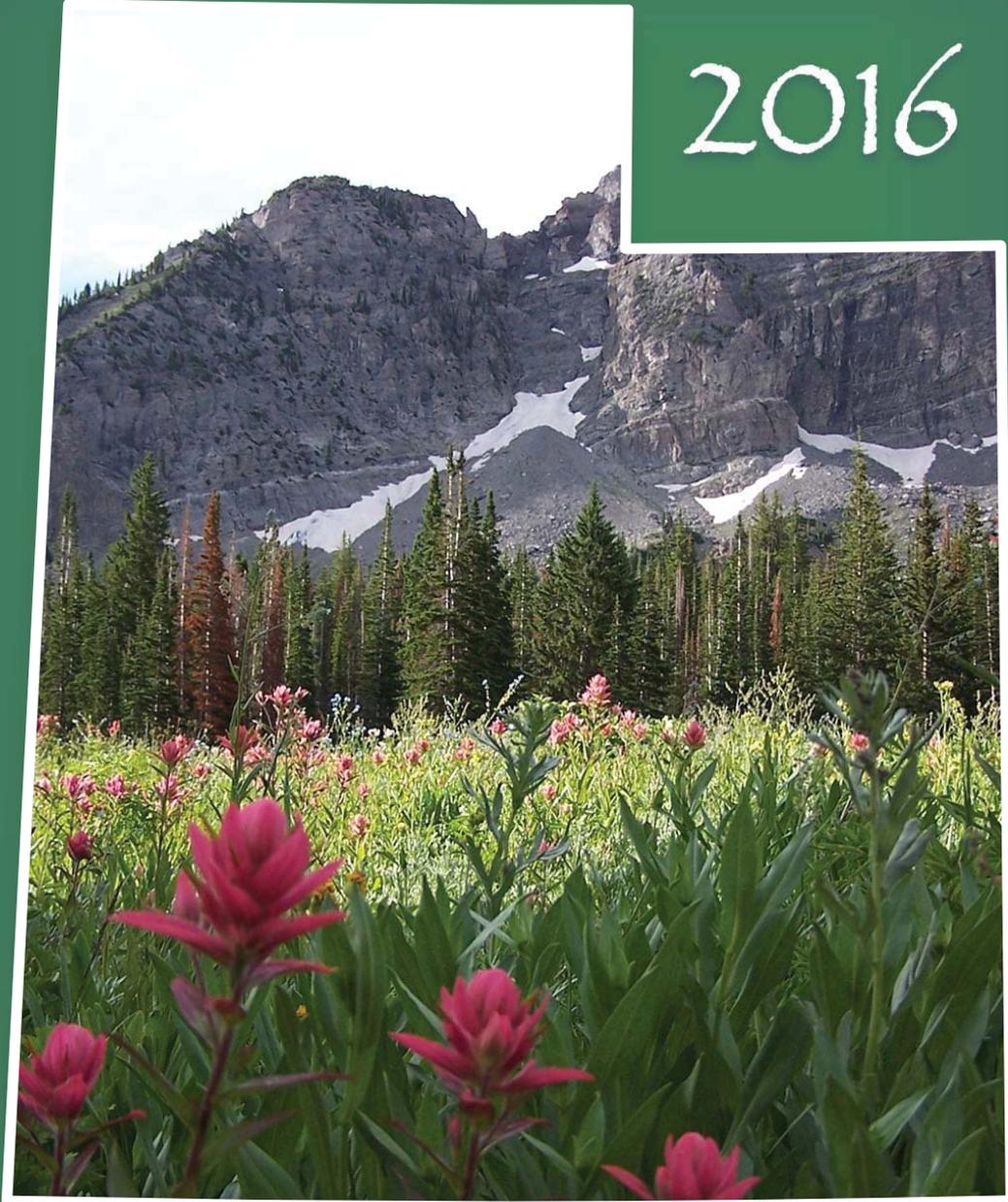


DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
ANNUAL REPORT

2016



HOPE • HEALTH • HEALING

Cover photo courtesy of Jeremy Christensen.
Taken in Big Cottonwood Canyon,
around the Lake Mary trail.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

2016
Annual Report



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

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State of Utah

GARY R. HERBERT
*Governor*SPENCER J. COX
Lieutenant Governor

January 2017

DEPARTMENT OF HUMAN SERVICES

ANN SILVERBERG WILLIAMSON
Executive Director

Division of Substance Abuse and Mental Health

DOUG THOMAS
Director

It is easy to slip into the feeling that to stop and look back over what has already occurred is a wasted exercise. It seems like it is always “full speed ahead” at the Division of Substance Abuse and Mental Health, with so much to do and no way to slow down. It is important for us to pause and reflect on our accomplishments, our “do-it-better-next-times,” and our plans for the future. We should recognize and celebrate the achievements of our agency, our workforce and the individuals we serve. We should be learning from our mistakes, measuring our efforts, and adjusting our plans and strategies accordingly. That’s the essence of continuous improvement, one of our fundamental values. Evidence of our progress and positive impacts on those we serve are documented throughout this report.

I hope this report broadens your understanding of the important role that the public behavioral health system has in the lives of individuals, families, and communities in Utah. “Hope, Health, Healing” is our continued theme. Prevention works, treatment is effective, and people can and do recover from mental health and substance use conditions. Together we can make a difference preventing illness, providing evidenced based interventions and fostering environments that promote recovery.

Changes in the healthcare landscape have opened the way for people to get their behavioral health needs met just like their physical health needs. Over time, these changes should decrease stigma and discrimination leading to increased access and understanding for people with mental illness and substance use disorders. The earlier people receive help, the better the outcomes people have, at less cost, with less disability. With Utah’s diverse population, it is more important than ever to have a trauma informed approach that does no harm, generates hope and encourages healing.

DSAMH has set the following priorities to emphasize specific goals and strategies in the coming year(s):

- Focus on prevention and early intervention
- Zero suicides in Utah
- Promote a recovery-oriented system of care led by people in recovery that is trauma informed and evidence-based
- Improve the system of care for children and youth
- Promote integrated healthcare

I invite you to review our plan and find a way to become involved in your local community or give us feedback, <http://dsamh.utah.gov/pdf/DSAMHStrategicPlan2016-10-19.pdf>. I want to thank those who help facilitate this process; the many caring and dedicated family members, friends and professionals, whose support is life-altering for so many. I also want to personally thank the brave individuals reaching out for hope, health and healing from mental illness and substance misuse head on in their own lives.

Sincerely,

Doug Thomas, Director

Trevor's Journey

My name is Trevor, and I am a person in long term recovery. What that means to me is I haven't put a drink or drug in my body since 2013. That was not always the case.

I remember having a great childhood. I had most material things that other kids my age didn't. The love I received was unconditional, and I felt that love every day. I grew up not knowing my biological father. I had the feeling like something was missing in my life. When I was in middle school, I was emotionally beat up for my weight, teased, and tormented.

At the age of 12, my addiction started. I would go to the local Drug Store to steal Dexatrim. I smoked weed for the first time and found that the marijuana made the pain go away. I began using crank at 15. That didn't last too long, because I was introduced to my soon to be best friend, my cocaine dealer. I used anything I could put in my body. I destroyed my marriage, and because of my actions, my children didn't know who their father was.

After multiple stays in jail and one too many let downs for my family and my children, I fought to enter into Drug Court, because I had no other option except incarceration. I needed to learn accountability, responsibility, and being a newly fulltime, single father, I needed to be taught how to show love, and empathy. I found out that the Drug Court team were actually caring people, not just authority figures. At some point, the judge started recognizing me for the positive things I was doing. Over time, I began to realize that I could be sober, and healthy.

I am a Drug Court Alumni of Summit County. I graduated in 2015 as the first to complete the program without an incident of use. Drug Court gave me all the tools I needed. The structure, support, and the friendships I developed, were the basis of my healthy foundation in the beginning.

Today, I am a leader in the community. I work for Utah's only Recovery Community Organization (RCO), giving hope to others in recovery. I am a full time, single father of 3 amazing children. Every day I choose to show up for them, to give them the support and strength they need.

For the first time as an adult, I am felony free and not on probation. I am a registered voter for the first time and soon to be a student at SLCC. Without Drug Court, I wouldn't be the father, brother, son and grandson I am today.



Utah's Public Behavioral Health System

This Annual Report summarizes the activities, accomplishments, and outcomes of Utah's public behavioral health system. In Utah, publicly funded behavioral health services are provided through a partnership of state and county government. This report provides information on the Division of Substance Abuse and Mental Health (DSAMH), the Utah State Hospital and our county partners.

DSAMH is authorized under Utah Code Annotated (UCA) §62A-15-103 as the single state authority in Utah. It is charged with ensuring a comprehensive continuum of substance use and mental health disorder services are available throughout the state. In addition, DSAMH is tasked with ensuring that public funds are spent appropriately.

Vision

DSAMH's vision is to contribute to the development of healthy individuals, families and communities. Substance use disorders and mental illnesses are chronic diseases. However, prevention works, treatment is effective, and people recover.

Mission

DSAMH's mission is to promote hope, health and healing by reducing the impact of substance abuse and mental illness. To achieve this mission, DSAMH provides leadership, promotes quality, builds partnerships, ensures accountability, and operates effective education and training programs. DSAMH uses a public health approach to make its vision a reality.

Guiding Principles

Systems, services, programs, activities, strategies, and policies should be trauma-informed, evidence-based, and culturally and linguistically competent.

Trauma-Informed

Most individuals with mental health and substance use disorders are also dealing with trauma issues. DSAMH recognizes the prevalence of trauma and takes a universal precautions position. Trauma affects all individuals involved, including staff and the local workforce. DSAMH is working to ensure that all aspects of its system recognize the impact of trauma and make every effort to avoid re-traumatization.

Evidence-based Practices

DSAMH provides training and consultation designed to promote evidence-based practices. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

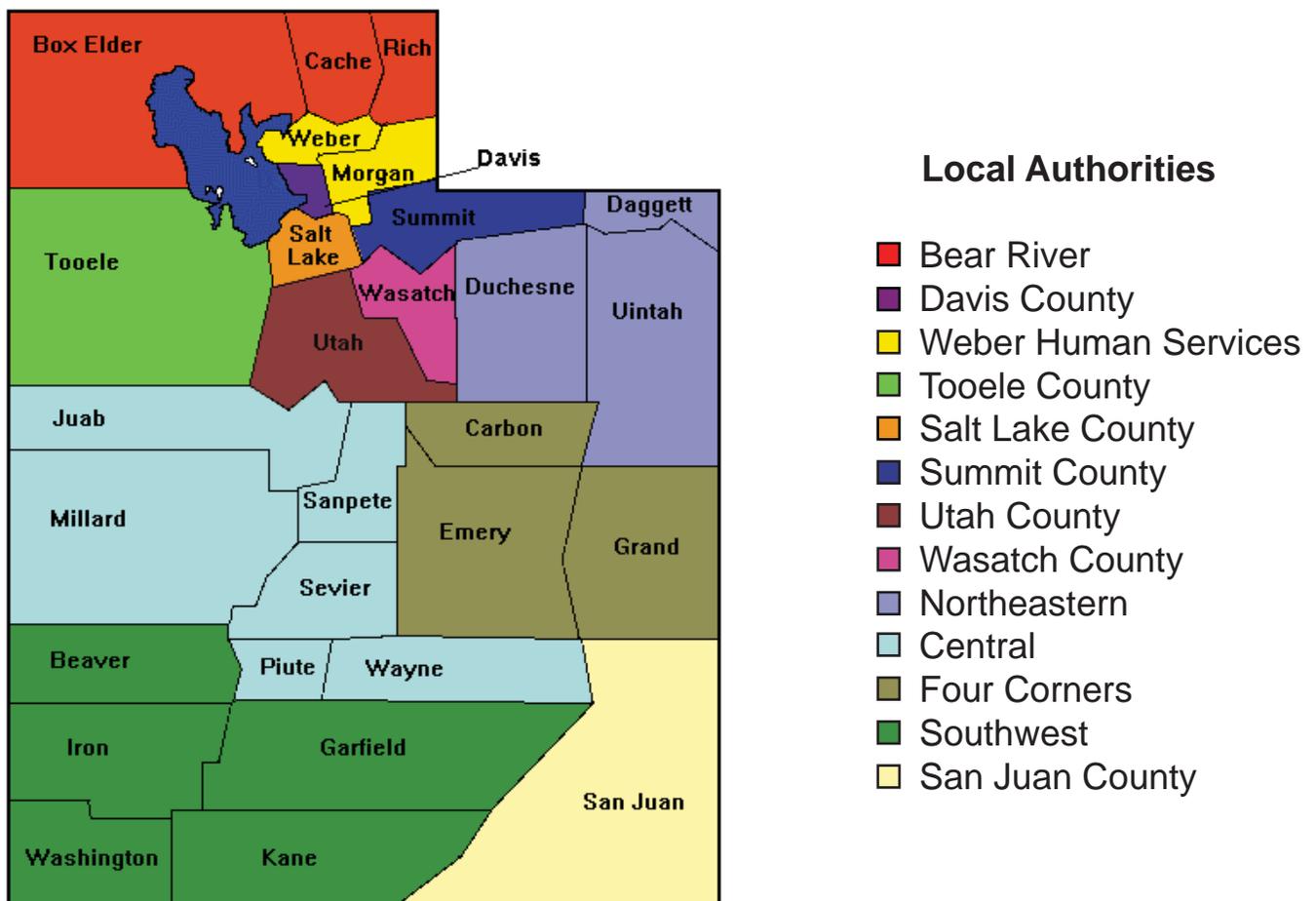
Culturally and Linguistically Competent

Individuals possess diverse cultural, economic, social backgrounds, values, beliefs, sexual orientations, ethnicity, religion, and languages. DSAMH believes all aspects of behavioral health services should recognize and adapt to reflect the diversity of Utah's individuals, families and communities.

Substance Abuse and Mental Health

As part of the Utah Department of Human Services, DSAMH contracts with local county governments who are statutorily designated as local substance abuse authorities and local mental health authorities to provide prevention, treatment, and recovery services. DSAMH

provides policy direction, monitoring, and oversight to Utah's 29 counties. Counties have formed 13 local authorities that deliver or contract for a comprehensive array of services. The map below shows the organizational structure of Utah's local authorities:

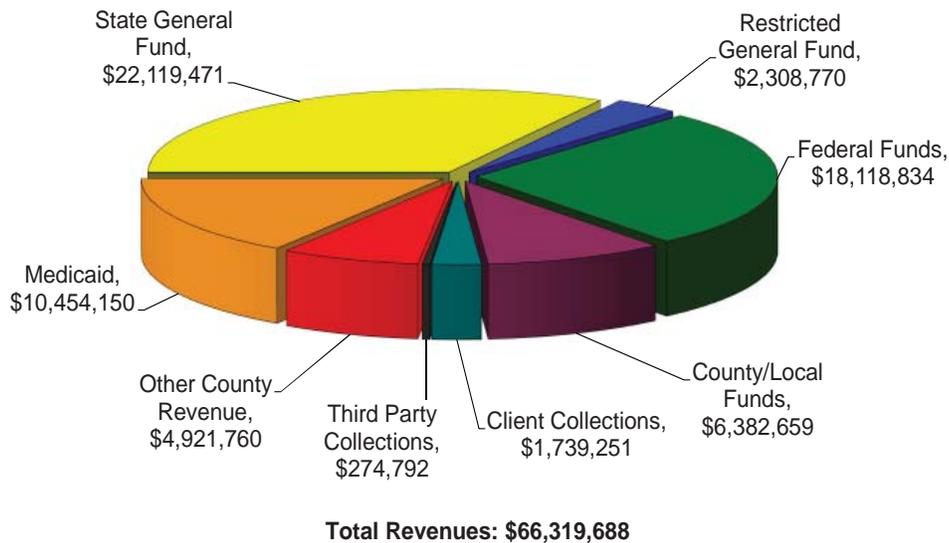


Source of Funding

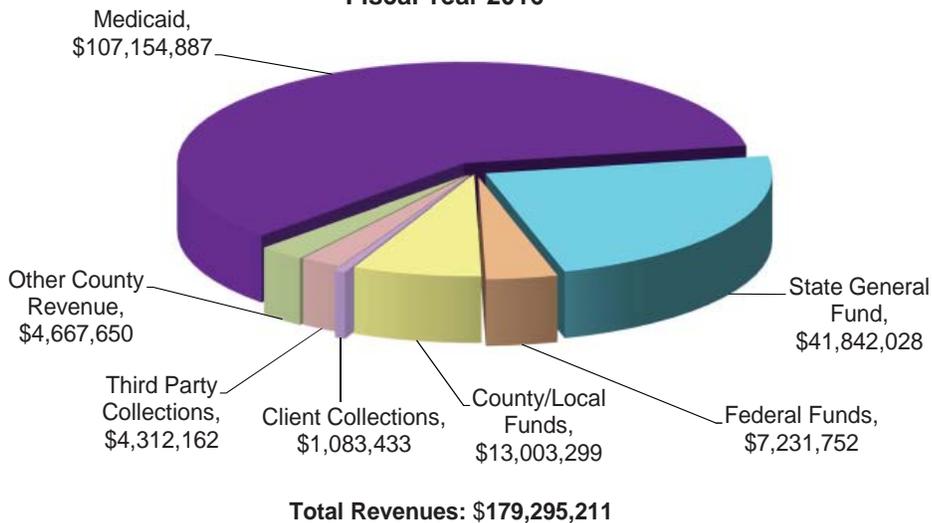
Funding for services comes from a variety of sources. State, county, and federal funds, as well as private insurance and payments directly from clients, are used to provide services. For mental health services, the primary funding source is Medicaid. For substance use disorder services,

the primary funding source is the State General Fund. 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.

Substance Use Disorder Services Funding Fiscal Year 2016



Mental Health Services Funding Fiscal Year 2016



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

2016 State Strategies

With input from key community stakeholders, DSAMH staff have developed and implemented a strategic plan that strives to enhance Utah's public behavioral health system. Quarterly reviews of goal implementation and outcomes allow the plan to be constantly updated, relevant and flexible to changes in a dynamic service system. The plan outlines five key strategic initiatives. The initiatives were carefully chosen to build on past achievements, and to take advantage of emerging opportunities in a changing world. The goal is to build a better behavioral health system for all.

Strategy One: Prevention and Early Intervention

Expansion of prevention and early intervention is the number one priority for DSAMH.¹ Prevention and early intervention help individuals, families and communities avoid the costs and consequences of addiction or mental illness. The Institute of Medicine and the Centers for Disease Control and Prevention indicate that there are clear windows of opportunity to prevent mental, emotional, and behavioral disorders and related problems before they occur. DSAMH believes that expansion of prevention and early intervention will result in positive outcomes for individuals, families and communities.

Prevention of substance abuse and mental illness are closely related. The risk and protective factors for both substance use disorders and mental illness are well established with first symptoms of mental illness typically preceding a disorder by 2 to 4 years.

DSAMH promotes systems and programs at the community level to target shared factors. Utah's

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*

prevention system follows a strategic, science-based planning process called the Strategic Prevention Framework (SPF). The SPF is used to ensure a culturally competent, sustainable, effective, and cost efficient system. Communities work through a five-step process to implement the SPF. The five steps are:

- Assess community needs
- Build capacity for services
- Plan based on needs, strengths, and resources
- Implement evidence-based strategies
- Evaluate the effectiveness of prevention services and activities.

The SPF provides assurance that Utah prevention initiatives are effective, efficient, and address local needs.

In 2012, Utah made an investment to early intervention services that increased access to school-based behavioral health, Youth Mobile Crisis Teams and Family Peer Support with High Fidelity Wraparound. These services are helping to keep more of Utah's children and youth in their homes, in school and out of trouble.

DSAMH plays critical roles in several statewide substance use, suicide, and mental illness prevention programs as well as mental health early intervention and promotion programs. These statewide initiatives include an underage drinking prevention campaign (Parents Empowered), a school-based prevention foundation curriculum (Prevention Dimensions), a Suicide Prevention Coalition, and a mental illness prevention/mental health promotion project (Prevention by Design).

Additional information about Utah's prevention efforts can be found on page 45 of this report.

Strategy Two: Zero Suicides in Utah

DSAMH is committed to the goal of Zero Suicides in Utah. Accomplishing this goal requires support and the involvement of the public behavioral health care system and the broader community.

Suicide impacts people from all socioeconomic, racial and ethnic backgrounds, and affects people of all ages. On average, over 557 people in Utah die by suicide every year. Suicide is the 7th leading cause of death for Utahns overall and Utah ranks 7th in the nation for suicide deaths. These statistics are the tip of the iceberg. More people make suicide attempts and consider suicide than are fatally injured. 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.

DSAMH has identified three overarching goals to guide efforts towards Zero Suicides in Utah.

Goal 1: Engage community stakeholders and prevention coalitions in suicide prevention and mental health promotion efforts statewide.

Key efforts and outcomes: In 2012, DSAMH contracted with NAMI Utah and launched the Utah Prevention by Design Project which partners with local community partners and coalitions for suicide prevention and mental health promotion efforts. Key 2012-2014 Prevention by Design outcomes have primarily been achieved by engaging communities, capacity building, and process outcomes.

In 2015, the focus changed from engagement and process driven, to effectiveness of strategies. Pre/Post data collection is a core priority.

With support of DSAMH, NAMI Utah completed a statewide Mental Health Needs Assessment and Community Action Plan to

ensure a data-driven approach to mental health promotion, mental illness prevention and suicide prevention. This Needs Assessment and Action Plan will drive prevention and promotion efforts of NAMI Utah, DSAMH and local stakeholders over the next several years. Over the past four years, this project has provided sub-contracting opportunities for up to 13 coalitions statewide. This represents one sub-contract in each of the defined Local Health Authority regions. Through legislatively approved state funding awarded in March of 2015, the number of sub-contractors has expanded to 23 local groups who receive funding for suicide prevention efforts. This greatly expanded the capacity of our state to engage in meaningful prevention strategies. Outcomes include the following:

Data Outcomes:

Outcome data from the skills based trainings included an evaluation score measuring change in participant's knowledge, understanding and confidence surrounding the skills presented in the training.

These scores are recorded, averaged and stated as a percentage of those who responded either a 4 or 5 on the Likert scale. This percentage is termed the "Evaluation Score." The higher the percentage, the greater the change in knowledge, understanding and confidence. The Evaluation Score for all reported skills based interventions was 94.2%.

Process Outcomes:

- Skills trainings (e.g. Mental Health First Aid, QPR, ASIST): Number of trainings: 417, Number of persons certified: 10,983
- Trainer for trainer (T4T) (e.g. QPR, SafeTALK): Number of persons certified as trainers: 51, Media and Events (e.g. interviews, articles, flyers etc.):
Articles: 64, Community Events: 69, Flyers: 120,520, Take back events: 15, Gun safety (i.e. gun locks and other resources): 1,312

- School based activities (e.g. NAMI's Hope for Tomorrow and Hope Squads)
4: Number of schools: 48, Total number of students involved: 1,193

Goal 2: Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts

DSAMH chairs the Utah Suicide Prevention Coalition and provides leadership to a variety of work groups working to implement the Utah Suicide Prevention Plan. Using the National Strategy for Suicide Prevention as a template, the Utah Suicide Prevention Coalition revised the State Suicide Prevention Plan in 2013. Strategies include partnering with state agencies to examine and use suicide related data, forming public and private partnerships, working with local coalitions to identify and implement suicide prevention strategies, and working to improve clinical care related to suicide prevention statewide.

Solid partnerships within the public and private sector are critical. The Utah Suicide Prevention Coalition 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 providers, behavioral health service providers, suicide survivors, University of Utah researchers, Intermountain Healthcare, Utah State Office of Education, legislators, mental health consumers, National Alliance on Mental Illness (NAMI) Utah, and other key stakeholders. The coalition has worked to release a new Utah Suicide Prevention Plan to be released January 2017. Our goal is to reduce suicide rates in Utah by 10% by 2021 with the ultimate goal of zero suicides in Utah. The Utah Suicide Prevention Plan will continue to promote the message that "Everyone has a Role to Play" in suicide prevention. For more information on the plan and the coalition visit: utahsuicideprevention.org.

Goal 3: Improve the ability of health providers (including Behavioral Health) to better support individuals who are at risk of suicide through adoption of Zero Suicide framework.

DSAMH has undertaken the aspirational goal of perfect patient safety for individuals receiving care through its public behavioral health system. DSAMH is partnering with community mental health centers to develop suicide safer care in communities through the adoption of best practices. The goals of Zero Suicide in Utah include improving identification, assessment, treatment, and recovery supports for individuals within the public system.

As identified by the National Action Alliance for Suicide Prevention, the core dimensions of Zero Suicide include:

- Creating a leadership-driven, safety-oriented culture that commits to dramatically reducing suicide among people under care and includes suicide attempt and loss survivors in leadership and planning roles
- Systematically identifying and assessing suicide risk levels among people at risk
- Ensuring every person has a pathway to care that is both timely and adequate to meet their needs
- Developing a competent, confident, and caring workforce
- Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality
- Continuing contact and support, especially after acute care
- Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk

The following division directive indicates the commitment of Zero Suicide within the public mental health and substance use treatment and within the prevention system as overseen by the state suicide prevention coordinator:

- Local Mental Health Authorities statewide conducted a suicide prevention behavioral healthcare assessment including a comprehensive evaluation of related policies and practices related to suicide prevention, intervention, and postvention. An assessment of staff knowledge, skills, and training related to suicide prevention, intervention, and postvention was conducted. A model tool was provided by DSAMH, or the Local Authority could choose another assessment tool. Local Authorities were required to complete the assessment and submit a written report to DSAMH by June 30, 2015.
- Based on assessment results, Local Authorities are developing policy and implementation plans to establish, implement and monitor comprehensive suicide prevention plan. A copy of the policy and implementation time line has been submitted to DSAMH.

All of the Local Mental Health Authorities have completed a suicide prevention behavioral healthcare assessment and submitted the report to DSAMH and the state suicide prevention coordinator for review. DSAMH will provide ongoing technical assistance to help all LMHAs use the assessment to form a local strategic plan for care quality improvement.

DSAMH and all Local Mental Health Authorities have partnered to implement a statewide Medicaid Performance Improvement Project for suicide safer care within the public behavioral health care system. 2015 is a baseline data collection year designed to provide information regarding current levels of screening and assessing for suicide risk,

and providing comprehensive safety planning interventions when warranted. In 2016, targeted interventions have been implemented in order to improve quality of care over the year. These interventions will continue for comprehensive quality improvement for those receiving care.

Strategy Three: Promote Recovery

DSAMH's third strategy is to develop and implement a "recovery-oriented system of care" (ROSC). Substance use disorder and mental illness are diseases.² However, people can and do recover. Recovery means more than abstinence from drugs or a remission of symptoms; recovery means achieving a meaningful life in the community, an improved quality of life and overall health. Behavioral health services should align with the needs of individuals seeking recovery or those in recovery. DSAMH recognizes that behavioral health services need to expand beyond acute care to help people recover.

The Federal Substance Abuse and Mental Health Services Administration (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

² National Institute on Drug Abuse

- Where possible, care in the person's community and home using natural supports"³

With the assistance of the local authorities, DSAMH continues to revise its rules, contract requirements, practice guidelines, strategic plan, division directives and data requirements to ensure that they incorporate ROSC principles in order to facilitate the significant shift in traditional practices that ROSC represents. As the Justice Reinvestment Initiative and the increase of individuals with insurance coverage continues to expand the availability of prevention, treatment and recovery support services to individuals, DSAMH will continue to ensure services are responsive to the needs of individuals and families and continue to identify and address barriers and gaps in the system. DSAMH will continue to provide training, educational opportunities and technical assistance to ensure best standard practice. Early identification, client engagement, person centered care, use of evidenced-based practices and appropriate and individualized long-term recovery support are the key factors that DSAMH and its partners are using to ensure high quality care across the continuum.

Strategy Four: Improve Services for Children and Adolescents

DSAMH estimates that 11,804 youth (ages 11-17) need substance use disorder treatment and 100,193 children and youth need mental health treatment. Almost 1 in 5 young people have one or more mental, emotional or behavioral disorders that cause some level of impairment within a given year; however, fewer than 20%

³ 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

receive mental health services.⁴ Improving services for children and adolescents will result in healthier individuals, families, and communities.

Children and adolescents are best served in a framework that involves collaboration across agencies, families, and youth, for the purpose of improving services, access and outcomes for children, youth and their families. The core values of the philosophy are:

- Family driven, with families having a primary decision making role and the strengths and needs of the child and family determining the types and mix of services and supports provided
- Youth guided, with the right to be empowered, educated (on the issues), and given a decision-making role in their care
- Community-based, with accessible services available at the community level
- Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve

A system of care approach provides effective, community-based services and supports organized into a coordinated network for children and youth that helps them function better at home, in school, in their community, and throughout life.

Family Resource Facilitation is available in 25 of the 29 counties in the state and encourages family driven and youth guided care. Family Resource Facilitators (FRFs) provide

⁴ Preventing Mental Emotional and Behavioral Disorders, Report Brief for Policymakers, The National Academies, <http://iom.nationalacademies.org/reports/2009/preventing-mental-emotional-and-behavioral-disorders-among-young-people-progress-and-possibilities.aspx>

peer support and wraparound facilitation to families and youth who have complex needs. Wraparound helps 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 (e.g., family members, youth groups, clergy, etc.) that helps increase family stabilization, increase school involvement and decrease involvement with the legal system.

Over 256 schools partner with their LMHA to provide community-based health services to children and youth whose mental, emotional or behavioral health symptoms are interfering with their academic success. Parental consent and involvement is integral for all school-based services. Youth participating in school-based health services experienced an 8% improvement in grade point average (GPA) and children in elementary school experienced a 49% increase in Dynamic Indicators of Basic Early Literacy Skills (DIBELS) scores. Children and youth receiving these services also experienced significant reductions in symptoms.

Juvenile Mobile Crisis Teams (MCTs) are another community-based service that helps children and youth remain in their homes and communities. Juvenile MCTs are available in four counties (Davis, Salt Lake, Utah and Washington counties) which contain 67% of the state's population. Families may contact the MCTs when their child or adolescent is experiencing a mental, emotional, or behavioral crisis. The two-person team 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.

Strategy Five: Health System Integration

Integrating the delivery of behavioral health services and physical health services is a key

component to recovery-oriented services and can greatly improve access to effective care and improved outcomes. This is because individuals with a behavioral health condition have poorer health outcomes than the general population.⁵

Individuals with a serious mental illness (SMI) have a life expectancy 25 years shorter than the general population. Almost one fourth of all adult stays in community hospitals involve a mental health or substance use disorder, making mental health disorders the third most costly health condition, behind only heart conditions and injury-related disorders, in the United States.⁶

Health reform efforts at the national and state level continue to focus on ways to improve health, improve healthcare, and lower costs. A central strategy to achieving this “triple aim,” both nationally and in Utah, is to focus on the integration of behavioral and physical health care. Individuals entering treatment with Local Authorities are briefly screened for physical health needs and nicotine use, in addition to mental health and substance use disorder assessments. Information on tobacco cessation programs are offered to individuals using nicotine. Individuals who are opioid or alcohol dependent will, when appropriate, have medication assisted treatment (MAT) included in the treatment plan. Individuals at risk for, or identifying, physical health care needs are provided with referrals to primary care providers. To facilitate integrated care, DSAMH encourages the formation of partnerships between the Local Authorities and Federally Qualified Health Centers/Community Health Centers.

⁵ Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states, Colton CW and Manderscheid RW, *Prevention of Chronic Disease*, 2006 Apr 3(2):A42.

⁶ *Mental Health: Research Findings: Program Brief*. September 2009. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/findings/factsheets/mental/mentalth/index.html>

Jenna's Strength

My name is Jenna and I am a survivor in long-term recovery. At 24, I was in a car accident that required surgeries. The doctor sent me home with narcotics to ease the pain. It felt good to take these medications. I got refills on the prescriptions before the doctor cut me off, but I was already physically dependent. When I went back to work as a nurse, I started stealing medications from my job site. I would spend the majority of my income buying pills off the streets. I didn't care if there was food in the house, whether the kid's had clean clothes, or even if they went to school. At home, I would usually nod out instead of spend time with them.

After twelve years of managing my addiction and going through the hell of daily physical withdrawal, I decided to switch my drug of choice to methamphetamine. I thought I could function better than being dependent on opiates. I would use all night and go to work and use on my breaks. My punctuality and attendance suffered. Eventually I was fired.

I turned to a life of crime and living on the streets. In my addiction, I lost my morals and my self-worth. I had convinced myself that I didn't matter. When I woke up in a jail cell, I felt devastated and completely lost. I knew that I had to change something. For the first time I admitted that I had an addiction and my life was out of control. I decided I had to make some drastic changes in my life and began to work to better myself right then and there in my jail cell.

I reached for strength through my higher power. I began to pray, and to participate in everything related to recovery. I opened my mind to all the concepts that I was introduced to and began the hard work of repairing my life.

Today, I live in recovery in every aspect of my life. I am blessed to have meaningful relationships with my children. My grandchildren only know me as the person I am today. I am blessed to be able to work in a treatment facility because it keeps me focused and shows me that I am making a difference. It's a beautiful privilege to see other people overcoming their addictions.

**I am not alone.
Neither are you!**



Who We Serve

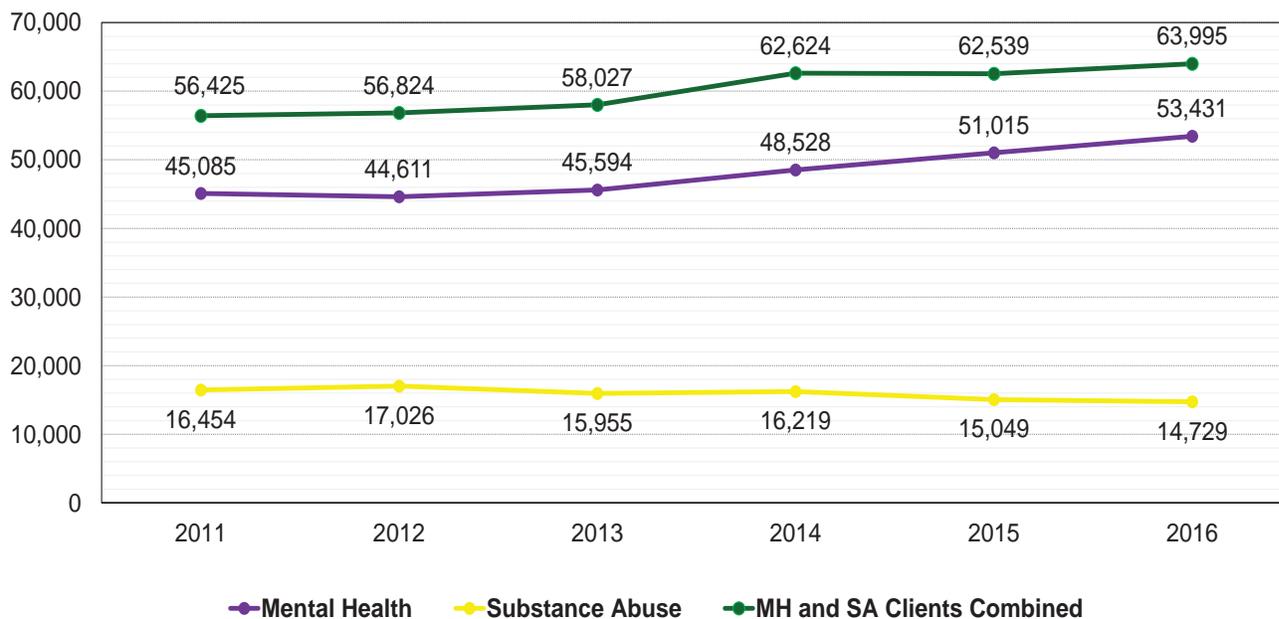
Who We Serve

The following chart shows the unduplicated total number of individuals served in the public behavioral health system, the number served in substance use disorder services, and the number

served in mental health services. This chart shows that there are a number of clients who are seeking treatment for both substance use disorders and mental health issues.

Total Number of Individuals Served in the Public Behavioral System

Fiscal Year 2011 through Fiscal Year 2016



Utahns in Need of Substance Use Disorder Treatment

The results of the most recent National Survey on Drug Use and Health and the 2015 Student Health and Risk Prevention Survey¹ indicate the following:

- 134,172 adults in Utah were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015.
- 12,080 youth in the 6th through 12th grades are in need of treatment for drug and/or alcohol dependence or abuse.
- The public system is currently serving 14,729 individuals, or 9.9% of the need.

- A combined total of approximately 146,252 adults and youth are in need of, but not receiving, substance abuse treatment services.

The following table demonstrates the estimated 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 2016, is also included to illustrate the unmet need.

Substance Use Disorder				
	Adults (18 years+)		Youth (Ages 12-17)	
	# Need Treatment	Capacity FY2016	# Need Treatment	Capacity FY2016
Bear River	6,977	887	713	88
Central	3,532	363	338	40
Davis County	13,163	1,003	1,479	69
Four Corners	1,924	512	142	40
Northeastern	2,286	427	250	31
Salt Lake County	56,112	6,575	4,077	636
San Juan County	694	63	73	15
Southwest	10,415	591	859	28
Summit County	1,696	237	158	25
Tooele County	2,404	346	302	30
Utah County	22,687	971	2,552	69
Wasatch County	1,139	131	130	19
Weber	11,152	1,460	1,001	243
State Totals*	134,172	13,400*	12,080	1,326*

* Because of rounding in the percentages, duplication of clients across Local Substance Abuse Authorities (LSAAs), LSAAs totals do not add up to the unduplicated total of clients served statewide.

¹ Adult-Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth-State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 5.

Utahns in Need of Mental Health Services

The results of the National Survey on Drug Use and Health and the 2015 Student Health and Risk Prevention Survey¹ indicate the following:

- 107,527 adults in Utah were classified as needing treatment for mental health issues in 2016.
- 100,192 youth in the 6th through 12th grades are in need of treatment for mental health issues in 2016.
- The public system served 53,431 individuals, or 28% of the current need.

- A combined total of approximately 154,288 adults and youth are in need of, but not receiving, mental health services.

The following table demonstrates the estimated number of adults and youth who need treatment, by local authority. The number served in fiscal year 2016, by local authority, is also included to illustrate the unmet need.

Mental Health				
	Adults (18 years+)		Children/Youth (Ages 0-17)	
	# Need Treatment	Clients Served FY2016	# Need Treatment	Clients Served FY2016
Bear River	7,435	1,871	5,190	1,590
Central	2,770	684	2,192	525
Davis County	10,958	3,925	11,363	2,154
Four Corners	1,509	930	1,244	457
Northeastern	2,437	1,617	3,052	933
Salt Lake County	39,717	10,041	38,425	6,753
San Juan County	545	403	592	208
Southwest	8,169	1,691	6,477	1,712
Summit County	1,808	441	886	237
Tooele County	2,563	941	2,810	528
Utah County	19,866	6,387	18,181	3,705
Wasatch County	1,214	332	702	181
Weber	8,536	4,343	9,078	1,773
State Totals*	107,527	32,963*	100,192	20,468*

*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 Adult-Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

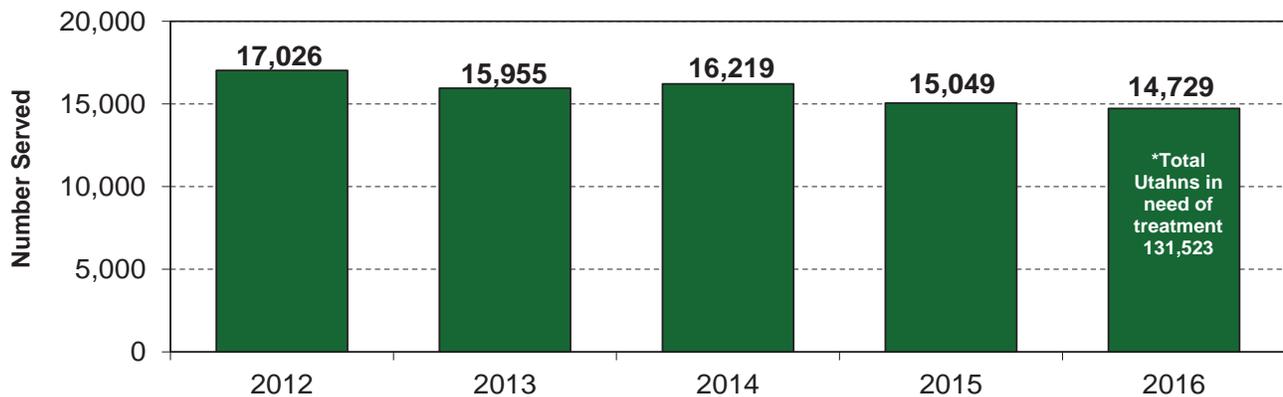
Children/Youth-State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 6.

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 2012 through fiscal year 2016.

Total Number of Individuals Served in Substance Use Disorder Treatment Fiscal Years 2012 - 2016

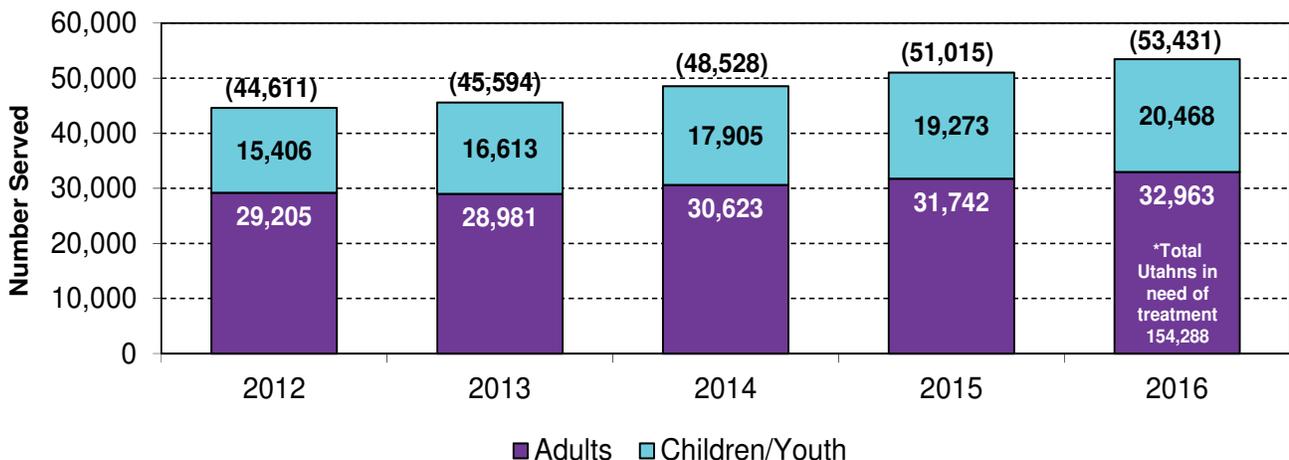


*Estimate of need. Does not take into account those served in the private sector.

Adult—Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth—State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 5.

Total Number of Adults and Children/Youth Served in Mental Health Services Fiscal Years 2012 - 2016



*Estimate of Need

Adult—Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD. <http://www.samhsa.gov/data/NSDUH/substate2k12/toc.aspx>.

Children/Youth—State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2015 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 6.

Household Income and Poverty

The following charts show the income levels by household size for those served in the public behavioral health system. Those highlighted in red are self-reported below the Federal Poverty Line

for 2016. The majority of public clients are below the poverty line with 12,487 substance use disorder clients (84%) and 43,121 mental health clients (84%) fitting the criteria.

Substance Use Disorder Clients and Poverty Level Fiscal Year 2016											
		Monthly Income Grouping									Total Clients
		None	\$1 - \$500	\$1000	\$1500	\$2000	\$2500	\$3000	\$3500	\$3500+	
Number in Family	1	4003	568	1238	494	280	94	52	19	88	6,836
	2	1058	297	415	286	192	53	37	18	80	2,436
	3	873	201	332	227	188	59	41	28	83	2,032
	4	602	129	259	176	147	64	39	25	103	1,544
	5	349	72	130	135	110	56	44	17	57	970
	6	166	29	69	66	57	37	24	6	22	476
	7	71	18	24	28	20	13	12	5	10	201
	8	32	9	10	14	8	4	4	2	8	91
	9	14	2	4	7	1	2	3	1	4	38
	10+	43	15	14	12	5	4	4	2	0	99
In Poverty		7,211	1,340	2,495	951	348	116	23	3	-	12,487
Not in Poverty		-	-	-	494	660	270	237	120	455	2,236
Total Clients		7,211	1,340	2,495	1,445	1,008	386	260	123	455	14,723

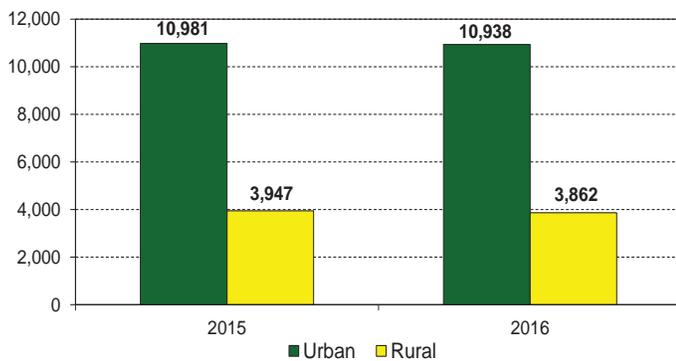
Mental Health Clients and Poverty Level Fiscal Year 2016											
		Monthly Income Grouping									Total Clients
		None	\$1 - \$500	\$501 - \$1,000	\$1,001 - \$1,500	\$1,501 - \$2,000	\$2,001 - \$2,500	\$2,501 - \$3,000	\$3,001 - \$3,500	\$3,500+	
Number in Family	1	8,182	2,695	4,833	1,000	343	127	78	31	156	17,445
	2	2,290	1,120	1,688	811	422	151	107	66	234	6,889
	3	2,418	1,083	1,589	959	678	268	163	117	401	7,676
	4	2,278	705	1,282	940	723	435	257	131	514	7,265
	5	1,648	439	808	643	563	421	257	148	469	5,396
	6	930	234	368	345	349	295	222	129	378	3,250
	7	478	115	175	150	141	150	121	71	232	1,633
	8	172	58	96	77	56	45	49	39	105	697
	9	85	21	40	19	25	28	20	14	34	286
	10+	146	22	49	40	23	29	20	18	69	416
In Poverty		18,627	6,492	10,928	3,984	1,880	968	210	32	-	43,121
Not in Poverty		-	-	-	1,000	1,443	981	1,084	732	2,592	7,832
Total Clients		18,627	6,492	10,928	4,984	3,323	1,949	1,294	764	2,592	50,953

Urban and Rural Areas¹

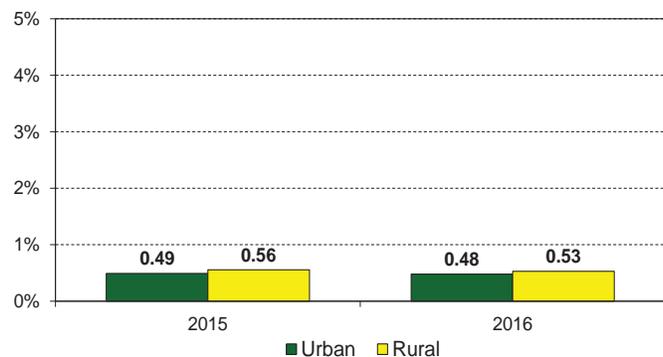
The following graphs show the total number of individuals served in urban and rural communities and the percentage of the total population

served for substance use disorders and mental health.

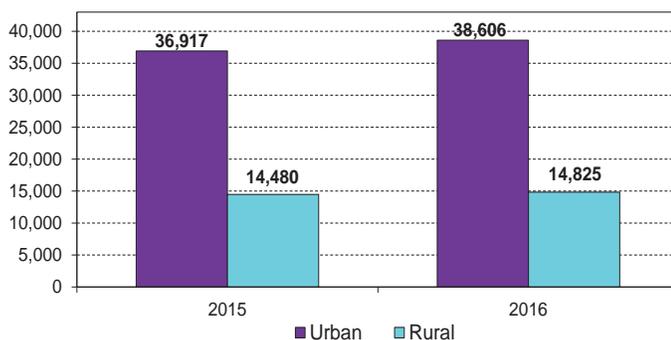
Number of Individuals Served in Substance Use Disorder Services in Urban and Rural Communities Fiscal Years 2015 - 2016



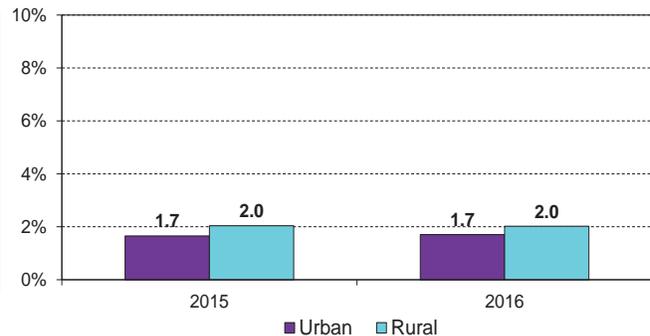
Percent of Total Population Served in Substance Use Disorder Services in Urban and Rural Communities Fiscal Years 2015 - 2016



Number of Individuals Served in Mental Health Services in Urban and Rural Communities Fiscal Years 2015 - 2016



Percent of Total Population Served in Mental Health Services in Urban and Rural Communities Fiscal Years 2015 - 2016



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.

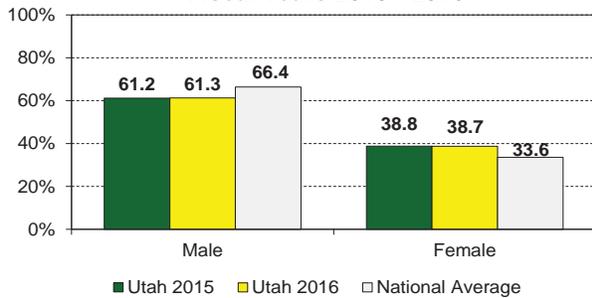
Demographics

Gender and Age

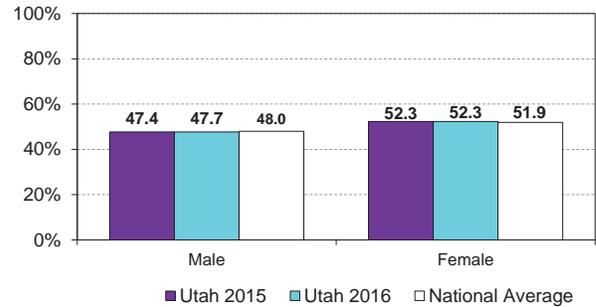
The charts below identify the distribution of services by gender and age for substance use disorder and mental health services.

order and mental health services. There are significant differences between the substance use disorder and mental health populations in both gender and age.

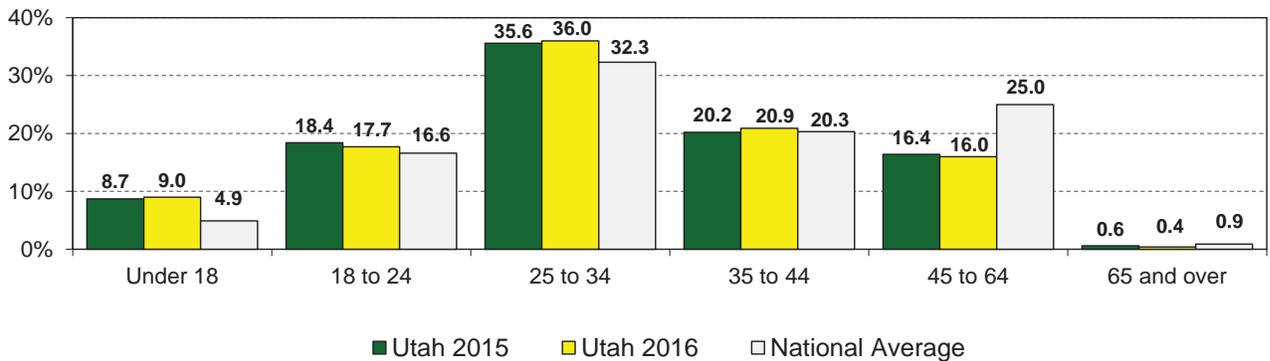
Gender of People Served in Substance Use Disorder Services
Fiscal Years 2015 - 2016



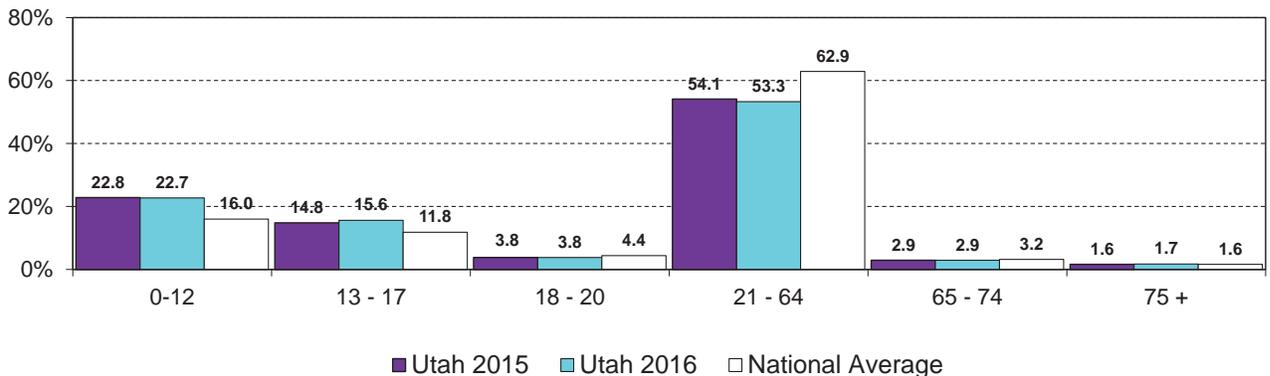
Gender of People Served in Mental Health Services
Fiscal Years 2015 - 2016



Age at Admission of People Served in Substance Use Disorder Services
Fiscal Years 2015 - 2016



Age of People Served in Mental Health Services
Fiscal Years 2015 - 2016

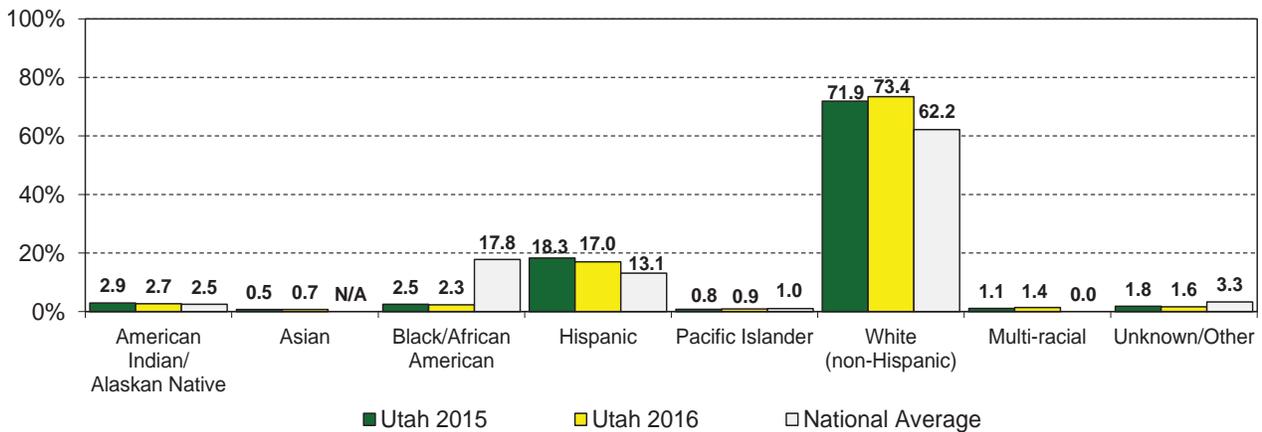


Race and Ethnicity

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

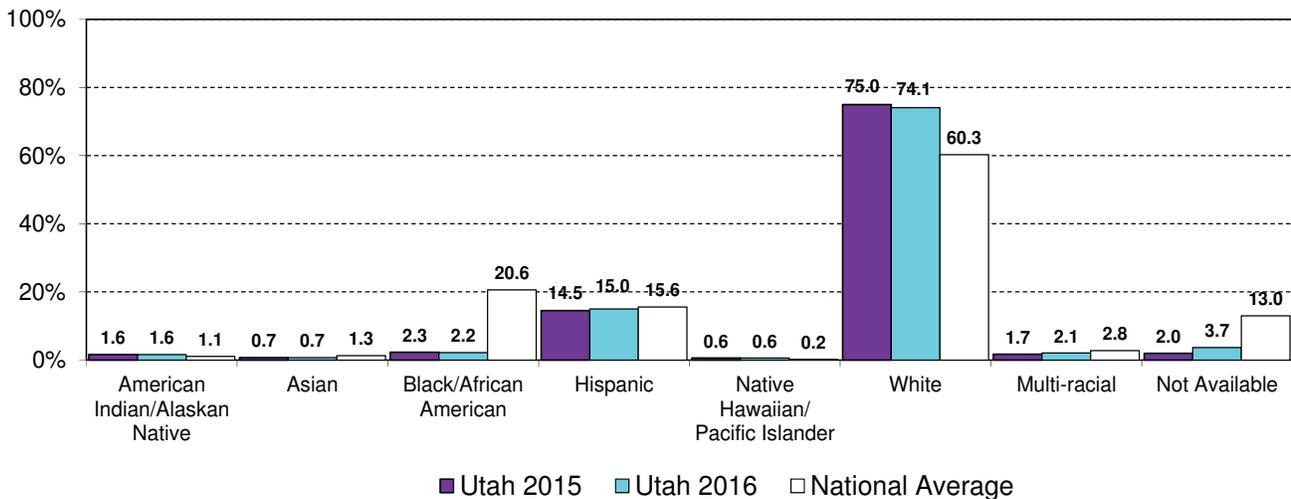
clients receiving substance use disorder or mental health services.

Race/Ethnicity of People Served in Substance Use Disorder Services
Fiscal Years 2015- 2016



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

Race/Ethnicity of People Served in Mental Health Service
Fiscal Years 2015 - 2016

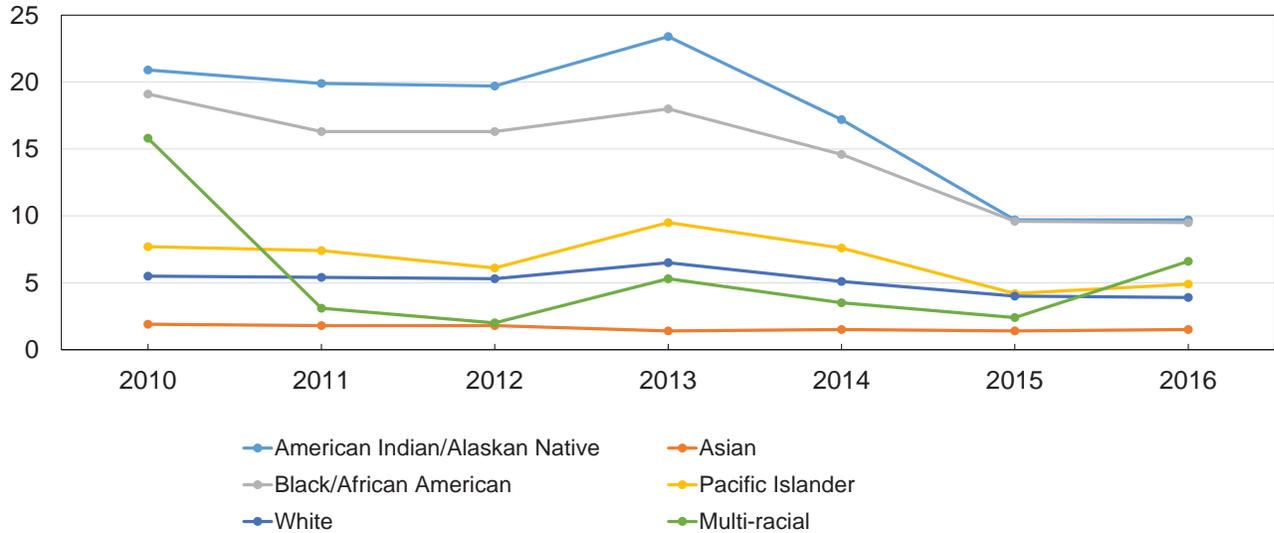


Note: More than one race/ethnicity may have been selected.

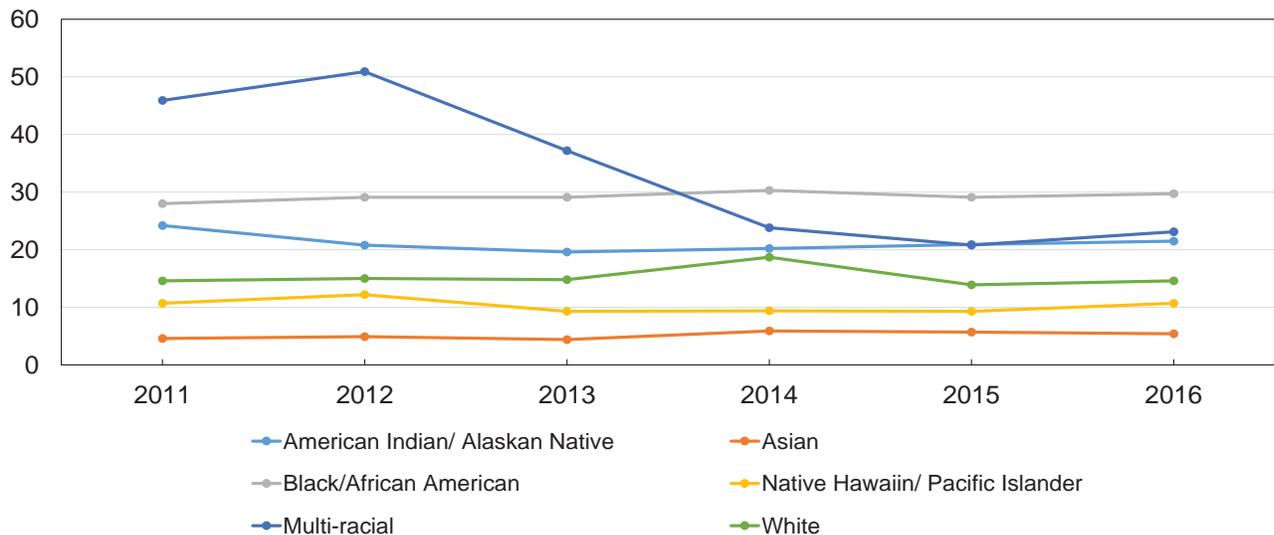
The charts below and on the following page show the trends in penetration of substance use disorder and mental health services by race/ethnicity. These graphs compare the rates that

people are seeking services and account for the widely differing numbers of people in those racial/ethnic groups.

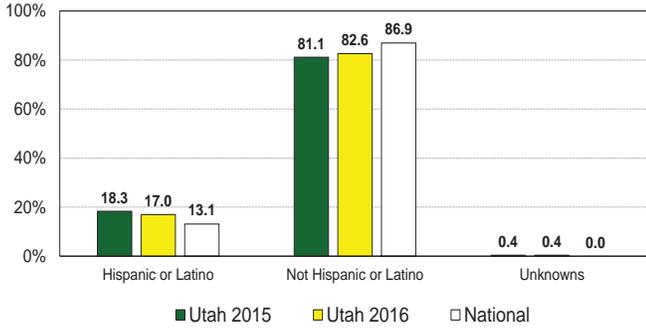
Penetration of People in Substance Use Disorder Treatment per 1,000 Population by Race Fiscal Years 2010 through 2016



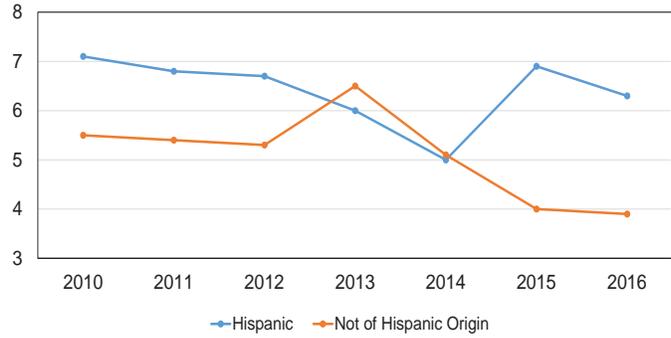
Penetration of People in Mental Health Treatment per 1,000 Population by Race Fiscal Years 2011 through 2016



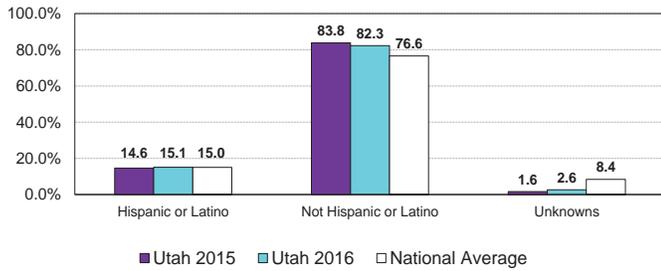
Ethnicity of People Served in Substance Use Disorder Services
Fiscal Years 2015 - 2016



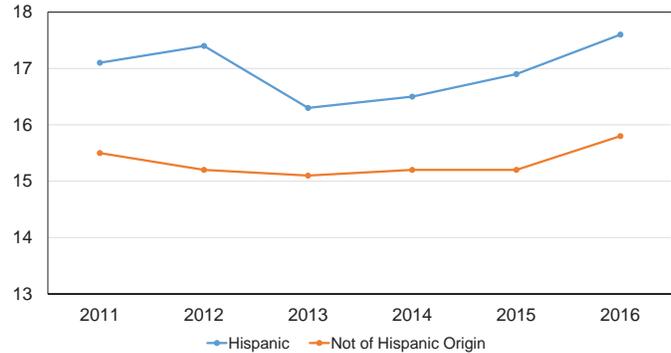
Penetration of People in Substance Use Disorder Treatment per 1,000 Population by Ethnicity
Fiscal Years 2010 through 2016



Ethnicity of People Served in Mental Health Services
Fiscal Years 2015 - 2016



Penetration of People in Mental Health Treatment per 1,000 Population by Ethnicity
Fiscal Years 2011 through 2016

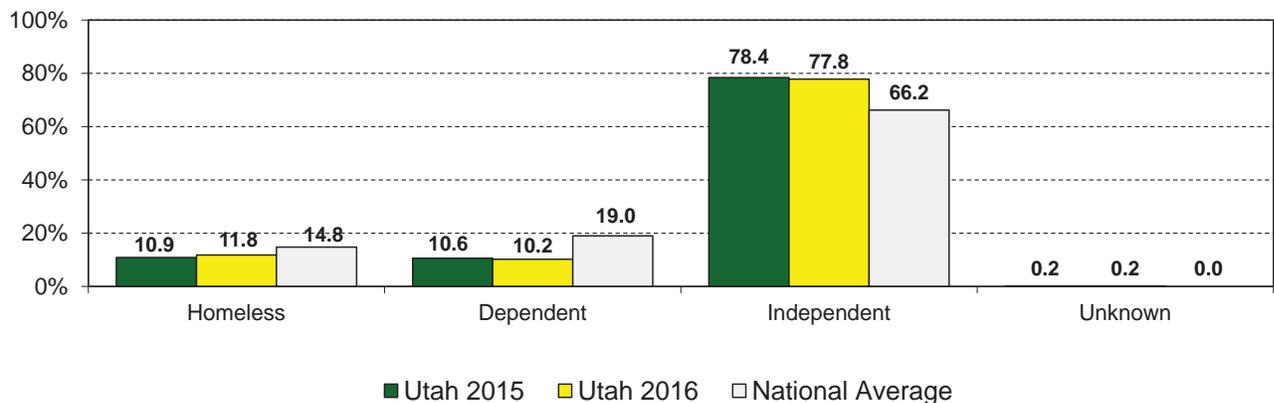


Living Arrangement

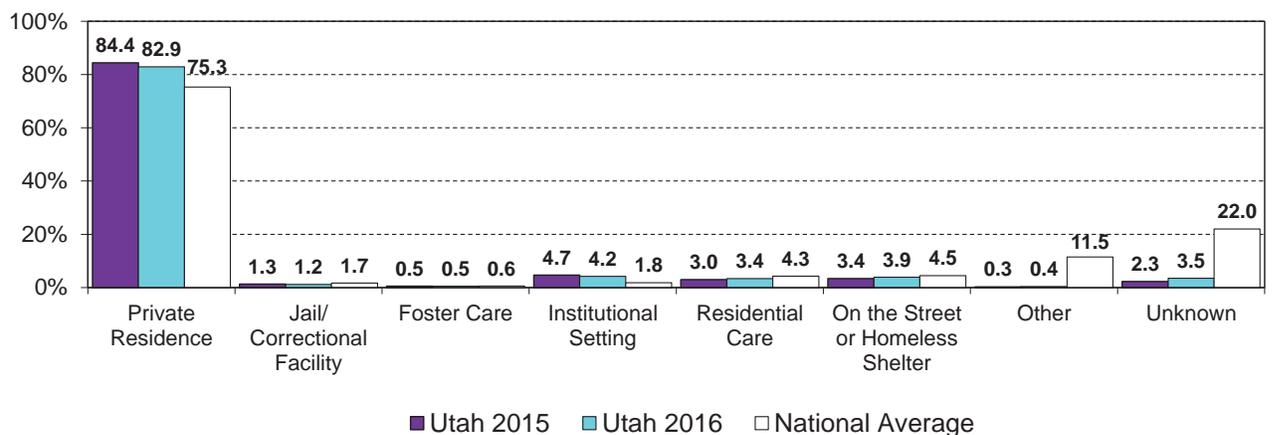
The following charts depict clients' living arrangement at admission for substance use disorder and for mental health clients served in fiscal years 2015 and 2016. By far, the majority of clients receiving substance use disorder and

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.

Living Arrangement at Admission of Adults Served in Substance Use Disorder Services
Fiscal Years 2015 - 2016



Living Arrangement of Adults Served in Mental Health Services
Fiscal Years 2015 - 2016

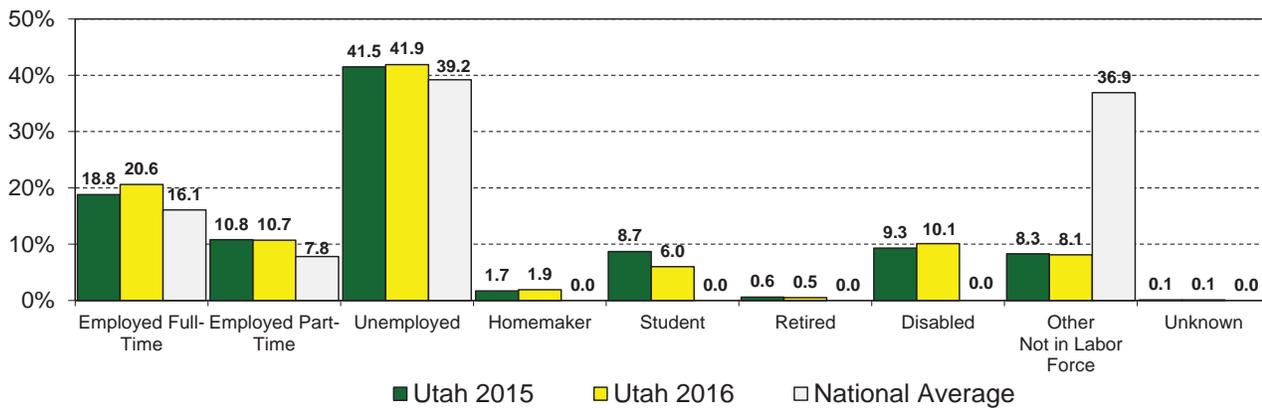


Employment Status

The following charts show the employment status at admission for substance use disorder and for mental health clients served in fiscal year 2015 and fiscal year 2016. The categories

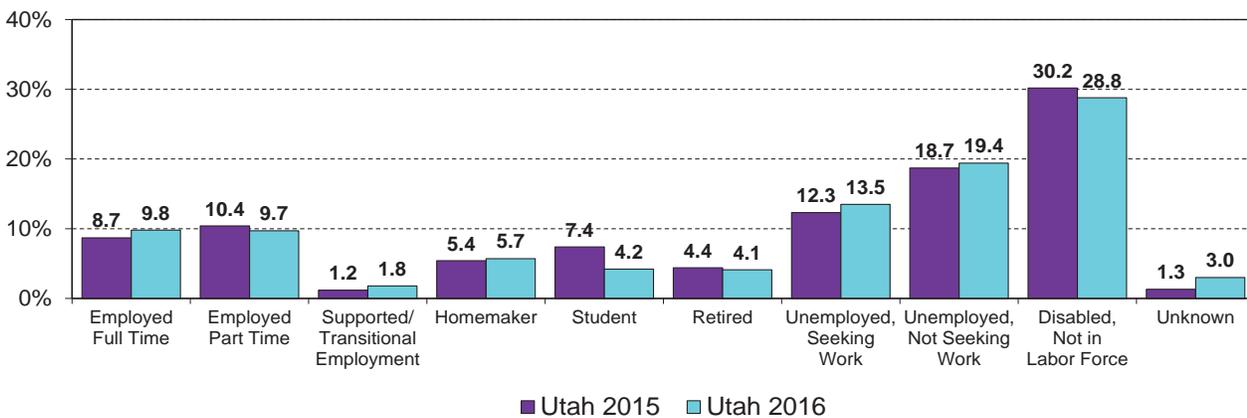
for mental health clients are different than those for substance use disorder clients due to different reporting requirements.

Employment Status at Admission for Substance Use Disorder Services Fiscal Years 2015 - 2016



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

Employment Status for Adults in Mental Health Services Fiscal Years 2015 - 2016

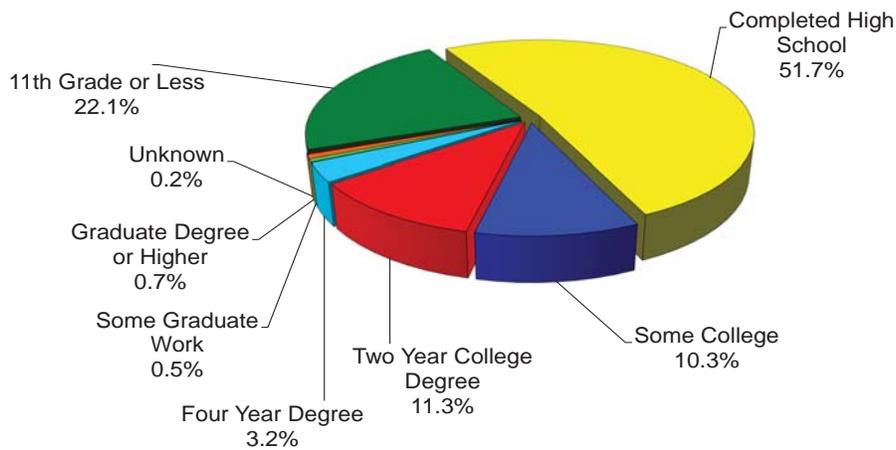


Highest Education Level Completed

In fiscal year 2016, over 77% of adults in substance use disorder treatment statewide completed at least high school. Of those adults, 26% had also

attended some college or technical training prior to admission. Still, 22% had not graduated from high school.

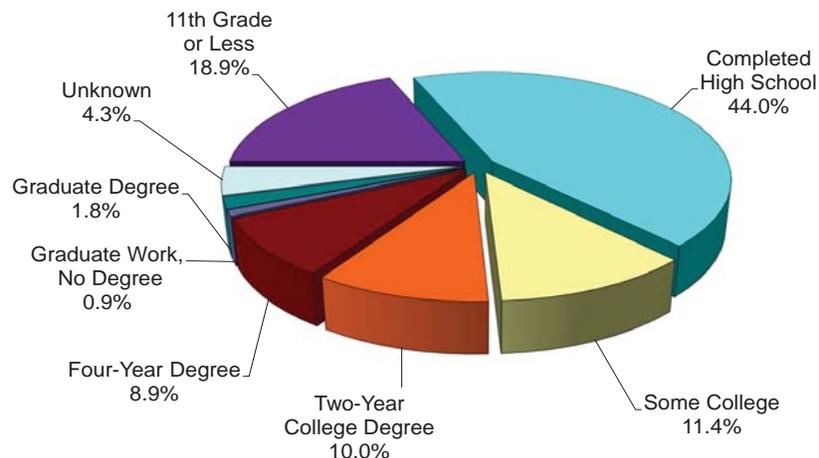
**Highest Education Level at Admission for Adults in Substance Use Disorder Services
Fiscal Year 2016**



In fiscal year 2016, almost 77% of adults in mental health treatment statewide completed at least high school. Of those adults, 33% had also attended

some type of college and/or technical training. Still, almost 19% had not graduated from high school.

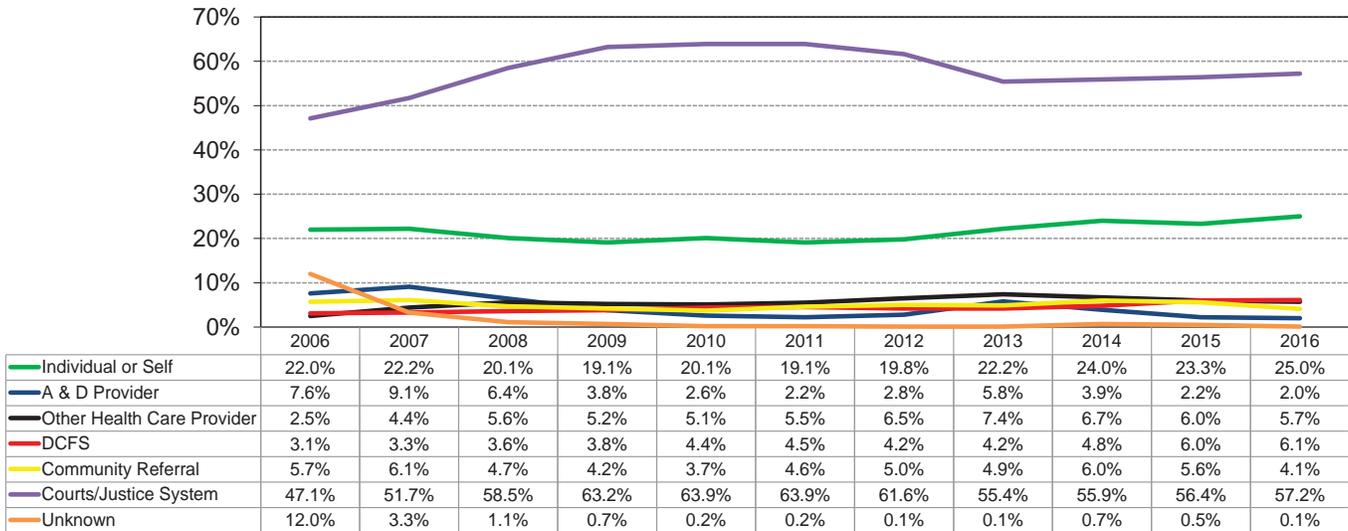
**Highest Education Level of Adults Served in Mental Health Services
Fiscal Year 2016**



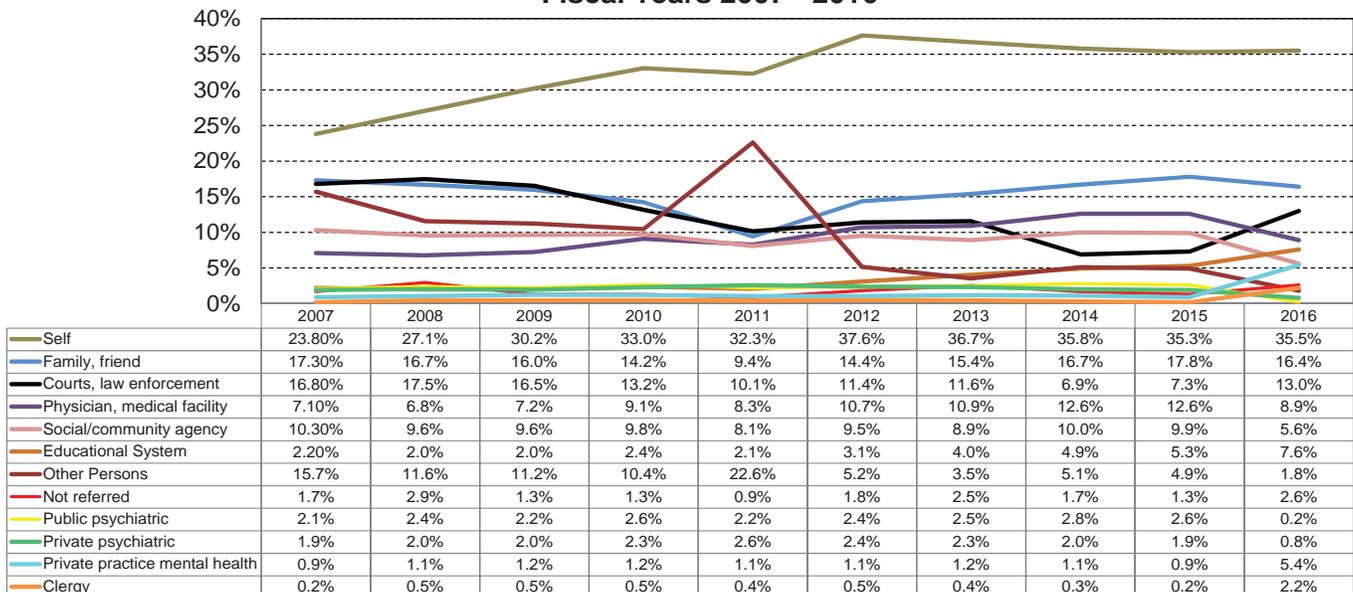
Referral Source

The charts below detail referral sources for substance use disorders for fiscal years 2006 through 2016 and for mental health for fiscal years 2007 through 2016.

Referral Source of Individuals in Substance Use Disorder Services Fiscal Years 2006 - 2016

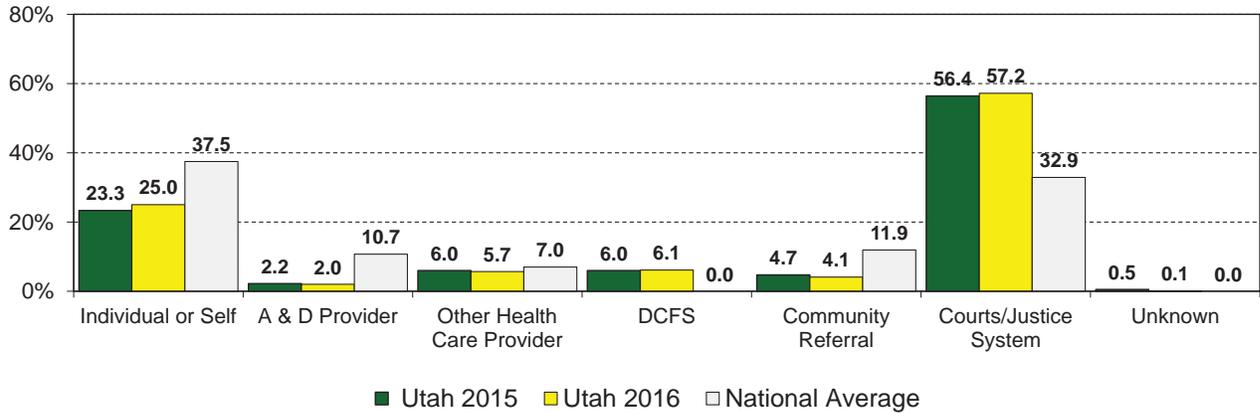


Referral Source of Individuals Served in Mental Health Services Fiscal Years 2007 - 2016



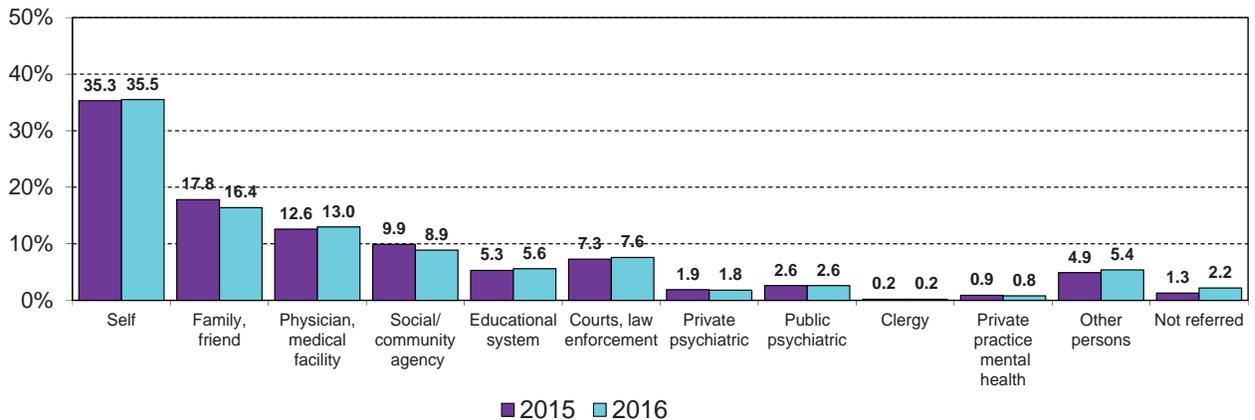
The graphs below detail referral sources for substance use disorder and mental health services for fiscal years 2015 and 2016.

Referral Source of Individuals Served in Substance Use Disorder Services Fiscal Years 2015 - 2016



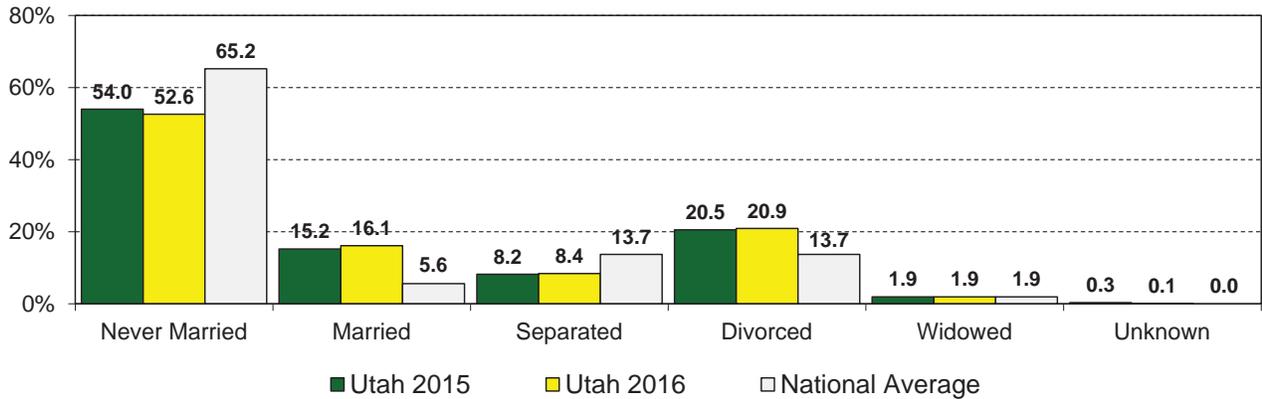
*Note: All other National categories are contained in Community Referral.

Referral Source of Individuals Served in Mental Health Services Fiscal Years 2015 - 2016

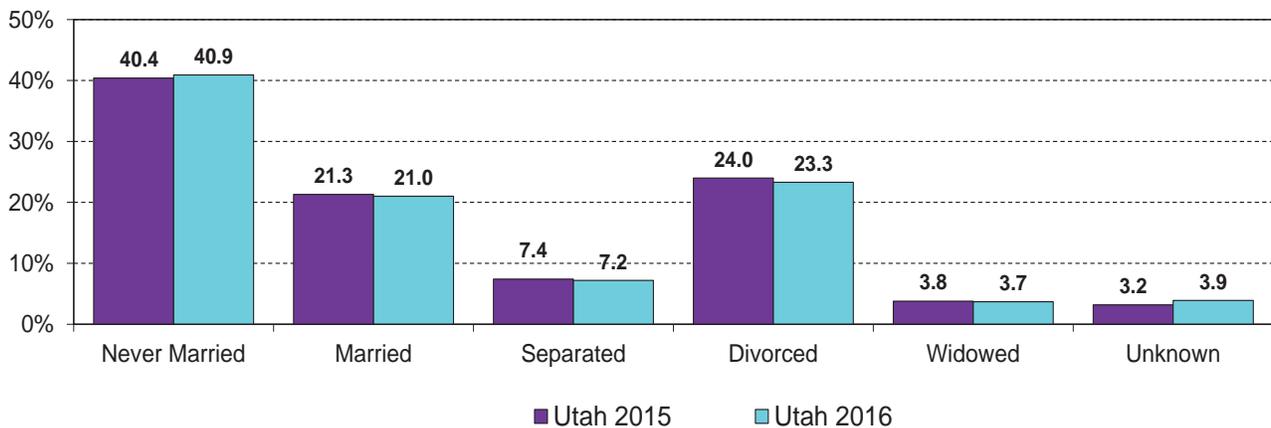


Marital Status

Marital Status of Adults Served in Substance Use Disorder Services
Fiscal Years 2015 - 2016

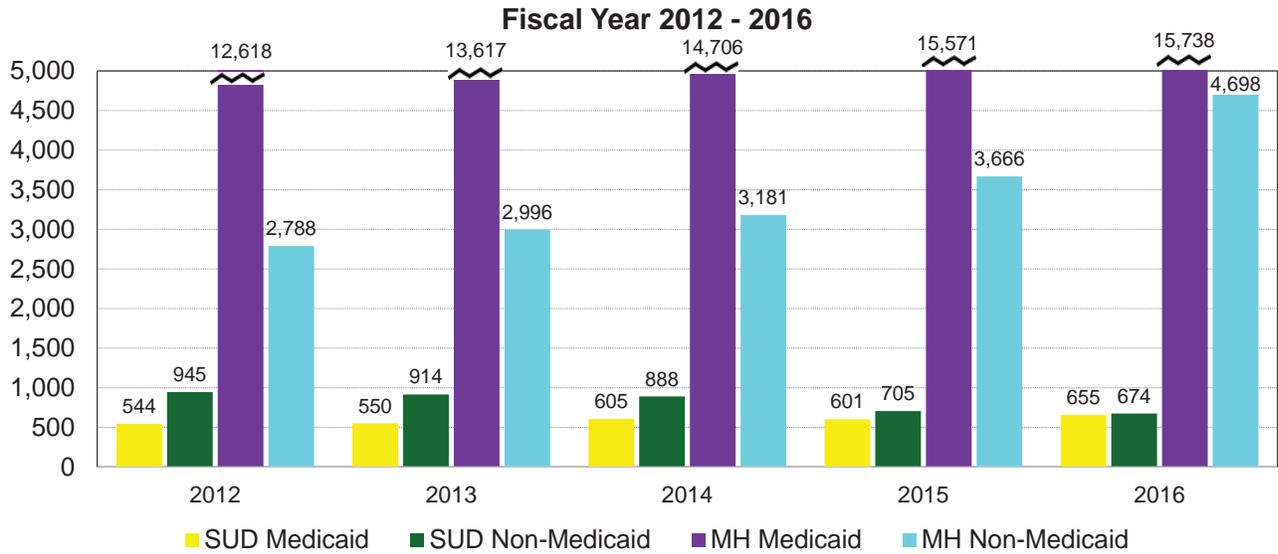


Marital Status of Adults Served in Mental Health Services
Fiscal Years 2015 - 2016

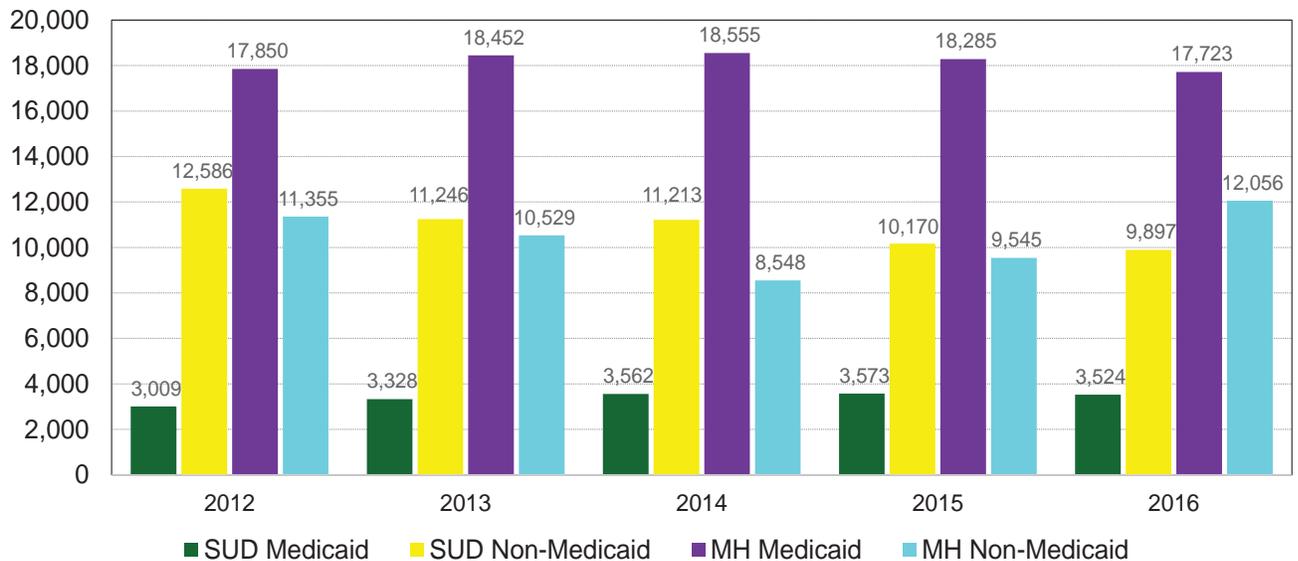


Medicaid and Non Medicaid Clients

Substance Use and Mental Health Clients Under Age 18 Medicaid and NonMedicaid



Adult Substance Use and Mental Health Clients Medicaid and NonMedicaid Fiscal Year 2012 - 2016



A Family's Story

Over 10 years ago, I overdosed on prescription pain medicine and nearly died. After that incident, I became motivated to conquer my addiction, but also vowed to help others with theirs. It's been an emotional journey for me and my family, one that nearly cost me my life.

After a car accident I was prescribed pain pills. I didn't want surgery, so I opted to take the opiate painkillers. That first pill started my addiction. Over time, the effects of my addiction grew worse. As the addiction grew, I doctor shopped to get additional prescriptions, and completely ignored the dosage directions on the bottle.

During the years of addiction, I would often call in sick or leave work early. I had no pride in anything I did. At home, I put my addiction in front of my responsibilities as a father and a husband. My life took a near-fatal turn in 2006. I accidentally overdosed in front of my wife and four children. My wife called the ambulance and gave me CPR. She saved my life. When we got home from the hospital, I proceeded to take more painkillers.

Eventually, my wife gave me an ultimatum. She said if I didn't seek treatment, she was going to leave me. I went into treatment that day. I realized that I was an addict, and that others knew it. I learned that I loved my addiction more than anything in my life, more than my family. I also realized that nobody is immune to addiction. Addiction has no compassion. It doesn't care how many stripes you have on your sleeve, or what degree you have on the wall.

The thought of returning to work after rehab was frightening. I needed to prove to myself and my team, that I was different now. They all welcomed me back with open arms.

It has been almost 11 years since I left the rehab center. Amy and I will celebrate our 28th wedding anniversary this April. She tells me I am a completely different person. I am closer to my family than I ever have been. I still remain conscious of the fact that I am an addict. It's important to respect the addiction because it's waiting every day, looking for any indication we are weakening in our recovery.

My wife and I were called and served as volunteers in the Addiction Recovery Program (ARP) for our church. We have witnessed the effect of loving our youth unconditionally and helping them realize things about themselves they did not know.

I work at Hill Air Force Base as a Wingman Advocate, connecting others to resources. Sharing my story helps others know addicts can change and recovery is possible. I'm not ashamed of my past. Going through my recovery process, assisting other people with their recoveries, has helped me realize that I could take something bad and turn it into something good. I am a proud Husband, Father, Grandfather and member of society.

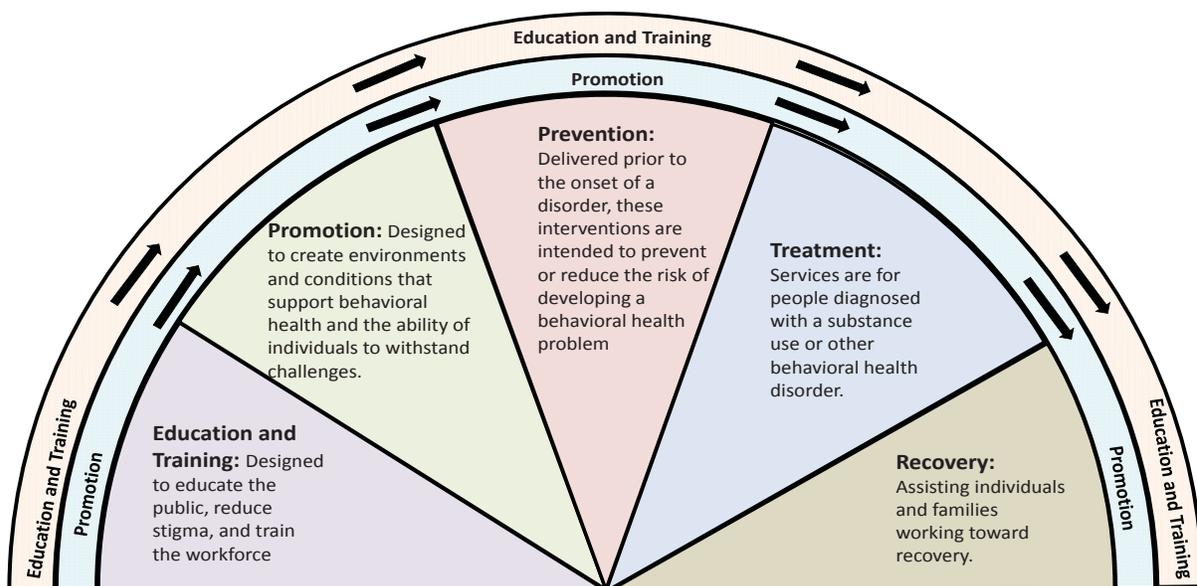


Services and Activities

In partnership with county governments, DSAMH oversees a comprehensive array of behavioral health services designed to address the full spectrum of substance use and mental

health disorders. The following table illustrates the continuum of behavioral health services provided.

Continuum of Services



Education and Training

Utah law assigns DSAMH the responsibility to educate the general public; operate workforce certification programs; and also disseminate information about effective practices. DSAMH delivers hundreds of hours training through certification programs, conferences and other events around the state each year. These learning opportunities drive societal change by increasing understanding and improving the response to substance use and mental health disorders.

Certification Programs

A competent workforce is critical to delivering effective behavioral health services. DSAMH delivers the following certification programs to help develop Utah's behavioral health workforce:

Substance Abuse Prevention Specialist (SAPST)

DSAMH trains and certifies prevention workers using the Utah-Substance Abuse Prevention Skills Training (SAPST). Utah-SAPST takes a curriculum developed by the federal government Substance Abuse and Mental Health Services Administration-Center for Substance Abuse Prevention (SAMHSA-CSAP) and adds to it to cover Utah specific issues and strategies. Utah-SAPST provides an introduction to the fundamentals of substance abuse, mental illness, and suicide prevention based on the current research and practice in the field. The training prepares practitioners to reduce the likelihood of substance abuse and

promote well-being among individuals, within families, workplaces, schools, and communities. The Utah-SAPST covers basic prevention science as well as policy issues and how the Utah Prevention System operates. Participants are introduced to Utah specific initiatives such as Parents Empowered, Prevention by Design, and how to build capacity at the local community level. In fiscal year 2016, there were three trainings held with 63 people trained in Utah-SAPST.

Driving Under the Influence (DUI) Education Instructors

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 2016, 7274 people attended DUI Education classes.

Off-Premise Sales Training

Utah law mandates training for grocery and convenience store employees who sell alcoholic beverages or directly supervise the sale of beer. Training is required within 30 days of hire and at least every 5 years thereafter. Stores may hire a trainer to train staff in person, purchase a training package to train their own staff, or create and submit their own training for approval, or an individual may take online training. DSAMH establishes the curriculum requirements and approves training providers. In 2016, 10,854 people were trained to sell alcoholic beverages for off-premise consumption.

On-Premise Alcohol Beverage Server Training

DSAMH certifies providers who train servers who sell alcoholic beverages in Utah. All “on-

premise” trainees must recertify at least every 3 years. During fiscal year 2016, 11,450 people were trained to serve alcohol for on-premise consumption.

Quality Treatment for Youth

Parents, treatment providers, policy makers and youth deserve effective treatment interventions. DSAMH is working to ensure that youth have access to evidence-based screening, assessment, treatment and recovery services. DSAMH has convened stakeholders to develop a comprehensive plan to ensure services are effective.

In addition, DSAMH has also partnered with Treatment Research Institute (TRI) to evaluate the quality of Utah’s adolescent treatment programs and to develop a Utah Consumer Guide to Adolescent Substance Abuse Treatment™ Website. The Consumer Guide will help parents, payors, referral sources, and the public evaluate program quality, convenience, and availability. Thirty four treatment agencies from all areas of the state are participating. These programs will receive technical assistance and support from local and national youth treatment experts to improve quality.

Justice Certification

Reducing recidivism requires more than treating substance use disorders and mental illness. Research shows that risks factors in a person’s life such as having antisocial friends, thinking patterns, personality traits and a criminal history that starts at a young age, are important in treatment programming, designed to reduce the likelihood of a person returning to criminal activities.

DSAMH is statutorily responsible to certify providers of treatment services that serve individuals involved in the justice system. DSAMH has completed the following to fulfill this mandate:

- All substance use and mental health Local Authorities are required to create and maintain committees that oversee the es-

establishment of justice treatment programs in each agency's area and work to overcome roadblocks;

- Worked with stakeholders to establish treatment and program standards for agencies that provide substance use and mental health treatment to individuals who are justice involved;
- Provided a list of all provisionally certified treatment agencies to district and justice court judges, the Department of Corrections and other justice agencies, who are required to refer persons in the justice system, with a substance use or mental health disorder to justice certified programs for treatment. To date;
- 143 agencies including Local Authorities, have been provisionally certified
- 6 prison programs have been provisionally certified
- 12 jail programs have been provisionally certified
- 22 Adult Probation and Parole programs have been provisionally certified
- DSAMH has provided training opportunities for certified providers to increase the use of evidence based practices by using Motivational Interviewing (MI), Moral Reconciliation Therapy (MRT), Seeking Safety, LS/RNR Assessment and Trauma Informed Care

Case Management

Case management is a central highlight of community mental health work, both in teams and individually working with people with mental illness and/or substance use disorders to help achieve their goals. Case Management is a mandated service in Utah, and the Local Mental Health and Substance Use Authorities are responsible to provide case management in their local areas. Case management provides four critical functions often referred to using the ac-

ronym CALM (Connecting Advocating, Linking and Monitoring): connecting with the individual, advocating for the individual, linking and planning for services, and monitoring service provision. Providers of case management services also provide skill development services, personal services, as well as psychosocial rehab groups. DSAMH has improved the quality of case managers through a certification process that has proven to be successful. DSAMH is also working with the local homeless service providers to develop a certification program with basic standards for all providers serving individuals that are homeless. DSAMH developed preferred practices for case management, including a training manual, and an exam with standards to promote, train, and support the practice of case management and service coordination in behavioral healthcare. In SFY 2016, DSAMH has certified 184 case managers compared to 176 in SFY 15, for a total of 650 certified case managers.

Crisis Counseling

The DSAMH Crisis Counseling Certification Program supports short term interventions with individuals and groups experiencing psychological reactions to small and large scale disasters. These interventions involve using Psychological First Aid goals to assist disaster survivors in understanding their current situation and reactions, mitigating additional stress, promoting the use or development of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that may help survivors recover to their pre-disaster level of functioning. While always cognizant of those individuals with mental illness and/or substance use disorders' special needs, the thrust of the Crisis Counseling Program has been to serve people responding normally to an abnormal experience. DSAMH has provided training on Psychological First Aid over the past several years and has seven-hundred and sixty-five (765) certified crisis counselors statewide.

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) Program is an innovative model of community policing that involves partnerships between law enforcement, the mental health system, and advocacy groups. CIT provides law enforcement personnel with specialized crisis intervention training to assist a person experiencing a mental health crisis, which improves officer and consumer safety, and redirects individuals with mental illness from the judicial system to the health care system. This training includes a 40-hour course that is completed in a one-week session. DSAMH has partnered with CIT Utah Inc. and its board of directors to provide statewide law enforcement training and support. In this partnership, law enforcement personnel who take the 40 hour training and pass a state test will achieve the CIT certification. A total of 127 law enforcement agencies have sent representatives to the CIT Academies. For more information, visit the CIT website:

CIT-Utah.com.

Designated Examiner (DE)

Designated Examiners are trained, licensed professionals familiar with severe mental illness, who evaluate whether an individual meets criteria for civil commitment. Civil commitment is a legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment. DE apply the rules of civil commitment to protect public safety and citizens' civil rights. In 2016, DSAMH trained and certified 66 DE. There are currently 323 DE across Utah.

Family Resource Facilitator (FRF)

Family Resource Facilitators are trained family members who ensure families have a voice in service delivery and policy decisions. At no charge to families, FRFs provide referrals to local resources and programs; advocacy for culturally appropriate services; links to information and support groups; and family wraparound

facilitation. DSAMH contracts with the Utah Family Coalition (NAMI Utah, Allies with Families and New Frontiers for Families) for standardized training, coaching, and supervision. Family Resource Facilitation and Wraparound is accessible in 25 of the 29 Utah counties, through 46 certified FRF's.

Certified Peer Support Specialists (CPSS)

Peer Support Specialists are adults in recovery from a substance use or mental health disorder that are fully integrated members of a treatment team. They provide highly individualized services in the community and promote client self-determination and decision-making. CPSS also provide essential expertise and consultation to the entire treatment team to promote a culture in which each client's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities. Since the program's inception, 488 individuals have been certified by DSAMH as CPSS. DSAMH currently contracts with Utah State University, Optum Health and the Salt Lake City Veteran Affairs Medical Center to provide standardized training across the state. Utah State University has developed or is developing additional special population peer support training modules for Youth-In-Transition (age 16-25), Refugee, Native American and Hispanic populations. To date, 122 CPSS have received Youth-In-Transition Training.

Conferences

Conferences play a vital role in disseminating information to the public, the behavioral health work force and other community partners such as law enforcement and the judiciary. DSAMH provides or sponsors a number of conferences throughout the year, designed to present emergent research, evidence-based practices and op-

opportunities for professionals to gain a broader understanding of our system.

Critical Issues Facing Children and Adolescents

The 20th Annual Critical Issues Facing Children and Adolescents Conference was held November 3-4, 2016. The focus of this conference is educating behavioral health professionals about critical behavioral health issues facing youth and families.

Generations Conference

The 2016 Generations Conference was held March 31-April 1, 2016. This conference provides the latest information and most effective practice techniques to deal with behavioral health. Sessions provide education in topics such as forensics, trauma, geriatrics, and autism. Pre and Post-conference workshops included Motivational Interviewing, Lethality Assessment and Dialectical Behavior Therapy (DBT) skills training.

Utah Fall Substance Abuse Conference

The 38th Annual Utah Fall Substance Conference was held in St. George, September 21-23, 2016. This conference, planned and hosted by DSAMH, brings the latest research and evidence-based tools to behavioral health providers and community partners. Due to overwhelming demand, the conference expanded to over 1,200 attendees from 24 different states.

Utah Peer Conference

A Peer Support Conference was held on June 10, 2016 sponsored by DSAMH. Over 145 Peers (Certified Peer Support Specialists and Family Resource Facilitators) attended this successful event organized by Latino Behavioral Health Services. The theme for this year's conference was "Recovery Works, Uniting our Voices." This event was primarily for individuals with their

own or a family member's lived experience with mental health or substance use conditions.

Supported Employment/Housing/CABHI Summit

DSAMH held the first annual Supported Employment/Individual Placement and Support (SE/IPS) and Supportive Housing/Cooperating Agreement to Benefit Homeless Individuals (CABHI) Summit in June 2016. The Summit hosted 125 Federal and State agency representatives, community partners, consumer advocates, individuals experiencing homelessness and people with mental illness and co-occurring disorders. This innovative Summit was specifically designed to assist in improving and increasing competitive and integrated employment as well as permanent housing outcomes for people with mental illness and co-occurring disorders. The Summit focused on Employment First and Housing First initiatives and educated participants on SE/IPS and Permanent Housing Evidence-Based Practices.

Other Training Events

In addition to conferences, DSAMH provides additional training each year to foster a better understanding of the symptoms, causes, treatment and prevention of substance use disorders and mental illness. In fiscal year 2016, DSAMH staff and partners invested thousands of hours to educate, inform, and motivate stakeholders and constituents to dispel myths surrounding these important societal issues. Some examples are:

Prevention Coalition Summit

DSAMH sponsored the third annual Prevention Summit where coalition members from across the state met to discuss coalition and system needs. In addition, several experts in the prevention field provided training on increasing the readiness for communities to provide effective prevention programming.

First Episode Psychosis Program

In 2014, a Congressional mandate to begin funding First Episode Psychosis (FEP) programs in all states and territories was added to the mental health block grant. Approximately 1 out of every 100 people will experience psychosis at some time in their lives, with a peak onset between 15-25 years of age. Psychosis is defined as a condition that affects the mind, with some loss of contact with reality, and disorders involving psychosis are among the most debilitating mental health conditions among youth and young adults. Research shows that early intervention with evidenced based practices can increase the chance of a successful recovery and quality of life for individuals who experience early onset psychosis. Coordinated Specialty Care (CSC) is a recovery-oriented evidenced based treatment program for people with First Episode Psychosis (FEP).

CSC is intended for youth, adolescents, and young adults, and is designed to bridge existing services for these groups and eliminate gaps between child, adolescent, and adult mental health programs. CSC programs are operating in Weber and Morgan Counties, Davis County, and Utah County. Both Weber Human Services and Davis Behavioral Health have hosted week long trainings on the First Episode Psychosis programming. DSAMH recently hosted a two day training from Ontrack New York on the CSC model for the Local Mental Health Authorities participating in FEP.

Forensic Evaluator

The Department of Human Services (DHS), train and contract with private forensic evaluators to provide forensic evaluations ordered by Utah courts. DHS, DSAMH, the Utah State Hospital and the Division of Services for People with Disabilities (DSPD) host an annual conference to provide ongoing training and support to the contracted evaluators. In November 2016, this training was expanded an additional day to focus on community partnership. Participants

were invited from Public Safety, Corrections and Judicial partners to discuss coordinated efforts to help encourage collaboration across the forensic mental health spectrum of services.

The evaluations are requested and submitted through the Forensic Evaluations System (FES), an electronic system developed by DSAMH. It is utilized to help standardize the adult and juvenile competency process and provide an interface between DHS, DSAMH, the Utah State Hospital, DSPD, contracted evaluators, and the courts. Quality is ensured by forensic evaluation peer review.

For fiscal year 2016, Forensic Evaluators performed 85 juvenile and 807 adult, court-ordered competency evaluations.

Pre-admission Screening Resident Review (PASRR)

The PASRR Program (Pre Admission Screening Resident Review) is mandated by federal law as part of the Federal Omnibus Budget Reconciliation (OBRA) Act, and administered by DSAMH. PASRR was enacted to ensure identification of individuals with mental illness and/or Intellectual Disabilities and/or Related Conditions are appropriately placed in Medicaid Certified Nursing Facilities and to ensure that they receive the services they require.

The PASRR regulations 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.

Utah remains the fifth most rapidly growing state. Utah grew by 1.7 percent last year according to population projections released by the U.S Census Bureau. The projections show Utah’s population is expected to approach 3.5 million by 2030, a growth rate of 56% over three decades.

The census projections also show a rapidly aging population nationwide. Utah is projected to gain 270,331 people age 65 and older by 2030, more than double the 2000 senior population.

In fiscal year 2016, DSAMH processed 3,186 compared to 3,126 evaluations in fiscal year 2015. The dramatic growth of the older population may have a significant impact on the PASRR Program as the number of PASRR evaluations will continue to increase to meet rising demands.

Wellness Recovery Action Plans (WRAP)

WRAP is a SAMHSA nationally registered, evidence-based Peer Support program that assists individuals in recovery in developing their own self-directed and personalized recovery plan. Formal WRAP groups typically range in size from 10 to 15 participants and are led by two trained co-facilitators, who are peers with lived experience and who use WRAP for their own recovery. Information is delivered and skills are developed through lectures, discussions, and individual and group exercises. In August 2015, DSAMH held a WRAP Training for CPSS, facilitated by the Copeland Center. Sixteen CPSS from nine of Utah's local mental health authorities, Latino Behavioral Health and DSAMH were trained in this evidenced-based peer support service. Another WRAP training was held in November 2016. 11 additional professionals were trained.

Peer Support Whole Health and Resiliency

A Peer Support Whole Health and Resiliency Training was sponsored by DSAMH in September of 2016. This two day training was provided by Appalachian Consulting for 20-25 participants. It focused on ten healthy lifestyle/resiliency domains, and was about motivating and helping people believe that they can take control of some part of their life and be successful. The program was designed to be taught to mental health peer

specialists who are in a position to teach what they have learned to their peers in mental health.

Applied Suicide Intervention Skills Training (ASIST)

Applied Suicide Intervention Skills Training is a two-day intensive, interactive and practice-dominated course designed to help clinical, non-clinical caregivers and parents recognize and review risk, and intervene to prevent the immediate risk of suicide. It is by far the most widely used, acclaimed and researched suicide intervention training workshop in the world.

Question, Persuade, Refer (QPR)

QPR stands for Question, Persuade, and Refer—3 simple steps that anyone can learn to help prevent suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR skills can be learned in as little as one hour.

Mental Health First Aid

Mental Health First Aid is an 8-hour course that teaches you how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps you identify, understand, and respond to signs of mental illnesses and substance use disorders.

Connect Postvention

A suicide can have a devastating impact on a community or organization. The shock and grief can ripple throughout the community affecting friends, co-workers, schools, and faith communities. Connect Postvention training helps service providers respond in a coordinated and comprehensive way in the aftermath of a suicide or any sudden death.

SafeTalk

SafeTALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK stresses safety while challenging taboos that inhibit open talk about suicide.

Columbia Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is a questionnaire used to assess the full range of evidence based suicidal ideation and behavior with criteria for next steps. The C-SSRS can be used across various settings including primary care, clinical practice, military setting, correction facilities and more.

Stanley Brown Safety Plan

Suicidal thoughts can seem like they will last forever—but for many, these thoughts and feelings pass. Having a plan in place that can help guide you through difficult moments can make a difference and keep you safe. Ideally, such a plan is developed jointly with your counselor or therapist. It can also be developed with a Lifeline counselor who can help you write down actions to take and people to contact in order to feel safe from suicide. Plans should be kept where they can be easily accessed (wallet or cell phone).

Trauma-informed Approach

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. 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. Child abuse, sexual assault, military combat, domestic violence, and a host of other violent inci-

dents help shape the response of the people we serve.

Adverse childhood experiences are strongly related to development and prevalence of a wide range of health problems, including substance abuse and mental illness. Over time people exposed to trauma adopt unhealthy coping strategies that lead to substance use, disease, disability and social problems, and premature mortality.

Since 2012, DSAMH embarked on several state-wide efforts to implement the Trauma-Informed Approach in public and private programs, by providing training; organizational evaluation and consultation; policy implementation and partnering with local and national organizations. Some of these initiatives and training events are listed below:

1. Ongoing Organizational Evaluation, Consultation, Training and Technical Assistance on the Trauma-Informed Approach, provided by Gabriella Grant, M.A., Director for the California Center of Excellence for Trauma-Informed Care for CABHI Grantees, Volunteers of America, DSAMH and other groups.
2. Utah Trauma Academy: October 31, November 4, 2016 for 110 public and provide providers. The Utah Trauma Academy was developed and provided by Gabriella Grant and several local trauma experts. The Utah Trauma Academy was based on the Victim Academy developed by the Office of Victims of Crimes at the Department of Justice.
3. Implementation of the Trauma-Informed Approach: DHS, DSAMH and several public and private providers have started the process for implementing a Trauma-Informed Approach in their practices.

Prevention Services

Prevention works. 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
5. Evaluation of prevention services to ensure effective prevention work

By using the Strategic Prevention Framework, Utahns are assured that services in their area match their local needs and factors that lead to costly problems are addressed.

¹ Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, <http://www.samhsa.gov/sites/default/files/cost-benefits-prevention.pdf>



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 (CommunitiesThatCare.net) system which has been scientifically proven to effectively start, run, and sustain local coalitions.

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

DSAMH has determined that the statewide priorities for substance abuse prevention are first, to prevent underage drinking and second, to prevent the abuse and misuse of prescription drugs.

Preventing Underage Drinking

Alcohol is the most commonly abused substance among youth. In fact, nearly one in every three 12th graders reported drinking alcohol sometime

in their life. The same survey shows that close to 14% of 12th graders reported using alcohol in the past 30 days. To relate this problem in dollars and cents, underage drinking cost the citizens of Utah \$218 million in 2013.

udetc.org/factsheets/ut.pdf

DSAMH supports the highly successful “Parents Empowered” campaign. This campaign is aimed at eliminating underage drinking “by providing parents and guardians with information about the harmful effects of alcohol on the developing teen brain, along with proven skills for preventing



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p o w e r o f l o c a l
p r e v e n t i o n

coalitions, the campaign also targets mobilizing local efforts to prevent underage drinking.

DSAMH provides research, oversight, and connections between Parents Empowered and community coalitions throughout the state. For more information, visit: parentsempowered.org.

Preventing the Abuse and Misuse of Prescription Drugs

In Utah, the illegal use of prescription drugs has reached epidemic proportions.

- An average of 21 Utahns die as a result of prescription opioids (pain killers) each month
- Opioids contribute to approximately three out of four drug overdose deaths
- The number of prescription opioid deaths decreased from 301 in 2014 to 278 in 2015

Over the last decade, prescription pain medications have been responsible for more drug deaths in Utah than all other drugs combined. However, coordinating with multiple partners and focusing prevention and intervention efforts has resulted in Utah seeing a decrease in opioid related deaths by 7.6% in one year.

DSAMH collaborates with the Department of Health to increase access to naloxone, a drug that reverses opiate overdose, and to increase efforts to prevention abuse and misuse. Following the Strategic Prevention Framework, prevention efforts include coalition work, changing laws, and strategic use of evidence-based prevention programs. Information from the 2015 SHARP survey is encouraging.

The following table shows the percent of students who used prescription drugs (stimulants, sedatives, tranquilizers, or narcotics) without a doctor telling them to take them. (SHARP 2015)



Grades	2011	2013	2015
6th	3.2	2.4	2.8
8th	7.5	4.5	4.9
10th	11.7	8.4	7.7
12th	14.5	10.9	10.1
All Grades	9.0	6.4	6.2

For more information, visit:

useonlyasdirected.org.

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 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 other coalition models or no coalition model at all. Highlights of the study are listed below:

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, anxiety, and depression. CTC is grounded in rigorous research from so-

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

cial 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 approach. It focuses on strengthening protective factors that can buffer young people from problem behaviors and promote positive youth development. Bonding between youth and adults with healthy beliefs and clear standards is an essential piece of this model.

Risk and Protective Factor Model

The Risk and Protective Factor Model was adopted by DSAMH to guide 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 to the focus populations. The chart on page 48, identifies the Risk Factors for substance use disorder and other problem behaviors.

The book Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities (2009) 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.

Utah Student Health and Risk Prevention (SHARP) Survey

The most recent biennial SHARP survey was completed in spring of 2015. The SHARP survey is a combination of three major surveys which include the Prevention Needs Assessment (PNA), the Youth Risk Behavior Survey, and questions from the Youth Tobacco Survey.

The SHARP 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 admin-

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

istered to students in grades 6, 8, 10, and 12 in 39 school districts and 14 charter schools across Utah. Nearly 50,000 students were surveyed. The data was gathered and reported as a full statewide report and also 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 2015 SHARP report include:

Alcohol

- There continues to be a decrease overall in the percentage of youth who reported using alcohol in the 30 days prior to the

survey. For Utah to continue to decrease the rate, even below 10% in some ages, demonstrates communities resolve to eliminate underage drinking.

- From 8.6% in 2011 to 6.5% in 2015 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 13.6% in 2015.
- Harmful drinking, as measured by binge drinking (drinking five or more drinks in a day, any time in the past two weeks), decreased overall from 6.6% in 2011 to 4.2% in 2015 with significant decreases in all but 6th grade. The largest decrease was for students in the 12th grade with

12.2% reporting binge drinking in 2011 and 8.1% in 2015.

Marijuana Use

- Marijuana use in the 30 days prior to the survey increased from 2007 to 2013 in all grades surveyed. In 2015, we saw a slight decrease in grades 6, 8, 10, and 12 overall, to only 5.2% reporting having used marijuana. While the decrease from 2013 to 2015 is not statistically significant, Utah will continue to monitor marijuana use statewide.
- The perceived risk of using marijuana has steadily decreased over several survey years.

E-Cigarette Use

- Utah continues to see staggering increases of e-cigarette use.
- Past 30 day e-cigarette use among all grades has increased. In grade 10, the percentage of youth reporting use increased from 1.0% in 2011 to 12.4% in 2015.

Mental Health and Suicide

- Overall, the number of students who need mental health treatment increased from 11.2% in 2011 to 15.0% in 2015 with a significant increase in 10th grade from 12.7% in 2011, to 20.0% in 2015.
- 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 7.4% in 2011 to 14.4% in 2015, with significant increases in all grades surveyed, 6, 8, 10, and 12. The largest increase was in the 10th grade with rates of 7.2% in 2011 and 20.0% in 2015.

Prevention Dimensions

Prevention Dimensions (PD) is a statewide curriculum used as a resource to address substance use and other problem behaviors for K-12 students. PD is delivered by trained teachers in a classroom setting to students in Utah. DSAMH collaborates with the Utah State Office of Education for implementation 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.

Because PD is a product of the Utah Office of Education, it can be adapted to meet current needs such as bullying, suicide or specific prevention priorities related to a school or community, such as prescription drugs. PD also complements drug policies and other prevention strategies practiced in the schools. PD 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 the 2015-16 year include the following:

- 883 individuals participated in PD teacher trainings and received resource materials. A total of 17,556 trained in the last 13 years.
- 25 teacher trainings were conducted during the year including 8 “whole school trainings” with 170 participants.

- 63% of those participating in traditional teacher trainings reported teaching a PD lesson during the year.
- 80% of those participating in the “whole school trainings” reported teaching a PD lesson.
- Based on online reporting, it is estimated that approximately 70% of Utah students in K through 6th grades received PD instruction.
- 78% of public school districts report providing drug prevention instruction in all schools.

Partnerships for Success Grant

The Partnerships for Success (PFS) Grant was designed to assist states to sustain successful efforts of previous grants. Utah applied for the PFS grant to sustain the community level organization and mobilization of prevention services. The purpose of this project is to increase community-centered evidence-based prevention (CCEBP) efforts.

CCEBP includes: increasing readiness of community members; collaborating with businesses,

agencies, local government and other groups in each community; and implementing programs which address community needs.

There are four regions, each with their own prevention director. The regions were determined using the data and geography of the LSAs by the State Epidemiological Outcomes Workgroup (SEOW). The Northern region includes: Bear River, Weber, and Davis Counties. The Salt Lake region includes Salt Lake, Tooele and Summit counties. The Eastern region includes: Wasatch County, Northeastern, Utah County, and Four Corners. The Southern region includes: Central, Southwest, and San Juan County.

The primary responsibility of the regional prevention directors is to increase self-efficacy and capacity regarding CCEBP science throughout the LSAs by: advocating and serving as a liaison between the state and LSAs; assessing needs for technical assistance, developing a technical assistance plan, and providing technical assistance as requested; participating on SEOW and Evidence-Based Programs EBP workgroups; and collaborating with the LSAs.

Substance Use Disorder Services

In Utah, a continuum of services has been designed to address the full spectrum of substance use problems. Treatment services are based on the

American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

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

Function	Prevention/Intervention			Treatment			Recovery Support Services
Program Level	<i>Universal</i>	<i>Selected</i>	<i>Indicated</i>	<i>Outpatient</i>	<i>Intensive Outpatient</i>	<i>Residential</i>	<i>All levels depending on need for services</i>
Appropriate for	<ul style="list-style-type: none"> General Population 	<ul style="list-style-type: none"> High Risk 	<ul style="list-style-type: none"> Misusing drugs or alcohol, but does not meet DSM-V Diagnostic Criteria 	<ul style="list-style-type: none"> DSM-V Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Serious Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Severe Abuse or Dependence DSM IV Diagnosis of Abuse or Dependence 	<ul style="list-style-type: none"> Individuals needing support services outside of treatment in order to maintain their recovery 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.

Opioid-Use Disorders in Utah: A Public Health Crisis

Opiates are drugs derived from opium. The term “opioid” is used for the entire family of opiates including prescribed, illicit natural, synthetic, and semi-synthetic opiate.

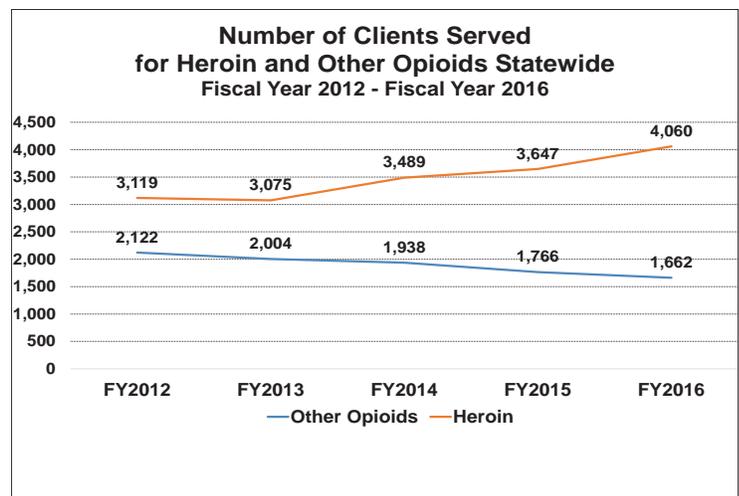
In the last decade, opioid overdose deaths in Utah increased by 400%. Utah has the 4th highest rate of overdose deaths in the United States. Over 90,000 individuals in Utah, ages 12 and older, reported nonmedical use of prescription opioids in the last year.

An opioid-use disorder is defined as the repeated occurrence within a 12-month period of 2 or more of 11 problems, including withdrawal, giving up important life events in order to use opioids, and excessive time spent using opioids. A cluster of 6 or more of the criteria below indicate a severe condition.

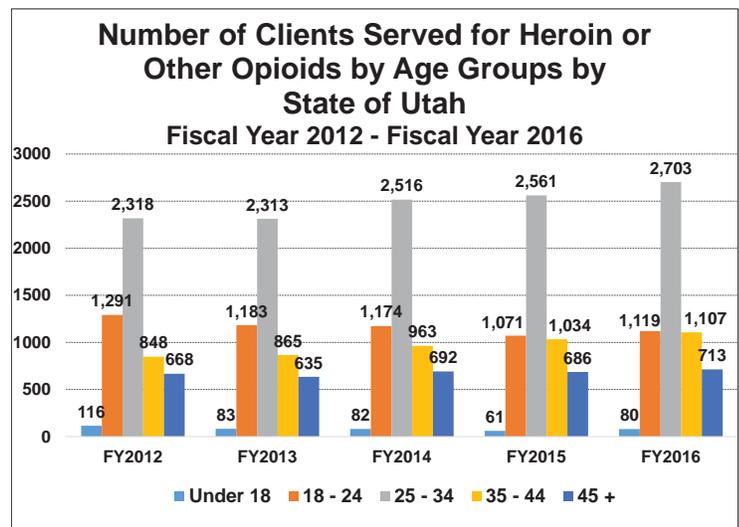
In Fiscal Year 2012, 30.7% of clients served had an opioid-use disorder. This number rose to 38.8% in Fiscal Year 2016, marking a percent increase of 26.4%.

Diagnostic Criteria for an Opioid-Use Disorder

1. Use of an opioid in increased amounts, or longer than intended
2. Persistent wish of unsuccessful effort to cut down or control opioid use
3. Excessive time spent to obtain, use, or recover from opioid use
4. Strong desire or urge to use an opioid
5. Interference of opioid use with important obligations
6. Continued opioid use despite resulting interpersonal problems, social problems (e.g., interference with work), or both
7. Elimination or reduction of important activities because of opioid use
8. Use of an opioid in physically hazardous situations (e.g., while driving)
9. Continued opioid use despite resulting physical problems, psychological problems, or both
10. Need for increased doses of opioid for effects, diminished effect per dose, or both
11. Withdrawal when dose of an opioid is decreased, use of drug to relieve withdrawal, or both



Individuals between the age of 25-34 are the most likely to be treated for for opioid disorders.



DSAMH has been actively involved in numerous state initiatives designed to reduce the impact of opioid abuse:

- Use Only As Directed (UOAD) began in 2007 in collaboration with the Utah Department of Health, Department of Human Services, Law Enforcement, and private industry. This statewide campaign focuses on safe use, storage, and disposal of prescription medications. Since 2013, Intermountain Healthcare has been an active partner. In August 2016, Intermountain Healthcare and UOAD launched a new campaign at McKay Dee Hospital, showing that every day, 7,000 prescriptions are filled in Utah.
- The Center for Disease Control released a revised set of Prescriber Guidelines in 2016. The guidelines outline appropriate prescribing protocols in an effort to decrease the over prescribing of opioids for non-cancer incidences.
- Take Back Events—semi-annual event collecting thousands of pounds of unused and expired medications.

Successful treatment may include:

- Detoxification (the process by which the body rids itself of a drug)
- Behavioral counseling, medication (for opioid, tobacco, or alcohol addiction)
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety with long-term follow-up to prevent relapse.

A range of care with a tailored treatment program and follow-up options can be crucial to success. Treatment should include both medical and mental health services as needed. Follow-up care may include community- or family-based recovery support systems.

Medication Assisted Treatment (MAT) is a safe and effective strategy for reducing opioid use and the risk of overdose. Currently, there are three MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. These medications are used in combination with counseling and behavioral therapies, to provide a “whole-patient” approach. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor.

Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opioids. By law, methadone used to treat opiate-use disorder can only be dispensed through an Opioid Treatment Programs (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), regulated by the Drug Enforcement Agency (DEA), Licensed by Department of Human Services and accredited by one of the major healthcare accreditation entities. There are 14 OTP providers in the State of Utah. Utah’s OTP’s provide safe and effective treatment that includes regular counseling sessions, drug testing, and medication assisted treatment and recovery support. In 2015, 3,495 individuals sought assistance at the OTP clinics in Utah.

Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. Buprenorphine is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs.

SAMHSA has developed an online prescriber locator: samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

Weber Human Services (WHS) and Davis Behavioral Health received funding from Intermountain Healthcare to provide medication assisted treatment and counseling for individuals with opioid dependence from prescription drugs that may have also led to current heroin use. Since its beginning, 120 clients have been served in the Opioid Community Collaborative.

Currently, in Salt Lake County, a pilot project was legislatively funded in FY15 offering clients coming out of jail or prison with the option of using Vivitrol in coordination with treatment. Salt Lake County Behavioral Health Services launched this project in September 2015 and has served 205 clients to date. The average length of stay in the program is 3-4 months. Salt Lake County anticipates ongoing growth and increased participation and length of stay in the program.

Syringe Exchange Programs (SEP) also known as syringe services programs (SSPs), needle exchange programs (NEPs), and needle-syringe programs (NSPs), are community-based programs that provide access to sterile needles and syringes free of charge. The programs also facilitate safe disposal of used needles and syringes. SEPs are an effective component of a comprehensive, integrated approach to HIV and hepatitis C prevention among people who inject drugs. Most SEPs offer other prevention materials and services, such as HIV/HCV education; overdose prevention, including Naloxone distribution; referral to substance abuse treatment programs; and counseling and testing for HIV and hepatitis C.

Syringe exchange programs became legal in Utah in 2016, the day Utah Governor Gary Herbert signed House Bill 308 into law. The bill went into effect May 2016, and states

that agencies in Utah “may operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs and those individuals’ contacts.” HB 308 does not fund syringe exchange programs in Utah, it only provides guidelines and reporting requirements and follows the restrictions of federal funding.

Naloxone (Narcan®) is a life-saving prescription medication used as an antidote to opioid overdose. Naloxone has mainly been used in the past in the hospital or by emergency medical personnel. However, Naloxone kits are now available for patients to use for emergency treatment of overdoses at home. In 2016, the executive director of the Utah Department of Health signed a statewide standing order allowing to dispense Naloxone, without a prior prescription, to anyone at increased risk of experiencing or witnessing an overdose. Through this standing order, anyone can purchase Naloxone without a prescription. DSAMH has worked to provide Naloxone kits and training to first responders, as well as all Adult Probation & Parole agents, and individuals in the community.

Links and Resources

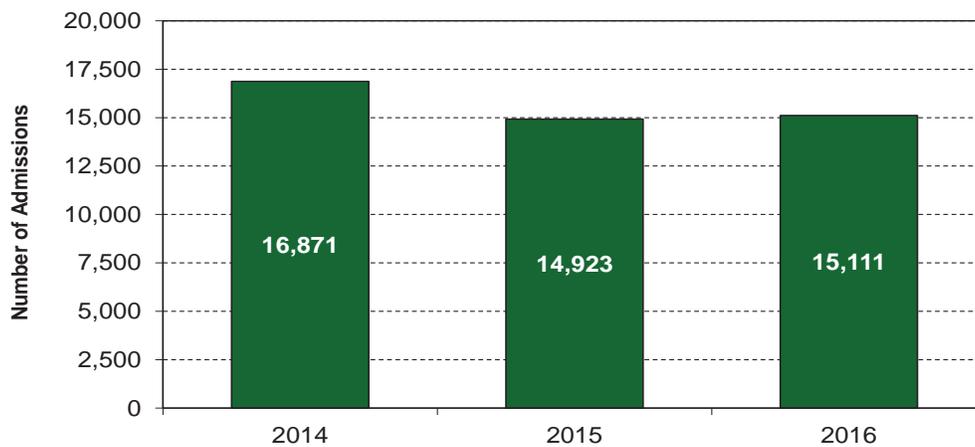
- Use Only As Directed Campaign: useonlyasdirected.org
- DSAMH Website: dsamh.utah.gov
- Treatment Locator: findtreatment.samhsa.gov/
- Buprenorphine prescriber locator: samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator?field_bup_physician_us_state_value=UT
- Naloxone: utahnaloxone.org
- Center for Disease Control and Prevention prescribing guideline: cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf

Number of Treatment Admissions

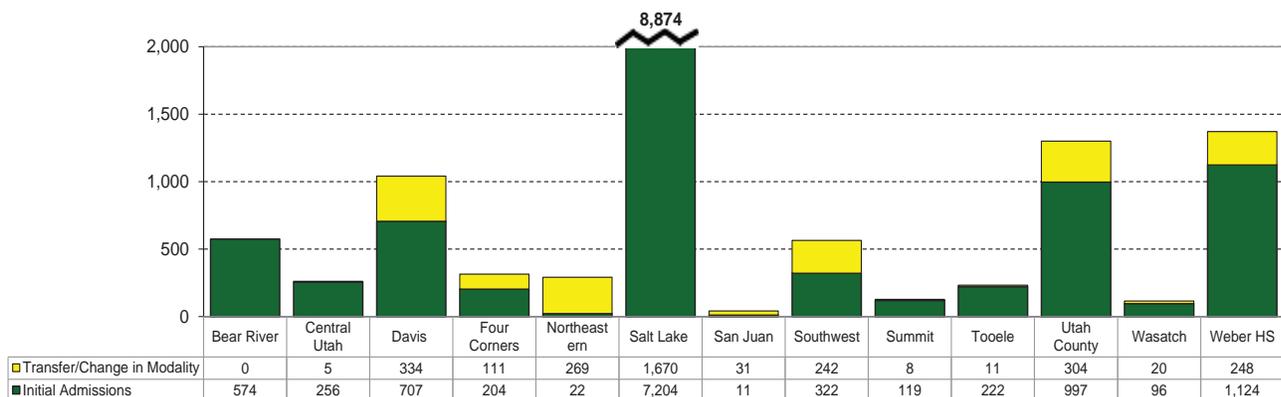
In 2016, 15,111 individuals were admitted to treatment for substance use disorders. The chart at the bottom of the page shows the number of admissions by each local authority in fiscal year

2016. It should be noted that six local authorities each have less than 2% of treatment admissions for the state, and Salt Lake County accounts for almost 61% of the state's admissions.

Substance Use Disorder Initial and Transfer Admissions into Modalities Fiscal Years 2014 to 2016



Substance Use Disorder Treatment Admissions and Transfers in Utah Fiscal Year 2016

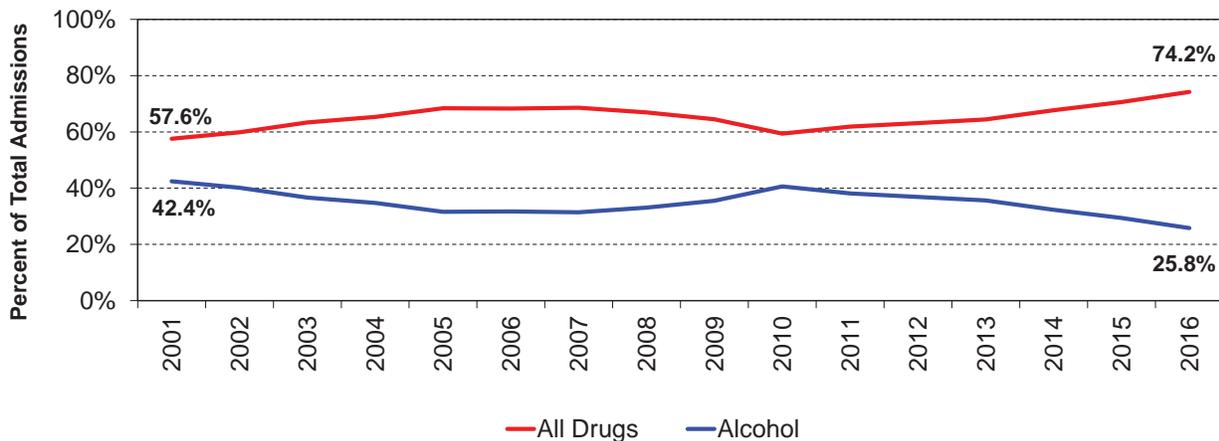


Primary Substance of Abuse

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

25.8% of clients reporting alcohol as their primary substance of abuse at admission.

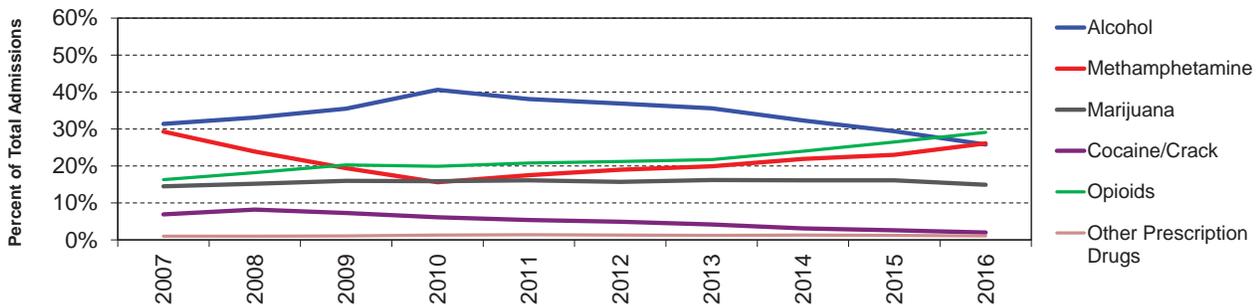
Patient Admissions for Alcohol vs. Drug Dependence
Fiscal Years 2001 to 2016



For the first time ever, Opioids are ranked as the number one drug of choice reported upon admission at 29.1%, followed by Methamphetamines at 26.1% and alcohol at 25.8%. Marijuana comes in

fourth at 14.9%, cocaine and crack at 2.0% and all other prescription drugs not including opiates at 1.1%.

Top Drugs of Choice by Year
Fiscal Year 2002 to Fiscal Year 2016



Primary Substance by Gender

The primary drug at admission for males remains to be alcohol at 28.9%. Secondary drugs at admission for males are methamphetamines at 23.2%, closely followed by heroin at 23.1%.

For females, methamphetamines are the primary drug at admission at 30.9%. Secondary drugs for females are heroin at 25.2% and then by alcohol at 20.7%.

Primary Substance by Gender Fiscal Year 2016

	Male	Male %	Female	Female %	Total	Total %
Alcohol	2,737	28.9%	1,167	20.7%	3,904	25.8%
Cocaine/Crack	193	2.0%	110	1.9%	303	2.0%
Marijuana/Hashish	1,585	16.7%	660	11.7%	2,245	14.9%
Heroin	2,188	23.1%	1,426	25.2%	3,614	23.9%
Other Opiates/Synthetics	218	2.3%	191	3.4%	409	2.7%
Hallucinogens	17	0.2%	3	0.1%	20	0.1%
Methamphetamine	2,198	23.2%	1,743	30.9%	3,941	26.1%
Other Stimulants	29	0.3%	34	0.6%	63	0.4%
Benzodiazepines	36	0.4%	34	0.6%	70	0.5%
Tranquilizers/Sedatives	10	0.1%	16	0.3%	26	0.2%
Inhalants	4	0.0%	0	0.0%	4	0.0%
Oxycodone/Hydrocodone	155	1.6%	226	4.0%	381	2.5%
Club Drugs	4	0.0%	5	0.1%	9	0.1%
Over-the-Counter	2	0.0%	7	0.1%	9	0.1%
Other	87	0.9%	25	0.4%	112	0.7%
Unknown	0	0.0%	1	0.0%	1	0.0%
Total:	9,463	100.0%	5,648	100.0%	15,111	100.0%

Primary Substance by Age

The chart below shows primary substance of abuse by age groupings. For adolescents (under the age of 18) marijuana is the primary drug of use at admission. Opiates, which include heroin and prescription pain medication, remain the number

one drug at admission for individuals between 18 and 24, and for individuals between 25 and 34, exceeding alcohol as the drug of choice for those two age groups.

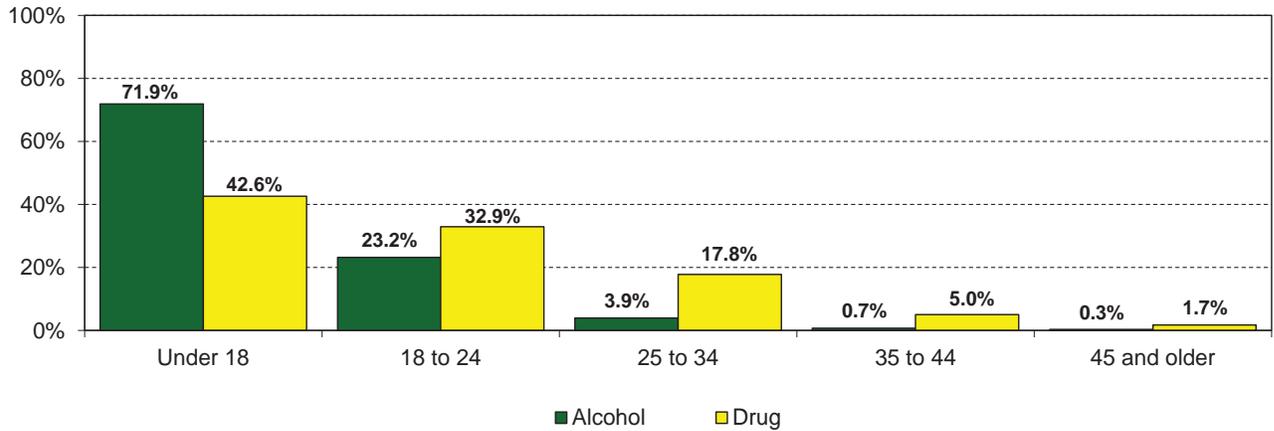
**Primary Substance of Abuse by Age Grouping
Fiscal Year 2016**

	Under 18	18 to 24	25 to 34	35 to 44	45 to 64	65 and over	Total
Alcohol	130	394	1,084	1,019	1,229	48	3,904
Cocaine/Crack	4	44	71	66	118	0	303
Marijuana/Hashish	1,004	487	454	192	107	1	2,245
Heroin	17	736	1,917	632	308	4	3,614
Other Opiates/Synthetics	5	44	180	102	75	3	409
Hallucinogens	5	4	6	5	0	0	20
Methamphetamine	33	645	1,587	1,112	559	5	3,941
Other Stimulants	2	8	27	18	8	0	63
Benzodiazepines	2	7	24	22	15	0	70
Tranquilizers/Sedatives	0	6	9	5	6	0	26
Inhalants	1	0	1	2	0	0	4
Oxycodone/Hydrocodone	2	24	181	118	51	5	381
Club Drugs	0	4	4	1	0	0	9
Over-the-Counter	1	2	3	2	1	0	9
Other	12	20	30	27	22	1	112
Unknown	0	0	0	1	0	0	1
Total:	1,218	2,425	5,578	3,324	2,499	67	15,111

Age of First Use of Alcohol or Other Drug

In 2016, the chart below shows that the majority of individuals began using their primary drug of choice prior to the age of 18.

Age of First Use of Primary Substance of Abuse
Fiscal Year 2016

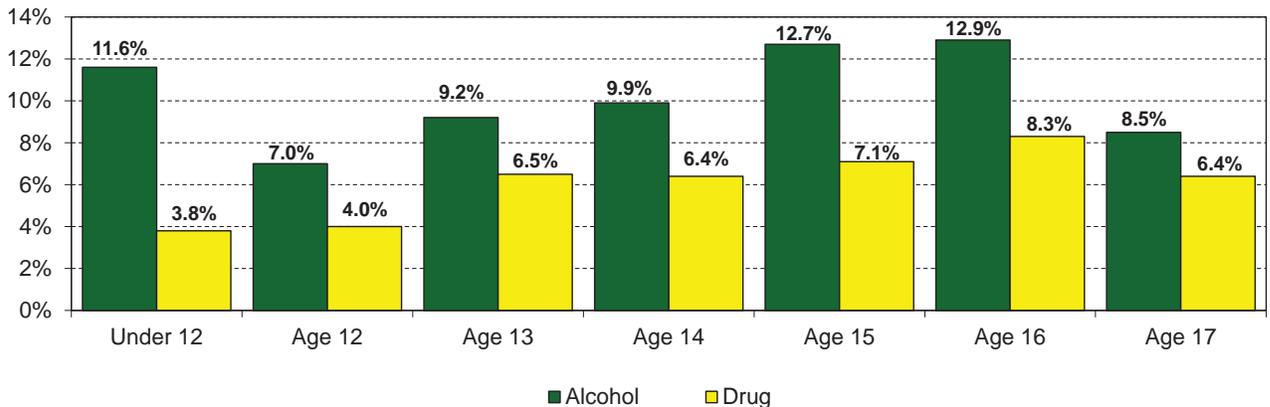


Age of First Use of Primary Substance—Under 18

Individuals in treatment report the first use of their primary substance prior to age 18. For alcohol and other drugs, age of first use peaks at age 16. 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.

Age of First Use of Primary Substance—Under 18
Fiscal Year 2016



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

numbers of clients reporting the use of drugs and alcohol in any combination at admission increased from 63.8% in 2015 to 65.2% in 2016.

Multiple Drug Use Fiscal Year 2016

	# Reporting Multiple Drug Use at Admission	% of Total Admissions for Each Area
Bear River	365	63.6%
Central Utah	105	40.2%
Davis County	922	88.6%
Four Corners	172	54.6%
Northeastern	176	60.5%
Salt Lake County	5,386	60.7%
San Juan County	23	54.8%
Southwest Center	459	81.4%
Summit County	71	55.9%
Tooele County	127	54.5%
Utah County	1,078	82.9%
Wasatch County	91	78.4%
Weber	878	64.0%
Total:	9,853	65.2%

Injection Drug Use

Individuals who inject drugs 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 2016, there was a slight increase in the percentage of individuals requesting services through the public treatment system, who reported IV drug use as their primary route of administration. This increase was not consistent across the state; however it is a reflection of the increased use of heroin.

Admissions Reporting IV Injection Drug Use at Admission Fiscal Year 2016

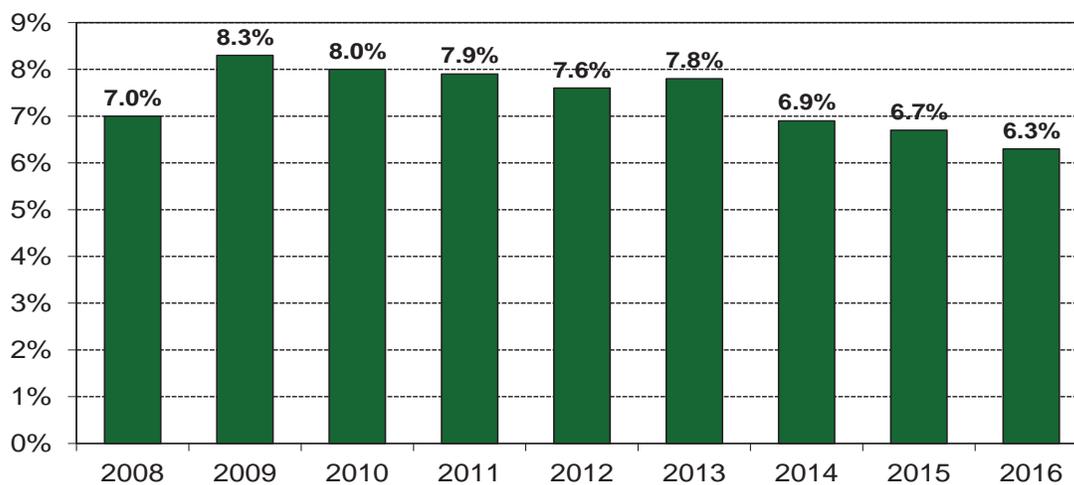
	# Reporting IV Injection Drug Use at Admission	% of Total Admissions for Each Area
Bear River	95	16.6%
Central Utah	46	17.6%
Davis County	366	35.2%
Four Corners	98	31.1%
Northeastern	55	18.9%
Salt Lake County	2,710	30.5%
San Juan County	2	4.8%
Southwest Center	191	33.9%
Summit County	4	3.1%
Tooele County	34	14.6%
U of U Clinic	0	0.0%
Utah County	550	42.3%
Wasatch County	27	23.3%
Weber	280	20.4%
Total:	4,458	29.5%

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. From 2013 to 2016 there has been a slight and steady decline in the percent of clients who report prescription drugs as their primary drug at admission.

**Admission for Primary Drug—
Prescription Drugs
Fiscal Years 2008 to 2016**



Opioids (not counting heroin, but other opiates/synthetics and oxycodone/hydrocodone) are the most commonly abused prescription drugs in Utah. Women tend to be admitted to treatment

more frequently than men for prescription drugs. The chart below shows prescription drug admissions by gender:

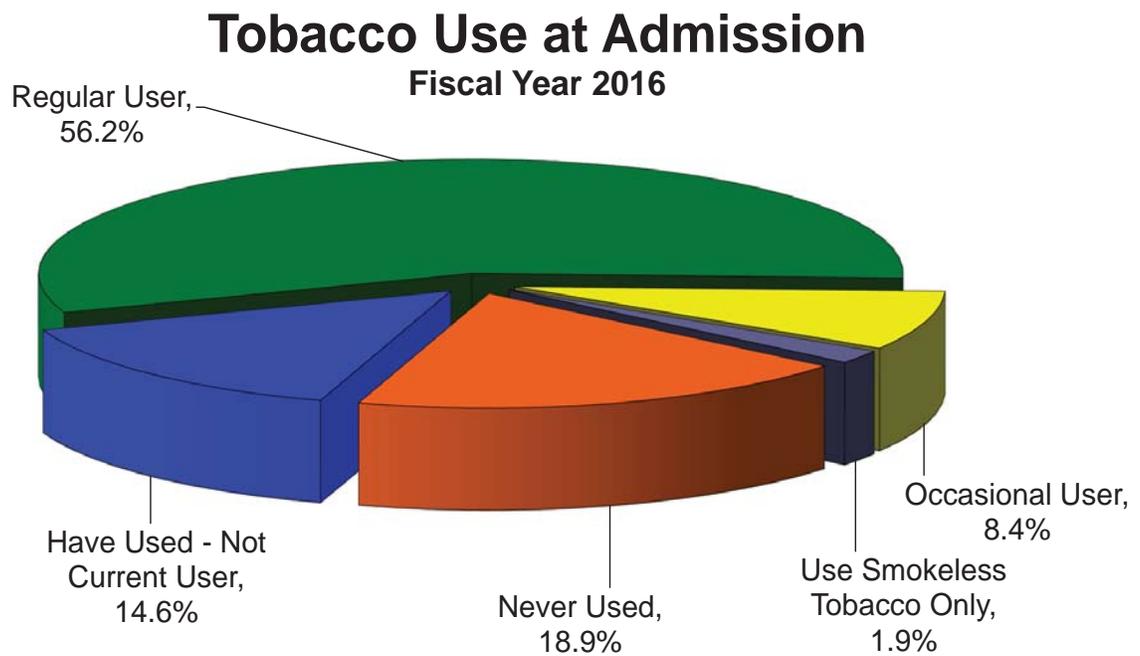
**Prescription Drug Abuse by Gender
Fiscal Year 2016**

	Male	Male %	Female	Female %	Total	Total %
Other Opiates/Synthetics	218	2.3%	191	3.4%	409	2.7%
Other Stimulants	29	0.3%	34	0.6%	63	0.4%
Benzodiazepines	36	0.4%	34	0.6%	70	0.5%
Tranquilizers/Sedatives	10	0.1%	16	0.3%	26	0.2%
Oxycodone/Hydrocodone	155	1.6%	226	4.0%	381	2.5%
Total:	448	4.7%	501	8.9%	949	6.3%

Tobacco Use

Individuals with substance use disorders are much more likely to use tobacco. In 2016, 66.5% of individuals reported to substance abuse treatment the use of tobacco, this number is down from the 68.8% reported in 2015. Tobacco use often results in poor health and shorter life expectancy, and an

increased risk or a return to alcohol or other drug use. DSAMH requires that all local authorities' services be provided in a tobacco free environment and that they provide education about benefits of smoking and/or nicotine cessation, as well as provide assistance to those desiring to quit.



In fiscal year 2016, almost 67% of clients use some type of tobacco at admission.

Pregnant Women in Treatment

In fiscal year 2016, 5.1% of women entering treatment (290) were pregnant at the time of admission. The percentage of admissions for pregnant women continues to stay relatively

constant. 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 2016

	Female Admissions	Number Pregnant at Admission	Percent Pregnant at Admission
Bear River	191	8	4.2%
Central Utah	102	5	4.9%
Davis County	474	17	3.6%
Four Corners	136	9	6.6%
Northeastern	128	10	7.8%
Salt Lake County	2,899	155	5.3%
San Juan County	16	0	0.0%
Southwest	263	4	1.5%
Summit County	34	0	0.0%
Tooele County	95	2	2.1%
Utah County	624	42	6.7%
Wasatch County	50	1	2.0%
Weber	636	37	5.8%
Total:	5,648	290	5.1%

Clients with Dependent Children

Children with a parent who abuses alcohol and/or other drugs are at a higher risk of developing substance use disorders themselves. 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 2016, the percentage of all clients with dependent children in Utah was 51.3%. The average number of dependent children per household decreased from 2.23 in 2015 to 2.17 in 2016. The table also depicts the percentage of women entering treatment who have dependent children and the average number of children in those households.

A total of 63.5% of women who are admitted to treatment, report having dependent children and the average number of children for those households. 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 (SAPT) block grant is required to be set aside for women's treatment, and the Utah Legislature has passed a special general fund appropriation specifically for the treatment of women and their dependent children. DSAMH closely tracks the use of these special funds to ensure that quality treatment is provided to this priority population.

Clients with Dependent Children Fiscal Year 2016

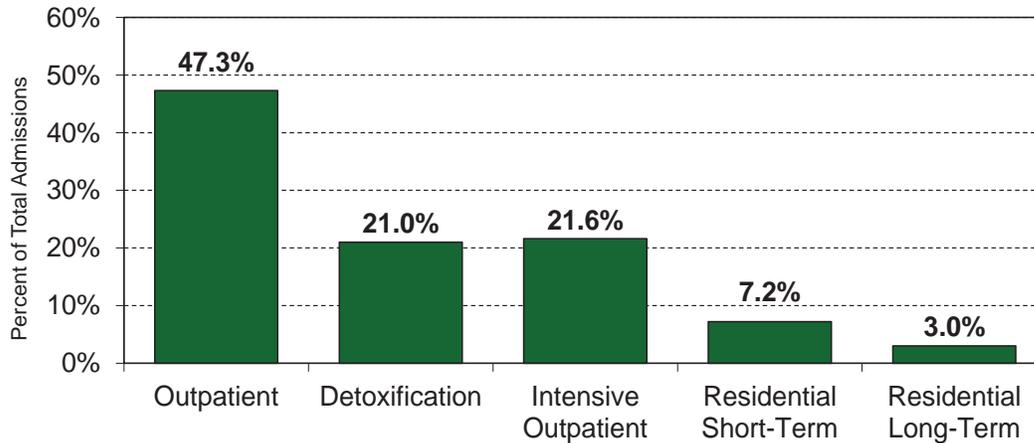
	Percent of all Clients with Children	Average Number of Children (of Clients with Children)	Percent of Women with Children	Average Number of Children (of Women with Children)
Bear River	35.5%	2.30	48.1%	2.32
Central Utah	48.9%	2.21	61.6%	2.28
Davis County	61.8%	2.37	76.7%	2.45
Four Corners	50.2%	2.14	60.3%	2.16
Northeastern	47.8%	2.17	58.3%	2.20
Salt Lake County	41.7%	2.01	54.6%	2.07
San Juan County	52.6%	2.61	61.5%	2.69
Southwest Center	60.6%	2.18	71.8%	2.27
Summit County	35.9%	1.97	48.6%	1.71
Tooele County	40.4%	2.11	53.0%	2.03
U of U Clinic	50.0%	2.33	52.6%	2.33
Utah County	64.5%	2.47	73.1%	2.50
Wasatch County	65.3%	2.48	72.7%	2.25
Weber	88.0%	2.24	87.8%	2.19
Total:	51.3%	2.17	63.5%	2.21

Service Types

In contrast to the earlier days of substance use disorder treatment when almost all treatment was residential, today 68.9% of admissions to treatment are to outpatient and intensive outpatient.

An expanded use of the American Society of Addiction Medicine (ASAM) Placement Criteria has helped place individuals in the level and intensity of care they need.

Service Type at Admission
Fiscal Year 2016

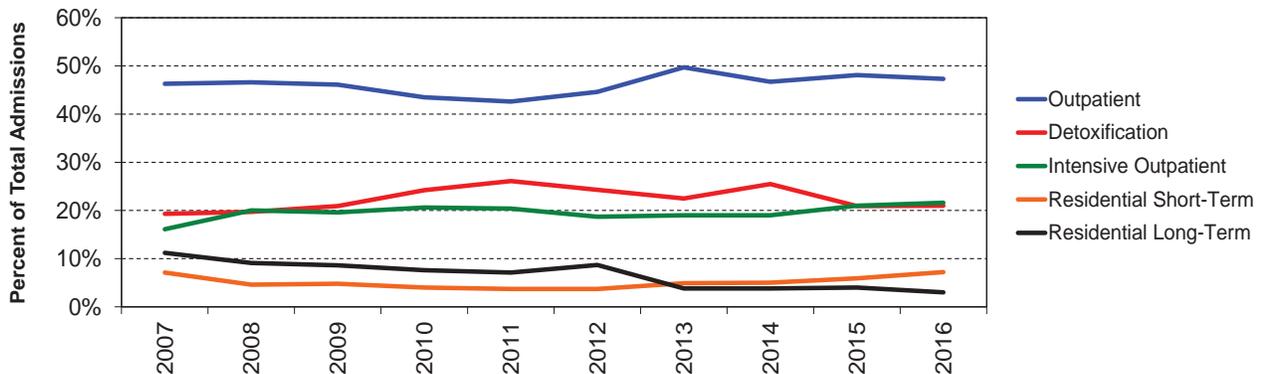


Trends in Service Types

Intensive outpatient services increased from 11.9% in 2005 to 20.4% in 2011. Since 2012 it has stayed steady with a slight increase to 21.6%. During that same period, residential admissions declined slightly until 2012, but then dropped significantly in 2013 and 2014, with a slight increase in 2016

resulting in at 10.2% (long-term and short-term combined). Since most of the decrease was in long-term residential admissions, it appears to reflect better use of the ASAM criteria and changes in agency approaches to treatment.

Trends in Service Types
Fiscal Years 2007 to 2016



Drug Courts

Individuals with a substance use disorder are disproportionately represented in our criminal justice system. Evidence indicates that approximately 80% of individuals in the criminal justice system meet the definition of substance use involvement and between one-half to two-thirds meet diagnostic criteria for substance abuse or dependence.

Drug courts are special court dockets designed to treat individuals with substance use disorders and provide them the tools they need to change their lives. The drug court judge serves as the leader of a multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, and treatment representatives.

Drug Courts provide an alternative to incarceration. Eligible participants for these programs have a moderate-to-severe substance use disorder, are charged with non-violent, drug-related offenses, such as possession or sale of a controlled substance, or another offense caused or influenced by drug use, such as theft or forgery to support a drug addiction, and who are at substantial risk for reoffending, commonly referred to as high-risk and high-need offenders. To effectively work with

this population, Drug Courts provide intensive supervision and treatment services in a community environment. Successful completion of the program results in expunged charges, vacated or reduced sentences, or rescinded probation. DSAMH funds 45 drug courts throughout the state of Utah; 25 adult felony drug courts, 15 family dependency drug courts, and 5 juvenile drug courts. In fiscal year 2016, Utah's drug court program served 2084 individuals, the majority of whom participated in the adult felony drug court program.

DSAMH and our partner agencies (the Administrative Office of the Courts and the Department of Corrections) work to improve quality assurance and monitoring processes of the program. In addition to conducting annual site visits and biennial certifications of the courts, DSAMH has partnered with the National Center of State Courts to conduct process and outcome evaluations at select Utah Drug Courts, once completed new performance measurements will be developed and implemented throughout the state to help insure best practice standards are followed.

The following chart shows drug court outcomes for fiscal years 2013-2016.

Drug Court Outcomes					
Measure Title	Purpose of Measure/Measure Definition	FY2013	FY2014	FY2015	FY2016
Successful Completion	Percent of participants who complete program successfully	51.5%	57.8%	56.5%	54.0%
Criminal Justice Involvement	Percent of clients reporting zero arrests while participating in Drug Court	88.0%	82.5%	81.0%	79.4%
	Percent decrease in clients arrested from 30 days prior to treatment to 30 days prior to discontinuation/discharge	66.1%	65.0%	62.9%	59.5%
Employment	Percent increase in full/part-time employment from admission to discharge	42.2%	57.1%	52.3%	64.5%
Substance Use—Alcohol	Percent increase in abstinence from alcohol from admission to discharge	30.7%	45.6%	36.2%	33.6%
Substance Use—Drug	Percent increase in abstinence from drugs from admission to discharge	194.4%	282.4%	304.8%	268.8%
Increase in Stable Housing	Percent increase in non-homeless clients admission to discharge	2.9%	2.1%	2.7%	2.2%

Drug Offender Reform Act (DORA)

The Drug Offender Reform Act (DORA), began in 2005 as a 3-year pilot project, and is currently operating in eight local substance abuse authorities. They are: 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 2016, 770 individuals were admitted to the DORA program statewide.

DORA was designed to expand and expedite offenders access to treatment, provide for smarter sentencing by judges, and provide increased community supervision. DORA is based on the following premise: Smarter Sentencing and

Smarter Treatment = Better Outcomes and Safer Neighborhoods. 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 or return to prison.

The Drug Offender Reform Act: DORA Statewide Report, is available on the UCJC website at:

ucjc.utah.edu/adult-offenders/dora-statewide

The following chart shows DORA outcomes from fiscal years 2013-2016:

Drug Offender Reform Act Outcomes					
Measure Title	Purpose of Measure/Measure Definition	FY2013	FY2014	FY2015	FY2016
Alcohol	Percent increase in abstinence from alcohol from admission to discharge	33.2%	35.3%	24.7%	29.9%
Drugs	Percent increase in abstinence from drugs from admission to discharge	129.9%	115.9%	170.7%	204.2%
Employment	Percent increase in full/part-time employment from admission to discharge	34.1%	46.1%	38.5%	26.5%
Increase in Stable Housing	Percent increase in non-homeless clients admission to discharge	3.9%	2.2%	1.0%	0.8%
Clients Served	Unduplicated number of clients served	706	769	755	795

Mental Health Services

The Utah public mental health system provides an array of services that assure an effective continuum of care. Under the administrative direction of 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 an annual 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 additional services in a variety of ways to meet the needs of their citizens.

Continuum of Services

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

1. Inpatient care
2. Residential care
3. Outpatient care
4. 24-hour crisis care
5. Psychotropic medication management
6. Psychosocial rehabilitation, including vocational training and skills development
7. Case management
8. Community supports, including in-home services, housing, family support services, and respite services
9. Consultation and education services, including case consultation, collaboration

with other county service agencies, public education, and public information

10. Services to people incarcerated in a county jail or other county correctional facility

In addition to the services described above, many of the local authorities also provide the following:

Clubhouses are a model of psychosocial rehabilitation where attendees are considered members and are empowered to function in a work-ordered day. Clubhouses provide a pre-educational, pre-vocational environment where individuals with a history of mental illness can rebuild their confidence, purpose, abilities, and community through education, productive work, and meaningful relationships. All of this is done within a uniquely supportive and collaborative Clubhouse setting in which members and staff work together in an atmosphere built on principles of mutual respect and caring. Clubhouses accredited by Clubhouse International adhere to 37 international standards which support the evidence based practice listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).

Peer Support 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. Peer-staffed crisis and warm lines are available in some areas for telephone support as well.

Nursing Home and Hospital Alternatives include community-based care such as intensive case management, assertive community treatment, outreach services, diversion beds, and coordination with other entities such as home health.

Recovery Support Services are provided across the state through various methods and across multiple partnerships. Accessible, effective, com-

prehensive, and integrated supports may include supportive housing, supported employment, peer support and recovery related goods and services.

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) and the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO) are the standard mental health and substance use disorders classification tools used by professionals in the United States. Each disorder has sets 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 tables on the next page describe the most common diagnoses treated in the public mental health system in Utah by local authority 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	Utah County	Wasatch County	Weber Human Services	Statewide Adults
Adjustment Disorders	2.2%	1.6%	3.4%	2.9%	2.7%	1.2%	2.2%	2.5%	2.6%	1.5%	1.6%	3.6%	1.0%	2.0%
Anxiety Disorders	20.5%	17.8%	21.3%	19.7%	23.1%	21.2%	21.4%	14.8%	18.4%	22.6%	23.6%	19.9%	16.2%	20.8%
Attention Deficit Disorders	5.0%	2.4%	4.5%	2.4%	2.3%	2.1%	5.3%	1.2%	3.7%	2.2%	4.1%	1.4%	1.0%	3.1%
Cognitive Disorders	1.9%	2.5%	1.3%	0.6%	1.4%	1.2%	2.1%	2.8%	0.8%	0.9%	4.2%	0.4%	1.8%	1.9%
Conduct Disorders	0.4%	0.4%	0.4%	0.1%	0.1%	0.1%	0.2%	0.4%	0.1%	0.1%	0.2%	0.3%	0.1%	0.2%
Depressive Disorders	18.1%	15.0%	10.2%	17.0%	18.2%	15.2%	20.8%	12.0%	15.8%	16.1%	13.5%	17.8%	10.3%	13.6%
Developmental Disorders	1.3%	1.3%	1.3%	0.5%	0.4%	0.4%	1.5%	2.2%	0.3%	0.6%	1.6%	0.3%	0.5%	1.0%
Dissociative Disorders	0.5%	0.6%	0.3%	0.4%	0.3%	0.1%	0.6%	0.1%	0.0%	0.1%	0.5%	0.1%	0.1%	0.3%
Eating Disorders	0.3%	0.4%	0.4%	0.7%	0.7%	0.1%	0.9%	0.1%	0.2%	0.2%	0.4%	0.3%	0.2%	0.3%
Factitious Disorders	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Impulse Control Disorders	0.4%	0.9%	0.6%	0.7%	1.0%	0.4%	1.5%	0.7%	0.3%	0.4%	1.0%	0.7%	0.6%	0.6%
Learning Disorders	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
Mood Disorders	8.1%	5.2%	9.9%	8.7%	7.5%	11.0%	4.9%	8.7%	5.0%	9.3%	7.2%	7.2%	8.0%	9.1%
Neglect or Abuse Disorders	0.5%	7.3%	0.1%	0.3%	1.8%	0.3%	0.1%	0.6%	0.2%	0.5%	2.3%	0.4%	1.4%	0.9%
Neurological Disorders	0.4%	0.2%	0.2%	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.1%
Personality Disorders	12.2%	11.7%	4.4%	4.1%	2.1%	7.2%	4.1%	6.9%	5.0%	5.2%	6.2%	4.1%	7.2%	6.3%
Personality Developmental Disorders	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	0.0%	0.1%	0.2%	0.3%	0.1%	0.2%
Physical Health Disorders	0.1%	1.5%	5.2%	0.8%	0.6%	0.8%	2.3%	1.6%	0.5%	0.5%	0.5%	0.0%	0.0%	1.6%
Schizophrenia and Other Psychotic	6.0%	7.3%	8.0%	6.2%	3.9%	11.5%	2.9%	6.7%	1.5%	4.6%	6.0%	5.1%	6.7%	7.9%
Substance Use Disorders	5.1%	10.1%	16.7%	20.6%	12.9%	7.2%	13.7%	13.3%	11.5%	8.7%	8.6%	19.2%	8.7%	9.6%
Other	4.9%	3.7%	4.8%	3.7%	4.0%	4.0%	9.7%	13.4%	11.0%	4.8%	8.9%	0.3%	26.9%	7.6%
V Codes	12.1%	10.1%	6.6%	11.2%	17.3%	15.5%	5.4%	11.8%	23.1%	21.5%	17.5%	18.5%	9.1%	12.8%
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 18 years and older, by Local Authority

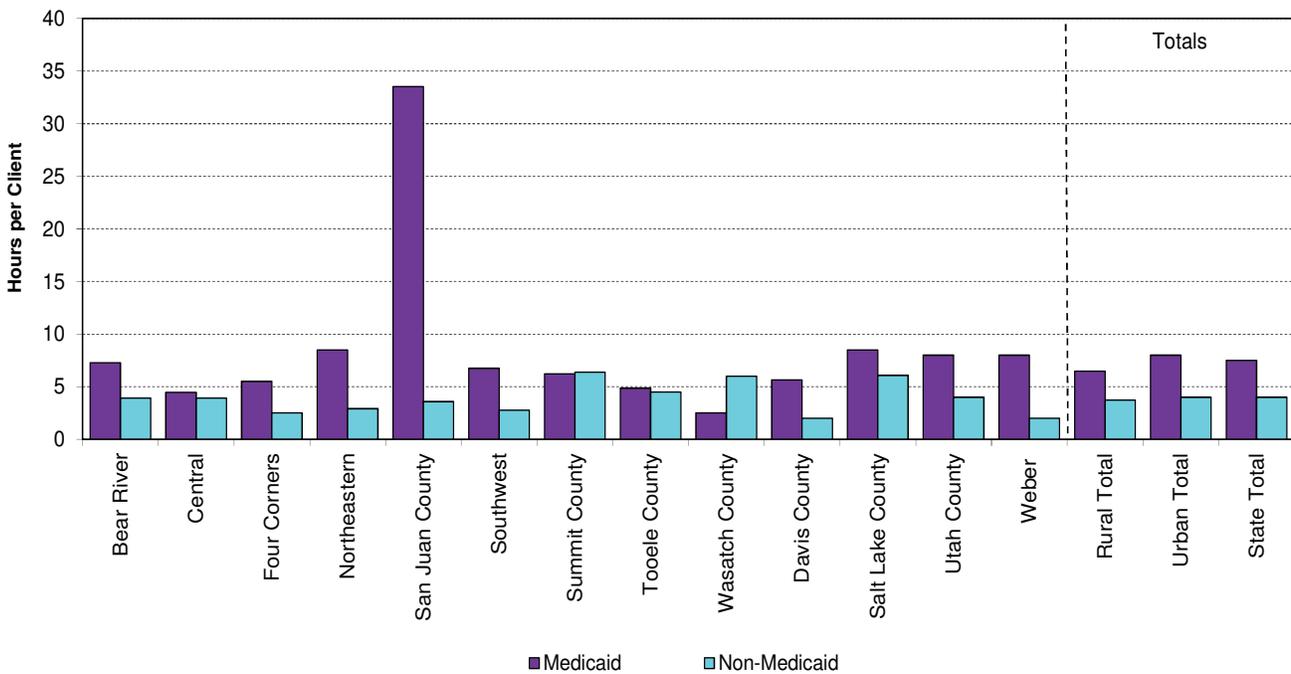
Diagnosis	Bear River Mental Health	Central Utah Counseling Center	Davis Behavioral Health	Four Corners Community Behavioral Health	Northeastern Counseling Center	Salt Lake County	San Juan Counseling	Southwest Behavioral Health Center	Summit County	Tooele County	Utah County	Wasatch County	Weber Human Services	Statewide Youth
Adjustment Disorders	18.3%	15.2%	9.0%	14.9%	9.3%	8.7%	14.3%	12.8%	8.7%	8.0%	8.7%	20.2%	5.7%	9.9%
Anxiety Disorders	14.5%	11.5%	16.5%	12.8%	15.6%	25.5%	16.9%	15.8%	19.4%	20.0%	18.6%	14.8%	17.1%	19.0%
Attention Deficit Disorders	11.8%	11.4%	16.2%	10.4%	6.6%	10.9%	14.6%	7.1%	7.2%	9.2%	10.1%	3.0%	13.9%	11.7%
Cognitive Disorders	1.0%	0.7%	0.4%	0.3%	0.2%	0.3%	0.0%	0.6%	0.2%	0.3%	0.8%	0.0%	0.6%	0.5%
Conduct Disorders	5.2%	11.0%	8.5%	7.3%	4.5%	9.3%	3.2%	4.1%	5.5%	6.6%	4.3%	3.0%	9.6%	7.3%
Depressive Disorders	10.5%	8.9%	8.9%	11.2%	18.5%	12.0%	18.8%	4.6%	11.4%	12.8%	8.2%	10.5%	7.6%	9.9%
Developmental Disorders	3.5%	3.4%	4.1%	3.3%	1.5%	2.9%	5.3%	5.1%	2.3%	1.8%	5.5%	2.7%	3.8%	3.8%
Dissociative Disorders	0.0%	0.1%	0.0%	0.4%	0.1%	0.0%	0.3%	0.1%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%
Eating Disorders	0.2%	0.3%	0.3%	2.6%	0.2%	0.1%	0.8%	0.2%	0.2%	0.1%	0.2%	0.9%	0.1%	0.2%
Factitious Disorders	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Impulse Control Disorders	0.6%	0.4%	0.8%	0.8%	1.5%	1.0%	0.5%	1.6%	0.0%	0.5%	0.8%	0.6%	1.1%	0.9%
Learning Disorders	0.0%	0.1%	0.4%	0.1%	0.0%	0.2%	0.0%	0.2%	1.0%	0.2%	0.2%	0.0%	0.1%	0.2%
Mood Disorders	2.7%	1.6%	8.2%	5.6%	6.8%	5.7%	6.8%	5.6%	4.5%	6.1%	6.7%	1.5%	8.2%	6.6%
Neglect or Abuse Disorders	0.5%	4.7%	4.0%	2.5%	8.3%	1.9%	1.9%	4.7%	1.3%	3.2%	7.2%	4.2%	3.6%	3.8%
Neurological Disorders	0.1%	0.1%	0.1%	0.1%	0.1%	0.0%	0.3%	0.1%	0.2%	0.0%	0.0%	0.0%	0.0%	0.1%
Personality Disorders	0.1%	0.3%	0.0%	0.4%	0.0%	0.1%	0.0%	0.0%	0.5%	0.0%	0.1%	0.0%	0.2%	0.2%
Personality Developmental Disorders	0.4%	0.1%	0.3%	0.3%	0.2%	0.8%	1.3%	1.3%	0.5%	0.5%	0.8%	0.0%	0.9%	0.7%
Physical Health Disorders	0.1%	1.3%	5.0%	0.0%	2.4%	0.1%	0.8%	1.2%	0.5%	0.1%	0.0%	0.0%	0.0%	1.4%
Schizophrenia and Other Psychotic	0.4%	0.2%	1.6%	3.3%	3.2%	1.4%	5.0%	2.4%	3.7%	1.8%	0.0%	5.7%	1.3%	0.5%
Substance Use Disorders	4.4%	2.6%	4.2%	6.4%	2.5%	2.2%	7.9%	8.8%	3.2%	3.0%	3.8%	2.7%	5.0%	4.1%
Other	25.6%	20.8%	10.3%	16.9%	19.2%	15.1%	4.2%	23.5%	29.0%	25.5%	23.6%	29.2%	19.9%	17.7%
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 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

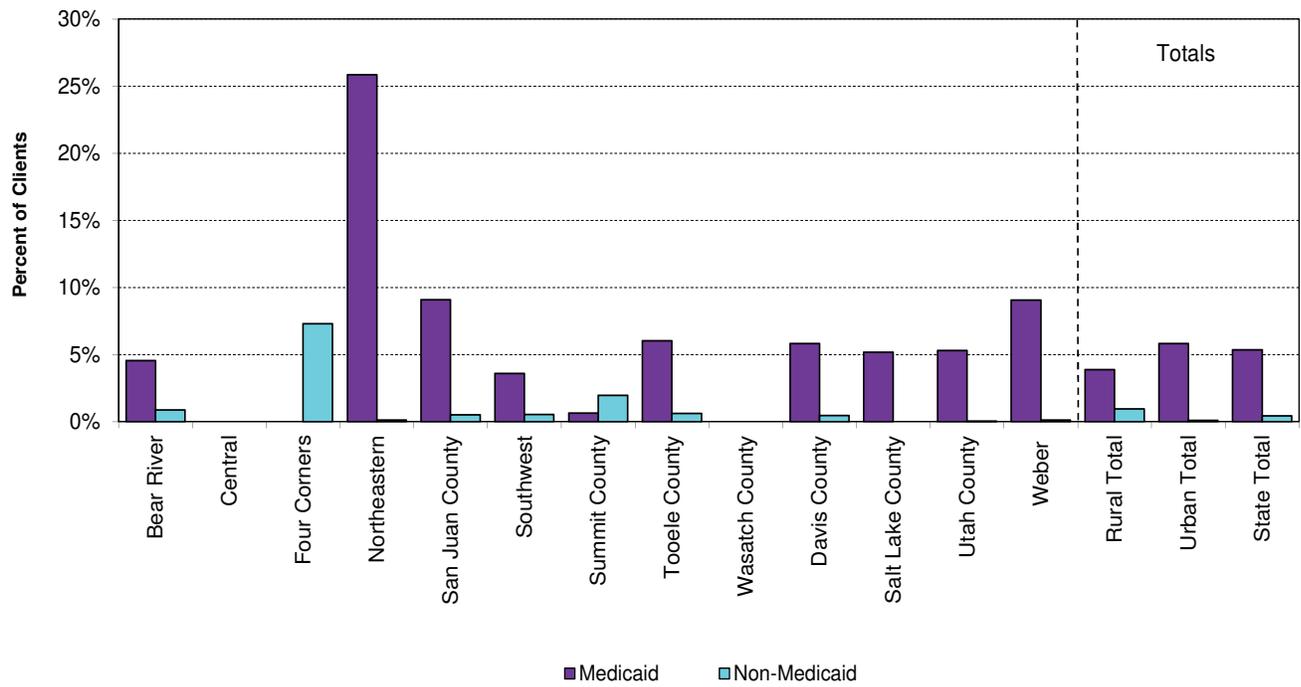
(based on utilization and median length of service) for each of the 13 local mental health authorities with rural, urban and statewide totals. The N= for the utilization charts can be found on page 168.

**Outpatient
Median Length of Service**
Mental Health Clients
Fiscal Year 2016



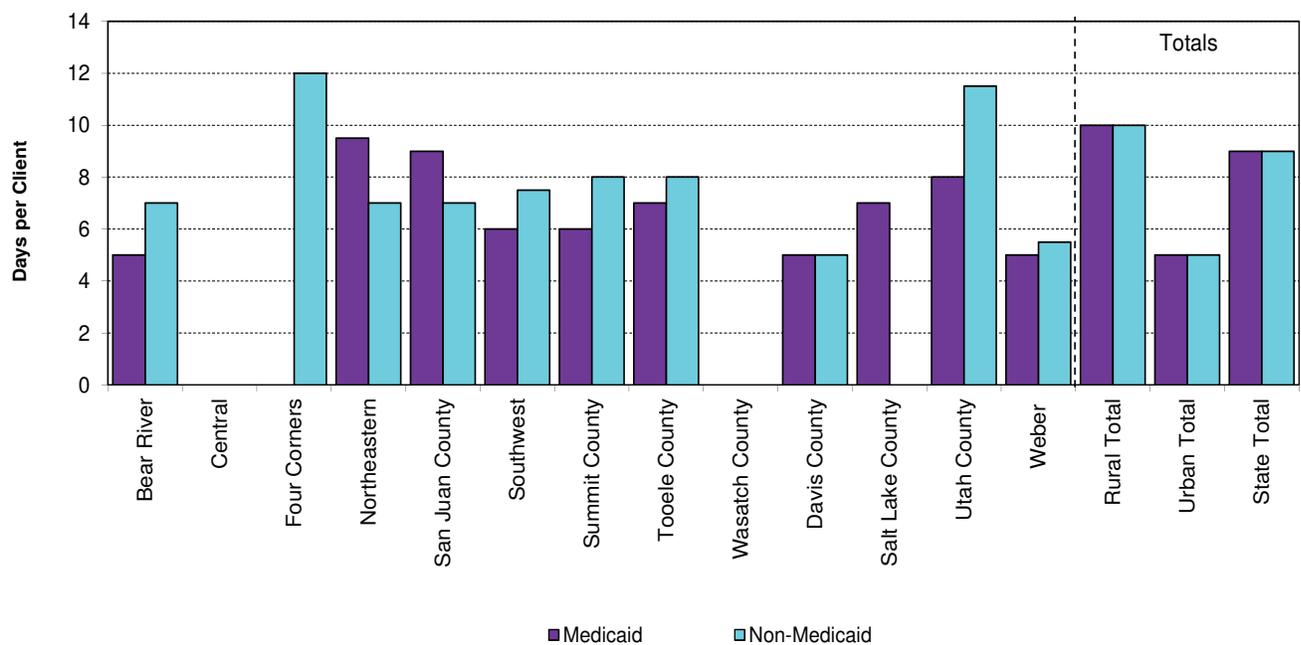
Inpatient Utilization

Mental Health Clients
Fiscal Year 2016

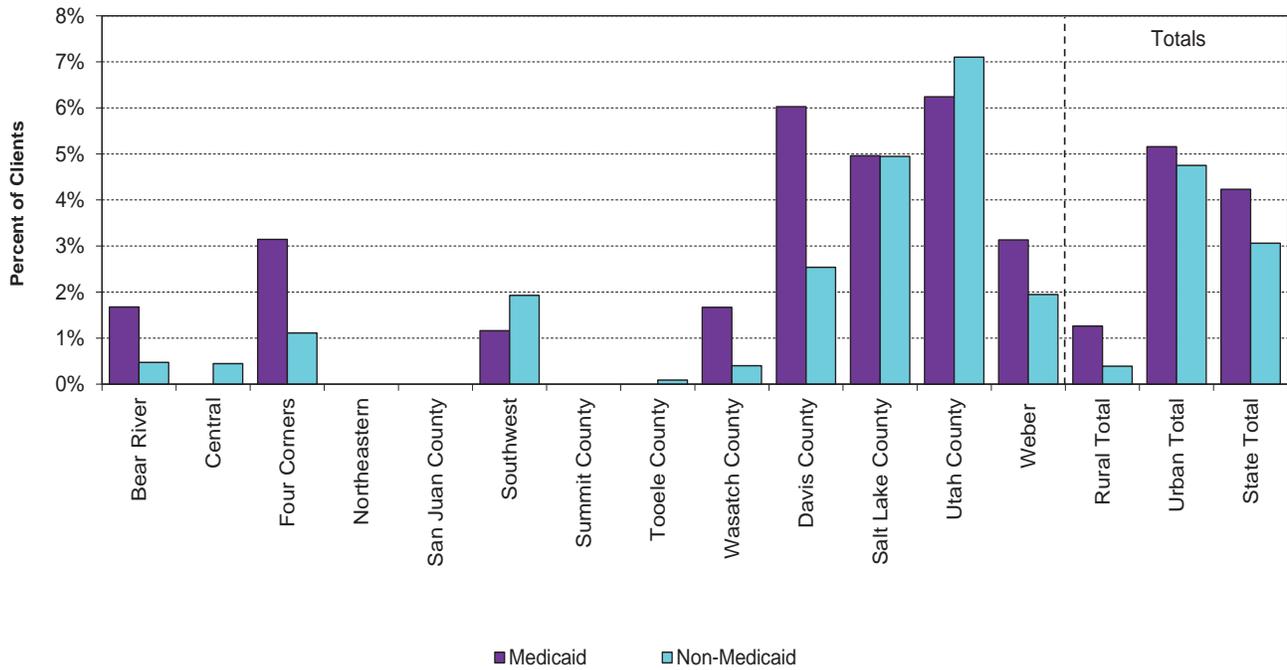


Inpatient Median Length of Service

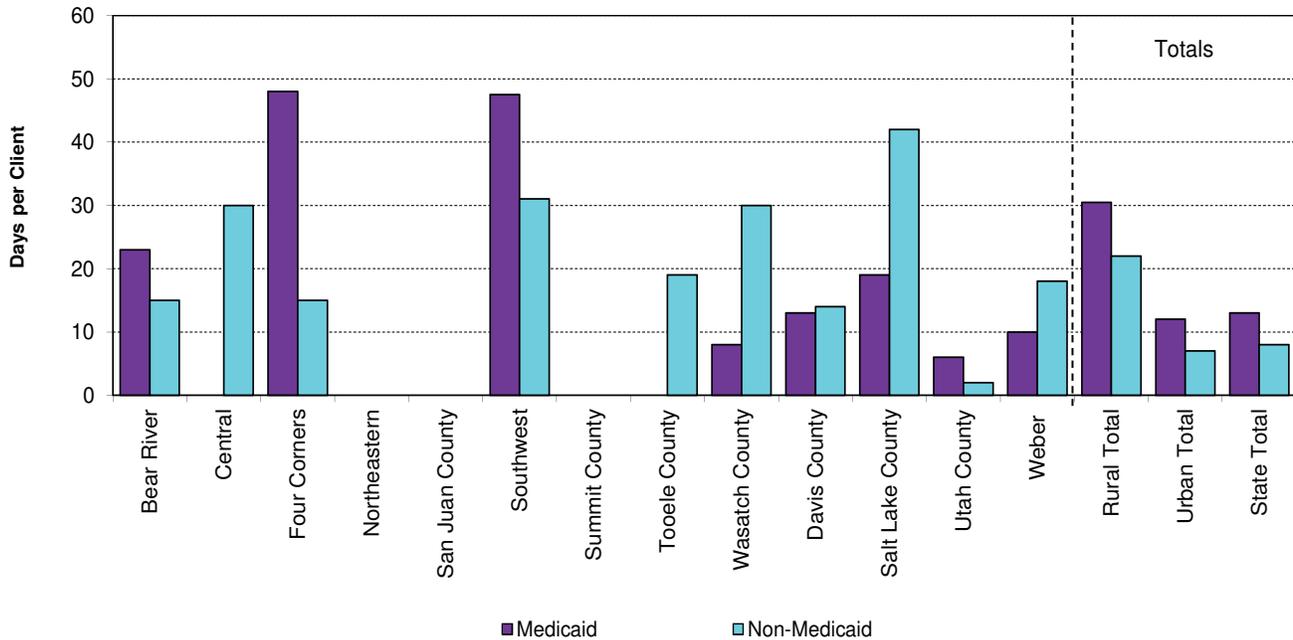
Mental Health Clients
Fiscal Year 2016



Residential Utilization Mental Health Clients Fiscal Year 2016

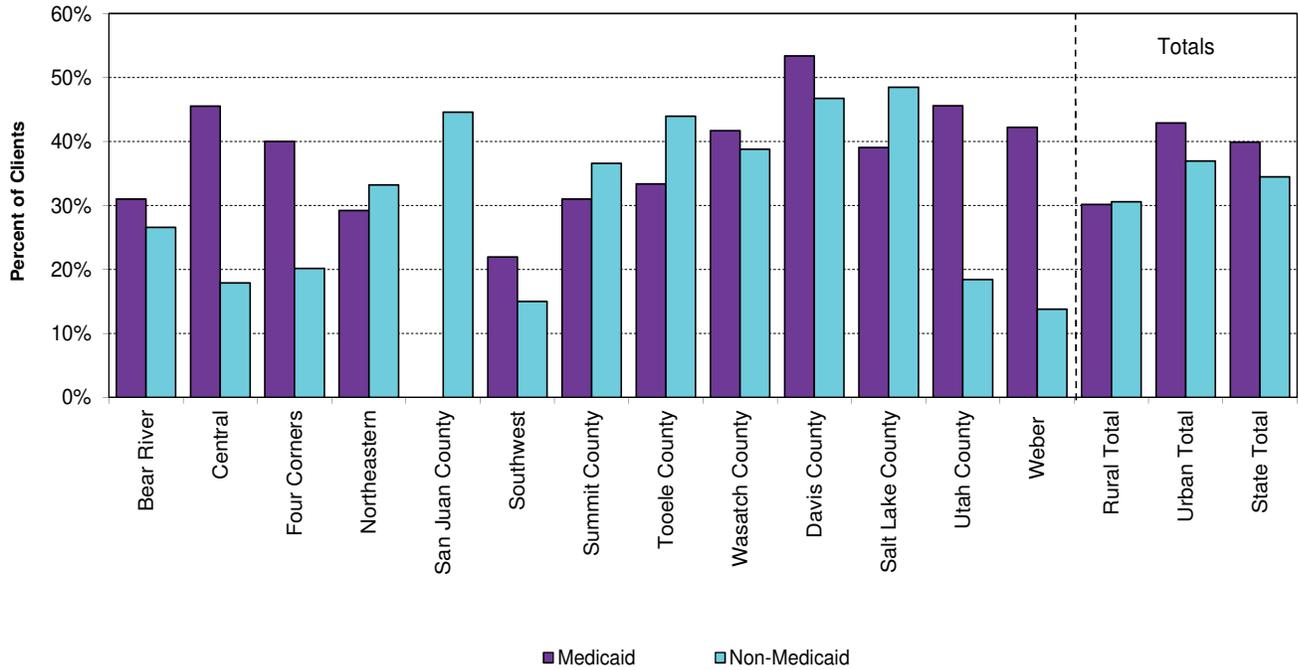


Residential Median Length of Service Mental Health Clients Fiscal Year 2016



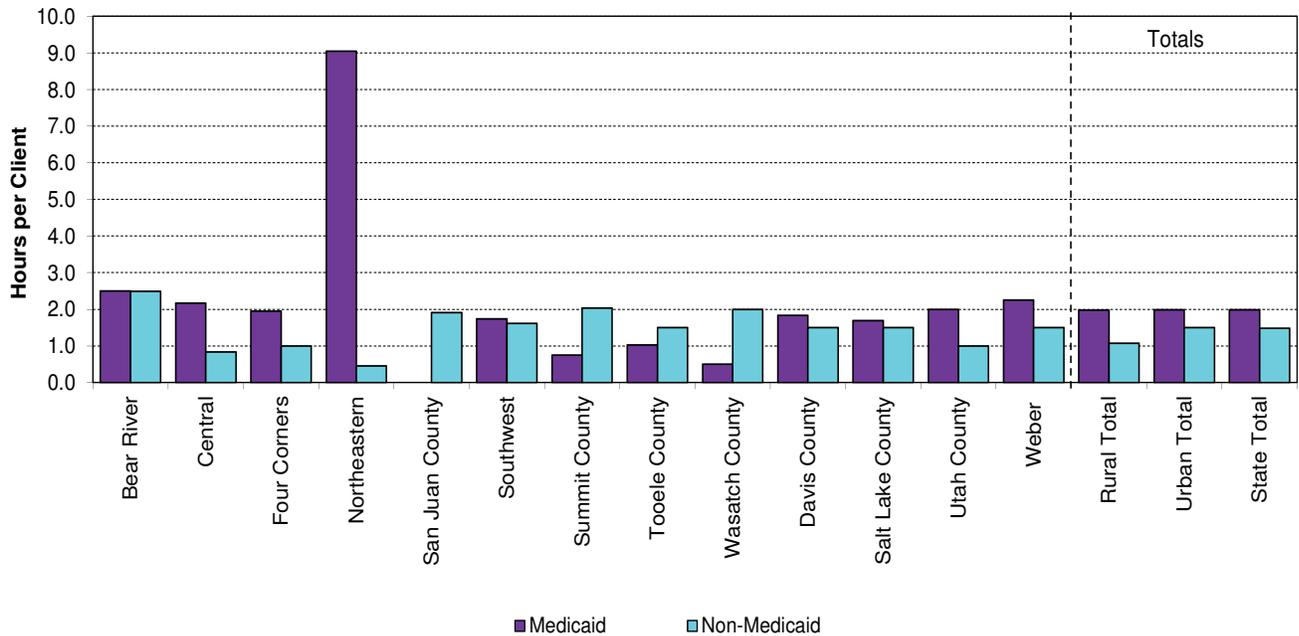
Medication Management Utilization

Mental Health Clients
Fiscal Year 2016



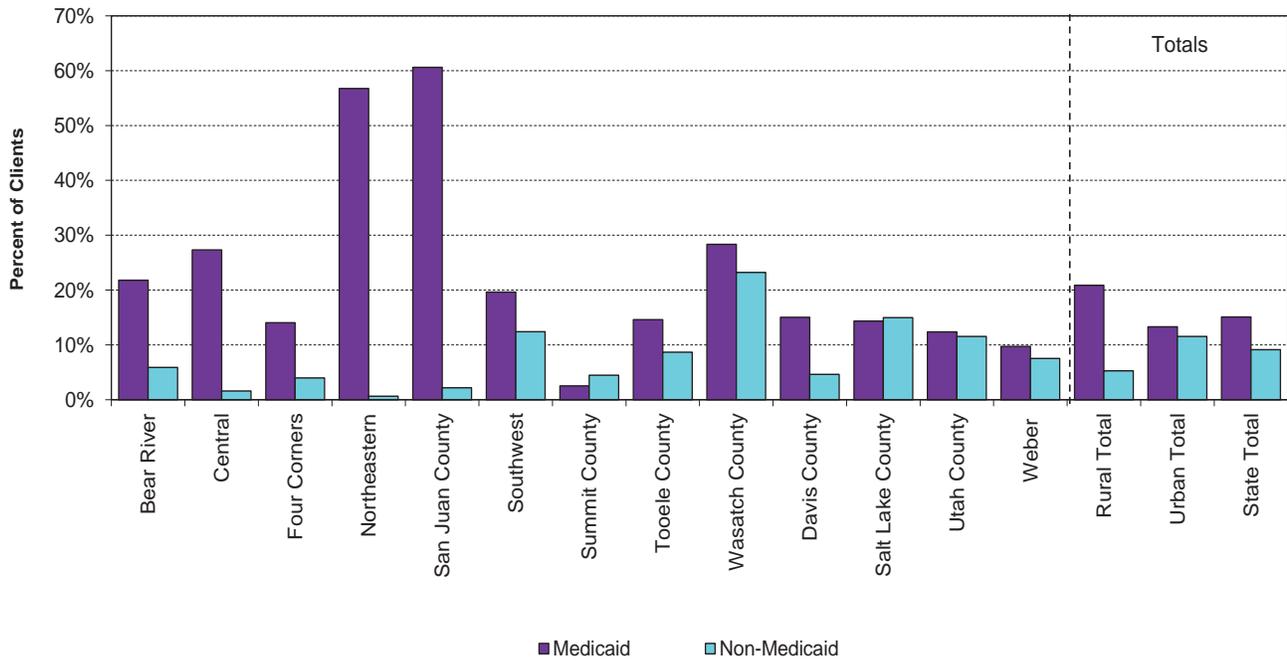
Medication Management Median Length of Service

Mental Health Clients
Fiscal Year 2016



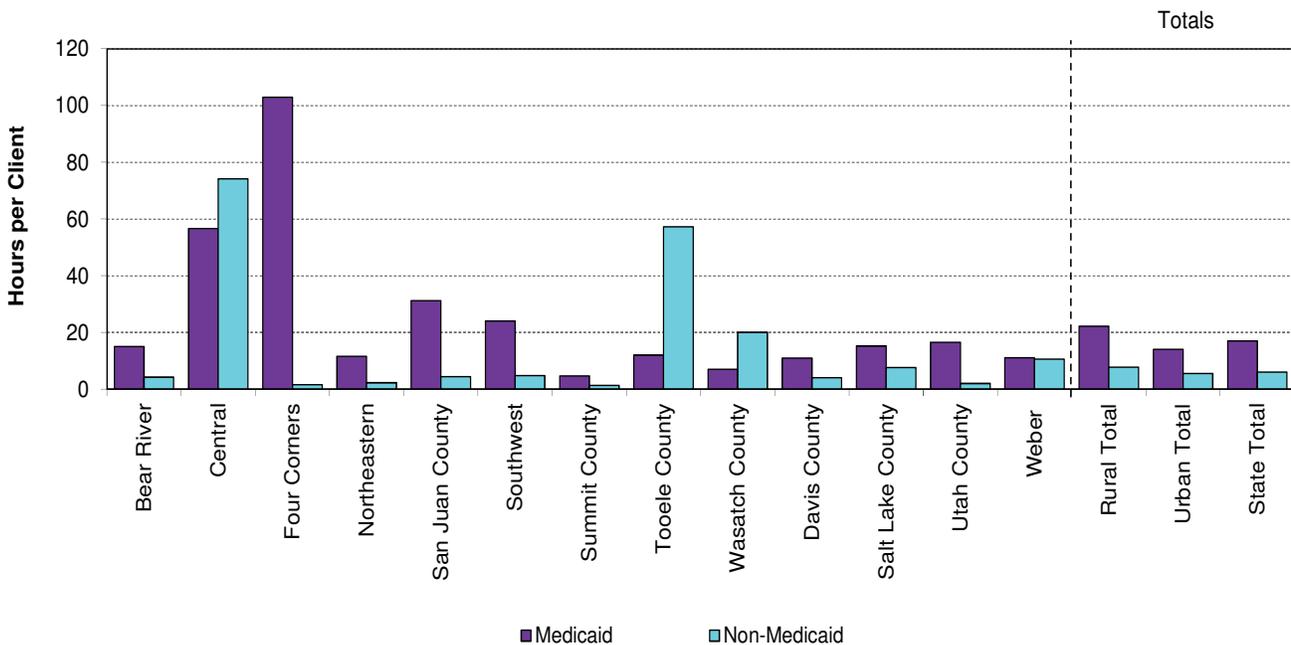
Psychosocial Rehabilitation Utilization

Mental Health Clients
Fiscal Year 2016



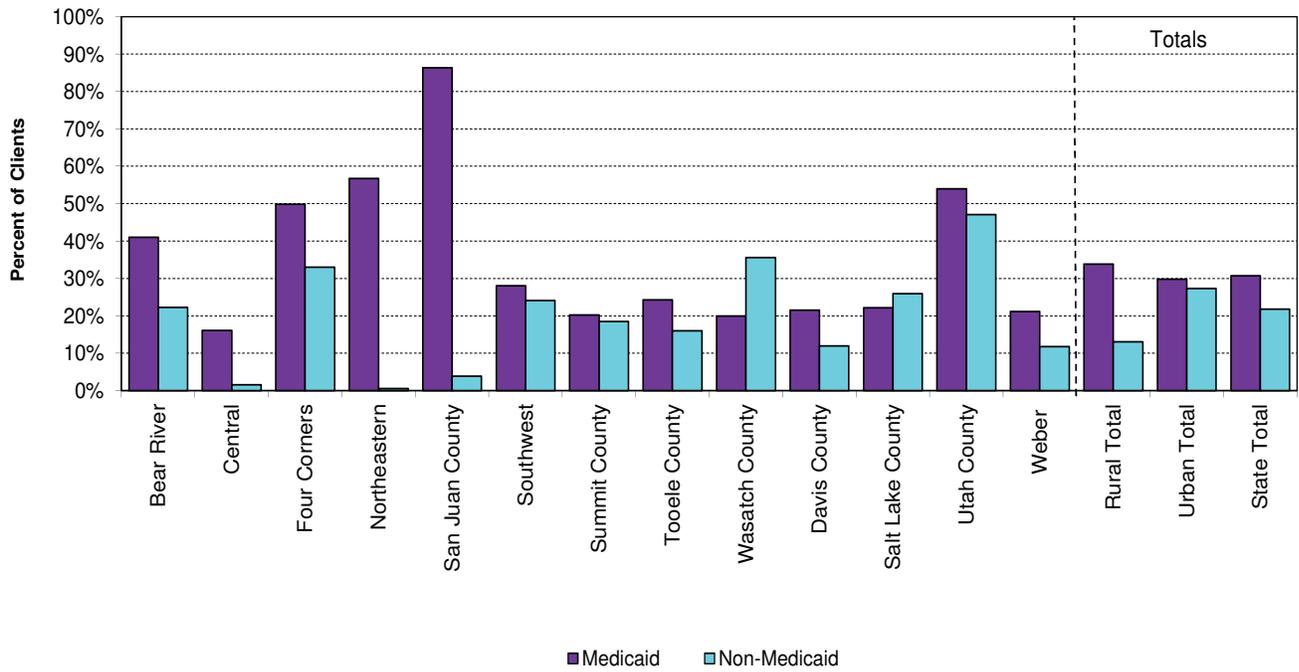
Psychosocial Rehabilitation Median Length of Service

Mental Health Clients
Fiscal Year 2016



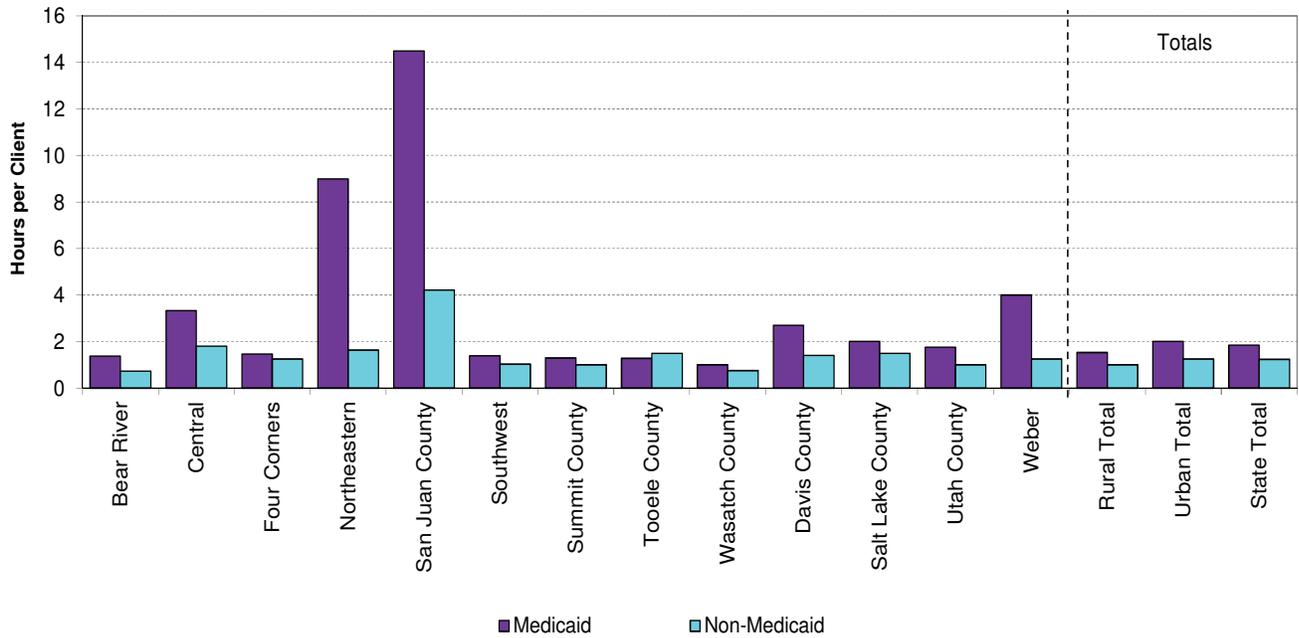
Case Management Utilization

Mental Health Clients
Fiscal Year 2016

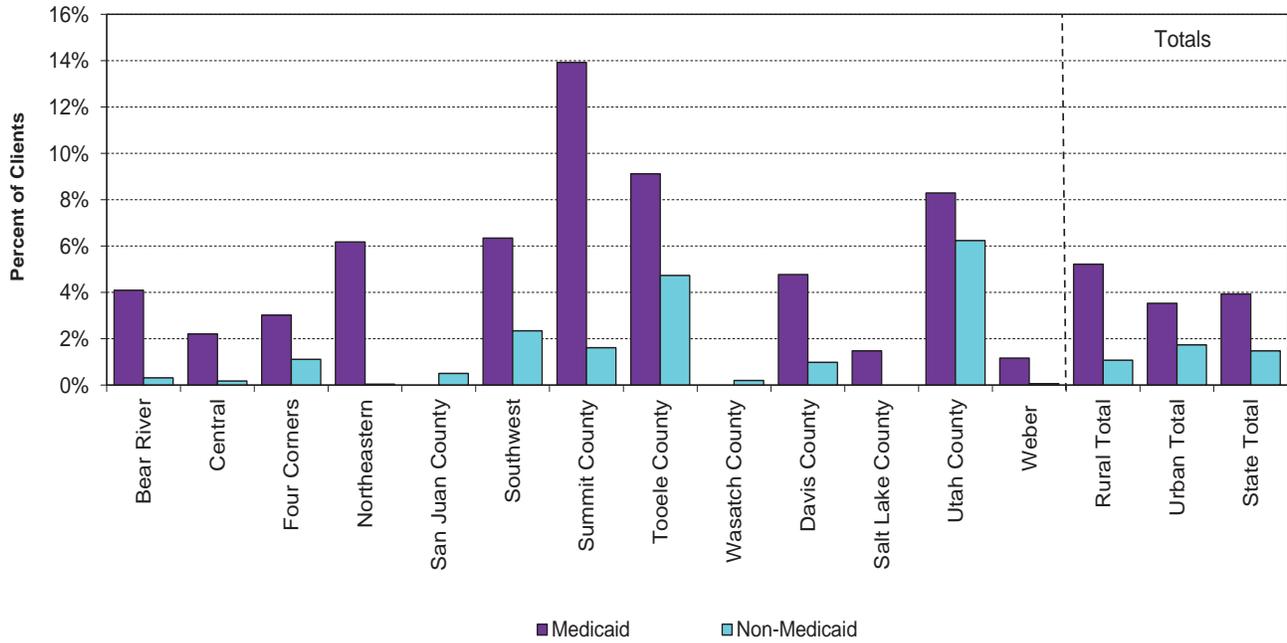


Case Management Median Length of Service

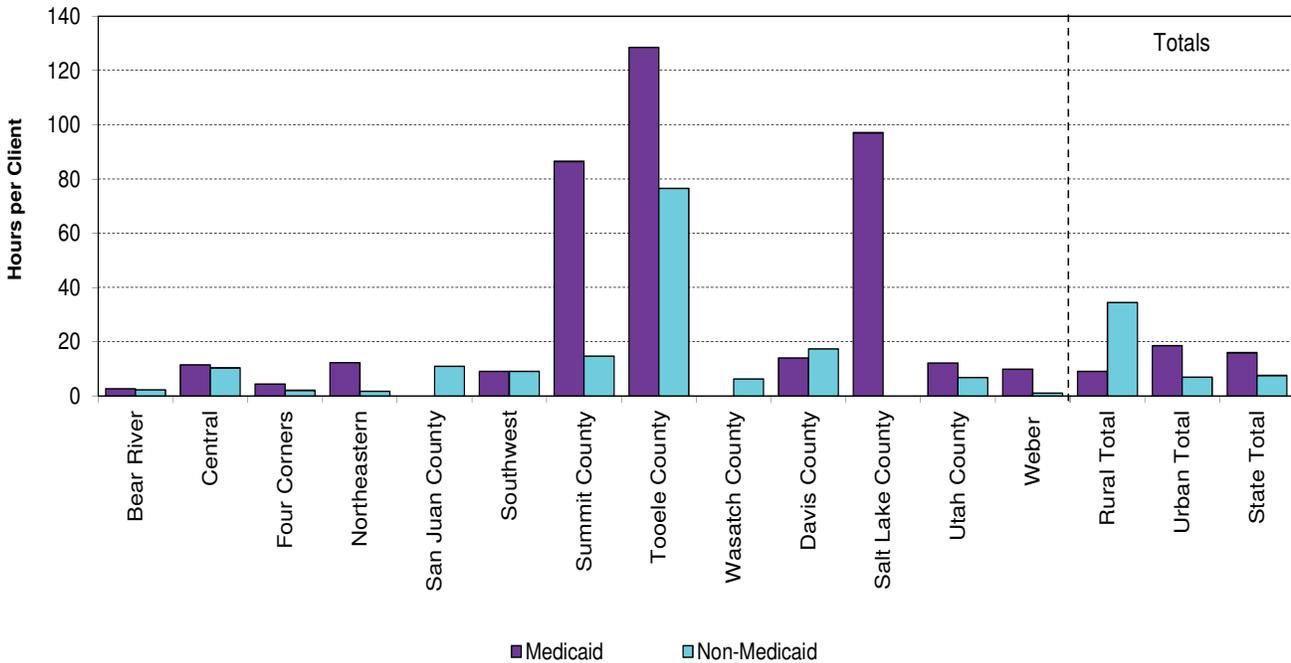
Mental Health Clients
Fiscal Year 2016



Respite Utilization Mental Health Clients Fiscal Year 2016

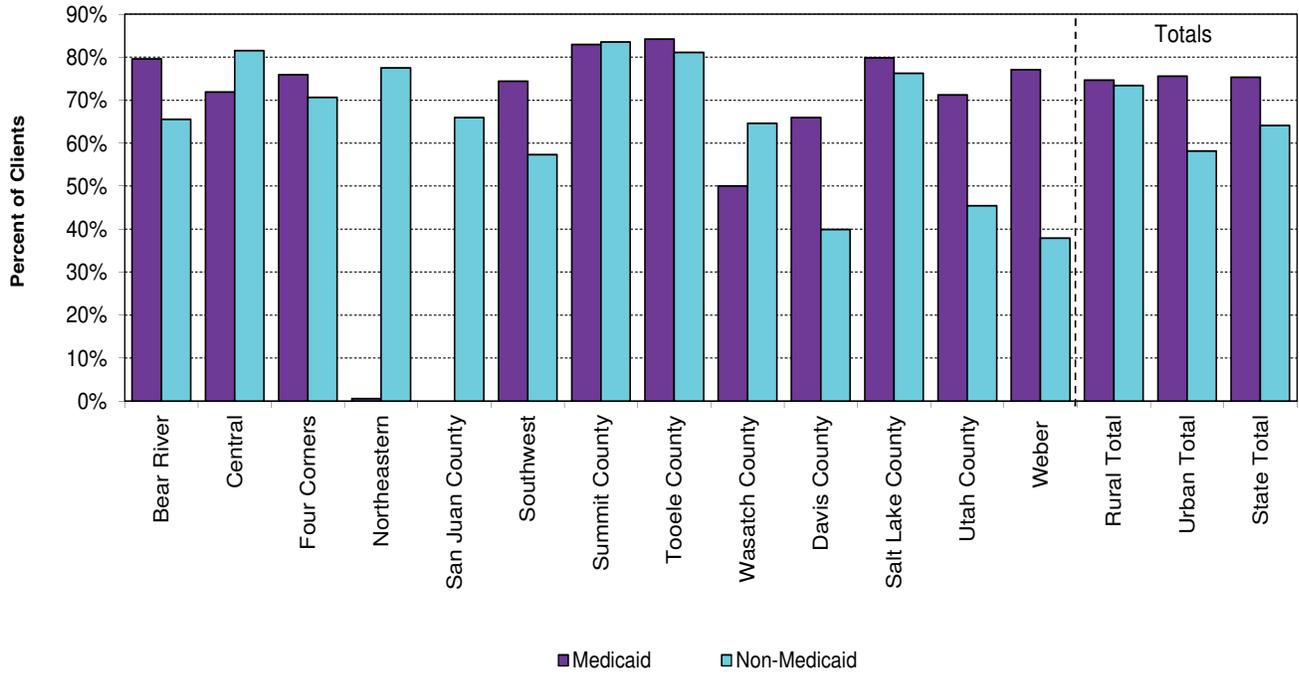


Respite Median Length of Service Mental Health Clients Fiscal Year 2016



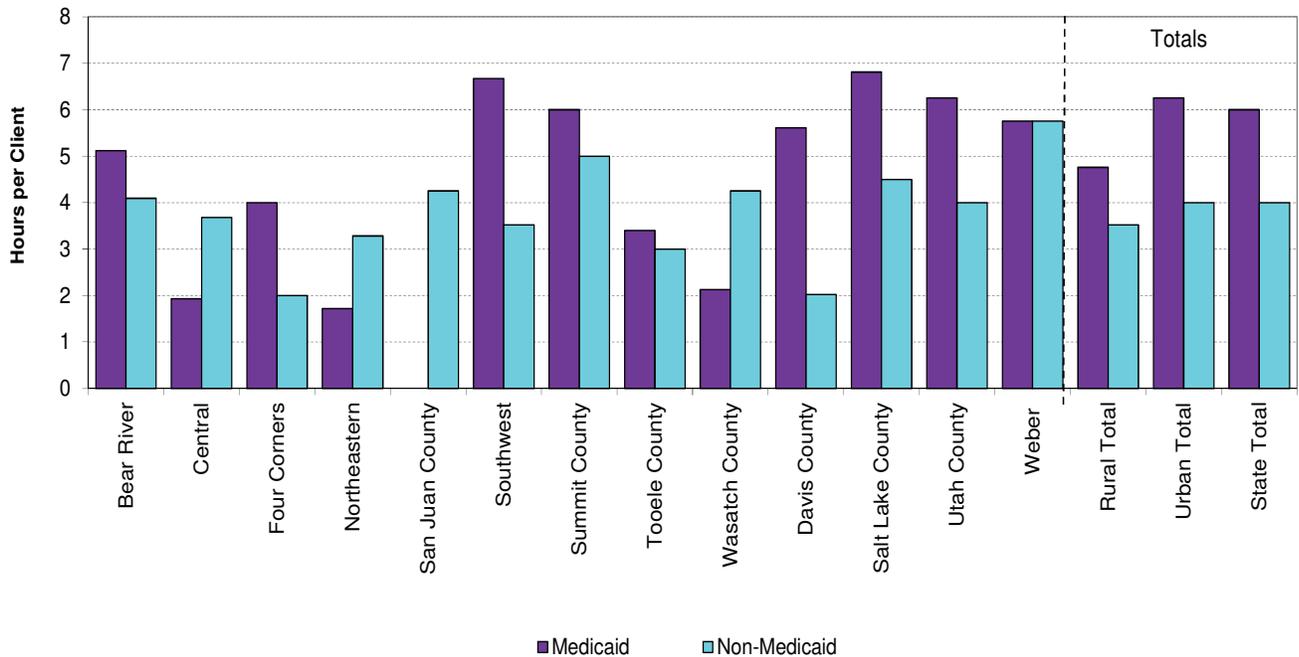
Therapy Utilization

Mental Health Clients
Fiscal Year 2016



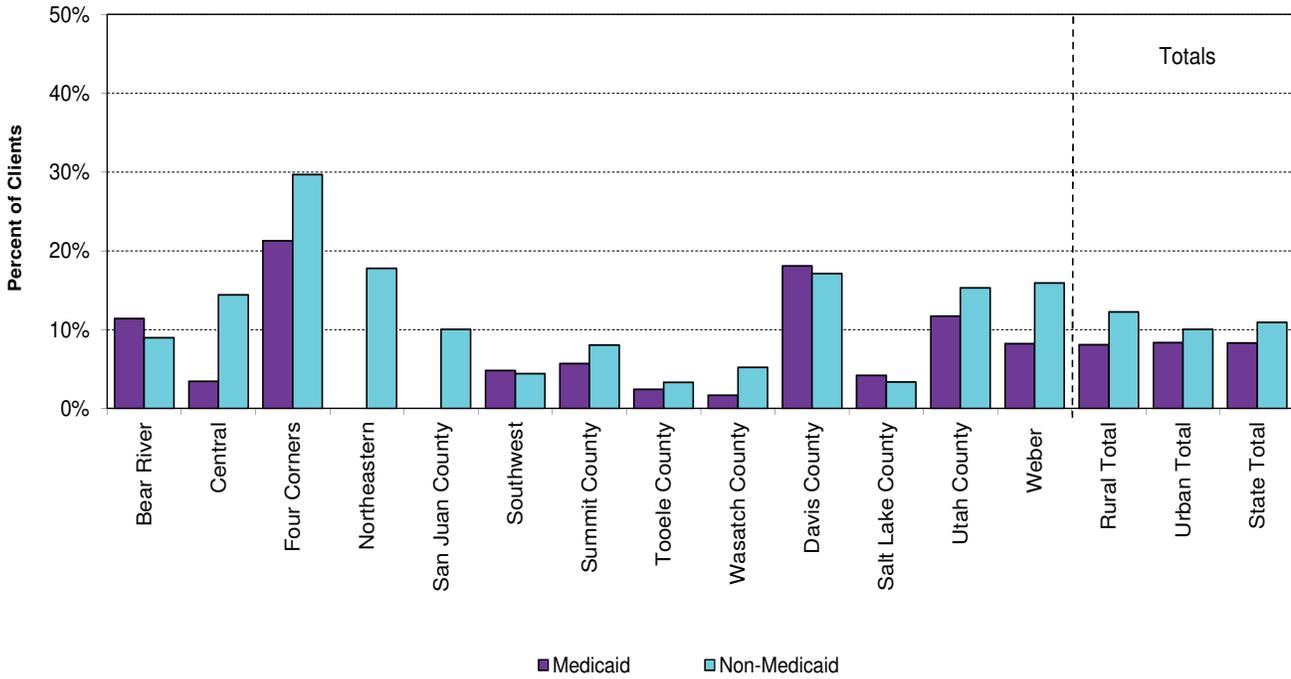
Therapy Median Length of Service

Mental Health Clients
Fiscal Year 2016



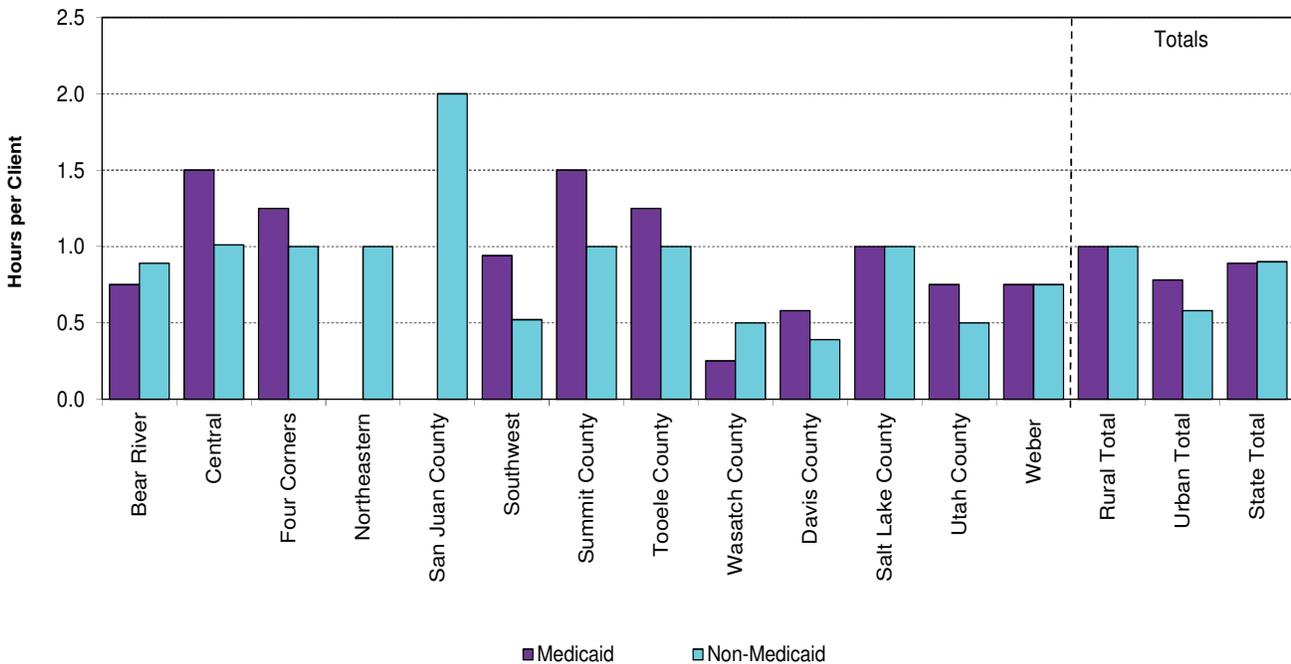
Emergency Utilization

Mental Health Clients
Fiscal Year 2016



Emergency Median Length of Service

Mental Health Clients
Fiscal Year 2016

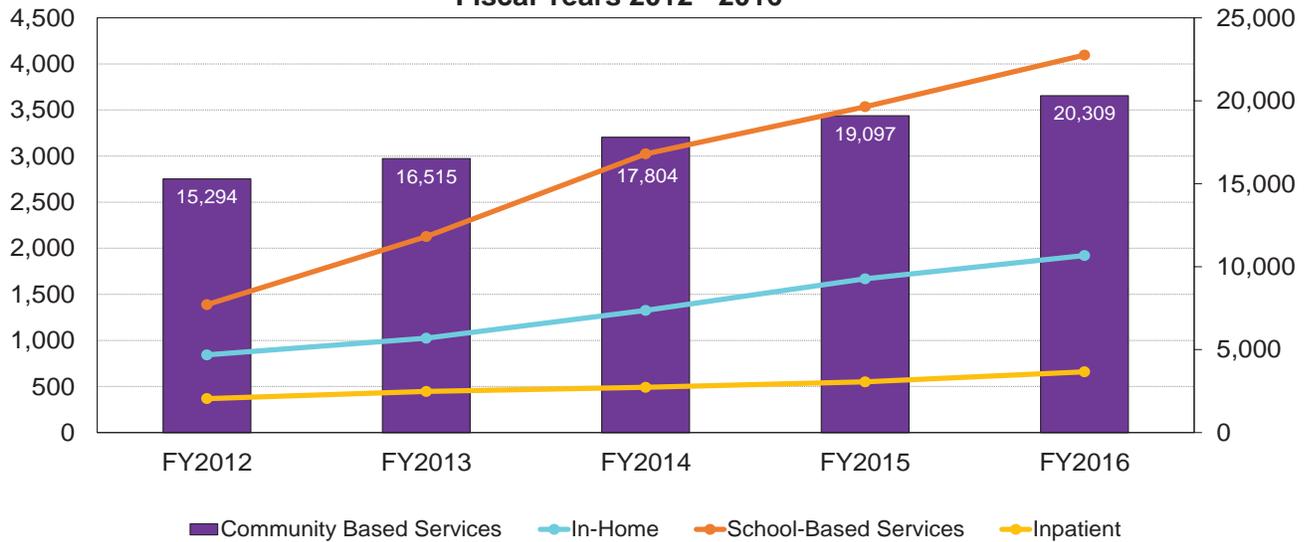


Mental Health Trends

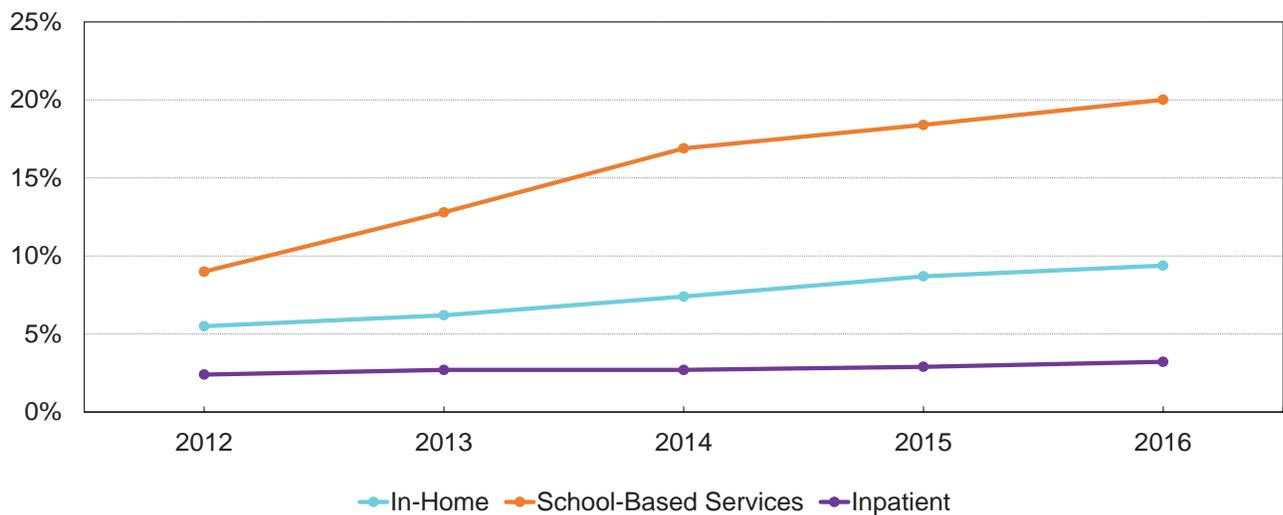
The following charts show trends in locations of services for children and youth (ages under 18) served in mental health services. Most children/youth are being served in the community. There has been significant increases in services provided in homes and at school (school-based

services) since fiscal year 2012. During the same timeframe services provided at inpatient facilities have remained steady with around 4% of the children/youth served receiving inpatient services.

Total Number of Youth Served by Location of Service
Fiscal Years 2012 - 2016



Percent of Youth Served by Location of Service
Fiscal Years 2012 - 2016

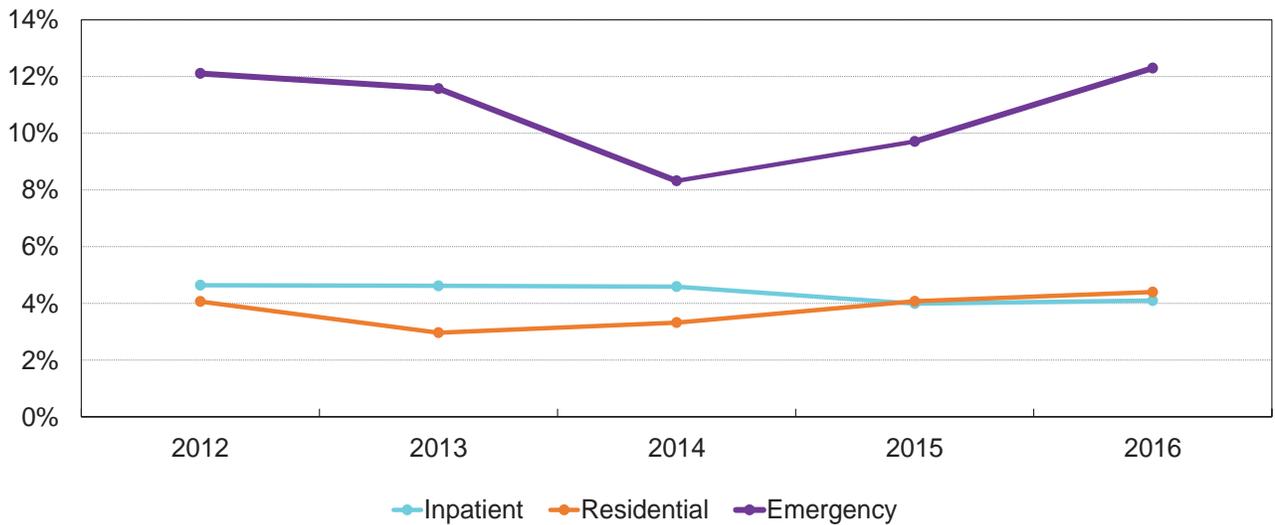


*Over 99% of clients are seen in community-based services.

The following chart shows the percent of adults who are receiving inpatient, residential, and emergency mental health services. It is interesting

to note that there has been a decrease in inpatient services while an increase in emergency services between fiscal years 2015 through 2016.

**Percent of Mental Health Adults
in Inpatient, Residential,
and Emergency Services
Fiscal Years 2012 - 2016**

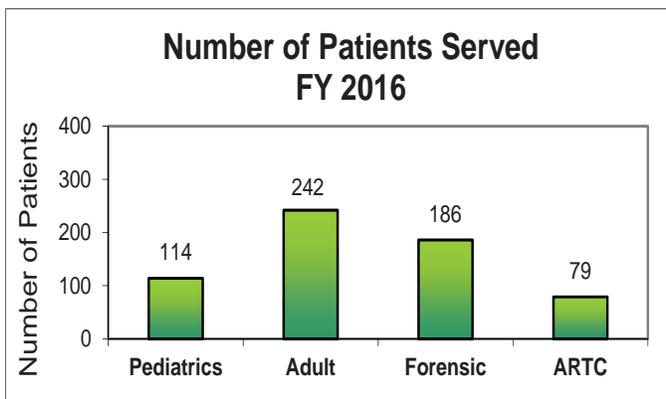


Utah State Hospital

The Utah State Hospital (USH) is a 24-hour inpatient psychiatric facility, located on East Center Street in Provo, Utah. The hospital serves people who experience severe and persistent mental illness (SPMI). In FY 2016 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 as part of its continuum of care. All adult and pediatric beds are allocated to the mental health centers based on population.

Individuals Served at the Utah State Hospital

- Adult patients age 18 and older who have severe mental disorders (civil commitment)
- Children and youth, ages 6-17, who require intensive inpatient treatment
- Persons adjudicated and found guilty and mentally ill
- Persons found not competent to proceed and need competency restoration
- Persons who are determined guilty and mentally ill and are ordered for treatment
- Persons with mental health disorders who are in the custody of the Utah Department of Corrections



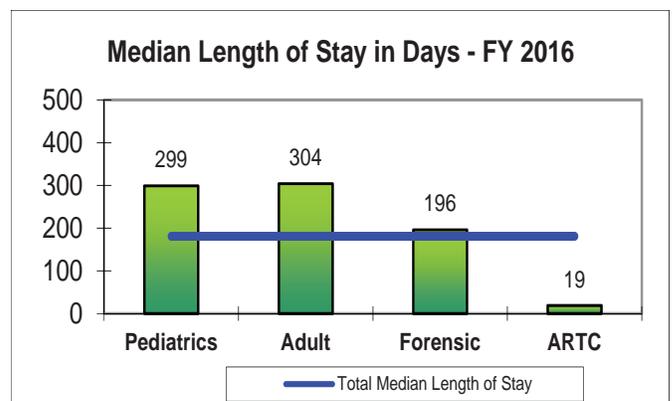
- Acute treatment service for adult patients from rural centers (ARTC)

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

Median Discharged Length of Stay

The Utah State Hospital discharged several long term patients from Adult Services this year, removing the top 10%, the median discharged length of stay for adult services is 273 days.

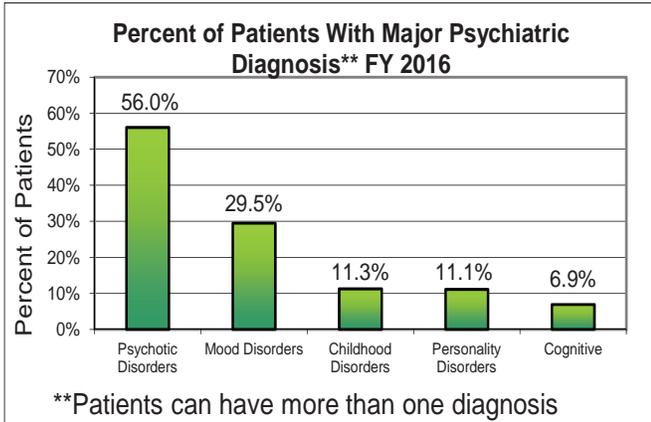


Types of Disorders Treated

- Psychotic Disorders: schizophrenia, schizoaffective disorder, other psychotic disorders, and delusional disorders
- Mood Disorders: major depression, anxiety disorders, bipolar disorder, and dysthymia
- Childhood Disorders: developmental disorders, autism, attention deficit disorder, conduct disorder, and adjustment disorder
- Personality Disorders: borderline, antisocial, paranoid, and narcissistic disorders. These are often a secondary diagnosis.

- Cognitive Disorders: primary degenerative dementia, mental disorders due to general medical conditions, and intellectual disabilities

43.6% of the patients treated also had a substance use disorder diagnosis.

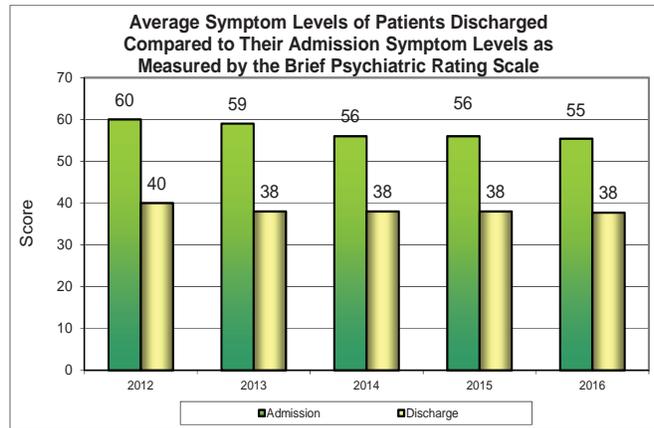


Services Provided

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

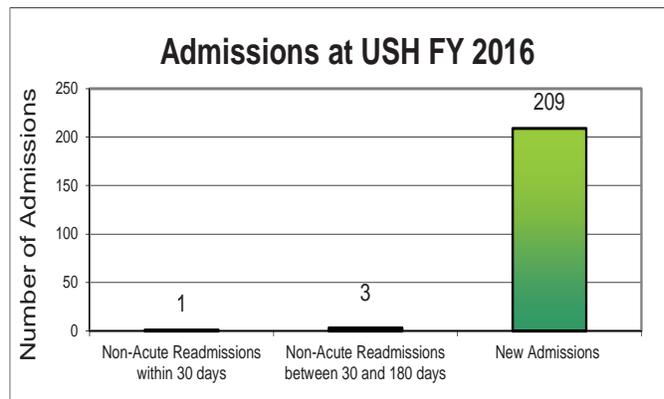
Assessment

In order to assess patient progress, the 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 psychiatric symptoms from admission to discharge in the 2016 fiscal year. A statistically reliable change score is a decrease of 15 points from admissions versus discharge.



Readmission

The hospital admitted a total of 246 patients (not including 75 ARTC admissions) in the 2016 fiscal year. Of these admissions, 1 was a prior patient who had been discharged from the hospital within the previous 30 days. Three of these admissions had been discharged from the hospital between 31 and 180 days prior to the current admission. There were 209 patients admitted to the hospital for the first time.



Recovery Support Services

Utah's public behavioral health system offers a range of recovery support services that help people develop resiliency and recover from mental and/or substance use disorders. The available services include, but are not limited to: peer support, supported employment, housing assistance, educational services, and physical health services. Recovery support services may be provided before, during, or after clinical treatment or may be provided to individuals who are not in treatment but seek support. Services may be provided by professionals or peers.

Parole-Access to Recovery

Parole Access to Recovery (PATR) offers recovery support to participants referred by the Department of Corrections. This program helps empower individuals to direct their own recovery. Funding is used for bus passes, emergency housing, sober housing, GED testing, securing state ID cards, child care, case management, and vocational services, and more depending on individualized need.

Recovering individuals have multiple and often unique needs. Navigating public resources can be overwhelming. Case managers provide direction, support and motivation. They also assist individuals in developing their own recovery plan and choosing services and providers that best meet their needs. Case managers maintain close contact and are available to resolve concerns or modify recovery plans as needed.

Participants, parole officers, corrections administration, and other community agencies agree this has filled a need within our system that helps individuals entering back into the community with a history of substance use disorders. To date, PATR has served 2,546 individuals with an average cost per parolee of around \$867.

Drug Court Recovery Support Services

Drug Court participants are offered service which include: transportation assistance, gas vouchers, ID cards, physical health services, medication assisted therapy, employment skills, life skills, case management, educational services, etc. These services help individuals acquire and maintain stable housing, employment, life time skills and overall sobriety and recovery. To this date 1,153 individuals have been provided recovery support services.

Peer Support Services

Certified Peer Support Specialists (CPSS) are trained specialists with lived experience who are in recovery from their own or a family member's mental health and/or substance use disorders. They have progressed in their recovery, and are willing to utilize that experience to help others. They work alongside other mental health and substance use professionals to improve the quality of life of those they serve. Peer support services are provided by all Local Mental Health Authorities, and CPSS use their recovery story to assist and support individuals as they transition through levels of care.

Family peer support is provided by Family Resource Facilitators (FRF) who are family members of individuals with complex needs. FRFs act as advocates and resource coordinators for children, youth and families. FRFs are located throughout the state and work in partnership with multiple community providers.

Utah Comrades Peer Support Program

DSAMH has partnered with The National Center for Veterans Studies (NCVS) at The University of Utah, and the Utah Army National Guard (UTARNG), to implement the Utah Comrades Peer Support Program. Recruitment of volunteer veterans from a variety of veteran service organizations and the community is underway. Volunteer veterans have received training in communication skills and available community resources to help them assist other service members in managing the many challenges that may arise throughout the deployment cycle. Volunteer veterans are trained to help veterans and service members address issues ranging from accessing financial, employment, legal, benefit, or educational resources to identifying mental health providers for emotional, substance use, or relationship concerns. Presentations have been held across Utah to generate awareness of the program and create a referral process for veterans in need of peer support.

The UTARNG Health and Wellness survey was distributed in January 2016 to guard personnel and their spouses. Thus far, 531 guard personnel and 109 spouses participated in filling out the survey. Data from this survey confirm that areas of greatest need include suicidal ideation, traumatic brain injury, post-traumatic stress disorder (PTSD) and depression.

Research shows that a service member's preferred source of support is another service member or veteran. Similarly, military spouses are much more likely to turn to other military spouses in time of need than to seek out professional assistance. The Utah Comrades Peer Support Program, in collaboration with NCVS and UTARNG, holds considerable promise for improving the mental health and well-being of Utah service members, veterans, and families.

Homeless Services

DSAMH has been actively involved in working to help people in Utah experiencing homelessness with behavioral health disorders by collaborating with private and public community stakeholders across the state, to help ensure service delivery and the development of Permanent Supportive Housing (PSH). Homeless Services are provided through various methods and across multiple partnerships with the Local Mental Health and Substance Abuse Authorities. As indicated in the latest report on homelessness, utah.gov/housing/ Utah is commended nationally for collaboration among state and local leaders, faith based organizations, nonprofits, with significant local volunteer involvement.

DSAMH has been active in working with the Local Mental Health Authorities on providing recovery support services and PSH for Veterans and other individuals experiencing chronic homelessness with mental illness and/or substance use disorders. This is funded through a federal grant: Cooperative Agreement to Benefit Homeless Individuals (CABHI-UT) by the Substance Abuse and Mental Health Services Administration (SAMHSA). The grant has helped to increase capacity along the Wasatch Front for the majority of the target population in four counties (Utah County, Salt Lake, Davis and Weber), to provide accessible, effective, comprehensive, and integrated evidence-based treatment and recovery services. The program is designed to coordinate housing and behavioral health programming with evidence-based practices that include PSH, Motivational Interviewing, Assertive Community Treatment, SSI/SSDI Outreach Access and Recovery (SOAR), Supported Employment and Individual Placement and Support for employment support while incorporating a Trauma Informed approach. The CABHI UT program has been successful over the past federal fiscal year coordinating

PSH placements, providing needed services and supports for 98 individuals, compared to 50 individuals last fiscal year.

Since the State fiscal year 2015 Point in Time Count, there has been a 5.6 percent decrease in the number of chronically homeless individuals and a 64.7 percent decrease in chronically homeless families. This population experiences a variety of health and social challenges, including substance abuse, mental health disorders, criminal records, and extended periods of unemployment. These challenges can pose significant barriers to maintaining stable housing. The United States Interagency Council on Homelessness notes, “People experiencing chronic homelessness cost the public between \$30,000 and \$50,000 per person per year through their repeated use of emergency rooms, hospitals, jails, psychiatric centers, detox, and other crisis services”. After being served in the CABHI-UT Program, an annual estimated cost is \$16,000 per person per year.

DSAMH was also awarded the CABHI States Enhancement Grant to enhance our efforts to help individuals gain public entitlements and employment opportunities using SOAR for entitlement supports and Individual Placement and Support to help gain competitive employment.

DSAMH was also awarded another federal grant Projects for Assistance in Transition from Homelessness (PATH) to provide flexible, assisted services to adults with serious mental illness or who have co-occurring substance use disorders and are homeless or at imminent risk of becoming homeless. Valley Behavioral Health provides services in Salt Lake County; Weber Human Services provides services in Weber and Morgan Counties; Four Corners provides services in Carbon, Emery, and Grand Counties; and Wasatch Mental Health provides services in Utah County. In federal fiscal year 2016, 1,610 people benefitted from PATH services.

Assisted Outpatient Treatment

In collaboration with Local Authorities, DSAMH is developing and implementing Assisted Outpatient Treatment programming (AOT). AOT is an evidence-based practice that includes court-ordered treatment and coordinated care across community services. It has been demonstrated to improve outcomes for adults with serious mental illness on civil commitment, who have a history of poor treatment compliance and multiple hospitalizations and/or incarcerations. This program will address gaps in resource collaboration, training and service provision, to increase the number of civilly committed individuals receiving sufficient services and supports to remain in the community.

Supported Employment

The Supported Employment (SE) Program utilizes the evidence-based model of Individual Placement and Support (IPS) to provide SE services for adults with serious mental illness and co-occurring substance use disorder conditions. According to SAMHSA (2012) Uniform Reporting System, 80.7% of individuals with mental illness in Utah are unemployed and approximately 60% of those individuals desire to work. Providing SE/IPS services assists individuals with mental illness obtain and maintain competitive, integrated, and meaningful employment, thereby increasing an individual’s sense of purpose, self-worth, and social acceptance. SE/IPS is a key component in recovery, decreasing hospitalizations, risk of isolation, marginalization, poverty and stigma.

The SE/IPS Program is provided to Utah by a Federal SAMHSA grant. The SE/IPS program coordinates with two Local Mental Health Authorities (LMHAs), Weber Human Services and Southwest Behavioral Health Center. Weber Human Services is the LMHA for urban Weber and Morgan County. Southwest Behavioral Health

Substance Abuse and Mental Health

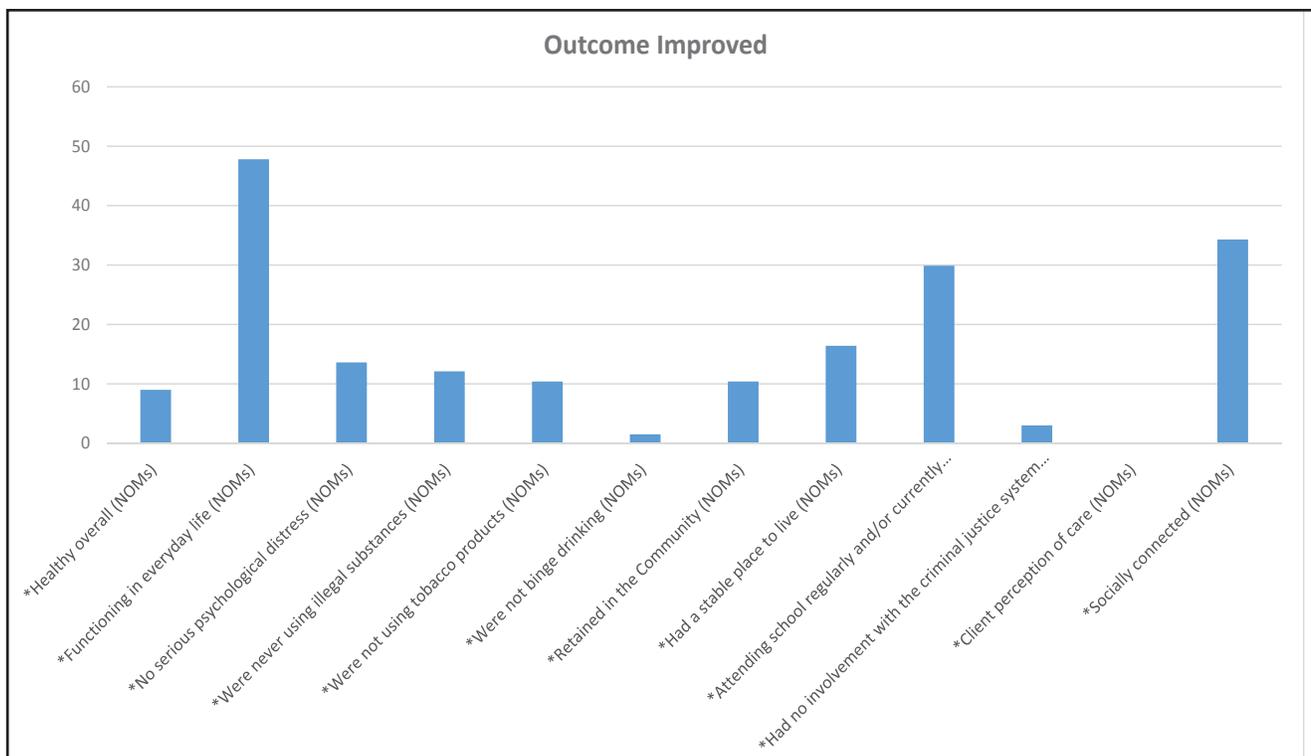
Center is the LMHA for the rural and frontier southwest region of Utah, which includes Beaver, Garfield, Kane, Iron and Washington Counties. In partnerships with Southwest Behavioral Health Center and Weber Human Services, 283 individuals have become gainfully employed. During Federal Fiscal Year 2016, the SE/IPS Program has expanded to 10 counties, providing services to over 700 persons.

Individuals enrolled in SE/IPS receive ongoing supports from multiple agencies, including Division of Substance Abuse and Mental Health, local mental health and substance abuse authorities, Vocational Rehabilitation, State Medicaid, Veterans Administration, Department of Workforce Services, Utah State Board of Education,

Division of Services for People with Disabilities, and other partnering agencies, families and community members. With meaningful, competitive and integrated employment as the target outcome, mental health consumers, their treatment providers, and their employers develop mutual understanding and successful relationships. The SE/IPS Program assists people with serious mental illness discover self-sufficiency and recovery.

Preliminary data on the chart below indicates that individuals who have engaged in the SE/IPS program demonstrate improved outcomes between the baseline interview and most recent interview (6 or 12 months after engaging in the program).

FY16 Supported Employment/ Individual Placement and Support Outcomes



Recovery Plus and Recovery Plus II

Recovery Plus is an initiative to promote health and wellness in individuals with mental illness and/or substance use disorders. The initiative was designed to improve the health and quality of life by increasing the number of individuals who live tobacco-free while recovering from a mental health or substance use disorder. Nationally, approximately 80-90% of those receiving services within behavioral health treatment facilities smoke cigarettes.¹ More individuals with alcohol disorders die of tobacco-related illness than alcohol-related problems.² Equally striking is that 44% of all cigarettes are consumed by individuals with addictions or mental health comorbidities.³ In Utah, 11.3% of adults smoke,⁴ yet 68.8% of individuals in treatment for substance use disorders smoke.

Initially supported by a federal stimulus grant from the Centers for Disease Control and Prevention, the project was focused on two cardinal rules:

1. No one will be denied treatment because of their tobacco use.
2. Assessment, education, treatment planning and Nicotine Replacement Therapy (NRT) will be provided to all clients as appropriate.

¹ 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

² 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

³ 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

⁴ Utah Department of Health Website (2011) Tobacco Free Utah. Retrieved on November 16, 2016 from http://www.tobaccofreeutah.org/tobacco_facts.html.

Local authorities were given three years 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 was March 2013, and since that date, Local Authorities have established tobacco-free campuses and have incorporated tobacco cessation into treatment plans. Recovery Plus initiatives continue in local communities, with plans to expand to address other risk factors (obesity) and chronic diseases (cardiovascular disease, diabetes, asthma).

In 2016, Utah took part of the National Council for Behavioral Health's Tobacco and Cancer Control Community of Practice initiative, referred to as Recovery Plus II. This initiative will focus on the development of a fluid identification and referral system between Primary Care (PC) and Behavioral Health (BH) organizations. Individuals with identified mental health and/or substance use needs will be referred from PC to BH, and individuals requiring cancer screens will be referred from BH to PC. Initial steps will involve identification of key stakeholders and facilitation of communication within the current system.

Healthy Minds Utah

In October 2015, DSAMH launched an on-line screening site, providing 24/7 access to anonymous screens for depression, adolescent depression, bipolar disorder, generalized anxiety disorder, posttraumatic stress disorder, eating disorders, alcohol use disorders and substance use disorders, in English and Spanish.

Each local mental health authority also has the screening site linked to their home page, and individuals completing a positive screen are given referral information based on their location. Crisis information is provided for anyone endorsing suicidal ideation at least some of the time (32% of the screening respondents).

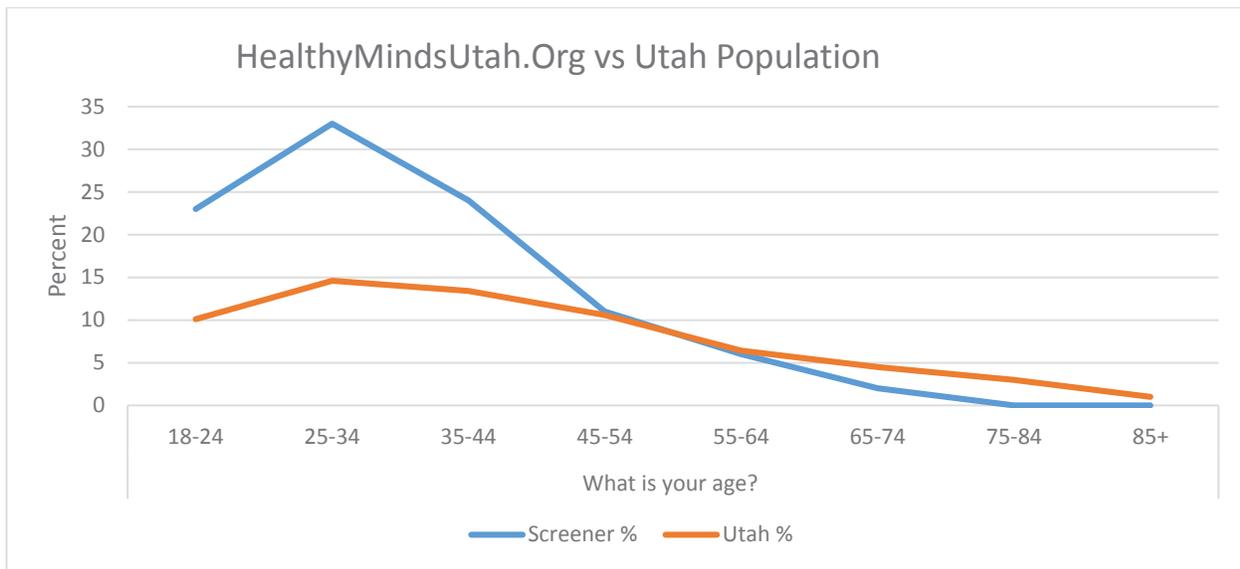
Substance Abuse and Mental Health

To date, 7,600 individuals have visited the site and over 5,000 screens have been completed. A majority of the screens (over 3,300) have been for depression and generalized anxiety disorder.

The demographics of all those completing the screens match the Utah population with the exception of gender (69% of the screens are com-

pleted by females) and age (screens are more often completed by younger individuals). Forty-eight percent of individuals indicated that they would seek help. To access the various screening tools, visit:

healthymindsutah.org



Heather's Story

My recovery journey turned out to be similar to many others. For 36 years I thought my experiences were unique. So unique that they almost killed me. I remember a feeling of separation that began at a very early age. For me it began a pattern of feeling “apart from, versus a “part of.” This separation only grew larger as I grew older.

At the age of 16 I took my first drink. I felt like I had come home, not just any home but the home I had always wished for, the one that had eluded me for the first 16 years of my life. All I had to do to live in this home was stay drunk, so that is what I did.

My story has many gory details including eventual drug use, periods of incarceration, homelessness, and the sickness that drove me. I gave up many people that loved me, including my children. I found that addiction isn't about what you used or drank or how much. It's about, “Did you feel the way I felt and did you think the way I thought?” What is important for me today, is to tell you what happened and what my life is like today.

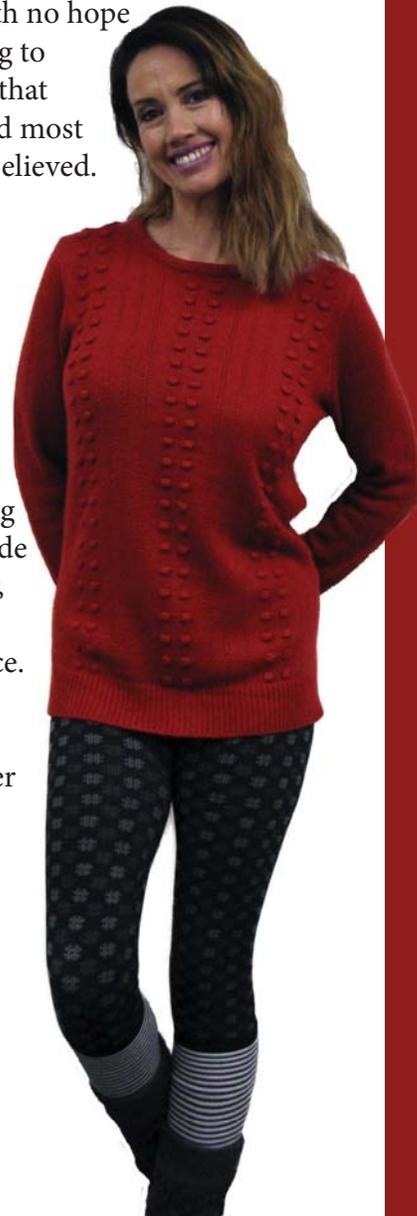
My journey to recovery started with jail. I was what the court system refers to as a “repeat offender.” I came into this recovery world, broken with no hope for a future. The judge offered me one last chance before going to prison and enrolled me in the Drug Court program. During that time I was taught gratitude, empowerment, accountability and most importantly, that I was capable of so much more than I ever believed. They offered me a chance to change my future. I grabbed it!

My recovery is filled with many different paths. I have the opportunity to build a new life, to get an education. I am blessed to work in the Recovery field, to give back to a community and its people. There is a life out there that is so much better than what we have known.

I know there are solutions to life's challenges that have nothing to do with drugs and alcohol. Recovery has taught me gratitude for the simple things. Sobriety restored my faith in humanity, especially my own. I will never forget those who helped me learn those lessons and who convinced me to give life a chance.

Today, I am a daughter, a mother, a sister, a friend, and a productive citizen in society. Life is infinitely better than I ever thought possible.

**We recover.
I did, so can you!**



Outcomes

Outcomes

DSAMH reviews numerous data sets to assist with assessment, planning, implementation, evaluation and reporting. For Prevention, DSAMH partners with the State Epidemiological Outcomes Workgroup's (SEOW) to review data sets regularly in order to prioritize issues such as the prescription drug epidemic, depression and anxiety in children, factors that lead to suicidal ideation, death by suicide and underage drinking. DSAMH looks at a full cadre of data sets in order to prioritize issues and factors that increase negative outcomes in substance use, mental illness and suicide.

For substance use disorder and mental health treatment, DSAMH monitors and evaluates pro-

grams provided by local authorities 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 health 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. To view the scorecards, go to:

dsamh.utah.gov/data/outcome-reports/

Student Health and Risk Prevention Survey (SHARP)

The biennial SHARP survey was completed in spring of 2015. The SHARP survey is a combination of three major surveys which include the Prevention Needs Assessment (PNA), the Youth Risk Behavior Survey, and questions from the Youth Tobacco Survey.

The SHARP 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. Nearly 50,000 students were surveyed. The data was gathered and reported as a full statewide report and for each 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.

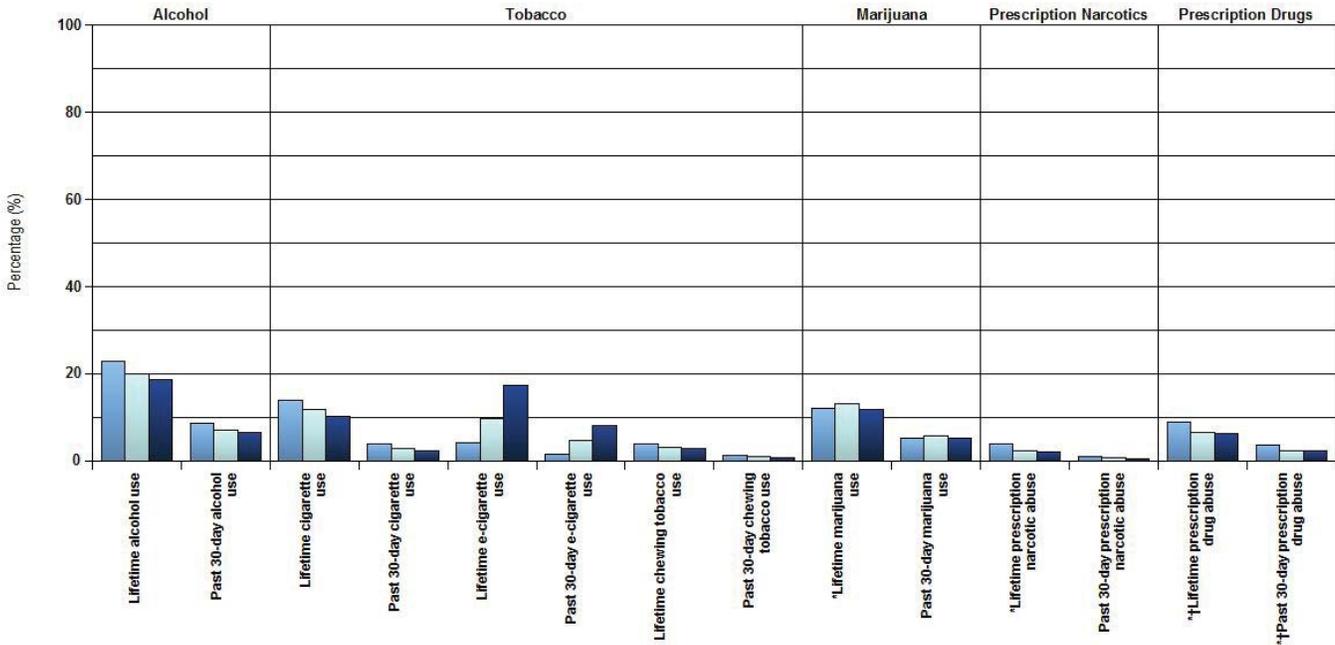
The following five tables show the trends of substance use and mental health needs of the youth in Utah.

State-Identified Prioritized Substance Use—All Grades

The table on the following page highlights the trends of substance use, that have been prioritized by the SEOW, reported by all grades combined. These substances were prioritized based on previous trends and numbers, including death

and treatment admissions. The table shows that most substance use among youth is decreasing. E-cigarettes use is trending upward and marijuana use is remaining about the same.

State-Identified Priority Substance Use
2015 State of Utah Student Survey, All Grades

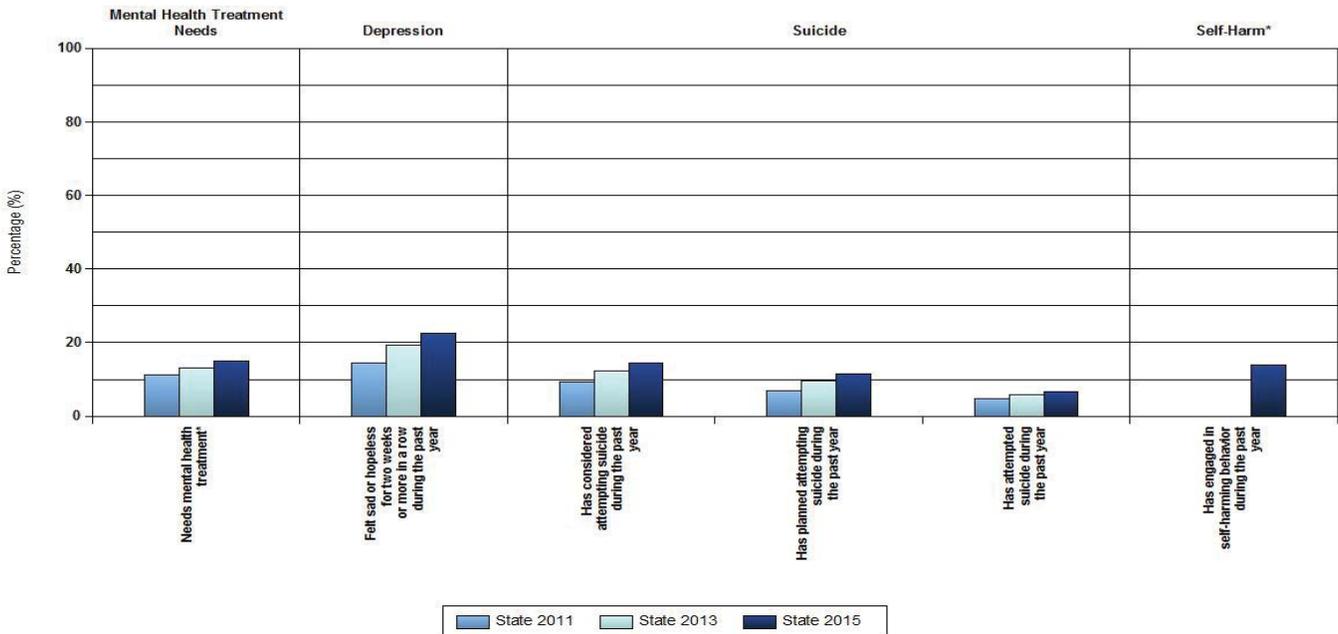


Mental Health and Suicide Indicators—All Grades

This table expresses the increase in need for mental health promotion. All indicators are trending upward. While substance use is mostly

decreasing, our youth’s mental health needs are increasing.

Mental Health and Suicide Indicators
2015 State of Utah Student Survey, All Grades

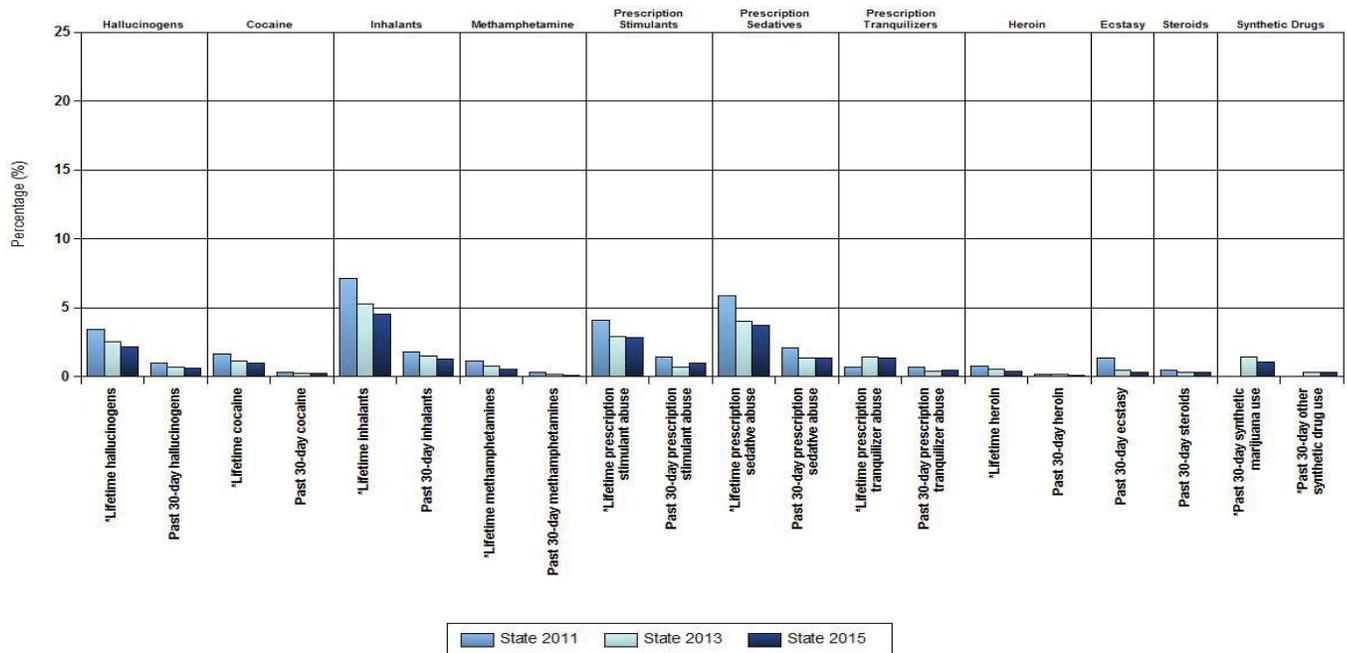


Other Substance Use—All Grades

The table below shows other substances that the survey collects data on. Just like with the prioritized substances, all indicators reflect a decreasing trend. Inhalants and some prescription drugs

may appear high, but the chart reflects both substances are only used by less than 3% of those surveyed.

Other Substance Use
2015 State of Utah Student Survey, All Grades

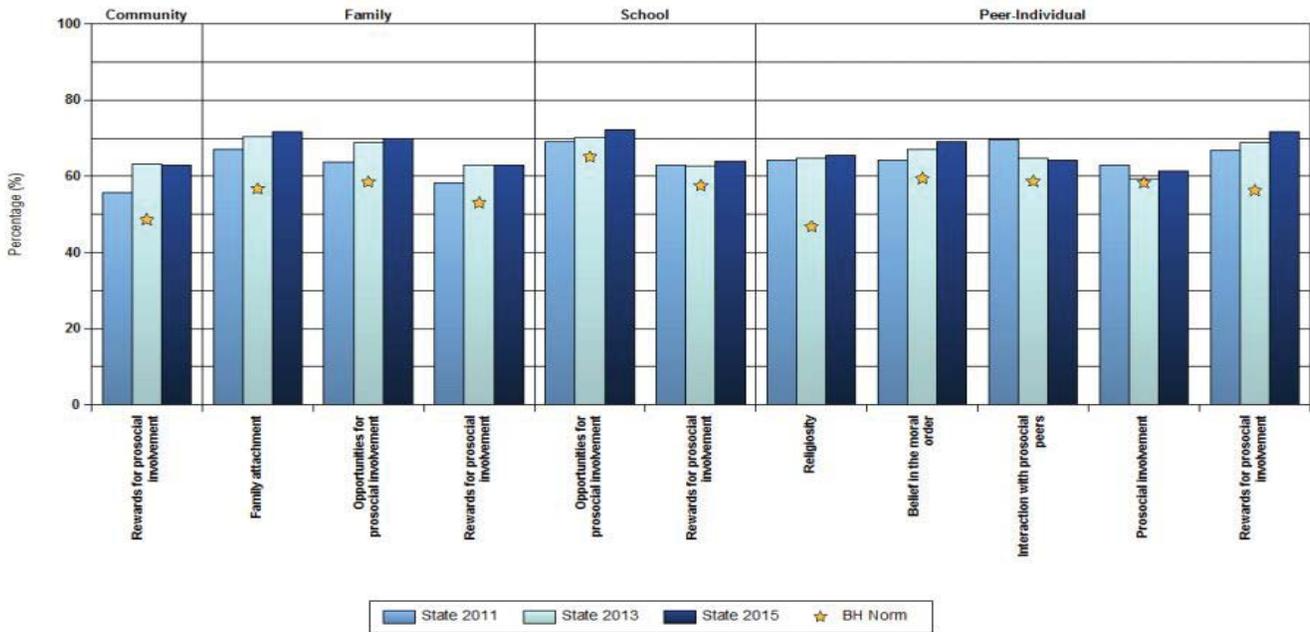


Protective Profile—All Grades

The table on the next page highlights what protective factors, things in place that help a youth be more successful, are great or need bolstering in Utah. This shows that Utah is doing some great things and youth are able to partake. Utah can

still improve, but it is important to see the state does some things well. Most indicators here are trending up, and are above the rates compared to seven other states (the Bach Harrison norm).

Protective Profile
2015 State of Utah Student Survey, All Grades

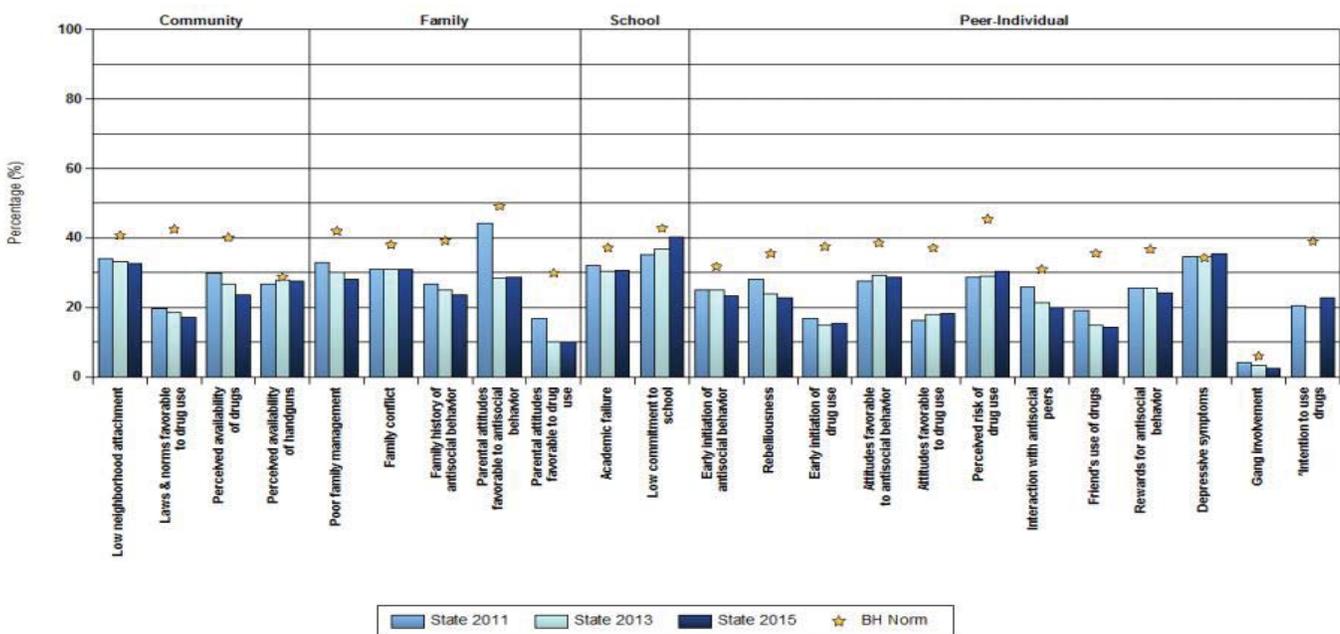


Risk Profile—All Grades

The Risk Profile shows what factors increase a youth’s risk for substance use, mental illness, delinquent behavior and other outcomes. While Utah still has risk rates that below the BH Norm,

some risk factors are increasing. This table helps to prioritize and select strategies that will improve communities.

Risk Profile
2015 State of Utah Student Survey, All Grades



Substance Use Disorder Treatment Outcomes

DSAMH regularly evaluates programs, practices and outcomes to ensure public dollars are used effectively.

Substance use treatment outcomes are derived from data collected on each individual served. DSAMH collected final discharge data on 6,985 (non-detox) clients in fiscal year 2016.

This section includes data from clients who were:

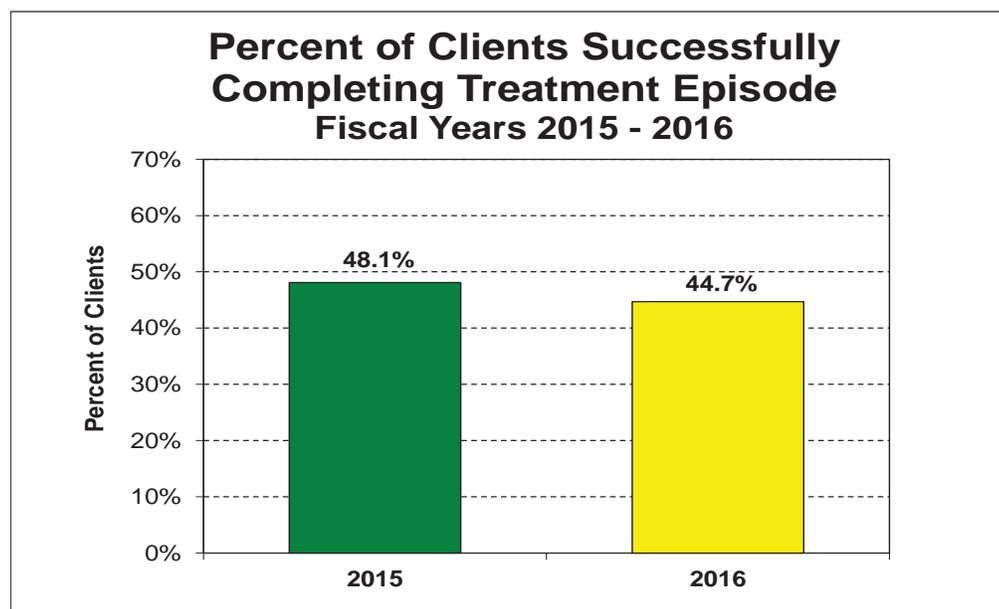
- Discharged successfully (completed the objectives of their treatment plan)
- Discharged unsuccessfully (left treatment against professional advice, or were involuntarily discharged by the provider due to non-compliance)

- 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-local authority contracted providers. For all outcomes, numbers are based on completed treatment episode, rather than a single treatment modality.

Discharge

The following chart depicts the percentage of clients discharged who successfully completed the entire treatment episode from fiscal years 2015 through 2016.

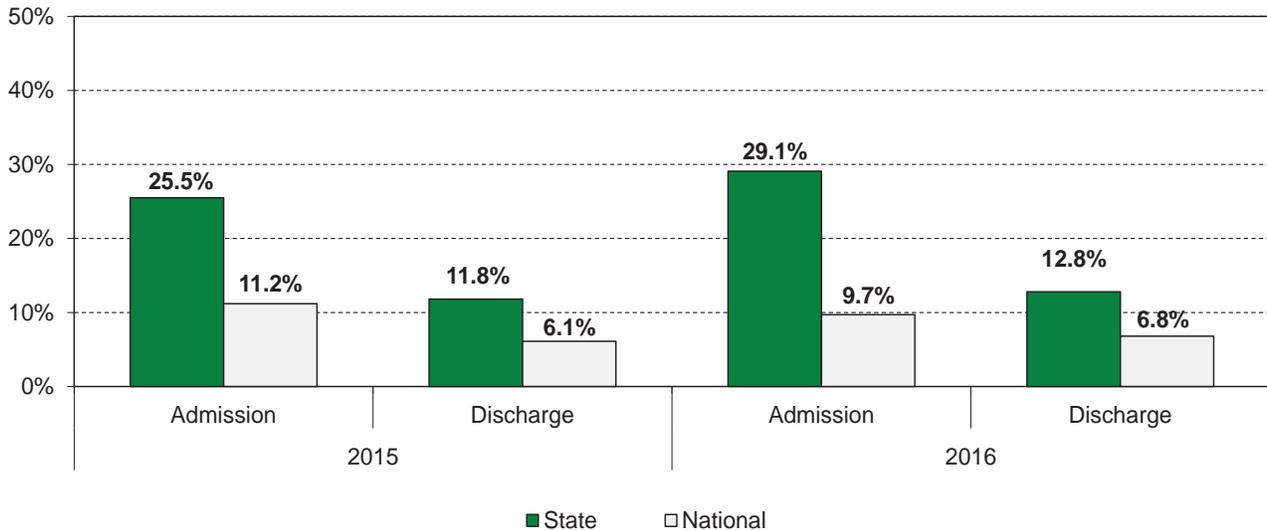


Criminal Activity

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 2015 through 2016, Utah had higher arrest rates at admission than the national average, but showed a considerable decrease at discharge even though the rate was still higher than the national average.

Percent of Clients Arrested Prior to Admission vs. Arrested During Treatment Fiscal Years 2015 - 2016

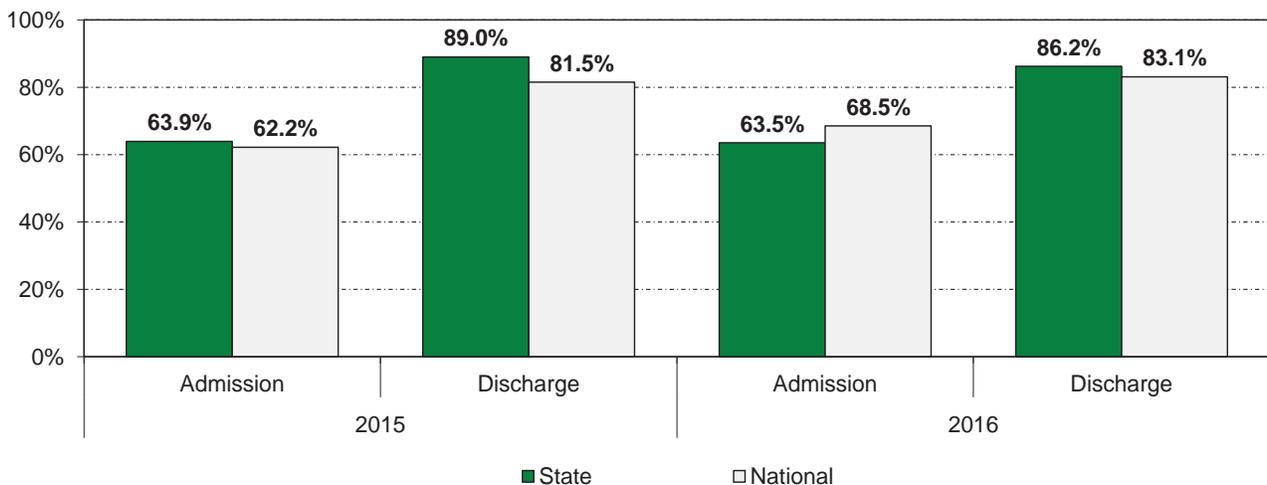


Changes in Abstinence from Drug and Alcohol Use During Treatment

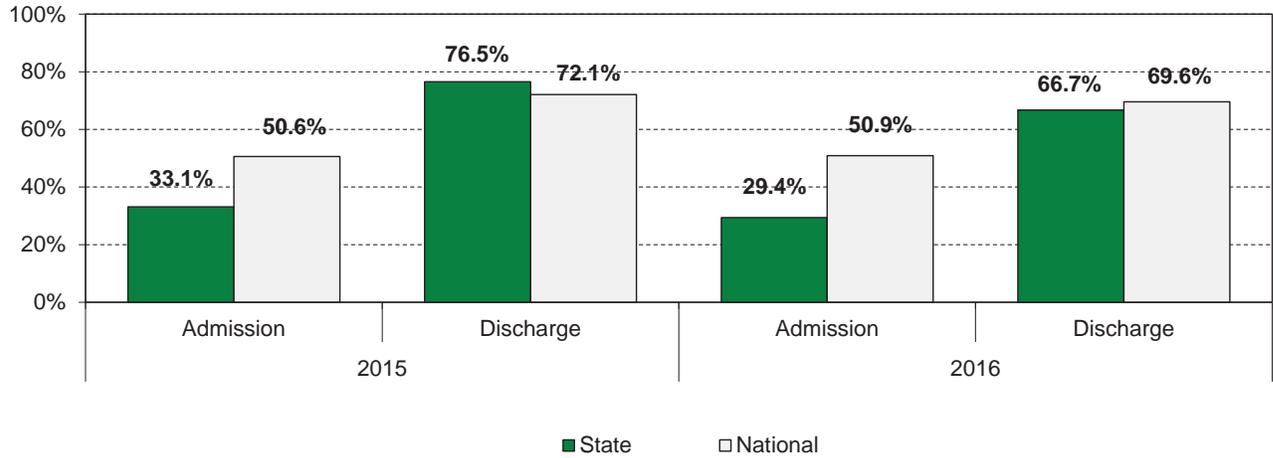
Abstinence rates at admission and discharge for clients in all treatment levels except detoxification are listed below. Substance use is evaluated 30 days prior to the client entering a controlled environment, such as treatment or jail, and again in the 30 days prior to discharge. As expected, the rate of abstinence increases during treat-

ment. Utah’s rate of abstinence from alcohol was comparable to the national rate at admission and slightly higher than the national rate at discharge in 2015 through 2016. For substance use, abstinence was substantially lower at admission and slightly higher at discharge compared to the national rates.

Percent of Clients Reporting Abstinence from Alcohol Use Prior to Admission vs. Abstinence at Discharge Fiscal Years 2015 - 2016



Percent of Clients Reporting Abstinence from Drug Use Prior to Admission vs. Abstinence at Discharge Fiscal Years 2015 - 2016

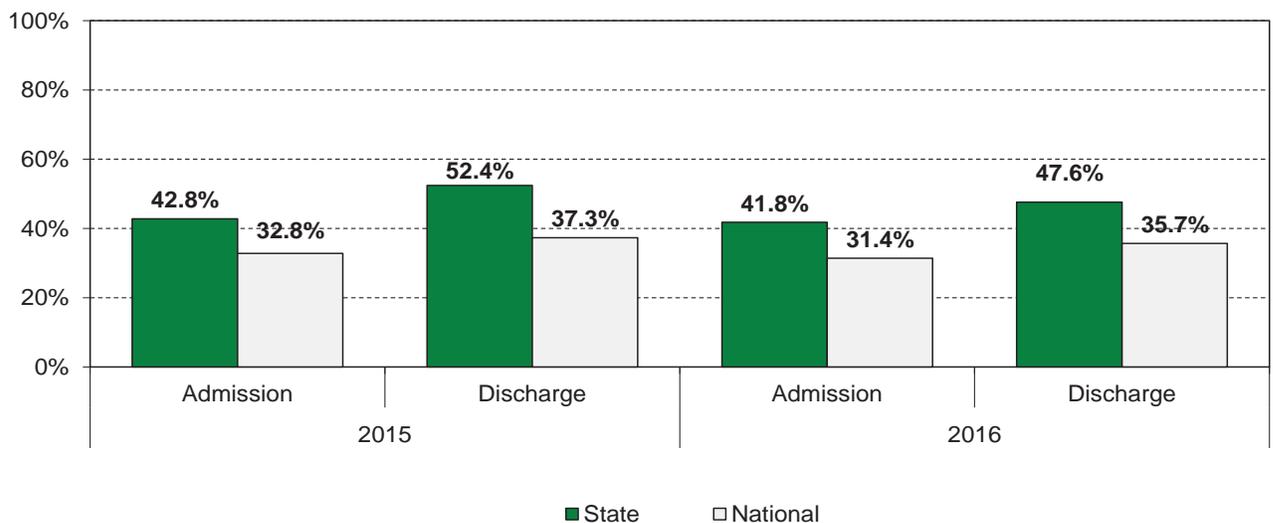


Employment

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 considerably higher than the national rate. Similarly, the percent at discharge of clients employed exceeds the national average.

Percent of Clients Who Are Employed Admission vs. Discharge Fiscal Years 2015 - 2016

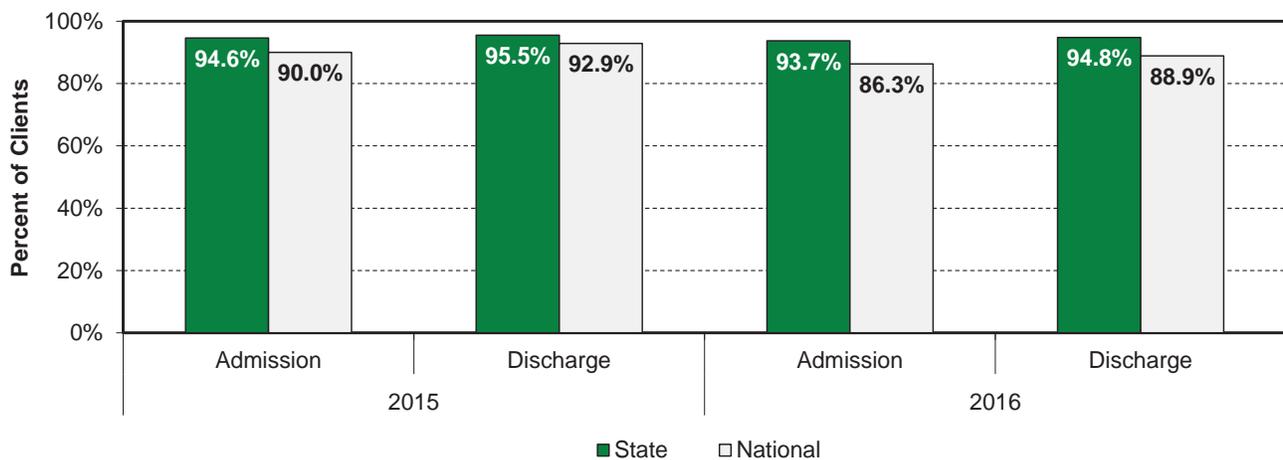


Clients in Stable Housing

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. 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.

**Percent of Clients in Stable Housing
Admission vs. Discharge
Fiscal Years 2015- 2016**



Retention in Treatment

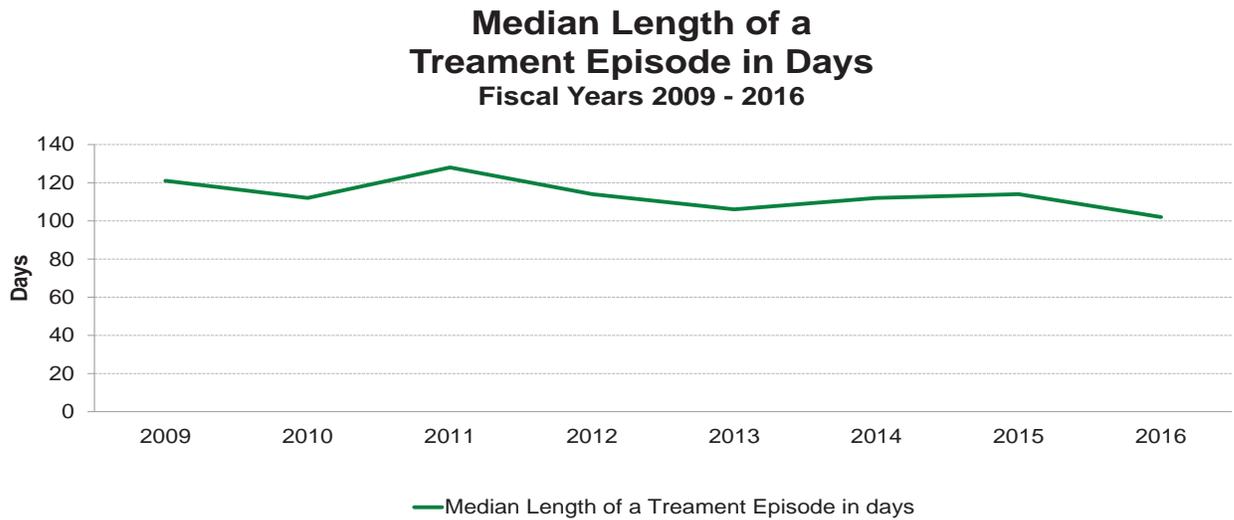
Retention in treatment is the factor most consistently associated with positive client outcomes. The appropriate length of a treatment varies based on the needs of the individual. However, the National Institute of Drug Addiction (NIDA) states:

“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 individuals with opioid use disorders continue to benefit from methadone maintenance for many years.”

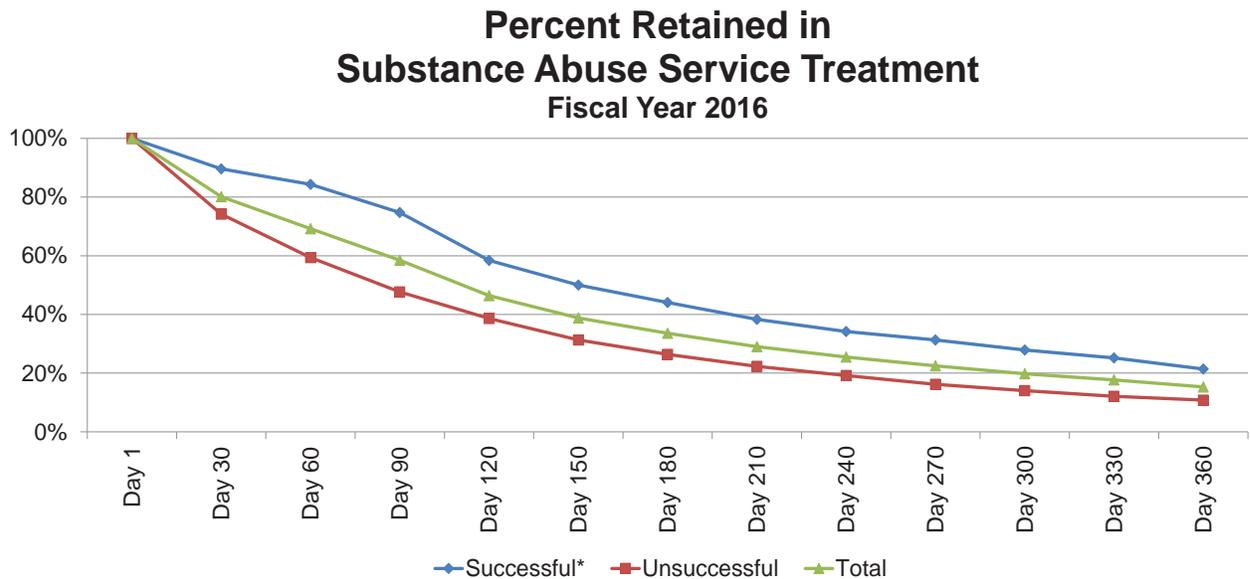
Just like treatment for any other chronic disease, addiction treatment must be of sufficient duration to succeed. Client progress over a short period of time should not be seen as a “cure.” Likewise, relapse should not be a reason to discontinue care.

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 chart below shows the median length of days in a treatment program from 2009-2016.



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



* Successful completion 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 2016, 85.2% 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 23.8% were considered in recovery.

Statewide OQ Client Outcomes Report for Fiscal Year 2016

Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	76%	24.5%	61.7%
Central Utah	96%	24.5%	61.4%
Davis County	86%	25.0%	60.6%
Four Corners	70%	19.3%	62.8%
Northeastern	78%	28.6%	59.8%
Salt Lake County	43%	20.4%	63.3%
San Juan County	33%	22.0%	60.2%
Southwest	51%	21.5%	64.3%
Summit County	53%	26.5%	63.3%
Tooele County	40%	22.5%	58.2%
Utah County	74%	24.1%	60.4%
Wasatch County	88%	34.2%	54.8%
Weber	83%	29.2%	58.6%
Statewide totals	63%	23.8%	61.4%

Youth OQ Client Outcomes Report for Fiscal Year 2016

Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	72%	25.6%	59.5%
Central Utah	91%	24.0%	60.0%
Davis County	100%	27.8%	56.5%
Four Corners	77%	21.9%	61.1%
Northeastern	87%	29.6%	58.0%
Salt Lake County	57%	21.2%	63.4%
San Juan County	44%	27.2%	53.1%
Southwest	60%	21.3%	64.0%
Summit County	61%	29.5%	60.7%
Tooele County	40%	28.6%	53.5%
Utah County	82%	29.5%	55.1%
Wasatch County	81%	37.2%	53.1%
Weber	97%	35.6%	52.5%
Statewide totals	73%	26.8%	58.8%

Adult OQ Client Outcomes Report for Fiscal Year 2016

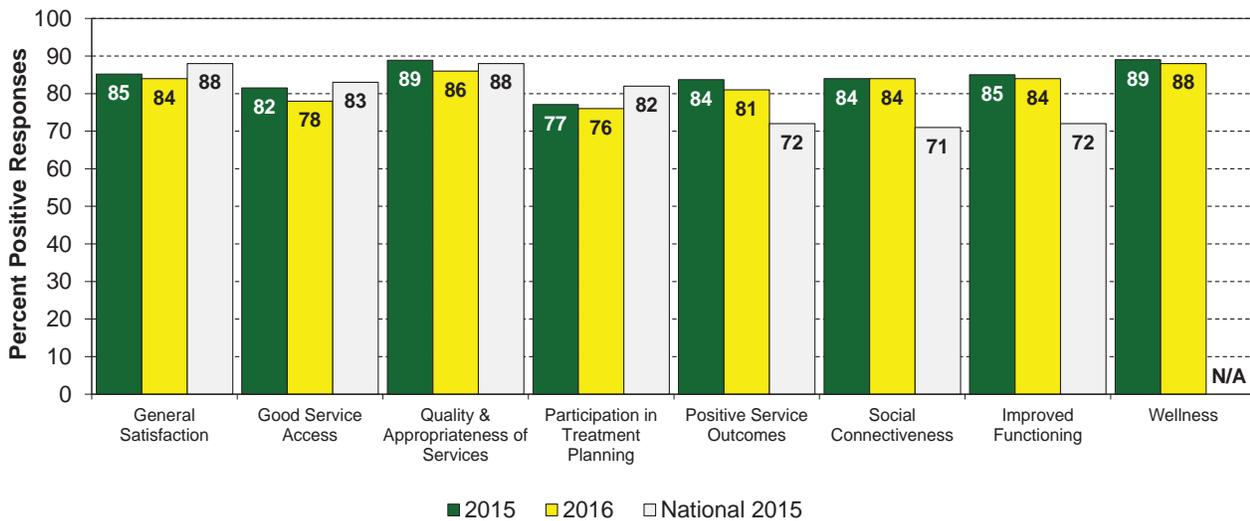
Local Mental Health Authority	Percent of Clients Participating	Percent Recovered	Percent Improved/ Stable
Bear River	81%	24.1%	62.6%
Central Utah	100%	25.0%	62.3%
Davis County	77%	19.0%	65.1%
Four Corners	67%	17.3%	64.1%
Northeastern	73%	28.5%	60.5%
Salt Lake County	36%	19.1%	63.5%
San Juan County	28%	20.0%	62.1%
Southwest	42%	23.1%	62.7%
Summit County	48%	23.9%	66.1%
Tooele County	40%	18.0%	62.4%
Utah County	68%	19.9%	63.8%
Wasatch County	91%	32.8%	55.4%
Weber	74%	23.3%	64.1%
Statewide totals	57%	20.9%	63.5%

Consumer Satisfaction

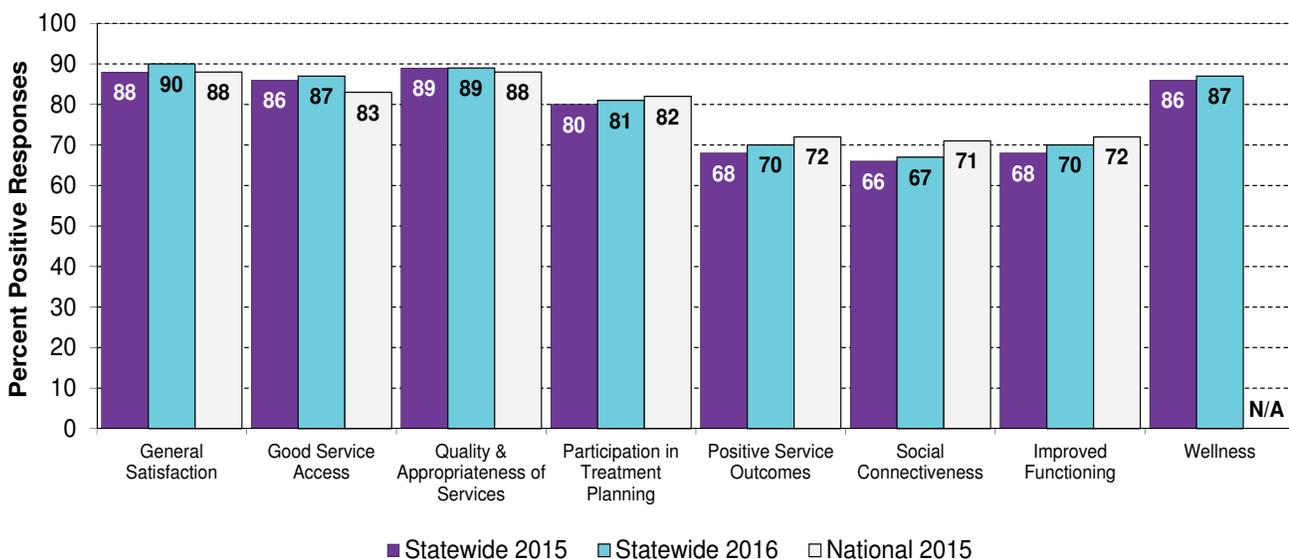
DSAMH and Federal funding grants require that all providers conduct an annual survey on consumer satisfaction and treatment outcomes. DSAMH requires that the survey is administered to consumers of both substance use disorder and

mental health services, and that providers comply with administration requirements and minimum sample rates. Below are the results of this survey comparing results from 2015 through 2016.

**Adult Consumer Satisfaction Survey
Mental Health Statistics Improvement Program (MHSIP)
Completed by Adults with Substance Use Disorders**

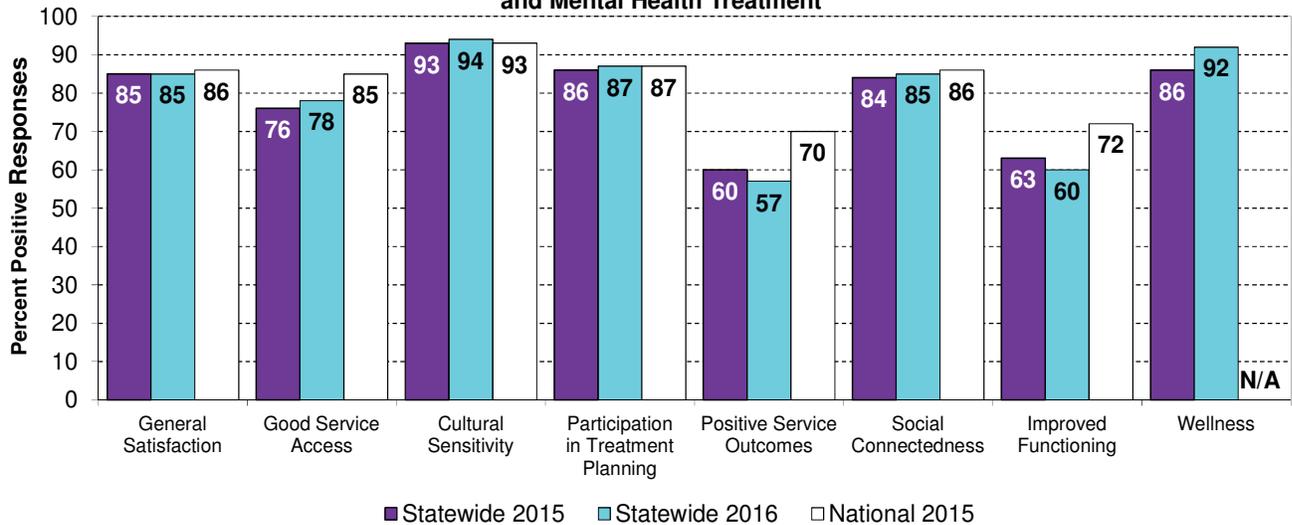


**Adult Consumer Satisfaction Survey
Mental Health Statistics Improvement Program (MHSIP)
Completed by Adults in Mental Health Treatment**



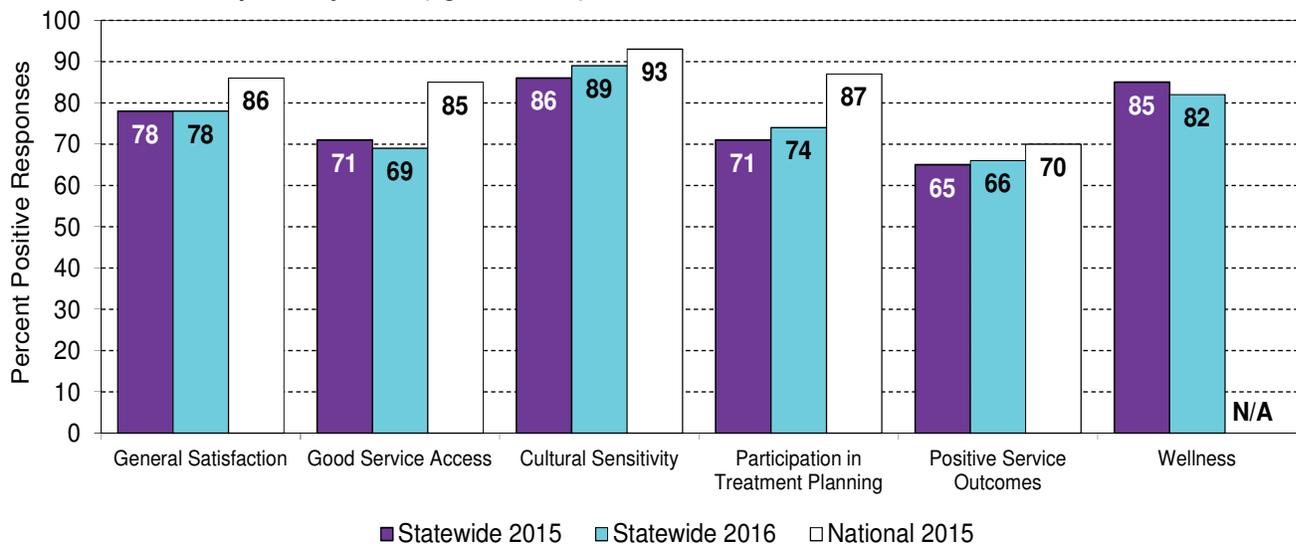
Youth Consumer Satisfaction Survey Youth Services Survey (YSS-F)

Completed by Parent/Guardian of Youth in Substance Use Disorder
and Mental Health Treatment



Youth Consumer Satisfaction Survey Youth Services Survey (YSS)

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



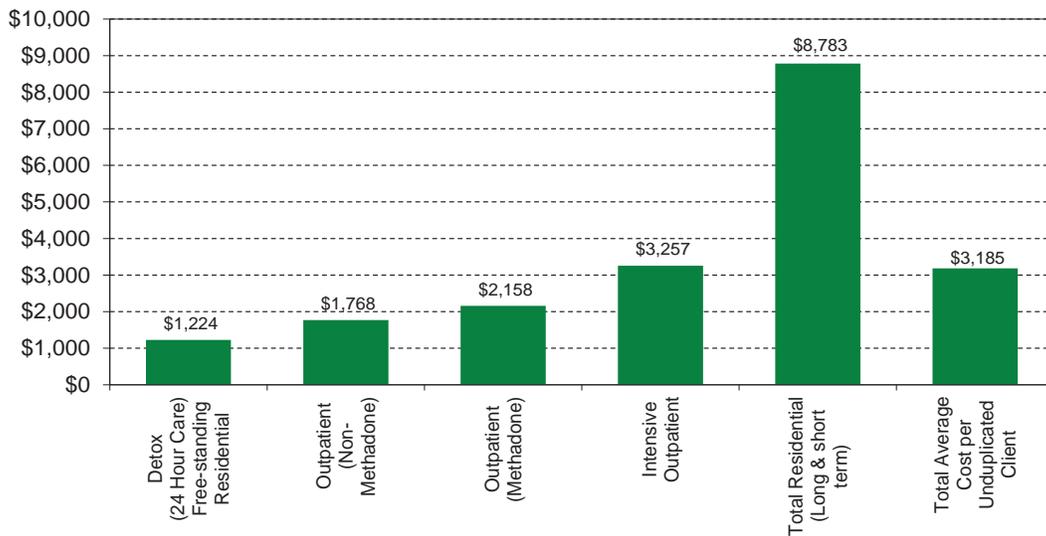
Cost Analysis

Client Cost by Service Category

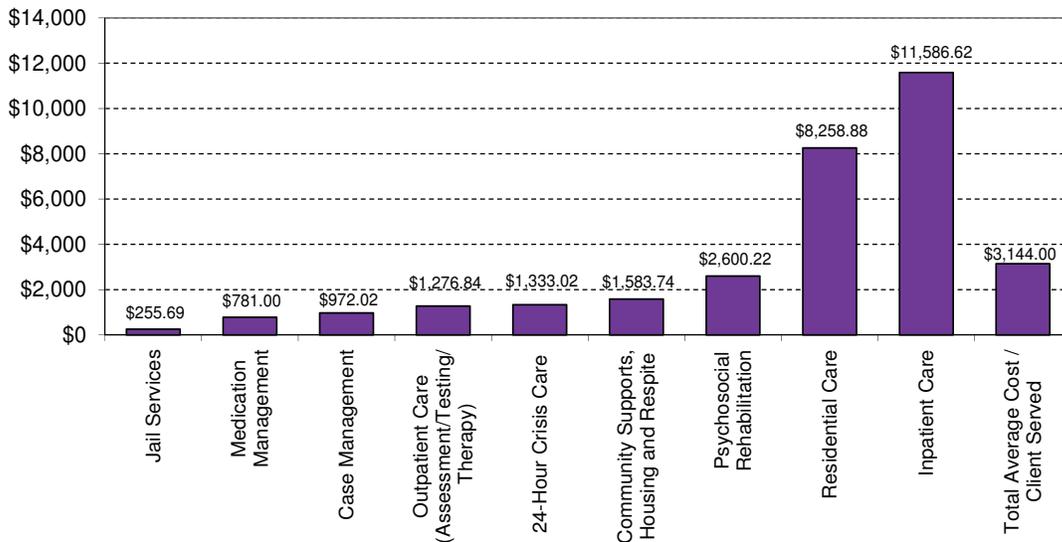
DSAMH requires the local authorities to submit year-end fiscal reports that describe local authority spending in specific categories. This fiscal information is then used to calculate a client cost by service category for both substance use

disorder and mental health. In fiscal year 2016, the statewide average cost for mental health services was \$3,144. For substance use disorder services, the average client cost was \$3,185.

**Substance Use Disorder Client Cost
by Service Category
Fiscal Year 2016**



**Mental Health Client Cost
by Service Category
Fiscal Year 2016**

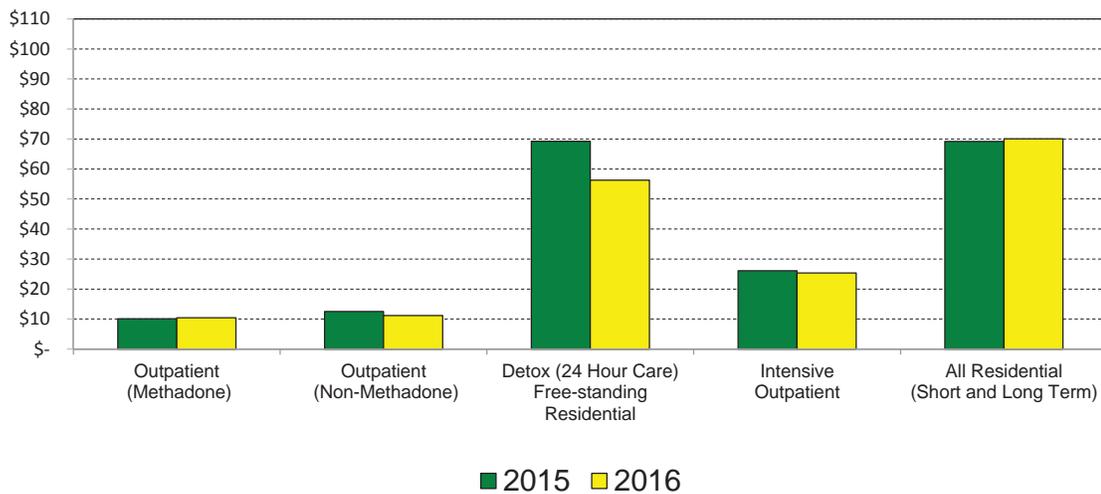


Additional Cost Analysis

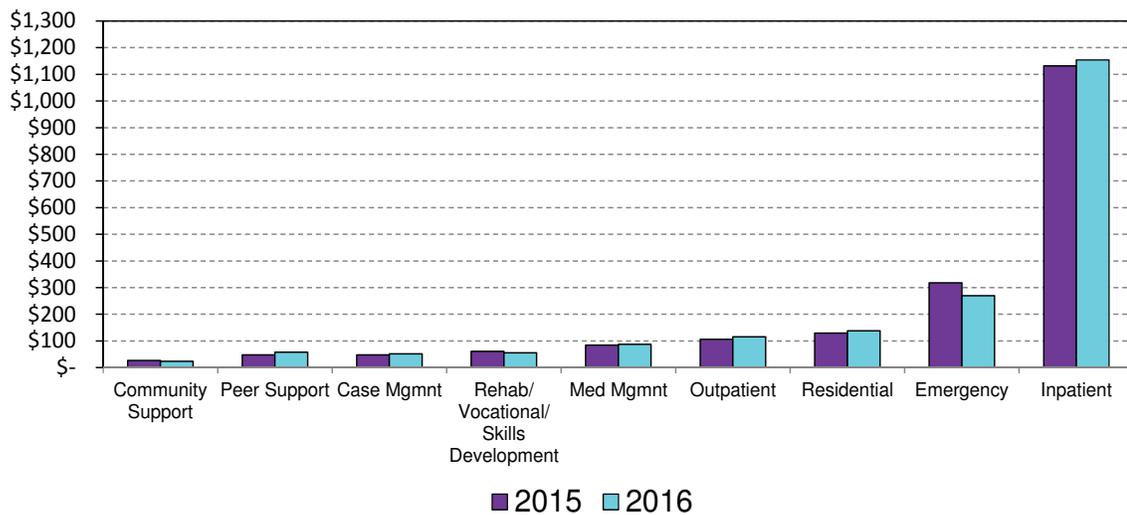
Using the service data reported in fiscal years 2015 and 2016, DSAMH calculated an average cost per day by substance use disorder service

type and an average cost per mental health service event.

Substance Use Disorder Average Cost per Day by Service Type Fiscal Years 2015 - 2016



Mental Health Average Cost per Service Event Fiscal Years 2015 - 2016



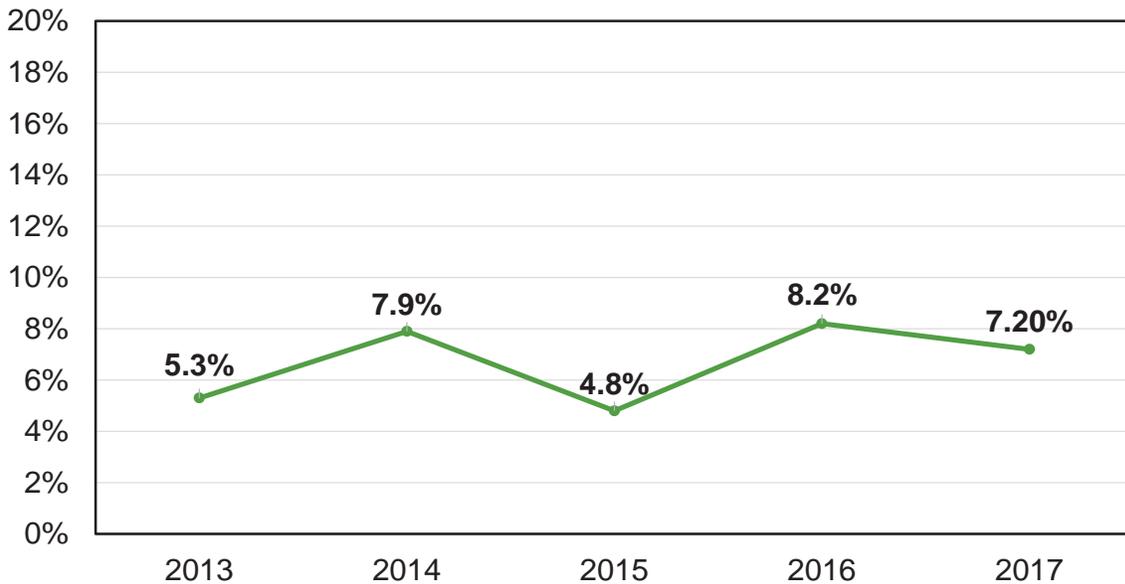
Youth Access to Tobacco

The Federal Synar Amendment is designed to protect the nations’ youth from nicotine addiction. It 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 continues to keep the rates low as shown in the graph below. The violation rate dropped from 8.2% in 2015, to 7.2%% in 2016. For more detailed information see:

dsamh.utah.gov/data/synar-reports/

Percentage of Outlets Found in Violation Federal Fiscal Years 2013-2017



Tyler's Road To Recovery

I grew up with hard working parents that would do anything for me. I was involved in many sports, Baseball, Basketball and Skiing. BMX racing was my passion. I had dreams of becoming a pro BMX racer, but my future took me in a different direction.

My introduction to drugs and alcohol started at 15 years old. At the age of 16, I tried Marijuana. I thought, I am an all-star athlete, I could handle it. Once turned into several times. It soon became clear that I was hooked. Over the years, I continued to spiral down into the disease of addiction, spending years under the influence of methamphetamines.

Because of addiction, I did a lot of things that I am not proud of. I missed out on many moments and memories with my 3 beautiful children because drugs were more important to me. I was arrested for possession and enrolled in a drug diversion program. A week before I was supposed to graduate, I moved to California. Eventually, U.S. Marshals came and arrested me in front of my children. Despite all that turmoil, the drugs had a hold of me and would not let go. I didn't know how to stop.

I spent 65 days at a local inpatient treatment facility, attending meetings and learning how to be a person again. I finally realized what the problem was. It was me. I know I can never safely use any mind altering substances again without triggering my addiction. I started to apply what I learned in treatment to my life on a daily basis. 18 months into my recovery I was asked to be on the Board of Directors at Valley Camp. Serving on the Board allowed me to give back to the organization where I found recovery.

I recently celebrated 5 years free from drugs and alcohol. I am a Peer Support Specialist with Weber Human Services, helping homeless individuals get access to the programs and services they need to find their recovery.

My life is amazing today. I fell in love with an amazing woman. Making fun, clean memories with my children and family is very gratifying. I get to be present in my children's life everyday! It has taken me 33 years to realize I have to be the one that puts in the work to get the rewards that life offers.

I currently serve on the Board of Directors for a non-profit organization. We recently purchased a property to open a Recovery Residence in Ogden.

**Keep the faith.
I can't but we can!**



Local Authorities

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 required services.

The following pages provide data and graphs describing how each local authority provided services to its residents during the state fiscal year 2016 (July 1, 2015 to June 30, 2016).

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: 175,191

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

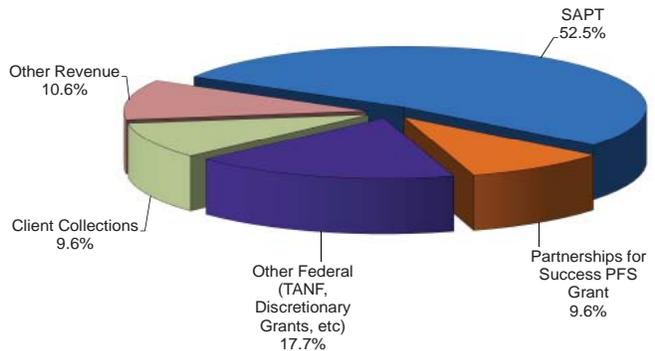
Protective Factors:

- Community rewards for pro-social involvement

Prioritized Risk Factors:

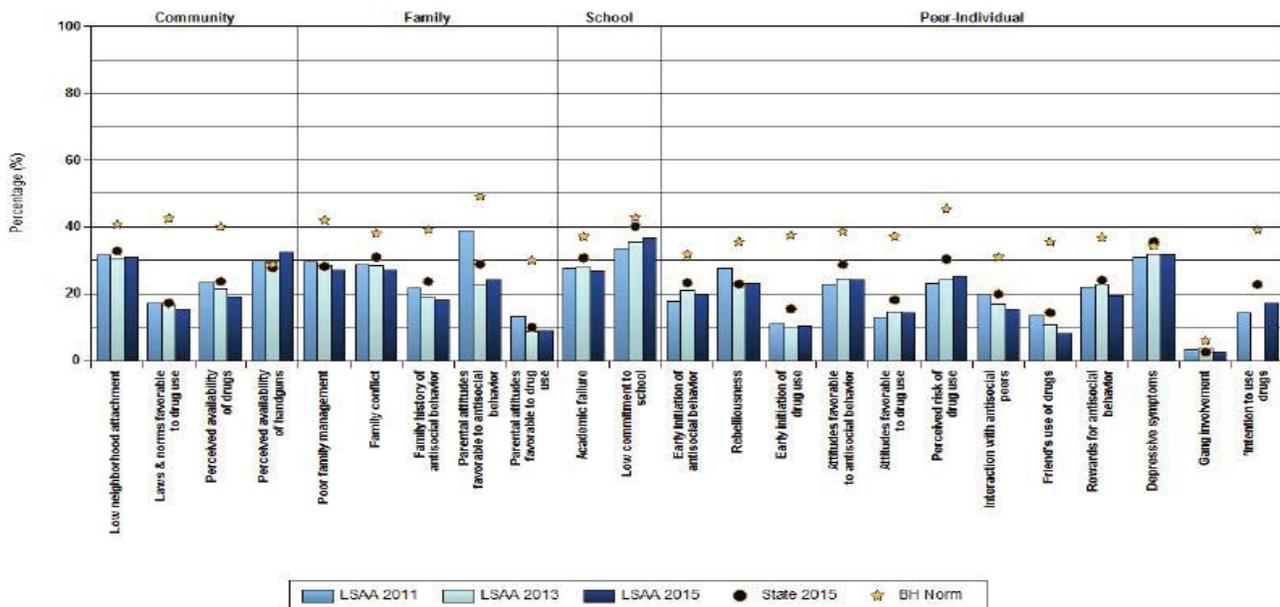
- Poor family management
- Parental attitudes favorable toward anti-social behavior
- Academic failure

Source of Revenues
Fiscal Year 2016



Risk Profile

2015 Bear River District LSAA Student Survey, All Grades

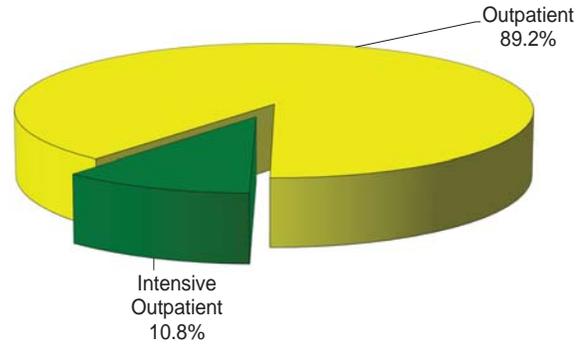


Bear River Health Department—Substance Abuse

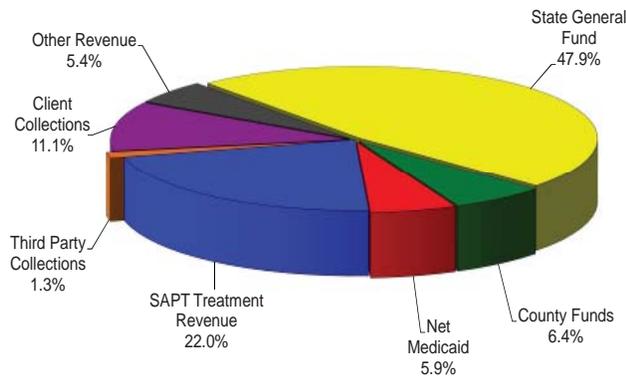
Total Clients Served.....975
 Adult887
 Youth.....88
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....574
 Initial Admissions574
 Transfers.....0

Admission into Modalities
Fiscal Year 2016



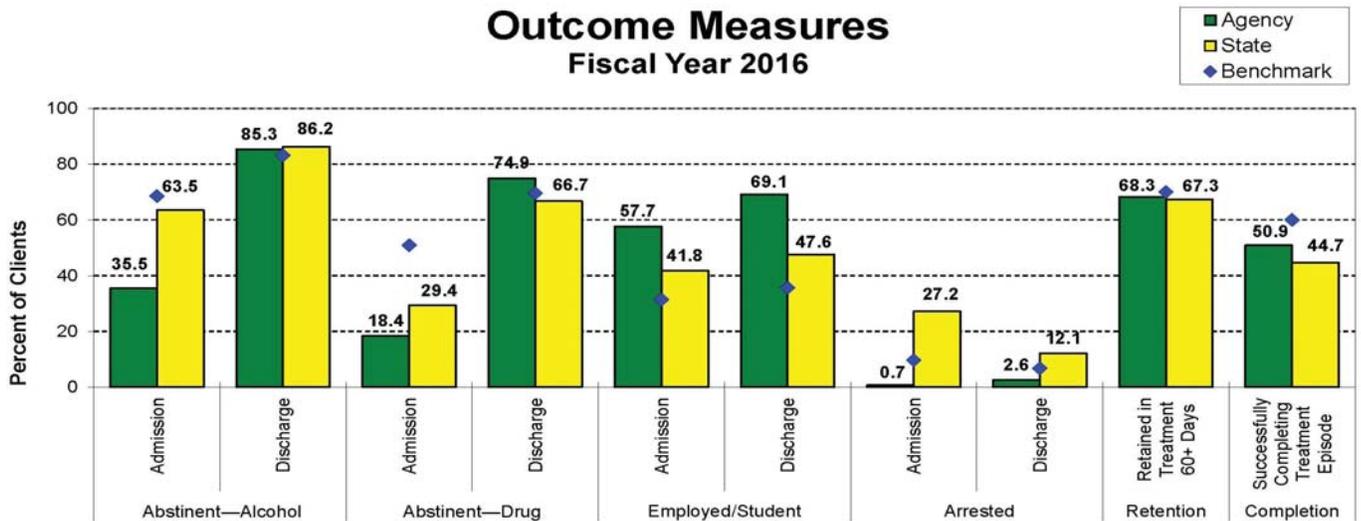
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	132	61	193
Cocaine/Crack	4	2	6
Marijuana/Hashish	117	32	149
Heroin	21	14	35
Other Opiates/Synthetics	7	8	15
Hallucinogens	1	0	1
Methamphetamine	80	59	139
Other Stimulants	4	4	8
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	3	5	8
Inhalants	0	0	0
Oxycodone	6	2	8
Club Drugs	0	0	0
Over-the-Counter	1	0	1
Other	6	4	10
Total	383	191	574

Outcome Measures
Fiscal Year 2016



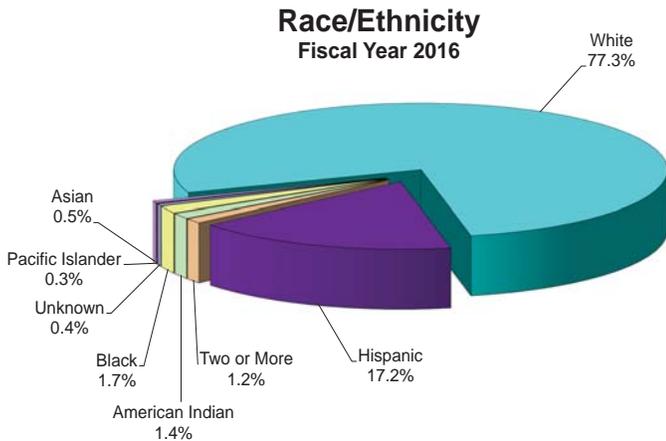
Benchmark is 75% of the National Average.

Bear River Mental Health—Mental Health

Total Clients Served.....3,461
 Adult1,871
 Youth.....1,590
 Penetration Rate (Total population of area)..... 2.0%
 Civil Commitment40
 Unfunded Clients Served557

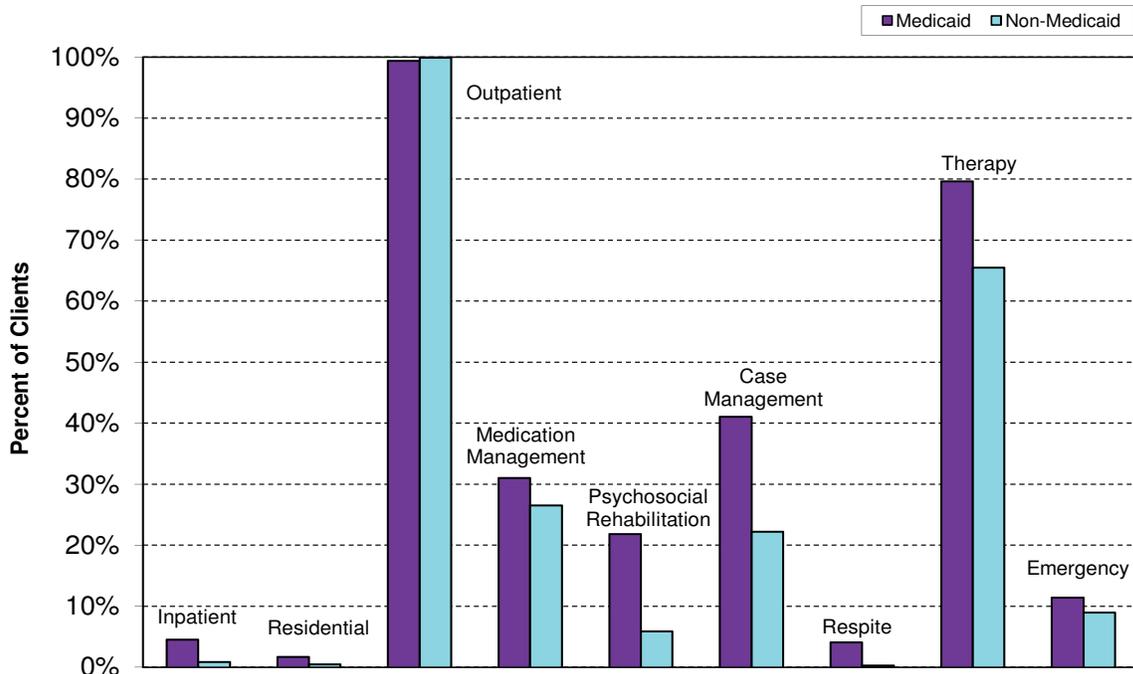
Diagnosis

	Youth	Adult
Adjustment Disorders	670	122
Anxiety Disorders	530	1,163
Attention Deficit Disorders	432	281
Cognitive Disorders	36	108
Conduct Disorders	190	20
Depressive Disorders	383	1,024
Developmental Disorders	127	76
Dissociative Disorders	1	30
Eating Disorders	6	18
Factitious Disorders	0	0
Impulse Control Disorders	21	24
Learning Disorders	1	6
Mood Disorders	99	456
Neglect or Abuse Disorders	20	27
Neurological Disorders	4	21
Other	161	276
Personality Disorders	4	689
Pervasive Developmental Disorders	16	5
Physical Health Disorders	2	6
Schizophrenia and Other Psychotic	7	338
Substance Use Disorders	13	287
V Codes	935	686
	3,658	5,663



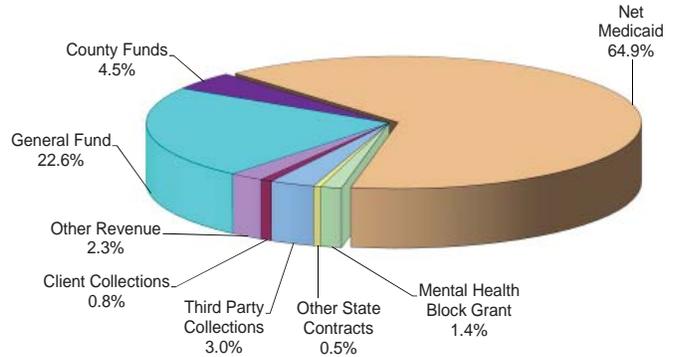
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

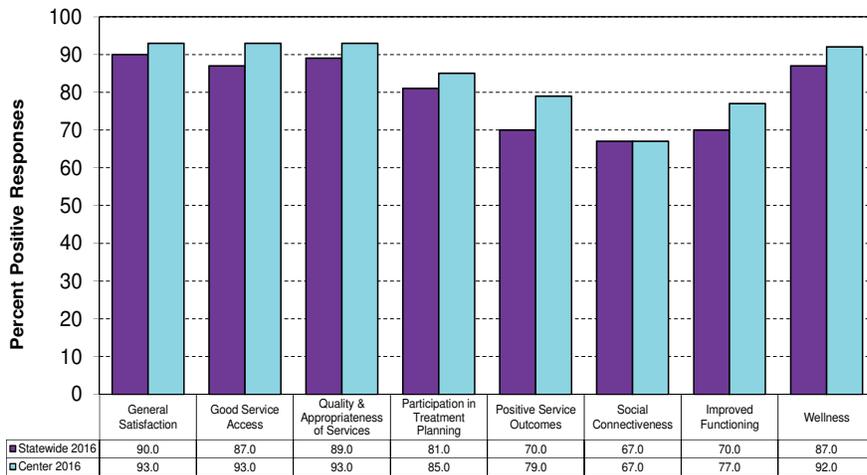


Bear River Mental Health—Mental Health (Continued)

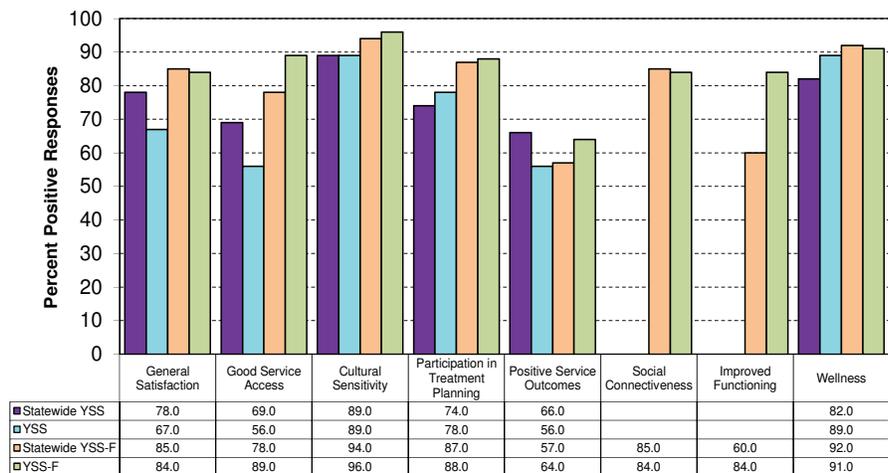
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2016



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2016



Central Utah Counseling Center

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



Population: 77,210

Central Utah Counseling

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 84627

Office: (435) 283-8400

www.cucc.us

Central Utah Substance Abuse—Prevention

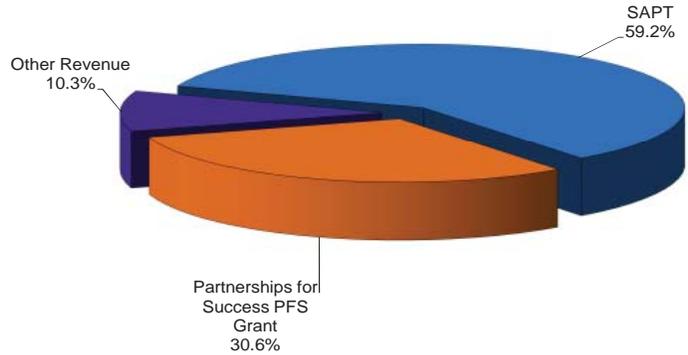
Protective Factors:

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

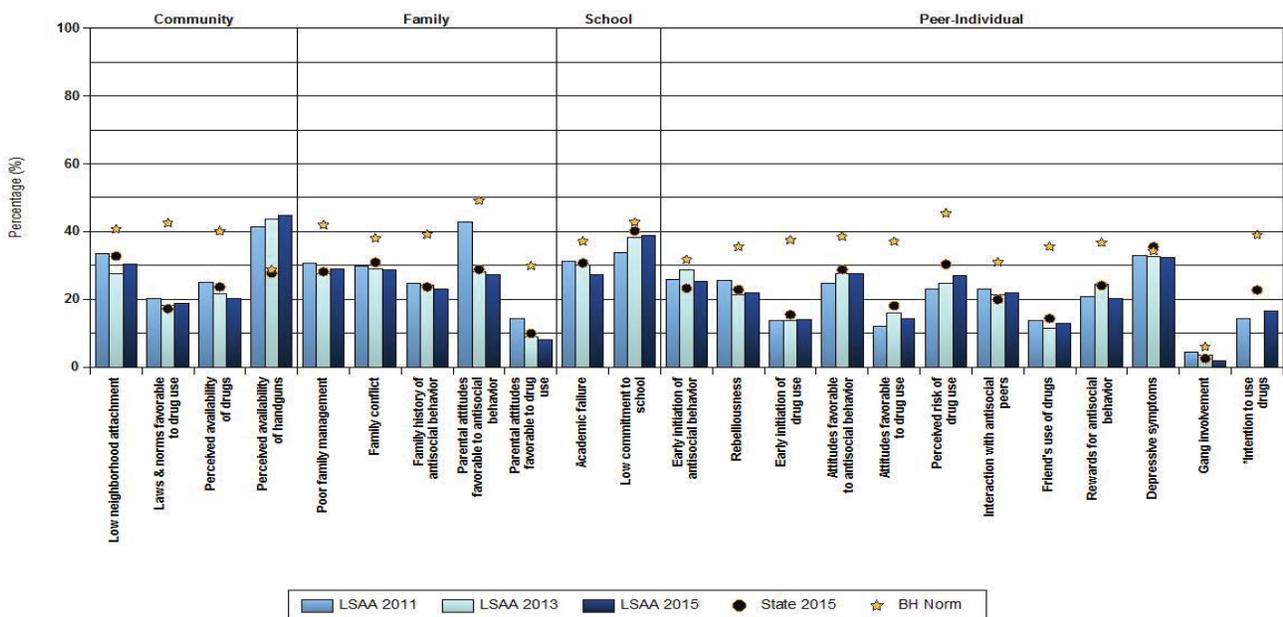
Prioritized Risk Factors:

- Perceived availability of alcohol and drugs
- Parental attitudes favorable to anti-social behavior
- Parental attitudes favorable to drugs
- Academic failure, depressive symptoms
- Poor family management

Source of Revenues
Fiscal Year 2016



Risk Profile 2015 Central Utah LSAA Student Survey, All Grades

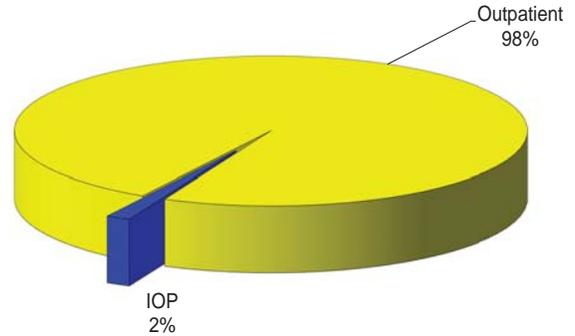


Central Utah Counseling Center—Substance Abuse

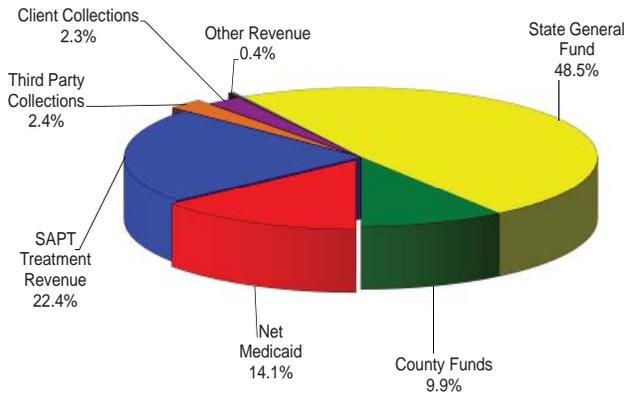
Total Clients Served403
 Adult363
 Youth.....40
 Penetration Rate (Total population of area)..0.3%

Total Admissions.....261
 Initial Admissions256
 Transfers.....5

Admission into Modalities
Fiscal Year 2016



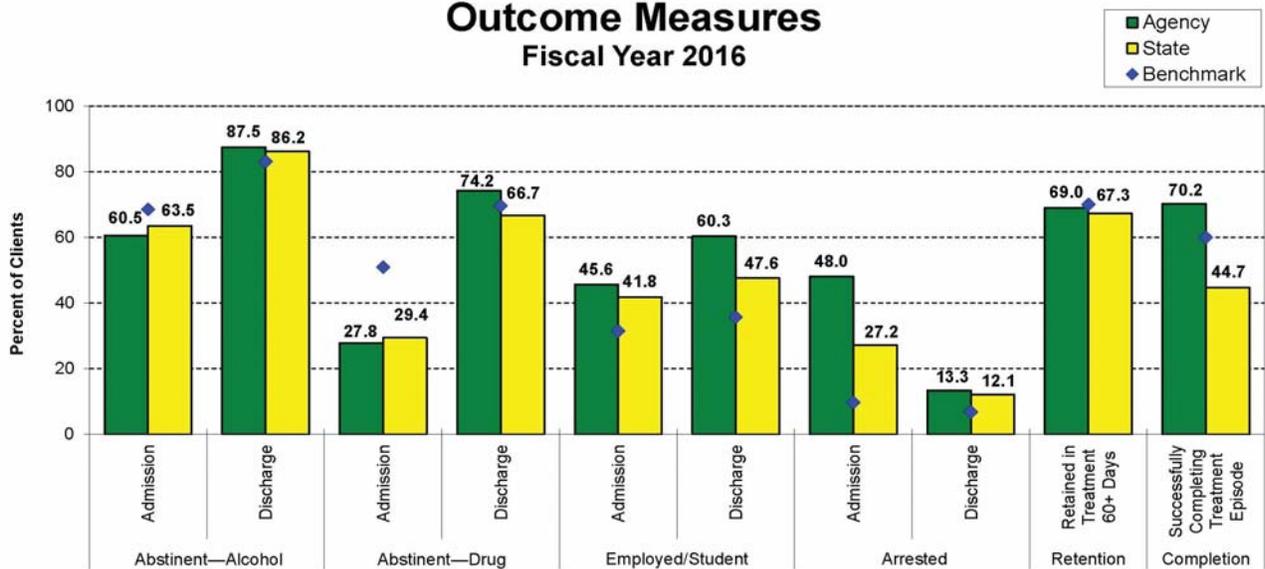
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	58	27	85
Cocaine/Crack	1	2	3
Marijuana/Hashish	26	11	37
Heroin	12	8	20
Other Opiates/Synthetics	10	8	18
Hallucinogens	1	0	1
Methamphetamine	42	36	78
Other Stimulants	2	1	3
Benzodiazepines	1	2	3
Tranquilizers/Sedatives	1	1	2
Inhalants	0	0	0
Oxycodone	4	5	9
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	1	1	2
Total	159	102	261

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

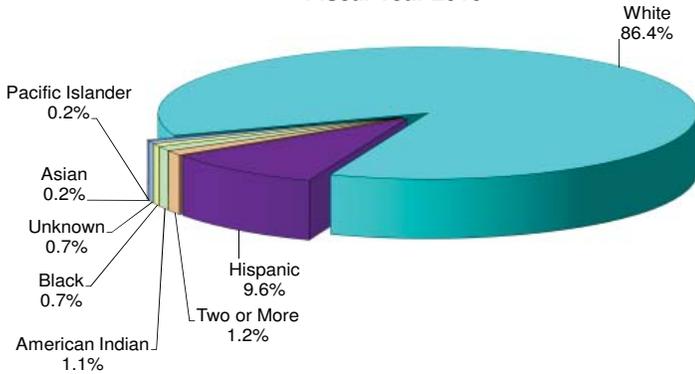
Central Utah Counseling Center—Mental Health

Total Clients Served1,209
 Adult684
 Youth.....525
 Penetration Rate (Total population of area)..... 1.6%
 Civil Commitment42
 Unfunded Clients Served147

Diagnosis

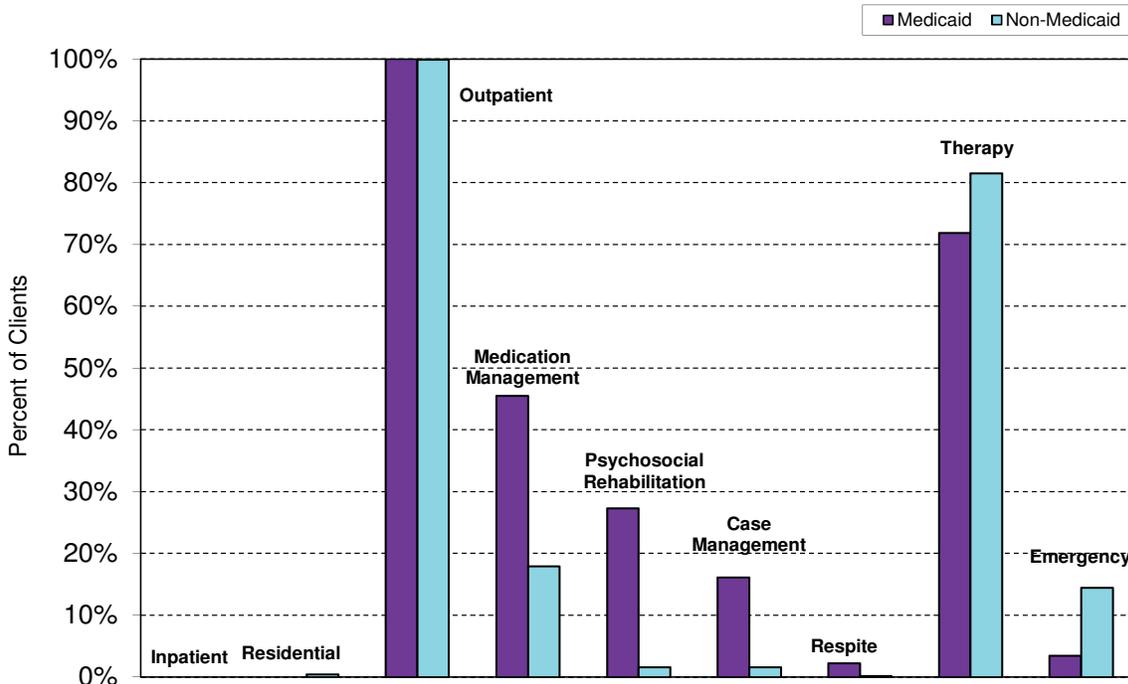
	Youth	Adult
Adjustment Disorders	1,178	801
Anxiety Disorders	2,165	5,089
Attention Deficit Disorders	2,124	1,084
Cognitive Disorders	49	306
Conduct Disorders	1,114	93
Depressive Disorders	1,172	2,425
Developmental Disorders	543	322
Dissociative Disorders	5	80
Eating Disorders	35	87
Factitious Disorders	0	0
Impulse Control Disorders	110	144
Learning Disorders	46	11
Mood Disorders	1,076	2,359
Neglect or Abuse Disorders	520	27
Neurological Disorders	11	53
Other	549	1,157
Personality Disorders	66	1,052
Pervasive Developmental Disorders	44	45
Physical Health Disorders	661	1,245
Schizophrenia and Other Psychotic	89	1,903
Substance Use Disorders	207	3,996
V Codes	1,353	1,585
	13,117	23,864

Race/Ethnicity Fiscal Year 2016



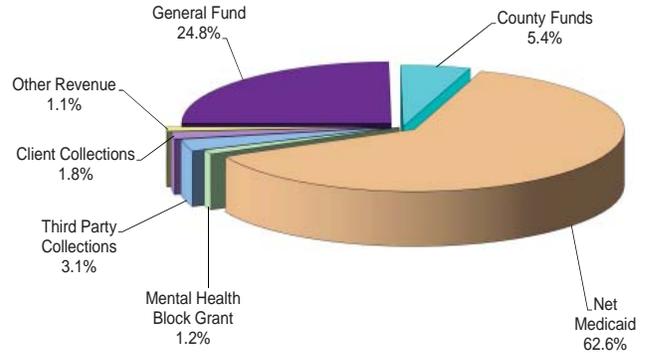
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

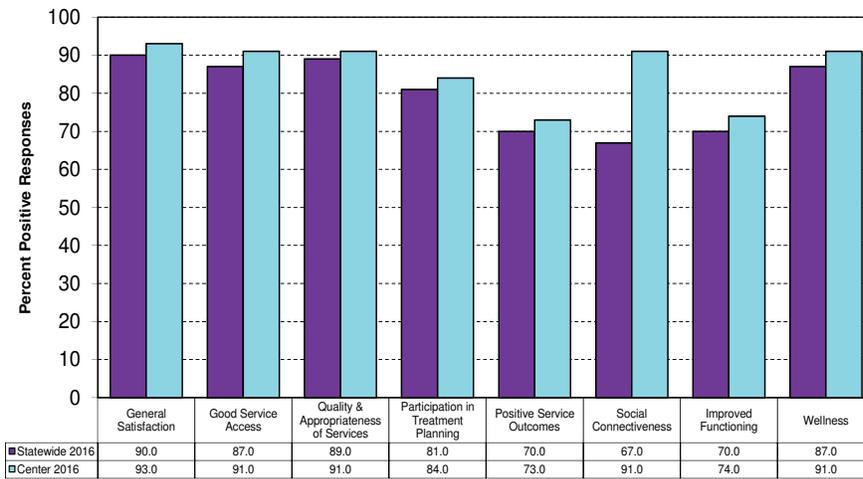


Central Utah Counseling Center—Mental Health (Continued)

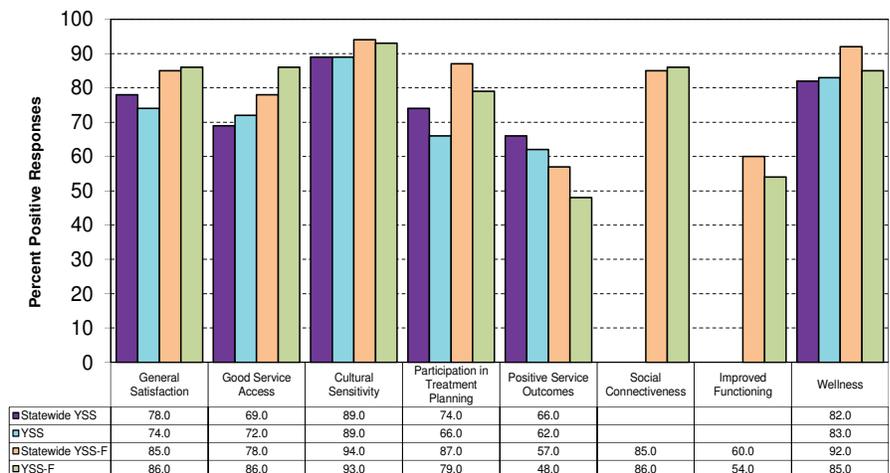
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Davis Behavioral Health

Davis County



DAVIS BEHAVIORAL HEALTH INC

Population: 336,043

Davis Behavioral Health

County: Davis

Substance Abuse and Mental Health Provider

Agency:

Brandon Hatch, CEO/Director
 Davis Behavioral Health
 934 S. Main
 Layton, UT 84041
 Office: (801) 773-7060
www.dbh.utah.gov

Davis Substance Abuse—Prevention

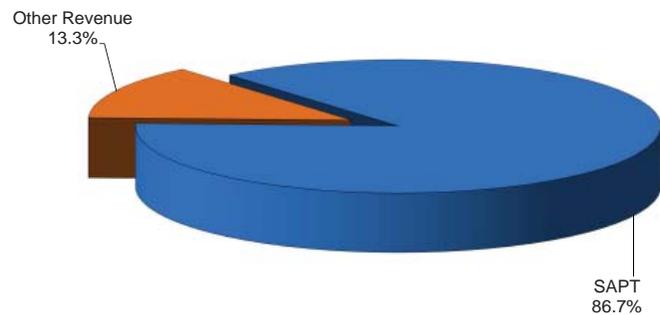
Protective Factors:

- Rewards & opportunities for pro-social involvement

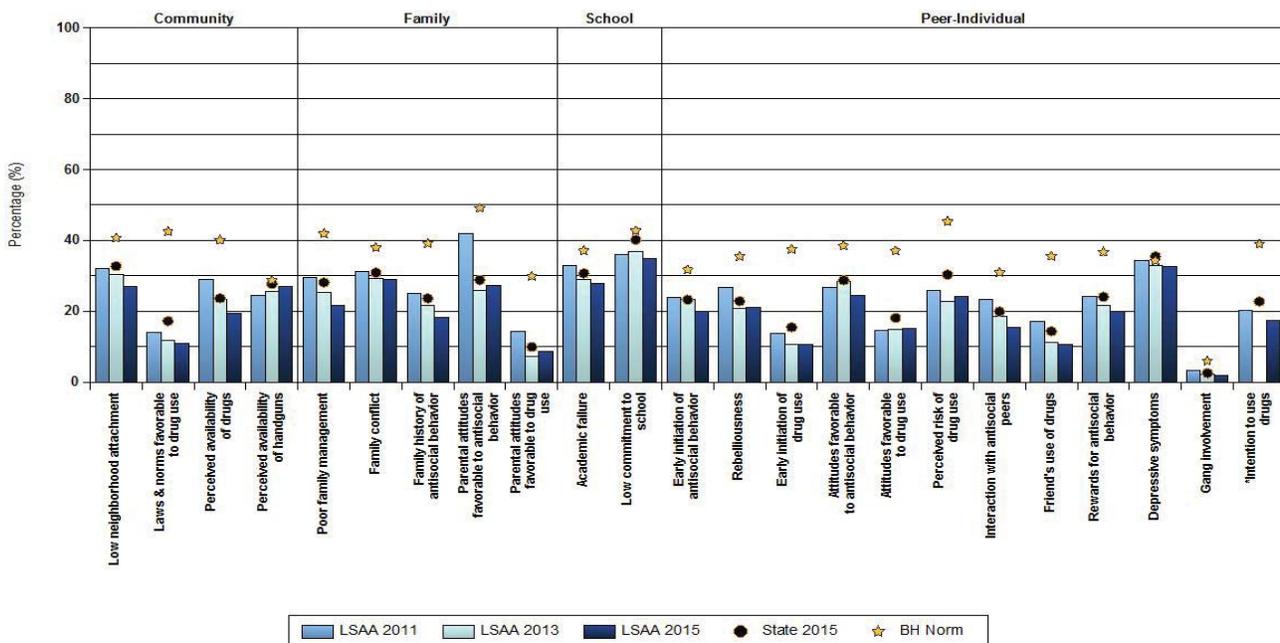
Prioritized Risk Factors:

- Family conflict
- Poor family management
- Low commitment to school
- Attitudes favorable to drug use
- Depressive symptoms

Source of Revenues
Fiscal Year 2016



Risk Profile
2015 Davis County LSAA Student Survey, All Grades

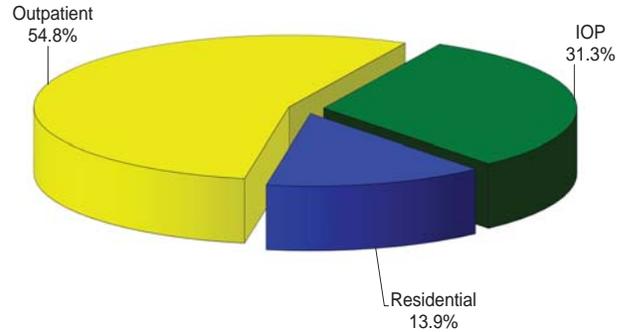


Davis Behavioral Health—Substance Abuse

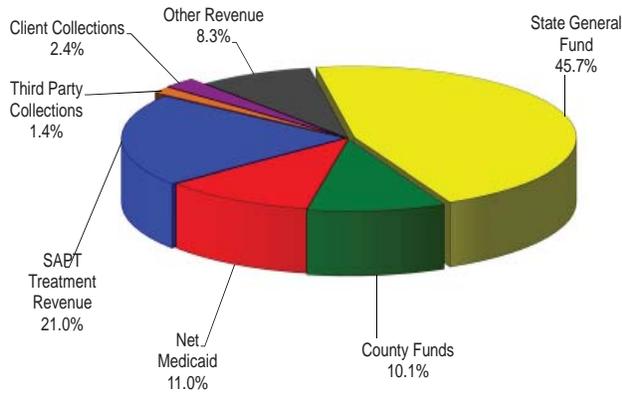
Total Clients Served1,072
 Adult1,003
 Youth69
 Penetration Rate (Total population of area)..0.3%

Total Admissions1,041
 Initial Admissions707
 Transfers.....334

Admissions into Modalities
Fiscal Year 2016



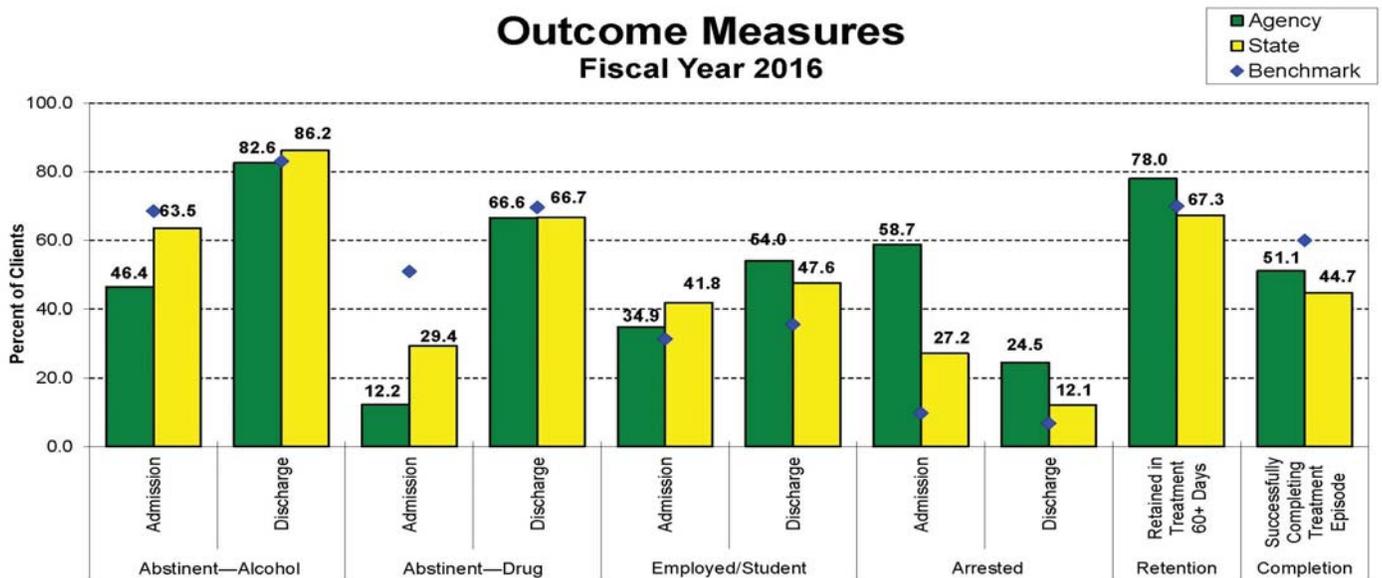
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	87	75	162
Cocaine/Crack	9	8	17
Marijuana/Hashish	80	30	110
Heroin	149	105	254
Other Opiates/Synthetics	15	19	34
Hallucinogens	1	0	1
Methamphetamine	175	146	321
Other Stimulants	6	2	8
Benzodiazepines	1	7	8
Tranquilizers/Sedatives	4	2	6
Inhalants	0	0	0
Oxycodone	37	79	116
Club Drugs	1	0	1
Over-the-Counter	1	0	1
Other	1	1	2
Total	567	474	1,041

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

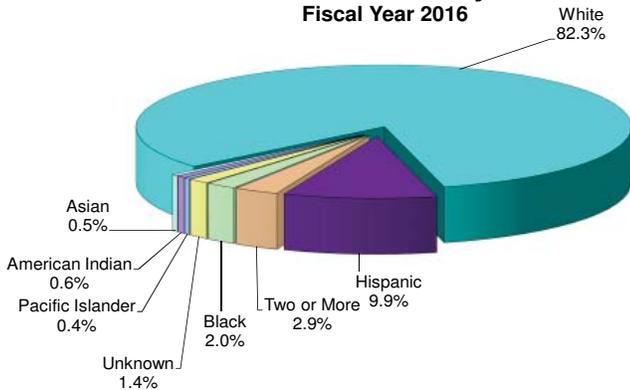
Davis Behavioral Health—Mental Health

Total Clients Served.....6,079
 Adult3,925
 Youth.....2,154
 Penetration Rate (Total population of area)..... 1.8%
 Civil Commitment124
 Unfunded Clients Served2,084

Diagnosis

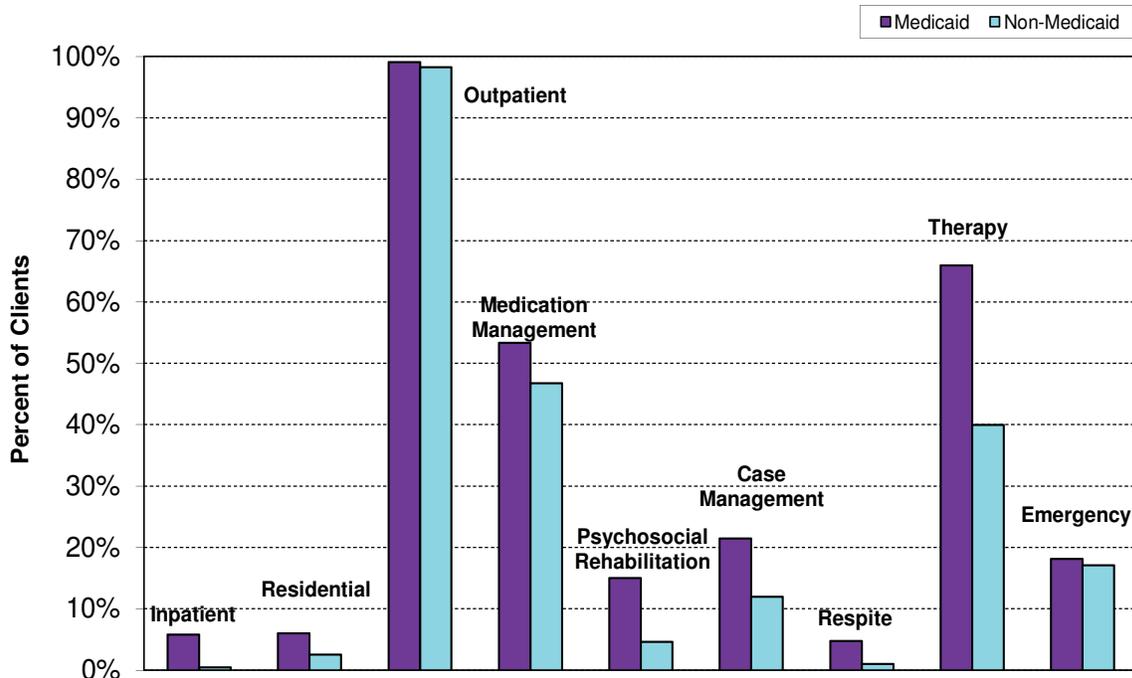
	Youth	Adult
Adjustment Disorders	1,178	801
Anxiety Disorders	2,165	5,089
Attention Deficit Disorders	2,124	1,084
Cognitive Disorders	49	306
Conduct Disorders	1,114	93
Depressive Disorders	1,172	2,425
Developmental Disorders	543	322
Dissociative Disorders	5	80
Eating Disorders	35	87
Factitious Disorders	0	0
Impulse Control Disorders	110	144
Learning Disorders	46	11
Mood Disorders	1,076	2,359
Neglect or Abuse Disorders	520	27
Neurological Disorders	11	53
Other	549	1,157
Personality Disorders	66	1,052
Pervasive Developmental Disorders	44	45
Physical Health Disorders	661	1,245
Schizophrenia and Other Psychotic Disorders	89	1,903
Substance Use Disorders	207	3,996
V Codes	1,353	1,585
	13,117	23,864

Race/Ethnicity Fiscal Year 2016



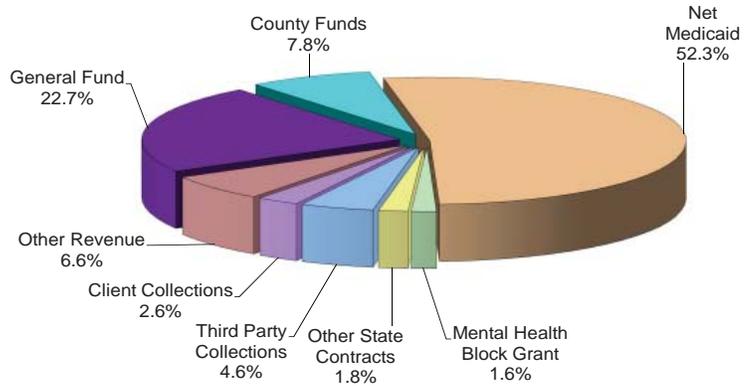
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

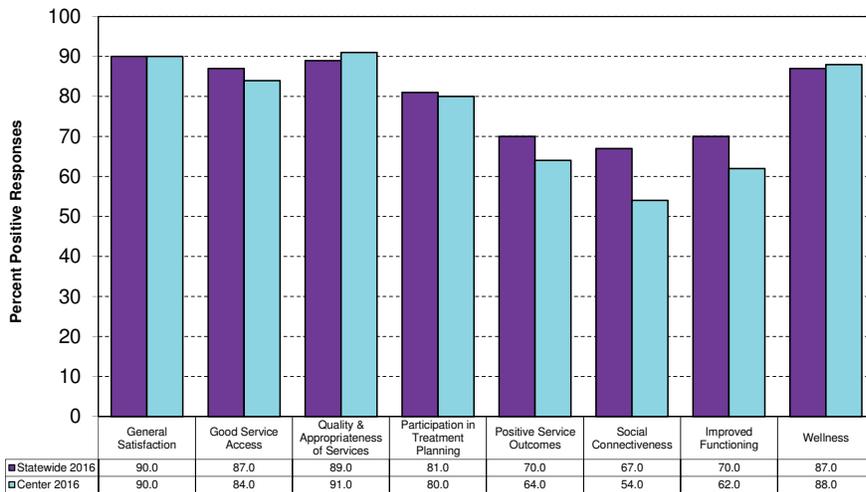


Davis Behavioral Health—Mental Health (Continued)

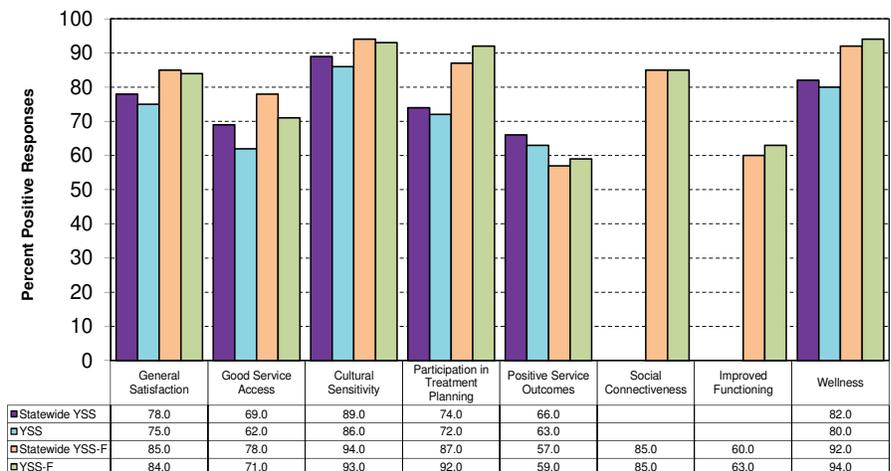
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Four Corners

Carbon, Emery & Grand Counties



Population: 40,365

Four Corners Community Behavioral Health

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

Four Corners Substance Abuse—Prevention

Protective Factors:

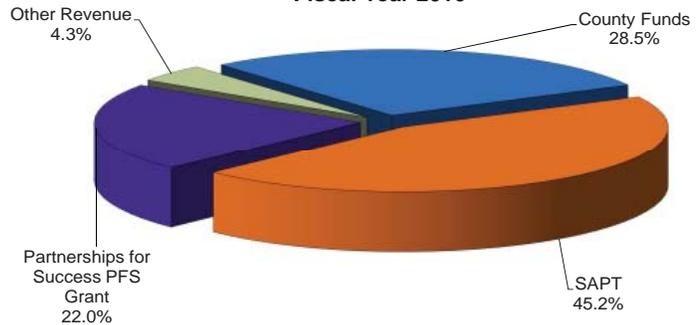
- Opportunities and rewards for pro-social involvement

Prioritized Risk Factors:

- Low neighborhood attachment
- Family history of problem behavior
- Friends who engage in problem behavior
- Lack of commitment to school

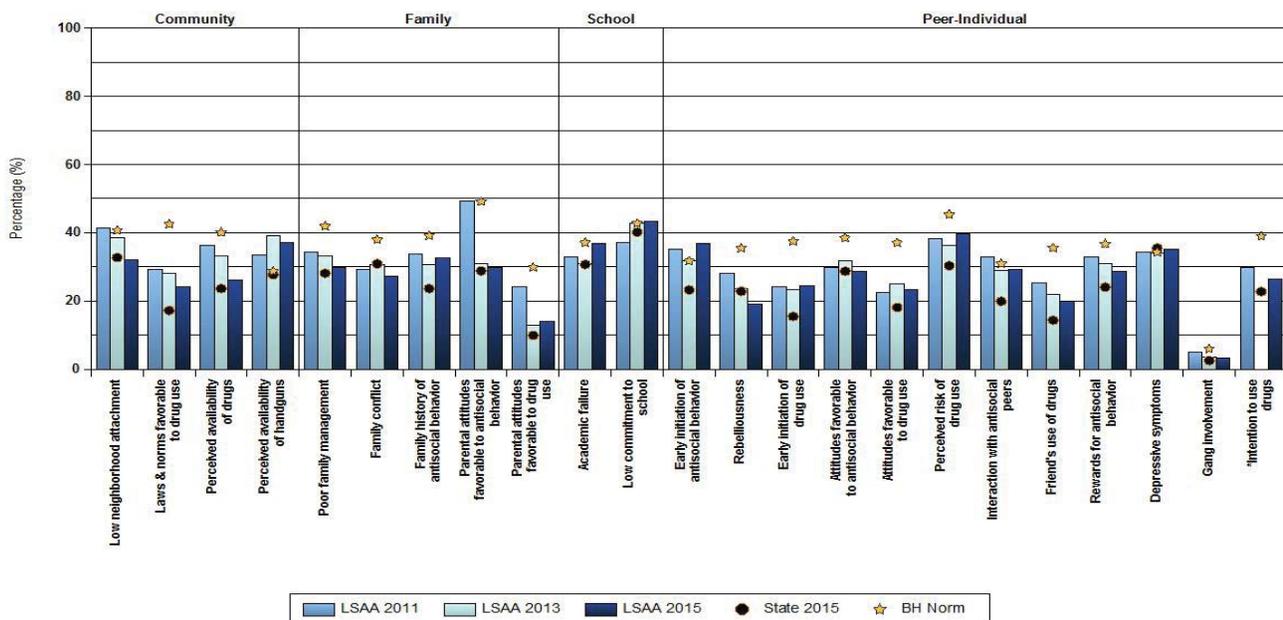
Source of Revenues

Fiscal Year 2016



Risk Profile

2015 Four Corners District LSAA Student Survey, All Grades

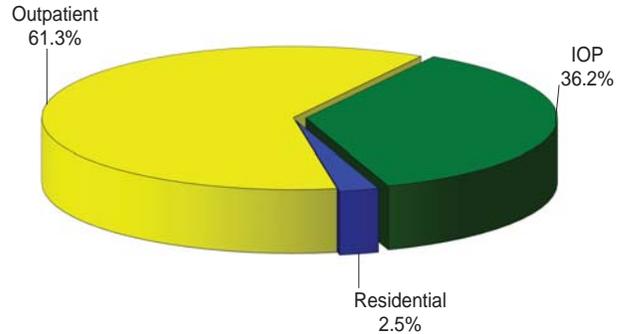


Four Corners Community Behavioral Health—Substance Abuse

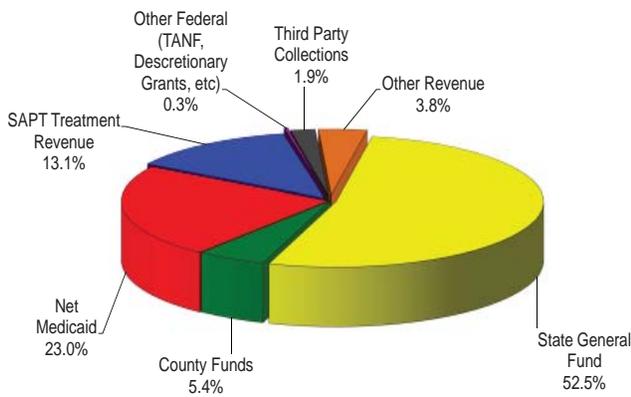
Total Clients Served.....552
 Adult512
 Youth.....40
 Penetration Rate (Total population of area)..0.8%

Total Admissions.....315
 Initial Admissions204
 Transfers..... 111

Admissions into Modalities
Fiscal Year 2016



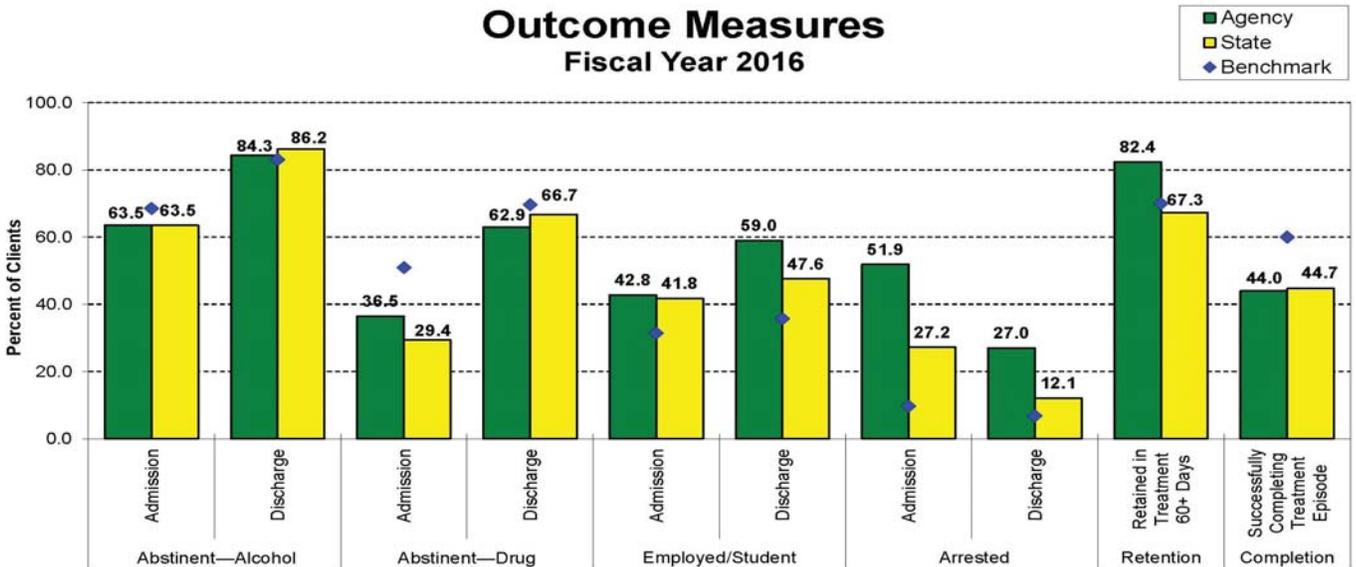
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	50	22	72
Cocaine/Crack	1	1	2
Marijuana/Hashish	35	16	51
Heroin	33	34	67
Other Opiates/Synthetics	16	13	29
Hallucinogens	0	0	0
Methamphetamine	41	48	89
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	1	3
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	1	0	1
Total	179	136	315

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

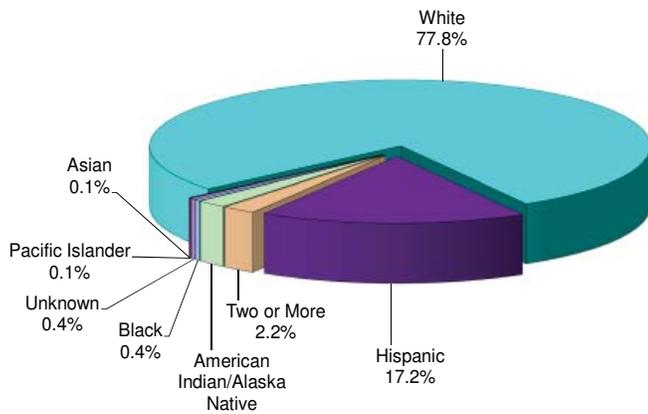
Four Corners Community Behavioral Health—Mental Health

Total Clients Served1,387
 Adult930
 Youth457
 Penetration Rate (Total population of area) 3.4%
 Civil Commitment15
 Unfunded Clients Served530

Diagnosis

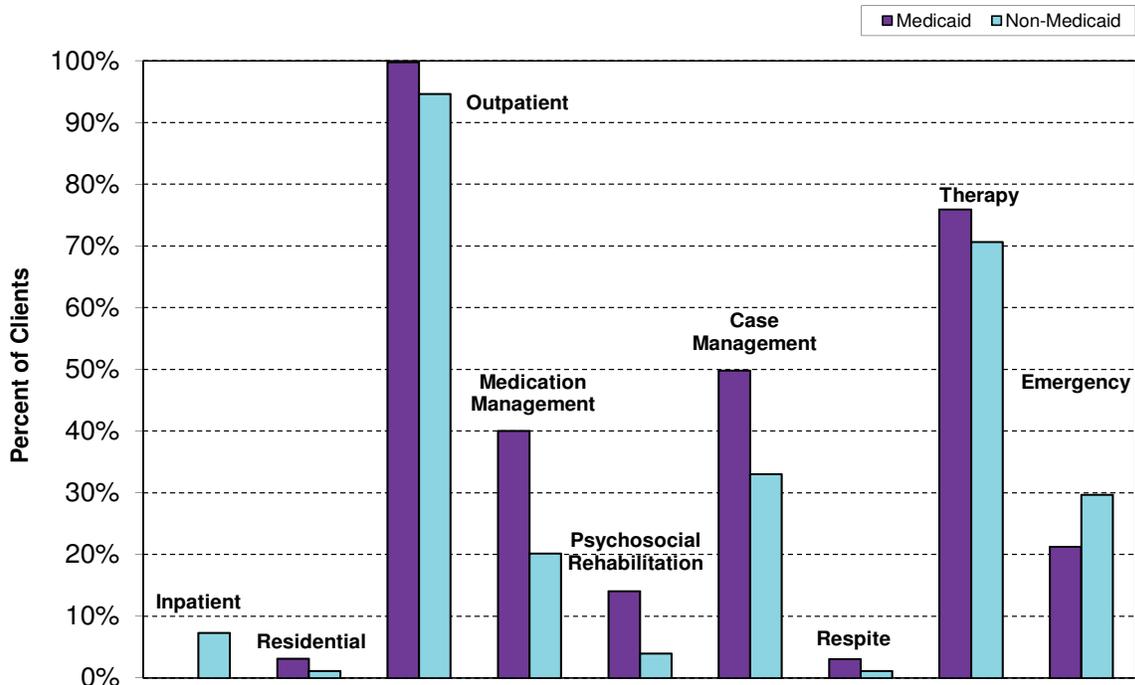
	Youth	Adult
Adjustment Disorders	206	87
Anxiety Disorders	177	594
Attention Deficit Disorders	144	73
Cognitive Disorders	4	19
Conduct Disorders	101	3
Depressive Disorders	155	515
Developmental Disorders	45	15
Dissociative Disorders	6	11
Eating Disorders	36	21
Factitious Disorders	0	0
Impulse Control Disorders	11	21
Learning Disorders	1	1
Mood Disorders	78	264
Neglect or Abuse Disorders	34	9
Neurological Disorders	2	0
Other	89	112
Personality Disorders	6	125
Pervasive Developmental Disorders	4	3
Physical Health Disorders	0	1
Schizophrenia and Other Psychotic	3	187
Substance Use Disorders	46	623
V Codes	234	338
	1,382	3,022

Race/Ethnicity Fiscal Year 2016



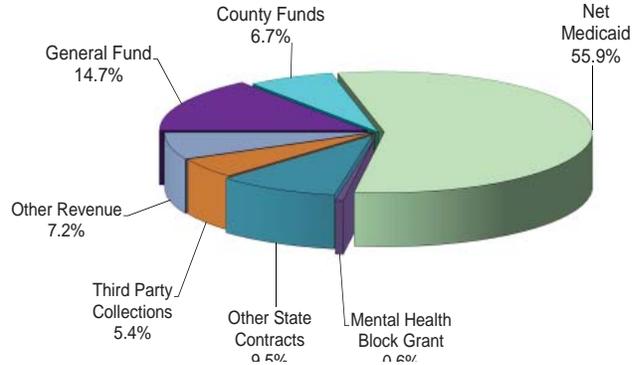
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

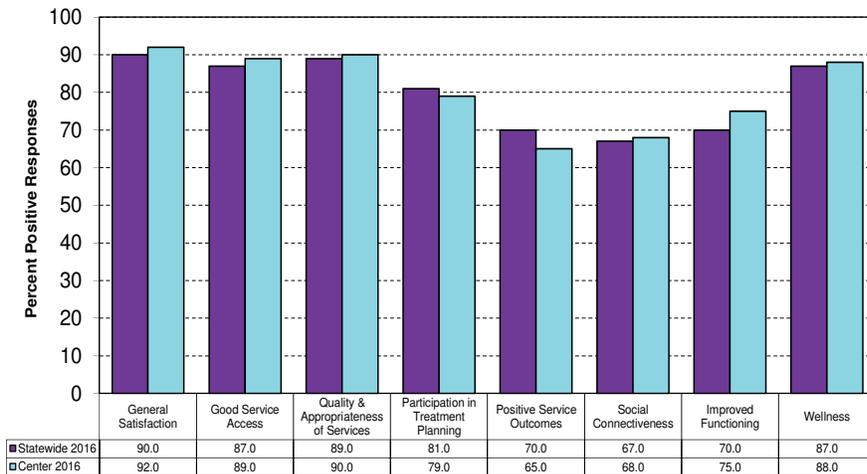


Four Corners Community Behavioral Health—Mental Health (Continued)

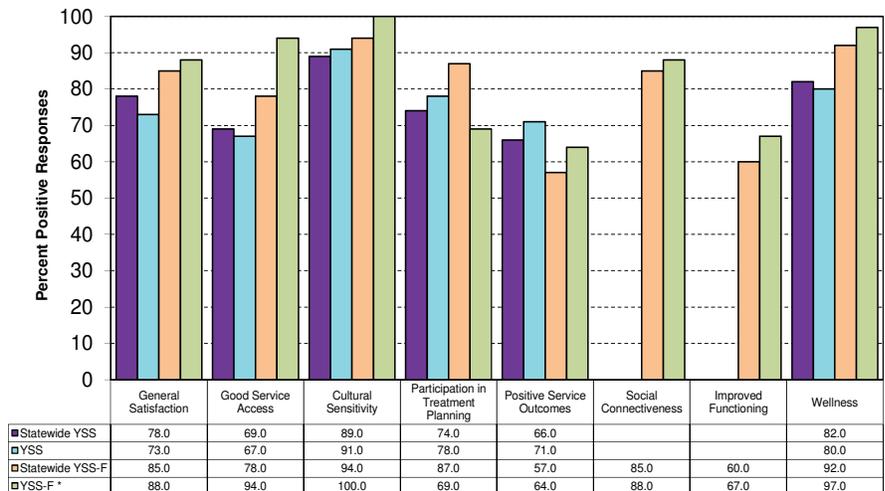
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



* An insufficient percent of clients were sampled. Utilize with care.

Northeastern Counseling Center

Daggett, Duchesne, & Uintah Counties



Population: 59,899

Northeastern Counseling Center

Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider

Agency:

Kyle Snow, Director
 Northeastern Counseling Center
 1140 West 500 South #9
 Vernal, UT 84078
 Office: (435) 789-6300
 Fax: (435) 789-6325
www.nccutah.org

Northeastern Substance Abuse—Prevention

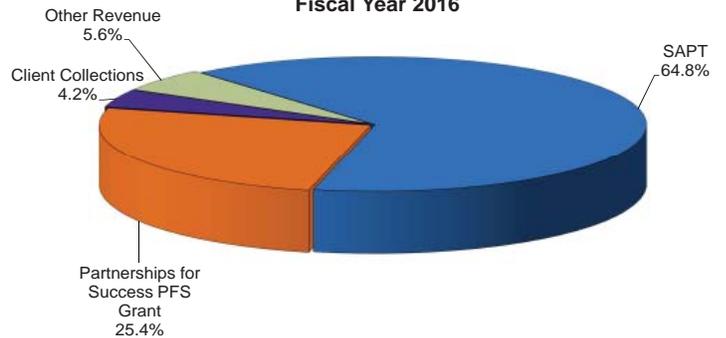
Protective Factors:

- Pro-social involvement

Prioritized Risk Factors:

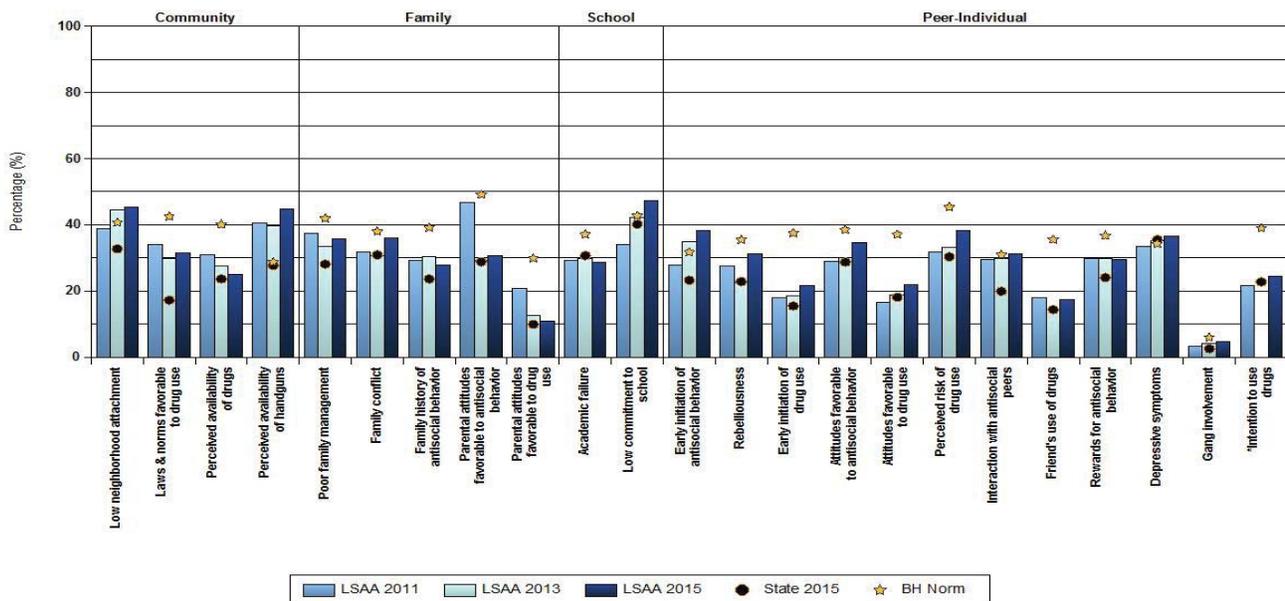
- Low neighborhood attachment
- Underage alcohol sales
- Low commitment to school
- Community laws and norms favorable to drug use
- Friends who engage in problem behavior

Source of Revenues
Fiscal Year 2016



Risk Profile

2015 Northeastern District LSAA Student Survey, All Grades

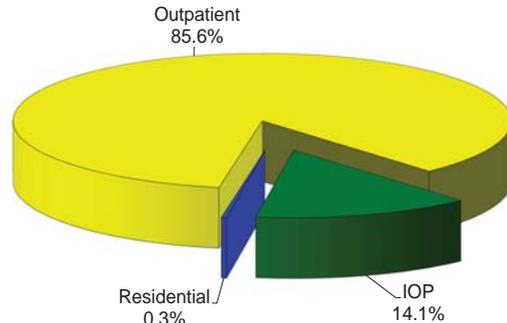


Northeastern Counseling Center—Substance Abuse

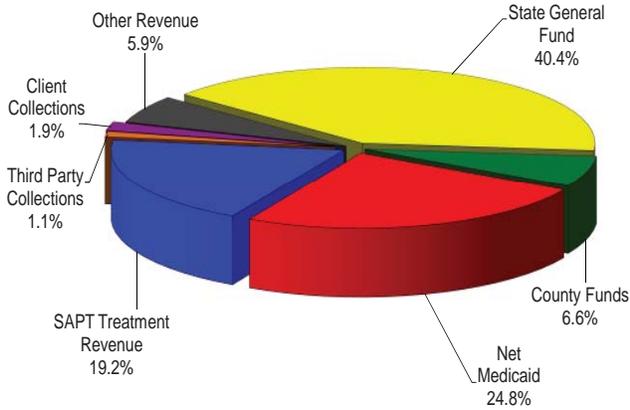
Total Clients Served.....458
 Adult427
 Youth.....31
 Penetration Rate (Total population of area)..0.8%

Total Admissions.....291
 Initial Admissions22
 Transfers.....269

Admission into Modalities
Fiscal Year 2016



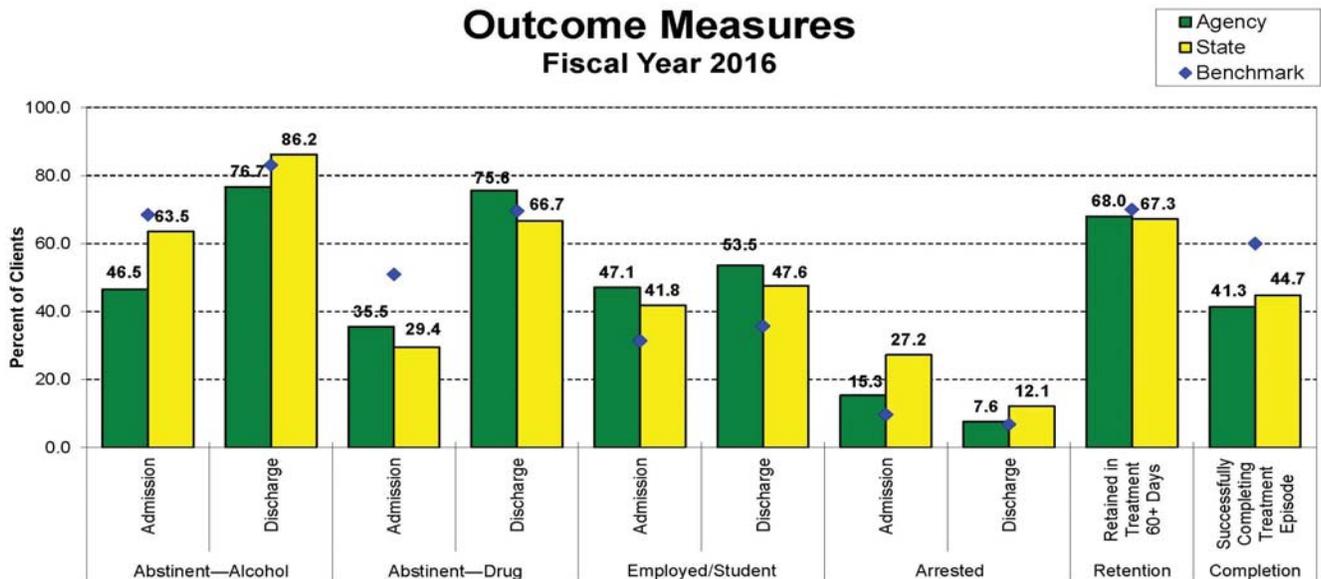
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	50	22	72
Cocaine/Crack	1	1	2
Marijuana/Hashish	35	16	51
Heroin	33	34	67
Other Opiates/Synthetics	16	13	29
Hallucinogens	0	0	0
Methamphetamine	41	48	89
Other Stimulants	0	0	0
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	1	3
Club Drugs	0	0	0
Over-the-Counter	0	1	1
Other	1	0	1
Total	179	136	315

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

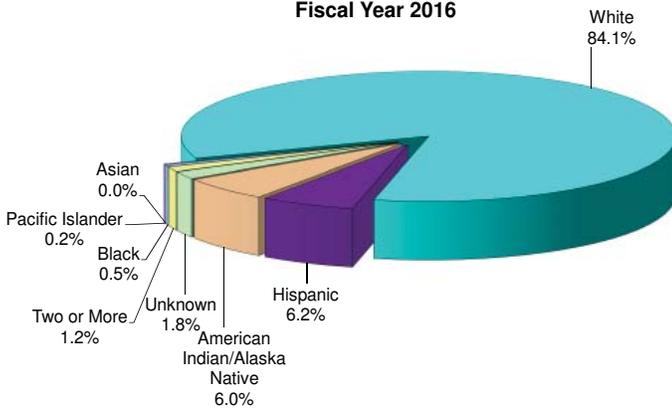
Northeastern Counseling Center—Mental Health

Total Clients Served.....2,550
 Adult1,617
 Youth.....933
 Penetration Rate (Total population of area)..... 4.3%
 Civil Commitment19
 Unfunded Clients Served.....373

Diagnosis

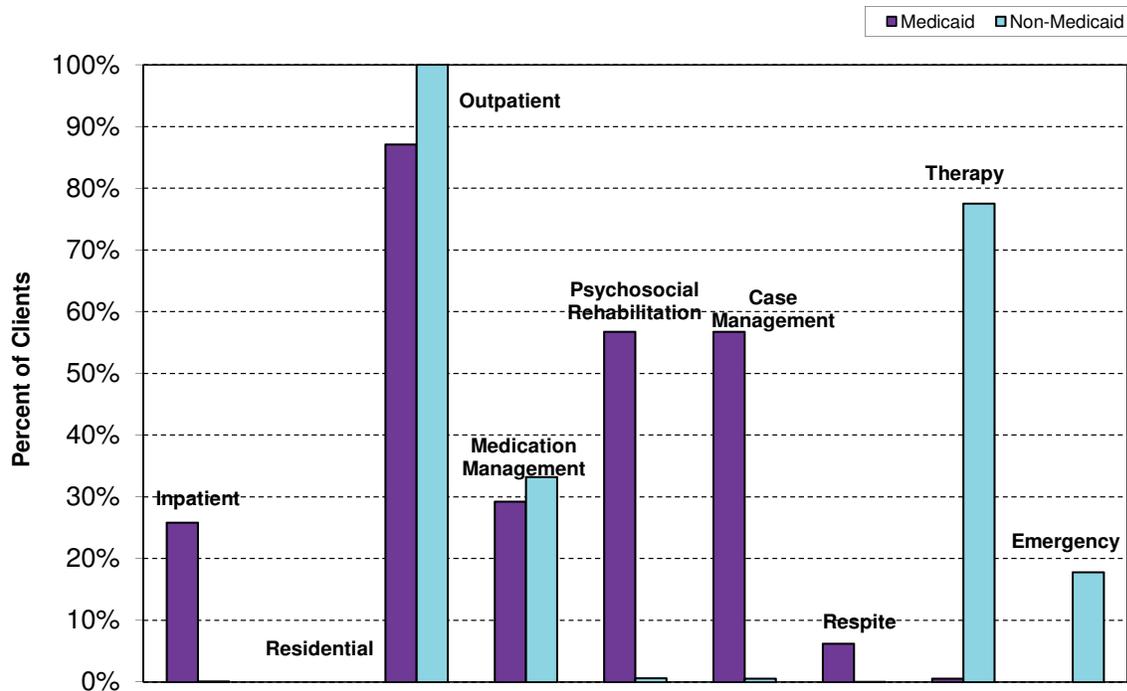
	Youth	Adult
Adjustment Disorders	199	110
Anxiety Disorders	333	956
Attention Deficit Disorders	140	93
Cognitive Disorders	4	57
Conduct Disorders	95	6
Depressive Disorders	395	752
Developmental Disorders	32	17
Dissociative Disorders	2	13
Eating Disorders	4	6
Factitious Disorders	0	0
Impulse Control Disorders	32	40
Learning Disorders	0	1
Mood Disorders	121	308
Neglect or Abuse Disorders	177	75
Neurological Disorders	2	0
Other	54	172
Personality Disorders	1	86
Pervasive Developmental Disorders	4	3
Physical Health Disorders	51	26
Schizophrenia and Other Psychotic	6	162
Substance Use Disorders	69	533
V Codes	410	717
	2,131	4,133

Race/Ethnicity Fiscal Year 2016



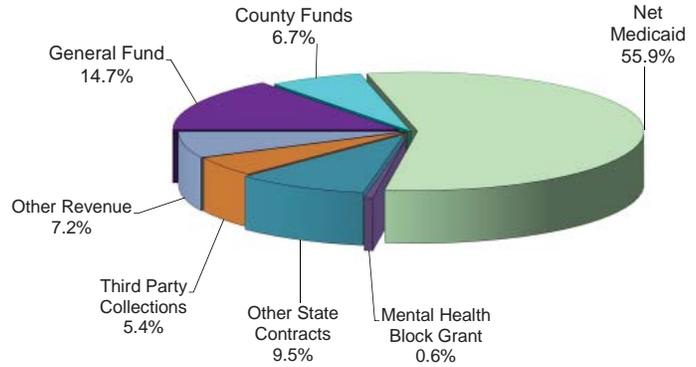
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

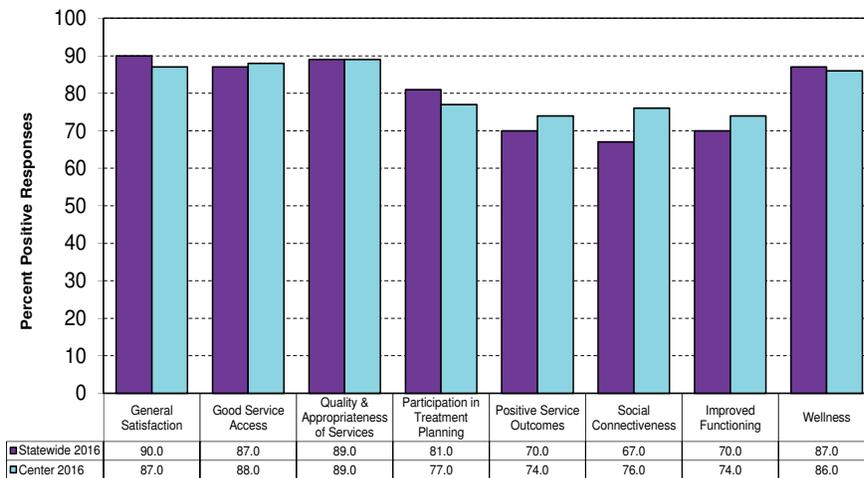


Northeastern Counseling Center—Mental Health (Continued)

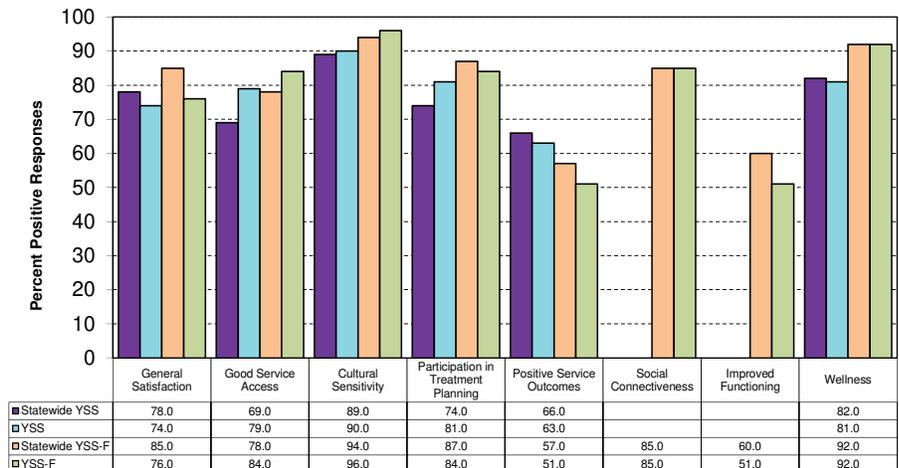
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Salt Lake County



Population: 1,107,314

Salt Lake County Behavioral Health Services

County: Salt Lake

Substance Abuse and Mental Health

Administrative Agency:

Tim Whalen, Director
 Salt Lake County
 Division of Behavioral Health Services
 2001 South State Street #S2300
 Salt Lake City, UT 84190-2250
 Office: (385) 468-4707
behavioralhealthservices.slco.org

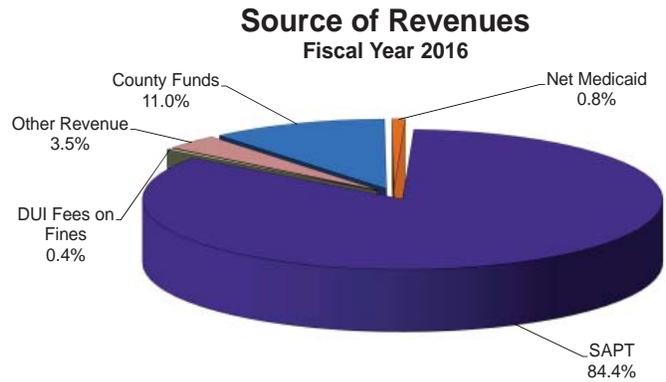
Salt Lake County Substance Abuse—Prevention

Protective Factors:

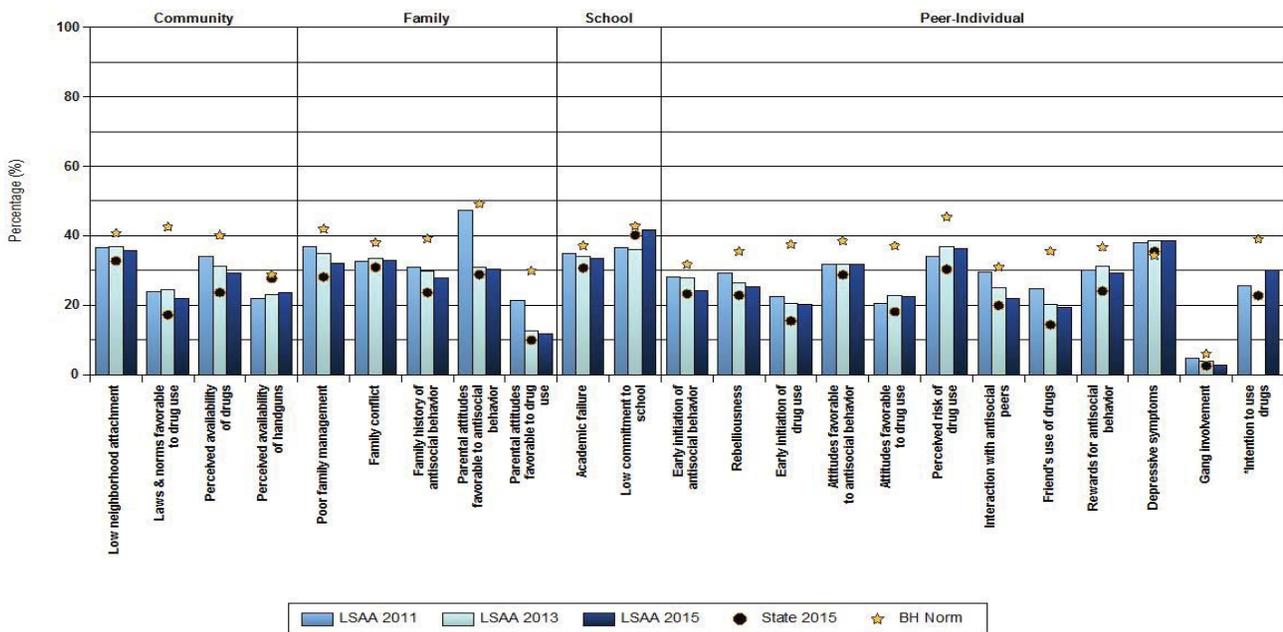
- Rewards for pro-social involvement in family and community domains
- Family attachments
- Opportunities for pro-social interaction

Prioritized Risk Factors:

- Parental/individual attitudes favorable to anti-social behavior
- Early initiation of drug use
- Low perceived risk of drug use



Risk Profile 2015 Salt Lake County LSAA Student Survey, All Grades

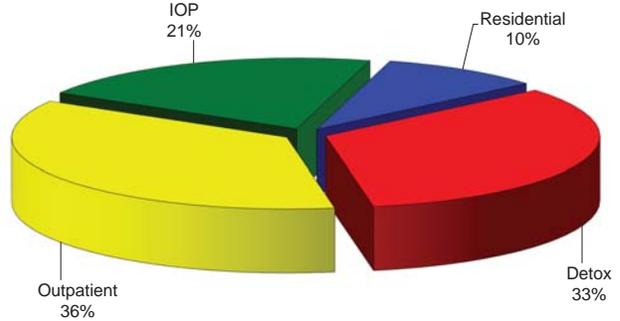


Salt Lake County—Substance Abuse

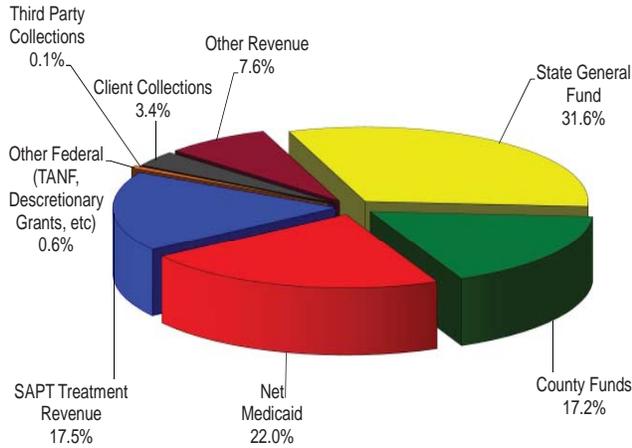
Total Clients Served.....7,214
 Adult6,575
 Youth.....639
 Penetration Rate (Total population of area)..0.7%

Total Admissions.....8,874
 Initial Admissions7,204
 Transfers.....1,670

Admissions into Modalities
Fiscal Year 2016



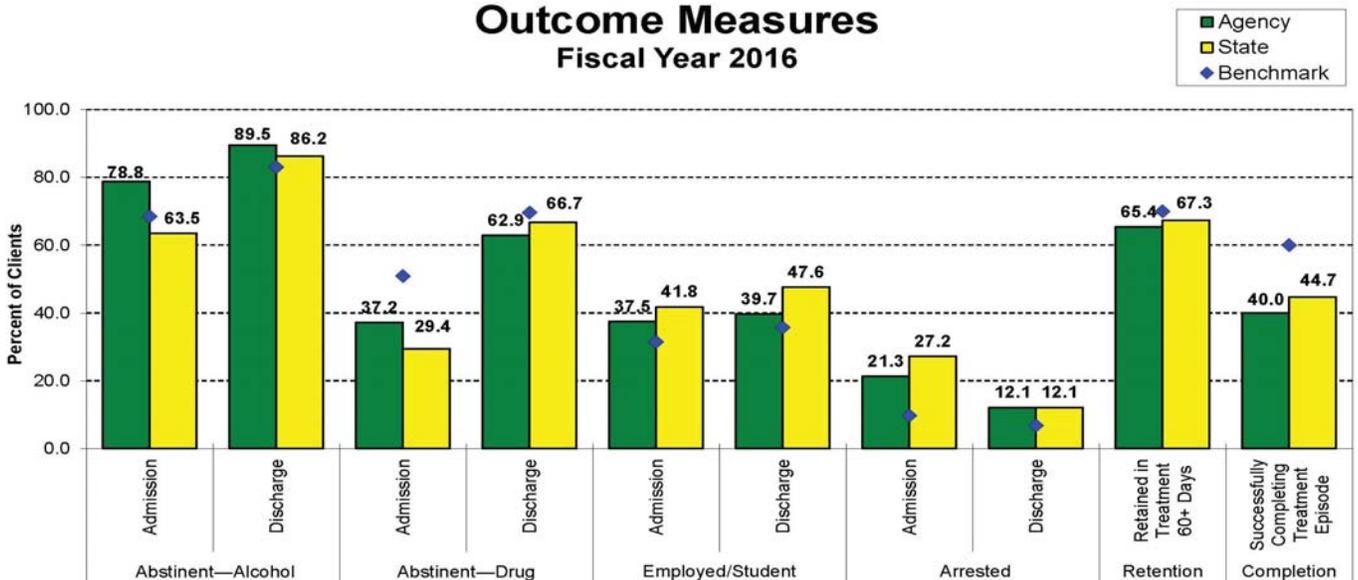
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	1,720	539	2,259
Cocaine/Crack	143	77	220
Marijuana/Hashish	804	311	1,115
Heroin	1,618	885	2,503
Other Opiates/Synthetics	108	93	201
Hallucinogens	10	0	10
Methamphetamine	1,418	898	2,316
Other Stimulants	11	20	31
Benzodiazepines	21	10	31
Tranquilizers/Sedatives	2	6	8
Inhalants	2	0	2
Oxycodone	43	41	84
Club Drugs	2	1	3
Over-the-Counter	0	3	3
Other	73	14	87
Unknown	0	1	1
Total	5,975	2,899	8,874

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

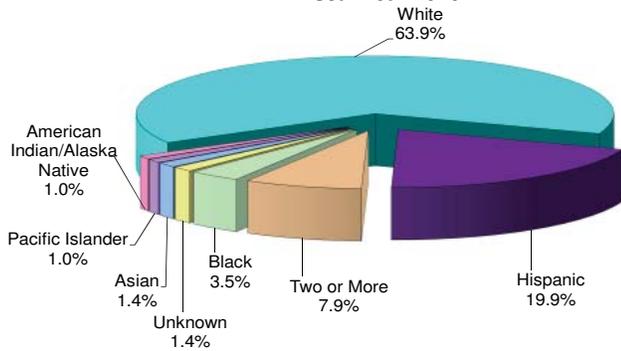
Salt Lake County—Mental Health

Total Clients Served16,794
 Adult10,041
 Youth6,753
 Penetration Rate (Total population of area)..... 1.5%
 Civil Commitment690
 Unfunded Clients Served3,352

Diagnosis

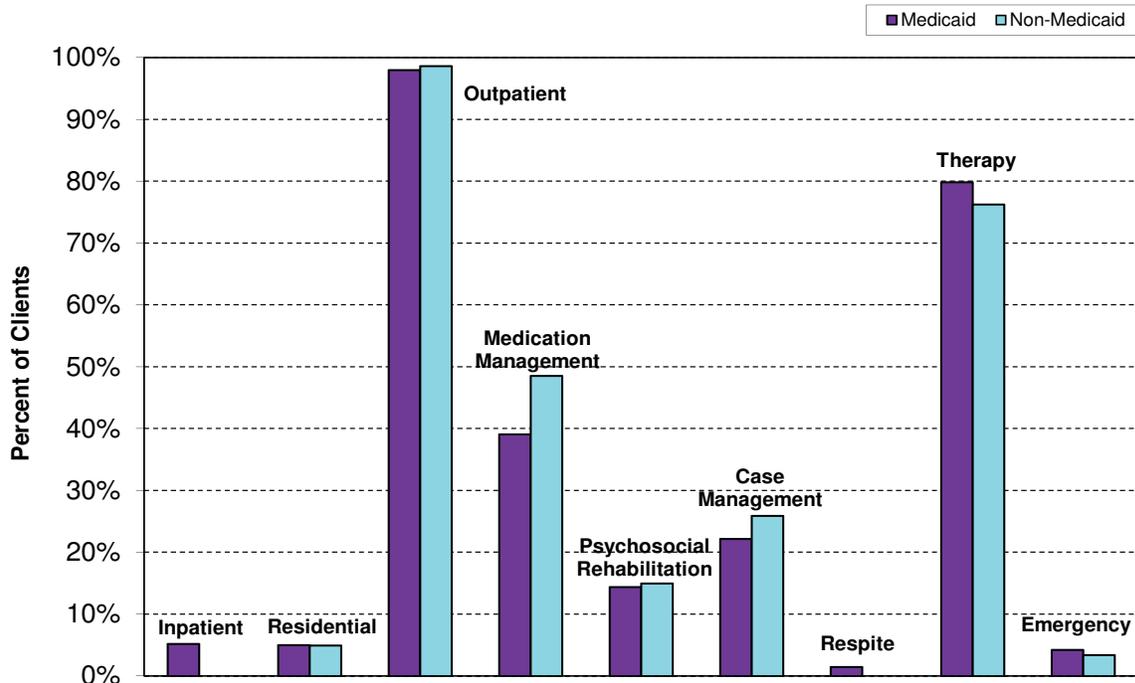
	Youth	Adult
Adjustment Disorders	1,333	329
Anxiety Disorders	3,899	5,893
Attention Deficit Disorders	1,666	597
Cognitive Disorders	48	332
Conduct Disorders	1,426	37
Depressive Disorders	1,842	4,236
Developmental Disorders	442	114
Dissociative Disorders	5	40
Eating Disorders	17	46
Factitious Disorders	1	1
Impulse Control Disorders	157	112
Learning Disorders	41	16
Mood Disorders	1,037	3,062
Neglect or Abuse Disorders	297	93
Neurological Disorders	2	44
Other	341	1,115
Personality Disorders	12	2,000
Pervasive Developmental Disorders	117	40
Physical Health Disorders	22	210
Schizophrenia and Other Psychotic	56	3,184
Substance Use Disorders	220	1,987
V Codes	2,311	4,298
	15,292	27,786

Race/Ethnicity Fiscal Year 2016



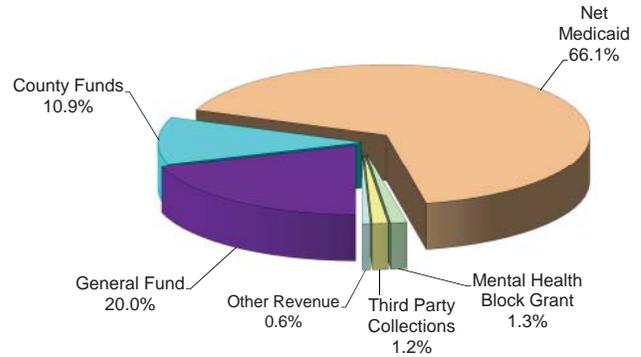
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

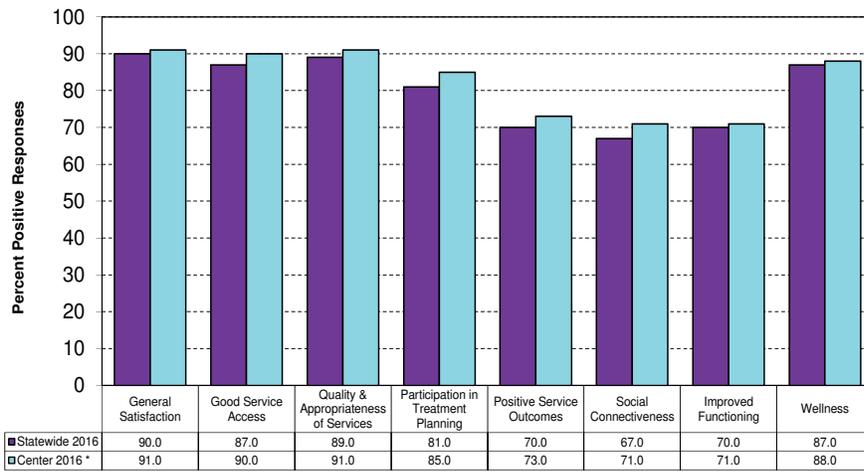


Salt Lake County—Mental Health (Continued)

Source of Revenues
Fiscal Year 2016

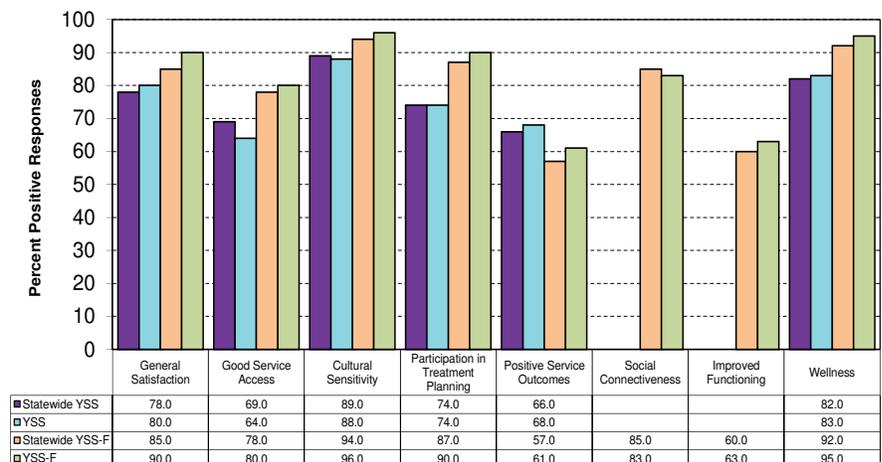


Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



* An insufficient percent of clients were sampled. Utilize with care.

Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



San Juan County



San Juan Counseling Center

County: San Juan

Substance Abuse and Mental Health Provider

Agency:

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

Population: 15,772

San Juan Substance Abuse—Prevention

Protective Factors:

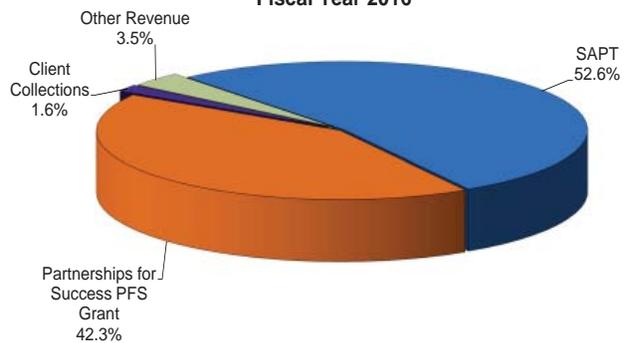
- Belief in the moral social order
- Opportunities for pro-social involvement

Prioritized Risk Factors:

- Perceived availability of drugs
- Parental attitudes favorable to anti-social behavior
- Favorable attitude toward problem behavior

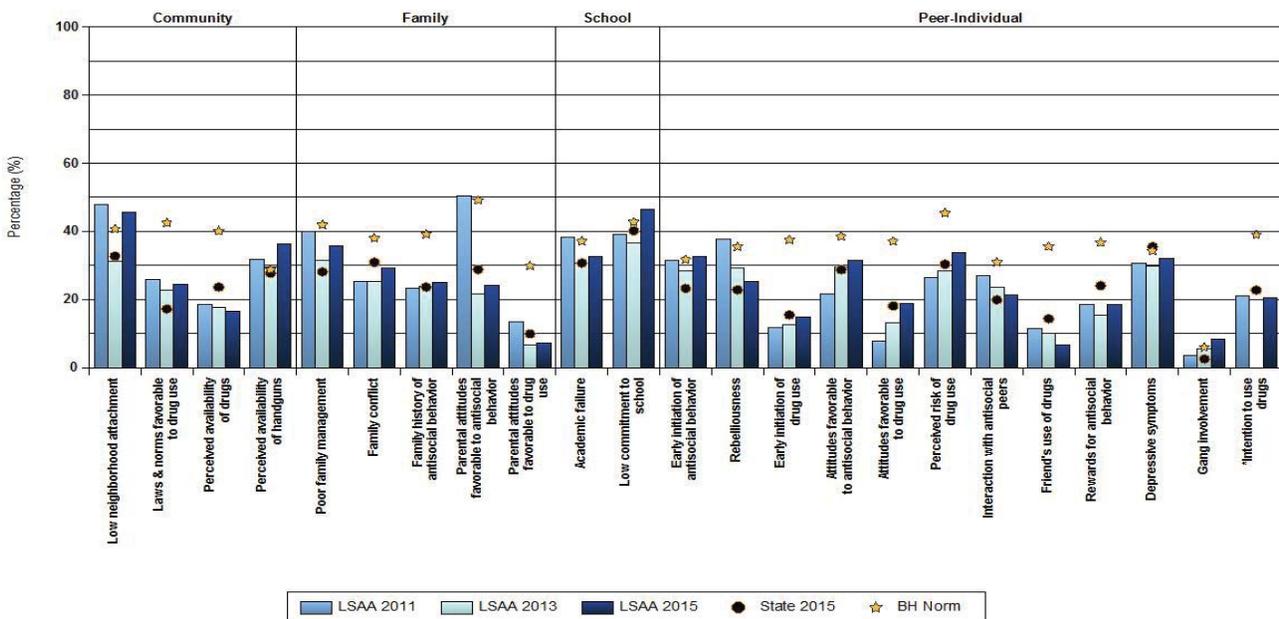
Source of Revenues

Fiscal Year 2016



Risk Profile

2015 San Juan County LSAA Student Survey, All Grades

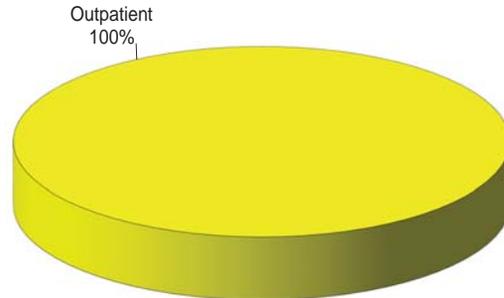


San Juan Counseling—Substance Abuse

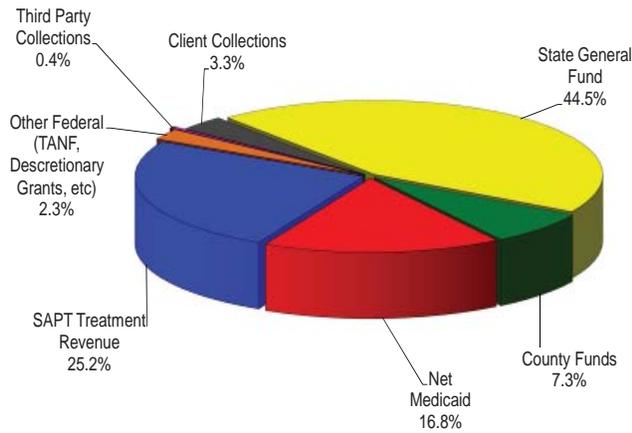
Total Clients Served.....78
 Adult63
 Youth.....15
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....42
 Initial Admissions11
 Transfers.....31

Admissions into Modalities
Fiscal Year 2016



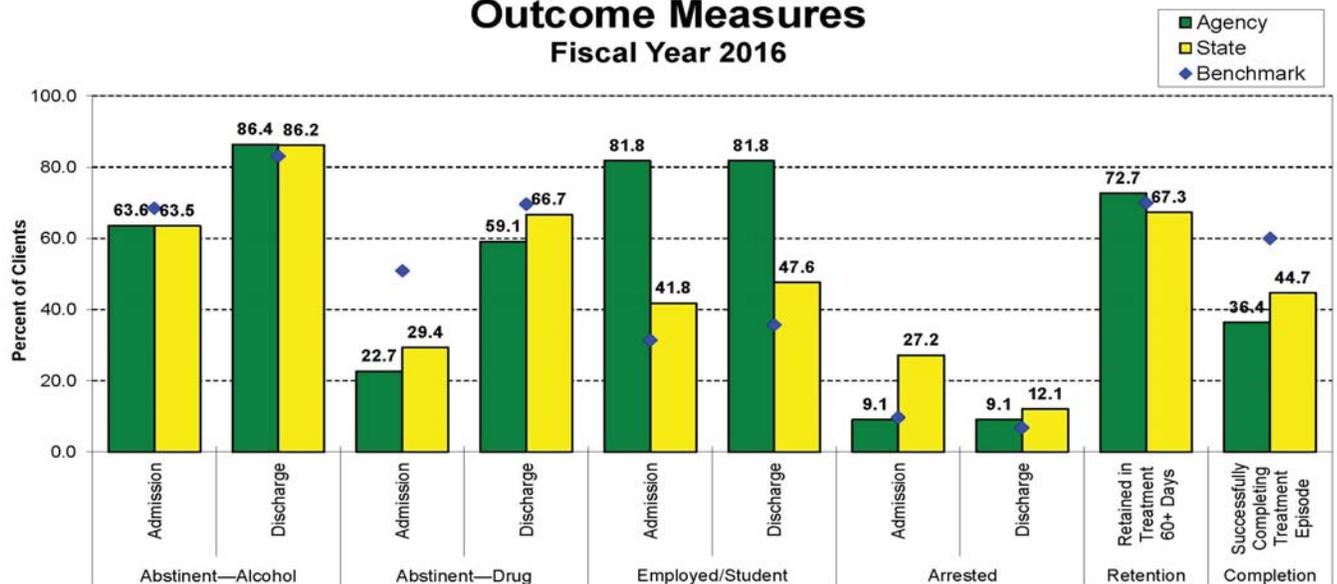
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	1,720	539	2,259
Cocaine/Crack	143	77	220
Marijuana/Hashish	804	311	1,115
Heroin	1,618	885	2,503
Other Opiates/Synthetics	108	93	201
Hallucinogens	10	0	10
Methamphetamine	1,418	898	2,316
Other Stimulants	11	20	31
Benzodiazepines	21	10	31
Tranquilizers/Sedatives	2	6	8
Inhalants	2	0	2
Oxycodone	43	41	84
Club Drugs	2	1	3
Over-the-Counter	0	3	3
Other	73	14	87
Unknown	0	1	1
Total	5,975	2,899	8,874

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

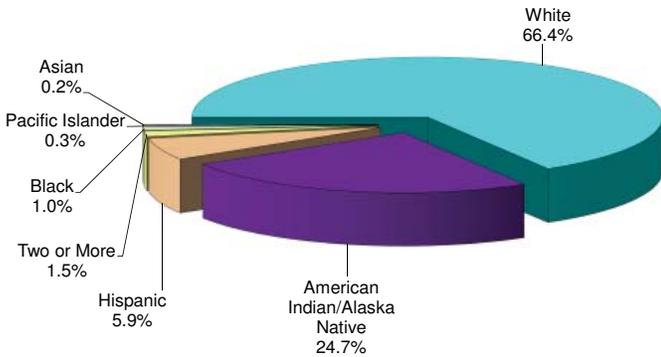
San Juan Counseling—Mental Health

Total Clients Served.....611
 Adult403
 Youth.....208
 Penetration Rate (Total population of area)..... 3.9%
 Civil Commitment2
 Unfunded Clients Served101

Diagnosis

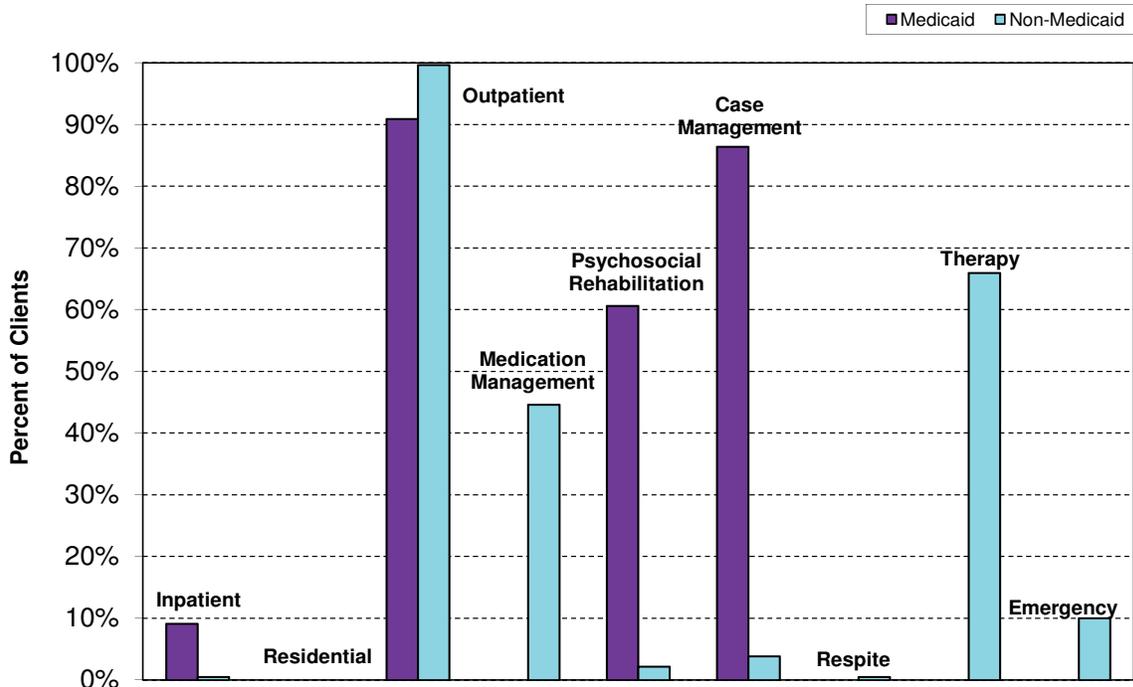
	Youth	Adult
Adjustment Disorders	54	23
Anxiety Disorders	64	221
Attention Deficit Disorders	55	55
Cognitive Disorders	0	22
Conduct Disorders	12	2
Depressive Disorders	71	215
Developmental Disorders	20	15
Dissociative Disorders	1	6
Eating Disorders	3	9
Factitious Disorders	0	0
Impulse Control Disorders	2	16
Learning Disorders	0	0
Mood Disorders	13	51
Neglect or Abuse Disorders	7	1
Neurological Disorders	1	2
Other	30	100
Personality Disorders	0	42
Pervasive Developmental Disorders	5	1
Physical Health Disorders	3	24
Schizophrenia and Other Psychotic	2	30
Substance Use Disorders	19	142
V Codes	16	56
	378	1,033

Race/Ethnicity Fiscal Year 2016



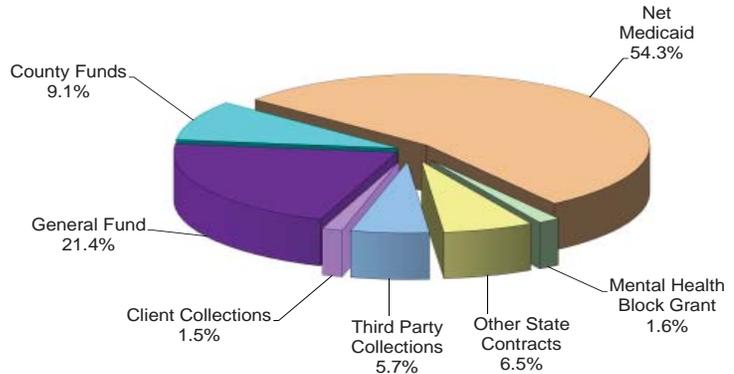
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

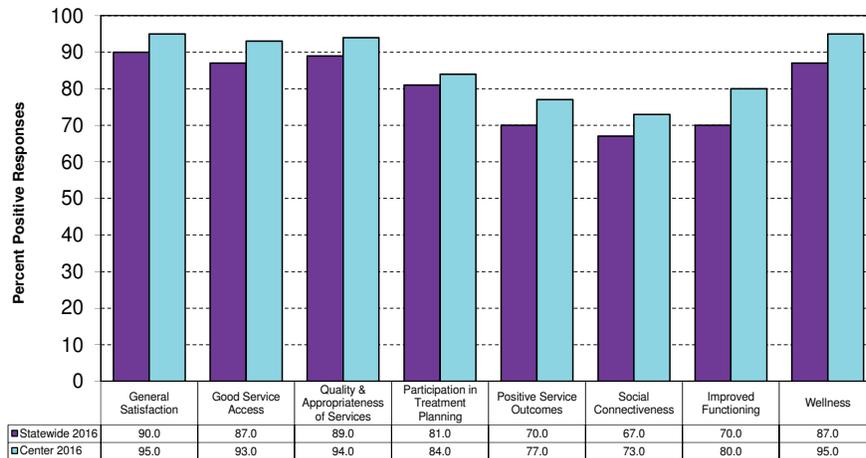


San Juan Counseling—Mental Health (Continued)

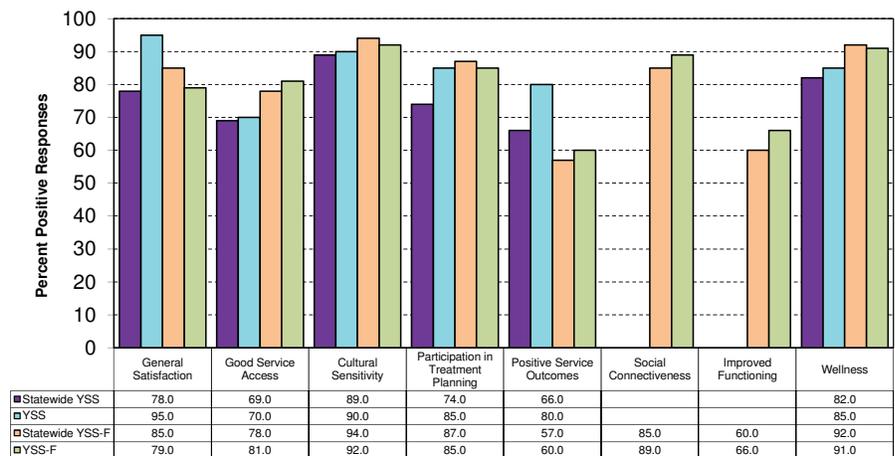
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Southwest Behavioral Health Center

Beaver, Garfield, Iron, Kane, and Washington Counties



Population: 222,464

Southwest Behavioral Health Center

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

Substance Abuse and Mental Health Provider Agency:

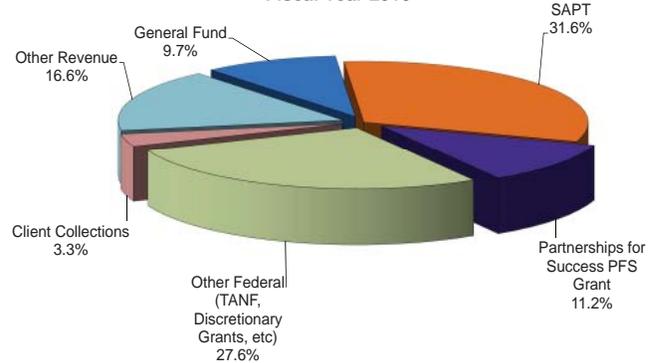
Mike Deal, Director
 Southwest Behavioral Health Center
 474 West 200 North, Suite 300
 St. George, UT 84770
 Office: (435) 634-5600
www.sbhc.us

Southwest Substance Abuse—Prevention

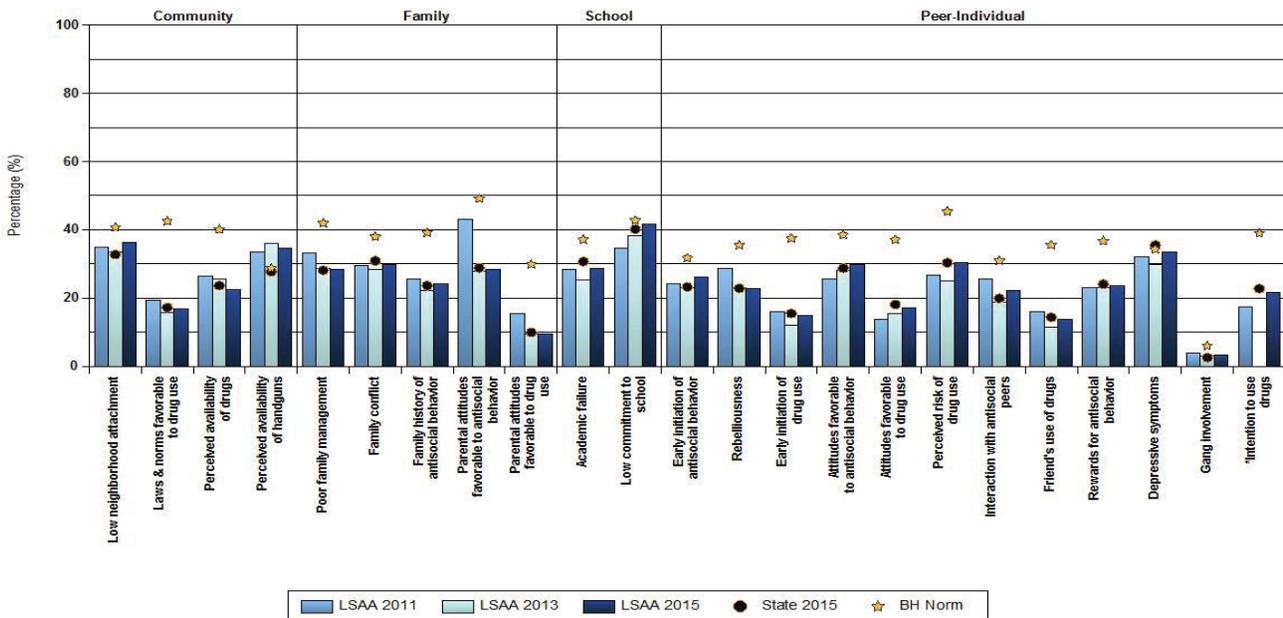
Prioritized Risk Factors:

- Family conflict, low commitment to school
- Attitudes favorable towards anti-social behavior
- Parental attitudes favorable to anti-social behavior
- Early initiation of drug use
- Depressive symptoms

Source of Revenues
Fiscal Year 2016



Risk Profile 2015 Southwest District LSAA Student Survey, All Grades

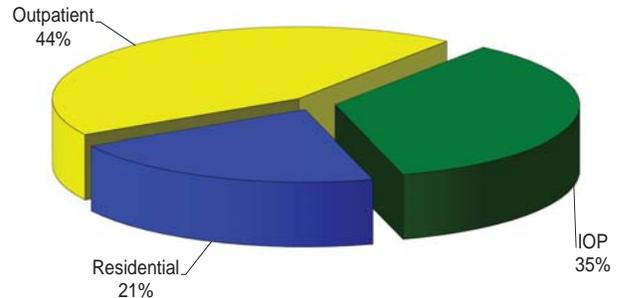


Southwest Behavioral Health Center—Substance Abuse

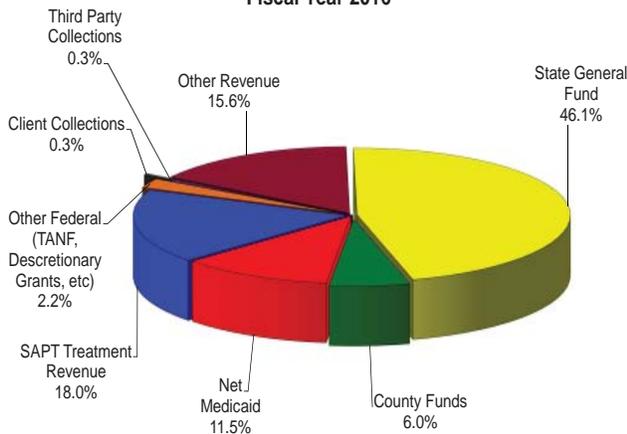
Total Clients Served.....619
 Adult501
 Youth.....28
 Penetration Rate (Total population of area)..0.3%

Total Admissions.....564
 Initial Admissions322
 Transfers.....242

Admissions into Modalities
Fiscal Year 2016



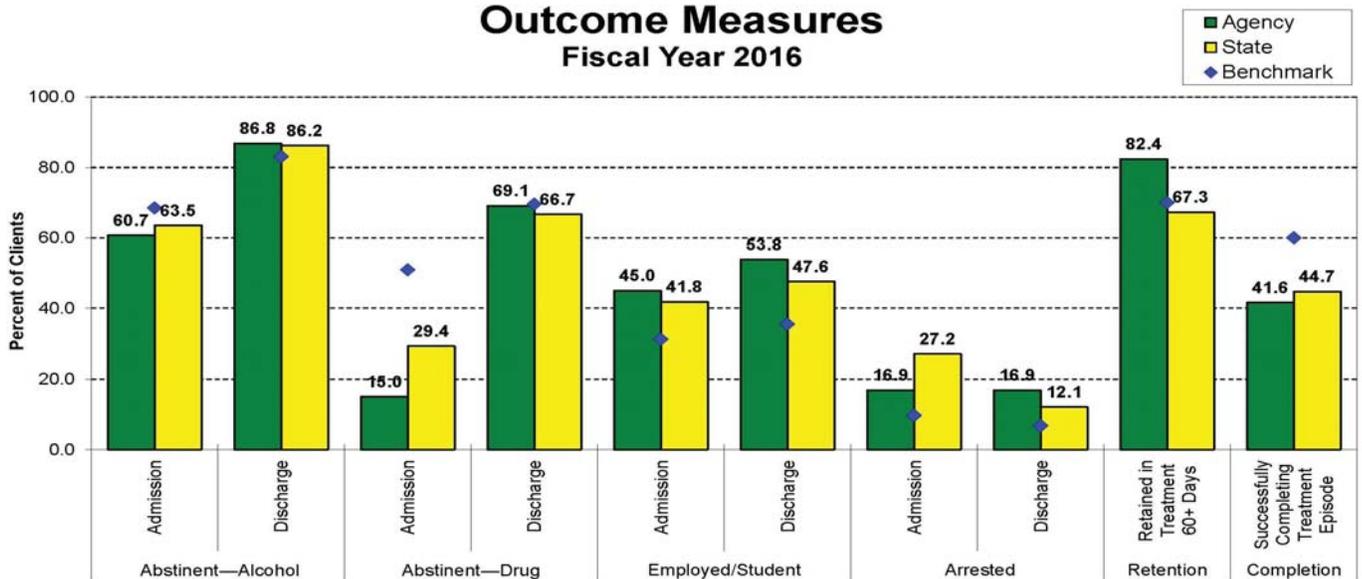
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	72	37	109
Cocaine/Crack	1	0	1
Marijuana/Hashish	38	24	62
Heroin	69	68	137
Other Opiates/Synthetics	10	6	16
Hallucinogens	0	0	0
Methamphetamine	92	104	196
Other Stimulants	0	0	0
Benzodiazepines	0	4	4
Tranquilizers/Sedatives	0	2	2
Inhalants	2	0	2
Oxycodone	16	15	31
Club Drugs	1	3	4
Over-the-Counter	0	0	0
Other	0	0	0
Total	301	263	564

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

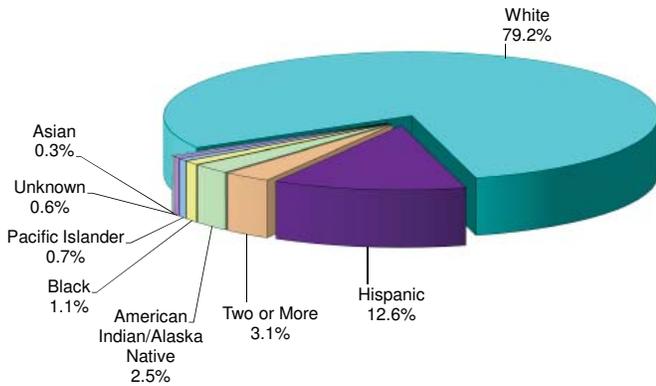
Southwest Behavioral Health Center—Mental Health

Total Clients Served.....3,403
 Adult1,691
 Youth.....1,712
 Penetration Rate (Total population of area)..... 1.5%
 Civil Commitment49
 Unfunded Clients Served445

Diagnosis

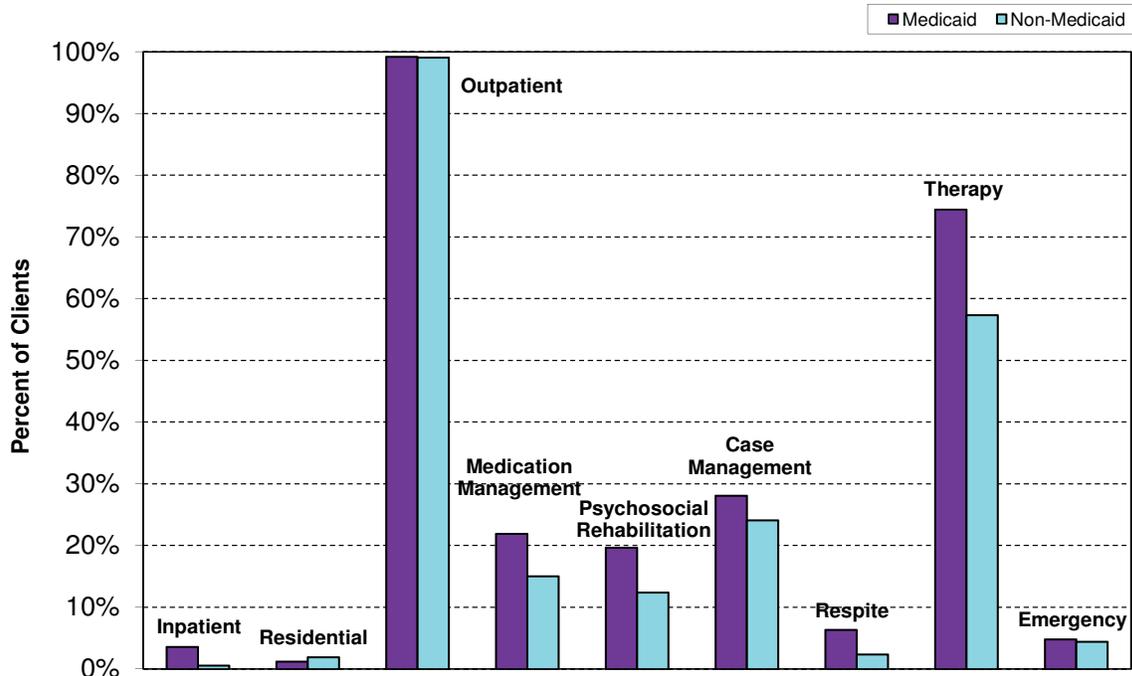
	Youth	Adult
Adjustment Disorders	646	119
Anxiety Disorders	797	714
Attention Deficit Disorders	358	60
Cognitive Disorders	31	134
Conduct Disorders	205	17
Depressive Disorders	231	582
Developmental Disorders	258	105
Dissociative Disorders	3	6
Eating Disorders	10	3
Factitious Disorders	0	0
Impulse Control Disorders	79	35
Learning Disorders	12	4
Mood Disorders	282	420
Neglect or Abuse Disorders	236	31
Neurological Disorders	3	1
Other	445	646
Personality Disorders	11	333
Pervasive Developmental Disorders	64	11
Physical Health Disorders	59	77
Schizophrenia and Other Psychotic	4	322
Substance Use Disorders	119	645
V Codes	1,183	571
	5,036	4,836

Race/Ethnicity Fiscal Year 2016



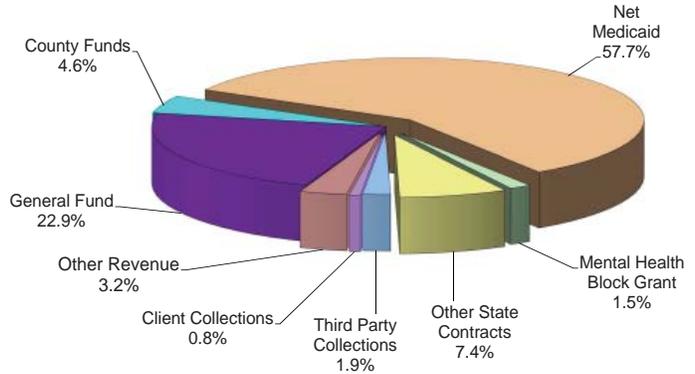
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

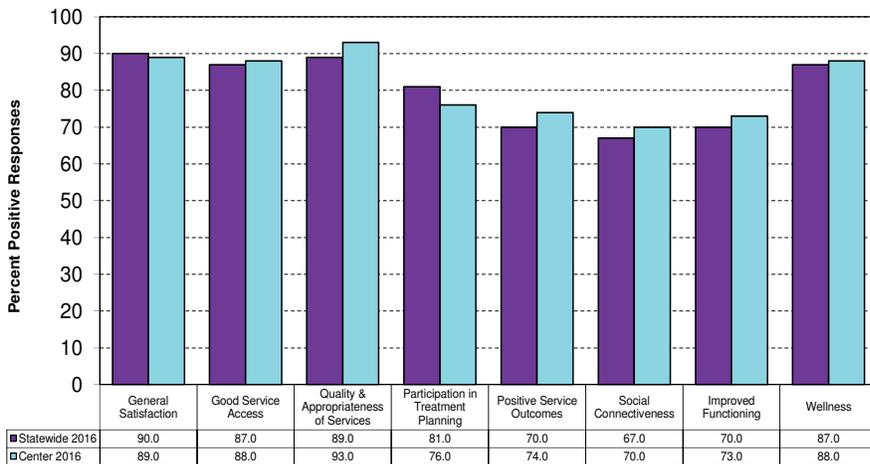


Southwest Behavioral Health Center—Mental Health (Continued)

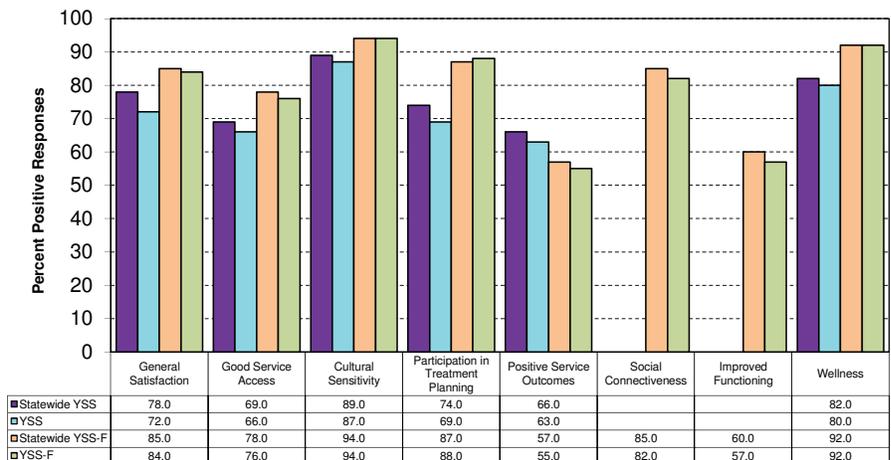
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Summit County



Population: 39,633

Valley Behavioral Health

County: Summit

Substance Abuse and Mental Health Provider Agency:

Gary Larcenaire, CEO/President
 Dodi Wilson, Program Manager
 Valley Behavioral Health, Summit County
 1753 Sidewinder Drive
 Park City, UT 84060-7322
 Office: (435) 649-8347
 Fax: (435) 649-2157
www.valleycares.com

Summit Substance Abuse—Prevention

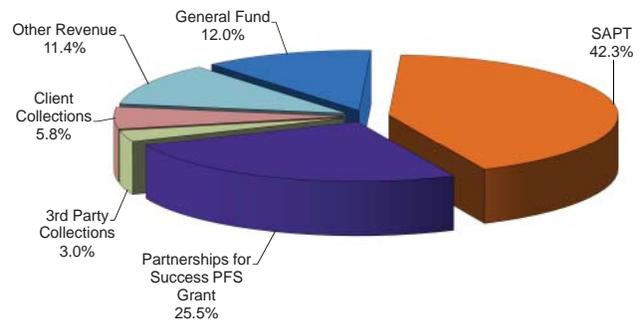
Protective Factors:

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

Prioritized Risk Factors:

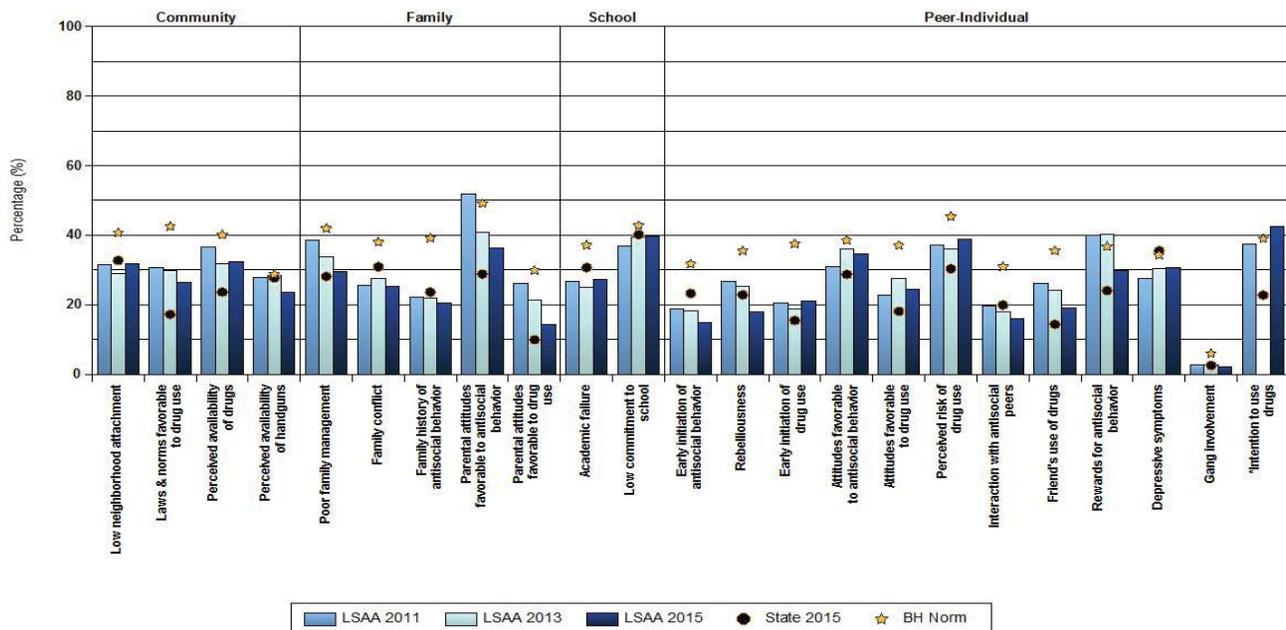
- Parental attitudes favorable to anti-social behavior
- Low perceived risk of drug use

Source of Revenues
Fiscal Year 2016



Risk Profile

2015 Summit County LSAA Student Survey, All Grades

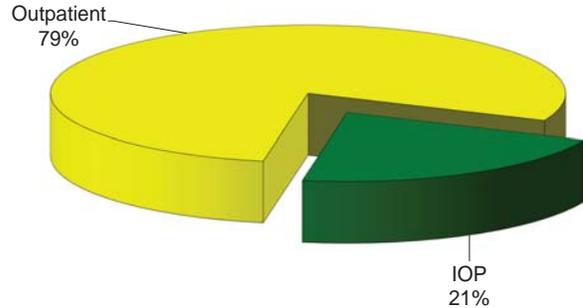


Summit County—Valley Behavioral Health—Substance Abuse

Total Clients Served.....262
 Adult237
 Youth.....25
 Penetration Rate (Total population of area)..0.8%

Total Admissions.....127
 Initial Admissions119
 Transfers.....8

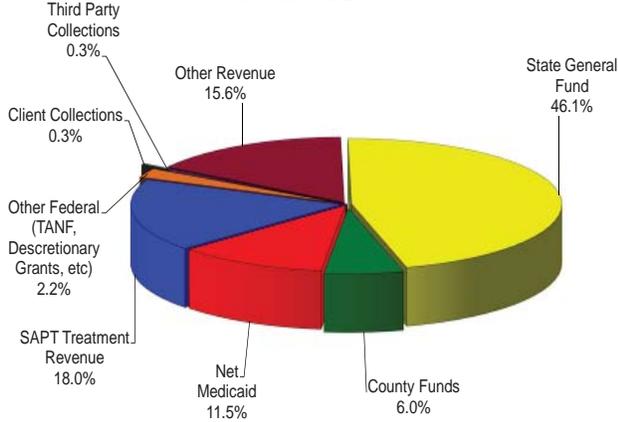
Admissions into Modalities
Fiscal Year 2016



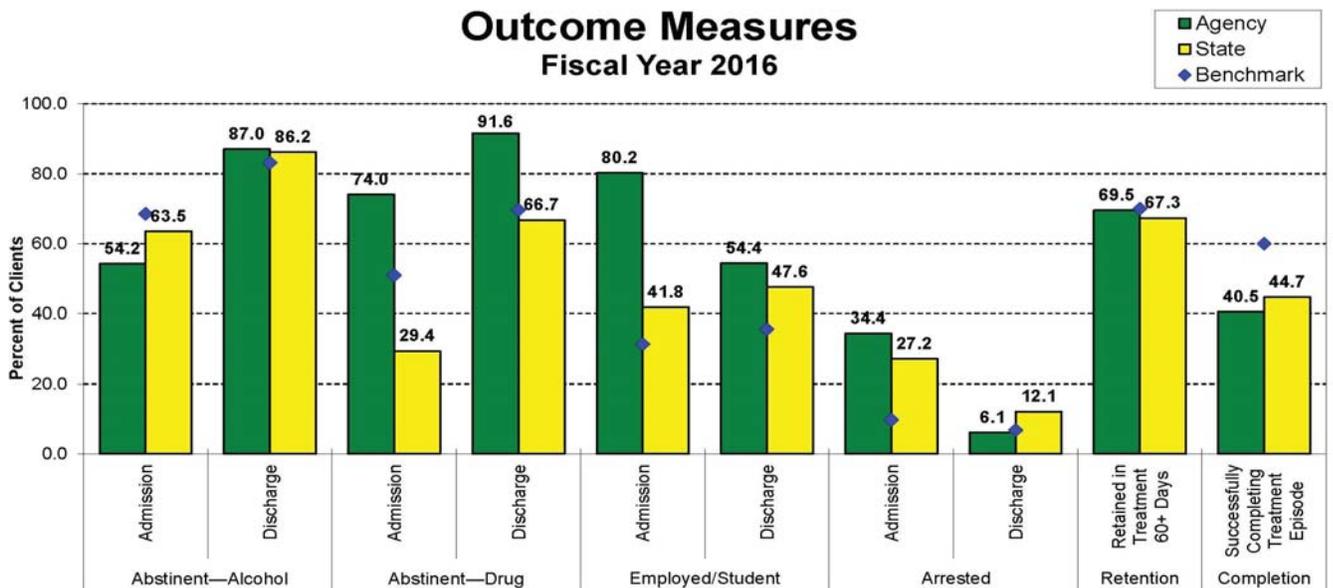
Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	72	37	109
Cocaine/Crack	1	0	1
Marijuana/Hashish	38	24	62
Heroin	69	68	137
Other Opiates/Synthetics	10	6	16
Hallucinogens	0	0	0
Methamphetamine	92	104	196
Other Stimulants	0	0	0
Benzodiazepines	0	4	4
Tranquilizers/Sedatives	0	2	2
Inhalants	2	0	2
Oxycodone	16	15	31
Club Drugs	1	3	4
Over-the-Counter	0	0	0
Other	0	0	0
Total	301	263	564

Source of Revenues
Fiscal Year 2016



Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

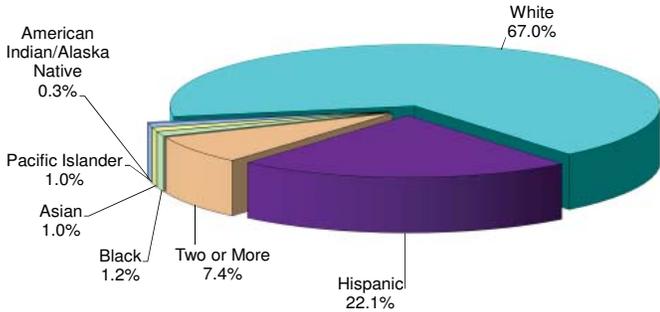
Summit County—Valley Behavioral Health—Mental Health

Total Clients Served.....678
 Adult441
 Youth.....237
 Penetration Rate (Total population of area)..... 1.7%
 Civil Commitment2
 Unfunded Clients Served289

Diagnosis

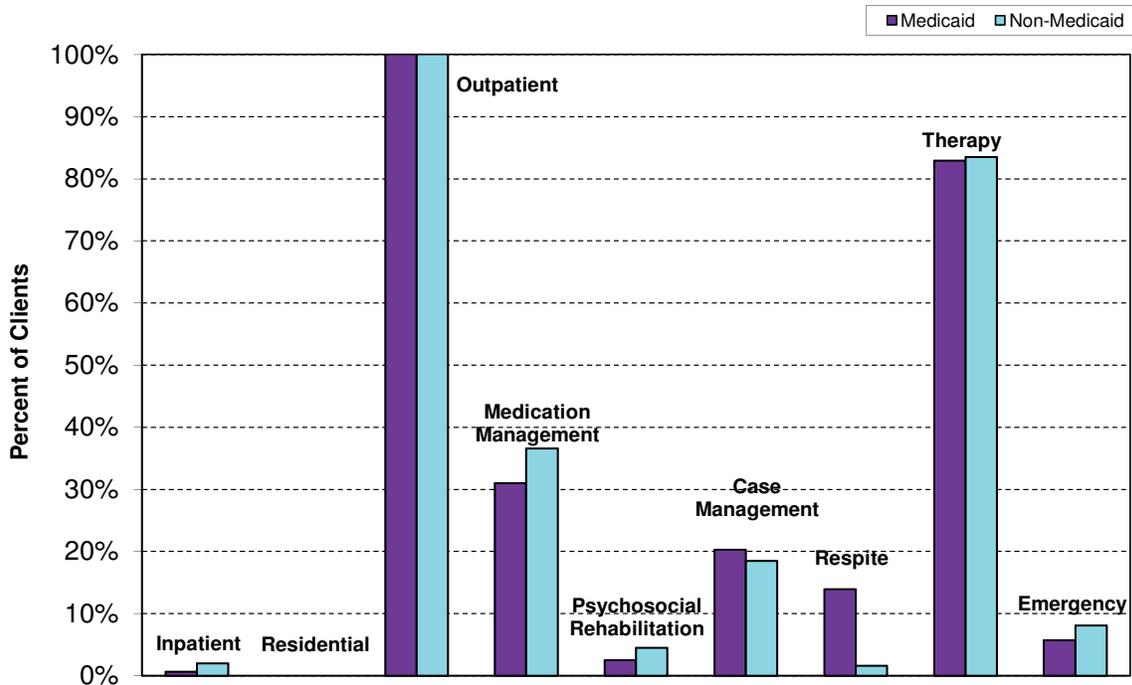
	Youth	Adult
Adjustment Disorders	52	25
Anxiety Disorders	116	176
Attention Deficit Disorders	43	35
Cognitive Disorders	1	8
Conduct Disorders	33	1
Depressive Disorders	68	151
Developmental Disorders	14	3
Dissociative Disorders	0	0
Eating Disorders	1	2
Factitious Disorders	0	0
Impulse Control Disorders	0	3
Learning Disorders	6	0
Mood Disorders	27	48
Neglect or Abuse Disorders	8	2
Neurological Disorders	1	0
Other	19	105
Personality Disorders	3	48
Pervasive Developmental Disorders	3	0
Physical Health Disorders	3	5
Schizophrenia and Other Psychotic	4	14
Substance Use Disorders	22	110
V Codes	173	221
	597	957

Race/Ethnicity Fiscal Year 2016



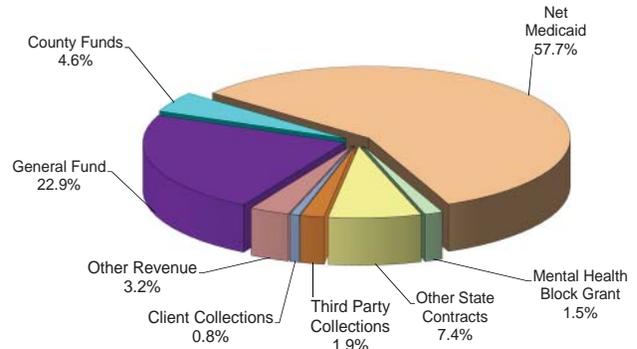
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

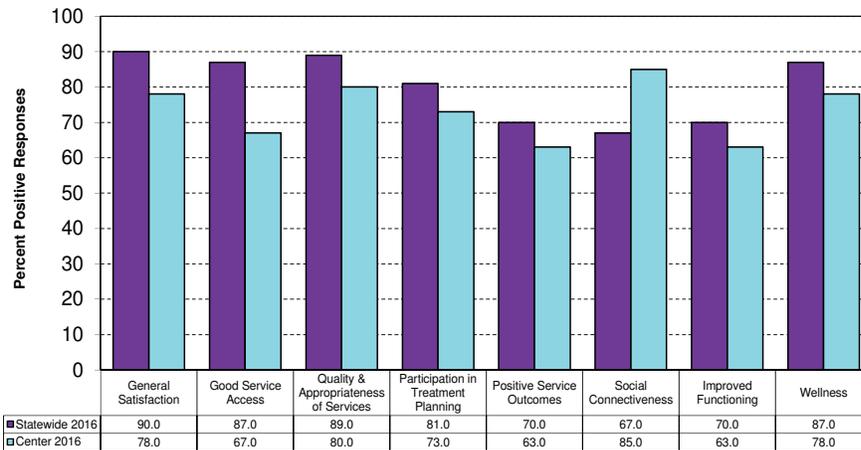


Summit County—Valley Behavioral Health—Mental Health (Continued)

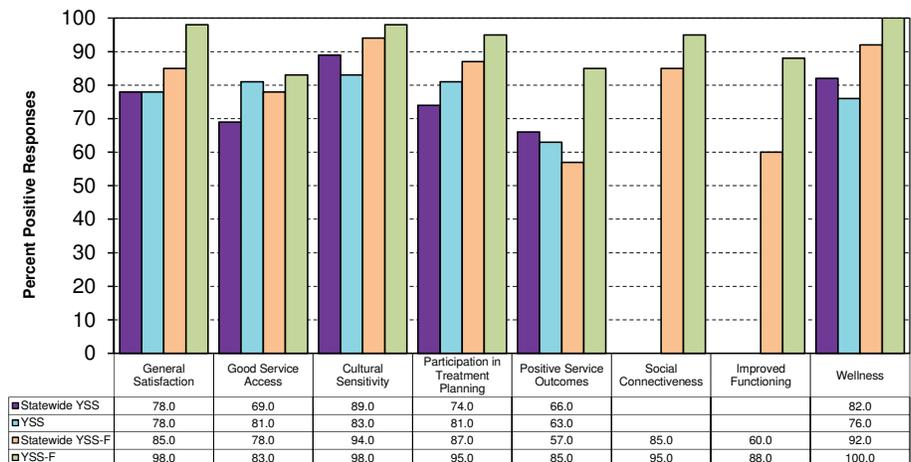
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health Statistics Improvement Program (MHSIP) 2016



Youth Consumer Satisfaction Surveys (YSS and YSS-F) 2016



Tooele County



Population: 62,952

Valley Behavioral Health

County: Tooele

Substance Abuse and Mental Health Provider Agency:

Gary Larcenaire, CEO/President
 Rebecca Brown, Interim Program Manager
 Randy Dow, Interim Program Manager
 Valley Behavioral Health, Tooele County
 100 South 1000 West
 Tooele, UT 84074
 Office: (435) 843-3520
www.valleycares.com

Tooele Substance Abuse—Prevention

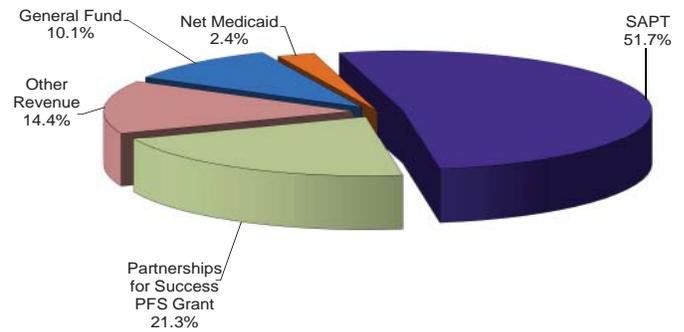
Protective Factors:

- Community opportunities for pro-social involvement
- Rewards for pro-social behavior

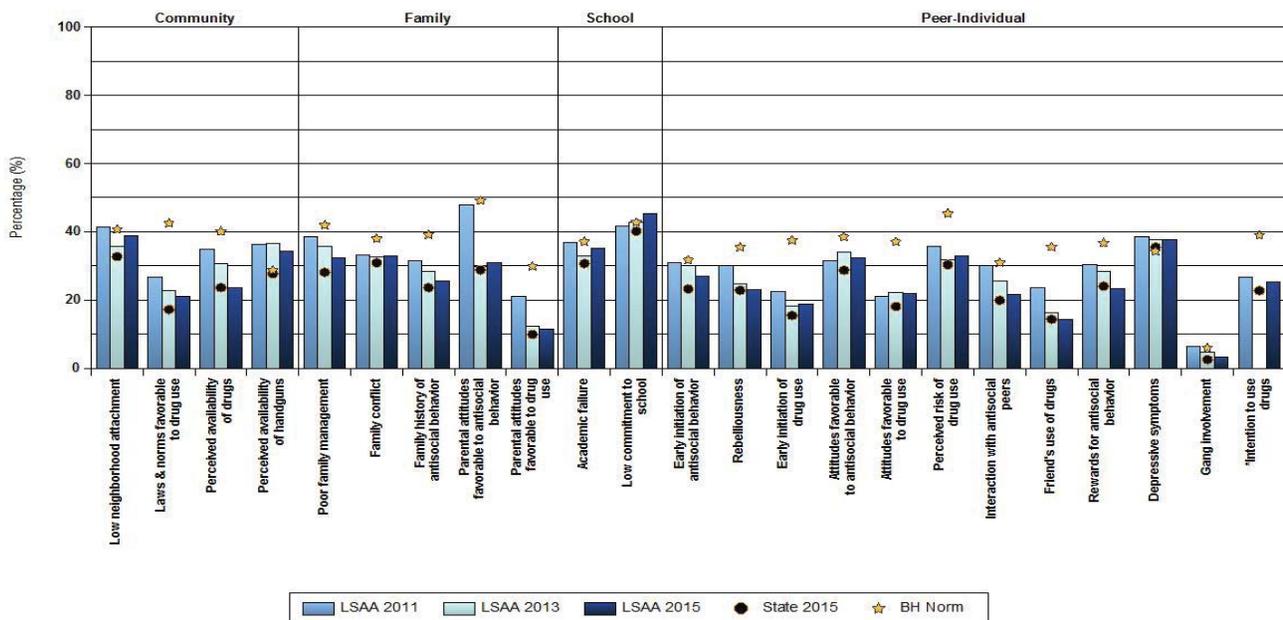
Prioritized Risk Factors:

- Low commitment to school
- Attitudes favorable to anti-social behavior
- Attitudes favorable to drug use
- Depressive symptoms

Source of Revenues
Fiscal Year 2016



Risk Profile 2015 Tooele County LSAA Student Survey, All Grades

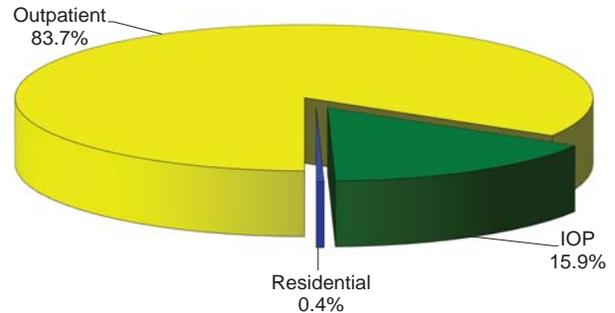


Tooele County—Valley Behavioral Health—Substance Abuse

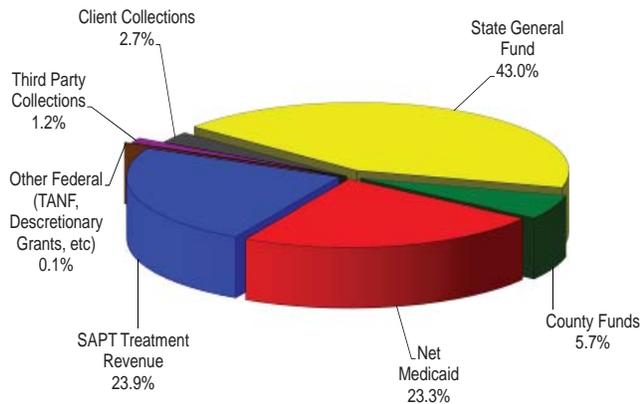
Total Clients Served.....376
 Adult346
 Youth.....30
 Penetration Rate (Total population of area) . 0.8%

Total Admissions.....233
 Initial Admissions222
 Transfers..... 11

Admissions into Modalities
Fiscal Year 2016



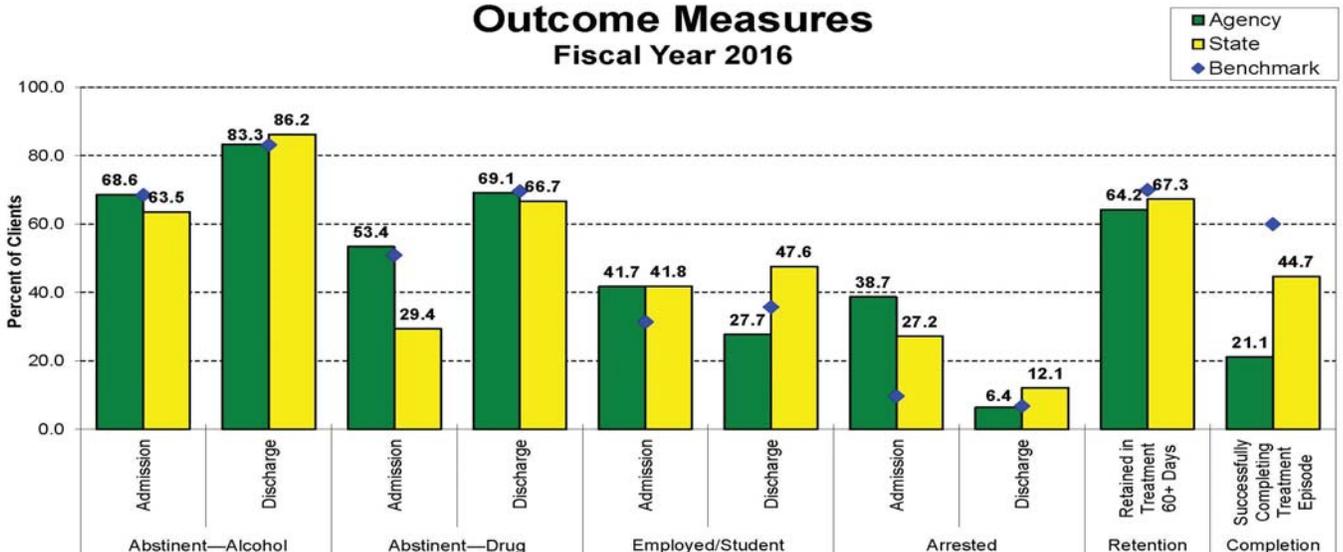
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	56	29	85
Cocaine/Crack	3	0	3
Marijuana/Hashish	30	19	49
Heroin	14	12	26
Other Opiates/Synthetics	6	8	14
Hallucinogens	1	1	2
Methamphetamine	25	23	48
Other Stimulants	1	0	1
Benzodiazepines	0	0	0
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	3	5
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Total	138	95	233

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

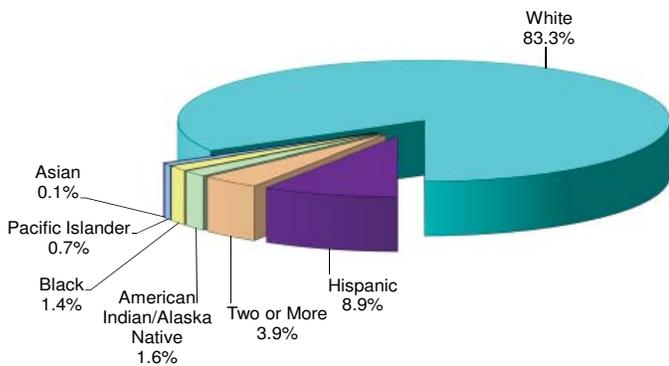
Tooele County—Valley Behavioral Health—Mental Health

Total Clients Served.....1,469
 Adult941
 Youth.....528
 Penetration Rate (Total population of area)..... 2.3%
 Civil Commitment21
 Unfunded Clients Served554

Diagnosis

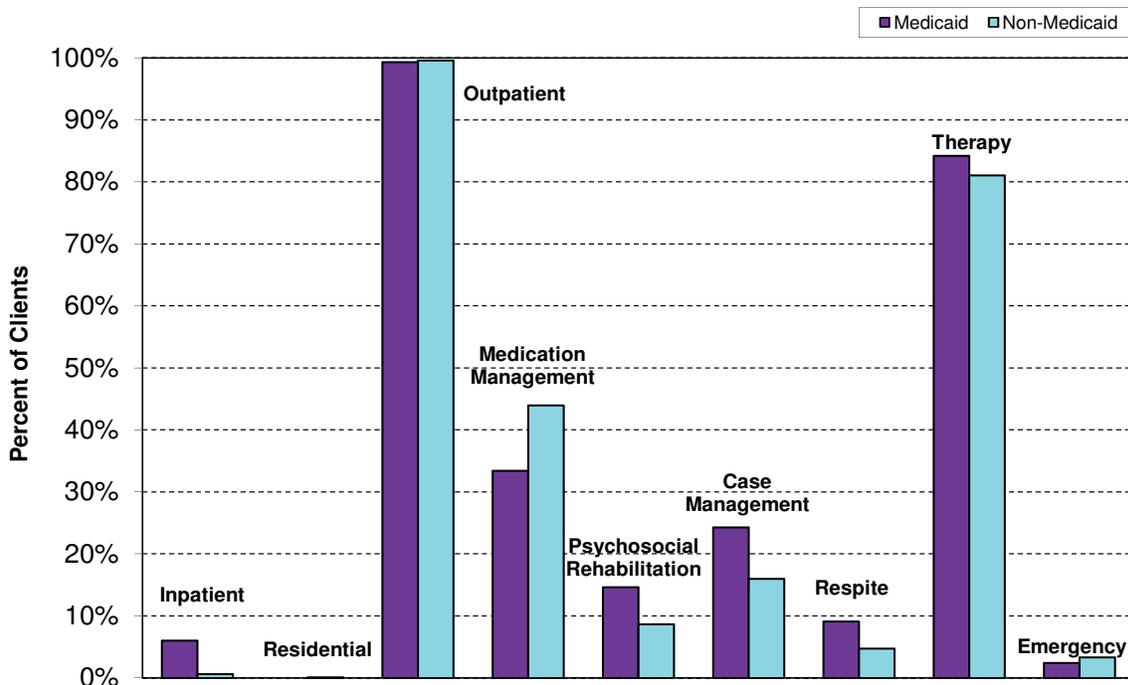
	Youth	Adult
Adjustment Disorders	88	41
Anxiety Disorders	221	603
Attention Deficit Disorders	102	59
Cognitive Disorders	3	25
Conduct Disorders	73	3
Depressive Disorders	141	430
Developmental Disorders	20	16
Dissociative Disorders	1	2
Eating Disorders	1	5
Factitious Disorders	0	0
Impulse Control Disorders	6	10
Learning Disorders	2	1
Mood Disorders	67	247
Neglect or Abuse Disorders	35	14
Neurological Disorders	0	2
Other	33	128
Personality Disorders	0	139
Pervasive Developmental Disorders	5	3
Physical Health Disorders	1	14
Schizophrenia and Other Psychotic	3	122
Substance Use Disorders	20	232
V Codes	282	573
	1,104	2,669

Race/Ethnicity Fiscal Year 2016



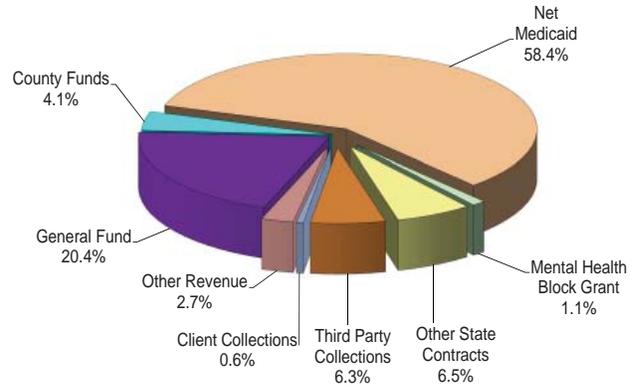
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

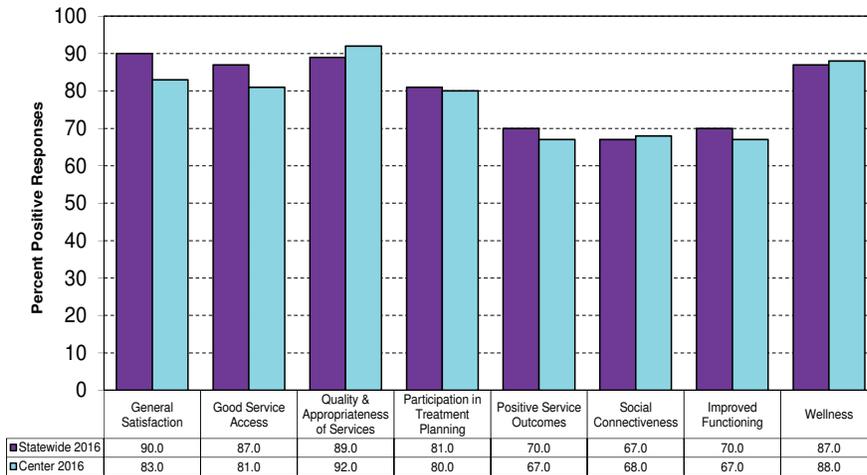


Tooele County—Valley Behavioral Health—Mental Health (Continued)

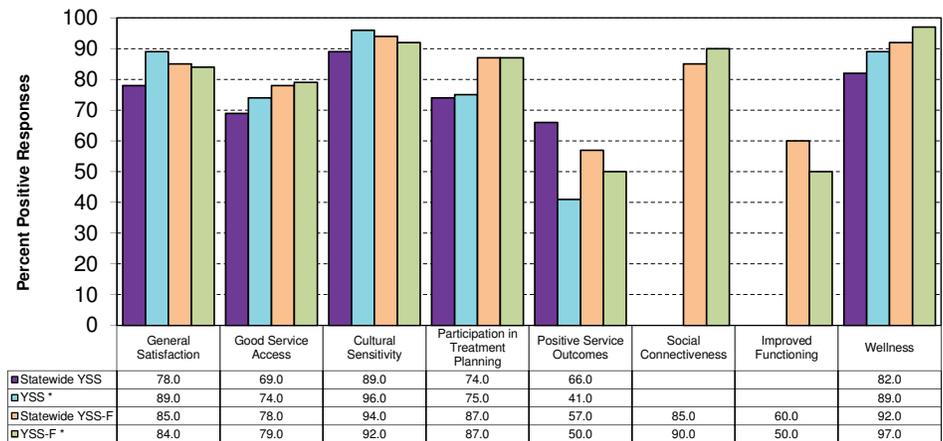
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



* An insufficient percent of clients were sampled. Utilize with care.

Utah County



Population: 575,205

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

Utah County—Prevention

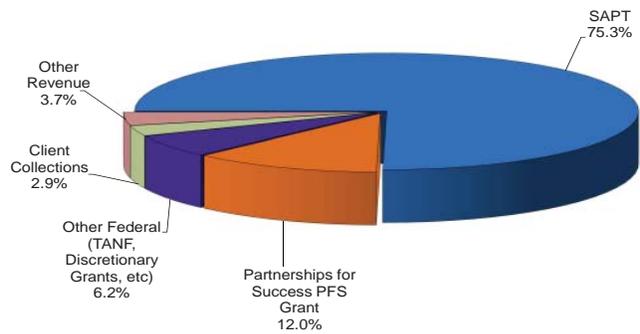
Protective Factors:

- Rewards for pro-social involvement in school
- Family and individual pro-social involvement

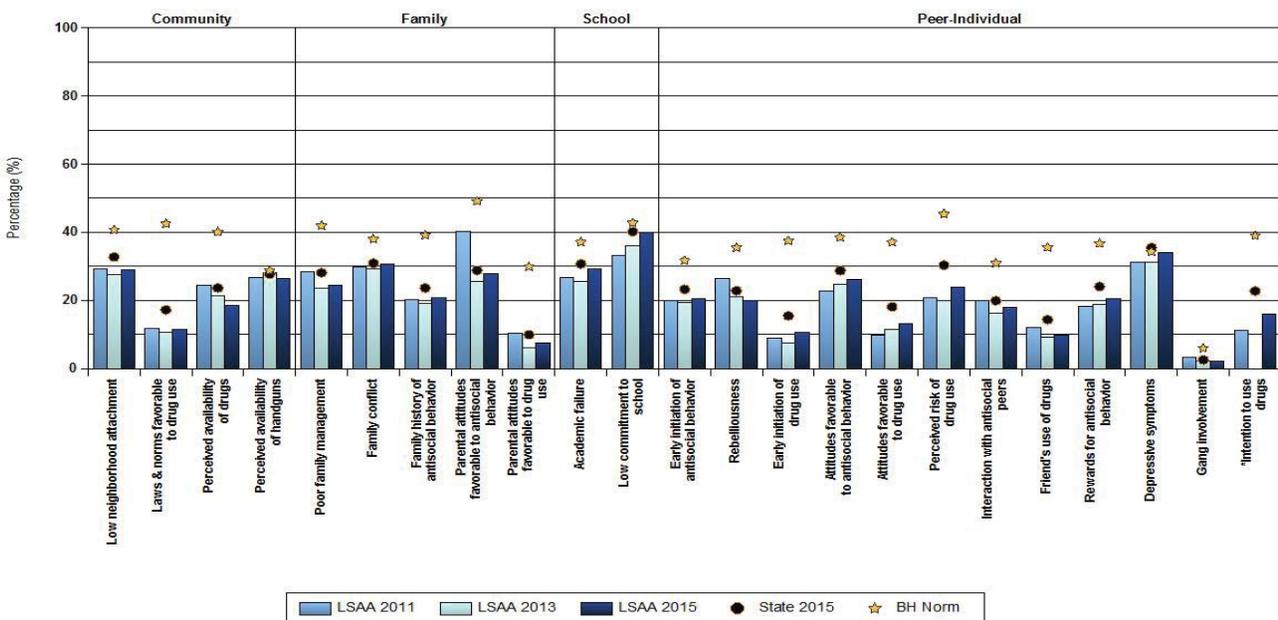
Prioritized Risk Factors:

- Low commitment to school
- Depressive symptoms
- Parental attitudes favorable to anti-social behavior

Source of Revenues
Fiscal Year 2016



Risk Profile
2015 Utah County LSAA Student Survey, All Grades

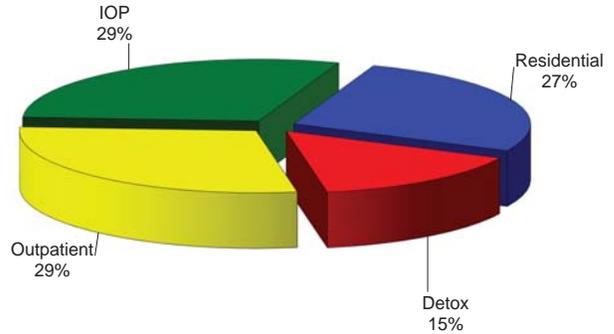


Utah County—Substance Abuse

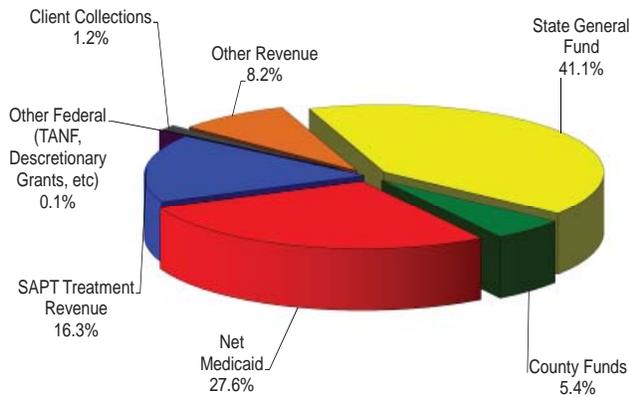
Total Clients Served.....1,040
 Adult971
 Youth.....69
 Penetration Rate (Total population of area)..0.2%

Total Admissions.....1,301
 Initial Admissions997
 Transfers.....304

Admissions into Modalities
 Fiscal Year 2016



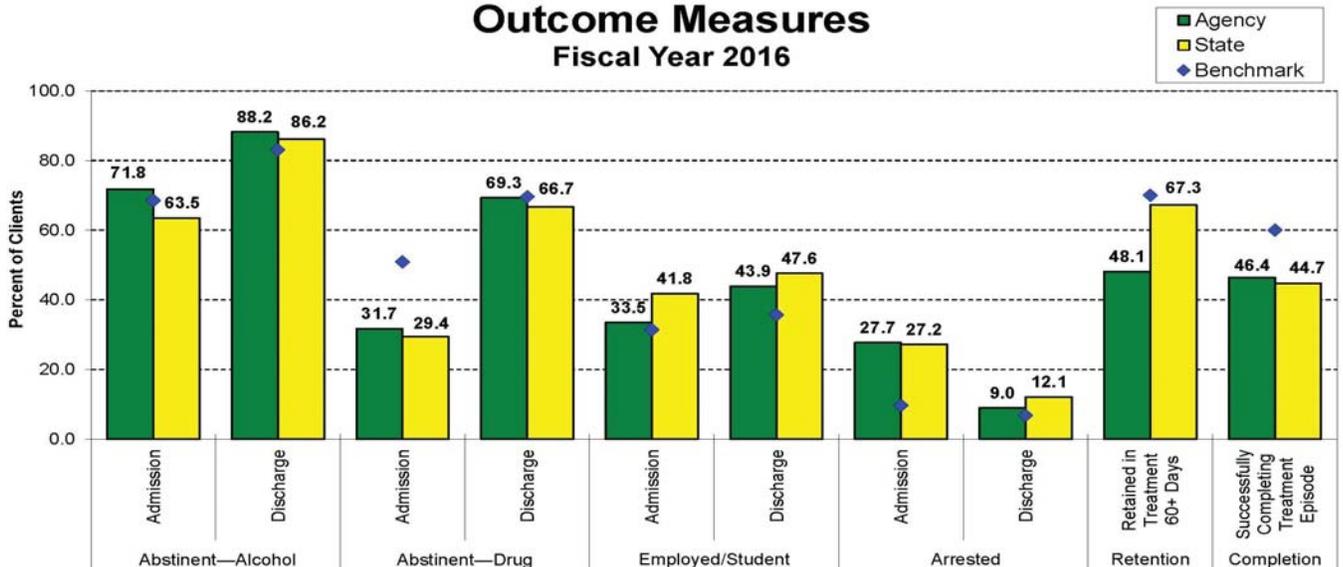
Source of Revenues
 Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	97	67	164
Cocaine/Crack	11	1	12
Marijuana/Hashish	114	67	181
Heroin	203	213	416
Other Opiates/Synthetics	30	27	57
Hallucinogens	3	2	5
Methamphetamine	189	192	381
Other Stimulants	2	0	2
Benzodiazepines	3	2	5
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	22	49	71
Club Drugs	0	0	0
Over-the-Counter	0	2	2
Other	3	2	5
Unknown	0	0	0
Total	677	624	1,301

Outcome Measures
 Fiscal Year 2016



Benchmark is 75% of the National Average.

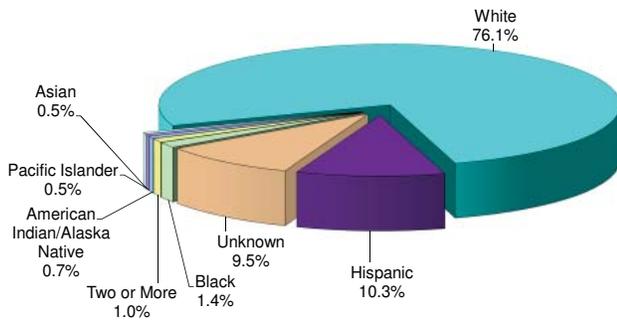
Utah County—Wasatch Mental Health

Total Clients Served10,092
 Adult6,387
 Youth3,705
 Penetration Rate (Total population of area) 1.8%
 Civil Commitment265
 Unfunded Clients Served1,060

Diagnosis

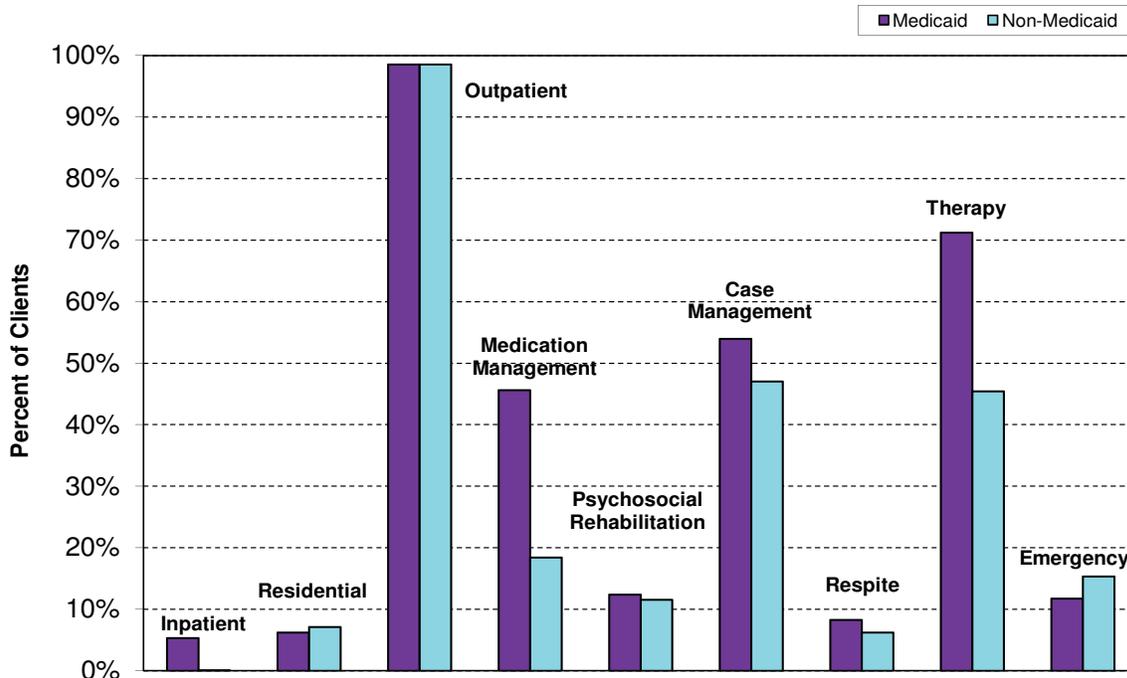
	Youth	Adult
Adjustment Disorders	763	252
Anxiety Disorders	1,634	3,697
Attention Deficit Disorders	890	645
Cognitive Disorders	73	664
Conduct Disorders	374	35
Depressive Disorders	719	2,119
Developmental Disorders	479	250
Dissociative Disorders	8	77
Eating Disorders	15	60
Factitious Disorders	0	0
Impulse Control Disorders	70	161
Learning Disorders	14	11
Mood Disorders	592	1,127
Neglect or Abuse Disorders	635	365
Neurological Disorders	2	7
Other	338	1,399
Personality Disorders	6	975
Pervasive Developmental Disorders	71	33
Physical Health Disorders	2	8
Schizophrenia and Other Psychotic	28	948
Substance Use Disorders	0	96
V Codes	2,069	2,745
	8,782	15,674

Race/Ethnicity Fiscal Year 2016



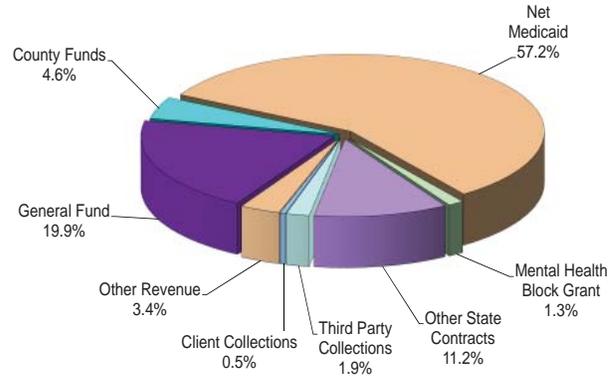
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

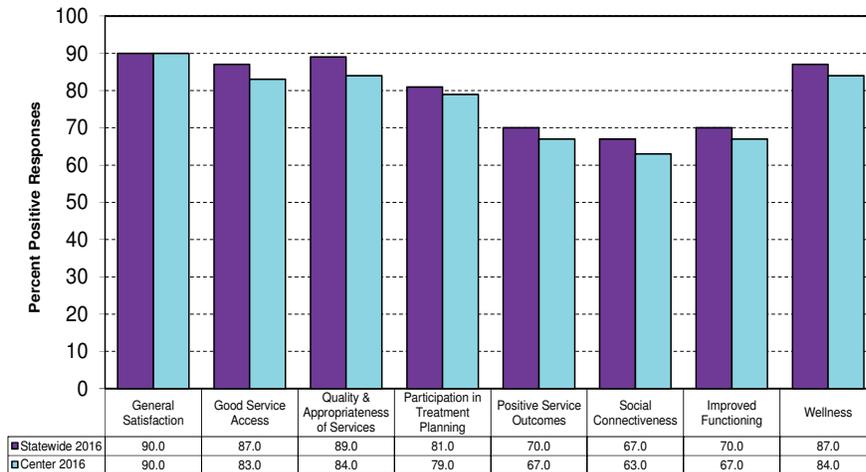


Utah County—Wasatch Mental Health (Continued)

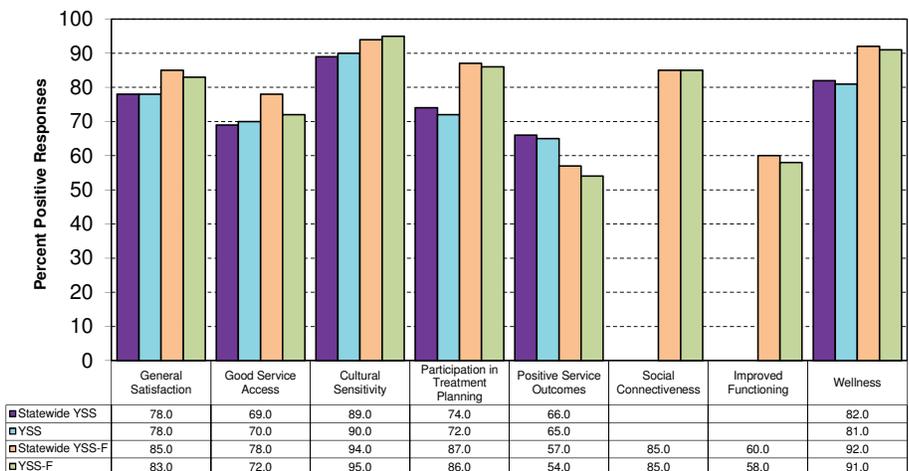
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Wasatch County



Population: 29,161

Wasatch County Family Clinic

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

Wasatch County Substance Abuse—Prevention

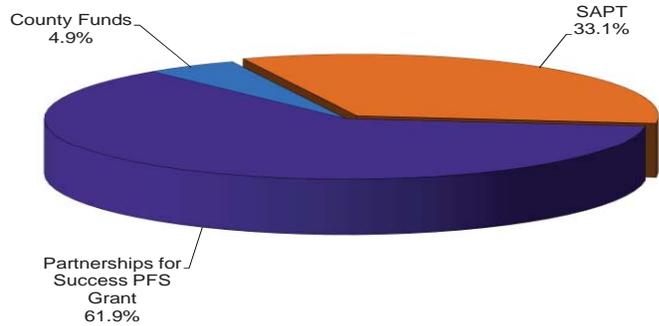
Protective Factors:

- Opportunities for pro-social involvement in community domain

Prioritized Risk Factors:

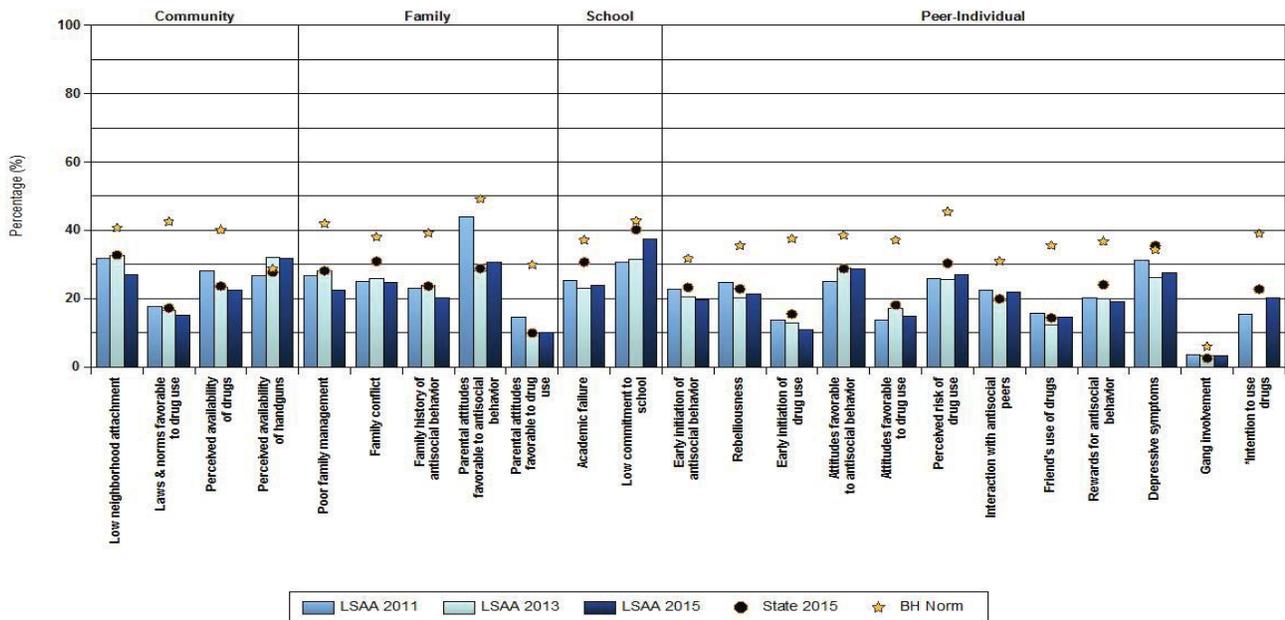
- Attitudes favorable towards drug use
- Low neighborhood attachment

Source of Revenues
Fiscal Year 2016



Risk Profile

2015 Wasatch County LSAA Student Survey, All Grades

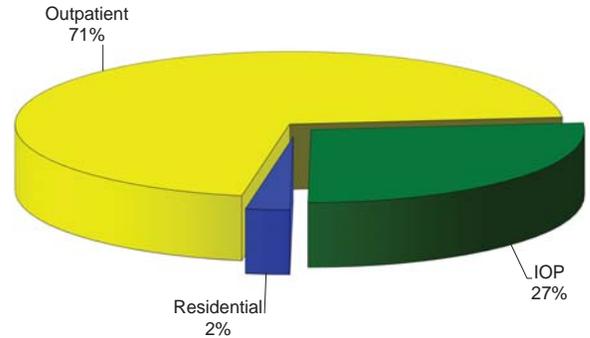


Wasatch County—Substance Abuse

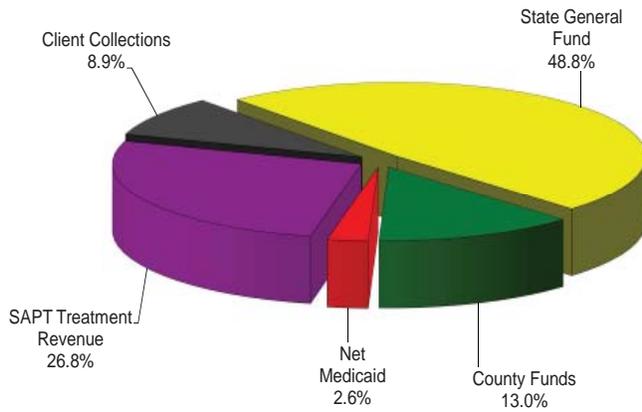
Total Clients Served.....150
 Adult131
 Youth.....19
 Penetration Rate (Total population of area)..0.4%

Total Admissions.....116
 Initial Admissions96
 Transfers.....20

Admissions into Modalities
Fiscal Year 2016



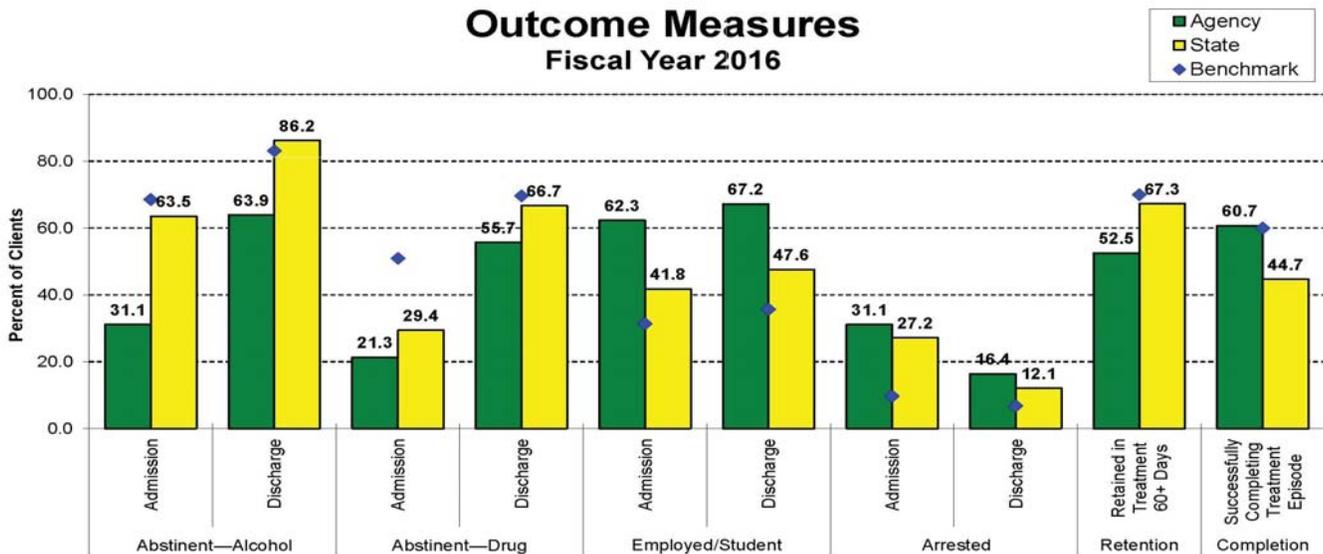
Source of Revenues
Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	30	22	52
Cocaine/Crack	1	2	3
Marijuana/Hashish	21	14	35
Heroin	5	3	8
Other Opiates/Synthetics	1	1	2
Hallucinogens	0	0	0
Methamphetamine	5	7	12
Other Stimulants	0	0	0
Benzodiazepines	1	0	1
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	2	1	3
Club Drugs	0	0	0
Over-the-Counter	0	0	0
Other	0	0	0
Unknown	0	0	0
Total	66	50	116

Outcome Measures
Fiscal Year 2016



Benchmark is 75% of the National Average.

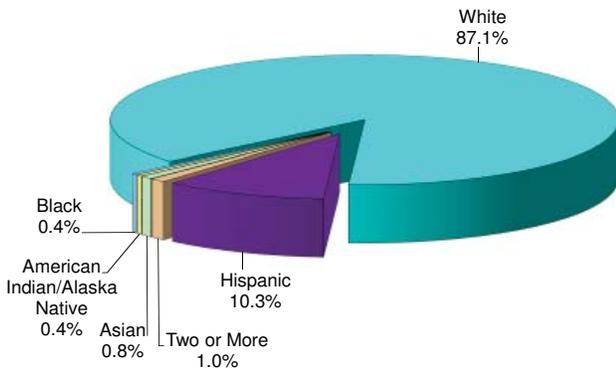
Wasatch County—Mental Health

Total Clients Served.....513
 Adult332
 Youth.....181
 Penetration Rate (Total population of area)..... 1.8%
 Civil Commitment2
 Unfunded Clients Served131

Diagnosis

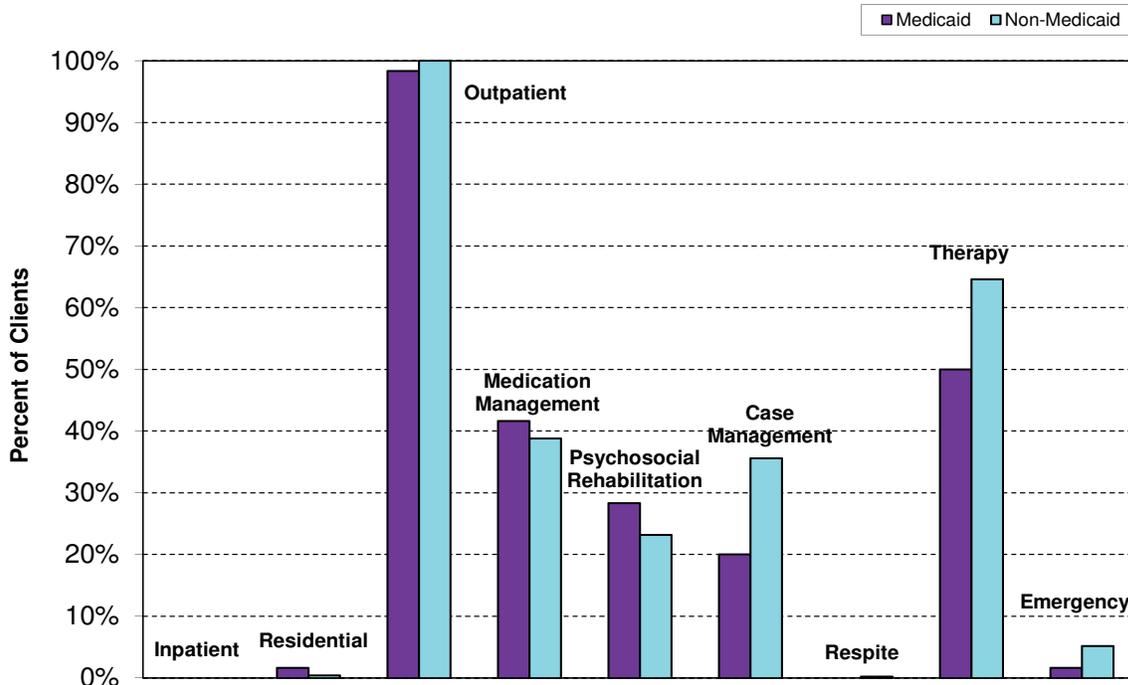
	Youth	Adult
Adjustment Disorders	67	26
Anxiety Disorders	49	144
Attention Deficit Disorders	10	10
Cognitive Disorders	0	3
Conduct Disorders	10	2
Depressive Disorders	35	129
Developmental Disorders	9	2
Dissociative Disorders	0	1
Eating Disorders	3	2
Factitious Disorders	0	0
Impulse Control Disorders	2	5
Learning Disorders	0	0
Mood Disorders	5	52
Neglect or Abuse Disorders	14	3
Neurological Disorders	0	0
Other	9	2
Personality Disorders	0	30
Pervasive Developmental Disorders	0	2
Physical Health Disorders	0	0
Schizophrenia and Other Psychotic	3	37
Substance Use Disorders	19	139
V Codes	97	134
	332	723

Race/Ethnicity Fiscal Year 2016



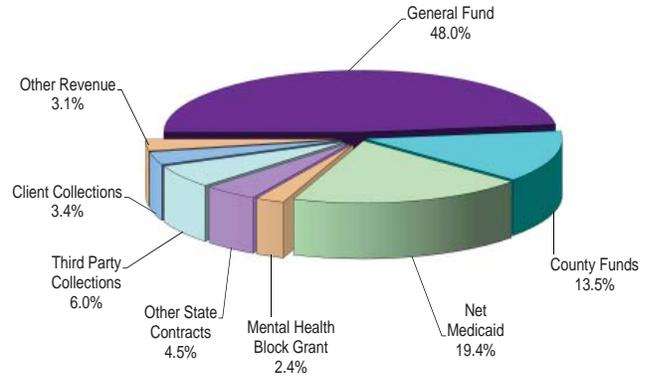
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

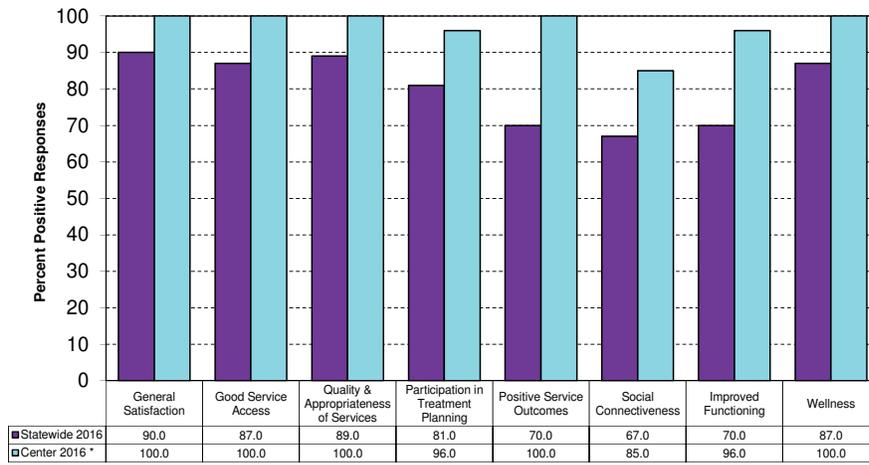


Wasatch County—Mental Health (Continued)

Source of Revenues
Fiscal Year 2016

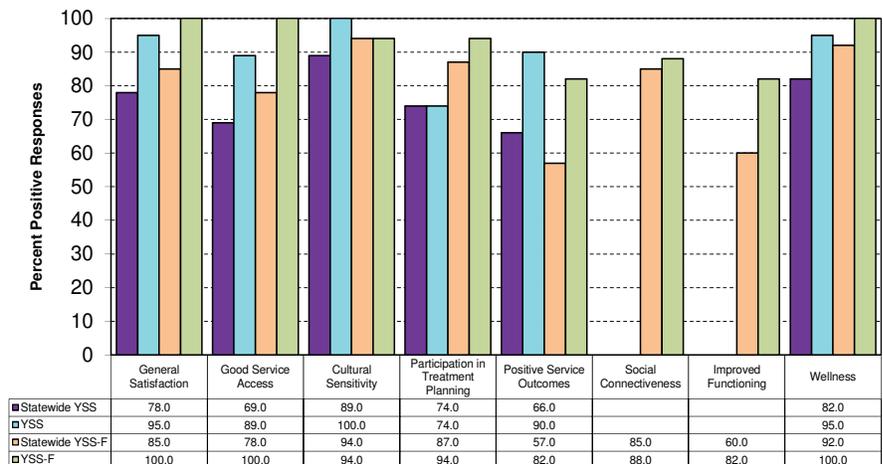


Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



* An insufficient percent of clients were sampled. Utilize with care.

Youth Consumer Satisfaction Surveys
(YSS and YSS-F)
2016



Weber Human Services

Weber and Morgan Counties



Population: 254,710

Weber Human Services

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) 625-3700

www.weberhs.org

Weber Substance Abuse—Prevention

Protective Factors:

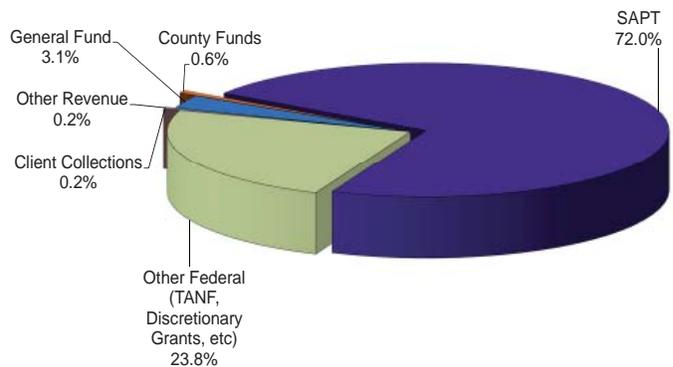
- Rewards for pro-social involvement in family and community domain
- Opportunities for pro-social interaction at school and with peers and in peer/individual domains
- Belief in a moral order, family attachment

Prioritized Risk Factors:

- Parental attitudes favorable to anti-social behavior
- Academic failure, depressive symptoms
- Low commitment to school
- Early initiation of anti-social behavior

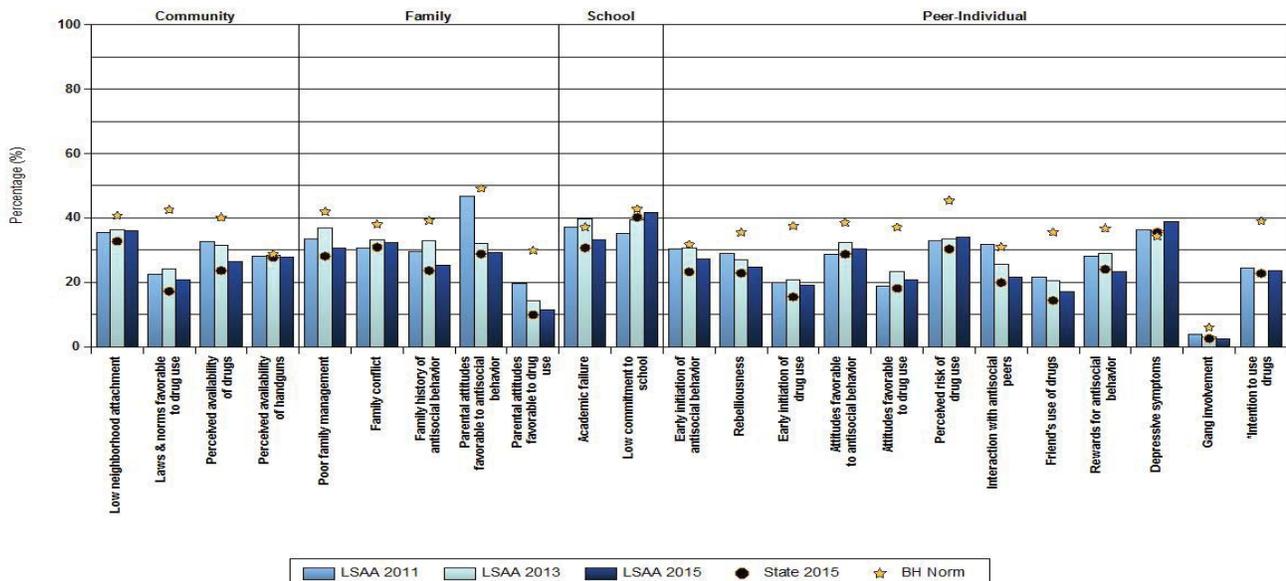
Source of Revenues

Fiscal Year 2016



Risk Profile

2015 Weber And Morgan Counties LSAA Student Survey, All Grades

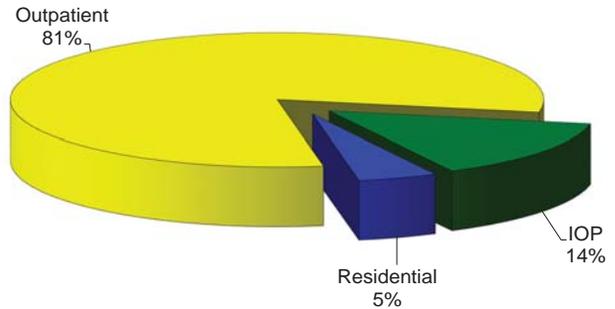


Weber Human Services—Substance Abuse

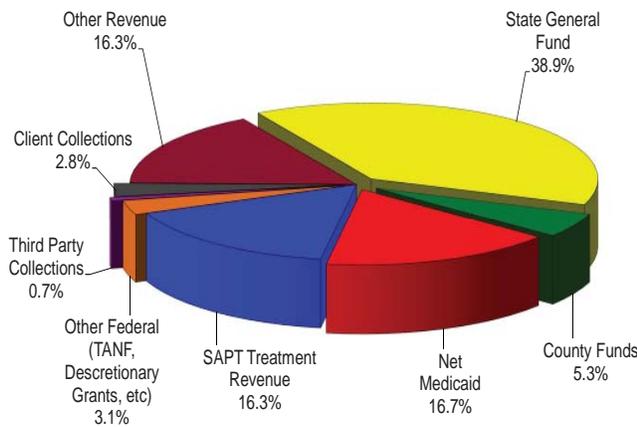
Total Clients Served1,703
 Adult1,460
 Youth243
 Penetration Rate (Total population of area)..0.6%

Total Admissions.....1,372
 Initial Admissions1,124
 Transfers.....248

Admission into Modalities Fiscal Year 2016



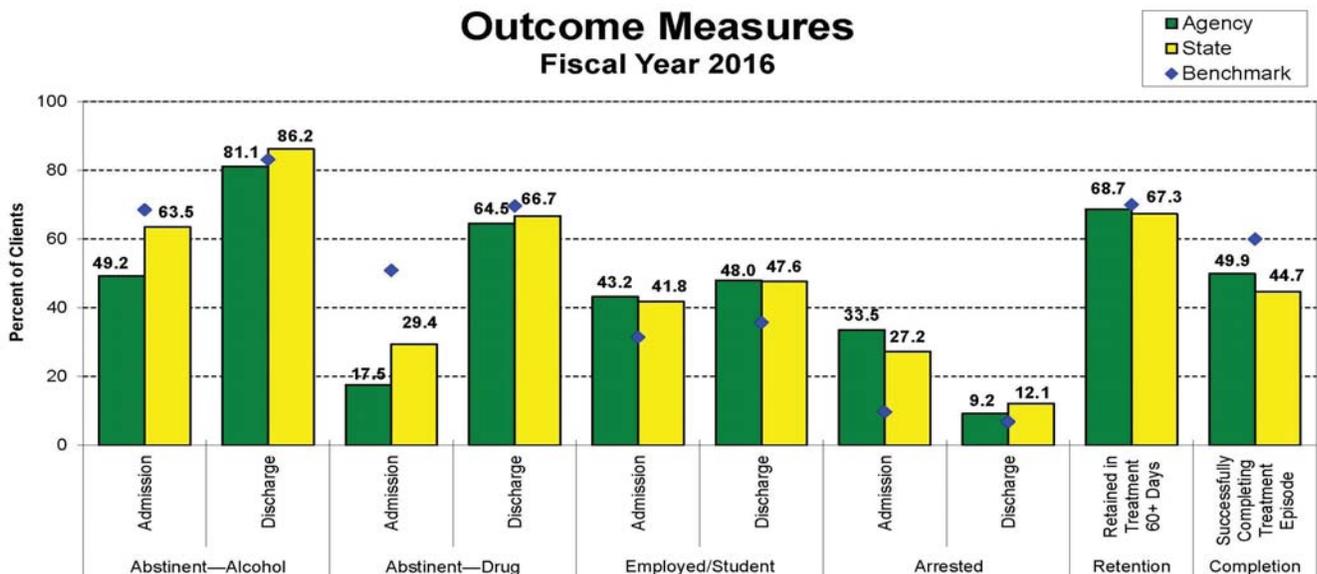
Source of Revenues Fiscal Year 2016



Primary Substance of Abuse at Admission

	Male	Female	Total
Alcohol	305	222	527
Cocaine/Crack	19	17	36
Marijuana/Hashish	236	110	346
Heroin	48	67	115
Other Opiates/Synthetics	11	4	15
Hallucinogens	0	0	0
Methamphetamine	92	182	274
Other Stimulants	3	5	8
Benzodiazepines	7	5	12
Tranquilizers/Sedatives	0	0	0
Inhalants	0	0	0
Oxycodone	13	19	32
Club Drugs	0	1	1
Over-the-Counter	0	1	1
Other	2	3	5
Unknown	0	0	0
Total	736	636	1,372

Outcome Measures Fiscal Year 2016



Benchmark is 75% of the National Average.

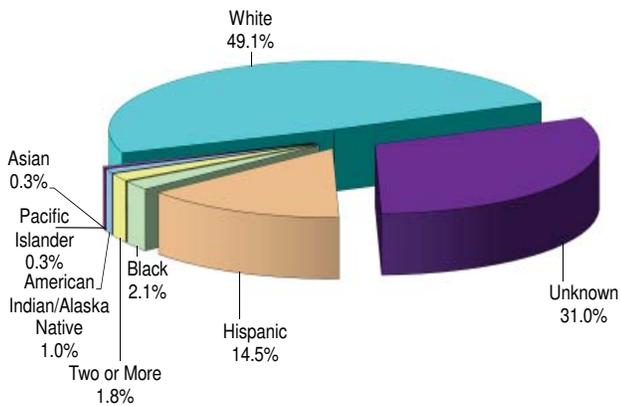
Weber Human Services—Mental Health

Total Clients Served.....6,116
 Adult4,343
 Youth.....1,773
 Penetration Rate (Total population of area)..... 2.4%
 Civil Commitment242
 Unfunded Clients Served901

Diagnosis

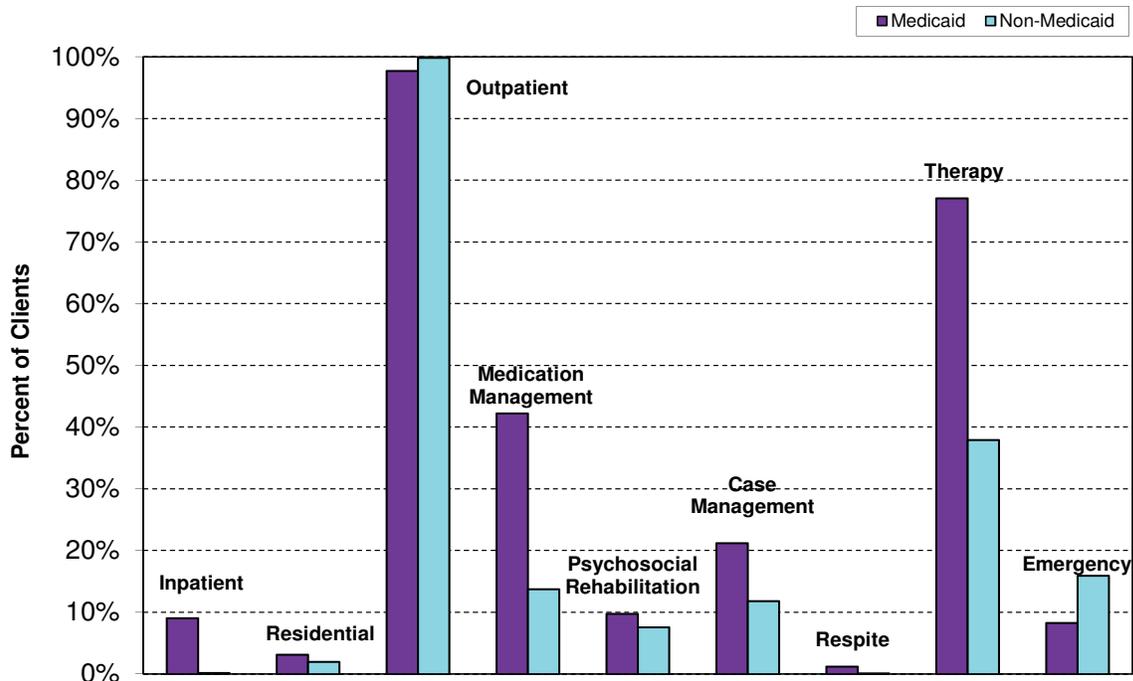
	Youth	Adult
Adjustment Disorders	221	91
Anxiety Disorders	662	1,506
Attention Deficit Disorders	538	93
Cognitive Disorders	23	172
Conduct Disorders	372	13
Depressive Disorders	295	962
Developmental Disorders	146	48
Dissociative Disorders	1	12
Eating Disorders	5	14
Factitious Disorders	0	0
Impulse Control Disorders	41	53
Learning Disorders	4	1
Mood Disorders	317	744
Neglect or Abuse Disorders	141	126
Neurological Disorders	0	2
Other	193	2,501
Personality Disorders	6	671
Pervasive Developmental Disorders	36	11
Physical Health Disorders	0	0
Schizophrenia and Other Psychotic	50	622
Substance Use Disorders	59	813
V Codes	771	851
	3,881	9,306

Race/Ethnicity Fiscal Year 2016



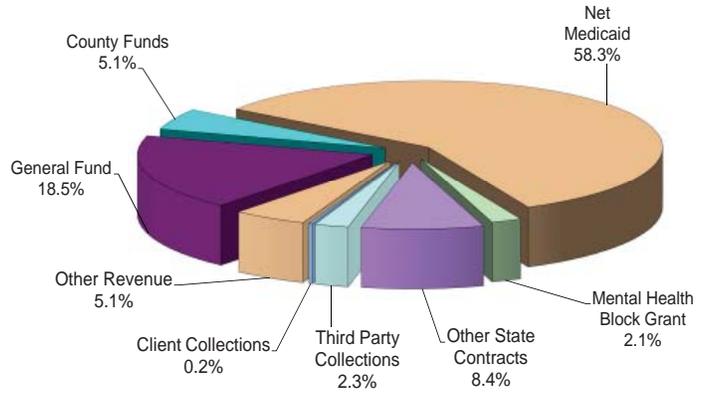
More than one race/ethnicity may have been selected.

Utilization of Mandated Services Fiscal Year 2016

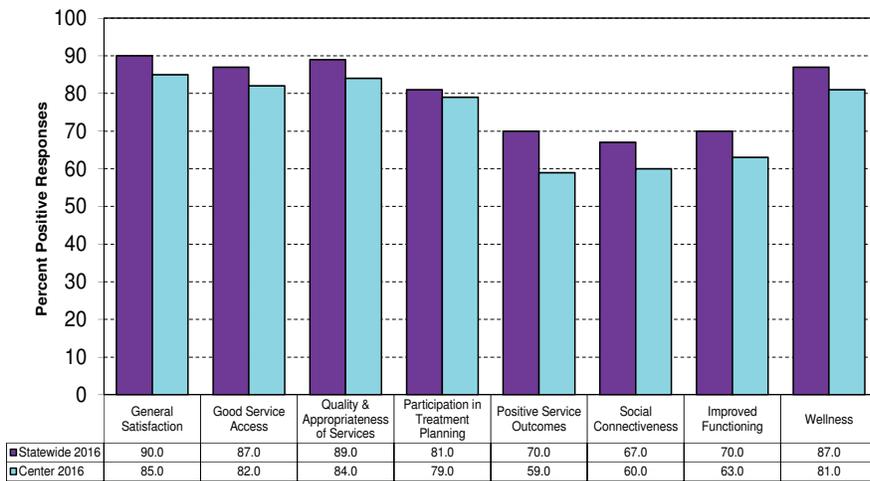


Weber Human Services—Mental Health (Continued)

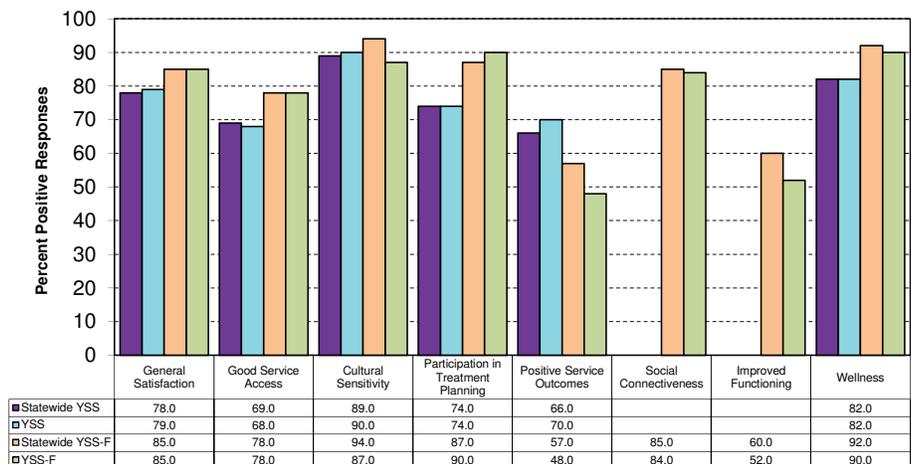
Source of Revenues
Fiscal Year 2016



Adult Consumer Satisfaction Survey Mental Health
Statistics Improvement Program (MHSIP)
2016



Youth Consumer Satisfaction Surveys (YSS and YSS-F)
2016



Shanin's Story

I started using when I was 14. Did you know that drinking alcohol very rapidly can stop your heart? That's exactly what happened to me at a brand new high school. Thanks to a quick-thinking school counselor and a teacher, I was given CPR and was revived. I had a difficult and abusive childhood and occasional experimentation with drugs in my teen years seemed to help me to escape my trauma. Later, working in a bar exposed me to other drugs, and when I was introduced to freebase or crack cocaine, I was instantly addicted.

Just like the Big Book says, I tried to move away from my addiction when it started getting unmanageable. I packed up all my belongings and moved out of state, only to find my drug problem intensified once I arrived there. My kids were separated from me and went to stay with family members that could keep them safe. As my health deteriorated, I became increasingly desperate for treatment, so I fought my way back to Salt Lake to be close to my family and get the help I needed. I worked through the traumatic experiences of my life and learned to forgive myself and others.

I worked very hard to put my life back together, and make things right with my children. I remember feeling like my recovery from addiction was like being reborn. I had a second chance at truly living. I went to school to become a drug counselor and to help others along the way find their own reasons for living. I immediately got active in the recovery community and I haven't stopped since. I have worked in many different capacities, but my most favorite is with the KOPPIR organization, a family recovery movement. I have been in recovery for 16 years.

I have amazing relationships with my children today. We talk openly about everything under the sun, including addiction. My life is meaningful and rewarding. I love my job, I give back to the community, and I am an active participant in my own life. I am so thankful for the opportunity to wake up, to embrace recovery, and to live consciously.



RESOURCES

List of Abbreviations

ACA—Affordable Care Act	MHSIP—Mental Health Statistical Improvement Program
ATR—Access to Recovery	NAMI—National Alliance on Mental Illness
ASAM—American Society of Addiction Medicine	NASMHPD—National Association of State Mental Health Program Directors
BPRS—Brief Psychiatric Rating Scale	OTP—Outpatient Treatment Program
CABHI-UT—Cooperative Agreement to Benefit Homeless Individuals-Utah	PASRR—Pre-Admission Screening and Residential Review
CCEBP—Community-Centered Evidence-based Prevention	PD—Prevention Dimensions
CTC—Communities that Care	SAMHSA—Substance Abuse and Mental Health Services Administration (Federal)
DORA—Drug Offender Reform Act	SAPT—Substance Abuse Prevention and Treatment Block Grant
DSAMH—Division of Substance Abuse and Mental Health	SED—Serious Emotional Disturbance
DUI—Driving Under the Influence	SHARP—Student Health and Risk Prevention
IOP—Intensive Outpatient Program	SMI—Serious Mental Illness
IV—Intravenous	SPF—Strategic Prevention Framework
JRI—Justice Reinvestment Initiative	SPMI—Serious and Persistent Mental Illness
LMHA—Local Mental Health Authorities	TEDS—Treatment Episode Data Set
LOS—Length of Stay	USH—Utah State Hospital
LSAA—Local Substance Abuse Authorities	

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 2016			
Local Mental Health Authority	Medicaid	Non-Medicaid	Both Medicaid and Non-Medicaid
Bear River	2,110	819	454
Central	83	482	642
Four Corners	728	531	99
Northeastern	7	2,322	171
San Juan County	5	538	61
Southwest	2,648	614	112
Summit County	47	447	111
Tooele County	306	680	440
Wasatch County	13	453	47
Davis County	2,807	1,982	462
Salt Lake County	10,064	4,152	2,578
Utah County	5,544	2,726	851
Weber	3,290	1,223	318
Rural Total	5,947	6,886	2,137
Urban Total	21,705	10,083	4,209
State Total	27,652	16,969	6,346

Contact Information

Single State Substance Use Authority and Mental Health Commissioner

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 Superintendent

Dallas Earnshaw,
Utah State Hospital
1300 East Center Street
Provo, Utah 84606
Office: (801) 344-4400
Fax: (801) 344-4291
www.us.h.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) 792-6500
www.brhd.org

Mental Health Provider Agency:

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

Davis Behavioral Health

County: Davis

Substance Abuse and Mental Health Provider Agency:

Brandon Hatch, CEO/Director
Davis Behavioral Health
934 S. Main
Layton, UT 84041
Office: (801) 773-7060
www.dbhutah.org

Central Utah Counseling

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 84627
Office: (435) 283-8400
www.cucc.us

Four Corners Community Behavioral Health

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 Counseling Center

Counties: Daggett, Duchesne, and Uintah

Substance Abuse and Mental Health Provider

Agency:

Kyle Snow, Director
Northeastern Counseling Center
1140 West 500 South #9
Vernal, UT 84078
Office: (435) 789-6300
Fax: (435) 789-6325
www.nccutah.org

Salt Lake County Behavioral Health Services

County: Salt Lake

Substance Abuse and Mental Health

Administrative Agency:

Tim Whalen, Director
Salt Lake County
Division of Behavioral Health Services
2001 South State Street #S2300
Salt Lake City, UT 84190-2250
Office: (385) 468-4707
behavioralhealthservices.slco.org

San Juan Counseling Center

County: San Juan

Substance Abuse and Mental Health Provider

Agency:

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

Southwest Behavioral Health Center

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.sbhc.us

Valley Behavioral Health

County: Summit

Substance Abuse and Mental Health Provider

Agency:

Gary Larcenaire, CEO/President
Christy Calderon, COO
Dodi Wilson, Program Manager
Valley Behavioral Health, Summit County
1753 Sidewinder Drive
Park City, UT 84060-7322
Office: (435) 649-8347
Fax: (435) 649-2157
www.valleycares.com

Valley Behavioral Health

County: Tooele

Substance Abuse and Mental Health Provider

Agency:

Gary Larcenaire, CEO/President
Christy Calderon, COO
Rebecca Brown, Program Manager
Randy Dow, Program Manager
Valley Behavioral Health, Tooele County
100 South 1000 West
Tooele, UT 84074
Office: (435) 843-3520
www.valleycares.com

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 84606
 Office: (801) 851-7127
www.utahcountyonline.gov

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

Weber Human Services

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) 625-3700
www.weberhs.org

Wasatch County Family Clinic

County: Wasatch

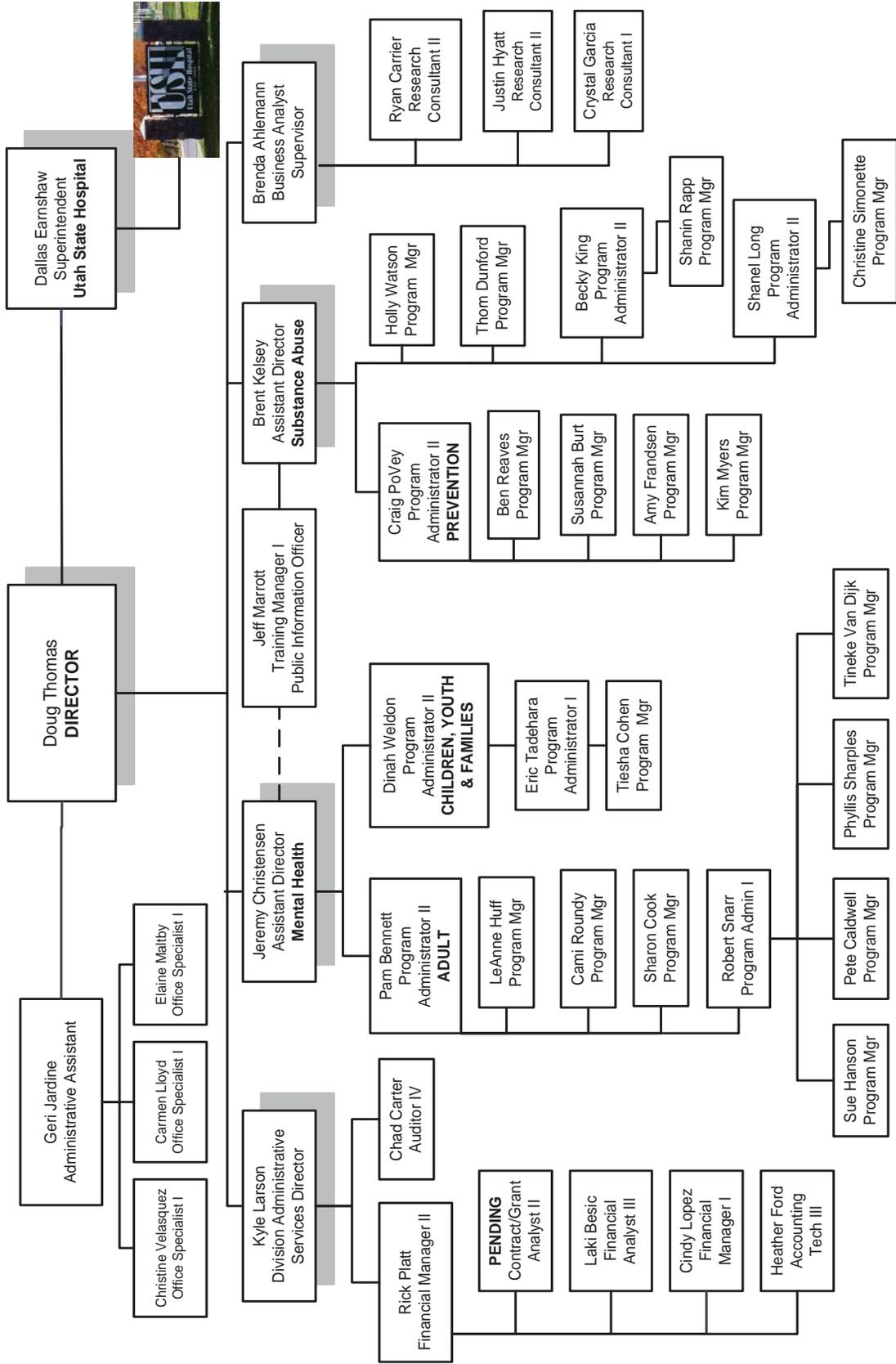
Substance Abuse and Mental Health Provider***Agency:***

Richard Hatch, Director
 Wasatch County Family Clinic
 55 South 500 East
 Heber, UT 84032
 Office: (435) 654-3003
www.wasatch.org

Local Authorities/Local Providers**Utah Association of Counties**

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

Utah Division of Substance Abuse and Mental Health



November 21, 2016

Substance Use Disorder and Mental Health Charts

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utah department of
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