Update to the Utah Behavioral Health Master Plan

Introduction

As required in statute (26B-5-703), the Utah Behavioral Health Commission (Commission) has updated the Utah Behavioral Health Master Plan. This updated version of the Master Plan includes:

- A review of Utah behavioral health data;
- A five-year behavioral health strategic plan for the State of Utah; and
- Legislative priorities for the 2026 General Session.

The strategic plan addresses high-priority behavioral health issues where there are especially acute needs or gaps in services. The plan is not a comprehensive summary of all necessary services in Utah's behavioral health system, but rather, acts as a guide for where Utah should focus efforts to change and improve the current system.

The Commission will update the strategic plan on an annual basis. Some tactics have not yet been developed and have been assigned to the Commission's committees. These tactics will be added to the plan as they are developed.

The Commission's strategic plan is data driven. The Commission will regularly assess the need for, and impact of, each of its objectives and tactics. These items may change over time as data continuously informs the Commission's strategic plan.

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Terminology

The Commission is using the Results-Based Accountability approach to strategic planning, which uses the following terminology:

Result: Condition of well-being for entire populations — children, adults, families or communities, stated in plain language.

Population indicators: Measures that help quantify the achievement of a population result. They answer the question "What data would tell us whether we achieved our desired result?"

Strategies: Broad categories of intervention that guide our focus and organize objectives and tactics.

Objectives: How we state specific things we want to achieve based on the stated strategies. Objectives are sometimes referred to as goals, milestones, or deliverables.

Tactics: Each objective will include tactics which describe the key steps or activities to be taken to accomplish the objective. These describe HOW we will achieve our stated objectives and can include engaging stakeholders, funding, developing resources, etc.

Performance measures: Data points that tell us whether the work we are doing is influencing our indicators and working towards our result.

Outputs: Tangible deliverables or tasks completed; used when performance measures are not yet available for measuring certain tactics.

Cross-cutting principles: General values that are integrated throughout the strategies, objectives, and tactics.

Review of Utah behavioral health data

The *2024 Utah Behavioral Health Assessment & Master Plan* provided an assessment of Utah's behavioral health systems to consider needs, gaps, and challenges. The Master Plan found that five system-level issues are creating and exacerbating challenges in our systems:

1) A lack of system-level coordination and unified approach to behavioral health.
2) Administrative burdens placed on behavioral health providers.
3) Siloed approaches among uncoordinated behavioral health administrative and service delivery systems.
4) Behavioral health workforce shortages.
5) A lack of long-term sustainable funding for behavioral health services.

The Behavioral Health Commission has developed this update to the Utah Behavioral Health Master Plan based on the initial findings in the 2024 Master Plan, a review of behavioral health data in Utah, and feedback from behavioral health stakeholders, including two public listening sessions. The following section briefly describes notable data findings that impacted the development of the strategic plan. Figures can be found in **Appendix C**.

Substance use disorder (SUD) and drug poisoning deaths

Utah has the lowest substance use disorder (SUD) rate in the nation; however, more than one in eight adult Utahns are estimated to have an SUD. Youth need for alcohol and drug treatment is low and has decreased since 2015. Drug poisoning deaths from fentanyl and methamphetamines have increased over the past ten years.

- The Utah adult substance use disorder (SUD) rate (14%) is the lowest in the nation (18%, Figs. 1, 2).
- Methamphetamine, alcohol, and opioids are the top primary substances of adults entering treatment in the county system in Utah (Fig. 5).
- The rate of Utah drug deaths has decreased slightly from its peak in 2015. During this time the U.S. rate of drug deaths increased significantly (Fig.16).
- Fentanyl and methamphetamine are the substances most commonly found in drug poisoning deaths. The percentages of deaths involving fentanyl and methamphetamines have increased since 2015, while the percentages involving prescription opioids and heroin have decreased (Fig. 18).
- More men die from drug poisoning than women in all age ranges. The highest rate of drug poisonings for men was in the 35-44 age range; for women, it was the 45-54 range (Fig. 21).
- Utah youth need for alcohol or drug treatment is low (2.7%) and has decreased from 4.1% in 2015 (Fig. 42).
- Youth identifying as LGBTQ+ were more likely to need alcohol or drug treatment than youth not identifying as non-LGBTQ+ (Figs. 43, 45).
- Youth from Pacific Islander, Hispanic, and multi-racial backgrounds had a higher need for substance use treatment than American Indian, White, Asian, and Black youth. Youth from Pacific Islander backgrounds showed an increase in need for substance use treatment from 2021 to 2023, while all other race and ethnicity backgrounds showed a decrease (Fig. 46).

Mental illness and suicide deaths

Utah has high rates of mental illness and suicide deaths compared to other states, and these rates have been increasing among both adults and youth.

- The Utah rate of adults with any mental illness (AMI, 30%) is among the highest in the nation (23%), and this rate has been increasing (Figs. 7, 8).

- The Utah rate of adults with serious mental illness (SMI, 9%) is the highest in the nation (6%, Figs. 9, 10).
- The Utah rate of youth with high need for mental health treatment (25%) has been increasing. The rate of Utah youth who have seriously considered suicide in the past year (18%) has also been increasing (Fig. 42).
- The Utah rate of adults with serious thoughts of suicide (8%) is the highest in the nation (5%, Fig. 24).
- The Utah rate of suicide deaths is higher than the national average for both men and women. Utah is among the six states with the highest suicide rates (Figs. 22, 23).
- In all age ranges in Utah, men are significantly more likely to die by suicide than women. The highest rates of suicide are in the age range of 35-54 for both men and women (Figs. 22, 28).
- Youth identifying as LGBTQ+ were more likely to have a high need for mental health treatment than youth not identifying as LGBTQ+. Suicidal ideation was particularly high among this population (61% for youth identifying as transgender; 51% for youth identifying as gay or lesbian, Figs. 47, 49, 51, 53).
- Youth from white backgrounds had lower needs for mental health treatment compared to all other racial and ethnic backgrounds (Fig. 50).
- Youth from Black or white backgrounds had the lowest rate of suicidal ideation in 2023. Pacific Islander youth had an increase in suicidal ideation between 2015 and 2023 (Fig. 54).

Behavioral health crisis response

Utah behavioral crisis workers have reported barriers to effective crisis response. These include facilities refusing to take patients, transportation difficulties, disagreement among agencies, stigma, and lack of awareness of crisis services.

- Behavioral health crisis workers reported that facilities sometimes refuse their patients, with the most common reasons being lack of beds, patient aggression, lack of staff or services, and insurance issues (Fig. 32).
- Behavioral health crisis workers reported difficulties in transporting patients, with the most common reason being patient or family reluctance to involve law enforcement. Other reasons were related to confusion or disagreement among responders about regulations around transporting (Fig. 33).
- Other barriers to effective behavioral health crisis care included disagreement among agencies about patient needs, lack of follow-up care for crisis patients, siloing of mental and physical health services, crisis worker availability, and law enforcement availability (Fig. 34).
- The majority of crisis workers reported that stigma is a barrier to engagement with crisis services (87%), along with lack of understanding of eligibility for services (84%), and lack of awareness of 988 and other crisis services (68%, Fig. 35).

Treatment

Many individuals struggle to access mental health treatment because of cost and navigation challenges. Nearly one in five youth think it is not okay to receive help for mental health, and this trend has not improved in recent years. Only a small percentage of Utah adults who need substance use disorder (SUD) treatment actually receive it. However, Utah generally has higher rates of SUD treatment than other states.

- The Utah rate of adults receiving mental health treatment (28%) is higher than the national average (22%, Fig. 29). Data are not currently available on the percentage of Utah adults with a mental illness who received mental health treatment.

- Cost of treatment is a concern for Utah adults with unmet mental health treatment needs, with 47% indicating they thought it would cost too much, and 34% indicating that health insurance would not pay enough of the cost (Fig. 31).
- Accessing treatment is an issue, with 41% of adults with unmet mental health treatment needs indicating they did not know how or where to get treatment, 32% indicating they could not find a program or professional they wanted to go to, and 12% indicating there were no openings where they wanted to go (Fig. 31).
- Stigma around behavioral health help-seeking is an issue in Utah.
    - 18% of youth in grades 6-12 think it is not okay to seek help for mental health. Students with high risk and students of color are even more likely to hold this belief (Figs. 40, 41).
    - 20% of adults reporting unmet mental health needs indicated they worried about what people would say about them if they got treatment; 23% worried they would be told they needed medication, 17% worried their information would not be kept private, 11% thought their family, friends, or religious group would not approve, and 9% worried seeking treatment would lead to negative consequences such as losing their job, home, or children (Fig. 31).
- The Utah rate of adults who *needed*, *but did not receive*, substance use treatment (71%) is among the lowest in the nation (77%, Fig. 30).
- Measures of behavioral and physical health parity in Utah indicate that behavioral health patients are more likely to use out-of-network providers. Out-of-network care can create a significant financial burden for patients.
- Reimbursement rates for behavioral health services are lower than rates for physical health providers relative to Medicare rates. (Figs. 38, 39). These lower rates may disincentivize behavioral health providers from participating on commercial insurance panels.

Strategic plan

Result

All children, adults, families, and communities in Utah have the opportunity to experience quality behavioral health and well-being.

Population indicators

- Prevalence of substance use disorder in adults
- Prevalence of any mental illness in adults
- Youth need for behavioral health treatment[1]
- Number and rate of deaths due to drug overdose
- Number and rate of deaths due to suicide
- Rate of 9th - 12th graders who indicate three positive childhood experiences

Cross-cutting principles

1. Advance a state in which everyone has a fair opportunity to attain their highest level of health.
2. Use data to prioritize efforts, evaluate their impact, and identify populations with the greatest needs.
3. Partner with people in recovery and their families, friends, and communities to foster health and resilience.
4. Use evidence-based interventions.
5. Ensure that programs are fiscally sustainable and affordable.
6. Integrate physical and behavioral health.
7. Promote resilience and emotional health for children, youth, and families.

[1] Although adult prevalence of any mental illness and youth need for behavioral health treatment are similar in that they both provide an estimate of need within the population, the two indicators are conceptually different and are estimated with different methods. Utah does not have a measure of prevalence of any mental illness or substance use disorder for youth.

Strategies

1. Strengthen behavioral health prevention and early intervention.
2. Continue to develop a comprehensive and integrated crisis response system.
3. Improve access to high-quality behavioral health treatment services.
4. Expand effective recovery services.

Pages 6 - 14 detail the specific objectives, tactics, performance measures, and outputs that address the gaps identified and support the four strategies.

Appendix A provides definitions for relevant terminology used throughout the strategic plan. **Appendix B** describes the responsible units described under each objective. **Appendix C** includes additional detail on behavioral health data, including time trends, subgroup trends, and national comparisons when available.

Strategy 1: Strengthen behavioral health prevention and early intervention

Objective 1: Ensure all Utah children grow up with a strong foundation of good behavioral health			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Identify 1-2 tactics to address risk and protective factors for youth mental health.	Prevention and Early Intervention Committee; Youth Behavioral Health Workgroup	December 31, 2025	**31%**: 9th - 12th graders reported three positive childhood experiences (2023). **25%:** Youth need for mental health treatment (2023). **2.7%:** Youth need for substance use disorder treatment (2023). **18%:** Youth who seriously considered suicide in the past year (2023).
2. Request recommendations from the Early Childhood Mental Health Working Groups on priorities for preventing youth behavioral health challenges.	Early Childhood Mental Health Working Group	December 31, 2025	To be identified by the responsible unit.

Objective 2: Expand coordination between education and behavioral health systems			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Create a school-based mental health workgroup to develop a framework for school-based mental health services.	Office of Substance Use and Mental Health; State Board of Education; Center for School-Based Health and Wellbeing Partnerships	December 31, 2025	To be determined by the responsible unit.

Objective 3: Expand early intervention models for behavioral health conditions			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**

1. Collaborate with private sector stakeholders to identify opportunities and barriers to the implementation of a private sector reimbursement model for first episode of psychosis coordinated specialty care.	Treatment and Recovery Committee	July 1, 2026	To be identified through Tactic 1:
			• Overview of the current private sector approach to providing coordinated specialty care.
			• Summary of implementation barriers for providing coordinated specialty care.
			• Recommendations for next steps in expanding access to coordinated specialty care.
			• Update data on clients based on findings:
			  ○ Number of Clinical High Risk of Psychosis individuals served: 55 (FY2024).
			  ○ Number of First Episode of Psychosis clients served: 42 (FY2024).
			  ○ Number of unserved First Episode Psychosis patients per year: 525 - 1,050 (FY2024).

2. Identify tactics for improving care coordination and transitions of care in behavioral health pediatric settings.	Treatment and Recovery Committee	July 1, 2026	To be identified by responsible unit.

Objective 4: Support prevention and early intervention activities that reduce suicide deaths and attempts			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
To be developed by the responsible unit.	Suicide Prevention Committee and Coalition	December 31, 2025	Rate of deaths due to suicide per 100,000 (2023): • Males: 32. • Females: 9. Adult serious suicidal ideation (2023): 7%.

Strategy 2: Continue to develop a comprehensive and integrated crisis response system

Objective 1: Expand crisis services to address identified need			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
To be developed by the responsible unit.	Behavioral Health Crisis Response Committee	December 31, 2025	To be determined by the responsible unit.

Objective 2: Evaluate the sustainability of crisis services through private and public partnerships			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Collaborate with the private sector to identify models that will improve the sustainability of crisis services.	Behavioral Health Crisis Response Committee	July 1, 2026	To be determined through implementation of Tactic 1: • Description of current funding of crisis services. • Number of receiving centers and current funding sources. • Number of MCOTs and current funding sources. • 988 call center funding sources.

Objective 3: Improve the effectiveness of crisis services			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Evaluate the effectiveness of current crisis services in the public and private sector.	Office of Substance Use and Mental Health; Behavioral Health Crisis Response Committee	July 1, 2026	The responsible unit will evaluate data on 988 crisis centers, mobile crisis outreach teams, and receiving centers. The following metrics are already available: ● Time to intervention: ○ 988 call answer times ○ Mobile dispatch times. ● Readmission rates at receiving centers. ● Number of individuals who stabilized in the community or a receiving center vs. inpatient hospitalization. ● Diversion rates. ● Event disposition. The responsible unit will explore options to collect the following metrics: ● Percentage of help-seekers who receive appropriate care. ● Time to receive appropriate care. ● Patient satisfaction scores. ● Symptom reduction during 988 calls. ● Percentage of people seeking care who are turned away.

Objective 4: Improve alignment and coordination between emergency departments, crisis services, treatment services, and law enforcement			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Develop an electronic system to create and track temporary civil commitment sheets.	Office of Substance Use and Mental Health	July 1, 2026	To be determined by the responsible unit.
2. Identify regions of Utah that need to improve alignment and coordination.	Behavioral Health Crisis Response Committee	July 1, 2027	To be determined by the responsible unit.
3. Explore barriers to implementing best practices in law enforcement crisis intervention training.	Behavioral Health Crisis Response Committee	July 1, 2028	To be identified through Tactic 3: • Percentage of law enforcement agencies that are implementing law enforcement crisis intervention training according to best practices. • List of barriers to implementation.

Strategy 3: Improve access to high-quality behavioral health treatment services

Objective 1: Improve alignment and coordination within and across the public and private behavioral health systems to reduce gaps in services			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Identify potential changes to the state's and counties' behavioral health responsibilities to be more patient-centered and ensure access.	Office of Substance Use and Mental Health	December 31, 2025	To be developed by responsible unit.
2. Collaborate with the Insurance Department to analyze options to monitor and improve the adequacy and accuracy of commercial health insurance networks.	Office of Substance Use and Mental Health; Insurance Department	July 1, 2026	To be developed through collaboration with the Insurance Department.
3. Organize a convening with employers and private health insurance companies to understand the barriers the private sector faces in improving behavioral health care in Utah.	Utah Behavioral Health Commission	July 1, 2026	Report that synthesizes the barriers that the private sector faces in improving behavioral health care.
4. Review study funded by HB365 on mental health therapy wait times for children and develop tactics as necessary.	Office of Substance Use and Mental Health	December 31, 2027	To be identified through study in Tactic 4: • Wait times for pediatric mental health care appointments. • Factors impacting wait times.
5. Evaluate access to day treatment, intensive outpatient, and residential treatment services for individuals in the public and private sector.	Treatment and Recovery Committee	July 1, 2028	To be identified through Tactic 5: • Methodology for evaluating access to services. • Estimate of unmet need for accessing services.

6. Request recommendations from the Governor's workgroup to enhance behavioral health infrastructure.	Governor's workgroup to enhance behavioral health infrastructure	July 1, 2026	• Number of inpatient behavioral health beds for patients with serious mental illness. • Other metrics to be identified by responsible unit.

Objective 2: Improve the quality of behavioral health treatment services			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Develop a detailed behavioral health dashboard that measures diagnosis, use of care, and cost of care across commercial insurance and Medicaid patients.	Office of Substance Use and Mental Health	July 1, 2026	To be identified through Tactic 1.
2. Assess available data on access to medications for opioid use disorder.	Office of Substance Use and Mental Health; Treatment and Recovery Committee	July 1, 2026	To be identified through Tactic 1: • Buprenorphine prescription rates by region. • Methadone prescription rates by region. • Other metrics identified by responsible unit.
3. Collaborate with the Insurance Department to identify tactics for improving parity of behavioral and physical health services.	Treatment and Recovery Committee; Insurance Department	July 1, 2027	Recommendations for improving parity and increasing patient access to behavioral health providers, which may impact the rate of use of out-of-network behavioral health providers and increase reimbursement for behavioral health providers: • Behavioral health out-of-network use compared to medical/surgical for acute inpatient facility: 5.1x (2021). • All behavioral health clinicians out-of-network use compared to medical/surgical for office visits: 3.4x (2021). • Reimbursement for medical/surgical compared to behavioral health: 39.2% (2021).

4. Identify barriers to expanding evidence-based treatment for substance use disorder, including stimulant use disorder.	Treatment and Recovery Committee	July 1, 2028	Report that analyzes access to evidence-based stimulant use disorder treatment and describes barriers to expanding access, including the percentage of Utahns with stimulant use disorder receiving treatment.

Objective 3: Improve coordination between the justice and behavioral health system			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
To be developed by responsible unit.	Forensic Mental Health Coordinating Council	July 1, 2026	To be identified by responsible unit.

Objective 4: Expand the behavioral health workforce to meet the community needs			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
To be developed by responsible unit.	Health Workforce Advisory Council	July 1, 2026	To be identified by responsible unit.

Objective 5: Expand integration of behavioral and physical health care			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Evaluate available data on behavioral health screenings, referrals, and follow-up in primary care in the public and private sectors.	Office of Substance Use and Mental Health	July 1, 2026	To be identified through Tactic 1: • Behavioral health screening rates for adults in primary care settings.
2. Request recommendations that align with Commission priorities on the integration of physical and behavioral health.	One Utah Health Collaborative	December 31, 2026	To be identified by responsible unit.
3. Identify barriers to expanding evidence-based approaches to integrated care.	Treatment and Recovery Committee	July 1, 2027	To be identified by responsible unit, including recommendations on tactics to expand evidence-based approaches to integrated care.
4. Identify options for improving information sharing across physical and behavioral health providers.	Treatment and Recovery Committee	July 1, 2028	To be identified by responsible unit.

Strategy 4: Expand effective recovery services

Objective 1: Promote sustainable and appropriate funding for recovery support services			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Identify method for assessing whether recovery support services are receiving adequate reimbursement.	Office of Substance Use and Mental Health	July 1, 2026	Method for assessing whether recovery support services are receiving adequate reimbursement.
2. Identify recovery services that are not receiving any and/or adequate reimbursement.	Office of Substance Use and Mental Health	December 31, 2026	Summary of recovery services that are not receiving any or adequate reimbursement.
3. Analyze potential models for creating sustainable funding for these services.	Office of Substance Use and Mental Health	December 31, 2027	Recommended model to create sustainable funding.
4. Explore options for expanding private health insurance reimbursement for peer support specialists.	Treatment and Recovery Committee	July 1, 2027	Summary of opportunities and barriers for expanding private health insurance reimbursement, with recommendations for next steps.

Objective 2: Expand workplace and employment policies and practices that support people with mental health and substance use challenges			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Collaborate with private employers to identify workplace policies and programs that support people in recovery or experiencing a behavioral health crisis.	Treatment and Recovery Committee	July 1, 2027	Policy brief that identifies relevant workplace policies and programs and how they can be implemented.
2. Expand access to supported employment services to at least one additional site in the state.	Office of Substance Use and Mental Health	July 1, 2028	• Number of sites providing supported employment services. • Percentage of individuals in Utah supported employment programs who receive competitive employment.

Objective 3: Evaluate trends in stigma towards mental health and substance use disorder			
Tactics	**Responsible units**	**Target date**	**Performance measures or outputs**
1. Explore opportunities for collecting Utah-level data that was previously collected by the National Survey on Drug Use and Health.	Office of Substance Use and Mental Health	July 1, 2026	**18%** of Utah youth who feel it is not okay to get mental health help (2023). **35%** of Utah youth who have a high need for mental health treatment and who think it is not okay to get help (2023). **20%** of Utah adults who needed mental health treatment and did not get help because they were worried about what other people would think (2022 - 2023).

Policy and budget recommendations to the Utah State Legislature: General Session 2026

Note: This section will be added in August 2025.

The Commission received policy and budget recommendations from its subcommittees and several commissioners. The Commission required subcommittees and commissioners to complete a template form for each recommendation and evaluated each proposal using a scoresheet aligned with the strategies and principles of this strategic plan.

The table below lists the top policy and budget recommendations of the Commission from 2025, ranked in order of priority. Each recommendation is described in greater detail below the table.

Rank	Recommendation
1	
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Appendix A: Definitions

Behavioral health: Refers to topics of mental distress, mental health conditions, suicidal thoughts and behaviors, and substance use.

Crisis services: Assess, stabilize, and treat individuals experiencing acute distress.

Evidence-based practice: An approach to prevention, crisis, treatment, or recovery that is supported by research evidence.

Mental disorder: A clinically significant disturbance in an individual's cognition, emotional regulation, or behavior.

Prevention services: Interventions intended to prevent or reduce the risk of developing a behavioral health problem.

Recovery services: Non-clinical services that address psychosocial factors in an individual's environment and provide emotional and practical support to maintain remission. Examples include peer support, supportive housing, skills training and development, comprehensive community support services, and supported employment.

Serious emotional disturbance: Someone under the age of 18 having a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious mental illness: Someone over 18 having a diagnosable mental, behavior, or emotional disorder that substantially interferes with a person's life and ability to function.

Substance use disorder: A pattern of substance use that causes damage to physical or mental health or leads to clinically significant functional impairment or distress.

Treatment services: Includes screening and assessment, outpatient, medication management, and inpatient services.

Appendix B: Responsible units

Behavioral Health Crisis Response Committee: Reports directly to the Commission. Responsible for coordinating crisis services across the state and providing recommendations on the crisis response system to both the Office of Substance Use and Mental Health and the Commission.

Center for School-Based Health and Wellbeing Partnerships: Does not report to the Commission. Serves as a school and community health mental health collective for Utah through school-based services, training and instruction, and research.

Early Childhood Mental Health Working Group: Does not report to the Commission. Composed of stakeholders from early childhood-related professions that are working to develop a robust early childhood mental health system in Utah.

Forensic Mental Health Coordinating Council: Reports to the Treatment and Recovery Committee. The Forensic Mental Health Coordinating Council advises criminal justice, juvenile justice, and civil commitment systems on interacting to best serve individuals with an intellectual disability or mental illness. The Council is required to study state hospital bed capacity and the forecast for long-term need and to annually report its findings and make recommendations for changes.

Prevention and Early Intervention Committee: Reports directly to the Commission. Responsible for coordinating the various subcommittees of the Commission that work in behavioral health prevention and early intervention.

Office of Substance Use and Mental Health: This office is part of the Utah Department of Health and Human Services and does not report to the Commission. Staff from the office provide support for the Commission and its members. The office is responsible for overseeing substance use and mental health needs for the State of Utah.

One Utah Health Collaborative: Does not report to the Commission. An independent organization that aims to use public and private funding to transform Utah health care.

Suicide Prevention Committee and Coalition: Reports directly to the Commission. The Utah Suicide Prevention Committee is composed of public and private sector leaders who gather, monitor, and analyze trends, data, research, and systems to identify prevention, intervention, and postvention needs. The Utah Suicide Prevention Committee and Coalition has multiple workgroups with specific focus areas. The committee develops a statewide suicide prevention plan and develops annual goals for its activities.

Treatment and Recovery Committee: Reports directly to the Commission. Develops policy recommendations for the Commission related to mental health and substance use treatment and recovery and supports the implementation and continual revision of the treatment and recovery strategies within the Commission's strategic plan.

Utah Insurance Department: Does not report to the Commission. The Utah Insurance Department is part of the U.S. insurance regulatory framework, which is a highly coordinated state-based national system designed to protect policyholders and to serve the greater public interest through the effective regulation of the U.S. insurance marketplace.

Utah State Board of Education: Does not report to the Commission. The State Board is a constitutionally established, elected, nonpartisan body that exercises general control and supervision over the public education system in Utah.

Youth Behavioral Health Workgroup: Does not report to the Commission. This workgroup was created to support an objective of the Governor's Built Here Second Term Strategic Plan: Ensure all Utah children grow up with a strong foundation of good behavioral health.

Appendix C: Behavioral health data

Substance use disorder (SUD)

Mental illness and poor mental health

Drug overdose deaths

Suicide

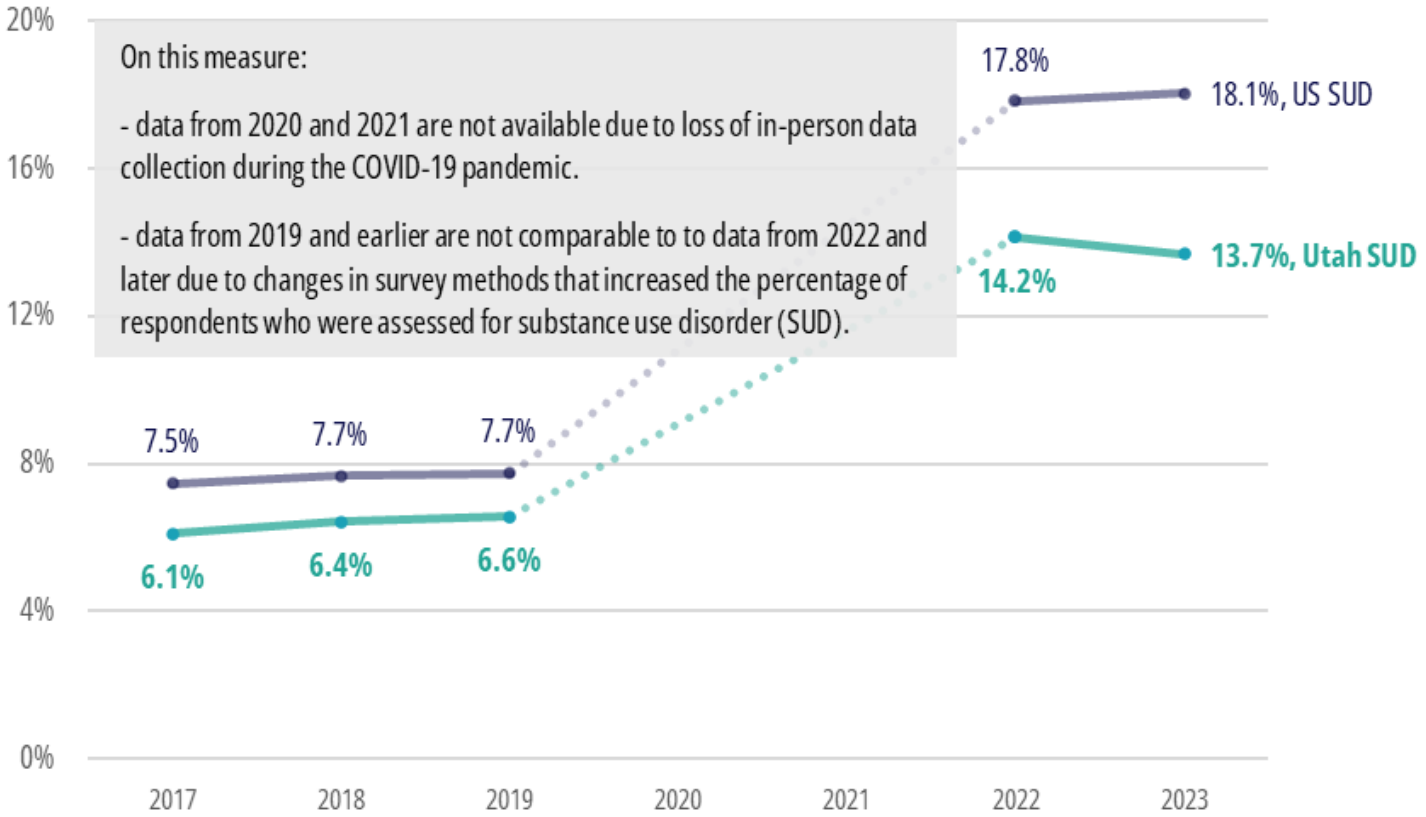
Treatment

Youth behavioral health

Sources for additional data

Substance Use Disorder (SUD)

Figure 1. Prevalence of substance use disorder (SUD) in adults in the past year, 2017-2023



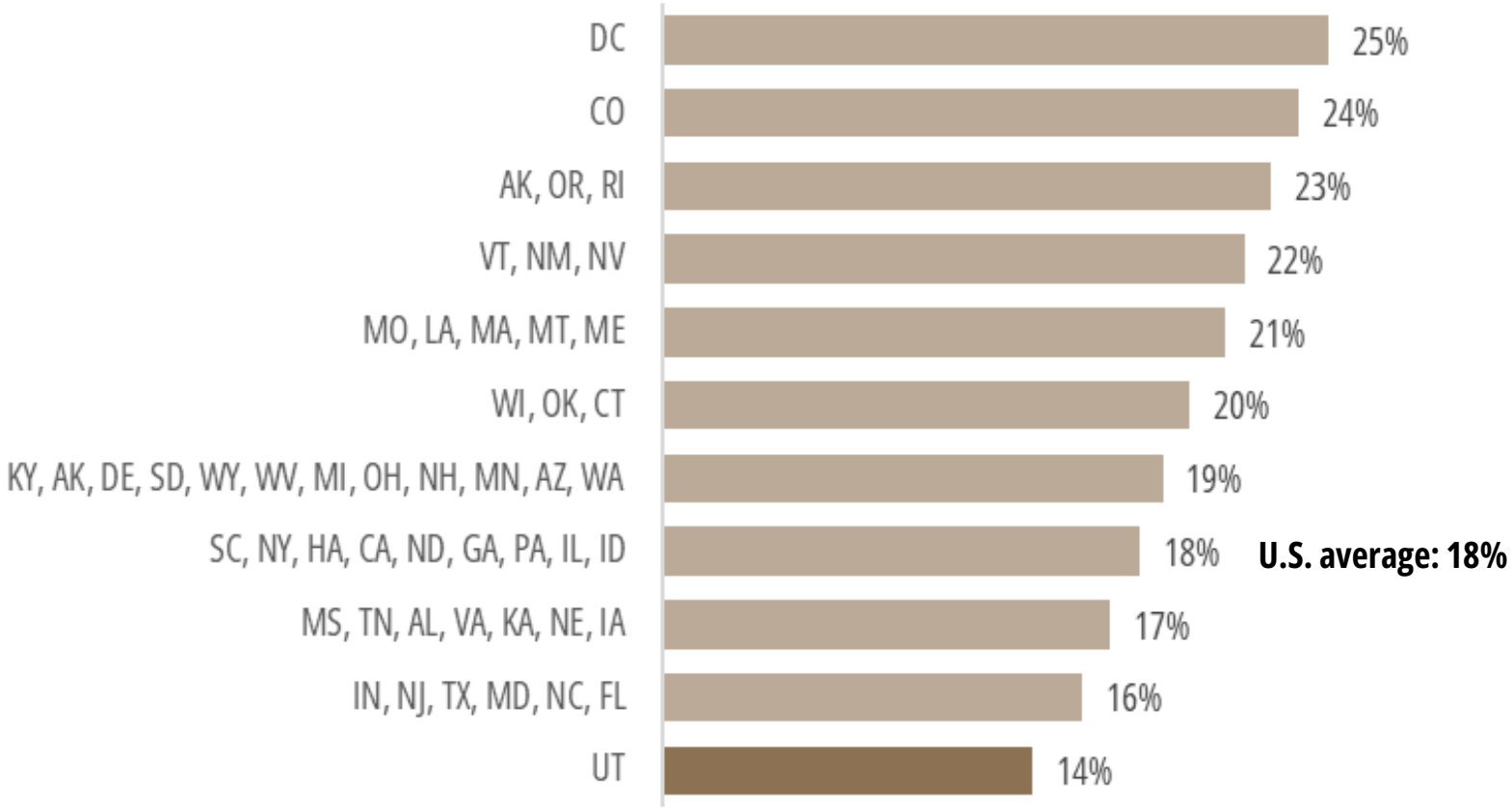
Data source: National Survey on Drug Use and Health (https://datatools.samhsa.gov/saes/state)

Utah has lower rates of substance use disorder (SUD) than the national average.

NOTE: Substance use disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. See 2023 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions at https://www.samhsa.gov/data/report/2023-methodological-summary-and-definitions for details on who was eligible to receive questions on SUD.

Substance Use Disorder (SUD)

Figure 2. Adults with substance use disorder (SUD) in the past year, by state, 2022-2023 combined



Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

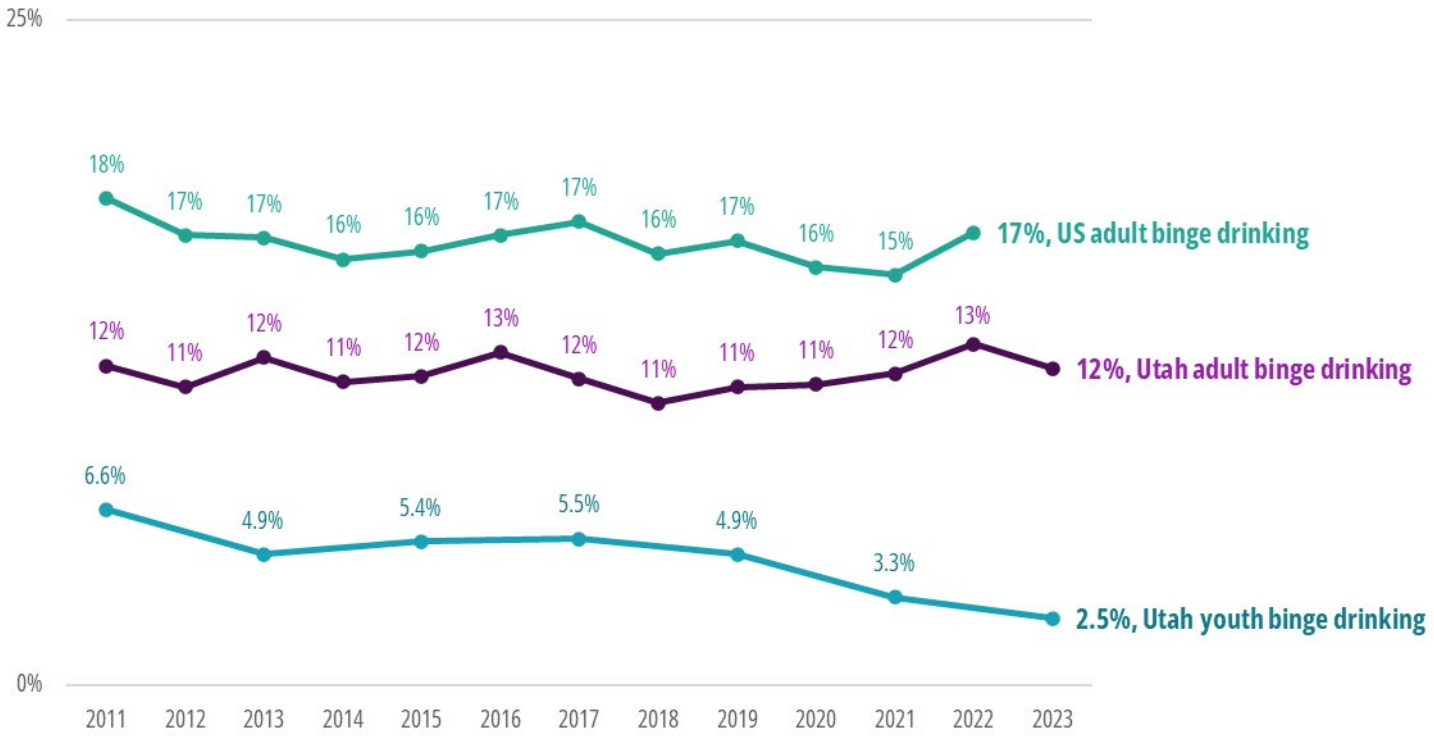
In 2022-2023, Utah had the lowest rate of substance use disorder (SUD) compared to the rest of the U.S.

Utah has consistently been among the lowest rates of SUD since at least 2017.

NOTE: Substance use disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. See 2023 National Survey on Drug Use and Health (NSDUH): Methodological Summary and Definitions at https://www.samhsa.gov/data/report/2023-methodological-summary-and-definitions for details on who was eligible to receive questions on SUD.

Substance Use Disorder (SUD)

Figure 3. Adult and youth past year binge drinking, 2011-2023



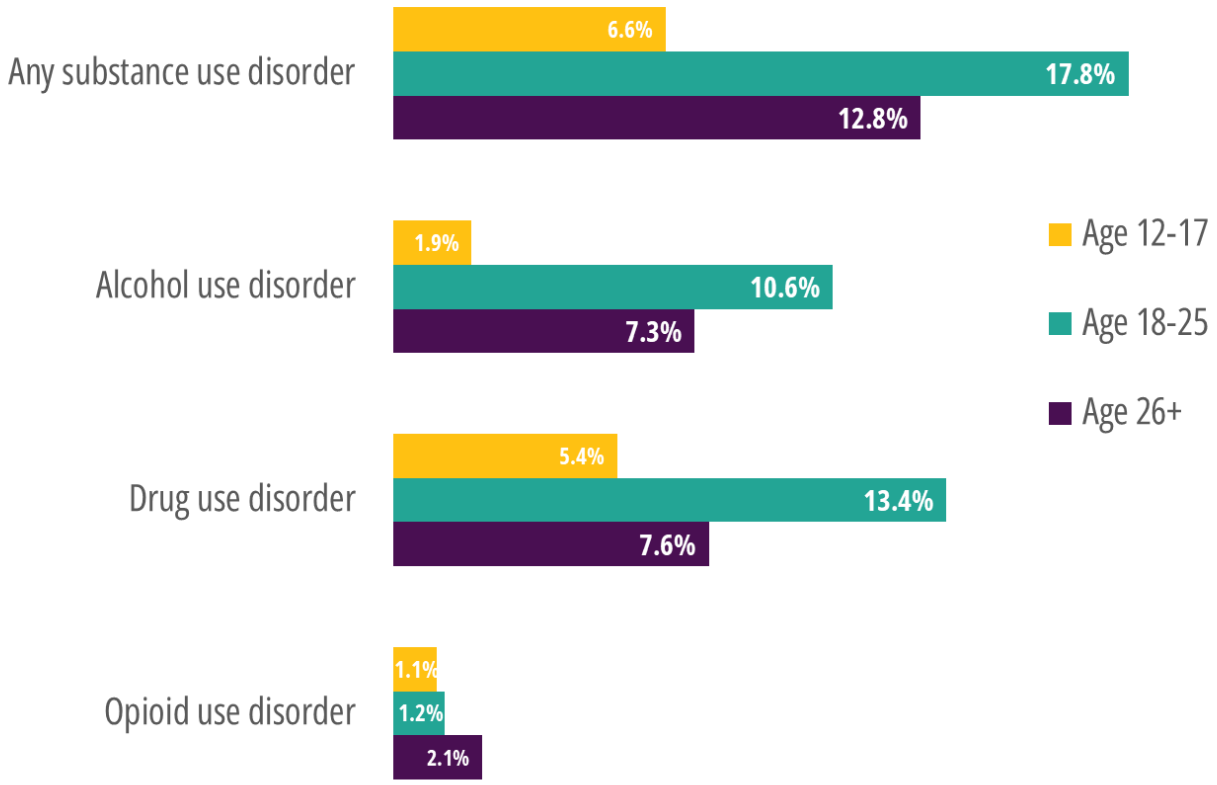
Data sources: Indicator-Based Information System (IBIS)
https://ibis.utah.gov/ibisph-view/indicator/view/AlcConBinDri.html;
https://ibis.utah.gov/ibisph-view/query/builder/pna/Bdrinking/Bdrinking.html
Adult data are from the Behavioral Risk Factor Surveillance System (BRFSS). Youth data are from the Utah Prevention Needs Assessment (PNA).

Adult binge drinking has been stable over time in both the U.S. and Utah.

Youth binge drinking has decreased from 2011 to 2023 in Utah.

Substance Use Disorder (SUD)

Figure 4. Prevalence of substance use disorder (SUD) by age and substance, Utah 2022-2023 combined



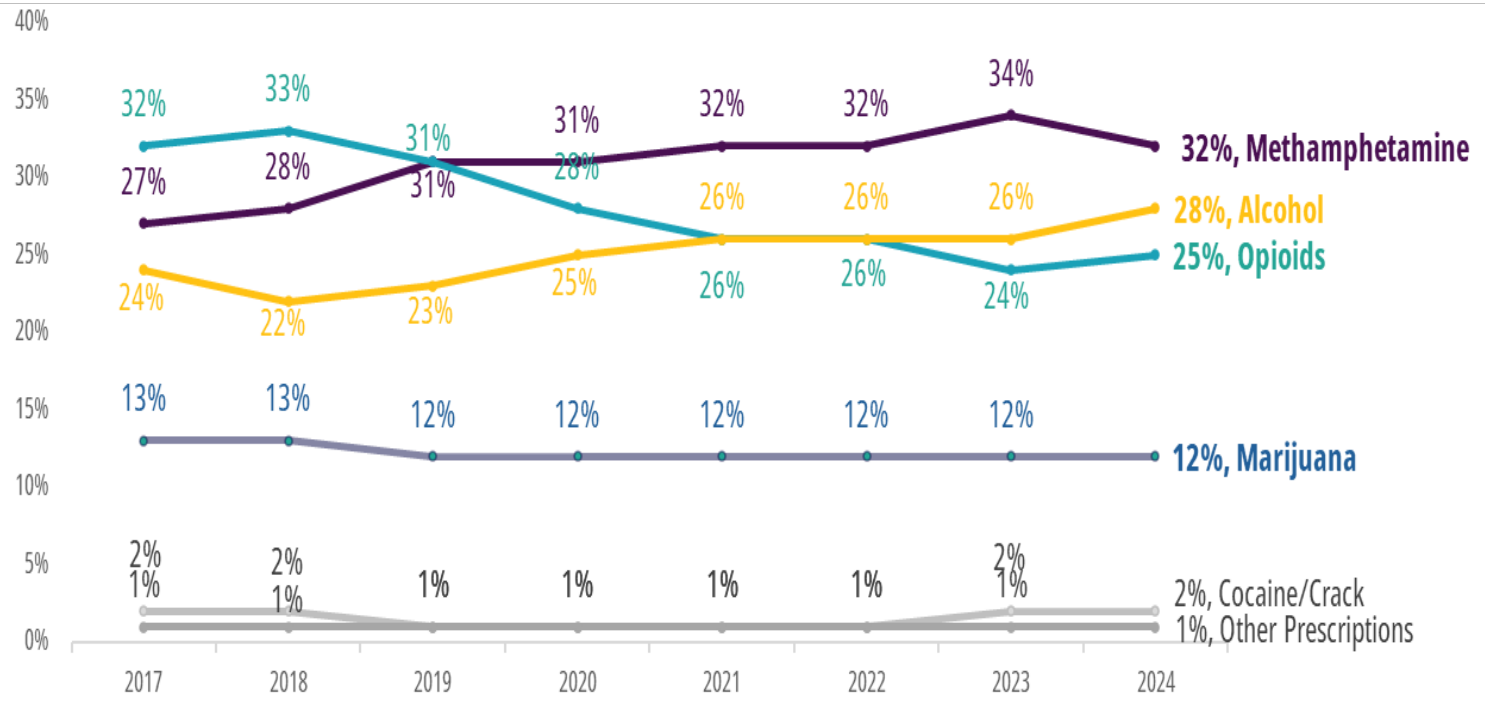
Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

Individuals between 18 and 25 have the highest rates of any substance use disorder, alcohol use disorder, and drug use disorder.

Individuals who are 26 and older have the highest rates of opioid use disorder.

Substance Use Disorder (SUD)

Figure 5. Primary substance of Utah adults entering substance use treatment in the county system, 2017-2024

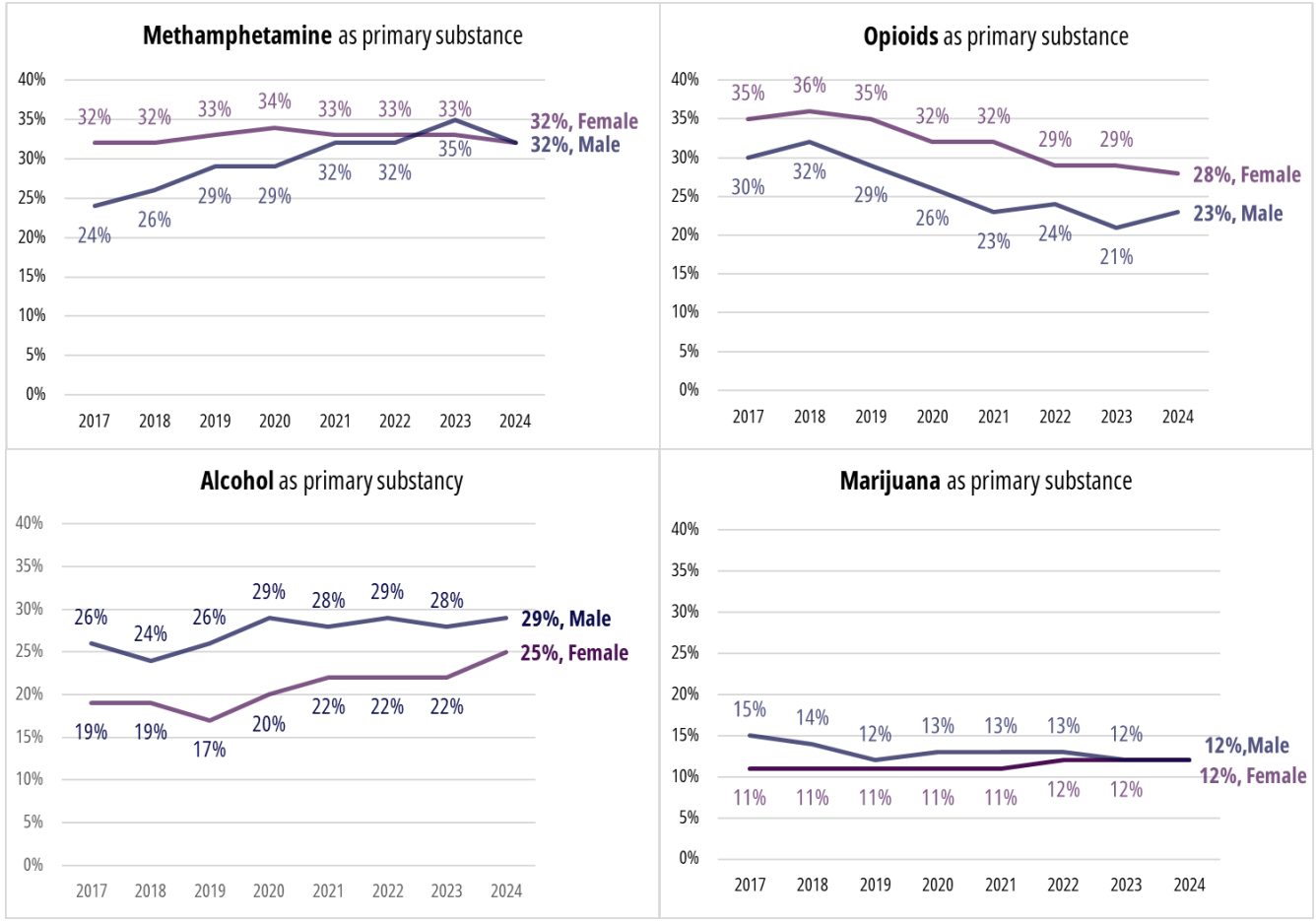


Data source: Utah Substance Abuse and Mental Health Information System (SAMHIS), Office of Substance Use and Mental Health, Utah Department of Health and Human Services

Methamphetamine, alcohol, and opioids are the substances for which Utahns most commonly enter substance use treatment in the county system.

Substance Use Disorder (SUD)

Figure 6. Primary substance of Utah adults entering substance use treatment in the county system by gender, 2017-2024



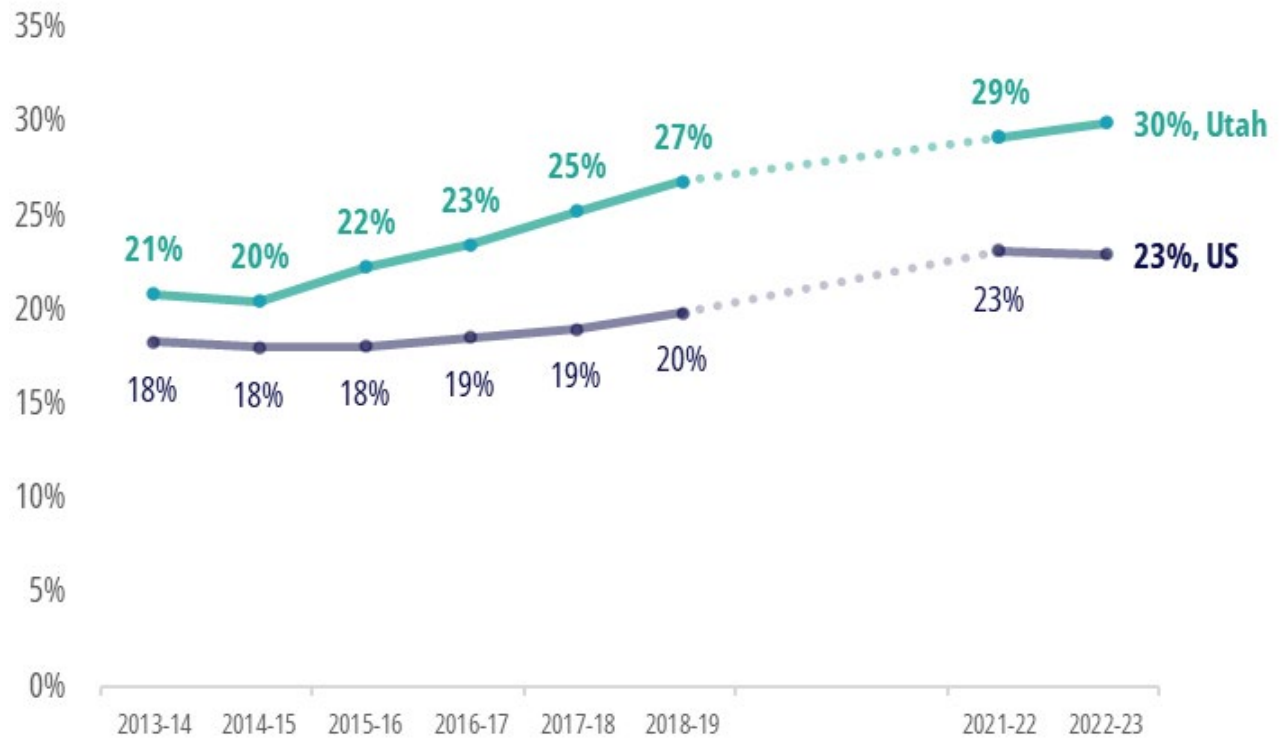
Data source: Utah Substance Abuse and Mental Health Information System (SAMHIS), Office of Substance Use and Mental Health, Utah Department of Health and Human Services

Women are more likely to receive treatment for opioids than men.

Men are more likely to receive treatment for alcohol than women.

Mental illness and poor mental health

Figure 7. Prevalence of any mental illness (AMI) in adults, 2013-2023



Data source: National Survey on Drug Use and Health (https://datatools.samhsa.gov/saes/state)

Rates of any mental illness (AMI) in Utah is higher than the national average. Utah has some of the highest rates of mental illness in the nation.

AMI in Utah has increased more than the national average from 2013 to 2023.

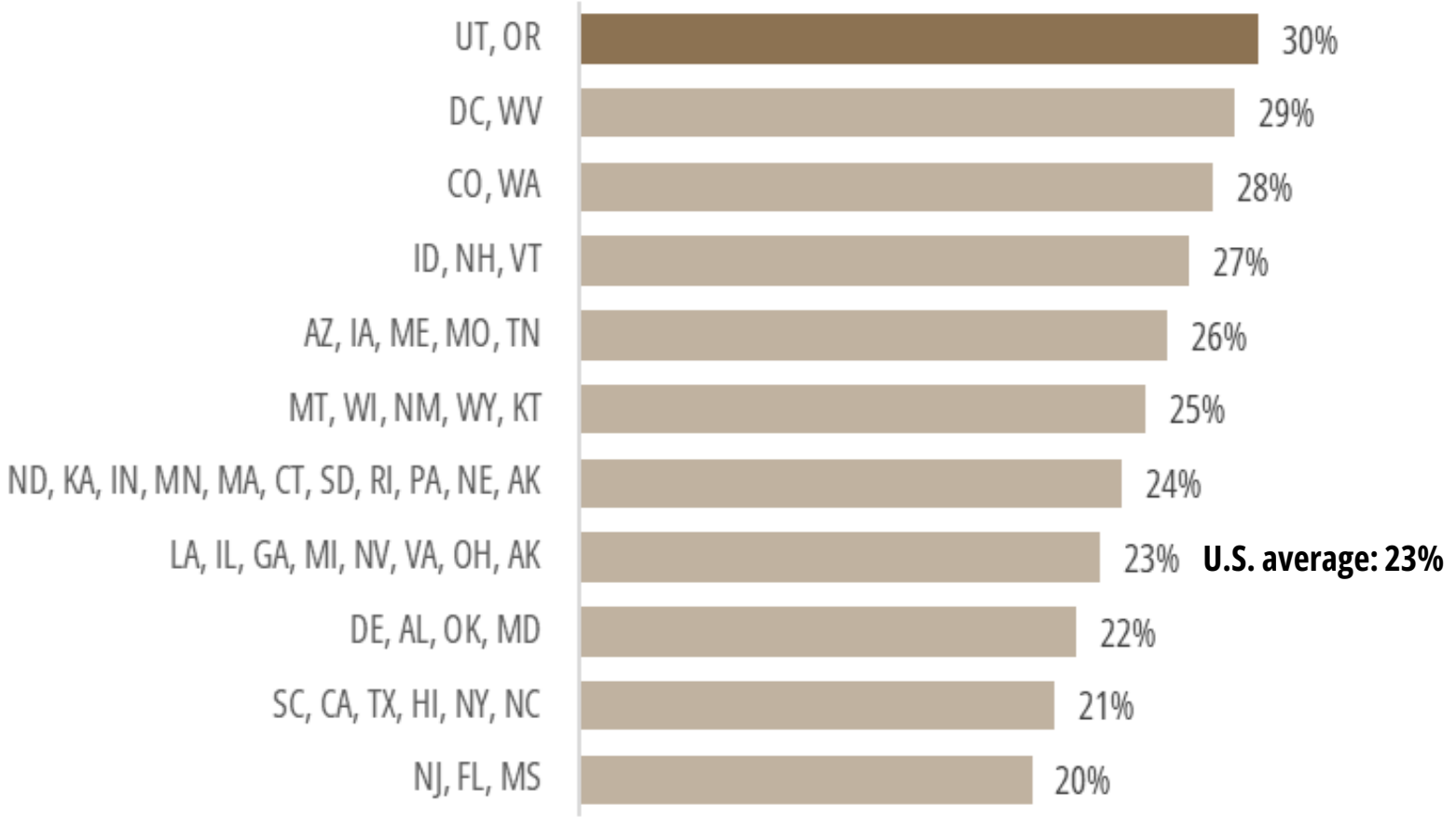
Data from 2019-20 and 2020-21 are not available due to loss of in-person data collection during the COVID-19 pandemic.

Any mental illness: Any Mental Illness (AMI) aligns with the Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. These estimates are based on indicators of AMI rather than direct measures of diagnostic status.

https://www.samhsa.gov/data/sites/default/files/reports/rpt47098/Methodological%20Summary%20and%20Definitions/2023-nsduh-method-summary-defs.pdf

Mental illness and poor mental health

Figure 8. Adults with any mental illness (AMI) in the past year, by state, 2022-2023 combined



Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

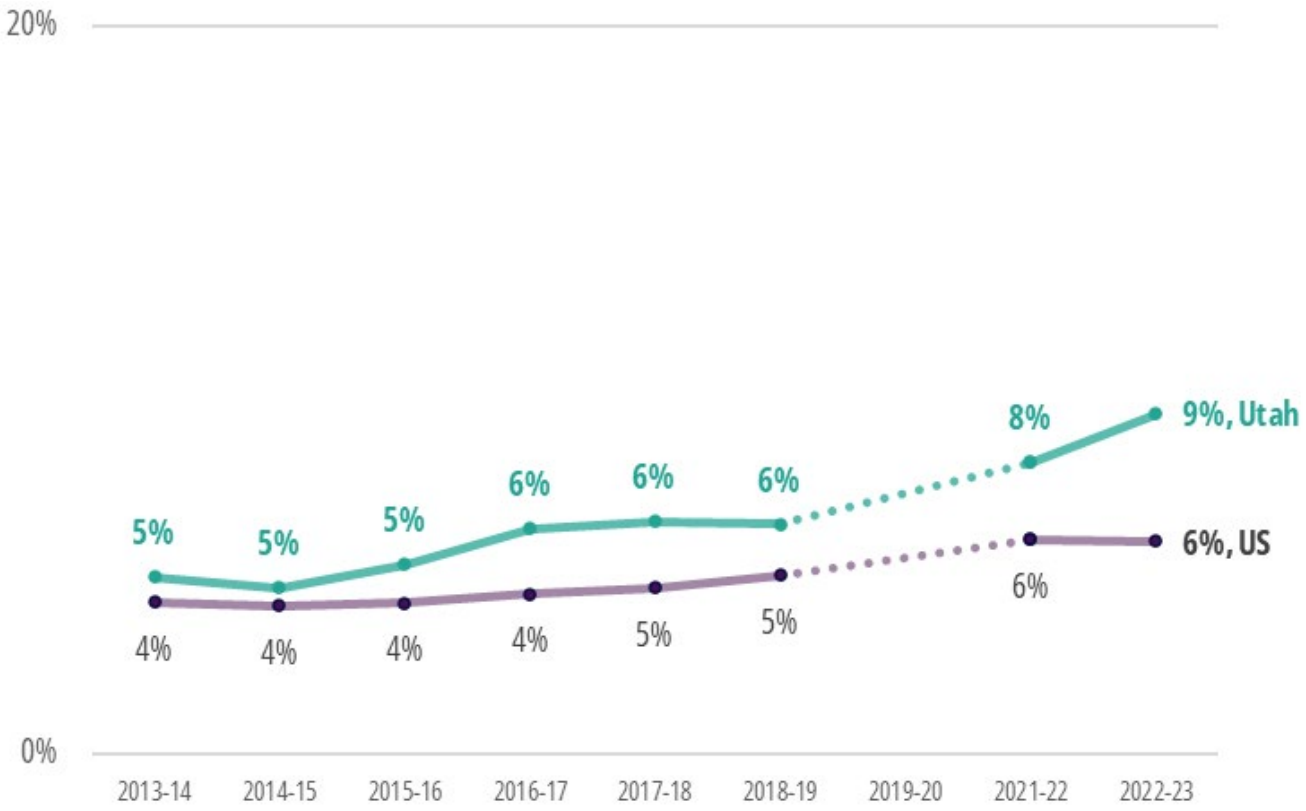
In 2022-2023, Utah and Oregon had the highest rate of any mental illness (AMI) compared to the rest of the U.S.

Utah has consistently been among the highest rates of AMI since at least 2017.

NOTE: Any mental illness (AMI) aligns with Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. These estimates are based on indicators of AMI rather than direct measures of diagnostic criteria. For details, see Section B of 2022-2023 National Surveys on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology at https://www.samhsa.gov/data/report/2022-2023-nsduh-guide-state-tables-and-summary-sae-methodology.

Mental illness and poor mental health

Figure 9. Prevalence of serious mental illness (SMI) in the past year, in adults, 2013-2023



Data source: National Survey on Drug Use and Health (https://datatools.samhsa.gov/saes/state)

Like any mental illness, Utah has a higher rate of serious mental illness (SMI) than the US rate.

SMI has increased in Utah since 2014.

Data from 2019-20 and 2020-21 are not available due to loss of in-person data collection during the COVID-19 pandemic.

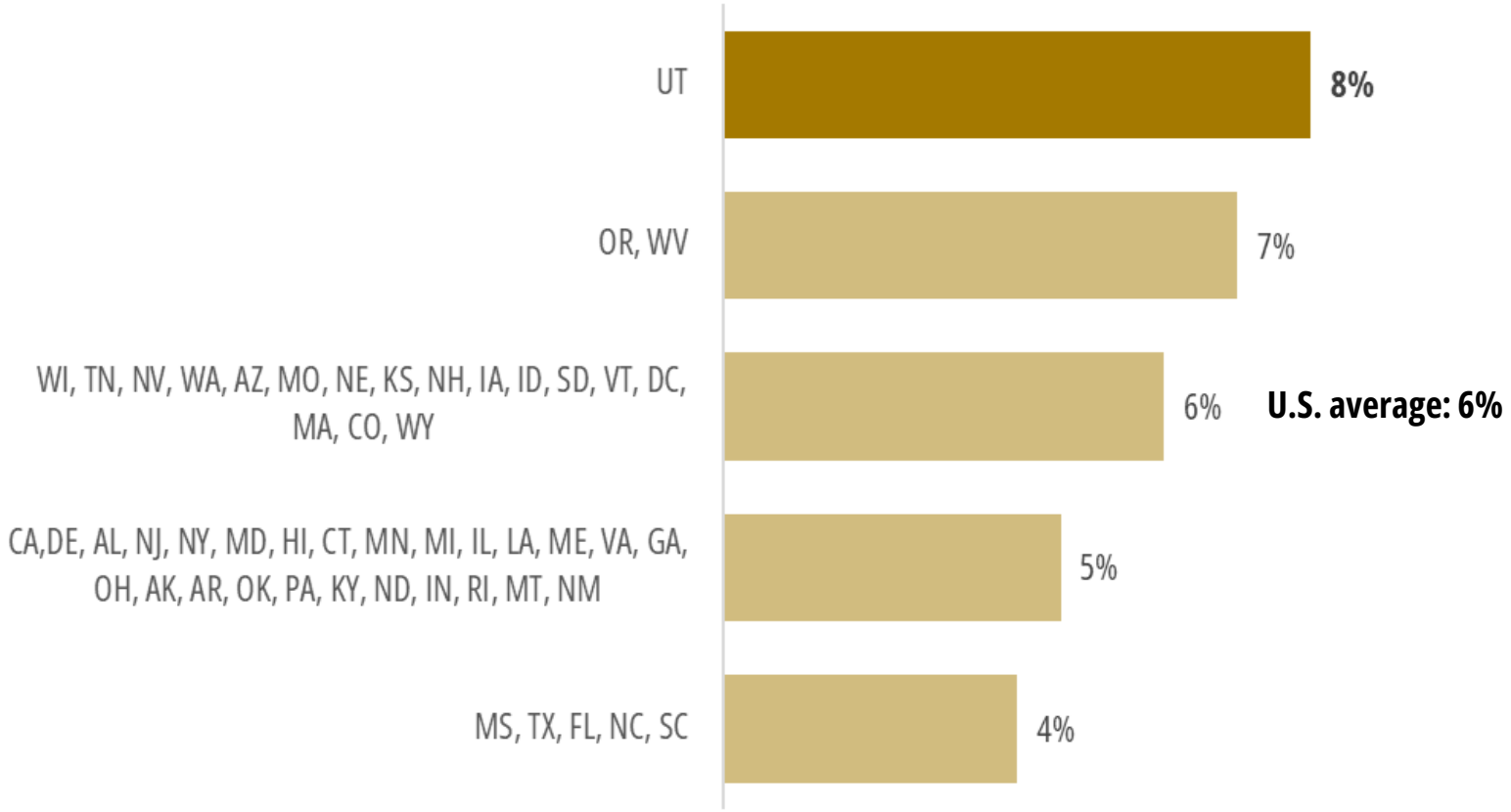
Adults with serious mental illness defined:

- Individuals aged 18 and over, who at any time during the past year, had diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet criteria specified within DSM-III-R resulting in functional impairment, substantially interfering with major life activities.
- DSM-III-R "V" codes, substance use disorders, and developmental disorders are excluded unless they co-occur with other diagnosable serious mental illness.
- All disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity or disabling effects.
- Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illness.

https://www.samhsa.gov/data/sites/default/files/reports/rpt47098/Methodological%20Summary%20and%20Definitions/2023-nsduh-method-summary-defs.pdf

Mental illness and poor mental health

Figure 10. Adults with serious mental illness (SMI) in the past year, by state, 2022-2023 combined



Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

In 2022-2023, Utah had the highest rate of serious mental illness (SMI) compared to the rest of the U.S.

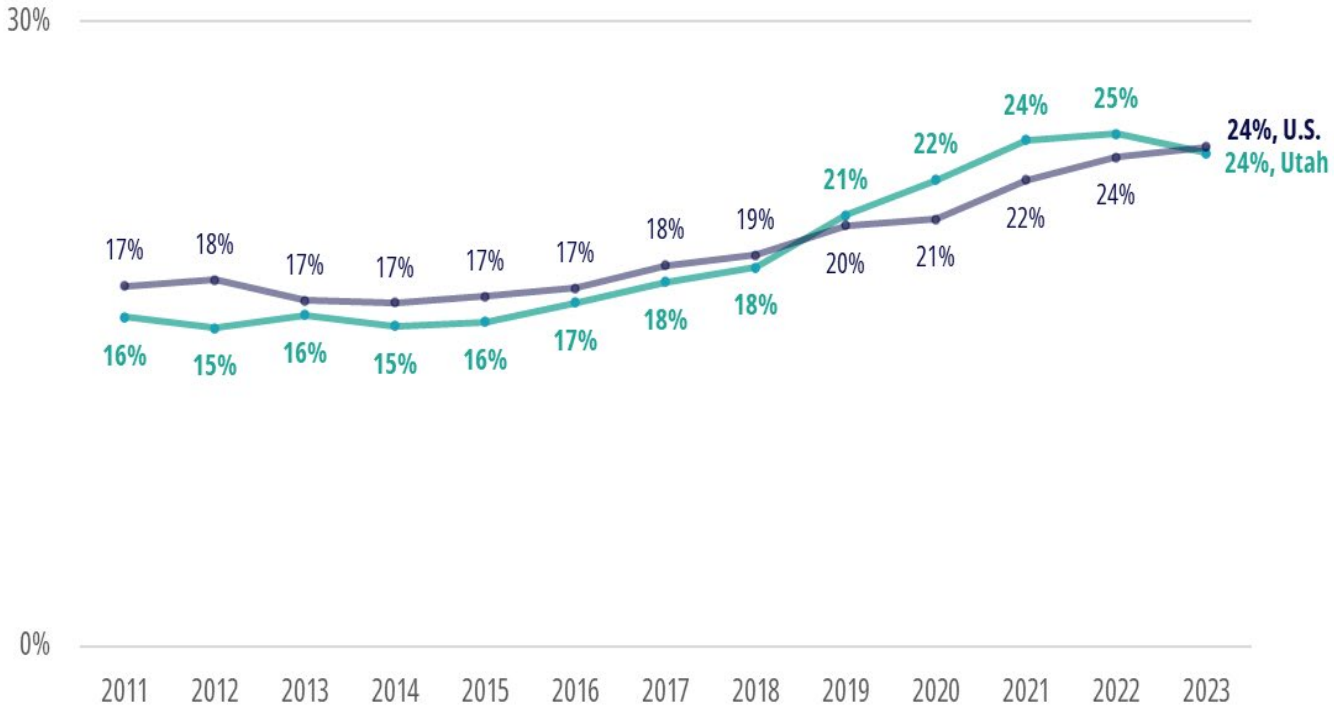
Adults with serious mental illness defined:

- Individuals aged 18 and over, who at any time during the past year, had diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet criteria specified within DSM-III-R resulting in functional impairment, substantially interfering with major life activities.
- DSM-III-R "V" codes, substance use disorders, and developmental disorders are excluded unless they co-occur with other diagnosable serious mental illness.
- All disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity or disabling effects.
- Adults who would have met functional impairment criteria during the referenced year without benefit of treatment or other support services are considered to have serious mental illness.

https://www.samhsa.gov/data/sites/default/files/reports/rpt47098/Methodological%20Summary%20and%20Definitions/2023-nsduh-method-summary-defs.pdf

Mental illness and poor mental health

Figure 11. Adults reporting poor mental health in 7 of the past 30 days, 2011-2023



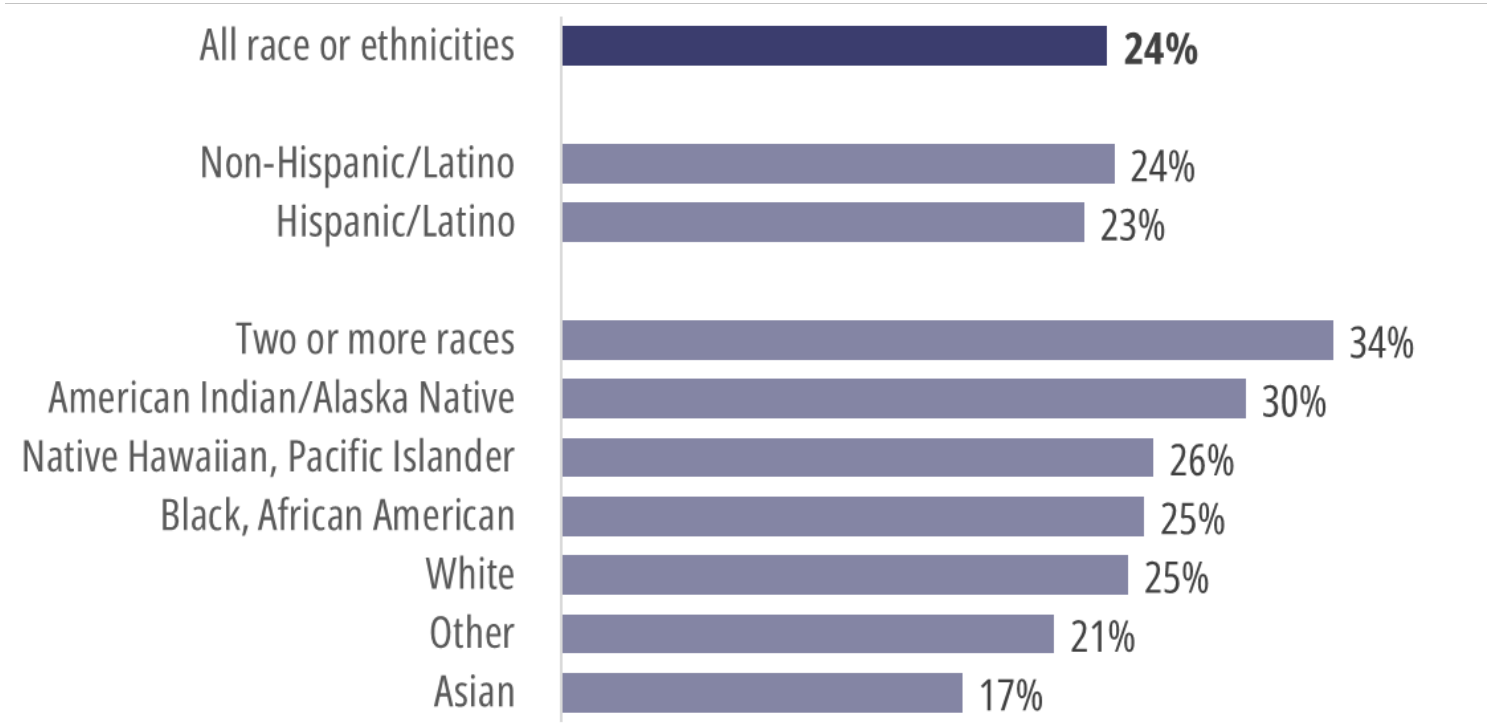
Data source: Indicator-Based Information System (IBIS); Utah Department of Health and Human Services and Human Services Behavioral Risk Factor Surveillance System (BRFSS).

Utah looks similar to the nation for adults reporting poor mental health. Starting in 2015, the number of adults reporting poor mental health has increased for both Utah and the nation.

Description:
These results come from survey data, in response to the question “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”

Mental illness and poor mental health

Figure 12. Utah adults reporting poor mental health by race (2021-2023 combined) and ethnicity (2023)



Data source: Indicator-Based Information System (IBIS); Utah Department of Health and Human Services and Human Services Behavioral Risk Factor Surveillance System (BRFSS).

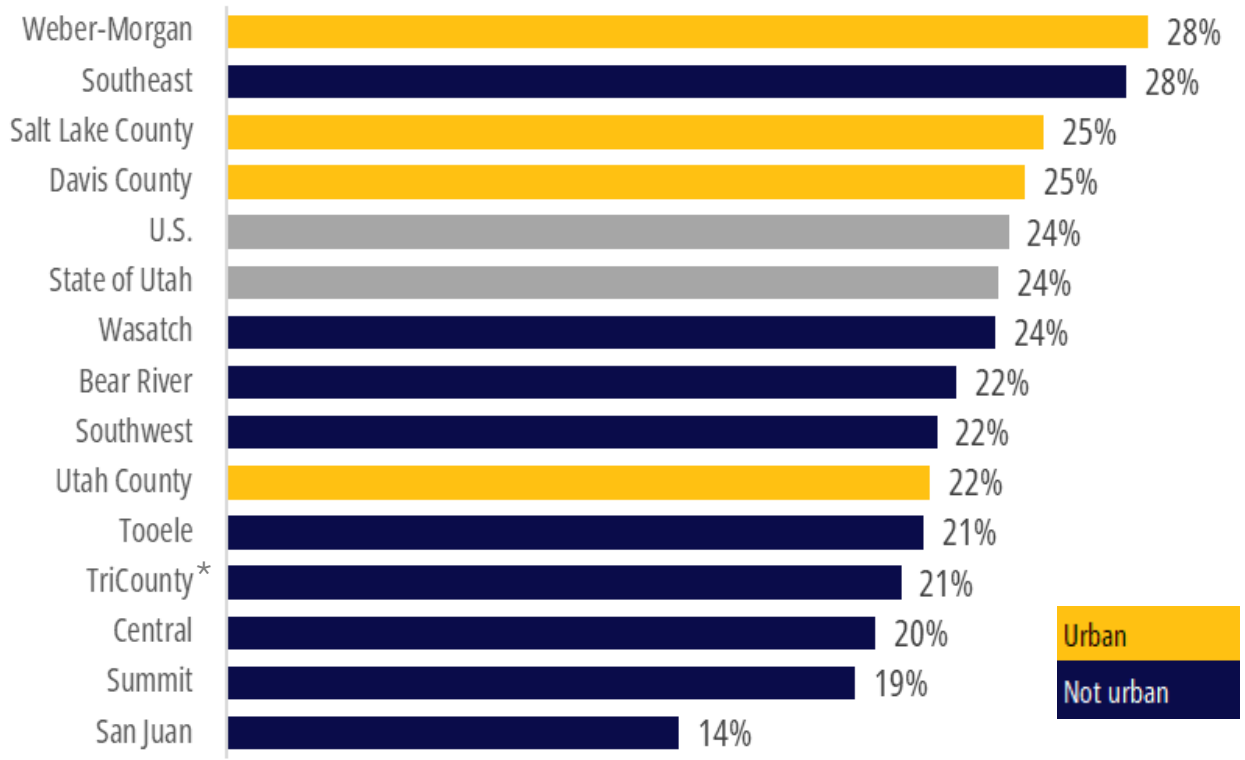
Approximately one-fourth of Utahns suffer from poor mental health.

Individuals identifying as two or more races or American Indian/Alaska Native have the highest rates of self-reported poor mental health, while individuals who are Asian have the lowest rate of self-reported poor mental health.

Notes:
These results come from survey data in response to the question “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Poor mental health is considered to be 7 or more days of poor mental health out of 30.

Mental illness and poor mental health

Figure 13. Utah adults reporting poor mental health by local authority, 2023



*The TriCounty area includes Daggett, Duchesne, and Uintah.

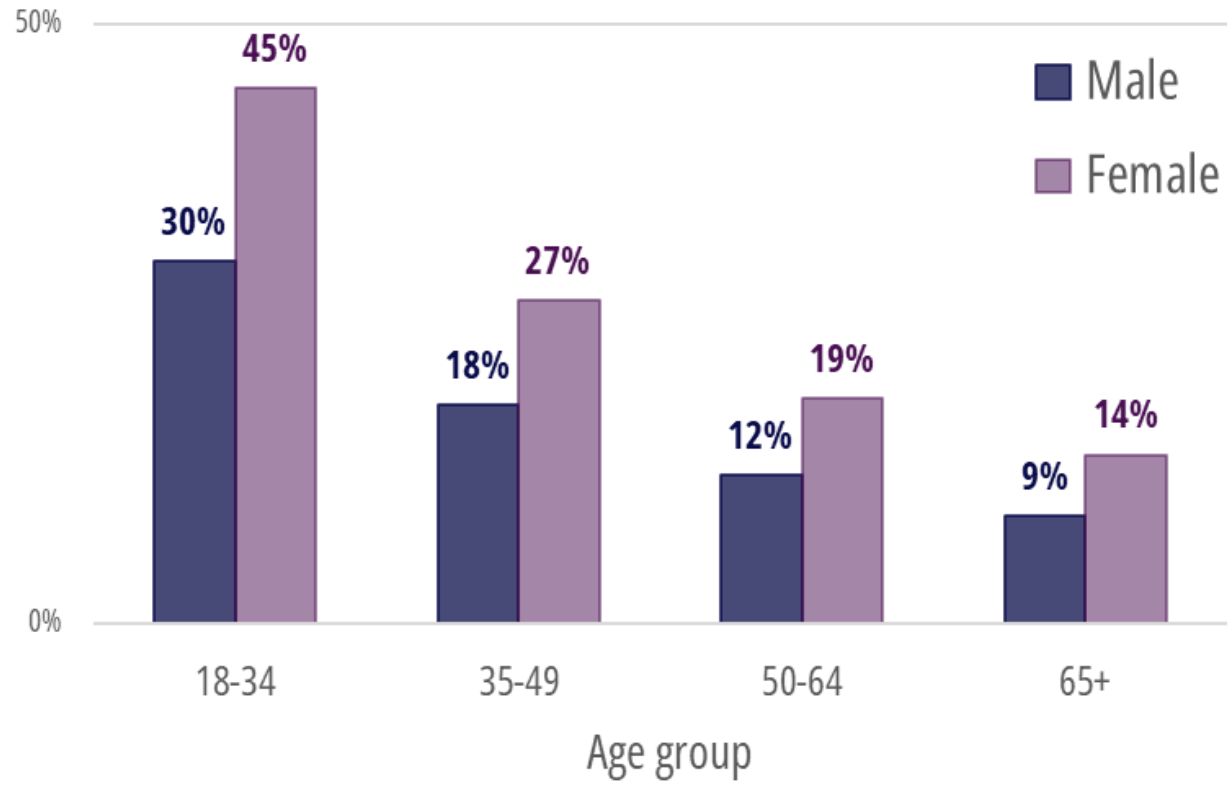
Data source: Indicator-Based Information System (IBIS); Utah Department of Health and Human Services and Human Services Behavioral Risk Factor Surveillance System (BRFSS).

Individuals from urban communities may have higher self-reported poor mental health than those from non-urban communities.

Notes:
These results come from survey data in response to the question "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Poor mental health is considered to be 7 or more days of poor mental health out of 30.

Mental illness and poor mental health

Figure 14. Utah adults reporting poor mental health by gender and age group, 2023



Data source: Indicator-Based Information System (IBIS); Utah Department of Health and Human Services and Human Services Behavioral Risk Factor Surveillance System (BRFSS).

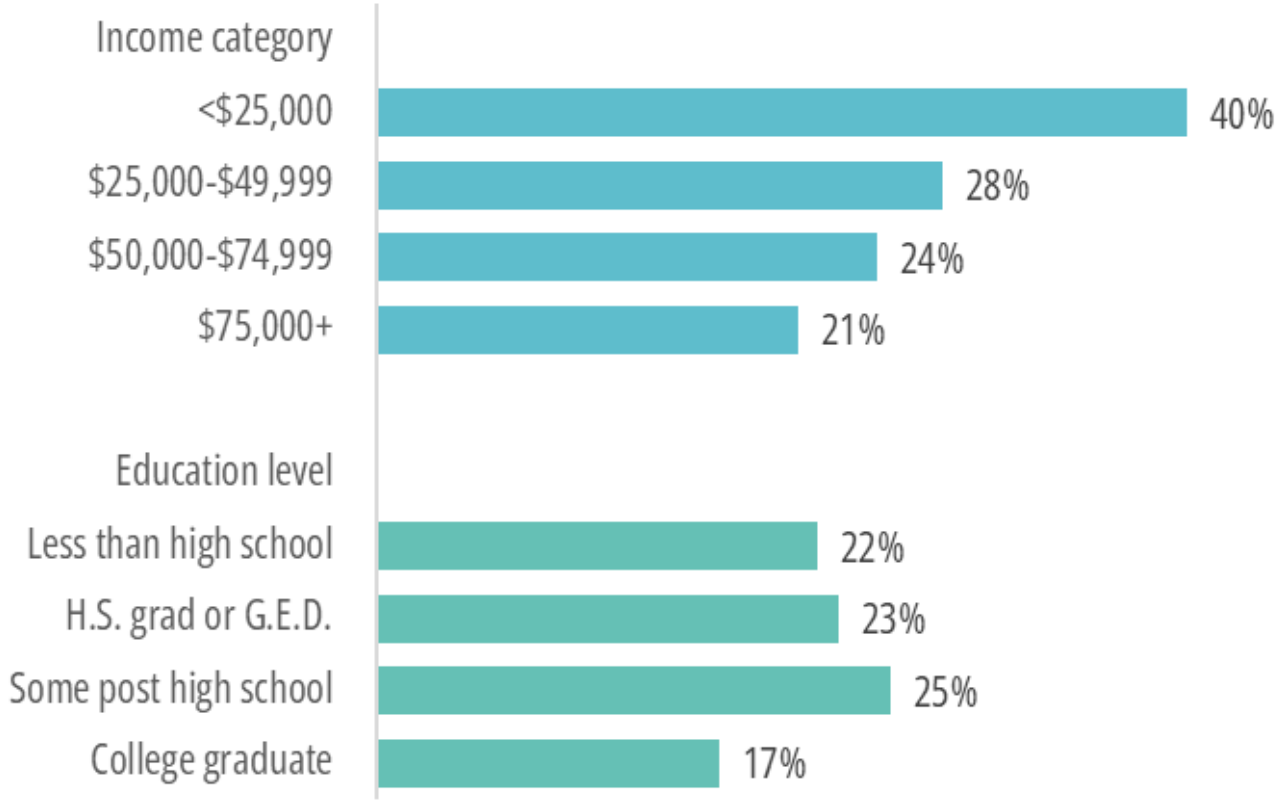
At all ages, more women report 7 or more days of poor mental health in the last 30 days than men.

Older respondents are less likely to report 7 or more days of poor mental health in the last 30 days.

Description:
These results come from survey data in response to the question “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Poor mental health is considered to be 7 or more days of poor mental health out of 30.

Mental illness and poor mental health

Figure 15. Utah adults reporting poor mental health by income and education level, 2023



Data source: Indicator-Based Information System (IBIS); Utah Department of Health and Human Services and Human Services Behavioral Risk Factor Surveillance System (BRFSS).

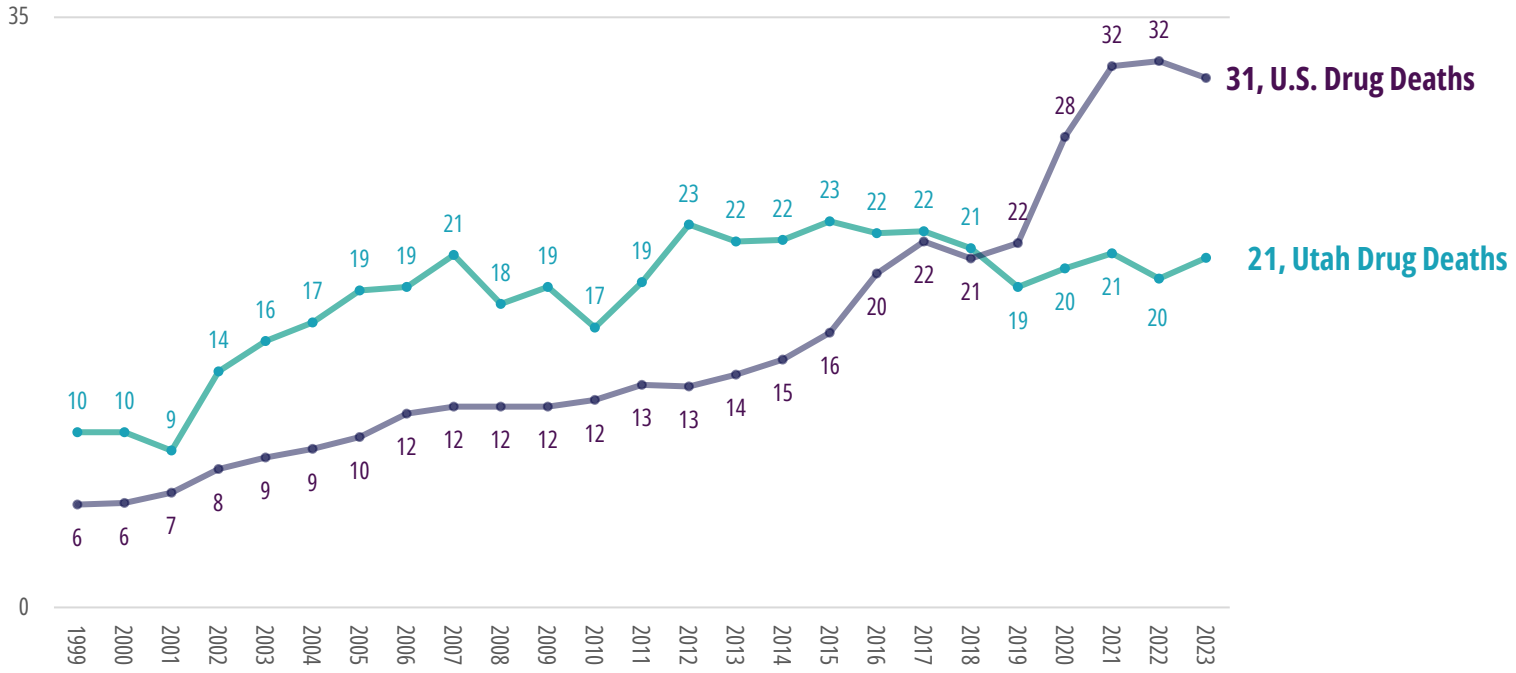
Lower income is associated with poorer mental health.

Fewer individuals with college degrees report poor mental health than those without.

Description:
These results come from survey data in response to the question “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?” Poor mental health is considered to be 7 or more days of poor mental health out of 30.

Drug overdose deaths

Figure 16. Drug overdose deaths per 100,000 population, 1999-2023



Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Utah drug death rates were significantly higher than national averages from 1999 to 2016.

Starting in 2019, Utah rates have been lower than the national rate.

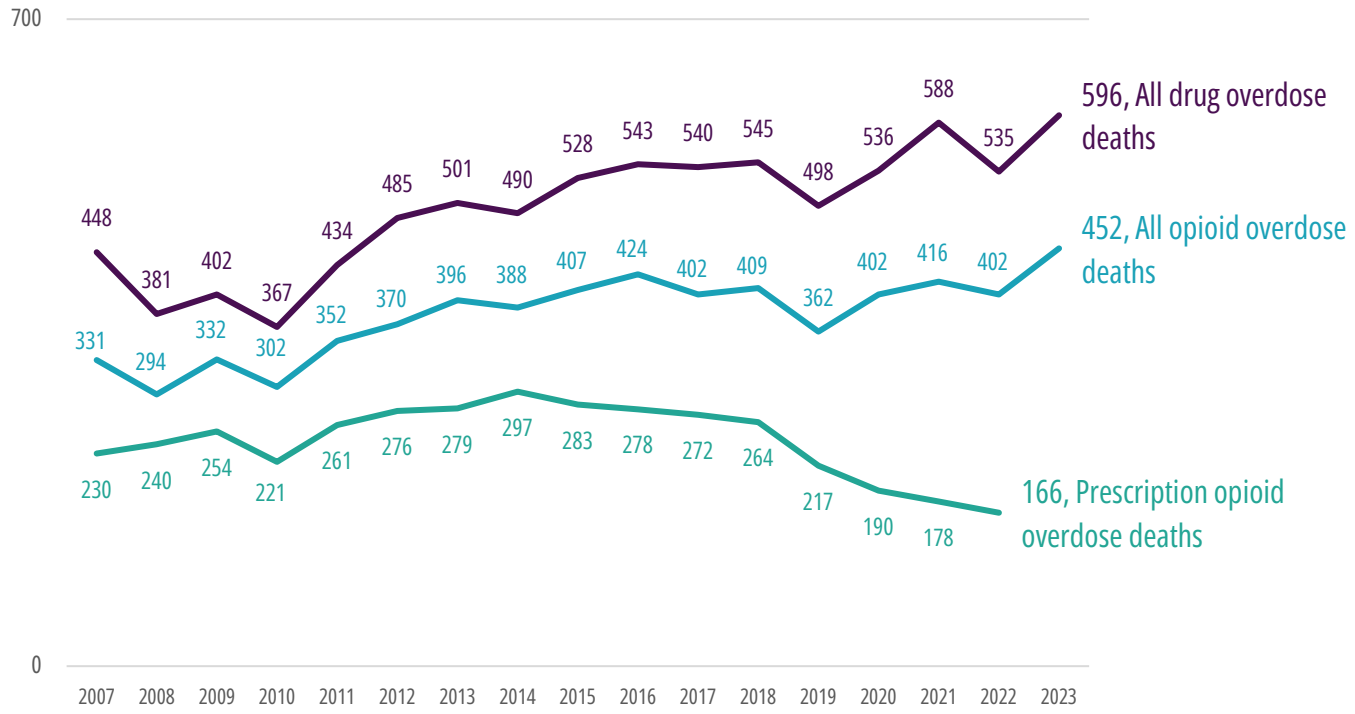
Description:
Drug poisoning/overdose deaths per 100,000 population (ICD-10 Codes x40-x44, x46, x60-x64, x66, y10-y14, y16).
Includes unintentional, suicide, homicide, undetermined, and other.

Data are age-adjusted to the 2000 U.S. standard population.

Drug poisoning deaths are a subset of all poisoning deaths, where drug is defined as "any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes."

Drug overdose deaths

Figure 17. Utah drug deaths from all drugs, all opioids, and prescription opioids, 2007-2023



Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Prescription opioid deaths have decreased since 2014, but all opioid deaths continue to be a high percentage of drug deaths.

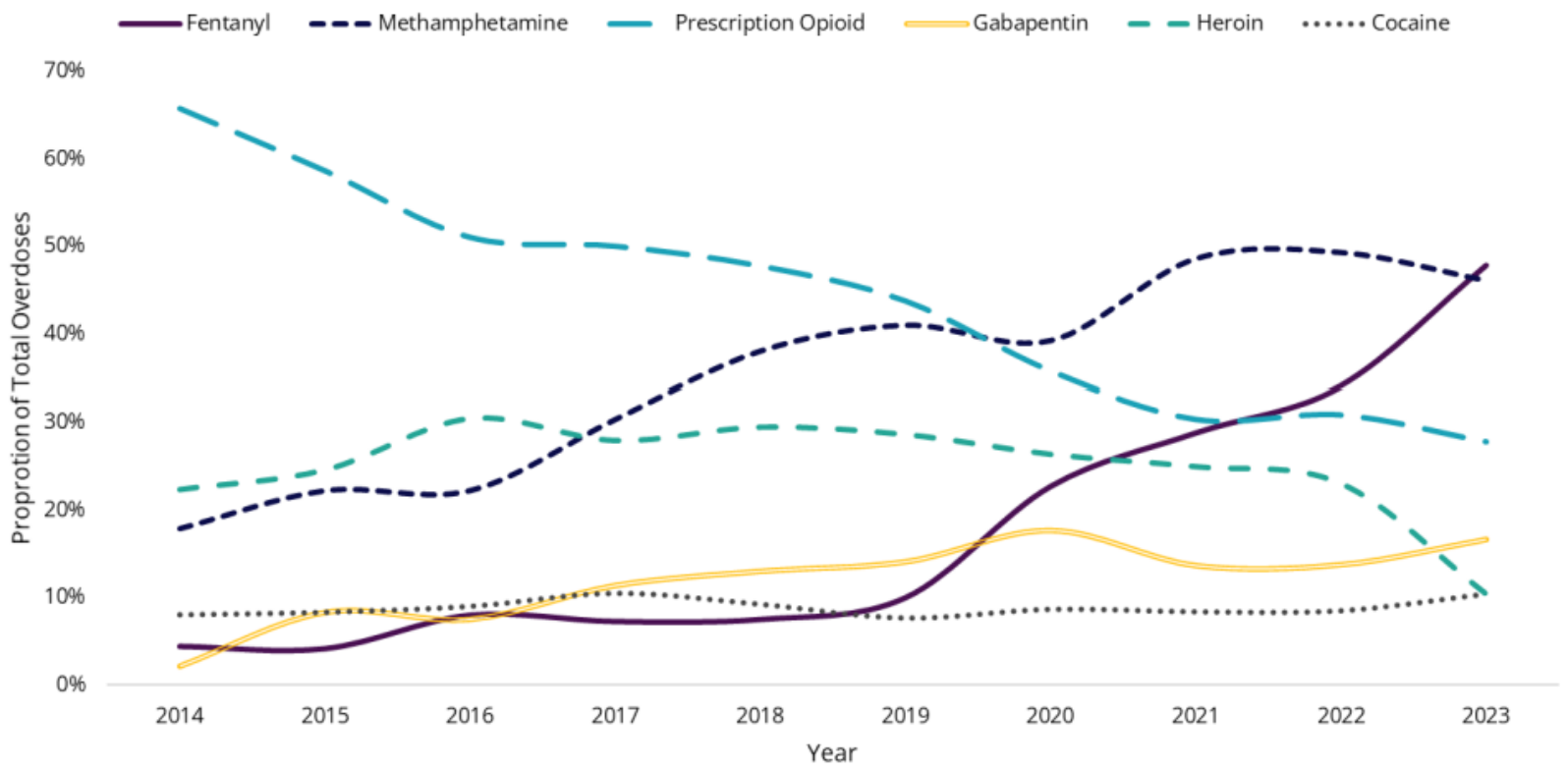
The number of drug overdose deaths has increased, but the population has also increased, leading to an overall lower rate (see Figure 16.)

Description:
Number of drug poisoning/overdose deaths (ICD-10 Codes x40-x44, x46, x60-x64, x66, y10-y14, y16).
Includes unintentional, suicide, homicide, undetermined, and other.

Drug poisoning deaths are a subset of all poisoning deaths, where drug is defined as "any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes."

Drug overdose deaths

Figure 18. Percentage of total Utah drug deaths for select drugs, 2014-2023



Graph source: Utah Department of Health and Human Services, Office of the Medical Examiner (2023), Fatal Drug Overdose Report

The percentages of drug deaths caused by fentanyl and methamphetamine have increased over time.

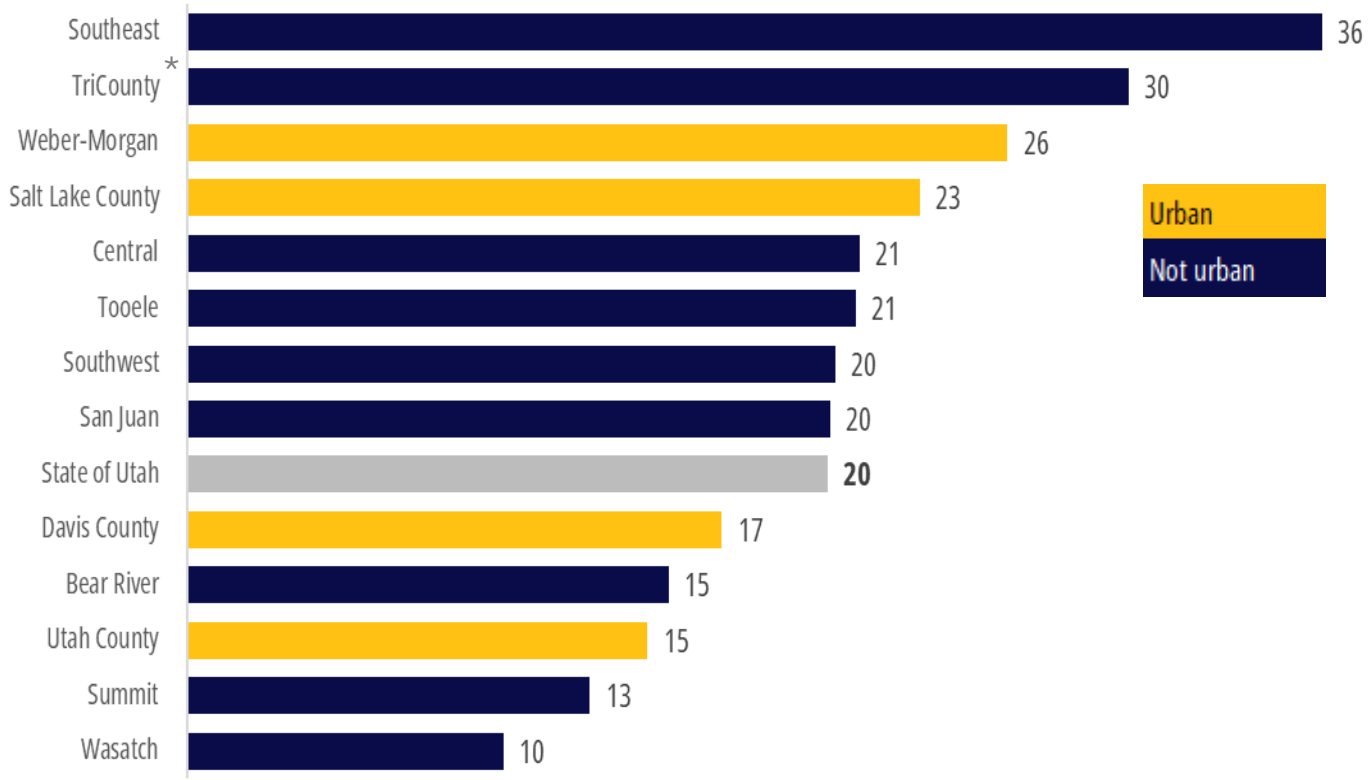
Fentanyl and methamphetamine were the most common in drug deaths in 2023.

Note:
Because drug deaths may involve more than one drug, the totals add to more than 100%.

This graph was taken directly from the Fatal Drug Overdose Report. See the entire report here: https://ome.utah.gov/wp-content/uploads/2023-OME-Fatal-Drug-Overdose-Report-1.16.2023.pdf.

Drug overdose deaths

Figure 19. Utah drug overdose deaths per 100,000 population by local authority, 2019-2023 combined



*The TriCounty area includes Daggett, Duchesne, and Uintah.

Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

There is no clear pattern indicating that urban or rural regions have higher rates of overdose deaths.

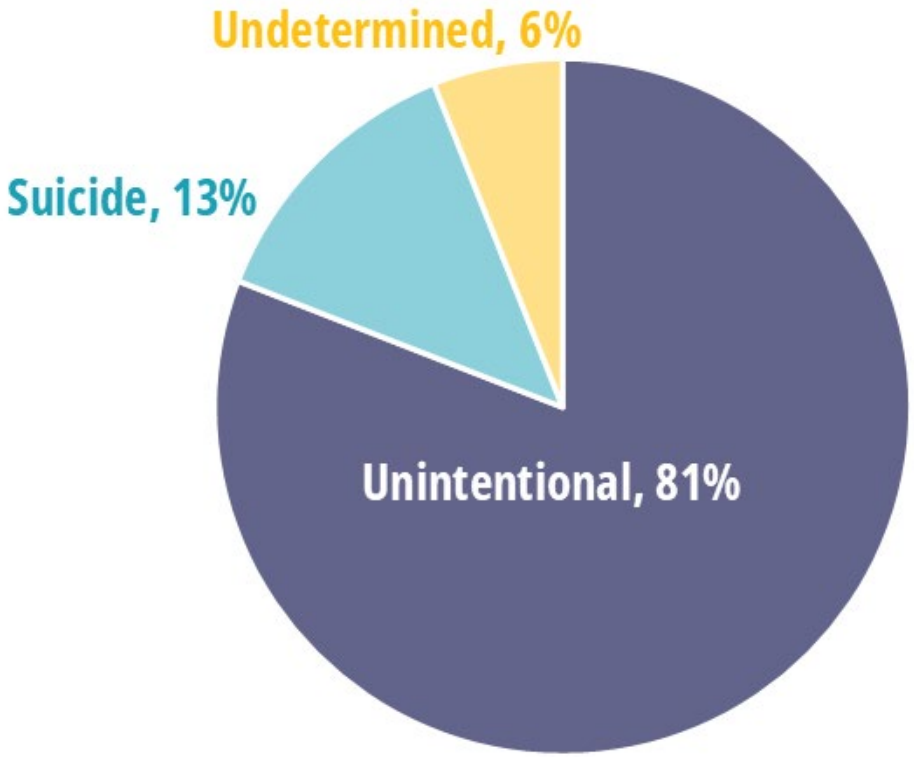
Description:
Drug poisoning/overdose deaths per 100,000 population (ICD-10 Codes x40-x44, x46, x60-x64, x66, y10-y14, y16). Includes unintentional, suicide, homicide, undetermined, and other.

Data are age-adjusted to the 2000 U.S. standard population.

Drug poisoning deaths are a subset of all poisoning deaths, where drug is defined as "any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes."

Drug overdose deaths

Figure 20. Utah drug overdose deaths by intent, 2019-2023 combined



Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

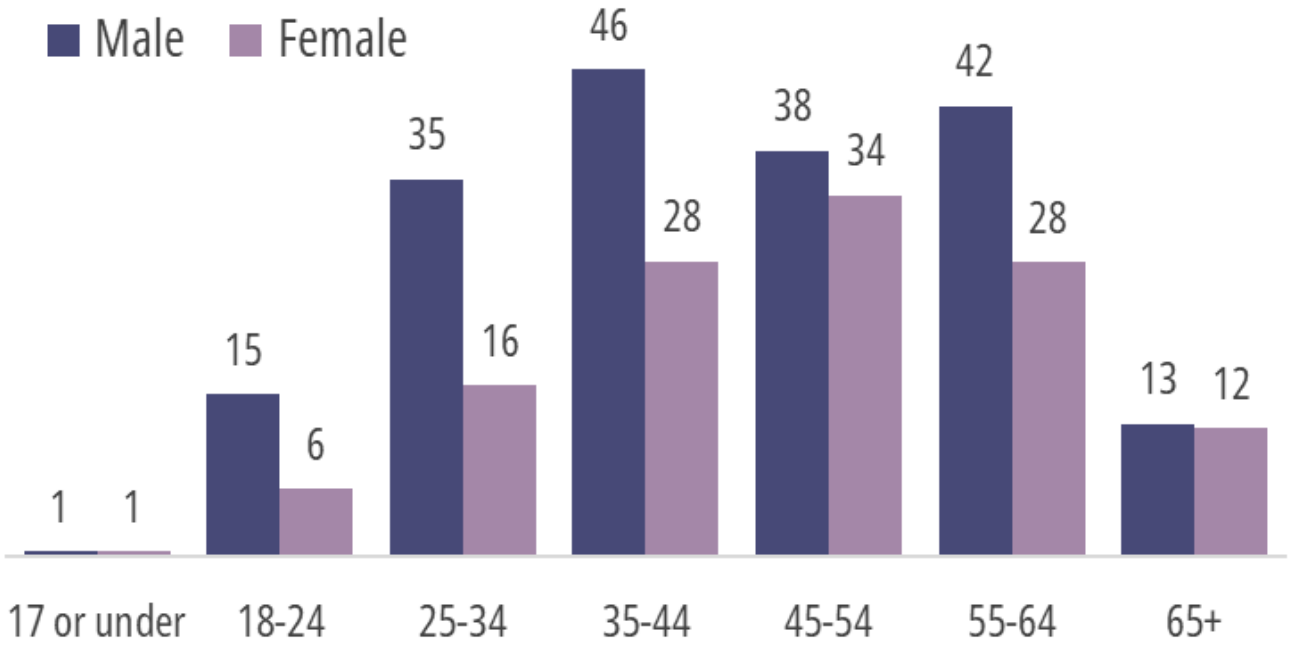
Most Utah drug overdose deaths are unintentional.

Notes:
Drug poisoning/overdose deaths (ICD-10 Codes x40-x44, x46, x60-x64, x66, y10-y14, y16) include unintentional, suicide, homicide, undetermined, and other.

Drug poisoning deaths are a subset of all poisoning deaths, where drug is defined as "any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes."

Drug overdose deaths

Figure 21. Utah drug overdose deaths per 100,000 population by gender and age group, 2019-2023 combined



Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

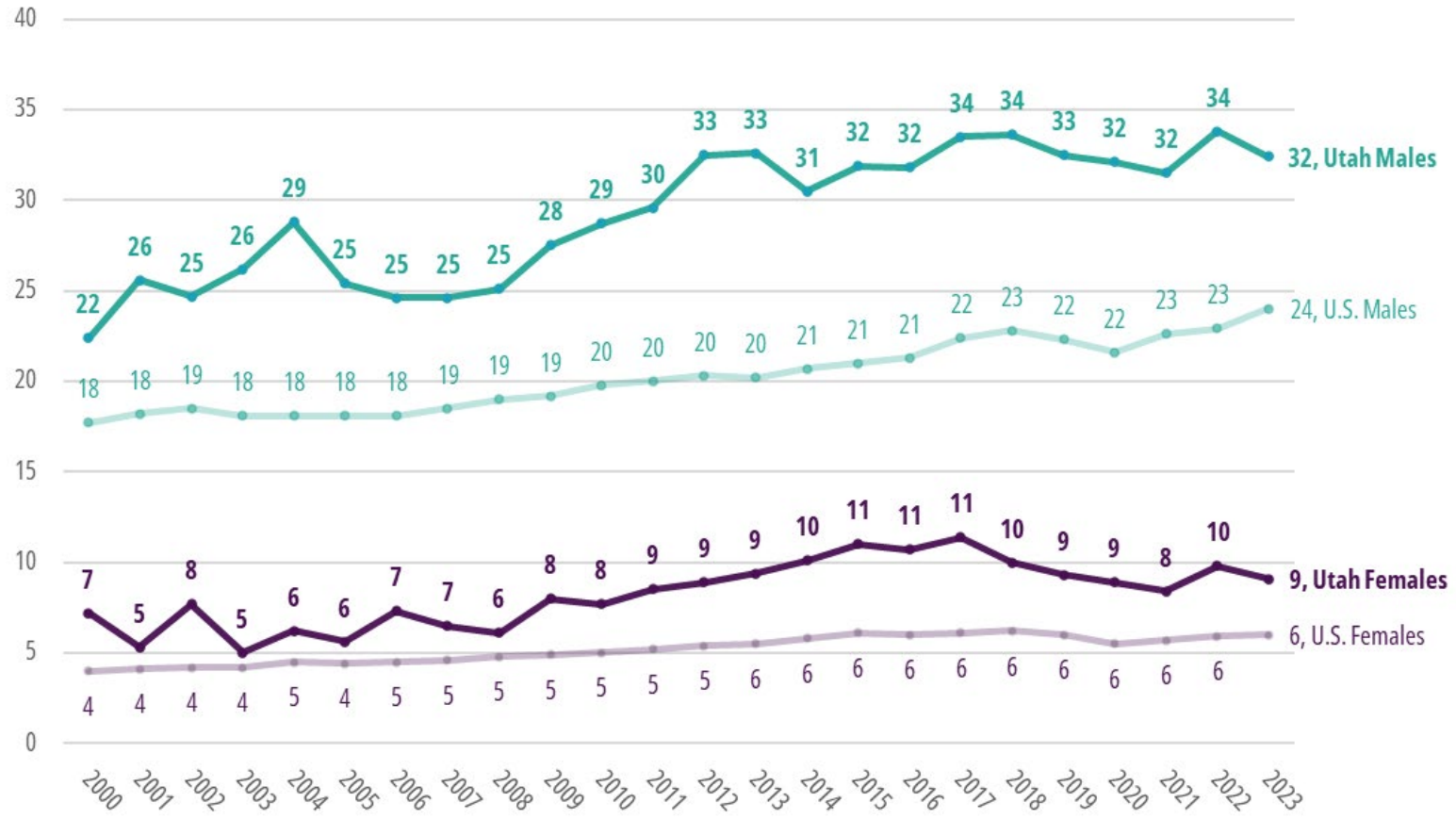
In all age groups, women are less likely to die from drug overdose than men.

Description:
Drug poisoning/overdose deaths per 100,000 population (ICD-10 Codes x40-x44, x46, x60-x64, x66, y10-y14, y16). Includes unintentional, suicide, homicide, undetermined, and other.

Drug poisoning deaths are a subset of all poisoning deaths, where drug is defined as "any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes."

Suicide

Figure 22. Suicide deaths per 100,000 population, 2000-2023



Source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

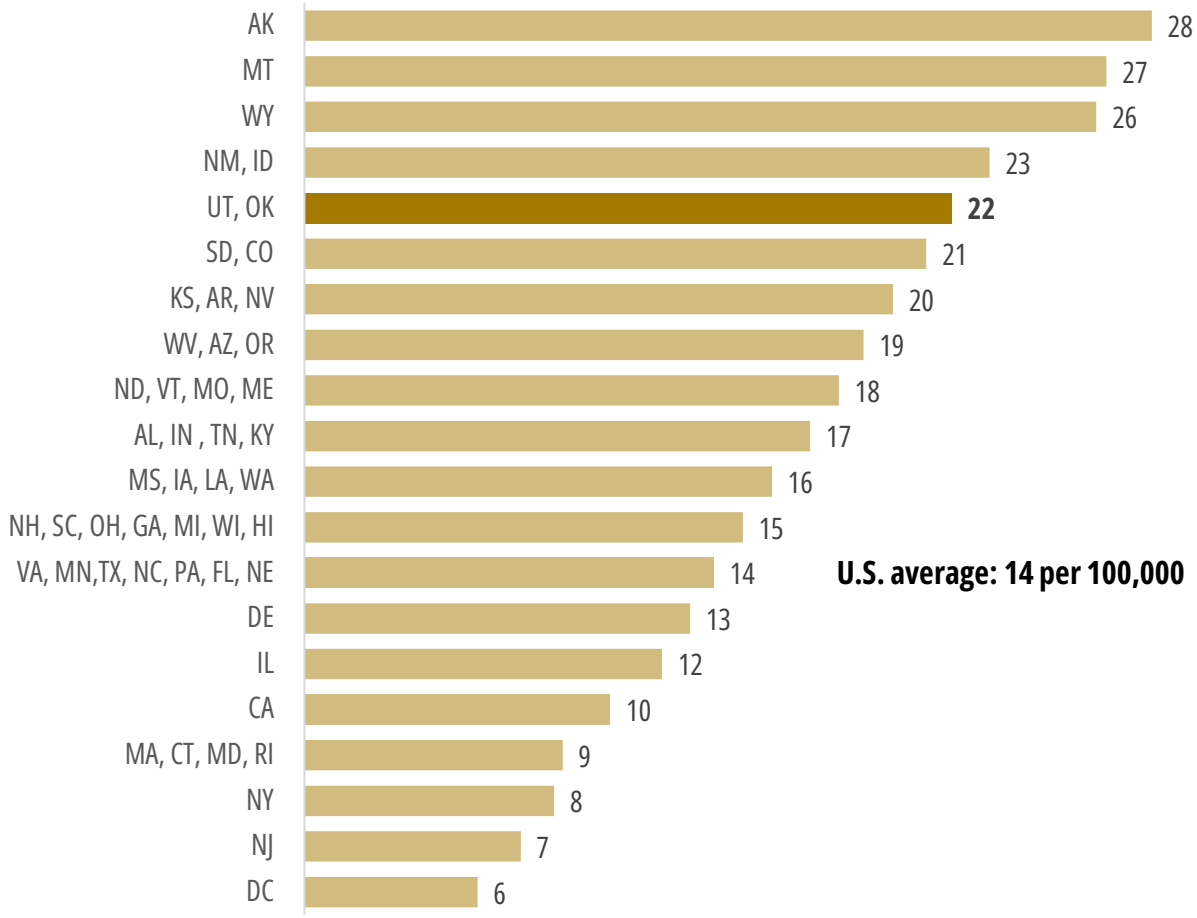
Utah suicide rates are higher than the national rate for both men and women.

Male rates of suicide are higher than female rates at both the state and national level.

Note:
Data are age-adjusted to the 2000 U.S. standard population.

Suicide

Figure 23. Suicide deaths per 100,000 population by state, 2023



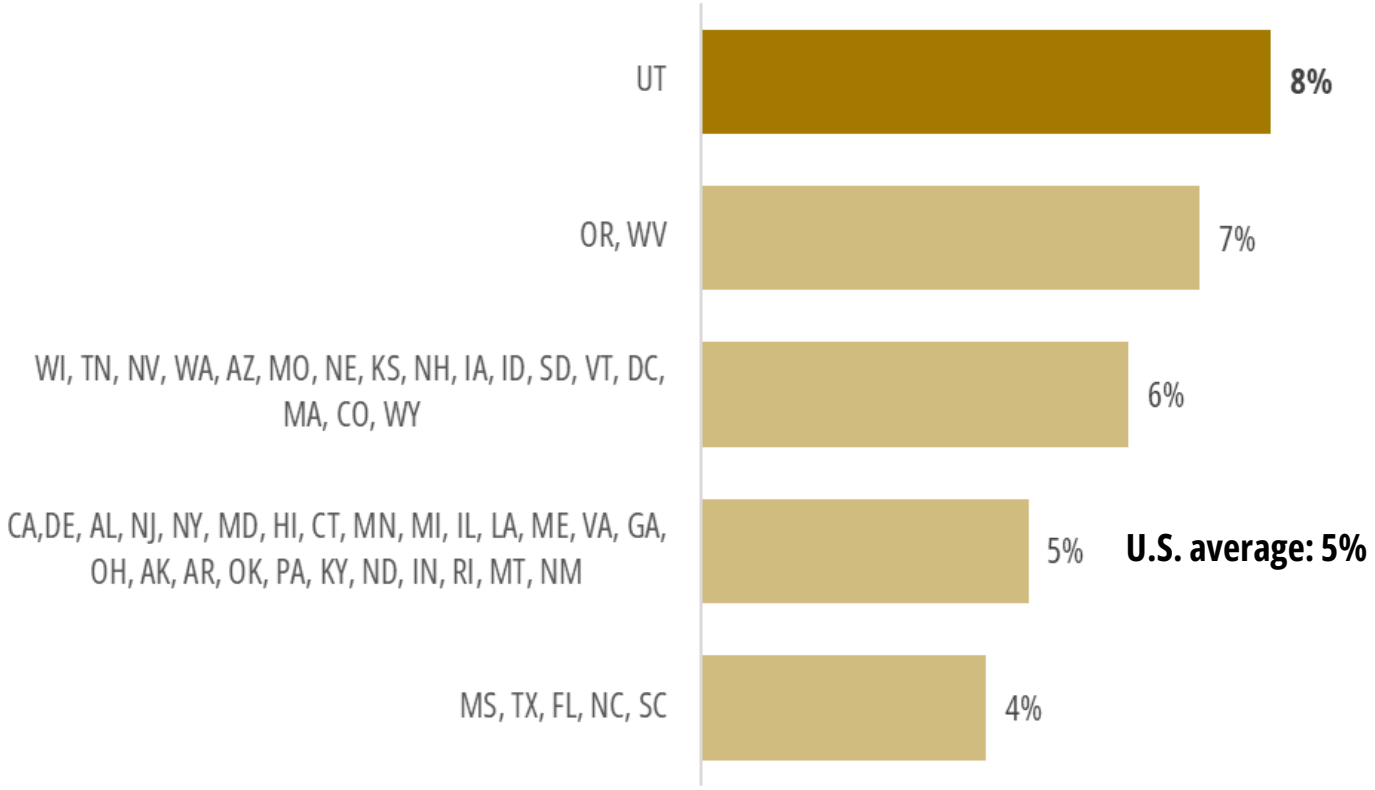
Data source: https://www.cdc.gov/suicide/facts/rates-by-state.html

Utah's rate of suicide is among the highest in the U.S.

Note:
Data are age-adjusted to the 2000 U.S. standard population.

Suicide

Figure 24. Adults with serious thoughts of suicide by state, 2022-2023 combined

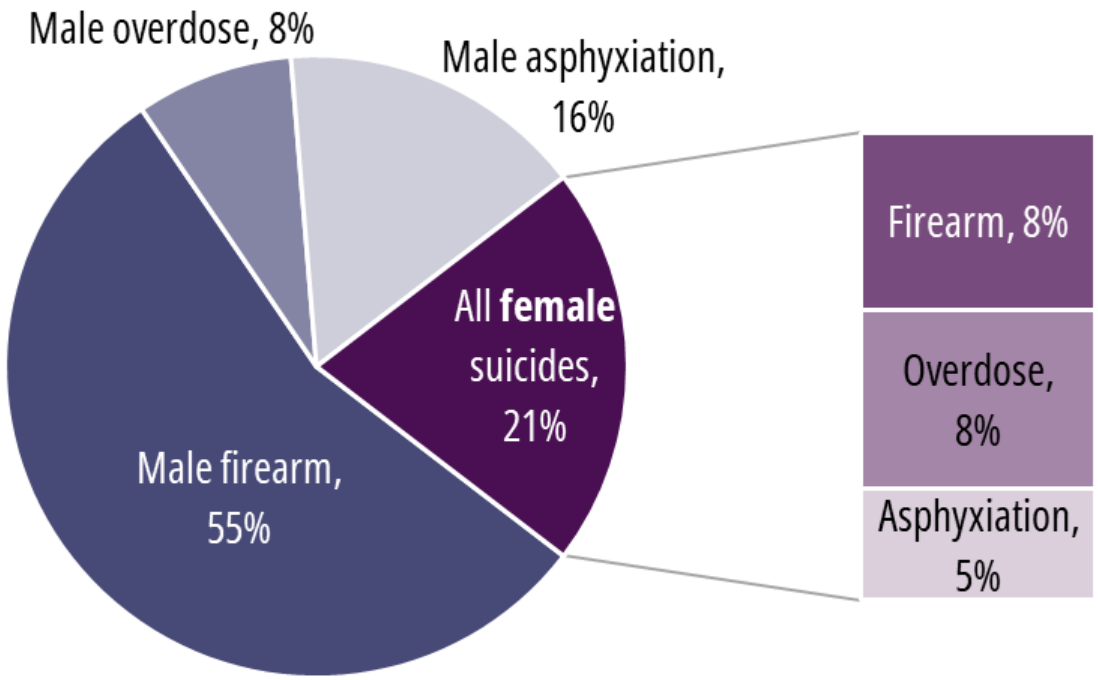


Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

In 2022-2023, Utah had the highest rate of serious thoughts of suicide compared to the rest of the U.S.

Suicide

Figure 25. Utah suicide deaths by gender and method, 2023

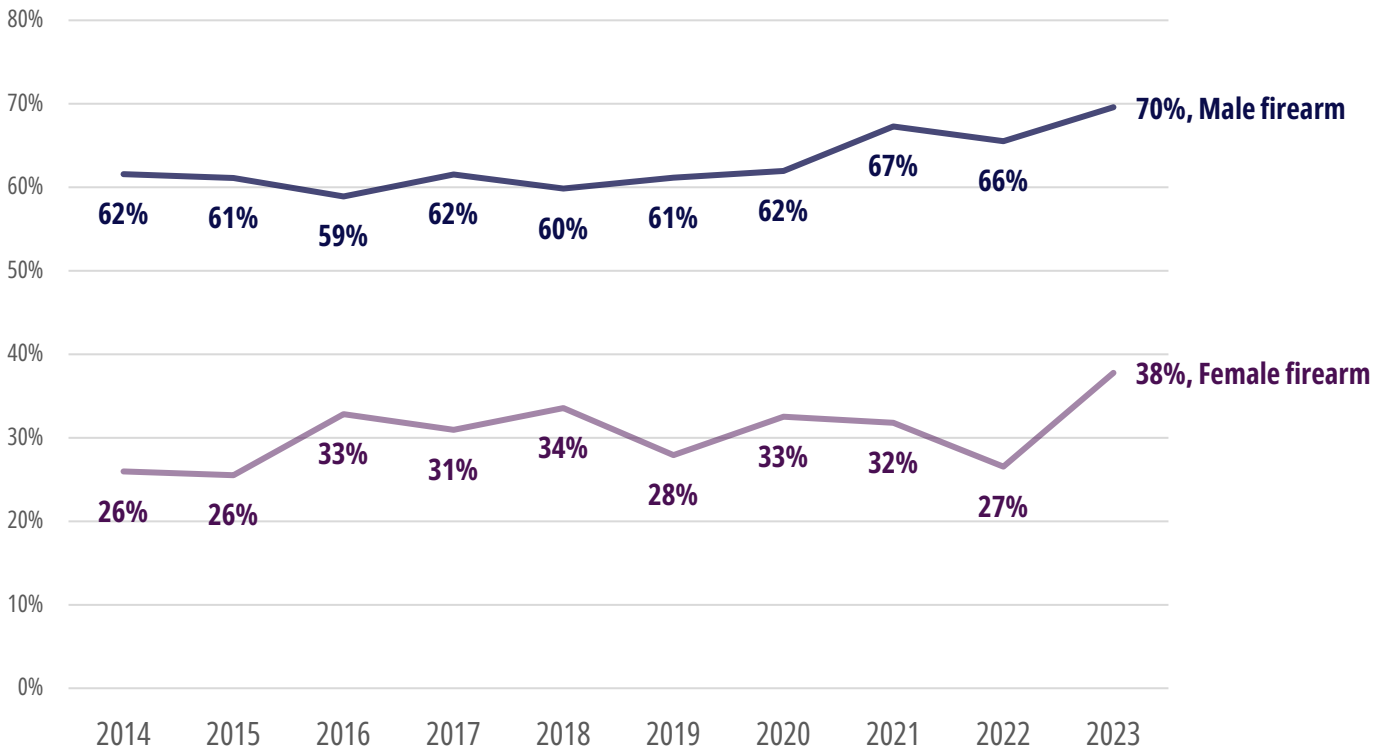


Men are most likely to die by suicide using a firearm. Women are approximately equally likely to die by firearm, poison, or suffocation.

Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

Suicide

Figure 26. Percentage of Utah suicides by firearm, 2014-2023

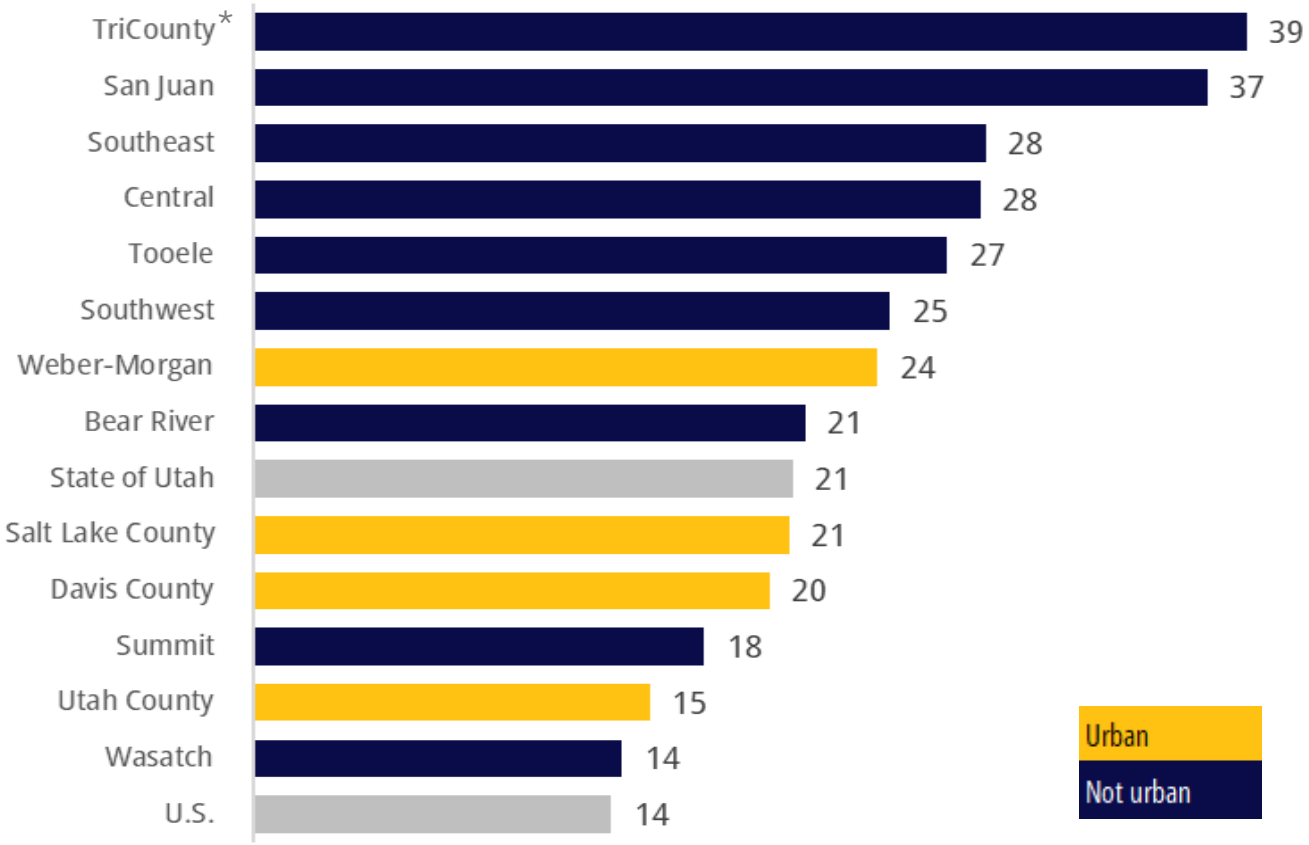


Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

The percentage of total Utah suicides that use firearms has increased for both men and women from 2014 to 2023.

Suicide

Figure 27. Utah suicide deaths per 100,000 population by local authority, 2021-2023 combined



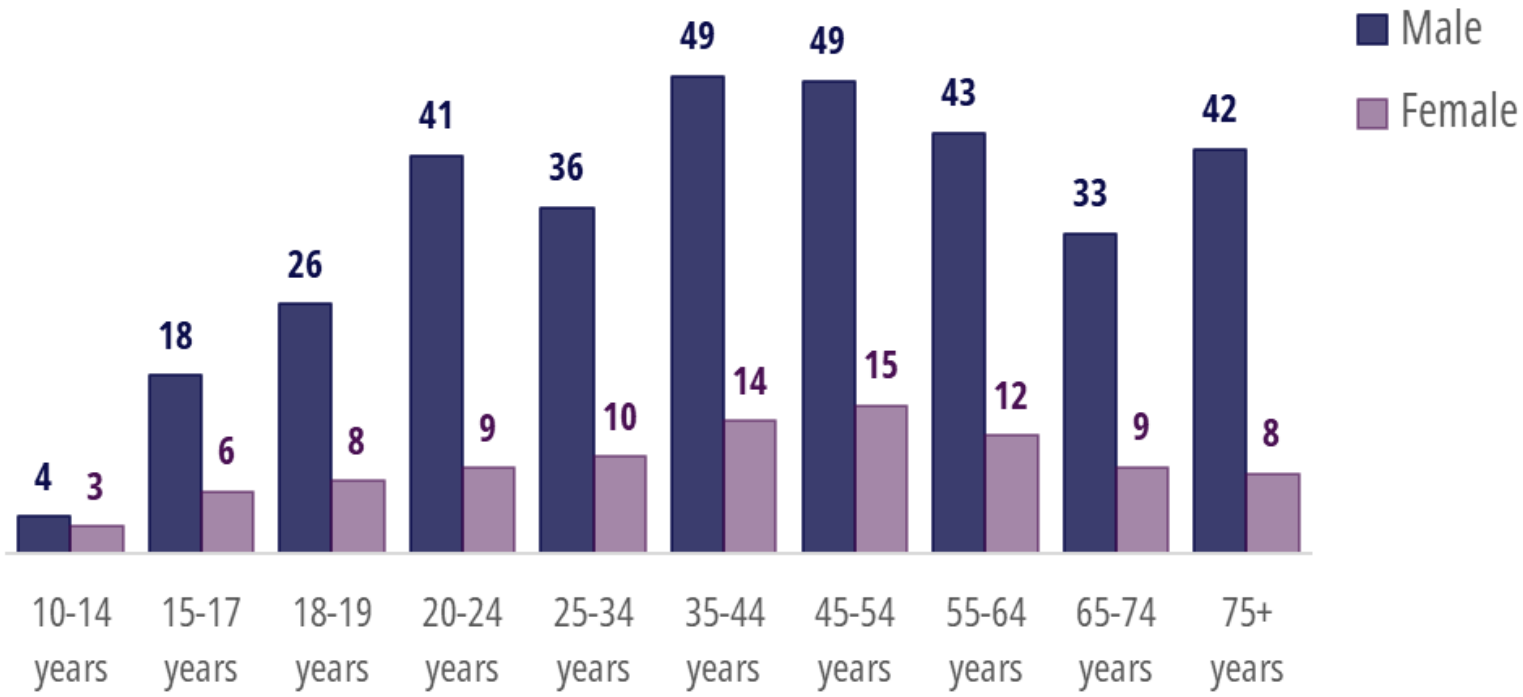
*The TriCounty area includes Daggett, Duchesne, and Uintah.

Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

The highest suicide rates are found in rural areas in Utah.

Suicide

Figure 28. Utah suicide deaths per 100,000 population by gender and age group, 2021-2023 combined



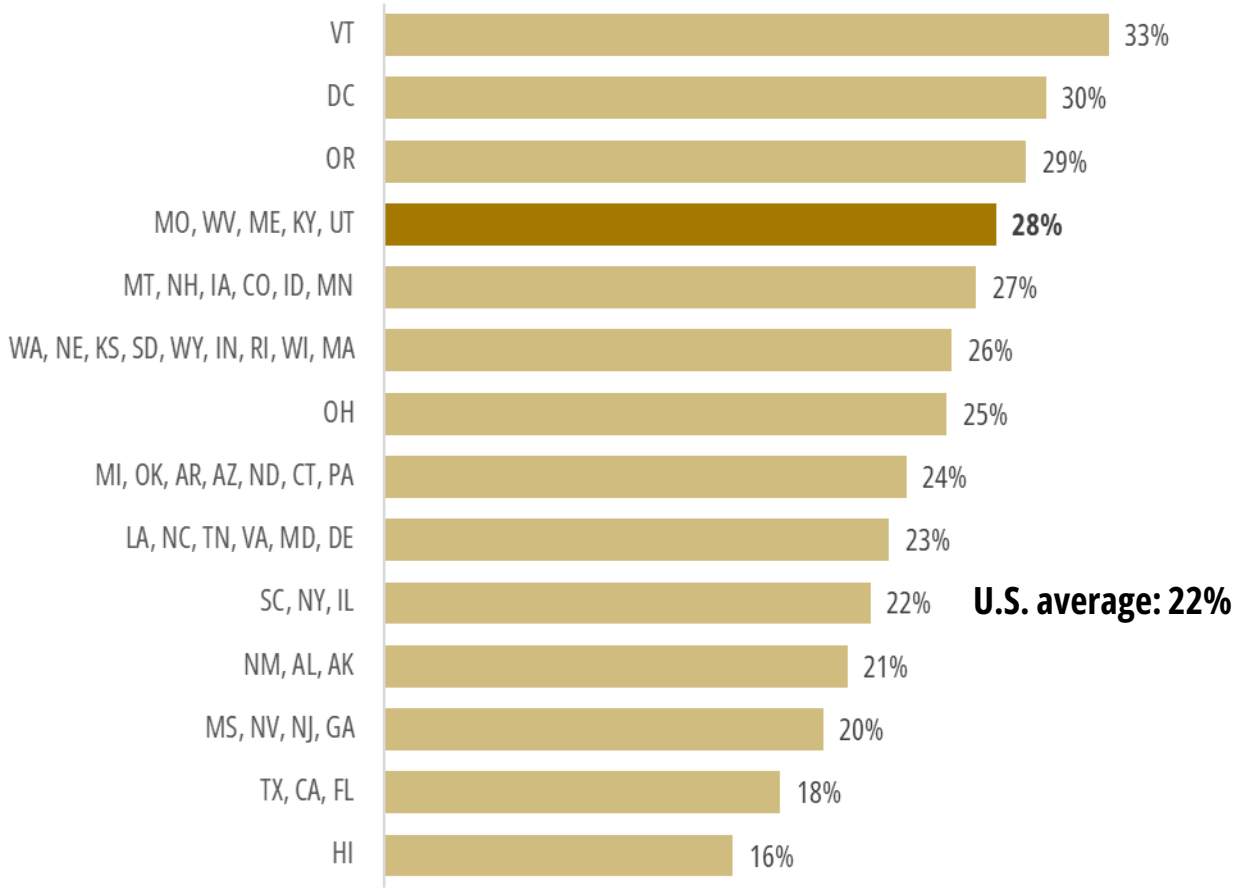
Data source: Indicator-Based Information System (IBIS); Utah Death Certificate Database, Office of Vital Records and Statistics, Utah Department of Health and Human Services

In all age groups in Utah, men are more likely to die by suicide than women.

The highest rates of suicide are in the age ranges of 35-54.

Treatment

Figure 29. Adults who received mental health treatment in the past year, by state, 2022-2023



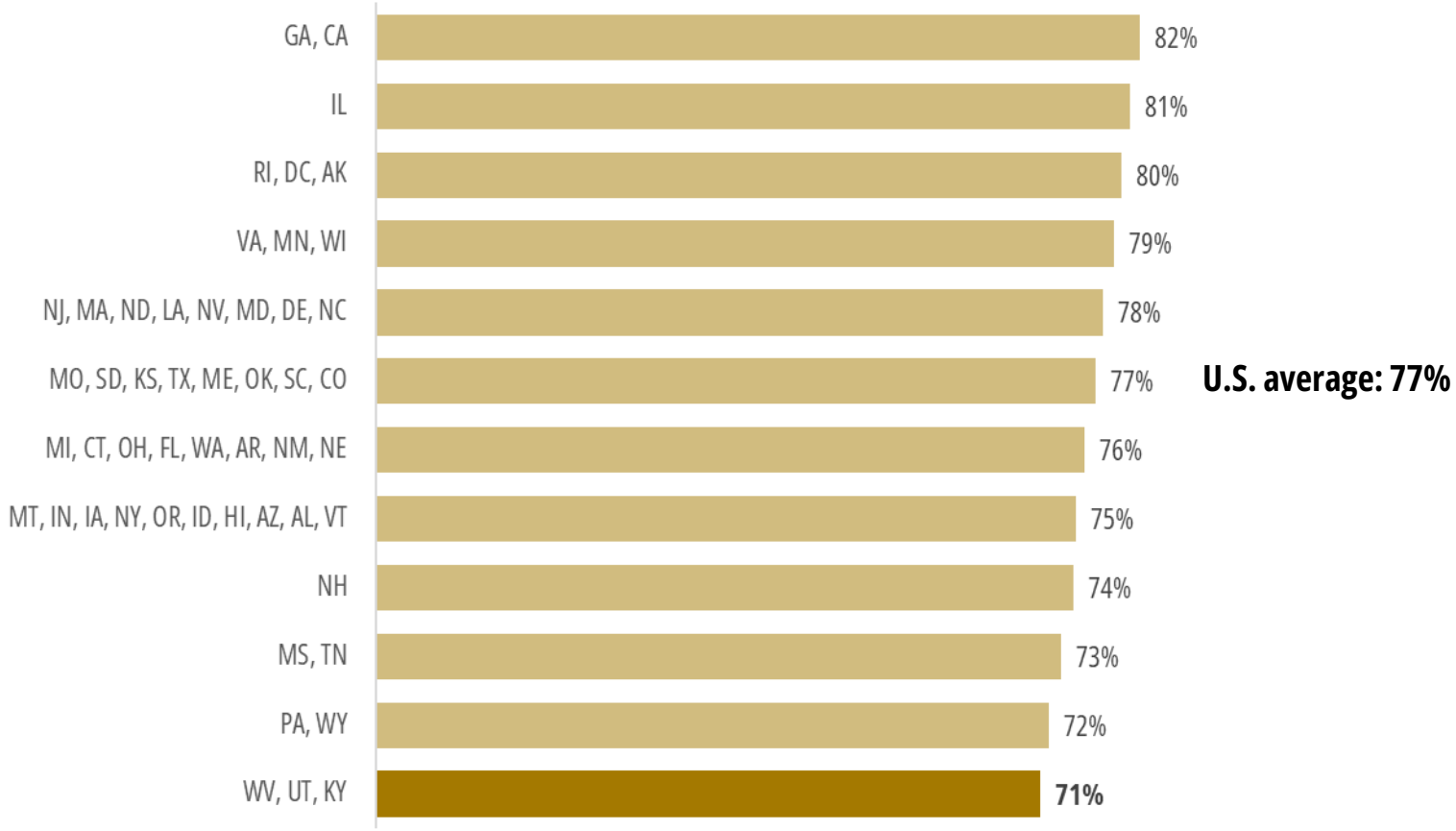
Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

In 2022-2023, Utah was among the top eight states for adults receiving mental health treatment.

Note: This is the percentage of all Utah adults who received mental health treatment. We do not currently have access to the percentage of adults with any mental illness (AMI) who received treatment.

Treatment

Figure 30. Adults who needed, but did not receive, substance use treatment in the past year, by state, 2022-2023



Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

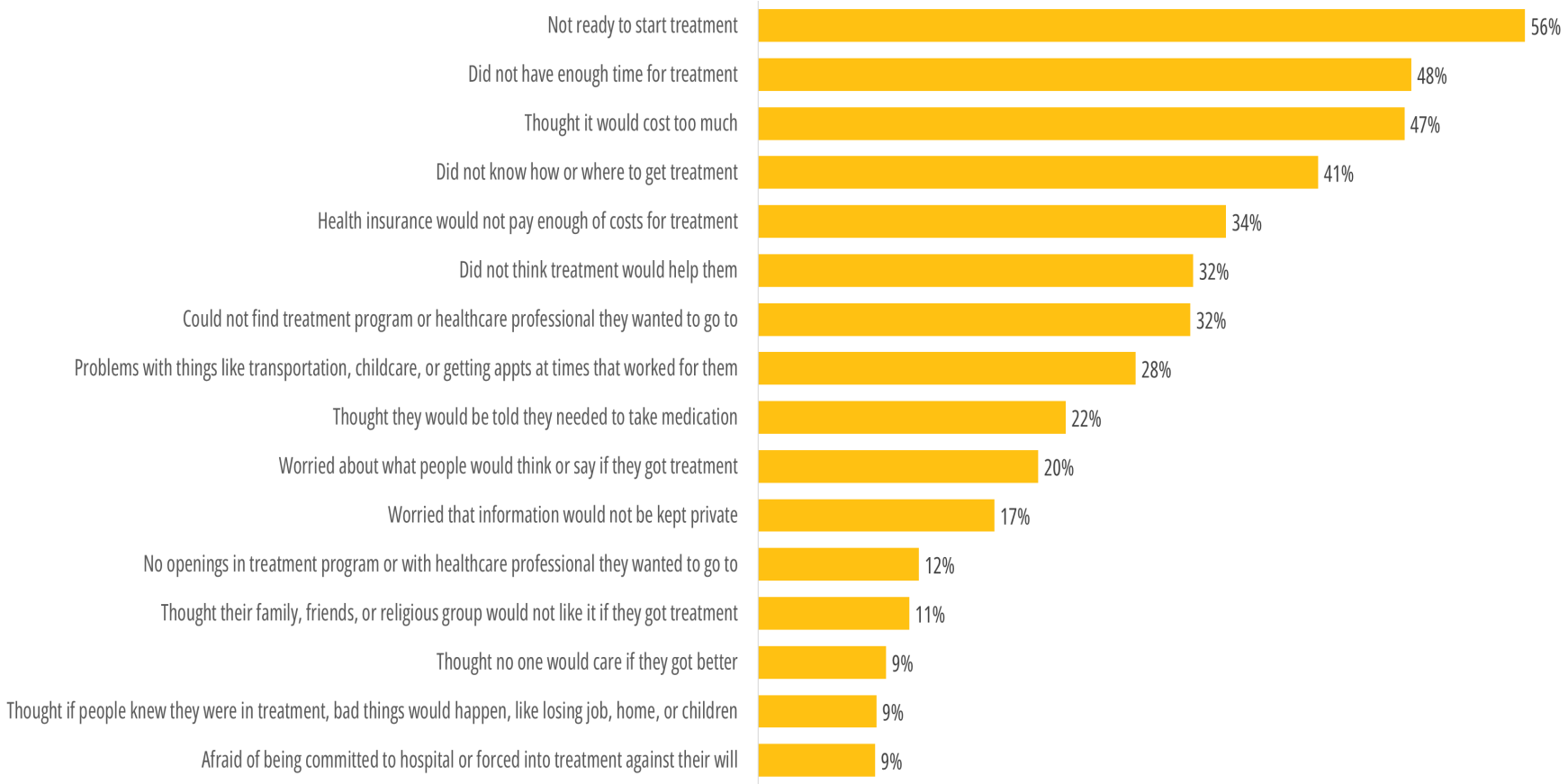
In 2022-2023, Utah was among the lowest state rates for adults who needed, but did not receive, substance use treatment in the past year.

Only a small percentage of adults who need substance use treatment actually receive it. However, Utah generally has higher rates of treatment than most other states.

Respondents were classified as needing substance use treatment if they met Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use through inpatient treatment/counseling, outpatient treatment/counseling, medication-assisted treatment, telehealth treatment, or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used drugs or alcohol in their lifetime.

Treatment

Figure 31. Utah reasons for adult unmet mental health treatment needs, 2022-2023 combined



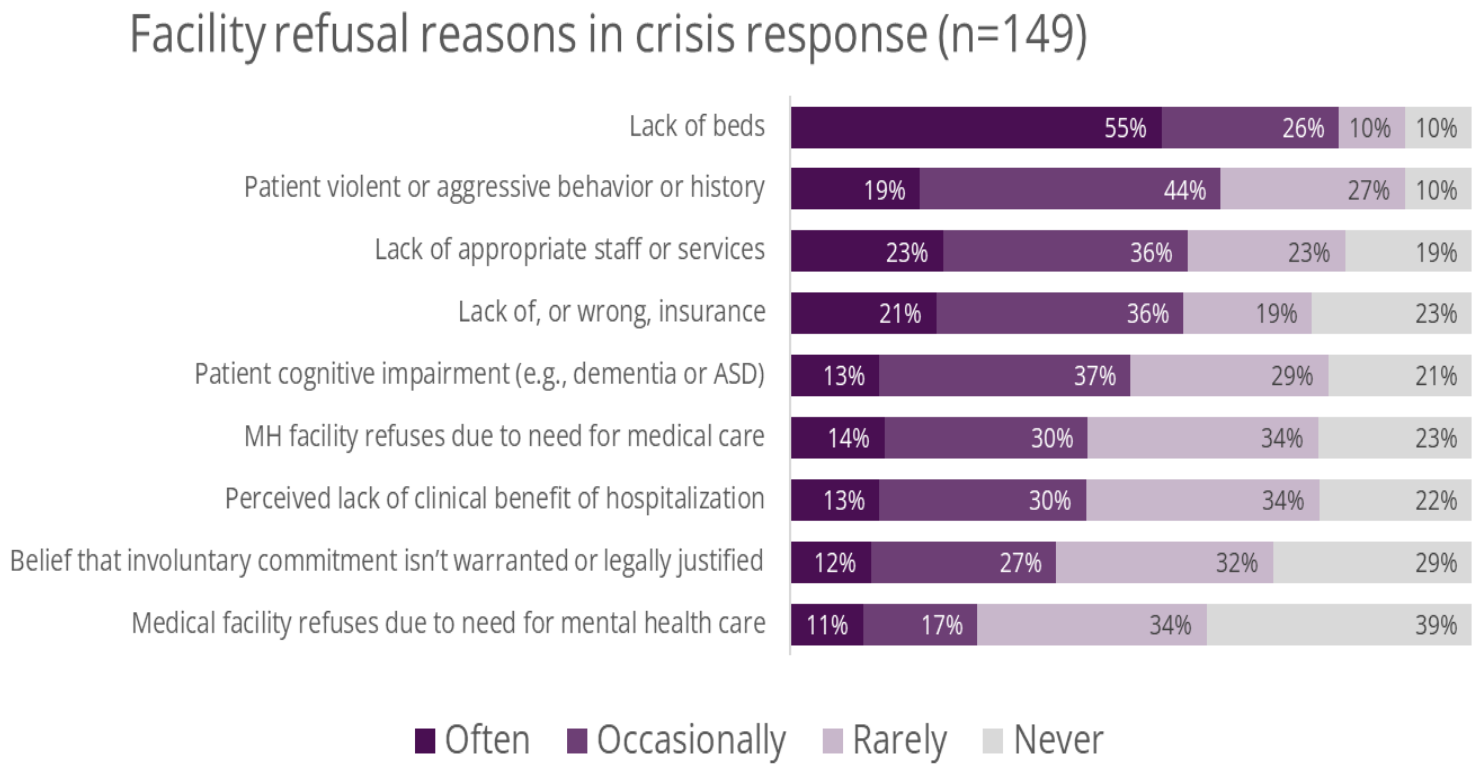
Data source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2022 and 2023.

While not being ready to start treatment or not having enough time are the most common reasons for not getting mental health treatment, many other issues create barriers.

Cost (with and without insurance), finding providers, and stigma are all barriers to receiving treatment.

Treatment

Figure 32. Barriers to facility placements during behavioral health crisis response, 2024



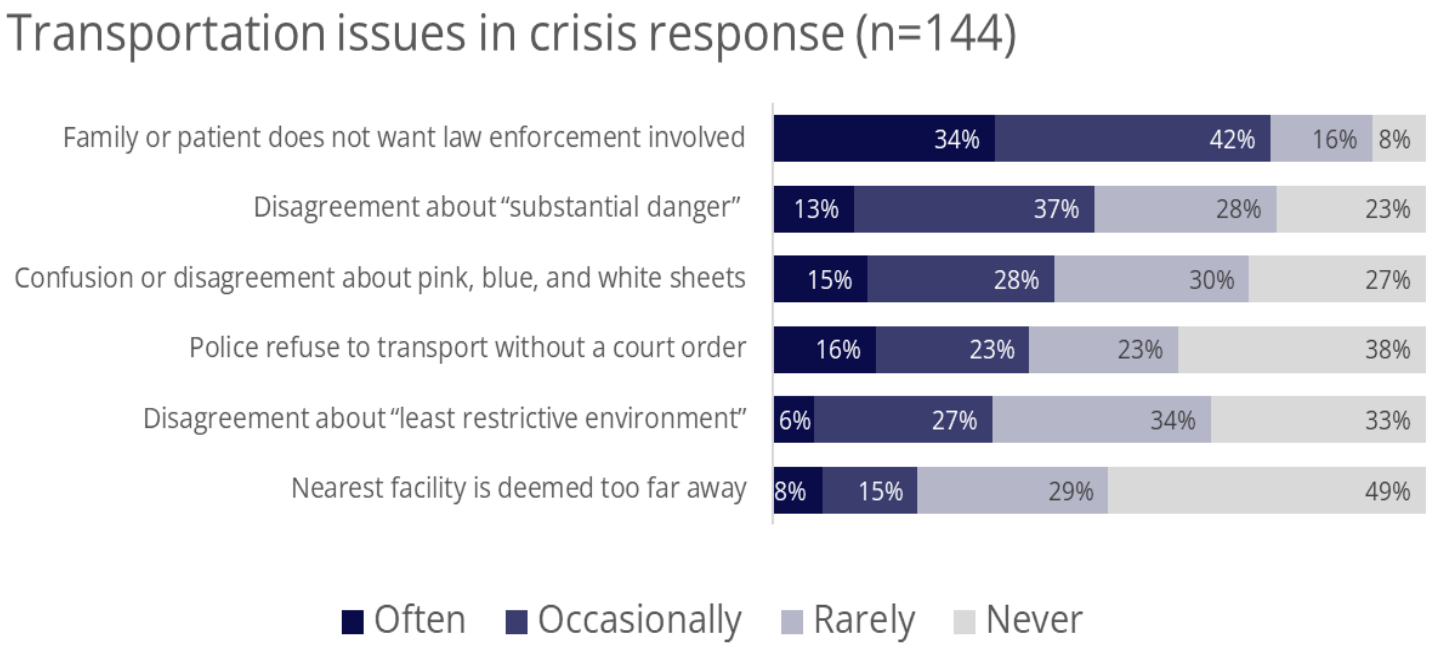
28% or more respondents marked *often* or *occasionally* for all of the listed reasons for facility refusal.

The most common reasons were lack of beds, patient aggression, lack of staff or services, and insurance issues.

Data source: 2024 survey conducted by the Utah Office of Substance Use and Mental Health, Department of Health and Human Services

Treatment

Figure 33. Barriers to transportation during behavioral health crisis response, 2024



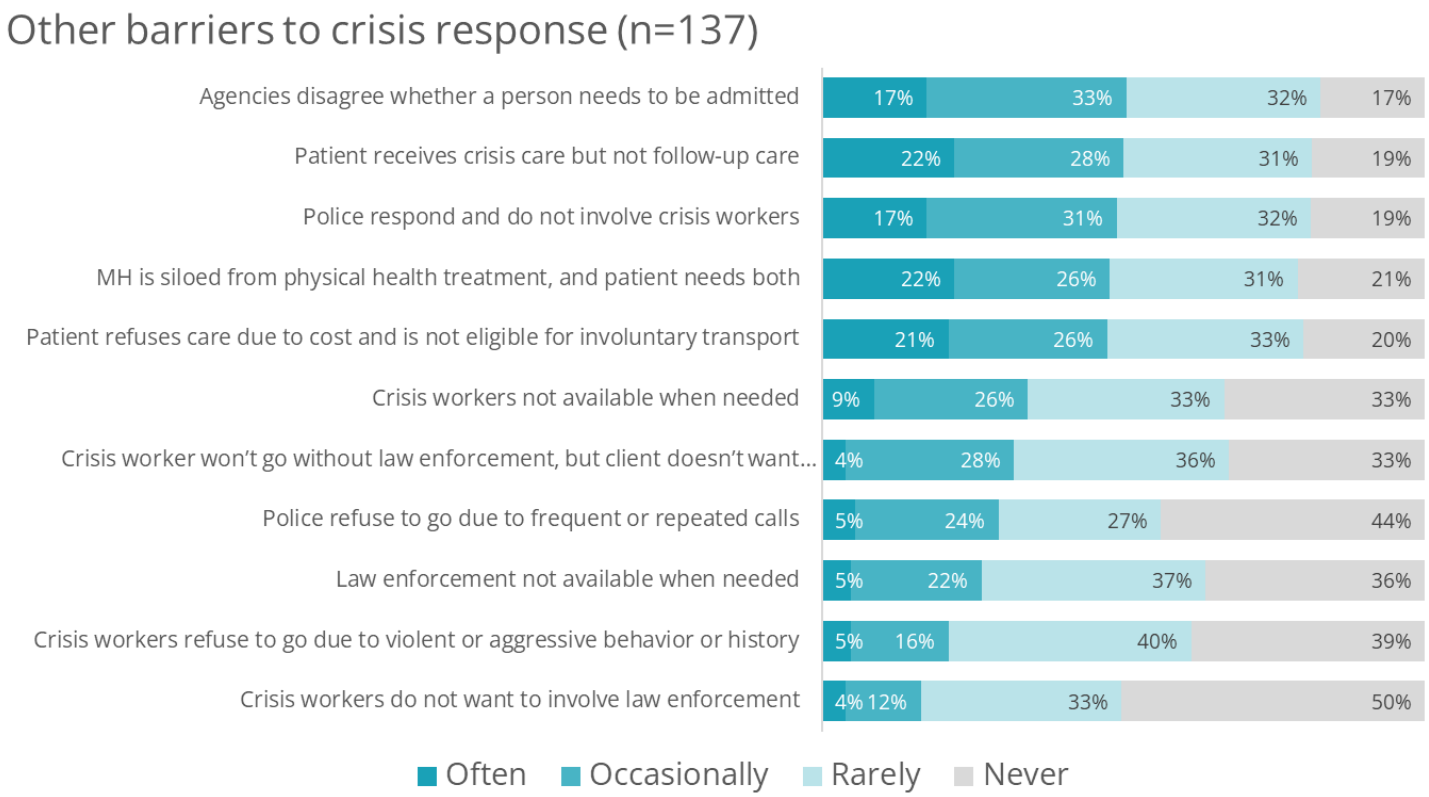
All six transportation issues were experienced *often* or *occasionally* by 23% or more respondents.

The most common reason was not wanting to involve law enforcement. Other reasons were related to confusion or disagreement about regulations around transporting.

Data source: 2024 survey conducted by the Utah Office of Substance Use and Mental Health, Department of Health and Human Services

Treatment

Figure 34. Other barriers to appropriate behavioral health crisis care, 2024

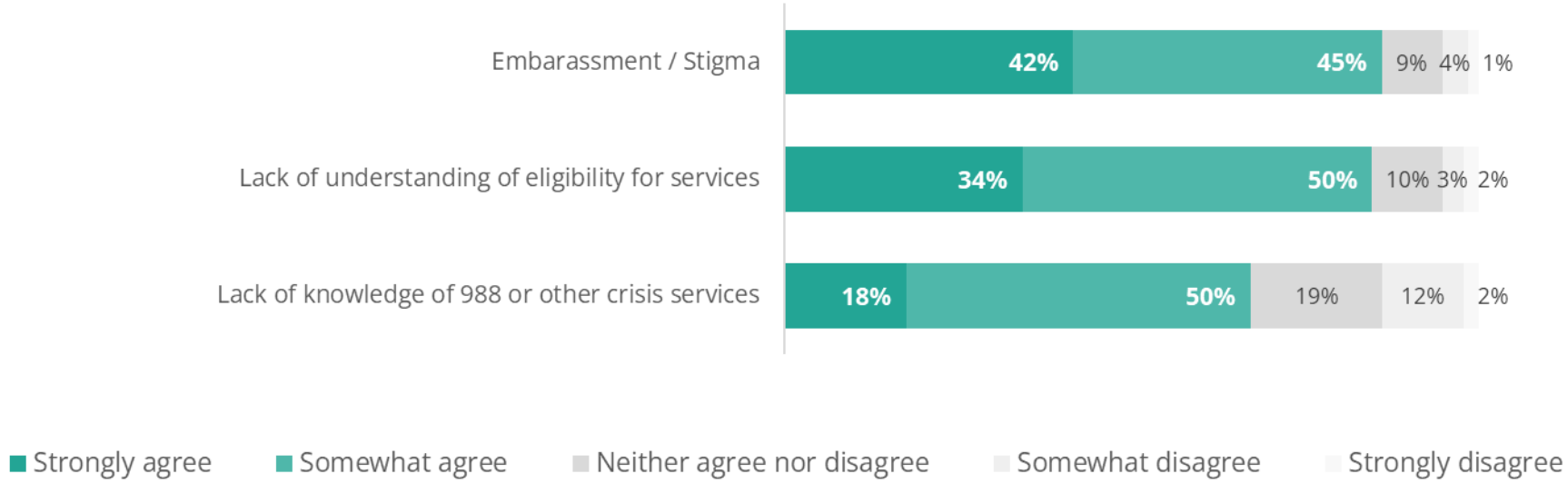


Although the most common barriers to crisis care were facility refusals (Figure 30) and transportation difficulties (Figure 31), other barriers are also common.

Data source: 2024 survey conducted by the Utah Office of Substance Use and Mental Health, Department of Health and Human Services

Treatment

Figure 35. Barriers to engagement with behavioral health crisis care, 2024

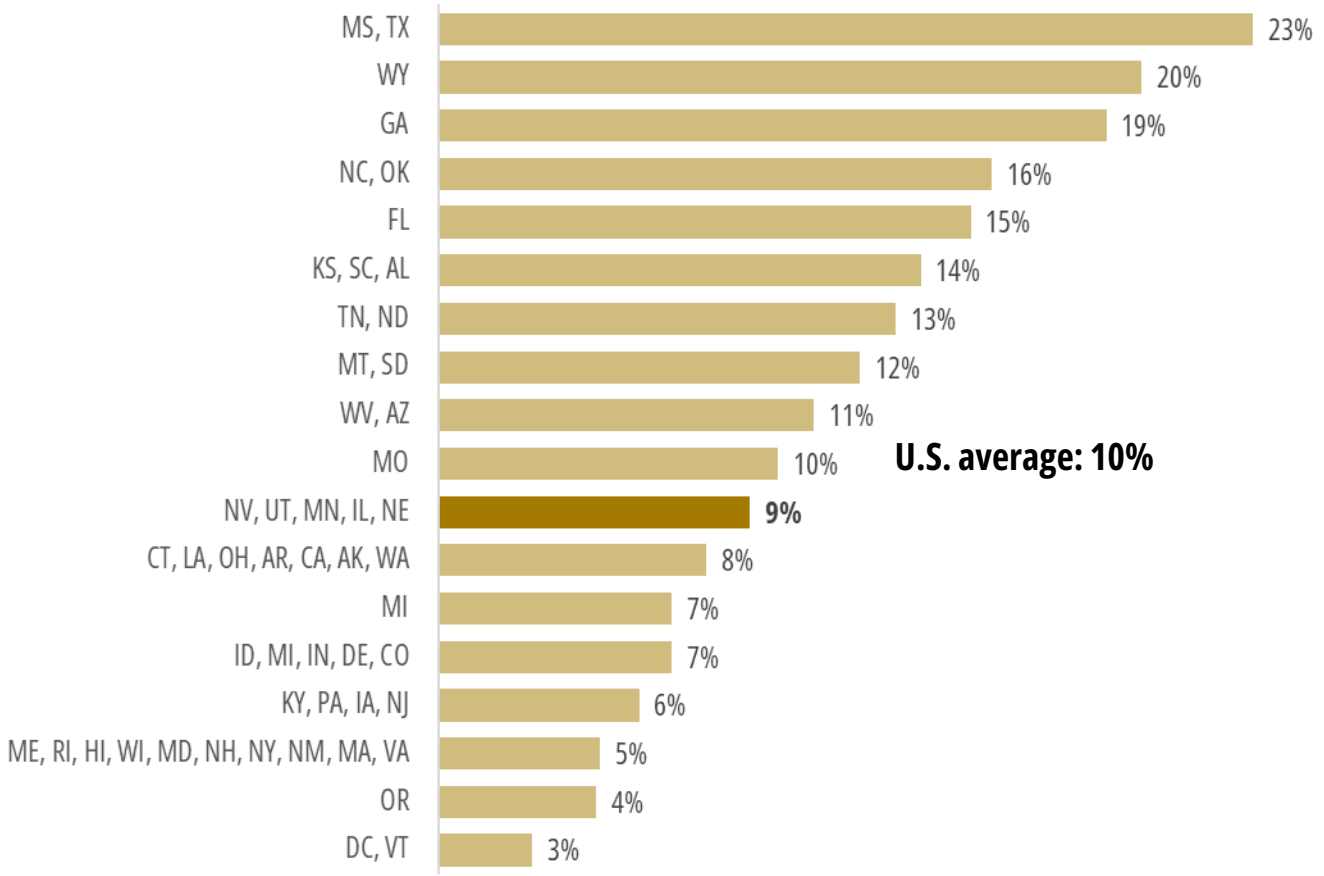


The majority of crisis workers agreed that patients may not engage with behavioral health crisis care due to embarrassment and stigma, lack of understanding of eligibility, and lack of knowledge about 988 and other crisis services.

Data source: 2024 survey conducted by the Utah Office of Substance Use and Mental Health, Department of Health and Human Services

Treatment

Figure 36. Adults with any mental illness who are uninsured by state, 2022



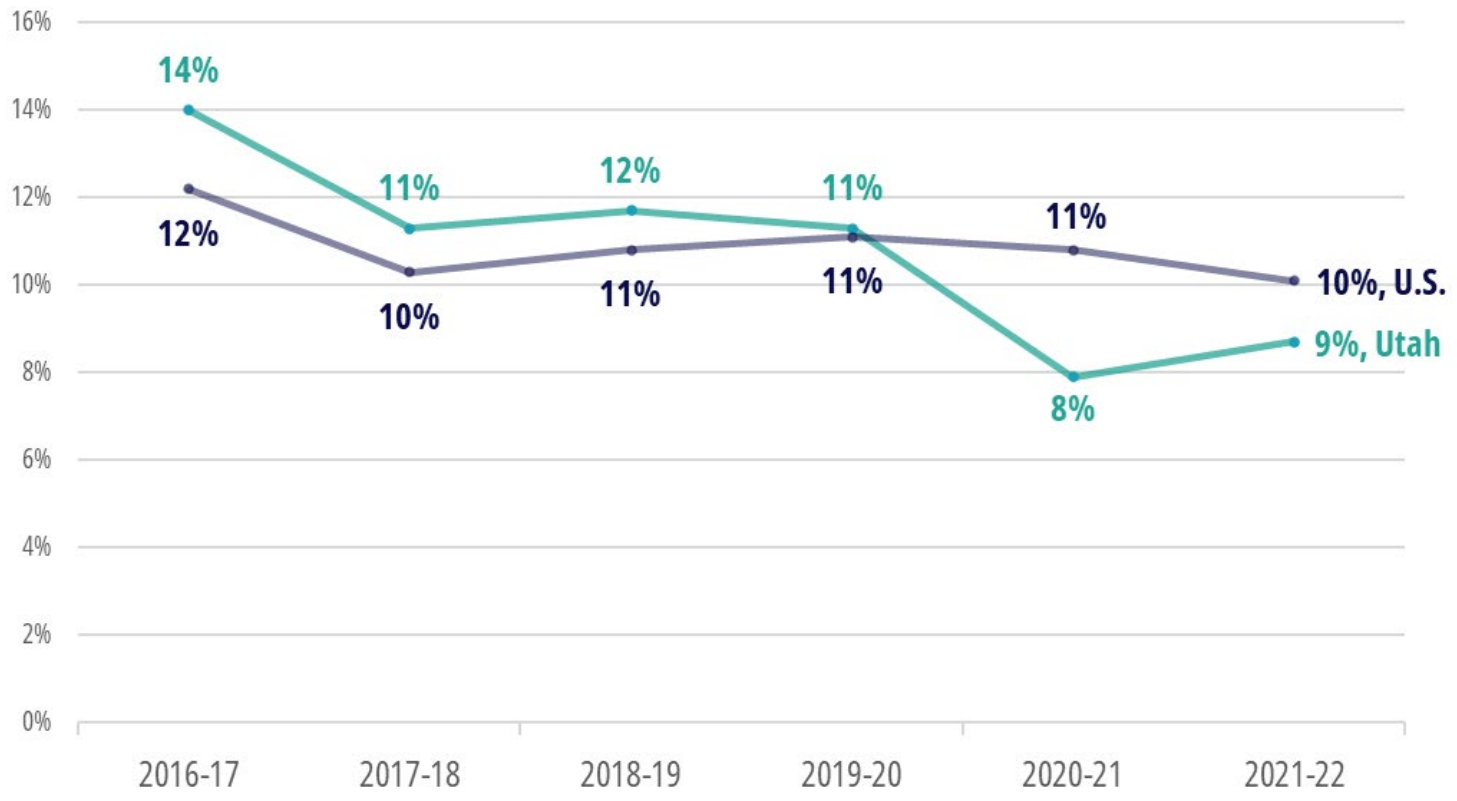
Data source: National Survey on Drug Use and Health (NSDUH); reported in Reinert, M, Fritze, D & Nguyen, T (July 2024). "The State of Mental Health in America 2024." Mental Health America, Alexandria VA.

9% of Utahns with any mental illness (AMI) are uninsured.

This is just under the U.S. average of 10%.

Treatment

Figure 37. Utah and U.S. adults with any mental illness (AMI) who are uninsured, 2016 - 2022

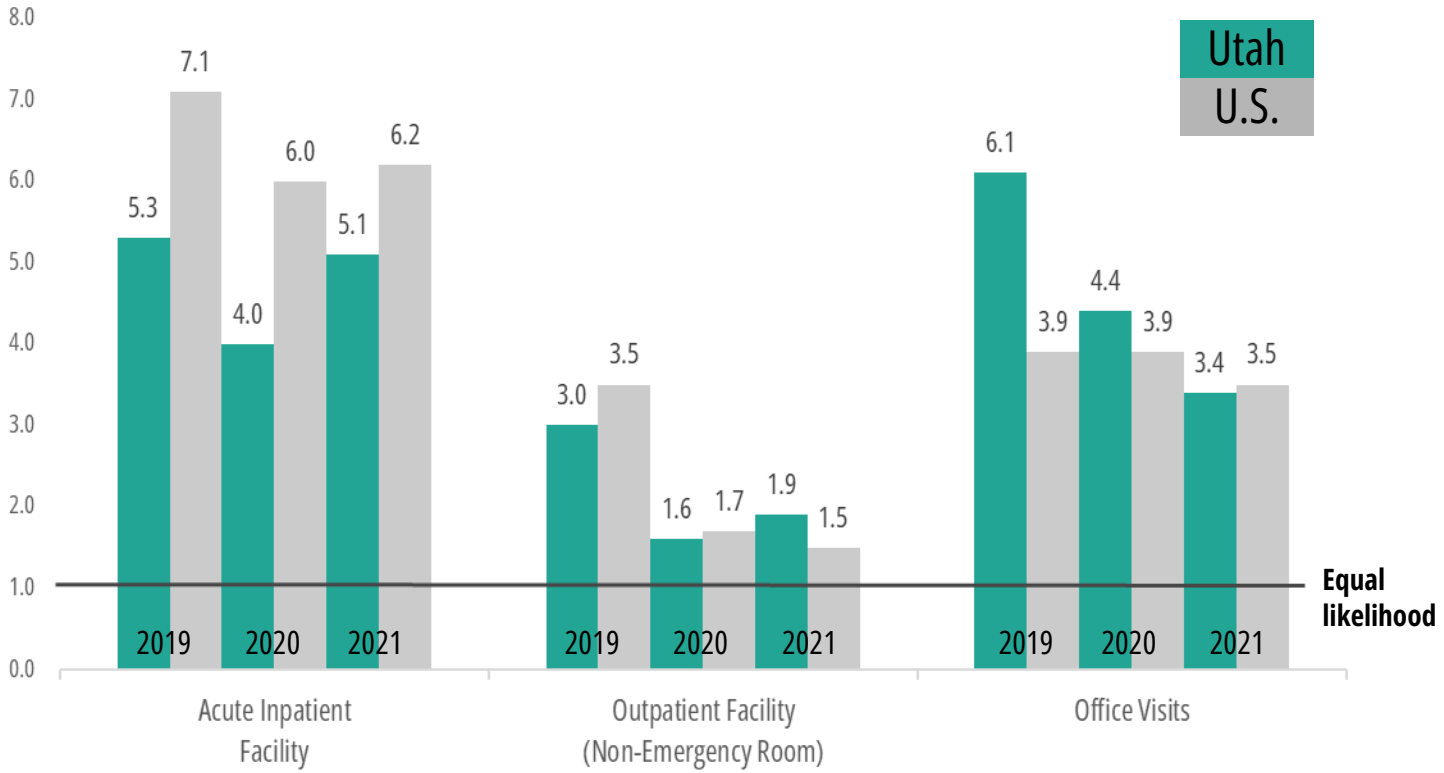


Data source: National Survey on Drug Use and Health (NSDUH); reported in Reinert, M, Fritze, D & Nguyen, T (July 2024). "The State of Mental Health in America 2024." Mental Health America, Alexandria VA.

The percentage of Utah adults with any mental illness who are uninsured has decreased slightly since 2016-17. The U.S. rate has been more stable during that time.

Treatment

Figure 38. Parity: Higher proportion of out-of-network use for behavioral vs. physical healthcare, 2019-2021



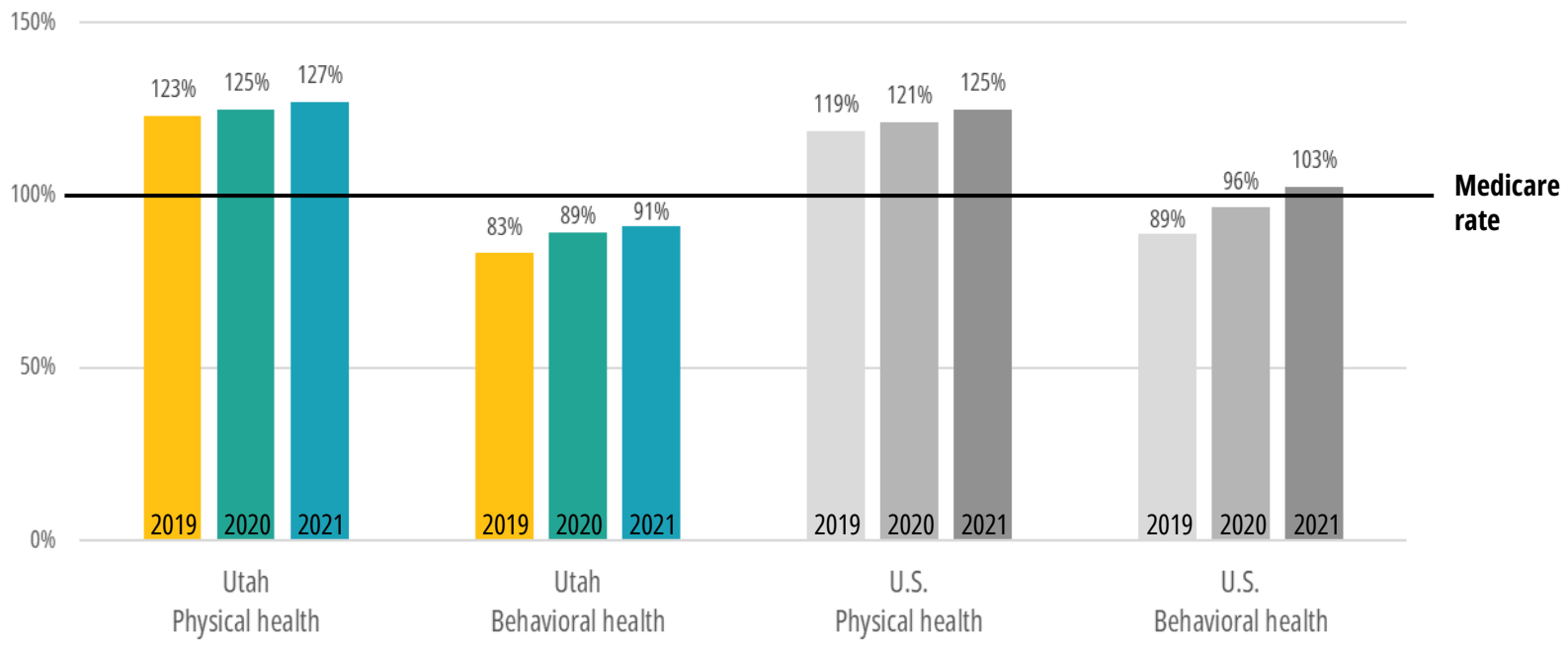
Data source: Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International. Utah data were drawn from the Utah All Payers Claims Database (APCD).

The figure shows how much more likely a patient is to receive out-of-network care for behavioral healthcare than physical. Out-of-network care can create a significant financial burden for patients.

For all three categories (acute inpatient, outpatient, and office visits), patients in Utah and the U.S. are more likely to receive behavioral healthcare out-of-network than physical healthcare.

Treatment

Figure 39. Parity: Commercial insurance reimbursement rates as a percentage of Medicare rates, 2019-2021



Data source: Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International. Utah data were drawn from the Utah All Payers Claims Database (APCD).

Commercial insurers reimburse physical healthcare providers at a higher relative rate than behavioral healthcare providers. This may disincentivize behavioral health providers from participating on commercial insurance panels.

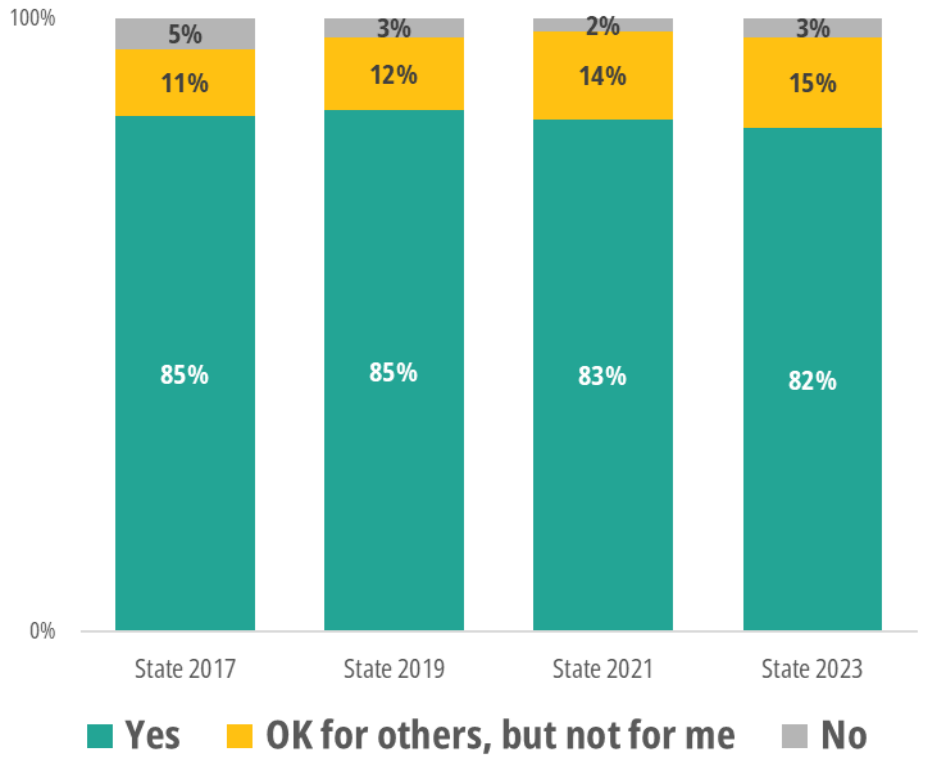
Notes on this measure:
Because physical healthcare typically costs more than behavioral healthcare, it can be difficult to assess parity in reimbursement rates. By using Medicare rates as a benchmark, we have a standard to compare payment for similar services across payers.

For more information on this methodology, see: https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf)

Youth behavioral health

Figure 40. Youth perceptions of stigma for mental health help-seeking, 2017-2023

Do you think it's ok to seek help and talk to a professional counselor, therapist, or doctor if you've been feeling very sad, hopeless, or suicidal?



Data source: SHARP student survey, grades 6, 8, 10, 12 combined

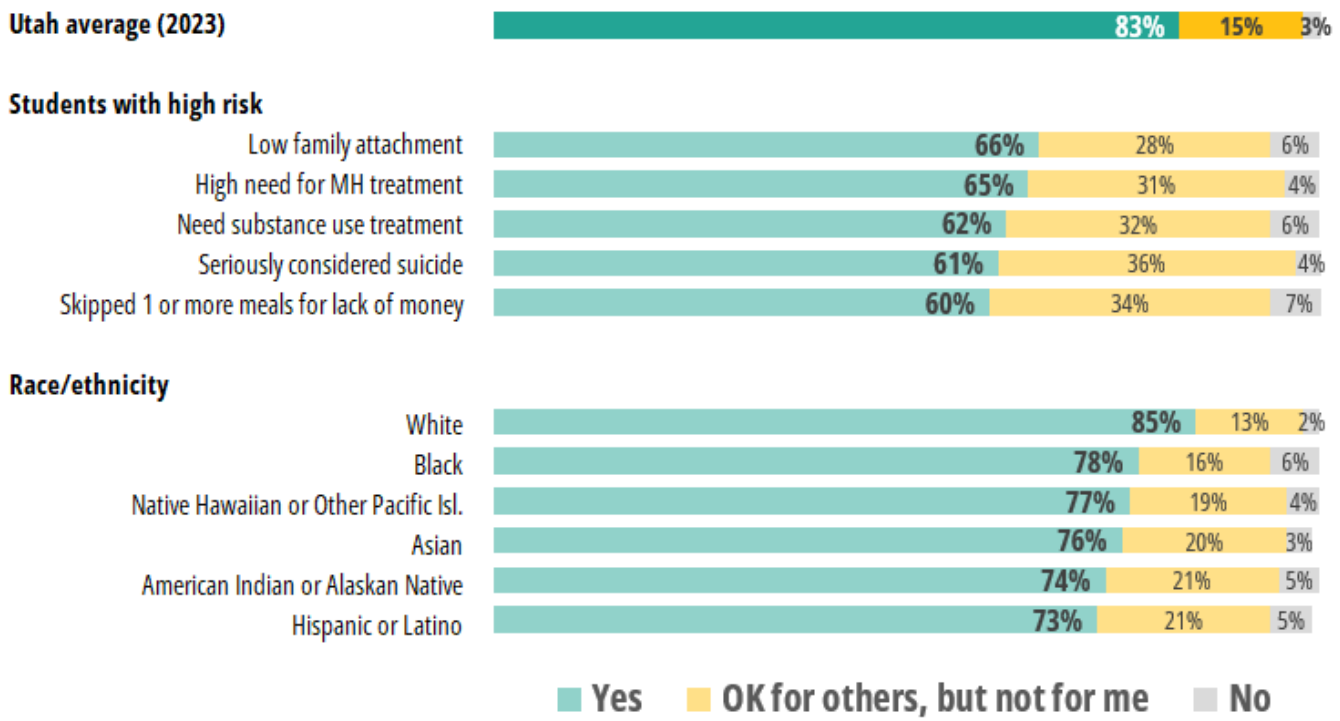
While most students believe seeking help is okay, 18% of students perceive that it is not okay.

Perceived stigma for seeking help has been stable from 2017 to 2023.

Youth behavioral health

Figure 41. Youth perceptions of stigma for mental health help-seeking by risk factors and ethnicity, 2023

Do you think it's ok to seek help and talk to a professional counselor, therapist, or doctor if you've been feeling very sad, hopeless, or suicidal?



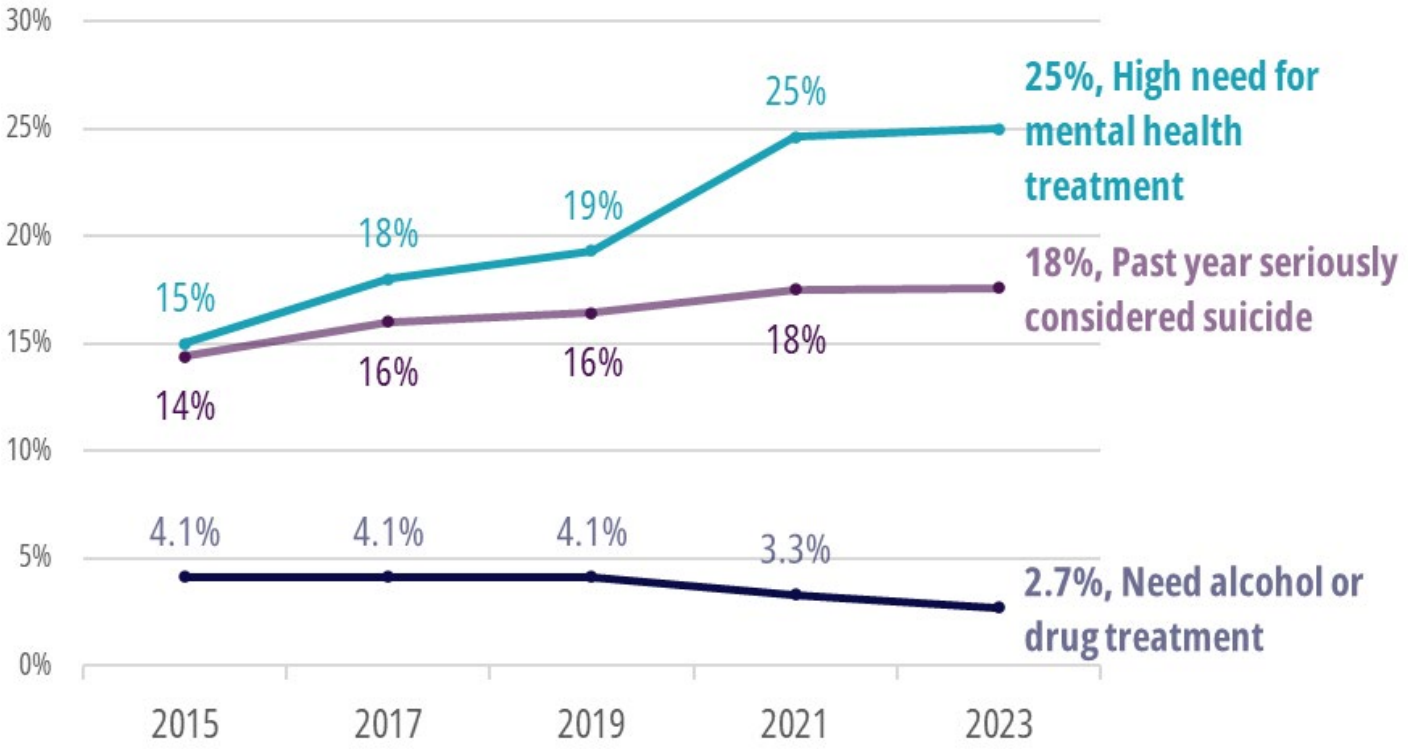
Data source: SHARP student survey, grades 6, 8, 10, 12 combined

Students who have the highest need for mental health treatment, need substance use treatment, or have other risk factors are more likely to perceive stigma associated with seeking that help.

Perceptions of stigma vary across different race and ethnicities.

Youth behavioral health

Figure 42. Utah youth with high need for mental health treatment, who need alcohol or drug treatment, or who seriously considered suicide in the past year (2015-2023)



Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

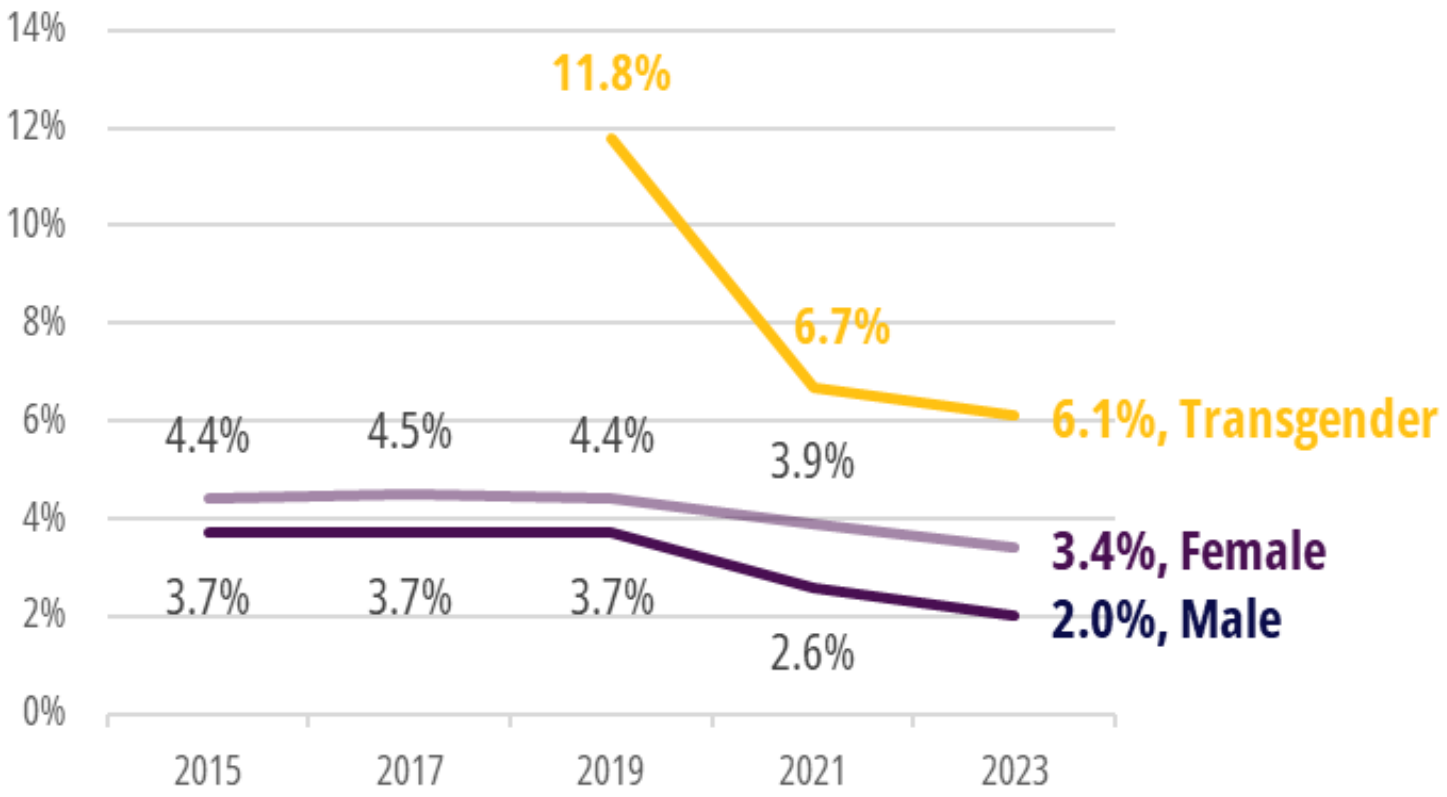
Youth with high need for mental health treatment has increased steadily since 2015.

Youth suicidal ideation has also increased but not as much.

Youth need for alcohol or drug treatment has decreased.

Youth behavioral health

Figure 43. Utah youth needing substance use treatment by gender, 2015-2023



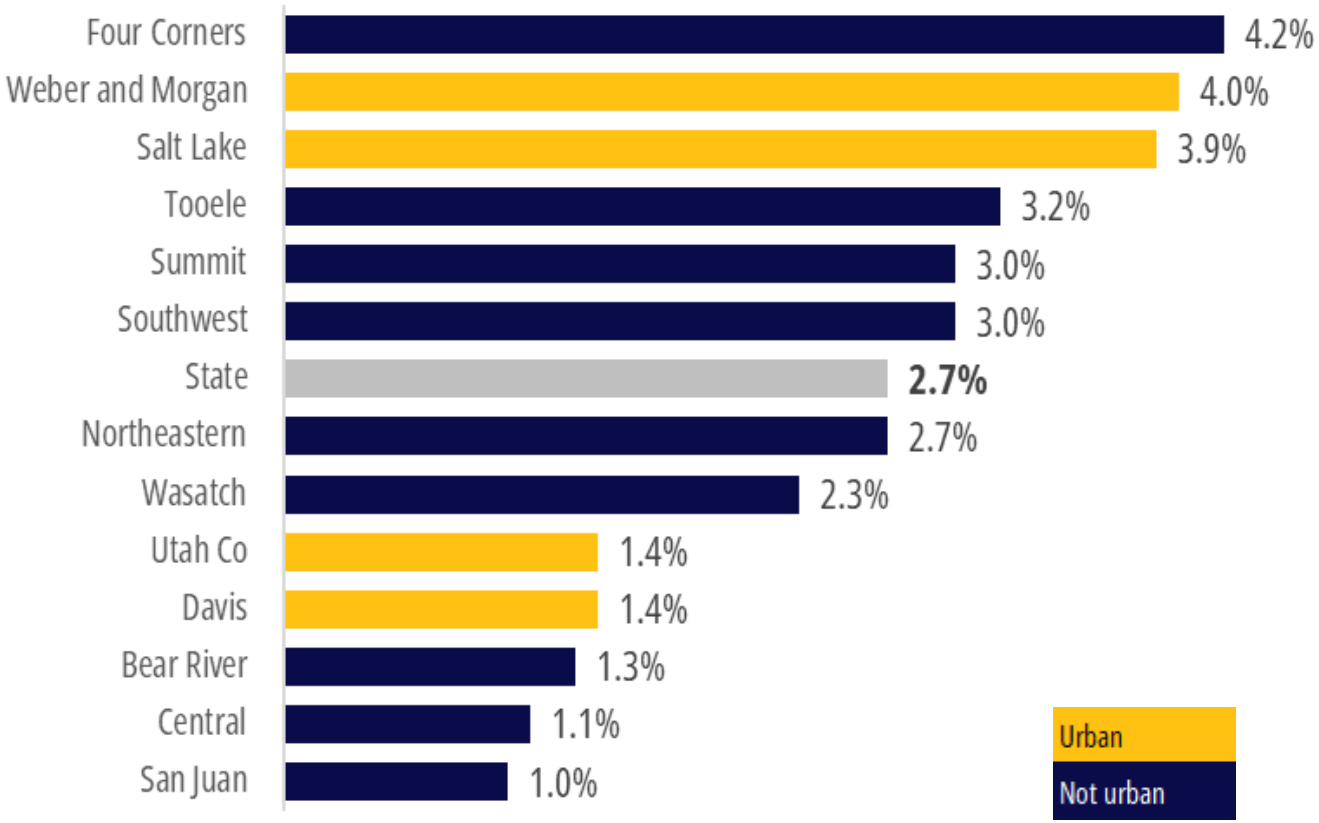
Data source: Utah SHARP Survey, grades 8, 10, 12 combined

Transgender youth were more likely to need substance use treatment than non-transgender youth.

Girls were more likely than boys to need substance use treatment.

Youth behavioral health

Figure 44. Utah youth needing substance use treatment by local authority, 2023



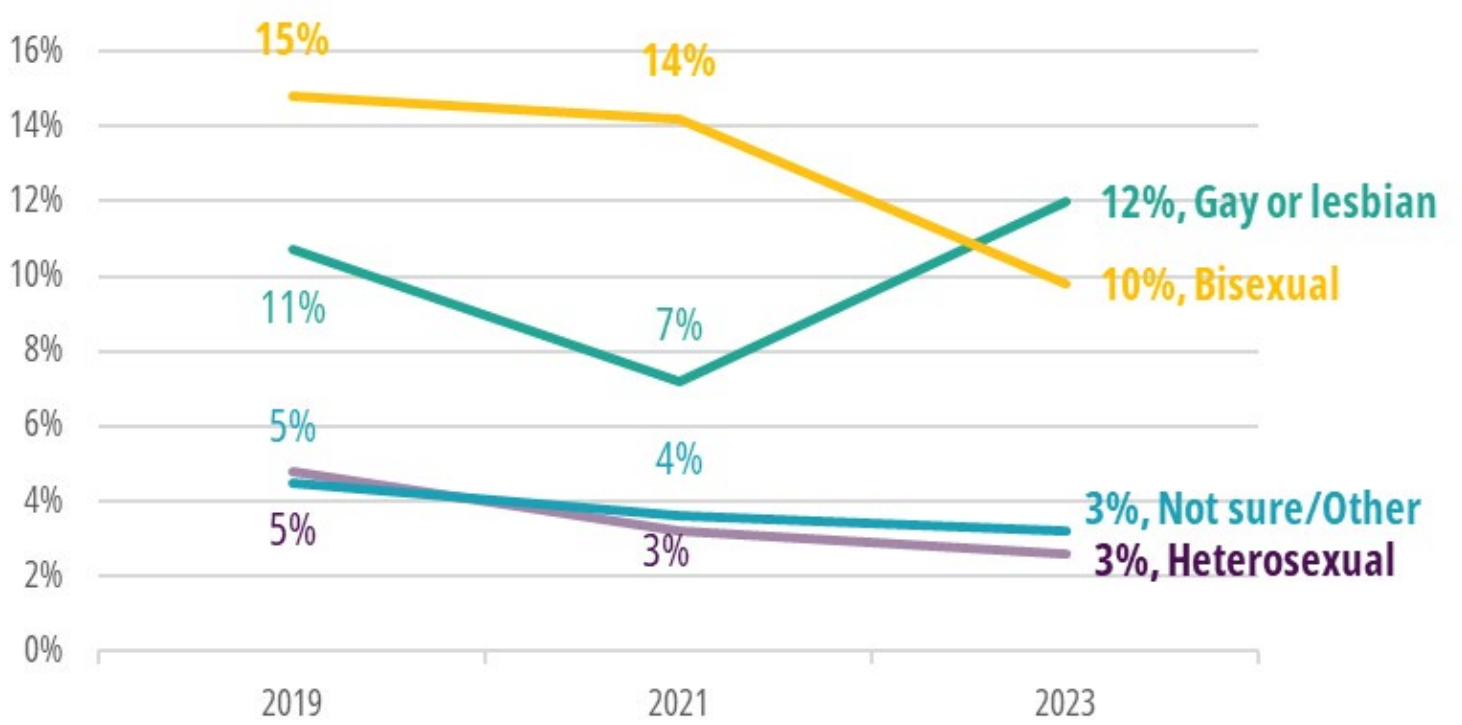
Data source : Utah SHARP Survey, grades 6, 8, 10, 12 combined

2.7% of Utah youth in grades 6-12 represents approximately 13,500 students needing substance use treatment.

There is no clear pattern indicating that urban or rural regions have higher rates of need.

Youth behavioral health

Figure 45. Utah youth needing substance use treatment by sexual orientation, 2019-2023

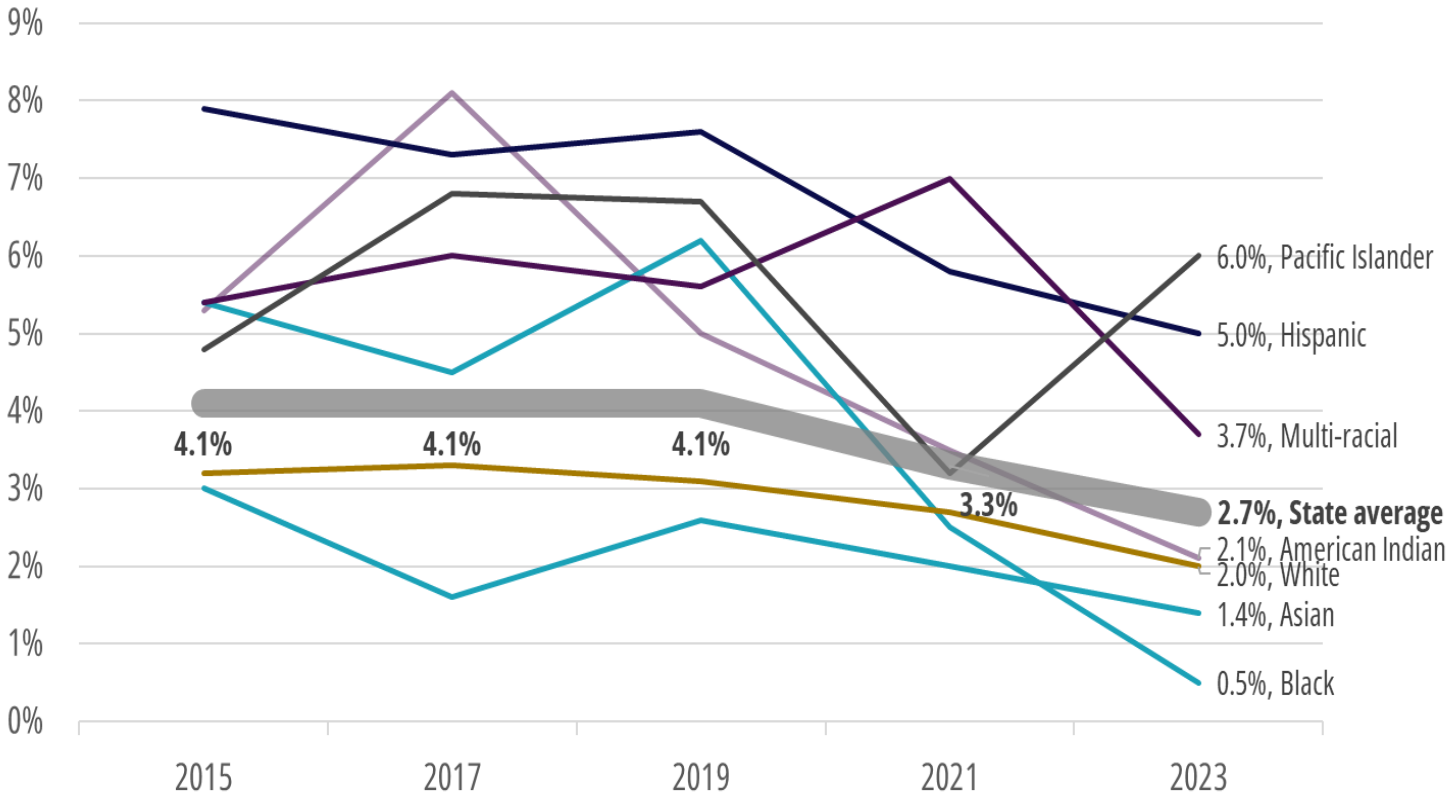


Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

LGBTQ+ youth were more likely to need substance use treatment than heterosexual students.

Youth behavioral health

Figure 46. Utah youth needing substance use treatment by race/ethnicity, 2015-2023



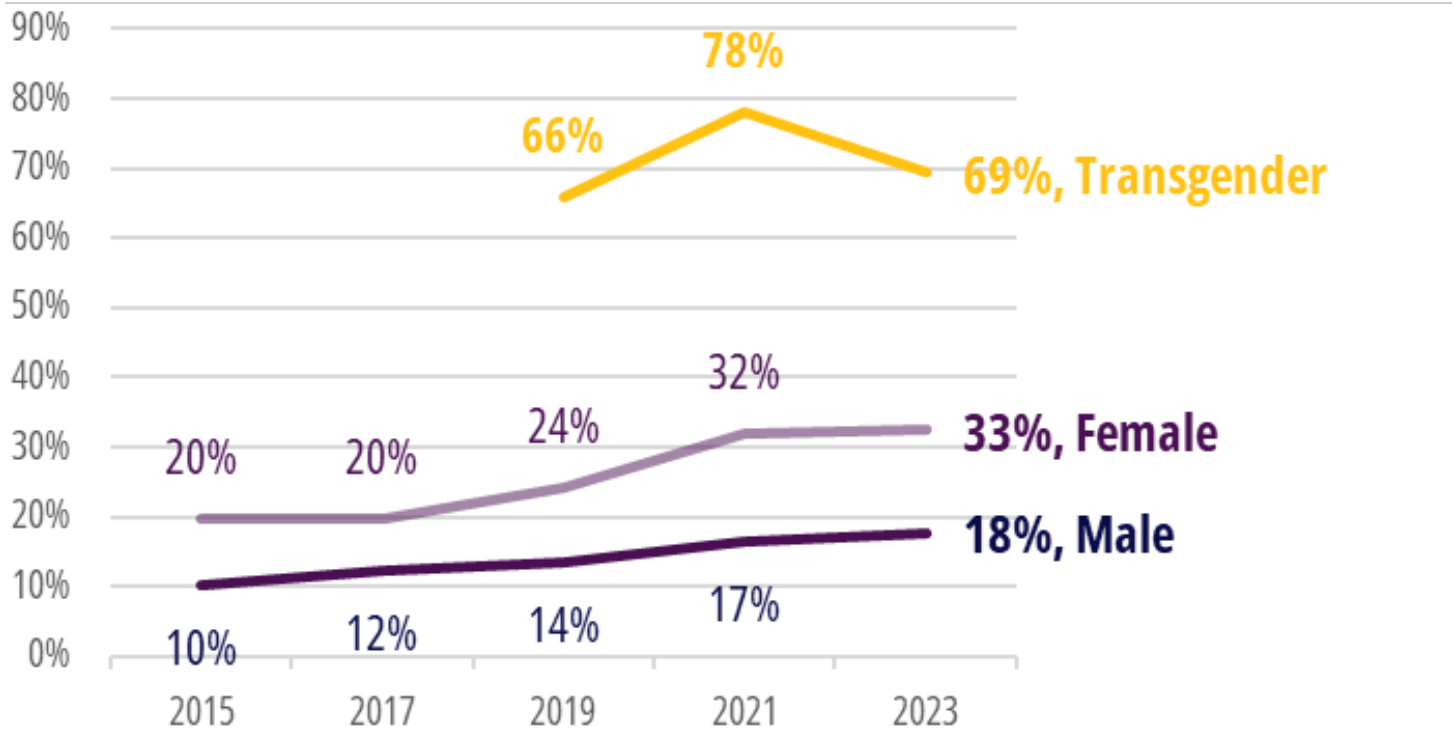
Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

Overall, youth need for substance use treatment has decreased from 4.1% in 2019 to 2.7% in 2023.

Youth from Pacific Islander, Hispanic, and multi-racial backgrounds have higher need for substance use treatment than American Indian, White, Asian, and Black youth.

Youth behavioral health

Figure 47. Utah youth with high need for mental health treatment by gender, 2015-2023



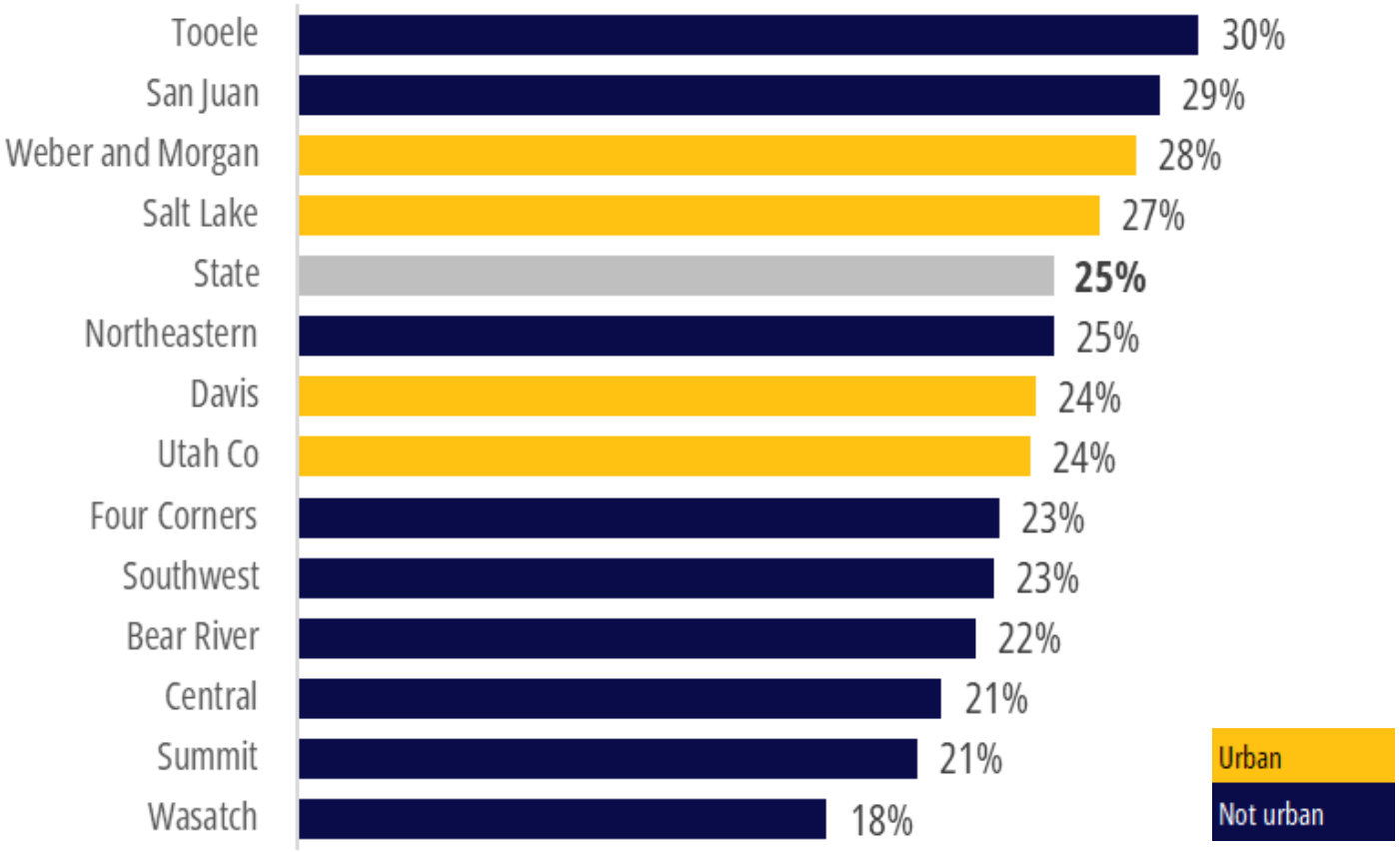
Data source: Utah SHARP Survey, grades 8, 10, 12 combined

More girls than boys have high need for mental health treatment.

Transgender youth have especially high rates of need for mental health treatment.

Youth behavioral health

Figure 48. Utah youth with high need for mental health treatment by local authority, 2023



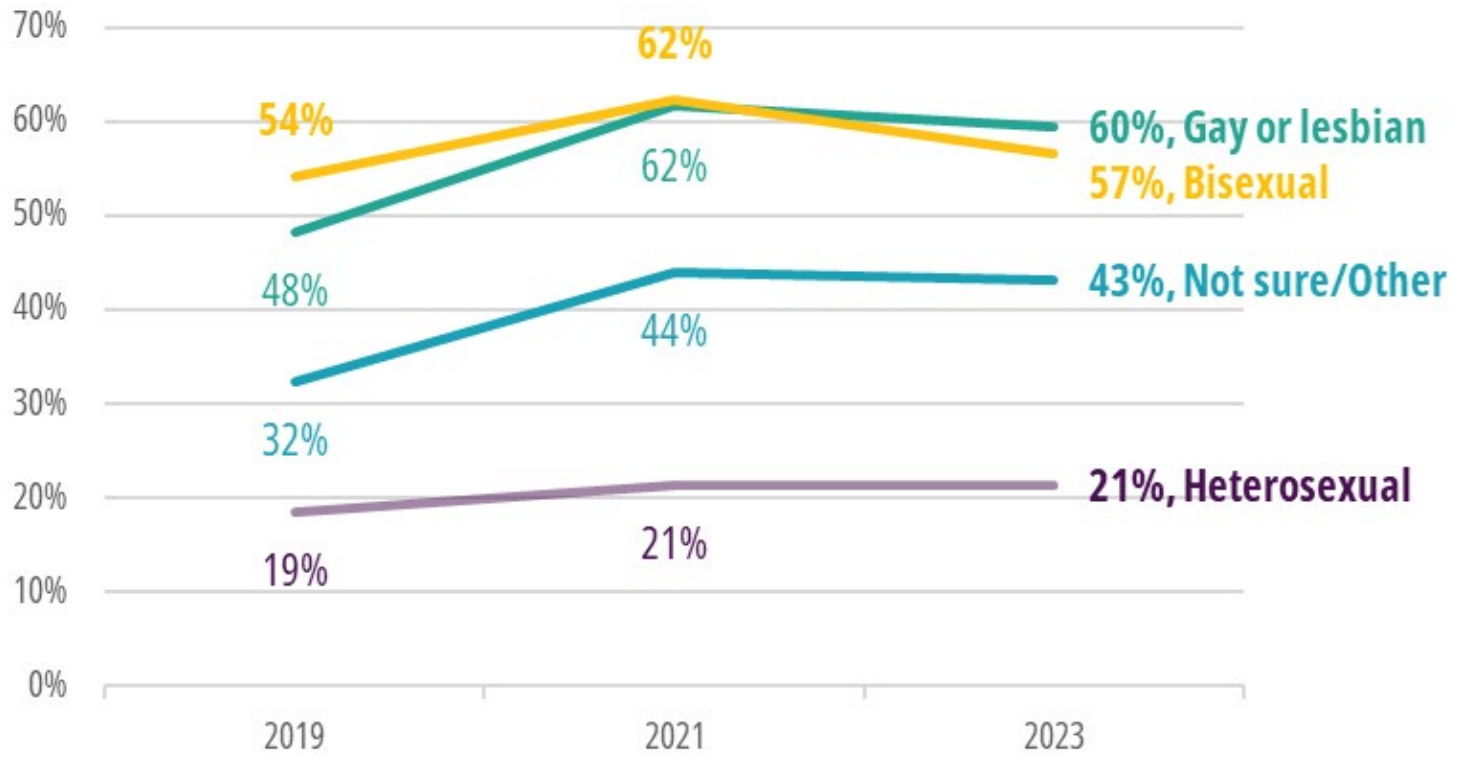
Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

25% of Utah youth in grades 6-12 represents approximately 125,000 students in high need of mental health treatment.

Youth need for mental health treatment varies in both urban and non-urban areas.

Youth behavioral health

Figure 49. Utah youth with high need for mental health treatment by sexual orientation, 2019-2023

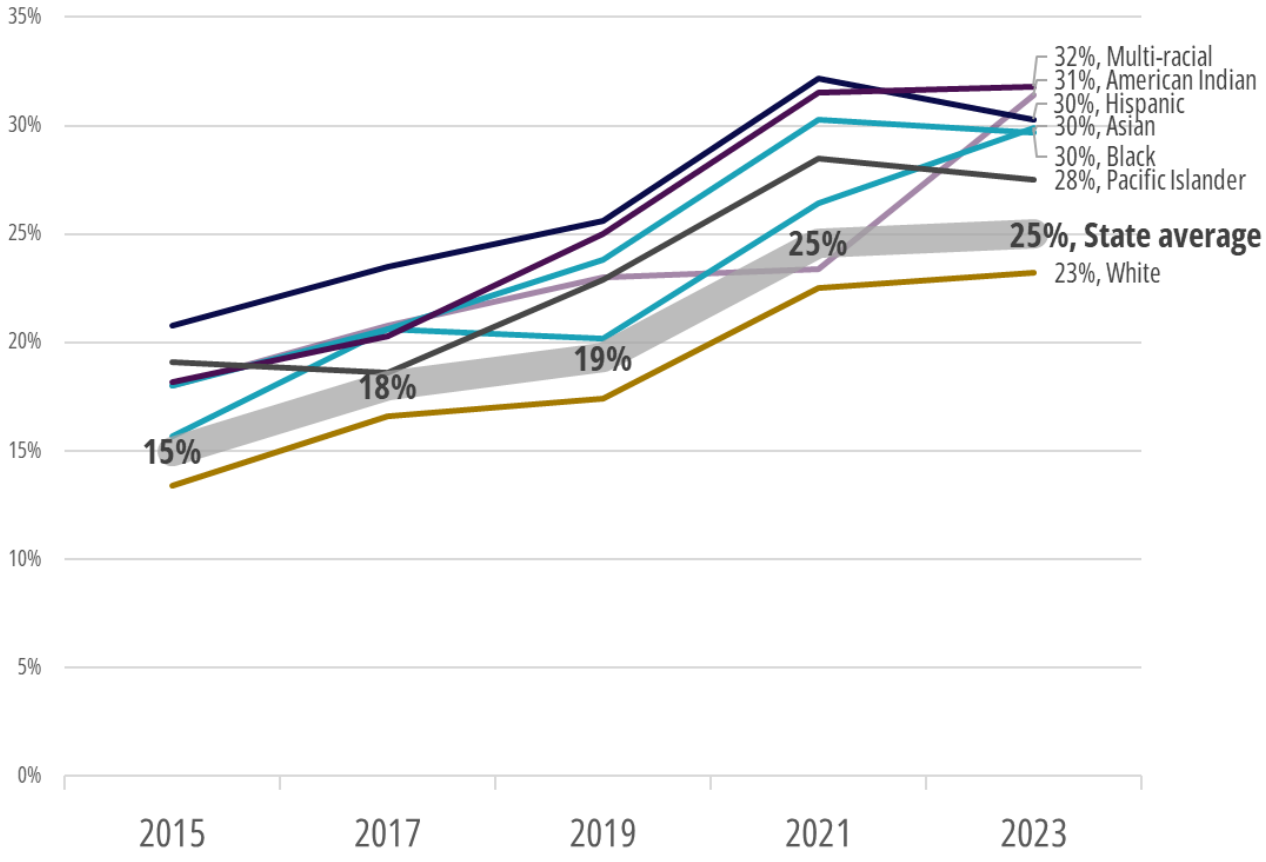


Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

Youth with gay, lesbian, bisexual, and not sure/other sexual orientations were more likely to have high need for mental health treatment.

Youth behavioral health

Figure 50. Utah youth with high need for mental health treatment by race & ethnicity, 2015-2023



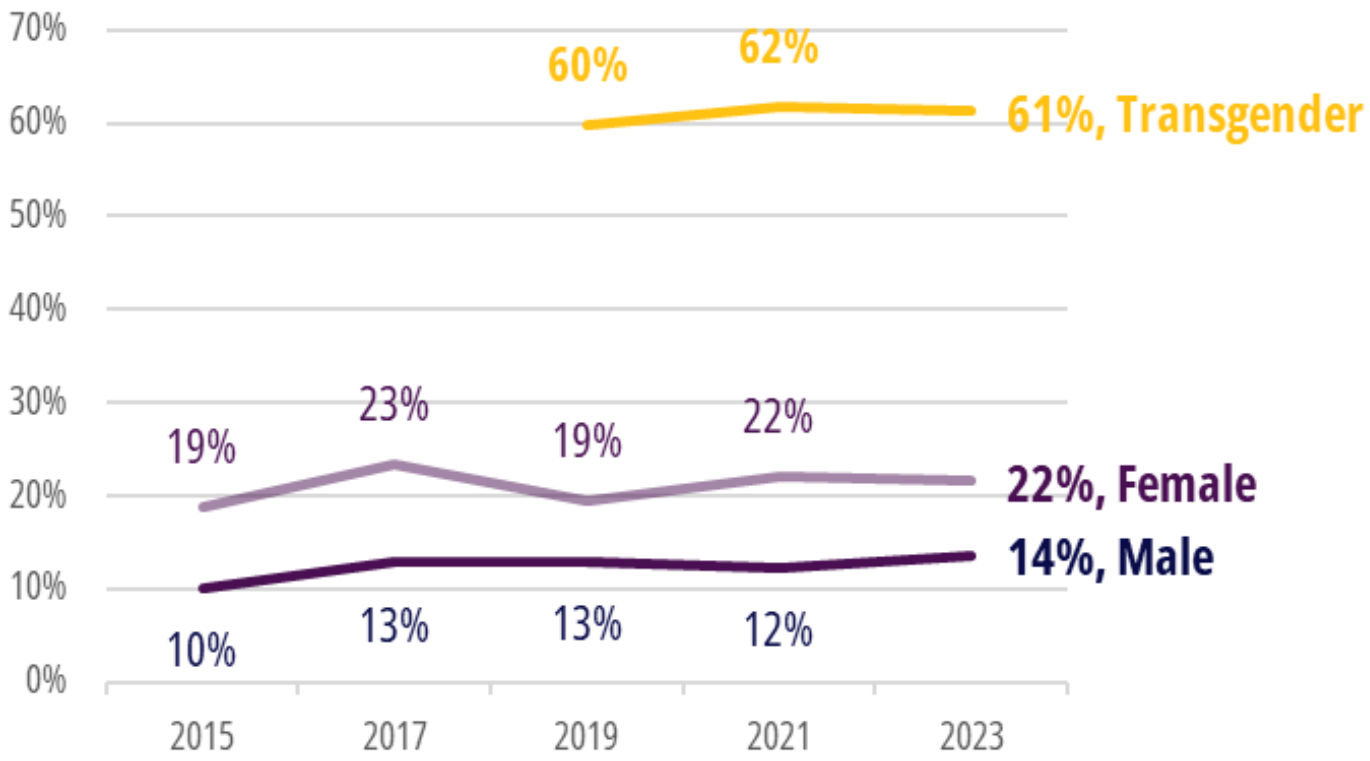
Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

Youth from white backgrounds had lower needs for mental health treatment compared to all other racial and ethnic backgrounds.

Youth from American Indian backgrounds had a particularly steep increase from 2021 to 2023.

Youth behavioral health

Figure 51. Utah youth who seriously considered suicide by gender, 2015-2023



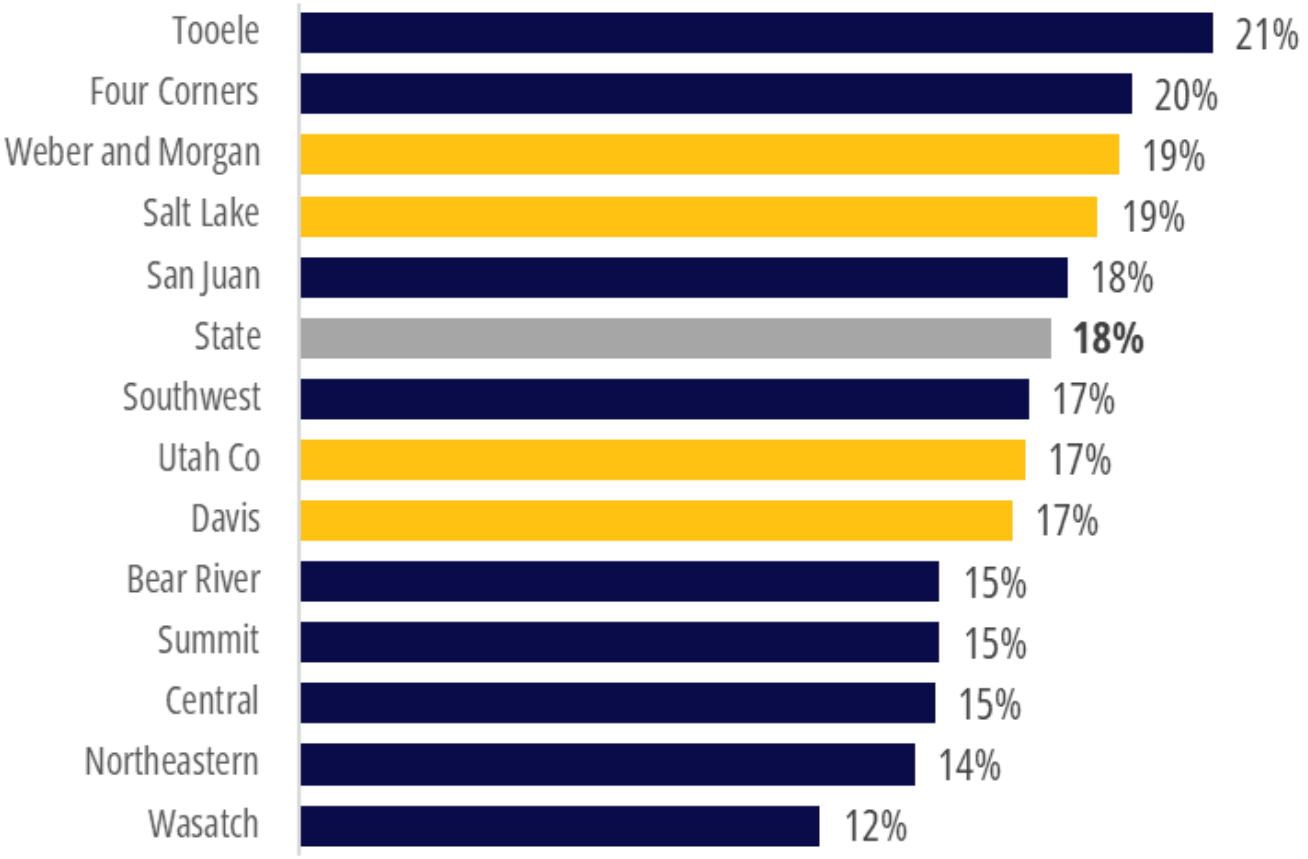
Data source: Utah SHARP Survey, grades 8, 10, 12 combined

Transgender youth were the most likely to have seriously considered suicide.

More female than male students seriously considered suicide.

Youth behavioral health

Figure 52. Utah youth who seriously considered suicide by local authority, 2023



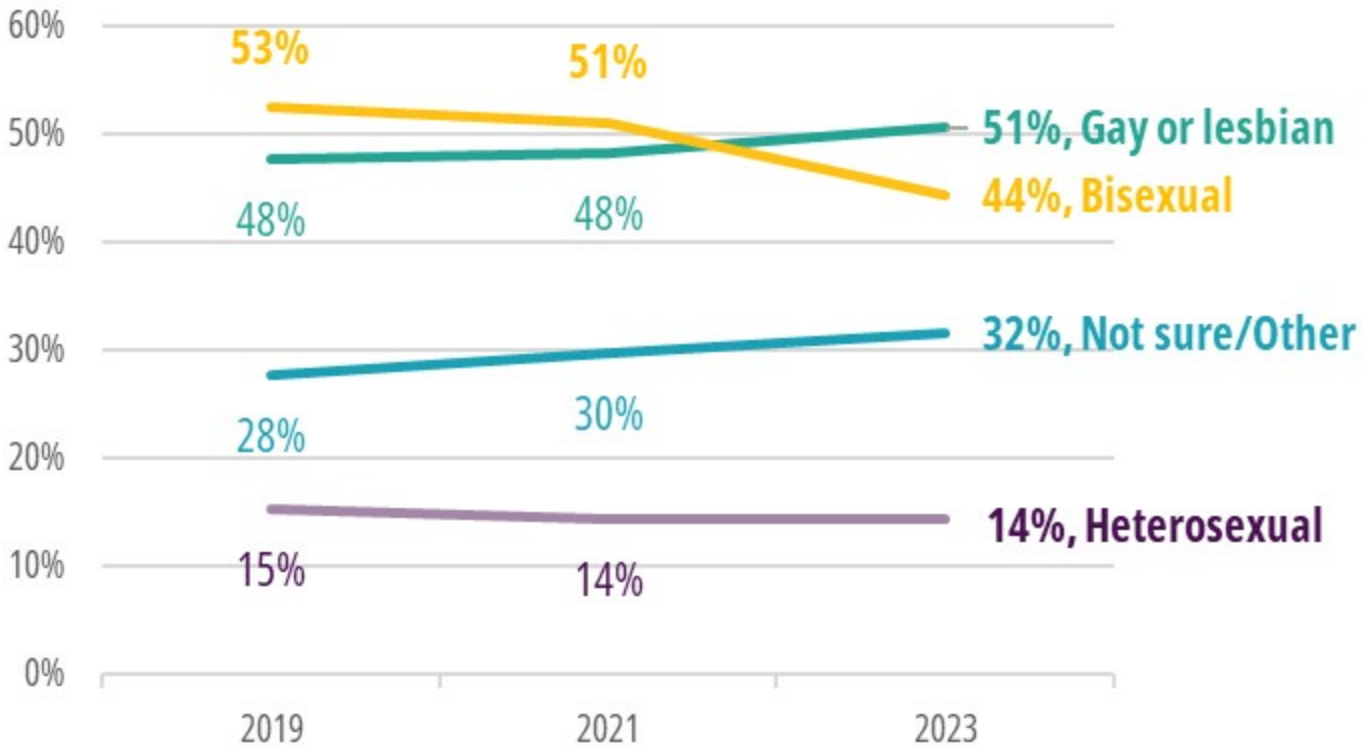
Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

18% of Utah youth in grades 6-12 represents approximately 90,000 students who have seriously considered suicide.

The percentage of youth who seriously considered suicide in 2023 varied in both urban and non-urban areas.

Youth behavioral health

Figure 53. Utah youth who seriously considered suicide by sexual orientation, 2019-2023

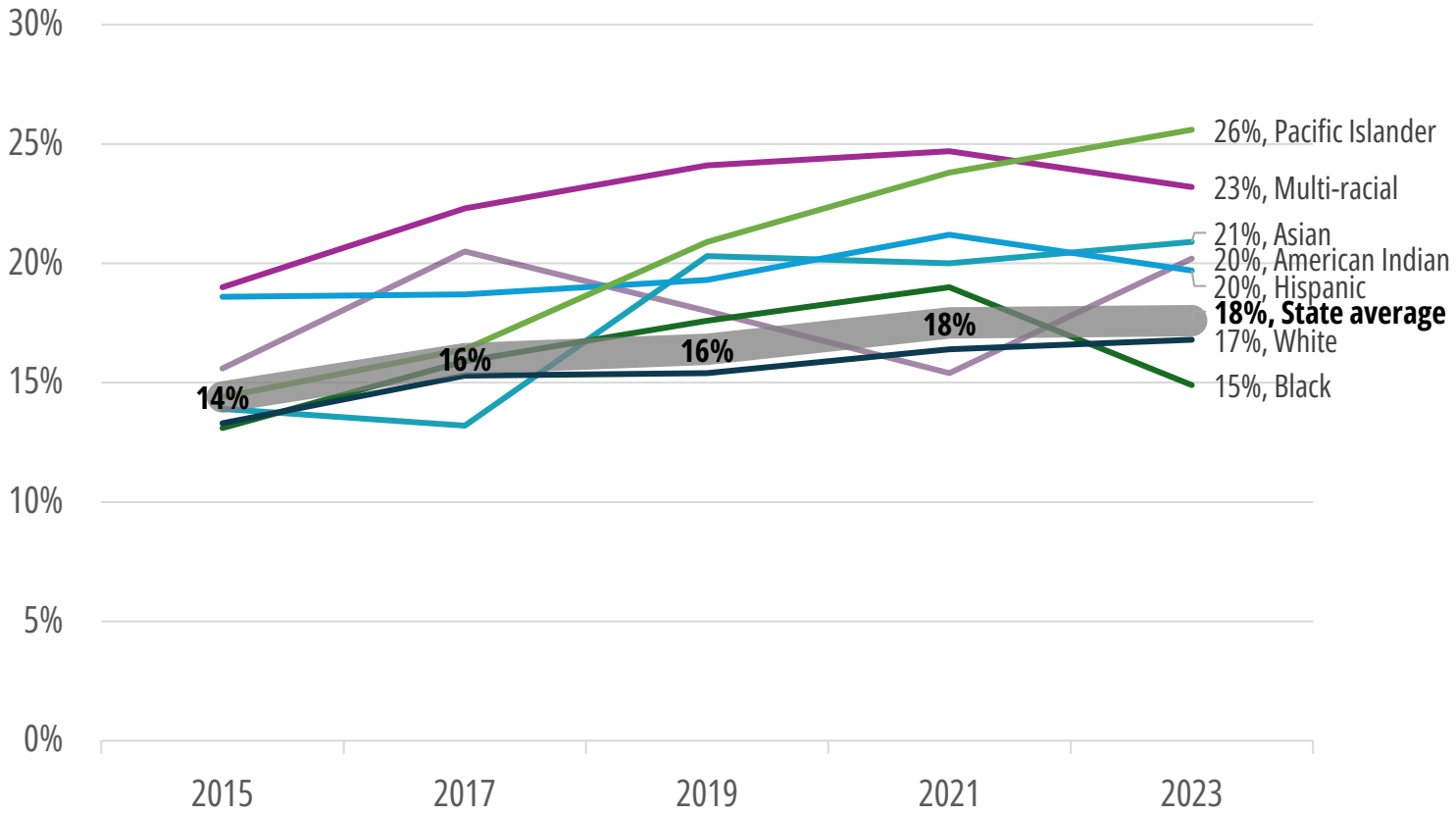


Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

Youth with gay, lesbian, bisexual and not sure/other sexual orientations had higher rates of suicidal ideation than heterosexual students.

Youth behavioral health

Figure 54. Utah youth who seriously considered suicide by race/ethnicity, 2015-2023



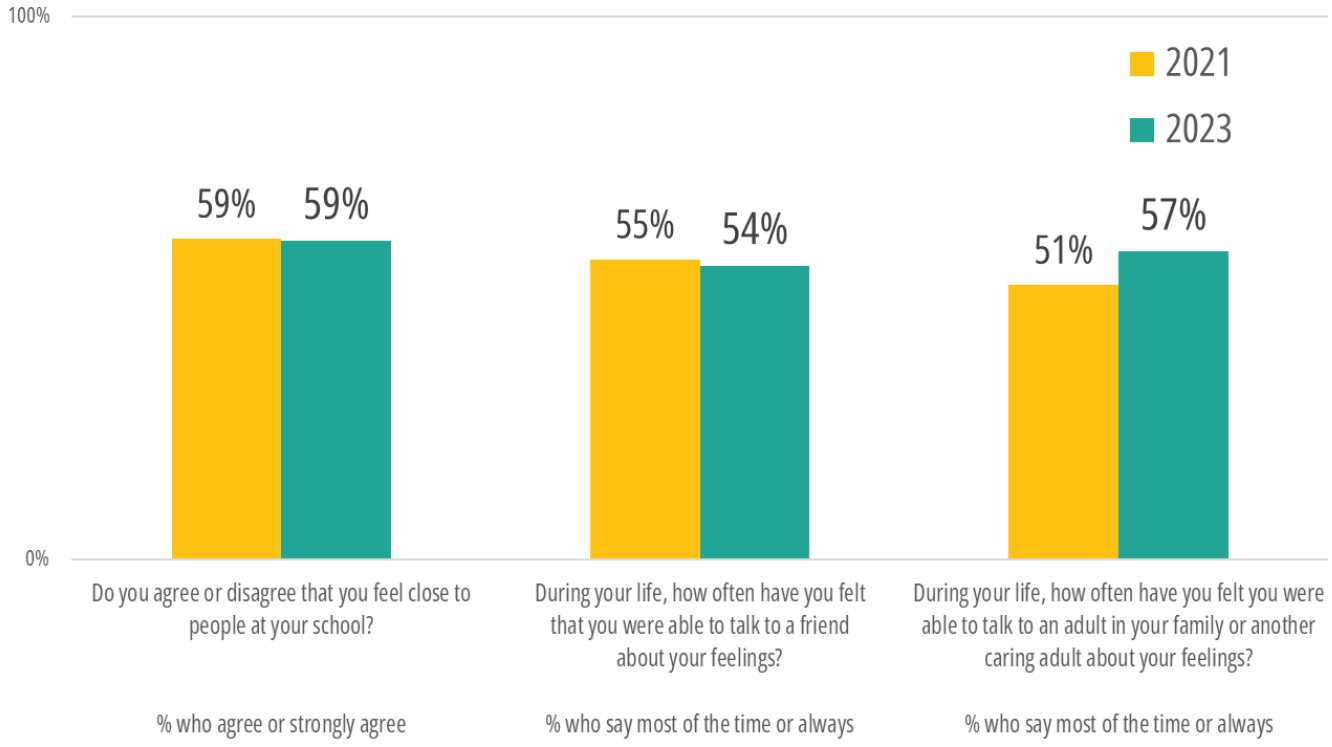
Data source: Utah SHARP Survey, grades 6, 8, 10, 12 combined

Overall, the percentage of Utah youth who seriously considered suicide increased from 14% in 2015 to 18% in 2023.

Youth from Black or white backgrounds had the lowest rate of considering suicide in 2023.

Youth behavioral health

Figure 55. Utah high school students who reported close relationships, 2021-2023

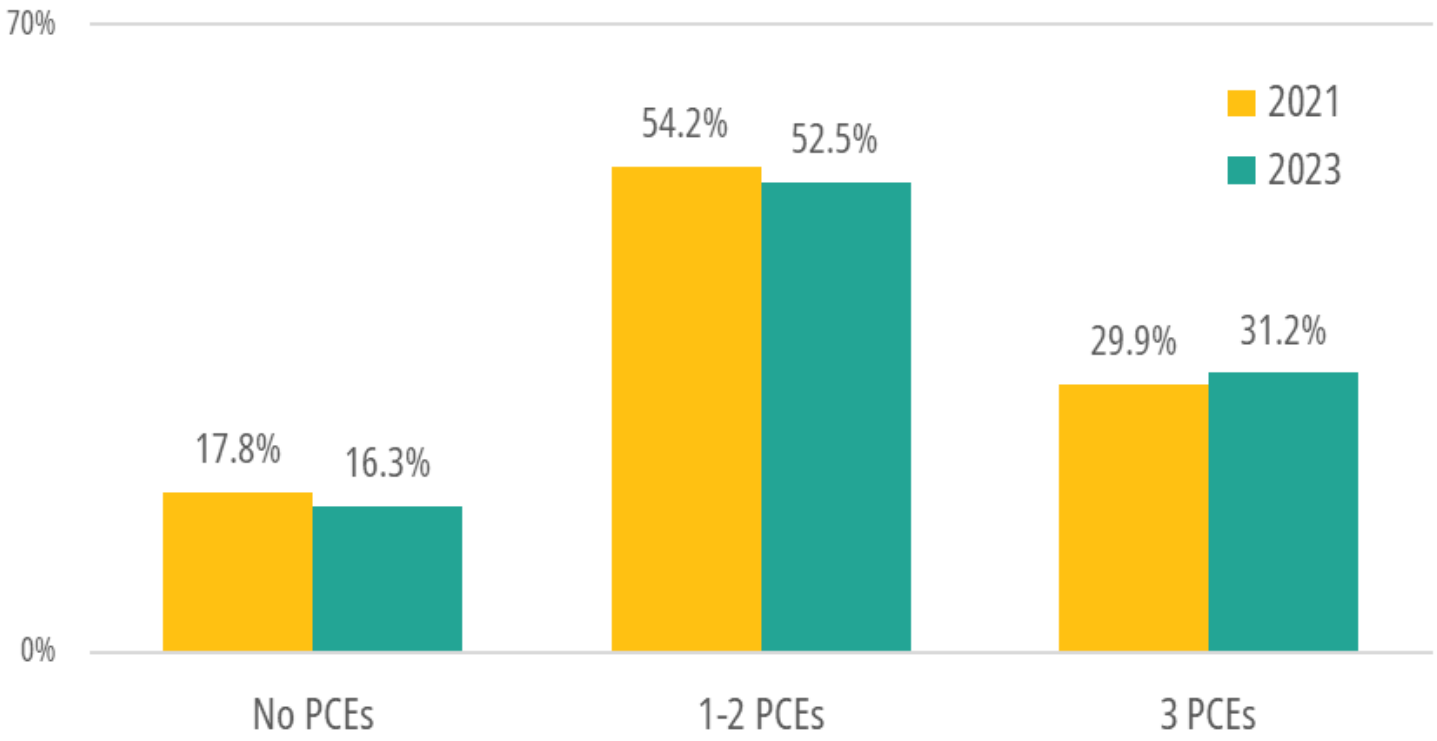


Data source: Indicator-Based Information System (IBIS) from the Youth Risk Behavior Survey, grades 9-12 combined

Over half of Utah high school students indicated they felt close to people at their schools and could talk to their friends or an adult about their feelings.

Youth behavioral health

Figure 56. Utah high school students with three positive childhood experiences, 2021-2023



Source: Youth Risk Behavior Survey (YRBS), grades 9-12 combined

Positive childhood experiences help to mitigate the negative impacts of adverse childhood experiences (ACEs).

The three positive childhood experiences assessed on the Youth Risk Behavior Survey (YRBS) include 1. Do you agree or disagree that you feel close to people at your school? 2. During your life, how often have you felt that you were able to talk to a friend about your feelings? 3. During your life, how often have you felt you were able to talk to an adult in your family or another caring adult about your feelings?

Sources for additional data

Division of Integrated Health Reports
https://sumh.utah.gov/data-reports/
Includes links to the following data sources:

- **Public behavioral health client data portal**
  https://sumh.utah.gov/data-portal-home/
- **Utah Student Health and Risk Prevention (SHARP) survey**
  https://sumh.utah.gov/data-reports/sharp-survey/survey-reports/
- **Mental Health Statistics Improvement Program Survey (MHSIP)**
  https://sumh.utah.gov/data-reports/consumer-satisfaction-surveys/

National Survey on Drug Use and Health (NSDUH)
https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

Behavioral Risk Factor Surveillance System (BRFSS)
https://www.cdc.gov/brfss/index.html

Utah State Epidemiological Outcomes Workgroup (SEOW) online data system
http://indicators.bach-harrison.com/utsocialindicators/Default.aspx

Indicator-Based Information System for Public Health (IBIS-PH)
https://ibis.utah.gov/ibisph-view/

National Survey of Children's Health (NSCH)
https://www.census.gov/programs-surveys/nsch.html

Utah Healthy Places Index
https://map.utah.healthyplacesindex.org/

Alcohol Abuse Tracking Committee 2024 report
https://dsamh-training.utah.gov/_documents/legislativereports/2024_AATCReportFinal.pdf

Utah DHHS Data, Systems, and Evaluation data request page
https://healthcarestats.utah.gov/about-the-data/data-series/

Utah Medicaid and CHIP annual reports
https://medicaid.utah.gov/Annual-Reports/

US Census Bureau
https://data.census.gov/