

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

State SAPT DUNS Number

Number 878593383

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Utah Department of Human Services

Organizational Unit Division of Substance Abuse and Mental Health

Mailing Address 195 North 1950 West

City Salt Lake City

Zip Code 84116

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Ann

Last Name Williamson

Agency Name Division of Substance Abuse and Mental Health

Mailing Address 195 North 1950 West

City Salt Lake City

Zip Code 84116

Telephone 801-538-4001

Fax 801-538-4016

Email Address annwilliamson@utah.gov

State CMHS DUNS Number

Number 878593383

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Utah Department of Human Services

Organizational Unit Division of Substance Abuse and Mental Health

Mailing Address 195 North 1950 West

City Salt Lake City

Zip Code 84116

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Ann

Last Name Williamson

Agency Name Division of Substance Abuse and Mental Health

Mailing Address 195 North 1950 West

City Salt Lake City

Zip Code 84116

Telephone 801-538-4001

Fax 801-538-4016

Email Address annwilliamson@utah.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name Shanel

Last Name Long

Telephone 801-538-4406

Fax 801-538-9892

Email Address shlong@utah.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
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 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
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Title XIX, Part B, Subpart II of the Public Health Service Act		
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Ann Williamson

Signature of CEO or Designee¹: _____

Title: Executive Director _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Ann Williamson

Signature of CEO or Designee¹: 

Title: Executive Director

Date Signed: 6/2/15

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Utah

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Ann Williamson

Signature of CEO or Designee¹: 

Title: Executive Director

Date Signed: 6/2/15

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Utah

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

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Signature of CEO or Designee¹: _____

Title: Executive Director _____

Date Signed: _____

mm/dd/yyyy

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State Information

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Ann Williamson

Signature of CEO or Designee¹: 

Title: Executive Director

Date Signed: 6/2/15

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Utah

Footnotes:

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955. as amended (42 U.S.C. §§7401 et seq.): (a)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

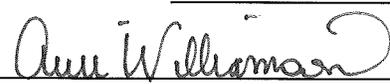
The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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Name of Chief Executive Officer (CEO) or Designee: Ann Williamson

Signature of CEO or Designee¹: 

Title: Executive Director

Date Signed: 6/2/15

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.
Utah

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	<input type="text" value="Ann Williamson"/>
Title	<input type="text" value="Executive Director"/>
Organization	<input type="text" value="Utah Department of Human Services"/>

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

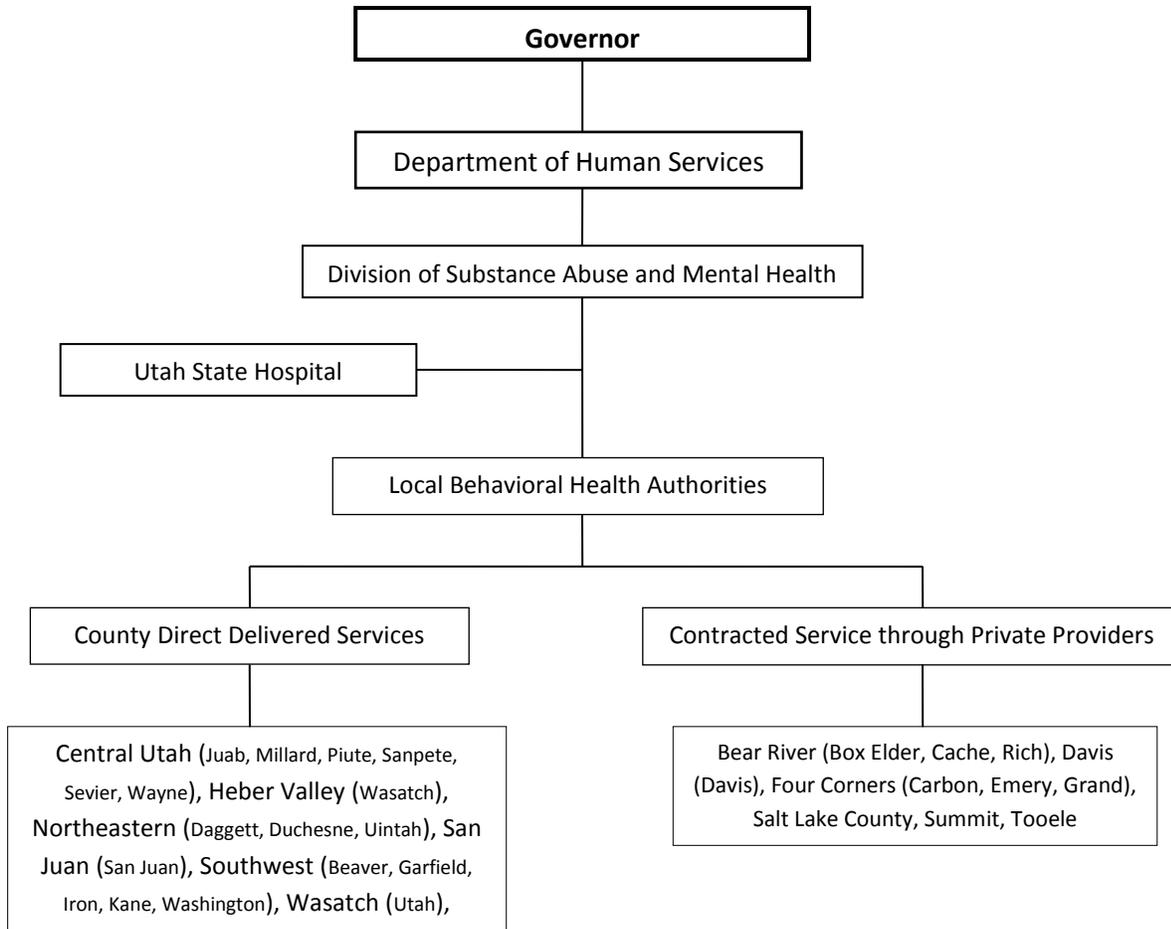
Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Step 1: Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

I. Overview of State Behavioral Health System



Organization of the Utah Public Behavioral Health System

a. State level organization—Utah Department of Human Services

The Department Director is a member of the Governor’s Cabinet Council along with all other department heads. The Department of Human Services is one of the largest departments in Utah State government and consists of the following service offices and divisions:

- Division of Substance Abuse and Mental Health

- Division of Aging & Adult Services (programs supported under the Older Americans Act and Adult Protective Services)
- Division of Services for People with Disabilities (persons with developmental delays, mental retardation and traumatic brain injuries)
- Division of Child & Family Services (child welfare)
- Division of Juvenile Justice Services (youth corrections)
- Office of Recovery Services (child support enforcement)
- Office of Public Guardian (guardian/conservator services for vulnerable adults)
- Office of Licensing (for all public and private human service provider agencies within Utah)

Coordination is a major emphasis in the Department, and this is accomplished through several means. The various division and office directors meet monthly to discuss interagency issues and to resolve interdepartmental conflicts. Additionally, there are numerous workgroups and committees that meet regularly to resolve issues and to improve collaboration. For example, in 2014-15 a DHS Drug Testing Committee worked to develop standard drug testing criteria and procedures for the entire Department to use. In 2014-15 a DHS wide committee addressed changes to the Background Check Investigation system, with DSAMH being a member advocating for policies that recognized the need for peer support specialists to work in the field, even when their drug related offenses were a barrier. There are currently multiple groups meeting to address Prescription Drug Abuse, Opioid Overdose Prevention, and Suicide Prevention, both to ensure collaboration and to maximize the use of available resources.

An ongoing focus of the Department of Human Services, in conjunction with the Department of Health is the ongoing effort to support the Governor's Healthy Utah Initiative, which, if approved by the Legislature, will expand health care coverage to individuals currently uninsured either through the State's Avenue H, private health insurance exchange or, if an individual qualifies as "medically frail, with the option of enrolling in Medicaid.

The recently passed House Bill 348, Justice Reform Initiative requires widespread collaboration between the Administrative Office of the Courts, the Departments of Corrections, Work Force Services, Human Services and the Department of Health, as well as collaboration at the Local Authority/county level.

b. Intermediate and local organization -Utah State Division of Substance Abuse and Mental Health and the local behavioral health authorities

The Utah Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority for mental health and substance abuse in Utah. Utah Statutes require that the State Division of Substance Abuse and Mental Health to: "... *set policy for its operation and for programs funded with state and federal money...establish, by rule, minimum standards for local substance abuse authorities and local mental health authorities...develop program policies, standards, rules, and fee schedules for the*

division...”(Utah Code Title 62A, Chapter 15, Section 105 “Authority and Responsibilities”) and that the Division “...*contract with local substance abuse authorities and local mental health authorities to provide a comprehensive continuum of services in accordance with division policy, contract provisions, and the local plan...*” (Utah Code 62A-15-103. “Division -- Creation – Responsibilities”).

In the 2015 Legislative Session, the Legislature passed House Bill 348, which is entitled Criminal Justice Programs and Amendments. This bill, which contains over 7,000 lines, added the following responsibility to section 62A-15-103 (2):

(v) promote integrated programs that address an individual's substance abuse, mental health, [and] physical [healthcare needs] health, and criminal risk factors;

(vi) establish and promote an evidence-based continuum of screening, assessment, prevention, treatment, and recovery support services in the community for individuals with substance abuse and mental illness that addresses criminal risk factors;

It also required the Division to expand its contracting responsibilities to include providing “(D) a statewide comprehensive continuum of community-based services designed to reduce criminal risk factors for individuals who are determined to have substance abuse or mental illness conditions or both, and who are involved in the criminal justice system.”

The Division of Substance Abuse and Mental Health carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities for the delivery of Behavioral Health services. The Division distributes federal and state funds through contracts, and monitors compliance by the Local Authorities to ensure compliance with statutory mandates and contracted services. Contracting requirements, monitoring and oversight, rule writing, interagency coordination, and technical assistance are used to influence and guide systems of care. The Division also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

The Director of the Utah Division of Substance Abuse and Mental Health serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Director of the Utah Division of Substance Abuse and Mental Health is supported by an Assistant Director of Mental Health and an Assistant Director of Substance Abuse. Utah’s Division of Substance Abuse and Mental Health, and the Utah public behavioral health system operates with the following mission statement:

DSAMH Vision -- Healthy Individuals, Families, and Communities

DSAMH Mission -- Promote health, hope, and healing from mental health and substance use disorders

DSAMH Functions-- Partnerships, Quality, Education, Accountability and Leadership

DSAMH Principles-- Trauma-Informed, Evidence Based Practices, Sustainable, Culturally and Linguistically Competent

STRATEGIC INITIATIVES

Strategic Initiative #1 - Prevention and Early Intervention

Strategic Initiative #2 – Zero Suicides

Strategic Initiative #3 – Promote Recovery

Strategic Initiative #4 – Improve Care for Children and Youth

Strategic Initiative #5 – Health System Integration

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.

DSAMH operates under four guiding principles:

Systems, services, programs, activities, strategies, and policies should be trauma-informed, evidence-based, sustainable 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. DSAMH will continue in its efforts to promote the use of trauma-informed care and trauma specific services through training and technical assistance for the local authorities and community partners.

Evidence-based Practices: Utah’s publicly funded behavioral health system is committed to provide the best possible services to individuals, families and communities. 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.

Sustainable: Utah’s Publicly funded system must be sustainable over time and be organized to provide a stable level of services.

Culturally and Linguistically Competent: DSAMH believes all aspects of behavioral health services should recognize and adapt to reflect the diversity of Utah’s individuals, families and communities. Individuals possess diverse cultural, economic, social backgrounds, values, beliefs, sexual orientations, ethnicity, religion, and languages. To be effective, behavioral health services need be culturally and linguistically competent.

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

Sub State Organization: Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a “continuum of services for Adolescents and Adults” aimed at substance abuse prevention and treatment; and requires Local Mental Health Authorities (LMHA) to provide ten mandatory services. Thus, Utah’s Local Mental Health Authorities are given the responsibility to provide mental health services to their citizens. Utah utilizes CMHS and SAPT Block Grant funds, along with State General Funds, other State and Federal appropriations and the Counties’ 20% funding match to fulfill these requirements to provide for services required by federal and state statute. State and federal funds are allocated to Local Authorities through a formula which takes into account the percent of the state's population residing within the county's boundaries and a rural differential. Each county is required to provide at least a 20% match on all state general funds. The majority of general and county funds allocated for mental health services are used to meet Medicaid match requirements. With only 17% of SUD clients qualifying for Medicaid, and as of June 2015, no authorization by the Utah State Legislature to expand health care coverage past to include individuals not qualifying for a commercial insurance subsidy on the Federal exchange, most SUD clients receive services that are funded by state and federal appropriations specifically for SUD services, and the accompanying 20% county match.

As authorized in statute, the 29 counties in Utah have organized themselves into 13 Local Substance Abuse Authorities and 13 Local Mental Health Authorities. (See attached diagram) Also by Statute, each local authority submits an Area Plan annually that must be approved by the DSAMH. The Area Plans are submitted in May of each year, and describe the Local Authority’s plan to provide services for the coming Fiscal Year. Each Area Plan describes what services will be provided and how Federal and State requirements will be met. This plan is based on statutory requirements and a Division Directive that is provided each year to the local authorities shortly after the Legislative Session ends in March. The current Division Directives are located at: <http://www.dsamh.utah.gov>. Contracts and with the Local Authorities and their funding allocations are approved only after the Area Plans have been approved by the Division Director. It should be noted that changes to State contracts require a minimum of four months lead time to ensure approval from the required reviewing authorities.

A Local Mental Health or Substance Abuse Authority is generally the governing body of a county i.e. a commissioner or council member. Many counties have joined together under inter-

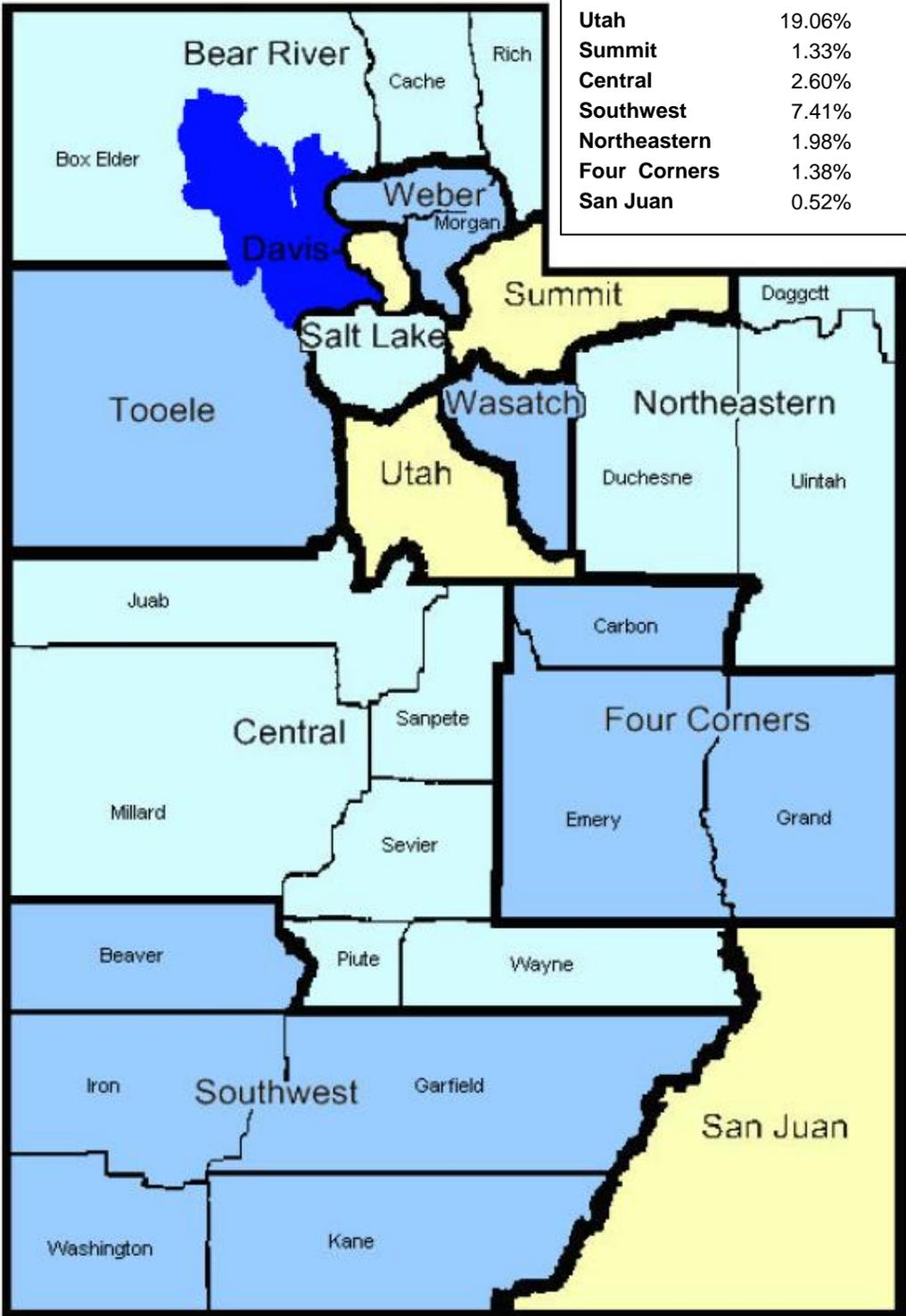
local agreements to create a single Local Authority where one commissioner representing each county holds a seat on the governing board. Services are delivered through contracts with Mental Health and Substance Abuse Providers, and in compliance with statute, administrative rule, and under the administrative direction of the Division of Substance Abuse and Mental Health. Short-term acute hospitalization is provided through contracts with local private hospitals in most areas. Local Authorities set the priorities to meet local needs, but at a minimum must provide ten statutorily mandated mental health services and a continuum of substance use disorder services either directly or through contracts and agreements. Area plans describing what services will be provided with state, federal and county funds are developed and submitted to the Division. These plans become the foundation of contracts between the Division and each of the Local Authorities. Utah's public Behavioral Health system for child, youth/adolescent and family services has the same organizational structure as the adult system. Local Authorities are required to outline in their area plan how they are planning to provide mental health and substance abuse treatment and prevention services to this population as well as the adult population.

As shown in the chart and map below, the Local Authorities have significant differences in the size of their areas of responsibility and in the density of their populations.

The Utah State Hospital provides statewide inpatient mental health services, is a 24-hour psychiatric facility located in Provo, Utah and is organized as a part of the Division of Substance Abuse and Mental Health. The State Hospital currently provides active psychiatric treatment for 252 adult patients and has the capacity to provide active psychiatric treatment for 72 children. Patients must be actively experiencing symptoms of severe and persistent mental illness to qualify for services, and are placed through a civil commitment or forensic commitment. The State Hospital is accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and certified for Medicare/Medicaid reimbursement by the Center for Medicare & Medicaid Services.

State statute allocates all pediatric and youth beds to the Local Mental Health Authorities, but the Division is responsible for establishing a bed allocation formula, which is based on the percentage of state population within each Local Authority's catchment area and a rural differential. The Community Mental Health Centers monitor State Hospital treatment and provide follow-up care in the community.

2014 Estimated Census Data		
Local Authority	% of Population	% of Land
Bear River	5.85%	9.7%
Weber	8.53%	1.4%
Salt Lake	37.1%	0.9%
Davis	11.20%	0.4%
Tooele	2.09%	8.4%
Wasatch	0.94%	1.4%
Utah	19.06%	2.4%
Summit	1.33%	2.3%
Central	2.60%	20.3%
Southwest	7.41%	21.3%
Northeastern	1.98%	10.2%
Four Corners	1.38%	11.7%
San Juan	0.52%	9.5%



c. Addressing the needs of Utah’s diverse racial, ethnic and sexual gender minorities, youth and the underserved

The greatest challenges faced in providing services for residents of Utah are due to the distribution of the population and the decentralized nature of the system. Utah is 84,900 square miles with urban, rural and frontier communities, and is currently one of the fastest growing states in the nation with population estimates to exceed 3.4 million persons by 2020.

Since, as stated above, by Statute and rule, the Counties/Local Authorities are responsible for planning and providing services for their residents, this widely varied geography and population presents significant challenges in this area.

An example of the diverse nature of the challenges facing authorities can be seen by comparing the following:

Salt Lake County	1 county	37.3% of the state’s population	0.9% of state’s area
Weber Human Services	2 counties,	8.6% of the state’s population	1.4% of state’s area,
Central Utah Counseling,	6 counties,	2.7% of the state’s population	20.3% of state’s area.

Additionally, the Native American Tribal organizations are fragmented and scattered throughout the state (see Map below). Since planning for and providing services is a County responsibility, each County and or local authority is tasked with the requirement to include Native Americans as well as other minority and underserved groups in their planning process.

Given the diverse nature of the various Local Authorities, geographically, culturally, economically and organizationally, the specifics of planning for services is left to the Counties and their Local Authorities, and monitored closely by the Division during its annual audits, area plan reviews and technical assistance visits. Each County is responsible for preparing and submitting their “Area Plan” to DSAMH for approval each year, and then the implementation of those plans is monitored throughout the year.

Utah Counties and Indian Tribal Lands



Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system.

- This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.
- Responses

Identifying the unmet Service Needs and Gaps:

Some Specific challenges faced by Utah include:

- Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Piute, Shoshone and Goshute people.
- Our state is growing increasingly diverse in culture: minority populations have increased from 2% to 20% of the total population during the past decade, and Utah's Hispanic population continues to be the fastest growing community in the state.
- Compared to national averages, our population is younger and lives longer, has a higher birth rate, and currently Utah averages the highest number of persons per household (3.12 for Utah versus 2.63 nationally).
- Compared to national averages, Utah is better educated at both the High school and bachelor's degree level, has a higher home ownership rate, and has a lower percentage of persons living below the poverty level.
- By legislative intent, with the exception of the Utah State Hospital, no substance abuse or community mental health center is operated by the State; the state does not provide clinical care.
- Native American populations reside in various "reservations" across the state, with the bulk living in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are all involved in providing services.
 - Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state's resources.
 - The direct planning and provision of services is a responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit.
 - Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities.

- Utah’s Department of Human Services has developed an inter-tribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.
- DSAMH attends the council meetings and has presented at several, and continues to work with the council on common issues.

The 2014 US Census estimates Utah’s adult population to be 2.94 million, an increase from 2.85 million in 2012.

- The Utah Department of Health reports 22% of Utah’s adult population suffers from chronic health conditions, and has continuously found statistical information concurrent with national research indicating a high rate of co-occurring chronic physical illness and mental illness in Utah’s adult population (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Utah’s adults with mental illness are at greater risk of chronic health conditions, just as those with chronic health conditions are at increased risk of mental illness. (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Through growing partnership with the Utah Department of Health, the Division of Substance Abuse and Mental Health is working to analyze the need and capacity for programming and create integrated solutions to support this population.
- Of twenty rural hospitals in the Utah, as of 2012, fourteen identified a “lack of access to mental health services” as the number one concern of their physicians and hospital administration.
- Economic Factors
 - Compared to National data, Utah has a higher median household income, but a significantly lower per capita income, a function of the high birthrate and lower median age.
 - Individuals and families living in rural Utah are more likely to experience more dire risk factors due to economic limitations and the geographic challenges that cause limited access to resources, services and opportunities.
 - According to the USDA Economic Research Service, the average per-capita income for Utahns in 2009 was \$31,584
 - although rural per-capita income lagged at \$27,373.
 - 2013 estimates indicate a poverty rate of 13.9% exists in rural Utah, compared to a 12.5% level in urban areas of the state.
 - ACS data from 2013, reports that 10.8% of the rural population has not completed high school, compared to 8.9% of urban populations.
 - The unemployment rate in rural Utah is at 4.4%, while in urban Utah it is at 3.7% (USDA-ERS, 2014).
- Tobacco Use
 - Although a relatively low number of adults use tobacco in Utah (9.1% compared to the national average of 20.1%),

- 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders. Source The Journal of the American Medical Association
 - 67% of individuals admitted for SUD Services use tobacco (TEDS Data, 2014).
 - In Utah, smoking claims the lives of more than 1,150 adults each year. We know smoking exacerbates or causes nearly every chronic condition and contributes to Utah's primary causes of death including heart disease, respiratory disease, and cancer, especially in the disparate population of adults with serious mental illness.
 - Nationally, people with mental illness die 25 years earlier on average than the general population, largely due to conditions caused or worsened by smoking. : (Source: National Association of State Mental Health Program Directors)
 - In Utah, adults with serious mental illness die 27 years earlier on average than the general population . . . at age 47.
- **Suicide**
 - The 2012 Utah suicide rate was 23.3 per 100,000 population ages 10 and over. Suicide was the 6th-leading cause of death in Utah and is the leading cause of injury related death in Utah from 2009-2013
 - An average of 503 Utahns died by suicide each year from 2009-2013
 - An average of 3,968 Utahns attempt suicide each year.
 - Use of a firearm was the most common method of suicide death for Utahns followed by suffocation and then poisoning.
 - 1 in 15 adults report considering suicide in a given year according to the National Survey on Drug Use and Health.
 - Utah's suicide rate has been consistently higher than the U.S. rate for the last decade. A recent CDC study found that Utah had the highest prevalence of suicidal thoughts among adults in the U.S. In addition, Utah has the
 - 7th highest adult male (ages 25-64) suicide rate in the U.S
 - 9th highest adult female (ages 25-64) suicide rate in the U.S.
 - In 2013, suicide surpassed unintentional injuries to become the leading cause of death among youth ages 10–19 in Utah. On average, 37 youth in Utah die from suicide and 942 are injured in a suicide attempt each year.^{1,2}
 - The youth suicide rate in Utah is consistently higher than the U.S. rate, and has been increasing for nearly a decade.
 - According to the 2013 Student Health & Risk Prevention Surveys, 14.1% of students in grades 8, 10, and 12 reported that during the past year they had seriously considered suicide.
 - **Whole Health and Resiliency** (Source: The 2009 Utah Disease/Risk Factor Integration Matrix),

- Utahns who have serious mental illness also have rates of arthritis, asthma, and hypertension that are significantly higher than the general population.
 - Adults with serious mental illness in Utah have excessively high rates of poor nutrition, smoking, obesity, and over 66% of this population does not engage in regular physical activity.
 - In 2005, Utah published its Wellness Directive which requires public behavioral healthcare providers to monitor weight and screen for primary health conditions such as diabetes,
 - Utah is committed to making SAMHSA-HRSA's Whole Health Wellness and Resiliency model readily available to our local authorities throughout the state to support the development of integrated primary and behavioral health services.
- Unmet Treatment Needs.
 - Utah continues to delay implementation of any form of Medicaid Expansion, even while Governor Herbert negotiates with HHS to find a plan that will meet legislative approval. This means that while other states have been able to expand their services using Medicaid and private insurance, Utah continues to rely on state and federal funding.
 - As a result, only 20.4% of individuals with past year illicit drug use received SUD treatment services, and 12.5% of individuals with Alcohol Dependence of Abuse received treatment. (Behavioral Health Barometer, 2013)
 - Due to the availability of Medicaid for individuals with serious mental illness, 42.5 % of individuals with any mental illness received services. (Behavioral Health Barometer, 2013)
 - Location of Treatment Services. A significant issue for much of Utah's Local Authorities is the difficulty in providing a complete continuum of ASAM level services due to the Frontier nature of much of the state. Over 75% of the state's population is concentrated in five local authorities comprising six counties and only 5.1% of the state's geographical area. This makes providing residential services extremely problematical and providing intensive services almost equally as challenging. This has led to focusing scant resources to provide a broader continuum of care on the priority populations of IV using Pregnant women, pregnant women with dependent children and women with dependent children.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Planning Step Quality and Data Collection Readiness

- Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

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Please indicate areas of technical assistance needed related to this section.

- Responses

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
 Priority Area: Prevention and Early Intervention - Underage Drinking
 Priority Type: SAP
 Population(s): Other (Adolescents w/SA and/or MH, Students in College, LGBTQ)

Goal of the priority area:

Prevent and Reduce Underage Drinking

Objective:

Objective 1.1.1: Reduce community norms favorable to underage drinking
 Objective 1.1.2: Reduce Parental Attitudes favorable towards underage drinking
 Objective 1.1.3: Reduce youth access to alcohol
 Objective 1.1.4 Increase Communities That Care coalitions
 Objective 1.1.5 Increase access to person-centered prevention services.

Strategies to attain the objective:

1.1.1. Parents Empowered Community Mobilization campaign
 1.1.2. Parents Empowered Community Mobilization, Parenting classes/resources, family dinner events
 1.1.3 Eliminating Alcohol Sales to Youth (EASY) alcohol compliance checks - retail access. Parents Empowered campaign (addressing parental or adult enabling underage drinking).

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: 30 day alcohol use - all grades
 Baseline Measurement: 7.0% in 2013
 First-year target/outcome measurement:
 Second-year target/outcome measurement: 6.0% in 2017

Data Source:

Student Health and Risk Prevention (SHARP) survey

Description of Data:

survey of 6, 8, 10, 12 grade students throughout the state. Asked if they had any alcohol more than a sip in the past 30 days.

Data issues/caveats that affect outcome measures::

Survey is collected biennially. Also note that confidence interval is +/-5%.

Indicator #: 2
 Indicator: 30 day binge drinking - all grades
 Baseline Measurement: 4.9% in 2013
 First-year target/outcome measurement:
 Second-year target/outcome measurement: 4.5% in 2017

Data Source:

Student Health and Risk Prevention (SHARP) survey

Description of Data:

statewide survey of 6, 8, 10, 12 grades regarding substance use, mental health, risk factors and protective factors. Question is have you had more than 5 drinks at one time in the past 30 days.

Data issues/caveats that affect outcome measures::

Survey administered biennially. Confidence interval is +/-5%.

Indicator #: 3

Indicator: Current Alcohol Use 18-20 year old

Baseline Measurement: 18.7% in 2013

First-year target/outcome measurement: 17.0% in 2014

Second-year target/outcome measurement: 16.5% in 2015

Data Source:

Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data:

statewide phone (cell included) survey of 18 and older residents of Utah. Conducted by Utah Dept. of Health

Data issues/caveats that affect outcome measures::

2013 data is the most recent year of data available. The confidence interval is +/-5%.

Indicator #: 4

Indicator: Binge Drinking among 18-20 year olds (past 30 days)

Baseline Measurement: 10.1% in 2013

First-year target/outcome measurement: 9.0% in 2014

Second-year target/outcome measurement: 8.5% in 2015

Data Source:

Behavioral Risk Factor Surveillance System (BRFSS)

Description of Data:

statewide phone (cell included) survey of 18 and older residents. Conducted by the Utah Dept. of Health

Data issues/caveats that affect outcome measures::

2013 is the most recent year data is available.

Indicator #: 5

Indicator: Reduce Community norms favorable to alcohol, tobacco and other drug use

Baseline Measurement: 18.6% in 2013

First-year target/outcome measurement: 17.0% in 2015

Second-year target/outcome measurement: 16.5% in 2017

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #:

6

Indicator:

Parental attitudes favorable towards alcohol, tobacco, and other drug use

Baseline Measurement:

10.2% in 2013

First-year target/outcome measurement:

Second-year target/outcome measurement: 9.0% in 2017

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #:

7

Indicator:

Increase number of Indicated services

Baseline Measurement:

State Fiscal Year 2016 area plans - 35 indicated services

First-year target/outcome measurement:

SFY 2017 area plans - 40 indicated services

Second-year target/outcome measurement:

SFY 2018 area plans - 45 indicated services

Data Source:

local substance abuse authority annual area plans

Description of Data:

number of indicated services as reported on area plans

Data issues/caveats that affect outcome measures::

with onset of medicaid funding or other Affordable Health Care Act funding, some prevention indicated services may be paid for out of other funding. We may see a decrease.

Priority #:

2

Priority Area:

Prevention and Early Intervention - Prescription Drugs

Priority Type:

SAP, SAT

Population(s):

Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice)

Goal of the priority area:

Goal 1.2 Prevent and reduce prescription drug misuse and abuse

Objective:

- Objective 1.2.1: Reduce community norms favorable to misuse and abuse
- Objective 1.2.2: Reduce illicit access to prescription drugs
- Objective 1.2.3: Increase Communities That Care efforts
- Objective 1.2.4 Increase access to person-centered prevention services.

Strategies to attain the objective:

- 1.2.1 address community norms through environmental strategies
- 1.2.2 Increase the number of statewide take back events to decrease availability
- 1.2.3 increase the training opportunities for Coalitions statewide.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Any Prescription drug use among youth - all grades
 Baseline Measurement: 2.3% in 2013
 First-year target/outcome measurement:
 Second-year target/outcome measurement: 1.7% in 2015
 Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%.

Indicator #: 2
 Indicator: Non-Medical use of Prescription Pain Reliever - 18-25 year olds
 Baseline Measurement: 8.84% in 2012
 First-year target/outcome measurement: 8% in 2013
 Second-year target/outcome measurement: 7.5% in 2014
 Data Source:

National Survey on Drug Use among Households (NSDUH)

Description of Data:

National survey of households, conducted annually.

Data issues/caveats that affect outcome measures::

The data has a significant lag. In two years, the most recent data will be from 2014. We will not have direct impact on that year.

Indicator #: 3
 Indicator: Non-Medical use of Prescription Pain Reliever - 26 year old and older
 Baseline Measurement: 3.35% in 2012
 First-year target/outcome measurement:
 Second-year target/outcome measurement: 3.35% in 2014
 Data Source:

National Survey on Drug Use among Households

Description of Data:

National survey of households, 12 years and older. Asking about past year non-medical use of prescription pain relievers.

Data issues/caveats that affect outcome measures::

The data has a significant lag. In two years, the most recent data will be from 2014. We will not have direct impact on that year.

Indicator #:

4

Indicator:

Reduce Community norms favorable to alcohol, tobacco and other drug use

Baseline Measurement:

18.6% in 2013

First-year target/outcome measurement:

17.0% in 2014

Second-year target/outcome measurement:

16.5% in 2015

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

Scale of questions asked of Utah youth regarding community norms. statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

This data is collected biennially. Confidence interval is +/-5%

Indicator #:

5

Indicator:

Reduce access to non-medical use of prescription drugs

Baseline Measurement:

35 - Number of take back events in 2014

First-year target/outcome measurement:

Second-year target/outcome measurement:

45 - number of take back events in 2016

Data Source:

Local reporting.

Description of Data:

Local communities will report the number and dates of local take back events in each calendar year.

Data issues/caveats that affect outcome measures::

Concerns: Human error. Planned events that may not occur. lack of consistent reporting. One concern is that these are under-reported with new federal laws allowing for disposal at pharmacies.

Indicator #:

6

Indicator:

Increase Communities that Care efforts

Baseline Measurement:

10 coalitions in 2013

First-year target/outcome measurement:

Second-year target/outcome measurement:

15 coalitions in 2015

Data Source:

Local reporting

Description of Data:

Local substance abuse authorities will report the active coalitions in their communities to the State.

Data issues/caveats that affect outcome measures::

There is no measure collected at this time to identify "high functioning" coalitions versus coalitions which are struggling to remain active.

Indicator #: 7
Indicator: Increase number of Indicated services
Baseline Measurement: State Fiscal Year 2016 area plans - 35 indicated services
First-year target/outcome measurement: SFY 2017 area plans - 40 indicated services
Second-year target/outcome measurement: SFY 2018 area plans - 45 indicated services

Data Source:

Local substance abuse authority annual area plans

Description of Data:

Data issues/caveats that affect outcome measures::

with onset of medicaid and Affordable healthcare Act funding, indicated prevention services may be paid for out of other funding. We may see a decrease.

Priority #: 3
Priority Area: Prevention and Early Intervention - Tobacco and nicotine
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB

Goal of the priority area:

Goal 1.5 Prevent tobacco and nicotine use

Objective:

Objective 1.5.1: Cooperate with the State Department of Health in the planning and administration of Synar Checks.
Objective 1.5.2: Reduce community norms favorable to use of tobacco and other nicotine products
Objective 1.5.3 Increase Communities That Care efforts

Strategies to attain the objective:

1.5.1: attend monthly and quarterly meeting with the Dept of Health regarding Synar checks
1.5.2. Increase the environmental strategies addressing tobacco and other nicotine products, including but not limited to city/county/state ordinances related to e cigarettes.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: 30 day tobacco use - youth all grades
Baseline Measurement: 2.7% in 2013
First-year target/outcome measurement:
Second-year target/outcome measurement: 1.7% in 2015

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data. question for data is "have you used tobacco in the past 30 days"

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #: 2
Indicator: 30 day e-cigarette use - youth all grades
Baseline Measurement: 4.7% in 2013
First-year target/outcome measurement:
Second-year target/outcome measurement: 4.0% in 2015

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #: 3
Indicator: Synar compliance
Baseline Measurement: 94% compliance rate - 2015
First-year target/outcome measurement: 94% compliance rate - 2016
Second-year target/outcome measurement: 94% compliance rate - 2017

Data Source:

Synar compliance checks

Description of Data:

State of Utah Dept of Health conducts tobacco sales compliance checks annually.

Data issues/caveats that affect outcome measures::

Utah will maintain a tobacco sales compliance check rate of 94%, which is higher than the federally required 80%.

Indicator #: 4
Indicator: Reduce Community norms favorable to alcohol, tobacco and other drug use
Baseline Measurement: 18.6% in 2013
First-year target/outcome measurement:
Second-year target/outcome measurement: 16.5% in 2015

Data Source:

Student Health and risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #: 5
Indicator: Increase Communities that Care efforts
Baseline Measurement: 10 coalitions in 2013
First-year target/outcome measurement:
Second-year target/outcome measurement: 15 coalitions in 2015

Data Source:

Local reports

Description of Data:

Local substance abuse authority areas will report active coalitions in their communities.

Data issues/caveats that affect outcome measures::

Priority #: 4
Priority Area: Prevention and Early Intervention - Marijuana
Priority Type: SAP, MHS
Population(s): PWWDC, PP, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ)

Goal of the priority area:

Goal 1.3 Prevent and reduce marijuana use

Objective:

Objective 1.3.1: Reduce community norms favorable to misuse and abuse
Objective 1.3.2: Reduce access to marijuana
Objective 1.3.3: Increase Communities That Care efforts
Objective 1.3.4 Increase access to person-centered prevention services.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: 30 day marijuana use - youth all grades
Baseline Measurement: 5.8% in 2013
First-year target/outcome measurement: 5.8% in 2015
Second-year target/outcome measurement: 5.8% in 2015

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%. There are a number of external factors impacting the consumption of

marijuana. Utah aims to maintain the current rate of 5.8%.

Indicator #: 2
Indicator: 30 day marijuana use - 18-25 year olds
Baseline Measurement: 9.83% in 2012
First-year target/outcome measurement: 9.83% in 2013
Second-year target/outcome measurement: 9.83% in 2014

Data Source:

NSDUH

Description of Data:

National survey on drug use in households.

Data issues/caveats that affect outcome measures::

The data has a significant lag. In two years, the most recent data will be from 2014. We will not have direct impact on that year. There are a number of external factors impacting marijuana consumption. Utah aims to maintain the 9.83% consumption rate.

Indicator #: 3
Indicator: 30 day marijuana use - 26 years and older
Baseline Measurement: 3.04% in 2012
First-year target/outcome measurement: 3.04% in 2013
Second-year target/outcome measurement: 3.04% in 2014 Maintain

Data Source:

NSDUH

Description of Data:

National survey on drug use in households.

Data issues/caveats that affect outcome measures::

The data has a significant lag. In two years, the most recent data will be from 2014. We will not have direct impact on that year. There are a number of external factors impacting marijuana consumption rates. Utah aims to maintain the 3.04% rate.

Indicator #: 4
Indicator: Reduce Community norms favorable to alcohol, tobacco and other drug use
Baseline Measurement: 18.6% in 2013
First-year target/outcome measurement:
Second-year target/outcome measurement: 16.5% in 2015

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #: 5
Indicator: Reduce access to Marijuana - work with law enforcement
Baseline Measurement: 13 law enforcement representatives on community coalitions - 2015
First-year target/outcome measurement: 20 law enforcement representatives on community coalitions - 2016
Second-year target/outcome measurement: 30 law enforcement representatives on community coalitions - 2017

Data Source:

reports from community coalitions

Description of Data:

Community coalitions rosters and meeting minutes.

Data issues/caveats that affect outcome measures::

Rosters may not be current. Minutes will show who is an active participant from the law enforcement communities.

Indicator #: 6
Indicator: Increase perception of harm of smoking marijuana once or twice a week - youth all grades
Baseline Measurement: 77.5% in 2013
First-year target/outcome measurement: 79.5% in 2015
Second-year target/outcome measurement: 80.5% in 2017

Data Source:

Student Health and Risk Prevention Survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #: 7
Indicator: Increase Communities that Care efforts
Baseline Measurement: 10 coalitions in 2013
First-year target/outcome measurement:
Second-year target/outcome measurement: 15 coalitions in 2015

Data Source:

reports from local areas

Description of Data:

report from local substance abuse authority areas on the number of active coalitions in their communities

Data issues/caveats that affect outcome measures::

Indicator #: 8
Indicator: Increase number of Indicated services
Baseline Measurement: State Fiscal Year 2016 area plans - 35 indicated services

First-year target/outcome measurement: SFY 2017 area plans - 40 indicated services

Second-year target/outcome measurement: SFY 2018 area plans - 45 indicated services

Data Source:

Local substance abuse authority annual plan

Description of Data:

local substance abuse authorities submit an annual plan of services to be provided. Indicated prevention services highlighted for this indicator.

Data issues/caveats that affect outcome measures::

with onset of medicaid funding or other Affordable Health Care Act funding, some prevention indicated services may be paid for out of other funding. We may see a decrease.

Priority #: 5

Priority Area: Prevention and Early Intervention - mental illness

Priority Type: SAP, MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Goal 1.4 Prevent and reduce depression and other mental illness

Objective:

Objective 1.4.1: Identify opportunities to integrate substance abuse and mental illness prevention systems, models, policies, and practices.

Objective 1.4.2: Increase access to evidence based programs proven to reduce mental illness.

Objective 1.4.3: Promote, educate, and provide leadership to increase the number of Communities That Care Coalitions addressing mental illness issues.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Needs mental Health treatment - youth

Baseline Measurement: 13.0% in 2013

First-year target/outcome measurement: 13.0% in 2015

Second-year target/outcome measurement: 12.0% in 2017

Data Source:

Student Health and Risk Prevention survey

Description of Data:

statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data. This indicator is from a scale of questions identifying a need for mental health treatment.

Data issues/caveats that affect outcome measures::

Survey is administered biennially. Confidence interval is +/-5%

Indicator #: 2

Indicator: Increase Communities that Care efforts - integrating substance abuse and mental illness prevention

Baseline Measurement: 9 coalitions in 2015

First-year target/outcome measurement: 11 coalitions in 2016

Second-year target/outcome measurement: 13 coalitions in 2017

Data Source:

community action plans

Description of Data:

plans that are developed by the local community coalitions through the CTC process

Data issues/caveats that affect outcome measures::

Plans are only updated every other year.

Indicator #: 3

Indicator: Increase Communities that Care efforts - engaged in Mental Health Prevention

Baseline Measurement: 9 coalitions in 2015

First-year target/outcome measurement: 11 coalitions in 2016

Second-year target/outcome measurement: 13 coalitions in 2017

Data Source:

Submissions to National Alliance for Mental Illness (NAMI) for Prevention by Design Grant

Description of Data:

information provided to State of Utah by NAMI. Names of coalitions that are participating in the grant.

Data issues/caveats that affect outcome measures::

Grant is only offered every 3 years.

Indicator #: 4

Indicator: Increase access to evidence based programs to reduce mental illness

Baseline Measurement: State Fiscal Year 2016 area plans - 30 evidence based Mental illness prevention strategies

First-year target/outcome measurement: SFY 2017 area plans - 40 evidence based Mental illness prevention strategies

Second-year target/outcome measurement: SFY 2018 area plans - 45 evidence based Mental illness prevention strategies

Data Source:

Annual Area plans submitted

Description of Data:

Local substance abuse authority area plans. These strategies may include strategies that address shared risk factors for mental illness and substance use disorder prevention.

Data issues/caveats that affect outcome measures::

Strategies identified may be included if they are addressing shared risk factors.

Priority #: 6

Priority Area: Prevention and Early Intervention - Promoting Substance Use Disorder and Mental Illness Prevention

Priority Type: SAP, SAT, MHS

Population(s):

Goal of the priority area:

Goal 1.6 Promote Substance Use Disorder and Mental Illness Prevention

Objective:

- Objective 1.6.1 Identify and respond to emerging behavioral health issues in a comprehensive and coordinated manner.
- Objective 1.6.2 Increase Communities That Care efforts
- Objective 1.6.3 Increase access to person-centered prevention services.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Increase the number of Fact Sheets on new and emerging trends
Baseline Measurement: 2 fact sheets per year, 2015
First-year target/outcome measurement: 4 fact sheets per year, 1 per quarter, 2016
Second-year target/outcome measurement: 8 fact sheets per year, 2 per quarter, 2017

Data Source:

State Epidemiological Outcomes Workgroup fact sheets, minutes

Description of Data:

Fact sheets related to new and emerging trends related to substance use disorder and mental illness prevention.

Data issues/caveats that affect outcome measures::

Indicator #: 2
Indicator: Increase Communities that Care efforts
Baseline Measurement: 10 coalitions in 2015
First-year target/outcome measurement: 11 coalitions in 2016
Second-year target/outcome measurement: 15 coalitions in 2017

Data Source:

Local substance abuse authority reports

Description of Data:

Local reports of active coalitions that are working with promoting substance use disorder and mental illness prevention. Including shared risk factors.

Data issues/caveats that affect outcome measures::

Indicator #: 3
Indicator: Increase number of Indicated services
Baseline Measurement: State Fiscal Year 2016 area plans - 35 indicated services
First-year target/outcome measurement: SFY 2017 area plans - 40 indicated services
Second-year target/outcome measurement: SFY 2018 area plans - 45 indicated services

Data Source:

Local Substance Abuse Authority area plan

Description of Data:

local substance abuse authorities submit an annual plan of services to be provided. Indicated prevention services highlighted for this indicator.

Data issues/caveats that affect outcome measures::

with onset of medicaid funding or other Affordable Health Care Act funding, some prevention indicated services may be paid for out of other funding. We may see a decrease.

Priority #: 7
Priority Area: Prevention and Early Intervention Overdose deaths
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs

Goal of the priority area:

Reduce Overdose Deaths

Objective:

Objective: 1.7.1 Educate the general public on ways to reduce overdose deaths
Objective 1.7.2 Educate the general public on Naloxone Project
Objective 1.7.3 Incorporate education, promotion and distribution of Naloxone kits among strategic plans of LSAA, LMHA, Communities That Care and other prevention coalitions.

Strategies to attain the objective:

-Increase knowledge in coalitions of overdose prevention
-Educate and provide technical assistance to Local Authorities and coalitions on dissemination of overdose prevention policy strategies and practices.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Overdose Deaths related to opiates
Baseline Measurement: DOH Report on Overdoses
First-year target/outcome measurement: Reduction of 5%
Second-year target/outcome measurement: Reduction of 10%

Data Source:

DOH reports and data

Description of Data:

Number of deaths attributed to opiate overdoses

Data issues/caveats that affect outcome measures::

Data is sometimes slow in coming.

Indicator #: 2
Indicator: Number of coalitions involved in distribution of Naloxone kits and information
Baseline Measurement:
First-year target/outcome measurement: 10% increase
Second-year target/outcome measurement: 25% increase

Data Source:

Coalition Reports, Area Plans, Site visits and reports

Description of Data:

Number of coalitions listing distribution of overdose prevention kits and information.

Data issues/caveats that affect outcome measures::

Indicator #:

2

Indicator:

Number of coalitions involved in distribution of Naloxone kits and information

Baseline Measurement:

First-year target/outcome measurement: 10% increase

Second-year target/outcome measurement: 25% increase

Data Source:

Coalition Reports, Area Plans, Site visits and reports

Description of Data:

Number of coalitions listing distribution of overdose prevention kits and information.

Data issues/caveats that affect outcome measures::

Priority #:

8

Priority Area:

Zero Suicides

Priority Type:

SAP, SAT, MHS

Population(s):

SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB

Goal of the priority area:

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

Objective:

Subcontract with a minimum of 13 local coalitions through Prevention by Design

Train community members in Gatekeeper awareness and evidence-based trainings.

Strategies to attain the objective:

An RFP process is used to request applications for Prevention by Design projects.

Coalitions have trainers that provide QPR, SafeTalk, ASIST and other evidence-based trainings.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number of engaged community prevention coalitions

Baseline Measurement:

of prevention coalitions engaging in suicide prevention efforts

First-year target/outcome measurement:

Increase # of prevention coalitions engaged by 10%

Second-year target/outcome measurement:

Increase # of prevention coalitions engaged by 20%

Data Source:

Prevention by Design funding recipients provide annual reports of progress toward proposal goals.

Description of Data:

Data will include numbers of individuals trained in evidence-based trainings, pre- and post-test results,

Data issues/caveats that affect outcome measures::

Suicide is a low baseline level event and long-term outcomes may be difficult to quantify.
Community leaders can be resistant to addressing suicide.

Priority #: 9
Priority Area: Zero Suicides
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB

Goal of the priority area:

Goal 2.2
Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts

Objective:

DSAMH will provide ongoing leadership to collaborate and coordinate the Utah Suicide Prevention Coalition, including the Executive Committee and relevant workgroups.

Maintain a current state suicide prevention plan

Strategies to attain the objective:

Hosting bimonthly Utah Suicide Prevention Coalition and Executive Committee meetings.

Review and update current plan, with input from community stakeholders.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Participation in Suicide Prevention Coalition meetings
Baseline Measurement: 15 stakeholders represented at meetings
First-year target/outcome measurement: Maintain or increase number of stakeholders engaged
Second-year target/outcome measurement: Maintain or increase number of stakeholders engaged

Data Source:

Bimonthly meeting minutes, agendas and sign in sheets

Description of Data:

Current strategies and resources, status of the State suicide prevention plan, critical issues

Data issues/caveats that affect outcome measures::

Conflicting meetings may impact attendance

Priority #: 10
Priority Area: Zero Suicides
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Goal 2.3

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.

Objective:

2.3.1

Promote the adoption of universal screening for suicide risk within the public behavioral healthcare system

2.3.2

Promote same day safety planning for individuals who screen positive for suicide risk

Strategies to attain the objective:

Zero Suicide Initiative
Performance Improvement Plan
Division Directives

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Universal Screening Rates in public mental health system
Baseline Measurement: Dependent on Local Authority
First-year target/outcome measurement: Increase screening rates by 25%
Second-year target/outcome measurement: Increasing screening rates by 50%

Data Source:

DSAMH reporting tool, Electronic Health Records

Description of Data:

Administrations of the Columbia Suicide Severity Rating Scale per intake at Local Authority

Data issues/caveats that affect outcome measures::

Some Local Authorities do not have the required data built into their EHR, there are multiple EHR systems state-wide.

Indicator #: 2
Indicator: Same-day safety planning for individuals screened as at risk for suicide
Baseline Measurement: Dependent on Local Authority
First-year target/outcome measurement: Increase same-day safety plans by 25%
Second-year target/outcome measurement: Increase same-day safety plans by 50%

Data Source:

DSAMH reporting tool, Electronic Health Records (EHRs)

Description of Data:

Use of same-day safety plan per individual endorsing 2 or higher on the C-SSRS.

Data issues/caveats that affect outcome measures::

Some local authorities do not have the data built into the EHRs, there are different EHRs in use around the state.

Priority Area: Promote Recovery
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, Other (Adolescents w/SA and/or MH, Military Families, Criminal/Juvenile Justice)

Goal of the priority area:

Goal 3.1 Promote and establish peer support services

Objective:

Objective 3.1.1 Provide Training for MH and SUD Peer Specialists
Objective 3.1.2 Educate and Promote the availability of trained PSS to Local Authorities and other potential employers (Public and Private MH, SUD and Health care providers) on benefits of using Peer Support Specialists
Objective 3.1.3 Increase Medicaid Billing Rates for PSS Services
Objective 3.1.4 Expand input to the Division and UBHPAC from Recovery Support organizations and individuals.

Strategies to attain the objective:

Continue to contract for Training Providers
Publicize training opportunities
Include Peer Services in audit discussions and visits
Publicize peer opportunities
Support through funding and other support an annual Peer Support Conference.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of Trainers for Peer Support that are approved by DSAMH
Baseline Measurement: Currently only 1 is approved
First-year target/outcome measurement: At least one additional Trainer
Second-year target/outcome measurement: Maintain at least one trainer and conduct Quarterly Trainings.

Data Source:

Division Records
Contract Approvals
Roster of trainees submitted

Description of Data:

One contract with University of Utah
Second contract with Utah State University in development through Department of Human Services (Peer Paraprofessional Training)

Data issues/caveats that affect outcome measures::

University of Utah is not interested in continuing to train. Therefore, only one trainer will continue to be available despite adding on a new trainer.

Priority #: 12
Priority Area: Promote Recovery
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Goal 3.2 Promote and establish employment services statewide

Objective:

Objective 3.2.1 Identify current programs and barriers in both urban and rural counties. Establish baseline measurements for employment.

Objective 3.2.2 Develop a continuum across available services to describe funding gaps and create a strategic plan to address barriers.
 Objective 3.2.3 Increase engagement of employment services for individuals in recovery
 Objective 3.2.4 Work with Medicaid to expand services through various funding mechanisms.

Strategies to attain the objective:

Preliminary resource and list, Funding gaps and strategic plan, Engage an average of 100 individuals per year, Develop draft of appropriate waiver for Medicaid consideration
 TA from PR Gains, grant advisor and BRSS TACS

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Individuals engaged in employment activities and finding employment
 Baseline Measurement: Dependent on Local Authority
 First-year target/outcome measurement: Engage an average of 100 individuals per year by December 30, 2016 in Supported Employment
 Second-year target/outcome measurement: Engage an average of 100 individuals per year by December 30, 2017 in Supported Employment

Data Source:

SAMHIS, CDP, Electronic health records for each Local Authority

Description of Data:

Demographics, full-time employment, part-time employment, volunteer positions, employers, community partners, individuals served, mental health services received for persons engaged in Supported Employment, IPS fidelity scales.

Data issues/caveats that affect outcome measures::

CDP has not been available for use, have not yet received formal IPS training

Priority #: 13
 Priority Area: Promote Recovery
 Priority Type: SAP, SAT, MHS
 Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Homeless)

Goal of the priority area:

Goal 3.3 Treat mental health and substance abuse disorders as chronic health conditions

Objective:

Objective 3.3.1 Review Division Directives and Contracts to remove barriers to integration and providing chronic care: (Program Administrators)
 Objective 3.3.2 Advocate to SAMHSA, NASADAD, National Council, NASMHPD and other organizations for changes to system that enforce silos, separate functioning and acute care management. (Director, Assistant Directors)
 Objective 3.3.3 Participate in State Level, Department Level and cross agency panels and committees with the goal of furthering integration with physical health and reducing separate systems of care. (All program managers and administrators)

Strategies to attain the objective:

Redo Contract Language by June 2015, then review for FY 16.
 Take proposed contract language changes to Clinical Directors by Jan 2016.
 Take Proposed Directive changes to Directors by February 2016.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Individuals engaged in Recovery Support Activities from admission to Discharge

Baseline Measurement: Numbers involved at admission compared to numbers at discharge

First-year target/outcome measurement: Each LA will increase the numbers engaged in recovery support services

Second-year target/outcome measurement: Each LA will increase by an additional 5% the numbers engaged in RS from admission to discharge

Data Source:

TEDS and Outcome Score Card

Description of Data:

Individuals reporting engagement in RS meetings at admission versus discharge.

Data issues/caveats that affect outcome measures::

Priority #: 14

Priority Area: Promote Recovery

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Homeless)

Goal of the priority area:

Goal 3.4 Provide MH and SUD services in a Trauma Informed environment for clients and staff

Objective:

Objective 3.4.1 Review Division Directives and Contracts to include the provision of services in a Trauma Informed environment.

Objective 3.4.2 Provide Increased Training and technical assistance for Local Authorities.

Objective 3.4.3 Create a Trauma Informed Workgroup that reports to the UBHC Clinical Directors to make recommendations about changes in policy, procedures, and funding strategy to move to a TIC system.

Strategies to attain the objective:

Provide TIC training during Fall Conference and Generation's Conference.

If Healthy Utah passes, then use SAPT to implement additional TIC and ROSC processes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Local Authorities providing Trauma Informed and oriented treatment groups

Baseline Measurement: Current number of agencies as of Jan 2016

First-year target/outcome measurement: 1/3 of LAs will provide trauma informed groups and treatment

Second-year target/outcome measurement: 1/2 of LAs will provide primary trauma informed services.

Data Source:

Audit Reports
Area Plans

Description of Data:

Each LA provides a listing of groups during monitoring visits. EBPs specific to trauma (ie. EMDR, Seeking Safety) are identified.

Data issues/caveats that affect outcome measures::

Resources for training and turnover of staff

Priority #: 15
Priority Area: Promote Recovery
Priority Type: SAP, SAT, MHS

Population(s):

Goal of the priority area:

Goal 3.5 Develop array of non-clinical services designed to provide necessary supports for individuals seeking recovery or in early recovery

Objective:

Objective 3.5.1 Expand Contract Language to encourage and incentivize expansion of services providing early intervention and post-acute treatment services to support recovery. (Program Administrators)
Objective 3.5.2 Work with appropriate committees and groups to ensure that essential health benefits in Utah include early intervention and Recovery Support services in insurance plans. (Program Administrators and Division Director)

Strategies to attain the objective:

Continue use of Voucher system to expand services available. (ATR Model)
Work with UBHC Clinical committees and JRI work groups to incorporate non traditions services as resources come available through implementation of Utah's Healthy Utah.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of Local Authorities providing Medication Assisted Services to over 5% of their SUD clients
Baseline Measurement: Currently only Two are providing significant numbers of clients the option of MAT.
First-year target/outcome measurement: Four Local Authorities will have contracted with OTPs and/or have physicians who are prescribing addiction medications to at least 5% of their clients
Second-year target/outcome measurement: Four Local Authorities will meet target
Data Source:
SAMHIs and Audit reports
Description of Data:
Number of Individuals who are reported as using MAT as an EBP.
Data issues/caveats that affect outcome measures::

Priority #: 16
Priority Area: Improve Care for children and youth
Priority Type: SAP, SAT, MHS
Population(s): Other (Adolescents w/SA and/or MH, Students in College, Military Families)

Goal of the priority area:

Goal 4.1 Promote Community Based Services (SOC Value) through increasing accountability of states placing youth in Residential Treatment Centers (RTCs) in Utah.

Objective:

Objective 4.1.1
Increase in state system knowledge of, and compliance with, the ICPC process through a collaboration with OL, DCFS, DSAMH and the LMHAs.
Objective 4.1.2
Establish and utilize collaboratively developed procedures to ensure ICPC compliance.

Objective 4.1.3

Identify all states sending children and youth to RTCs in Utah and increase collaboration regarding compliance and oversight by sending state.

Strategies to attain the objective:

Office of Licensing (OL) is incorporating ICPC compliance in monitoring.

- All LMHAs will have been trained by DCFS regarding the ICPC system.
- All LMHAs will have been trained by DSAMH regarding procedures to follow when ICPC issues arise.

DSAMH (and DCFS) will be notified by LMHAs when ICPC issues arise.

DSAMH and DCFS will resolve ICPC situations and will involve OL when violations occur.

Children and youth placed in Utah by other states will not enter the Department of Human Services' custody when avoidable by compliance with ICPC.

State of Utah and County funds will not be used to pay for inpatient hospitalizations for children and youth placed in Utah by other states without seeking reimbursement through the ICPC process.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Compliance with ICPC Process

Baseline Measurement: Numbers of clients paid for by State Funds without reimbursement through the IPC process

First-year target/outcome measurement: 30% reduction

Second-year target/outcome measurement: Additional 20% reduction

Data Source:

partner agencies, DCFS, Office of Licensing, ICPC Local Authorities

Description of Data:

Research results, reports, SAMHIS and Outcome Data

Data issues/caveats that affect outcome measures::

Priority #: 17

Priority Area: Improve Care for children and youth

Priority Type:

Population(s): Other (Adolescents w/SA and/or MH, Students in College, Military Families, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Goal 4.2 Increasing system knowledge and establish preferred practice guidelines for adolescent co-occurring substance use and mental health disorders treatment.

Objective:

Objective 4.2.1 Increase utilization of LMHA/LSAA supplied data regarding the provision of services and outcomes for adolescents with co-occurring substance use and mental health disorders.

Objective 4.2.2 Develop preferred practice guidelines for adolescent co-occurring substance use and mental health disorders treatment.

Objective 4.2.3 Disseminate knowledge

Strategies to attain the objective:

All available measurements of provision of services and outcomes for adolescents have been evaluated.

Gaps in the data and recommend changes to data elements have been identified.

Utilization of data has increased, trends have been identified and utilization standards (similar to the youth mental health scorecard) have been established.

An ad hoc committee has been established and preferred practice guidelines have been drafted.

Division leadership will have made a determination regarding the committee being led by DSAMH or UBHC.

Preferred practice guidelines will have been disseminated to all LMHAs/LSAAs.

Additional training needs, specific to adolescent co-occurring substance use and mental health disorders treatment will have been identified.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Adolescent Scorecard for Co-Occurring Mental Health and Substance Use Disorders developed and used
Baseline Measurement: No current scorecard
First-year target/outcome measurement: Outcome measures agreed upon and collection methods established.
Second-year target/outcome measurement: Score card published.

Data Source:

SAMHIS, Local Authority Reports,

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 18
Priority Area: Health system Integration
Priority Type: SAP, SAT, MHS
Population(s):
Goal of the priority area:

Goal 5.1 Develop partnerships with and between accountable/primary care organizations and federally qualified health centers and the Local Authorities

Objective:

Objective 5.1.1 DSAMH will actively participate in the 1) ACO quality measurement committee; 2) Health Systems Partnership; 3) Recovery Plus Committee; 4) Behavioral Health Sub Committee of the Health System Reform Task Force, and help coordinate efforts between committees
Objective 5.1.2 Coordinate with LAs not currently partnering with a primary care provider to identify barriers and strategies for overcoming barriers for integrating care
Objective 5.1.3 Develop a best practices learning collaborative between behavioral health and Primary Care (integrated service clinics) – developing some best practice strategies.

Strategies to attain the objective:

Increase the number of partnerships with and between accountable/primary care organizations and FQHCs and the LAs by 20%

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Publish Integration Best Practices Guidance for LMHA
Baseline Measurement: No current standard or guidance established
First-year target/outcome measurement: Establish Best Practice Learning Collaborative
Second-year target/outcome measurement: Publish Collaborative's best practices guidance.

Data Source:

Area plans, monitoring reports, ACOs (Health Choice Utah, Healthy U, Molina Healthcare of Utah, Selecthealth Community Care)

Description of Data:

Research results, reports, SAMHIS and Outcome Data

Data issues/caveats that affect outcome measures::

Rural areas struggle with inadequate resources; MOUs can be helpful, but may also limit options

Priority #: 19
Priority Area: Health system Integration
Priority Type: SAP, SAT, MHS
Population(s): Other

Goal of the priority area:

Goal 5.2 Develop/Determine/Publish/Disseminate standards and procedures for integrated care activities (screening and identification)

Objective:

Objective 5.2.1 Review Division Directives and Contracts to remove barriers to integration and providing chronic care.
Objective 5.2.2 Participate in State Level, Department Level and cross agency panels and committees with the goal of furthering integration with physical health and reducing separate systems of care.
Objective 5.2.3 In conjunction with the UBHC Clinical Directors, develop a learning collaborative to share information and lessons learned regarding EBPs and their utility in Utah.

Strategies to attain the objective:

Redo Contract Language and take proposed contract language changes to Clinical Directors by Jan 2016
Take Proposed Directive changes to Directors by February 2016

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Establish Collaborative Contract Language to Promote Integration
Baseline Measurement: Current contract language, which may include barriers to integration
First-year target/outcome measurement: Proposed contract language approved by LA Clinical Directors
Second-year target/outcome measurement: Assessment of current contracts to remove language barriers to integration

Data Source:

Local Authorities, Community Stakeholders, Behavioral Health Partnership Committee members

Description of Data:

Current contracts, Utah Medicaid Office

Data issues/caveats that affect outcome measures::

Priority #: 20
Priority Area: Health system Integration
Priority Type: MHS
Population(s): SMI, SED

Goal of the priority area:

Goal 5.3
Connection between Division and USH and site visit

Objective:

Objective 5.5.1
Review JCAHO, Legislative Audits and REDI Program to identify and work to resolve any findings/issues.
Objective 5.5.2
Chair the Continuity of Care Committee and work with USH and LMHA's to integrate individuals with mental illness ready for discharge into community placements to promote recovery and quality of life.

Strategies to attain the objective:

Review audits and trends with REDI.
Bring issues to Governing Body quarterly to resolve any issues and improve quality of care.
Monthly meetings to improve time frames for patients discharging to the community.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Continuity of Care with USH and LMHAs
Baseline Measurement: Current time frame for discharging patients
First-year target/outcome measurement: Improve discharge time by 5%
Second-year target/outcome measurement: Improve discharge time by 10%

Data Source:

REDI, JTC Legislative Audits

Description of Data:

Discharge time, barriers to discharge

Data issues/caveats that affect outcome measures::

Broker services within SLC can be an issue, Discharge housing remains an ongoing problem

Priority #: 21
Priority Area: Health system Integration
Priority Type: SAT, MHS
Population(s): SMI, SED, PWWDC, PP, IVDUs, Other

Goal of the priority area:

Goal 5.4 Improve housing and employment services across the state.

Objective:

Objective 5.4.1 Identify current programs and barriers in both urban and rural counties. Establish baseline measurements for chronic homelessness and employment.
Objective 5.4.2 Develop a continuum across available services to describe funding gaps and create a strategic plan to address barriers.
Objective 5.6.3 Work with Medicaid to expand services through various funding mechanisms.

Strategies to attain the objective:

Preliminary resource and list , Funding gaps and strategic plan, Increase employment by 20%, Decrease chronic homelessness by 20%

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Decrease homelessness in both urban and rural counties
Baseline Measurement: Baseline established, reported to SAMHSA
First-year target/outcome measurement: Identification of funding gaps
Second-year target/outcome measurement: Creation of strategic plan to address barriers

Data Source:

HMIS

Description of Data:

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$14,629,624		\$21,258,414	\$24,247,462	\$16,233,528	\$10,127,390	\$0
a. Pregnant Women and Women with Dependent Children*	\$2,634,890		\$8,385,770	\$4,266,608	\$3,488,860	\$2,073,080	\$0
b. All Other	\$11,994,734		\$12,872,644	\$19,980,854	\$12,744,668	\$8,054,310	\$0
2. Substance Abuse Primary Prevention	\$8,162,318		\$112,846	\$548,538	\$152,806	\$1,190,886	\$0
3. Tuberculosis Services	\$71,368		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$1,059,031		\$0	\$0	\$0	\$0	\$0
13. Total	\$23,922,341	\$0	\$21,371,260	\$24,796,000	\$16,386,334	\$11,318,276	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$0	\$0	\$0	\$0	\$0
6. Other 24 Hour Care		\$0	\$0	\$3,431,498	\$0	\$8,111,870	\$0
7. Ambulatory/Community Non-24 Hour Care		\$667,214	\$0	\$1,909,268	\$0	\$8,331,866	\$0
8. Mental Health Primary Prevention**		\$75,908	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$347,856	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$312,882	\$0	\$0	\$0	\$0	\$0
13. Total	\$0	\$1,403,860	\$0	\$5,340,766	\$0	\$16,443,736	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	\$	\$

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	\$	\$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	\$	\$
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	\$	\$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	\$	\$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	\$	\$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	\$	\$
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	\$	\$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	\$	\$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	\$	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	\$	\$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	\$	\$
Total	\$0	\$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	
2 . Substance Abuse Primary Prevention	
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	
6. Total	\$0

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
		SA Block Grant Award	
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Education	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		\$0

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$0
Total SABG Award*		\$0
Planned Primary Prevention Percentage		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Column Total	\$0	
Total SABG Award*	\$0	
Planned Primary Prevention Percentage		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

Targeted Substances	
Alcohol	€
Tobacco	€
Marijuana	€
Prescription Drugs	€
Cocaine	€
Heroin	€
Inhalants	€
Methamphetamine	€
Synthetic Drugs (i.e. Bath salts, Spice, K2)	€
Targeted Populations	
Students in College	€
Military Families	€
LGBT	€
American Indians/Alaska Natives	€
African American	€
Hispanic	€
Homeless	€
Native Hawaiian/Other Pacific Islanders	€
Asian	€
Rural	€
Underserved Racial and Ethnic Minorities	€

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$0	\$0	\$0	\$0
2. Quality Assurance	\$0	\$0	\$0	\$0
3. Training (Post-Employment)	\$0	\$0	\$0	\$0
4. Education (Pre-Employment)	\$0	\$0	\$0	\$0
5. Program Development	\$0	\$0	\$0	\$0
6. Research and Evaluation	\$0	\$0	\$0	\$0
7. Information Systems	\$0	\$0	\$0	\$0
8. Total	\$0	\$0	\$0	\$0

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$0
Comments on Data: <input data-bbox="100 911 1521 940" type="text"/>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁷ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁸ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁹ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{30 31} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³² Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral and physical health. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³³ In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³⁴ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁵ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁶ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁷

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁸ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁹ Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes⁴⁰ and ACOs⁴¹ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

Implementation by SMHAs, SSAs and their partners of the Affordable Care Act is an important part of efforts to ensure access to care and better

integrate care. In a recent report, the Congressional Budget Office estimates that by 2018, 25 million persons will have enrolled in the Affordable Care Act Marketplace and 12 million in Medicaid and the Children's Health Insurance Program (CHIP).⁴² The Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) estimates that more than 60 million individuals will have new or expanded access to coverage because of the Affordable Care Act, including both previously uninsured persons and those enrolled in plans that lacked adequate coverage.⁴³ In 2014, non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴⁴ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴⁵

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴⁶ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁷ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁸ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁹ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁵⁰ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁵¹

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁵² Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices. The Affordable Care Act provides for workforce development and training grants that may be helpful in staff retention, recruitment, and training efforts.⁵³

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁴

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. - may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵⁵ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs,

community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?
10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

Please indicate areas of technical assistance needed related to this section.

²⁷ BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun;49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013;91:102–123

<http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52–77

²⁸ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHS's Wellness Efforts,

<http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <http://www.integration.samhsa.gov/health-wellness/samhsa-10x10> Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁹ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

³⁰ 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8); *JAMA*. 2014;311(5):507-520.doi:10.1001/jama.2013.284427

³¹ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³² Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <http://www.cdc.gov/socialdeterminants/Index.html>

³³ Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral Health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

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³⁶ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

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<http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

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³⁹ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicaid.gov/Medicaid-CHIP-Program->

- ⁴⁰ Health homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>
- ⁴¹ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx
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- ⁴³ http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.pdf
- ⁴⁴ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>
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- ⁴⁶ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>
- ⁴⁷ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>
- ⁴⁸ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707
- ⁴⁹ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218
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- ⁵¹ Clarifying Guidance on Peer Support Services Policy, May 2013, CMS, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Clarifying-Guidance-Support-Policy.pdf>; Peer Support Services for Adults with Mental Illness and/or Substance Use Disorder, August 2007, <http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html>; Tri-Agency Letter on Trauma-Informed Treatment, July 2013, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>
- ⁵² Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Annapolis Coalition, An Action Plan for Behavioral Health Workforce Development, 2007, <http://annapoliscoalition.org/?portfolio=publications>; Creating jobs by addressing primary care workforce needs, <http://www.hhs.gov/healthcare/facts/factsheets/2013/06/jobs06212012.html>
- ⁵³ Mental and Behavioral Health Education and Training, <http://bhpr.hrsa.gov/grants/mentalbehavioral/mbhet.html>
- ⁵⁴ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>
- ⁵⁵ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. The Health Care System and Integration

General: At this time, Utah has not yet decided to adopt Medicaid Expansion (ME), and may not decide in time for this application to address all of the questions and issues raised in the application guidelines. As of the writing and posting of the application for public review, Utah has formed a six person committee to resolve differences between the House, the Senate and the Governor's office on the approach to take for expanding health care to individuals that the ACA covers under the Medicaid Expansion Process. It is unclear if this will be resolved prior to submission of the application, and if so, the final process will define many of the answers to specific questions.

The Division has promoted a focus on health and recovery in both SUD and MH services for at least five years. As such, the Division's leadership has been at the table for virtually every meeting regarding integrating expanding health care and implementing health care reform. The Division has spearheaded efforts in legislative meetings to include behavioral health care in all plans for expansion, if in fact the state decides on the expansion of health care. The Division's leadership continues to provide briefings to the legislature on a monthly basis, and as negotiations around the expansion of health care in Utah continue, requests for information are received on a weekly basis.

As stated above, it is unclear what the structure will be in January 2016. At the current time there is a Behavioral Health Carve out and it is doubtful that it will end in the next two years. As a result, Medical services and Behavioral Health Services are dealt with differently, and currently the Counties are responsible for the Medicaid Match requirement for Behavioral Health Services, which impacts what services are provided.

There has been increased interest by the ACOs in expanding their Behavioral Health Services, especially as more insurance has become available under the ACA. The Division meets with the ACOs and with the largest Health Care Provider in the State, Intermountain Health Care (IHC) and has assisted IHC in developing a Care Process Model for their system. While they serve a different population, their expansion of services will only improve the availability of BH care across the state. They are also of assistance in identifying MHPAEA violations.

As decisions are made at the state and national level about the Utah Plan(s) they will be implemented through the current Local Authority system, which means that there will be variance across the system based on the availability of levels of care, distances and availability of other providers. The Division will continue to provide guidance.

Specific changes to funding, what is covered and to what degree, will depend on the acceptance of some form of health care expansion, and which form it takes. The implementation of the 2015 Legislative initiative call the Justice Reform Initiative will also have significant impact on the Behavioral Health Care System.

In 2009, the Division began a partnership with the Department of Health to implement tobacco free policies in all publicly funded SUD and MH facilities. Dubbed "Recovery Plus", the program set out a three year plan for all agencies to become Tobacco Free by March 2013. The three year plan included an assessment phase, an education and policy development phase, and an implementation phase. While it has not yet been fully implemented in all areas of the state, the requirement is that all publicly funded programs have policies in place. There are two requirements that were the backbone of the program: first, that no individual be denied services because of their tobacco use, and secondly, that all individuals be given assistance in quitting their tobacco use. All publicly funded MH and SUD treatment facilities are now tobacco free, and the reduction of tobacco use from admission to discharge is now on the Division's "Scorecard". The FY 16 Division Directive requires all Local Authorities to reduce smoking by at least five percent from admission to discharge.

The Division and DOH continue to partner on tobacco cessation efforts and in June, provided a webinar to Alaska on the Recovery Plus Project.

Since the initiation of Recovery Plus, the Division has continued to work closely with the Department of Health (DOH) on several issues during the past five years. Those issues include Prescription Drug overdoses, Fetal Alcohol Syndrome, Drug Endangered Children, and most recently, Tobacco Cessation. Most recently the Division and the DOH met to review opportunities to collaborate on other health related issues that affect both BH and Physical Health care providers. There is significant energy towards coordinating our efforts towards reducing the impact of co-occurring chronic health care conditions on both systems through coordinated care. Likewise, there is a statewide effort by the DOH and partner agencies to apply for an innovations grant to implement further integration activities. An initiative called Recovery Plus II has worked to integrate and coordinate the Department of Health's health promotion and other activities with the Behavioral Health Local Authorities, and five of the DOH regions and Local Authorities are having ongoing meetings to continue this process.

Wellness: In 2008, the Division Directive for FY 2009 required that the Local Mental Health Authorities implement a "Wellness Directive" that included the following guidance:

"The division has embraced two guiding principles in its effort to promote recovery:

- *Recovery includes WELLNESS; and*
- *Overall health is essential to mental health.*

Because of the premature mortality rate of seriously mentally ill persons, 25 years earlier than non-mentally ill persons, include in your area plan the how you plan to incorporate physical health care issues in the overall treatment planning for adults.

The directive went on to require Local authorities to:

- *monitoring weight*
- *diabetes screening*
- *tobacco use*
- *provide training for staff in recognizing health issues*
- *the adoption of policies to ensure integration of mental health and physical health care*
- *providing information to consumers on physical health concerns and ways to improve their physical health*
- *how to incorporate wellness into individual person-centered plans*
- *how the center will improve prevention, screening and treatment in context of better access to health care*
- *identified a specific practitioner to be the responsible party to ensure that each person's medical health care needs are being addressed"*

This directive has remained in place since that time. While the SUD services have been slower to adopt the guidance, largely due to the lack of medical personnel in the SUD provider network outside of the combined centers, the general approach to treating the whole person has long been an element of SUD assessment and treatment planning. Across the state system, Recovery Plus has been promoted as part of the overall wellness approach to recovery planning, rather than a specific service.

The 2016 Division Directive, the following language was included:

Wellness:

a. Local Authorities will use a Holistic Approach to Wellness and will:

- 1. Identify tobacco use in the assessment.*
- 2. Provide services in a tobacco free environment.*

3. *Provide appropriate tobacco cessation services and resources (including medication).*
 4. *Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.*
 - (a) *Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. When deemed appropriate:*
 - (b) *Include the use of MAT in the treatment plan, and*
 - (c) *Either provide the medications as part of the treatment, or*
 - (d) *Refer the individual for Medication assisted treatment .*
 5. *Provide training for staff in recognizing health issues.*
 6. *Provide information to clients on physical health concerns and ways to improve their physical health.*
 7. *Incorporate wellness into individual person centered Recovery Plans.*
- ix. *Local Authorities will cooperate with efforts of the Division of Substance Abuse and Mental Health to promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs, as described in UCA 62A-15-103.*

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵⁶, [Healthy People, 2020](#)⁵⁷, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁸, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁹

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁶⁰

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁶¹ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁶² In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states are routinely asked to define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://www.healthypeople.gov/2020/default.aspx>

⁵⁸<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁹<http://www.ThinkCulturalHealth.hhs.gov>

⁶⁰http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁶¹<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁶³http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. Health Disparities

- Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

General: As discussed in the planning section, the diversity of population mixes, density and cultural approaches in Utah supports the Local Authority Planning system. While the state as a whole has 13% of the population identifying themselves as Hispanic or Latino, West Valley City in Salt Lake County's population is 33% Hispanic or Latino. While Utah is becoming more diverse, it continues to be one of the the least diverse states, with over 91% of its population identifying themselves as being white, and 80% being while not Hispanic or Latino. While this doesn't remove the need to provide diverse services to diverse cultures, in a resource constrained environment, without Medicaid Expansion and the reduction of SAPT and MH block grant dollars over the past five years, expanding services becomes more challenging.

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?

The Division collects demographic SUD (TEDS) and MH (SAMHIS) data, which does give us the client level data and the enrollment into types and levels of services. This is used to continue to monitor the compliance of the Local Authorities with their area plans and ensure that they are providing the most diverse services possible. At this time the Division does not attempt to collect sexual orientation information, and it is not a required data element. While Local Authorities do identify sexual orientation when it is relevant and at an appropriate time in the therapeutic process, we have not decided to require its submission.

2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.

The Division focuses heavily on providing education to its workforce through the MH and SUD conferences it supports each year, and through its monitoring process. The SUD Fall Conference hosts over 800 individuals and there are numerous presentations and workshops that address cultural competence, LGBTQ issues, working with traumatized populations and options for the increased use of technology in order to expand the capabilities of the frontier agencies.

During the Audit and Monitoring processes, there has been a focused discussion during the past two years on how the local authorities are improving their ability to provide culturally sensitive and appropriate services, and especially in areas with larger than average minority populations, specific discussions on how those needs are met. Specific examples were discussions on Summit County's provision of services in Spanish, to include Prime for Life services. Likewise, in Northeastern's Local Authority, the Division met with tribal providers and discussed how North Eastern Counseling Center was meeting the needs of the tribal organization in that area.

3. Are linguistic disparities/language barriers identified, monitored, and addressed?

See Above.

4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.

Local Authorities are required to address the needs of their clients in their Area Plans. Provision of services to underserved populations include the provision of language services to Medicaid clients and to other populations as resources are available.

5. Is there state support for cultural and linguistic competency training for providers?
 - The Division focuses heavily on providing education to its workforce through the MH and SUD conferences it supports each year, and through its monitoring process. The SUD Fall Conference hosts over 800 individuals and there are numerous presentations and workshops that address cultural competence, LGBTQ issues, working with traumatized populations and options for the increased use of technology in order to expand the capabilities of the frontier agencies.
 - Additionally, with the assistance of the ATTC, several Day Long Cultural Competence Workshops have been provided, and will continue to be a focus.

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁶³ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁴, The New Freedom Commission on Mental Health⁶⁵, the IOM⁶⁶, and the NQF.⁶⁷ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁸ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁹ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁷⁰ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

- c. Use of financial incentives to drive quality.
- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

⁶³ [Ibid, 47, p. 41](#)

⁶⁴ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶⁵ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶⁶ Institute of Medicine Committee on Crossing the Quality Chasm: *Adaptation to Mental Health and Addictive Disorders* (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶⁷ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁸ <http://psychiatryonline.org/>

⁶⁹ <http://store.samhsa.gov>

⁷⁰ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

3. Use of Evidence in Purchasing Decisions

General: By legislative statute and rule, the Division does not purchase services, as planning for and providing services is a county responsibility (See planning section 1). As a result, DSAMH is primarily a pass through agency that operates on a cost reimbursement basis.

The Division has a Program Administrator over each of SUD treatment, Adult MH, Children's MH, ATR Justice, and SUD Prevention services. Each of those Program Administrators is responsible for researching, providing training for, monitoring the implementation of and supporting the use of Statewide EBPs. Additionally, each Program Administrator works to expand the use of EBPs that the Local Authorities choose to implement in their own areas based on their assessment of need and effectiveness of the EBP to meet those needs.

The Division has chosen not to mandate that any EBP be used by all Local Authorities, as the diversity of populations, geography and cultures discussed earlier makes that impractical. All Mental Health Providers have been required to use the OQ and YOQ, and all SUD providers use some form of relapse prevention.

DSAMH monitors the use and implementation of Evidence Based Practices in several ways. The monitoring teams review supervision models and training for EBPs during the annual site reviews and the Local Authority Clinical Directors regularly collaborate with the Division on what practices are carried on the EBP list of practices reported to the SAMHIS as well as requirements for a program to practice an EBP to fidelity.

We routinely use the following as measures of a program's effectiveness and to encourage improvement in the use of EBPs.

- a. Leadership support, including investment of human and financial resources.
- b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- c. Gained consensus on the use of accurate and reliable measures of quality.
- d. Quality measures focus on consumer outcomes rather than care processes.
- e. Development of strategies to educate consumers and empower them to select quality services.
- f. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁷¹ The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁷² In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁷³ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{74 75} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

⁷¹ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁷² Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁷³ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁴ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷⁵ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

4. Prevention of Serious Mental Illness

DSAMH has chosen to focus on strategies designed to help individuals, families and communities improve their health; provide and share hope; and create places where healing can take place. In support of prevention of serious mental illness, strategies include a focus on prevention and early intervention and a stronger system of care for children and youth. As MHBG and the 5% set-aside funds are not available for the at risk population, DSAMH is focusing efforts on coordinating efforts across the State and across other funding streams. For example, DHS has received funding for the Utah Transition Youth Empowered to Succeed (UT YES) program. UT YES is designed to assist young people between the ages of 16 and 25 that either have, or are at risk of developing a serious mental health condition to successfully transition into adulthood (youth-in-transition services). This will be done by helping young people gain competencies in mental and physical wellness, education, employment, housing and independent living skills. DSAMH is an active partner in the coordination of this program with two Local Mental Health Authorities. Another example is the TAN-F funds which are available to address intergenerational poverty. This may include tackling barriers to coordinated treatment for both parents and children, potentially decreasing trauma exposure and the associated sequelae, and improving education and employment outcomes.

Utah has worked with existing systems, such as community coalitions, to reach a larger, more universal population in order to prevent mental illness. Through the Utah initiative Prevention by Design, Utah communities have reached families, first responders, school personnel and youth to raise awareness of mental illness and how to connect those in need to services.

Utah acknowledges the shared risk factors between substance use and mental illness. Our system strives to address and decrease these shared risk factors through universal approaches tailored to the specific needs of each community.

DSAMH has made Prevention its primary focus in an effort to decrease the incidence of Serious Mental illness.

Environmental Factors and Plan

5. Evidence-Based Practices for Early Intervention (5 Percent)

Narrative Question:

In its FY 2014 appropriation, SAMHSA was directed to require that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷⁶ SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷⁷, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. States should be reviewing their data collection efforts related to demonstrating the effectiveness of the programs for the targeted population. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Describe the state's assessed need for the target population and proposed evidence-based programs; provide an explanation for why this population was chosen, a description of planned activities, and a budget showing how the set-aside will be spent.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.).
2. Describe the evidence-based programs using the set-aside.
3. Are there alternative uses of the funds other than EBP's (i.e. staff development, regional plan, etc.) to support this required funding?
4. Describe the data collection efforts being used to demonstrate the effectiveness of the programs for this targeted population.

Please indicate areas of technical assistance needed related to this section.

⁷⁶ <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷⁷ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5. EBPs for Early Intervention:

1. Identify a specific diagnostic category (i.e. psychosis, schizophrenia, bipolar, etc.).

- Psychosis NOS
- Bipolar Disorders
- Schizoaffective Disorders
- Schizophrenia
- Delusional Disorders
- Brief Intermittent Psychotic Syndrome

2. Describe the evidence-based programs using the set-aside.

- The PIER Model is an early detection and intervention approach that focuses on the prodrome phase of a developing psychotic illness. The model is designed for adolescents and young adults ages 12-25 participating in Psychoeducational and Multi Family Group (PMFG & MFG) therapy. Clients are the young people who have been diagnosed with a psychotic disorder or any of the mood disorders with psychotic symptoms. The early stage goals of MFG is for families to plan and implement strategies to cope with the change the client experiences during recovery from early psychosis. Two skill sets are targeted: formal problem solving and communication skills training. In addition to MFG, treatment includes: social/vocational re-engagement, supported education and employment, medication management, individual and family therapy, case management, occupational therapy (may be referred out) and incorporating Family-Aided Assertive Community Treatment (FACT). FACT aims to improve community functioning and increasing the community participation of persons with severe mental illness. Another key component of the PIER model is community education presentations and outreach activities to (1) give specific information about early signs of psychosis; (2) network with community members outside the mental health system; (3) demystify and de-stigmatize mental illness; and (4) provide information on how to make a referral to the mental health system.

3. Are there alternative uses of the funds other than EBP's (i.e. staff development, regional plan, etc.) to support this required funding?

- Outreach beyond Weber and Morgan Counties

- Additional staff training on Structured Interview for Prodromal Syndromes (SIPS)
- Funding for an Occupational Therapist as recommended by the MFG model
- Hearing aid and other supportive devices
- Funding for transportation for families to attend MFG and other recommended interventions

4. Describe the data collection efforts being used to demonstrate the effectiveness of the programs for this targeted population.

- Weber Human Services created a spreadsheet to track referrals and client participation and progress in treatment
- Weber Human Services has data collection on outreach contacts in the community and track intakes into the program.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

6. Participant Directed Care

In 2010, the Division received an ATR grant, and began implementation of a voucher system for ATR Recovery Support Services in Salt Lake, Weber/Morgan and Utah Counties. This has been expanded into use with Drug Court Funds into several other local authorities and the Corrections System has provided funds to be used to provide services for Parolees needing SUD and Recovery Support Services through the Voucher Management System. While the ATR funding has run out, the Division continues to fund Recovery Support Services for Justice clients, DCFS clients and Correction's clients using the voucher management system, and is moving to expand it to some prevention services.

At the same time, a combined MH/SUD initiative to move from event based, therapist centered, program focused documentation to person centered, engagement focused current documentation was being worked on by the Division and the Local Authority Clinical Directors as part of the Recovery Oriented Systems of Care initiative. This led to the following principles being adopted as guides for person centered care in 2014, and the ongoing implementation of the principles through massive modification of the electronic health care records from event based, time based, rigid checklist assessments and treatment plans to easily updated and maintained ongoing assessment and recovery planning tools for the clinician.

- i. Each client shall have a strength-based assessment. (Please note that when the client is a child or youth, the word client also refers to the parent/guardian.) The following principles are to be used to enhance a clinically sound assessment:*
 - a. Initial Engagement: (These principles are shared with Substance Abuse Treatment.)*
 1. *Focus on the immediate/pertinent needs of the client.*
 2. *Clinician establishes rapport with the client.*
 3. *Client can expect to gain something (relief, clarity, answers, hope) from the initial engagement session.*
 4. *Clinicians check that client's needs are being met.*
 5. *Clinicians gather and document relevant information in an organized way.*
 6. *Clinicians make recommendations and negotiate with and respect the client.*
 - b. Ongoing Assessment: (These principles are shared with Substance Abuse Treatment.)*
 1. *Assessment information is kept current.*
 2. *Clinicians gather comprehensive relevant assessment information based on the client's concerns, in an ongoing manner as part of the treatment process.*
 3. *Assessment includes an ongoing focus on strengths and supports that aid the client in their recovery.*
 4. *Assessment includes identifying those things that motivate the client and how those motivations have been impeded by mental illness and/or addiction.*
 5. *Assessment information is organized coherently and available in a readable, printable format.*
 - c. Each client must have a Person-Centered Recovery Plan. Recovery Planning Principles: (These principles are shared with Substance Abuse Treatment.)*

1. *The client is involved in ongoing and responsive recovery planning.*
 2. *Plans incorporate strategies based on the client's motivations.*
 3. *The plan represents a negotiated agreement between the client and provider.*
 4. *The plan is kept current and up to date.*
 5. *Short term goals/objectives are measureable, achievable and within a timeframe.*
 6. *Planning anticipates developing and maintaining independence.*
- d. *Treatment Principles: (These principles are shared with Substance Abuse Treatment.)*
1. *Treatment is individualized dynamic and adjusts according to feedback and concerns of the client.*
 2. *Treatment is recovery/resiliency focused and based on outcomes, sound practice and evidence.*
 3. *Family and other informal and natural supports are involved (as approved by adult clients).*
 4. *Treatment is provided in a culturally competent, gender appropriate and trauma informed manner.*

There has been discussion of utilizing vouchers for women's residential care for programs outside the Wasatch Front's four Local Authorities, but there continues to be problems with this model until whatever form of expansion of health care benefits is decided on.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to: promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays and premium payments, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. If a state chooses to allow the use of block grant funds for these purposes, specific policies and procedures for assuring compliance with the funding requirements must be in place. Under 42 USC § 300x-55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

7. Program Integrity:

General: Since Utah continues to struggle with what form, if any, of expansion of health care to individuals currently not eligible for insurance assistance and who do not qualify for Medicaid, the Block Grant continues to be the primary source of funding for SUD services, and the MHBG helps cover only a small part of the non Medicaid population. Both grants serve as a safety net for those who cannot afford other services. Combined with the State's County Based organization, the Division's role as a pass through agency for cost reimbursement contracts and the fact that only 15-17% of SUD clients qualify for Medicaid assistance, there have not been major changes in our efforts for the past two years.

In the 2015 Legislative session, the Governor's proposal, labeled "Healthy Utah" was passed by the Senate, while a House version, labeled "Utah Cares" was passed by the House. The differences between the two were not resolved, but a six person working group was established with the goal of bringing a proposal to a special session of the Legislature in July or August. It is unclear if they will actually achieve that goal. The "group of six" is comprised of the Governor, Lt. Governor, President of the Senate, Speaker of the House and the two sponsors of the two different proposed bills.

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?

Yes, and the Division continues to work to improve accountability and ensure that funds are used appropriately.

2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?

The Division uses its contracts, its Division Directives, its onsite auditing process, a review of all billing statements and review of annual Area Plans and end of year Area Plan reports to ensure information is disseminated and followed appropriately. The Division leadership meets with the 15 Local Authority Directors each month, and there are also monthly meetings of the Division with the Local Authority Prevention Managers, Finance Managers, Data Managers and Clinical Directors,

3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:

- a) Budget reviews are accomplished as part of the Area Plan Approval Process. <http://dsamh.utah.gov/provider-information/local-authoritycounty-area-plans/>
- b) Claims/payment adjudication; Cost Reimbursement billings are reviewed by program administrators and finance managers prior to disbursement.
- c) Expenditure report analysis; These are done periodically during the year with a wrap up at year end.
- d) Compliance reviews; The Division conducts onsite audit visits to all Local Authorities annually.
- e) Client level encounter/use/performance analysis data. The Division uses Outcome Score Cards as well as information submitted to SAMHIS for ongoing analysis. Please see the Division's annual report at: <http://dsamh.utah.gov/data/annual-reports/>
- f) Audits. As stated above the Division conducts annual audits of each Local Authority. <http://dsamh.utah.gov/provider-information/local-authoritycounty-monitoring-reports/>

4. Does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes,

- through yearly audit visits of each Local Authority that along with compliance checks, provide technical assistance on improving procedures and practices.
- Through yearly educational conferences funded by the Division (Generations Conference, Fall Substance Abuse Conference, Utah Valley Addictions Conference).
- Through monthly and Semi annual meetings of the Utah Behavioral Health Care Committee that includes meetings with Agency Directors, Clinical Directors, Finance Directors and Data/Information Systems Directors.
- Through Annual Division Directive Trainings.
- Through Reviews of Area Plans submitted annually.

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁸ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. In further recognition of strengthening state/tribal relations, tribal governments shall not be required to waive sovereign immunity as a condition of receiving block grant funds or services. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

⁷⁸ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

P. Consultation with the Tribes (Grant Guidance is in Blue)

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Through consultation with American Indian Tribes, suicide prevention is a major concern over the last couple years. The Ute Tribe, Urban Indian Center, and the Navajo Tribe has requested support from DSAMH in this area. Money from the MHBG, through the Prevention by Design contract is supporting communities to raise awareness on suicide prevention and is providing training and education. For example, The Navajo Tribe in coordination with Indian Health Services is providing Applied Suicide Intervention Skills Training (ASIST) training and has trained over 250 gatekeepers in their community. In addition to ASIST, the DSAMH is promoting Mental Health First Aid (MHFA), Question, Persuade, and Refer (QPR), and post-vention training. A representative from the Urban Indian Center sits on the Statewide Suicide Prevention Coalition and we have representation from the Navajo Tribe on the Suicide Prevention Executive Committee. DSAMH is continually reaching out to other American Indian Tribes for representation.

Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Piute, Shoshone and Goshute people. Our state is increasingly diverse in culture: minority populations have increased from 2% to 20% of the total population during the past two decades, and Utah's Hispanic population continues to be the fastest growing community in the state. Compared to national averages, our population is younger and lives longer, has a higher birth rate, and currently Utah averages the highest number of persons per household. Due to the expanse of rural and frontier regions throughout

Utah, some counties have joined together to provide services for their residents. Consequently, there are 29 counties in Utah (including 19 rural classified counties), and 13 local behavioral health authorities. By legislative intent, with the exception of the Utah State Hospital, no substance abuse or community mental health center is operated by the State; the state does not provide clinical care.

Native American populations reside in various “reservations” in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are involved in providing services. Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state’s resources. The direct planning and provision of services is a responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit. Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities. Utah’s Department of Human Services has developed an intertribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.

While as stated above, planning for and providing services is a responsibility of the Counties, DSAMH has taken an active role in working with the Native American tribal organizations. This has included attendance at the quarterly DHS intertribal Council and active discussions with the tribal authorities during the annual site visits to the local authorities. A representative from the DSAMH attends the Annual Native American Governor’s Summit.

There are ongoing efforts to include representatives from the tribal organizations on the Behavioral Health Consumer Advisory Council.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse-related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds;
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Assistance in identifying adult risk factors.

Footnotes:

1. Please indicate if the state has an active SEOW. If so, please describe:

- The types of data collected by the SEOW (i.e., incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
- The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
- The data sources used (i.e., archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

Utah's State Epidemiological Outcomes Workgroup has been in existence since 2006. The SEOW meets every other month on a regular basis, with participation from multiple agencies and disciplines including the Military, Health Department, Poison Control Center, State Office of Education, Local Prevention staff, Mental Health Agencies, National Alliance for Mental Illness, Utah Addictions Center, Legislators, Division of Child and Family services, Juvenile Justice Services, University of Utah and Division of Substance Abuse and Mental Health.

Utah's SEOW has been collecting, analyzing, and reporting on substance abuse and mental health indicators. Recently, the SEOW has focus on indicators related to behavioral health in order to support both substance abuse and mental health prevention efforts. Utah's SEOW has continued to build on those efforts and enhance the ability to collect additional indicators; conduct more detailed analyses of the indicators; and provide reports at the state, regional, and community levels. The indicators are collected from many state and federal sources such as survey data from:

- 1) The Utah Student Health and Risk Prevention (SHARP) survey;**
- 2) Monitoring the Future (MTF) Survey;**
- 3) Youth Risk Behavior Survey (YRBS);**
- 4) The Utah Higher Education Health Behavior Survey and/or the American College Health Assessment given in the nine public colleges in Utah;**
- 5) Behavior Risk Factor Surveillance System (BRFSS);**
- 6) National Survey on Drug Use and Health (NSDUH).**

Examples of other data sources that are used to collect indicators are the Alcohol Epidemiologic Data System, Drug Abuse Warning Network, Fatality Analysis Reporting System, National Center for Health Statistics, National Vital Statistics System, The Treatment Episode Data Set, The State Epidemiological Data Systems, Uniform Crime Reporting Program, Web-based Injury Statistics Query and Reporting System, Utah Crash Summary Report Data, Utah Department of Public Safety, Utah Department of Health, Prescription Pain Medication Management and Education Program, Utah Indicator Based Information System for Public Health, and Utah databases such as birth and death certificates,

emergency department encounters, Pregnancy Risk Assessment Monitoring System, and Medical Examiner Database.

SEOW reviews data from all points of the logic model; consequence (death, injury), consumption (adult and youth use), shared risk factors of substance use disorder and mental illness, and outcome data. The workgroup collects and analyzes data for all demographics, across the lifespan and on health disparate populations. Most recently, the SEOW reviewed data related to the LGBTQ population from the Behavioral Risk Factor Surveillance System and Mental Health issues for young adults.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

The SEOW reviews and updates the Epidemiological Profile biennially. When the new data is released, the Division of Substance Abuse and Mental Health takes the data into consideration in regards to the funding formula used to disseminate SABG statewide. Since Utah is statutorily required to pass through the funding throughout the state, the needs assessment primarily impacts the funding formula.

Utah used the needs assessment data to identify 4 regions around the state. The four regions group areas with similar needs and demographics together. These four regions work together to address priority issues, stretching the SABG funds further.

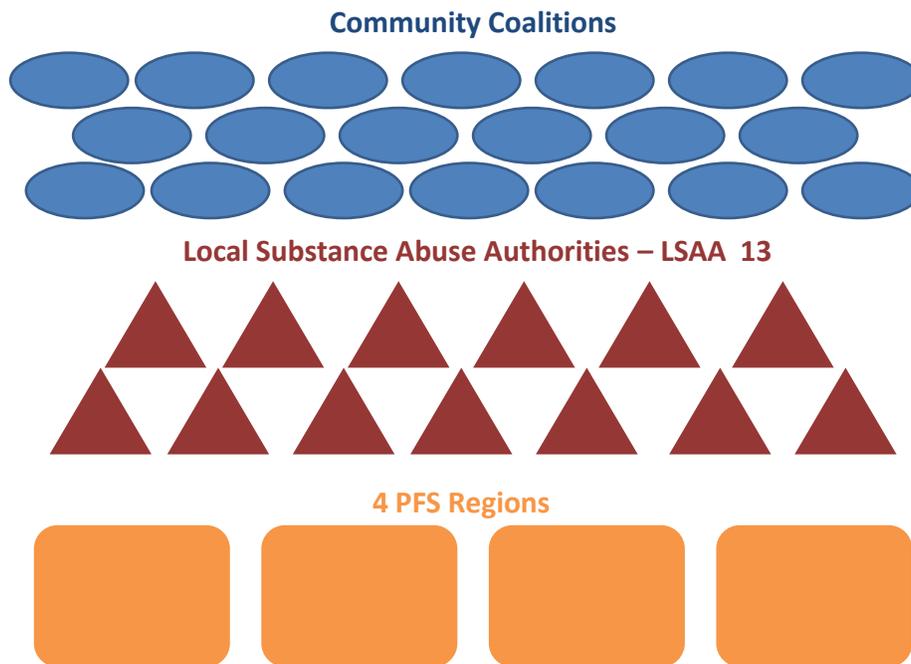
In addition, the needs assessment data helps State Level staff to prioritize areas in need of technical assistance, which is funded in part by the SABG.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Utah has a strong prevention background, but it can always improve. It is a priority for the Division of Substance Abuse and Mental Health to build capacity by providing education and certification opportunities for coalitions, local level staff and state staff. Training is offered through a variety of venues including coalition trainings, Utah Fall Conference on Substance Abuse, Generations Conference, and in-services at Prevention Coordinator meetings.

Utah has put building capacity and redesigning the prevention system as a top priority. Utah recently identified four regions and has assigned Regional Directors to assess the needs of the local Prevention Coordinators and coalitions in those areas and provide technical assistance as needed.

Utah is now set up with four Regions (Northern, Salt Lake, Central and Southern), 13 Local Substance Abuse Authorities (LSAAs) and approximately 35 local community coalitions. (See image below.) This system builds on the strengths of local communities and provides coaching/technical assistance to all areas.



The Regional directors assess the LSAAs and Coalitions and identify their needs for technical assistance. The Regional Directors then support the Prevention Coordinators at the LSAA level so the Coordinators can provide the needed training, assistance, and guidance. The state’s role is to support all levels and to move the system forward. We anticipate Utah’s Prevention System to be strong and sustainable by redesigning it.

4. Please describe if the state has:

- A statewide licensing or certification program for the substance abuse prevention workforce;
- A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
- A formal mechanism to assess community readiness to implement prevention strategies.

Utah does not currently have a statewide licensing or certification program for the substance abuse prevention workforce. In place of a certification program, Utah prevention specialists have partnered with the Association of Utah Substance Abuse Professionals (AUSAP) to provide certification www.ausap.org . This certification is not required by the state. Instead, the Division of Substance Abuse and Mental Health requires all providers to attend Substance Abuse Prevention Specialist Training.

Utah has connected the prevention workforce with the offerings from the CAPT system sponsored by the Center for Substance Abuse Prevention / SAMHSA. The workforce can request trainings from that venue. In addition to that option, the Regional Directors coordinate all training and technical assistance requests from the LSAAs and coalitions.

The LSAs and Coalitions all implement the Tri-Ethnic Center's Community Readiness model to identify the readiness of their communities. The LSAs do the Community Readiness surveys biennially at the minimum.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

Utah uses data on substance use consumption/consequences to prioritize substance abuse issues. Using this data, Utah prioritized Underage Drinking, Prescription Drug Misuse and Abuse, and Marijuana Use among Youth. The LSAA then uses the available risk and protective factor data to prioritize the factors prevalent in their communities. From that point, using the Strategic Prevention Framework and/or the Communities that Care model, they identify the appropriate strategies that impact both the risk and protective factors and the substance use issue.

The LSAs use logic models to demonstrate how the selected strategies impact the overall priority issue and risk and protective factors. These are submitted to the Division of Substance Abuse and Mental Health for review annually.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Utah's Division of Substance Abuse and Mental Health received technical assistance from the JBS in 2013 to assist in drafting a strategic plan. Since that time, the Division of Substance Abuse and Mental Health has worked together to create the current, Division wide, State Strategic Plan.

This State Strategic Plan is the basis for the entire SABG plan. All the Priority Areas and Annual Performance Indicators are directly from the State Strategic Plan. The primary prevention set-aside only addresses the prioritized areas noted.

The State Strategic Plan is a joint effort between Substance Abuse and Mental Health teams. It is considered a working document as it evolves as new data becomes available or as the system changes.

The DSAMH has determined it's top priority is Prevention and Early Intervention for all disciplines. Prevention's goals include the following:

- **Underage drinking**
- **Prevent and reduce Prescription drug misuse and abuse**
- **Prevent and reduce Marijuana use**
- **Prevent and reduce Depression and mental illness**

- **Prevent and reduce Tobacco and nicotine use, including e-cigarettes.**
- **Promote substance use disorder and mental illness prevention**

The State Strategic Plan requires collaboration within the Department of Human Services, the Division of Substance Abuse and Mental Health, and with other entities that have prioritized similar issues.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

Utah's Evidence Based Workgroup has been in existence since 2007. During the SPF-SIG grant, Utah used the guidance from CSAP/SAMHSA to structure Utah's Evidence Based Workgroup. In addition Utah received technical assistance from the CAPT system to enhance the functioning of the workgroup.

Currently the EBW is set up to review all programs submitted that are not on a national registry or in a peer reviewed journal (with efficacy). The programs submitted and approved are available for the LSAs to use in their communities as appropriate. SABG funding from Utah requires that 80% of the programs offered are evidence based. This requirement has encouraged more program submissions and robust evaluation of local programs.

The programs, even if approved as Evidence based, must all be a part of a comprehensive prevention plan. This approach reinforces Utah's goal of using evidence based programs to impact the priority issues at the state and local level.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

The primary prevention programs, practices and strategies Utah will fund with SABG prevention dollars were selected using the Strategic Prevention Framework or Communities that Care model. LSAs used data collected through assessment, identified needs, gaps, and capacity of each community, then selected evidence based or research informed strategies.

The identified strategies are grouped by the CSAP Strategy Types.

Information Dissemination

- **Parents Empowered**
- **Community Awareness Events**
- **Women's Prevention Resource Facilitation**
- **Conferences, Local**
- **Protecting You, Protecting Me**

Prevention Education

- **All Stars**
- **Prevention Dimensions**
- **Parenting Wisely**
- **Parenting with Love and Logic**
- **Incredible Years**
- **Guiding Good Choices**
- **Mindfulness Based Stress Reduction**
- **Botvins LifeSkills**
- **Anger Management**
- **Families Plus: Making Choices**
- **Families Plus: Strong Families**
- **Too Good for Drugs**
- **SMART Moves**
- **Active Aging**
- **Parent and Teen Alternative Program**
- **Prevention Relationship Enhancement Program**
- **Cool Minds**
- **Hope for Tomorrow**
- **Why Try**
- **Nueva Dia**
- **Parents as Teachers**
- **Collaborative Multi-Family Prevention Program**
- **Systematic Training for Effective Parenting**
- **Growing Up Strong**
- **Dare to Be You**
- **GrandFamilies**
- **Keepin' it REAL**
- **Community Empowering Parents**
- **Sixth Sense**
- **Strengthening Families**
- **Project Davis**
- **Smoking Cessation Classes**
- **Children's Program Kit**
- **Drug Offenders Classroom**
- **Daily ATOD Class**
- **Discovering Possibilities**
- **Prevention Dimension Training**
- **Prevention Dimension – Elementary Lessons**
- **Prevention Dimension – Secondary Lessons**

Alternative Activities

- **Tutoring**
- **Social Media Prevention**

- **Voices**
- **Friend 2 Friend Support Group**
- **SPORT Prevention + Wellness**
- **Vocational Mentoring**
- **APP – Activities that Promote Prevention**
- **Mentoring**
- **Tradition of Caring**
- **Leadership and Resiliency**
- **Trio Talent Search**
- **Big Brothers Big Sisters**

Community Based Process

- **Rx Drug Drop Boxes/Take Back Events**
- **Communities That Care**
- **Eliminating Alcohol Sales to Youth (EASY) Compliance Checks**
- **Governing Youth Council (GYC)**
- **Synar**
- **Coalitions – Non CTC**
- **Indian Walk In Center**
- **Statewide Prevention Networking**

Environmental Approaches

- **Minor in Possession**
- **Shoulder Tap**
- **Retailer Education**
- **Server Management Alcohol Responsibility Training – On Premise**
- **Server Management Alcohol Responsibility Training – Off Premise**
- **Counter Advertising**

Problem Identification and Referral

- **Prime for Life – Adult**
- **Prime for Life – Under 21**
- **IPASS**
- **Psycho-Educational Group**
- **Alcohol and Drug Intervention**
- **Courage to Change**
- **Personal Empowerment Program**
- **Kid Power**
- **Personal Power**
- **Truancy Program**
- **First Offender**
- **Getting it Right**
- **Mental Health First Aid**

- **QPR – Question Persuade Refer**
- **Peer Court**
- **Youth Mental Health First Aid**
- **Academic Assistance**
- **Drop Out Prevention**

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

Throughout the fiscal year, the Division of Substance Abuse and Mental Health reviews and monitors the funding and programming at the local level. This includes at least one on-site review and monthly review of the submitted invoices. Since the Division of Substance Abuse and Mental Health is considered the “Pass Through Agency” for State and Federal funding, the Division monitors both funding streams. The program managers for prevention monitor the reimbursement requests and ensure there is no duplication of payment. The site visits and area plan review make certain that the prevention services are appropriate and fill the needs of the community.

Resource assessment

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state’s prevention system?

Utah uses the WITS data collection system that collects the process data as required by the SABG. In addition the data collected supports Utah and the efforts to advocate for needs and gaps in prevention services at the local and state levels.

The specific process data collected includes the following: numbers served (duplicated and unduplicated), demographics, CSAP strategies and activities, areas served, population served, service dates, and in some cases (indicated services) health disparity and veteran status.

This data allows local areas and the state to evaluate and identify gaps in services. In addition, the State uses this data to produce fact sheets and respond to requests from Utah State Legislature related to prevention and substance use disorders. When gaps are identified, the data can guide the State and LSAAs in enhancing the current prevention system.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state’s prevention system?

Utah will collect consumption data for youth and adults on alcohol use, prescription drug use and marijuana use. In addition, Utah will be collecting risk factor data for youth. Research states risk factors are predictors of problem behaviors.

The barrier Utah runs into when collecting outcome data is finding reliable and accessible risk

factor data with adult populations. Because of this Utah only has risk factor data from youth statewide.

All of the outcome measures are identified within Utah's State Strategic Plan.

The following are the outcome measures Utah will be using to evaluate the efficacy of the prevention system:

Underage Drinking:

- **Decrease the percentage of underage drinking from 7.0% in all grades 2013 to 5.0% in all grades in 2023. (Student Health and Risk Prevention survey)**
- **Decrease binge drinking from 4.9% in all grades 2013 to 4.0% in all grades in 2023. (Student Health and Risk Prevention survey)**
- **Decrease underage drinking in the past 30 days among 18-20 y.o. from 18.7% in 2013 to 15% in 2023. (Behavioral Risk Factor Surveillance System)**
- **Decrease binge drinking among 18-20 y.o. from 10.1% in 2013 to 7.0% in 2023.**
- **Reduce community norms favorable to Alcohol, tobacco and other drug use 2013 18.6% to 15.0% by 2019. (Student Health and Risk Prevention survey)**
- **Reduce Parental Attitudes favorable towards underage drinking 2013 10.2% to 8.5% by 2019 (Student Health and Risk Prevention survey)**
- **Reduce youth access to alcohol by increasing the number of EASY checks from 1877 in 2013 to 2000 by 2017**
- **Increase Communities That Care coalitions from 10 in 2013 to 20 by 2019.**
- **Increase access to person-centered prevention services.**

Prescription Drug Abuse:

- **Decrease percentage of prescription drug misuse and abuse among youth, all grades, 2.3% in 2013 to 1.7% in 2017.**
- **Decrease non-medical use of prescription pain reliever among 18-25 year olds, 8.84% in 2012 to 7.5% in 2017.**
- **Maintain non-medical use of prescription pain reliever among 26 years and older at 3.35%.**
- **Reduce community norms favorable to Alcohol, tobacco and other drug use 2013 18.6% to 15.0% by 2019. (Student Health and Risk Prevention survey)**
- **Reduce illicit access to prescription drugs by providing a minimum of one take back day statewide annually.**

Marijuana Use

- **Maintain percentage of marijuana use among youth, 5.8%.**
- **Maintain percentage of marijuana use among 18-25 year olds, 9.83%.**
- **Maintain percentage of marijuana use among 26 years and older, 3.04%.**
- **Reduce access to marijuana by working with law enforcement. Increase the number of law enforcement representatives on community coalitions throughout the state.**

- **Reduce community norms favorable to Alcohol, tobacco and other drug use 2013 18.6% to 15.0% by 2019. (Student Health and Risk Prevention survey)**
- **Increase perception of harm from 77.5% in 2013 to 80.5% in 2017.**

Tobacco Prevention

- **Decrease 30 day tobacco use among youth, all grades, from 2.7% in 2013 to 1.7% in 2017.**
- **Decrease 30 day e-cigarette use among youth, all grades, from 4.7% in 2013 to 4.0% in 2017.**
- **Maintain a 90% Synar compliance check rate (90% of establishments refuse to sell tobacco to youth)**

Prevent Mental Illness

- **Needs Mental Health treatment (youth) from 13.0% in 2013 to 11.0% in 2023.**
- **Reducing the percentage of youth considering suicide from 12.3% in 2013 to 10.0% in 2023.**
- **Identify opportunities to integrate substance abuse and mental illness prevention systems, models, policies, and practices.**
- **Increase access to evidence based programs proven to reduce mental illness. This is process data and will be collected annually from LSAA's. *This needs some technical assistance. Utah needs additional support in identifying evidence based programs proven to reduce mental illness.**

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

10. Quality Improvement Plan

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states must submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

The Utah Division of Substance Abuse and Mental Health does not have a formal CQI plan. However, both CQI and TCM concepts are integral to the way that DSAMH measures performance of its Behavioral Health Care. The DSAMH collects and utilizes extensive data on the “health of the mental health and addictions systems.”

Providers and contract compliance.

The DSAMH uses a variety of scorecards measuring for all publicly funded behavioral health services. These documents allow the State to monitor and audit providers by tracing penetration rates, amounts of service, duration of services, trends, comparisons to other providers, etc. In the spirit of efficient and effective systems, as defined in the good and modern guidance, Utah believes this scorecard an effective use of data. These scorecards compare the Local Authorities on their performance, both across all sites and within urban and rural sites. Results are provided to the County governmental officials and are publicized on the DSAMH website. Targets for each performance indicator are published in the Division Directive and attainment of those targets is reviewed during each contract compliance review. Targets are based on meeting National norms, improvement on past performance, and/or reaching a set level of performance and maintaining that standard. The score cards are color coded for easy reading. They indicate successful achievement (green), improvement needed (yellow), or performance below the state standards (red).

Additionally, Consumer Surveys are distributed each year and a consumer report card is also published, comparing the Local Authorities on their results. The reports are broken down by substance abuse and

mental health, as well as by adult, youth and family satisfaction. These are also color coded for easy reference. Copies of the Mental Health, Substance Abuse and Consumer Surveys are attached.

A major portion of the quality improvement process in Utah is based on the yearly contract monitoring audits that the DSAMH conducts with each Local Authority. These audit visits are a combination of audit, technical assistance, and performance review. These extensive reviews include on site visits, client interviews, extensive review of clinical charts and records, inspections of administrative and financial records, meeting with local stakeholders, comprehensive discussions with program managers, reviews of program schedules and policies, and discussions about progress towards meeting goals set out in the DSAMH Division Directives. A review of corrective actions taken since the last review is also an integral part of the process. At the conclusion of these 1 to 2 day visits, the Local Authority Directors are provided feedback in preparation of a formal written report that is sent to the County Government Representative for each Local Authority. As shown below, findings are graded as being Significant, Major, or Minor Findings. A draft copy of the agenda for the combined Substance Abuse and Mental Health site visit and an example of the monitoring checklist used to monitor the Substance Abuse Agencies is also attached.

Clinical directors from each Local Authority and Division Program Administrators meet monthly to review pertinent issues. Beginning in FY2016, this meeting will be the promotion of sites that have met and exceeded quality expectations. This is in response to a request from the clinical directors, indicating that they would like the opportunity to reach out to each other for quality improvement models and ideas.

FY 2014 Mental Health Scorecard for Adults

September 25, 2014

Local Authority	Number of Clients Served		Estimated Need of Treatment (SMI)			# SMI Served		Unfunded		Supported Housing		Jail Services		Employment					
			% in Need of Treatment SMI	# in Need of Treatment SMI	% SMI Need Served									Supported Employment		# Employed		% Employed	
														FY2013	FY2014	FY2013	FY2014	FY2013	FY2014
Rural Counties																			
Bear River	1,902	1,709	6.17%	7,328	19.5%	1,628	1,426	32	186	29	25	222	203	8	8	290	228	60.8%	58.3%
Central	685	683	5.09%	2,783	20.8%	594	579	117	14	13	10	2	3	11	5	126	104	60.9%	56.5%
Four Corners	890	940	5.09%	1,553	41.7%	610	648	81	131	0	10	29	48	2	13	261	233	76.1%	60.4%
Northeastern	1,133	1,224	6.17%	2,390	14.7%	364	352	372	376	21	21	16	23	1	1	465	493	74.4%	73.8%
San Juan	406	407	5.09%	530	17.2%	97	91	106	105	0	0	0	0	1	3	155	178	76.0%	76.1%
Southwest	1,180	1,250	5.09%	7,912	9.3%	744	734	139	206	25	27	2	4	6	13	238	245	58.8%	56.1%
Summit Co.	436	256	6.17%	1,778	6.5%	146	115	46	28	0	0	1	0	2	1	263	133	84.3%	88.7%
Tooele Co.	1,151	1,082	6.17%	2,508	33.6%	942	842	122	117	0	0	1	0	6	6	343	291	75.4%	75.0%
Wasatch Co.	324	396	6.17%	1,115	15.1%	100	168	154	99	0	1	11	3	0	0	153	188	77.3%	79.3%
Total	8,077	7,805	5.62%	27,898	17.4%	5,203	4,849	1,165	1,237	87	93	284	271	37	50	2,288	2,078	59.3%	68.3%
Urban Counties																			
Davis	2,753	3,239	4.87%	10,678	18.3%	1,725	1,958	892	1,295	244	81	188	846	151	128	684	781	55.1%	56.1%
Salt Lake Co.	10,098	9,583	4.99%	39,275	17.2%	7,392	6,748	386	1,252	352	516	0	12	205	153	1,702	1,558	61.6%	58.0%
Utah Co. - Wasatch MH	4,516	6,262	5.28%	19,419	16.0%	3,009	3,101	493	651	208	199	25	1,652	41	86	788	882	59.4%	62.4%
Weber	4,102	4,253	4.73%	8,465	19.9%	1,658	1,685	1,546	1,286	35	41	1,475	1,598	11	12	403	375	56.4%	53.6%
Total	21,165	22,818	5.01%	77,837	17.0%	13,609	13,210	3,219	4,346	822	819	1,626	3,947	403	375	3,539	3,541	71.1%	58.3%
State	28,981	30,623	5.16%	105,737	17.1%	18,597	18,059	4,352	5,583	902	912	1,895	4,218	439	425	5,800	5,619	63.5%	61.7%

- Client totals are unduplicated across areas; i.e., State is unduplicated across the state, Rural is unduplicated across the rural centers, etc.
- Clients can receive multiple services and where applicable are duplicated.
- Supported employment includes # of clients with a supported employment status anytime during the fiscal year.
- Supported Housing includes # of clients that received that service anytime during the fiscal year (DSAMH service code #174).
- Jail Services and In-Home Services includes # of clients who received services with a location code of Jail or In Home.
- Employment includes # of clients who were employed or did not stay unemployed during the fiscal year.
- % Employed includes # of clients employed (full time, part time, or supported employment) divided by the number of clients in the workforce. Workforce includes clients who are employed (full time, part time or supported employment) and/or unemployed but seeking work.

*Estimate of Need— 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>

Notes for page 2:

Red: Minimum requirements not met.
Orange: Median number of days/hours or utilization percentages are below 75% or above 300% of the rural or urban median or utilization totals.

Utilization: Percent of all clients receiving services. Total Outpatient number of clients served is an unduplicated count by provider of any client receiving an outpatient service.
 Median Length of Stay: Median length of time for all clients who received that service. Median is the middle value in a list of numbers.
 Average Length of Stay: Average length of time for all clients who received that service. Average or mean is the total number of time for that service divided by the number of clients receiving that service.
 Inpatient includes MHE service code 170
 Residential includes MHE service codes 171 and 173
 Medication Management includes MHE service codes 61
 Psychosocial Rehabilitation includes MHE service codes 70, 80, 100, and 160
 Case Management includes MHE service code 120 and 130
 Respite includes MHE service code 150

Assessment includes MHE service code 22 Diagnosis and Assessment
 Testing is not shown on the scorecard but is included in Total Outpatient
 Treatment Therapy includes MHE service codes 30 Individual Therapy, 31 Electroconvulsive Therapy, 35 Individual Behavior Management, 40 Family Therapy, and 50 Group Therapy
 Total Outpatient includes all MHE service codes except those reported on the same day as a bed day (170 Inpatient, 171 Residential, and 173 Residential Support)
 Emergency includes all service codes with emergency indicator set to "yes."
 Peer Support services includes MHE service codes 130 Peer Support.
 State Hospital data used to calculate utilization, median and average number of days in the state hospital during the fiscal year only.
 Data for services provided in Jail are not included.

Local Authority	Utilization of Mandated Services (Percent of clients receiving services)																									
	State Hospital Inpatient		Community Inpatient		Residential		Outpatient Services														Emergency		Peer Support Services		In-Home Services	
							Medication Management		Psychosocial Rehabilitation		Case Management		Respite		Assessment		Treatment Therapy		Total Outpatient							
	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent
Rural Counties																										
Bear River	14	0.9%	53	3.4%	33	2.1%	720	45.8%	248	15.8%	617	39.2%	0	0.0%	816	51.9%	1,195	76.0%	1,558	99.1%	238	15.1%	21	1.3%	236	15.0%
Central	9	1.3%	12	1.8%	0	0.0%	316	46.3%	109	16.0%	85	12.4%	3	0.4%	358	52.4%	554	81.1%	683	100.0%	136	19.9%	16	2.3%	54	7.9%
Four Corners	9	1.0%	48	5.2%	42	4.5%	332	35.9%	126	13.6%	414	44.8%	1	0.1%	370	40.0%	656	71.0%	918	99.4%	181	19.6%	65	7.0%	93	10.1%
Northeastern	7	0.6%	21	1.7%	0	0.0%	589	48.2%	67	5.5%	99	8.1%	0	0.0%	686	56.1%	906	74.1%	1,221	99.8%	217	17.7%	0	0.0%	46	3.8%
San Juan	4	1.0%	4	1.0%	0	0.0%	215	52.8%	33	8.1%	59	14.5%	0	0.0%	187	45.9%	231	56.8%	404	99.3%	19	4.7%	0	0.0%	15	3.7%
Southwest	20	1.6%	67	5.4%	27	2.2%	431	34.5%	149	11.9%	302	24.2%	1	0.1%	699	55.9%	861	68.9%	1,228	98.2%	55	4.4%	77	6.2%	127	10.2%
Summit Co.	0	0.0%	5	2.0%	0	0.0%	140	54.7%	4	1.6%	24	9.4%	0	0.0%	114	44.5%	162	63.3%	254	99.2%	2	0.8%	0	0.0%	0	0.0%
Tooele Co.	3	0.3%	47	4.3%	0	0.0%	543	50.2%	87	8.0%	325	30.0%	1	0.1%	540	49.9%	790	73.0%	1,071	99.0%	7	0.6%	2	0.2%	22	2.0%
Wasatch Co. - Heber	0	0.0%	0	0.0%	1	0.3%	144	36.5%	36	9.1%	142	35.9%	0	0.0%	197	49.9%	288	72.9%	395	100.0%	77	19.5%	9	2.3%	18	4.6%
Total	64	0.8%	242	3.1%	103	1.3%	3,349	43.1%	834	10.7%	2,013	25.9%	6	0.1%	3,924	50.5%	5,543	71.3%	7,599	97.8%	901	11.6%	189	2.4%	609	7.8%
Urban Counties																										
Davis	26	1.0%	125	5.0%	231	9.3%	1,477	59.4%	285	11.5%	504	20.3%	0	0.0%	1,071	43.1%	1,267	51.0%	2,463	99.1%	497	20.0%	125	5.0%	387	15.6%
Salt Lake Co.	108	1.1%	491	5.1%	291	3.0%	5,830	60.8%	1,267	13.2%	1,985	20.7%	17	0.2%	6,038	63.0%	6,428	67.1%	9,373	97.8%	50	0.5%	1,139	11.9%	420	4.4%
Utah Co. - Wasatch MH	48	1.0%	209	4.3%	193	4.0%	2,571	52.8%	505	10.4%	2,714	55.7%	6	0.1%	3,011	61.8%	2,655	54.5%	4,829	99.1%	607	12.5%	62	1.3%	211	4.3%
Weber	28	1.0%	216	7.6%	84	3.0%	1,095	38.7%	157	5.5%	494	17.5%	0	0.0%	1,767	62.5%	1,782	63.0%	2,762	97.6%	251	8.9%	0	0.0%	136	4.8%
Total	210	1.1%	1,002	5.1%	797	4.1%	10,816	55.2%	2,170	11.1%	5,584	28.5%	23	0.1%	11,744	60.0%	11,958	61.1%	19,115	97.6%	1,354	6.9%	1,305	6.7%	1,153	5.9%
State	274	1.0%	1,244	4.6%	900	3.3%	14,165	52.3%	3,004	11.1%	7,597	28.0%	29	0.1%	15,668	57.8%	17,501	64.6%	26,714	98.6%	2,255	8.3%	1,494	5.5%	1,762	6.5%

Local Authority	Time in Service for Mandated Services (Days or hours for only clients receiving service)																									
	State Hospital Inpatient		Community Inpatient		Residential		Outpatient Services														Emergency		Peer Support Services		In-Home Services	
							Medication Management		Psychosocial Rehabilitation		Case Management		Respite		Assessment		Treatment Therapy		Total Outpatient							
	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average
Rural Counties																										
Bear River	196.50	183.71	4.00	6.83	30.00	52.09	2.53	3.35	16.13	67.44	1.87	9.46	0.00	0.00	2.31	2.56	6.22	12.60	7.68	30.30	0.80	1.20	6.25	13.04	2.78	10.90
Central	139.00	162.00	9.00	12.42	0.00	0.00	3.39	5.17	159.18	215.77	7.13	10.77	3.45	4.22	1.96	2.18	6.22	11.48	7.38	52.17	1.32	1.83	7.60	19.77	1.04	2.42
Four Corners	71.00	65.78	1.00	1.71	58.50	101.00	2.00	2.76	93.15	202.80	1.58	11.27	9.50	0.00	1.84	1.81	3.25	7.04	4.00	40.51	2.00	13.67	3.57	6.67	2.00	11.99
Northeastern	234.00	202.00	8.00	13.76	0.00	0.00	0.75	3.26	52.25	156.95	8.50	17.98	0.00	0.00	2.00	2.01	4.00	8.92	4.25	25.25	1.00	1.25	0.00	0.00	3.50	14.81
San Juan	110.50	96.75	4.50	6.75	0.00	0.00	1.50	3.42	167.50	204.12	2.50	9.41	0.00	0.00	2.00	2.17	4.25	9.00	3.63	26.02	1.50	1.66	0.00	0.00	4.25	8.62
Southwest	133.50	168.55	6.00	8.24	123.00	157.67	2.00	2.69	7.46	24.73	4.09	27.14	39.00	39.00	1.83	2.16	5.00	12.03	5.25	26.13	1.00	1.24	10.40	29.18	6.87	41.71
Summit Co.	0.00	0.00	13.00	14.80	0.00	0.00	0.90	1.25	2.30	3.45	1.00	1.29	0.00	0.00	2.00	2.12	5.00	8.24	4.00	7.07	0.88	0.88	0.00	0.00	0.00	0.00
Tooele Co.	268.00	239.67	8.00	18.34	0.00	0.00	0.60	0.84	69.90	266.96	0.40	3.37	271.30	271.30	2.00	1.88	4.00	6.93	4.00	29.46	1.30	1.28	2.18	2.18	1.08	2.26
Wasatch Co. - Heber	0.00	0.00	0.00	0.00	42.00	42.00	2.00	2.08	6.13	24.53	1.00	3.58	0.00	0.00	2.00	2.18	3.50	7.17	4.25	10.79	2.75	2.70	5.50	6.97	1.13	1.92
Total	123.00	159.29	6.00	9.33	64.00	99.61	1.50	2.83	31.08	129.05	1.75	11.41	7.80	55.41	2.00	2.15	4.65	9.82	5.00	29.88	1.12	3.86	7.75	17.46	2.38	16.38
Urban Counties																										
Davis	254.00	225.81	4.00	6.34	11.00	18.97	1.57	2.76	10.00	100.94	3.66	18.90	0.00	0.00	1.91	1.96	3.03	6.68	3.00	28.63	0.50	1.16	1.75	5.79	2.50	51.59
Salt Lake Co.	170.00	206.86	6.00	9.92	252.00	232.51	1.20	2.75	5.00	31.79	2.90	9.37	12.75	23.93	2.00	3.94	5.25	11.42	7.50	26.95	0.45	0.99	5.25	23.90	1.15	2.17
Utah Co. - Wasatch MH	208.50	222.69	6.00	8.98	30.00	91.47	2.25	3.74	4.50	90.31	2.00	10.20	4.38	5.38	2.50	2.85	5.75	11.72	6.00	31.34	1.00	1.56	2.50	5.10	2.00	19.17
Weber	129.00	171.18	5.00	10.23	24.00	44.49	2.25	3.03	31.00	103.66	3.75	12.14	0.00	0.00	2.00	2.38	5.50	10.31	5.50	20.07	0.50	0.92	0.00	0.00	1.25	2.37
Total	175.00	207.73	6.00	9.37	38.00	116.94	1.57	3.01	6.37	59.13	2.50	10.85	6.25	19.09	2.00	3.25	5.00	10.83	6.00	27.28	0.75	1.29	4.48	21.32	1.30	21.87
State	155.00	196.36	6.00	9.36	41.50	114.96	1.50	2.97	8.88	78.68	2.25	11.00	6.25	26.60	2.00	2.98	5.00	10.51	5.81	28.02	1.00	2.31	4.50	20.85	1.60	19.97

Local Authority	OQ Measures													
	Valid OQ Clients Served FY2012 Q2	Unduplicated Number of Clients Participating	Percent Unduplicated Clients Participating	Percent of Clients Matching to SAMHIS **	Treatment					Discharged (Subset of Treatment)				
					Positive Outcomes					Positive Outcomes				
					Stable	Improved	In Recovery*	Total	Deteriorated	Stable	Improved	In Recovery*	Total	Not Recovered
					% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes
Rural Counties														
Bear River	1,218	882	72.4%	99.1%	41.32	21.95	21.72	84.99	15.01	6.27	9.41	5.26	20.94	13.66
Central	586	377	64.3%	97.6%	45.36	16.29	26.07	87.72	12.28	5.76	6.52	4.51	16.79	9.02
Four Corners	807	427	52.9%	89.8%	47.11	16.17	21.96	85.23	14.77	7.98	6.19	3.99	18.16	12.38
Northeastern	1,066	536	50.3%	95.3%	43.20	18.62	24.95	86.78	13.22	11.92	14.90	9.12	35.94	21.60
San Juan	361	105	29.1%	98.9%	44.76	15.24	24.76	84.76	15.24	10.48	5.71	3.81	20.00	13.33
Southwest	996	504	50.6%	97.7%	42.17	20.12	20.89	83.17	16.83	8.12	6.58	3.68	18.38	14.31
Summit Co.	237	172	72.6%	84.0%	45.66	17.34	25.43	88.44	11.56	8.09	8.67	4.62	21.39	15.03
Tooele Co.	976	492	50.4%	90.2%	46.22	15.54	20.92	82.67	17.33	11.95	7.17	4.18	23.31	18.53
Wasatch Co. - Heber	340	219	64.4%	98.3%	44.67	18.59	20.55	83.81	16.19	10.36	9.06	5.11	24.53	17.80
Total														
Urban Counties														
Davis	2,031	1,123	55.3%	96.9%	53.19	15.17	14.73	83.09	16.91	9.72	6.31	3.19	19.23	16.04
Salt Lake Co.	9,015	3,521	39.1%	85.4%	47.66	15.76	18.96	82.38	17.62	10.32	6.55	3.61	20.48	16.87
Utah Co. - Wasatch MH	3,580	2,725	76.1%	97.9%	52.27	10.45	24.55	87.27	12.73	22.73	9.09	5.91	37.73	30.45
Weber	1,889	1,408	74.5%	97.5%	41.95	18.99	24.26	85.20	14.80	12.68	14.05	7.20	33.93	23.17
Total														
State	22,745	12,429	54.6%	0.0%	46.17	17.17	20.42	83.77	16.23	10.25	8.31	4.63	23.20	17.34

Red: Minimum requirements not met.

^ Discharge includes clients who have been discharged in the current year or have not received any events of service for at least 7 months.

Valid OQ Clients Served exclude clients who received assessment and testing only and clients served while in Jail.

Percent of Clients Participating: Minimum requirement is 50% or more.

**Minimum requirement of matching clients with SAMHIS is 90%, if results are in red it means the provider did not meet this requirement.

Clients and Episodes are included if there are 2 or more valid administrations per instrument where one or more was administered within the fiscal year.

Deteriorated: Clients who have had a *Clinically Significant increase in symptoms from intake.

Improved: Clients who have had a *Clinically Significant reduction in symptoms from intake.

Recovery: If a client's score drops below the empirically derived cutoff between clinical scores and community normative scores and there has been *Clinically Significant change, then the client is classified as recovered. This number does not include clients in Recovery who are only receiving medication management services.

Clinically Significant: calculated using the instrument's Reliable Change Index (RCI) and cutoff score, which together define standards for clinically significant change achieved during mental health treatment. The RCI is the amount by which a client's total score must increase (deterioration) or decrease (improvement) from intake to be considered clinically significant. Changes in the total score that are less than the RCI are not statistically relevant (i.e. no change). Outcomes are not calculated until there has been reliable change within a given instrument.

Outcomes; Improved, Stable, Recovered, and Deteriorated are calculated by episode.

Local Authority	Number of Clients Served		Number of Clients Served (ages 5-17)	Estimated Need of Treatment for Children/Youth (ages 5-17)		% of Those in Need of Treatment Served (ages 5-17)	# SED Served		Unfunded		Youth Enrolled in School		Youth Employed		Justice Services		Family Resource Facilitators Peer Support Services Clients Served^			
	FY2013	FY2014		# in Need of Treatment	% in Need of Treatment		FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014
	Rural Counties																			
Bear River	1,208	1,221	1,145	4,852	12.70%	23.6%	898	833	120	270	1,040	1,086	6	8	8	7	36	68		
Central	484	494	458	1,967	11.30%	23.3%	390	378	21	7	451	459	4	9	1	1	96	105		
Four Corners	455	465	432	1,171	14.60%	36.9%	290	296	13	40	304	300	36	52	1	6	50	73		
Northeastern	677	752	729	2,031	15.10%	35.9%	162	156	111	107	579	658	10	23	16	16	27	14		
San Juan	131	143	138	362	10.00%	38.1%	29	42	27	25	127	139	2	1	0	0	142	186		
Southwest	1,435	1,526	1,424	5,143	11.50%	27.7%	933	982	120	221	1,306	1,400	6	9	8	2	27	28		
Summit Co.	169	145	135	823	10.50%	16.4%	79	81	31	21	160	134	14	22	0	0	40	27		
Tooele Co.	539	652	615	2,361	14.90%	26.1%	401	437	103	81	484	592	6	1	0	0	128	301		
Wasatch Co.	160	170	162	573	8.60%	28.3%	88	96	44	36	142	147	5	3	0	0	22	46		
Total	5,240	5,471	5,145	19,283	12.38%	26.7%	3,264	3,289	590	808	4,577	4,895	89	128	34	31	568	848		
Urban Counties																				
Davis	1,510	1,689	1,597	9,594	12.20%	16.6%	1,226	1,302	182	254	1,362	1,563	3	5	0	6	476	540		
Salt Lake Co.	5,401	5,934	5,322	33,600	15.30%	15.8%	4,116	4,318	253	399	4,442	5,125	99	79	0	3	278	360		
Utah Co. - Wasatch MH	3,191	3,380	3,109	14,136	10.40%	22.0%	2,542	2,625	113	99	2,816	2,969	64	58	13	15	190	180		
Weber	1,511	1,639	1,513	7,020	13.30%	21.6%	1,155	1,198	90	115	1,291	1,383	14	24	15	20	132	105		
Total	11,516	12,434	11,342	64,350	13.21%	17.6%	8,963	9,341	628	853	9,825	10,924	114	166	28	43	1,076	1,185		
State	16,613	17,905	16,487	83,633	13.01%	19.7%	12,113	12,512	1,211	1,642	14,289	15,684	267	292	61	75	1,658	2,033		

Client totals are unduplicated across areas; i.e., State is unduplicated across the state, Rural is unduplicated across the rural centers, etc. Clients can receive multiple services and where applicable are duplicated.

Youth Enrolled in Education includes # of clients that were enrolled in education anytime during the fiscal year.
 Youth Employed includes # of clients who were employed or did not stay unemployed during the fiscal year.
 Justice Services includes # of clients with services using a location code of Jail.

^ Clients shown on the Family Resource Facilitators Peer Support Services are from the FRF database and are not extracted from SAMHIS.

* Estimate of Need based on State of Utah Department of Human Services, Division of Substance Abuse and Mental Health. n.d. Student Health and Risk Prevention (SHARP) 2013 Prevention Needs Assessment Survey Results, Region Profile Reports, Data Table 5

Notes for page 2:

Red: Minimum requirements not met.
Orange: Median number of days/hours or utilization percentages are below 75% or above 300% of the rural or urban median or utilization totals.

Utilization: Percent of all clients receiving services. Total Outpatient number of clients served is an unduplicated count by provider of any client who receives an outpatient service.
 Median Length of Stay: Median length of time for all clients who received that service. Median is the middle value in a list of numbers.
 Average Length of Stay: Average length of time for all clients who received that service. Average or mean is the total number of time for that service divided by the number of clients receiving that service.
 Inpatient includes MHE service code 170
 Residential includes MHE service codes 171 and 173
 Medication Management includes MHE service codes 61
 Psychosocial Rehabilitation includes MHE service codes 70, 80, 100, and 160
 Case Management includes MHE service codes 120 and 130
 Respite includes MHE service code 150

Assessment includes MHE service code 22 Diagnosis and Assessment
 Testing is not shown on the scorecard but is included in Total Outpatient
 Treatment Therapy includes MHE service codes 30 Individual Therapy, 31 Electroconvulsive Therapy, 35 Individual Behavior Management, 40 Family Therapy, and 50 Group Therapy
 Outpatient includes all MHE service codes except 170 Inpatient, 171 Residential, 173 Residential Support, and 174 Housing.
 Emergency includes all services codes with emergency indicator set to "yes."
 Peer Support Services includes MHE service code 130 Peer Support.
 In-Home and School-Based Services are based on service location code.
 State Hospital data used to calculate utilization, total and average days of service during the fiscal year only.
 Data for services provided in Jail are not included.

Local Authority	Utilization of Mandated Services (Percent of clients receiving services)																													
	State Hospital Inpatient		Community Inpatient		Residential		Outpatient Services																Emergency		Peer Support Services		School-Based Services		In-Home Services	
							Medication Management		Psychosocial Rehabilitation		Case Management		Respite		Assessment		Treatment Therapy		Total Outpatient											
	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent	# of Clients	Percent		
Rural Counties																														
Bear River	2	0.2%	18	1.5%	0	0.0%	208	17.0%	337	27.6%	598	49.0%	130	10.7%	789	64.7%	1,059	86.8%	1,219	99.9%	69	5.7%	0	0.0%	443	36.3%	266	21.8%		
Central	5	1.0%	8	1.6%	0	0.0%	89	18.0%	141	28.5%	34	6.9%	17	3.4%	327	66.2%	395	80.0%	492	99.6%	35	7.1%	26	5.3%	15	3.0%	36	7.3%		
Four Corners	0	0.0%	5	1.1%	1	0.2%	84	18.1%	43	9.3%	142	30.6%	27	5.6%	246	53.0%	365	78.7%	462	99.6%	20	4.3%	40	8.6%	92	19.8%	34	7.3%		
Northeastern	4	0.5%	8	1.1%	0	0.0%	118	15.7%	24	3.2%	41	5.5%	18	2.4%	530	70.7%	608	81.1%	750	100.0%	95	12.7%	1	0.1%	108	14.4%	5	0.7%		
San Juan	0	0.0%	2	1.4%	0	0.0%	40	28.0%	1	0.7%	11	7.7%	1	0.7%	92	64.3%	99	69.2%	141	98.6%	3	2.1%	0	0.0%	18	12.6%	2	1.4%		
Southwest	9	0.6%	23	1.5%	0	0.0%	108	7.1%	329	21.6%	692	45.3%	244	16.0%	1,019	66.8%	1,161	76.1%	1,525	99.9%	59	3.9%	70	4.6%	569	37.3%	26	1.7%		
Summit Co.	0	0.0%	2	1.4%	0	0.0%	45	31.0%	3	2.1%	9	6.2%	19	13.1%	80	55.2%	107	73.8%	145	100.0%	3	2.1%	0	0.0%	33	22.8%	0	0.0%		
Tooele Co.	2	0.3%	19	2.9%	0	0.0%	108	16.6%	24	3.7%	206	31.6%	73	11.2%	454	69.6%	544	83.4%	652	100.0%	16	2.5%	11	1.7%	3	0.5%	36	5.5%		
Wasatch Co. - Heber	0	0.0%	0	0.0%	4	2.4%	9	5.3%	32	18.8%	54	31.8%	4	2.4%	101	59.4%	142	83.5%	169	99.4%	20	11.8%	11	6.5%	59	34.7%	16	9.4%		
Total	21	0.4%	83	1.5%	4	0.1%	791	14.5%	914	16.7%	1755	32.1%	516	9.44%	3,558	65.1%	4,409	80.6%	5,459	99.9%	314	5.7%	158	2.9%	1,334	24.4%	421	7.7%		
Urban Counties																														
Davis	17	1.0%	69	4.1%	2	0.1%	701	41.6%	269	16.0%	208	12.3%	112	6.6%	1,057	62.7%	1,276	75.7%	1,681	99.8%	192	11.4%	117	6.9%	236	14.0%	271	16.1%		
Salt Lake Co.	28	0.5%	198	3.3%	0	0.0%	1,348	22.7%	1,117	18.8%	962	16.2%	307	5.2%	3,982	67.1%	5,193	87.5%	5,904	99.5%	4	0.1%	129	2.2%	450	7.6%	111	1.9%		
Utah Co. - Wasatch MH	27	0.8%	108	3.2%	571	16.9%	927	27.4%	708	20.9%	1,447	42.8%	541	16.0%	1,994	59.0%	2,740	81.1%	3,338	98.8%	203	6.0%	65	1.9%	678	20.1%	484	14.3%		
Weber	13	0.8%	54	3.3%	16	1.0%	422	26.0%	114	7.0%	102	6.3%	17	1.0%	1,117	68.7%	1,224	75.3%	1,611	99.1%	100	6.2%	71	4.4%	326	20.0%	38	2.3%		
Total	87	0.7%	408	3.3%	566	4.6%	3,334	26.8%	2,170	17.5%	2,678	21.6%	959	7.72%	7,997	64.4%	10,293	82.9%	12,345	99.4%	485	3.9%	376	3.0%	1,690	13.6%	904	7.3%		
State	108	0.6%	491	2.7%	570	3.2%	4,125	23.1%	3,084	17.2%	4,433	24.8%	1,475	8.25%	11,555	64.6%	14,702	82.2%	17,804	99.5%	799	4.5%	534	3.0%	3,024	16.9%	1,325	7.4%		

Local Authority	Time in Service for Mandated Services (Days or hours for clients receiving services)																													
	State Hospital Inpatient		Inpatient		Residential		Outpatient Services																Emergency		Peer Support Services		School-Based Services		In-home Services	
							Medication Management		Psychosocial Rehabilitation		Case Management		Respite		Assessment		Treatment Therapy		Total Outpatient											
	# of Bed Days	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average		
Rural Counties																														
Bear River	369	184.50	5.50	7.11	0.00	0.00	2.47	2.65	12.42	18.81	1.25	3.16	4.31	8.59	2.00	2.18	5.65	9.55	8.52	18.17	0.77	1.37	0.00	0.00	4.50	6.15	3.88	7.73		
Central	628	125.60	8.00	10.38	0.00	0.00	1.59	2.14	23.18	48.67	2.34	6.40	27.73	32.81	1.90	1.85	2.85	5.69	5.14	22.02	1.13	1.47	4.59	5.98	1.50	2.03	3.16	5.55		
Four Corners	0	0.00	1.00	1.20	1.00	1.00	1.42	1.56	2.92	6.59	0.83	1.84	8.25	16.98	2.00	1.76	4.00	8.08	4.00	10.26	1.00	1.81	2.00	5.93	2.21	3.36	2.00	3.17		
Northeastern	482	120.50	9.00	17.00	0.00	0.00	0.75	0.95	3.63	6.08	0.50	2.22	5.75	11.82	2.00	1.89	5.50	8.16	5.75	8.78	1.00	1.16	10.00	10.00	6.25	7.31	2.00	4.60		
San Juan	0	0.00	6.00	6.00	0.00	0.00	2.00	2.69	1.00	1.00	0.50	2.30	16.00	16.00	1.75	1.94	4.00	5.75	3.75	6.37	1.00	1.33	0.00	0.00	2.00	3.13	8.50	8.50		
Southwest	1,152	128.00	9.00	10.13	0.00	0.00	1.46	1.70	23.00	35.47	0.51	1.49	9.50	21.55	1.99	2.17	5.81	16.28	6.23	26.05	1.00	1.60	1.66	3.33	3.49	4.60	1.13	1.86		
Summit Co.	0	0.00	6.00	6.00	0.00	0.00	1.00	1.04	506.00	342.88	0.15	0.31	154.30	207.68	2.00	2.00	4.05	8.22	5.00	41.82	1.30	1.47	0.00	0.00	3.40	7.63	0.00	0.00		
Tooele Co.	364	182.00	11.00	28.58	0.00	0.00	0.50	0.63	21.90	62.36	0.45	1.49	189.00	214.14	2.00	1.84	4.50	15.21	5.30	40.87	1.30	1.23	1.00	1.59	1.30	1.30	0.45	1.95		
Wasatch Co. - Heber	0	0.00	0.00	0.00	2.00	3.00	0.75	1.53	7.50	7.44	0.75	1.78	5.38	60.13	2.00	1.81	4.75	9.91	6.50	13.54	2.25	2.34	6.25	10.02	7.50	13.16	2.38	4.16		
Total	2,995	136.14	8.00	13.56	2.00	2.60	1.25	1.74	15.92	30.05	0.75	2.19	10.63	51.55	2.00	2.01	5.00	11.23	6.10	21.59	1.00	1.44	2.08	4.80	4.00	5.64	2.54	6.15		
Urban Counties																														
Davis	2,888	169.88	6.00	9.81	6.00	6.00	2.00	2.17	9.14	37.22	3.35	6.90	9.00	14.67	2.00	2.37	6.54	11.79	7.00	19.50	0.75	1.16	1.75	5.35	3.35	7.67	2.75	7.35		
Salt Lake Co.	5,147	183.82	7.00	8.90	0.00	0.00	1.00	1.44	52.30	214.67	0.90	2.06	103.75	138.45	4.00	5.26	7.00	27.83	11.95	77.01	1.30	1.40	2.30	6.43	5.78	6.71	5.90	10.69		
Utah Co. - Wasatch MH	4,402	163.04	10.00	12.49	2.00	7.46	2.75	3.17	3.38	77.55	1.25	5.61	5.75	11.58	2.00	2.06	7.00	29.30	9.75	47.66	1.00	1.42	3.00	5.08	8.00	87.83	1.75	3.66		
Weber	2,304	177.23	6.50	8.44	7.00	33.88	2.25	2.37	42.13	241.70	1.50	2.21	13.75	19.01	2.50	2.39	6.75	10.42	7.75	28.26	0.75	0.78	1.50	2.70	12.00	15.51	1.75	5.65		
Total	15,367	176.63	8.00	9.90	2.00	8.17	1.50	2.18	18.00	150.48	1.25	4.33	9.50	51.93	2.00	3.71	6.88	24.21	10.00	55.22	1.00	1.19	2.05	5.18	6.75	41.09	2.11	5.71		
State	18,362	168.46	8.00	10.50	2.00	8.12	1.50	2.09	17.00	114.68	1.00	3.48	9.75	51.79	2.00	3.18	6.00	20.31	8.50	44.89	1.00	1.29	2.08	5.07	5.25	25.41	2.25	5.85		

Local Authority	OQ Measures													
	Valid YOQ Clients Served through FY2014 Q2	Unduplicated Number of Clients Participating	Percent Unduplicated Number of Clients Participating	Percent of Clients Matching to SAMHIS **	Treatment					Discharged (Subset of Treatment)				
					Positive Outcomes					Positive Outcomes				
					Stable	Improved	In Recovery*	Total	Deteriorated	Stable	Improved	In Recovery*	Total	Deteriorated
					% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes	% of Episodes
Rural Counties														
Bear River	989	684	69.2%	99.1%	43.40	17.76	24.17	85.33	14.67	12.08	12.21	7.27	31.57	20.35
Central	381	234	61.4%	97.6%	45.28	18.90	22.83	87.01	12.99	10.63	7.87	4.33	22.83	16.54
Four Corners	356	254	71.3%	89.8%	51.44	13.10	23.00	87.54	12.46	6.07	4.47	2.24	12.78	10.22
Northeastern	587	412	70.2%	95.3%	39.50	15.07	30.14	84.70	15.30	12.10	13.01	8.68	33.79	21.46
San Juan	120	45	37.5%	98.9%	56.90	15.52	22.41	94.83	5.17	5.17	8.62	5.17	18.97	10.34
Southwest	1,145	744	65.0%	97.7%	44.49	18.11	22.06	84.65	15.35	7.08	8.09	4.60	19.76	12.87
Summit Co.	122	93	76.2%	84.0%	34.65	19.69	26.77	81.10	18.90	11.02	16.54	8.66	36.22	26.77
Tooele Co.	531	277	52.2%	90.2%	38.55	21.45	24.34	84.34	15.66	12.53	12.05	5.30	29.88	24.34
Wasatch Co. - Heber	140	74	52.9%	98.3%	46.67	13.33	28.00	88.00	12.00	18.67	22.67	16.00	57.33	30.67
Total														
Urban Counties														
Davis	1,380	1,180	85.5%	96.9%	44.74	14.09	26.74	85.57	14.43	6.87	6.67	4.54	18.08	11.07
Salt Lake Co.	4,549	2,416	53.1%	85.4%	39.49	21.32	23.01	83.82	16.18	9.92	12.12	6.44	28.48	19.54
Utah Co. - Wasatch MH	2,707	2,029	75.0%	97.9%	34.91	18.26	33.52	86.69	13.31	9.51	15.55	11.03	36.09	17.58
Weber	1,169	1,076	92.0%	97.5%	31.31	21.63	37.79	90.74	9.26	13.64	26.52	19.11	59.26	24.07
Total														
State	13,941	9,464	67.9%	0.0%	39.60	18.93	27.06	85.59	14.41	9.86	12.97	8.10	30.93	18.16

Red: Minimum requirements not met.

^ Discharge includes clients who have been discharged in the current year or have not received any events of service for at least 7 months.

Valid YOQ Clients Served excludes children 5 years of age and younger, and any client who receives only assessment or testing services or received services in Jail.

Percent of Clients Participating: Minimum requirement is 50% or more.

**Minimum requirement of matching clients with SAMHIS is 90%, if results are in red it means the provider didn't meet this requirement.

Clients and Episodes are included if there are 2 or more valid administrations per instrument where one or more was administered within the fiscal year.

Deteriorated: Clients who have had a *Clinically Significant increase in symptoms from intake.

Improved: Clients who have had a *Clinically Significant reduction in symptoms from intake.

Recovery: If a client's score drops below the empirically derived cutoff between clinical scores and community normative scores and there has been *Clinically Significant change, then the client is classified as recovered. This number does not include clients in Recovery who are only receiving medication management services.

Clinically Significant: calculated using the instrument's Reliable Change Index (RCI) and cutoff score, which together define standards for clinically significant change achieved during mental health treatment. The RCI is the amount by which a client's total score must increase (deterioration) or decrease (improvement) from intake to be considered clinically significant. Changes in the total score that are less than the RCI are not statistically relevant (i.e. no change). Outcomes are not calculated until there has been reliable change within a given instrument.

Outcomes; Improved, Stable, Recovered, and Deteriorated are calculated by episode.

Process Measures														
LSAA	Admissions (Initial and Transfer)		Number of Clients Served		Percent of Admissions in Outpatient/IOP/ Residential/Detox		Number of Completed Treatment Episodes, excluding Detox		Median Days in Treatment		Percent of clients retained in treatment 60 or more days		Percent Completing Treatment Episode Successfully	
	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014
Bear River	845	513	1,309	985	81/19/0/0	82/17/1/0	909	479	119	164	66.4%	76.0%	48.3%	56.4%
Central Utah	315	282	443	416	95/5/0/0	94/6/0/0	180	177	126.5	162	72.8%	85.9%	32.8%	52.5%
Davis County	1,045	936	997	1,106	72/18/10/0	63/27/10/0	399	596	117	195.5	79.4%	83.1%	28.8%	51.3%
Four Corners	494	520	605	631	75/24/1/0	73/26/1/0	297	292	71	57.5	52.2%	49.3%	31.3%	28.1%
Northeastern	316	357	524	518	99/0/1/0	99/0/1/0	171	314	120	129.5	72.5%	70.1%	40.9%	38.0%
Salt Lake County	10,524	10,237	8,172	8,158	36/19/9/36	34/17/9/40	4,310	3,745	98	99	72.7%	74.4%	47.4%	45.7%
San Juan County	98	49	159	86	99/0/1/0	94/0/6/0	67	44	87	153.5	55.2%	70.5%	68.7%	38.6%
Southwest Center	547	668	556	635	43/35/22/0	48/34/18/0	340	366	154.5	198	85.0%	79.0%	41.2%	44.3%
Summit County	255	234	344	347	77/22/1/0	81/18/1/0	221	187	86	40	54.8%	44.9%	49.8%	58.3%
Tooele County	330	347	459	592	80/20/0/0	76/23/1/0	192	305	92	107	59.9%	62.6%	30.7%	38.4%
University of Utah Clinic	157	110	330	320	100/0/0/0	100/0/0/0	113	141	42	60	36.3%	50.4%	58.4%	66.7%
Utah County	1,134	1,287	964	957	37/34/23/6	29/32/21/17	779	566	106	113.5	64.6%	68.6%	45.7%	55.8%
Wasatch County - Heber Valley	142	120	143	159	75/23/2/0	67/28/5/0	66	77	95	68	68.2%	51.9%	16.7%	42.9%
Weber Human Services	1,053	1,211	1,391	1,538	84/10/6/0	84/11/5/0	878	960	135	121	75.7%	71.4%	44.4%	57.1%
State Average/Total	17,255	16,871	15,955	16,219	50/19/9/22	47/19/9/25	8,809	8,249	106	112	70.8%	72.0%	44.6%	48.2%
State Urban Average/Total	13,756	13,671	11,272	11,603	43/19/10/28	40/19/10/31	6,366	5,867	105	108	72.6%	74.2%	45.6%	49.1%
State Rural Average/Total	3,342	3,090	4,531	4,322	77/19/4/0	75/20/5/0	2,443	2,241	113	129	66.4%	67.6%	42.0%	44.4%
National Average/Benchmark														
Men	10,955	10,887	9,887	10,064	47/18/8/27	43/17/9/31	5,411	5,217	98	106	70.1%	72.1%	48.2%	50.9%
Women	6,300	5,984	6,068	6,155	54/21/10/14	53/22/9/16	3,511	3,032	125	125	70.9%	71.9%	39.5%	43.3%
Adolescents	1,374	1,394	1,464	1,493	78/20/2/0	79/18/3/0	1,273	1,174	105	112	72.3%	75.0%	54.7%	55.6%
DORA	772	832	706	631	48/30/16/5	49/31/18/2	439	381	162	200	80.2%	74.8%	40.8%	60.9%
Drug Court	1,804	2,039	2,172	1,919	44/32/17/7	46/33/17/4	1,031	703	259	275	85.3%	81.4%	51.5%	57.8%

Outcome Measures														
LSAA	Increased Alcohol Abstinence - Percent increase in those reporting alcohol abstinence from admission to discharge		Increased Drug Abstinence - Percent increase in those reporting other drug abstinence from admission to discharge		Increase in Stable Housing - Percent increase in non-homeless clients admission to discharge		Increased Employment - Percent increase in those employed full/part time or student from admit to discharge		Decreased Criminal Justice Involvement - Percent decrease in number of clients arrested prior to admission to prior to discharge		Social Support Recovery - Percent increase in those using social recovery support		Tobacco Use At Admission and Discharge for FY2014	
	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	FY2013	FY2014	Admission	Discharge
Bear River	191.3%	162.9%	264.8%	285.1%	1.2%	-0.2%	6.5%	21.9%	87.1%	0.0%	211.5%	217.7%	61.0%	61.8%
Central Utah	53.0%	59.8%	90.0%	109.7%	-1.1%	-1.1%	-0.6%	14.4%	19.4%	49.4%	44.1%	51.8%	71.6%	71.1%
Davis County	103.1%	200.7%	215.0%	388.1%	-0.3%	-2.7%	27.8%	48.5%	56.0%	52.0%	45.0%	100.5%	50.7%	70.3%
Four Corners	77.8%	23.6%	85.8%	63.6%	0.6%	-1.7%	16.7%	15.5%	76.4%	71.5%	0.0%	170.8%	62.9%	63.0%
Northeastern	40.7%	41.8%	57.7%	87.2%	0.5%	-0.3%	12.5%	28.0%	71.5%	86.4%	-1.9%	-61.3%	75.8%	74.0%
Salt Lake County	23.6%	27.3%	72.3%	81.5%	1.5%	2.9%	17.8%	15.8%	63.1%	68.6%	63.1%	68.6%	61.3%	56.7%
San Juan County	90.7%	49.9%	27.2%	100.3%	0.0%	0.0%	16.4%	0.0%	59.7%	50.0%	1203.3%	157.2%	47.7%	45.5%
Southwest Center	29.6%	25.5%	194.3%	219.0%	2.0%	0.3%	11.4%	15.5%	38.9%	23.4%	16.6%	11.5%	67.1%	62.9%
Summit County	149.7%	79.0%	65.6%	34.9%	0.0%	0.0%	12.2%	1.9%	81.3%	86.0%	107.1%	206.7%	55.1%	47.6%
Tooele County	37.8%	47.1%	74.0%	92.8%	0.0%	-2.3%	2.9%	10.2%	71.5%	64.7%	45.2%	-7.6%	61.3%	61.7%
University of Utah Clinic	28.8%	39.1%	25.6%	25.1%	7.2%	0.8%	16.6%	26.4%	100.0%	100.0%	-7.5%	-1.8%	65.2%	63.1%
Utah County	96.5%	94.0%	530.9%	914.9%	0.4%	-0.4%	48.8%	43.1%	38.5%	48.1%	18.5%	33.5%	68.8%	68.5%
Wasatch County - Heber Valley	150.2%	138.8%	177.7%	99.7%	*	*	22.6%	11.1%	50.0%	50.0%	17.4%	-5.9%	50.6%	47.4%
Weber Human Services	107.2%	84.5%	354.8%	270.4%	0.6%	1.7%	26.2%	26.6%	77.5%	64.7%	11.0%	18.0%	62.3%	62.1%
State Average/Total	108.1%	49.7%	116.2%	119.5%	1.5%	1.0%	17.9%	20.4%	64.1%	63.9%	47.8%	46.8%	61.9%	62.0%
State Urban Average/Total	40.2%	47.0%	111.0%	127.3%	1.8%	1.8%	22.8%	23.4%	63.8%	63.3%	44.5%	56.5%	61.1%	61.7%
State Rural Average/Total	93.8%	58.6%	132.3%	113.6%	0.3%	-0.7%	8.9%	15.5%	64.7%	64.4%	59.1%	25.6%	64.0%	63.0%
National Average/Benchmark	36.7%	36.7%	44.9%	44.9%	2.7%	2.7%	12.8%	12.8%	50.4%	50.4%				
Men	58.0%	53.8%	111.7%	114.8%	0.6%	1.1%	16.3%	17.8%	62.4%	64.3%	56.0%	65.4%	61.3%	61.2%
Women	41.6%	43.3%	117.9%	128.1%	2.9%	1.2%	20.9%	27.5%	67.0%	63.1%	33.9%	21.3%	62.9%	63.3%
Adolescents	39.7%	40.9%	153.8%	177.0%	-0.2%	-1.0%	-2.2%	0.5%	62.3%	62.6%	86.8%	56.7%	28.0%	29.2%
DORA	33.2%	35.3%	129.9%	115.9%	3.9%	2.2%	34.1%	46.1%	50.4%	54.2%	18.2%	41.3%	66.9%	74.3%
Drug Court	30.7%	45.6%	194.4%	282.4%	2.9%	2.1%	42.2%	57.1%	66.1%	65.0%	43.2%	40.4%	69.1%	65.1%

Note: Outcomes exclude detox discharges
Salt Lake, Davis, Weber (Mogan is included in Weber County), and Utah Counties are reported as Urban. All other counties are reported as rural.

Green = 90% or greater of the National Average or meets/exceeds division standards.
Yellow = Between 75% and 90% of the National Average or does not meet/exceeds division standards.
Red = Less than 75% of the National Average or not meeting division standards.

* No one homeless at admission so no opportunity for change.

Decreased Use and Completing Modality Successfully are not national measures and are not scored.

State Total for Clients Served is an unduplicated client count across all modalities and is not a sum of the clients served for the providers listed.

Final Discharges are reported by treatment episode.

Admissions are the number of duplicated admissions to a treatment modality that occurred within the fiscal year. Clients served are an unduplicated count of clients served during the fiscal year. Due to a change in reporting procedures, The numbers on this chart may not be the same as reported in previous years.

Calculations for SA Outcomes:

All outcomes are percent increase or decrease. Specific percentages are calculated as follows using FY final discharges, excluding detox-only clients. Percents at admission and discharge are calculated by dividing the number of clients reporting the outcome divided by the total number of discharged clients with valid, non-missing, data for that measure:

Abstinence (Percent Increase):
(Percent abstinent at discharge minus percent abstinent at admission) divided by percent abstinent at admission

Stable Housing (Percent Increase):
(Percent not homeless at discharge minus percent not homeless at admission) divided by percent not homeless at admission.

Employment/School (Percent Increase):
(Percent employed/student at discharge minus percent employed/student at admission) divided by percent employed/student at admission.

Criminal Justice (Percent Decrease):
(Percent arrested at 30-days prior to admission minus percent arrested 30-days prior to discharge) divided by percent arrested 30-days prior to admission.

Length of Stay:
Median length of stay calculated from admission date to date of last contact for those discharged in the fiscal year

Agency	Number Served FY2013	Number of Forms Returned		Percent of Clients Sampled	General Satisfaction		Good Service Access		Quality & Appropriateness of Services		Participation in Treatment Planning		Positive Service Outcomes		Social Connectivity		Improved Functioning		Wellness		
		2013	2014																		
Bear River Health Dept.	1,225	↑	137	148	12.1%	→	69	↓	72	↓	86	↓	67	→	73	→	81	→	79	→	86
Bear River Mental Health	1,902	↓	460	448	23.6%	→	94	→	94	↑	93	↑	83	→	67	→	65	→	68	→	89
Central Utah	992	↓	208	156	15.7%	↑	91	↑	87	→	89	→	85	↓	70	→	67	→	71	→	89
Davis Behavioral	3,437	↓	440	372	10.8%	↑	91	↑	86	→	92	↑	83	→	69	↑	71	↑	71	→	88
Four Corners	1,260	↑	220	316	25.1%	↑	89	↑	88	↑	91	→	77	→	79	↑	75	→	79	→	88
Northeastern	1,507	↑	246	316	21.0%	↑	91	↑	91	→	92	↑	82	↑	72	→	70	↑	72	↑	89
Salt Lake County	16,015	↓	2,699	2,613	16.3%	→	84	→	78	↓	85	→	74	→	75	↑	73	→	75	→	84
San Juan	516	↑	49	107	20.7%	→	90	→	89	↓	88	→	81	→	80	↑	75	→	78	→	92
Southwest	1,637	↓	246	224	13.7%	→	91	→	86	→	91	↓	73	↓	69	↓	67	→	72	→	90
Summit Co. - Valley Mental Health	661	↓	120	90	13.6%	↑	89	↑	90	↓	87	→	77	→	78	→	74	→	79	→	88
Tooele Co. - Valley Mental Health	1,401	↓	240	184	13.1%	↓	84	↓	76	↓	86	→	78	→	77	↑	77	→	77	→	86
U of U	330	↓	38	34	10.3%	→	100	→	97	→	100	→	94	→	85	→	100	→	91	→	91
Utah Co. - Wasatch Mental Health	4,517	↑	749	792	17.5%	→	85	→	80	→	85	→	76	→	67	→	62	→	67	→	82
Utah County Substance Abuse	931	↓	481	479	51.5%	→	83	→	74	↓	87	↓	78	→	84	→	80	→	84	→	88
Wasatch Co. - Heber Valley Counseling	396	↑	56	70	17.7%	↓	83	→	87	→	87	↑	83	↓	65	→	71	→	71	↓	85
Weber	4,716	↑	758	821	17.4%	→	85	→	84	↑	89	→	75	→	69	→	68	↑	71	→	84
State	40,159		7,147	7,170	17.9%		86		82		88		77		73		71		74		86
National (2008)							88		85		88		81		71		70		70		

Adult Consumer Satisfaction Survey 2014 MH Clients

Agency	Number Served FY2013	Number of Forms Returned		Percent of Clients Sampled	General Satisfaction		Good Service Access		Quality & Appropriateness of Services		Participation in Treatment Planning		Positive Service Outcomes		Social Connectivity		Improved Functioning		Wellness		
		2013	2014																		
Bear River Mental Health	1,902	↓	460	448	23.6%	→	94	→	94	↑	93	↑	83	→	67	→	65	→	68	→	89
Central Utah	685	↓	158	124	18.1%	→	92	→	85	↓	88	→	84	→	68	→	85	→	69	→	87
Davis Behavioral	2,755	↑	272	280	10.2%	↑	90	→	84	↑	89	→	80	↑	60	→	61	→	63	→	85
Four Corners	890	↑	122	186	20.9%	↑	91	↑	91	↑	92	→	77	↑	76	↑	91	→	77	↑	88
Northeastern	1,134	↓	246	211	18.6%	↑	90	↑	90	→	92	→	79	→	63	→	63	→	67	→	87
Salt Lake County	10,101	↓	1,586	1,353	13.4%	↑	90	→	86	→	87	→	80	→	70	→	67	↑	71	→	84
San Juan	406	↑	44	96	23.6%	→	92	→	92	→	89	↑	85	→	82	→	75	→	80	→	93
Southwest	1,180	↓	172	153	13.0%	→	89	↓	85	↓	88	↓	77	↓	60	→	59	↓	63	→	87
Summit Co. - Valley Mental Health	436	↓	63	44	10.1%	↑	91	↑	91	→	90	→	81	→	81	↑	77	→	84	→	91
Tooele Co. - Valley Mental Health	1,151	↓	188	90	7.8%		*		*		*		*		*		*		*		*
Utah Co. - Wasatch Mental Health	4,517	↑	749	792	17.5%	→	85	→	80	→	85	→	76	→	67	→	62	→	67	→	82
Wasatch Co. - Heber Valley Counseling	331	↓	56	33	10.0%	↓	79	↓	85	→	81	→	73	↓	53	↓	67	↓	50	↓	77
Weber	4,103	↑	453	665	16.2%	→	84	→	82	→	87	→	73	→	60	→	61	→	62	→	80
State	28,992		4,569	4,475	15.4%		89		85		88		79		67		65		68		84
National (2008)							88		85		88		81		71		70		70		

Adult Consumer Satisfaction Survey 2014 SA Clients

Agency	Number Served FY2013	Number of Forms Returned		Percent of Clients Sampled	General Satisfaction		Good Service Access		Quality & Appropriateness of Services		Participation in Treatment Planning		Positive Service Outcomes		Social Connectivity		Improved Functioning		Wellness		
		2013	2014																		
Bear River Health Dept.	1,225	↑	137	148	12.1%	→	69	↓	72	↓	86	↓	67	→	73	→	81	→	79	↓	86
Central Utah	388	↓	50	32	8.2%		*		*		*		*		*		*		*		*
Davis Behavioral	884	↓	168	92	10.4%	→	94	→	95	→	99	→	93	→	96	→	97	→	96	→	98
Four Corners	547	↑	98	130	23.8%	→	86	↓	85	→	90	→	77	→	84	→	81	→	83	→	89
Northeastern	466	↑	-	105	22.5%	→	92	→	91	→	94	→	87	→	89	→	86	→	84	→	93
Salt Lake County	7,159	↑	1,113	1,260	17.6%	→	78	→	70	→	83	→	69	→	79	→	80	→	80	→	85
San Juan	135	↑	5	11	8.1%		*		*		*		*		*		*		*		*
Southwest	512	↓	74	71	13.9%	→	94	→	89	→	96	↓	66	→	90	→	84	→	93	→	94
Summit Co. - Valley Mental Health	303	↓	57	46	15.2%	→	87	↑	89	→	84	↓	73	→	75	→	72	→	73	→	85
Tooele Co. - Valley Mental Health	393	↑	52	94	23.9%	→	75	→	69	→	82	→	70	→	85	→	83	→	82	↓	85
U of U	330	↓	38	34	10.3%	→	100	→	97	→	100	→	94	→	85	→	100	→	91	→	97
Utah Co.	931	↓	481	479	51.5%	↓	83	→	74	↓	87	↓	78	→	84	→	80	→	84	↓	88
Wasatch Co.	125	↑	-	37	29.6%	→	87	→	89	→	92	→	89	→	75	→	75	→	89	→	91
Weber	1,114	↓	303	256	23.0%	↑	89	↑	88	↑	93	→	78	→	87	→	85	→	91	↑	92
State	14,318		2,576	2,795	19.5%		82		76		87		74		82		81		83		88
National (2009)							88		85		87		81		71		70		70		

Youth Satisfaction Survey 2013 (Youth Ages 12-17)

Agency	Number Served FY2013	Number of Forms Returned		Percent of Clients Sampled	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Wellness							
		2013	2014														
Bear River Health Dept.	83	↑	6	11	** 13.3%	↑	64	↑	64	→	64						
Bear River Mental Health	493	↑	100	122	24.7%	→	84	→	81	→	78	↑	69	→	84		
Central Utah	244	↑	29	38	15.6%	→	76	→	69	↑	97	→	71	↑	68	→	79
Davis Behavioral	753	↓	92	90	12.0%	→	74	→	59	↑	85	→	67	↑	68	→	76
Four Corners	241	↓	76	58	24.1%	→	81	→	81	↑	93	→	71	→	64	→	91
Northeastern	351	↓	23	19	5.4%	*	*	*	*	*	*	*	*	*	*	*	*
Salt Lake County	2,834	↓	668	665	23.5%	→	81	↑	69	↑	89	→	73	→	65	↑	82
San Juan	98	↑	10	37	37.8%	↑	81	→	73	→	89	↑	84	→	64	→	78
Southwest	659	↑	85	95	14.4%	→	66	→	61	→	84	→	69	→	60	→	75
Summit Co. - Valley Mental Health	135	↑	20	73	54.1%	→	79	→	72	→	86	→	76	→	65	→	74
Tooele Co. - Valley Mental Health	335	↑	61	74	22.1%	→	81	↑	70	↑	92	→	68	→	58	→	80
Utah Co. - Wasatch Mental Health	1,598	↓	89	69	4.3%	*	*	*	*	*	*	*	*	*	*	*	*
Utah County Substance Abuse	31	↓	26	13	** 41.9%	→	77	↑	69	→	85	→	77	→	85	→	85
Wasatch Co. - Heber Valley Counseling	90	↑	9	12	** 13.3%	→	83	→	67	→	83	→	83	→	58	→	75
Weber	788	↑	132	148	18.8%	→	74	→	62	→	83	→	69	↑	66	→	80
State	8,573		1,426	1,524	17.8%		79		68		88		72		65		81
National (2009)							86		85		93		88		68		

Youth Satisfaction Survey (Family) 2014

Agency	Number Served FY2013	Number of Forms Returned		Percent of Clients Sampled	General Satisfaction	Good Service Access	Cultural Sensitivity	Participation in Treatment Planning	Positive Service Outcomes	Social Connectiveness	Improved Functioning	Wellness										
		2013	2014																			
Bear River Health Dept.	83	↓	9	4	4.8%	*	*	*	*	*	*	*										
Bear River Mental Health	1,208	↑	180	186	15.4%	→	91	→	92	→	97	→	89	↑	62	→	88	↑	62	→	92	
Central Utah	524	↓	38	36	6.9%	*	*	*	*	*	*	*										
Davis Behavioral	1,587	↑	144	186	11.7%	→	84	→	70	→	92	→	89	→	53	→	86	→	54	→	91	
Four Corners	480	↓	87	75	15.6%	→	70	↓	75	↑	96	→	79	→	49	↓	83	→	48	↓	82	
Northeastern	699	↑	66	80	11.4%	↓	81	→	89	↑	97	→	89	↓	54	→	84	↓	95	→	80	
Salt Lake County	6,103	↑	893	1,042	17.1%	→	90	→	78	↑	95	→	89	→	62	→	82	→	64	→	91	
San Juan	153	↑	17	27	17.6%	→	93	→	67	↓	92	↑	96	→	89	→	85	→	89	↑	92	
Southwest	1,454	↑	175	180	12.4%	↑	88	→	77	→	93	→	88	→	58	↑	86	→	59	→	90	
Summit Co. - Valley Mental Health	204	↓	22	10	4.9%	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Tooele Co. - Valley Mental Health	584	↑	64	129	22.1%	→	91	→	91	↑	96	↑	88	↓	56	↑	85	↓	56	↓	89	
Utah Co. - Wasatch Mental Health	3,190	↓	602	533	16.7%	↓	82	→	74	→	94	→	83	→	63	↓	82	→	64	↓	90	
Utah Co. Substance Abuse	31	↓	49	14	** 45.2%	↑	93	→	93	↑	100	→	86	→	71	→	93	→	71	→	100	
Wasatch Co. - Heber Valley Counseling	178	↑	11	12	6.7%	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Weber	1,696	↑	235	249	14.7%	↓	87	→	85	↓	94	→	94	↓	56	↓	83	↓	57	↑	92	
State	17,868		2,592	2,763	15.5%		87		79		94		88		60		84		61		91	
National (2009)							86		85		93		88		68		85		69			

* Insufficient sample rate.

** Small numbers of surveys may make for unreliable comparisons year-to-year.

Green = Percentage meets or exceeds National Average for MHSIP (except Wellness) or Statewide Average for the YSS and YSS-F Surveys.
 Yellow = Percentage between 75% of the National Average and the National Average for MHSIP (except Wellness) or 75% of the Statewide Average and the Statewide Average on YSS and YSS-F.
 Red = Percentage below 75% of the National Average for the MHSIP (except Wellness) or of the Statewide Average for the YSS and YSS-F.
 ↑ ↓ Indicates change in color from prior year. → No change from prior year.
 Chart results are based on round numbers.
 Client served counts for each provider are unduplicated for that provider and across substance abuse and mental health combined.
 State client served count is unduplicated across substance abuse and mental health combined and is not a sum of the provider client counts.

Sample Monitoring Schedule

TUESDAY

	Adult MH	CYF- MH	SA Treatment	SA Prevention	G & O
9:00 AM	Opening Conference				
9:30 AM	Combined Managers Discussion				Finance Discussion: 1 hour
10:00 AM	Managers Discussion: 1-2 hours	Records Review	Records Review Drug court staffing (if possible)	Managers Discussion: 1-2 hours	Records Review
Noon	Lunch				
1:00 PM	Records Review R&R Manager – Meet with LMHA Peer Specialists	Records Review	Managers Discussion: 1-2 hours	Records Review	Records Review
3:00 PM	R&R Manager – Consumer Feedback		Records Review Client interviews		
5:00 PM	Dinner				
6:00 PM		Family Feedback Group	Continue interviews		

WEDNESDAY

	Adult MH	CYF- MH	SA Treatment		
9:00 AM	Program & allied agency visits	Managers Discussion: 1.5 -2 hours		Records Review (if needed)	Records Review (if needed)
11:00 AM	Continue visits	Case Staffing or Program/Allied Agency Visits			
Noon	Lunch				
1:00 PM	Records Review	Continue visits	R&R Manager – Consumer Feedback		
3:00 PM			R&R Manager – Consumer Feedback		
5:00 PM	Dinner and travel				

THURSDAY

	Adult MH	CYF- MH	SA Treatment	SA Prevention	G & O
3:00 PM	Exit Conference: Via telecommunications equipment from Salt Lake				

Environmental Factors and Plan

11. Trauma

Narrative Question:

[Trauma](#)⁷⁹ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁸⁰. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach".⁸¹ This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁸² paper.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state's policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

⁷⁹ Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

⁸⁰ <http://www.samhsa.gov/trauma-violence/types>

⁸¹ <http://store.samhsa.gov/product/SMA14-4884>

⁸² <http://store.samhsa.gov/product/SMA14-4884>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Trauma

1. Does your state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?

The Division of Substance Abuse and Mental Health (DSAMH) does not have a formal written policy requiring this, however it is considered a best practice. DSAMH has adopted the principle that all treatment should be provided in a trauma informed and gender specific manner. Good clinical practice dictates that anyone with a history of trauma should be referred to trauma-focused therapy, which is available through Local Authority Substance Use Disorders/Mental Health Treatment Programs and private providers.

2. Describe the state's policies that promote the provision of trauma-informed care.

Since Dr. Stephanie Covington's Training: "*Creating a Trauma-Informed and Gender-Responsive Culture of Care*" for DSAMH and other Divisions in the Utah Department of Human Services on January 2013, DSAMH has continued efforts in promoting the provision of trauma-informed care (TIC) in substance use disorders and mental health programs across the state of Utah. These efforts include: (1) Providing keynote presentations, workshops and presentations regarding TIC at the following events: 2013 and 2014 Fall Substance Abuse Annual Conference; Generations Conference; Critical Issues Facing Children and Adolescents Conference; Christmas Box House Conference (*Annual Division of Child and Family Services Conference*); Division of Services for People with Disabilities All Staff Meeting; Four Corners Behavioral Health; Salt Lake County Behavioral Health Services; Utah Board of Juvenile Justice Services; (2) Participating in group national efforts to develop standards for TIC through co-chairing the National Association of Drug and Alcohol Directors (NASADAD) Trauma Workgroup; (3) Including technical assistance, training and consultation regarding TIC with Gabriella Grant, Director for the California Center of Excellent for Trauma Informed Care with the following groups: Volunteers of America – Utah; SAMHSA – Utah Cooperative Agreement to Benefit Homeless Grant Recipients.

3. How does the state promote the use of evidenced-based trauma-specific interventions across the lifespan?

DSAMH promotes the use of evidenced-based trauma-specific interventions across the lifespan through training, consultation and technical assistance provided by DSAMH staff, community and national experts, such as Gabriella Grant and Dr. Stephanie Covington.

In addition, DSAMH in conjunction with the DHS System of Care (SOC) Initiative have continued to work on the following goals:

- a. Improve trauma awareness in the provider network

Trauma awareness has been improved in the provider network system through (1) Annual conferences and trainings sponsored by DSAMH; (2) national conferences; (3) community training events; (4) ongoing training and technical assistance provided by DSAMH, local and national experts.

- b. Plan for ways to implement trauma informed care across the state system

DSAMH has been providing TIC training, consultation and technical assistance to the sixteen Local Authority Substance Use Disorder and Mental Health Providers, contract providers and community partners across the State system and plans to continue in these efforts in the coming years.

- c. Begin a long term systemic transformation to a trauma-informed, recovery oriented, gender responsive and culturally competent system of care.

DSAMH has been working closely with the DHS System Of Care (SOC) Initiative by participating in the following SOC Committees to promote long term systematic transformation to a trauma-informed, recovery oriented, gender responsive and culturally competent system of care: (1) Governance and Oversight; (2) Training and Technical Assistance; (3) Treatment; (4) Finance and Data

4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

In addition to the process outlined in #2 above, for the past five years DSAMH has conducted a statewide training for clinicians to improve their ability to identify and treat trauma. These trainings include: (1) Helping Women Recover: A Program for Treating Addiction (*Stephanie Covington, LCSW, Ph.D*); (2) Beyond Trauma: A Healing Journey for Women (*Stephanie Covington, LCSW, Ph.D*); (3) Trauma Recovery and Empowerment Model (TREM) (*Community Connections*); (4) Seeking Safety (*Lisa Najavits, Ph.D*); (5) Trauma-Informed Care for Veterans. DSAMH will continue to conduct these trainings into the foreseeable future. DSAMH also anticipates offering multiple workshops and keynote speakers on the topic of trauma informed care at the 2015 Annual Fall Substance Abuse Conference and other state sponsored conferences.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁸³

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{84 85} Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸⁶

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

⁸³ <http://csqjusticecenter.org/mental-health/>

⁸⁴ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸⁵ A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

⁸⁶ Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

12. Criminal and Juvenile Justice

Please consider the following items as a guide when preparing the description of the state's system:

General: As stated earlier, at this time Utah has not yet decided whether or not it will expand insurance coverage for individuals in the coverage gap, nor how it will do so if does make that decision. One possibility is that some will be covered by insurance offered through Avenue H, while those who qualify as “Medically Frail” will be offered the option of enrolling in Medicaid. Another possibility is that a much smaller number will be provided coverage through a Primary Care Network, which provides a much more limited coverage (excluding hospital and specialty care). Therefore, many of the answers provided will be conditional as the grant application also requires that it be available to be reviewed by the public for 30 days prior to submission

Currently DSAMH contracts with the 13 local authorities to provide treatment in 44 certified drug courts, where state funds are allocated to provide treatment, drug testing, and case management services. The Administrative Office of the Courts also receives additional funding to fund these services. In addition there are at least 3 Mental Health Courts that receive direct support from DSAMH or one of the Local Authorities, and three Veteran’s courts have also been established.

Justice Reform Initiative: In 2015, the legislature passed House Bill 348, which radically restructures the Criminal Justice approach to sentencing drug offenders, and moves the focus from punishment to rehabilitation and treatment. This bill, which contains over 7150 lines and modifies twelve major chapters of state code, is based on recommendations from the Pew Charitable Trust which conducted a major study of Utah’s Criminal Justice System. This significantly expands the role of the Division by requiring it to set standards for all treatment programs, including jails and prisons that provide SUD and Mental Health Services to individuals involved in the criminal justice system. This is a significant expansion of the Division’s authority and responsibility. Another key element of the reform is the requirement that individuals be screened for criminogenic risk factors and that treatment be based on those risk factors as well as the severity of the MH or SUD.

This initiative will be at least a five year process to implement, especially since some of the funding decisions were made based on the assumption that the Health Care Expansion would be enacted, which has not yet taken place.

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?

The Division is already working to change current Medicaid rules so that individuals who are jailed or in ineligible treatment don’t have their Medicaid cancelled, but only have it suspended, so that it is available immediately upon release from incarceration. The Division will continue to work to simplify rules so that coverage is as seamless as is possible.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

See above. In accordance with Utah Code 17-43, the Counties are responsible for planning for and providing services to their population, “including substance abuse needs and services for individuals incarcerated in a county jail or other county correctional facility”. Because of that, the services provided to inmates vary with the priorities of each county government and their designated local substance abuse

and mental health authorities. All Local Authorities provide some services for individuals within the criminal justice system, however, the numbers of individuals in the CJS requiring services outstrips the resources available to the local authorities to provide to them.

However, by state statute any individual who is charged with a Driving under the influence (DUI) of drugs or alcohol is required to receive a screening prior to their case being adjudicated. If the screening indicates the likelihood of a SUD, then a full assessment is required. If no SUD is present, then Prime for Life education is required. If a SUD is present, then the sentence will include an order to complete the treatment recommended by the assessment.

As stated above, the JRI requires all individuals be screened for criminogenic risk, as well as the need for MH and SUD services. This will involve a much wider group of individuals and agencies involved in the screening, assessment and placement process, and is still being designed.

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?

The Division has a long history of cooperation with the Department of Corrections and with the Administrative Office of the Courts to provide services through a variety of programs aimed at the criminal justice population. These include Drug Courts, Drug Boards, Mental Health courts, the Drug Offender Reform Act, technical assistance to the prison treatment system, and close cooperation between the local authorities and their local County Sheriffs.

In anticipation of the changes required by the JRI, representatives from the Department of Corrections and the Division have been meeting regularly to exchange information, keep the other agency updated on changes and initiatives and to share and collaborate on projects. Additionally, the Commission on Criminal and Juvenile Justice, the Administrative Office of the Courts, the Utah Association of Counties, the Utah Behavioral Health Care Council, the Utah Substance Abuse Advisory Council, and the Division have been meeting regularly since April to plan implementation of the legislation.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

The Division provides scholarships to individuals in the criminal justice profession to attend The Utah Generation's conference and/or the Fall Substance Abuse Conference. The Fall Substance Abuse Conference has an entire track dedicated to the treatment of individuals involved in the criminal justice system. Additionally, the Division is hosting a Drug Court Conference in October 2015, to educate drug court personnel on the latest information and evidence on effective treatment in a drug court setting.

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸⁷ Further guidance will be released in the winter of 2014-2015.

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁸

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in implementing Affordable Care Act provisions and ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

⁸⁷ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁸ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

General: DSAMH will continue to use its administrative portion of behavioral health care block grant funds to work with other state agencies to ensure that parity is well understood and the importance of including BH care services in any state plan. During the past year, Division staff members have met on an almost weekly basis with Legislative Committees, Local Authority Directors and staff, other state agencies, county officials and other public partners to educate and advocate for full parity for behavioral health care services. Due to the active and vocal involvement by the DSAMH in these forums, the decision to adopt the state benchmark plan was made with the knowledge that it did not meet parity requirements and most of those issues have been at least partially addressed.

There is clearly awareness at the state executive and legislative level of the requirements, but along with other parts of the implementation process, the state is awaiting further guidance.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

DSAMH has and will continue to advocate for parity, and to encourage all of the state and local partners to advocate and educate as well.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

The Division meets regularly with Medicaid officials, insurance commissioners, private providers, ACOs and health care providers to provide additional information about Behavioral Health and the requirements of MHPAEA

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁹, 43⁹⁰, 45⁹¹, and 49⁹². SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have failed abstinence-based treatment in the past and who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

⁸⁹ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁹⁰ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁹¹ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁹² <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

14. Medication Assisted Treatment

1. *How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?*

DSAMH has engaged in numerous efforts to raise awareness regarding MAT in the substance use disorder/mental health programs and public:

- a. Local and National Training Events: Training has been provided by state and national experts at conferences, local training events, webinars, conference calls and other means. A major effort to further this process will be made during the Bi Annual Drug Court Conference this Oct when a national speaker will address the use of medications.
 - b. Widespread dissemination of Television, Radio and Newspapers: Information regarding MAT has been made through emails and discussions in meetings of providers, partners and clients. A list of statewide clinical supervisors is maintained and used to disseminate new information of this and other topics. Over three hundred supervisors in both public and private organizations are regularly provided information on MAT and other evidence based practices.
 - c. Brochures and Flyers: Brochures and flyers regarding MAT have been and will continue to be distributed to Local Authority Substance Use Disorder and Mental Health (*LSAA and LMHA*) programs and contract providers; Utah Department of Human Services (*DHS*) Programs; private practices; community partners and stakeholders; health care settings; educational settings; legal and judicial systems; vocational and employment programs and other appropriate systems.
2. *What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?*

In addition to the suggestions listed in #1 above, outreach to pregnant women regarding MAT can be accomplished by ensuring that training events, public service announcements, radio shows, press releases and articles in the newspaper include a focus on the use of MAT with pregnant women. Brochures and flyers should be distributed to programs that provide services to pregnant women, such as (1) Women's Programs in the LSAA/LMHA system, private and other community providers; (2) Women's medical, health clinics and hospitals; (3) Physicians (*OBGYN's*), nurses, therapists, case managers and other helping professionals; (4) Department of Workforce Services; (5) Pregnancy Resource Center; (6) Pregnancy Risk Line; (7) Crisis Pregnancy Center; (8) Young Mother's Program; (9) Planned Parenthood; (10) Utah Fetal Alcohol Coalition; (11) Women, Infants and Children and other programs where pregnant women receive services.

DSAMH has taken a systematic approach to improving the use of MAT in Utah. This has included:

- a. Yearly changes in Division Directives and Contracts that incrementally increased requirements for the use of MAT.
- b. Published comparisons of agencies and providers showing their use of MAT.
- c. Ongoing discussions and written findings during Audits and site visits on the use of MAP.
- d. Targeted efforts towards judges, courts and providers that resist the use of MAT. These have included educational outreach, contract reviews, comments and corrective action requirements on certification visits.

3. *What steps will the state take to assure that evidence-based treatment related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?*

Division Directives, Area Plan Guidelines and Contract Rules developed by DSAMH specify the requirements for the use of FDA-approved medications for treatment of substance use disorders; combining psychosocial treatment with medications; use of peer support in the recovery process; safeguards against misuse and/or diversion of controlled substances and advocacy with state payers.

DSAMH conducts annual audits of LSAA and LMHA Providers to ensure compliance with Division Directives, Guidelines and Rules. Training and technical assistance is provided upon request.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁹³,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

⁹³Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

MENTAL HEALTH CRISIS

The Division of Substance Abuse and Mental Health (DSAMH) promotes and encourages Crisis Prevention/ Intervention/ and Post Crisis Support on a statewide level and annually monitors the LMHA's on the types of crisis services provided. All 13 Local Mental Health Authorities (LMHA) in Utah provide 24/7 crisis response to their communities, however; due to the organization of the State Mental Health System, crisis services vary upon LMHA needs and priorities. Our largest County, Salt Lake (SLCo) has approximately 37% of Utah's population and has a robust crisis response system to support individuals with SMI, and SED. These services include crisis prevention, intervention, and post intervention/support. Utah has a 24 hour Crisis Line, the National Suicide Prevention Lifeline, Mobile Crisis Outreach Teams (MCOT), Law Enforcement Crisis Intervention Teams (CIT), Assessment Triage Center, Residential Crisis/Respite, Assertive Outreach Treatment Teams, Peer Bridger Program, and Peer Operated Warm Lines. Collaboration between all these services happens regularly to ensure quality treatment and response to the community.

Juvenile Mobile Crisis teams are available in 4 of the 5 counties in Utah that have populations over 125,000. These include Salt Lake County, Davis, Utah and Washington counties also provide mobile crisis response for children, youth and families. Each of the teams have a partnership with parent support centers and receiving centers and provide crisis respite and follow-up services.

Crisis Prevention and Early Intervention

- The DSAMH has a Statewide Suicide Prevention Coordinator who promotes the use of Columbia Suicide Severity Rating Scale (CSSR-s), Safety Planning, on a state-wide level. Most of the LMHA's have added these two tools to their electronic medical record. Utah has a State Suicide Prevention Coalition that meets monthly to address Suicide Prevention, Intervention, and Postvention.
- Wellness Recovery Action Plan (WRAP) is also being utilized on a statewide level and SLCo utilizes WRAP in both the Crisis Residential Center and the Assessment/Triage Center.
- SLCo has a multidisciplinary Assertive Community Treatment (ACT) Team that provides mobile psychiatric services to individuals with SMI in their homes, or to those who are homeless to prevent hospitalization and promote recovery. SLCo has a warm line ran by Certified Peer Specialists and Certified Peer Specialists work in all areas of the crisis response system in SLCo providing support to individuals with SMI and SED.

Crisis Intervention/Stabilization

- SLCo's MCOT teams operate 24/7 seven days a week and consist of Licensed Mental Health Therapist and a Certified Peer Support Specialist. There are three teams that serve SLCo, two adult teams and one adolescent team. MCOT works closely with CIT Law Enforcement and dispatch to provide outreach and information if needed on mental health crisis in the community.

- CIT Utah is a statewide program of the Division of Substance Abuse and Mental Health and the program is administered through the Salt Lake Police Department. Eleven of the thirteen LMHA's statewide participate in CIT; there are 11 regional coordinators from the mental health side and 11 regional coordinators from the law enforcement side who work as a team to provide crisis response to individuals experiencing a mental health crisis.
- MCOT and CIT can refer the Receiving Center which is the crisis assessment/triage center otherwise known as the "living room model". The Juvenile Receiving Center offers crisis support and respite to children and adolescents.
- The Wellness Center is a 16 bed facility that provides short term residential crisis care to individuals with SMI.
- Hopeful Beginnings offers in home crisis support, including respite to families with SMI and SED. The crisis team operates seven days a week from 6:00 am to 11:00pm and works closely with MCOT when additional support is needed. Hopeful Beginnings utilizes Certified Peer Specialist and is a host-agency for Family Resource Facilitators.

Post Crisis Intervention/Support:

SLCo utilizes Peer Bridger Program and Peer Support to support the transition of individuals with SMI and SED out of an inpatient setting back into the community and to prevent the need for readmission to the hospital. All the LMHA are encouraged to work with their area hospitals to coordinate care and provide follow up services post discharge. On the annual site visits conducted by the DSAMH, visits are conducted to the area hospitals and jails to discuss coordination of care and follow up services.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist | • Peer wellness coaching | • Person-centered planning |
| • Promotoras | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Supported employment | | |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?.
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

16. Recovery

General: The Division has been incorporating the concepts of Recovery into both MH and SUD services for the past six years. In 2011 Peer Support Specialists (PSS) services were added to the State Medicaid Plan and the Division began conducting quarterly MH PSS trainings. In 2012, House Bill 496 was passed which gave the Division the authority to develop rules for a SUD Peer Support Specialist. That rule has been developed (R523-2) which can be found at: <http://www.rules.utah.gov/publicat/code/r523/r523-002.htm>

In addition, the Division formed an SUD Recovery Oriented System of Care (ROSC) Workgroup that has been meeting for the past six years to expand traditional clinical acute care SUD services into a true ROSC. That has been expanded to include the Performance Development Committee, the Clinical Committed and the Finance Director's committee of the Behavioral Health Care committee, which is the Provider Organization for the State. This has been reinforced by workshops and presentations at the Utah Substance Abuse Fall conference for the past five years, where innovative practices that support Recovery Support Services and activities are highlighted. Additionally, use of the ATR funds has greatly expanded the ability of the DSAMH to provide Recovery Support Services.

The Local Authority Clinical Directors, along with the finance managers and Performance Data committee have been meeting monthly to work to expand the ability of the system to provide SUD services outside of the traditional treatment episode. To do this, the system has had to develop ways to track clients "after discharge" and instead of tracking an episode of care, track recovery services post episode of acute care.

There has been an ongoing discussion with SAMHSA representatives to move past the TEDS data system which focuses only on the short term episode of care, and requires individuals to be "discharged" from services, even though SAMHSA continually encourages the states to develop a Recovery Oriented system of Care and treat SUDs as chronic conditions. Thus far there has been no assistance in these efforts.

Since Utah is still resolving its health care expansion policy and approach, there has not been a large addition to the funding system for traditional care, so planned use of the block grant to pay for additional recovery support services has not been able to be implemented.

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?.

Yes. The state has adopted and uses the SAMHSA definition of recovery and has encouraged all of the local authorities to expand their use of Peers and Peer Support Services. On the Mental Health side this has been fairly successful due to the inclusion of Peer Support in the Medicaid Manual, and the recent increase in rates for PSS Services. With only 15-17 % of SUD clients eligible for Medicaid, it has been more difficult to expand Peer Services for SUD clients, as any additional services have to be financed by cuts in currently existing services.

The Division, in conjunction with the Local Authority Directors has shifted the focus for the system from Event Based documentation to Ongoing and concurrent documentation with a focus on engagement. This

has led to major revisions of the EHR's and the publication of a set of principles for SUD and MH treatment that is based on engagement and person centered planning and self directed care.

Additionally, the Division has continued to expand the use of Vouchered services, even as our ATR funding has gone away. We are using money from the Block Grant, State Treatment Services, the Division of Child and Family Services, TANF and the Department of Corrections to continue the ability of clients to choose the services they need for support.

Finally, the Division maintains and Recovery and Resiliency Program Manager who is a peer in recovery as part of the staff responsible of monitoring local authorities and meeting with local recovery advocates and peers.

2. How are treatment and recovery support services coordinated for any individual served by block grant funds?

In accordance with each Local Authority's Area Plan.

3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

Each Local Authority is responsible for determining the needs of their area/county and tailoring the services purchased with available funding to those needs.

4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?

Yes. The Division has supported an annual two day Peer Support Conference for the past three years, and is conducting a half day Meeting this October for Peers. In addition, The Generation's and Fall SUD conference both have sessions for peers, and peer supervisors.

By Statute, the Division is responsible to certify the training of Peer Support Specialists, which is not equivalent to providing a full certification, which the Division does not have the authority or staff to do. The Division approves the curricula of organizations who apply to provide the training, ensures the training is conducted in accordance with the contracted standards, and issues a certificate of training to graduates.

5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?

No, the Division is not authorized, funded or staffed to conduct research.

6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).

As stated above, the Division has a Peer in recovery working as a Program Manager for the Recovery and Resilience. Additionally, the Division meets monthly with the Consumer's advisory council.

7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Yes. The Division helps fund USARA and other advocacy organizations.

8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.

We use a Consumer Satisfaction survey every year to measure how Local Authorities are faring with their consumers.

9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.

In 2009, the Division began a partnership with the Department of Health to implement tobacco free policies in all publicly funded SUD and MH facilities. Dubbed “Recovery Plus”, the program set out a three year plan for all agencies to become Tobacco Free by March 2013. The three year plan included and assessment phase, an education and policy development phase, and an implementation phase. While it has not yet been fully implemented in all areas of the state, the requirement is that all publicly funded programs have policies in place. There are two requirements that were the backbone of the program: first, that no individual be denied services because of their tobacco use, and secondly, that all individuals be given assistance in quitting their tobacco use. All publicly funded MH and SUD treatment facilities are now tobacco free, and the reduction of tobacco use from admission to discharge is now on the Division’s “Scorecard”. The FY 16 Division Directive requires all Local Authorities to reduce smoking by at least five percent from admission to discharge.

The Division and DOH continue to partner on tobacco cessation efforts and in June, provided a webinar to Alaska on the Recovery Plus Project.

Since the initiation of Recovery Plus, the Division has continued to work closely with the Department of Health (DOH) on several issues during the past five years. Those issues include Prescription Drug overdoses, Fetal Alcohol Syndrome, Drug Endangered Children, and most recently, Tobacco Cessation. Most recently the Division and the DOH met to review opportunities to collaborate on other health related issues that affect both BH and Physical Health care providers. There is significant energy towards coordinating our efforts towards reducing the impact of co-occurring chronic health care conditions on both systems through coordinated care. Likewise, there is a statewide effort by the DOH and partner agencies to apply for an innovations grant to implement further integration activities. An initiative called Recovery Plus II has worked to integrate and coordinate the Department of Health’s health promotion and other activities with the Behavioral Health Local Authorities, and five of the DOH regions and Local Authorities are having ongoing meetings to continue this process.

Wellness: In 2008, the Division Directive for FY 2009 required that the Local Mental Health Authorities implement a “Wellness Directive” that included the following guidance:

“The division has embraced two guiding principles in its effort to promote recovery:

- *Recovery includes WELLNESS; and*
- *Overall health is essential to mental health.*

Because of the premature mortality rate of seriously mentally ill persons, 25 years earlier than non-mentally ill persons, include in your area plan the how you plan to incorporate physical health care issues in the overall treatment planning for adults.

The directive went on to require Local authorities to:

- *monitoring weight*
- *diabetes screening*
- *tobacco use*
- *provide training for staff in recognizing health issues*
- *the adoption of policies to ensure integration of mental health and physical health care*
- *providing information to consumers on physical health concerns and ways to improve their physical health*
- *how to incorporate wellness into individual person-centered plans*
- *how the center will improve prevention, screening and treatment in context of better access to health care*
- *identified a specific practitioner to be the responsible party to ensure that each person's medical health care needs are being addressed”*

This directive has remained in place since that time. While the SUD services have been slower to adopt the guidance, largely due to the lack of medical personnel in the SUD provider network outside of the combined centers, the general approach to treating the whole person has long been an element of SUD assessment and treatment planning. Across the state system, Recovery Plus has been promoted as part of the overall wellness approach to recovery planning, rather than a specific service.

The 2016 Division Directive, the following language was included:

Wellness:

- a. *Local Authorities will use a Holistic Approach to Wellness and will:*
 1. *Identify tobacco use in the assessment.*
 2. *Provide services in a tobacco free environment.*
 3. *Provide appropriate tobacco cessation services and resources (including medication).*
 4. *Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.*
 - (a) *Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. When deemed appropriate:*
 - (b) *Include the use of MAT in the treatment plan, and*
 - (c) *Either provide the medications as part of the treatment, or*
 - (d) *Refer the individual for Medication assisted treatment .*
 5. *Provide training for staff in recognizing health issues.*
 6. *Provide information to clients on physical health concerns and ways to improve their physical health.*
 7. *Incorporate wellness into individual person centered Recovery Plans.*
- ix. *Local Authorities will cooperate with efforts of the Division of Substance Abuse and Mental Health to promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs, as described in UCA 62A-15-103.*

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

As discussed earlier, the Division has worked with the Office of Licensing to establish licenses for Recovery Residences, and continues to work with the Local authorities and Local governments to ease the restrictions on housing. Much of this work is accomplished at the local authority level.

11. Describe how the state is supporting the employment and educational needs of individuals served.

Since there has been no significant increase in funding while the need for employment and housing has become more and more important, the Division has applied for and received several grants for both employment and housing. Some of these are focused strictly on Housing, and while Housing First is an important initiative, it does not automatically lead to success in treatment. The Division has aligned with the Employment First Initiative (assisting individuals with disabilities/mental illness obtain and maintain competitive employment). Pilot projects focused on Supported Employment, using the evidence-based practice of Individual Placement and Support (IPS), have been initiated at two sites, representing both urban and rural populations. This program is in the first of five years, with an expectation to engage 100 people per year at each site and to extend the project state-wide.

Technical assistance is being received from PRA Gains, BRSS TACS, Dartmouth and assigned grant advisors.

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Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
 2. How are individuals transitioned from hospital to community settings?
 3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
 4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?
1. The Division of Substance Abuse and Mental Health incorporates the ADA's mandate (as recognized in Olmstead) to serve clients in the least restrictive, most integrated setting into every aspect of our organization. DSAMH programming or partnerships include:
 - a. Housing Services: DSAMH has worked with all of the Local Mental Health Authorities to develop housing services and/or work with the local Public Housing Authorities to provide housing services.
 - b. HCB services: Utah Has Seven Medicaid 1915(c) HCBS Waivers help ensure people to remain independent in the community:
 - Acquired Brain Injury Waiver
 - Aging Waiver (For Individuals Age 65 or Older)
 - Community Supports Waiver for Individuals with Intellectual Disabilities or Other Related Conditions
 - Medicaid Autism Waiver
 - New Choices Waiver
 - Physical Disabilities Waiver
 - Waiver for Technology Dependent Children
 - c. Peer Support: DSAMH has a certified peer support specialist program for individuals who have progressed in their own recovery and are willing to utilize their experience to help others.
 - d. Employment: DSAMH has received a federal grant for Supported Employment/Individual Placement and Support (IPS), to serve 450 individuals with serious mental illness within the duration of the grant. This includes employment specialists to provide job coaching, job development and job placement services. DSAMH also works to help facilitate supported and transitional employment through the Clubhouse model.
 2. Transition from Hospital to Community Settings: DSAMH, with input from stakeholders has addressed the transition from the Utah State hospital (Utah's only state institution for mental diseases) to community settings by cataloguing community alternatives and capacities across the state and establishing a process to track discharge readiness and transition planning that focuses on strengths and barriers to discharge into a community based setting.
 3. Efforts to address ADA community Integration: Utah incorporates the ADA community integration mandate into all of its practices. DSAMH PASRR Program (Preadmission Screening and Resident Review) helps to ensure that individuals are not inappropriately placed in nursing facilities, that individualized services are offered depending on their needs and to help determine the most appropriate setting. The PASRR program also works with the Utah Department of Health Waiver Program to help individuals transition into community based settings.
 4. Litigation of Settlement Agreements: Utah DSAMH is not involved in any litigation or settlement agreement with the DOJ or any other entity regarding community integration for children with SED or adults with SMI.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁴ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹⁵ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹⁶

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹⁷ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁸

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁹:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁴ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹⁵ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹⁶ Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹⁷ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁸ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁹ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

- MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁴ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹⁵ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹⁶

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹⁷ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁸

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁹:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

7. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
8. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use, and co-occurring disorders?
9. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
10. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
11. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
12. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
13. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

⁹⁴ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹⁵ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹⁶ Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹⁷ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁸ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁹ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

19. Pregnant Women and Women with Dependent Children

- 1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.**

DSAMH has encouraged LSAA/LMHA Providers to inform the community regarding priority admission into treatment for pregnant women through brochures, flyers, websites community presentations and sharing this information with clients and their families. DSAMH requires that Local Authority Providers also address the priority admission for pregnant women in their Area Plan and Division Contract.

The DSAMH Division Directives provide guidance to Local Authority Providers regarding best practice standards, including priority for admission into treatment for pregnant women. These directives are posted on the DSAMH website, which are available to the public. Providers are reminded of the requirement for priority admission into treatment for pregnant women through annual Area Plan Training and Site Visits.

- 2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.**

In 2008, the Utah State Legislature passed Senator Hutching's H.B. 316 - *Substance Abuse Treatment for Pregnant Women and Pregnant Minors*, which requires that Local Substance Use Disorders and Mental Health Authority providers (*that receive public funds*), ensure priority for admission to a pregnant woman or a pregnant minor.

- a. It also requires a local substance abuse authority to provide a comprehensive referral for interim services to a pregnant woman or pregnant minor that cannot be admitted for substance abuse treatment within 24 hours of the request for admission.
- b. It provides that, if a substance abuse treatment program is not able to accept and admit a pregnant woman or pregnant minor within 48 hours of the time that request for admission is made, the local substance abuse authority shall contact, and the Division of Substance Abuse and Mental Health shall provide, assistance in providing services to the pregnant woman or pregnant minors.
- c. It requires a local substance abuse authority to provide counseling on the effects of alcohol and drug use during pregnancy.

DSAMH has incorporated HB 316 along with SAPT Block Grant Requirements for Priority Admission in the Division Directives, which all Local Authority Providers are required to follow.

- 3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.**

If the LSAA/LMHA has insufficient capacity to provide treatment services for a pregnant woman, they provide the following interim services until treatment is available: (1) Interim Groups (*open-ended educational or peer run groups that the client can attend as long as needed*); (2) Individual Therapy; (3) Case Management Services; (4) Peer Counseling Services; (5) Recovery Support Groups; (6) Community Support Groups.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

Becky King, LCSW, DSAMH Program Manager, is responsible for monitoring the requirements in 1-3. Dave Felt, Program Administrator, assists with the monitoring of these requirements as needed.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP).

There are sixteen LSAA/LMHA Providers that serve pregnant women and their infants:

- (1) Bear River Mental Health: OP, IOP
- (2) Bear River Substance Abuse: OP, IOP
- (3) Central Utah Counseling: OP, IOP
- (4) Davis Behavioral Health: OP, IOP
- (5) Four Corners Community Behavioral Health: OP, IOP
- (6) Northeastern Counseling Center: OP, IOP
- (7) Salt Lake County Behavioral Health Services: OP, IOP, Residential
- (8) Salt Lake Valley Mental Health: OP, IOP, Residential
- (9) San Juan Counseling Center: OP
- (10) Southwest Behavioral Health Center: OP, IOP, Residential
- (11) Summit County Substance Abuse and Mental Health: OP, IOP
- (12) Tooele County Substance and Mental Health: OP, IOP
- (13) Utah County Division of Substance Abuse: OP, IOP, Residential
- (14) Wasatch County Family Clinic: OP, IOP
- (15) Wasatch Mental Health: OP, IOP
- (16) Weber Human Services: OP, IOP, Residential

a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

All sixteen Local Substance Use and Mental Health Authorities offer medication assisted treatment for pregnant women by referring them to local Opioid Treatment Programs or private physicians. There are thirteen Opioid Treatment Programs in Utah:

- (1) Bountiful Treatment Center - Bountiful
- (2) Discovery House – Salt Lake, Taylorsville, Orem, Layton
- (3) De Novo – Salt Lake City
- (4) Metamorphosis – Salt Lake, Ogden
- (5) Project Reality – Salt Lake, Provo
- (6) Tranquility Place – Salt Lake
- (7) True North – Orem
- (8) St. George Metro Treatment Center – St. George

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?

The rural areas of the state do not always have access to residential treatment or MAT for pregnant women or the general population since most of these programs are located in the urban areas of the state, (i.e. Salt Lake City), which are located quite a distance from the rural areas. The following geographic areas struggle with this issue:

- (1) Northeastern Utah – Duchesne, Uintah and Dagget County
- (2) Central Utah - Juab, Sanpete, Millard, Sevier, Piute & Wayne County
- (3) Southern Utah – San Juan County
- (4) Four Corners Utah - Carbon, Emery and Grand County

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IOP, OP).

- a. How many of the programs offer medication assisted treatment for the pregnant woman in their care?**
- b. Are there geographic areas within the State that are not adequately served by the various level of care and/or where women can receive MAT? If so, where are they?**

See #5 above.... The answers are the same.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).¹⁰⁰

Please indicate areas of technical assistance needed related to this section.

¹⁰⁰ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

- In the FY 2016/2017 block grant application, SAMHSA asks states to:
 1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
 2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
 3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).¹⁰⁰

1. In fall of 2011, the Utah Division of Substance Abuse and Mental Health (DSAMH) assisted in the formation of a Suicide Prevention Coalition that meets monthly. This group is a broad coalition that includes representatives from active duty Air Force, Army and Air Force National Guard, the Veteran's Administration, Community Coalitions and groups, State Agencies and Departments, County and City Governments and citizen representatives. A copy of the most current Suicide Prevention Plan, completed in 2013 is [attached](#). The plan was designed based on the revised National Strategy for Suicide Prevention (2012).

DSAMH continues to provide leadership and support to the full coalition, the Executive Committee, and various work groups. The coalition is focused on implementation of the Utah Suicide Prevention Plan.

Between the 2012 Legislative Session and the most recent 2015 Legislative Session, the Utah State Legislature passed many proactive suicide prevention related bills. Summaries are as follows:

- *2012 legislation required licensed school staff to do suicide prevention training- <http://le.utah.gov/~2012/bills/static/HB0501.html>.*
- *2013 legislation that created and funded two state positions for suicide prevention- one in Dept. Human Services and one in the State Office of Education. <http://le.utah.gov/~2013/bills/static/HB0154.html>*
- *2013 legislation requires school districts to hold parent seminars on a range of topics including suicide prevention-<http://le.utah.gov/~2013/bills/static/HB0298.html>.*
- *2014 legislation requires secondary schools to implement suicide prevention, intervention and postvention strategies and appropriated a small amount of funding for school based suicide prevention programs . <http://le.utah.gov/~2014/bills/static/HB0329.html>.*
- *2014 legislation creates a voluntary firearm safety program for suicide prevention <http://le.utah.gov/~2014/bills/static/HB0134.html>.*
- *2015 HB 209, Suicide Prevention Program Amendments, will require certain professions to include suicide 2015 prevention training. <http://le.utah.gov/~2015/bills/static/HB0209.html>*
- *2015 HB 128, Maintenance of School Records, will focus on record keeping within schools when it comes to suicide or bullying incidents. <http://le.utah.gov/~2015/bills/static/HB0128.html>*
- *2015 HJR 12, Joint Resolution on Homelessness and Runaway Youth, will recognize November as homeless and runaway youth month. <http://le.utah.gov/~2015/bills/static/HJR012.html>*

- 2015 HB 364, *Suicide Prevention Amendments*, will expand the role of the state suicide prevention coordinator and appropriates funds to the program. <http://le.utah.gov/~2015/bills/static/HB0364.html>
- 2015 SB 175, *School Safety and Crisis Line*, will expand the state suicide hotline while also adding texting capabilities. <http://le.utah.gov/~2015/bills/static/SB0175.html>

2. DSAMH has worked with the Utah Suicide Prevention Coalition, the Utah Behavioral Health Committee and other stakeholders to address suicide prevention specifically with the following populations.

a. SMI/SED/PWWDC/IVDU's/TB

In order to address suicide prevention within the required populations DSAMH has led a comprehensive care quality improvement process with care providers statewide. DSAMH has participated in the Zero Suicide Collaborative since 2013. In 2014 DSAMH applied to be part of the Zero Suicide Breakthrough Series. Utah was accepted as one of six states to participate and have been implementing zero suicide and data led quality improvement efforts in partnership with that project through 2015. In 2015 DSAMH partnered with the Utah Behavioral Health Committee and care centers statewide to apply to Utah Department of Health Medicaid Office for a statewide Performance Improvement Project. The goal of the project is to reduce suicide by increasing overall suicide screening and assessment rates and provide evidence based interventions, such as same day safety planning with those who are identified as at risk. In 2015 the focus is on collecting baseline data and in 2016-2017 the focus will focus will be on care quality improvement efforts.

DSAMH has worked through Division Directives with Local Authorities statewide to help each organization formally evaluate their policies, procedures, and work

DSAMH continues to work with local communities across the state to address suicide prevention within additional priority populations. DSAMH partners with NAMI Utah on the Prevention by Design Project. It is a plan for enhancing and coordinating local community networks and coalitions in systematic and evidence based approaches to the prevention of mental illness, promotion of mental health, and suicide prevention. This process is based on the Strategic Prevention Framework (SPF)¹ and will be implemented using the Communities That Care (CTC)² prevention planning system. 2014 outcomes are listed below. In 2015 the contract with NAMI Utah was renewed and as of July 2015 the number of coalitions who receive funding has increased from 13 coalitions to 22. This will allow Utah to offer more suicide prevention strategies statewide including a focus on gatekeeper trainings such as QPR, MHFA, and SafeTalk.

QPR*	QPR Instructors Trained	MHFA Instructors Trained	MHFA*	YMHFA*	ASIST*	Hope Squad	Guiding Good Choices	Town Hall*
Bear River	397	3	0	0	0	0	0	120
Central Davis	121 1,134	2 0	2 0	66 0	0 0	0 0	0 232	65 0
Four Corners	30	14	0	0	0	0	0	0
Northeastern SJCC	0 58	0 17	3 0	58 0	44 0	0 0	0 0	0 0
UNHS	0	0	0	0	0	209	0	0

South Salt Lake	19	2	3	19	0	0	0	0	250
Southwest	97	17	0	60	0	0	0	0	0
Summit	258	2	0	0	0	0	12	0	56
Tooele	1,100	14	0	0	0	0	56	0	0
Utah County	204	0	0	0	0	0	0	0	0
Wasatch	274	7	0	0	0	0	0	0	450
Weber	516	5	0	32	0	0	340	0	724
TOTALS	4208	83	8	235	44	209	640	65	2180

* Attendee numbers

DSAMH will continue to expand its suicide prevention strategies including training and education efforts across the state system and is working on initiatives that can better identify high risk populations and develop ways to better identify individuals at risk of self-harm and the system's ability to respond to those threats.

3. Updated plan is attached.

Summary of Utah's Suicide Prevention Plan 2013

The following goals were developed by the Utah Suicide Prevention Coalition. Many thanks to all those who contributed ideas, hard work and dedication to this process for all the citizens of Utah. We dedicate this plan to those whose life has been impacted by suicidal thoughts or feelings and who bravely face each day and choose to hope and continue to live. We also dedicate this plan to survivors who have lost a loved one to suicide and to those professionals, first responders, individuals and families who continue to engage in this work of Suicide Prevention. Our overarching goal is to reduce the number of people who die as a result of suicide in Utah. The objectives and details about how these goals will be achieved are outlined in the pages that follow.

Goal 1: Promote public awareness that suicide is a preventable public health problem.

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

Goal 3: Improve the ability of health providers (including Behavioral Health) and first responders to better support individuals who are at risk of suicide.

Goal 4: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all helping professionals, including graduate and continuing education programs.

Goal 5: Increase access to health and behavioral health services, prevention programs and other community resources to better support individuals and families of individuals at risk of suicide.

Goal 6: Develop policy through State Agencies, legislature, and other avenues as possible to promote mental health and prevent mental illness and eliminate suicide.

Goal 7: Promote efforts to decrease the risk of suicides by reducing access to lethal means.

Goal 8: Improve surveillance, data, research and evaluation relevant to suicide prevention.

Goal 9: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicide attempts and deaths from suicides.

Utah Suicide Prevention Plan 2013

Goal 1: Promote public awareness that suicide is a preventable public health problem.

Objective 1.1: By August 1, 2013 publish a website to provide resources for suicide prevention, and support for individuals, families and communities impacted by suicide

Evaluation of Objective: Website has been established and is discoverable on popular internet search engines. Web hits will be tracked and presented to committee.

Activity	Committee	Progress
Develop a website for Utah citizens and professionals to act as a clearinghouse of information and resources for suicide prevention and support.	Community Awareness	<p>Feb. 11, 2013: Type of Website needs to be determined (DSAMH, UDH, and Coalition) DSAMH will be adding a webpage to their site specific to Suicide Prevention information, updates and tools. There are barriers around having a coalition run and maintained website. DSAMH working on a one page fact sheet of what to do if you or a friend is considering suicide (will be available on website). We can consult with prevention team to see how they have UPAC's website set up.</p> <p>June 2014: Website Live</p> <p>June 2015: Website continually updated</p>

Objective 1.2: By August 31, 2013, design a flyer(s) to be distributed to 5,000 professionals and individuals in Utah which includes suicide data, prevention resources and crisis line numbers.

Evaluation of Goal: The flyer(s) will be approved through the executive committee of the Utah Suicide Prevention Coalition and distribution will be tracked in an Access database.

Activity	Committee	Progress
Support the promotion of SPRC, USARA,	Epidemiology	Development of print media campaign will follow completion of the Suicide Prevention Universal Tools, campaign may target use of tools for medical, mental health, first responders etc... Booths at various conferences will be manned by DSAMH in conjunction with various community partners to distribute population specific information

NAMI print media available.		for suicide prevention June 2015 - 5000+ flyers from SPRC, USARA, NAMI, and others regularly disseminated.
Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines.	Community Awareness	June 2014: Lifeline info is posted on DSAMH, and UDOH. Info on life line will be disseminated at fall conference, and will be at up upcoming generations, and troubled youth conferences in a booth July 2015 : Lifeline info continues to be put out through local coalition event, state conferences,
Update suicide fact sheets with new data, yearly and distribute widely.	Epidemiology	Feb. 11, 2013: Fact sheets concerning Suicide demographics have been developed by UDOH. Sept. 10, 2012: World Suicide Prevention Week: Joint press release between DHS and DOH focused on accessing the crisis line and emphasizing the message that suicide is preventable May 2015 : UDOH developed new fact sheet on youth suicide- distributed via press release, email distribution, and through coalition.
Objective 1.3: By January 2016, at least one professional in Utah, serving on the Coalition, will be certified as a Master Trainer in ASIST, Mental Health First Aid and/or Question, Persuade, Refer (QPR) in order to improve training access for Utahans to help reduce stigma of and to improve general knowledge of how to engage in behavioral health services.		
<i>Evaluation of Goal: Utah will have at least one Master Trainer and provide a minimum of one QPR or Mental Health Train the Trainers session each year. Training evaluations will be distributed and analyzed and numbers reached will be collected and stored in an Access database.</i>		
Activity	Committee	Progress
Activity 1: Collaborate with the Utah Domestic Violence Council and Domestic	Education and Training	Feb. 11, 2012: DV rep invited to coalition to work on collaborating trainings materials. QPR sessions have been included in many conferences. There will be sessions on QPR provided at Generations Conference. MHFA is being offered in various parts of the state including Northeast Counseling Center, Southwest Behavioral Health Center, NAMI and DSAMH have teamed up to provide a training to Drug Court and SL Co Jail. Dec, 2012: Work to coordinate and list trainings on DSAMH website. June 2015 :

Violence Program in the Department of Human Services to integrate QPR or Mental Health First Aid into existing conferences and trainings.		
Activity 2: Train 10,000 educators and the general population on the QPR program.	Education and Training	June 2015: 7500 People trained as QPR Gatekeepers through Prevention by Design. Over 100 individuals trained at trainers.
Activity 3: Train up to 20 trainers and then train up to 2,000 individuals per year on Mental Health First Aid.	Education and Training	June 2015:
Objective 1.4: From January, 2014 through December, 2016, establish initiatives which promote an understanding, among Utahns, that recovery from mental and substance use disorders are possible.		
<i>Evaluation of Goal: Materials are finalized and available on website.</i>		
Activity	Committee	Progress

<p>Activity 1: Support and promote community plans that aim to reduce stigma around mental health and suicide.</p>	<p>Community Awareness</p>	<p>June 2015:</p>
<p>Activity 2: Encourage and support community town hall meetings around suicide awareness and prevention.</p>	<p>Community Awareness</p>	<p>June 2015:</p>
<p>Activity 3: Create a sample initiative for town hall meetings for communities to adopt and replicate inclusive of different populations ie; LGBTQ, homeless, seniors, and</p>	<p>Community Awareness</p>	<p>June 2015: Model townhall template put together by Community Awareness committee and distributed April 2014</p>

others at high risk.		
Objective 1.5: Develop educational materials instructing communities, individuals and organizations about how they can become involved in suicide prevention within their scope of influence.		
<i>Evaluation of Goal: Initiatives will be published and their outcomes evaluated. Process evaluation will also be conducted and stored in an Access database.</i>		
Activity	Committee	Progress
Activity 2: Engage peer support specialists in designing materials.	Community Awareness	Feb. 11, 2013: Recovery Day 5k run/walks throughout the Utah each fall. Town hall meetings focused on Substance Use Prevention to include topics of Suicide Prevention in Davis Co, this is a model we can work to promote throughout Utah. "Prevention by Design" plans were due Jan. 1, 2013. These plans are community plans for the promotion of mental health and prevention of mental illness across Utah, the target of these plans is to decrease suicides across Utah. June 2015:
Objective 1.6: By January 2014, the coalition will establish accounts with at least three social media applications. Prevention, resource, and treatment messages will be pushed through these applications at least once a week.		
<i>Evaluation of Objective: Social media accounts will be established for the coalition and numbers of hits, connections and friends will be tracked.</i>		
Activity	Committee	Progress
Activity 1: Establish social media accounts through Facebook, Twitter, Tumblr, Pinterest, etc.	Community Awareness	Feb. 11, 2013: on hold for other priorities June 2015: Facebook presence strongly established with approximately 800 followers.
Activity 2: Develop talking points for partners to	Community Awareness	Kim Myers is currently developing June 2015: Draft developed for community awareness to review.

use on all social media sites to ensure a consistent message.		
Goal 2: Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts.		
Objective 2.1: By August 2015, establish recruitment initiatives with a broad range of organizations and programs to integrate suicide prevention into the values, culture, leadership, and work of these organizations and programs.		
<i>Evaluation of Objective: Outcome and process evaluation will be conducted with attendees of the Prevention Summit's.</i>		
Activity	Committee	Progress
Activity 1: Work to develop a State Suicide Prevention Summit.	Education and Training	Feb. 11, 2013: IHC will be attending Coalition meetings and participating in committees and work groups. Oct. 9, 2012: Report on progress: Identifying specific groups we can collaborate with, and work to cultivate a relationship with shared values. Educate and collaborate with others to promote suicide prevention through faith-based summit and Utah Summit on Suicide Prevention. June 2015: Utah has integrated suicide prevention into all major existing conferences. DSAMH currently in process of planning a Zero Suicide Summit for early 2016.
Activity 2: Work to develop an Interfaith Suicide Prevention Summit.	Education and Training	June 2015: Still needs to be addressed
Objective 2.2: Between June 2013 and December 2016, the Utah Suicide Prevention Council will provide technical assistance to a minimum of five organizations who work with at-risk groups to implement suicide prevention policies and evidence-based programs that address the needs of these groups.		
<i>Evaluation of Goal: Meeting agendas, minutes, and logs of technical assistance will be retained.</i>		
Activity	Committee	Progress
Activity 1:	Policy	Feb. 11. 2013: Working to bring Native American Population, D.V., IHC, Local Mental Health & Substance Abuse

Work with Work Force Services, Faith based groups to promote suicide prevention trainings		<p>Authorities to the table.</p> <p>Oct. 9, 2012: Great community representation, we need to explore who we are missing from the community as representation in our workgroups and coalition. Currently efforts are being made to bring both health professional and tribal voices to the table.</p> <p>June 2015: Through Prevention by Design we currently provide TA to 22 coalitions which include faith based services, work forces services, Native American Tribes, and more.</p>
<p>Objective 2.3: Between June 2013 and December 2016, the Utah Suicide Prevention Coalition will establish partnerships and offer technical assistance with a minimum of five Utah communities to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors.</p>		
<p><i>Evaluation of Goal: Technical assistance opportunities will be logged and reported. In some cases, MOU's will be implemented with partnering organizations. Copies of approved MOU's will be provided by request. Completed fact sheets will be published on websites and web hits will be tracked.</i></p>		
Activity	Committee	Progress
Activity 1: Conduct town hall meetings and focus groups to identify community needs.	Education Training	<p>Feb. 11, 2013: Review progress made through Davis Co Prevention Town Hall meeting, Consider Start Date for Town Hall meetings, discuss promotion of Universal Tools (Screening (C-SSRS), Assessment (C-SSRS) and Safety Planning (Stanley/Brown)) and training to utilize them. UDOH has release fact sheets on data around Suicides in Utah.</p> <p>June 2015: Town hall meeting template developed and disseminated statewide. 10+ Townhall meetings including suicide prevention. 20 coalitions have gone through strategic planning process for suicide prevention with Prevention by Design.</p>
Activity 2: Develop Fact Sheets on evidence based intervention and Postvention for suicide prevention	Epidemiology	<p>Feb. 11, 2013: UDOH has release fact sheets on data around Suicides in Utah. DSAMH working on a one page fact sheet of what to do if you or a friend are considering suicide (will be available on website)</p> <p>June 2015: Needs to be developed</p>

and protective factors.		
Goal 3: Improve the ability of health providers (including Behavioral Health) and first responders to better support individuals who are at risk of suicide.		
Objective 3.1: By June 2013, Identify and promote a universal screening and assessment tool to be used and promoted throughout Utah.		
<i>Evaluation of Goal: Tools and consultant for tools has been identified.</i>		
Activity	Committee	Progress
Activity 1: Assess screening tools to establish the most effective on to use universally with Utah's population.	Education and Training	<p>Dec. 10, 2012: Recommendation to use the C-SSRS screening and assessment tools along with the Stanley/Brown Safety planning tool were formally given.</p> <p>Nov. 13, 2012: Work has begun to review C-SSRS tools and Stanley/Brown Safety planning tool to better identify and support individuals with Suicidal Ideation.</p> <p>August 2013: The Columbia Suicide Severity Rating Scale has been chosen as Utah's universal screening tool.</p> <p>July 2014: The C-SSRS has been adopted/used by several organizations and individuals throughout Utah including many LMHA, Intermountain, University of Utah Health Care, AUCH, DCFS, DV providers, Utah Navajo Health Services, and more.</p>
Objective 3.2: Through August 2015, train a minimum of 1, 500 health care providers (including Behavioral Health), and first responders to utilize the Universal tools		
<i>Evaluation of Goal: Trainees will complete a training and presenter evaluation of all training sessions. Evaluation compilations will be used to improve the training.</i>		
Activity	Committee	Progress
Activity 1: Promote a universal screening tool to be utilized by all	Education and Training	<p>Feb. 11, 2013: Phone call with Melanie Puerto-Conte director of NY Suicide Prevention took place Jan. 31, 2013 to better identify barriers to presenting universal tools, and how best to promote and train on use of tools. Work is being done to lay a foundation for training through conferences, webinars and outreach to key players to support Utah wide integration of universal tools into treatment and screening processes.</p> <p>July 2014: The C-SSRS has been adopted/used by several organizations and individuals throughout Utah including many LMHA, Intermountain, University of Utah Health Care, AUCH, DCFS, DV providers, Utah Navajo Health</p>

behavioral health providers and first responders to better identify individuals with suicide risk.		Services, and more. DSAMH, UofU, and IHC had recent conversation on opportunities for joint trainings. June 2015: Medicaid PIP- ensures use of CSSRS across public behavioral health system. DSAMH currently working with Mountainstar and IASIS on incorporating CSSRS.
Activity 2: Provide training to a minimum of 1,500 professionals on the Stanly-Brown Safety Planning method.	Education and Training	July 2014: In person training has been recorded for approximately 1250 providers plus Weber Human Services and Wasatch Mental Health have trained most providers (over 1500?) Zero Suicide recently released an electronic training option which we have also been promoting- hard to track. June 2015: Medicaid PIP- ensures training of all local authority staff on use of Stanley Brown Safety Plan. Training at Generations by Dr. Craig Brian.
Objective 3.3: By January 2014, develop a sample protocol to share and promote with crisis centers, emergency departments, law enforcement, mobile crisis teams, and social services to improve collaboration and client centered follow-up.		
<i>Evaluation of Goal: Written protocols will be published and shared and available for review by SAMHSA.</i>		
Activity	Committee	Progress
Activity 1: Write, publish and disseminate guidelines for health care professionals on the identification, support and	Policy	July 2014: National guidelines should be released by the fall. DOH has a new staff/intern doing a literature review and will make recommendations. DSAMH is applying for a grant to help support this project. June 2015 Adoption and dissemination of recently released ED guidelines by SPRC. Working with UMA on training for physicians including PCP's.

referral of suicidal patients.		
Activity 2: Promote protocols among crisis centers, emergency departments, mobile crisis teams, and social services to provide follow up phone calls for individuals with suicide risk.	Policy	<p>July 2014: National guidelines should be released by the fall. DOH has a new staff/intern doing a literature review and will make recommendations. DSAMH is applying for a grant to help support this project.</p> <p>June 2015: Planning on pilot project in process.</p>
Activity 3: Promote protocols and improve collaboration among crisis centers, emergency departments, law enforcement, mobile crisis teams, and social services to ensure	Policy	<p>July 2014: UNI- actively engaged in process. Others? DSAMH asked LMHA to report on collaboration with ED in area plans. National guidelines should be released by the fall. DOH has a new staff/intern doing a literature review and will make recommendations. DSAMH is applying for a grant to help support this project.</p> <p>June 2015: Division Directives asking LA to have a plan for partnering with local hospitals on release of clients. CIT Fidelity/Partnership Training Upcoming mobile crisis team summit</p>

timely access to care for individuals with suicide risk.		
Activity 4: Promote continuity of care and the safety and well-being of all individuals treated for suicide risk in emergency departments, behavioral health settings and other settings.	Policy	<p>July 2014: National guidelines should be released by the fall. DOH has a new staff/intern doing a literature review and will make recommendations. DSAMH is applying for a grant to help support this project.</p> <p>June 2015: DSAMH and DOH working on a state survey for ED re continuity of care. Promoting use of recently released ED Guidelines.</p>
Objective 3.4: By November 2014, increase ASIST Master Trainers from 0 to 15.		
<i>Evaluation: A minimum of 15 professionals will be trained as ASIST master trainers.</i>		
Activity	Committee	Progress
Activity 1: Obtain funding for ASIST training	Education and Training	<p>July 2014- 4 additional non-military trainers trained in Utah for a total of 6. 3 in San Juan County and 3 Wasatch Front. No additional funding sources. (Army Reserves and Army National Guard have made some indication they may be able to partner to train additional civilians)</p> <p>June 2015: Three Prevention by Design subcontractors/coalitions using funding for ASIST. Partnering with AFSP Utah to offer</p> <p>Need to further explore ASIST funding.</p>
Activity 2: ASIST master trainers will train a	Education and Training	<p>July 2014: UNI team: by end of July will have done 3 training in 2014 approx 75 people.</p> <p>San Juan: by end of July will have done 4 trainings in 2014 approx 100 people.</p> <p>June 2015: 240 individuals trained in ASIST through Prevention by Design through 2014.</p>

minimum of 720 trainers per year in ASIST.		
Goal 4: Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all helping professionals, including graduate and continuing education.		
Objective 4.1: By January 2015, coalition members will submit abstracts for at least 10 training meetings, health conferences or other conferences, designed specifically for high-risk populations, on suicide prevention, intervention and postvention.		
<i>Evaluation of Goal: Agendas, minutes and evaluation feedback will be compiled.</i>		
Activity	Committee	Progress
Activity 1: Consider partnering with Hope Task Force to expand current Youth Suicide Prevention conference to focus on all ages and specific groups of people at risk of suicide, their families and survivor programs and information.	Education and Training	Report on progress: Feb. 11, 2013: With regards to activity 1, Hope Task Force has utilized this conference to train individuals within the education system primarily. Discuss if there is interest from the Hope Task Force in expanding reach of conference, or how to move forward with suicide prevention specific material in conferences at this point. Consider having a targeted activity towards education population. June 2015: No Update
Activity 2: Schedule	Education and	Feb. 11, 2013: Suicide Track focused on use of universal tools will be included in Generations Conference in April 2013. Troubled Youth Conference held in May 2013 will have one session dedicated to suicide prevention. QPR has

<p>suicide prevention track in two or more behavioral health provider conferences yearly. Areas of focus should be on prevention, intervention and postvention.</p>	<p>Training</p>	<p>been offered as a break out session at multiple conferences in 2012 and will be offered at Generations. Utah Substance Use Fall Conference will also have a Suicide Prevention Track in 2013. July 2014: 2013 Critical Issues, 2013 NAMI State Conference, 2013 Youth Suicide Prevention Conference, 2014 USOE Suicide Prevention Conference, 2014 Generations, 2014 Crisis Counseling Conference, 2014 ISCC, 2014 Troubled Youth Conference, 2014 EMS Conference, 2014 Youth Move Conference, 2014 Suicide Prevention for Spanish Speakers Conference, 2014 Fall Substance Abuse Conference, 2014 Critical Issues Conference, June 2015: Suicide Prevention included in many conferences including 2014 UDVC Conference, 2015 Generations, 2015 UVU Addiction Conference, 2015 Utah Society for Social Work Leadership in Healthcare, 2015 AUCH Conference, 2015 Troubled Youth Conference, 2015 USOE School Counselors Conference, 2015 School Nurses Institute, 2015 Aging and Adult Services Conference, 2015 Fall Conference, 2015 Critical Issues Conference, and 2015 Youth Suicide Prevention Conference.</p>
<p>Activity 3: Utilize conferences to train providers and first responders to recognizing signs and symptoms of suicidal ideation, use of universal C-SSRS screener & assessment, and the Stanley/Brown Safety Planning tools.</p>	<p>Education and Training</p>	<p>Feb. 11, 2013: Suicide Track focused on use of universal tools will be included in Generations Conference in April 2013. July 2014: The following conferences included CSSRS and Safety Plan: 2013 Critical Issues, 2013 NAMI State Conference, 2013 Youth Suicide Prevention Conference,, 2014 Crisis Counseling Conference, 2014 Troubled Youth Conference, 2014 Suicide Prevention for Spanish Speakers Conference, 2014 Fall Substance Abuse Conference, June 2015: CSSRS/Safetly Plan Training provided to IHC Employee Training (Oct 2014- 250+people), Utah DOC Trainings, UVU Addiction Conference, 2015 Generations, UDVC Conference</p>

<p>Activity 4: Work to increase opportunities for instructors of Question, Persuade & Refer (QPR), and other trainings specific to suicide prevention to be presented in professional conferences across the state targeting audiences where individuals may provide services inclusive of prevention, first responders, intervention, and postvention.</p>	<p>Educational and Training</p>	<p>Feb. 11, 2013: Improvement frequency of instructor trainings in QPR and MHFA are being worked on by DSAMH, and instructors are working in their communities to provide trainings in both QPR and MHFA multiple times a year.</p> <p>July 2014: Prevention by Design 2013 3370 community members trained at QPR Gatekeepers 387 community members trained in Mental Health First Aid</p> <p>June 2015</p>
<p>Activity 5: Promotion of training for suicide</p>	<p>Educational and Training</p>	<p>Feb. 11, 2013: Organized presentation for Medical Professionals working in Corrective Institutes across Utah. (Nov. 2012). QPR has been offered at a number of professional conferences this year. Power of Prevention Conference (Jan. 2013)</p> <p>July 2014: See above for conference summary</p>

prevention, intervention and postvention within health care conferences, and other conferences specific to high risk populations.		June 2015: See above for conference summary
Objective 4.2: By January 2014, work with at least two Utah Institutions of higher education to adopt core education and training guidelines on the prevention of suicide in health and behavioral health programs across the state.		
<i>Evaluation of Goal: Core education and training guidelines have been implemented in two Utah Colleges, Universities or trade schools.</i>		
Activity	Committee	Progress
Activity 1: Work with University of Utah College of Social Work to include Suicide Prevention, Intervention and Postvention curriculum into education process for Masters Level Students. Specific to	Education and Training/Policy	University of Utah College of Social Work is working to include Suicide Prevention, Intervention and Postvention information into their Curriculum for Fall 2013. July 2014: NO Update June 2015: HB 209 in 2015 requires 2 hours of suicide specific training for pre-licensure and as ongoing continuing education requirement. DSAMH currently working with USAAV Behavioral Health workgroup to implement rules related to policy change and training guidelines included in higher ed.

using Universal Tools with Suicide Prevention.		
Objective 4.3: By January of 2014, identify best practices for prevention and facilitate ongoing training and education to the medical, education, aging and substance abuse prevention communities.		
<i>Agendas, minutes and evaluation feedback will be retained.</i>		
Activity	Committee	Progress
Activity 1: Promote and assist ongoing State Office of Education Training	Education and Training	Feb. 11, 2013: Teachers needing recertification have been taking the 2 hr online Suicide Prevention Training created by USOE in June 2012. July 2014: USOE hosted a successful suicide prevention conference in Feb and embedded suicide prevention as a core topic in June Counselors conference. Currently working on RFP for schools. June 2015: USOE included suicide prevention in 2015 USOE Guidance Counselor Conference both as break out and as keynote.
Activity 2: Include suicide prevention training in Medicaid certification training for nursing home facilities	Education and Training	Feb. 11, 2013: Robert has been working to include Suicide Prevention Curriculum in trainings across Utah for 2013. June 2015: No Update
Activity 3: Promote and assist in suicide prevention training for medical community	Education and Training	Feb. 11, 2013: Work to present Universal Prevention Tools and develop training to implement and sustain improvement. June 2015: DSAMH currently with UMA to approve guidelines for CME Trainings.

Activity 4: BYU Nurses Training- Presents information to BYU Nurses about Suicide Prevention	Educatio n and Training	June 2015: Needs to be revised- no update.
Activity 5: Train 50 professionals in the CONNECT program, across the state to train first responders and social service agencies in their community.	Educatio n and Training	June 2015: Coalitions statewide providing Connect postvention training with at least 200 individuals trained in 2015 so far.
Goal 5: Increase access to health and behavioral health services, prevention programs and other community resources to better support individuals and families of individuals at risk of suicide.		
Objective 5.1: By August 2014, build an online network list of behavioral health providers and their specific skills sets, and a speakers/training bureau of professionals and their expertise.		
<i>Evaluation of Goal: Online network is live and web-hits being logged.</i>		
Activity	Committ ee	Progress
Activity: Assess the best place to	Communi ty Awarene	Nov. 9, 2012: Review of goal and discussion around barriers: Difficult due to changing information and challenges to keep current. Recommendation made to work with Barry, I-carol, 201, and DV Council July 2014- No update-??? REASSESS

house the website and begin design.	ss	June 2015: Coalition has chosen to abandon goal.
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Objective 5.2: Before January 2015, collaborate with at least five community networks such as local mental health authorities, Substance Abuse Coalitions, local health departments, and other prevention organizations to include suicide prevention support into their work.

Evaluation of Goal: Memorandums of Understanding or contracts will be established with each coalition willing to include suicide work into their missions.

Activity	Committee	Progress																																																												
Utah Prevention by Design		<p>July 2014: • DSAMH contract with NAMI Utah and local coalitions for suicide prevention activities.</p> <ul style="list-style-type: none"> • Key Outcomes 2013-2014 <ul style="list-style-type: none"> o Contracts with local coalitions in all 13 areas of the state o 52 people trained as QPR Gatekeeper Training Instructors o 3370 community members trained at QPR Gatekeepers o 387 community members trained in Mental Health First Aid o 30 community members trained as trainers for Connect Postvention o 5 + Town Hall Meetings on Suicide Prevention o Several school based suicide prevention initiatives began including Hope Squads, Positive Action Program, and Personal Empowerment Program o Community Awareness campaigns as local level with social media, bill boards, and local media advertising <p>June 2015:</p> <table border="1"> <thead> <tr> <th>QPR*</th> <th>QPR Instructors Trained</th> <th>MHFA Instructors Trained</th> <th>MHFA*</th> <th>YMHA*</th> <th>ASIS T*</th> <th>Hope Squads</th> <th>Guiding Good Choices</th> <th>Town Hall*</th> <th>Community Meetings**</th> <th>School/Other***</th> <th>Area Totals</th> </tr> </thead> <tbody> <tr> <td>Bear River</td> <td>397</td> <td>3</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>120</td> <td>2,176</td> <td>0</td> <td>2696</td> </tr> <tr> <td>Central Davis</td> <td>121</td> <td>2</td> <td>2</td> <td>66</td> <td>0</td> <td>0</td> <td>65</td> <td>0</td> <td>0</td> <td>0</td> <td>256</td> </tr> <tr> <td>Four Corners</td> <td>1,134</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>232</td> <td>0</td> <td>530</td> <td>0</td> <td>4,921</td> <td>6,817</td> </tr> <tr> <td></td> <td>30</td> <td>14</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>44</td> </tr> </tbody> </table>	QPR*	QPR Instructors Trained	MHFA Instructors Trained	MHFA*	YMHA*	ASIS T*	Hope Squads	Guiding Good Choices	Town Hall*	Community Meetings**	School/Other***	Area Totals	Bear River	397	3	0	0	0	0	0	120	2,176	0	2696	Central Davis	121	2	2	66	0	0	65	0	0	0	256	Four Corners	1,134	0	0	0	0	232	0	530	0	4,921	6,817		30	14	0	0	0	0	0	0	0	0	44
QPR*	QPR Instructors Trained	MHFA Instructors Trained	MHFA*	YMHA*	ASIS T*	Hope Squads	Guiding Good Choices	Town Hall*	Community Meetings**	School/Other***	Area Totals																																																			
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		* Attendee numbers 2014- RFP released for re-contracting. Award given to NAMI Utah. 20 additional subcontracts to coalitions awarded July 2015.
Activity 1: Weber County identified as doing well with coordinating integrated health, mental health, substance use, prevention	Education and Training	Feb. 11, 2013: House Bill 57 will require DSAMH oversight of integration between health and mental health. June 2015 : No update

and other community resources, and may be used as a model for other areas.		
Goal 6: Develop policy through State Agencies, legislature, and other avenues as possible to promote mental health and prevent mental illness and eliminate suicide.		
Objective 6.1: By January 2016, increase the number of specialty mental health and substance use treatment centers that have policies, procedures, and evaluation programs designed to assess suicide risk and intervene to reduce suicidal behaviors among their patients by ten.		
<i>Evaluation of Goal: A survey will be conducted to assess the number of agencies with policies in place. A post survey will be conducted after intervention to determine the increase in participation.</i>		
Activity	Committee	Progress
Activity 1: Review Local Mental Health Authorities Suicide Prevention policies and procedures.	Policy	Nov. 9, 2012: DSAMH monitoring teams have been reviewing Suicide Prevention procedures with Local Mental Health Authorities on Site Monitoring Visits beginning in Fall of 2012. June 2015: June 30 all Local Authorities submitted an evaluation of policies and procedures related to suicide prevention.
Objective 6.2: By August 2014, partner with Utah Department of Corrections, county jails and Juvenile Justice Services to implement guidelines, for at least five correctional facilities, jails and detention centers for mental health assessment and treatment of suicidal individuals who are incarcerated.		
<i>Evaluation of Goal: Guidelines on assessment and treatment of suicidal individuals will be established in a minimum of five correctional institutions.</i>		
Activity	Committee	Progress
Activities 1: DSAMH Adult	Policy	Report on progress: Nov. 9, 2012: Work to develop a small group to address these issues more fully. DSAMH adult MH team reports policies and procedures for each county jail vary. Some areas are doing really well, while others

Mental Health review policies and procedures for suicide prevention in jails across Utah.		seem to have a more difficult time. Work to develop a workgroup around these issues and to introduce Universal tools for screening, assessment and safety planning for correction facilities. June 2015: NO update
Objective 6.3: By August 2015, in conjunction with Utah's institutions of higher education, implement policies and guidelines for mental health assessment and referrals for students in at least five facilities.		
<i>Evaluation of Goal: Surveys will be conducted to determine any increase in policies and analyzed.</i>		
Activity	Committee	Progress
Conduct an assessment to determine if and what they are using currently to assess students.	Policy	Workforce survey will be distributed to Utah's higher education professional's through the Board of Regent's. June 2015: HB 209 in 2015 requires 2 hours of suicide specific training for pre-licensure ad as ongoing continuing ed requirement. DSAMH currently working with USAAV Behavioral Health workgroup to implement rules related to policy change and training guidelines included in higher ed.
Objective 6.4: By September 2013, encourage the Utah legislature to adopt legislation to require health insurance plans to cover mental health and substance abuse care on par with coverage for physical health and well-being.		
<i>Evaluation of Goal: Legislation passed and policies enacted.</i>		
Activity	Committee	Progress
Formulate a position statement on mental health care and insurance coverage.	Policy	Report on progress: Nov. 9, 2012: NAMI (Kim) will draft a letter of support for the coalition to sign off on. June 2015: No update

Objective 6.5: By January 2014, improve access to services for individuals on Medicaid who are in need of mental health services.		
<i>Evaluation of Goal: A compilation of findings and recommendations will be published.</i>		
Activity	Committee	Progress
Review Medicaid expansion for ways to improve access to services for individuals who are in need of mental health services.	Policy	Report on progress: Feb. 11, 2013: Research around Medicaid expansion can be done in Utah. Expansion will not take place in 2013 for Utah. Discuss Target completion date. June 2015: Utah Suicide Prevention Coalition received training on issues related to Medicaid Expansion and options being discussed in Dec 2014. Several members took part in legislative education and advocacy related to Medicaid expansion. No Medicaid Expansion decisions have been made at the state level.
Objective 6.6: By January 2014 Assess laws that inhibit policies on suicide prevention and screening on mental health in Utah.		
<i>Evaluation of Goal: Policy assessment is completed and available for review.</i>		
Activity	Committee	Progress
Activity 1: Conduct a policy assessment including HIPAA, FERPA, etc to assess codes that inhibit screening and obtaining mental health in Utah.	Policy	March 2012- pass HB 23 June 2015: March 2012- pass HB 23 Working with USOE to educate educators on policy change.

Objective 6.7: By August 2014, promote rules, policies, laws that are supportive of suicide prevention.		
<i>Evaluation of Goal: Policies are established that support screening and prevention of suicide.</i>		
Activity	Committee	Progress
Activity 1: Develop sample policies and revisions that will promote and support increased screening and prevention.	Policy	
Goal 7: Promote efforts to decrease the risk of suicides by reducing access to lethal means.		
Objective 7.1: By July 2013, promote “Take Back Prescription Drug” events by developing and distributing electronic media messages to a 500 partners about events.		
Evaluation: Media messages will be tracked		
Activity	Committee	Progress
Develop a list of “Take Back Events” and distribute widely to partners and through social media	Community Awareness	July 2014: 2 take back events annually. Most recent (april?) promoted through coalition. Could do more to partner with use only as directed. June 2015: Continue to compile and distribute information on take back events.
Objective 7.2: By December 2013, promote awareness that prescription drugs can be dropped off at any local police department for disposal through 5 social media and electronic messaging campaigns.		
Evaluation: Drop off locations have been compiled and “pushed” to partners and communities.		
Activity	Committee	Progress

	ee	
Develop a list of drop off locations for each community and promote the locations through social media.	Community Awareness	<p>July 2014: List is compiled through Use Only As Directed- need to promote through coalition and social media.</p> <p>June 2015: Continue to partner and promote Use Only as Directed including new partnership with IHC.</p>
Objective 7.3: By January 2014, educate the public about implementing proper safety measures of owning and storing guns through 5 media, social media and electronic messaging.		
<i>Evaluation of Goal: Electronic and media messages have been developed and distributed.</i>		
Activity	Committee	Progress
Partner with existing efforts (Bulletproof kids) or develop educational materials and campaigns to educate the public on risks and the safe storage of firearms.	Community Awareness	<p>July 2014: Have had Bulletproof kids present both at the exec committee and general coalition.</p> <p>HB 134 (2014) creates firearm safety program. DSAMH, DOH, BCI currently working on implementation.</p> <p>June 2015: 2014 legislation creates a voluntary firearm safety program for suicide prevention http://le.utah.gov/~2014/bills/static/HB0134.html.</p> <p>Partnered with DOH, DPS, DHS, and USSC to create firearm safety brochure. Over 30,000 have currently been disseminated. Partnered with DPS on purchase and distribution of cable style gun locks. Over 20,000 locks have currently been distributed from above partners .</p> <p>Partnering with above stakeholders and Harvard school of public health to develop and pilot suicide prevention training module for concealed carry permit classes.</p>
Objective 7.4: By September 2013, promote Safety Planning tools for the general public (including safe environment, and supervision of individuals at risk of Suicide) through an education campaign using social networking, media releases, and electronic messaging.		
<i>Evaluation of Goal:</i>		

Activity	Committee	Progress
Assess existing tools or develop tools suitable for distribution to the population on safety planning and distribute through electronic messaging and social media.	Community Awareness	<p>July 2014- USPC promotes safety planning and lifeline information through facebook /social media page on regular basis as does VIPP and DHS. Safety plan tool is listed on USPC website.</p> <p>July 2015- USPC promotes safety planning and lifeline information through facebook /social media page on regular basis as does VIPP and DHS. Safety plan tool is listed on USPC website.</p>

Goal 8: Improve surveillance, data, research and evaluation relevant to suicide prevention.

Objective 8.1: By December 2013, create a plan to improve the timeliness, usefulness, and quality of suicide-related data in the Utah Violent Death Reporting System.

Evaluation of Goal: An evaluation plan has been developed and available for review.

Activity	Committee	Progress
Activity 1: Collect vital records and medical examiner death data within three months of a suicide.	Epidemiology	Ongoing July 2015- Ongoing. Back up/underfunding of ME office has led to delays.
Activity 2: Collect police report data	Epidemiology	Ongoing July 2015- done by NVDRS and ME Office

within six-nine months of a suicide.		
Activity 3: Explore opportunities to import medical examiner data into UTVDRS as the web-based conversion is completed providing timely, possibly monthly, suicide counts on the website.	Epidemiology	July 2015 Carryover funding has been applied for to expand the UMED system to directly import into UTVDRS.
Objective 8.2: By January 2014, Increase from one to two, the number of nationally representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.		
<i>Evaluation of Goal: Survey data have been developed collected and analyzed and is available for review.</i>		
Activity	Committee	Progress
Activity 1: Work to add PHQ9, ACES, K6 and other questions on the BRFSS.	Epidemiology	July 2015- PHQ9, and ACES questions have been paid for and are being used in the 2013 BRFSS survey. Reports on data collected have been issued
Activity 2: Review	Epidemiology	July 2015- NO update

<p>questions/information included on the YRBS, PNA, and PROFILES surveys administered in schools, looking at community-based surveys or doing focus groups to collect specific data in communities.</p>		
<p>Objective 8.3: By October 2013, explore increasing data linkage across organizations and systems, to include hospitals, psychiatric and other medical institutions, police departments, and/or local behavioral health authorities to better capture information on suicide attempts and completions.</p>		
<p><i>Evaluation of Goal: Memorandums of Understanding have been implemented to share data.</i></p>		
<p>Activity</p>	<p>Committee</p>	<p>Progress</p>
<p>Activity 1: Using the emergency department, hospital, intimate partner violence, and child fatality data modules in UTVDRS,</p>	<p>Epidemiology</p>	<p>July 2015</p>

including state-added variables in UTVDRS to collect data from SAMHIS and perhaps data from other mental health organizations.		
Activity 2: Explore ways to link VA data or include the data in the state-added variables module.	Epidemiology	July 2015- No update
Activity 3: Support information sharing between Hill Air Force Base with State Agencies.	Epidemiology	July 2015- No update
Activity 4: Support information sharing between Army National Guard with	Epidemiology	July 2015- No update

State Agencies.		
Objective 8.4: By June 2013, develop and implement a suicide fatality review committee to look at the circumstances and dynamics of suicides to improve systematic approach and make recommendations.		
<i>Evaluation of Goal: The Utah Suicide Fatality Review has been established and is systematically reviewing all Utah suicides.</i>		
Activity	Committee	Progress
Activity 1: Link and complete analysis of retrospective data to inform purpose and goals of review, identify partners, develop and implement fatality review protocol and procedures, encourage and support internal fatality review for public behavioral health system, share information on trends, aggregate data and make	Suicide Fatality Review Team	July 2015 - UDOH and DSAMH partnered to pilot local suicide fatality review process with Davis Behavioral Health. Draft of policies and procedures put together to review with team. Draft of audit tool put together to review with team. Team has met 3 times to pilot review process with good success. Need more consistency and need to finalize policies/procedures and audit tool.

recommendations.		
Activity 2: Identify Partners	Suicide Fatality Review Team	July 2015- UDOH and DSAMH partnered to pilot local suicide fatality review process with Davis Behavioral Health. Draft of policies and procedures put together to review with team. Draft of audit tool put together to review with team. Team has met 3 times to pilot review process with good success. Need more consistency and need to finalize policies/procedures and audit tool.
Activity 3: Develop and implement fatality review protocol and procedures.	Suicide Fatality Review Team	July 2015- UDOH and DSAMH partnered to pilot local suicide fatality review process with Davis Behavioral Health. Draft of policies and procedures put together to review with team. Draft of audit tool put together to review with team. Team has met 3 times to pilot review process with good success. Need more consistency and need to finalize policies/procedures and audit tool.
Activity 4: Encourage and support internal fatality review for public behavioral health system	Suicide Fatality Review Team	July 2015- UDOH and DSAMH partnered to pilot local suicide fatality review process with Davis Behavioral Health. Draft of policies and procedures put together to review with team. Draft of audit tool put together to review with team. Team has met 3 times to pilot review process with good success. Need more consistency and need to finalize policies/procedures and audit tool.
Activity 5: Share results	Community Awareness	July 2015- UDOH and DSAMH partnered to pilot local suicide fatality review process with Davis Behavioral Health. Draft of policies and procedures put together to review with team. Draft of audit tool put together to review with team. Team has met 3 times to pilot review process with good success. Need more consistency and need to finalize policies/procedures and audit tool.
Activity 6: Explore options to create more suicide fatality reviews within specific demographic communities i.e. Child, VA,	Suicide Fatality Review Team	July 2015- UDOH and DSAMH partnered to pilot local suicide fatality review process with Davis Behavioral Health. Draft of policies and procedures put together to review with team. Draft of audit tool put together to review with team. Team has met 3 times to pilot review process with good success. Need more consistency and need to finalize policies/procedures and audit tool.

DV, Hill Air Force Base, and Army National Guard.		
Goal 9: Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.		
Objective 9.1: By July 2014, promote appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.		
Evaluation of Goal:		
Activity	Committee	Progress
		July 2015: No update
Objective 9.2: By January 2015, adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training and consultation.		
<i>Evaluation of Goal: Universal guidelines have been adopted and distributed to Utah Communities.</i>		
Activity	Committee	Progress
1. Connect Postvention Train the Trainer	Education and Training / Policy	<p>July 2014: By July 2014 Utah will have 32 Connect Postvention Trainers available in most regions of the state. The training includes information on objective 9.2</p> <p>July 2015- Trained 30 Individuals as Connect Postvention Trainers. At least 15 trainings have been conducted statewide since training over 250 individuals. Next step is to bring active trainers back together to assess community needs and next steps.</p>
Objective 9.3: By December 2014, encourage health and behavioral health systems, police departments, fire departments and other entities that employ health care and behavioral health care providers, first responders, and others who intervene, with individuals at risk of suicide, to implement policies that offer care and support when an individual under their care dies by suicide.		
<i>Evaluation of Goal: Sample Policies have been developed and distributed to helping professionals across the state.</i>		
Activity	Committee	Progress

	ee	
Assess existing policies to standardize and tailor to Utah and distribute to Utah's helping professionals.	Policy	Report on progress: July 2015 - DSAMH, AFSP Utah, U of U Trauma Center and SL Fire partnered to put on a kick off dinner for first responder suicide prevention initiative in June 2015. The kick off dinner was attended by 65 individuals including leaders/Chiefs from across the Wasatch Front, reps from State Associations, and key partners to learn about what strategies are in place and what the needs are. A workgroup has been formed to follow up on next steps.

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Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

21. Support of State Partners

- Please consider the following items as a guide when preparing the description of the state's system:
 1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.

General: The Division is involved in numerous partnerships, committees, workgroups, coalitions and day to day collaboration with program managers and administrators of both internal and external organizations. Listed below are just a few of the ongoing partnerships that the division is currently involved in.

- a. Utah Substance Abuse Advisory Council (USAAV) is a committee established by statute to advise the Governor on Substance Use Disorder issues. The Division sits on the council and provides member ship to all four of the Council's Committees.
- b. Office of Licensing: The Division has worked closely with the Office of Licensing to update rules and requirements for Opioid Treatment programs as well as a workgroup that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery.
- c. Criminal Justice: The Division has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Division in the Department of Corrections which provides SUD services inside the prison system, with Adult Probation and Parole, and with the judges and other Drug Court Team Members. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) has already been discussed in section 12.
- d. Department of Education (DOE)
- e. University of Utah. The Division conducts quarterly meetings with three key departments of the University of Utah to continue the partnership established over many years.
- f. Recovery Support: The Division contracts with and meets with the following Recovery support organizations on numerous issues on a monthly basis.
 - National Alliance for Mental Illness (NAMI)
 - Utah Support Advocates for Recovery Awareness (USARA)
- g. Utah Department of Veterans Affairs and the Utah National Guard: The Assistant Division Director sits on a statutory mandated Veteran's Affairs Committee, and monthly meetings are held with the VA and UDOVA to coordinate on issues such as Suicide Prevention, Mental Health Conferences, and improving service to Veterans and National Guard members.
- h. Department of Health (DOH). A few of the committees and workgroups that the Division either attends with the DOH, cochairs with the DOH or has DOH membership on its committees are:
 - 1) Recovery Plus (Tobacco Cessation)
 - 2) Recovery Plus II (Disease Prevention and Control and collaboration with Local Authorities)
 - 3) Prescription Drug Abuse Task Force
 - 4) Narcan Distribution work group.
 - 5) Care Management Workgroup.
 - 6) Prevention Coalitions statewide
 - 7)
- i. DSAMH and other DHS divisions meet regularly with Department leadership, these include the Division for Child and Family Services, Division for the Aging, Division of People with Disabilities, Division of Juvenile Justice
- j. Department of Workforce Services
- k. Insurance Commissioner
- l. Opioid Treatment Programs
- m. Private Health Care and Managed Care.

- n. Department of Professional Licensing (DOPL)
- o. Utah Behavioral Health Care Council (UBHC)

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).¹⁰¹

If the state does not have an integrated BHPC, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*¹⁰²

¹⁰¹<http://beta.samhsa.gov/grants/block-grants/resources>

¹⁰²There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. State Behavioral health Planning/Advisory Council and Input on the MH/SUD Block Grant Application

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

- 1) The Division of Substance Abuse and Mental Health (DSAMH) presented on and provided the State Plan to the Utah Behavioral Health Planning and Advisory Council (UBHPAC) The Chair of the Council printed a version of the plan and distributed them to members for continued discussion and feedback. Sub committees have been formed, including a Block Grant Committee to look over the State Plan and provide feedback. The September minutes document the discussion of the State Plan.

Link to DSAMH Website where Minutes are attached: <http://dsamh.utah.gov/provider-information/ubhpac/>

- 2) The Division provides guidance to all of the Local Substance Abuse Authorities (and Local Mental Health Authorities in late March, shortly after the end of the legislative session. (See : http://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison%20Directives_FY2016%20Final..pdf)

The Local Authorities use that guidance to develop their Area Plans, in conjunction with their local partners. Each Local Authority also has consumers involved in the development of their plans and priorities.

As stated earlier, the Counties, represented by the Local Authorities, are responsible for planning for and providing MH and SUD services to the residents of their counties.

The Division has developed a draft submission and will post it not later than July 21st for review by the Combined Coordinating Council.

- 3) The UBHPAC began the process of integration four years ago, by laws, stipend policy, and subcommittees have been created. The Council has representation from Substance Abuse Providers, including Utah Support Advocates for Recovery Awareness (USARA), Odyssey House, and House of Hope (provides substance use disorders treatment, education, and prevention services throughout Utah. In addition we have two peers on the Council who are in Recovery. Minutes will reflect co-occurring disorder issues, concerns, and activities being addressed and announced during the UBHPAC. See June, July, August, September minutes in above link.
- 4) The UBHPAC has good representation from Utah's largest County and the Council is always striving to increase representation from diverse populations. The UBHPAC with the support of the DSAMH has been working together to increase participation from Utah's rural areas. In an effort to improve rural and Peer representation the Council revised the Stipend Policy. The reimbursement rate for attendance was increased and additional funds will be provided for individuals traveling longer distances. The UBHPAC recently relocated to a space that has video technologies so rural areas can attend via video conferencing. Over the last year the UBHPAC has increased its Peer representation to over 51%. The UBHPAC will continue its efforts in broadening representation of diverse populations through outreach activities.
- 5) The Public Health Service Act (42 U.S.C.300x) mandates each state establish a State Mental Health Planning Council. The council is required to review and provide feedback on the states Mental Health Block Grant (MHBG) application and submit any recommendations. The Council will Monitor, Review, and evaluate the allocation and adequacy of mental health services in their state; and serve as an advocate for adults with serious mental illness, children with serious emotional disturbances and other individuals with mental illness or emotional disturbances. The UBHPAC is comprised of mental health and substance use disorder providers, peers in recovery, and family members of individuals in recovery, and state agencies. From each member's perspective, Issues and concerns are brought up in this meeting and the council works together to better serve individuals with SMI and SED. For example, The Council wrote a letter supporting the Governor's Healthy Utah version of Medicaid Expansion and sent it to representatives of the House and Senate. The Council has been active during the legislative period showing their support of Healthy Utah and other important legislative concerns affecting the care of individuals with SMI and SED. This last year the Council has made unfunded individuals a priority in an effort to address the lack of treatment options for this population. The council advocated for additional state funds for the continuation of the Crisis Intervention Team Program for law enforcement and the funds were granted on going. The Council along with the DSAMH planning council coordinator is participating in TA from SAMSHA for the Leadership Academy.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year:
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Jenifer Lloyd	Others (Not State employees or providers)	Association for Utah Community Health		jenifer@auch.org
Mary Jo McMillen	Others (Not State employees or providers)	USARA		maryjo@usara.us
Brandee Casias	Others (Not State employees or providers)	Salt Lake City Police Department		
Peggy Hostetter	Others (Not State employees or providers)	Advocate		
Ron Bruno	Others (Not State employees or providers)	Law Enforcement		
Carol Anderson	State Employees	Utah State Office of Education	250 East 500 South Salt Lake City, UT 84114 PH: 801-538-7727	carol.landerson@schools.utah.gov
Carol Ruddell	State Employees	Work Ability Utah		cruddell@utah.gov
Nicole Fraedrich	State Employees	Utah State Office of Rehabilitation		
Karen Ford	State Employees	Medicaid		
Christina Zidow	Providers	Odyssey House of Utah		czidow@odysseyhouse.org
Sam Vincent	Providers	4th Street Clinic		
Valerie Fritz	Providers			vfritz@houseofhopeut.org
Ginger Phillips	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		PH: 801-503-8920	gingerspice72@msn.com
Michelle Vance	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Allies with Families		mnicole1540@gmail.com
Walt moore	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Jacqueline Gomez- Anas	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Latino Behavioral Health		
William Bryant	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Lana Lomax	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

Ken Rosenbaum	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	USARA		
Liz Felt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Mathew Campbell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Lori Cerar	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Allies with Families	505 East 200 South , STE 25 Salt Lake City, UT 84102 PH: 801-433-2595 FAX: 801-521-0872	lori@allieswithfamilies.org
Lynda Krause	Family Members of Individuals in Recovery (to include family members of adults with SMI)		PH: 801-918-5909	kraushaus95@hotmail.com
Kimbal Gardner	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI-Utah		

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	24	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	9	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	5	
Total Individuals in Recovery, Family Members & Others	17	70.83%
State Employees	4	
Providers	3	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	7	29.17%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="1"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="2"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	3	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="3"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes: