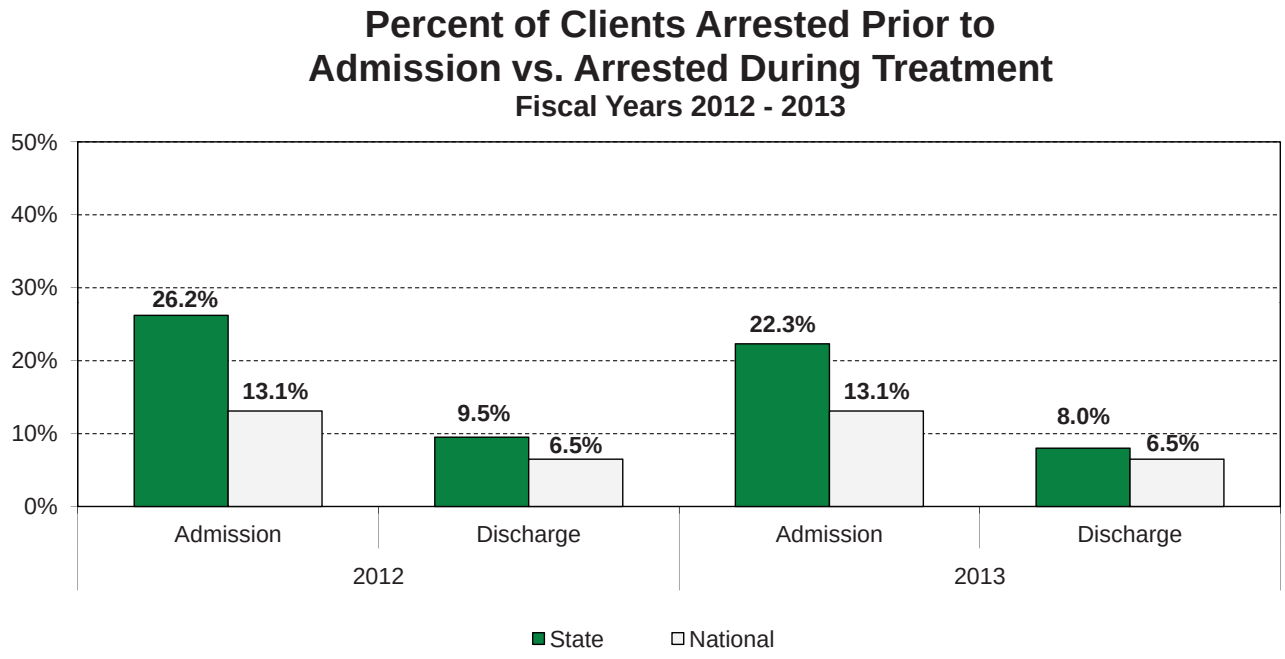
Discharge

The following graph depicts the percentage of clients discharged in fiscal year 2013 who successfully completed the entire treatment episode.



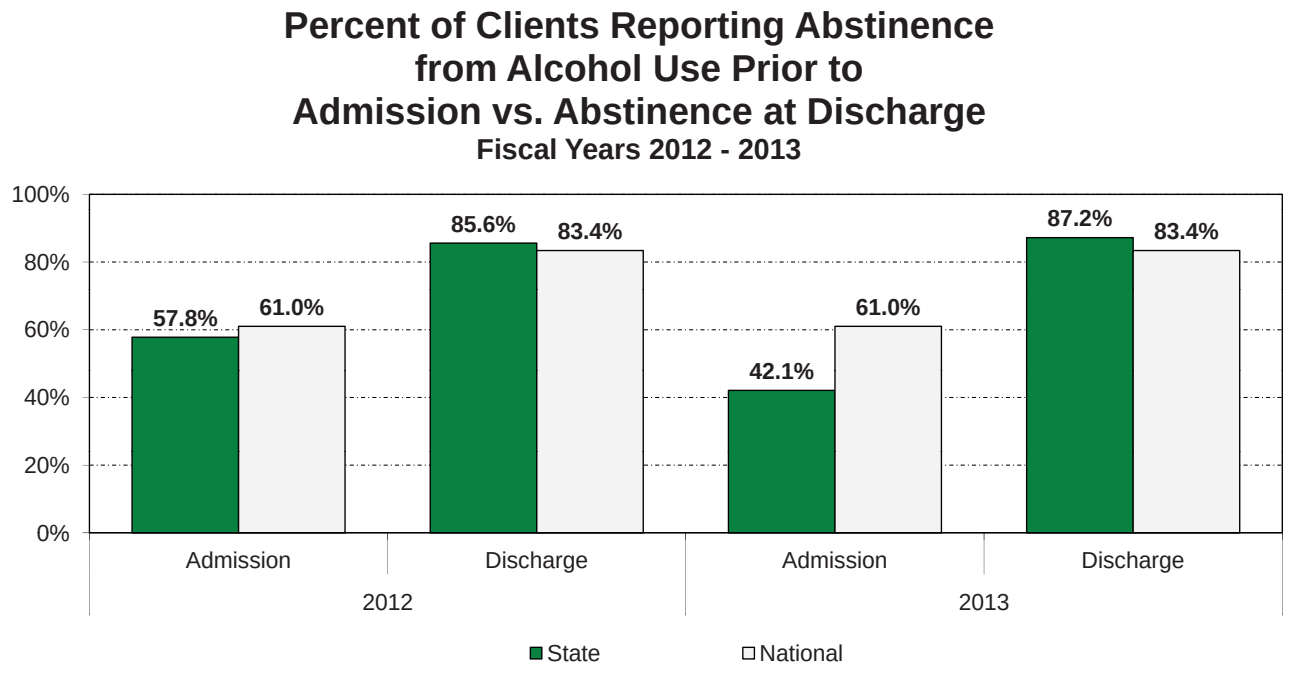
Criminal Activity

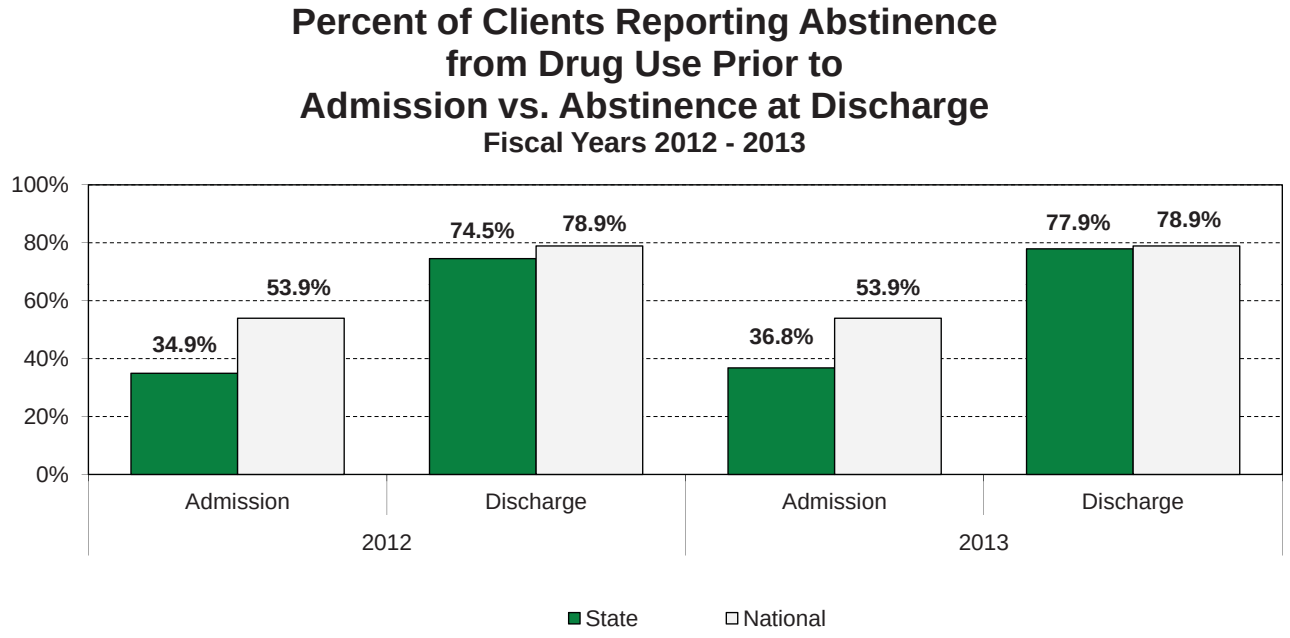
Approximately 72% of Utah's clients are involved with the criminal justice system. Reduction of criminal activity is an important goal for treatment and a good predictor of a client's long-term success. Treatment results in significant decreases in criminal activity and criminal justice involvement. In 2012 and 2013, Utah had higher arrest rates at admission than the national average, but the arrest rates at discharge are comparable to the national norm.



Changes in Abstinence from Drug and Alcohol Use During Treatment

The following charts provide abstinence rates at admission and discharge for clients in all treatment levels except detoxification. Substance use is evaluated 30 days prior to the client entering a controlled environment, such as treatment or jail, and again in the 30 days prior to discharge. As expected, the rate of abstinence increases during treatment. Utah's 2013 rates of abstinence from alcohol and drug use at admission are lower than the national rates but at discharge are comparable to the national rates.

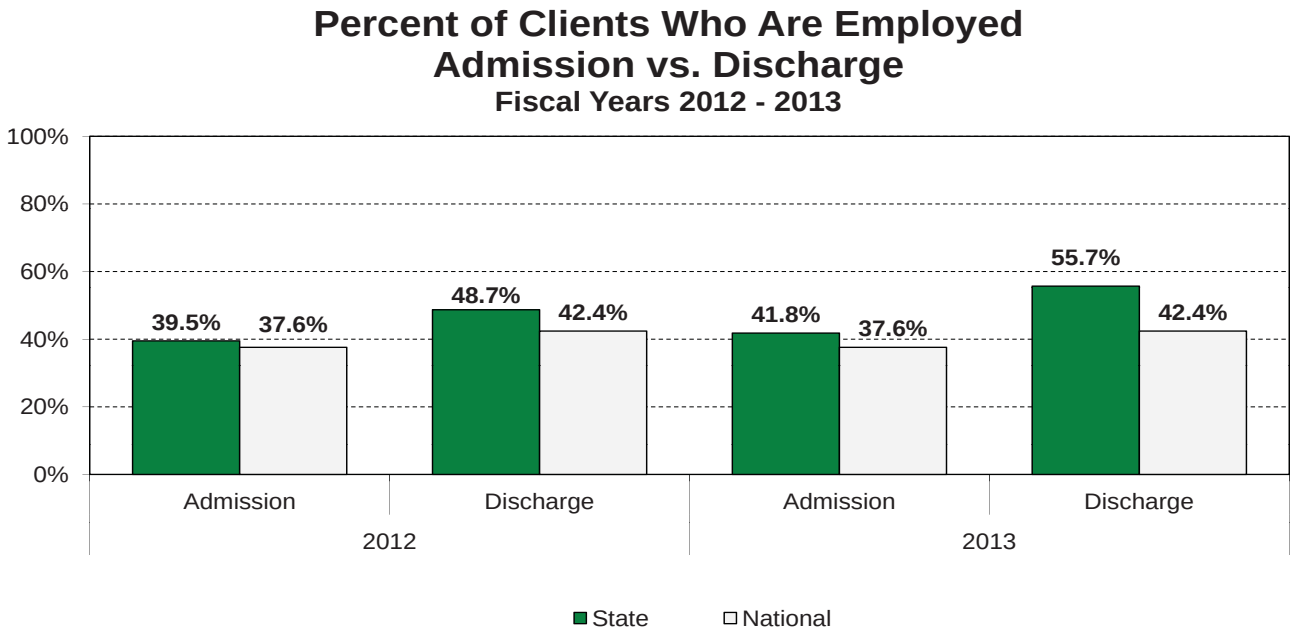




Employment and Stable Housing

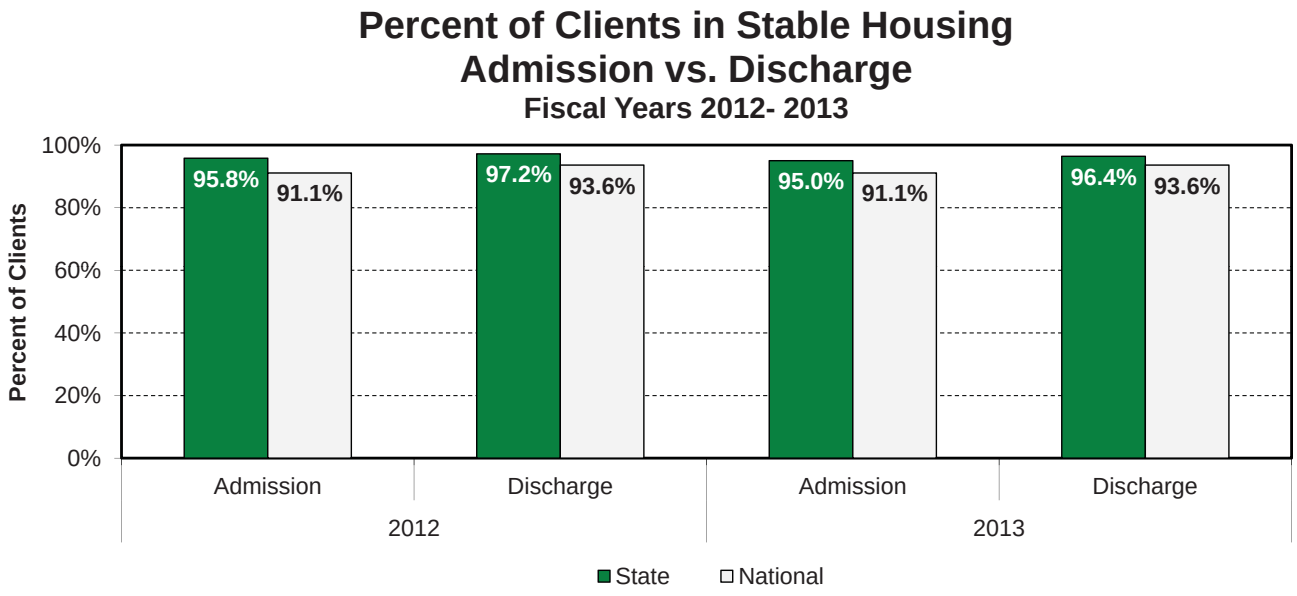
Employment

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. At admission the percent of clients employed is comparable to the national average. However, at discharge, the percent of clients employed exceeds the national average.



Clients in Stable Housing

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. Treatment also has been shown to help individuals with a substance use disorder achieve and maintain a stable living environment. As shown in this chart, 95% of clients entering Utah's public substance abuse treatment in 2013 were in stable housing at the time of their admission to treatment. At discharge, 96.4% of clients in 2013 were in stable housing. Utah's rate of change is slightly below the national average, but the percentage in stable housing at discharge is higher than the national average.

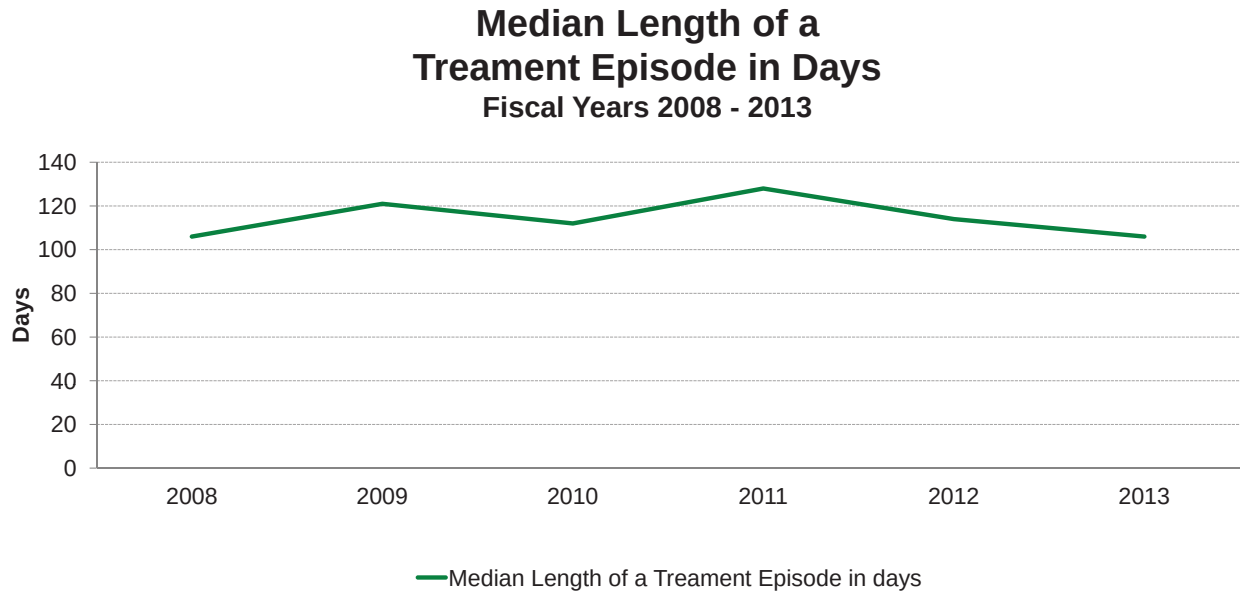


Retention in Treatment

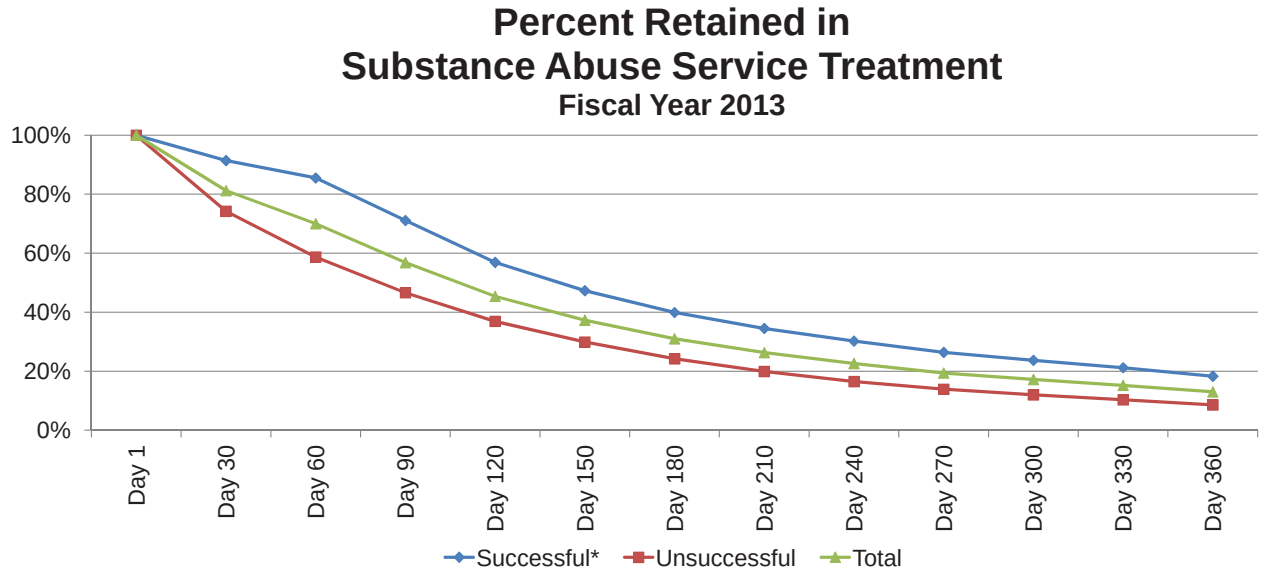
Retention in treatment is the factor most consistently associated with positive client outcomes. The appropriate length of a treatment varies based on the needs of the individual. However, the National Institute of Drug Addiction (NIDA) states: "Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered a minimum, and some opiod-addicted individuals continue to benefit from methadone maintenance for many years."

Just like treatment for any other chronic disease, addiction treatment must be of sufficient duration to succeed. Client progress over a short period of time should not be seen as a "cure." Likewise, relapse should not be a reason to discontinue care. Programs should employ multiple strategies to engage and retain clients. Successful programs offer continuing care, and use techniques that

have been proven to enhance client motivation. It is also important to recognize that multiple episodes of treatment may be necessary. The following chart shows the median length of days in a treatment episode from 2008-2013.



The chart below shows the percent of clients retained in treatment by month. Just under 60% of all clients in Utah are in treatment for more than 90 days.



* Sucessful completetion of Treatment in most cases mean that the client has completed at least 75% of their treatment

Mental Health Treatment Outcomes

Outcome Questionnaire (OQ)/Youth Outcome Questionnaire (YOQ)

People seeking mental health services are generally doing so because of increasing problems with social or functional domains in their lives. Some request services through a self-motivated desire to feel better. Many do so with the encouragement and support of friends, family and clergy, while 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 interventions. The Utah public mental health system uses the Outcome Questionnaire (OQ) and Youth Outcome Questionnaire (YOQ), both scientifically valid instruments, to measure change and functioning in people. These instruments are like measuring the vital signs of a person's mental health status. In fiscal year 2013, 85% of people who received mental health services and participated in the OQ/YOQ program either stabilized/improved or recovered from the distress that brought them into services. Of these, almost 24% were considered in recovery. In fiscal year 2013, 58% of clients participated in this outcome survey.

Statewide OQ Client Outcomes Report for Fiscal Year 2013

Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	72%	23.2%	61.0%
Central Utah	74%	21.5%	63.8%
Davis County	47%	17.2%	65.9%
Four Corners	61%	22.6%	61.8%
Northeastern	70%	26.1%	61.2%
Salt Lake County	41%	21.7%	62.1%
San Juan County	16%	13.5%	58.1%
Southwest	66%	23.2%	63.9%
Summit County	65%	25.5%	63.0%
Tooele County	46%	24.4%	57.1%
Utah County	77%	25.7%	59.5%
Wasatch County	42%	25.5%	60.2%
Weber	80%	31.5%	57.6%
Statewide totals	**58%**	**23.8%**	**61.2%**

Youth OQ Client Outcomes Report for Fiscal Year 2013

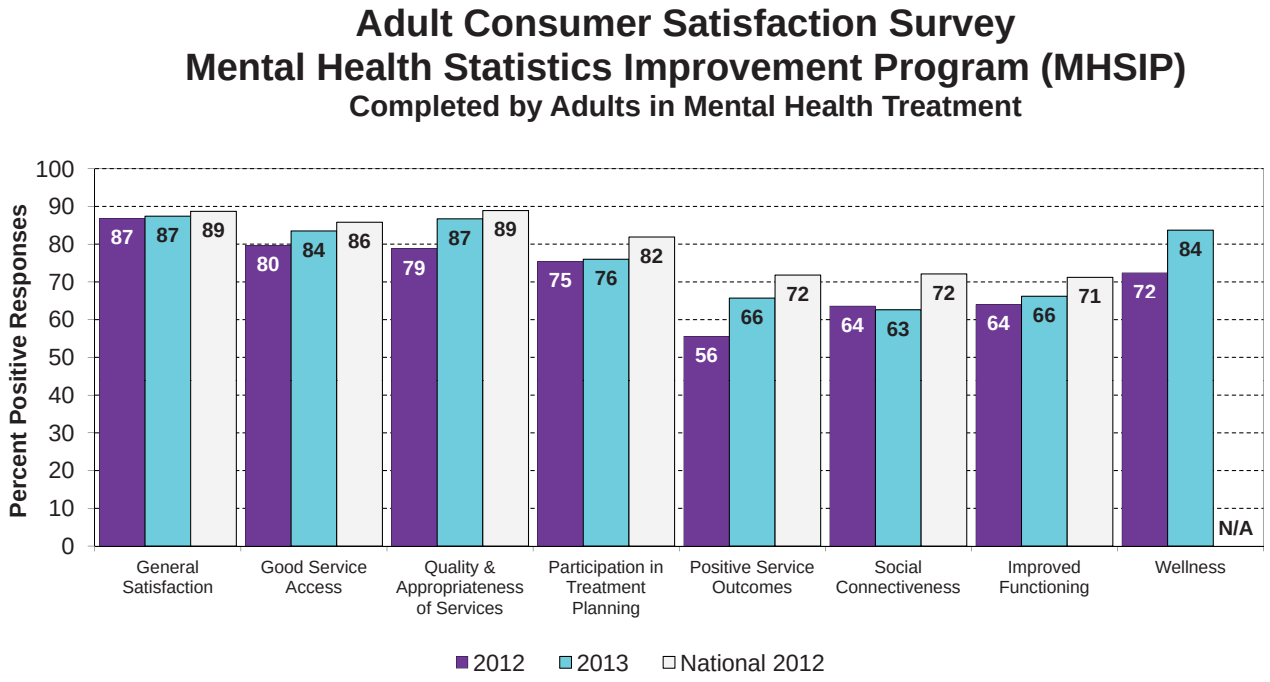
Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	70%	23.6%	60.9%
Central Utah	66%	20.9%	64.0%
Davis County	53%	22.8%	62.1%
Four Corners	66%	25.4%	59.8%
Northeastern	78%	30.8%	57.7%
Salt Lake County	60%	25.7%	59.5%
San Juan County	19%	14.3%	66.7%
Southwest	72%	23.6%	63.2%
Summit County	61%	26.2%	65.4%
Tooele County	49%	25.1%	55.9%
Utah County	78%	31.8%	54.9%
Wasatch County	32%	45.9%	40.5%
Weber	94%	38.6%	52.1%
Statewide totals	**68%**	**27.7%**	**58.4%**

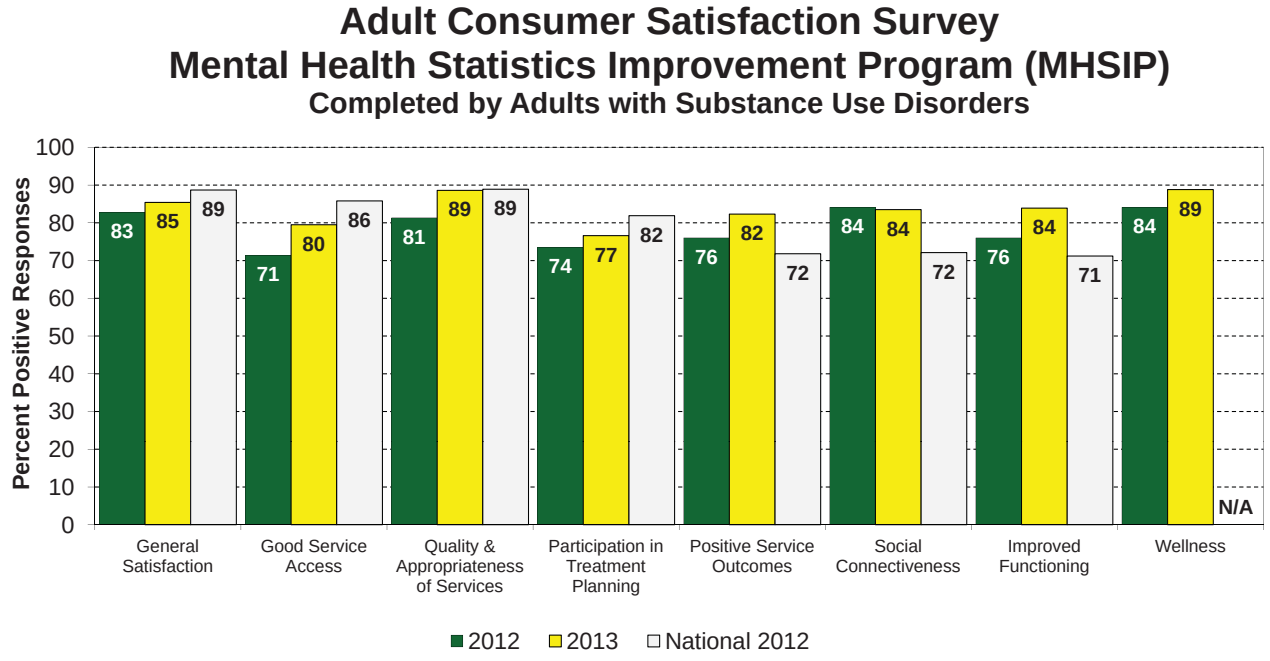
Adult OQ Client Outcomes Report for Fiscal Year 2013

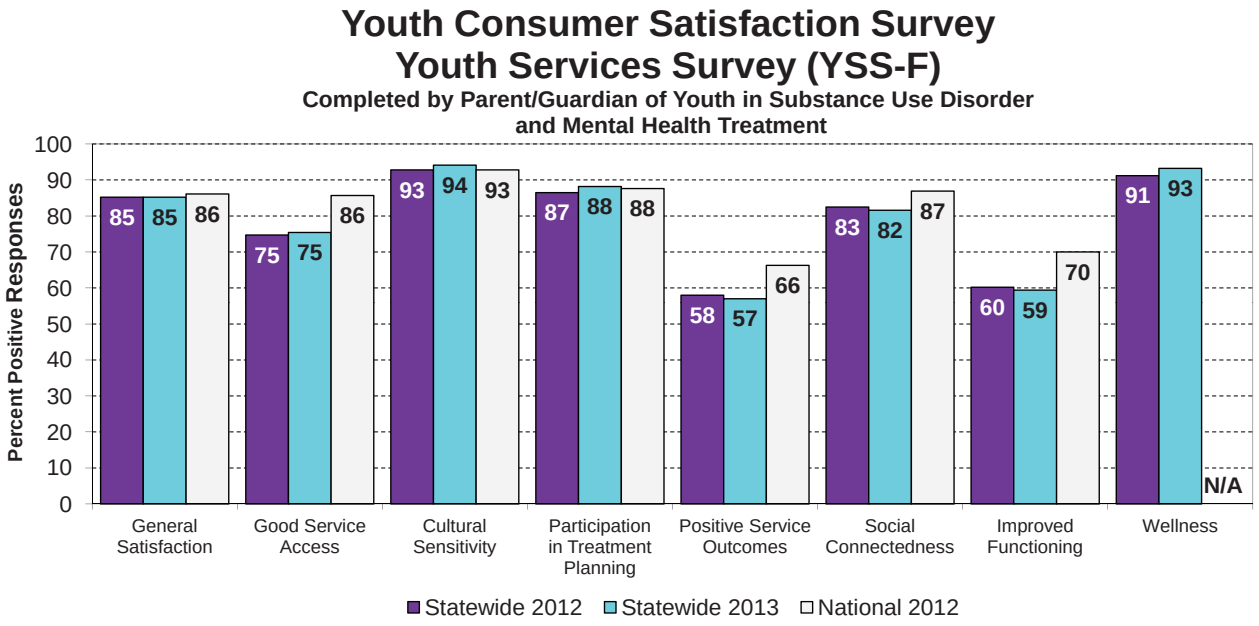
Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	74%	23.0%	61.1%
Central Utah	79%	21.8%	63.7%
Davis County	43%	12.6%	69.1%
Four Corners	59%	21.1%	63.0%
Northeastern	67%	22.9%	63.5%
Salt Lake County	33%	17.7%	64.7%
San Juan County	15%	13.2%	54.7%
Southwest	61%	22.4%	65.0%
Summit County	67%	25.2%	62.0%
Tooele County	45%	24.0%	57.7%
Utah County	77%	20.7%	63.3%
Wasatch County	47%	19.4%	66.1%
Weber	73%	26.2%	61.7%
Statewide totals	**52%**	**20.4%**	**63.6%**

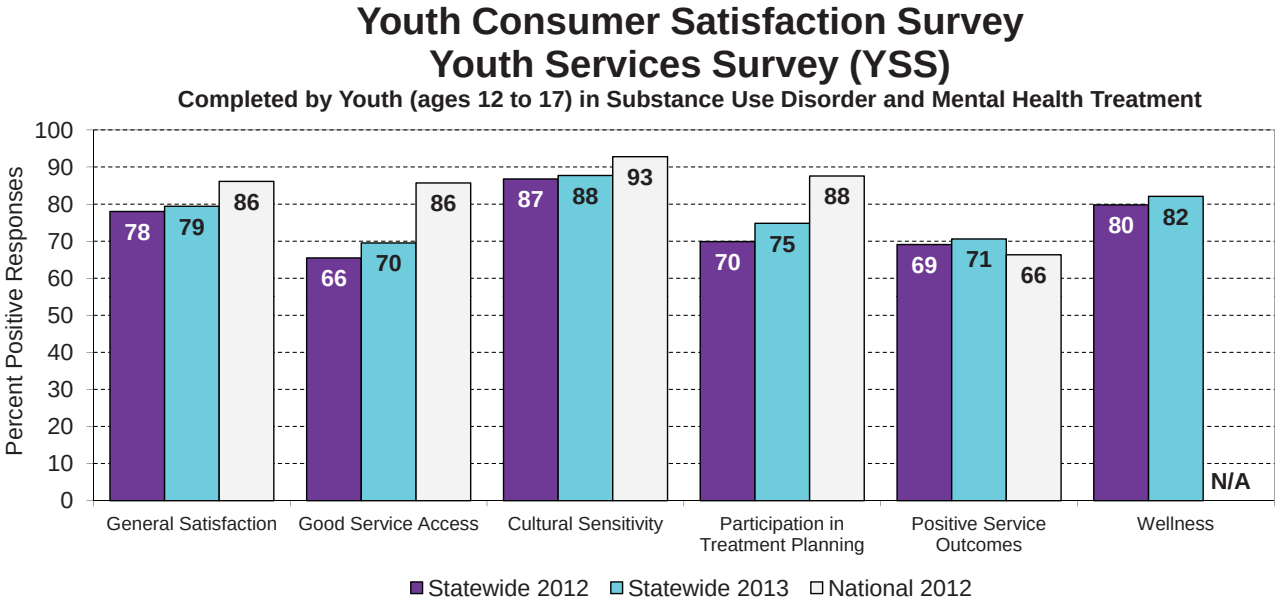
Consumer Satisfaction

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 comparing results from 2012 to 2013.





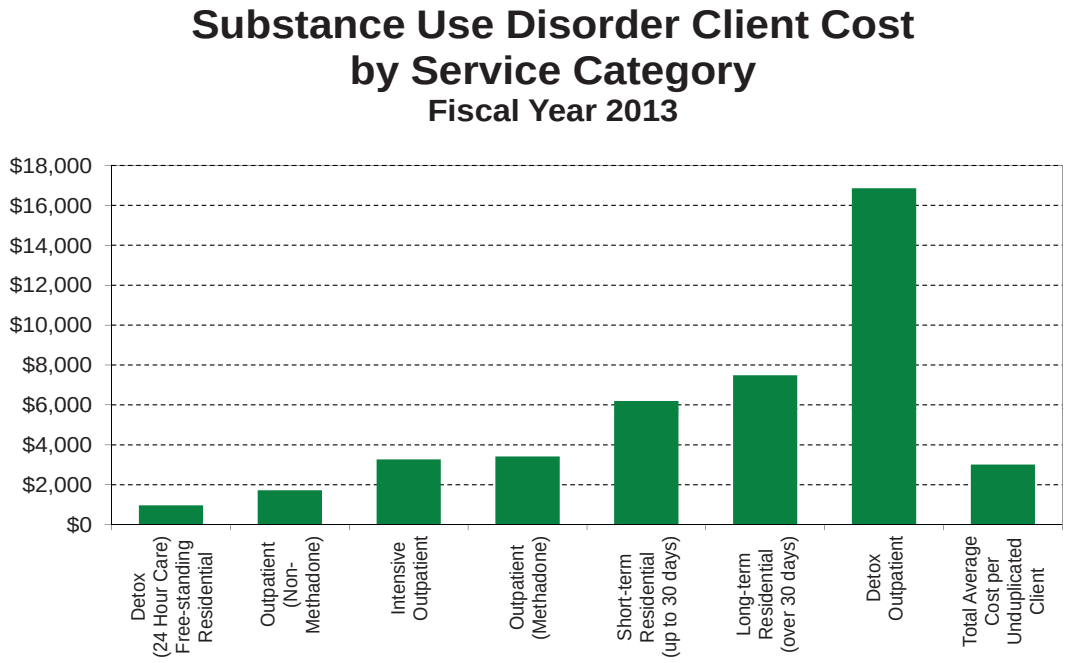

Youth Consumer Satisfaction Survey
Youth Services Survey (YSS-F)
Completed by Parent/Guardian of Youth in Substance Use Disorder and Mental Health Treatment
Percent Positive Responses
100
90
80
70
60
50
40
30
20
10
0
85 85 86
75 75 86
93 94 93
87 88 88
58 57 66
83 82 87
60 59 70
91 93
N/A
General Satisfaction
Good Service Access
Cultural Sensitivity
Participation in Treatment Planning
Positive Service Outcomes
Social Connectedness
Improved Functioning
Wellness
Statewide 2012
Statewide 2013
National 2012

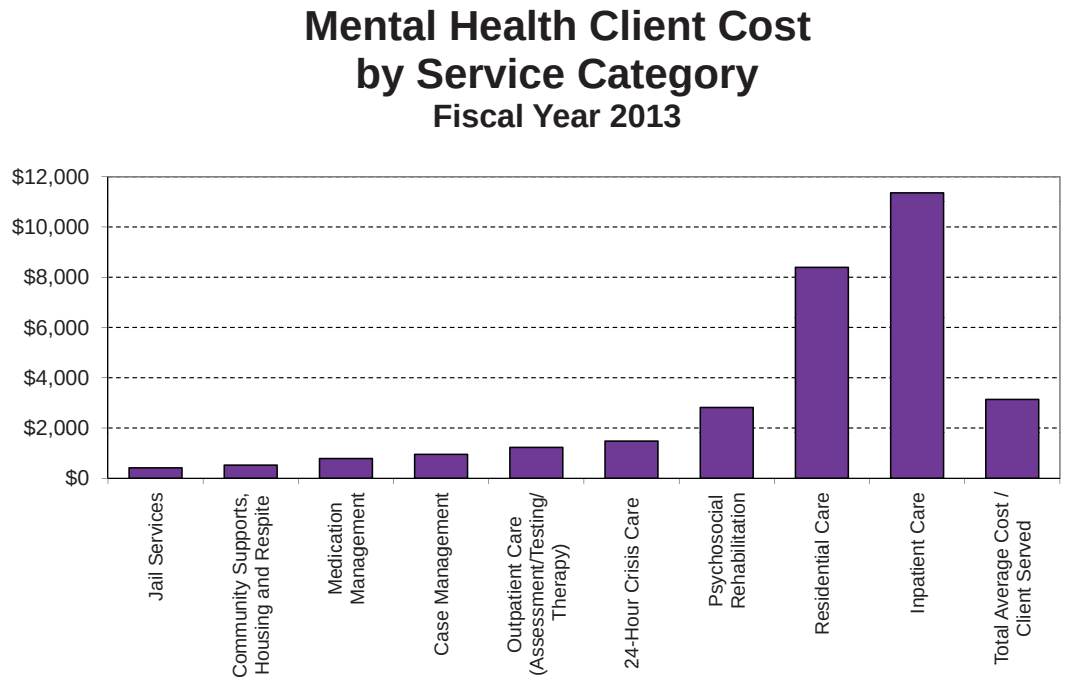

Youth Consumer Satisfaction Survey
Youth Services Survey (YSS)
Completed by Youth (ages 12 to 17) in Substance Use Disorder and Mental Health Treatment
Percent Positive Responses
100
90
80
70
60
50
40
30
20
10
0
78 79 86
66 70 86
87 88 93
70 75 88
69 71 66
80 82
N/A
General Satisfaction
Good Service Access
Cultural Sensitivity
Participation in Treatment Planning
Positive Service Outcomes
Wellness
Statewide 2012
Statewide 2013
National 2012

Cost Analysis

Client Cost by Service Category

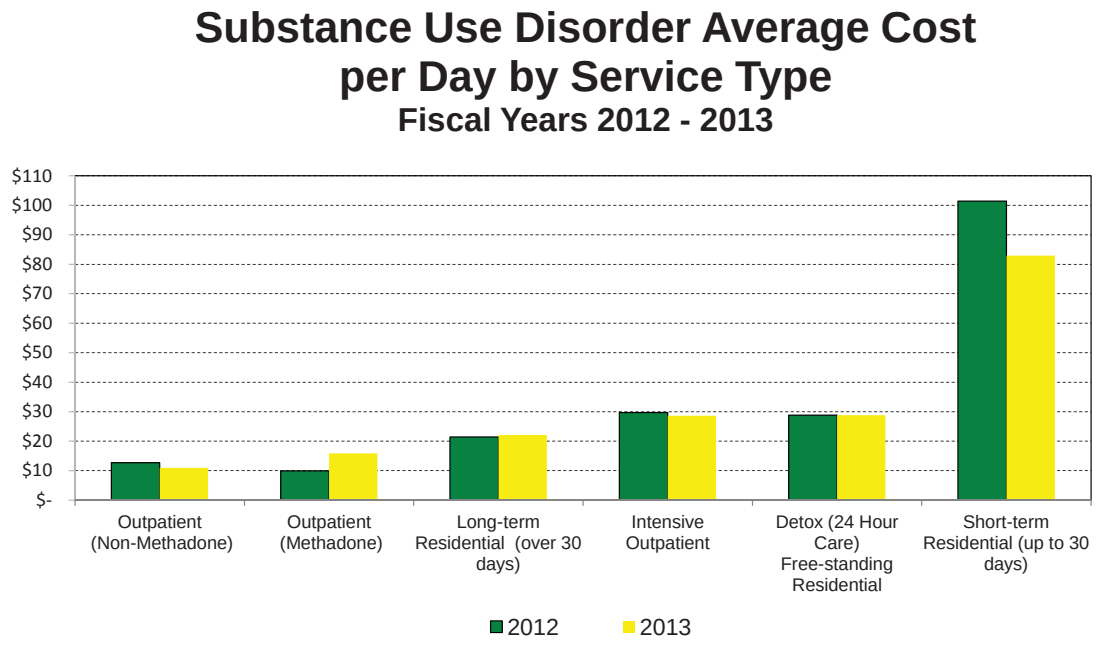
DSAMH requires the local authorities to submit year-end fiscal reports that describe local authority spending in specific categories. This fiscal information is then used to calculate a client cost by service category for both substance abuse and mental health. In 2013, the statewide average cost for mental health services was $3,137. For substance abuse services, the average client cost was $3,015.

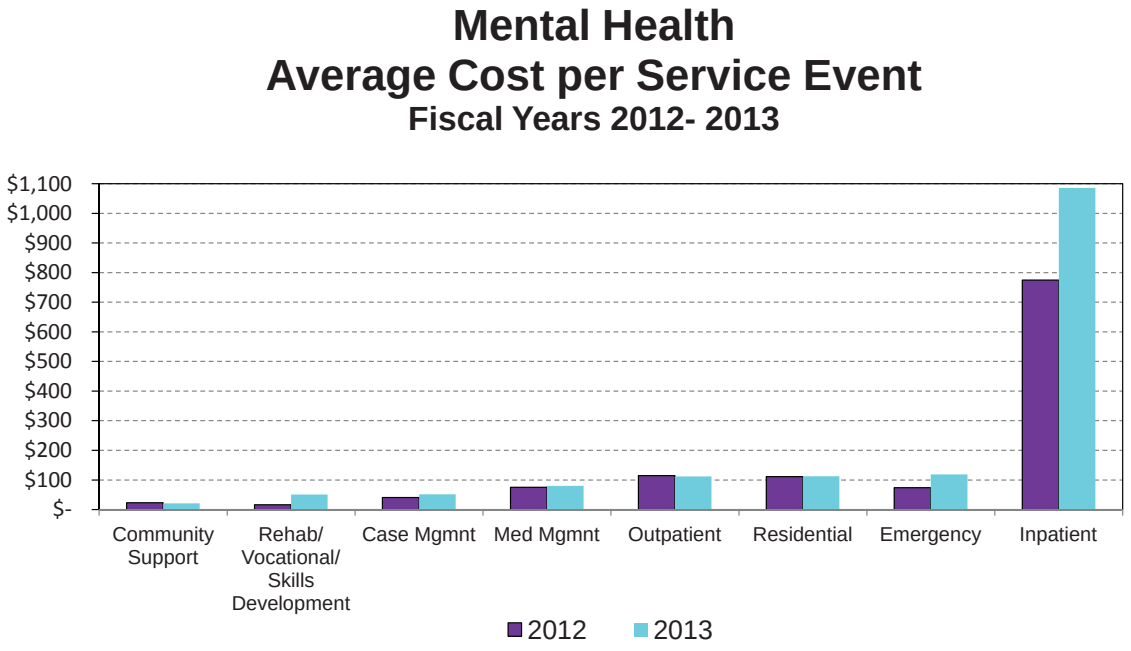




Additional Cost Analysis

Using the service data reported in fiscal years 2012 and 2013, DSAMH calculated an average cost per day by substance abuse service type and an average cost per mental health service event.

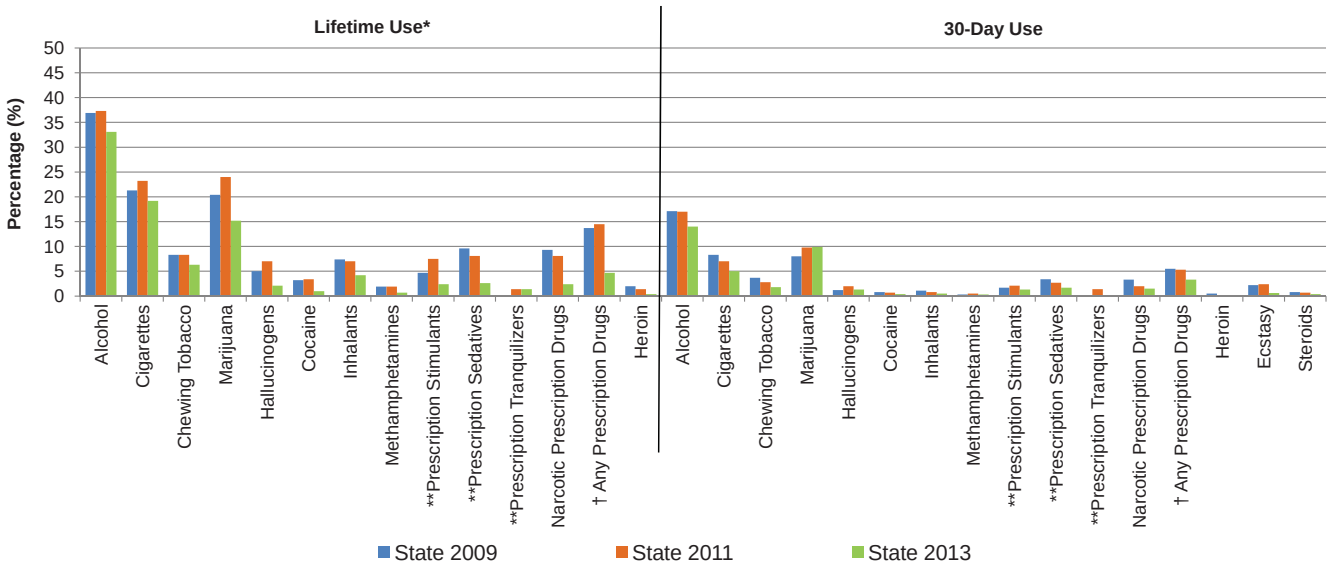




Student Health and Risk Prevention (SHARP) Survey

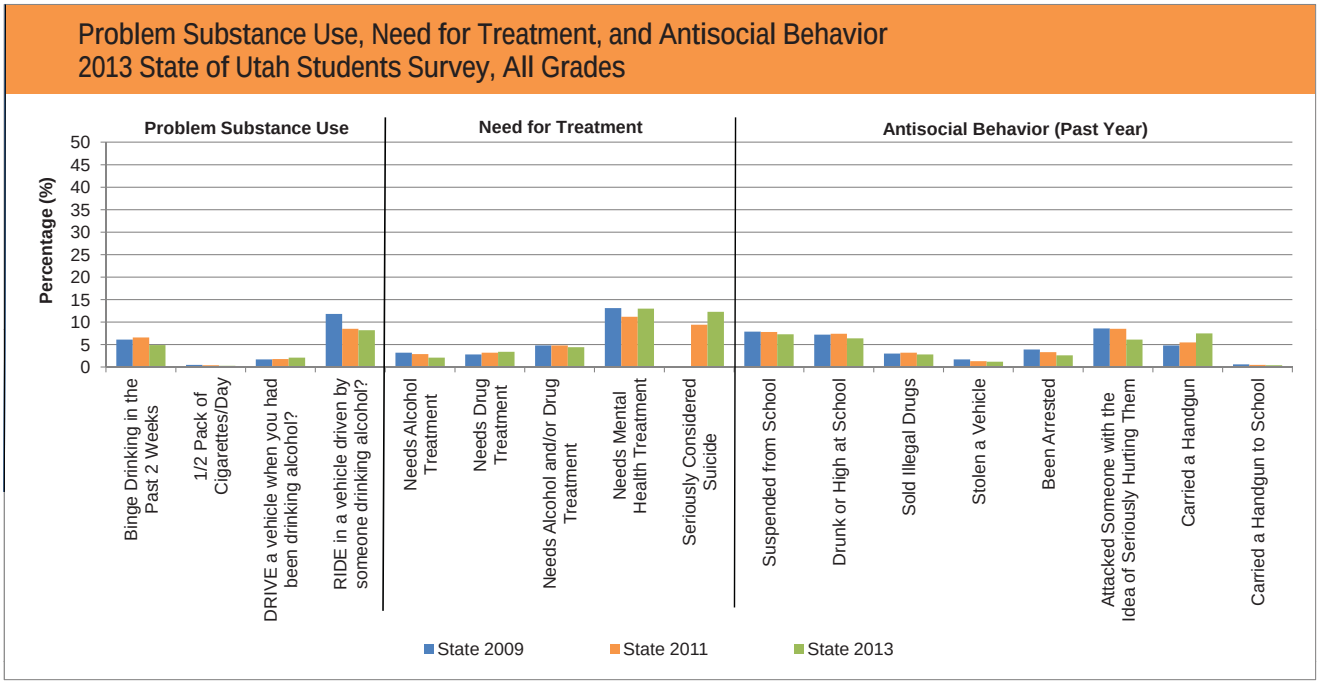
This chart shows the percentage of 12th grade students who reported using alcohol, tobacco or other drugs (ATOD) in their lifetime and within the 30 days prior to taking the survey. The survey shows Utah has had success in decreasing the amount of students using alcohol and prescription drugs. See the full report http://dsamh.utah.gov/sharp.htm.

Lifetime and 30-Day ATOD Use
2013 State of Utah Student Survey, Grade 12

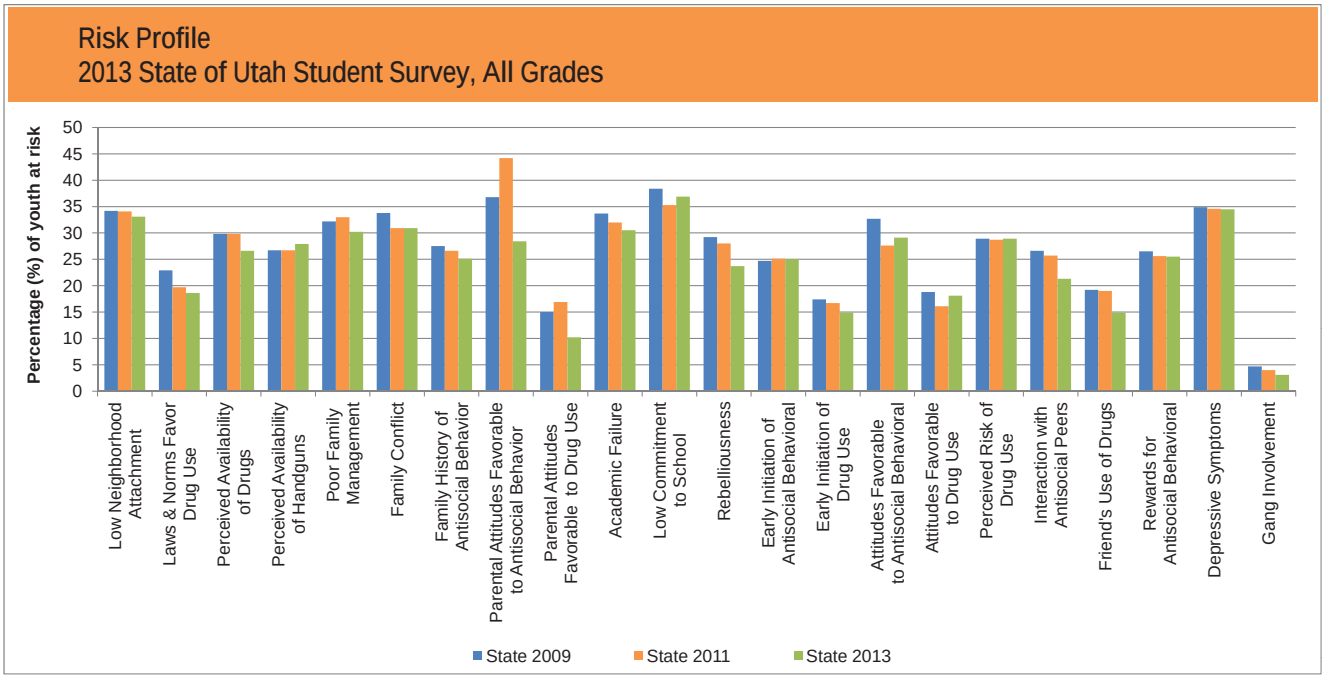


*2013 lifetime use is calculated from a different set of questions than previous years.
** In 2011, Sedatives was replaced by Prescription Sedatives and Prescription Tranquilizers.
† Prescription Drugs is a combined measure showing the total use of any stimulant, sedative, tranquilizer, or narcotic prescription drugs.

The chart on the following page shows the percentage of students who are in need of alcohol treatment, drug treatment, mental health treatment, and the percent of those that have seriously considered suicide. In addition, the chart shows highly problematic behavior, such as binge drinking and riding in a vehicle driven by someone drinking alcohol. See the full report at http://dsamh.utah.gov/sharp.htm.



The following chart shows percentage of students indicating increased risk in research based variables that have been proven to be predictive of alcohol, tobacco, other drugs, school dropout, teen pregnancy, anxiety/depression, and violence. See the full report at http://dsamh.utah.gov/sharp.htm.

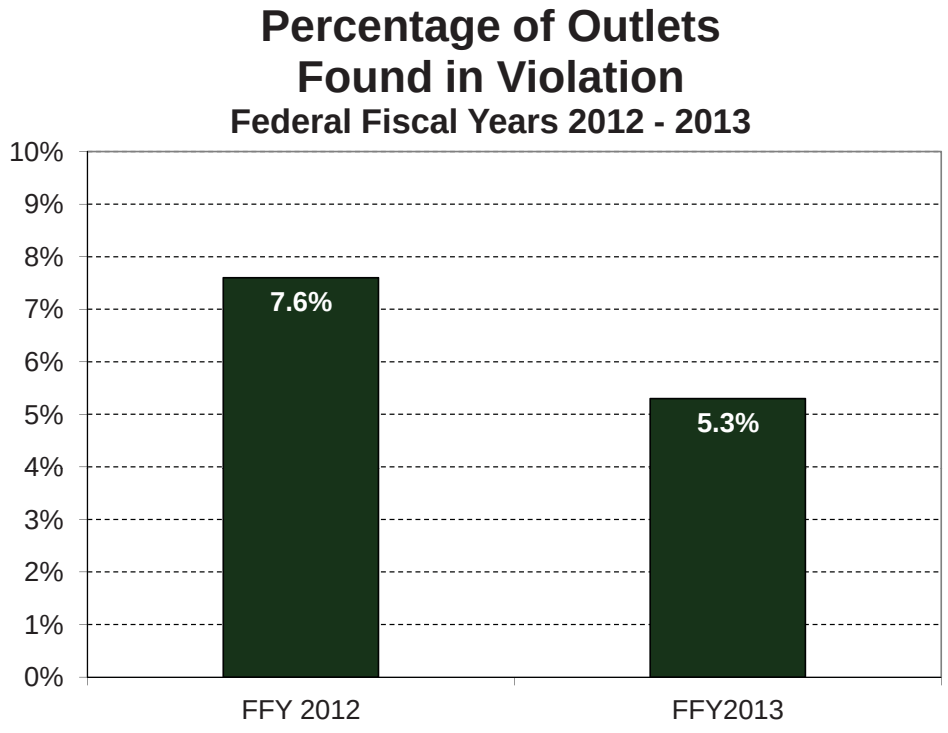


Federal Synar Amendment: Protecting the Nation's Youth from Nicotine Addiction

The Federal Synar Amendment requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under the legal age (19 in Utah) and to enforce those laws effectively. States are to achieve a sale to minors' rate of not greater than 20%. In a collaborative effort between the Department of Health and DSAMH, Utah has effectively decreased the number of tobacco sales to minors and has a violation rate of 7.6% out of 1,655 eligible outlets checked in 2012 and 5.3% from 1,632 eligible outlets checked in 2013.

Other declines in Utah smoking rates that can be attibuted to the Master Settlement Agreement funds that are allocated to the Tobacco Prevention and Control Program:

- 63% decline in rate of youth smokers (1999-2013)—Youth Risk Behavior Survey
- 24% decline in rate of pregnant smokers (1999-2011)—Vital Statistics
- 34% decline in rate of adult smokers (1999-2010)—Behavioral Risk Factor Surveillance System (Land line results only)
- 68% decline in rate of children exposed to smoking in their homes (2001-2010)—Behavioral Risk Factor Surveillance System—(Land line results only)



Michael's Journey

I have been in recovery with an anxiety disorder for 14 years and a co-occurring substance use disorder. I spent my adolescent and early adulthood years in the mental health system in another state, an experience that was not entirely positive. The stigma of having a mental health and substance use disorder at times was worse than any of the symptoms I was experiencing. It was very demoralizing and made me feel like I was "less than human." I always tried to take care of my mental health, but at times I made poor choices by self-medicating using substances. I later realized that this really impeded my progress and made my symptoms worse.

Later on, I got to a stage in my life where I had an "awakening" and decided I needed to get sober and take responsibility for my life. I started enjoying sobriety, utilizing my supports, went back to school, and began helping other people who were struggling with similar life issues. My spiritual faith is something that really helped me progress and greatly added to my recovery. There were many things that doctors, clinicians, and others told me I would not be capable of doing in life; they were wrong.

I am now working full-time in the field of Peer Support, am married to my beautiful wife, am an expecting father, and am attending college as a psychology major. I also volunteer by facilitating a 12-step program. In my free time, I enjoy spending time with my family, hiking, and playing and recording music.

"Do not underestimate your potential and let others be the judge of yourself. Be true to yourself, work hard, and you can accomplish your greatest dreams"

Although my life is not perfect, and I experience symptoms of my disorders every day of my life, I am happy. I continue to work on the lifelong process of recovery. RECOVERY IS POSSIBLE!

Who We Serve

Utahns in Need of Substance Use Disorder Treatment

The results of the Synthetic Estimates of Needs for Utah[1] and the 2013 Student Health and Risk Prevention Survey indicate the following:

- 90,956 adults in Utah were classified as needing treatment for alcohol and/or drug dependence or abuse in 2013.
- 12,106 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 is currently serving 16,396 individuals, or 16% of the current need.
- A combined total of approximately 86,566 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 local authority. The current capacity of each local authority, or the number who were actually served in fiscal year 2013, is also included to illustrate the unmet need. The same data is depicted on the graphs on the following page.

Substance Use Disorder Treatment Needs vs. Treatment Capacity

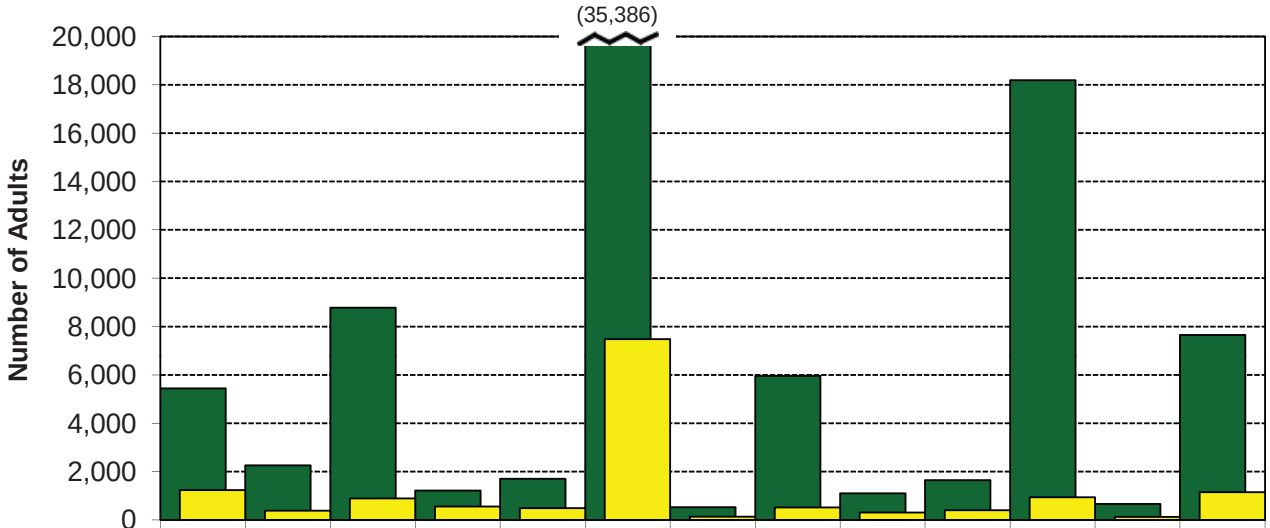
	Adults (18 years+)		Youth (Under age 18)	
	# Need Treatment	Capacity FY2013	# Need Treatment	Capacity FY2013
Bear River	5,447	1,232	561	77
Central	2,259	386	365	57
Davis County	8,782	889	1,083	108
Four Corners	1,214	554	216	51
Northeastern	1,706	490	252	34
Salt Lake County	35,386	7,475	5,369	697
San Juan County	526	133	26	26
Southwest	5,961	516	569	40
Summit County	1,106	304	201	40
Tooele County	1,644	400	335	59
Utah County	18,189	936	1,621	28
Wasatch	664	129	108	14
Weber	7,648	1,151	1,399	240
State Totals	90,856*	14,925**	12,106*	1,471**

* 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 330 clients that were served by statewide contract are reflected in the state total.

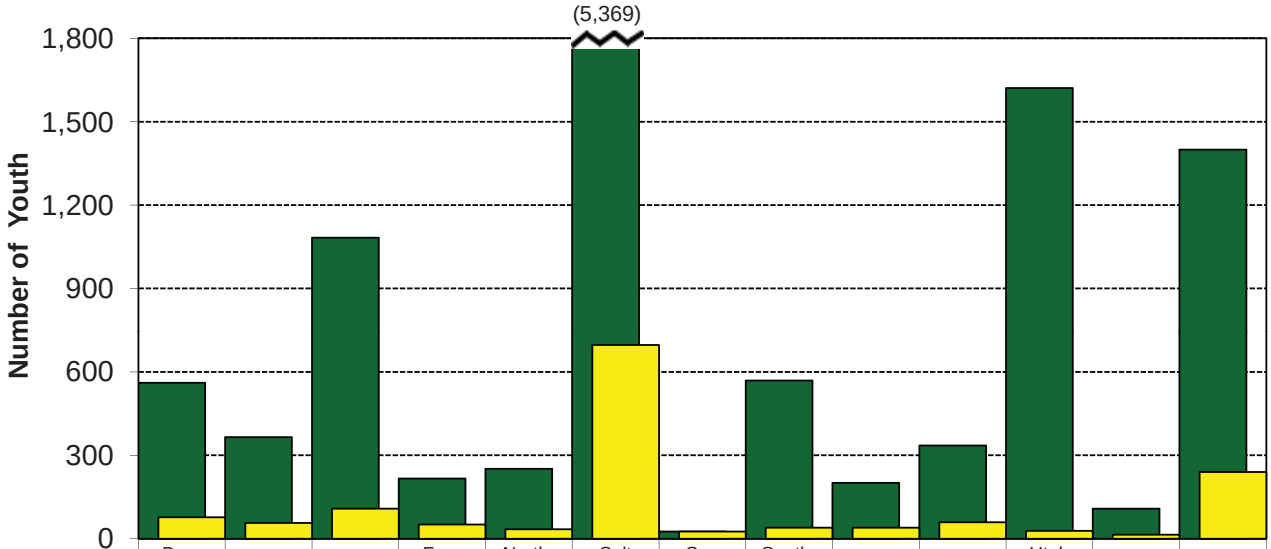
[1] Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimate).

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



	Bear River	Central	Davis	Four Corners	North-eastern	Salt Lake	San Juan	South-west	Summit	Tooele	Utah County	Wasatch	Weber
Need	5,447	2,259	8,782	1,214	1,706	35,386	526	5,961	1,106	1,644	18,189	664	7,648
Capacity	1,232	386	889	554	490	7,475	133	516	304	400	936	129	1,151

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



	Bear River	Central	Davis	Four Corners	North-eastern	Salt Lake	San Juan	South-west	Summit	Tooele	Utah County	Wasatch	Weber
Need	561	365	1,083	216	252	5,369	26	569	201	335	1,621	108	1,399
Capacity	77	57	108	51	34	697	26	40	40	59	28	14	240

Utahns in Need of Mental Health Services

The results of the Synthetic Estimates of Needs for Utah[1] indicate the following:

- 12.7% of adults in Utah were classified as needing treatment for mental health issues in 2012.
- 7.9% of Utah youth under age 18 were in need of treatment for mental health issues in 2012.
- The public mental health treatment system served 45,594 individuals or just over 14% of the current need.
- A combined total of approximately 274,957 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 local authority varies considerably. 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 a need exists. The following table demonstrates the estimated percent of adults and youth who need treatment by local authority. The current number in need of treatment in each local authority and the number who were actually served in fiscal year 2013 is also included to illustrate the unmet need. The same data is depicted on the following graphs.

Mental Health
Treatment Needs vs. Clients Served

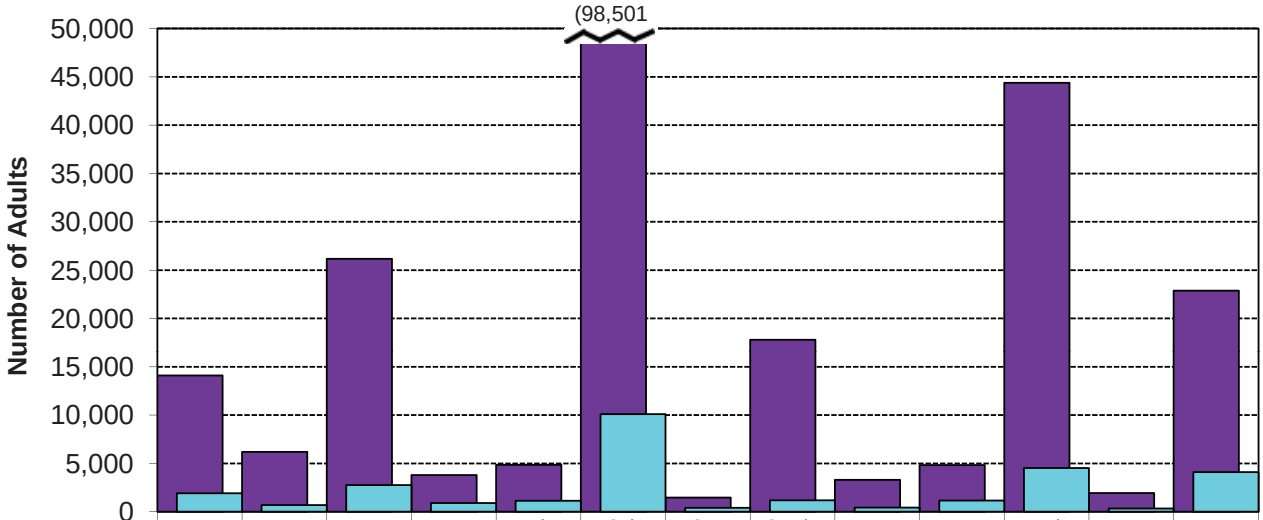
	Adults (18 years+)			Children/Youth (Under age 18)		
	% Need Treatment	# Need Treatment	# Served in FY2013	% Need Treatment	# Need Treatment	# Served in FY2013
Bear River	12.3%	14,090	1,902	7.9%	4,174	1,208
Central	11.8%	6,193	685	8.1%	1,903	484
Davis	12.5%	26,176	2,753	7.8%	8,304	1,510
Four Corners	12.6%	3,800	890	8.2%	922	455
Northeastern	13.3%	4,862	1,133	8.3%	1,510	677
Salt Lake	13.0%	98,501	10,098	8.0%	24,446	5,401
San Juan	14.5%	1,465	406	8.6%	417	131
South-west	12.0%	17,793	1,180	8.1%	5,026	1,435
Summit	11.9%	3,311	436	7.8%	800	169
Tooele	12.5%	4,819	1,151	7.8%	1,646	539
Utah County	12.6%	44,371	4,516	7.9%	14,782	3,191
Wasatch	11.5%	1,940	324	7.8%	650	160
Weber	13.2%	22,874	4,102	8.0%	5,881	1,511
State Totals*	12.7%	*250,046	*28,981	7.9%	*70,505	*16,613

*Because of rounding in the percentages and duplication of clients across Local Mental Health Authorities (LMHA), LMHA's 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).

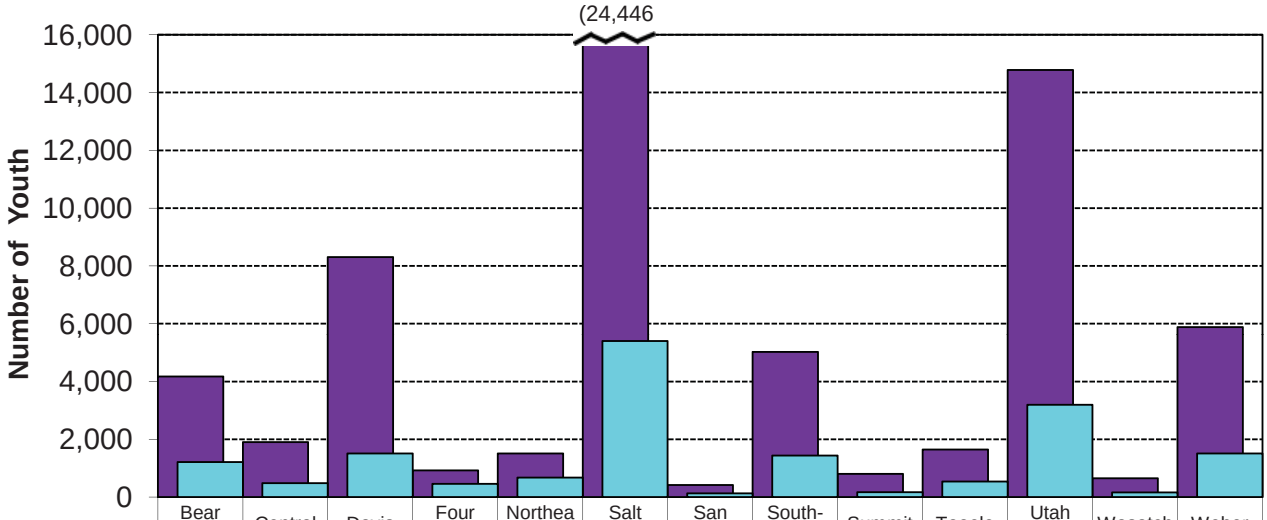
Note: These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition at 300% of poverty. The MHM3 definition requires a current or chronic disorder and a disability duration of at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



	Bear River	Central	Davis	Four Corners	Northeastern	Salt Lake	San Juan	South-west	Summit	Tooele	Utah County	Wasatch	Weber
Need	14,090	6,193	26,176	3,800	4,862	98,501	1,465	17,793	3,311	4,819	44,371	1,940	22,874
Served	1,902	685	2,753	890	1,133	10,098	406	1,180	436	1,151	4,516	324	4,102

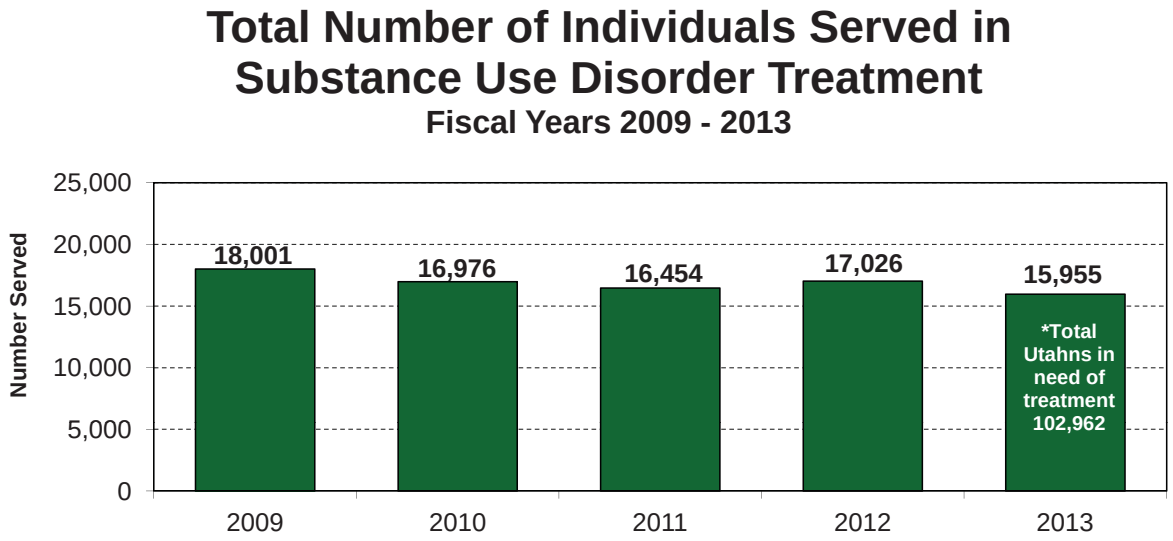
Number of Children/Youth Who Need Mental Health Treatment Compared to the Current Number of Clients Served



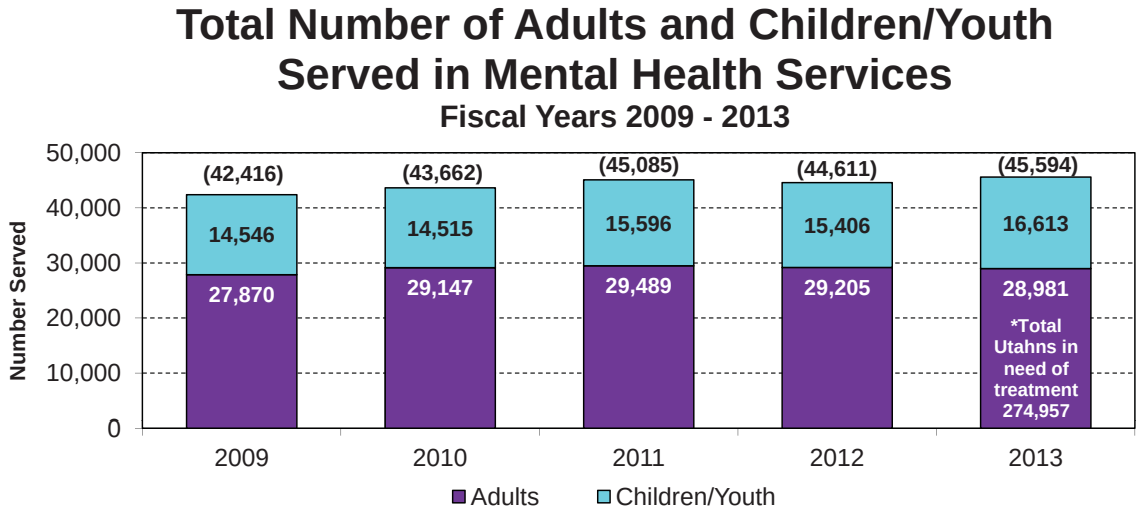
	Bear River	Central	Davis	Four Corners	Northeastern	Salt Lake	San Juan	South-west	Summit	Tooele	Utah County	Wasatch	Weber
Need	4,174	1,903	8,304	922	1,510	24,446	417	5,026	800	1,646	14,782	650	5,881
Served	1,208	484	1,510	455	677	5,401	131	1,435	169	539	3,191	160	1,511

Total Number Served

The charts below show the total number of individuals served in all publicly funded substance use disorder treatment facilities, and the total number served for adults and children/youth by the local mental health authorities for fiscal year 2009 through fiscal year 2013.



*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) and the 2013 SHARP Survey.



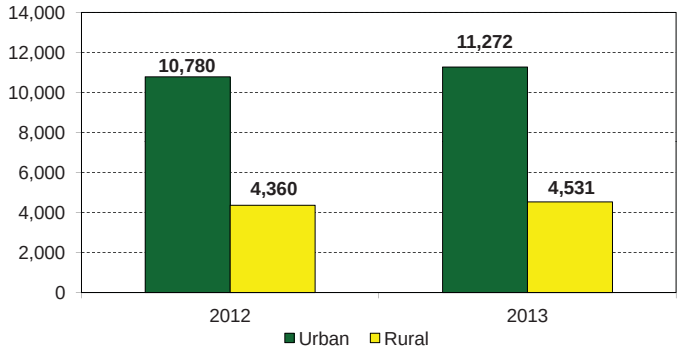
*Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric epidemiological Surveys and the U.S. Census 2009 Population Estimate).

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 up to 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).

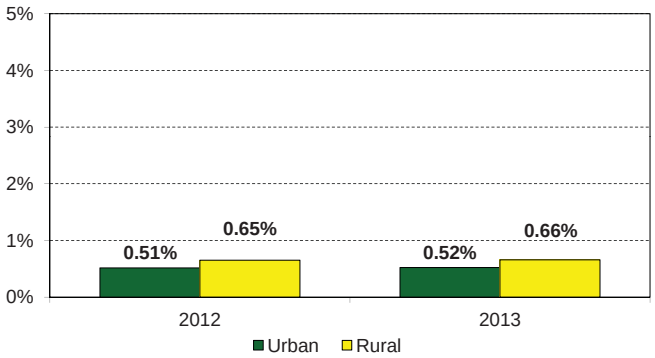
Urban and Rural Areas[1]

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 use disorders and mental health.

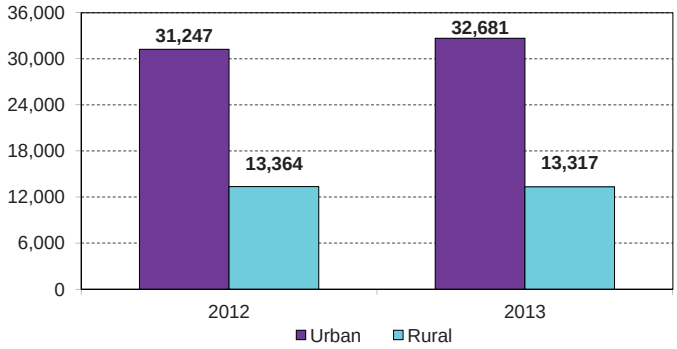
Number of Individuals Served in Substance Use Disorder Services in Urban and Rural Communities
Fiscal Years 2012 - 2013



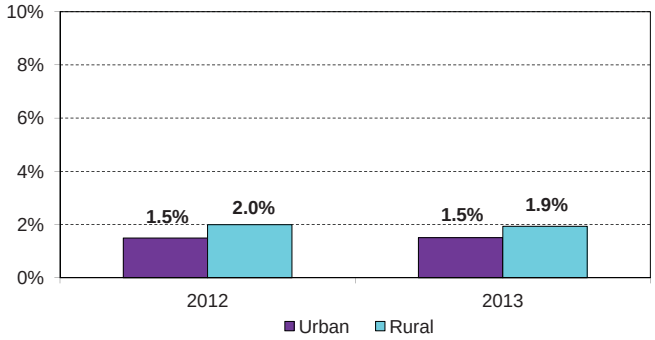
Percent of Total Population Served in Substance Use Disorder Services in Urban and Rural Communities
Fiscal Years 2012 - 2013



Number of Individuals Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2012 - 2013



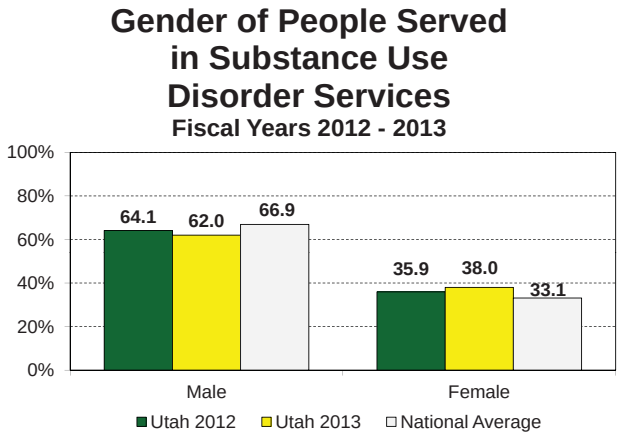
Percent of Total Population Served in Mental Health Services in Urban and Rural Communities
Fiscal Years 2012 - 2013

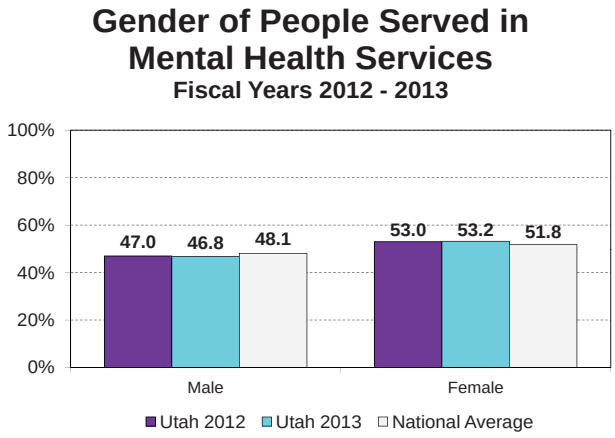


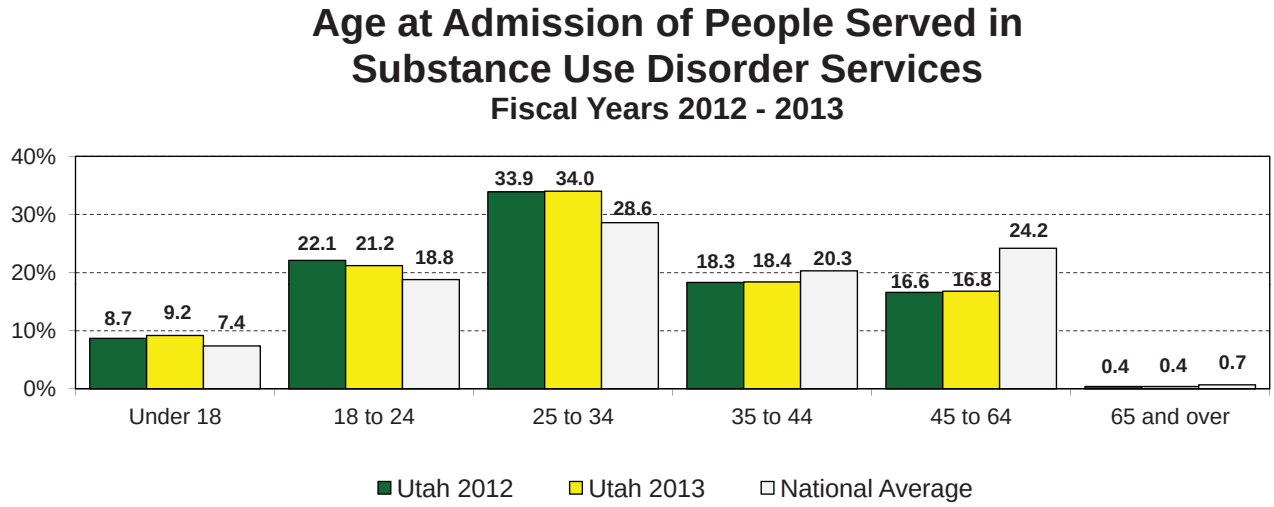
[1] Salt Lake, Davis, Weber (Morgan is included in Weber County district), and Utah Counties are reported as Urban. All other counties in Utah are reported as Rural.

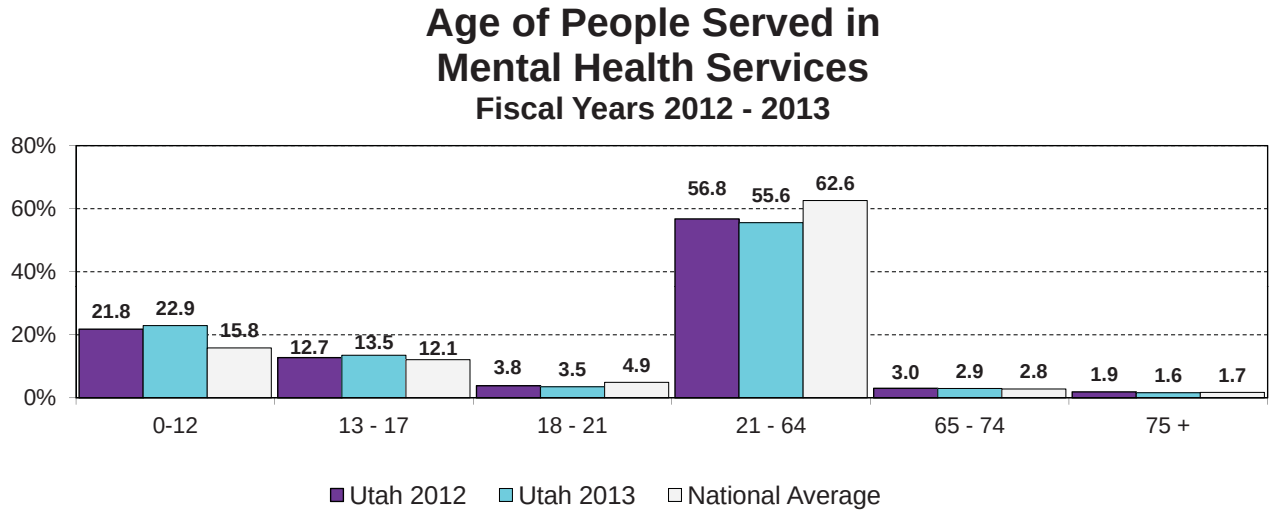
Gender and Age

The charts below identify the distribution of services by gender and age for substance use disorder and mental health services. There are significant differences between the substance use disorder and mental health populations in both gender and age.



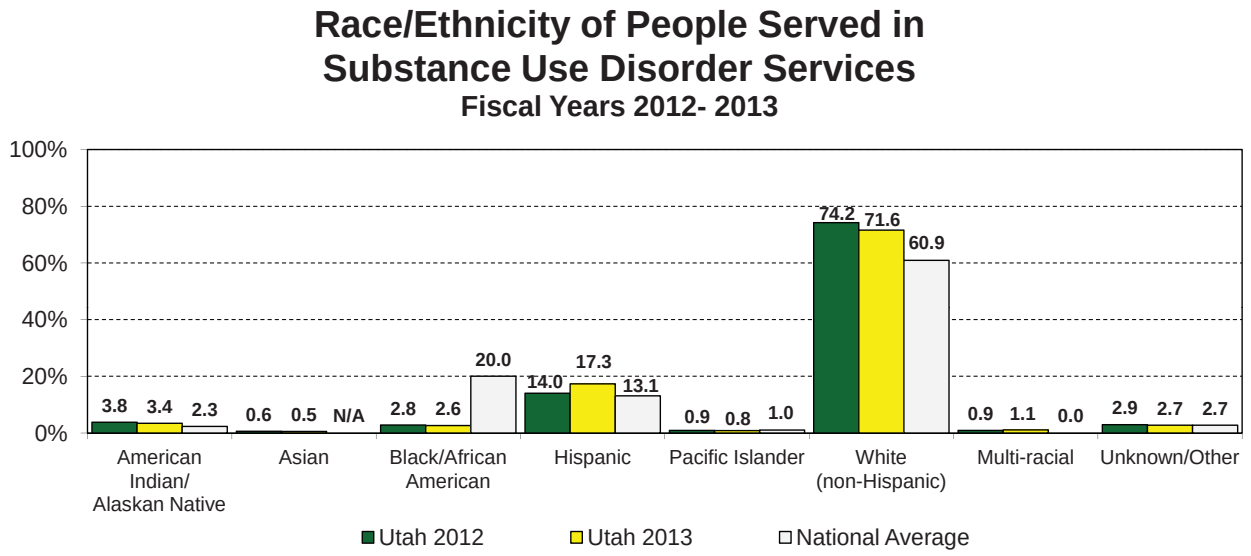




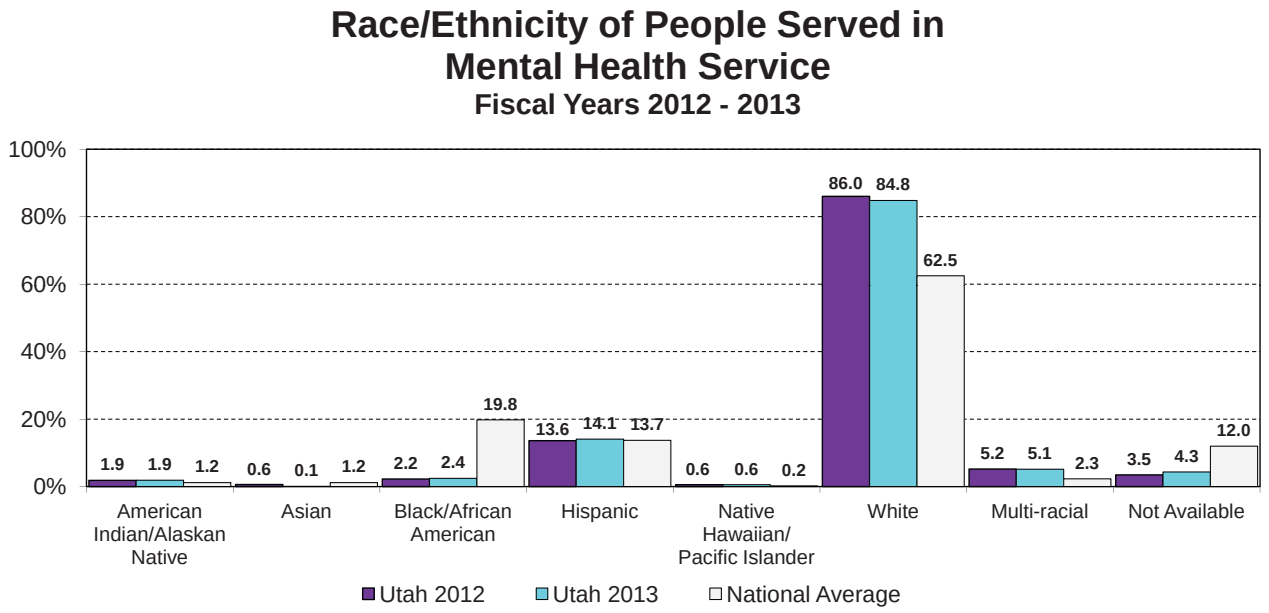


Race and Ethnicity

The charts below report the distribution of the treatment population by race categories. There are no significant differences in race and ethnicity for clients receiving substance use disorder or mental health services.

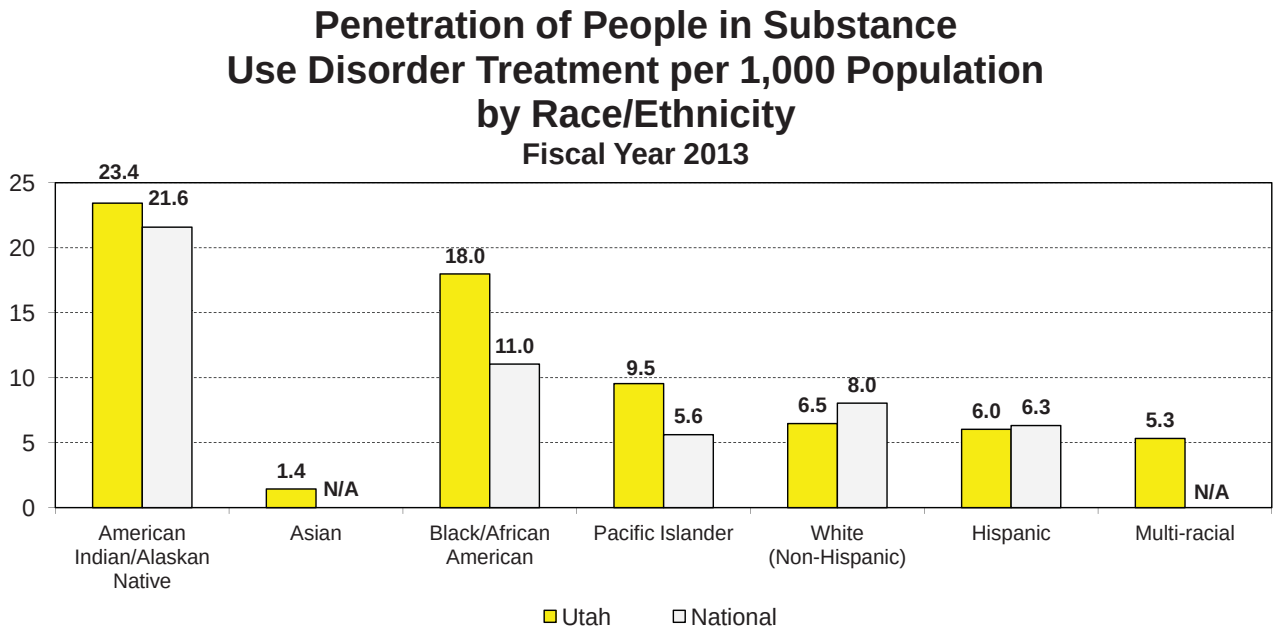


*Note: Pacific Islander and Asian reported together in National Averages

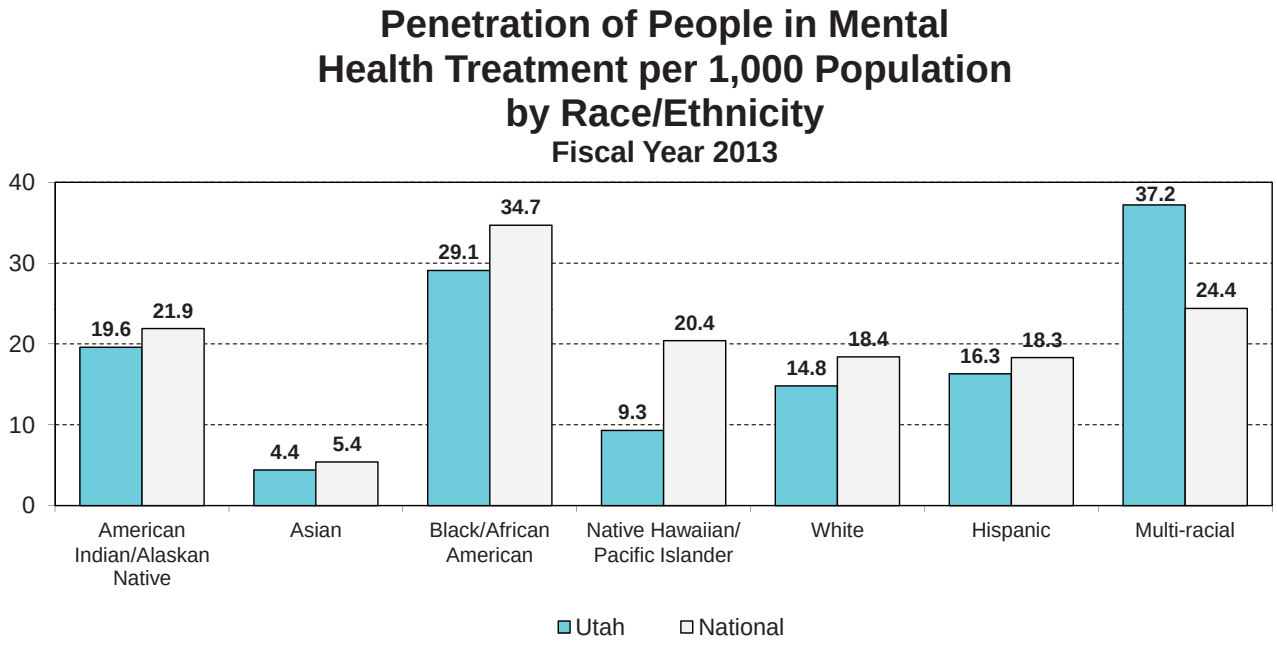


Note: More than one race/ethnicity may have been selected.

The charts below show the penetration of substance use disorder and mental health services by race/ethnicity. These graphs compare the rates that people are seeking services and account for the widely differing numbers of people in those racial/ethnic groups. For example, for every 1,000 whites in Utah, 6.5 are receiving substance use disorder treatment; however, for every 1,000 American Indians in Utah, 23.4 are receiving substance use disorder services.

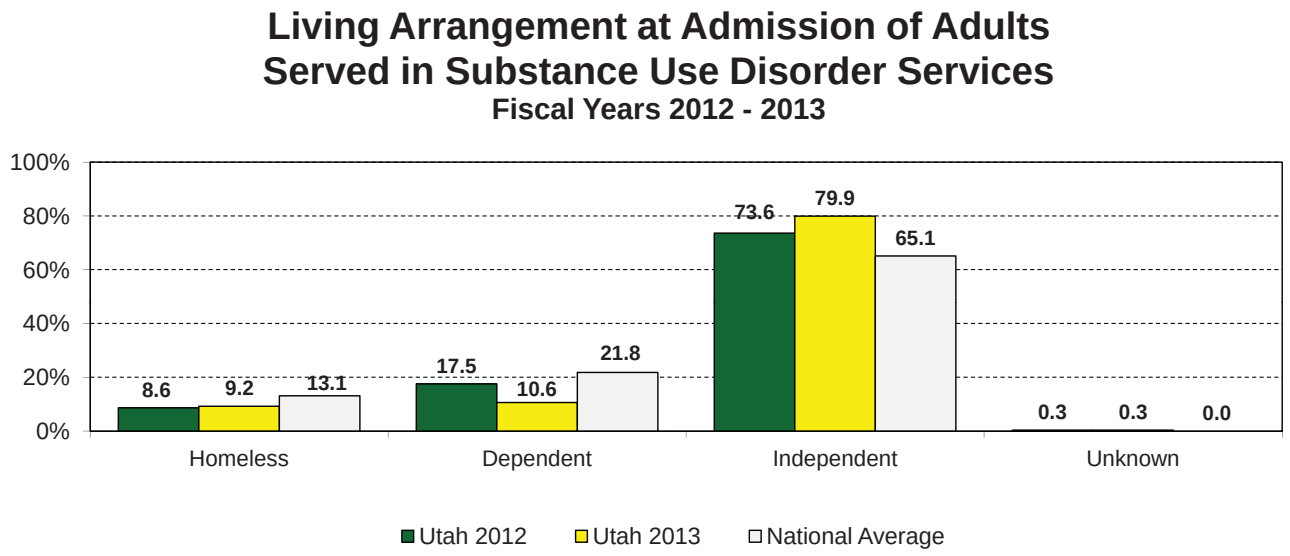


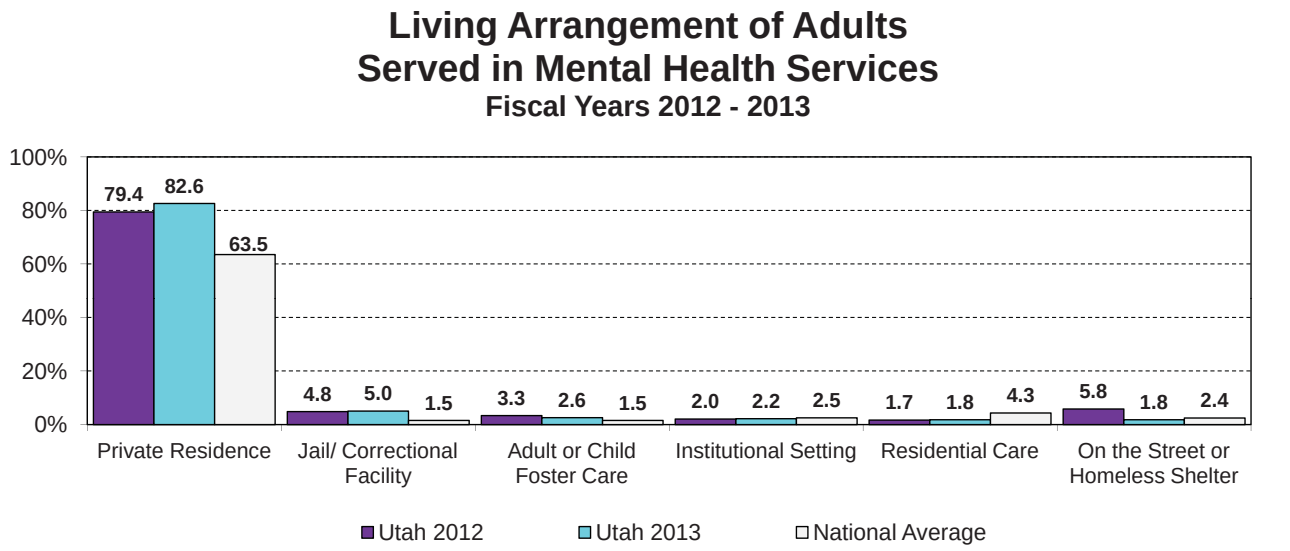
Note: Pacific Islander and Asian reported together in National data. There was no data available for multi-racial clients in the National data.



Living Arrangement

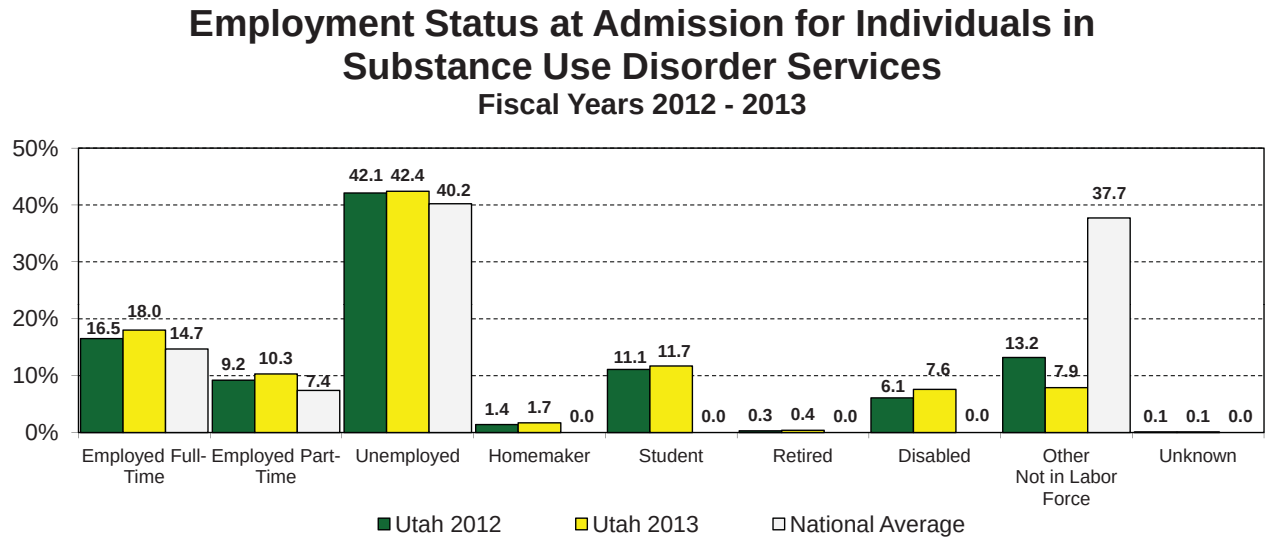
The following charts depict clients' living arrangement at admission for substance use disorder and for mental health clients served in fiscal year 2012 and fiscal year 2013. By far, the majority of clients receiving substance use disorder and mental health services are in independent living during treatment. Due to reporting requirements, more detailed data on living arrangement categories is available for mental health clients than substance use disorder clients.



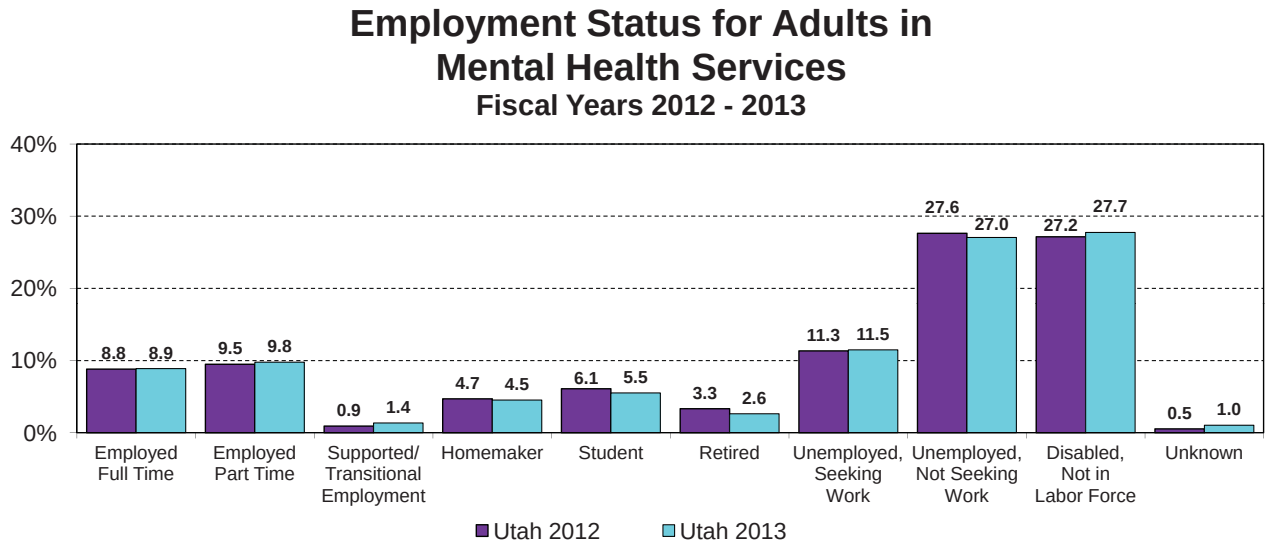


Employment Status

The following charts show the employment status at admission for substance use disorder and for mental health clients served in fiscal year 2012 and fiscal year 2013. The categories for mental health clients are different than those for substance use disorder clients due to different reporting requirements.

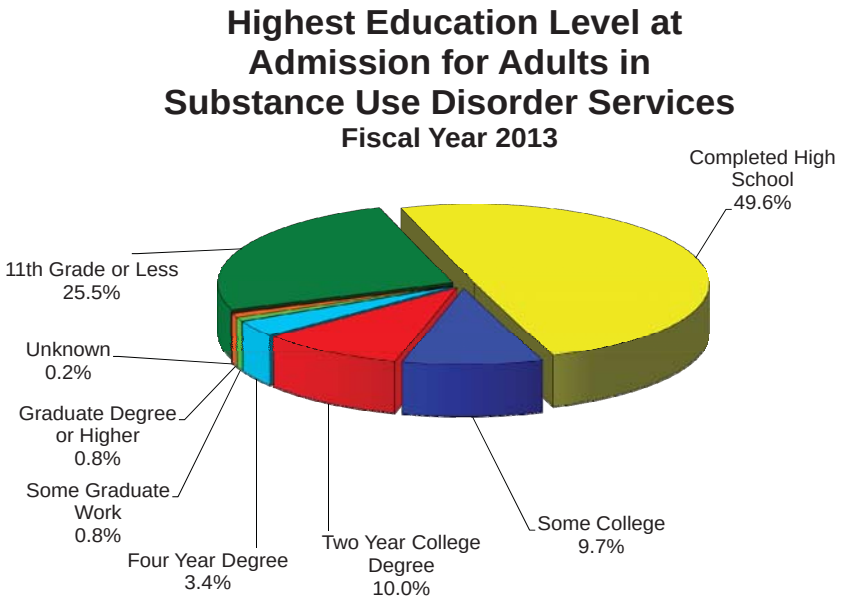


*Note: All National "Not in Labor Force" categories are collapsed into "Other Not in Labor Force."

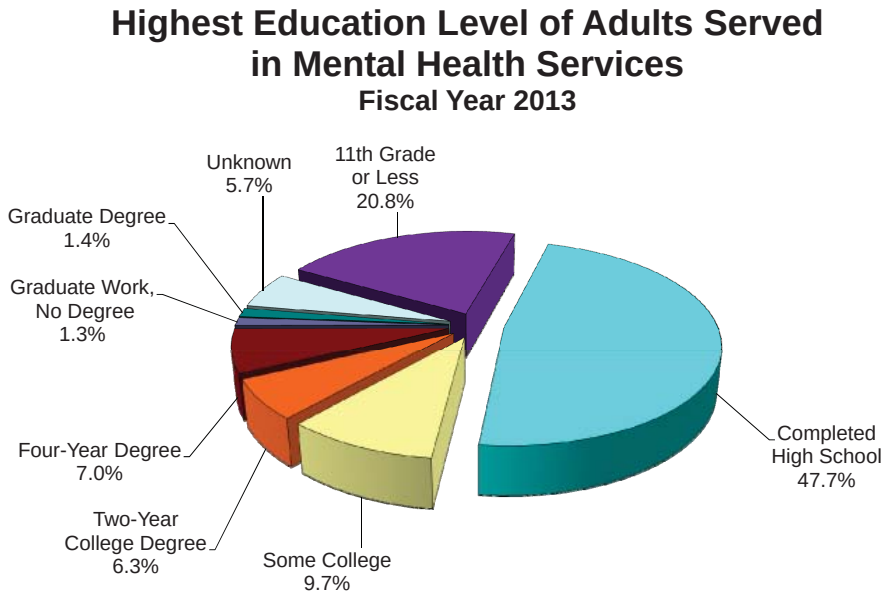


Highest Education Level Completed

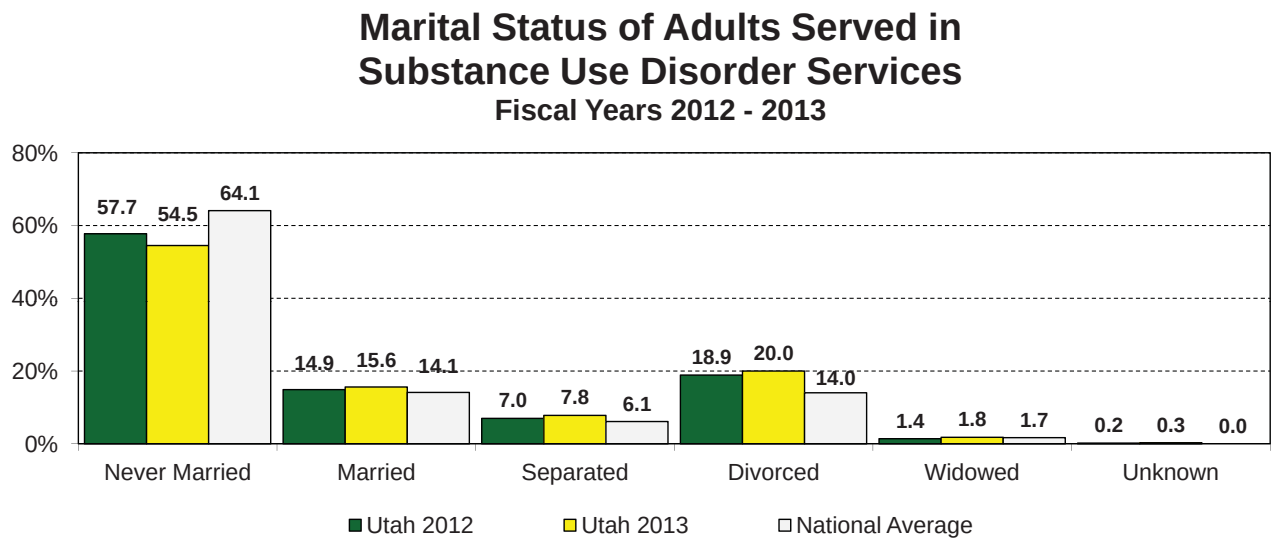
In fiscal year 2013, over 74% of adults in substance use disorder treatment statewide completed at least high school, which included those clients who had attended some college or technical training. Additionally, almost 25% of the clients had received some type of college training prior to admission. Still, over 25% had not graduated from high school.

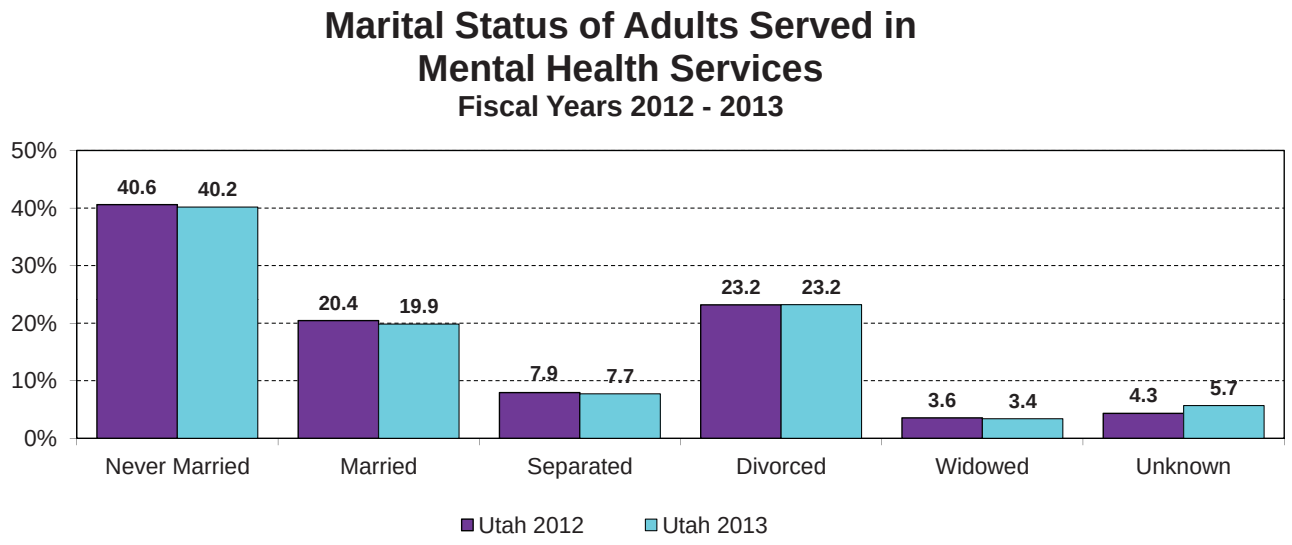


In fiscal year 2013, over 73% of adults in mental health treatment statewide completed at least high school, which included those clients who had attended some college or technical training. Additionally, almost 26% of the clients had received some type of college. Still, 21% had not graduated from high school.



Marital Status



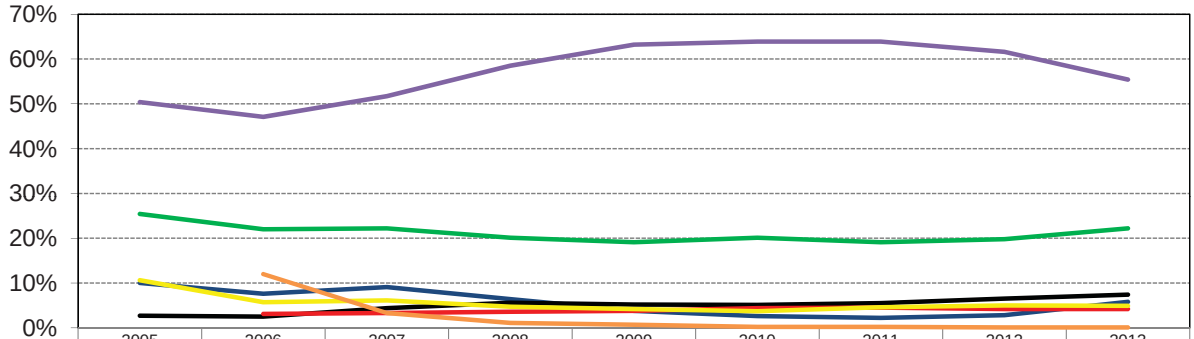


Referral Source

The charts below detail referral sources for fiscal years 2005 through 2013 for substance use disroders and fiscal years 2006 through 2013 for mental health.

Referral Source of Individuals in Substance Use Disorder Services

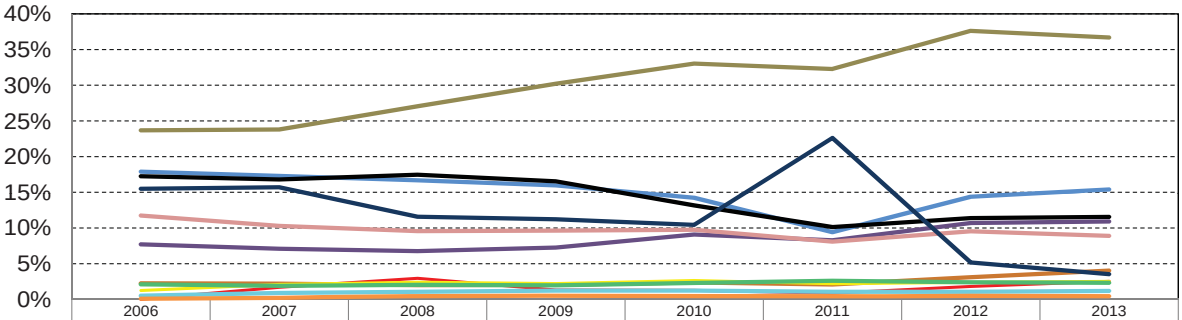
Fiscal Years 2005 - 2013



	2005	2006	2007	2008	2009	2010	2011	2012	2013
Individual or Self	25.4%	22.0%	22.2%	20.1%	19.1%	20.1%	19.1%	19.8%	22.2%
A & D Provider	10.0%	7.6%	9.1%	6.4%	3.8%	2.6%	2.2%	2.8%	5.8%
Other Health Care Provider	2.7%	2.5%	4.4%	5.6%	5.2%	5.1%	5.5%	6.5%	7.4%
DCFS		3.1%	3.3%	3.6%	3.8%	4.4%	4.5%	4.2%	4.2%
Community Referral	10.6%	5.7%	6.1%	4.7%	4.2%	3.7%	4.6%	5.0%	4.9%
Courts/Justice System	50.4%	47.1%	51.7%	58.5%	63.2%	63.9%	63.9%	61.6%	55.4%
Unknown		12.0%	3.3%	1.1%	0.7%	0.2%	0.2%	0.1%	0.1%

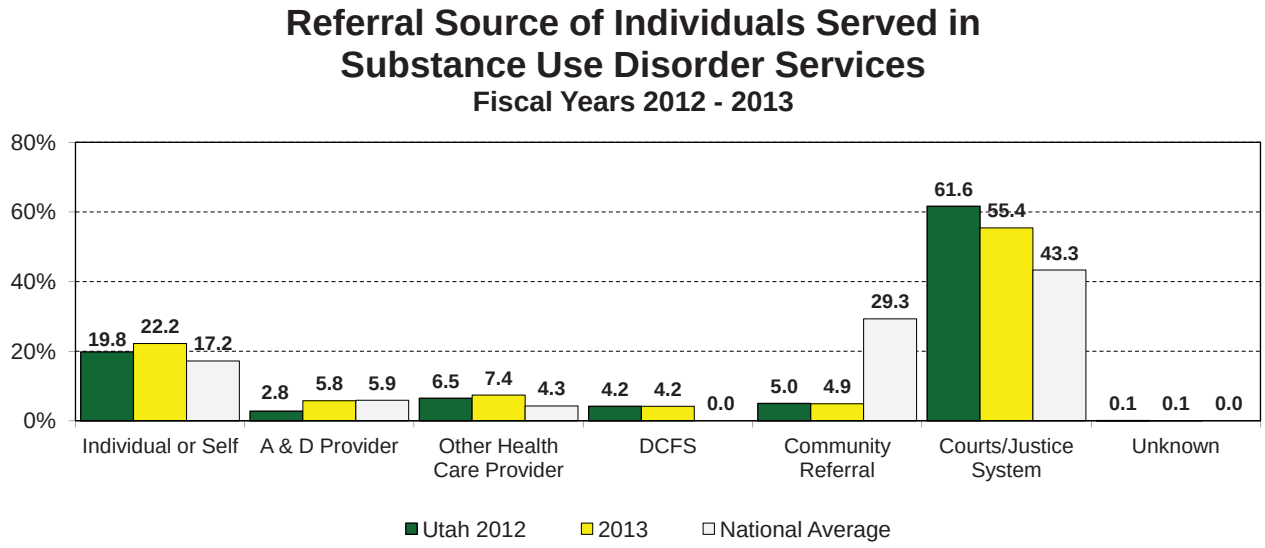
Referral Source of People Served in Mental Health Services

Fiscal Years 2006- 2013

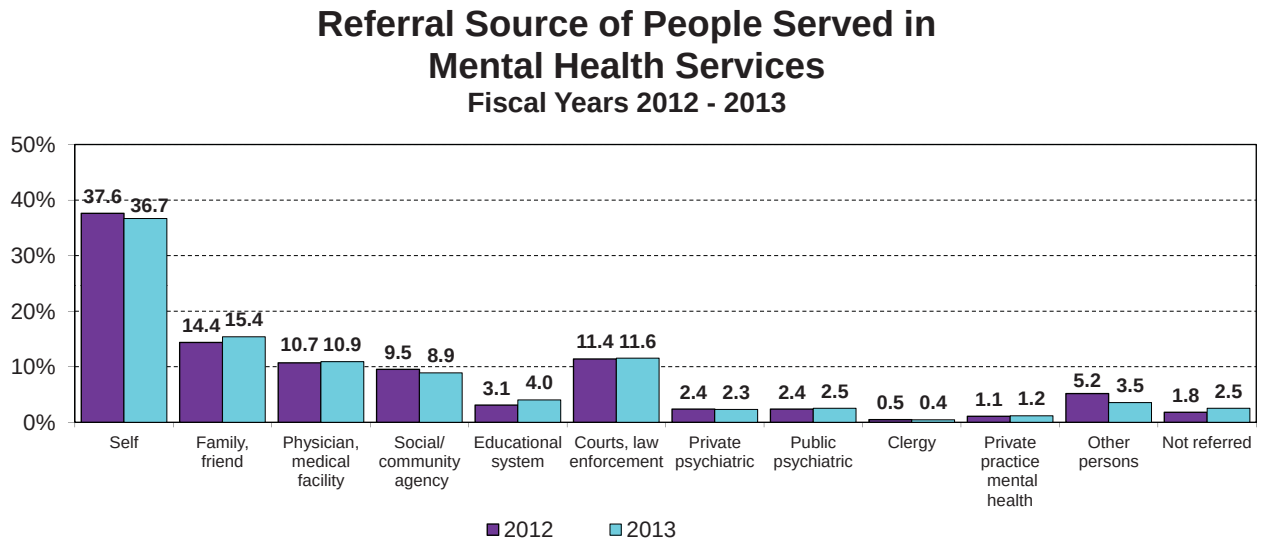


	2006	2007	2008	2009	2010	2011	2012	2013
Self	23.7%	23.80%	27.1%	30.2%	33.0%	32.3%	37.6%	36.7%
Family, friend	17.9%	17.30%	16.7%	16.0%	14.2%	9.4%	14.4%	15.4%
Courts, law enforcement	17.3%	16.80%	17.5%	16.5%	13.2%	10.1%	11.4%	11.6%
Physician, medical facility	7.7%	7.10%	6.8%	7.2%	9.1%	8.3%	10.7%	10.9%
Social/community agency	11.7%	10.30%	9.6%	9.6%	9.8%	8.1%	9.5%	8.9%
Educational System	2.2%	2.20%	2.0%	2.0%	2.4%	2.1%	3.1%	4.0%
Other Persons	15.5%	15.7%	11.6%	11.2%	10.4%	22.6%	5.2%	3.5%
Not referred	0.0%	1.7%	2.9%	1.3%	1.3%	0.9%	1.8%	2.5%
Public psychiatric	1.2%	2.1%	2.4%	2.2%	2.6%	2.2%	2.4%	2.5%
Private psychiatric	2.1%	1.9%	2.0%	2.0%	2.3%	2.6%	2.4%	2.3%
Private practice mental health	0.5%	0.9%	1.1%	1.2%	1.2%	1.1%	1.1%	1.2%
Clergy	0.1%	0.2%	0.5%	0.5%	0.5%	0.4%	0.5%	0.4%

The graphs below detail referral sources for fiscal years 2012 and 2013 for substance use disorder and mental health services.



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



Utah Youth Council Contest Award Winner

"Out of the Shadows, Exposing Stigma"

Prevention

Prevention

Prevention works. Prevention science has grown exponentially in the past 20 years. Reliable and valid studies show us what works to decrease a myriad of negative health problems in communities. At the top of the list of these major health issues is the misuse and abuse of alcohol, tobacco, and other drugs. Communities that use effective prevention strategies, programs, and policies see decreases in major health and social issues in their community. An ounce of prevention is worth a pound of cure.

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 SPF, Utahns are assured that services in their area match local needs, and factors that lead to costly problems are addressed.

Vital to a successful and sustainable prevention effort is a mobilized and organized community prevention coalition. DSAMH provides incentives to local substance abuse authorities (LSAAs) who utilize the Communities That Care system which has been scientifically proven to effectively run local coalitions and address local substance use disorder issues.

To support community efforts in following the SPF, 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

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

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 use disorder prevention are first, to prevent underage drinking and second, to prevent the abuse and misuse of prescription drugs. The latest data also sheds light on an increased use of marijuana among students throughout Utah.

DSAMH has provided leadership, technical assistance, and additional funding to LSAAs 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 2013 Student Health and Risk Prevention (SHARP) Survey, alcohol is the most commonly abused substance among youth. In fact, nearly one in every three 12th graders reported drinking alcohol sometime in their lifetime. The same survey shows that 14% of 12th graders reported using alcohol in the past 30 days. To relate this problem to dollars and cents, underage drinking cost the citizens of Utah $400 million in 2010 (www.udect.org/factsheets/ut.pdf)

DSAMH prevention staff participates on the advisory committee for the highly successful "Parents Empowered" campaign. This campaign is aimed at eliminating underage drinking. DSAMH staff provides research, oversight, and connections between Parents Empowered and community coalitions throughout the state. For more information, visit www.parentsempowered.org.

Preventing the Abuse and Misuse of Prescription Drugs

Data has driven Utah to make prescription drug abuse a top priority for Utah Prevention. In Utah, the illegal use of prescription drugs has reached epidemic proportions. While Utah has seen some success in prescription drug abuse prevention, it remains a very troubling issue.

- An average of 23 Utahns die as a result of prescription opioids (pain killers) each month.
- Prescription opioid deaths outnumbered motor vehicle crash deaths in 2007.
- The number of prescription opioid deaths increased 4.2% from 2010 to 2011.
- 71% of those who overdosed on opioud drugs had a substance abuse problem (Substance abuse problems include those in which the individual was noted as using illegal drugs, abusing prescription medications, or regularly using inhalants at the time of death).[2]

Following the Strategic Prevention Framework, prevention efforts included coalition work, changing laws, and strategic use of evidence based prevention programs. The data suggest these efforts are making a positive change in Utah.

Information from the SHARP survey is encouraging.

The following shows the percent of students who used prescription drugs (stimulants, sedatives,

[2] http://www.health.utah.gov/vipp/RxDrugs/overview.html

tranquilizers, or narcotics) without a doctor telling them to take them. (SHARP 2013)

	2009	2011	2013
6th	2.3	3.2	2.3
8th	6.4	7.5	4.5
10th	11.2	11.7	7.7
12th	13.7	14.5	4.7
All Grades	8.3	9.0	4.8

Recent changes to Utah Law include:

- All Prescribers to attend 4 hours of substance use disorder classes
- New prescribers must register with Utah's Control Substance Database (PMP)
- April, clean out your cabinet month in Utah
- DUI law clarified to include drugged driving

For more information, visit www.useonlyasdirected.org.

Prevention Dimensions

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 Education for implementation and evaluation of PD to ensure it meets the State Board of Education's core curriculum requirements. The PD 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.

Highlights for 2012-2013 include the following:

- 1,361 individuals participated in PD teacher trainings and received resource materials.
- 80% of all teachers trained reported teaching PD lessons during the year.
- A total of 36 teacher trainings were conducted during the year.
- Based on online reporting, it is estimated that 65% of all public school students in the K through 6th grades received PD materials.
    - More than 240,000 students participated in PD resource lessons in their classrooms.
    - 8,568 4th grade students participated in "Mind over Matter," a PD subject lesson that uses music to reinforce a strong no underage drinking message.

Risk and Protective Factor Model

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 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. The following chart identifies the Risk Factors for substance use disorder and other problem behaviors.

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	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓

Protective factors include, family attachment, prosocial involvement, interaction with prosocial peers, and rewards for prosocial involvement.

The 2009 report Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities, presents four key features of risk and protective factors:

1. Risk and protective factors can be found in multiple contexts.
2. Effects of risk and protective factors can be correlated and cumulative.
3. Some risk and protective factors have specific effects, but others are associated with multiple behavioral health problems.
4. Risk and protective factors influence each other and behavioral health problems over time.

DSAMH's goal is to increase protective factors and decrease risk factors. Each local authority has prioritized risk and protective factors that are based on their individual community's needs. This allows communities to target specific needs for their area which helps creating the largest impact for their prevention work.

Communities That Care

Whether it be public health concerns, environmental concerns, or issues related to major social problems such as poverty, scientists are postulating that the best effort to address large scale social problems is to develop community level coalitions. One such example is found in *Collective Impact* published by Stanford Social Innovation Review, Winter 2011. In this article, Kania & Kramer report that "large-scale social change requires broad cross-sector coordination." Furthermore, in the Community Youth Development Study, University of Washington Scientists compared outcomes between communities that used the Communities That Care (CTC) model of coalition organization to communities that used either other coalition models or no coalition model at all. Some of those results follow:

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

CTC helps community stakeholders and decision makers understand and apply information about issues in their community that are proven to

make a difference in promoting healthy youth development. Specific issues include underage drinking, substance abuse, violence, delinquency, school dropout, and anxiety and depression.

CTC is grounded in rigorous research from social work, public health, psychology, education, medicine, criminology, and organizational development. It engages all community members who have a stake in healthy futures for young people and sets priorities for action based on community challenges and strengths. Clear, measurable outcomes are tracked over time to show progress and ensure accountability.

The Social Development Strategy is CTCs primary strategy. It focuses on strengthening protective factors that can buffer young people from problem behaviors and promote positive youth development.

In an effort to encourage communities to increase effectiveness by increasing partnerships and decrease isolated initiatives within their community, DSAMH provides incentives to communities in Utah that commit to using CTC.

Evidence-Based Project

In a collaborative effort with the Utah Division of Children and Family Services (DCFS), DSAMH did a pilot project for fiscal year 2013 involving prevention programs targeting both DCFS and DSAMH target populations. The premise of this pilot was to show evidence-based prevention programs impacted a community, and how collaboration between state divisions could increase the number of Utah residents impacted by prevention programs.

Eleven of the thirteen local substance abuse authorities participated. During this project period, 3,843 people received evidence-based prevention programming. Positive change was demonstrated by those who attended the services as demonstrated by pre and post tests given to each participant. An analysis of these tests showed the project "improves Family Skills, Communication, and Parental Attitudes." Other positive outcomes from this pilot study included an increase in collaboration between agencies.

The project used a little over $500,000 to serve 3,843 in 19 counties. This works out to $130 a family to attend parenting classes that are evidence based, tested, and proven to be effective.

2013 State of Utah Student Health and Risk Prevention (SHARP) Survey

The biannual SHARP survey was completed in spring of 2013. The SHARP survey is a combination of three major surveys delivered which include the Prevention Needs Assessment (PNA), the Youth Risk Behavior Survey, and questions from the Youth Tobacco Survey.

The PNA Survey was designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. The survey was administered to students in grades 6, 8, 10, and 12 in 39 school districts and 14 charter schools across Utah. The results of the Prevention Needs Assessment for the State of Utah are presented in reports on the DSAMH website www.dsamh.utah.gov. Results for the most current administration of the survey along with comparisons to 2009 and 2011 SHARP Survey results can be found in the report. Results from administrations prior to 2009 may be found by consulting past years' profile reports also found on the DSAMH website.

Nearly 50,000 students were surveyed. The data was gathered and reported as a full statewide report and by local substance abuse authority. Some school districts and individual schools elected to survey enough students where results can be analyzed to portray accurate survey results for their district or school.

Key findings of the 2013 SHARP report include:

Alcohol

- There was a decrease overall in the percentage of youth who reported using alcohol in the 30 days prior to the survey from 8.6% in 2011 to 7.0% in 2013 for students in grades 6, 8, 10 and 12. The students in the 12th grade reported the largest decrease from 17.0% in 2011 to 14.0% in 2013. This is consistent with 12th grade students also reporting a large increase in their parents feeling it was very wrong for them to drink alcohol and an increase in students reporting that drinking one or two drinks of an alcoholic beverage nearly every day put them at great risk physically or other ways, 53.6% in 2011 and 58.3% in 2013.

- Harmful drinking, as measured by binge drinking (drinking five or more drinks in a row any time in the past two weeks), decreased overall from 6.6% in 2011 to 4.9% in 2013 with significant decreases in all but 6th grade. The largest decrease (3.1%) was for students in the 12th grade with 12.2% reporting binge drinking in 2011 and 9.1% in 2013.

Marijuana Use

- Marijuana use in the 30 days prior to the survey has increased since 2007 in all grades surveyed. In grades 6, 8, 10, and 12 overall, 4.1% reported using marijuana in 2007, 4.6% in 2009, 5.3% in 2011, and 5.8% in 2013. While the increase from 2011 to 2013 is not statistically significant, there is definitely a trend for increased marijuana use over the past six years.

- The perceived risk of using marijuana regularly decreased from 72.9% of students indicating great risk in smoking marijuana regularly in 2011 to 69.9% indicating great risk in 2013.

Mental Health and Suicide

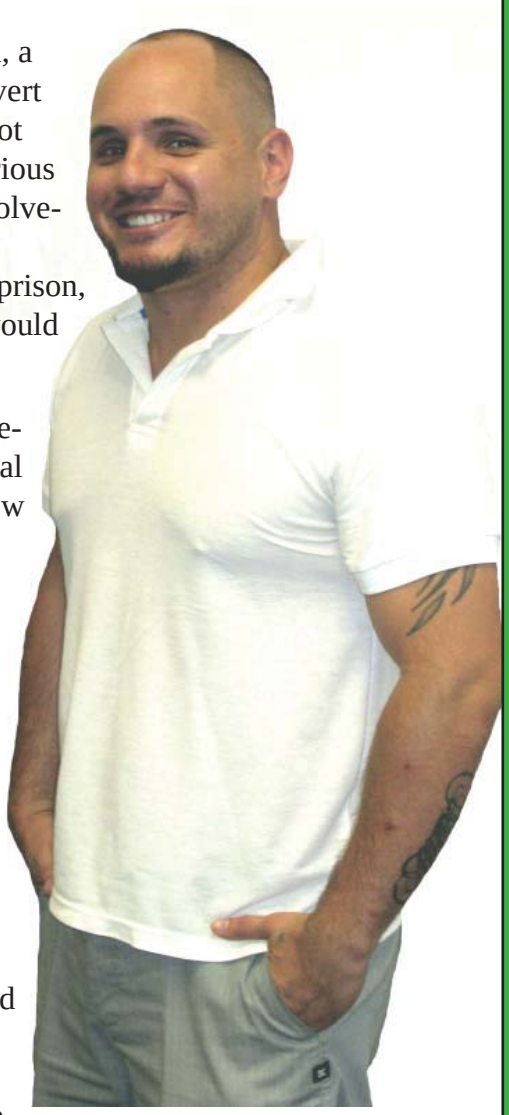
- Overall, the number of students who need mental health treatment increased from 11.2% in 2011 to 13.0% in 2013 with significant increases in 8th grade (from 11.7% in 2011 to 13.6% in 2013) and in 10th grade (from 12.7% in 2011 to 15.6% in 2013).

- The percentage of students considering suicide (those who marked “yes” to the question, “During the past 12 months did you ever seriously consider attempting suicide?”) increased from 9.4% in 2011 to 12.3% in 2013, with significant increases in all grades surveyed, 6, 8, 10, and 12. The largest increase of 4.2% was in the 10th grade with rates of 11.4% in 2011 and 15.6% in 2013.

Damion

I grew up in a loving family. We were not wealthy, but we were happy. By the 6th grade, I started rebelling and began to skip school. By junior high, I had assumed the role of the "tough guy." I liked to fight and relished the respect I received from my classmates. I started to bully other students and by the 8th grade, was suspended for the first time. I began experimenting with marijuana and alcohol and got expelled for bringing a gun to school. When I drank alcohol, I became violent.

By age 19, I had been in and out of juvenile detention, a group home and jail several times. I would always revert back to my old friends and behaviors, because I did not know how to change. My behaviors escalated into serious criminal activity and I gravitated into heavy gang involvement. The substance use grew into frequent meth and cocaine use. After many arrests and multiple stays in prison, I knew something had to change or these behaviors would take my life.



I believe I have been given a great opportunity in life, a second chance, and that it is my responsibilty to live up to my potential and help as many people as I can.

My Probation Officer referred me to a residential treatment facility. I knew that treatment was my last chance to change my life. I got clean and became honest, no matter how unfamiliar and uncomfortable it was. For the first time in my life, I began to think I could rebuild and overcome the challenge of addiction/crime and live a healthy, happy and productive life.

I began volunteering at an inpatient facility and mentoring those in trouble as a way to stay in recovery and to give back. For the last three years I have worked part time at an all male treatment center. In 2012 I received an internship advocating for substance abuse and mental health issues during the legislative session. I was recently accepted into the SUDC program at the U of U and now have an internship at an outpatient treatment center. The way I live life today makes my family proud of the man they once thought they were going to lose.

Substance Use Disorder Treatment

In Utah, a continuum of services has been designed to address the full spectrum of substance use problems, from harmful use to chronic conditions. Treatment services are based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Clients are matched to the appropriate level, type, and intensity of treatment based on a clinical assessment. The following table illustrates the continuum of services provided:

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

Function	Prevention/Intervention			Treatment			Recovery Support Services
Program Level	***Universal***	***Selected***	***Indicated***	***Outpatient***	***Intensive Outpatient***	***Residential***	***All levels depending on need for services***
Appropriate for	• General Population	• High Risk	• Using but does not meet DSM IV Diagnostic Criteria	• DSM IV Diagnosis of Abuse or Dependence	• Serious Abuse or Dependence • DSM IV Diagnosis of Abuse or Dependence	• Severe Abuse or Dependence • DSM IV Diagnosis of Abuse or Dependence	• Individuals needing support services outside of treatment in order to maintain their recovery and build a meaningful life in the community

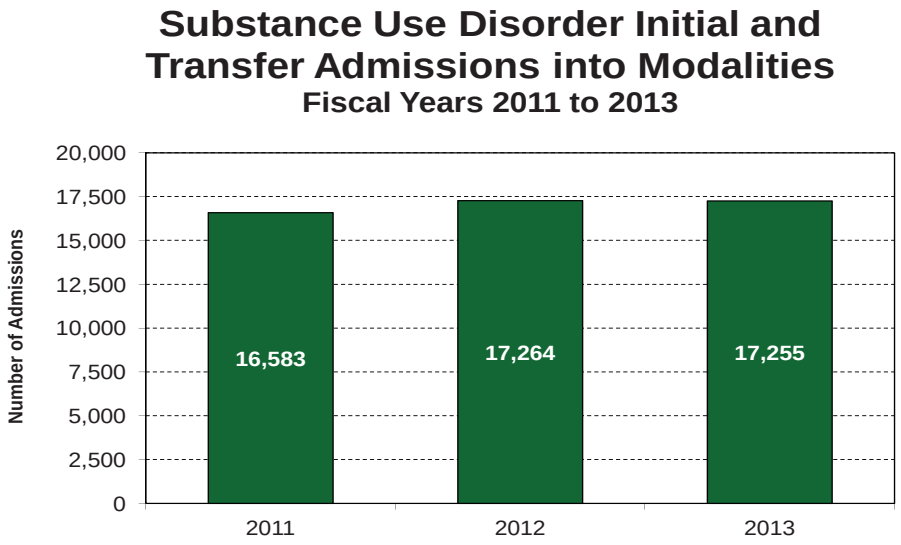
Source of Data

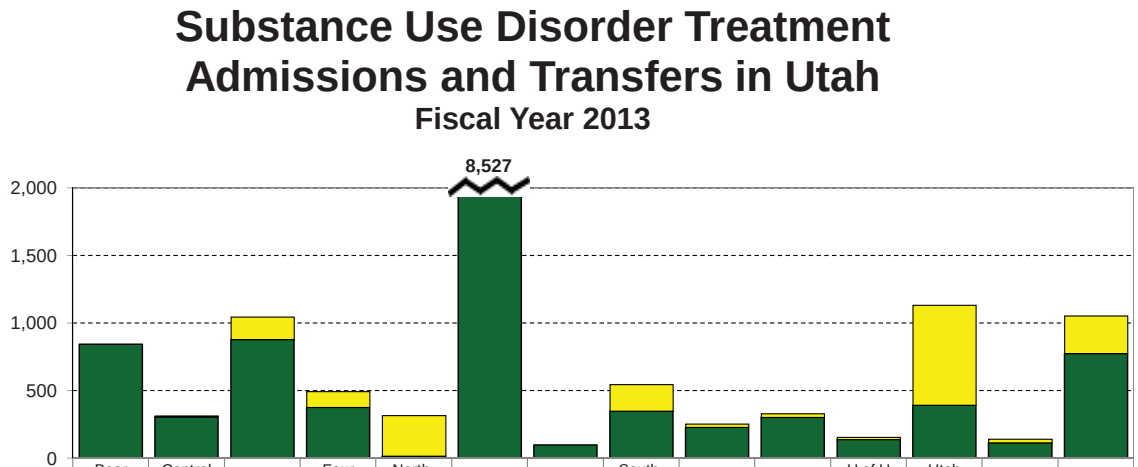
The federal government requires that each state collect demographic and treatment data on all clients admitted into any publicly funded substance abuse treatment facility. This data is called the Treatment Episode Data Set (TEDS). TEDS is the source that the Division of Substance Abuse and Mental Health (DSAMH) uses for treatment admission numbers and characteristics of clients entering treatment. Unless otherwise stated, the data in the following charts comes from this source.

Number of Treatment Admissions

In 2013, total treatment admissions remained virtually constant, with 17,264 admissions in 2012 and 17,255 in 2013.

The second chart shows the number of admissions by each local authority and the University of Utah Clinic in fiscal year 2013. It should be noted that six local authorities each have less than 2% of treatment admissions for the state, and Salt Lake County provides services to 61% of the state's admissions.

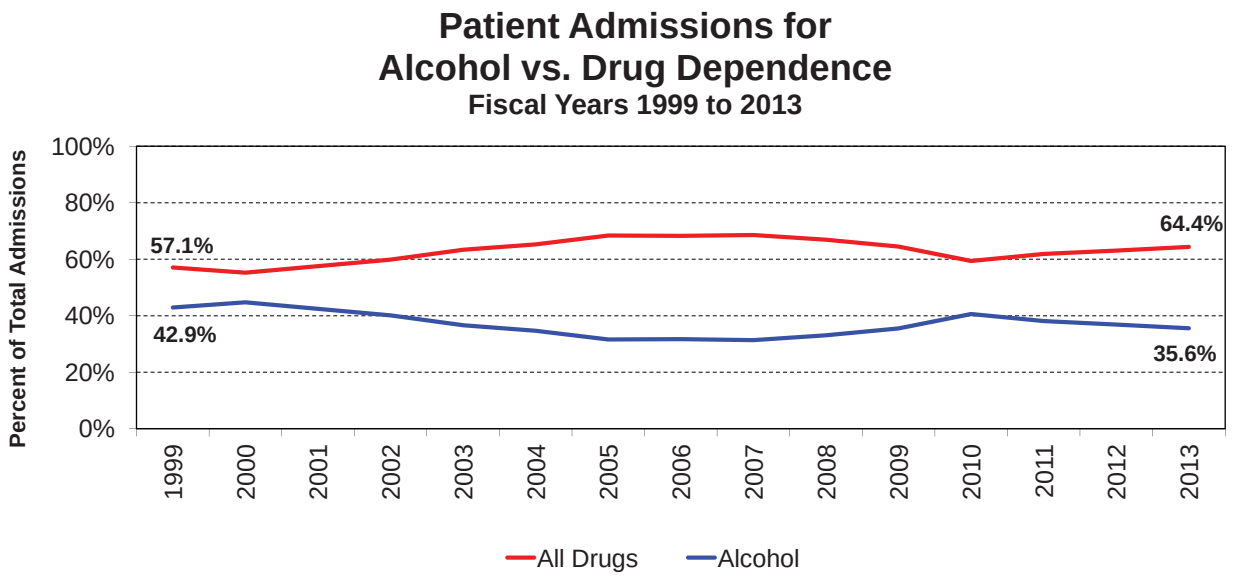




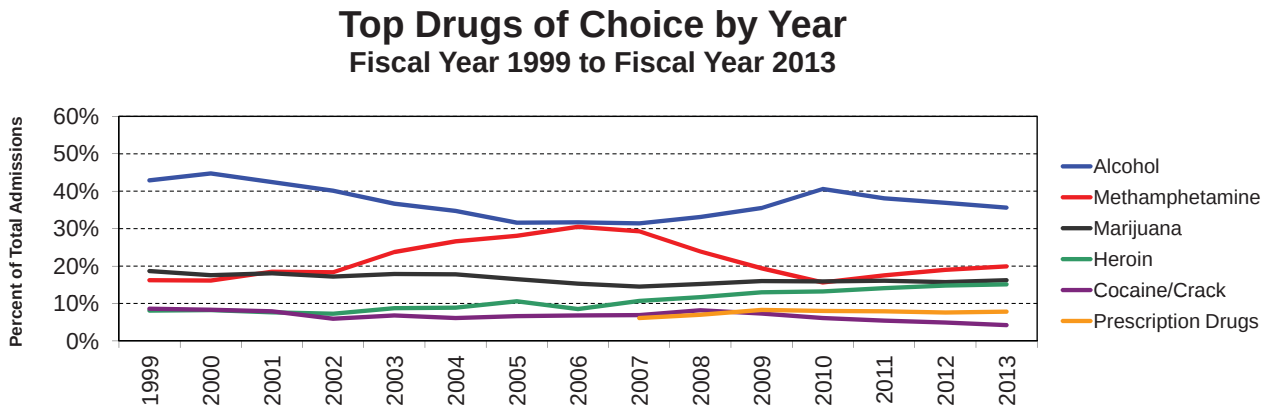
	Bear River	Central Utah	Davis	Four Corners	North-eastern	Salt Lake	San Juan	South-west	Summit	Tooele	U of U Clinic	Utah County	Wasatch	Weber HS
Transfer/Change in Modality	0	10	165	116	300	1,997	0	198	26	28	17	741	28	276
Initial Admissions	845	305	880	378	16	8,527	98	349	229	302	140	393	114	777

Primary Substance of Abuse

At admission, clients report their primary, secondary (if any), and tertiary (if any) drug use. Alcohol remains the primary substance of abuse, with 35.6% of clients reporting alcohol as their primary substance of abuse at admission.



Opioids are the second most abused drug at admission, accounting for just under 22% of all admissions. Methamphetamines and marijuana are the third and fourth most common drugs at admissions with 19.9% and 16.2% of admissions respectively. For the fifth straight year, Cocaine/crack dropped again in 2013 to 4.2%, the lowest on record.



Primary Substance by Gender

The primary drug at admission for men remains alcohol, at 40.1% of admissions. However for women, admission rates for alcohol and methamphetamines are statistically identical at 27.8% and 27.6% respectively continuing a multi-year increase in methamphetamine admissions, and decrease of admissions for alcohol. Opiates (heroin and prescription opiates such as methadone and oxycodone) were the second most commonly used drug at admission for men, and were the third most commonly used drug for women.

Primary Substance by Gender
Fiscal Year 2013

	Male	Male %	Female	Female %	Total	Total %
Alcohol	4,396	40.1%	1,753	27.8%	6,149	35.6%
Cocaine/Crack	488	4.5%	229	3.6%	717	4.2%
Marijuana/Hashish	2,046	18.7%	751	11.9%	2,797	16.2%
Heroin	1,588	14.5%	1,011	16.0%	2,599	15.1%
Other Opiates/Synthetics	286	2.6%	350	5.6%	636	3.7%
Hallucinogens	31	0.3%	10	0.2%	41	0.2%
Methamphetamine	1,691	15.4%	1,738	27.6%	3,429	19.9%
Other Stimulants	36	0.3%	44	0.7%	80	0.5%
Benzodiazepines	32	0.3%	51	0.7%	83	0.5%
Tranquilizers/Sedatives	10	0.1%	15	0.2%	25	0.1%
Inhalants	17	0.2%	5	0.1%	22	0.1%
Oxycodone/Hydrocodone	215	2.0%	295	4.7%	510	3.0%
Club Drugs	12	0.1%	8	0.1%	20	0.1%
Over-the-Counter	15	0.1%	3	0.1%	18	0.1%
Other	90	0.8%	37	0.6%	127	0.7%
Unknown	2	0.1%	0	0.0%	1	0.1%
Total:	10,955	100.0%	6,300	100.0%	17,255	100.0%

Primary Substance by Age

Age plays a significant role in drug preference. For adolescents (under the age of 18) marijuana is the primary drug of use at admission. In a significant shift, opiates, including prescription pain medication, are the number one drug at admission for individuals between 18 and 24, and are statistically identical with admissions for alcohol for the 25 to 34 age group. Alcohol is the primary drug of choice for all older age groups. The data shows that there has been a significant increase in admissions for opiates, replacing alcohol as the primary drug for a growing segment of the population.

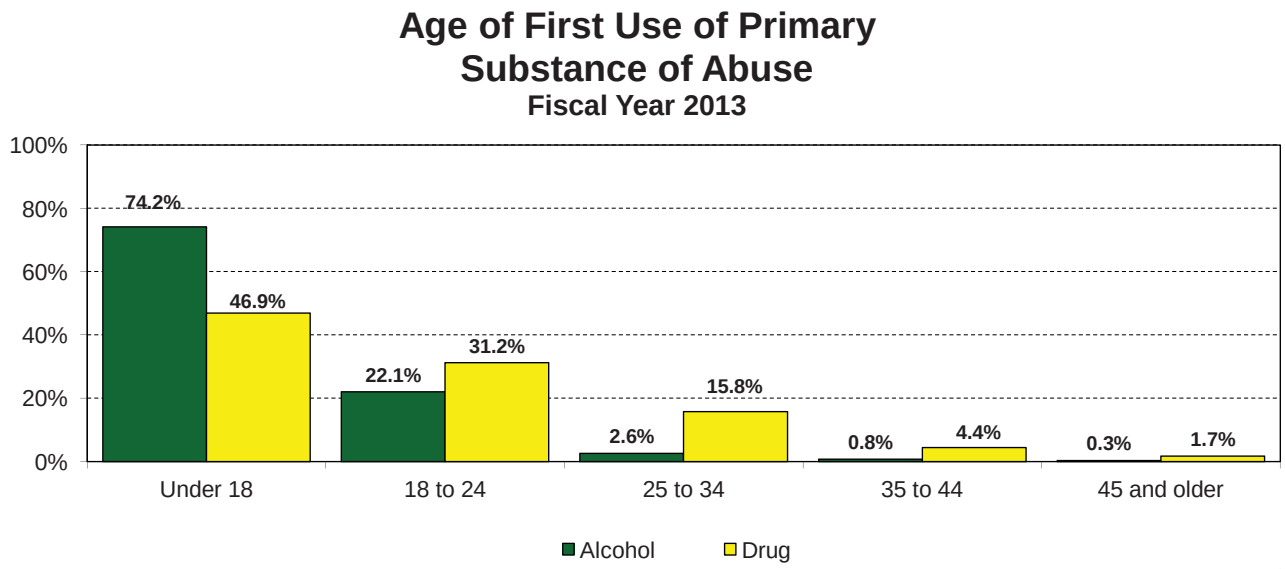
Primary Substance of Abuse by Age Grouping

Fiscal Year 2013

	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	226	823	1,834	1,334	1,888	44	6,149
Cocaine/Crack	1	68	228	182	236	2	717
Marijuana/Hashish	1,040	874	537	207	139	0	2,797
Heroin	16	743	1,235	335	258	12	2,599
Other Opiates/Synthetics	9	89	313	140	82	3	636
Hallucinogens	5	17	10	4	5	0	41
Methamphetamine	36	478	1,408	963	541	3	3,429
Other Stimulants	2	14	34	24	6	0	80
Benzodiazepines	0	9	28	20	25	1	83
Tranquilizers/Sedatives	1	4	8	4	8	0	25
Inhalants	4	3	7	4	4	0	22
Oxycodone/Hydrocodone	8	61	274	94	70	3	510
Club Drugs	3	9	8	0	0	0	20
Over-the-Counter	7	4	2	3	2	0	18
Other	16	34	33	21	23	0	127
Unknown	0	0	0	2	0	0	2
Total:	1,374	3,230	5,959	3,337	3,287	68	17,255

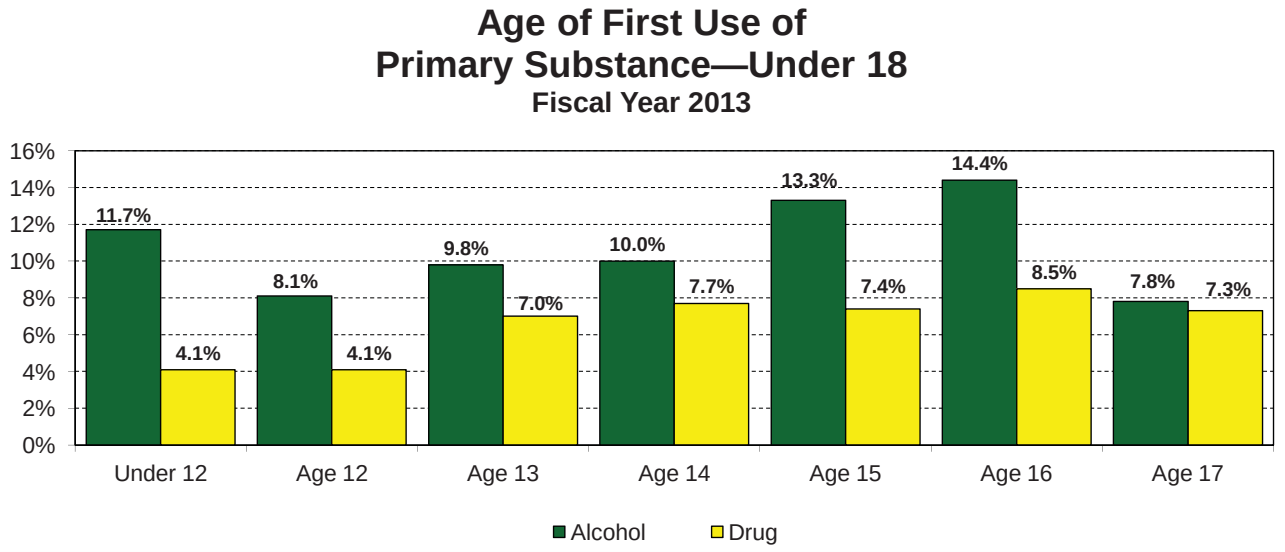
Age of First Use of Alcohol or Other Drug

In 2013, 74% of individuals who report alcohol as their primary drug began using prior to the age of 18, slightly down from 2012. Individuals seeking treatment primarily for drug use tend to begin their drug use at a later age, with 47% beginning their use prior to the age of 18, and 31% reporting their first use between ages 18 and 24. These numbers have remained relatively constant for several years.



Age of First Use of Primary Substance–Under 18

The following chart breaks down age of first use for individuals who reported using their primary substance prior to age 18. For alcohol and other drugs, age of first use peaks at age 16. Just under 40% of individuals who report alcohol as their primary substance of abuse started at or before age 14, with another 13% starting during their 15th year. Approximately 23% of individuals admitted for drug abuse started under the age of 15. This data is important as the research clearly shows that those that start using drugs or alcohol prior to the age of 18 have a significantly higher probability of becoming chemically dependent as adults.



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. The report of multiple drug use by clients at admission averages 41.5% across the state, ranging from 8.2% in San Juan County to 78.2% in Utah County.

These figures reflect that multiple use rates have stabilized after a slow upwards trend over the past three years. Once considered primarily an urban problem, multiple use appears to be widely spread across the state, with only four local authorities reporting less than one-third of their admissions are for single substances.

Multiple Drug Use

Fiscal Year 2013

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	342	40.5%
Central Utah	68	21.6%
Davis County	365	34.9%
Four Corners	186	37.7%
Northeastern	61	19.3%
Salt Lake County	4,116	39.1%
San Juan County	8	8.2%
Southwest Center	199	36.4%
Summit County	59	23.1%
Tooele County	137	41.5%
U of U Clinic	102	65.0%
Utah County	887	78.2%
Wasatch County	63	44.4%
Weber	575	54.6%
Total:	7,168	41.5%

Injection Drug Use

Injecting drug users are a priority population for receiving treatment because they are at greater risk of contracting and transmitting HIV/AIDS, tuberculosis, and hepatitis B and C. This table indicates the number of clients who report intravenous needle use as the primary route of administration for any reported drug use in the past year. In 2013 there was a slight decrease in the number of individuals requesting services through the public treatment system who reported IV drug use as their primary route of administration. This decrease was not consistent across the state, with Davis and Southwest reporting an increase of over 10% in IV drug admissions from 2012. Davis, Southwest, and Utah County report that over 30% of their admissions are IV drug users.

Admissions Reporting IV Injection Drug Use at Admission

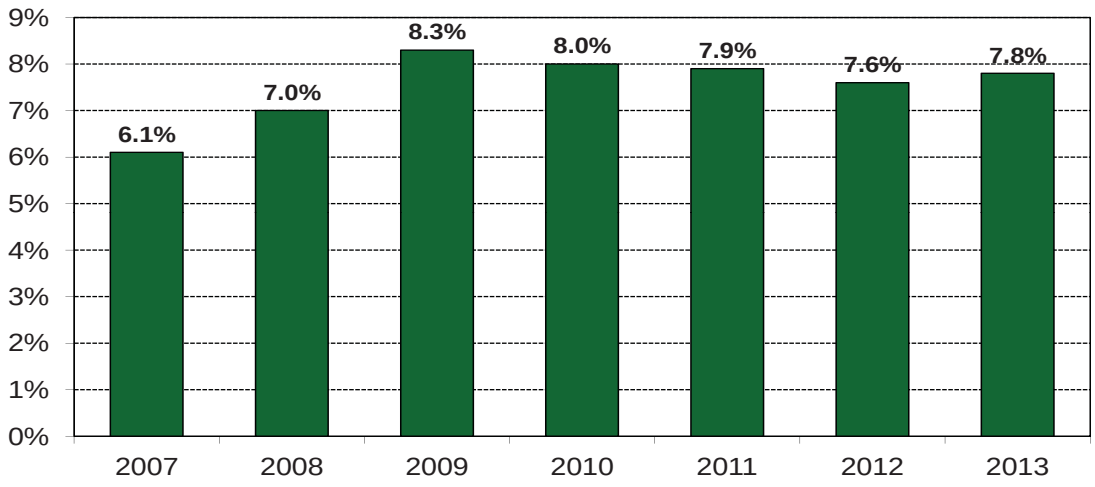
Fiscal Year 2013

	# Reporting IV Injection Drug Use at Admission	% of Total Admissions for Each Area
Bear River	100	11.8%
Central Utah	31	9.8%
Davis County	334	32.0%
Four Corners	95	19.2%
Northeastern	30	9.5%
Salt Lake County	2,197	20.9%
San Juan County	4	4.1%
Southwest Center	170	31.1%
Summit County	6	2.4%
Tooele County	42	12.7%
U of U Clinic	43	27.4%
Utah County	371	32.7%
Wasatch County	15	10.6%
Weber	170	16.1%
Total:	3,608	20.9%

Prescription Drug Abuse

The nonmedical use or abuse of prescription drugs is a serious and growing public health problem. The abuse of certain prescription drugs—opioids, central nervous system (CNS) depressants, and stimulants—can alter the brain's activity and lead to addiction. The Utah Department of Health reports that in 2011, more individuals died from prescription drug overdose (246) than died in car accidents (235). The chart below shows the percent of clients who report prescription drugs as their primary drug at admission:

Admission for Primary Drug—Prescription Drugs
Fiscal Years 2007 to 2013



Opioids (not counting heroin, but other opiates/synthetics and oxycodone/hydrocodone) are the most commonly abused prescription drugs in Utah. Taken as directed, opioids can be used to manage acute pain very effectively. However, if taken inappropriately, their use may lead to addiction. Additionally, mixing prescription drugs with alcohol and other substances can be a deadly combination. Women tend to be admitted to treatment more frequently than men for prescription drugs. The chart below shows prescription drug admissions by gender:

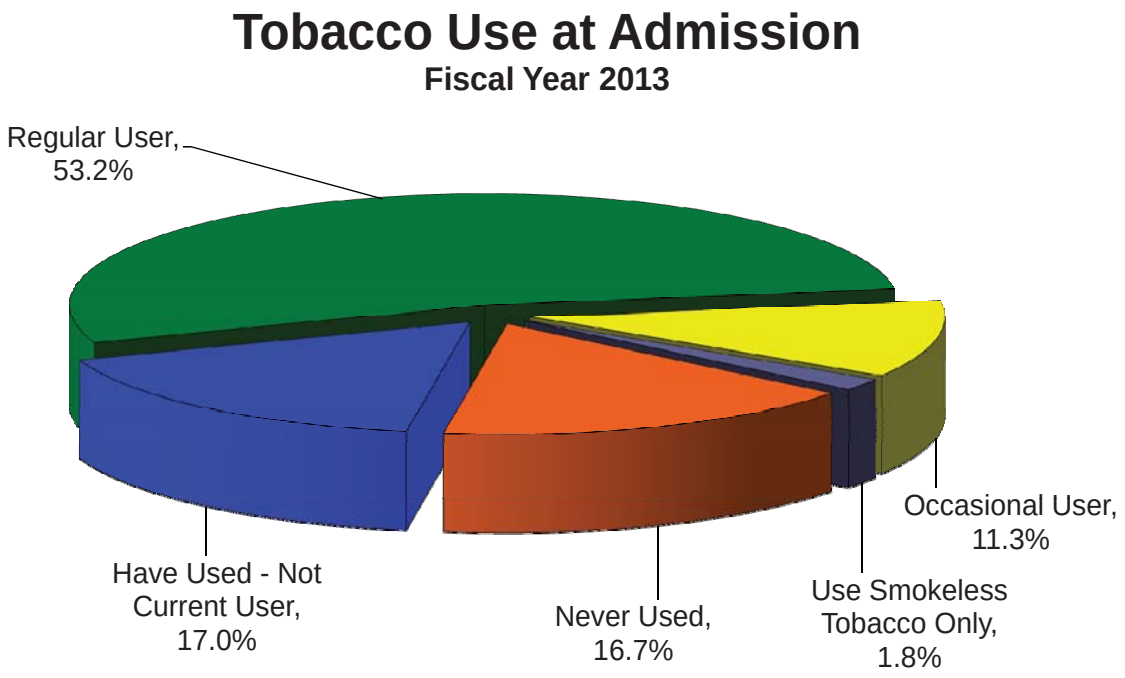
Prescription Drug Abuse by Gender

Fiscal Year 2013

	Male	Male %	Female	Female %	Total	Total %
Other Opiates/Synthetics	286	2.6%	350	5.6%	636	3.7%
Other Stimulants	36	0.3%	44	0.7%	80	0.5%
Benzodiazepines	32	0.3%	51	0.7%	83	0.5%
Tranquilizers/Sedatives	10	0.1%	15	0.2%	25	0.1%
Oxycodone/Hydrocodone	215	2.0%	295	4.7%	510	3.0%
Total:	579	5.3%	755	11.9%	1,334	7.8%

Tobacco Use

Individuals with substance use disorders are much more likely to use tobacco. In Utah, 66% of individuals admitted to substance use disorder treatment use tobacco compared to only 11% of the general population. This is a significant decrease from data in 2012 that indicated that over 70% of admissions used tobacco. This often results in poor health and shorter life expectancy. Additionally, local authorities reported the percentage of individuals who used tobacco at discharge decreased to 62% of clients.



In fiscal year 2013, around 66% of clients use some type of tobacco at admission.

Pregnant Women in Treatment

In fiscal Year 2013, 5.5% of women entering treatment (347) were pregnant at the time of admission. This is a slight decrease from a four-year high of 6.0% in 2012, but overall, the percentage of women who meet this criteria has remained stable over the past five years. State and federal law requires treatment providers to admit pregnant women into care within 48 hours of their first contact with the treatment provider.

Pregnancy at Admission
Fiscal Year 2013

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	311	9	2.9%
Central Utah	137	9	6.6%
Davis County	413	19	4.6%
Four Corners	192	1	0.5%
Northeastern	130	4	3.1%
Salt Lake County	3,458	210	6.1%
San Juan County	28	1	3.6%
Southwest	239	5	2.1%
Summit County	61	2	3.3%
Tooele County	125	4	3.2%
U of U Clinic	57	1	1.8%
Utah County	553	34	6.1%
Wasatch County	59	3	5.1%
Weber	537	45	8.4%
Total:	6,300	347	5.5%

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. As a result, providing treatment services to women with dependent children is a priority for the state. The table below indicates the percentage of adult clients with dependent children as well as the number of women entering treatment who have dependent children, and the average number of children in those households. In fiscal year 2013, the percentage of women clients with dependent children in Utah was 64.4%, an increase compared to the 58.2% in fiscal year 2012 and the highest since at least 2009. The average number of dependent children per household increased, while the percentage of clients with children dropped significantly.

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. A portion of the Federal Substance Abuse Prevention and Treatment 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.

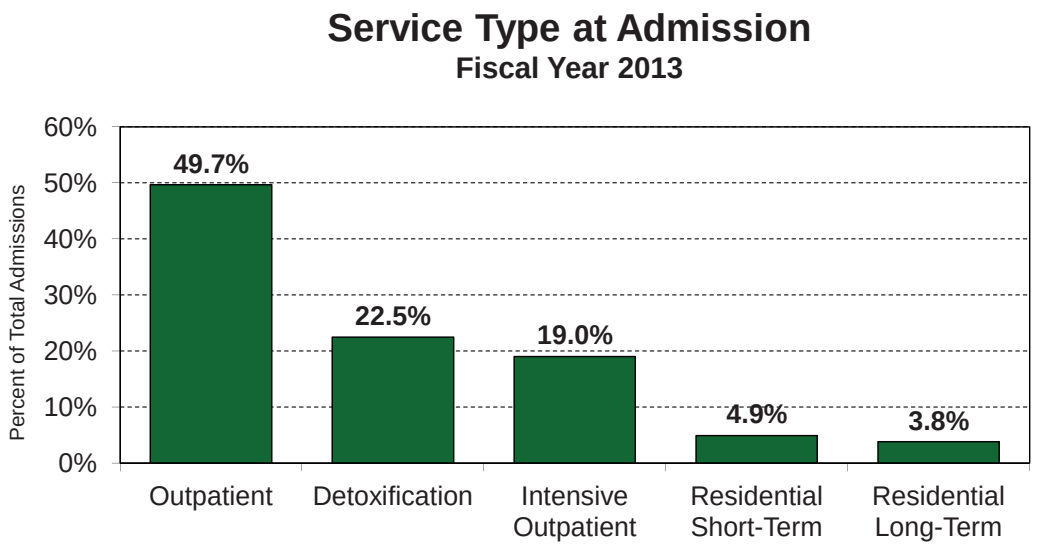
Clients with Dependent Children

Fiscal Year 2013

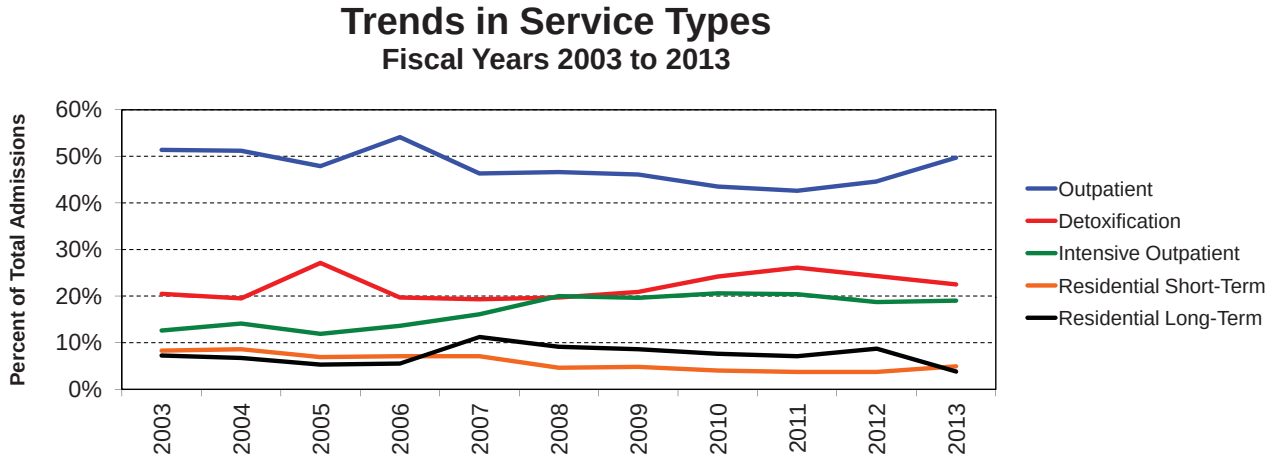
	Percent of all Clients with Children	Average Number of Children (of Clients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	34.7%	1.98	50.9%	1.96
Central Utah	54.2%	2.17	66.8%	2.17
Davis County	55.2%	2.28	72.2%	2.44
Four Corners	45.8%	2.25	57.6%	2.30
Northeastern	61.1%	2.02	49.8%	2.03
Salt Lake County	39.6%	2.04	54.0%	2.07
San Juan County	44.7%	2.53	47.9%	2.87
Southwest Center	44.8%	2.13	66.9%	2.22
Summit County	23.8%	1.98	37.9%	1.56
Tooele County	38.1%	1.96	51.6%	1.92
U of U Clinic	45.2%	2.17	51.9%	2.38
Utah County	61.5%	2.28	62.3%	2.20
Wasatch County	54.5%	3.23	57.4%	2.83
Weber	60.6%	2.71	58.6%	2.38
Total:	44.2%	2.19	64.4%	2.16

Service Type

In contrast to the earlier days of substance use disorder treatment when almost all treatment was residential, today 68.7% of admissions to treatment are to outpatient and intensive outpatient treatment. 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.



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 20.4% in 2011, a slight decrease in 2012 and 2013 to 19.0%. During that same period, residential admissions declined slightly until 2012, but then dropped significantly from 12.4% in 2012 to 8.7% in 2013, a 30% decrease. Since most of this decrease was in long-term residential admissions, it appears to reflect better use of the ASAM criteria and changes in agency approaches to treatment.



Drug Courts

Drug Courts provide participants intensive court-supervised drug treatment as an alternative to jail or prison. Intensive services are provided to 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.

Four primary models of drug court exist in Utah: adult felony drug courts, adult misdemeanor drug courts, juvenile drug courts, and family drug courts. In 1996, there were two drug courts in Utah. In fiscal year 2013, DSAMH provided funding for 40 courts, but will extend that funding to 42 courts in fiscal year 2014. DSAMH provides funding for 24 felony drug courts, 13 family drug courts, and 5 juvenile courts.

DSAMH and the Administrative Office of the Courts (AOC) have worked together to develop a drug court certification and contract monitoring process. DSAMH and AOC conduct annual site visits to ensure quality and monitor contract compliance. Contracts require drug courts to target eligibility towards individuals who are at high risk for continued criminal behavior and in high need of treatment services.

The following chart shows drug court outcomes for fiscal year 2013.

Drug Court Outcomes

Measure Title	Purpose of Measure/Measure Definition	FY2012	FY2013
Successful Completion	Percent of participants who complete program successfully	56.0%	51.5%
Criminal Justice Involvement	Percent of clients reporting zero arrests while participating in Drug Court	87.9%	88.0%
	Percent decrease in clients arrested from 30 days prior to treatment to 30 days prior to discontinuation/discharge	67.0%	66.1%
Employment	Percent increase in full/part-time employment from admission to discharge	43.0%	42.2%
Substance Use–Alcohol	Percent increase in abstinence from alcohol from admission to discharge	41.0%	30.7%
Substance Use–Drug	Percent increase in abstinence from drugs from admission to discharge	158.0%	194.4%
Increase in Stable Housing	Percent increase in non-homeless clients admission to discharge	2.0%	2.9%

Drug Offender Reform Act (DORA)

The Drug Offender Reform Act (DORA), began in 2005 as a pilot project, and as of July 1, 2013, is implemented in eight local substance abuse authority areas of Utah: Bear River, which includes Box Elder, Cache, and Rich Counties; Carbon County; Davis County; Salt Lake County; Southwest, which includes Iron and Washington Counties; and Utah County. In 2013, 365 individuals were admitted to the DORA program statewide.

The key components of DORA are intensive supervision, timely treatment access, and collaboration between treatment and supervision staff. Retention in, and adherence to treatment, are positively related to post-supervision criminal justice outcomes, according to the latest DORA research conducted by the University of Utah Criminal Justice Center. Individuals who are successful in treatment are less likely to be rearrested and enter or return to prison.

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

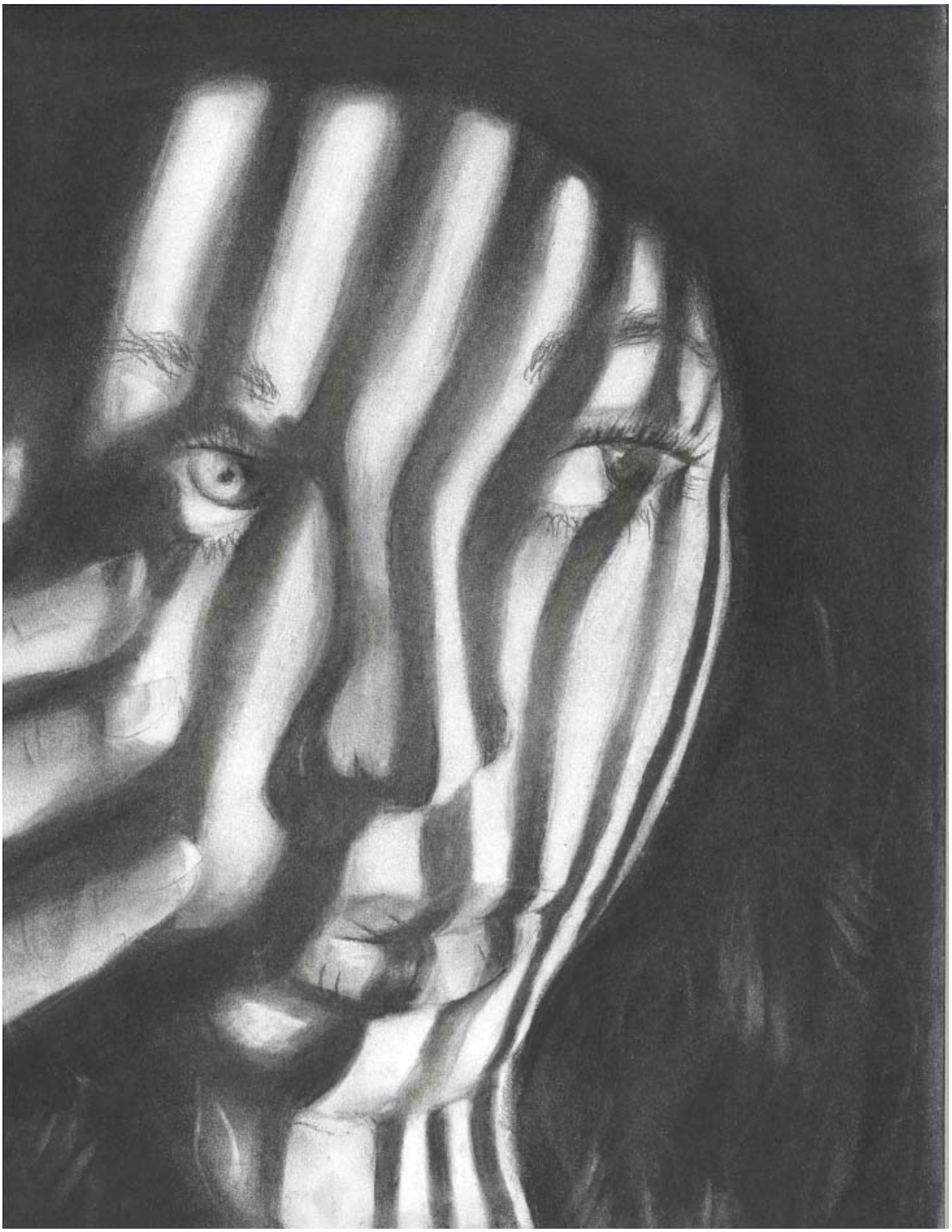
The following chart illustrates DORA's effectiveness:

Drug Offender Reform Act Outcomes

Measure Title	Purpose of Measure/Measure Definition	FY2009	FY2010	FY2011	FY2012	FY2013
Alcohol	Percent increase in abstinence from alcohol from admission to discharge	17.7%	26.1%	24.7%	23.0%	33.2%
Drugs	Percent increase in abstinence from drugs from admission to discharge	45.9%	64.0%	84.8%	91.4%	129.9%
Employment	Percent increase in full/part-time employment from admission to discharge	33.1%	55.1%	62.7%	64.3%	34.1%
Decreased Homelessness	Percent decrease in homeless clients from admission to discharge	50.0%	54.3%	61.8%	67.6%	67.6%
Clients Served	Unduplicated number of clients served	1,288	759	737	668	706

Utah Youth Council Contest Award Winner

"Out of the Shadows, Exposing Stigma"



Feeling Locked Out of Normal

Mental Health Treatment

Mental Health Treatment

Overview

Under Utah State Statute §17-43-301, the public mental health system provides an array of services that assure an effective continuum of care. Under the administrative direction of the Division of Substance Abuse and Mental Health (DSAMH), the counties and their local mental health authority (LMHA) are 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 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 listed below, counties may deliver services in a variety of ways that meet the needs of their citizens.

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 LMHAs 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.
- **Clubhouses** are a model of psycho-social rehabilitation where attendees are considered members and empowered to function in a work-ordered day. Clubhouses serve as a launching pad to help individuals with serious mental illness, who have become disabled, return to competitive employment.
- **Consumer Drop-In Centers** are places where individuals in crisis can receive support from peers in recovery to promote connectedness, social interaction,

and encourage them to take responsibility for their treatment and recovery. Warm lines are available in some areas for telephone support as well.

- **Nursing Home and Hospital Alternatives** include community-based care, i.e., intensive case management, outreach services, coordination with other entities such as home health, etc.

Source of Data

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

Diagnostic Data

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) is the standard classification of mental disorders used by mental health professionals in the United States. Each disorder in the DSM-IV has a set of diagnostic criteria that includes applicable symptoms, parameters for duration of symptoms, and symptoms that must not be present for clinical diagnosis. An individual may have more than one diagnosis, and each diagnostic category listed may have several subsets. For example, an anxiety disorder may include a subset for generalized anxiety disorder, post traumatic stress disorder, or panic disorder.

If an individual has both a substance use disorder and a mental health disorder it is called a "co-occurring disorder." Today it is clear that the co-occurrence of mental illness and substance use disorders is common. According to the Federal Substance Abuse and Mental Health Services Administration, 50% of individuals with severe mental illness are affected by substance use disorders. This data is driving the need for an integrated approach to mental health promotion, mental illness and substance use disorder prevention, treatment, and recovery services.

The following tables describe the most common diagnoses treated in the public mental health system in Utah by LMHA with statewide totals for both children and adults.

Diagnosis of Mental Health Clients 18 years and older, by Local Authority

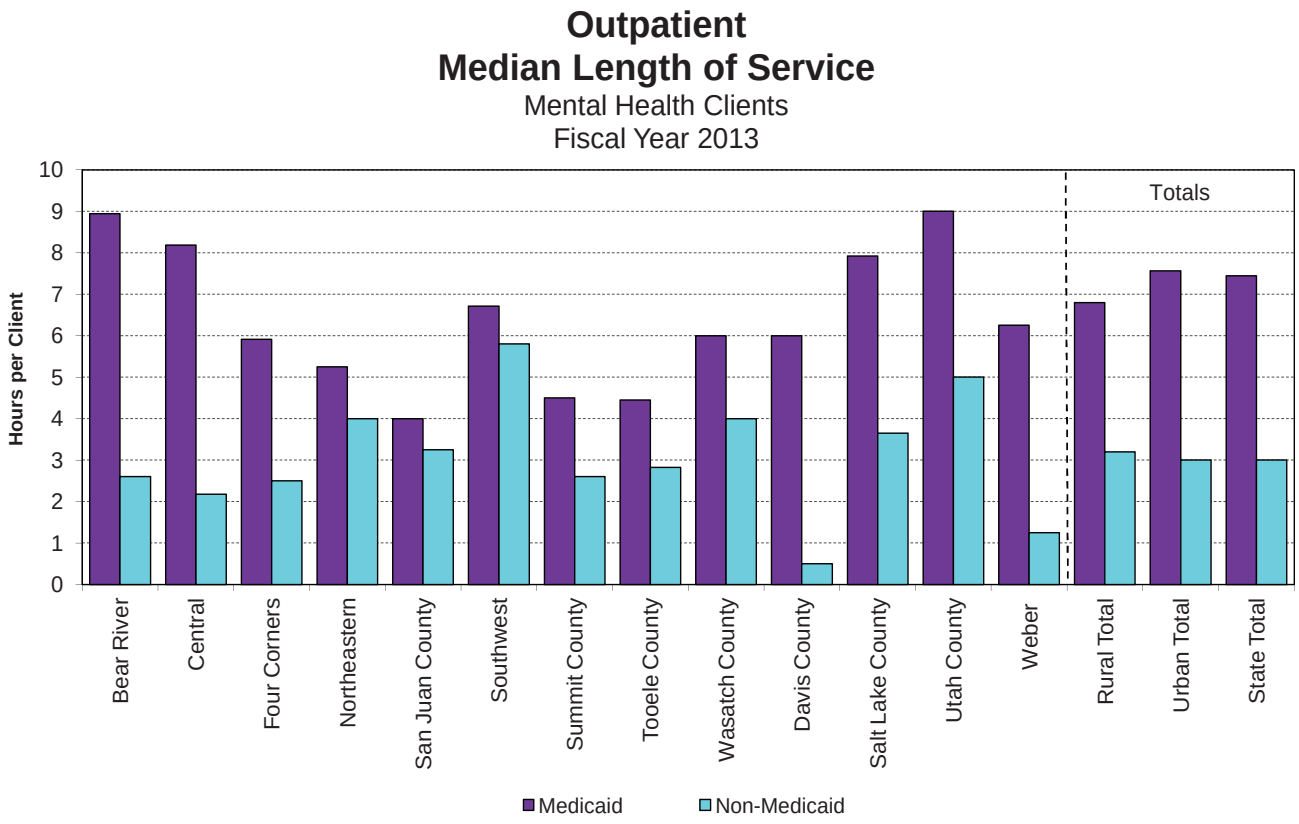
Diagnosis	Bear River Mental Health	Central Utah Counseling Center	Davis Behavioral Health	Four Corners Community Behavioral Health	Northeastern Counseling Center	Salt Lake County	San Juan Counseling	Southwest Behavioral Health Center	Summit County	Tooele County	Wasatch County	Utah County	Weber Human Services	Statewide Adults
Anxiety	24.0%	18.5%	26.4%	19.6%	28.7%	23.0%	23.5%	16.8%	26.1%	25.7%	35.4%	29.1%	20.9%	24.3%
Mood Disorder	17.3%	8.7%	19.2%	16.2%	13.7%	18.2%	14.8%	20.3%	17.3%	13.8%	14.5%	14.5%	22.5%	17.4%
Depression	12.4%	17.5%	8.5%	14.1%	18.8%	12.8%	30.1%	9.8%	11.5%	16.2%	16.0%	13.0%	6.9%	12.2%
Substance Abuse	8.0%	11.7%	15.4%	19.2%	7.8%	12.9%	4.2%	11.5%	14.2%	15.3%	10.1%	2.5%	12.7%	11.5%
Personality Disorder	11.1%	12.9%	6.3%	11.1%	3.8%	9.6%	3.4%	14.6%	3.4%	6.4%	4.6%	6.8%	10.7%	8.7%
Schizophrenia and Other Psychotic	5.4%	7.2%	9.7%	6.6%	4.1%	8.9%	3.0%	7.8%	1.0%	2.5%	4.4%	6.1%	7.6%	7.6%
Attention Deficit	6.3%	2.0%	5.3%	2.1%	3.8%	3.3%	4.4%	1.4%	6.4%	3.2%	1.8%	5.9%	2.3%	4.0%
Cognitive Disorder	2.8%	2.8%	2.2%	1.7%	2.0%	2.5%	5.9%	3.1%	0.7%	1.1%	0.4%	4.5%	3.2%	2.7%
Adjustment Disorder	2.7%	1.2%	1.4%	1.7%	2.4%	1.0%	3.0%	4.3%	3.0%	1.4%	2.9%	1.3%	1.4%	1.5%
Neglect or Abuse	0.2%	9.7%	0.3%	0.4%	1.5%	0.2%	0.6%	1.3%	1.3%	1.2%	0.8%	3.3%	1.6%	1.2%
Pervasive Developmental Disorders	1.1%	0.9%	1.1%	0.4%	0.6%	0.9%	1.1%	1.1%	0.4%	0.6%	0.1%	1.8%	0.8%	1.0%
Impulse Control Disorders	1.1%	1.3%	0.7%	0.8%	2.2%	0.9%	0.2%	0.8%	0.6%	0.5%	1.2%	1.5%	1.0%	1.0%
Oppositional Defiant Disorder	0.3%	0.0%	0.1%	0.4%	0.2%	0.1%	0.4%	0.0%	0.0%	0.1%	0.0%	0.3%	0.2%	0.2%
Conduct Disorder	0.2%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%	0.1%
Other	2.9%	2.0%	2.1%	1.8%	1.7%	1.8%	2.3%	1.4%	1.8%	1.9%	1.5%	3.8%	1.2%	2.1%
V Codes	4.1%	3.4%	1.2%	3.6%	8.6%	3.9%	3.2%	5.5%	12.2%	10.1%	6.3%	5.5%	7.0%	4.5%
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 Local Authority

Diagnosis	Bear River Mental Health	Central Utah Counseling Center	Davis Behavioral Health	Four Corners Community Behavioral Health	Northeastern Counseling Center	Salt Lake County	San Juan Counseling	Southwest Behavioral Health Center	Summit County	Tooele County	Wasatch County	Utah County	Weber Human Services	Statewide Youth
Anxiety	17.8%	10.9%	18.7%	10.7%	14.1%	21.7%	12.8%	17.0%	17.2%	17.9%	18.9%	17.5%	13.6%	18.4%
Attention Deficit	18.1%	19.4%	19.7%	15.7%	14.8%	14.2%	24.4%	8.8%	19.5%	13.6%	12.9%	14.2%	15.9%	15.4%
Mood Disorder	11.8%	5.9%	15.3%	11.6%	13.7%	13.1%	14.0%	8.7%	13.4%	8.9%	11.7%	10.8%	13.3%	12.4%
Adjustment Disorder	12.2%	14.3%	5.4%	10.9%	9.2%	6.5%	19.5%	11.5%	8.2%	5.7%	11.7%	8.6%	4.1%	7.6%
Oppositional Defiant Disorder	4.0%	11.7%	8.3%	6.9%	3.5%	10.1%	1.8%	3.4%	8.2%	6.1%	3.3%	5.4%	6.7%	7.5%
Neglect or Abuse	4.5%	8.3%	6.9%	4.7%	11.9%	5.2%	2.4%	7.9%	3.2%	10.8%	8.7%	7.6%	7.3%	6.6%
Pervasive Developmental Disorders	3.5%	4.0%	4.4%	4.1%	3.0%	4.8%	6.1%	4.1%	3.5%	2.8%	3.3%	6.6%	5.6%	4.8%
Impulse Control Disorders	4.6%	2.3%	3.9%	4.3%	5.4%	4.8%	3.7%	6.1%	2.6%	2.3%	4.5%	3.2%	9.0%	4.6%
Depression	5.9%	7.0%	2.4%	4.4%	6.8%	5.5%	7.9%	5.4%	4.7%	6.5%	6.3%	4.3%	1.4%	4.6%
Substance Abuse	0.9%	2.6%	1.6%	6.0%	1.9%	1.5%	0.0%	4.7%	4.1%	3.6%	4.5%	0.7%	2.4%	1.9%
Conduct Disorder	0.7%	1.5%	1.4%	0.8%	1.0%	1.2%	0.0%	1.2%	0.6%	1.1%	0.3%	0.6%	1.0%	1.1%
Cognitive Disorder	2.1%	0.7%	1.1%	0.8%	1.1%	0.8%	0.6%	0.8%	0.6%	0.6%	0.3%	1.2%	1.6%	1.0%
Personality Disorder	0.3%	0.6%	0.3%	0.7%	0.2%	0.1%	0.0%	1.1%	0.0%	0.6%	0.3%	0.2%	0.1%	0.3%
Schizophrenia and Other Psychotic	0.0%	0.1%	0.3%	0.1%	0.2%	0.1%	0.0%	0.2%	0.0%	0.0%	0.0%	0.1%	0.2%	0.1%
Other	7.1%	5.3%	6.3%	6.8%	4.4%	3.2%	3.0%	4.9%	4.1%	4.2%	2.4%	4.9%	4.6%	4.7%
V Codes	6.4%	5.3%	4.2%	11.3%	8.9%	7.0%	3.7%	14.4%	10.2%	15.2%	10.8%	14.1%	13.2%	9.0%
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%**

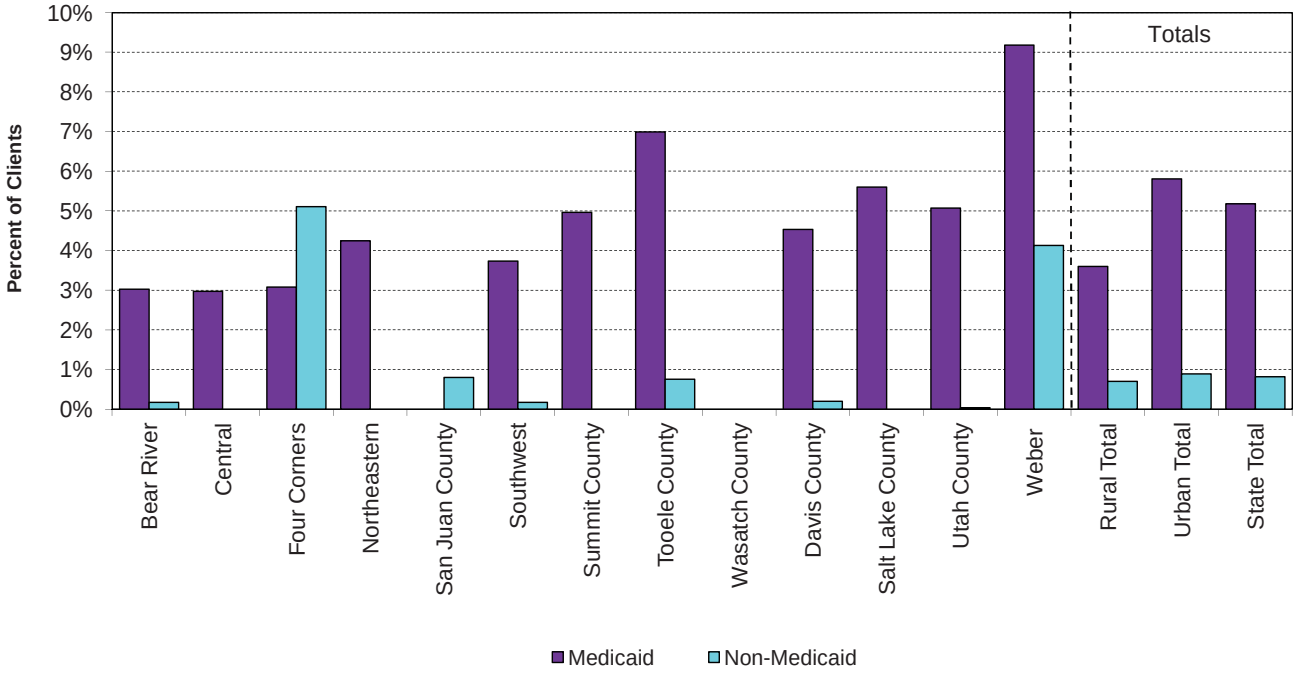
Mandated Services Data by Local Authority

DSAMH monitors the following statutorily mandated services for quality of care. Services provided to individuals and families in the public system are captured in these service areas. The following tables illustrate the service priorities (based on utilization and median length of service) for each of the 13 local mental health authorities with rural, urban and statewide totals. The N= for the utilization charts can be found on page 160.



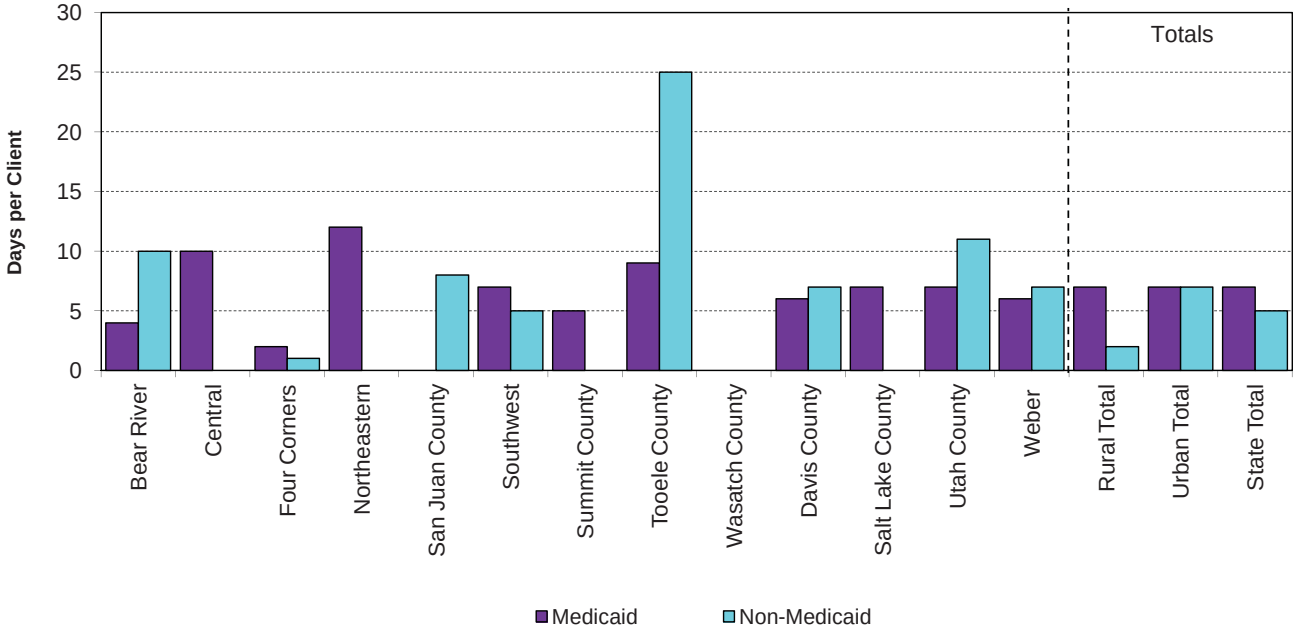
Inpatient Utilization

Mental Health Clients
Fiscal Year 2013



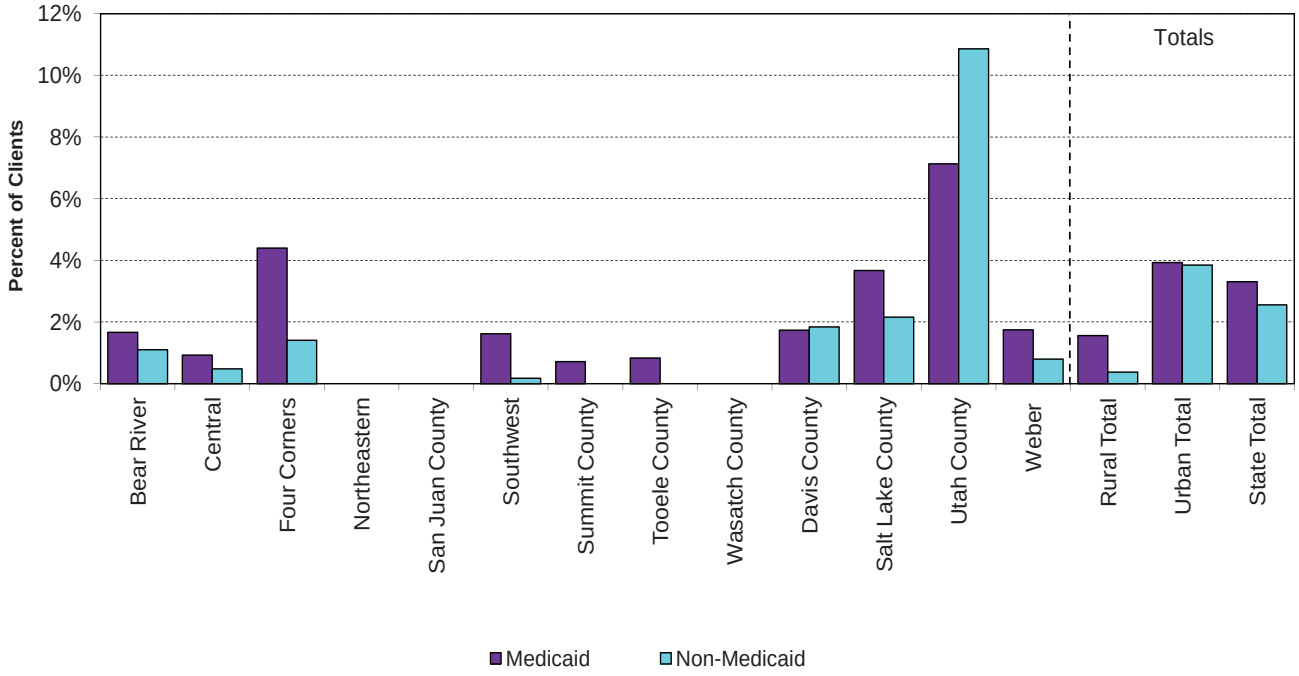
Inpatient Median Length of Service

Mental Health Clients
Fiscal Year 2013



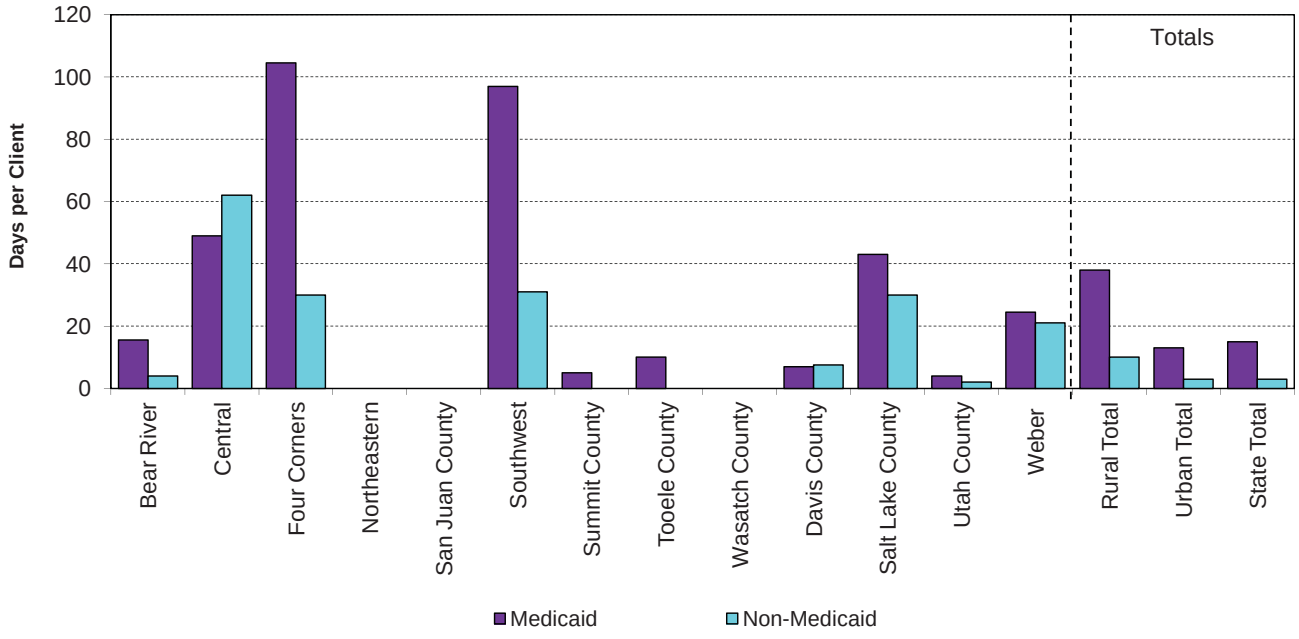
Residential Utilization

Mental Health Clients
Fiscal Year 2013



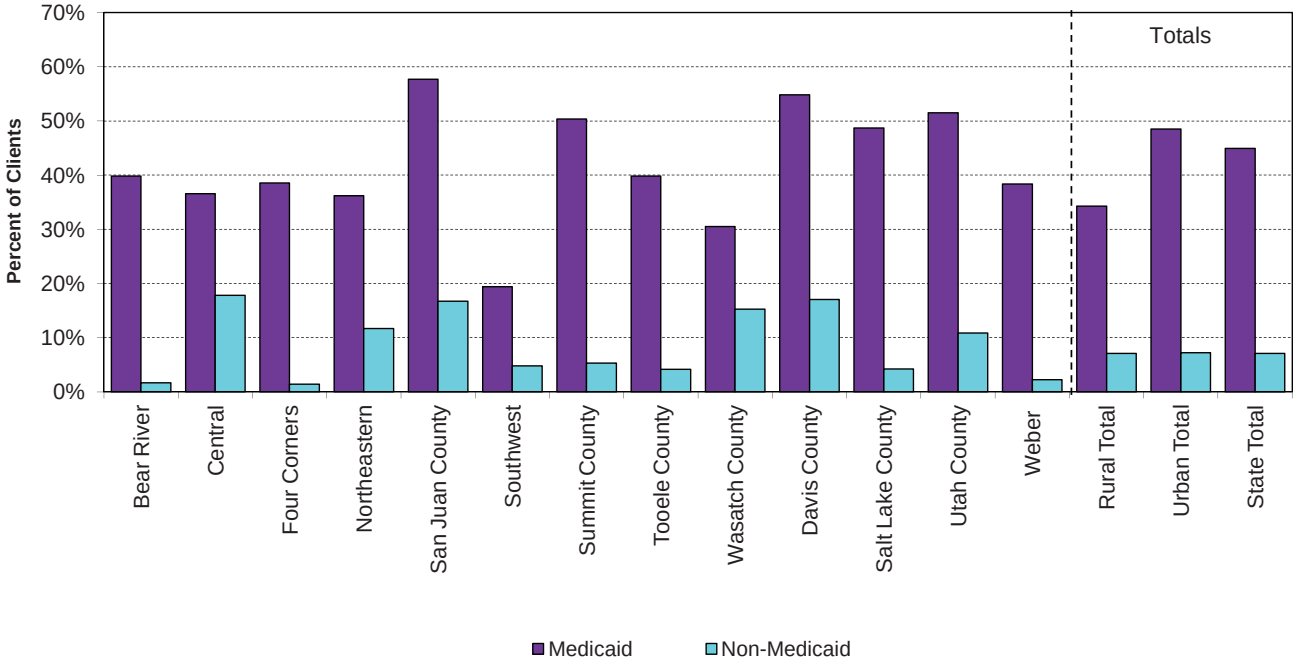
Residential Median Length of Service

Mental Health Clients
Fiscal Year 2013



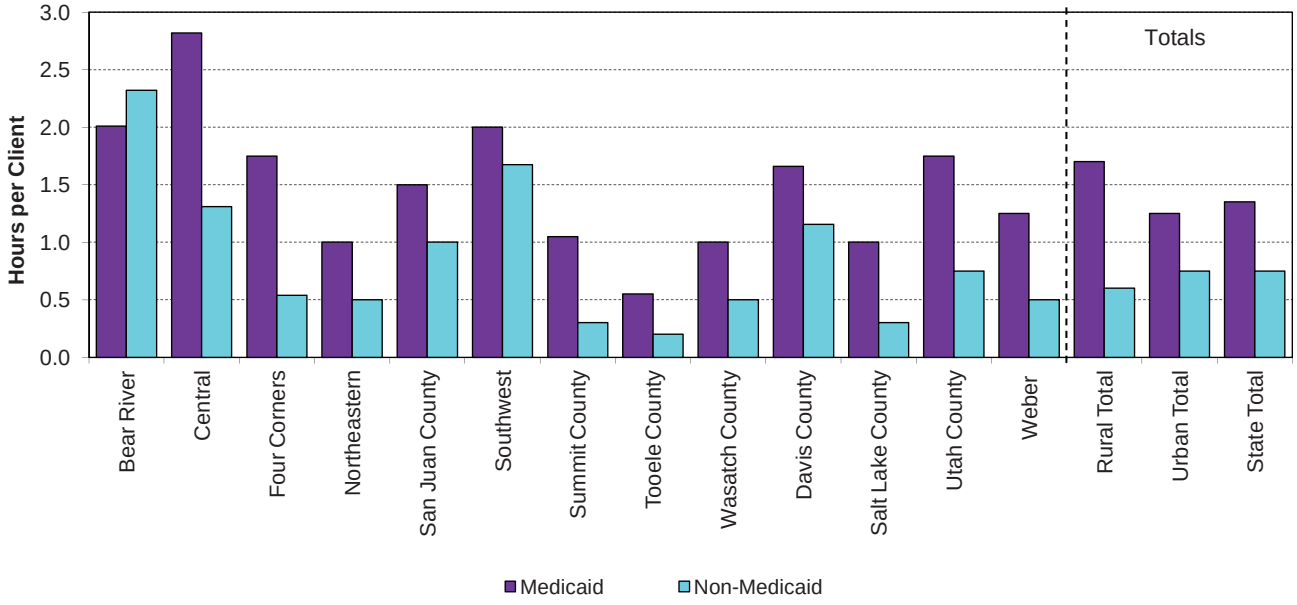
Medication Management Utilization

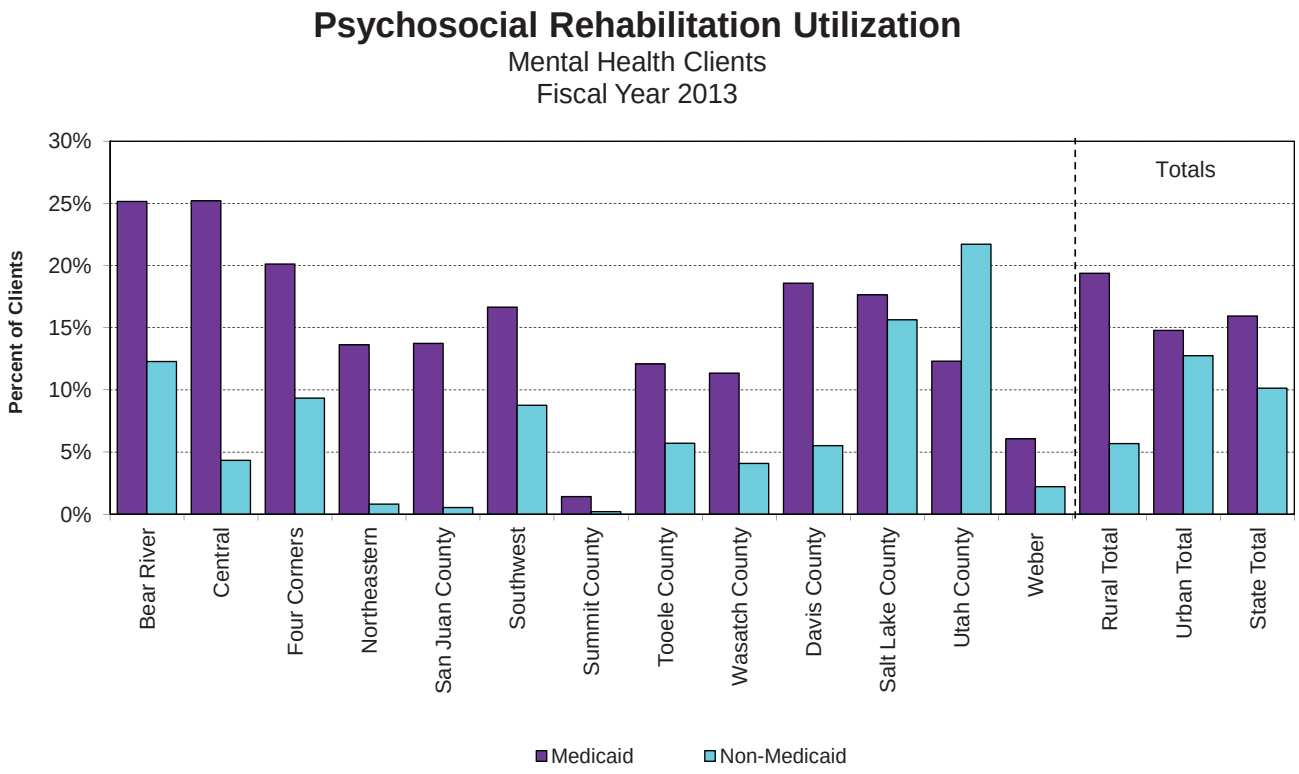
Mental Health Clients
Fiscal Year 2013

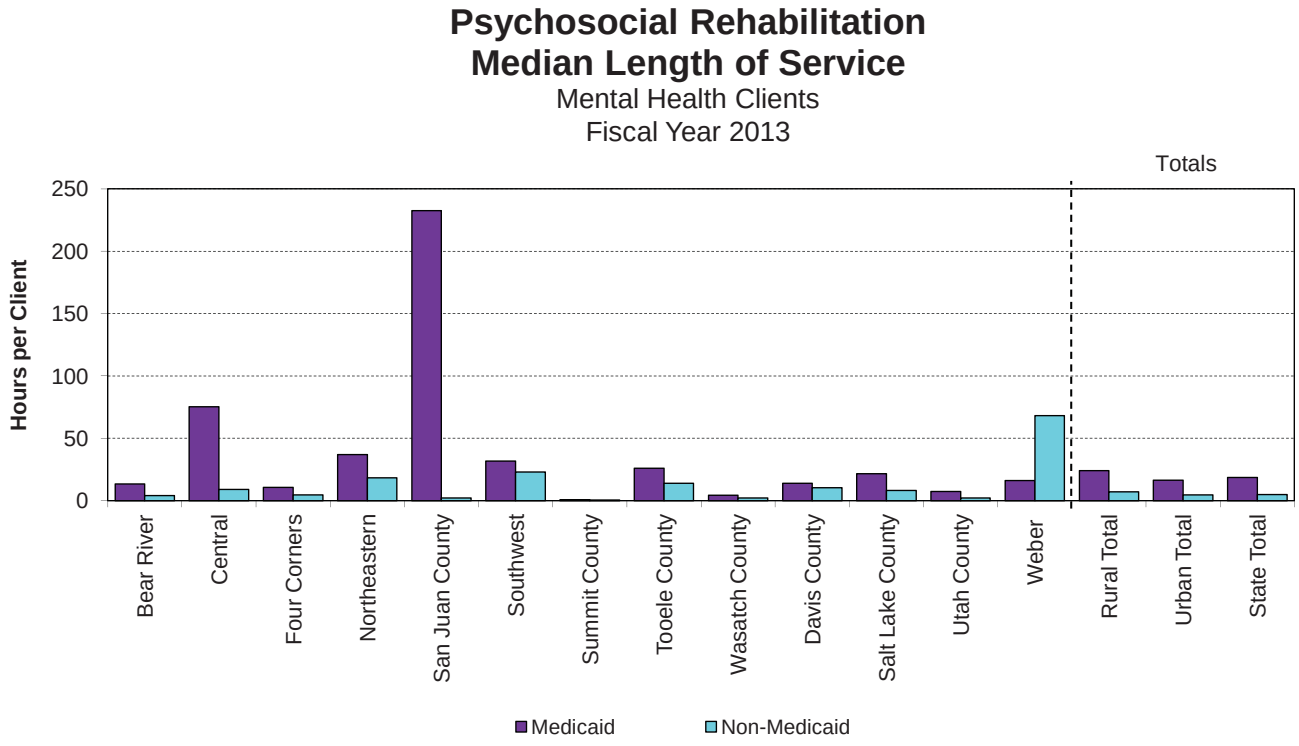


Medication Management Median Length of Service

Mental Health Clients
Fiscal Year 2013

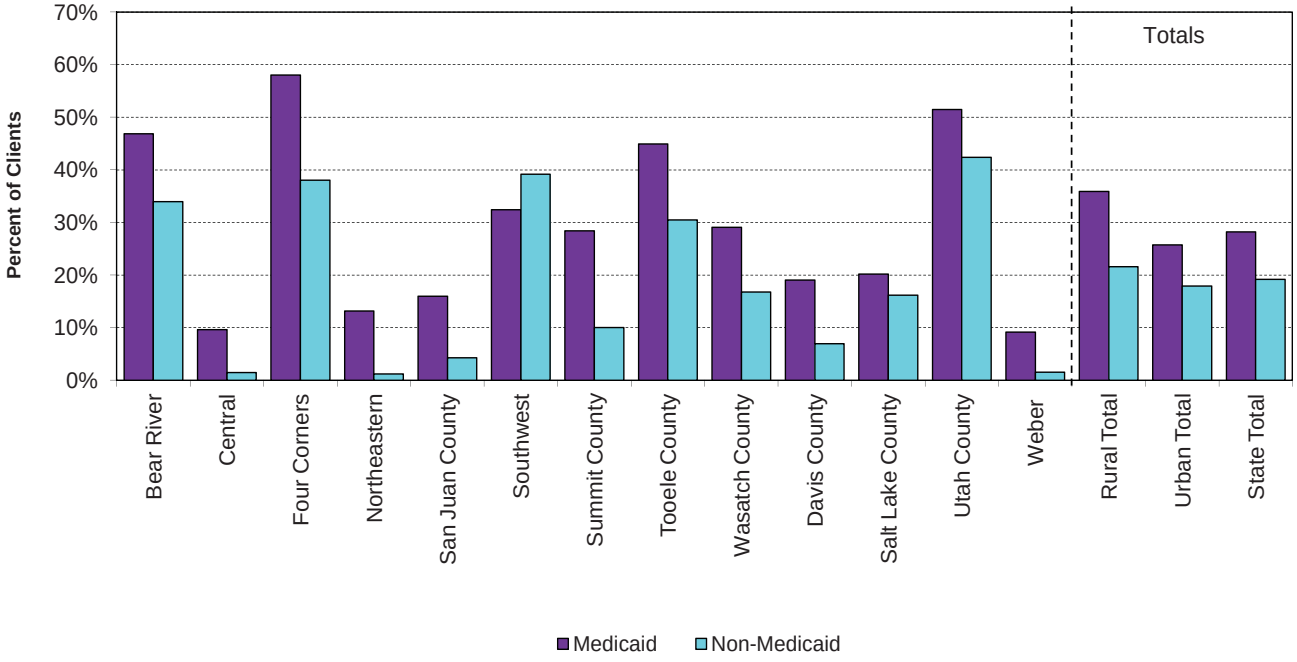



Psychosocial Rehabilitation Utilization
Mental Health Clients
Fiscal Year 2013
Percent of Clients
30%
25%
20%
15%
10%
5%
0%
Totals
Bear River
Central
Four Corners
Northeastern
San Juan County
Southwest
Summit County
Tooele County
Wasatch County
Davis County
Salt Lake County
Utah County
Weber
Rural Total
Urban Total
State Total
Medicaid
Non-Medicaid


Psychosocial Rehabilitation
Median Length of Service
Mental Health Clients
Fiscal Year 2013
Hours per Client
250
200
150
100
50
0
Totals
Bear River
Central
Four Corners
Northeastern
San Juan County
Southwest
Summit County
Tooele County
Wasatch County
Davis County
Salt Lake County
Utah County
Weber
Rural Total
Urban Total
State Total
Medicaid
Non-Medicaid

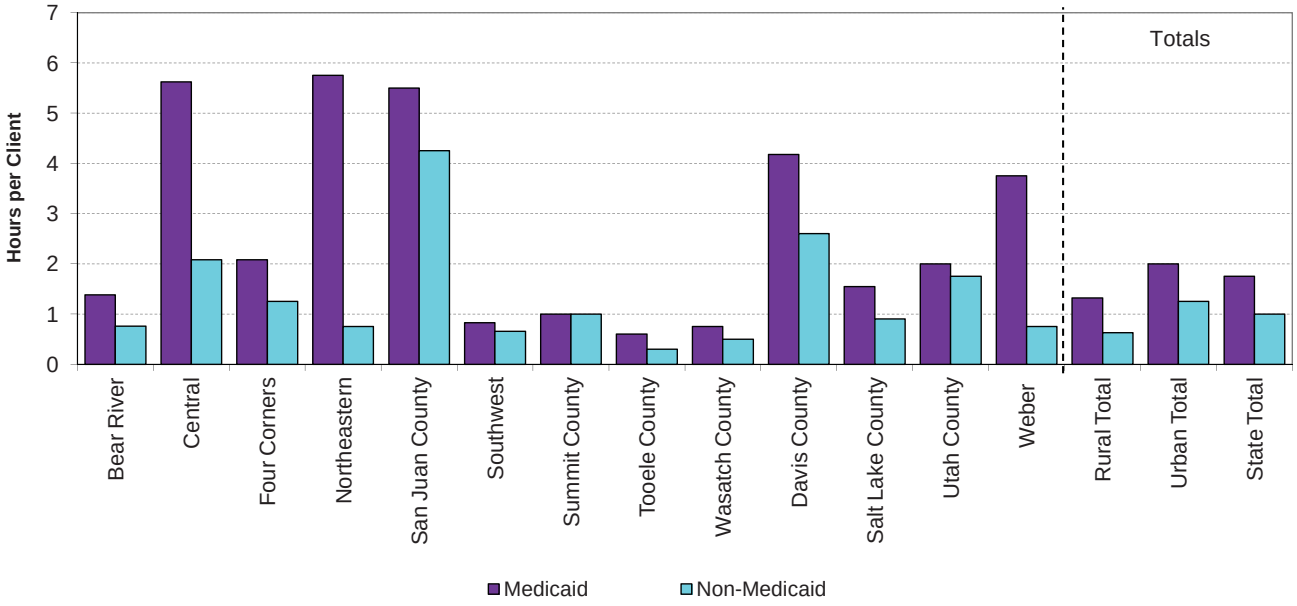
Case Management Utilization

Mental Health Clients
Fiscal Year 2013



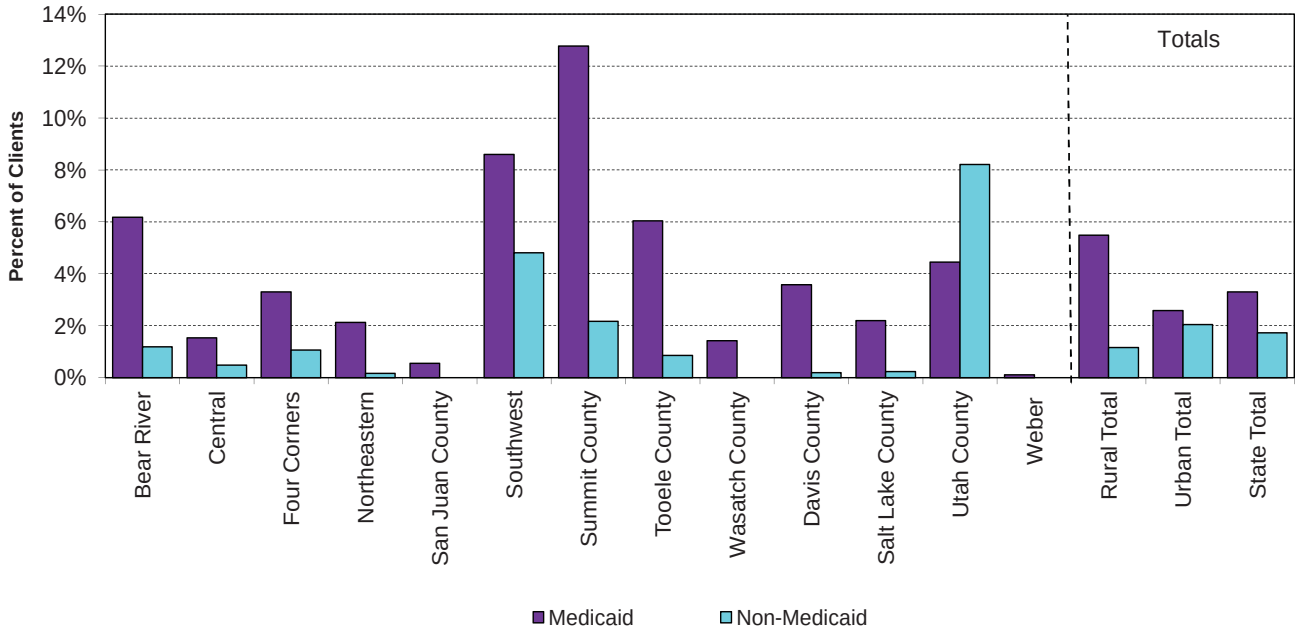
Case Management Median Length of Service

Mental Health Clients
Fiscal Year 2013



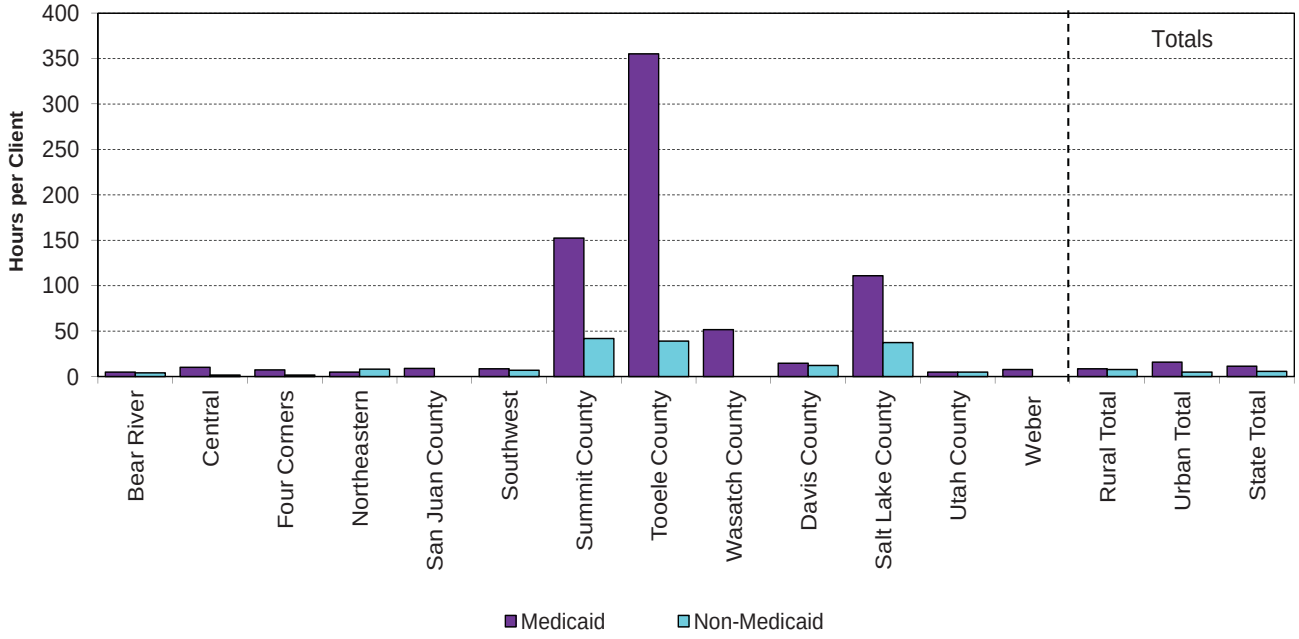
Respite Utilization

Mental Health Clients
Fiscal Year 2013



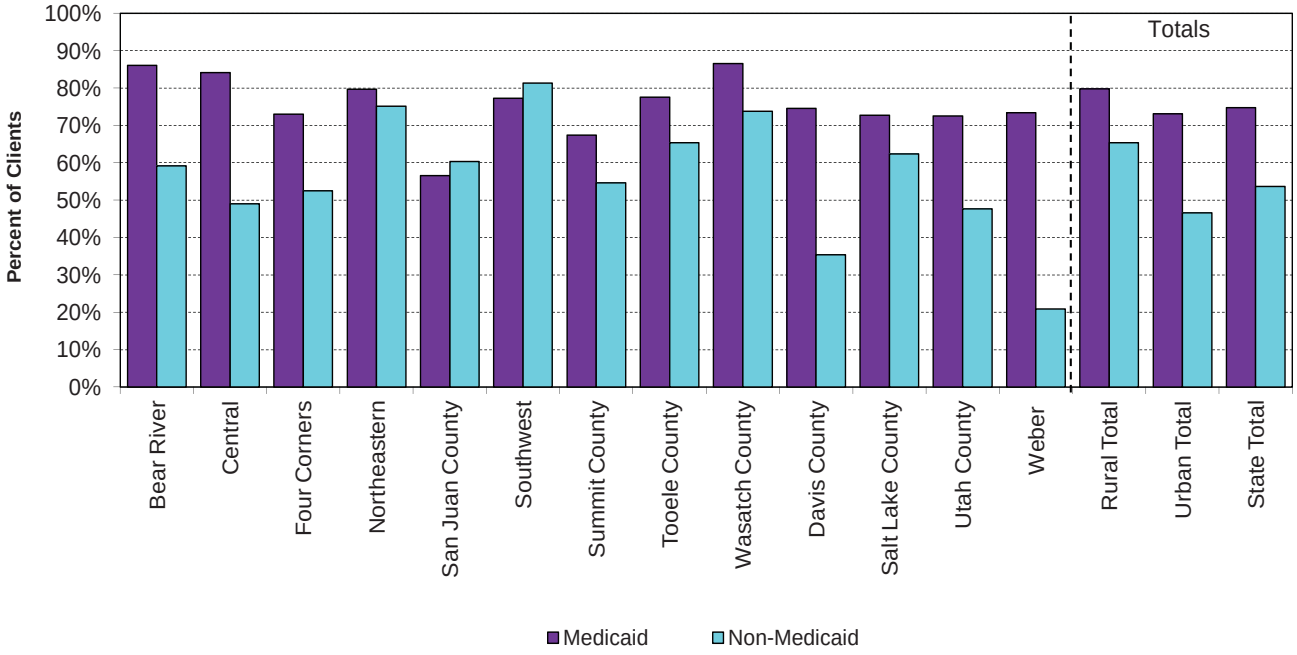
Respite
Median Length of Service

Mental Health Clients
Fiscal Year 2013



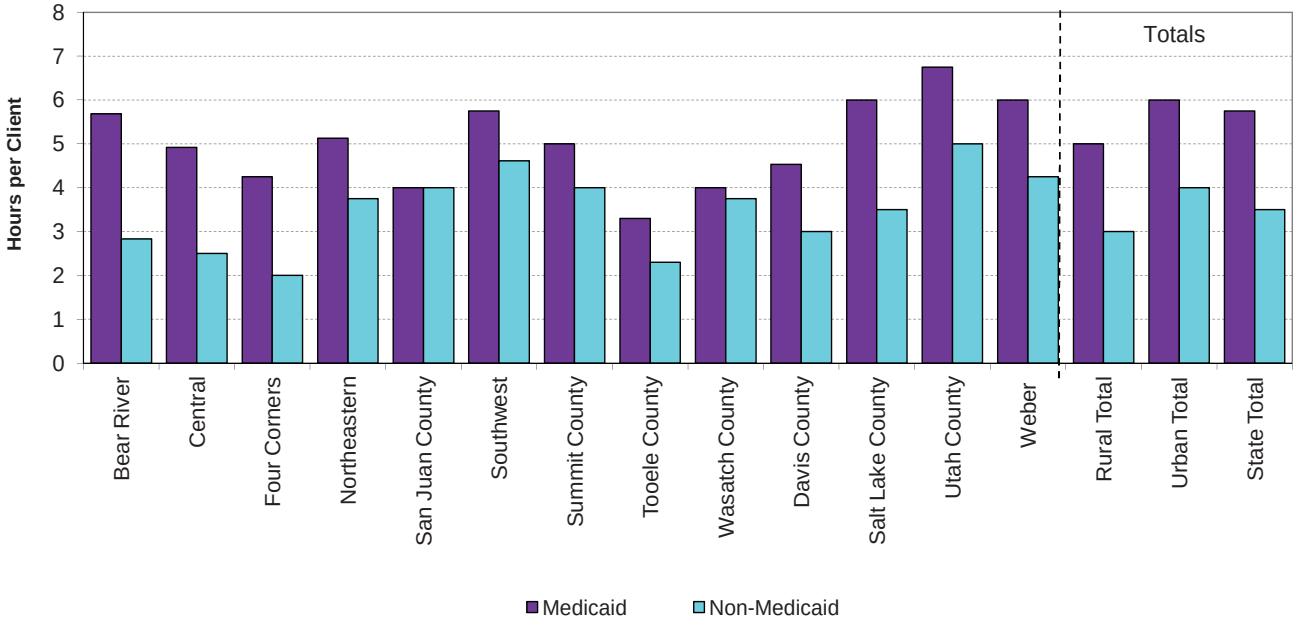
Therapy Utilization

Mental Health Clients
Fiscal Year 2013



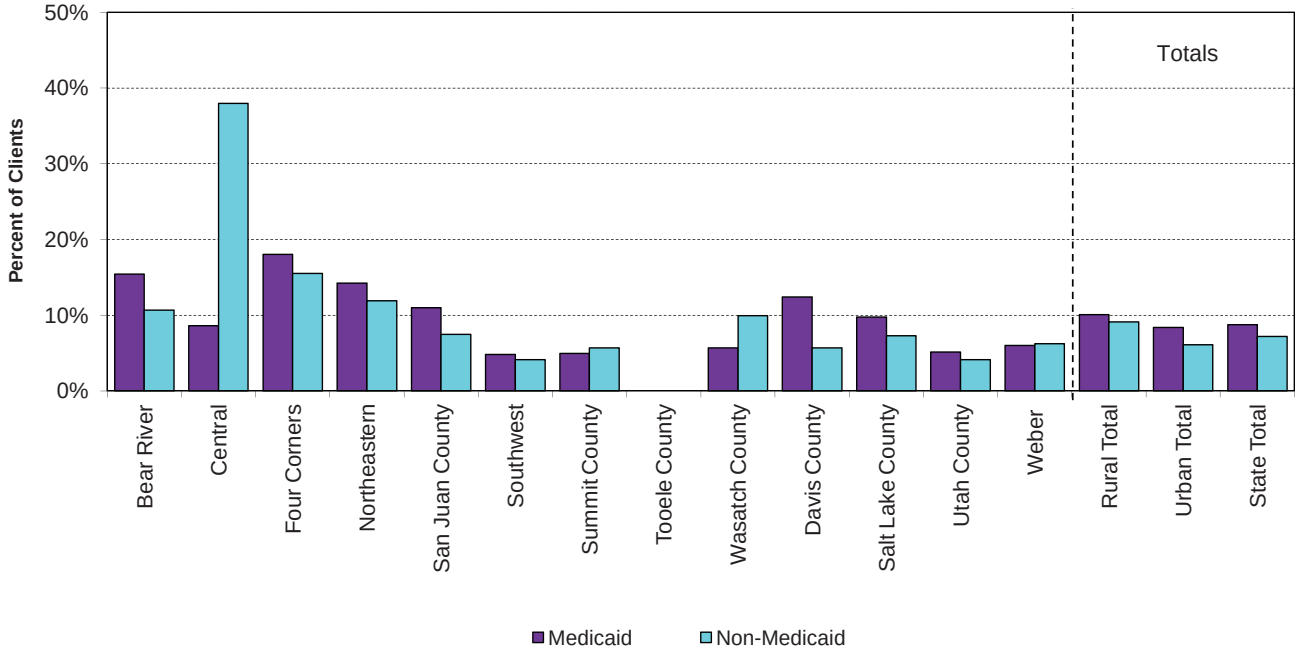
Therapy
Median Length of Service

Mental Health Clients
Fiscal Year 2013



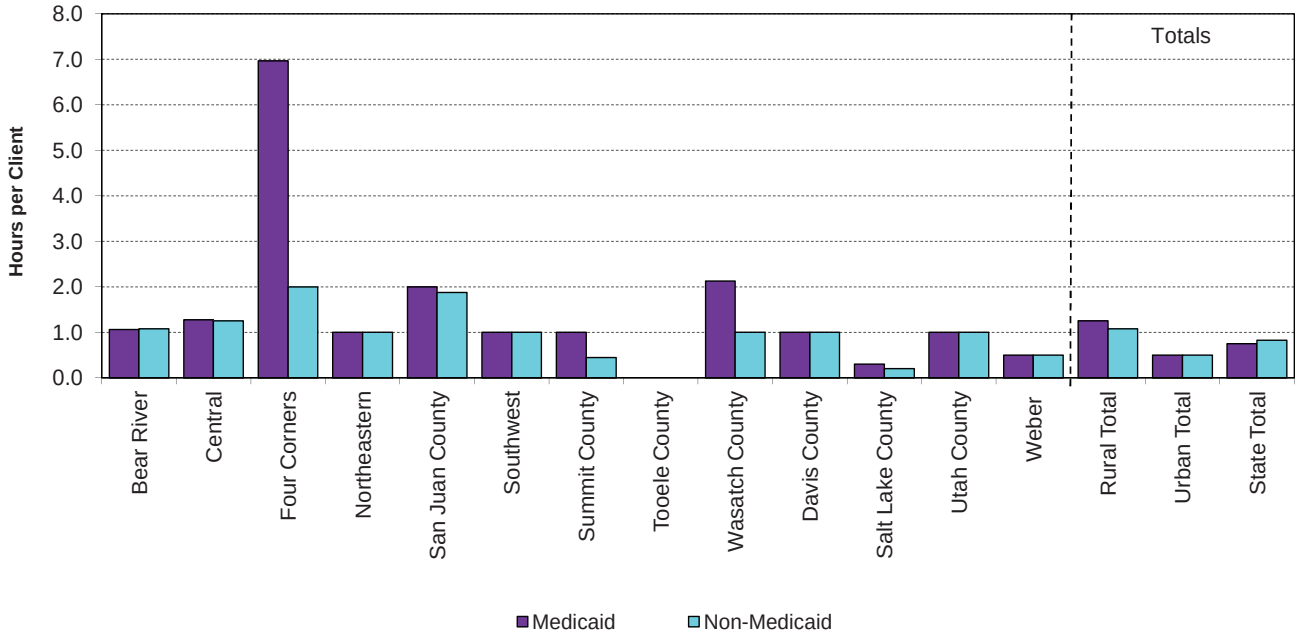
Emergency Utilization

Mental Health Clients
Fiscal Year 2013



Emergency
Median Length of Service

Mental Health Clients
Fiscal Year 2013



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

PASSAGES is a program that helps young people between the ages of 16 and 25 with mental health conditions successfully transition into adulthood. It employs transitional facilitators to coach and mentor program participants and help them gain competency in five major transitional domains: employment, education, housing, community life, and personal well-being.

The program is implemented in San Juan and Tooele Counties. From October 2, 2009 to July 31, 2013, 265 individuals have received youth-in-transition services. The program participants have diverse characteristics—poverty, teen parents, homelessness, developmental disabilities, sexual orientation, and childhood trauma—all of which complicate their transitional process. Slightly more program participants received services from Tooele than San Juan. A slight majority were female. Almost 56% of participants were Caucasian, with slightly less than a third of participants reporting being Native Americans. About 15% were Latino. Almost all program participants were between 18 and 24 years of age. The outcome evaluation indicates that program participants improved in general functioning and social connectedness. Substance use appears to be decreasing over time. Participants also showed increases in housing stability over time. One critical component of the program is the flexible funds to help program participants address barriers in transitioning. The number one flexible funds request is for education, followed by housing, and driving related expenses.

One good example is a 25-year-old young woman who had experienced a lot of trauma and violence in her childhood. She had difficulties trusting others and getting along with people. With the assistance from the transition facilitator, she is now having a good support system among family members and friends. She is a full time student at Utah State University/College of Eastern Utah, studying criminal justice and hopes to become a U.S. Marshall.

Olmstead (REDI Program)

Individuals with mental illness want what we all want: a meaningful life in the community. The law also recognizes this desire. In 1999, The United States Supreme Court ruled in Olmstead v. L.C. that unnecessary segregation of individuals with disabilities is a violation of the American with Disabilities Act. States now are asked to create comprehensive, effective working programs to place qualified persons living in institutions in less restrictive settings.

DSAMH jointly developed the REDI Program (Readiness Evaluation and Discharge Implementation) with the Utah State Hospital (USH) and the local mental health authorities (LMHAs) to identify patients ready for discharge from USH. The REDI program is a tracking system to document home and community-based services needed by patients preparing for discharge. The REDI system identifies preferences and obstacles to transition from institutional treatment settings. REDI also increases local level participation to identify barriers and other system issues which enable people with mental illness and co-occurring substance abuse disorders to live in the community. DSAMH works with the LMHAs to provide supportive services for people leaving institutional settings to reside safely in their own home or in a community-based setting of their choice.

REDI prevents unnecessary or prolonged institutional placements and gives the LMHAs improved accessibility to patient information. The information is completely secure and no patient information can be accessed by any unauthorized person. DSAMH is also using this program as a monitoring tool to ensure that the LMHA provid-

ers are actively working on a plan for people who are ready for discharge to the community.

The REDI program has proven successful in working to help identify and facilitate additional discharges. The REDI program was used to help facilitate discharge of 141 adults with serious mental illness in fiscal year 2012 and 136 adults in fiscal year 2013.

PASRR (Pre-Admission Screening Resident Review)

Health, hope and healing is only possible for some if they receive appropriate and needed care. For seniors, and others who need the service provided by nursing homes, ensuring that mental illness and intellectual disabilities are appropriately addressed can be a significant challenge. PASRR, mandated by federal law, ensures individuals with mental illness and/or intellectual disability are placed and served appropriately in Medicaid certified nursing facilities.

The regulations that govern PASRR were written post-American Disability Act (ADA) and reflect the intent of that law. The PASRR regulations also focus on the person-centered, community-focused ruling of Olmstead v. L.C. (1999), in which the Supreme Court found that the requirements of Title II of the ADA apply to persons with disabilities, and that states must serve qualified individuals “in the most integrated setting appropriate” to their needs.

All individuals applying to nursing facilities are screened for mental illness and/or intellectual disabilities by licensed mental health therapists contracted by DSAMH. If the screen indicates a potential issue, the person is referred for an evaluation that confirms the diagnosis and determines whether placement in the nursing facility is appropriate. The goal is to ensure that individuals live a meaningful life in the community,

The demand and need for PASRR is growing. Utah has the 6th fastest growth rate in the nation for people 65 years and older. The population of people age 65 and older increased by 31% from 2000 to 2010. However, the general population in Utah increased 23% from 2000 to 2010. DSAMH processed 2,445 evaluations in 2013. Given Utah’s population growth and especially the growth in those over the age of 65, it is likely that the number of PASRR evaluations will continue to increase.

Utah State Hospital

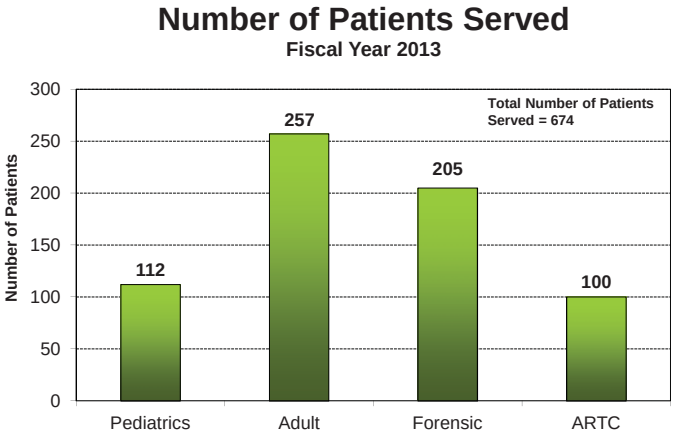
The Utah State Hospital (USH) is a 24-hour inpatient psychiatric facility located on East Center Street in Provo, Utah. The hospital serves adults who experience severe and persistent mental illness (SPMI) and children with severe emotional disturbance (SED). In fiscal year 2013, the hospital had a capacity of 329 patients (including a 5-bed acute unit). The hospital provides active psychiatric treatment services to all age groups and covers all geographic areas of the state. The USH works with the local mental health authorities (LMHA) as part of its continuum of care. All adult and pediatric beds are allocated to the LMHAs 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)

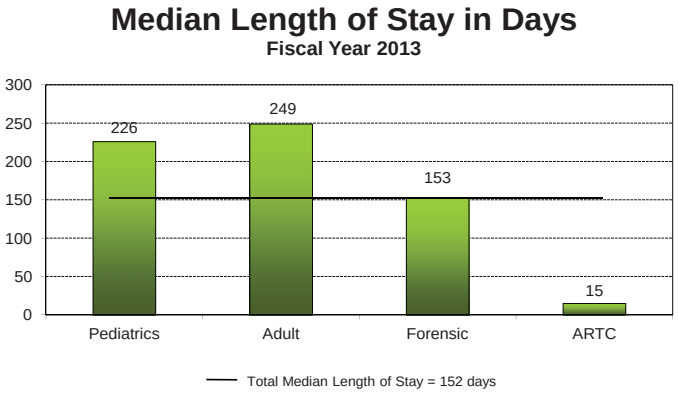
Programs

Children's Unit (ages 6-12)	22 Beds
Adolescent Unit (ages 13-17)	50 Beds
Adult Services (ages 18+)	152 Beds
Adult Recovery Treatment Center (ages 18 and above)	5 Beds
Forensic Unit (ages 18+)	100 Beds



Length of Stay

The median length of stay at the USH is 152 days. The median discharged length of stay for adult patients with civil commitment is 249 days.

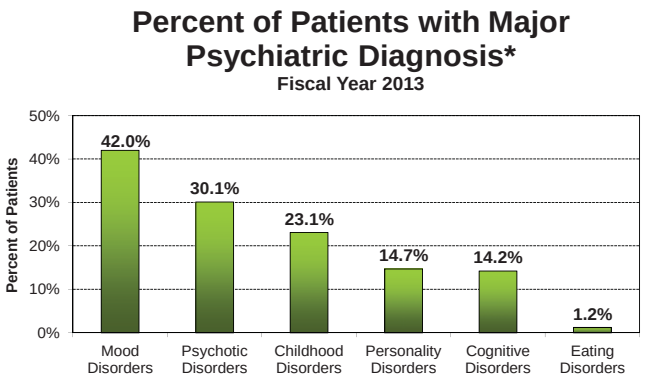


Types of Disorders Treated

- Psychotic Disorders: schizophrenia, schizo-affective 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, 36% of the patients treated at USH also had a substance abuse diagnosis.



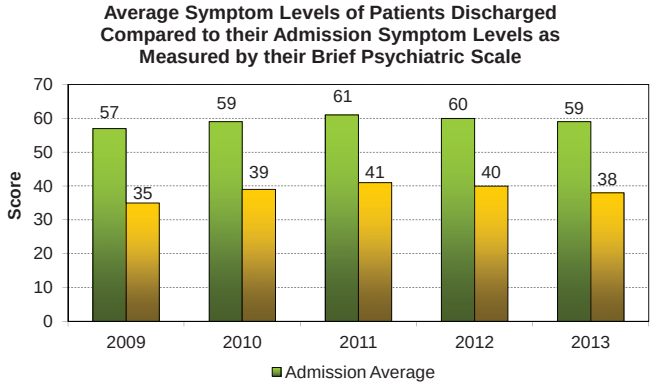
*Patients can have more than one diagnosis

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

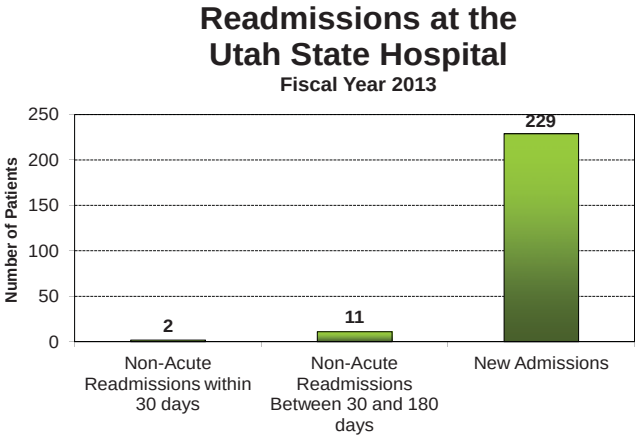
In order to assess patient progress, USH uses the Brief Psychiatric Rating Scale (BPRS). The BPRS is a clinical measurement of patient symptoms. The scores from the BPRS indicate the level of improvement from admission to discharge. The patients at USH continued to show a decrease in BPRS scores from admission to discharge in fiscal year 2013. Lower scores indicate a reduction of symptoms.



Readmission

USH admitted a total of 277 patients (with an additional 95 ARTC admissions) in fiscal year 2013. Of these admissions, there were 2 non-acute readmissions within 30 days and 11 non-acute readmissions within 180 days.

The readmissions within 30 days accounted for less than 1% of the total discharges in fiscal year 2013.



Addict II Athlete

Growing up in an environment of abuse and substance use problems, my siblings and I struggled to learn the behaviors that build effective life skills. I began to fall behind in school and life. With little guidance or supervision, I began to exhibit bad behaviors including frequent substance abuse. Eventually I dropped out of high school. I wanted something more, but did not know how to change my life. At work, I met a man who saw something special in me. He took me under his wing and became my mentor. He showed me that there was more to life, a "better way." Over time, he challenged me to hope and guided me to see a new reality. I completed my GED and began to plan for the next steps in my life.

I learned about the University of Utah's Licensed Substance Abuse Counselor program. I was accepted and fell in love with assisting people in recovery. After graduation, I got a job as a therapist for Utah County. As a way to help my clients, I started looking for programs that focused on goal attainment and alternative paths to recovery. Seeing a void in the community, I created Addict II Athlete.

In the beginning, five addicts became athletes as they erased addiction and replaced it with recreation. Our numbers grew as word of mouth circulated and soon Addict II Athlete was creating positive results based on health, recovery and purpose. The new athletes understood that addiction did not define them and that by challenging themselves physically, they could achieve positive results in all aspects of their lives.

Your Mess Can Be Your Message of Hope. Resolve to choose "A Better Way."

Entire families began to participate by reestablishing relationships based on playing together. Addict II Athlete is not just an outlet for sport. The team serves the community at large with fund raising, education, and community service projects. Through goal attainment, service and team/family unity, athletes see that addiction dissolves and a life of health and happiness can be achieved.

Athletes see that the choice is theirs to make. The support of the team and goal attainment inspires people to understand what happens to you is not nearly as important as what happens within you. Helping them see that they are strong and in control, inspires them to find their way to long-term recovery.

Local Authorities Service Outcomes

Substance Use Disorder and Mental Health Statistics by Local Authority

Under Utah law, local substance use disorder 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 state fiscal year 2013 (July 1, 2012 to June 30, 2013).

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

Bear River

Cache, Rich & Box Elder Counties

Population: 167,958

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

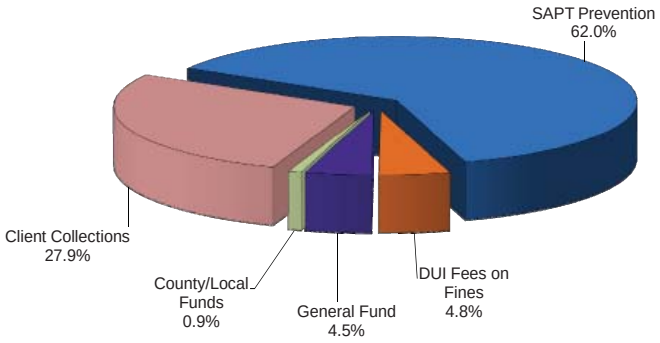
Bear River Substance Abuse—Prevention

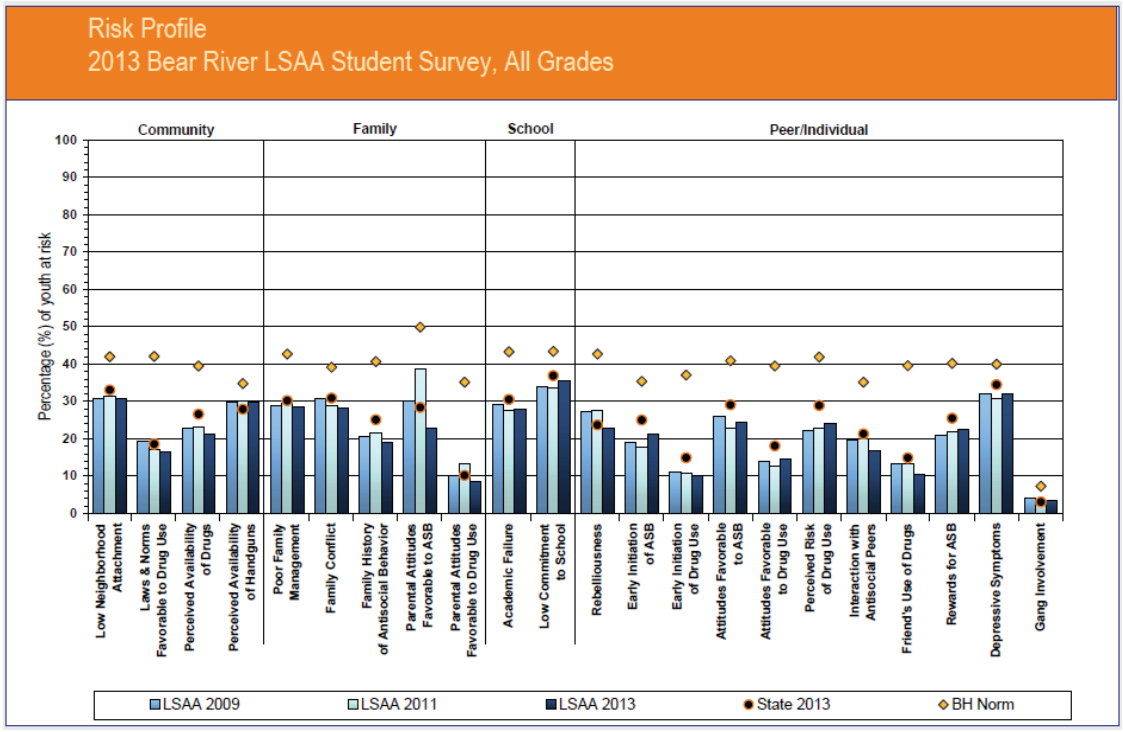
Prioritized Risk Factors: parental attitudes favorable toward antisocial behavior

Coalitions:

- Northern Utah Substance Abuse Prevention Team
- Youth Empowerment Team
- Safe Communities Coalition
- Hispanic Health Coalition

Source of Revenues
Fiscal Year 2013



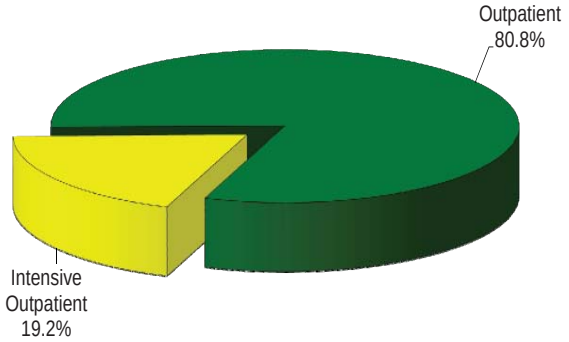


Bear River Health Department—Substance Abuse

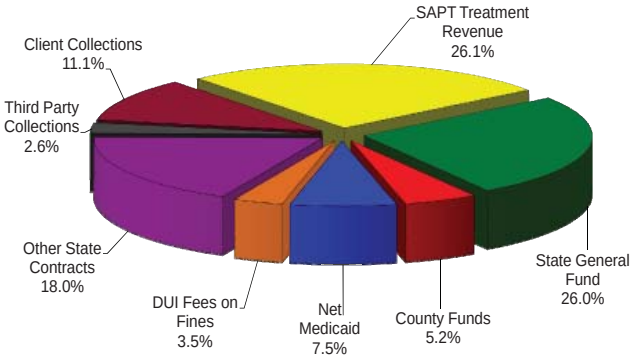
Total Clients Served.....1,309
Adult 1,232
Youth.....77
Penetration Rate (Total population of area)..0.8%

Total Admissions.....845
Initial Admissions 845
Transfers.....0

Admission into Modalities
Fiscal Year 2013



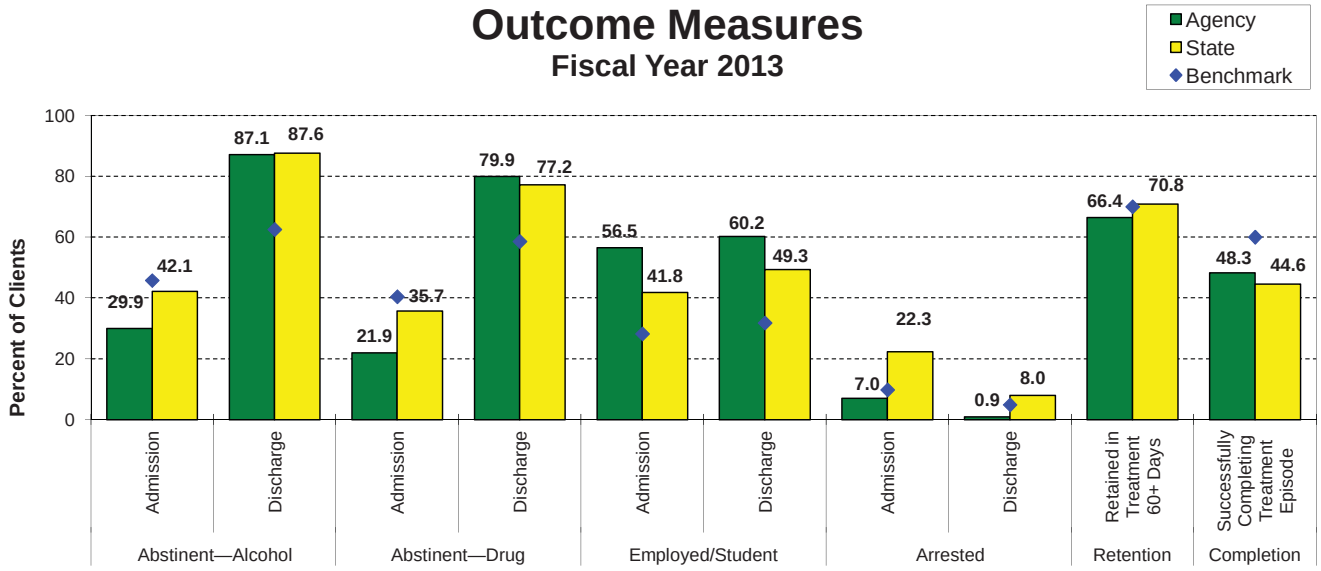
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	224	110	334
Cocaine/Crack	2	3	5
Marijuana/Hashish	156	47	203
Heroin	39	16	55
Other Opiates/Synthetics	13	30	43
Hallucinogens	9	1	10
Methamphetamine	66	75	141
Other Stimulants	1	1	2
Benzodiazepines	2	6	8
Tranquilizers/Sedatives	3	4	7
Inhalants	2	2	4
Oxycodone	16	15	31
Club Drugs	1	0	1
Over-the-Counter	0	0	0
Other	0	1	1
Total	**534**	**311**	**845**

Outcome Measures
Fiscal Year 2013



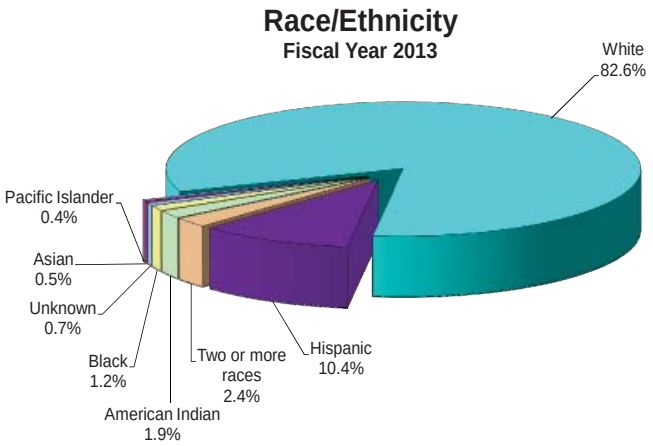
Benchmark is 75% of the National Average.

Bear River Mental Health—Mental Health

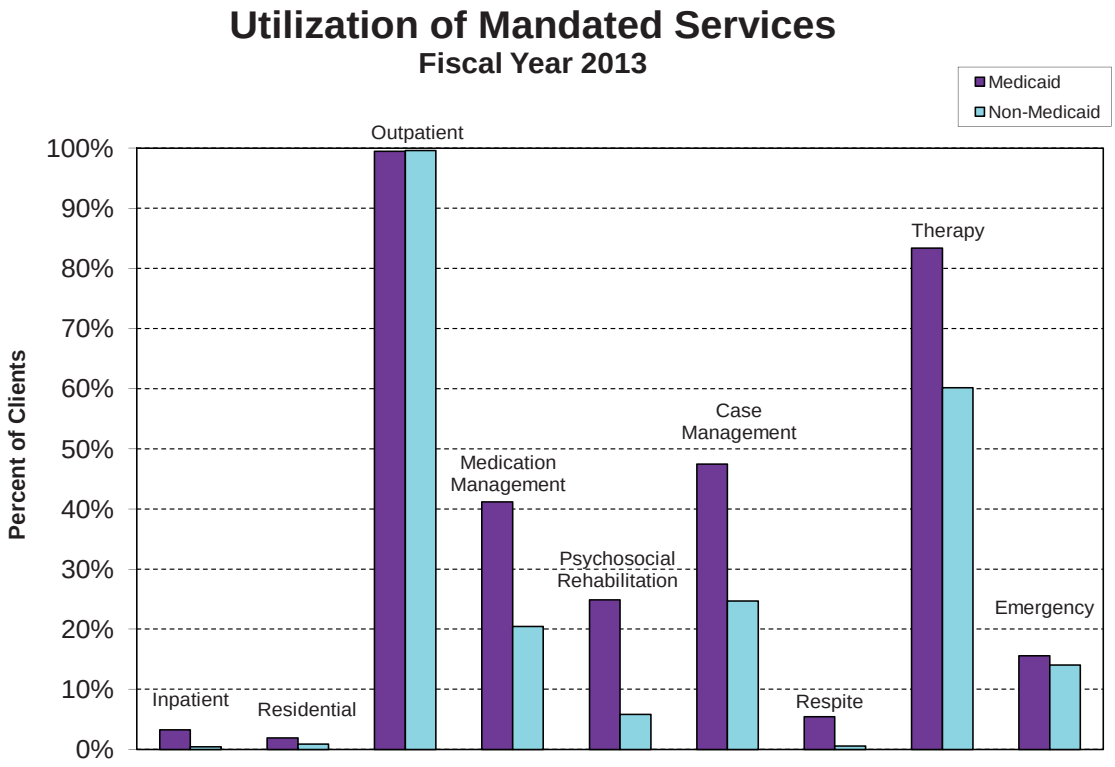
Total Clients Served.....3,110
Adult 1,902
Youth.....1,208
Penetration Rate (Total population of area)..... 1.9%
Civil Commitment 36
Unfunded Clients Served.....152

Diagnosis

	Youth	Adult
Adjustment Disorder	292	138
Anxiety	424	1,213
Attention Deficit	431	316
Cognitive Disorder	51	144
Conduct Disorder	17	12
Depression	140	627
Impulse Control Disorders	110	54
Mood Disorder	281	873
Neglect or Abuse	107	12
Oppositional Defiant Disorder	96	13
Personality Disorder	8	559
Pervasive Developmental Disorders	84	57
Schizophrenia and Other Psychotic	1	273
Substance Abuse	21	407
Other	169	149
V Codes	153	209
Total	2,385	5,056

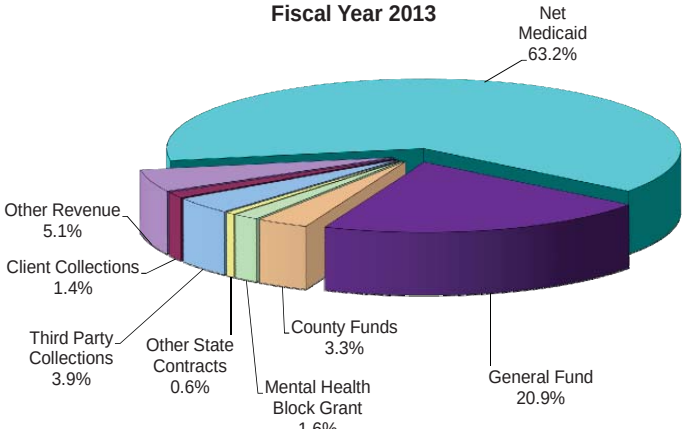


More than one race/ethnicity may have been selected.

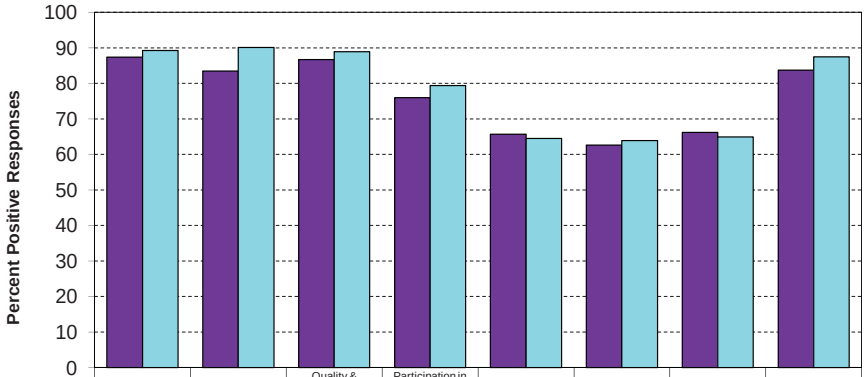


Bear River Mental Health—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

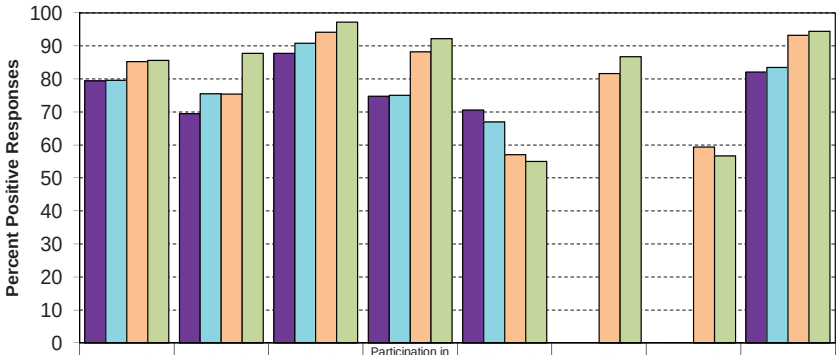


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	89.3	90.1	88.9	79.4	64.5	63.9	64.9	87.5

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	79.6	75.5	90.8	75.0	67.0			83.5
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	85.6	87.7	97.2	92.2	55.0	86.7	56.7	94.4

Central Utah Counseling Center

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

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

Population: 75,861

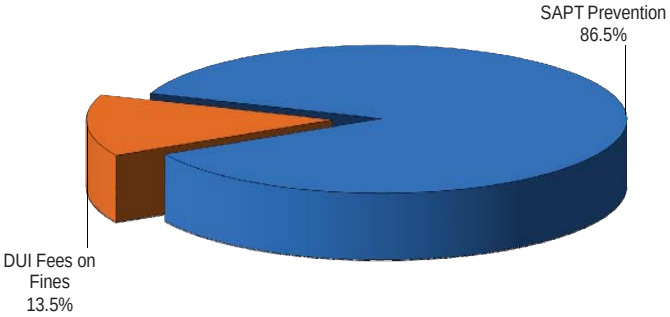
Central Utah Substance Abuse—Prevention

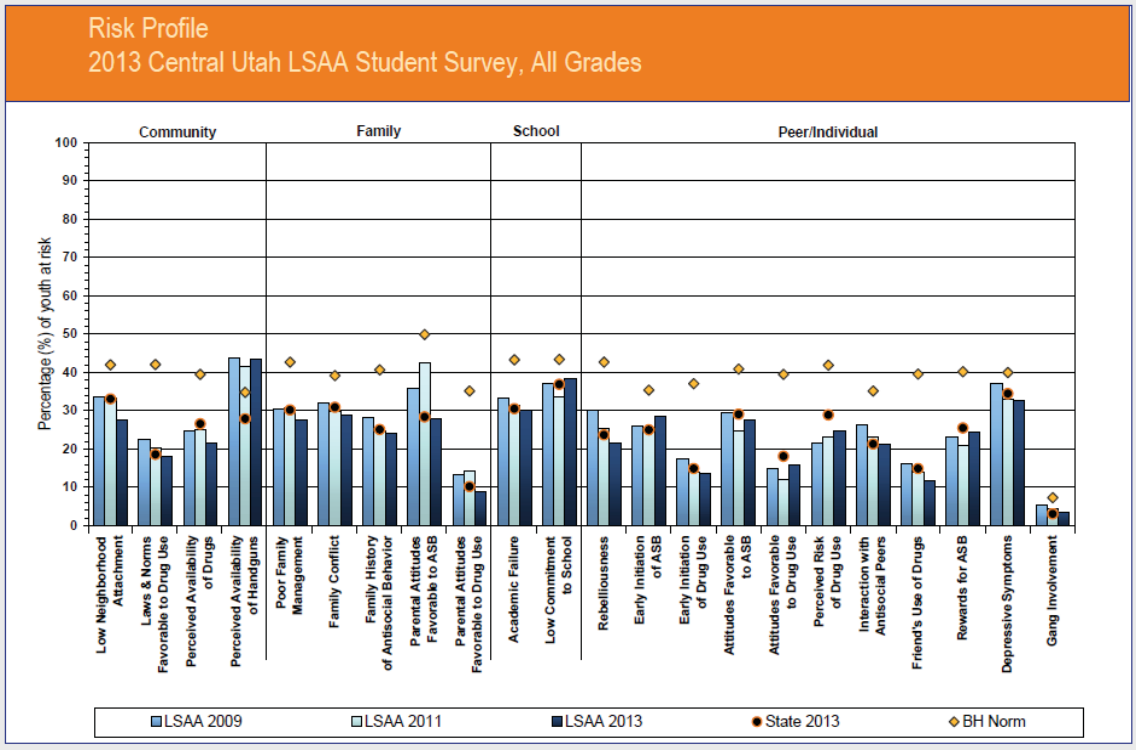
Prioritized Risk Factors: parental attitudes favorable to antisocial behavior, antisocial peers, low commitment to school, academic failure, low neighborhood attachment, depressive symptoms

Coalitions:

- Sevier Valley Substance Abuse Coalition
- Sanpete County LIC
- Delta Community First

Source of Revenues
Fiscal Year 2013



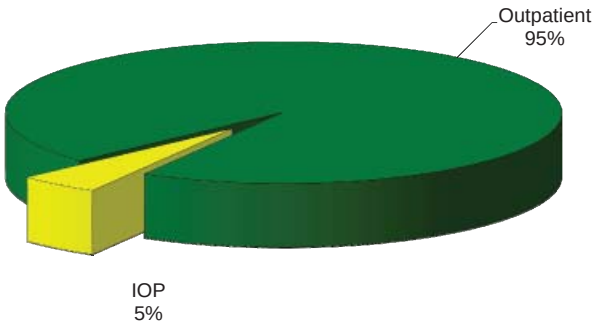


Central Utah Counseling Center—Substance Abuse

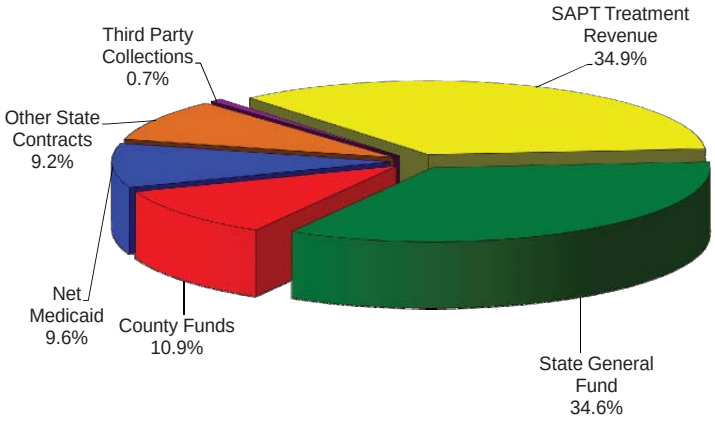
Total Clients Served.....443
Adult 386
Youth.....57
Penetration Rate (Total population of area)..0.6%

Total Admissions.....315
Initial Admissions 305
Transfers.....10

Admission into Modalities
Fiscal Year 2013



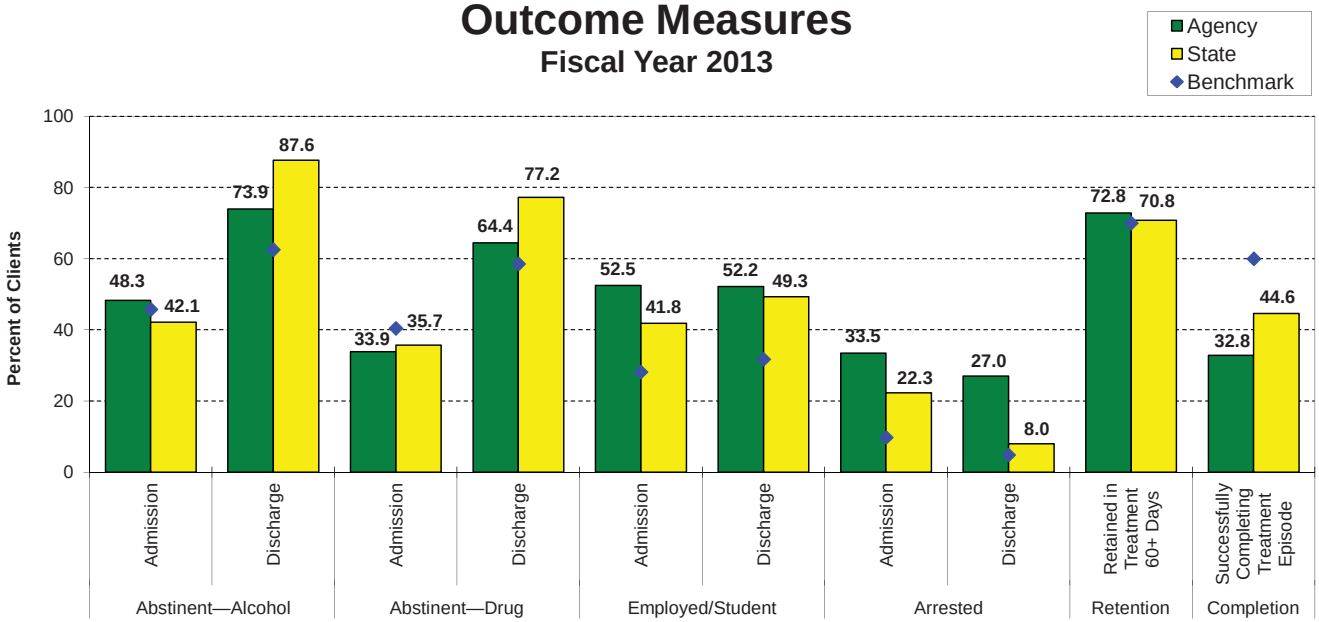
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	70	47	117
Cocaine/Crack	1	2	3
Marijuana/Hashish	50	12	62
Heroin	15	12	27
Other Opiates/Synthetics	5	16	21
Hallucinogens	0	0	0
Methamphetamine	25	32	57
Other Stimulants	0	1	1
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	1	0	1
Inhalants	0	0	0
Oxycodone	10	12	22
Club Drugs	0	0	0
Over-the-Counter	1	0	1
Other	0	3	3
Total	**178**	**137**	**315**

Outcome Measures
Fiscal Year 2013

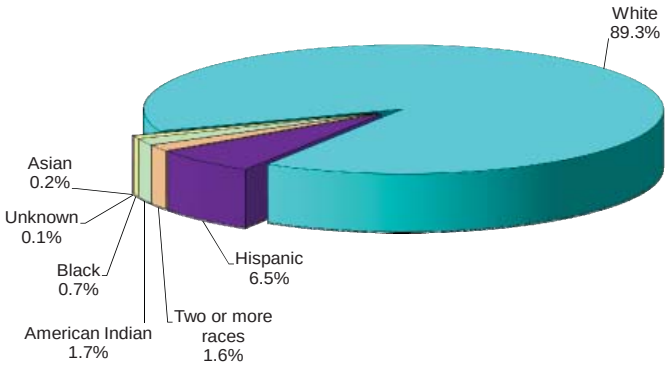


Benchmark is 75% of the National Average.

Central Utah Counseling Center—Mental Health

Total Clients Served.....1,169
Adult 685
Youth.....484
Penetration Rate (Total population of area)..... 1.5%
Civil Commitment 22
Unfunded Clients Served.....138

Race/Ethnicity
Fiscal Year 2013

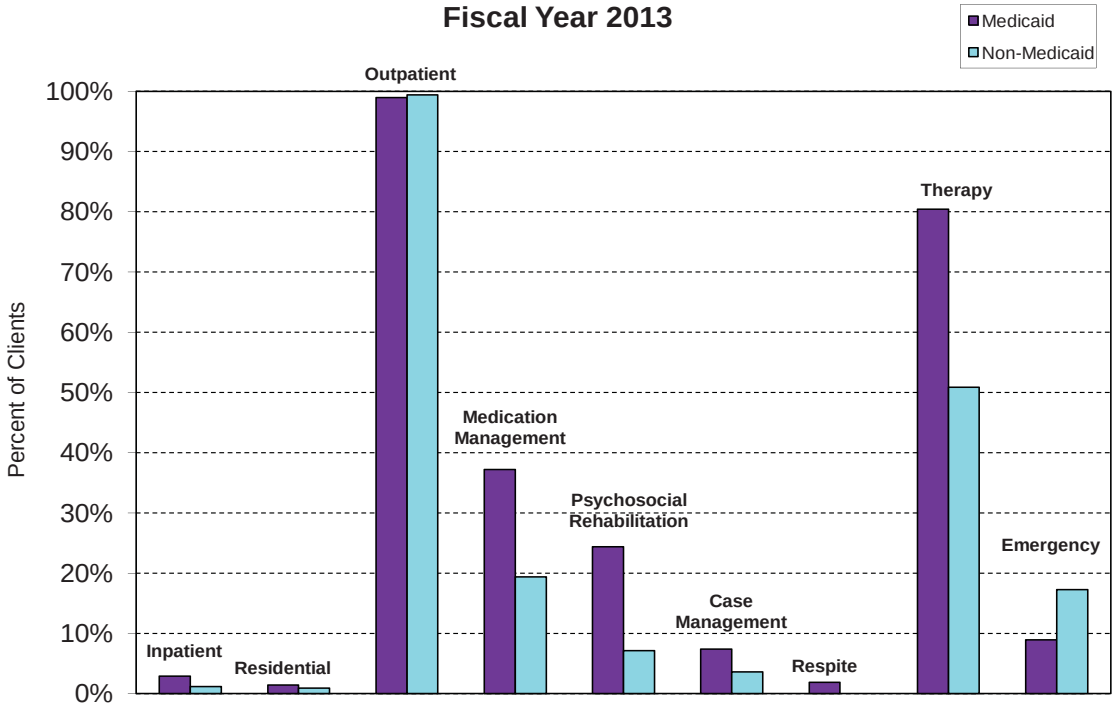


More than one race/ethnicity may have been selected.

Diagnosis

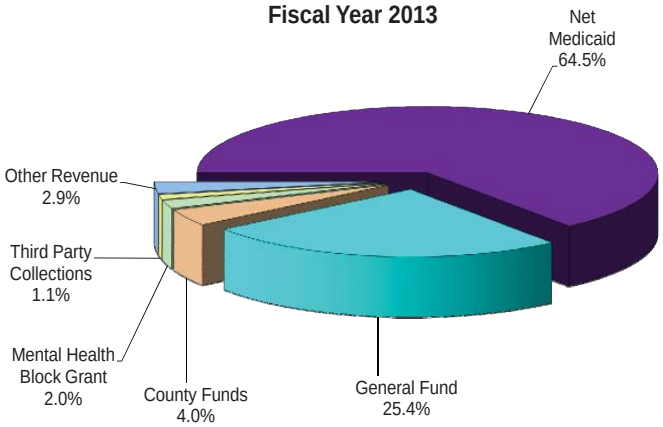
	Youth	Adult
Adjustment Disorder	174	29
Anxiety	133	447
Attention Deficit	236	48
Cognitive Disorder	9	69
Conduct Disorder	18	2
Depression	85	424
Impulse Control Disorders	28	32
Mood Disorder	72	211
Neglect or Abuse	101	236
Oppositional Defiant Disorder	142	1
Personality Disorder	7	312
Pervasive Developmental Disorders	49	21
Schizophrenia and Other Psychotic	1	175
Substance Abuse	32	283
Other	64	49
V Codes	65	83
Total	1,216	2,422

Utilization of Mandated Services
Fiscal Year 2013

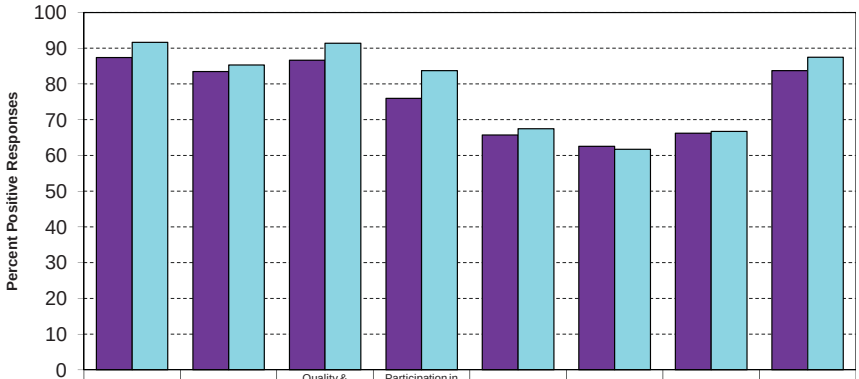


Central Utah Counseling Center—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

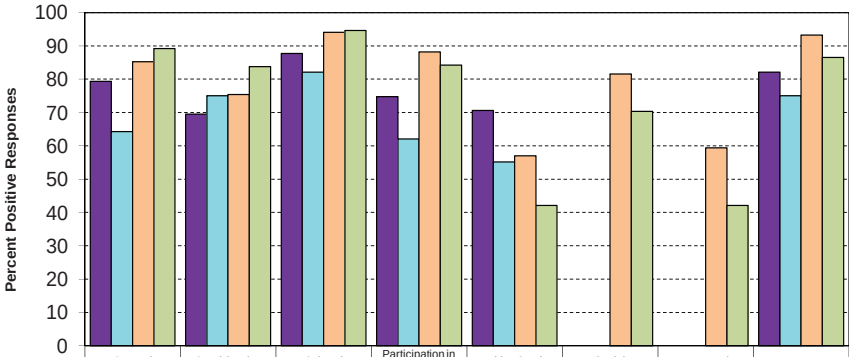


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	91.7	85.3	91.4	83.7	67.5	61.7	66.7	87.5

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	64.3	75.0	82.1	62.1	55.2			75.0
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	89.2	83.8	94.6	84.2	42.1	70.3	42.1	86.5

Davis Behavioral Health

Davis County

DAVIS BEHAVIORAL HEALTH INC

Population: 315,809

Substance Abuse and Mental Health Provider Agency:

Brandon Hatch, CEO/Director
Davis Behavioral Health
934 S. Main
Layton, UT 84041
Office: (801) 544-0585
www.dbhutah.org

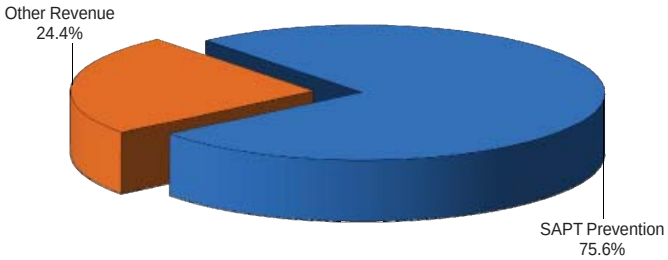
Davis Substance Abuse—Prevention

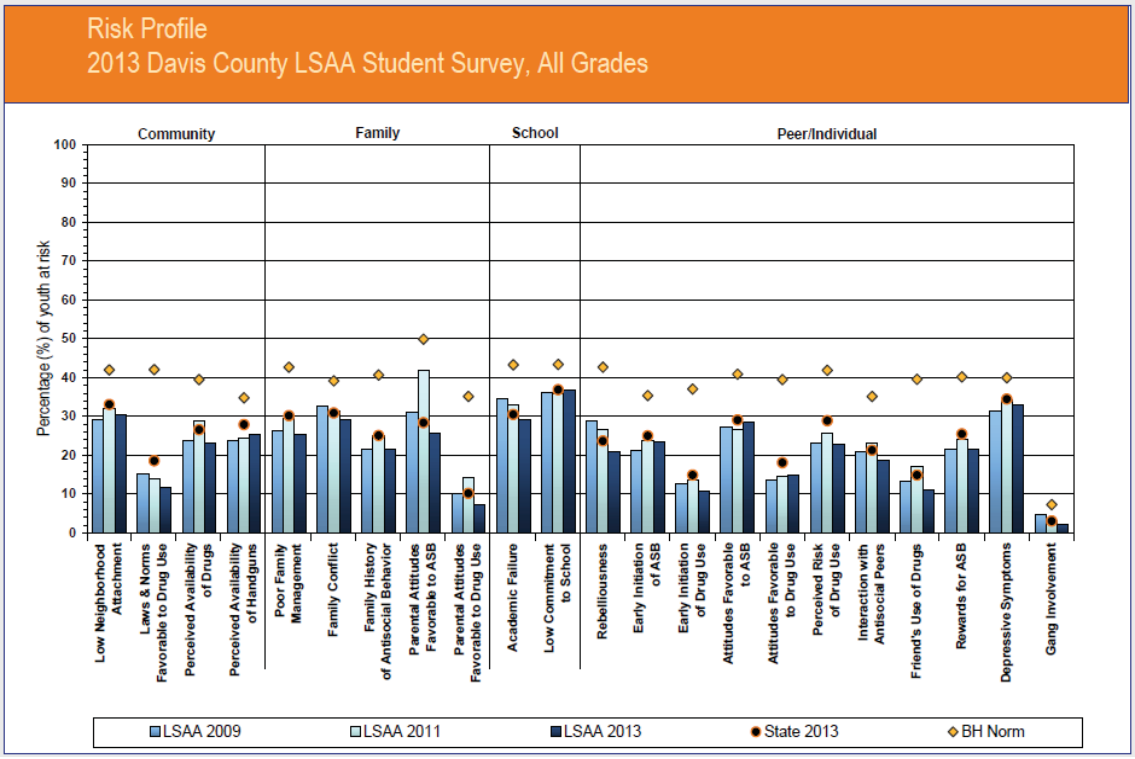
Prioritized Risk Factors: family conflict, poor family management, and depression

Coalitions:

- Layton Communities that Care
- Bountiful Communities that Care

Source of Revenues
Fiscal Year 2013



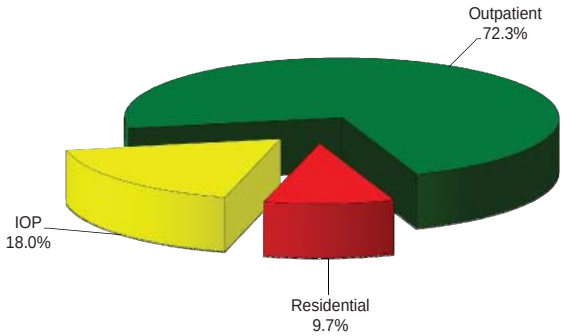


Davis Behavioral Health—Substance Abuse

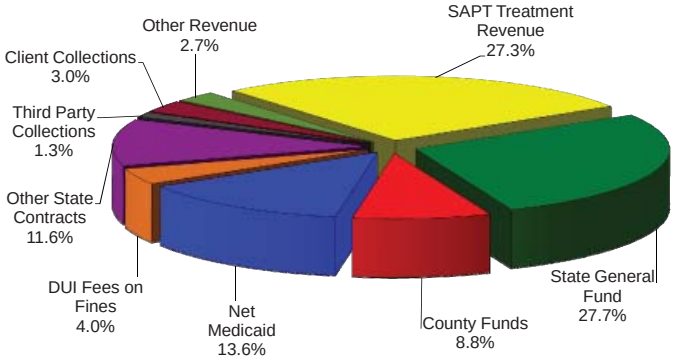
Total Clients Served.....997
Adult 889
Youth.....108
Penetration Rate (Total population of area)..0.3%

Total Admissions.....1,045
Initial Admissions 880
Transfers.....165

Admissions into Modalities
Fiscal Year 2013



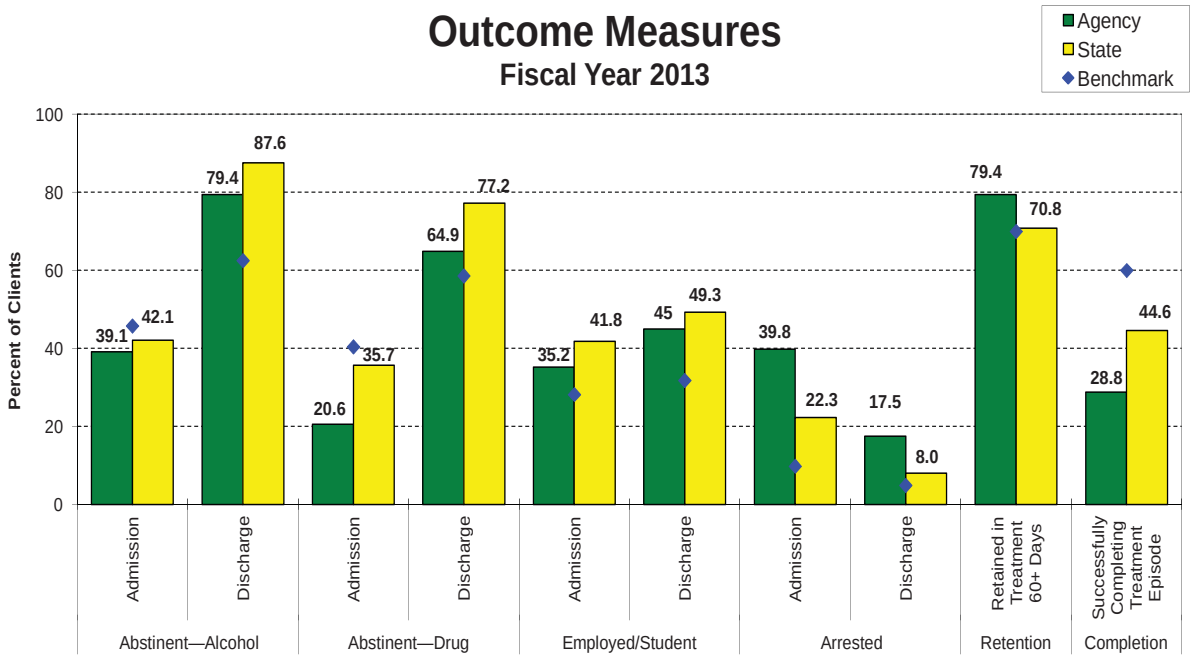
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	144	66	210
Cocaine/Crack	10	3	13
Marijuana/Hashish	178	57	235
Heroin	102	65	167
Other Opiates/Synthetics	25	22	47
Hallucinogens	5	0	5
Methamphetamine	139	154	293
Other Stimulants	1	1	2
Benzodiazepines	3	4	7
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	24	39	63
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	2	3
Total	**632**	**413**	**1045**

Outcome Measures
Fiscal Year 2013



Benchmark is 75% of the National Average.

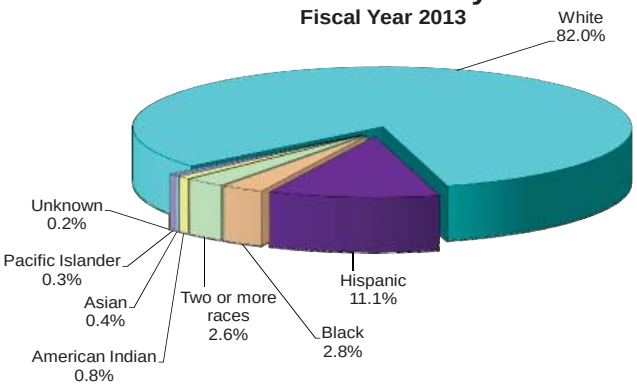
Davis Behavioral Health—Mental Health

Total Clients Served.....4,263
Adult 2,753
Youth.....1,510
Penetration Rate (Total population of area)..... 1.3%
Civil Commitment 113
Unfunded Clients Served.....1,074

Diagnosis

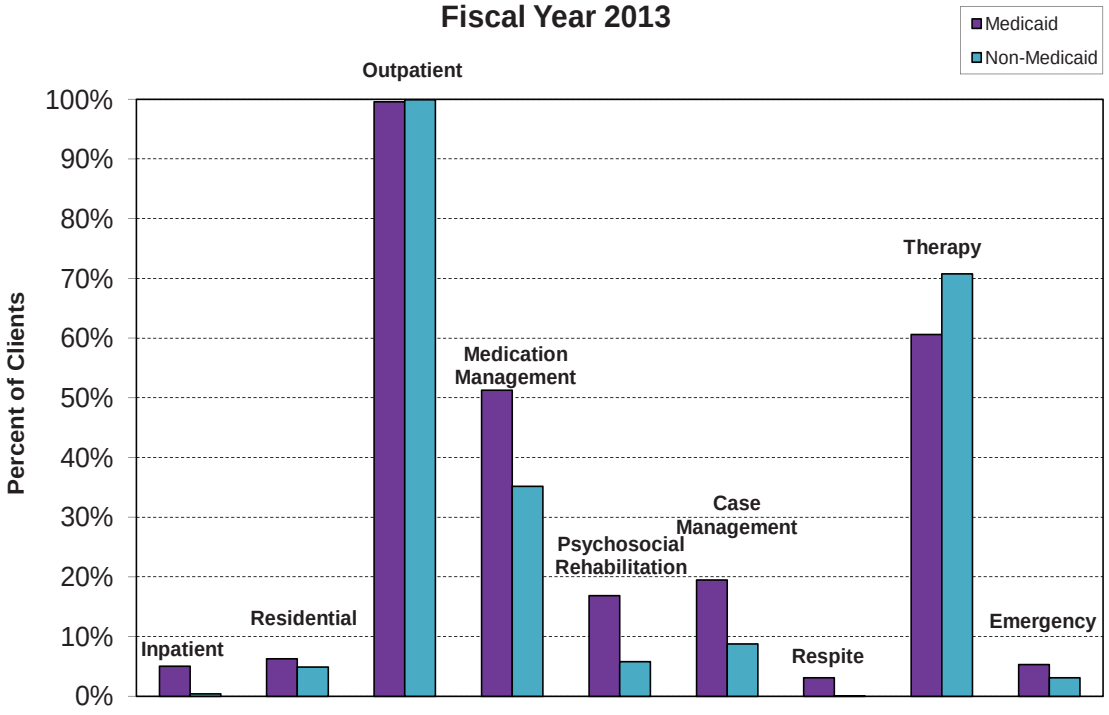
	Youth	Adult
Adjustment Disorder	380	173
Anxiety	1,322	3,176
Attention Deficit	1,396	634
Cognitive Disorder	77	265
Conduct Disorder	97	3
Depression	168	1,025
Impulse Control Disorders	275	84
Mood Disorder	1,083	2,313
Neglect or Abuse	487	38
Oppositional Defiant Disorder	586	16
Personality Disorder	18	756
Pervasive Developmental Disorders	309	137
Schizophrenia and Other Psychotic	20	1,172
Substance Abuse	110	1,858
Other	446	249
V Codes	299	150
Total	7,073	12,049

Race/Ethnicity
Fiscal Year 2013



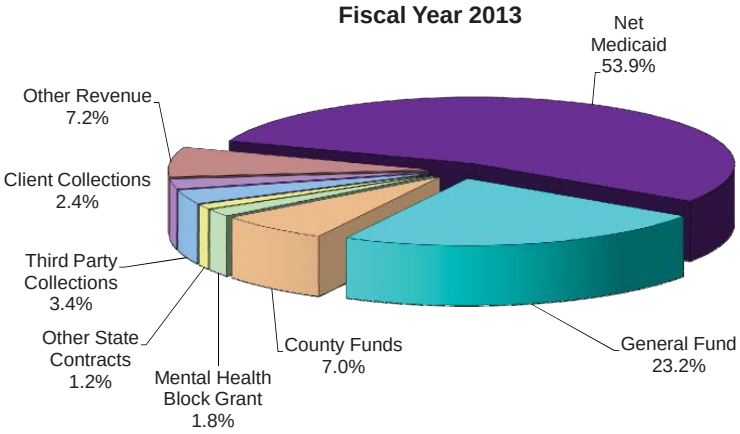
More than one race/ethnicity may have been selected.

Utilization of Mandated Services
Fiscal Year 2013

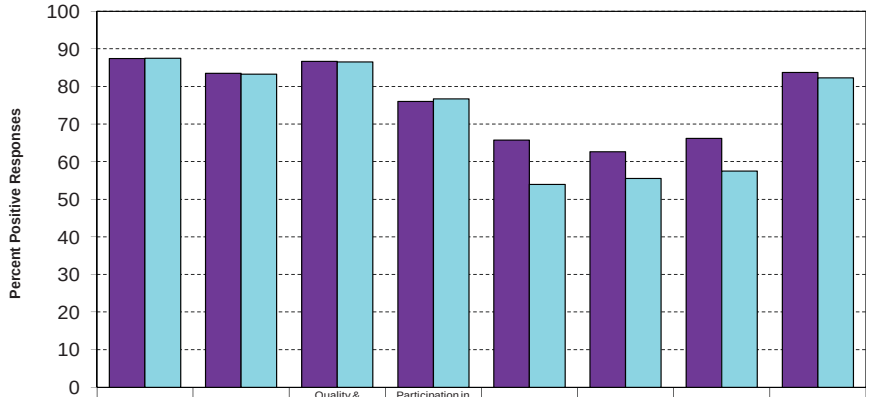


Davis Behavioral Health—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

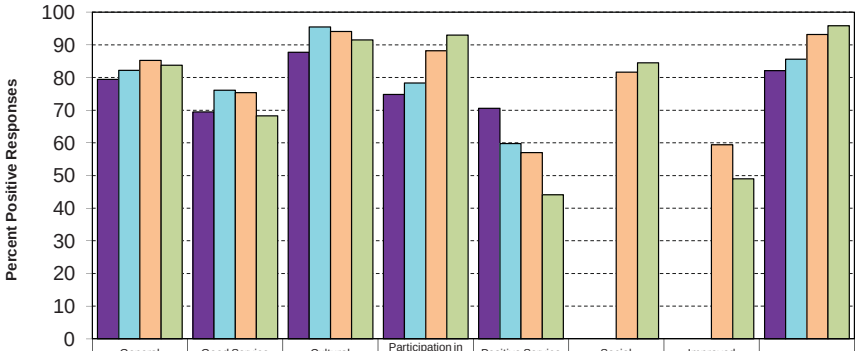


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	87.5	83.3	86.5	76.7	53.9	55.5	57.5	82.3

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	82.2	76.1	95.5	78.3	59.8			85.6
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	83.8	68.3	91.5	93.0	44.1	84.5	49.0	95.8

Four Corners

Carbon, Emery & Grand Counties

FCCBH

FOUR CORNERS COMMUNITY BEHAVIORAL HEALTH

Population: 41,507

Substance Abuse and Mental Health Provider Agency:

Karen Dolan, CEO
Four Corners Community Behavioral Health
105 West 100 North
P.O. Box 867
Price, UT 84501
Office: (435) 637-7200
www.fourcorners.ws

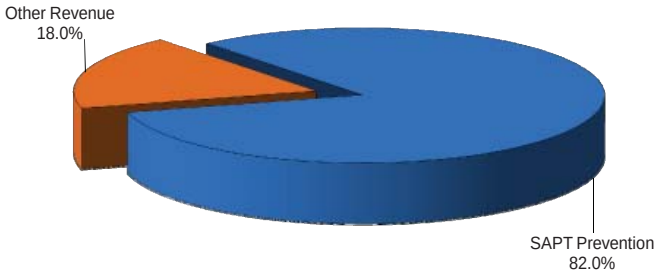
Four Corners Substance Abuse—Prevention

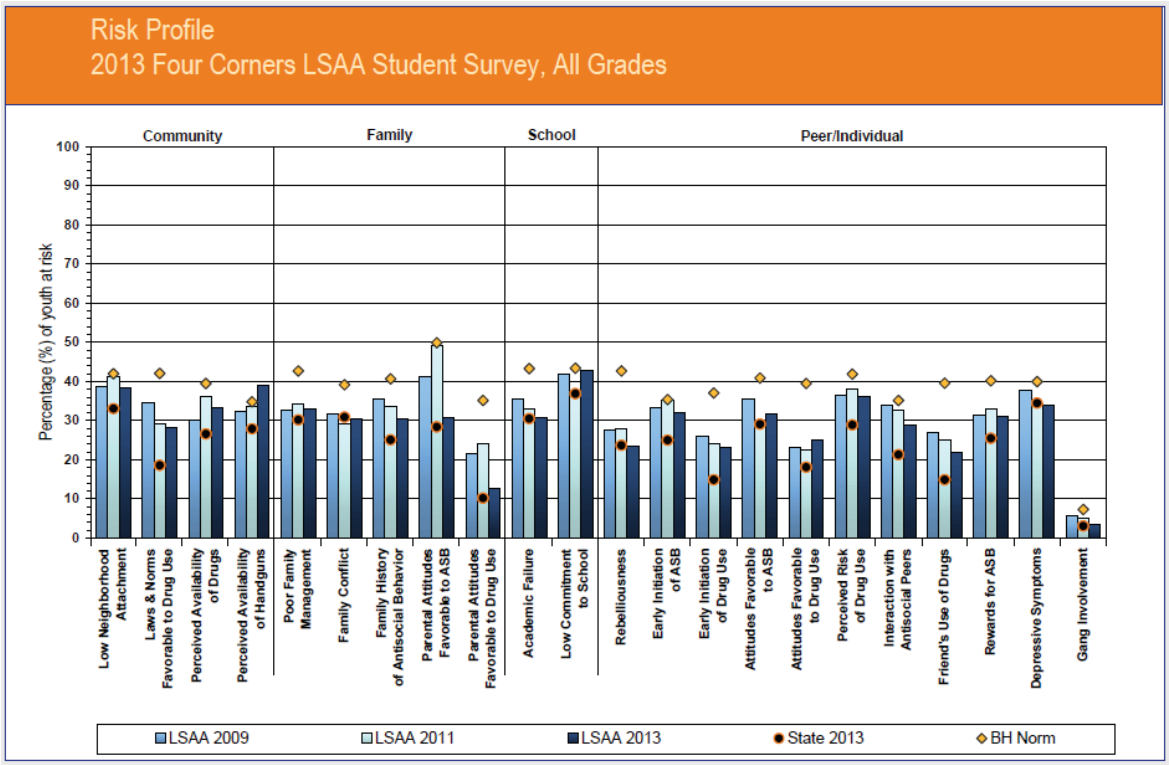
Prioritized Risk Factors: intention to use drugs, community norms favorable to drug use

Coalitions:

- Moab Community Action Coalition (MCAC)
- CHEER (Green River)
- Communities that Care of Carbon County

Source of Revenues
Fiscal Year 2013



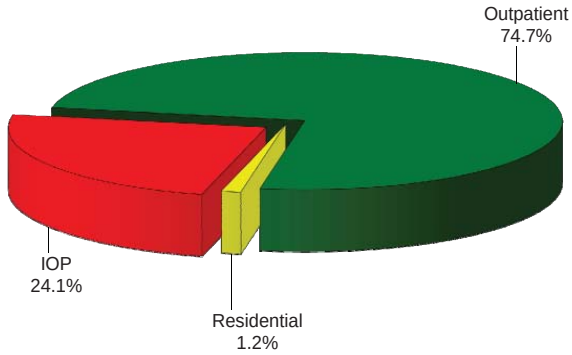


Four Corners Community Behavioral Health—Substance Abuse

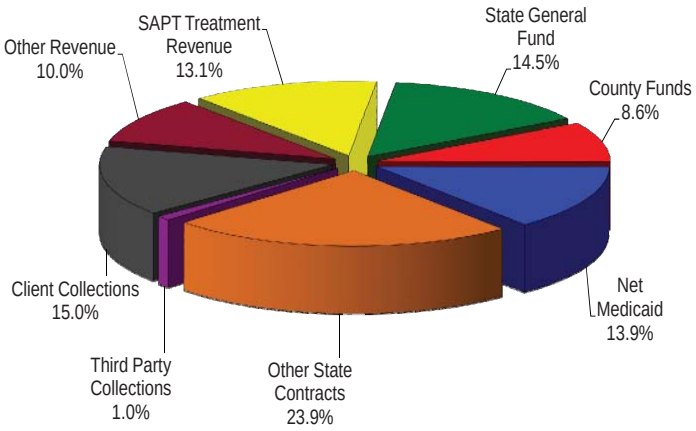
Total Clients Served.....605
Adult 554
Youth.....51
Penetration Rate (Total population of area)..1.5%

Total Admissions.....494
Initial Admissions 378
Transfers.....116

Admissions into Modalities
Fiscal Year 2013

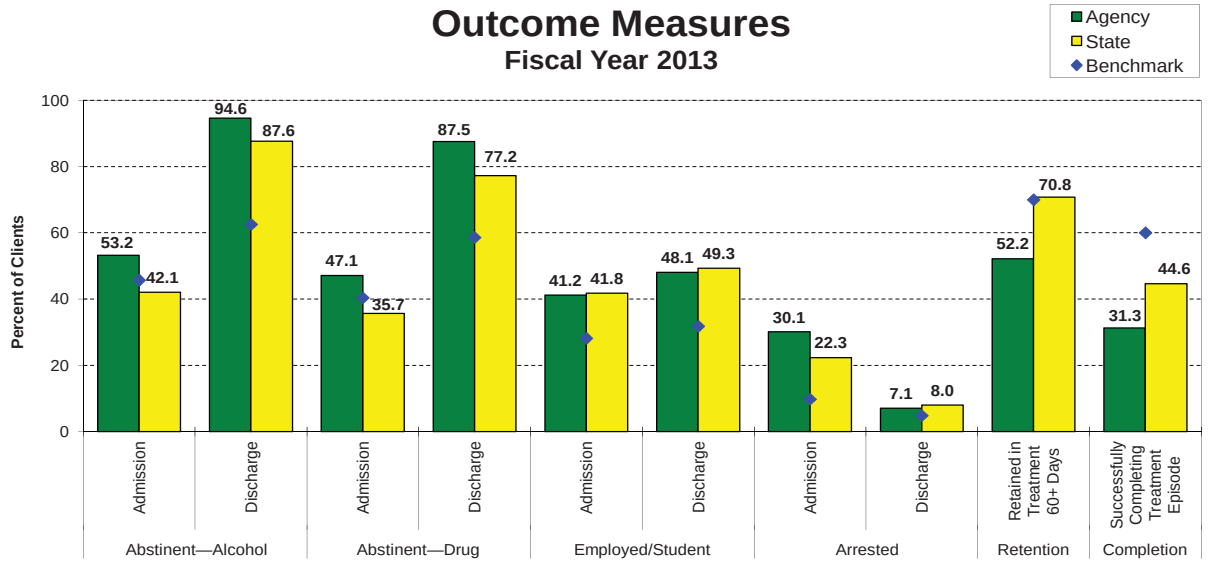


Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission			
	Male	Female	Total
Alcohol	113	62	175
Cocaine/Crack	2	1	3
Marijuana/Hashish	77	30	107
Heroin	20	13	33
Other Opiates/Synthetics	38	27	65
Hallucinogens	0	0	0
Methamphetamine	39	47	86
Other Stimulants	0	1	1
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	0	0
Inhalants	1	0	1
Oxycodone	11	9	20
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	1	2
Total	**302**	**192**	**494**

Outcome Measures
Fiscal Year 2013



Benchmark is 75% of the National Average.

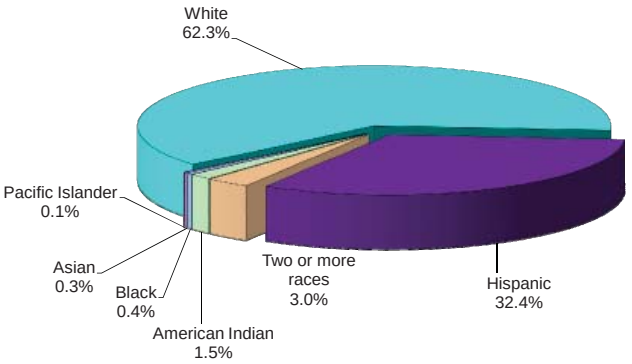
Four Corners Community Behavioral Health—Mental Health

Total Clients Served.....1,345
Adult 890
Youth.....455
Penetration Rate (Total population of area)..... 3.2%
Civil Commitment 0
Unfunded Clients Served 94

Diagnosis

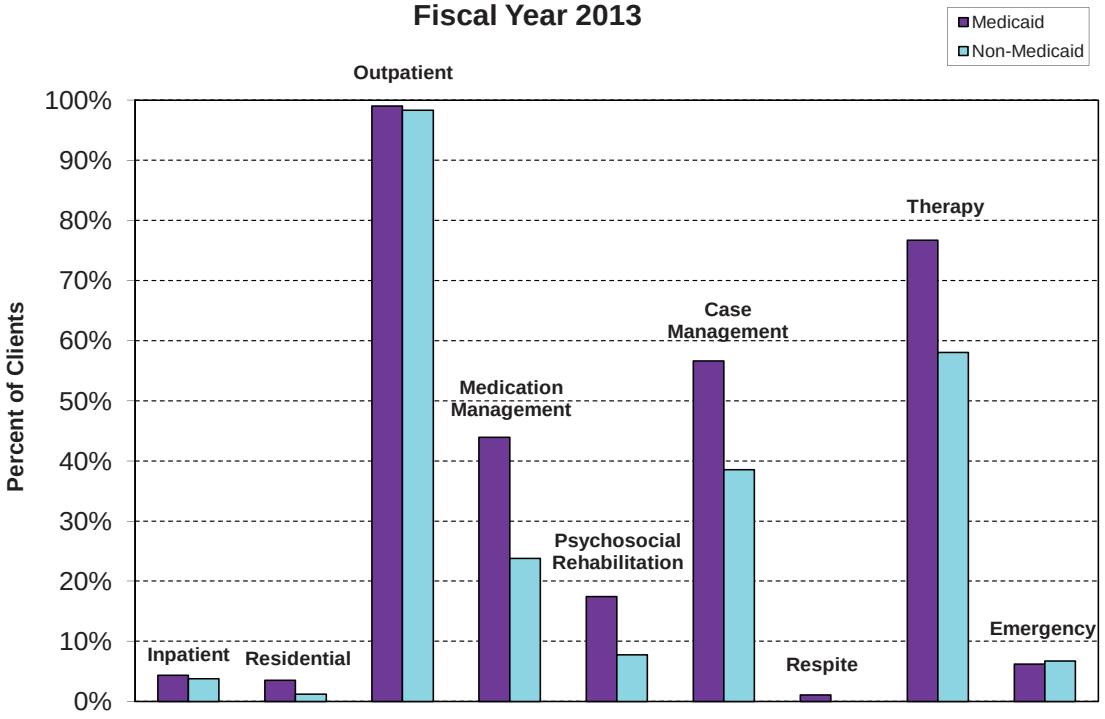
	Youth	Adult
Adjustment Disorder	96	35
Anxiety	94	395
Attention Deficit	138	43
Cognitive Disorder	7	35
Conduct Disorder	7	1
Depression	39	285
Impulse Control Disorders	38	17
Mood Disorder	102	327
Neglect or Abuse	41	9
Oppositional Defiant Disorder	61	8
Personality Disorder	6	223
Pervasive Developmental Disorders	36	9
Schizophrenia and Other Psychotic	1	133
Substance Abuse	53	388
Other	60	37
V Codes	99	72
Total	878	2,017

Race/Ethnicity
Fiscal Year 2013



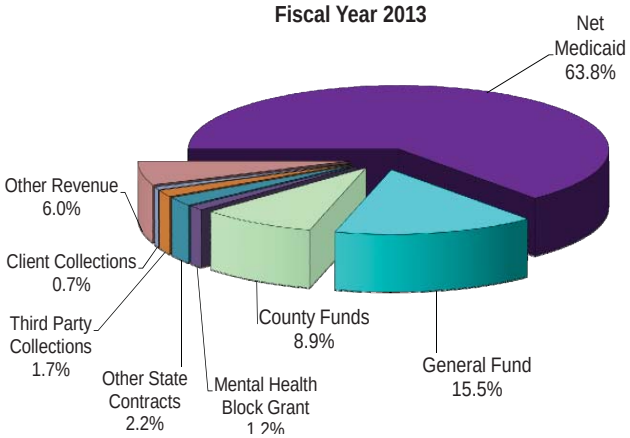
More than one race/ethnicity may have been selected.

Utilization of Mandated Services
Fiscal Year 2013

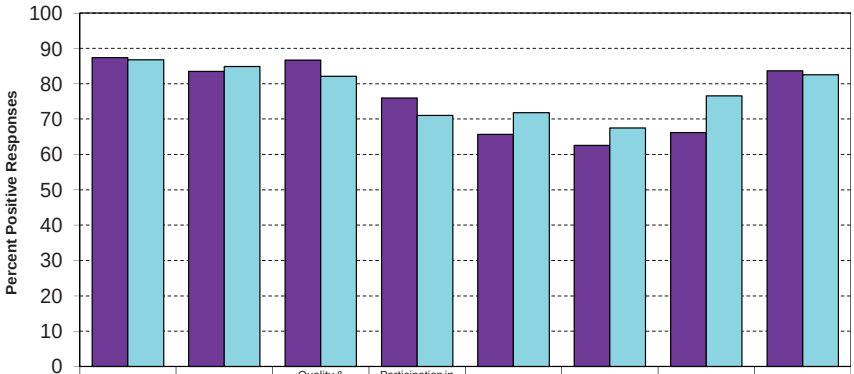


Four Corners Community Behavioral Health—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

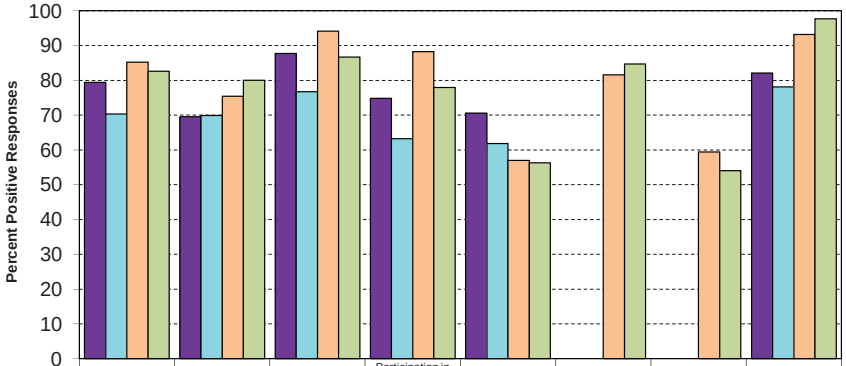


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	86.8	84.9	82.1	71.0	71.8	67.5	76.6	82.5

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	70.3	69.9	76.7	63.2	61.8			78.1
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	82.6	80.0	86.7	77.9	56.3	84.7	54.0	97.7

Northeastern Counseling Center

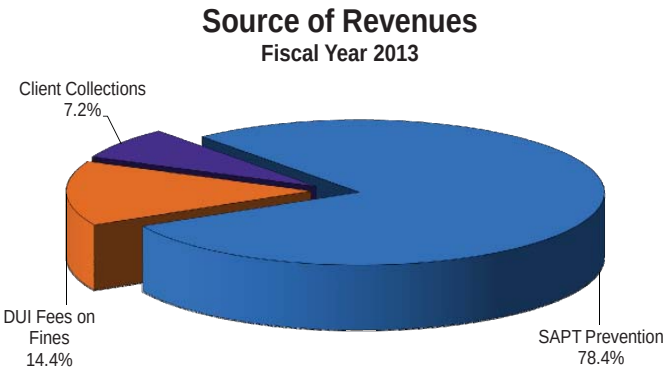
Daggett, Duchesne, & Uintah Counties

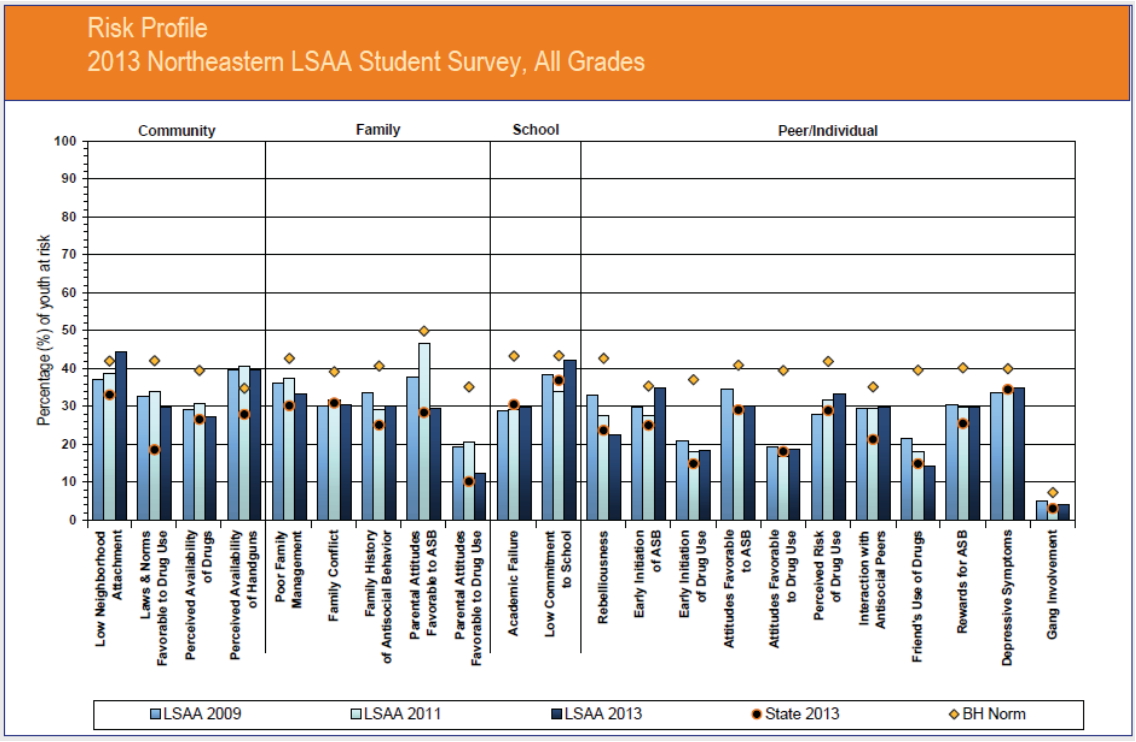
Substance Abuse and Mental Health Provider Agency:
Kyle Snow, Director
Northeastern Counseling Center
1140 West 500 South
P.O. Box 1908
Vernal, UT 84078
Office: (435) 789-6300
Fax: (435) 789-6325
www.nccutah.org

Population: 54,858

Northeastern Substance Abuse—Prevention

Prioritized Risk Factors: parental attitudes favorable to anti-social behavior, community norms



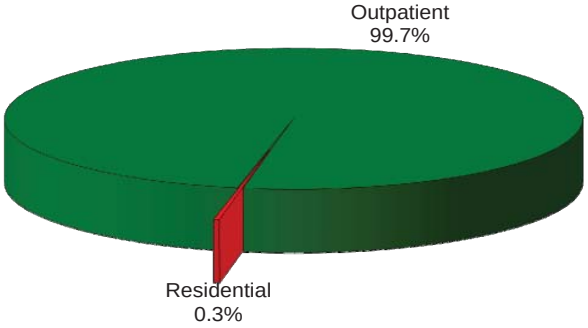


Northeastern Counseling Center—Substance Abuse

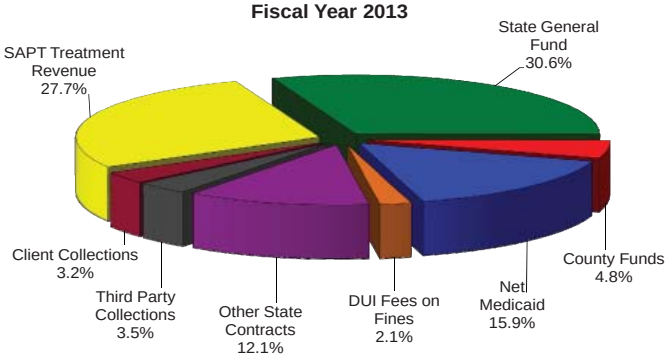
Total Clients Served.....524
Adult 490
Youth.....34
Penetration Rate (Total population of area)..1.0%

Total Admissions.....316
Initial Admissions 300
Transfers.....16

Admission into Modalities
Fiscal Year 2013



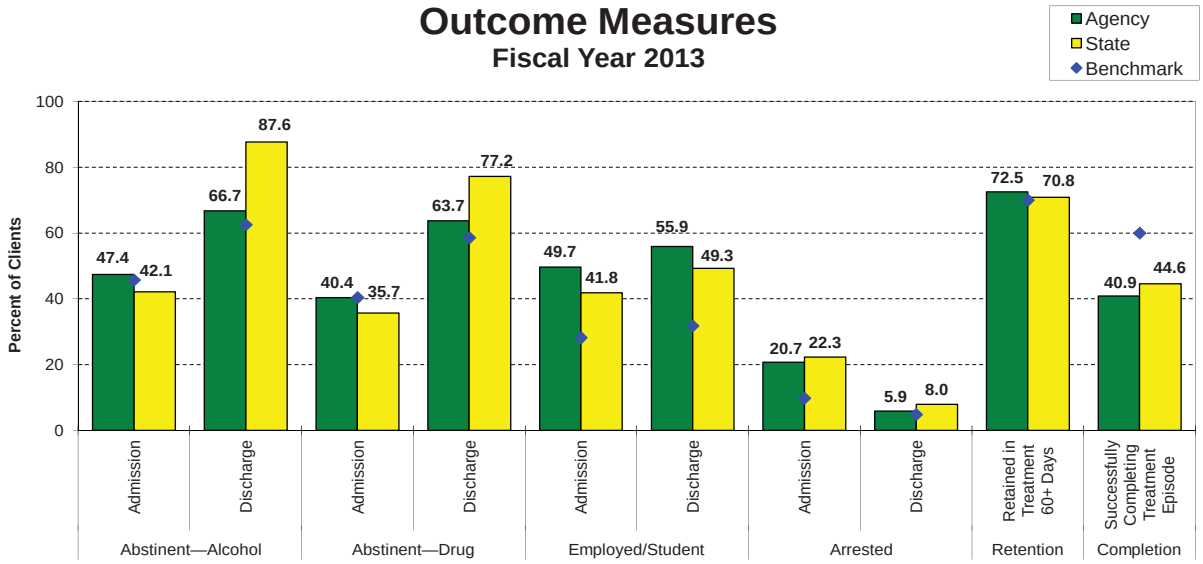
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	93	38	131
Cocaine/Crack	2	0	2
Marijuana/Hashish	36	23	59
Heroin	2	2	4
Other Opiates/Synthetics	8	8	16
Hallucinogens	0	0	0
Methamphetamine	43	51	94
Other Stimulants	0	0	0
Benzodiazepines	1	2	3
Tranquilizers/Sedatives	0	0	0
Inhalants	0	2	2
Oxycodone	1	4	5
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	**186**	**130**	**316**

Outcome Measures
Fiscal Year 2013

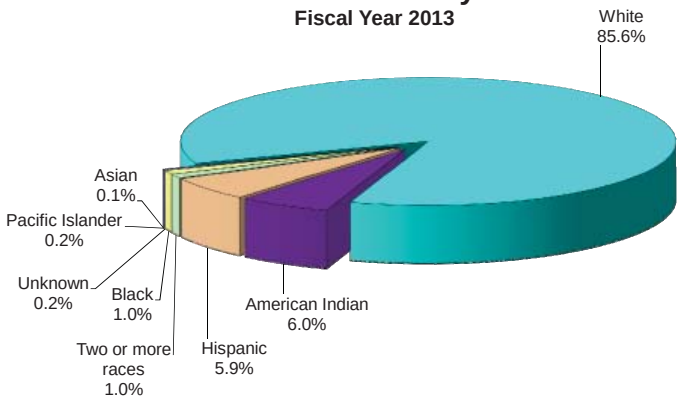


Benchmark is 75% of the National Average.

Northeastern Counseling Center—Mental Health

Total Clients Served.....1,810
Adult 1,133
Youth.....677
Penetration Rate (Total population of area)..... 3.3%
Civil Commitment 9
Unfunded Clients Served.....483

Race/Ethnicity
Fiscal Year 2013

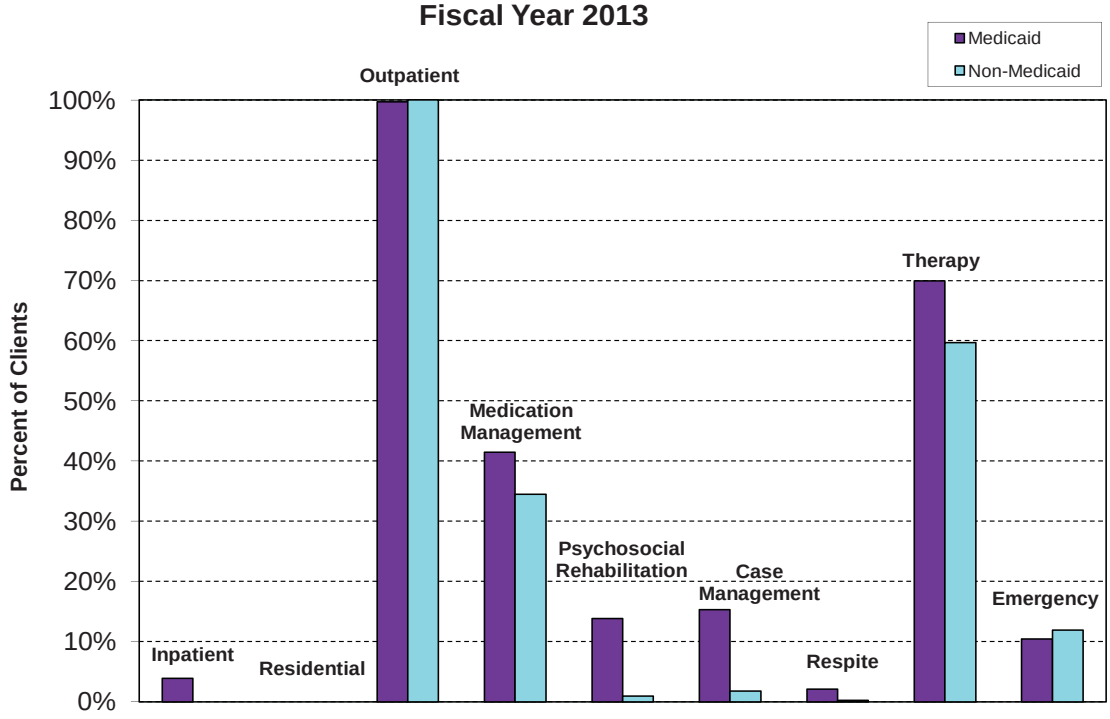


More than one race/ethnicity may have been selected.

Diagnosis

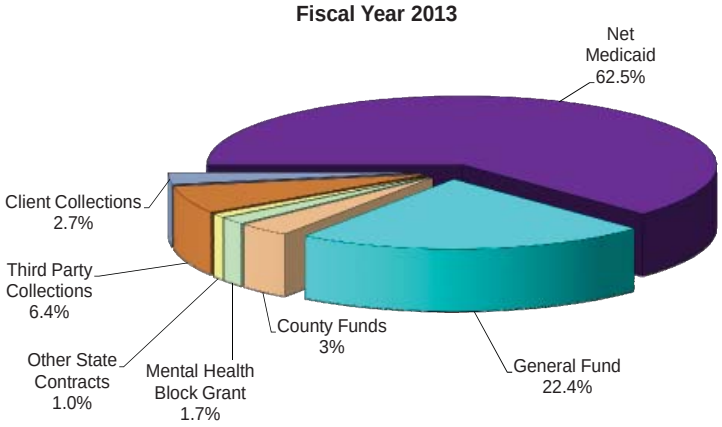
	Youth	Adult
Adjustment Disorder	115	59
Anxiety	177	693
Attention Deficit	185	91
Cognitive Disorder	14	49
Conduct Disorder	13	1
Depression	85	454
Impulse Control Disorders	67	52
Mood Disorder	171	331
Neglect or Abuse	149	37
Oppositional Defiant Disorder	44	4
Personality Disorder	2	92
Pervasive Developmental Disorders	38	14
Schizophrenia and Other Psychotic	2	100
Substance Abuse	24	189
Other	55	42
V Codes	111	207
Total	1,252	2,415

Utilization of Mandated Services
Fiscal Year 2013

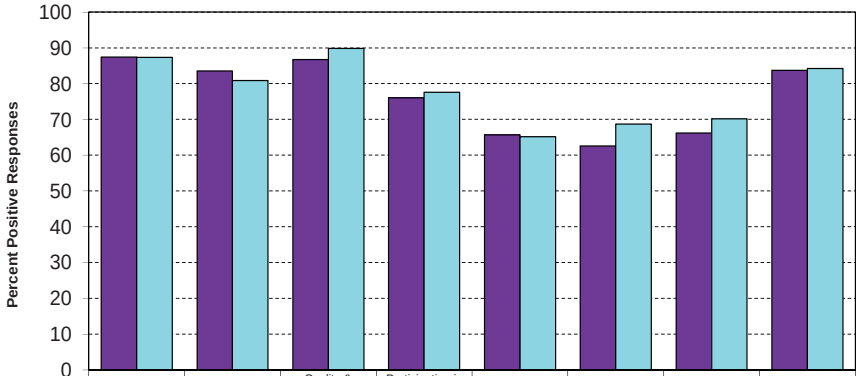


Northeastern Counseling Center—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

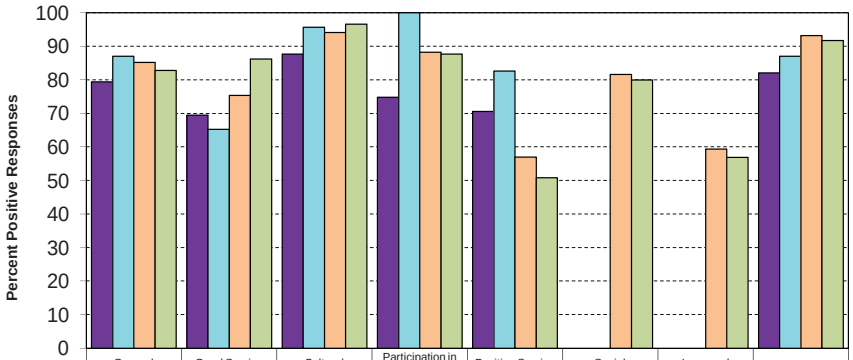


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	87.3	80.9	89.8	77.6	65.2	68.7	70.2	84.2

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	87.0	65.2	95.7	100.0	82.6			87.0
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	82.8	86.2	96.6	87.7	50.8	80.0	56.9	91.7

Salt Lake County

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
behavioralhealthservices.slco.org

Population: 1,063,842

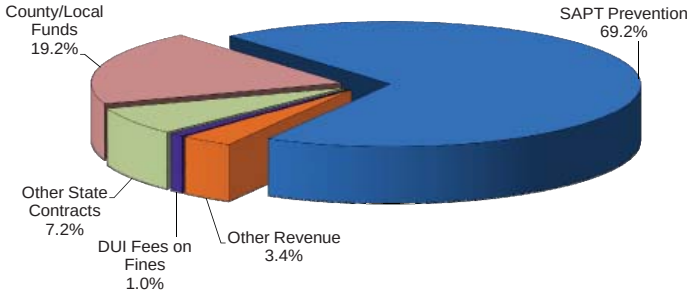
Salt Lake County Substance Abuse—Prevention

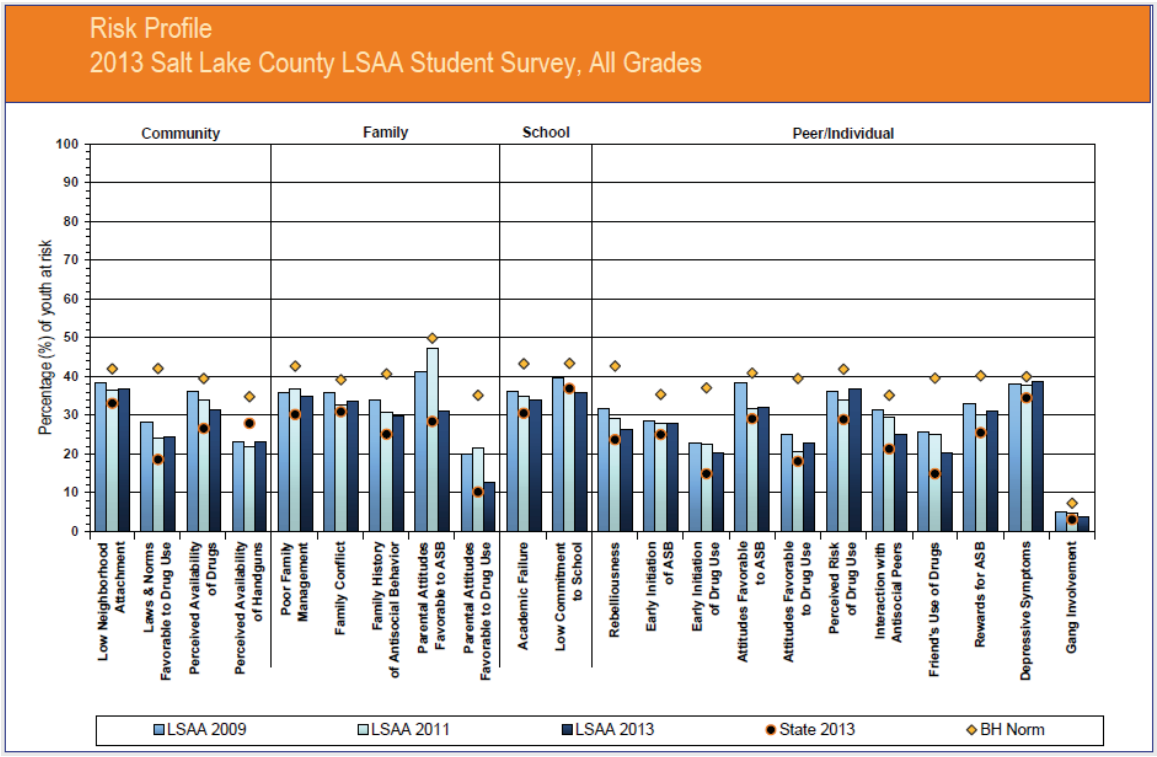
Prioritized Risk Factors: parental and individual attitudes favorable to antisocial behavior, early initiate of use, and perceived risk of use

Coalitions:

- Drug Free Draper
- Midvale United
- Neightborhoods United (West SLC)
- Salt Lake City Mayor's Coalition
- South Salt Lake Drug Free Youth
- Utah Council for Crime Prevention
- West Valley United

Source of Revenues
Fiscal Year 2013



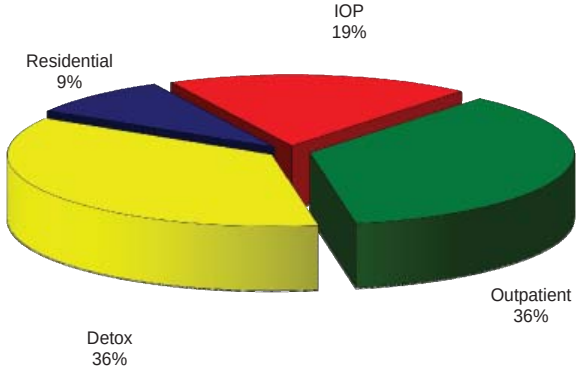


Salt Lake County Division of Substance Abuse

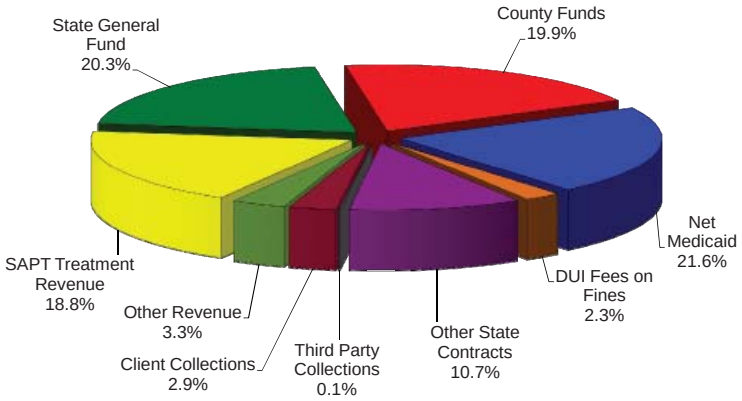
Total Clients Served.....8,172
Adult 7,475
Youth.....697
Penetration Rate (Total population of area)..0.8%

Total Admissions.....10,524
Initial Admissions 8,527
Transfers.....1,997

Admissions into Modalities
Fiscal Year 2013



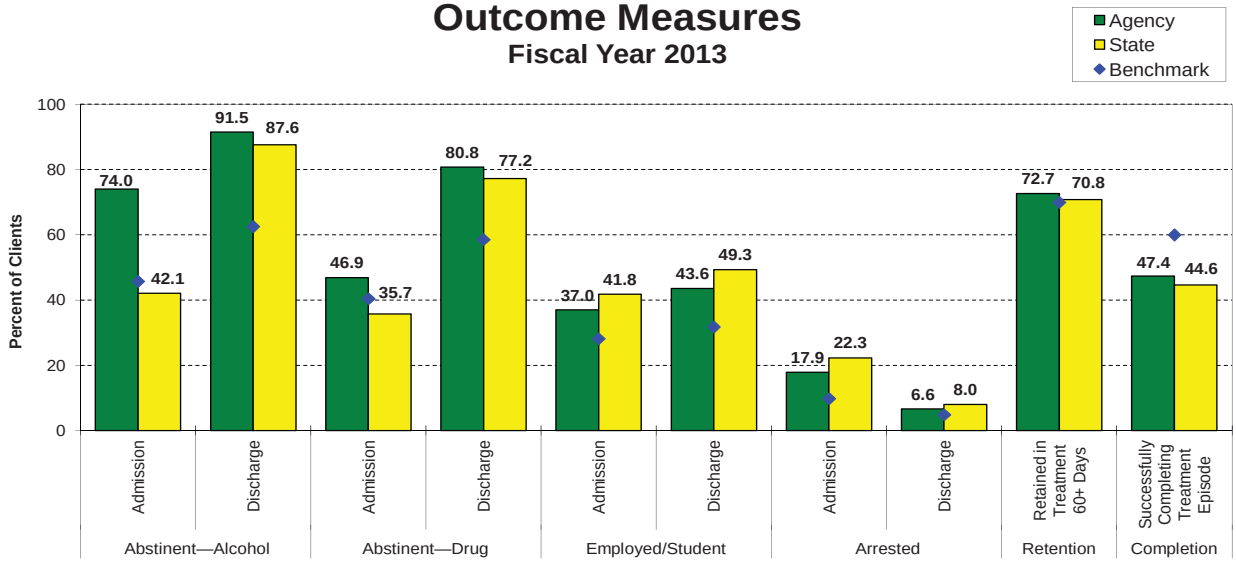
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	2,779	756	3,535
Cocaine/Crack	398	140	538
Marijuana/Hashish	1,106	350	1,456
Heroin	1,188	709	1,897
Other Opiates/Synthetics	147	196	343
Hallucinogens	15	2	17
Methamphetamine	1,163	1,072	2,235
Other Stimulants	26	31	57
Benzodiazepines	20	20	40
Tranquilizers/Sedatives	3	7	10
Inhalants	10	0	10
Oxycodone	106	142	248
Club Drugs	10	5	15
Over-the-Counter	13	2	15
Other	82	26	108
Total	**7,066**	**3,458**	**10,524**

Outcome Measures
Fiscal Year 2013



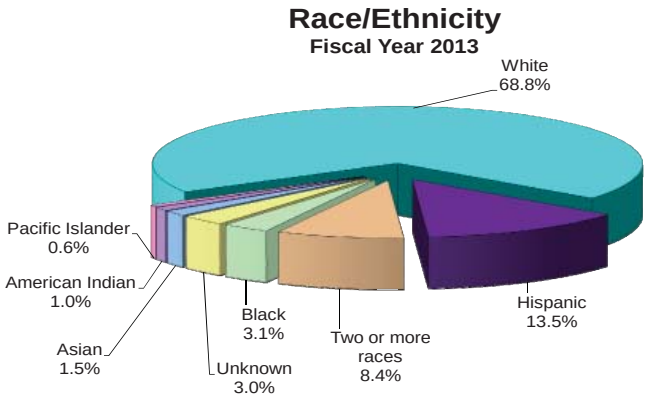
Benchmark is 75% of the National Average.

Salt Lake County—Mental Health

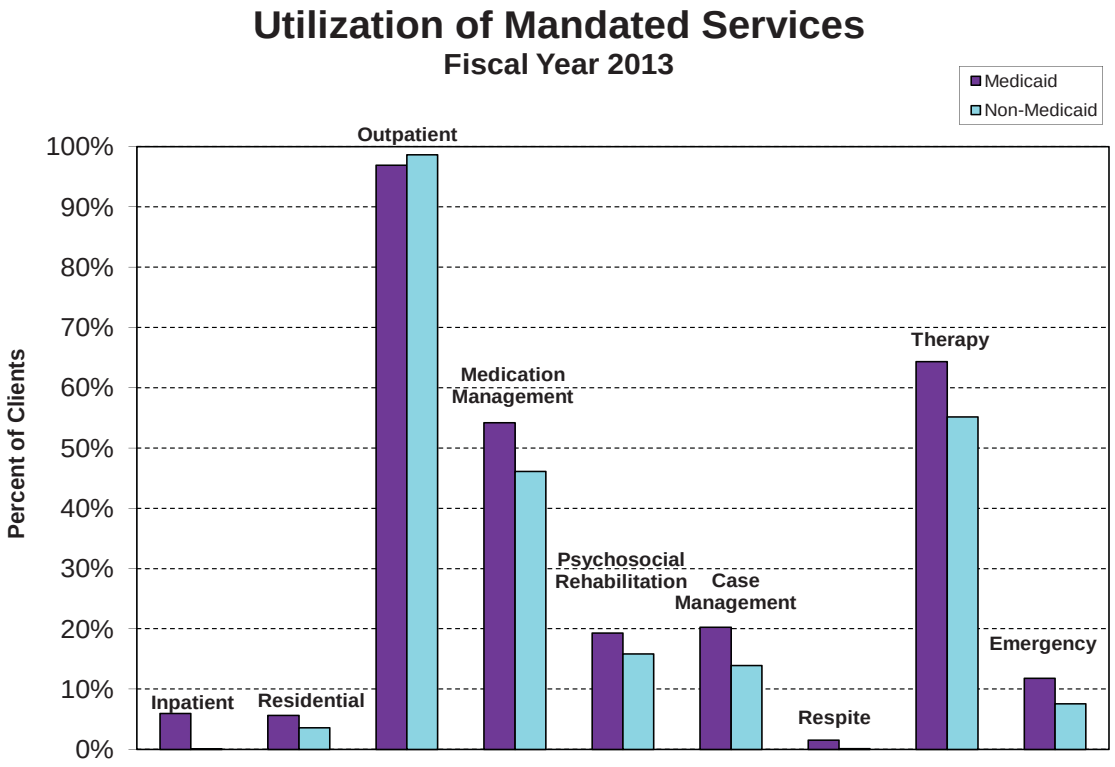
Total Clients Served.....15,499
Adult 10,098
Youth.....5,401
Penetration Rate (Total population of area)..... 1.5%
Civil Commitment 576
Unfunded Clients Served 639

Diagnosis

	Youth	Adult
Adjustment Disorder	920	305
Anxiety	3,079	6,775
Attention Deficit	2,018	976
Cognitive Disorder	111	723
Conduct Disorder	174	16
Depression	784	3,760
Impulse Control Disorders	676	253
Mood Disorder	1,859	5,356
Neglect or Abuse	742	71
Oppositional Defiant Disorder	1,438	39
Personality Disorder	14	2,837
Pervasive Developmental Disorders	683	272
Schizophrenia and Other Psychotic	14	2,608
Substance Abuse	215	3,783
Other	460	521
V Codes	988	1,139
Total	14,175	29,434

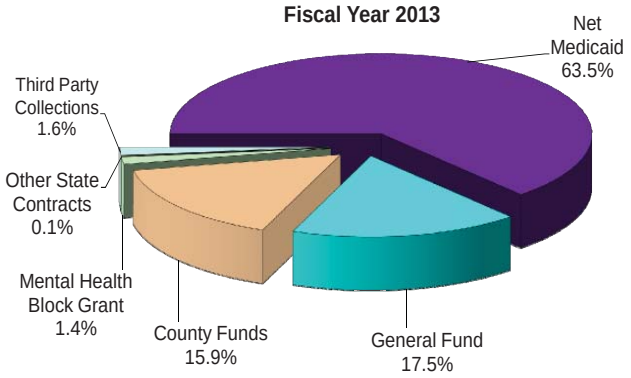


More than one race/ethnicity may have been selected.

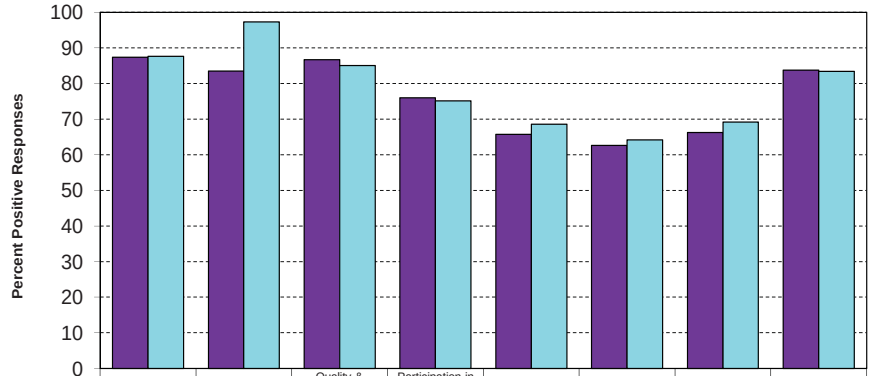


Salt Lake County—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

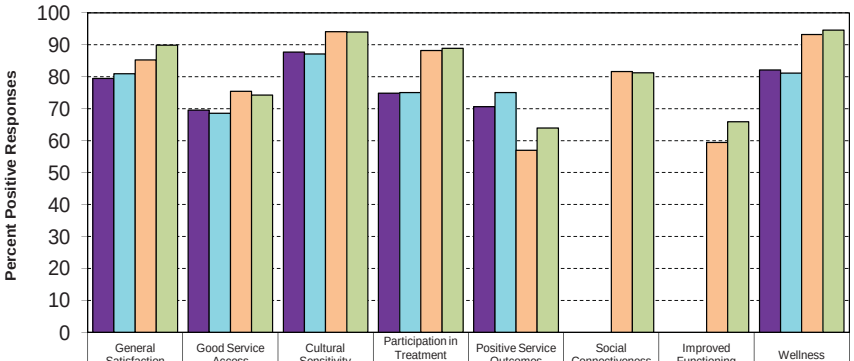


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	87.6	97.3	85.0	75.1	68.6	64.2	69.2	83.4

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	80.9	68.6	87.1	75.0	75.0			81.1
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	89.9	74.2	94.0	88.9	63.9	81.2	65.9	94.6

San Juan County

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

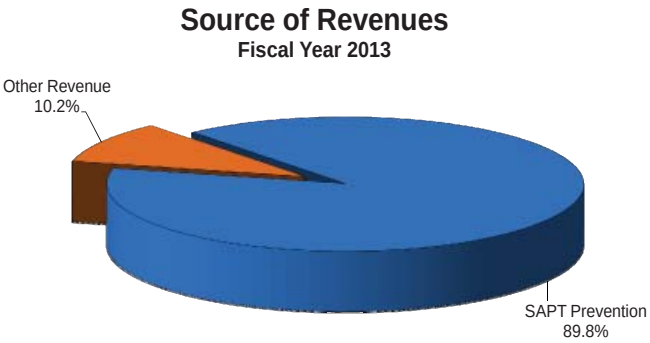
Population: 14,965

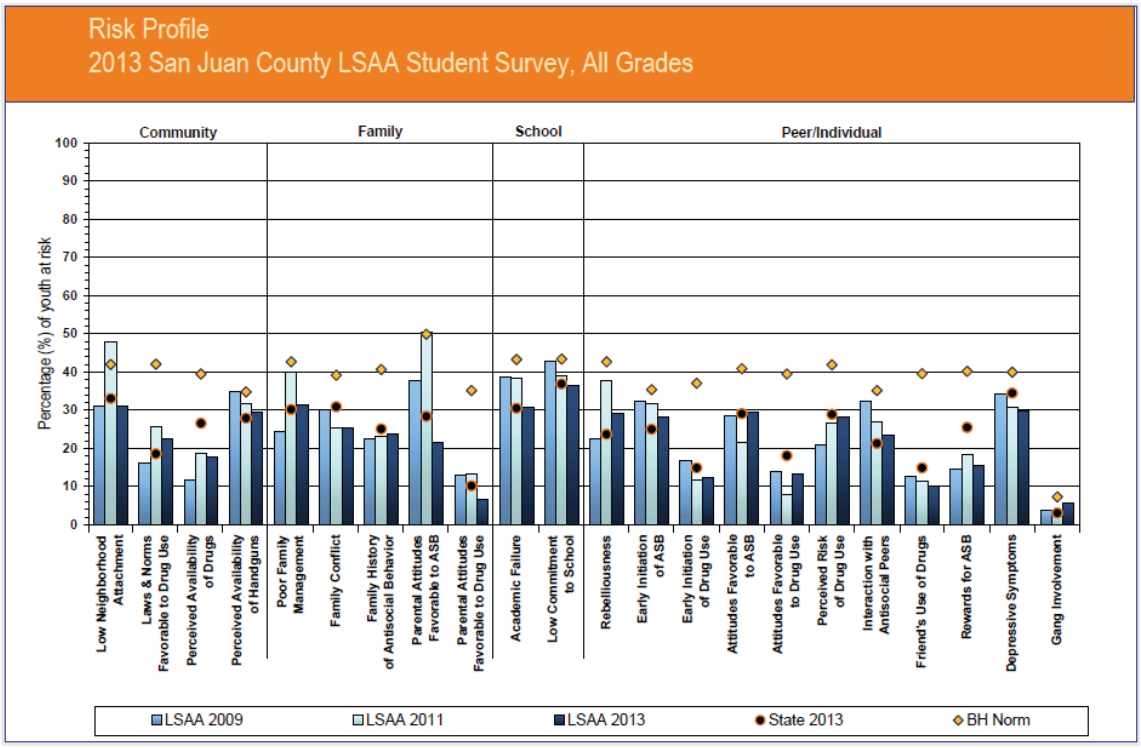
San Juan Substance Abuse—Prevention

Prioritized Risk Factors: parental attitude favorable to antisocial behavioral and favorable attitude toward the problem behavior and perceived availability of drugs

Coalitions:

- Blanding Prevention Advisory Committee



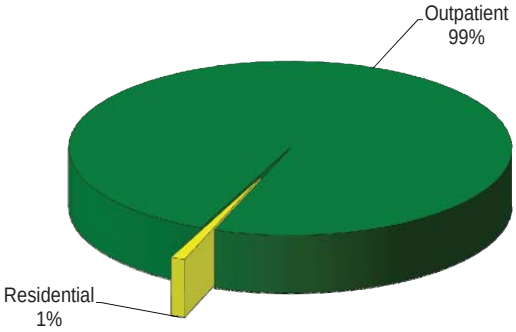


San Juan Counseling—Substance Abuse

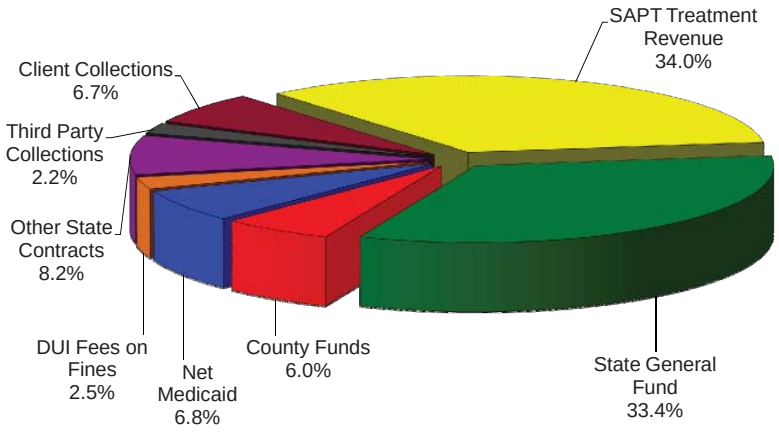
Total Clients Served.....159
Adult 133
Youth.....26
Penetration Rate (Total population of area)..1.1%

Total Admissions.....98
Initial Admissions 98
Transfers.....0

Admissions into Modalities
Fiscal Year 2013



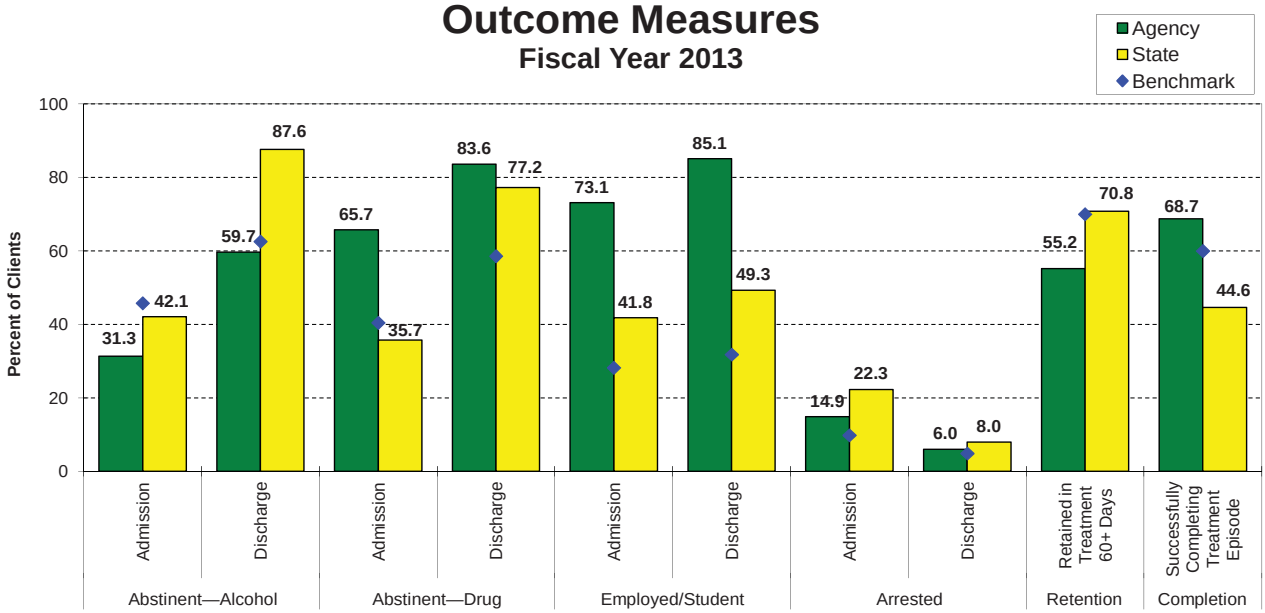
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	39	14	53
Cocaine/Crack	2	0	2
Marijuana/Hashish	17	8	25
Heroin	0	0	0
Other Opiates/Synthetics	2	1	3
Hallucinogens	0	0	0
Methamphetamine	6	3	9
Other Stimulants	0	0	0
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	1	3
Club Drugs	1	0	1
Over-the-Counter	0	0	0
Other	0	1	1
Total	**70**	**28**	**98**

Outcome Measures
Fiscal Year 2013



Benchmark is 75% of the National Average.

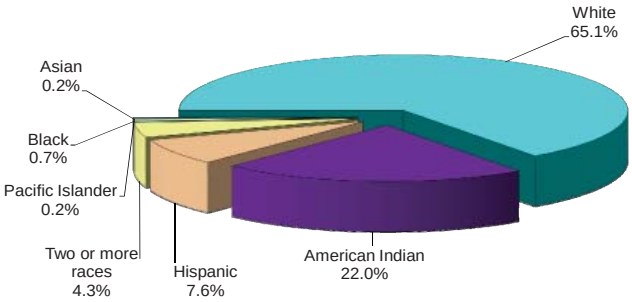
San Juan Counseling—Mental Health

Total Clients Served.....537
Adult 406
Youth.....131
Penetration Rate (Total population of area)..... 3.6%
Civil Commitment 1
Unfunded Clients Served.....133

Diagnosis

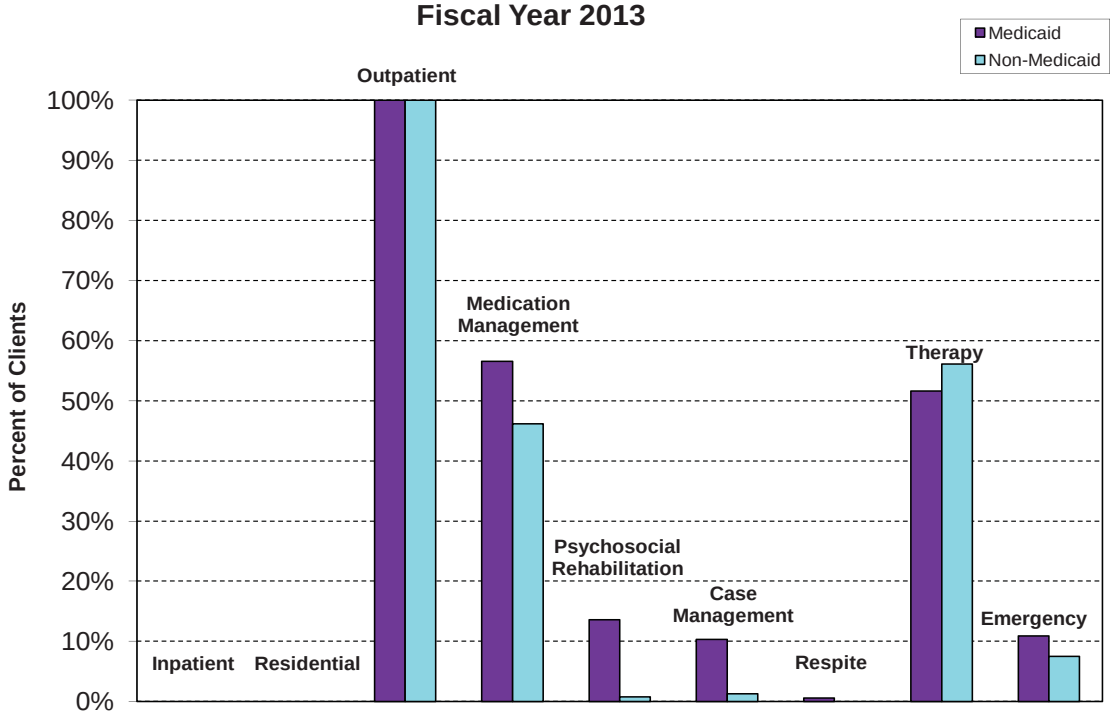
	Youth	Adult
Adjustment Disorder	32	16
Anxiety	21	124
Attention Deficit	40	23
Cognitive Disorder	1	31
Conduct Disorder	0	0
Depression	13	159
Impulse Control Disorders	6	1
Mood Disorder	23	78
Neglect or Abuse	4	3
Oppositional Defiant Disorder	3	2
Personality Disorder	0	18
Pervasive Developmental Disorders	10	6
Schizophrenia and Other Psychotic	0	16
Substance Abuse	0	22
Other	5	12
V Codes	6	17
Total	164	528

Race/Ethnicity
Fiscal Year 2013



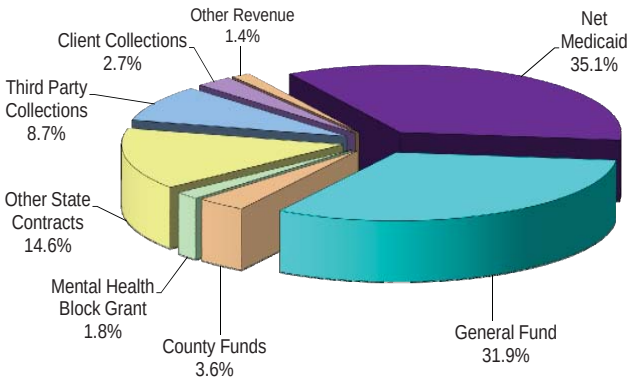
More than one race/ethnicity may have been selected.

Utilization of Mandated Services
Fiscal Year 2013

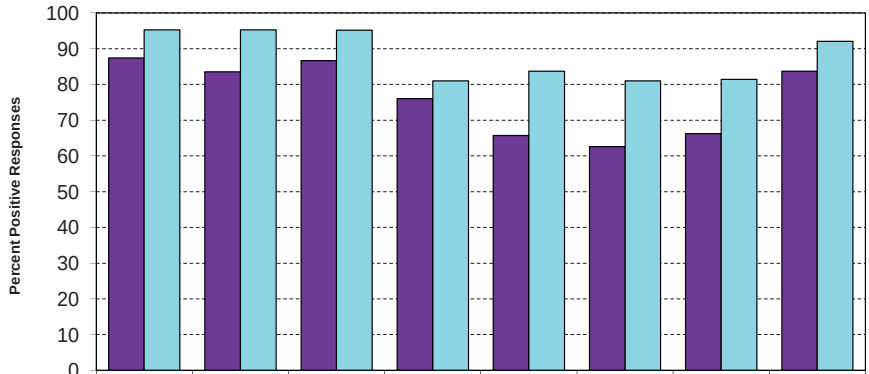


San Juan Counseling—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

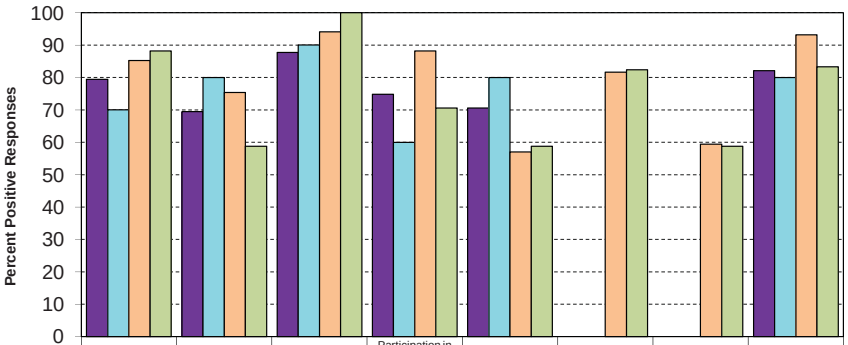


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	95.3	95.3	95.2	81.0	83.7	81.0	81.4	92.1

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	70.0	80.0	90.0	60.0	80.0			80.0
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	88.2	58.8	100.0	70.6	58.8	82.4	58.8	83.3

Southwest Behavioral Health Center

Beaver, Garfield, Iron, Kane, and Washington Counties

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

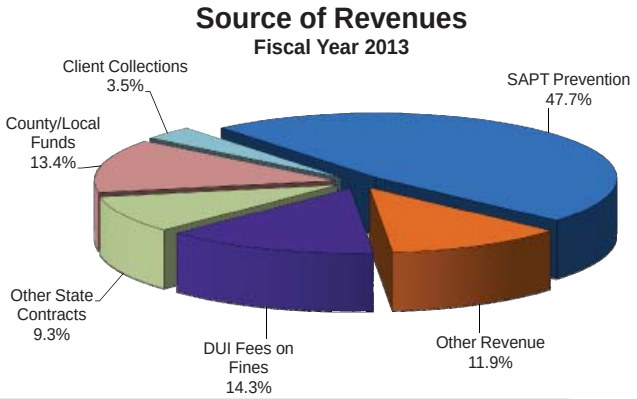
Population: 210,376

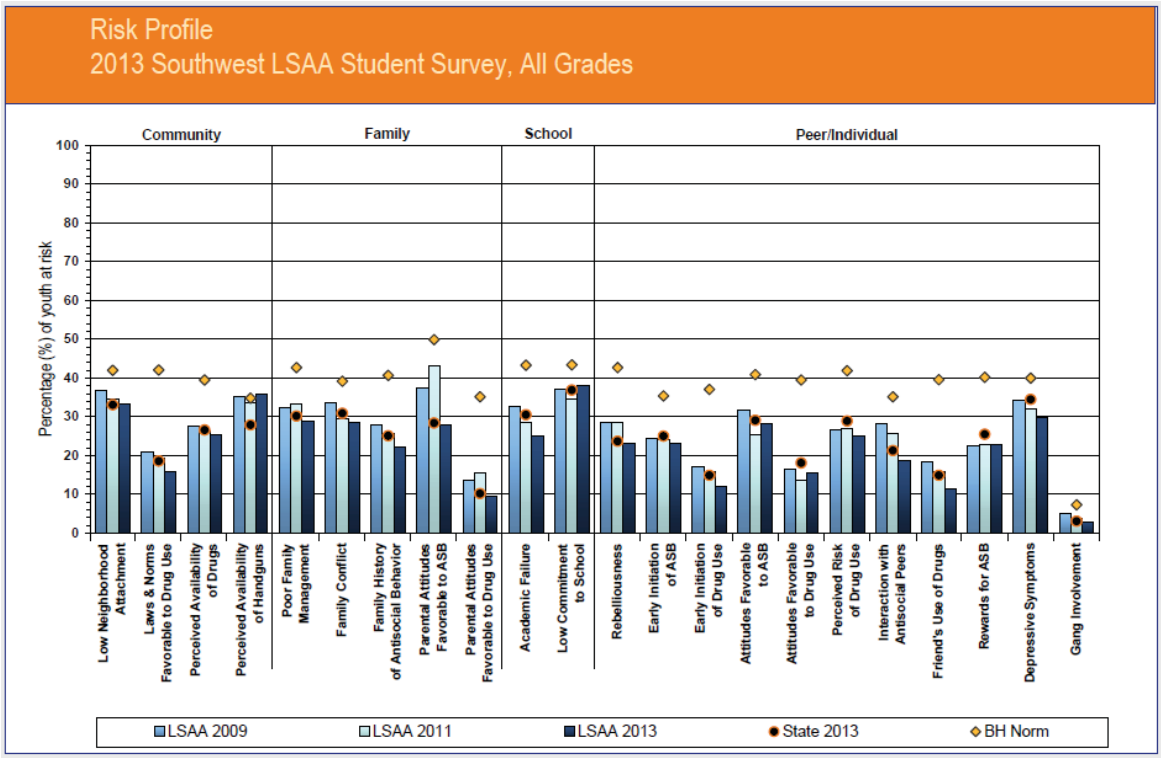
Southwest Substance Abuse—Prevention

Prioritized Risk Factors: Favorable to antisocial behavior, family conflict, early initiation of antisocial behavior, attitudes favorable to antisocial behavior

Coalitions:

- Washington County Prevention Coalition
- Beaver County Prevention Coalition
- Garfield County Prevention Coalition



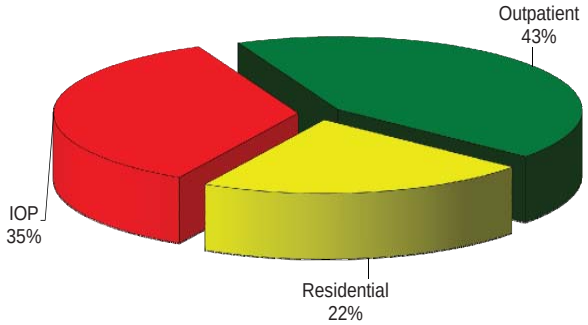


Southwest Behavioral Health Center—Substance Abuse

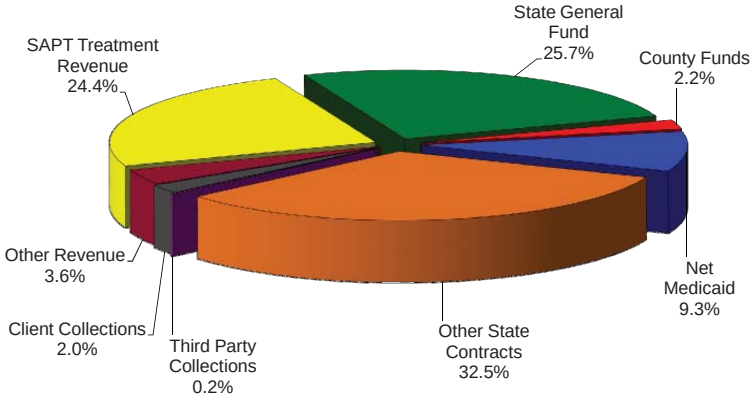
Total Clients Served.....556
Adult 516
Youth.....40
Penetration Rate (Total population of area)..0.3%

Total Admissions.....547
Initial Admissions 349
Transfers.....198

Admissions into Modalities
Fiscal Year 2013



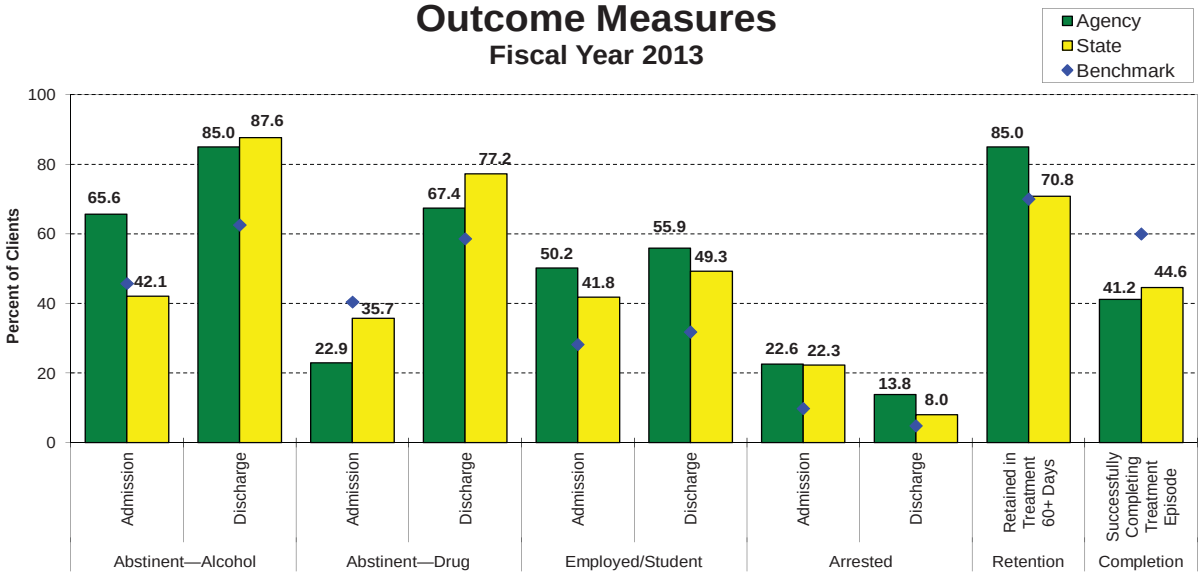
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	74	43	117
Cocaine/Crack	3	4	7
Marijuana/Hashish	50	16	66
Heroin	80	54	134
Other Opiates/Synthetics	27	11	38
Hallucinogens	0	0	0
Methamphetamine	59	91	150
Other Stimulants	5	2	7
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	10	17	27
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	308	239	547

Outcome Measures
Fiscal Year 2013



Benchmark is 75% of the National Average.

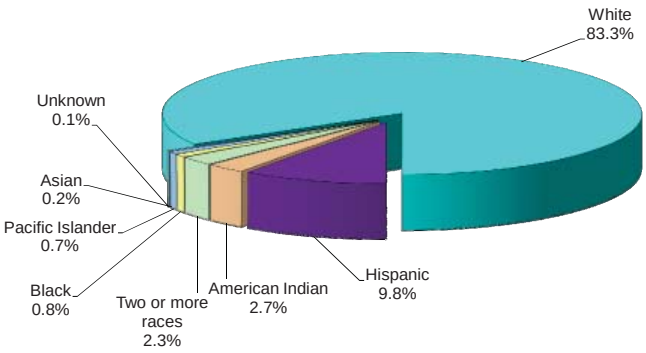
Southwest Behavioral Health Center—Mental Health

Total Clients Served.....2,615
Adult 1,180
Youth.....1,435
Penetration Rate (Total population of area)..... 1.2%
Civil Commitment 48
Unfunded Clients Served.....259

Diagnosis

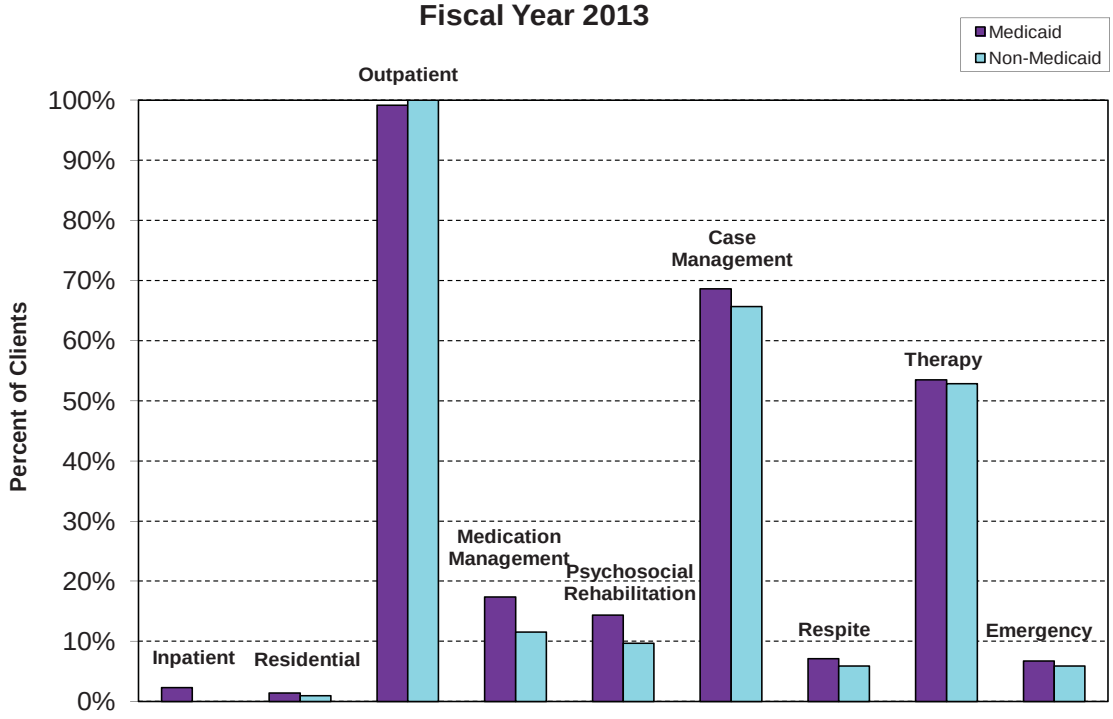
	Youth	Adult
Adjustment Disorder	332	111
Anxiety	492	431
Attention Deficit	255	37
Cognitive Disorder	23	79
Conduct Disorder	35	0
Depression	155	252
Impulse Control Disorders	176	20
Mood Disorder	251	521
Neglect or Abuse	229	33
Oppositional Defiant Disorder	97	1
Personality Disorder	31	375
Pervasive Developmental Disorders	118	28
Schizophrenia and Other Psychotic	6	199
Substance Abuse	136	295
Other	142	37
V Codes	417	142
Total	2,895	2,561

Race/Ethnicity
Fiscal Year 2013



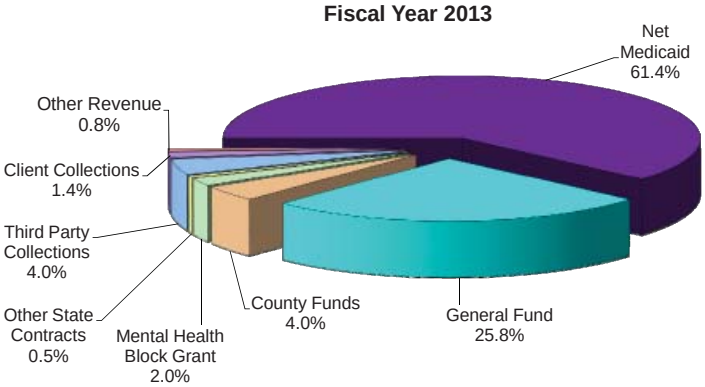
More than one race/ethnicity may have been selected.

Utilization of Mandated Services
Fiscal Year 2013

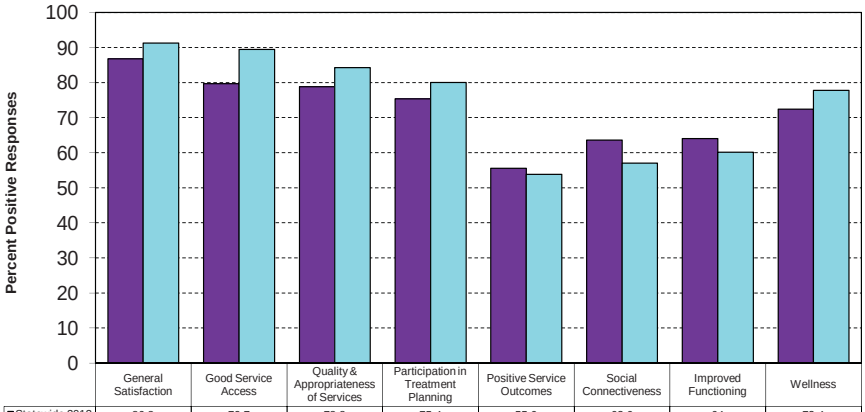


Southwest Behavioral Health Center—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

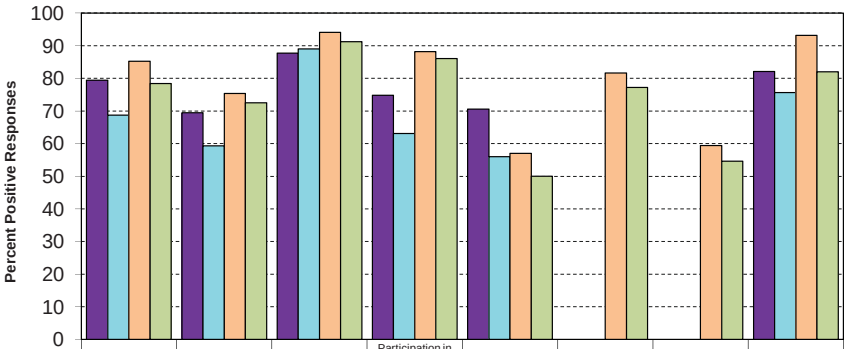


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2012	86.8	79.7	78.8	75.4	55.6	63.6	64	72.4
Center 2012	91.3	89.5	84.3	80	53.8	57	60.1	77.8

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	68.7	59.3	89.0	63.1	56.0			75.6
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	78.4	72.5	91.2	86.1	50.0	77.2	54.6	82.0

Summit County

Substance Abuse and Mental Health Provider Agency:

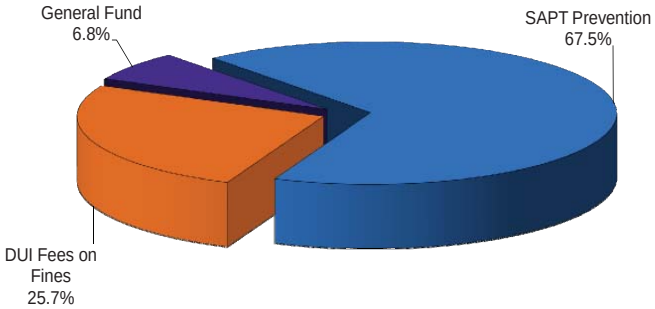
Gary Larcenaire, CEO/President
Victoria Delheimer, County Program Manager
Valley Mental Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157
www.valleymentalhealth.org/summit_county

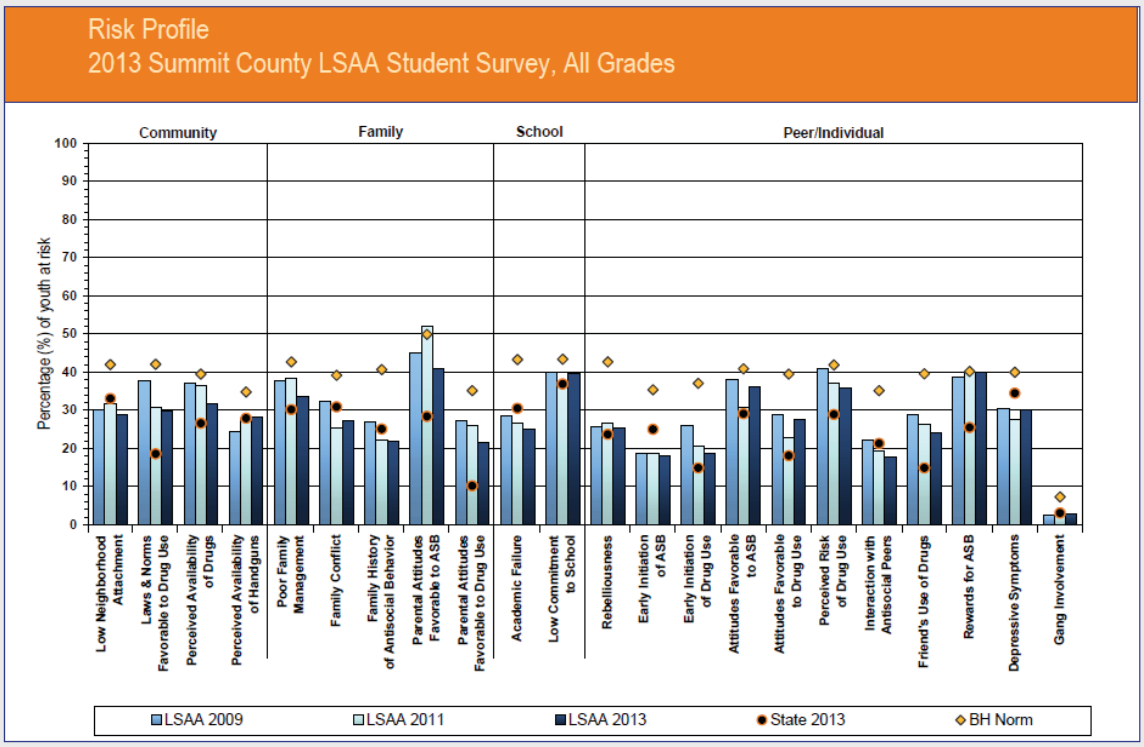
Population: 38,003

Summit Substance Abuse—Prevention

Prioritized Risk Factors: favorable to antisocial behavior, rewards for antisocial behavior

Source of Revenues
Fiscal Year 2013



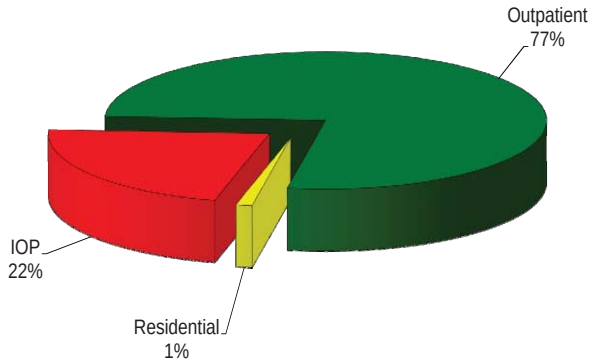


Summit County - Valley Mental Health - Substance Abuse

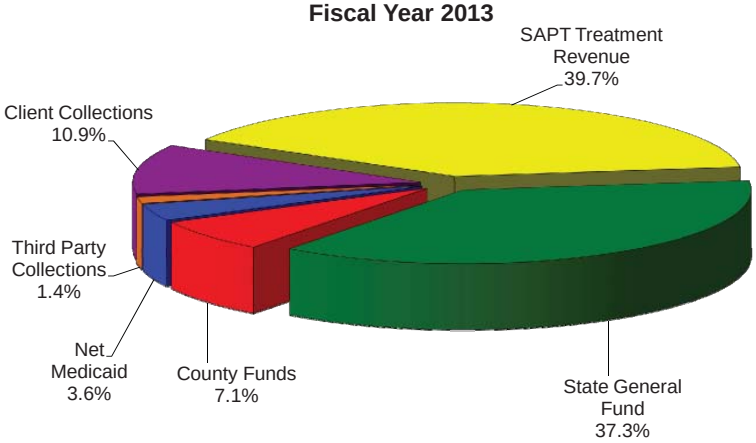
Total Clients Served.....344
Adult 304
Youth.....40
Penetration Rate (Total population of area)..0.9%

Total Admissions.....255
Initial Admissions 229
Transfers.....26

Admissions into Modalities
Fiscal Year 2013



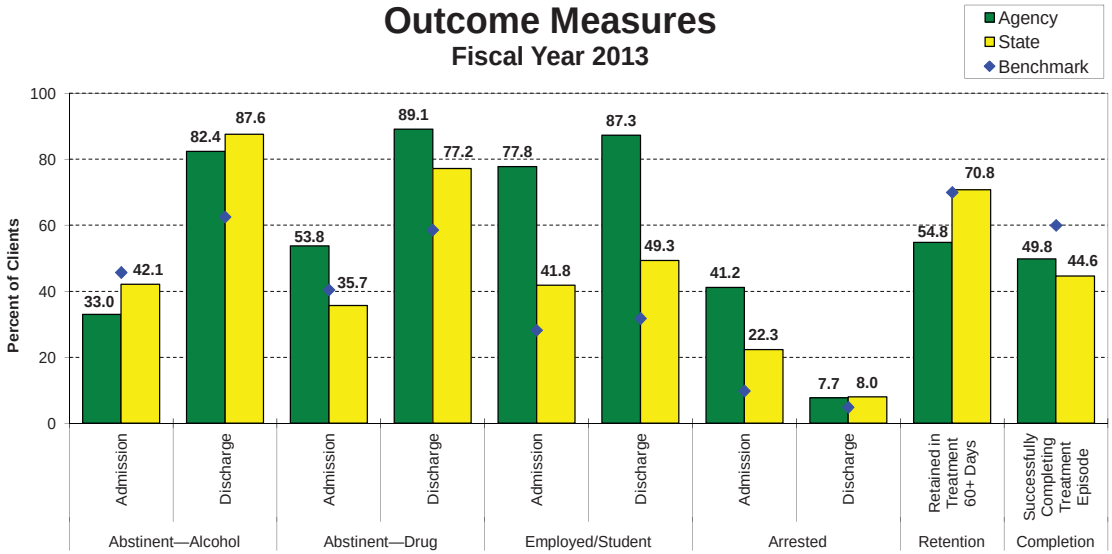
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	114	42	156
Cocaine/Crack	1	1	2
Marijuana/Hashish	63	3	66
Heroin	4	3	7
Other Opiates/Synthetics	3	5	8
Hallucinogens	1	2	3
Methamphetamine	4	2	6
Other Stimulants	1	0	1
Benzodiazepines	0	1	1
Tranquilizers/Sedatives	1	0	1
Inhalants	0	0	0
Oxycodone	2	2	4
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	194	61	255

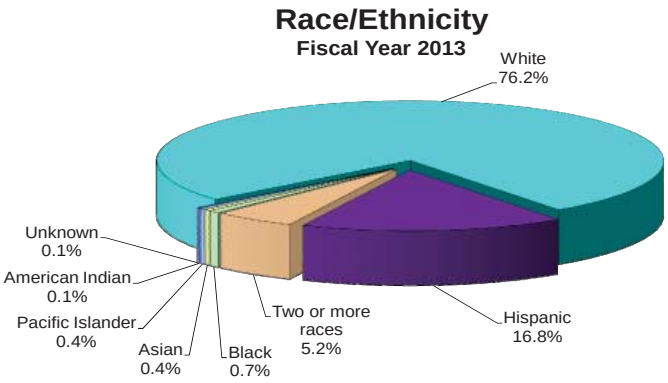
Outcome Measures
Fiscal Year 2013



Benchmark is 75% of the National Average.

Summit County—Valley Mental Health—Mental Health

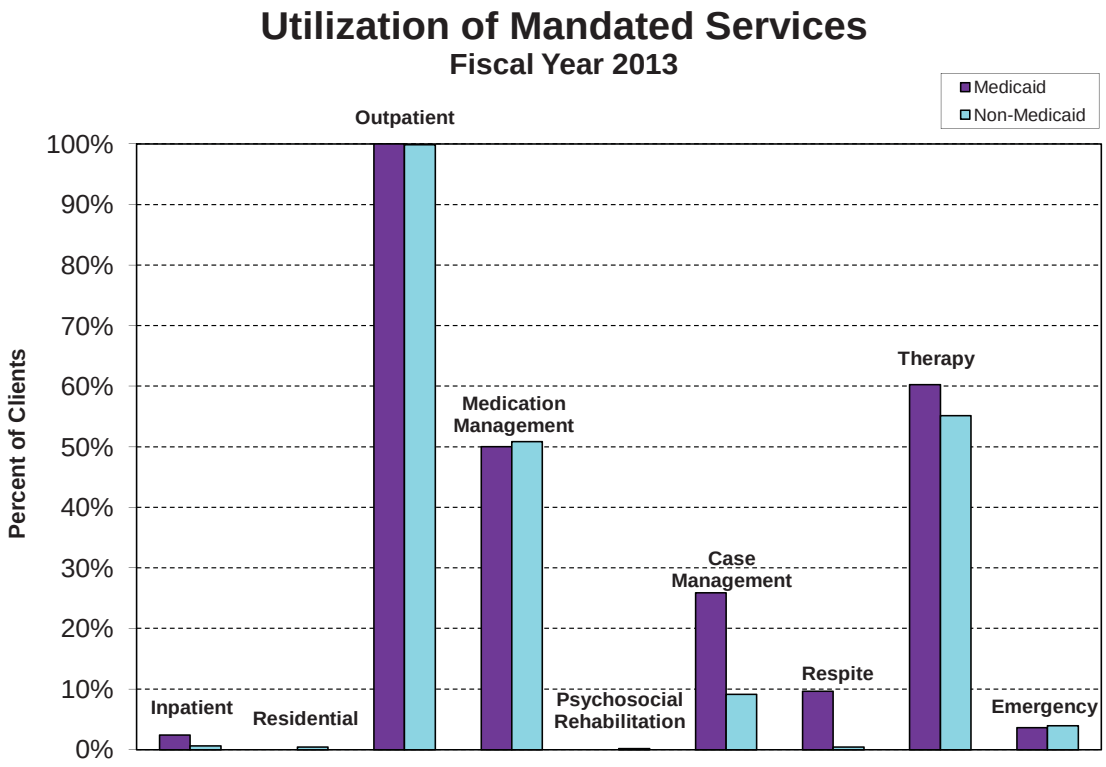
Total Clients Served.....605
Adult 436
Youth.....169
Penetration Rate (Total population of area)..... 1.6%
Civil Commitment 6
Unfunded Clients Served.....77



More than one race/ethnicity may have been selected.

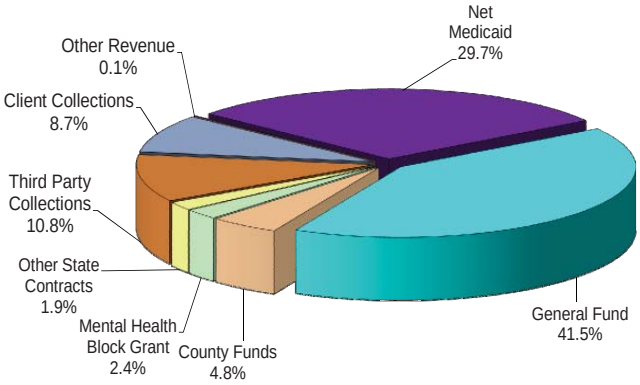
Diagnosis

	Youth	Adult
Adjustment Disorder	28	30
Anxiety	59	257
Attention Deficit	67	63
Cognitive Disorder	2	7
Conduct Disorder	2	0
Depression	16	113
Impulse Control Disorders	9	6
Mood Disorder	46	171
Neglect or Abuse	11	13
Oppositional Defiant Disorder	28	0
Personality Disorder	0	34
Pervasive Developmental Disorders	12	4
Schizophrenia and Other Psychotic	0	10
Substance Abuse	14	140
Other	14	18
V Codes	35	120
Total	343	986

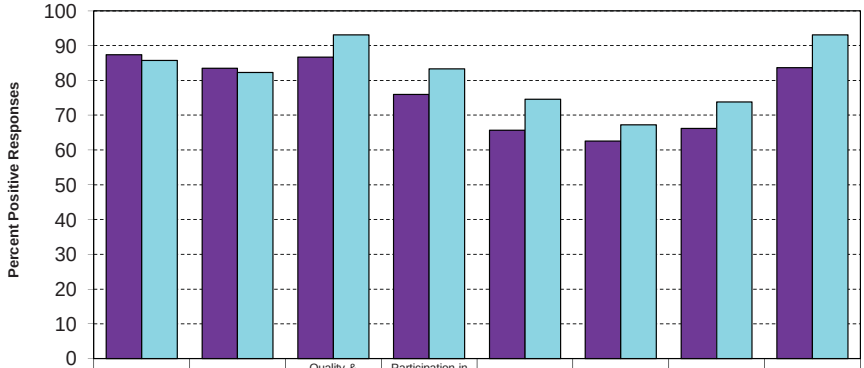


Summit County—Valley Mental Health—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

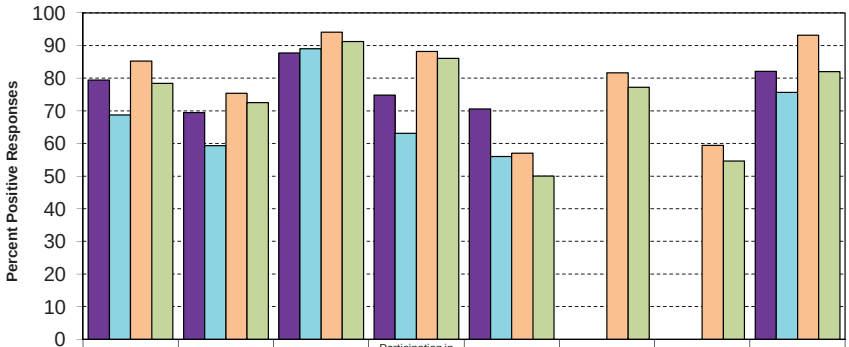


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	85.7	82.3	93.1	83.3	74.6	67.2	73.8	93.1

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	68.7	59.3	89.0	63.1	56.0			75.6
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	78.4	72.5	91.2	86.1	50.0	77.2	54.6	82.0

Tooele County

Substance Abuse and Mental Health Provider Agency:

Gary larcenaire, CEO/President
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

Population: 59,870

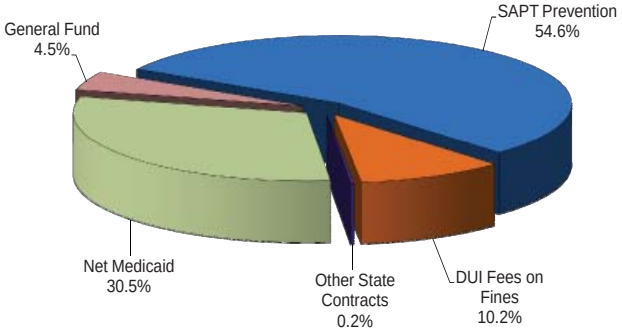
Tooele Substance Abuse—Prevention

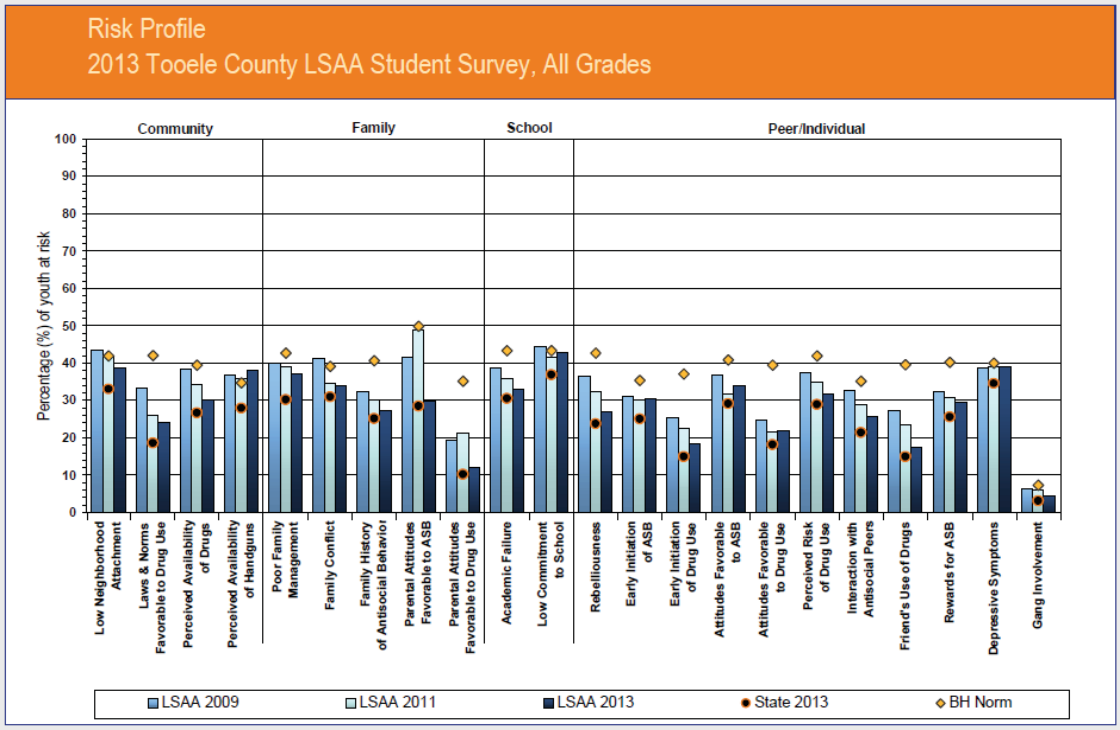
Prioritized Risk Factors: low commitment to school, rewards for antisocial behavior, friends' antisocial behavior, depressive symptoms, family conflict

Coalitions:

- Tooele Communities That Care
- Tooele Interagency Prevention Professionals (TIPP)
- Tooele County Domestic Violence Coalition

Source of Revenues
Fiscal Year 2013



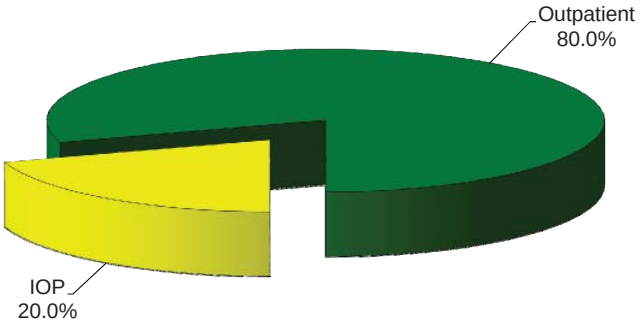


Tooele County—Valley Mental Health—Substance Abuse

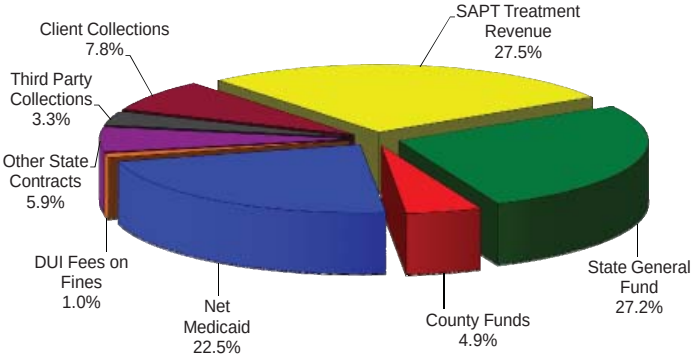
Total Clients Served.....459
Adult 400
Youth.....59
Penetration Rate (Total population of area)..0.8%

Total Admissions.....330
Initial Admissions 302
Transfers.....28

Admissions into Modalities
Fiscal Year 2013



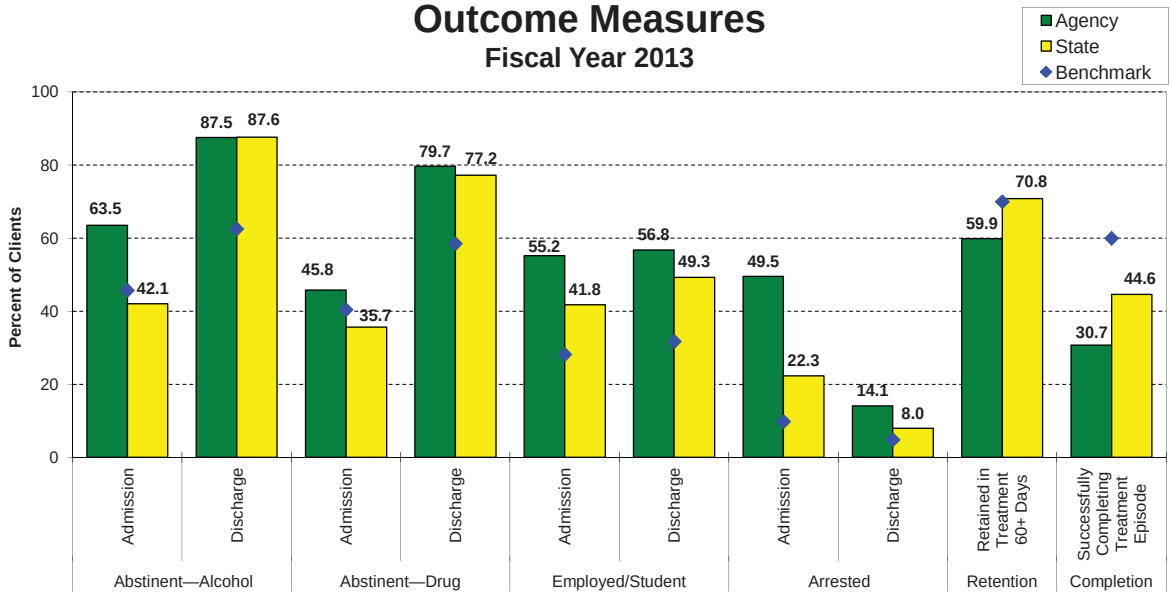
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	80	41	121
Cocaine/Crack	2	2	4
Marijuana/Hashish	65	17	82
Heroin	19	15	34
Other Opiates/Synthetics	6	11	17
Hallucinogens	0	3	3
Methamphetamine	30	30	60
Other Stimulants	0	1	1
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	1	0	1
Inhalants	0	0	0
Oxycodone	1	5	6
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	**205**	**125**	**330**

Outcome Measures
Fiscal Year 2013



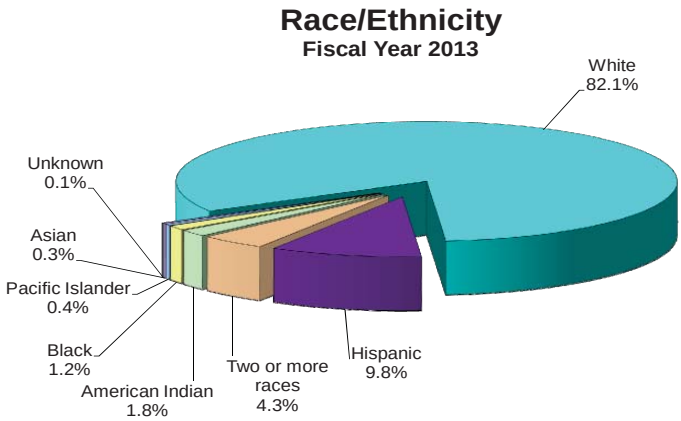
Benchmark is 75% of the National Average.

Tooele County—Valley Mental Health—Mental Health

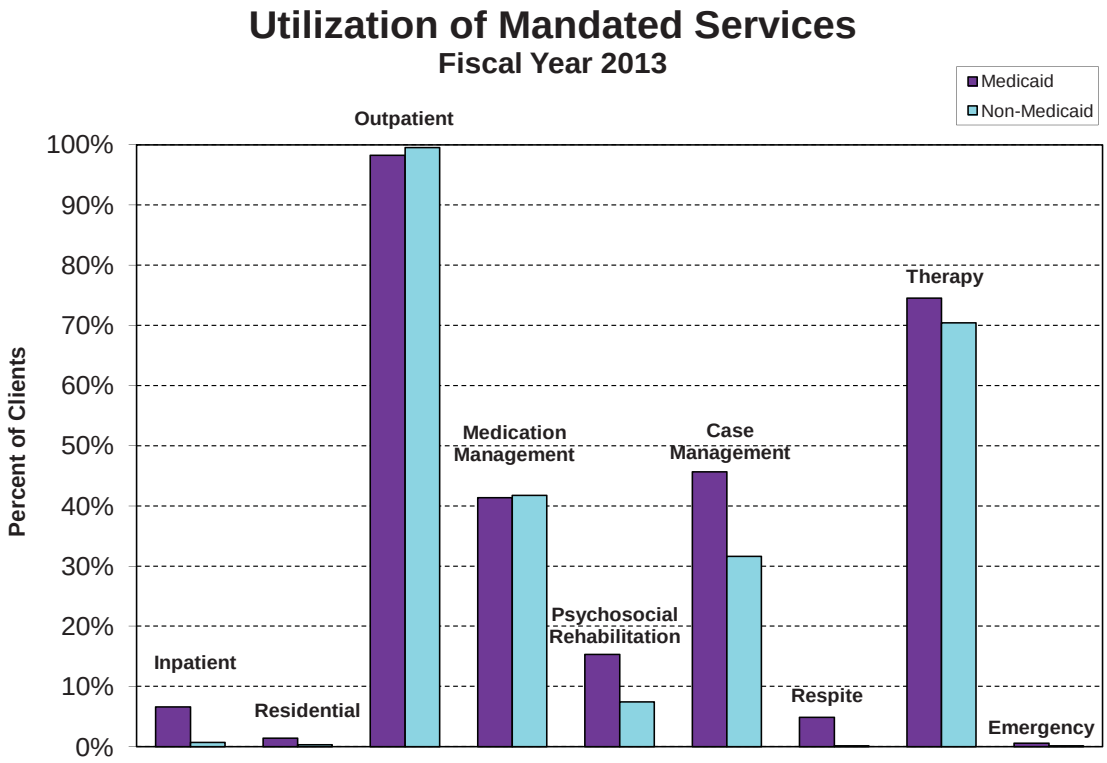
Total Clients Served.....1,690
Adult 1,151
Youth.....539
Penetration Rate (Total population of area)..... 2.8%
Civil Commitment 44
Unfunded Clients Served.....225

Diagnosis

	Youth	Adult
Adjustment Disorder	72	39
Anxiety	225	716
Attention Deficit	170	89
Cognitive Disorder	7	30
Conduct Disorder	14	3
Depression	81	453
Impulse Control Disorders	29	13
Mood Disorder	112	385
Neglect or Abuse	136	34
Oppositional Defiant Disorder	76	2
Personality Disorder	8	179
Pervasive Developmental Disorders	35	17
Schizophrenia and Other Psychotic	0	71
Substance Abuse	45	426
Other	53	53
V Codes	191	281
Total	1,254	2,791

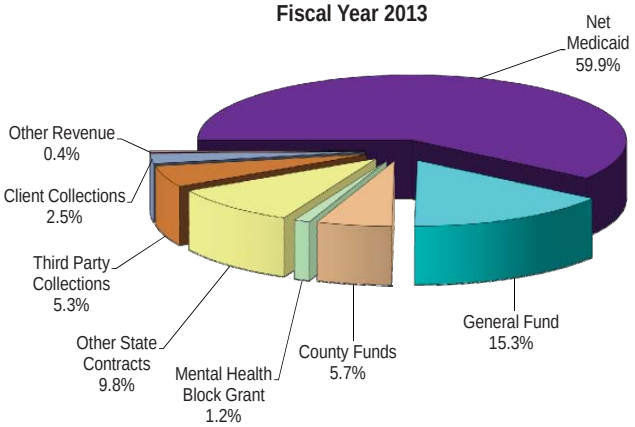


More than one race/ethnicity may have been selected.

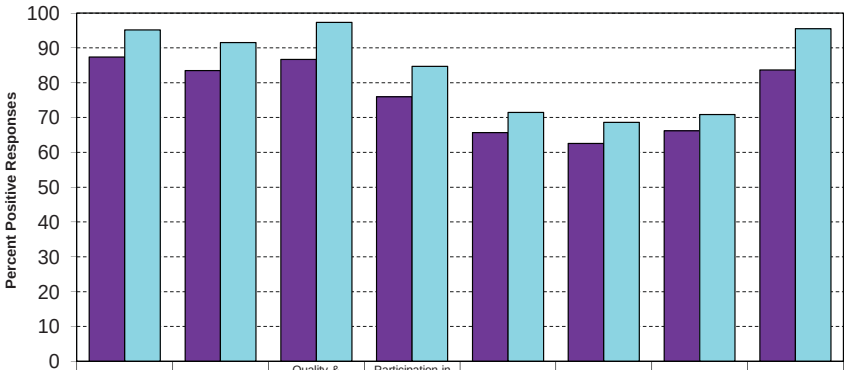


Tooele County—Valley Mental Health—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

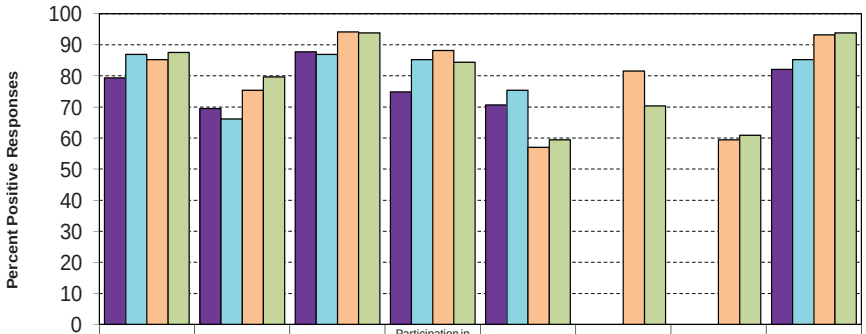


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	95.2	91.5	97.3	84.7	71.5	68.6	70.9	95.5

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	86.9	66.1	86.9	85.2	75.4			85.2
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	87.5	79.7	93.8	84.4	59.4	70.3	60.9	93.8

Utah County

Substance Abuse Provider Agency:
Richard Nance, Director
Utah County Department of Drug and Alcohol Prevention and Treatment
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 Freedom Blvd., Ste 300
Provo, UT 84601
Office: (801) 852-4703 www.wasatch.org

Population: 540,504

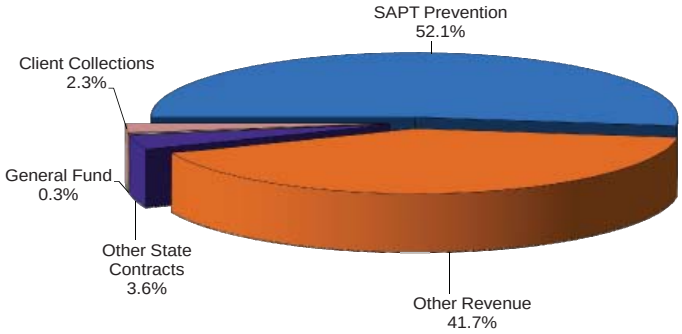
Utah County—Prevention

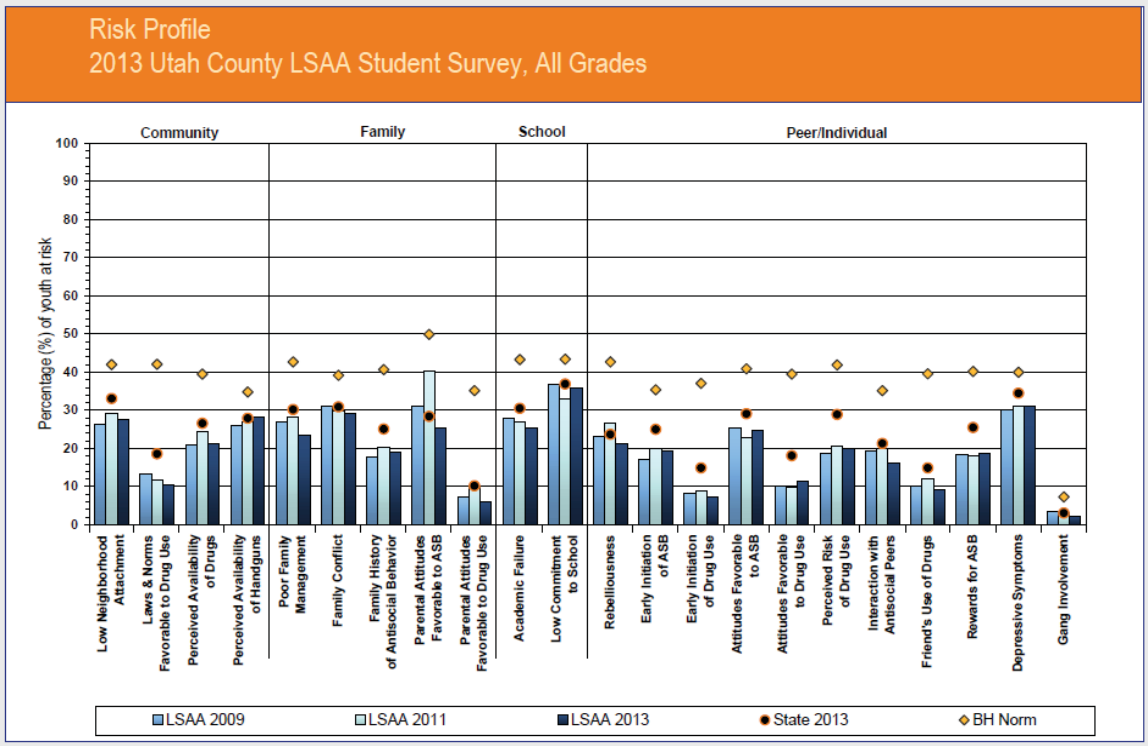
Prioritized Risk Factors: parental attitudes favorable to antisocial behavior

Coalitions:

- Utah County
- Springville City
- Payson City
- Saratoga Springs and Eagle Mountain

Source of Revenues
Fiscal Year 2013



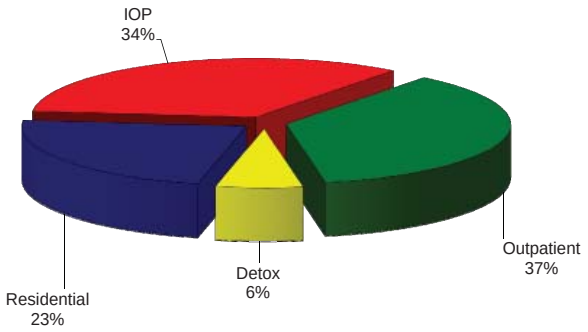


Utah County—Substance Abuse

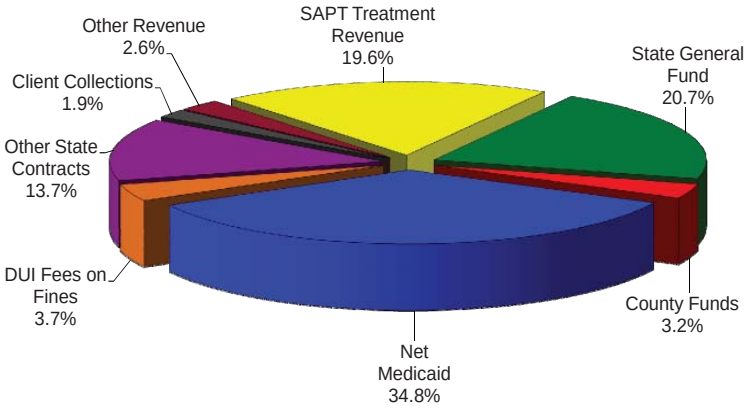
Total Clients Served.....964
Adult 936
Youth.....28
Penetration Rate (Total population of area)..0.2%

Total Admissions.....1,134
Initial Admissions 393
Transfers.....741

Admissions into Modalities
Fiscal Year 2013



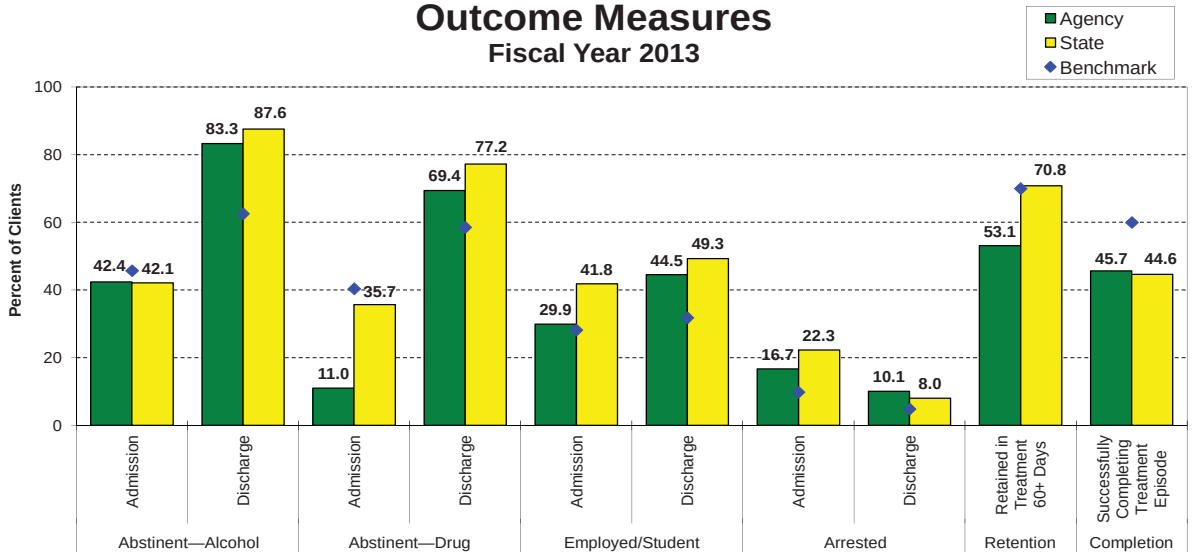
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	330	259	589
Cocaine/Crack	47	40	87
Marijuana/Hashish	66	66	132
Heroin	74	82	156
Other Opiates/Synthetics	9	10	19
Hallucinogens	0	0	0
Methamphetamine	39	58	97
Other Stimulants	1	5	6
Benzodiazepines	1	7	8
Tranquilizers/Sedatives	0	4	4
Inhalants	3	0	3
Oxycodone	11	21	32
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	1	1
Total	581	553	1,134

Outcome Measures
Fiscal Year 2013



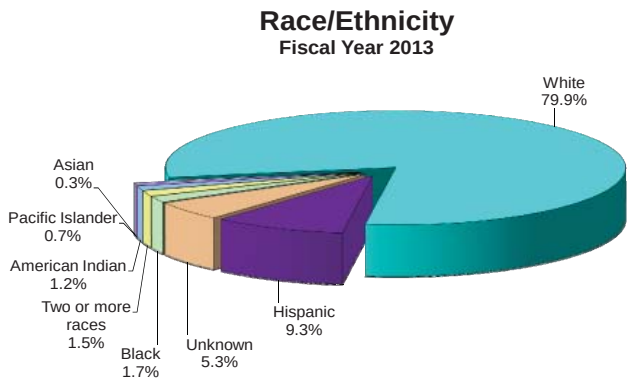
Benchmark is 75% of the National Average.

Utah County—Wasatch Mental Health

Total Clients Served.....7,707
Adult 4,516
Youth.....3,191
Penetration Rate (Total population of area)..... 1.4%
Civil Commitment 184
Unfunded Clients Served 606

Diagnosis

	Youth	Adult
Adjustment Disorder	586	136
Anxiety	1,199	3,058
Attention Deficit	976	616
Cognitive Disorder	79	471
Conduct Disorder	41	5
Depression	296	1,360
Impulse Control Disorders	218	157
Mood Disorder	742	1,519
Neglect or Abuse	521	349
Oppositional Defiant Disorder	370	28
Personality Disorder	13	718
Pervasive Developmental Disorders	454	194
Schizophrenia and Other Psychotic	7	639
Substance Abuse	47	266
Other	336	401
V Codes	965	581
Total	6,850	10,498



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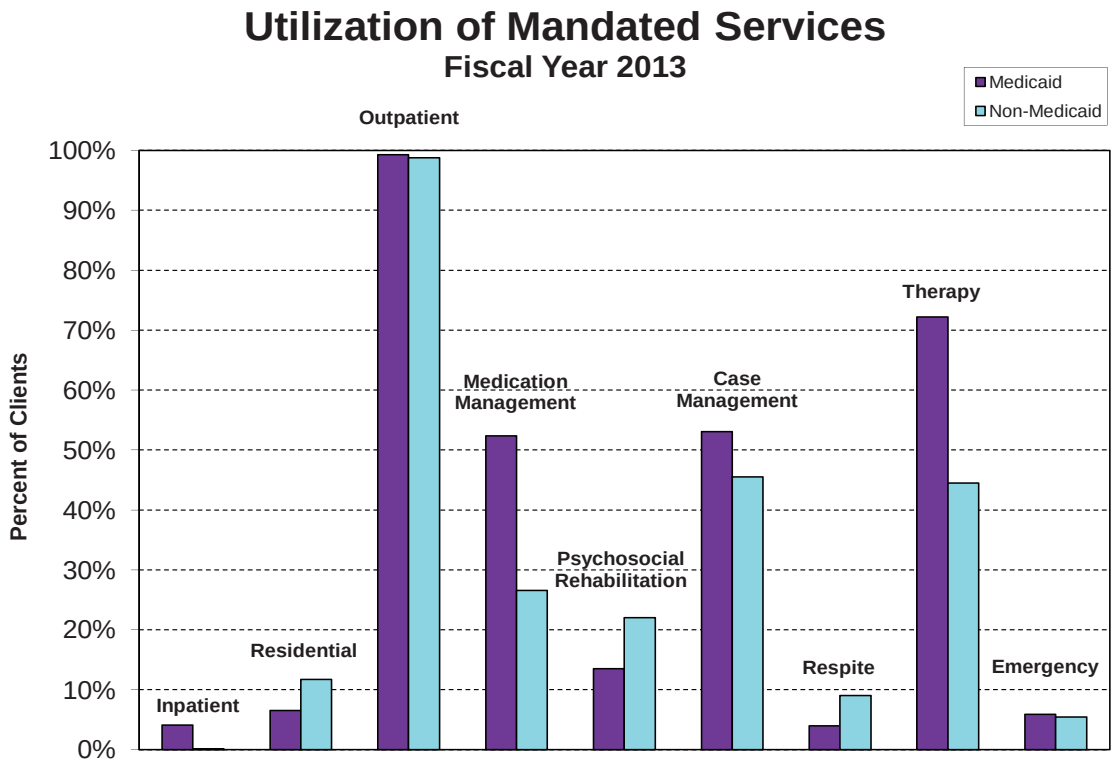
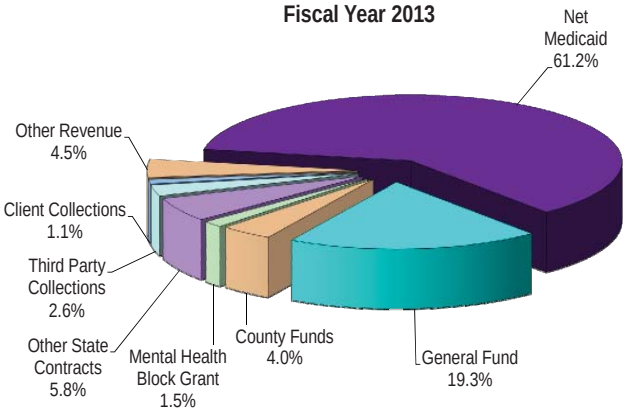
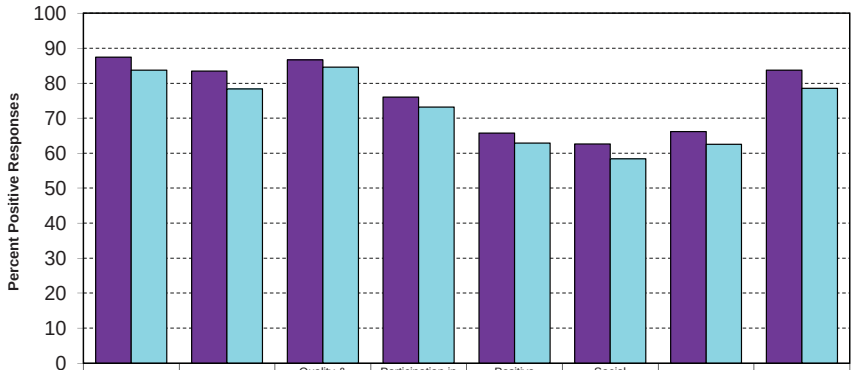


Utah County—Wasatch Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

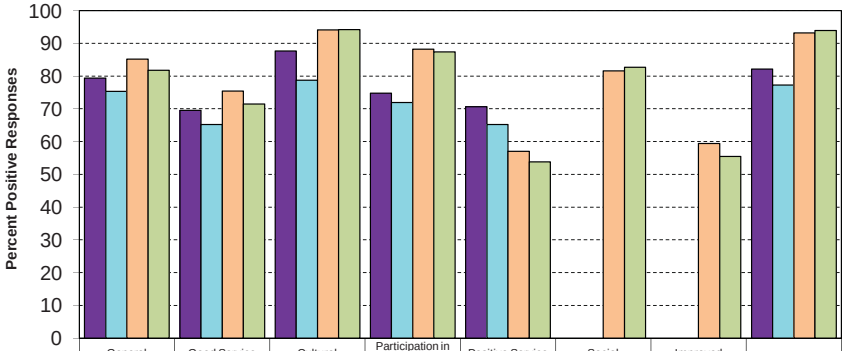


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	83.7	78.4	84.6	73.2	62.9	58.4	62.5	78.5

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	75.3	65.2	78.7	71.9	65.2			77.3
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	81.8	71.5	94.2	87.4	53.8	82.7	55.5	93.9

Wasatch County

Substance Abuse and Mental Health Provider Agency:
Richard Hatch, Director
Wasatch County Family Clinic
55 South 500 East
Heber, UT 84032
Office: (435) 654-3003
www.wasatch.org

Population: 25,273

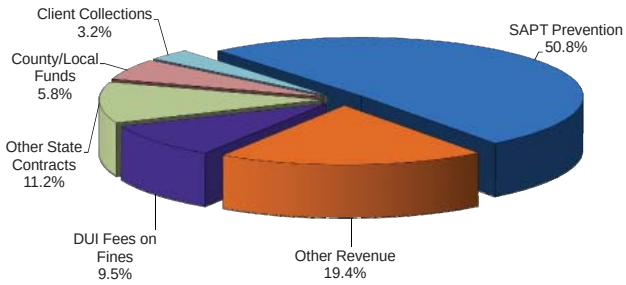
Wasatch County Substance Abuse—Prevention

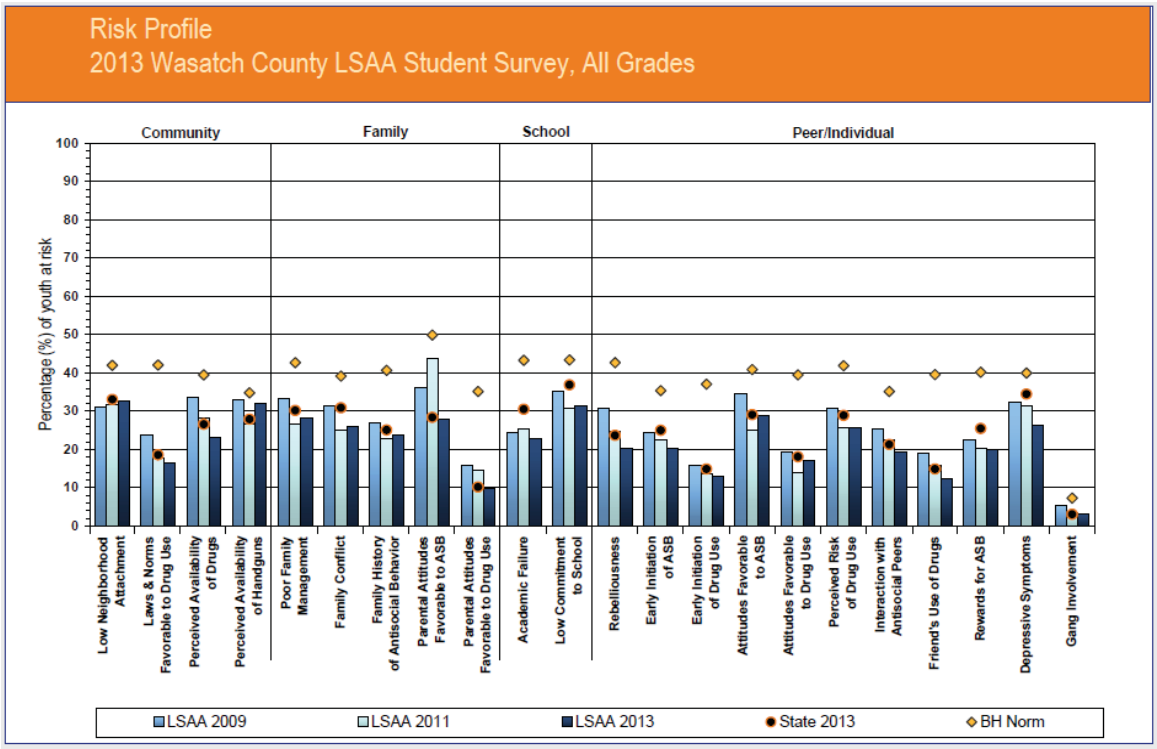
Prioritized Risk Factors: attitudes favorable to antisocial behavior. perceived risk of substance abuse. parental attitudes favorable to antisocial behavior

Coalitions:

- Safe Kids Coalition
- Caring Community Coalition

Source of Revenues
Fiscal Year 2013



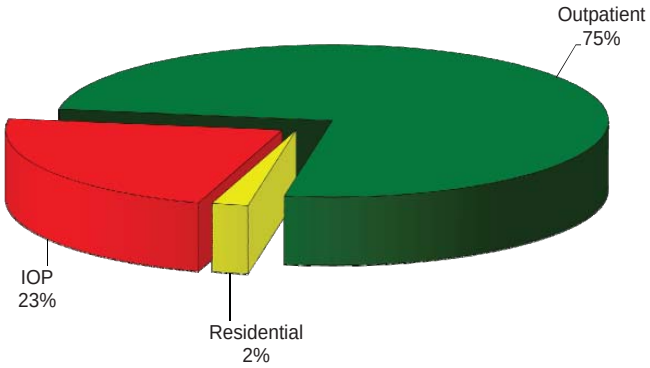


Wasatch County—Substance Abuse

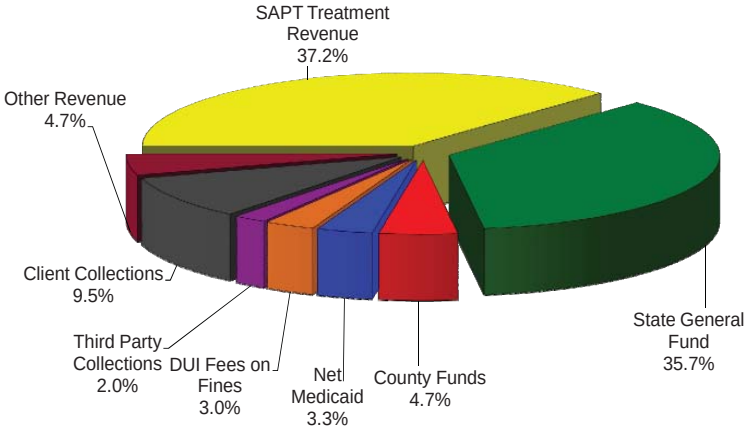
Total Clients Served.....143
Adult 129
Youth.....14
Penetration Rate (Total population of area)..0.6%

Total Admissions.....142
Initial Admissions 114
Transfers.....28

Admissions into Modalities
Fiscal Year 2013



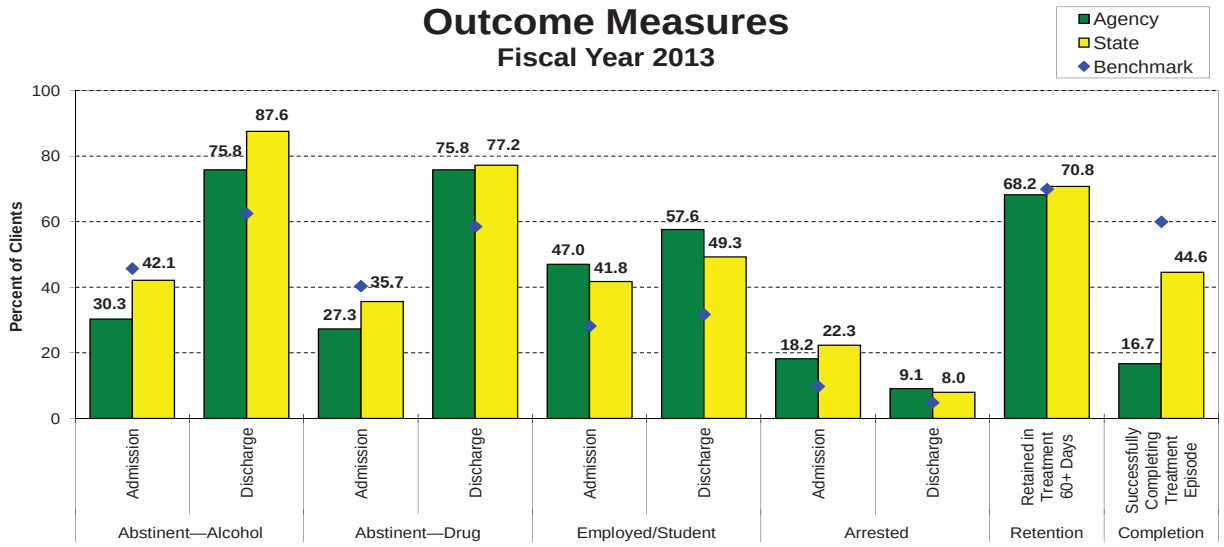
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	48	28	76
Cocaine/Crack	1	2	3
Marijuana/Hashish	20	16	36
Heroin	4	1	5
Other Opiates/Synthetics	1	1	2
Hallucinogens	0	0	0
Methamphetamine	4	7	11
Other Stimulants	0	0	0
Benzodiazepines	0	2	2
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	3	1	4
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	1	1
Unknown	2	0	2
Total	**83**	**59**	**142**

Outcome Measures
Fiscal Year 2013

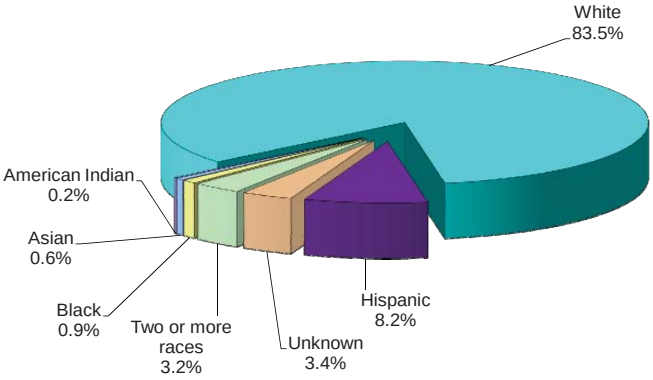


Benchmark is 75% of the National Average.

Wasatch County—Mental Health

Total Clients Served.....484
Adult 324
Youth.....160
Penetration Rate (Total population of area)..... 1.9%
Civil Commitment 1
Unfunded Clients Served 198

Race/Ethnicity
Fiscal Year 2013

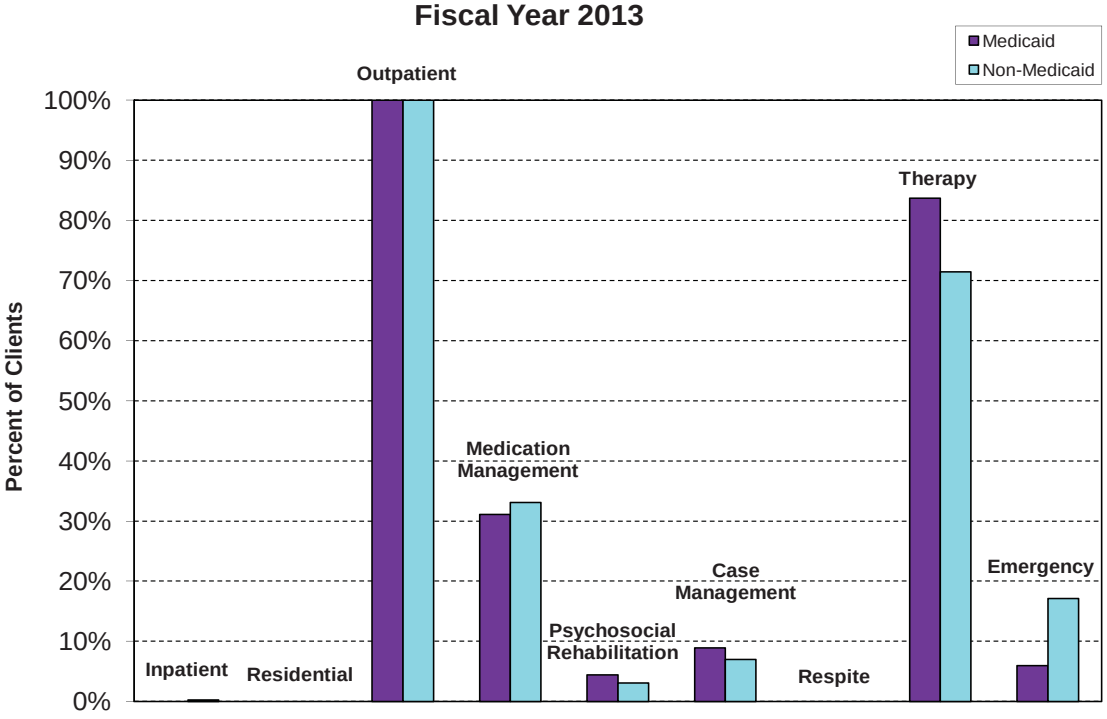


More than one race/ethnicity may have been selected.

Diagnosis

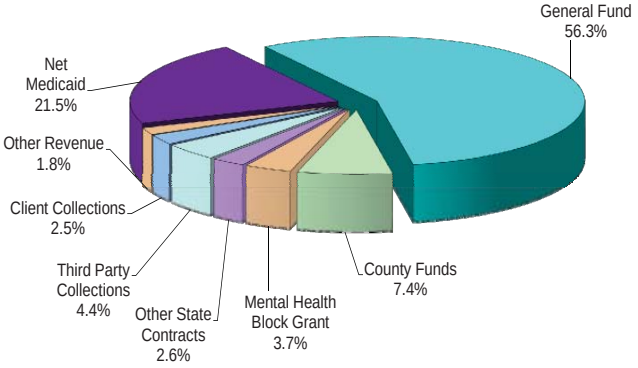
	Youth	Adult
Adjustment Disorder	39	26
Anxiety	63	320
Attention Deficit	43	16
Cognitive Disorder	1	4
Conduct Disorder	1	0
Depression	21	145
Impulse Control Disorders	15	11
Mood Disorder	39	131
Neglect or Abuse	29	7
Oppositional Defiant Disorder	11	0
Personality Disorder	1	42
Pervasive Developmental Disorders	11	1
Schizophrenia and Other Psychotic	0	40
Substance Abuse	15	91
Other	8	14
V Codes	36	57
Total	333	905

Utilization of Mandated Services
Fiscal Year 2013

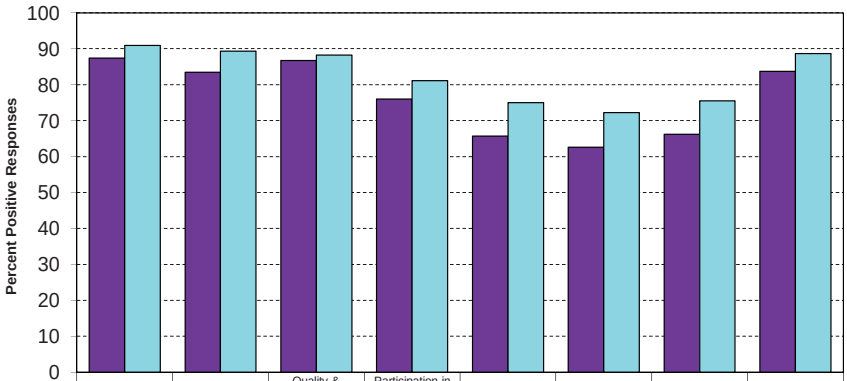


Wasatch County—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013

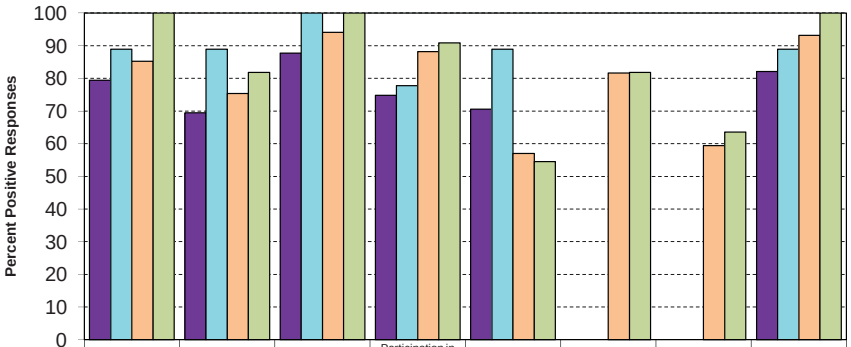


Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



	General Satisfaction	Good Service Access	Quality & Appropriateness of Services	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide 2013	87.4	83.5	86.7	76.0	65.7	62.6	66.2	83.7
Center 2013	90.9	89.3	88.2	81.1	75.0	72.2	75.5	88.7

Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	88.9	88.9	100	77.8	88.9			88.9
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	100	81.8	100	90.9	54.5	81.8	63.6	100

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

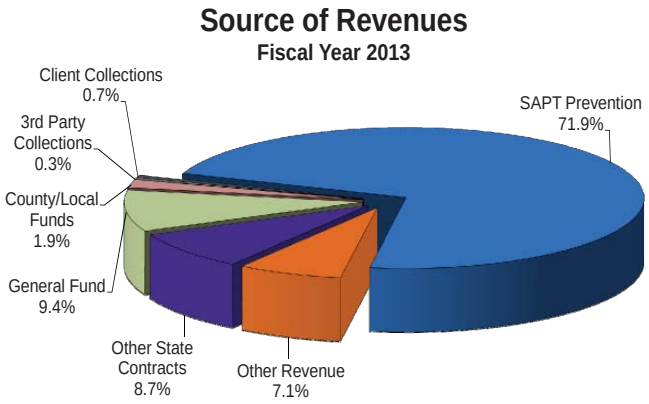
Population: 246,461

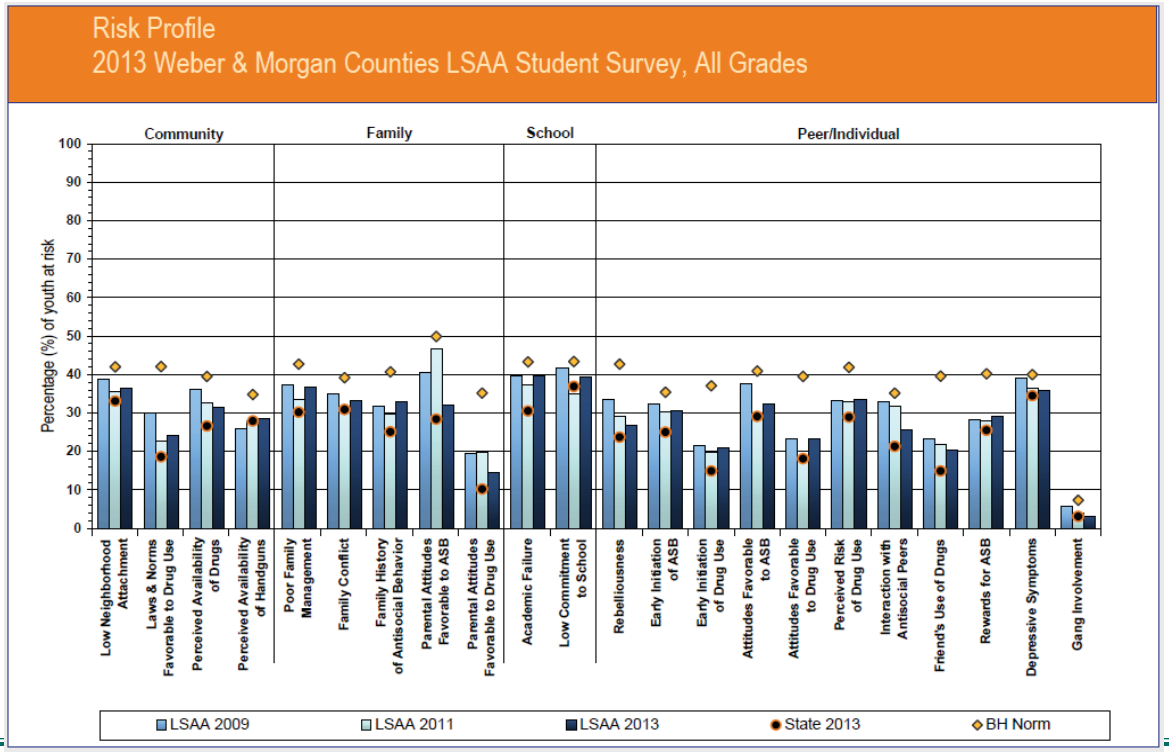
Weber Substance Abuse—Prevention

Prioritized Risk Factors: parental and individual attitudes favorable to antisocial behavior, underage drinking, poor family management, and perception of risk of drug use

Coalitions:

- Coalition of Resources
- Morgan Empowered
- Weber Morgan SPF Coalition
- Weber Morgan PAC
- Bonneville Cone CTC
- Ogden Area Youth Alliance
- Weber Coalition for a Healthy Community



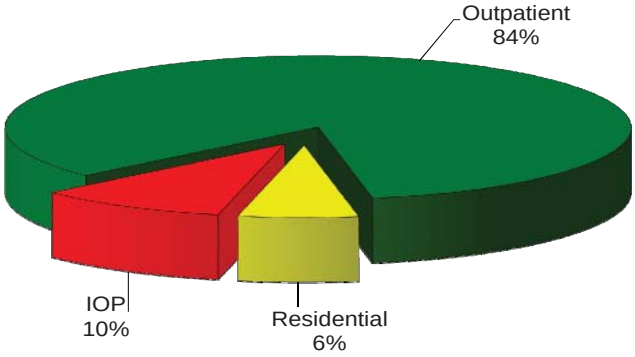


Weber Human Services—Substance Abuse

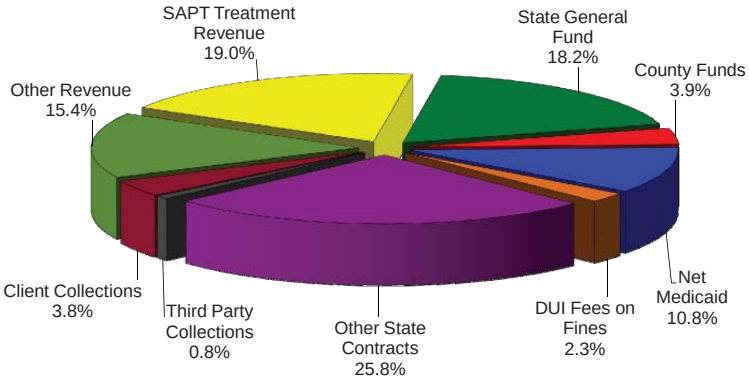
Total Clients Served.....1,391
Adult 1,151
Youth.....240
Penetration Rate (Total population of area)..0.6%

Total Admissions.....1,053
Initial Admissions 777
Transfers.....276

Admission into Modalities
Fiscal Year 2013



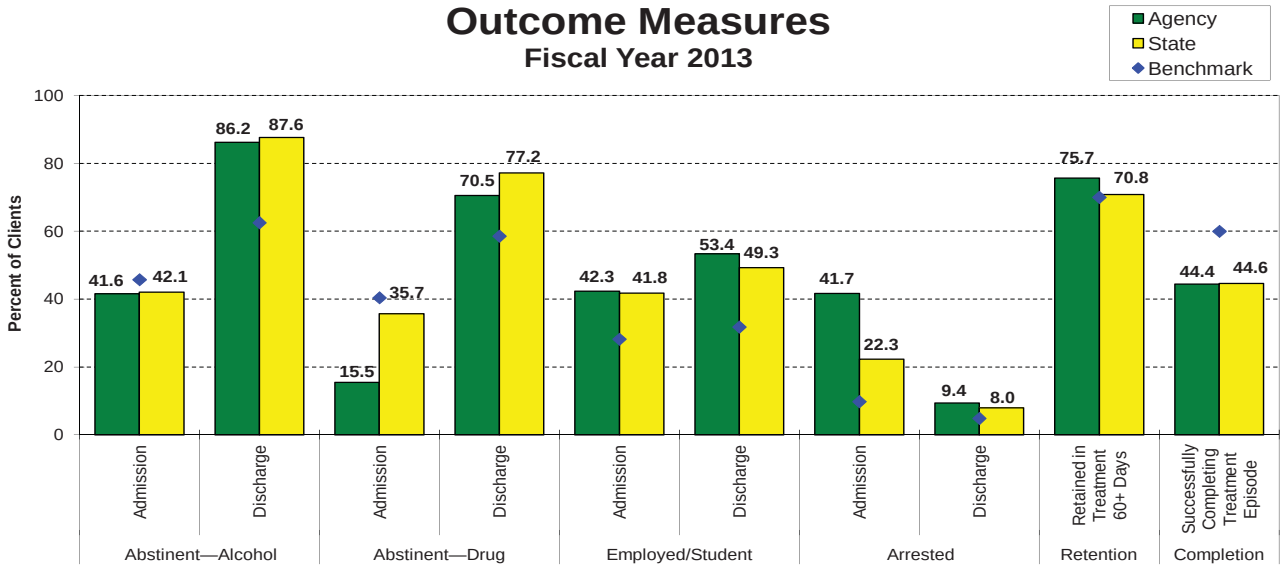
Source of Revenues
Fiscal Year 2013



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	245	231	476
Cocaine/Crack	12	25	37
Marijuana/Hashish	153	104	257
Heroin	19	29	48
Other Opiates/Synthetics	2	11	13
Hallucinogens	1	2	3
Methamphetamine	57	100	157
Other Stimulants	1	1	2
Benzodiazepines	3	6	9
Tranquilizers/Sedatives	1	0	1
Inhalants	1	1	2
Oxycodone	14	22	36
Club Drugs	0	3	3
Over-the-Counter	1	1	2
Other	6	1	7
Unknown	0	0	0
Total	**516**	**537**	**1,053**

Outcome Measures
Fiscal Year 2013



Benchmark is 75% of the National Average.

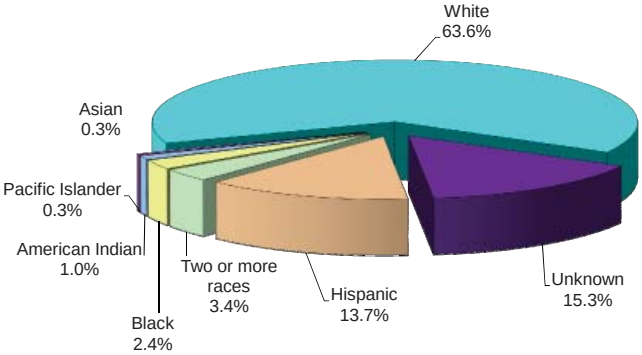
Weber Human Services—Mental Health

Total Clients Served.....5,613
Adult 4,102
Youth.....1,511
Penetration Rate (Total population of area)..... 2.3%
Civil Commitment 236
Unfunded Clients Served 1,636

Diagnosis

	Youth	Adult
Adjustment Disorder	134	73
Anxiety	440	1,084
Attention Deficit	514	117
Cognitive Disorder	51	165
Conduct Disorder	33	3
Depression	45	355
Impulse Control Disorders	291	53
Mood Disorder	431	1,162
Neglect or Abuse	238	82
Oppositional Defiant Disorder	216	9
Personality Disorder	4	554
Pervasive Developmental Disorders	183	40
Schizophrenia and Other Psychotic	6	395
Substance Abuse	79	655
Other	148	64
V Codes	426	364
Total	3,239	5,175

Race/Ethnicity
Fiscal Year 2013



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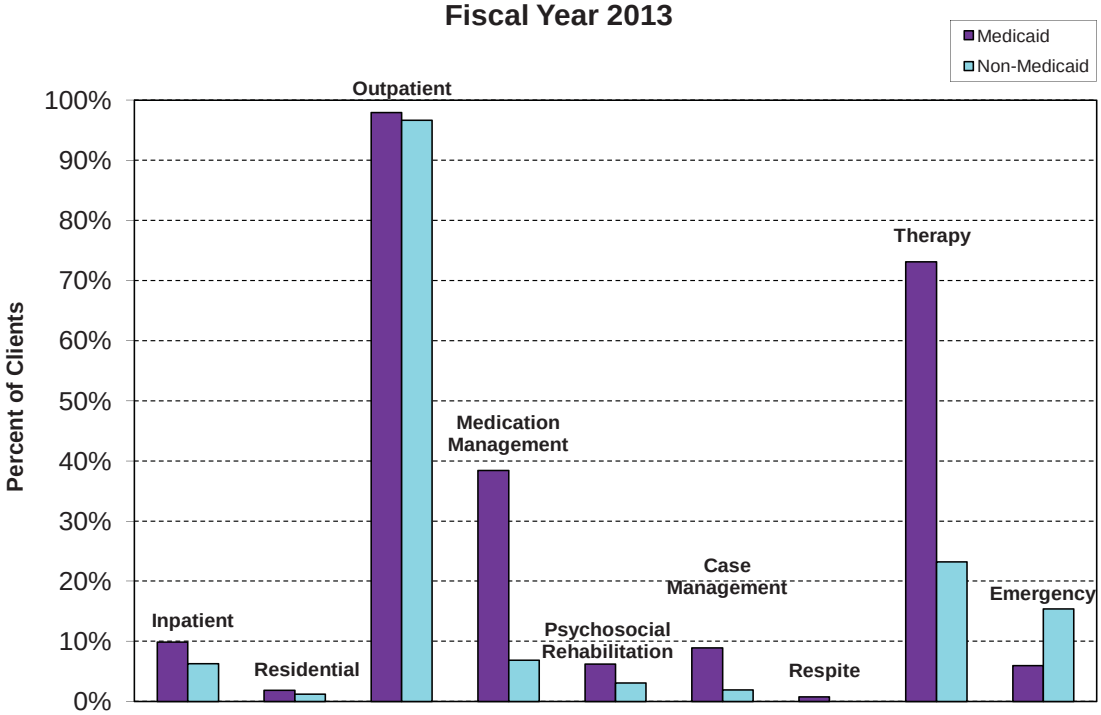
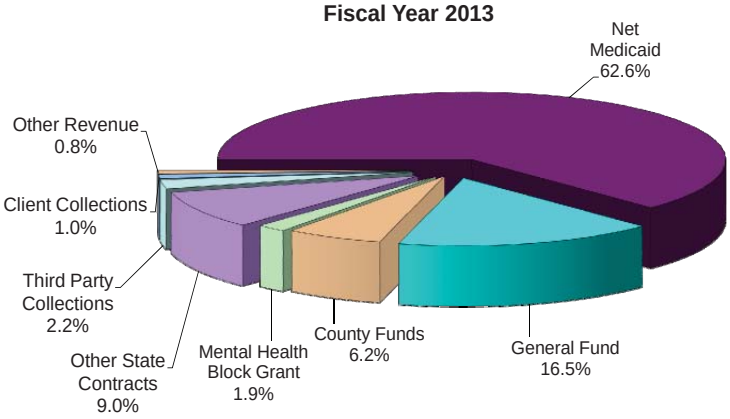
Utilization of Mandated Services
Fiscal Year 2013

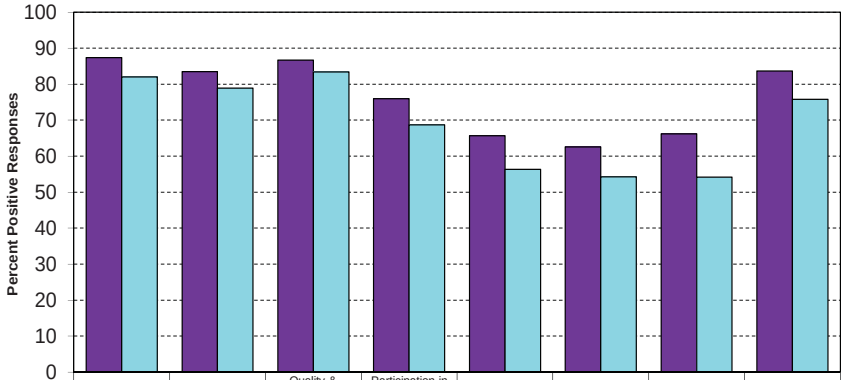


Weber Human Services—Mental Health *(Continued)*

Source of Revenues
Fiscal Year 2013



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP)
2013



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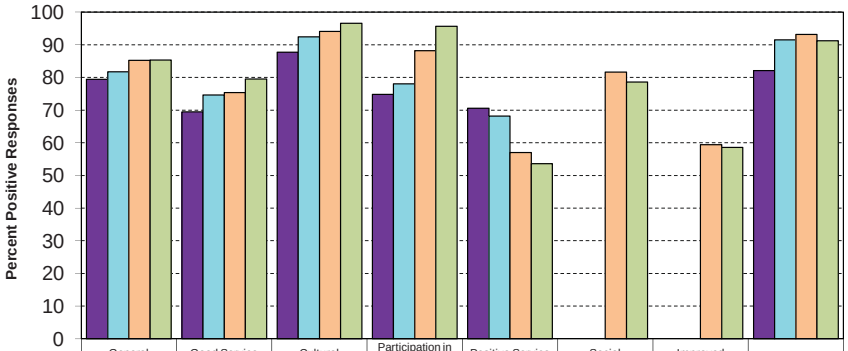
Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2013



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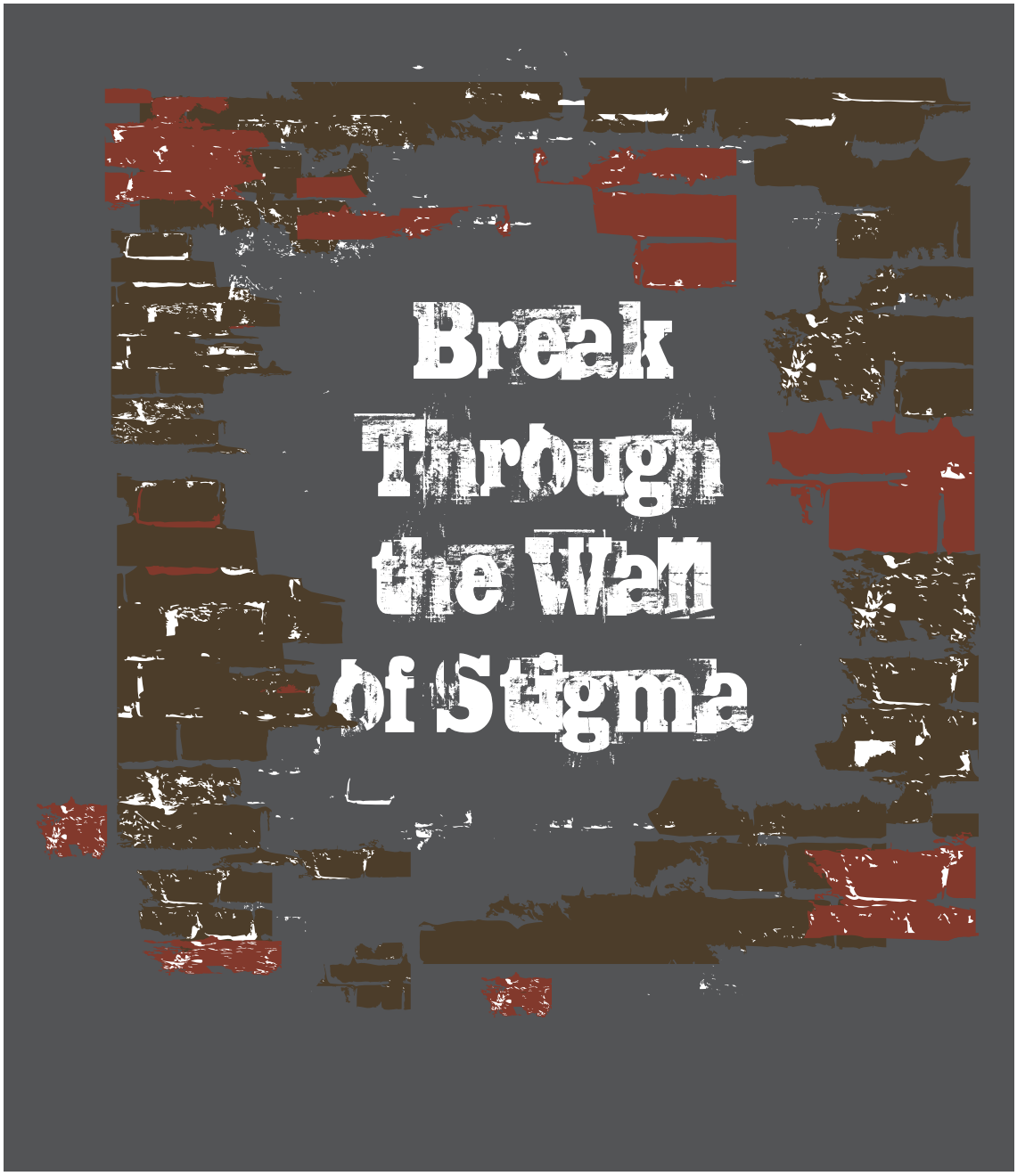
Statewide YSS	79.4	69.5	87.7	74.8	70.6			82.1
YSS	81.7	74.6	92.4	78.0	68.2			91.5
Statewide YSS-F	85.2	75.4	94.1	88.2	57.0	81.6	59.4	93.2
YSS-F	85.3	79.5	96.6	95.7	53.6	78.6	58.6	91.2

Utah Youth Council Contest Award Winner

“Out of the Shadows, Exposing Stigma”



“The brick wall represents how hard it is to break through the wall of stigma. The cracks represents the time and effort put into breaking down the wall and how it is possible.”

Resources

RESOURCES

List of Abbreviations

ATR—Access to Recovery

ASAM—American Society of Addiction Medicine

ASI—Addiction Severity Index

BPRS—Brief Psychiatric Rating Scale

CMHC—Community Mental Health Center

CTC—Communities that Care

DORA—Drug Offender Reform Act

DSAMH—Division of Substance Abuse and Mental Health

DUI—Driving Under the Influence

IOP—Intensive Outpatient Program

IV—Intravenous

LMHA—Local Mental Health Authorities

LOS—Length of Stay

LSAA—Local Substance Abuse Authorities

MHSIP—Mental Health Statistical Improvement Program

NAMI—National Alliance on Mental Illness

OTP—Outpatient Treatment Program

PASRR—Pre-Admission Screening and Residential Review

PASSAGES—Progressive Adulthood: Skills, Support, Advocacy, Growth and Empowerment = Success

PD—Prevention Dimensions

SAMHSA—Substance Abuse and Mental Health Services Administration (Federal)

SAPT—Substance Abuse Prevention and Treatment Block Grant

SED—Serious Emotional Disturbance

SHARP—Student Health and Risk Prevention

SMI—Serious Mental Illness

SPF—Strategic Prevention Framework

SPMI—Serious and Persistent Mental Illness

TEDS—Treatment Episode Data Set

UBHC—Utah Behavioral Healthcare Committee

USARA—Utah Support Advocates for Recovery Awareness

USH—Utah State Hospital

Mental Health Reference Table

The following table provides the number or 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 local mental health authorities 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
Fiscal Year 2013

Local Mental Health Authority	Medicaid	Non-Medicaid	Both Medicaid and Non-Medicaid
Bear River	1,929	829	352
Central	961	193	15
Four Corners	777	435	133
Northeastern	568	1,150	92
San Juan County	161	355	21
Southwest	2,033	578	4
Summit County	96	464	45
Tooele County	636	846	208
Wasatch County	91	343	50
Davis County	2,736	1,436	91
Salt Lake County	11,183	3,194	1,122
Utah County	5,285	1,971	451
Weber	3,362	1,953	298
Rural Total	7,219	5,182	916
Urban Total	22,334	8,409	1,938
State Total	**29,267**	**13,515**	**2,812**

Contact Information

Single State Authority

Doug Thomas, 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.ush.utah.gov

Local Authorities and Providers

Bear River
Counties: Box Elder, Cache, and Rich

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

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

Davis County
County: Davis

Substance Abuse and Mental Health Provider Agency:
Brandon Hatch, CEO/Director
Davis Behavioral Health
934 S. Main
Layton, UT 84041
Office: (801) 544-0585
www.dbhutah.org

Four Corners
Counties: Carbon, Emery, and Grand

Substance Abuse and Mental Health Provider Agency:
Karen Dolan, CEO
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
www.nccutah.org

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
behavioralhealthservices.slco.org

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:
Gary Larcenaire, CEO/President
Victoria Delheimer, Regional Director Rural Counties
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:
Gary Larcenaire, CEO/President
Victoria Delheimer, Regional Director Rural Counties
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 Department of Drug and Alcohol Prevention and Treatment
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 Freedom Blvd, Suite 300
Provo, UT 84601
Office: (801) 852-4703
www.wasatch.org

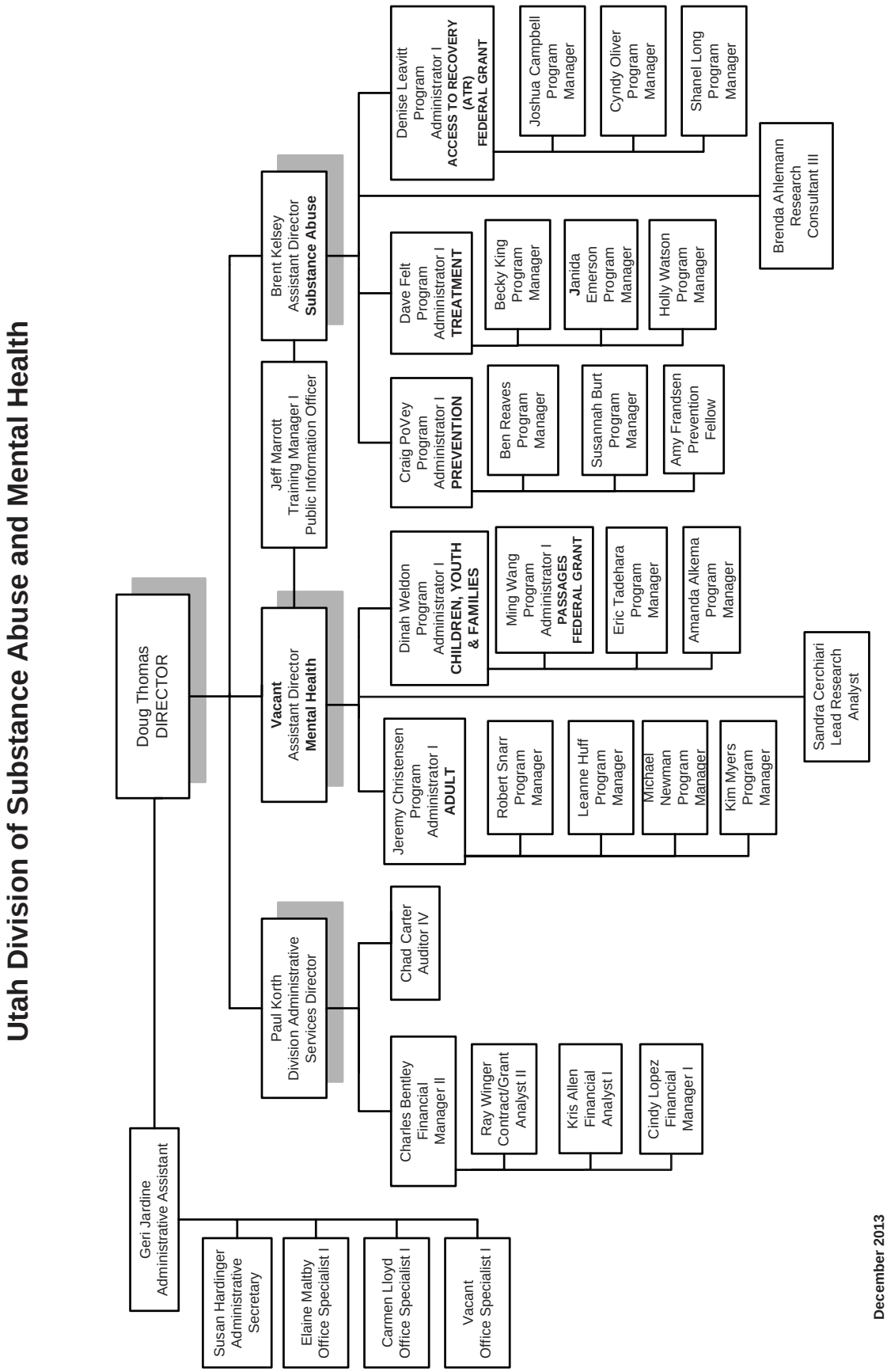
Wasatch County
County: Wasatch

Substance Abuse and Mental Health Provider Agency:
Richard Hatch, Director
Wasatch County Family Clinic
55 South 500 East
Heber, UT 84032
Office: (435) 654-3003
www.wasatch.org

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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Susan Hardinger Administrative Secretary
Elaine Maltby Office Specialist I
Carmen Lloyd Office Specialist I
Vacant Office Specialist I
Paul Korth Division Administrative Services Director
Chad Carter Auditor IV
Charles Bentley Financial Manager II
Ray Winger Contract/Grant Analyst II
Kris Allen Financial Analyst I
Cindy Lopez Financial Manager I
Vacant Assistant Director Mental Health
Jeff Marrott Training Manager I Public Information Officer
Jeremy Christensen Program Administrator I ADULT
Robert Snarr Program Manager
Leanne Huff Program Manager
Michael Newman Program Manager
Kim Myers Program Manager
Dinah Weldon Program Administrator I CHILDREN, YOUTH & FAMILIES
Ming Wang Program Administrator I PASSAGES FEDERAL GRANT
Eric Tadehara Program Manager
Amanda Alkema Program Manager
Sandra Cerchiari Lead Research Analyst
Brent Kelsey Assistant Director Substance Abuse
Craig PoVey Program Administrator I PREVENTION
Ben Reaves Program Manager
Susannah Burt Program Manager
Amy Frandsen Prevention Fellow
Dave Felt Program Administrator I TREATMENT
Becky King Program Manager
Janida Emerson Program Manager
Holly Watson Program Manager
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Joshua Campbell Program Manager
Cyndy Oliver Program Manager
Shanel Long Program Manager
Brenda Ahlemann Research Consultant III
December 2013

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Published 1/23/2014