

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

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

Palmer

Last Name

DePaulis

Agency Name

Utah State Department of Human Services

Mailing Address

195 North 1950 West

City

Salt Lake City

Zip Code

84116

Telephone

801-538-4001

Fax

801-538-4016

Email Address

palmer@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
Palmer
Last Name
DePaulis
Agency Name
Utah State Department of Human Services
Mailing Address
195 North 1950 West
City
Salt Lake City
Zip Code
84116
Telephone
801-538-4001
Fax
801-538-4016
Email Address
palmer@utah.gov

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

From
To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date
9/3/2013 4:53:30 PM
Revision Date
3/5/2014 10:41:24 AM

V. Contact Person Responsible for Application Submission

First Name
Janida
Last Name
Emerson
Telephone
801-538-4406
Fax
801-538-9892
Email Address
jemerson@utah.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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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.
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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.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

PALMER DEPAULIS

Title

EXECUTIVE DIRECTOR

Organization

HUMAN SERVICES

Signature:

Palmer DePaulis

Date:

8/13/13

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications 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).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. 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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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.

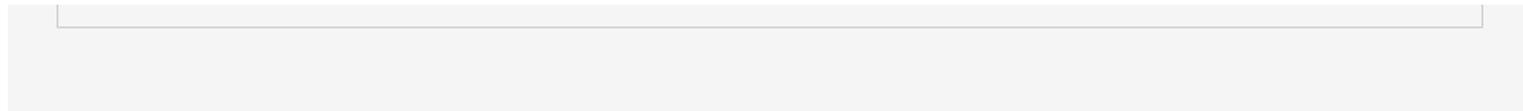
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

Name	Palmer DePaulis
Title	Executive Director
Organization	Utah Department of Human Services

Signature: _____ Date: _____

Footnotes:



I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (d), (e), and (f).

For purposes of paragraph 7 regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications 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).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. 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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

Name	PALMER DEPAULIS
Title	EXECUTIVE DIRECTOR
Organization	HUMAN SERVICES

Signature: _____

Palmer DePaulis

Date: _____

8/13/13

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - [SA]

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
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 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

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

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.

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee¹: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
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Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
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Section 1943	Additional Requirements	42 USC § 300x-53

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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

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.

Name of Chief Executive Officer (CEO) or Designee: PALMER DEPAULIS
 Title: EXECUTIVE DIRECTOR

Signature of CEO or Designee: *Palmer DePaulis* Date: 8/13/13

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

Footnotes:

I. State Information

Chief Executive Officer's Funding Agreements, Assurances Non-Construction Programs and Certifications (Form 3)
Fiscal Year 2014

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
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

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Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
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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

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 which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

State: Utah

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

Signature of CEO or Designee: *Ann Williamson*

Title: Executive Director, DHS

Date Signed: 12/30/13
mm/dd/yyyy

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

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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. 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: State Information

Chief Executive Officer's Funding Agreements (Form 3) - [MH]

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 I 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 I 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
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Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I 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.

Name of Chief Executive Officer (CEO) or Designee

Palmer DePaulis

Title

Executive Director

Signature of CEO or Designee¹: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
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Name of Chief Executive Officer (CEO) or Designee

Palmer DePaulis

Title

Executive Director

Signature of CEO or Designee¹:

Palmer DePaulis

Date:

8/29/13

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

Footnotes:

I: 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"/>
Title	<input type="text"/>
Organization	<input type="text"/>

Signature: _____ Date: _____

Footnotes:

The Division of Substance Abuse and Mental Health does not engage in lobbying activities.

II: Planning Steps

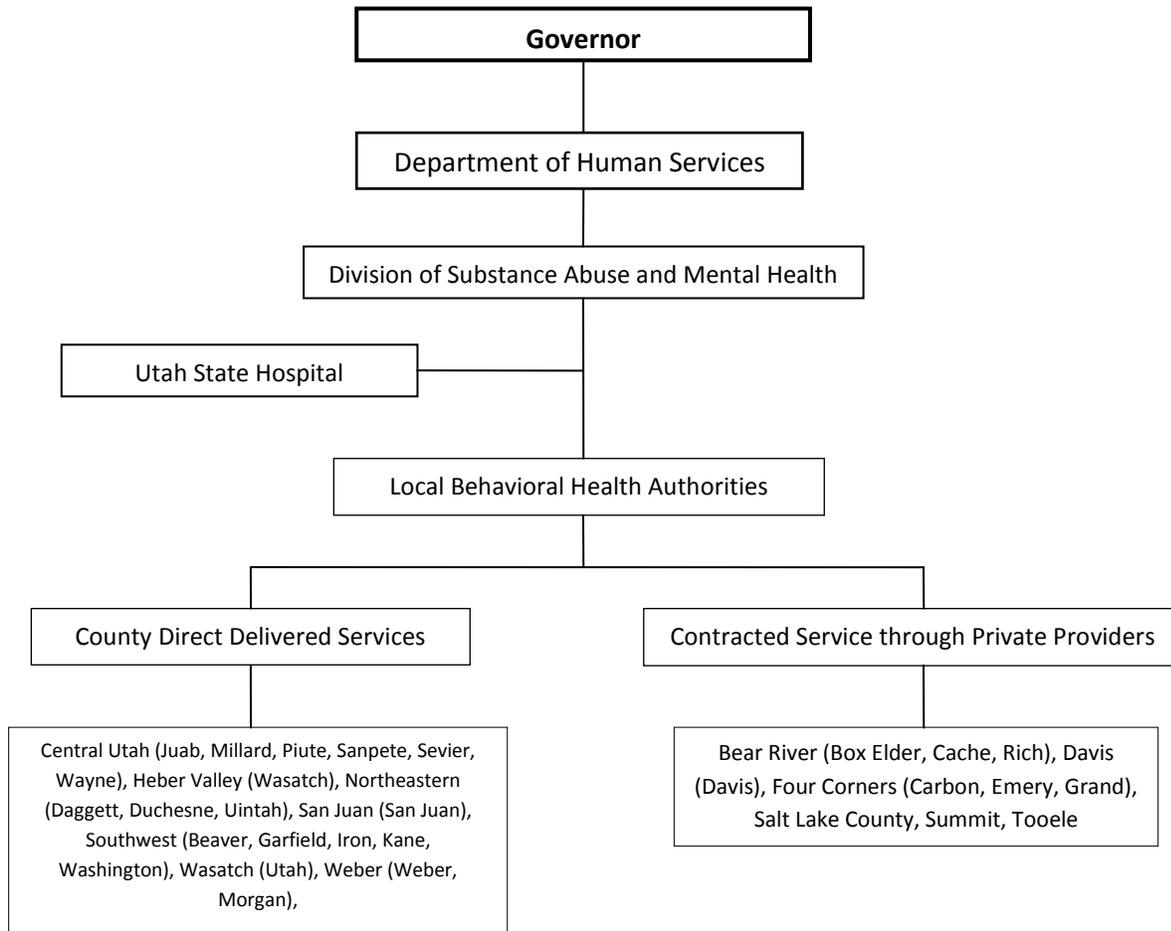
Step 1: Assess the strengths and needs of the service system to address the specific populations.

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.

Footnotes:

Figure 1: Organizational Chart of Utah’s Behavioral Health System



The Department of Human Services 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’s State government and consists of the following service offices and divisions:

- Division of Substance Abuse and Mental Health (DSAMH)
- 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 resolve interdepartmental conflicts. Additionally there are numerous working groups and committees that meet to coordinate specific programs and initiatives that cross division and office boundaries.

The 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 DSAMH "... 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..." and that the DSAMH "...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..."¹

The DSAMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities (Local Authorities) for the delivery of Behavioral Health services. The DSAMH distributes federal and state funds through contracts, and monitors 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 DSAMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

The Director of the DSAMH serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Director of the DSAMH is supported by an Assistant Director of Mental Health and an Assistant Director of Substance Abuse. Utah's DSAMH, and the Utah public behavioral health system operates under the official mission statement of "**Hope and Recovery**" and we are guided by the following key principles:

Quality services, programs, and systems promote individual and community wellness.

Education enhances understanding of prevention and treatment of substance abuse services.

Leadership understands and meets the needs of consumers and families.

Partnerships with consumers, families, providers and local/state authorities are strong.

Accountability in services and systems that is performance focused and fiscally responsible.

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. It also requires Local Mental Health Authorities (LMHA) to provide ten mandatory services. Utah's LSAA and LMHA, under the direction of the County Governments, are given the responsibility to provide substance use disorder and mental health services to their citizens. Funding to provide required

¹ Utah Code Title 62, Chapter 15, §105 and §103.

federal and state services is a combination of CMHS and SAPT block grant funds, State General Funds, County matching funds (20 percent), and other State and Federal funds. 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 matching funds are used to meet Medicaid match requirements.

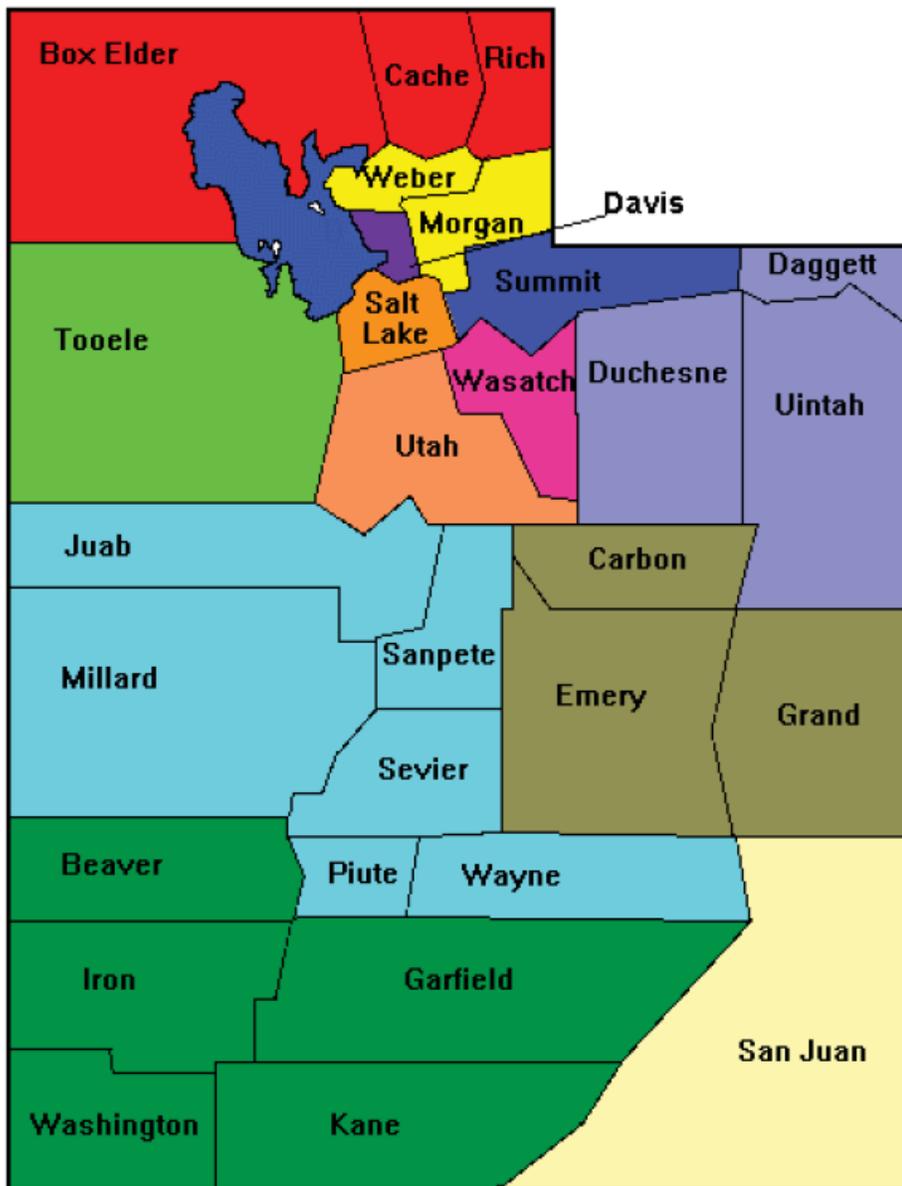
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Figure 2: Thirteen Local Authorities in Utah



The Utah State Hospital provides statewide inpatient mental health services. It is a 24-hour psychiatric facility located in Provo, Utah and is a part of the DSAMH. 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 actively be 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 and certified for Medicare/Medicaid reimbursement by the Center for Medicare & Medicaid Services.

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Please find the response to the section in the attached document.

**UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH
SUBSTANCE USE DISORDER SERVICES MONITORING CHECKLIST
(FY 2014)**

Program Name	
Reviewer Name	
Date(s) of Review	

GENERAL PROGRAM REQUIREMENTS

Part I: Substance Abuse Program Schedule Review

- Adult ASAM Levels reflect appropriate hours of treatment services:(ASAM PPC2R)

- (a) ASAM I.0 Up to 8 Hours per week
- (b) ASAM II.1 Over 9 Hours per week
- (c) ASAM II.5 Over 20 Hours per week
- (d) ASAM III.1 5 hours programming per week
- (e) ASAM III.3 24 Hour Staffing
- (f) ASAM III.5 24 Hour Staffing

- Adolescent ASAM Levels reflect appropriate hours of treatment services:

- (a) ASAM I.0 Up to 6 Hours per week
- (b) ASAM II.1 Over 6 Hours per week
- (c) ASAM II.5 Over 20 Hours per week
- (d) ASAM III.1 Over 5 hours programming per week
- (e) ASM III.5 24 hour staffing

- Provide for a comprehensive continuum of substance abuse services (UCA62A-15-103).

- (a) Detoxification (24 Hour Care) - How is it provided?
- (b) Jail or other Correctional Facility (UCA 17-43-201)
How & where is it provided?
- (c) Recovery Support Services:
Which Services are provided and where are they provided.

- (d) Early Intervention Services
Describe coordination with Prevention programs to provide early interventions to Indicated populations.
- (e) Integration/Collaboration with Primary Health Care Services and Service Providers.

Comments:

- Include provisions for services, either directly or by contract, for adults, youth and children (including those incarcerated in a county jail or other county correctional facility) as required by UCA 17-43-201.
 - (a) Adults Direct_____ Contract/refer_____
 - (b) Youth Direct_____ Contract/refer_____
- Include provisions for persons convicted of driving under the influence in violation of Section 41-6a-502 or 41-6a-517, as required by UCA 17-43-201.

Comments:

Part II: Justice Services Programs

Drug Court

- Drug Court participants accurately reported in TEDs data submission by judge and court?
- Case management services are provided and documented?
Who provides them?

Where are the services documented, Treatment or Drug court records?
- Fees are assessed on a sliding fee scale (would like to review a copy of the sliding fee scale):
 - a. Treatment Fees:
 - b. Court Fees:
 - c. Drug Testing Fees:
 - d. Program Fees:
- Drug Testing is conducted:

- a. A minimum of 2 times per week initially – per participant
- b. Decreases with abstinence
- c. A minimum of twice per month if not active – per participant
- d. Is administer in a trauma informed sensitive manner
- e. Participants sign a chain of custody
- f. Drug Testing is Random

Training Requirement:

- Each key program member attended 8 hours of continuing education with a focus on substance abuse in the past year:
 - a. How are Drug Court Team Members receiving the training?
 - b. Where are Drug Court Team Members receiving the training?
- Incentives and Sanctions offer immediate consequences for identified behavior, provide for a broad array of consequences, are appropriate for the behavior and participant circumstances. (Provide a copy of the List of Drug Court Incentives and Sanctions)

Comments:

DORA

- Participants assessed and beginning in services within 45 days
- Where DORA supervision model is also funded are the DORA team meetings at least quarterly?
- Are DORA participants accurately reported in TEDs data submission?

Comments:

Part III: Wellness:

- a. Local Authorities will use a Holistic Approach to Wellness and will:
 - Identify tobacco use in the assessment.
 - Provide services in a tobacco free environment

- Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.
- Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment.
- Provide training for staff in recognizing health issues.
- Provide information to clients on physical health concerns and ways to improve their physical health.
- Incorporate wellness into individual person centered Recovery Plans as needed.

Comments:

Part IV. DATA Reporting Timeliness and Accuracy?

- Is data being submitted monthly? _____Yes _____No
- Are Drug Court participants identified correctly?
 - Number of clients by court and judge by agency report

 - Number of clients by court and judge reported in TEDS

- Are DORA Clients being identified correctly?
 - Number of DORA Clients by agency report.

 - Number of DORA Clients reported in TEDS.

- Are cases being closed appropriately?
 - Old open admissions account for less than 4% of clients served for a given fiscal year for non-methadone Outpatient and/or IOP and any residential and/or detox
_____Yes
_____No
- Outcome measures: FY14 Quarterly reports compared to FY 13 Outcomes (Progress check and discussion item only)

Substance Abuse Treatment Performance Measures FY 2013: Achievement of these measures will be reviewed in the FY 2014 Audit visit.

Retention in Treatment:

- Local Substance Abuse Authorities will meet or exceed their FY2012 treatment retention in FY 2013 and will work towards achieving a goal of 70%. Local Substance Abuse Authorities whose FY 2012 retention rate was over 70% are required to meet or exceed a 70% retention rate in FY2013. Retention is defined as the percentage of clients who remain in treatment over 60 days.

- Retention in Treatment FY 13 rate_____ Current FY 14 rate_____

Successful Treatment Episode Completion:

- Local Substance Abuse Authorities will meet or exceed their FY2012 Successful Treatment Episode Completion rates in FY 2013 and will work towards achieving a goal of 60%. Local Substance Abuse Authorities whose FY 2012 completion rate was over 60% are required to meet or exceed a 60% completion rate in FY2013. Successful Treatment Episode Completion is defined as a successful completion of an episode of treatment without a readmission within 30 days. An episode of treatment is as defined in the Treatment Episode Data Set

- Treatment Completion FY 13 rate_____ Current FY 14 rate_____

Abstinence from Alcohol:

- Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of clients who are Abstinent from Alcohol from admission to discharge at a rate that is greater than or equal to 75% of the National Average. Abstinence from Alcohol is defined as no alcohol use for 30 days.

- Abstinence from Alcohol FY 13 rate_____ Current FY 14 rate_____

Abstinence from Drugs:

- The Local Substance Abuse Authorities' Outcome Scorecard will show that they increased the percentage of clients who are Abstinent from Drugs from admission to discharge at a rate that is greater than or equal to 75% of the National Average. Abstinence from drugs is defined as no drug use for 30 days.

- Abstinence from Drugs FY 13 rate_____ Current FY 14 rate_____

Decrease in Criminal Activity:

- Local Substance Abuse Authorities' Outcome Scorecard will show that they decreased the percentage of their clients who were involved in Criminal Activity from admission to discharge at a rate greater to or equal to 75% of the national average. Criminal Activity is defined as being arrested within the past 30 days.

- Decrease in Criminal acts FY 13 rate____ Current FY 14 rate____

Recovery Support:

- Local Substance Abuse Authorities' Scorecard will show that the percent of clients participating in social support of recovery activities increased from admission to discharge. Participation is measured as those participating in social support recovery activities during the 30 days prior to discharge minus percent of clients participating in social support of recovery activities in 30 days prior to admission.
 - Recovery Support FY 13 rate____ Current FY 14 rate____

- Tobacco Cessation: Local Substance Abuse Authorities' scorecard will show that the percent of clients who use tobacco will decrease from admission to discharge.
 - Decrease in Tobacco Use FY 13 rate____ Current FY 14 rate____

SAPT Block Grant Requirements

Part V: § 96.127 Requirements Regarding Tuberculosis

- The program directly, or through arrangements with other public or nonprofit private entities, routinely makes available the following TB services to each individual receiving treatment for substance abuse:
 - a. Counseling the individual with respect to TB
 - b. Testing to determine whether the individual has been infected with mycobacterium TB to determine the appropriate form of treatment for the individual
 - c. Appropriate medical evaluation and treatment for individuals infected by mycobacterium TB

- For clients denied admission to the program on the basis of lack of capacity, the program refers such clients to other providers of TB services.

- The program has implemented infection control procedures that are consistent with those established by the Utah Department of Health and the Department of Human Services Office of Licensing to prevent the transmission of TB and that address the following.
 - Screening patients and identifying those individuals who are at high risk of becoming infected

- Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including 42 CFR part 2
- Case management activities to ensure that individuals receive such services
- The program reports all individuals with active TB to the Utah State Department of Health as required by State law and in accordance with Federal and State confidentiality requirements, including 42 CFR part 2.

Comments:

Part VI: § 96.126 Capacity of Treatment for Intravenous Drug Abusers

- Within 7 days of reaching 90 percent of its treatment capacity, the program notifies the State whenever the program reaches 90 percent of its treatment capacity.
- The program admits each individual who requests and is in need of treatment for intravenous drug abuse:
 - a. Not later than 14 days after making the request or
 - b. Within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance abuse treatment program
- When appropriate, the program offers interim services that include, at a minimum¹ of the following:
 - a. Counseling and education about HIV and TB, the risks of needle sharing, the risks of transmission to sexual partners and infants, the steps that can be taken to ensure that HIV and TB transmission does not occur
 - b. Referral for HIV or TB treatment services, if necessary
 - c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women
- The program has established a waiting list that includes a unique patient identifier for each injecting drug abuser seeking treatment, including patients receiving interim services while awaiting admission.
- The program has a mechanism that enables it to:
 - Maintain contact with individuals awaiting admission

- Consult with the State’s capacity management system to ensure that waiting list clients are admitted or transferred to an appropriate treatment program within a reasonable geographic area at the earliest possible time
- The program takes clients awaiting treatment for intravenous substance abuse off the waiting list only when such persons:
 - a. Cannot be located for admission into treatment or
 - b. Refuse treatment

Comments:

¹ Interim services may also include federally approved interim methadone maintenance.

Part VII: § 96.124 & § 96.131 Program Services for Pregnant Women and Women with Dependent Children

- The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate².
- The program provides or arranges for primary medical care, including prenatal care, for women who are receiving substance abuse services.
- The program provides or arranges for child care while the women are receiving services.
- The program provides or arranges for primary pediatric care, including immunizations, for the women’s children.
- The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.
- The program provides or arranges for therapeutic interventions for children in custody of women in treatment which may, among other things, address the children’s developmental needs and their issues of sexual abuse, physical abuse, and neglect.
- The program provides or arranges for sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (39.) through (43.) above.
- The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services.
- The program gives preference to treatment in following order:

- a. Pregnant injecting drug users
 - b. Other pregnant substance abusers
 - c. Other injecting drug users
 - d. All others
- The program refers pregnant women to the State Division of Substance Abuse and Mental Health when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program.

² Such an admission may not be appropriate; however, if for example, the father of the child(ren) is able to adequately care for the child(ren).

- The program makes interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.
- When appropriate, the program offers interim services that include, at a minimum³ of the following:
- a. Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual partners and infants, and steps that can be taken to ensure that HIV and TB transmission does not occur
 - b. Referral for HIV or TB treatment services, if necessary
 - c. Counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women
- Employment and training programs
- Education and special education programs
- Drug-free housing for women and their children
- Other early childhood programs
- Women's Treatment Programs provide for Women's Specific Training and/or Certification for Women's Treatment Staff.

Comments:

Part VIII Discussion Items.... No findings will be based on the following:

- What is the Clinical Supervision Policy for the agency? What changes are you considering? What training are you providing to supervisors?

- What efforts is the agency making to improve engagement and increase retention?

- 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 .

- What Medication Assisted Therapies are in use and how many clients are receiving MAT?

³Interim services may also include federally approved interim methadone maintenance.

IX. Clinical Requirements

Programs will meet the documentation requirements outlined in statute and rule and as outlined in the enclosed document.

1 Enclosure.

SERVICE CASE FILE REVIEW FY '14

Case Number:

Confidentiality

a. Consent form found in file (only required if information released) is complete, has statement that consent is subject to revocation, is signed and has complete information.	YES	NO	
b. <i>Signature of patient and guardian if minor and date signed *</i>	YES	NO	
c. Acknowledgement of receipt of Privacy statement present, signed, and witnessed.	YES	NO	

Engagement session and Assessment of Service Level

a. Engagement session identifies client goals and identifies initial diagnosis.	YES	NO	
b. Engagement session includes statement of client's presenting problem and:	YES	NO	
1. Identification and documentation of acute psychosis, intoxication/withdrawal relevant to presenting problem.	YES	NO	
2. Identification and documentation of biomedical conditions and complications relevant to presenting problem	YES	NO	
3. Identification and documentation of Emotional, Behavioral, Cognitive Conditions and or Complications relevant to client's current situation and presenting problem. <i>(include learning disabilities)*</i>	YES	NO	
4. Identification, evaluation and documentation of readiness to change relevant to presenting problem.	YES	NO	
5. Identification and documentation of Relapse, or Continued Problem Potential relevant to presenting problem.	YES	NO	
6. Identification and documentation of client's Recovery Environment relative to presenting problem	YES	NO	
7. Identification of Recovery Support services needed relevant to presenting problem.	YES	NO	
c. Engagement session summary includes recommendations for level of care and intensity of services needed.	YES	NO	

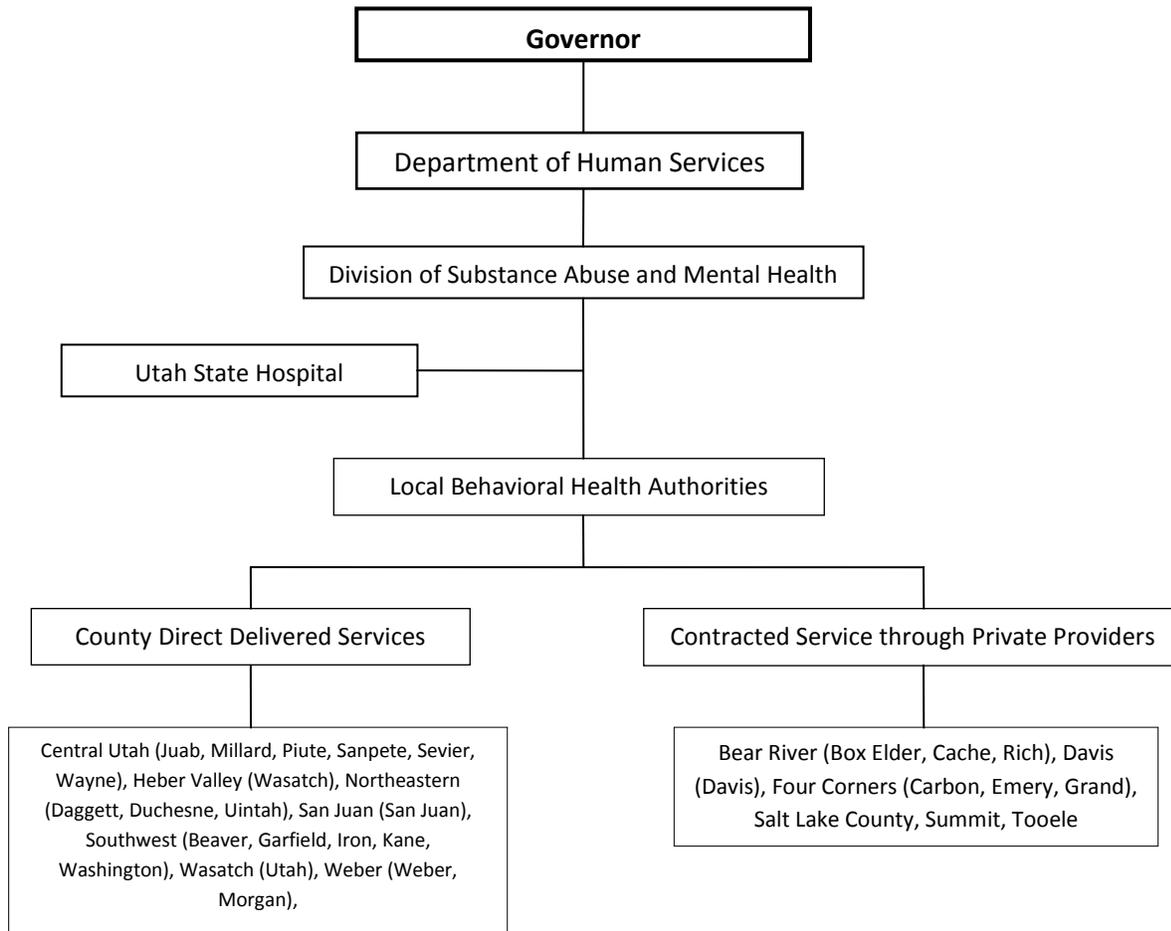
Ongoing Assessment

a. Assessment Dimensions are current and are updated as new information is received, new goals are identified and client progresses	YES	NO	
b. Assessment process is ongoing and changes to assessment information are reflected throughout record.	YES	NO	
c. Level of care and intensity of serves are supported by ongoing assessment information, or difference is clinically justified.	YES	NO	

Case Number:		
<u>Recovery Plan</u>		
a. Evidence of Client/Patient participation in development of Plan.	YES NO	
b. The plan is individualized and based on the client's goals and other needs agreed on by the client.	YES NO	
c. Objectives are measurable, achievable within a specified time frame and reflect <i>developmentally</i> * appropriate activities that support progress towards achievement of client goals.	YES NO	
d. Documentation of client's status is reflected throughout the client record, reflecting changes in types, schedule, duration and frequency of therapeutic interventions to facilitate client progress as well as changes in client objectives and goals.	YES NO	
e. Recovery Plan is current.	YES NO	
f. <i>Evidence of family involvement in treatment.*</i>	YES NO	
<u>Co-occurring Treatment</u>		
a. Co-occurring mental health and physical health issues identified during assessment process	YES NO	
b. If identified, Co-occurring diagnosis present.	YES NO	
c. If identified, evidence that it was discussed, and if agreed upon, addressed in recovery plan through direct services or referral for services. .	YES NO	
d. Progress on Co-occurring issue and/or follow through on referrals are documented in record.	YES NO	
<u>Progress Notes</u>		
a. Every service contact documented.	YES NO	
b. Clinical service notes include the date, duration and type of intervention.	YES NO	
c. Progress notes are used to document progress or lack of progress on client's goals and objectives and reflect behavioral changes as well as changes in attitudes and beliefs.	YES NO	
d. Progress reports and letters submitted as required and are individualized to reflect client progress.	YES NO	
e. Recovery support services are documented to the extent required for clinical continuity and in order to meet financial requirements.	YES NO	

<u>Gender and Cultural Specificity</u>		
Record reflects cultural and gender specificity in treatment.	YES	NO
Case Number:		
<u>Continuing Recovery Recommendations</u>		
a. Recommendations for ongoing services include the extent to which established goals and objectives were achieved, what ongoing services are recommended, and a description of the client's recovery support plan.	YES	NO
b. Signature and title of an appropriately licensed professional.	YES	NO
c. Referrals and follow-up care provided (preferred).	YES	NO
* <i>Italics indicate adolescent requirements</i>		
Remarks		

Figure 1: Organizational Chart of Utah’s Behavioral Health System



The Department of Human Services 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’s State government and consists of the following service offices and divisions:

- Division of Substance Abuse and Mental Health (DSAMH)
- 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 resolve interdepartmental conflicts. Additionally there are numerous working groups and committees that meet to coordinate specific programs and initiatives that cross division and office boundaries.

The 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 DSAMH "... 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..." and that the DSAMH "...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..."¹

The DSAMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities (Local Authorities) for the delivery of Behavioral Health services. The DSAMH distributes federal and state funds through contracts, and monitors 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 DSAMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

The Director of the DSAMH serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Director of the DSAMH is supported by an Assistant Director of Mental Health and an Assistant Director of Substance Abuse. Utah's DSAMH, and the Utah public behavioral health system operates under the official mission statement of "**Hope and Recovery**" and we are guided by the following key principles:

Quality services, programs, and systems promote individual and community wellness.

Education enhances understanding of prevention and treatment of substance abuse services.

Leadership understands and meets the needs of consumers and families.

Partnerships with consumers, families, providers and local/state authorities are strong.

Accountability in services and systems that is performance focused and fiscally responsible.

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. It also requires Local Mental Health Authorities (LMHA) to provide ten mandatory services. Utah's LSAA and LMHA, under the direction of the County Governments, are given the responsibility to provide substance use disorder and mental health services to their citizens. Funding to provide required

¹ Utah Code Title 62, Chapter 15, §105 and §103.

federal and state services is a combination of CMHS and SAPT block grant funds, State General Funds, County matching funds (20 percent), and other State and Federal funds. 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 matching funds are used to meet Medicaid match requirements.

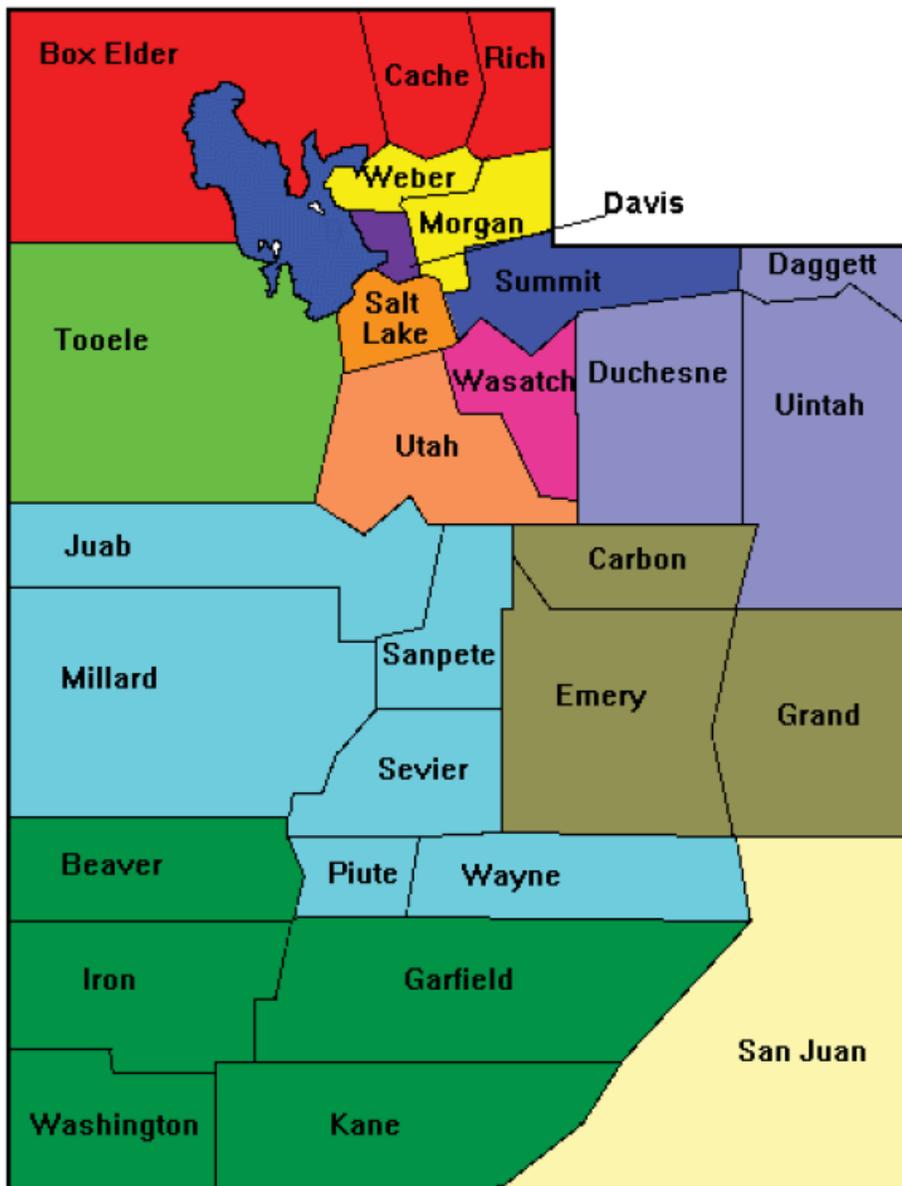
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II: Planning Steps

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

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

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, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must 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 serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, 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.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Please find response in the attache document.

According to the 2011 US Census, Utah's adult population is 1.9 million. The 2012 Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report (BRFFS) found that 22 percent of Utah's adult population suffers from a chronic health condition and high rates of co-occurring chronic physical and mental illness among Utah's adult population. This research indicates that adults with mental illness in Utah have an increased risk of having a co-occurring physical health condition. Similarly, it indicates that adults in Utah with a chronic health conditions are at increased risk of a co-occurring mental health condition. Currently, the Utah Division of Substance Abuse and Mental Health (DSAMH) are working with the Utah Department of Health to assess the need and capacity for programming and creating integrated solutions to support this population.

The State's Epidemiological Profile and DSAMH's annual report shows that only 17% of those needing SUD services and 30% of those needing MH services receive them through the public treatment system. While private insurance and self funding covers services for a portion of those still needing services, there is still a significant majority of individuals in Utah whose needs are not met. Adapting the public treatment system's capabilities and capacity to meet the increased demand that implementation of the Affordable Care Act will bring is a key element of our future strategy and is a priority. With our without the full expansion of Medicaid, the Division is focusing on integrating services with primary healthcare, and improving the system's connection with other providers and treatment systems.

Much of the state of Utah is classified as either rural or frontier land. Populations in living in these areas face economic limitations and geographic challenges that limit access to resources, services, and opportunities. According to the USDA Economic Research Service, the average per-capita income for Utahans in 2009 was \$31,584 although rural per-capita income lagged at \$27,373. 2010 estimates indicate a poverty rate of 14.6% exists in rural Utah, compared to a 13.1% level in urban areas of the state. Data from 2010 US Census American Community Survey indicates rural populations have higher high school drop-out rates than urban populations (11.6% of the rural population has not completed high school, compared to 9.1% of urban populations). The unemployment rate in rural Utah is at 7.6%, while in urban Utah it is at 6.6% (USDA-ERS, 2011). 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.

Although a relatively low number of adults use tobacco in Utah (9.1% compared to the national average of 20.1%), a study by [The Journal of the American Medical Association](#) reported that 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders. In Utah, sadly, we are at even greater risk than the national average: over 68% of individuals using tobacco has a diagnosed mental illness and/or substance use disorder (Utah Department of Health, 2010). 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.

According to the National Association of State Mental Health Program Directors, people with mental illness die 25 years earlier on average than the general population, largely due to conditions caused or worsened by smoking. Again, Utah has a higher rate than the national average with this identified population; in Utah, adults with serious mental illness die 27 years earlier on average than the general population. We have taken the need for tobacco-cessation seriously, three years ago we successfully developed statewide tobacco-free policy (Recovery Plus) to create tobacco-free environments and implement effective tobacco-cessation programming.

Prescription Drug Use and Abuse and the resultant number of drug overdose deaths have been a major issue and area of attention for Utah since 2008. The Utah Department of Health data reports that Utah’s death rate from the use of prescription opioids increased by 600% from 1999 to 2006; during that same period the prescription rate increased by 250%. In 2008, unintended drug overdose deaths exceeded traffic fatalities in Utah. Again, according to the Utah Department of Health, the 2006-2010 Utah prescription opioid death rate is 14.3 per 100,000 adults. Despite significant efforts to reduce these figures, and success in reducing the rate of unintended overdoses from 2007 to 2010 (16.8 and 11.5 per 100,000 adults), according the July 2013 MMWR

report, Utah's rate of overdose deaths for women remains among the six highest in the nation. Reducing these deaths remains a priority for Utah's prevention and treatment systems.

Suicide was the leading cause of injury-related death and the third leading cause of hospitalizations for all ages in Utah from 2008-2010. Suicide is the 2nd leading cause of death for Utah teens ages 15-19, and the 4th leading cause of death for Utah adults ages 20-64. On average:

- 22 Utah teens ages 15-19 die from suicide each year;
- two Utah teens ages 15-19 are treated in the emergency department or hospitalized every day because of suicide attempts;
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- eight Utahans 20-64 years of age are treated in the emergency department or hospitalized every day because of suicide attempts;
- 35 Utahans 65 years and older die from suicide each year; and
- 1 Utahan 65 years or older is treated in the emergency department or hospitalized every week because of a suicide attempt.

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 nation (U.S. Surveillance Summaries, October 21, 2011 / 60(SS13); 1-22). Additionally, Utah has the 8th highest adult suicide rate in the U.S., the 12th highest teen suicide rate in the U.S., and the 14th highest older adult suicide rate in the U.S.

The 2009 Utah Disease/Risk Factor Integration Matrix, developed with support from the National Center for Health Statistics provided a grim report of the quality of life for individuals living with multiple chronic conditions in Utah. This report analyzed the prevalence of chronic diseases and chronic disease risk factors for the adults in Utah. It showed that Utahans who have a serious mental illness also have higher rates of arthritis, asthma, and hypertension that are significantly higher than the general population. Furthermore, adults with serious mental illness in Utah have excessively high rates of poor nutrition, smoking, obesity, and over 66 percent of this population does not engage in regular physical activity. In addition to the Wellness Directive implemented in

2005, 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. The Whole Health Wellness and Resiliency model is intended to provide person-centered goal setting support to consumers, primary care providers, and behavioral health providers as they develop treatment goals that address the "whole person" and promote prevention through resiliency.

DSAMH has numerous past successes in improving community outcomes, and we have learned a few lessons along the way too. One of the best recent examples is the Recovery Plus initiative, Utah's statewide policy to address the need for tobacco-cessation which has successfully created policy and programming to help people stop using tobacco. Utah now requires all campuses and treatment facilities to be smoke-free, has initiated tobacco-cessation coaching and the Utah Quit Net, and launched a successful awareness campaign to connect people with resources to stop using tobacco. Much of this work was accomplished in partnership with the Department of Health and with the support of the Local Authorities. Although there was some strong initial criticism of tobacco-free policy in the state, outcomes for tobacco cessation indicate that Recovery Plus is a strong and valuable program. Through partnership with Department of Health Leadership team, stigma and bias about smoking is being corrected through collaborative efforts with the media, policy change, and ongoing public awareness efforts.

Another promising example of past successes in improving community outcomes is the work DSAMH Prevention Specialists have engaged in with the Communities That Care Model, a coalition-based prevention operating system that uses a public health approach to prevent adverse experiences such as violence, delinquency, depression, anxiety, and substance abuse. Utah now has 17 communities using the CTC model and key findings indicate a significant reduction in youth substance use and delinquency. Trusting the past success of the CTC model, the DSAMH mental health team, prevention team, and children youth and families team recently collaborated to create a shared funding opportunity for the local community to conduct a statewide data-driven

needs and strengths assessment to support local authorities in developing key relationships to address the most urgent needs in their regions.

Tracking Progress in Treatment Goals

Measuring patient outcomes is essential to Utah's plan for transforming the public mental health care system. The implementation of science and progress in treatment is a priority. The Division requires all publicly funded community mental health and substance abuse providers to utilize a statewide system for assessing and measuring patient outcomes. OQ-HS[®] created by OQ Measures, automates the administration and reporting on the adult Outcome Questionnaire[®] (OQ[®]). This instrument is recognized as one of the leading outcome tracking methodologies for quantifying and evaluating the progress of behavioral health therapy, and has been widely adopted by a variety of behavioral and other health care service organizations. OQ Measures is working on an enhancement that will help track symptom relief and progress towards meeting person-centered planning objectives. Block Grant funds are planned to supplement this project which provides treatment providers, authorities, and administrators with an important tool for scientifically measuring progress towards recovery.

Given the above, the Division, in conjunction with its partner agencies, Local Authorities, and Community Partners has developed the following Priority areas and Annual Performance indicators.

According to the 2011 US Census, Utah's adult population is 1.9 million. The 2012 Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report (BRFFS) found that 22 percent of Utah's adult population suffers from a chronic health condition and high rates of co-occurring chronic physical and mental illness among Utah's adult population. This research indicates that adults with mental illness in Utah have an increased risk of having a co-occurring physical health condition. Similarly, it indicates that adults in Utah with a chronic health conditions are at increased risk of a co-occurring mental health condition. Currently, the Utah Division of Substance Abuse and Mental Health (DSAMH) are working with the Utah Department of Health to assess the need and capacity for programming and creating integrated solutions to support this population.

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Given the above, the Division, in conjunction with its partner agencies, Local Authorities, and Community Partners has developed the following Priority areas and Annual Performance indicators.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Improve Coordination and integration of mental health and substance use disorder treatment with physical health providers.
Priority Type:	SAP, SAT, MHP, MHS
Population (s):	SMI, SED, PWWDC, IVDUs, 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 A: Improve coordination and integration of mental health and substance use disorder treatment with physical health providers. Goal B: Improve the ability of mental health and substance use disorder treatment providers to bill Medicaid and other 3rd party insurers, including Qualified Health Plans sold on the Health Insurance Marketplace.
Strategies to attain the goal:	
	Strategies for Goal A: 1. Participate in all legislative, departmental, provider associations, and interagency health care integration committee meetings and initiatives. 2. Participate and provide leadership to Department of Human Services Committees and workgroups developing policy and procedures for integrating Behavioral Health care with other health care services. 3. Participate in all SAMHSA meetings on integration of behavioral health services. 4. Promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs. Strategies for Goal B: 1. Participate and provide leadership in legislative, Department of Health (DOH), other partners, and interagency workgroups revising Medicaid reimbursement plans and policies. 2. Provide recommendations to the Director of the Department of Human Services (DHS) on policy, statute and rule changes needed to prepare the DHS for implementation of Health Care 3. In coordination with DHS and DOH agencies and private behavioral health care providers, develop procedures to expand Medicaid coverage to additional qualified providers. 4. Participate and provide leadership in workgroups with DOH and other state partners in revising Medicaid reimbursement plans and policies.

- 5. Provide recommendations to the Utah Department of Insurance (DOI) on mental health parity to ensure QHPs plans are in compliance.
- 6. Work with the DOI and other behavioral health stakeholders to ensure clients have access to adequate behavioral health services and that mental health parity requirements are being met in the Marketplace.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Goal A: Increase the number of referrals into the public behavioral health system from the physical health system.

Baseline Measurement: FY 2012 Data -- i. Substance Use Disorder Clients -- 6.5 % were referred by another healthcare provider ii. Mental Health Clients -- 10.92% were referred by another healthcare provider

First-year target/outcome measurement: b. 1st Year (FY 2015) -- Increase the number of referrals into the behavioral health system from primary care by 20%

Second-year target/outcome measurement: c. 2nd Year (FY 2016) -- Increase the number of referrals into the behavioral health system

Data Source:

TEDS:
Item 12 in TEDS/SAMHI's Admissions record: Referral Source.

Description of Data:

Describes the specific person or agency referring the client to the alcohol or drug treatment program.

Data issues/caveats that affect outcome measures::

none

Indicator #: 2

Indicator: Goal B: Numbers of individuals receiving SUD services funded by Medicaid and insurance.

Baseline Measurement: a. Baseline (FY 2012)—17% of clients were funded by Medicaid or 3rd party insurance

First-year target/outcome measurement: b. 1st Year (FY 2014)—Increase number of clients funded by Medicaid or 3rd party insurance

measurement: to 25%

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Increase the number of clients funded by Medicaid or 3rd party insurance to 40%

Data Source:

TEDS and Agency reports
Item 34 on TEDS/SAMHIS admission record: Health Insurance
and Item 35 on TEDS/SAMHIS admission record: Payment source.

Description of Data:

34 Specifies the client's health insurance.
35 Identifies the primary source of payment for the current treatment event/modality

Data issues/caveats that affect outcome measures::

Utah's governor has not yet decided on the option of expanding Medicaid and will not decide until late December 2013. Given the current timeline it is unlikely that Utah will have a Medicaid expansion in 2014.

Priority #: 2

Priority Area: Provide Services for the following priority populations: a. Persons who are intravenous drug users (IDU). b. Women who are pregnant and have a substance use and/or mental disorder. c. Parents with substance use and /or mental disorders who have dependent children d. Individuals with tuberculosis. e. Children with serious emotional disturbances (SED) and their families. f. Adults with Serious Mental Illness (SMI).

Priority Type: SAP, SAT, MHP, MHS

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

Goal of the priority area:

Goal A: Provide Services for persons who are intravenous drug users (IDU)
Goal B: Provide behavioral health services to pregnant women and have a substance use and/or mental disorder.
Goal C: Provide Services for parents with substance use and or mental disorders who have dependent children.
Goal D: Provide Services for individuals with tuberculosis (TB)
Goal E: Provide Services for children with serious emotional disturbances (SED) and their families.

Goal F: Provide Services for adults with serious mental illness (SMI)

Strategies to attain the goal:

- Goal A: 1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
- Goal B: 1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
- Goal C: 1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
3. Contract with Local Authorities for services as per statute
4. Include Block Grant requirements in Local Authority contracts.
- Goal D: 1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
3. Coordinate with Department of Health for coordinated services.
- Goal E: 1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
- Goal F: 1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Annual Performance Indicators to measure goal success

- Indicator #: 1
- Indicator: Goal A: 1. Compliance with Contract Requirements
- Baseline Measurement: a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
- First-year target/outcome measurement: b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
- Second-year target/outcome measurement: c. 2nd Year (FY FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports.

Description of Data:

Agencies will be evaluated on their services provided to their specific minority underserved populations that can be identified. Evaluations will be based on compliance with contract requirements; compliance with Division Directives; compliance with SAPT and MH Block Grant requirements; compliance with state statutes and rules; numbers served according to TEDS, SAMHIS and other report data.

Data issues/caveats that affect outcome measures::

Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population's needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.

Indicator #:	2
Indicator:	Goal B: Compliance with Contract Requirements
Baseline Measurement:	a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population.
First-year target/outcome measurement:	b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
Second-year target/outcome measurement:	c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports

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Agencies will be evaluated on their services provided to their specific minority underserved populations that can be identified. Evaluations will be based on compliance with contract requirements; compliance with Division Directives; compliance with SAPT and MH Block Grant requirements; compliance with state statutes and rules; numbers served according to TEDS, SAMHIS and other report data.

Data issues/caveats that affect outcome measures::

Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population's needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.

Indicator #: 3

Indicator: Goal C: Compliance with Contract Requirements

Baseline Measurement: a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population.

First-year target/outcome measurement: b. 1st year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

Second-year target/outcome measurement: c. 2nd year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports

Description of Data:

Agencies will be evaluated on their services provided to their specific minority underserved populations that can be identified. Evaluations will be based on compliance with contract requirements; compliance with Division Directives; compliance with SAPT and MH Block Grant requirements; compliance with state statutes and rules; numbers served according to TEDS, SAMHIS and other report data.

Data issues/caveats that affect outcome measures::

Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population's needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.

Indicator #: 4

Indicator: Goal D: Compliance with Contract Requirements

Baseline Measurement: a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Populations

First-year target/outcome measurement: b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on

measurement: their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports.
Department of Health Reports and DATA

Description of Data:

Agencies will be evaluated on their services provided to their specific minority underserved populations that can be identified. Evaluations will be based on compliance with contract requirements; compliance with Division Directives; compliance with SAPT and MH Block Grant requirements; compliance with state statutes and rules; numbers served according to TEDS, SAMHIS and other report data.

Data issues/caveats that affect outcome measures::

Data on TB clients is not specifically maintained or gathered by DSAMH due to the structure of TB funding and State testing requirements. Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population's needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.

Indicator #:

5

Indicator:

Goal E: 1. Compliance with Contract Requirements

Baseline Measurement:

a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population

First-year target/outcome measurement:

b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

Second-year target/outcome measurement:

c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports

Description of Data:

Agencies will be evaluated on their services provided to their specific minority underserved populations that can be identified. Evaluations will be based on compliance with contract requirements; compliance with Division Directives; compliance with SAPT and MH Block Grant requirements; compliance with state statutes and rules; numbers served according to TEDS, SAMHIS and other report data.

Data issues/caveats that affect outcome measures::

Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population's needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.

Indicator #:	6
Indicator:	Goal F: 1. Compliance with Contract Requirements
Baseline Measurement:	a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
First-year target/outcome measurement:	b. 1st year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
Second-year target/outcome measurement:	c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports

Description of Data:

Agencies will be evaluated on their services provided to their specific minority underserved populations that can be identified. Evaluations will be based on compliance with contract requirements; compliance with Division Directives; compliance with SAPT and MH Block Grant requirements; compliance with state statutes and rules; numbers served according to

Data issues/caveats that affect outcome measures::

Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population's needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.

Priority #: 3

Priority Area: Substance Use Disorder and Mental Illness prevention and treatment services and Mental Health promotion

Priority Type: SAP, SAT, MHP, MHS

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

Goal of the priority area:

Goal A: Reduce lifetime and 30 day marijuana use for 8th, 10th, and 12th grades through education, awareness and referrals prevention programs.

Goal B: Reduce underage drinking in adolescents.

Goal C: Reduce prescription drug abuse through collaboration with state and local agencies, as well as provide education and awareness to communities to reduce abuse, increase early intervention, and expand use of medication assisted treatment and recovery.

Goal D: Mental Illness Prevention

Goal E: Build an infrastructure of prevention prepared communities through SAPST certification and CTC implementation to prioritize prevention risk factors and focus resources on reducing substance abuse and mental health problems or disorders.

Strategies to attain the goal:

Goal A: 1. Review Student Health and Risk Prevention (SHARP) survey data and other epidemiological data sources for the state and Local Substance Abuse Authorities (LSAA) to identify risks and trends associated with the lifetime and 30 day use rates of marijuana. Focus on counties or LSAA areas with high marijuana use rates. Collaborate with other state and local agencies through education and awareness campaigns regarding the reduction of marijuana use rates. Emphasize the need to address marijuana use rates as a statewide issue during SAPST, CTC trainings, town hall meetings and other community forums.

2. Monitor LSAA programs identified for addressing marijuana use for 8th, 10th and 12th graders. This process will include evaluation of strategies, outcomes and methods used to reduce marijuana use rates.

3. Enhance existing programs through technical assistance and monitoring. Use evidenced-based strategies and/or programs to strengthen these efforts.

Goal B: 1. Through collaboration with partner agencies develop a comprehensive strategy to:

- a. reduce availability of alcohol to underage adolescents through compliance; and
- b. delay time of first use and 30 day use.

Goal C: 1. Include information and education on Prescription Drug abuse in all Division sponsored and supported conferences and trainings.

2. Participate and provide prevention and treatment expertise in the Department of Health and DEA Prescription Drug Committees.

3. Assist prevention prepared communities in addressing Prescription Drug abuse in their communities as appropriate.

4. Provide information about the benefits of medication assisted therapies to support recovery for opiate and alcohol related admissions.

Goal D: 1. Early Intervention: reduce mental illness in SED populations through School Based intervention, Family Resource Facilitator with

wrap around and mobile crisis teams.

2. Suicide prevention: Collaborate on a state level with Utah State Office of Education (USOE) to build capacity of suicide prevention specialists throughout communities by offering Train the trainer (T4T) trainings to local coalitions. Promote evidenced based programming on suicide prevention, intervention, and postvention across the lifespan.

3. Increase ASIST and CONNECT T4T trainers throughout the state.

Goal E: 1. Engage citizens to find solutions to substance abuse problems in their communities through research and evidence based programming.

2. Train LSAA and their staff including coalition members and volunteers in SAPST curriculum as needed.

3. Train LSAA and their staff in the CTC model of prevention.

4. Increase the number of trained prevention professionals in the CTC and subsequent coalitions each year

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Goal A: Lifetime marijuana use data

Baseline Measurement: a. Baseline (FY 2012)-- (the following outcomes are based on 2011 SHARP survey data and will be revised once the 2013 SHARP data is available) i. Marijuana use in lifetime for 8th grade is 7% ii. Marijuana use in lifetime for 10th grade is 17% iii. Marijuana use in lifetime for 12th grade is 23%

First-year target/outcome measurement: b. 1st Year (FY 2014)— i. Reduce lifetime use of marijuana in 8th grade from 7% in 2011 to 6% in 2014. ii. Reduce lifetime use of marijuana in 10th grade from 17% in 2011 to 16% in 2014. iii. Reduce lifetime use of marijuana in 12th grade from 23% in 2011 to 22% in 2014.

Second-year target/outcome measurement: c. 2nd year (FY 2015)— i. Reduce lifetime use of marijuana in 8th grade from 6% in 2014 to 5% in 2015. ii. Reduce lifetime use of marijuana in 10th grade from 16% in 2014 to 15% in 2015. iii. Reduce lifetime use of marijuana in 12th grade from 22% in 2014 to 21% in 2015.

Data Source:

The Utah Prevention Needs Assessment (PNA) Survey, SHARP Survey and Local Authority Reports

Description of Data:

The Utah Prevention Needs Assessment (PNA) Survey portion of the Student Health and Risk Prevention (SHARP) Statewide Survey is designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. It was administered every two years to students in grades 6, 8, 10, and 12 in

39 school districts and 14 charter schools across Utah.

Data issues/caveats that affect outcome measures::

Survey does not reach every student or school district due to a small number of districts resistant to reporting to the State.

Indicator #: 2

Indicator: Goal A: 30 Day marijuana use data

Baseline Measurement: a. Baseline (FY 2012)-- (the following outcomes are based on 2011 SHARP survey data and will be revised once the 2013 SHARP data is available) i. 30 day Marijuana use in 8th grade is 3% ii. 30 day marijuana use in 10th grade is 8% iii. 30 day marijuana use in 12th grade is 22%

First-year target/outcome measurement: b. 1st Year (FY 2014)— i. Reduce 30 Day marijuana use in 8th grade from 3% in 2011 to 2% in 2014. ii. Reduce 30 Day marijuana use in 10th grade from 8% in 2011 to 7% in 2014. iii. Reduce 30 Day marijuana use in 12th grade from 10% in 2011 to 9% in 2014.

Second-year target/outcome measurement: c. 2nd year (FY 2015)— i. Reduce 30 Day marijuana use in 8th grade from 2% in 2014 to 1% in 2015. ii. Reduce 30 Day marijuana use in 10th grade from 7% in 2014 to 6% in 2015. iii. Reduce 30 Day marijuana use in 12th grade from 9% in 2014 to 8% in 2015.

Data Source:

Sharp Survey and Local Authority Reports

Description of Data:

The Utah Prevention Needs Assessment (PNA) Survey portion of the Student Health and Risk Prevention (SHARP) Statewide Survey is designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. It was administered every two years to students in grades 6, 8, 10, and 12 in 39 school districts and 14 charter schools across Utah.

Data issues/caveats that affect outcome measures::

Survey does not reach every student or school district due to a small number of districts resistant to reporting to the State.

Indicator #: 3

Indicator: Goal B: EASY compliance report with collaboration from Department of Highway Safety,

OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

LSAA area reports of EASY compliance and review of program outcomes targeting underage drinking as a measure, and the 2015, 2017 SHARP survey data.

Baseline Measurement: a. Baseline (FY 2011)—www.dsamh.utah.gov/docs/State%20of%20Utah%20Profile%20Report.pdf

First-year target/outcome measurement: b. 1st Year (FY 2014)—Reduce use by 10 %

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Maintain reduction achieved in FY 2014

Data Source:

SHARP Survey and BRFSS Data

Description of Data:

The Utah Prevention Needs Assessment (PNA) Survey portion of the Student Health and Risk Prevention (SHARP) Statewide Survey is designed to assess adolescent substance use, anti-social behavior, and the risk and protective factors that predict adolescent problem behaviors. It was administered every two years to students in grades 6, 8, 10, and 12 in 39 school districts and 14 charter schools across Utah.

Utah Behavioral Risk Factor Surveillance System (BRFSS) is used to assess the prevalence of and trend in health-related behaviors in the non-institutionalized Utah adult population aged 18 years and older.

Data issues/caveats that affect outcome measures::

SHARP survey only done every two years
The BRFSS is a telephone survey

Indicator #: 4

Indicator: Goal C: Reduction of overall statewide admissions for opiates.

Baseline Measurement: a. Baseline (FY 2012)—21.2% total admissions for opiates

First-year target/outcome measurement: b. 1st Year (FY 2014)— Decrease to 20%

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Decrease to 19%

Data Source:

Center for Disease Control Data
TEDS/SAMHIS Admissions record Data: Substance of use: Items 20 (Primary at Admission); 21 (Secondary at Admission); and 22 (Tertiary at Admission)

Description of Data:

Identifies the client's primary, secondary or tertiary substance problem

Data issues/caveats that affect outcome measures::

client report

Indicator #: 5
Indicator: Goal C: Reduce Number of Overdose Deaths
Baseline Measurement: a. Baseline (FY 2012)—834 deaths
First-year target/outcome measurement: b. 1st Year (FY 2014)—2% reduction
Second-year target/outcome measurement: c. 2nd Year (FY 2015)—10% reduction
Data Source:

Center for Disease Control Data and Utah Department of Health Reports. Medical Examiner Reports are also used.

Description of Data:

Reports track numbers of suicides, overdose deaths and causes of death.

Data issues/caveats that affect outcome measures::

Data is often two years behind.

Indicator #: 6
Indicator: Goal D: Increase the number of T4T trainers in local coalitions
Baseline Measurement: a. Baseline (FY 2012)— i. 30 Question Persuade Refer (QPR) ii. 6 Mental Health First Aid

First-year target/outcome measurement: b. 1st Year (FY 2014)—Increase by 5 percent

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Increase by 10 percent

Data Source:

Internal data monitoring
Prevention and MH LA reports

Description of Data:

Numbers of T4T trained individuals

Data issues/caveats that affect outcome measures::

availability of trainings and resources for training.

Indicator #: 7

Indicator: Goal E: 1. Number of CTC

Baseline Measurement: a. Baseline (FY 2012)—As of FY14, there are 9 CTC coalitions that either have contracts with DSAMH or are in the planning phase to do so.

First-year target/outcome measurement: b. 1st Year (FY 2014)—Increase by 25% which equal to 11 CTC coalitions

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Increase by 45% which equal to 16 CTC coalitions

Data Source:

Area Plans and monitoring reports

Description of Data:

Area Plans describe specific prevention plans and strategies.
Monitoring visits by DSAMH staff review on the group activities against plans and written reports.

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Develop a plan to improve services to the following populations within the state: a. American Indian; b. Military personnel and their families; c. Individuals with mental and or substance abuse disorders who live in rural areas or who are homeless; and d. Underserved racial, ethnic and LGBTQ populations.

Priority Type: SAP, SAT, MHP, MHS

Population SMI, SED, Other (LGBTQ, Rural, Military Families, Underserved Racial and Ethnic Minorities, American Indian)
(s):

Goal of the priority area:

Goal A: Improve service delivery to identified special populations

Strategies to attain the goal:

1. Provide ongoing education through Generations, U of U June School and Fall Substance Abuse Conferences on cultural competence and special populations.
2. Focus on services to appropriate special populations during site visits to local authorities.
3. Participate in councils representing special populations when BH issues are involved. (DHS Tribal Council; Veteran's Councils; Legislative Committee on Veteran's affairs)
4. Include representatives of special populations in educational planning committees.
5. Review Local Authority Area Plans for emphasis on planning for special populations.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	1. Admissions by special populations
Baseline Measurement:	a. Baseline (FY 2012)—TEDS admission data for each population where available.
First-year target/outcome measurement:	b. 1st Year (FY 2014)—Improve admissions and retention for each of the populations where data is available.
Second-year target/outcome measurement:	c. 2nd Year (FY 2015)—Improve admissions and retention by 10% over baseline.
Data Source:	

TEDS/SAMHIS The following are admission data entries for special populations

1. Military and Veteran Status: Item 95 (Have you ever are are you currently serving in the Military?)
2. Child and Family Services case: Item 80 (DCFS Indicator)
3. Legal Status: Items 78 and 79 (Probation and Parole Indicators)
4. Student: Item 50: (Enrolled in Education)
5. Pregnancy: Item 37 (Pregnant at time of admission)
6. Disability Status: Item 19 (Employment at admission - Code 7 disabled)
7. Ethnicity Item 16 (Ethnicity)
8. Race Item 15 (Race)
9. Gender Item 14 (Gender)
10. Age Item 13 (Date of Birth)

Description of Data:

The above items are not exhaustive. Rural/Frontier residents can be determined largely through the identification of the LSAA/LMHA providing services. While Sexual Preference and identity is often determined during the assessment process, it is not reported at admission as it would not be reliable, especially in rural and frontier areas.

Data issues/caveats that affect outcome measures::

Some populations are not reported by TEDS, nor are there accurate ways to measure or collect the data. An example is LGBTQ admissions are not collected, or asked for. Nor would they be reliable figures, especially in frontier areas of the state. Likewise, Tribal status is not reported and data about veterans status is notoriously inaccurate.

Priority #: 5

Priority Area: Plan for and implement Wellness and Recovery Oriented Systems of Care principles for persons with mental health and/or substance use disorders.

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, SED, PWWDC, 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 A: Expand the continuum of care to include early interventions and long term support of recovery

Goal B: Improve use of data to evaluate treatment and prevention systems and guide improvements and changes.

Strategies to attain the goal:

- Goal A: 1. As SAPTBG funds become available through the expansion of other payment options, Utah will expand ATR type vouchers to provide RSS services.
2. Work through the UBHC Data, Financial and Clinical committees to expand the state Substance Abuse and Mental Health Information System (SAMHIS) to allow for tracking of clients outside of the TEDS data system in order to provide recovery support services prior to admission and after discharge from an episode of acute treatment.
3. Continue to work with SAMHSA to modify NOMS and TEDS to reflect and support a Recovery Oriented System of Care.
- Goal B: 1. Work through the UBHC Data, Financial and Clinical committees to expand the state Substance Abuse and Mental Health Information System (SAMHIS) to allow for tracking of clients outside of the TEDS data system in order to provide recovery support services prior to admission and after discharge from an episode of acute treatment.
2. Improve the utility of Prevention Data by developing an alternative tracking system that will also provide input to SAMHIS.
3. Develop a Prevention Scorecard to better measure achievement of Prevention goals and objectives

Annual Performance Indicators to measure goal success

- Indicator #: 1
- Indicator: Goal A: Number of Local Authorities using of Vouchers to provide Recovery Support Services to SUD Priority Populations.
- Baseline Measurement: a. Baseline (FY 2012)—Vouchers used to provide services in three Local Authorities
- First-year target/outcome measurement: b. 1st Year (FY 2014)—Increase the number of Local Authorities using vouchers by one, for a total of four Local Authorities using vouchers
- Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Increase the number of Local Authorities using vouchers in 2014 by two, for a total of six Local Authorities using vouchers

Data Source:

Annual Reports and Local Authority Area Plans
Monitoring of Voucher System by Division Staff

Description of Data:

The data will be the number of agencies utilizing vouchers, either through the current ATR voucher management system or the continuation of it at the completion of the ATR Grant.

Data issues/caveats that affect outcome measures::

This is conditional on expansion of funding and retention of SAPT funds for RSS

Indicator #: 2

Indicator: Goal B: 1. Inclusion of RSS services and pre and post treatment episode of care data in SA and Mental Health Score Cards.

Baseline Measurement: a. Base Line (FY 2012)—See current Scorecards at www.dsamh.utah.gov

First-year target/outcome measurement: b. 1st Year (FY 2014)—Two measures for RSS services on scorecards

Second-year target/outcome measurement: c. 2nd Year (FY 2015)—Targets for RSS measures included in Division Directives and used for monitoring reports.

Data Source:

SAMHIS; Audit Reports; Division Directives; Agency Reports.
TEDS/SAMHI's data:
RSS Item 83 at admission and Item 54 at Discharge (Participation in Social Support)
Tobacco Use: Item 43 at admission and item 55 at Discharge (Tobacco Use)

Description of Data:

Data will be the percentage of individuals using tobacco or recovery report services at admission, versus the number reporting use of tobacco or attendance at recovery support at discharge.

Data issues/caveats that affect outcome measures::

Difficulty in Local Authorities in collecting accurate information.

footnote:

PDF of this section has been uploaded into the Attachments.

Step 3 and 4 Priority Area and Annual Performance Indicators

State Priority 1—Plan for and implement Health Reform

Goal A--Improve coordination and integration of mental health and substance use disorder treatment with physical health providers.

Populations--Mental Health and Substance Use Disorder clients

Strategies:

1. Participate in all legislative, departmental, provider associations, and interagency health care integration committee meetings and initiatives.
2. Participate and provide leadership to Department of Human Services Committees and workgroups developing policy and procedures for integrating Behavioral Health care with other health care services.
3. Participate in all SAMHSA meetings on integration of behavioral health services.
4. Promote integrated programs that address an individual's substance abuse, mental health, and physical healthcare needs.

Indicator:

1. Increase the number of referrals into the public behavioral health system from the physical health system.
 - a. Baseline (FY 2012) --
 - i. Substance Use Disorder Clients -- 6.5 % were referred by another healthcare provider
 - ii. Mental Health Clients -- 10.92% were referred by another healthcare provider
 - b. 1st Year (FY 2015) -- Increase the number of referrals into the behavioral health system from primary care by 20%
 - c. 2nd Year (FY 2016) -- Increase the number of referrals into the behavioral health system from primary care by 20%

Source of Data-- TEDS

Comments--

Goal B-- Improve the ability of mental health and substance use disorder treatment providers to bill Medicaid and other 3rd party insurers, including Qualified Health Plans sold on the Health Insurance Marketplace.

Populations—All

Strategies:

1. Participate and provide leadership in legislative, Department of Health (DOH), other partners, and interagency workgroups revising Medicaid reimbursement plans and policies.
2. Provide recommendations to the Director of the Department of Human Services (DHS) on policy, statute and rule changes needed to prepare the DHS for implementation of Health Care
3. In coordination with DHS and DOH agencies and private behavioral health care providers, develop procedures to expand Medicaid coverage to additional qualified providers.
4. Participate and provide leadership in workgroups with DOH and other state partners in revising Medicaid reimbursement plans and policies.
5. Provide recommendations to the Utah Department of Insurance (DOI) on mental health parity to ensure QHPs plans are in compliance.
6. Work with the DOI and other behavioral health stakeholders to ensure clients have access to adequate behavioral health services and that mental health parity requirements are being met in the Marketplace.

Indicator:

1. Numbers of individuals receiving SUD services funded by Medicaid and insurance.
 - a. Baseline (FY 2012)—17% of clients were funded by Medicaid or 3rd party insurance
 - b. 1st Year (FY 2014)—Increase number of clients funded by Medicaid or 3rd party insurance to 25%
 - c. 2nd Year (FY 2015)—Increase the number of clients funded by Medicaid or 3rd party insurance to 40%

Source of Data—TEDS and Agency reports

Comments— Utah’s governor has not yet decided on the option of expanding Medicaid and will not decide until late December 2013. Given the current timeline it is unlikely that Utah will have a Medicaid expansion in 2014.

State Priority 2—Plan for and implement Wellness and Recovery Oriented Systems of Care principles for persons with mental health and/or substance use disorders.

Goal A—Expand the continuum of care to include early interventions and long term support of recovery.

Populations— ALL

Strategies:

1. As SAPTBG funds become available through the expansion of other payment options, Utah will expand ATR type vouchers to provide RSS services.
2. Work through the UBHC Data, Financial and Clinical committees to expand the state Substance Abuse and Mental Health Information System (SAMHIS) to allow for tracking of clients outside of the TEDS data system in order to provide recovery support services prior to admission and after discharge from an episode of acute treatment.
3. Continue to work with SAMHSA to modify NOMS and TEDS to reflect and support a Recovery Oriented System of Care.

Indicator:

1. Number of Local Authorities using of Vouchers to provide Recovery Support Services to SUD Priority Populations.
 - a. Baseline (FY 2012)—Vouchers used to provide services in three Local Authorities
 - b. 1st Year (FY 2014)—Increase the number of Local Authorities using vouchers by one, for a total of four Local Authorities using vouchers
 - c. 2nd Year (FY 2015)—Increase the number of Local Authorities using vouchers in 2014 by two, for a total of six Local Authorities using vouchers

Source of DATA: Annual Reports and Local Authority Area Plans

Comments: This is conditional on expansion of funding and retention of SAPT funds for RSS.

2. Use of “Limited Treatment” code in SAMHIS to provide RSS outside of the TEDS episode of acute Care
 - a. Baseline (FY 2012)—No Local Authorities using.
 - b. 1st Year (FY 2014)—Increase the number of Local Authorities using code for RSS outside of TEDS episode to three.
 - c. 2nd Year (FY 2015)—Increase the number of Local Authorities using code for RSS outside of TEDS in 2014 by three, for a total of six Local Authorities using RSS outside of TEDS episode.

Source of DATA: Annual Reports and LA Area Plans

Goal B—Improve use of data to evaluate treatment and prevention systems and guide improvements and changes.

Populations—All

Strategies:

1. Work through the UBHC Data, Financial and Clinical committees to expand the state Substance Abuse and Mental Health Information System (SAMHIS) to allow for tracking of clients outside of the TEDS data system in order to provide recovery support services prior to admission and after discharge from an episode of acute treatment.

2. Improve the utility of Prevention Data by developing an alternative tracking system that will also provide input to SAMHIS.
3. Develop a Prevention Scorecard to better measure achievement of Prevention goals and objectives.

Indicators:

1. Inclusion of RSS services and pre and post treatment episode of care data in SA and Mental Health Score Cards.
 - a. Base Line (FY 2012)—See current Scorecards at www.dsamh.utah.gov
 - b. 1st Year (FY 2014)—Two measures for RSS services on scorecards
 - c. 2nd Year (FY 2015)—Targets for RSS measures included in Division Directives and used for monitoring reports.

Source of Data: SAMHIS; Audit Reports; Division Directives; Agency Reports.

State Priority 3—Substance Use Disorder and Mental Illness prevention and treatment services and Mental Health promotion

Goals A— Reduce lifetime and 30 day marijuana use for 8th, 10th, and 12th grades through education, awareness and referrals prevention programs.

Population—8th, 10th, and 12th graders

Strategies:

1. Review Student Health and Risk Prevention (SHARP) survey data and other epidemiological data sources for the state and Local Substance Abuse Authorities (LSAA) to identify risks and trends associated with the lifetime and 30 day use rates of marijuana. Focus on counties or LSAA areas with high marijuana use rates. Collaborate with other state and local agencies through education and awareness campaigns regarding the reduction of marijuana use rates. Emphasize the need to address marijuana use rates as a statewide issue during SAPST, CTC trainings, town hall meetings and other community forums.
2. Monitor LSAA programs identified for addressing marijuana use for 8th, 10th and 12th graders. This process will include evaluation of strategies, outcomes and methods used to reduce marijuana use rates.
3. Enhance existing programs through technical assistance and monitoring. Use evidenced-based strategies and/or programs to strengthen these efforts.

Indicators:

1. Lifetime marijuana use data.
 - a. Baseline (FY 2012)-- (the following outcomes are based on 2011 SHARP survey data and will be revised once the 2013 SHARP data is available)
 - i. Marijuana use in lifetime for 8th grade is 7%
 - ii. Marijuana use in lifetime for 10th grade is 17%
 - iii. Marijuana use in lifetime for 12th grade is 23%
 - b. 1st Year (FY 2014)—

- i. Reduce lifetime use of marijuana in 8th grade from 7% in 2011 to 6% in 2014.
 - ii. Reduce lifetime use of marijuana in 10th grade from 17% in 2011 to 16% in 2014.
 - iii. Reduce lifetime use of marijuana in 12th grade from 23% in 2011 to 22% in 2014.
 - c. 2nd year (FY 2015)—
 - i. Reduce lifetime use of marijuana in 8th grade from 6% in 2014 to 5% in 2015.
 - ii. Reduce lifetime use of marijuana in 10th grade from 16% in 2014 to 15% in 2015.
 - iii. Reduce lifetime use of marijuana in 12th grade from 22% in 2014 to 21% in 2015.
- 2. 30 Day marijuana use data
 - a. Baseline (FY 2012)-- (the following outcomes are based on 2011 SHARP survey data and will be revised once the 2013 SHARP data is available)
 - i. 30 day Marijuana use in 8th grade is 3%
 - ii. 30 day marijuana use in 10th grade is 8%
 - iii. 30 day marijuana use in 12th grade is 22%
 - b. 1st Year (FY 2014)—
 - i. Reduce 30 Day marijuana use in 8th grade from 3% in 2011 to 2% in 2014.
 - ii. Reduce 30 Day marijuana use in 10th grade from 8% in 2011 to 7% in 2014.
 - iii. Reduce 30 Day marijuana use in 12th grade from 10% in 2011 to 9% in 2014.
 - c. 2nd year (FY 2015)—
 - i. Reduce 30 Day marijuana use in 8th grade from 2% in 2014 to 1% in 2015.
 - ii. Reduce 30 Day marijuana use in 10th grade from 7% in 2014 to 6% in 2015.
 - iii. Reduce 30 Day marijuana use in 12th grade from 9% in 2014 to 8% in 2015.

Source of Data— Sharp Survey and Local Authority Reports

Comments—

Goal B—Reduce underage drinking in adolescents.

Population—Universal, Selective, and Indicative

Strategies:

1. Through collaboration with partner agencies develop a comprehensive strategy to:
 - a. reduce availability of alcohol to underage adolescents through compliance; and
 - b. delay time of first use and 30 day use.
2. Provide education and awareness to parents of youth within target population.

Indicators:

1. EASY compliance report with collaboration from Department of Highway Safety, LSAA area reports of EASY compliance and review of program outcomes targeting underage drinking as a measure, and the 2015, 2017 SHARP survey data.
 - a. Baseline (FY 2011)—
www.dsamh.utah.gov/docs/State%20of%20Utah%20Profile%20Report.pdf
 - b. 1st Year (FY 2014)—Reduce use by 10 %
 - c. 2nd Year (FY 2015)—Maintain reduction achieved in FY 2014

Source of Data—SHARP Survey and BRFSS Data

Comments—SHARP survey only done every two years.

Goal C—Reduce prescription drug abuse through collaboration with state and local agencies, as well as provide education and awareness to communities.

Populations—Universal, Selective, and Indicative

Strategies:

1. Include information and education on Prescription Drug abuse in all Division sponsored and supported conferences and trainings.
2. Participate and provide prevention and treatment expertise in the Department of Health and DEA Prescription Drug Committees.
3. Assist prevention prepared communities in addressing Prescription Drug abuse in their communities as appropriate.
4. Provide information about the benefits of medication assisted therapies to support recovery for opiate and alcohol related admissions.

Indicator:

1. Reduction of Admissions for opiates.
 - a. Baseline (FY 2012)—21.2% total admissions for opiates
 - b. 1st Year (FY 2014)— Decrease to 20%
 - c. 2nd Year (FY 2015)—Decrease to 19%
2. Reduce Number of Overdose Deaths
 - a. Baseline (FY 2012)—834 deaths
 - b. 1st Year (FY 2014)—2% reduction
 - c. 2nd Year (FY 2015)—10% reduction

Source of Data—Center for Disease Control Data

Comments—

Goal D: Mental Illness Prevention

Population—Lifespan

Strategies:

1. Early Intervention: reduce mental illness in SED populations through School Based intervention, Family Resource Facilitator with wrap around and mobile crisis teams.
2. Suicide prevention: Collaborate on a state level with Utah State Office of Education (USOE) to build capacity of suicide prevention specialists throughout communities by offering Train the trainer (T4T) trainings to local coalitions. Promote evidenced based programming on suicide prevention, intervention, and postvention across the lifespan.

3. Increase ASIST and CONNECT T4T trainers throughout the state.

Indicators:

1. Increase the number of T4T trainers in local coalitions
 - a. Baseline (FY 2012)—
 - i. 30 Question Persuade Refer (QPR)
 - ii. 6 Mental Health First Aid
 - b. 1st Year (FY 2014)—Increase by 5 percent
 - c. 2nd Year (FY 2015)—Increase by 10 percent

Data Source: Internal data monitoring

Comments:

Goal E—Build an infrastructure of prevention prepared communities through SAPST certification and CTC implementation to prioritize prevention risk factors and focus resources on reducing substance abuse and mental health problems or disorders.

Populations—All SUD and MH

Strategies:

1. Engage citizens to find solutions to substance abuse problems in their communities through research and evidence based programming.
2. Train LSAA and their staff including coalition members and volunteers in SAPST curriculum as needed.
3. Train LSAA and their staff in the CTC model of prevention.
4. Increase the number of trained prevention professionals in the CTC and subsequent coalitions each year

Indicator:

1. Number of CTC
 - a. Baseline (FY 2012)—As of FY14, there are 9 CTC coalitions that either have contracts with DSAMH or are in the planning phase to do so.
 - b. 1st Year (FY 2014)—Increase by 25% which equal to 11 CTC coalitions
 - c. 2nd Year (FY 2015)—Increase by 45% which equal to 16 CTC coalitions

Data Source—Area Plans and monitoring report

State Priority 4—Provide Services for the following priority populations:

- a. **Persons who are intravenous drug users (IDU).**
- b. **Women who are pregnant and have a substance use and/or mental disorder.**
- c. **Parents with substance use and /or mental disorders who have dependent children**
- d. **Individuals with tuberculosis.**
- e. **Children with serious emotional disturbances (SED) and their families.**
- f. **Adults with Serious Mental Illness (SMI).**

Goal A—Provide Services for persons who are intravenous drug users (IDU)

Population—IVDUs

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator:

1. Compliance with Contract Requirements
 - a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
 - b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
 - c. 2nd Year (FY FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data—Division Reports.

Goal B—Provide behavioral health services to pregnant women and have a substance use and/or mental disorder.

Population—SUD; PWWDC: SED

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator:

1. Compliance with Contract Requirements
 - a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population.
 - b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
 - c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data—Division Reports.

Goal C—Provide Services for parents with substance use and or mental disorders who have dependent children.

Population—PWWDC; SUD; SED

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
3. Contract with Local Authorities for services as per statute
4. Include Block Grant requirements in Local Authority contracts.

Indicator:

1. Compliance with Contract Requirements
 - a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population.
 - b. 1st year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
 - c. 2nd year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal D—Provide Services for individuals with tuberculosis (TB)

Population—TB

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.
3. Coordinate with Department of Health for coordinated services.

Indicator:

1. Compliance with Contract Requirements
 - a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Populations
 - b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
 - c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

Goal E—Provide Services for children with serious emotional disturbances (SED) and their families.

Population: SED

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator:

1. Compliance with Contract Requirements
 - a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
 - b. 1st Year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
 - c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data—Division Reports

Goal F—Provide Services for adults with serious mental illness (SMI)

Population—SMI

Strategies:

1. Contract with Local Authorities for services as per statute
2. Include Block Grant requirements in Local Authority contracts.

Indicator:

1. Compliance with Contract Requirements
 - a. Baseline (FY 2012)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
 - b. 1st year (FY 2014)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
 - c. 2nd Year (FY 2015)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Source of Data: Division Reports.

State Priority 5—Develop a plan to improve services to the following populations within the state:

- a. **American Indian;**
- b. **Military personnel and their families;**
- c. **Individuals with mental and or substance abuse disorders who live in rural areas or who are homeless; and**
- d. **Underserved racial, ethnic and LGBTQ populations.**

Population—SUD; SMI; SED; Other

Strategies:

1. Provide ongoing education through Generations, U of U June School and Fall Substance Abuse Conferences on cultural competence and special populations.

2. Focus on services to appropriate special populations during site visits to local authorities.
3. Participate in councils representing special populations when BH issues are involved. (DHS Tribal Council; Veteran's Councils; Legislative Committee on Veteran's affairs)
4. Include representatives of special populations in educational planning committees.
5. Review Local Authority Area Plans for emphasis on planning for special populations.

Indicator:

1. Admissions by special populations
 - a. Baseline (FY 2012)—TEDS admission data for each population where available.
 - b. 1st Year (FY 2014)—Improve admissions and retention for each of the populations where data is available.
 - c. 2nd Year (FY 2015)—Improve admissions and retention by 10% over baseline.

Source of Data—TEDS

Comments—Some populations are not reported by TEDS, nor are there accurate ways to measure or collect the data. An example is LGTBQ admissions are not collected, or asked for. Nor would they be reliable figures, especially in frontier areas of the state. Likewise, Tribal status is not reported and data about veterans status is notoriously inaccurate.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	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	\$25,195,892		\$	\$13,641,844	\$21,423,632	\$12,211,186	\$12,968,038
a. Pregnant Women and Women with Dependent Children*	\$20,156,714		\$	\$1,405,336	\$2,390,280	\$631,758	\$1,861,730
b. All Other	\$5,039,178		\$	\$12,236,508	\$19,033,352	\$11,579,428	\$11,106,308
2. Substance Abuse Primary Prevention	\$6,718,904		\$1,246,274	\$158,000	\$160,882	\$1,129,518	\$1,419,202
3. Tuberculosis Services	\$		\$	\$	\$732,178	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$1,679,726		\$	\$	\$	\$	\$
11. Total	\$33,594,522	\$	\$1,246,274	\$13,799,844	\$22,316,692	\$13,340,704	\$14,387,240

* Prevention other than primary prevention

footnote:

The above are a forecast of the SA expenditures for SFY2014. At the current time, we do not anticipate any major changes during SFY2015.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2014

Activity (See instructions for using Row 1.)	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			\$	\$	\$	\$	\$
6. Other 24 Hour Care		\$	\$	\$1,715,749	\$	\$4,055,935	\$
7. Ambulatory/Community Non -24 Hour Care		\$333,607	\$	\$954,634	\$	\$4,165,933	\$
8. Mental Health Primary Prevention		\$37,954	\$	\$	\$	\$	\$
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$225,000	\$	\$	\$	\$	\$
10. Administration (Excluding Program and Provider Level)		\$156,441	\$	\$	\$	\$	\$
11. Total	\$	\$753,002	\$	\$2,670,383	\$	\$8,221,868	\$

* Prevention other than primary prevention

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$	\$
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 Dissemination			\$	\$
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			\$	\$
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			\$	\$
Children's Mental Health 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			\$	\$
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 (please list)			\$	\$

footnote:

The state is not currently focusing on this area.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$11,623,776	
2 . Substance Abuse Primary Prevention	\$4,023,837	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$823,559	
6. Total	\$16,471,172	

* Prevention other than primary prevention

** HIV Early Intervention Services

footnote:

The first submission was based on a 20% primary prevention estimate. The \$4,023,837 estimation is much more accurate as it is a sum of our subcontractors' budgets.

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	\$414,860	
	Selective	\$32,267	
	Indicated	\$13,829	
	Unspecified		
	Total	\$460,956	
Education	Universal	\$1,200,345	
	Selective	\$720,207	
	Indicated	\$480,137	
	Unspecified		
	Total	\$2,400,689	
Alternatives	Universal	\$77,951	
	Selective	\$92,409	
	Indicated	\$34,893	
	Unspecified		
	Total	\$205,253	
Problem Identification and Referral	Universal		
	Selective	\$50,588	
	Indicated	\$310,756	
	Unspecified		
	Total		

	Total	\$361,344	
Community-Based Process	Universal	\$432,051	
	Selective		
	Indicated		
	Unspecified		
	Total		
Environmental	Universal	\$163,544	
	Selective		
	Indicated		
	Unspecified		
	Total		
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Total Prevention Expenditures		\$4,023,837	
Total SABG Award*		\$16,471,172	
Planned Primary Prevention Percentage		24.43 %	

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

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$1,071,877	
Universal Indirect	\$513,345	
Selective	\$1,684,871	
Indicated	\$753,744	
Column Total	\$4,023,837	
Total SABG Award*	\$16,471,172	
Planned Primary Prevention Percentage	24.43 %	

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

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

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	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2014

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	40088.00			\$40,088				
2. Quality Assurance								
3. Training (Post-Employment)	124025.00	63000.00		\$187,025				
4. Education (Pre-Employment)		15000.00		\$15,000				
5. Program Development		66022.00		\$66,022				
6. Research and Evaluation								
7. Information Systems	114000.00			\$114,000				
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	\$278,113	\$144,022		\$422,135				

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ <input type="text"/>
MHA Planning Council Activities	\$ <input type="text" value="5,000"/>
MHA Administration	\$ <input type="text" value="222,950"/>
MHA Data Collection/Reporting	\$ <input type="text" value="170,000"/>
Enrollment and Provider Business Practices (3 percent of total award)	\$ <input type="text"/>
MHA Activities Other Than Those Above	\$ <input type="text"/>
Total Non-Direct Services	\$397950
Comments on Data: <input type="text"/>	

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

Please see the attached file titled Final IV C Coverage (M)SUD Services.

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late 2013 and the funding to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a “bifurcated” Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the “bifurcated” model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

During the 2013 Interim Legislative Session, Utah selected its Essential Health Benefit (EHB) benchmark plan. This plan was approved by HHS, despite it not meeting all of the requirements of the Affordable Care Act (ACA). Specifically, the EHB Utah selected does not meet the ACA’s standards for ensuring mental health parity for substance use disorder and mental health benefits and it does not meet the standards established for child pediatric vision and dental benefits. The Utah Department of Insurance has acknowledged that the selected plan does not meet mental health parity requirements and have indicated that during the certification process of QHPs they intend to enforce parity, but have not offered specifics on how they will achieve parity.

Due to the uncertainty that these issues create, many of the answers provided will be conditional and subject to change.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?

The Utah Division of Substance Abuse and Mental Health (DSAMH) intends to use SAPT and MH block grant funding to pay for services not covered by private and/or public insurers. The DSAMH estimates that over 80 percent of the individuals currently being served in the public Substance Use Disorder (SUD) treatment system and over 95 percent of individuals currently served in the public Mental Health treatment system would qualify for the Medicaid Expansion in the Affordable Care Act (ACA). If Utah chooses to expand access to Medicaid then the DSAMH anticipates shifting block grant funding to Recovery Support Services, early screening and intervention services, and to cover gaps in funding for individuals who are not yet enrolled in Medicaid or other third party insurance. If the state chooses to not expand access to Medicaid, then SAPT and MH block grant funding will be used as they currently are, to provide services to the priority populations and provide the bulk of non Medicaid services in the public system.

The Essential Health Benefits (EHB) selected by the state does not currently meet parity requirements and we are working with the Utah Department of Insurance (DOI) to determine how to best enforce those requirements during the certification of Qualified Health Plans (QHP). In our conversations with the DOI we have determined that despite the fact that the majority of

health plans who are submitting applications to be QHPs on the Marketplace are exceeding the benchmark levels for SUD and MH coverage outlined in our EHB. We have also determined that the majority of these plans are taking steps to meet mental health parity and the DOI anticipates by 2015 all plans sold on the Marketplace will meet parity. The DSAMH will continue to work with the Utah Legislature, the DOI and our community partners to monitor the situation and report any issues with accessing SUD and MH services.

2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

The Local Authorities are statutorily required to plan for and provide SUD and MH services in Utah. As a result, the Local Authorities are responsible for monitoring whether individuals and families have access to SUD and MH services offered through QHPs and Medicaid. The Utah Division of Substance Abuse and Mental Health will work to the Local Authorities to ensure that individuals are enrolled and receiving the appropriate level of care.

3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

The DOI is responsible for the certification of all QHPs in the state of Utah and the ongoing monitoring of those plans. The deadline for QHPs to submit applications to the DOI was the end of June, and the review process of these applications has begun. The DSAMH is working with the DOI to ensure that all plans offered on the marketplace meet parity requirements.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?

DSAMH anticipates receiving complaints from the Local Authorities and clients on violations of MHPAEA. The DSAMH does not have authority to directly address complaints, so it will be necessary for us to partner with the DOI on addressing these issues. The DSAMH would like to establish a process with the DOI to address these complaints, but at this point a formal process has not yet been established.

5. What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?

Behavioral health services are provided through cost based reimbursement contracts that exist between the DSAMH and the Local Authorities. The DSAMH does not currently purchase any specific services. The DSAMH does require the local authorities provide specific services, which are outlined in Utah Statute 62A-15 (<http://le.utah.gov/UtahCode/section.jsp?code=62A-15>) and 17-43 (<http://le.utah.gov/UtahCode/section.jsp?code=17-43>). These services are further expanded upon in Administrative Rule (<http://www.rules.utah.gov/publicat/code/r523/r523.htm>). These require that the Local Authorities provide 10 mandated mental health services and a “continuum of services” for treatment of SUD. As other funding sources such as Medicaid and QHP cover the basic required services, the DSAMH will direct that the Local Authorities shift state and federal funds portions of the continuum of services not covered by insurance. This will

be done through additions to the DSAMH directives and monitored through the Local Authorities success in implementing those directives through their annual Area Plans.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

Please see the attached document titled final IV D Affordable Insurance Marketplace

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late 2013 and the funding to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a “bifurcated” Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the “bifurcated” model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

During the 2013 Interim Legislative Session, Utah selected its Essential Health Benefit (EHB) benchmark plan. This plan was approved by HHS, despite it not meeting all of the requirements of the Affordable Care Act (ACA). Specifically, the EHB Utah selected does not meet the ACA’s standards for ensuring mental health parity for substance use disorder and mental health benefits and it does not meet the standards established for child pediatric vision and dental benefits. The Utah Department of Insurance has acknowledged that the selected plan does not meet mental health parity requirements and have indicated that during the certification process of QHPs they intend to enforce parity.

Due to the uncertainty that these issues create, many of the answers provided will be conditional and subject to change.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

State is not currently addressing.

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

State is not currently addressing.

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing third party Medicaid, the CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

Our current contracts with the Local Authorities are cost reimbursement contracts, so drawing down funds isn’t done on a client services basis. However, if, the State adopts Medicaid expansion and the Utah Division of Substance Abuse and Mental Health (DSAMH) is then able to use block grant funds for expanded services and recovery support services, we will monitor

the expansion of services during our annual site visits. Additionally, the state is moving towards a different contracting system and hopes to have that in place in 2015.

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

Currently all of the providers that are contracted with the DSAMH are eligible for Medicaid reimbursement and are working to expand their participation in other insurance plans.

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

Only 17% of SUD clients receiving SUD services are currently covered by Medicaid. At least 90% of the remainder are uninsured or under insured. In FY 12 this translates as approximately 13,000 uninsured clients. Most of the clients served in the Mental Health Centers are covered by Medicaid, but it is estimated that there are at least 13,000 uninsured clients. Most of the clients served in the Mental Health Centers are covered by Medicaid, but it is estimated that at least 15 percent of current clients are currently uninsured.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

This depends totally on whether or not Utah adopts the Medicaid expansion. If Medicaid expansion is adopted, it is anticipated that by 2015, the number of individuals not insured will mirror the Massachusetts experience. Initially they found that 20-30% of individuals seeking SUD/MH services were uninsured at admission. Given that figure we anticipate that approximately 4,500 SUD clients and 8,000 MH clients will be uninsured at admission. We anticipate that the numbers of uninsured will drop dramatically from close to 100% of SUD clients and non SPMI MH clients in FY 13 through FY 14 to reach the percentage of clients

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2012 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

Currently 100% of the providers that are contracted with the Division are eligible for Medicaid reimbursement and are working to expand their participation in other insurance plans.

It is not an estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

100% 2014

100% 2015

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (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 utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

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. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. 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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

Please see attached document titled Final IV E Program Integrity

At this time, Utah is still determining whether or not they want to participate in the optional adult Medicaid Expansion. The Governor has indicated he will make a decision sometime in late 2013 and the funding to move forward with this program would need to be approved by the State Legislature, which will convene in late January of 2014.

Utah has received approval from the US Department of Health and Human Services (HHS) to operate a "bifurcated" Health Insurance Exchange (Marketplace). This means that the Utah will have a federally operated Individual Marketplace and a State operated small business Marketplace. The State small business Marketplace, is currently in operation, and is known as Avenue H. Additionally, as a part of the "bifurcated" model, Utah was given authority to maintain regulatory authority of Qualified Health Plans (QHP) on both the federal and state marketplace. This means that the Utah Department of Insurance will be responsible for the certification of QHPs on both the federal and state marketplaces.

During the 2013 Interim Legislative Session, Utah selected its Essential Health Benefit (EHB) benchmark plan. This plan was approved by HHS, despite it not meeting all of the requirements of the Affordable Care Act (ACA). Specifically, the EHB Utah selected does not meet the ACA's standards for ensuring mental health parity for substance use disorder and mental health benefits and it does not meet the standards established for child pediatric vision and dental benefits. The Utah Department of Insurance has acknowledged that the selected plan does not meet mental health parity requirements and have indicated that during the certification process of QHPs they intend to enforce parity, but have not offered specifics on how they will achieve parity.

Due to the uncertainty that these issues create, many of the answers provided will be conditional and subject to change.

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

Yes

2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?

Yes

3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:

a. Budget review; Yes

b. Claims/payment adjudication; Yes we deal with complaints

c. Expenditure report analysis; Yes

d. Compliance reviews; Yes

e. Encounter/utilization/performance analysis; Yes

and

f. Audits. Yes

4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?

The Utah Division of Substance Abuse and Mental Health (DSAMH) conducts yearly audit visits of each local authority. These audits allow the DSAMH to review billing documents, compare service costs between similar providers (rural and urban), and compare outcome data, per client costs and client satisfaction surveys and complaints. Additionally, these annual audits allow the DSAMH to assess each local authority's compliance with federal and state requirements, prescribed billing practices and accounting procedures, clinical practice guidelines and procedures, and with requirements for clinical documentation. Finally, the annual audit allows the DSAMH to interview local authority clients, review Client Satisfaction Surveys and evaluate outcome measures to assess the effectiveness of the program.

5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

There are numerous ways the DSAMH assists providers in adopting best practices that promote compliance with program requirements. During yearly audit visits to the each local authority the DSAMH conducts compliance checks and provides technical assistance on improving procedures and practices. Additionally, the DSAMH sponsors a number of statewide training conferences to provide regular training opportunities to providers including—the Generations Conference, the Fall Substance Abuse Conference, and the Utah Valley Addictions Conference. Additionally, the DSAMH holds 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. Finally, the DSAMH conducts an annual training of our Division Directives, which allows the DSAMH to highlight any changes to existing requirements or new requirements the local authorities are expected to meet during the upcoming year. Once the Division Directive is presented to the local authorities, they submit an annual Area Plan outlining how each local authority plans on meeting DSAMH requirements and the plans are reviewed and approved by DSAMH leadership.

6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

This is currently monitored through the audit process explained above. Audit teams consist of administrative, financial and clinical staff from the DSAMH. Additionally, as stated earlier, contracts with the Local Authorities are cost reimbursement contracts, and services for clients with Medicaid, Medicare, and other insurance are billed separately to those agencies.

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

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. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

Please see the attached document titled final IV F Use of Evidence in Purchasing Decisions

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

Yes, the Utah Division of Substance Abuse and Mental Health (DSAMH) employees a Program Administrator for each of the following areas—Substance Use Disorder (SUD) treatment services, Adult Mental Health Services, Children’s Mental Health Services, Access to Recovery Services, and SUD Prevention services. Each Program Administrator is responsible for researching evidence based practices and providing training to providers; as well as supporting and monitoring the implementation of statewide evidence based practices. 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.

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

The DSAMH is primarily a pass through agency that contracts with Local Authorities on a cost reimbursement basis. Planning for providing direct services is the responsibility of the Local Authority. Although the DSAMH does use information regarding evidence-based or promising practices in our policy decisions and in setting requirements for the Local Authorities.

a) What information did you use?

The DSAMH uses multiple sources to inform our policy decisions on evidence based practices. These include, but are not limited to the following:

- Documents published and distributed by SAMHSA;
- SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP);
- Prevention’s Planning Process;
- Practices shared by Local Substance Abuse and Mental Health Authorities through the Utah Behavioral HealthCare Clinical committee;
- Research from other sources (AATOD, CESAR Fax, NIDA, NIAA, NASADAD, NASMHPD, etc); and
- Practice Guidelines developed collaboratively with the Local Authorities.

b) What information was most useful?

Each of the above sources have strengths and weakness and all are useful.

3) How have you used information regarding evidence-based practices?

a) Educating State Medicaid agencies and other purchasers regarding this information?

b) Making decisions about what you buy with funds that are under your control?

As established by Utah state statute, the DSAMH is not authorized to purchase direct services. As a result information on evidence-based practices is not used by the DSAMH in purchasing decisions. However, we do disseminate information on evidence-based practices to educate providers, consumers,

partners, and administrators and develop specific policies in our contracts that local authorities must adhere to.

**Division Directives for Division of Substance Abuse and Mental Health Prevention Portion
(Section D ii) Evidence-Based Process and Strategies for Purchase**

Fiscal Year 2014

DSAMH FY2014 DIRECTIVES

I. The Local Authority shall refer to the contract, state and federal statute and administrative rule to comply with all of the requirements attached to the funding in these contracts. The directives are intended to be additional requirements that are not already identified in the contract, state and federal statute and administrative rule. These directives shall remain in effect from July 1, 2013 through June 30, 2014. The Local Authority shall comply with the directives, as identified below...

D. SUBSTANCE ABUSE PREVENTION SERVICES

i. Prevention services

a. Local Authority shall use the Strategic Prevention Framework (SPF) developed by the Substance Abuse Mental Health Services Administration (SAMHSA) to implement comprehensive community level prevention systems within their area. DSAMH encourages LSAA to utilize the Communities that Care model to meet this directive.

1. Assess local prevention needs based on epidemiological data. This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data.
2. Build prevention capacity, including assurances that all prevention personnel are certified and trained for implementation and delivery for all required programs.
3. Develop a strategic plan.
4. Implement effective community prevention programs, policies and practices.
5. Use logic models as the basis for evaluation plan and to demonstrate expected short and long term outcomes.
6. Submit an annual report that summarizes performance of prevention programs policies and strategies based on the short and long term outcomes identified in the logic models.
7. LSAA shall spend a minimum of 30% of SAPT Block Grant funds on prevention policies, programs, strategies, administration.

ii Evidenced-Based Indicated Prevention for Parents and Families

- a. Funding shall be used to develop, expand or enhance indicated prevention programs that are evidenced-based. Programs, strategies and services listed on one of the following registries shall be considered eligible:
 1. Center for the Study and Prevention of Violence-Blueprints <http://www.colorado.edu/cspv/blueprints/>;
 2. U.S. Department of Justice Model Programs Guide <http://www.ojjdp.gov/mpg/>;
 3. Communities That Care Prevention Strategies Guide <http://www.sdrp.org/ctcresource/>; and
 4. Programs determined by the Utah Evidence Based Workgroup to be Level III: Supported, Efficacious Practices, or Level IV: Well Supported- Effective Practices using the Program Assessment Rating Tool (PART) developed by the Office of Child Abuse and Neglect (OCAN).

- b. Allowable expenses will be limited to:
 1. Promotion of selected program(s);
 2. Evidence-based program (EBP) program training and certification costs;
 3. Purchase of consumables and materials required to deliver EBP;
 4. Implementation (Direct staff time devoted to preparation and delivery of EBP);
 5. Monitoring and evaluation;
 6. Other expenses necessary to promote, implement, enhance or bring EBP to fidelity;

- c. The Local Substance Abuse Authority agrees to the following:
 1. Implement services as described by EBP program curriculum;
 2. Monitor implementation of program to ensure critical elements are delivered as described by program developer (fidelity);
 3. Collect process data and report on DSAMH approved data collection system;
 4. Administer approved pre-post matched surveys to participants;
 5. Provide matched Pre/Post tests to each program participant;
 6. Ensure all services are delivered by individuals certified and/or licensed for the implemented program;
 7. Ensure that providers are Substance Abuse Prevention Specialist Training certified; and
 8. Submit invoice monthly.

- d. Allocation letters will be amended upon submission and approval of a plan containing the following elements:

1. Budget that identifies how funds will be expended; and Description of the target population, program, training and certification requirements, monitoring plan and evaluation plan.

PERFORMANCE MEASURES

- iii. Substance Abuse Prevention Performance Measures:
 - a. All prevention services entered in DSAMH approved data system accurately and within 60 days of services. For instruction, see <http://kitusers.kithost.net/support/dcarsupport/UserManualsDocuments/MDSDocuments/tabid/1512/Default.aspx> .
 - b. Percent of retail establishments within Local Authority area that refused to sell tobacco to minors during Synar tobacco compliance checks. (Target for FY2014 is 90%.)
 - c. Percentage of students in each grade (6, 8, 10, 12) using alcohol during the past 30 days (will use trend data from 2003, 2005, 2007, 2009, 2011, 2013).
 - d. Percent of students in each grade (6, 8, 10, 12) using illegal drugs during the past 30 days (will use trend data from 2003, 2005, 2007, 2009, 2011, 2013).
 - e. Number of “Eliminate Alcohol Sales to Youth” (EASY) alcohol compliance checks within Local Authority area. (Target for FY2014 is an increase from the previous year.)
 - f. Number of coalitions as defined by DSAMH in local substance abuse authority area.
 - g. Number of evidence-based policies, programs and strategies implemented. This process shall include:
 1. Number of EB policies, programs and strategies.
 2. Number of certified individuals to deliver evidence based policies, programs and strategies.
 3. Percent of funding spent on evidence based policies, programs, and strategies.
 4. Number of people reached by evidence based policies, programs and strategies.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

Please see the attached document titled final IV G quality

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

See Tables 1-4 below.

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

See Tables 1-4 below.

3) What are your states' specific priority areas to address the issues identified by the data?

Utah's priority in Substance Use Disorder (SUD) treatment and prevention is to expand the continuum of care to include early identification and intervention, increasing the availability of recovery support services, and relapse prevention services to support long term recovery. Utah's Mental Health priorities are to expand services past the traditional Medicaid population, as well as to improve the range of employment and recovery services available. An additional priority for both SUD and Mental Health Services is to reduce the impact of stigma on the ability of individuals to seek out and utilize treatment services and to improve the availability of services to support those individuals in their recovery.

4) What are the milestones and plans for addressing each of your priority areas?

The Utah Division of Substance Abuse and Mental Health (DSAMH) anticipate that achieving these priorities will take three to five years. There will be many challenges in achieving these priorities including the nature of the behavioral health care system in Utah, variation in the Local Authorities priorities as defined by County Governments, and the nature of the DSAMH priorities. These priorities are focused more on cultural changes rather than practice changes, making it difficult to establish a statewide schedule. Additionally, reducing stigma requires changing attitudes of employers, landlords, administrators, government officials and the public; as well as changing the attitudes of the current behavioral health workforce.

Table 1: Mental Health Scorecards for Adults

FY 2012 Mental Health Scorecard for Adults

September 28, 2012

Local Authority	Number of Clients Served		Estimate of Need at 300% of Poverty*					# SPMI Served		Unfunded		Supported Housing/In Home Skills		Jail Services		Employment					
			# In Need of Treatment	% In Need of Treatment	% of Need Served	# In Need of Treatment SPMI	% SPMI Need Served	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	Supported Employment		# Employed		% Employed	
																FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Rural Counties																					
Bear River	1,972	1,972	6,760	5.9%	29.2%	1,928	86.9%	1,660	1,575	33	28	38	34	149	229	18	14	342	329	54.6%	61.0%
Central	702	760	3,178	6.1%	23.9%	361	58.8%	534	565	136	143	0	0	0	3	6	6	135	146	58.4%	58.4%
Four Corners	1,050	914	1,836	6.1%	49.8%	576	106.3%	652	612	619	69	0	2	14	0	0	0	336	194	76.4%	71.1%
Northwestern	865	955	2,349	6.6%	40.7%	740	45.8%	353	339	346	331	20	19	3	9	0	0	296	352	63.9%	70.5%
San Juan	385	415	955	9.6%	43.5%	322	29.8%	94	96	119	117	0	0	0	0	1	1	150	163	78.1%	81.1%
Southwest	1,290	1,367	9,386	6.4%	14.6%	2,827	31.0%	821	875	376	366	8	20	6	1	8	5	250	288	48.8%	52.4%
Summit Co.	581	598	1,309	4.8%	45.7%	379	47.2%	176	179	53	45	0	0	0	4	14	6	332	337	86.2%	84.9%
Tooele Co.	1,269	1,215	2,196	5.8%	55.3%	657	144.3%	892	948	111	68	1	0	14	3	8	6	375	353	77.0%	77.8%
Wasatch Co. - Heber	325	285	742	4.6%	38.4%	217	21.2%	74	46	206	159	0	0	6	3	0	0	139	113	65.3%	73.9%
Total	8,430	7,046	28,711	6.1%	24.5%	8,607	61.8%	5,236	5,317	1,590	1,321	67	75	192	249	55	38	2,347	2,264	68.4%	68.6%
Urban Counties																					
Davis	2,290	2,698	8,269	4.0%	32.6%	2,448	73.1%	1,738	1,790	406	297	75	81	224	786	52	49	448	569	48.5%	56.4%
Salt Lake Co.	10,936	10,046	38,060	5.1%	26.4%	11,040	67.8%	7,938	7,483	1,661	377	425	218	67	4	224	200	1,908	1,752	69.9%	65.9%
Utah Co. - Wasatch MH	4,145	4,455	21,652	6.3%	20.6%	6,089	39.5%	2,867	2,403	716	706	170	210	21	7	0	10	655	703	49.3%	51.8%
Weber	4,308	4,165	9,463	5.5%	44.0%	2,805	45.6%	1,610	1,280	1,592	1,552	32	37	1,258	1,129	0	5	528	402	42.7%	52.8%
Total	21,407	21,764	77,444	5.3%	28.1%	22,382	57.1%	13,963	12,772	4,305	2,883	695	542	1,545	1,870	276	261	3,510	3,387	57.1%	59.3%
State	29,489	29,205	105,369	5.4%	27.7%	30,813	57.9%	18,943	17,851	6,220	4,167	754	612	1,720	2,092	323	296	5,791	5,615	60.4%	62.9%

- * 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/In Home Skills 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.

*Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimate), from www.charles.holzer.com. Note: These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition and the MHM1 definition at 300% of poverty. The MHM3 definition requires a current or chronic disorder and a disability duration of at least 30 days, and is comparable to Seriously Mentally Disturbed (SMD). For children and adolescents, the estimates use poverty levels to assign rates of Serious Emotional Disturbance (SED). The MHM1 definition includes Severe and Persistent Mental Illness.

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, 120, and 160
 Target Case Management includes MHE service code 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.

Table 2: Mental Health Scorecard for Children and Youth 9age 17 and younger)

FY 2012 Mental Health Scorecard for Children and Youth (age 17 and younger)											September 28, 2012				
Local Authority	Number of Clients Served		Estimate of Need at 300% of Poverty*			# SED Served		Unfunded		Youth Enrolled in School		Youth Employed		Justice Services	
			# In Need of Treatment	% In Need of Treatment	% of Need Served										
	FY2011	FY2012				FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Rural Counties															
Bear River	1,162	1,120	2,731	6.14%	41.0%	777	796	148	167	888	874	19	14	4	20
Central	417	488	1,398	6.82%	34.8%	316	370	35	46	377	448	0	1	0	0
Four Corners	484	437	667	4.93%	78.5%	343	308	378	19	403	368	18	8	1	0
Northwestern	448	651	992	5.95%	61.3%	144	142	118	121	339	433	8	4	0	8
San Juan	193	163	398	8.82%	45.5%	31	23	34	37	166	149	0	0	0	0
Southwest	1,462	1,668	3,802	6.86%	43.3%	937	1,026	319	190	1,213	1,334	4	1	3	8
Summit Co.	230	217	468	4.42%	47.8%	80	73	38	21	209	203	12	23	0	6
Tooele Co.	472	626	988	4.69%	64.2%	327	366	43	44	446	476	7	9	0	0
Wasatch Co. - Heber	123	136	321	3.92%	42.1%	22	21	78	62	93	116	6	9	0	0
Total	4,930	5,183	11,261	6.30%	46.8%	2,940	3,106	1,181	883	4,204	4,474	71	89	8	38
Urban Counties															
Davie	1,280	1,446	3,984	3.76%	38.3%	1,238	1,329	124	48	1,155	1,313	2	2	0	6
Salt Lake Co.	5,208	4,702	13,422	4.42%	35.9%	4,348	3,783	628	209	4,478	4,082	23	22	0	6
Utah Co. - Wasatch MH	2,886	2,868	8,348	6.07%	30.8%	2,189	2,188	162	80	2,613	2,492	60	41	16	6
Weber	1,660	1,479	3,481	4.72%	42.7%	1,112	1,087	130	81	1,272	1,262	25	17	9	18
Total	10,817	10,380	30,213	4.62%	34.4%	9,786	9,324	922	419	9,329	9,066	102	81	23	32
State	16,698	16,408	41,373	4.70%	37.2%	11,819	11,316	2,084	1,084	13,396	13,426	173	160	31	68

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.

*Holzer, C.E., & Nguyen, H. T. (2008). Synthetic Estimates of Mental Health Needs for Utah (based on the Collaborative Psychiatric Epidemiological Surveys and the U.S. Census 2009 Population Estimates), from www.charles.holzer.com Note: These estimates are based on the Collaborative Psychiatric Epidemiological Surveys (CPES) conducted in 2001 to 2003 and the U.S. Census updated to 2009, using the MHM3 broad definition and the MHM1 definition at 300% of poverty. The MHM3 definition requires a current or chronic disorder and a disability duration of at least 30 days, and is comparable to Seriously Mentally Disturbed (SMD). For children and adolescents, the estimates use poverty levels to assign rates of Serious Emotional Disturbance (SED). The MHM1 definition include Severe and Persistent Mental Illness.

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, 120, and 160
 Target Case Management includes MHE service code 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/In Home Skills
 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, median and average days of service during the fiscal year only.

Table 3: Substance Abuse Treatment Outcomes Measures Scorecard for all Clients

FY2012 Utah Substance Abuse Treatment Outcomes Measures Scorecard for all clients

8/27/2012

Process Measures														
LSAA	Admissions (Initial and Transfer)		Number of Clients Served		Percent of Admissions in Outpatient/OP/ Residential/Defox		Number of Final Discharges, excluding Defox		Median Days in Treatment		Percent of clients in retained in treatment 60 or more days		Percent Completing Treatment Episode Successfully	
	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Bear River	905	1,101	1,377	1,491	84/95/1/0	85/14/1/0	904	1,026	106	79	81.8%	57.5%	46.8%	45.4%
Central Utah	211	243	336	385	94/6/0/0	91/6/1/0	160	212	104.5	127	71.9%	70.8%	25.0%	37.7%
Davis County	919	847	1,001	831	75/22/3/0	71/29/0/0	855	674	115	155	67.6%	78.6%	40.8%	42.0%
Four Corners	575	572	634	584	74/25/1/0	74/24/2/0	429	314	55	47	49.0%	47.5%	27.3%	34.7%
Northeastern	365	363	604	559	98/2/0/0	100/0/0/0	230	123	96	114	54.3%	69.9%	35.2%	42.3%
Salt Lake County	9,150	9,280	8,759	7,193	24/22/8/47	29/19/8/44	3,537	3,538	123	115	76.7%	75.4%	49.3%	45.3%
San Juan County	99	106	146	168	97/1/2/0	97/1/2/0	59	99	136	119	78.6%	71.7%	32.1%	33.3%
Southwest Center	545	585	616	570	46/33/20/0	53/29/20/0	512	470	146	167.5	85.4%	85.3%	59.4%	58.1%
Summit County	130	102	240	163	75/23/1/1	79/21/0/0	177	93	126	128	73.4%	80.6%	63.8%	57.0%
Yovelle County	293	314	461	328	79/20/1/0	86/20/0/0	312	139	139	143	74.7%	75.9%	51.5%	50.3%
Utah County	1,066	1,481	1,103	1,324	38/36/21/5	29/26/39/6	724	973	117.5	69	67.5%	53.1%	40.3%	53.1%
Wasatch County - Heber Valley	75	114	96	115	71/21/6/0	83/14/3/0	79	85	114.5	114	78.9%	78.8%	32.9%	38.8%
Weber Human Services	968	1,127	1,287	1,399	76/17/7/0	79/15/6/0	858	951	143	138	78.0%	78.5%	46.9%	51.0%
Statewide Contracts	1,247	1,147	2,228	2,333										
State Average/Total	18,583	17,284	16,454	17,026	43/20/11/26	45/19/11/24	8,833	8,745	120	114	72.1%	70.8%	46.1%	48.8%
State Urban Average/Total	12,086	12,735	10,101	10,790	33/22/8/36	39/20/11/33	5,877	6,136	125	118	74.5%	72.7%	46.7%	47.0%
State Rural Average/Total	3,238	3,382	4,508	4,360	78/18/4/0	79/17/4/0	2,856	2,609	110	199	67.0%	66.3%	44.8%	45.7%
National Average														

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 fullpart 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	
	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012	FY2011	FY2012
Bear River	170.8%	198.3%	126.5%	148.5%	**	-0.4%	17.1%	7.4%	93.9%	96.6%
Central Utah	30.3%	39.3%	62.9%	53.8%	0.6%	-0.5%	16.9%	7.2%	46.8%	73.0%
Davis County	17.9%	19.0%	98.3%	109.0%	-0.4%	0.0%	10.0%	14.8%	71.8%	73.0%
Four Corners	33.4%	39.2%	46.2%	26.6%	-0.2%	0.3%	7.3%	5.1%	63.6%	22.8%
Northeastern	33.1%	63.4%	45.8%	62.7%	0.0%	*	14.9%	31.2%	53.0%	75.1%
Salt Lake County	39.1%	23.9%	69.3%	59.6%	4.0%	4.1%	36.4%	23.1%	70.8%	59.5%
San Juan County	60.1%	85.6%	11.4%	13.8%	*	*	17.6%	6.6%	26.2%	61.1%
Southwest Center	30.7%	77.2%	169.3%	175.4%	-1.7%	-3.6%	40.7%	39.7%	58.5%	48.7%
Summit County	201.5%	222.3%	60.8%	57.8%	0.6%	1.1%	8.1%	19.0%	67.7%	47.0%
Yovelle County	131.5%	52.0%	111.5%	87.8%	0.6%	-1.6%	25.6%	26.9%	67.7%	48.9%
Utah County	53.6%	65.6%	219.0%	520.7%	0.2%	0.8%	46.4%	38.6%	63.2%	49.5%
Wasatch County - Heber Valley	142.4%	198.1%	151.8%	308.5%	*	1.2%	24.5%	38.1%	72.2%	61.0%
Weber Human Services	169.5%	162.8%	165.9%	291.5%	0.9%	0.5%	28.7%	44.9%	61.1%	62.1%
Statewide Contracts										
State Average/Total	48.2%	47.5%	94.2%	102.0%	1.6%	1.5%	24.6%	22.8%	70.6%	64.1%
State Urban Average/Total	37.6%	36.7%	63.6%	102.3%	2.4%	2.6%	27.6%	27.2%	72.3%	65.4%
State Rural Average/Total	78.2%	83.1%	85.0%	101.9%	-0.1%	-0.8%	19.2%	15.2%	66.8%	59.7%
National Average	36.7%	36.7%	44.9%	44.9%	2.7%	2.7%	12.6%	12.6%	50.4%	50.4%

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

Green = 80% or greater of the National Average.
 Yellow = 60% or greater of the National Average.
 Red = Less than 50% of the National Average.

* No one homeless at admission so no opportunity for change.
 ** No one reported at discharge.
 n/a = no clients reported/not applicable to incarcerated population.
 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. Percent 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 abstinence at discharge minus percent abstinence at admission) divided by percent abstinence 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.

Table 4: Consumer Satisfaction Survey Results

Adult Consumer Satisfaction Survey 2012 combined MH and SA Clients													8/26/2012		Scoreboard	
Agency	Number Served FY2011	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 Connectedness	Improved Functioning	Wellness				
		2011	2012													
Bear River Health Dept.	1,248	139	151	12.1%	79	76	89	80	78	84	81	86				
Bear River Mental Health	1,972	498	562	28.5%	90	88	87	78	50	87	84	78				
Central Utah	801	172	85	8.4%	*	*	*	*	*	*	*	*				
Devils Behavioral	3,008	430	437	14.5%	85	78	81	82	84	71	71	81				
Four Corners	1,308	246	367	28.8%	88	88	80	73	83	84	71	74				
Northeastern	1,283	344	314	23.2%	88	78	74	73	83	71	71	74				
Salt Lake Co.	15,993	4,414	3,109	19.4%	83	79	73	73	83	70	70	74				
San Juan	482	50	66	13.7%	89	89	80	87	70	73	72	88				
Southwest	1,770	246	238	13.4%	89	85	70	81	81	80	88	82				
Summit Co. - Valley Mental Health	751	185	153	20.4%	90	90	74	73	85	81	88	79				
Tooele Co. - Valley Mental Health	1,540	334	187	12.1%	88	78	81	73	83	78	74	74				
U of U	358	31	40	11.2%	100	90	95	83	78	98	90	90				
Utah Co. - Wasatch Mental Health	4,145	534	483	11.7%	90	81	81	75	80	88	88	76				
Utah County Substance Abuse	998	412	478	47.9%	88	88	85	73	78	84	85	85				
Wasatch Co. - Heber Valley Counseling	353	137	118	33.4%	93	92	85	73	87	72	70	78				
Weber	4,753	728	731	15.4%	87	83	85	75	83	73	70	79				
State	39,647	8,900	7,509	19.2%	85	76	80	75	84	72	71	76				
National (2011)					88	85	88	80	71	70	70					

Adult Consumer Satisfaction Survey 2012 MH Clients																
Agency	Number Served FY2011	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 Connectedness	Improved Functioning	Wellness				
		2011	2012													
Bear River Mental Health	1,972	498	562	28.5%	90	88	87	78	50	87	84	78				
Central Utah	792	128	65	8.3%	*	*	*	*	*	*	*	*				
Devils Behavioral	2,200	244	259	11.7%	89	78	81	81	50	81	81	74				
Four Corners	1,049	187	259	24.7%	88	88	73	73	83	89	89	70				
Northeastern	887	200	230	25.9%	88	84	74	74	83	88	87	74				
Salt Lake Co.	10,957	2,912	1,862	17.0%	84	74	75	73	84	83	83	88				
San Juan	385	37	53	13.8%	91	91	86	86	71	71	71	88				
Southwest	1,590	150	162	12.6%	91	90	85	85	83	83	80	78				
Summit Co. - Valley Mental Health	581	105	91	15.7%	93	87	73	85	84	87	88	81				
Tooele Co. - Valley Mental Health	1,269	154	105	8.3%	*	*	*	*	*	*	*	*				
Utah Co. - Wasatch Mental Health	4,145	534	483	11.7%	90	81	81	75	80	88	88	76				
Wasatch Co. - Heber Valley Counseling	326	108	89	27.3%	92	91	83	73	83	84	81	73				
Weber	4,308	491	478	11.1%	87	83	85	75	83	73	70	74				
State	29,508	5,726	4,708	16.0%	87	80	79	75	86	74	74	72				
National (2011)					88	85	88	80	71	70	70					

Adult Consumer Satisfaction Survey 2012 SA Clients																
Agency	Number Served FY2011	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 Connectedness	Improved Functioning	Wellness				
		2011	2012													
Bear River Health Dept.	1,248	139	151	12.1%	79	76	89	80	78	84	81	86				
Central Utah	252	46	20	7.9%	*	*	*	*	*	*	*	*				
Devils Behavioral	849	198	168	19.8%	89	83	81	84	86	86	86	91				
Four Corners	548	82	128	23.4%	88	84	73	73	83	84	81	81				
Northeastern	470	144	144	30.6%	78	74	75	83	83	80	76	74				
Salt Lake Co.	5,950	1,502	1,247	21.0%	80	83	76	76	73	82	79	78				
San Juan	125	13	13	10.4%	83	85	92	92	89	85	77	85				
Southwest	541	98	78	14.0%	84	78	87	82	82	84	86	90				
Summit Co. - Valley Mental Health	221	80	62	28.1%	83	88	76	88	84	84	88	76				
Tooele Co. - Valley Mental Health	395	180	82	20.7%	78	77	83	75	70	90	73	80				
U of U	358	31	40	11.2%	100	90	95	83	78	98	90	100				
Utah County Substance Abuse	998	412	478	47.9%	88	88	85	73	78	84	85	85				
Wasatch Co. - Heber Valley Counseling	81	29	29	35.8%	97	97	93	83	93	97	97	93				
Weber	1,013	237	253	25.0%	85	83	89	78	83	89	87	90				
State	12,908	3,177	2,891	22.4%	83	71	81	74	76	84	76	84				
National (2011)					88	85	88	80	71	70	70					

Additional Narrative Plan IV_Prevention

1. Review Student Health and Risk Prevention (SHARP) survey data and other epidemiological data sources for the state and Local Substance Abuse Authorities (LSAA) to identify risks and trends associated with the lifetime and 30 day use rates of marijuana. Focus on counties or LSAA areas with high marijuana use rates. Collaborate with other state and local agencies through education and awareness campaigns regarding the reduction of marijuana use rates. Emphasize the need to address marijuana use rates as a state wide issue during SAPST, CTC trainings, town hall meetings and other community forums.
2. Monitor LSAA programs identified for addressing marijuana use for 8th, 10th and 12th graders. This process will include evaluation of strategies, outcomes and methods used to reduce marijuana use rates.
3. Enhance existing programs through technical assistance and monitoring. Use evidenced-based strategies and/or programs to strengthen these efforts.

Indicators:

1. Lifetime marijuana use data

- a. Baseline (FY 2012) — the following outcomes are based on 2011 SHARP survey data and will be revised once the 2013 SHARP data is available.
 - Baseline marijuana use in lifetime for 8th grade is 7% and 3% for 30 Day use
 - Baseline marijuana use in lifetime for 10th grade is 17% and 8% for 30 Day use
 - Baseline marijuana use in lifetime for 12th grade is 23% and 10% for 30 Day use
- b. 1st Year (FY 2014)—
 - Reduce lifetime use of marijuana in 8th grade from 7% in 2011 to 6% in 2014.
 - Reduce lifetime use of marijuana in 10th grade from 17% in 2011 to 16% in 2014.
 - Reduce lifetime use of marijuana in 12th grade from 23% in 2011 to 22% in 2014.
- 2nd year (FY 2015)—
 - Reduce lifetime use of marijuana in 8th grade from 6% in 2014 to 5% in 2015.
 - Reduce lifetime use of marijuana in 10th grade from 16% in 2014 to 15% in 2015.
 - Reduce lifetime use of marijuana in 12th grade from 22% in 2014 to 21% in 2015.

2. 30 Day marijuana use data

a. 1st Year (FY 2014)—

- Reduce 30 Day marijuana use in 8th grade from 3% in 2011 to 2% in 2014.
- Reduce 30 Day marijuana use in 10th grade from 8% in 2011 to 7% in 2014.
- Reduce 30 Day marijuana use in 12th grade from 10% in 2011 to 9% in 2014.

2nd year (FY 2015)—

- Reduce 30 Day marijuana use in 8th grade from 2% in 2014 to 1% in 2015.
- Reduce 30 Day marijuana use in 10th grade from 7% in 2014 to 6% in 2015.
- Reduce 30 Day marijuana use in 12th grade from 9% in 2014 to 8% in 2015.

Source of Data— Sharp Survey and Local Authority Reports

The state has already added a measure of Social Support to the Scorecard, with an initial target of each local authority increasing the number of clients utilizing Social Support Groups from admission to discharge. The measure of success will be modified and increased as the local authorities improve. A second issue that has been added to the SAPT Scorecard is Tobacco Cessation, again, with the target of decreasing tobacco use from admission to discharge. A copy of the updated scorecard is attached.

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 in treatment 60 or more days		Percent Completing Treatment Episode Successfully		
	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	
Bear River	1,101	845	1,481	1,309	85/14/1/0	81/19/0/0	1,026	909	79	119	57.5%	66.4%	45.4%	48.3%	
Central Utah	243	315	385	443	91/8/1/0	95/5/0/0	212	180	127	126.5	70.8%	72.8%	37.7%	32.8%	
Davis County	847	1,045	931	997	71/29/0/0	72/18/10/0	674	399	156	117	78.6%	79.4%	42.0%	28.8%	
Four Corners	572	494	605	584	74/24/2/0	75/24/1/0	314	297	47	71	47.5%	52.2%	34.7%	31.3%	
Northeastern	363	316	559	524	100/0/0/0	99/0/1/0	123	171	114	120	69.9%	72.5%	42.3%	40.9%	
Salt Lake County	9,280	10,524	7,193	8,172	29/19/8/44	36/19/9/36	3,538	4,310	115	98	75.4%	72.7%	45.3%	47.4%	
San Juan County	108	98	188	159	97/1/2/0	99/0/1/0	99	67	119	87	71.7%	55.2%	33.3%	68.7%	
Southwest Center	565	547	570	556	52/28/20/0	43/35/22/0	470	340	167.5	154.5	85.3%	85.0%	58.1%	41.2%	
Summit County	102	255	163	344	79/21/0/0	77/22/1/0	93	221	128	86	80.6%	54.8%	57.0%	49.8%	
Tooele County	214	330	326	459	80/20/0/0	80/20/0/0	187	192	143	92	75.9%	59.9%	50.3%	30.7%	
Utah County	1,481	1,134	1,324	964	29/26/39/6	37/34/23/6	973	779	69	106	53.1%	64.6%	53.1%	45.7%	
Wasatch County - Heber Valley	114	142	115	143	83/14/3/0	75/23/2/0	85	66	119	95	78.8%	68.2%	38.8%	16.7%	
Weber Human Services	1,127	1,053	1,398	1,391	79/15/6/0	84/10/6/0	951	878	138	135	78.5%	75.7%	51.0%	44.4%	
State Average/Total	17,264	17,255	17,026	15,955	45/19/12/24	50/19/9/22	8,745	8,809	114	106	70.8%	70.8%	46.6%	44.6%	
State Urban Average/Total	12,735	13,756	10,780	11,272	36/20/11/33	43/19/10/28	6,136	6,366	116	105	72.7%	72.6%	47.0%	45.6%	
State Rural Average/Total	3,382	3,342	4,360	4,531	79/17/4/0	77/19/4/0	2,609	2,443	109	113	66.3%	66.4%	45.7%	42.0%	
National Average/Benchmark															
Men	11,515	10,955	10,907	9,887	42/16/12/30	47/18/8/27	6,292	5,411	123	98	73.2%	70.1%	50.5%	48.2%	
Women	5,749	6,300	6,119	6,068	50/24/12/14	54/21/10/14	3,701	3,511	134	125	73.0%	70.9%	44.1%	39.5%	
Adolescents	1,376	1,374	1,489	1,464	73/22/2/0	78/20/2/0	1,320	1,273	107	105	70.8%	72.3%	53.3%	54.7%	
DORA	643	772	668	706	46/37/13/4	48/30/16/5	440	439	174	162	82.0%	80.2%	50.0%	40.8%	
Drug Court	2,087	1,804	2,687	2,172	48/32/14/6	44/32/17/7	1,459	1,031	324	259	89.4%	85.3%	56.0%	51.5%	

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 FY2013		
	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	FY2012	FY2013	Admission	Discharge	
Bear River	198.3%	191.3%	148.5%	264.8%	-0.4%	1.2%	7.4%	6.5%	96.6%	87.1%	91.4%	211.5%	62.6%	62.4%	
Central Utah	29.3%	53.0%	53.8%	90.0%	-0.5%	-1.1%	7.2%	-0.6%	73.0%	19.4%	86.3%	44.1%	69.6%	72.1%	
Davis County	19.0%	103.1%	109.0%	215.0%	0.0%	-0.3%	14.8%	27.8%	73.0%	56.0%	82.8%	45.0%	60.3%	60.8%	
Four Corners	28.2%	77.8%	26.6%	85.8%	0.3%	0.6%	5.1%	16.7%	22.8%	76.4%	0.0%	0.0%	64.6%	^	
Northeastern	63.4%	40.7%	62.7%	57.7%	*	0.5%	31.2%	12.5%	75.1%	71.5%	-12.8%	-1.9%	81.7%	82.7%	
Salt Lake County	23.9%	23.6%	59.6%	72.3%	4.1%	1.5%	23.1%	17.8%	59.5%	63.1%	37.2%	63.1%	63.4%	^	
San Juan County	65.5%	90.7%	13.8%	27.2%	*	0.0%	6.6%	16.4%	61.1%	59.7%	32.6%	1203.3%	55.2%	60.9%	
Southwest Center	27.8%	29.6%	175.4%	194.3%	-3.6%	2.0%	39.7%	11.4%	48.7%	38.9%	57.7%	16.6%	68.8%	65.7%	
Summit County	222.3%	149.7%	57.8%	65.6%	1.1%	0.0%	10.0%	12.2%	47.0%	81.3%	46.4%	107.1%	46.3%	39.7%	
Tooele County	52.0%	37.8%	87.8%	74.0%	-1.6%	0.0%	26.1%	2.9%	46.9%	71.5%	26.1%	45.2%	61.4%	64.0%	
Utah County	65.5%	96.5%	520.7%	530.9%	0.8%	0.4%	38.6%	48.8%	46.5%	39.5%	7.2%	18.5%	67.6%	63.8%	
Wasatch County - Heber Valley	196.1%	150.2%	508.5%	177.7%	1.2%	*	38.1%	22.6%	81.0%	50.0%	-6.0%	17.4%	73.8%	72.7%	
Weber Human Services	102.8%	107.2%	261.5%	354.8%	0.5%	0.6%	44.9%	26.2%	82.1%	77.5%	34.7%	11.0%	62.3%	61.7%	
State Average/Total	47.5%	108.1%	102.0%	116.2%	1.5%	1.5%	22.6%	17.9%	64.1%	64.1%	35.6%	47.8%	63.9%	62.0%	
State Urban Average/Total	36.7%	40.2%	102.3%	111.0%	2.6%	1.8%	27.2%	22.8%	65.4%	63.8%	30.0%	44.5%	63.6%	60.3%	
State Rural Average/Total	83.1%	93.8%	101.9%	132.3%	-0.8%	0.3%	15.2%	8.9%	59.7%	64.7%	61.6%	59.1%	64.1%	63.6%	
National Average/Benchmark	36.7%	36.7%	44.9%	44.9%	2.7%	2.7%	12.8%	12.8%	50.4%	50.4%					
Men	56.4%	58.0%	113.4%	111.7%	1.2%	0.6%	20.6%	16.3%	61.6%	62.4%	77.8%	56.0%	62.6%	60.6%	
Women	36.3%	41.6%	113.3%	117.9%	1.7%	2.9%	29.7%	20.9%	67.5%	67.0%	46.8%	33.9%	65.9%	63.6%	
Adolescents	46.9%	39.7%	155.2%	153.8%	-0.7%	-0.2%	4.9%	-2.2%	66.1%	62.3%	257.1%	86.8%	34.5%	41.9%	
DORA	23.0%	33.2%	91.4%	129.9%	2.4%	3.9%	64.3%	34.1%	58.3%	50.4%	64.7%	18.2%	73.9%	70.6%	
Drug Court	26.7%	30.7%	161.7%	194.4%	0.9%	2.9%	39.9%	42.2%	67.0%	66.1%	59.2%	43.2%	68.8%	67.5%	

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.
Yellow = Greater than or equal to 75% or less than 90% of the National Average.
Red = Less than 75% of the National Average or not meeting division standards.

* No one homeless at admission so no opportunity for change.
** No one reported at discharge.
^ Unknown count too high (above 50%)
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

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better 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 care approach consistent with SAMHSA's trauma-informed care definition and principles. 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 more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

Please see the attached document titled final IV H Trauma

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?

The Division of Substance Abuse and Mental Health does not have a formal written policy requiring this, however it is considered a best practice.

2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?

The DSAMH has adopted the principle that all treatment should be provided in a trauma informed manner. Good clinical practice dictates that anyone with a history of trauma should be referred to trauma-focused therapy.

3. Does your state have any policies that promote the provision of trauma-informed care?

In December, the Utah Department of Human Services (DHS) conducted a two day training/Planning Session with Dr. Stephanie Covington designed to be the first step towards adopting Trauma Informed Care Principles across all DHS Divisions including— The Division of Substance Abuse and Mental Health (DSAMH), Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (JJS), and the Division of Services for People with Disabilities (DSPD). DHS anticipates that this will become an ongoing process and that these trainings/planning sessions will continue for the foreseeable future. Additionally, the DHS is undertaking a broad Systems of Care Integration Project lead by the DHS's Director and the Division Directors, the Trauma Informed Care Initiative has been rolled into that initiative.

4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?

As part of the DHS's System of Care initiative, the DSAMH is in the process of planning a statewide training system and planning session for Mental Health and Substance Use Disorder providers to:

- a. Improve trauma awareness in the provider network;
- b. Plan for ways to implement trauma informed care across the state system; and
- c. Begin a long term systemic transformation to a trauma informed, recovery oriented, gender responsive and culturally competent system of care.

This will be the first step of a process that is estimated to take at least three years. It is envisioned that Dr. Covington or her staff will be utilized in at least one of the initial trainings with the Local Authority Directors and their key clinical staff. Implementation after that will be based on plans developed by each local authority.

5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

In addition to the process outlined above, for the past four years the DSAMH has conducted a statewide training for clinicians to improve their ability to identify and treat trauma. This has included trainings on TREM, Stephanie Covington's trauma informed care, Seeking Safety, and trauma informed care for veterans. The DSAMH will continue to conduct these trainings into the foreseeable future. The DSAMH also anticipates offering multiple workshops and keynote speakers on the topic of trauma informed care

at our 2013 Fall Conference. Key note speakers include Tonier Cain and William Killebrew. Finally, the DSAMH has invited Dr. Stephanie Covington to present at our Drug Court Conference in October.

IV: Narrative Plan

I. Justice

Narrative Question:

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 abuse 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.^{42,43} 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 utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. 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 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 answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating 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. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide 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?

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

43 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.

44 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, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

Please see attached file titled Final IV I Justice

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice system in Medicaid as a part of coverage expansion?

Utah has not yet determined if it will participate in the optional Medicaid Expansion under the Affordable Care Act. The Governor has indicated that he will not make a decision on Utah's participation in the optional program until late in 2013, making it very unlikely that there will be a Medicaid Expansion in Utah ready in 2014, regardless of the Governor's decision. As a result the state is not currently addressing this question.

Additionally, the Utah Division of Substance Abuse and Mental Health (DSAMH) is working to change current Medicaid rules so that individuals who are jailed or in treatment will not have their Medicaid eligibility revoked, but only have it suspended, so that it is available immediately upon release from incarceration. The DSAMH will continue to work to simplify rules so that coverage is as seamless as is possible.

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

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 (CJS); however, the individuals in the CJS requiring services are greater than the resources available to the local authorities to provide those services.

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 an SUD is present, then the sentence will include an order to complete the treatment recommended by the assessment.

3. Are your SMHA and SSA coordinating 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?

Currently, the Utah Division of Substance Abuse and Mental Health (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 funding for court costs. Additionally, some of our local authorities partner with mental health courts in their region, although neither the DSAMH nor the local authorities provide any direct funding to this program.

4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal justice systems?

The DSAMH 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.

5. What cross-trainings do you provide 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 The Utah Generation's conference and Fall Substance Abuse Conference to individuals in the criminal justice profession. The Fall Substance Abuse Conference has an entire track dedicated to the treatment of individuals involved in the criminal justice system. Additionally, the Division hosted a Drug Court conference in 2012 and plans an additional conference in 2013, to educate drug court personnel on the latest information and evidence on effective treatment in a drug court setting.

IV: Narrative Plan

J. Parity Education

Narrative Question:

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. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

Please see the attached document titled Final IV J Parity Education.

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?

The Utah Division of Substance Abuse and Mental Health (DSAMH) will continue to use the administrative portion of the behavioral health care block grant funds to work with other state agencies to ensure that parity is well understood and the importance of including behavioral health care services in any state plan. During the past year, DSAMH staff 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. There is clearly awareness at the state executive and legislative level of the requirements to meet parity requirements. The Department of Insurance has stated that the evaluation of Qualified Health Plans (QHP) being sold on the Marketplace has included an assessment of whether or not QHPs are meeting parity requirements.

2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.)?

DSAMH will continue to use the administrative portion of the behavioral health care block grant funds to educate all public and private sector entities on mental health parity.

3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

The DSAMH continues to educate state and local partners on mental health parity. SAMHSA can assist these efforts by ensuring that the US Department of Health and Human Services issues clear guidance on how states should implement parity legislation and ensure Qualified Health Plans are compliant with parity requirements.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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 rewarded to coordinate 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 answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

Please see the attached document titled Final IV K primary and behavioral health care integration activities

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

Utah was awarded a State Innovation Models Initiative: Model Design award from the Centers for Medicare and Medicaid Innovation. This grant has allowed Utah to develop a State Health Care Innovation Plan. The effort is being lead by the Department of Health – but has included several partnering agencies, including the Division of Substance Abuse and Mental Health. The multi-stakeholder group is addressing strategies for healthcare transformation in five key areas—expanded health information technology, adequate health care workforce, wellness and healthy lifestyle promotion, payment reform, and medical malpractice and dispute resolution.

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

The Division of Substance Abuse and Mental Health (DSAMH) has worked 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 Tobacco Cessation (see question 4 below). Most recently, the DSAMH 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.

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

Yes, the Division has provided training at both the state level and local level on integrating behavioral health care with primary health care. Two of the Local Authorities have already established pilot programs for co-located services with the FQHC in their area, and two more are moving forward with establishing similar pilots. In 2011 the DSAMH, some of the local authorities and the FQHCs in their area, and the Association for Utah Community Health (the state PCA) submitted an application to the Centers for Medicare and Medicaid Innovations Center to expand these co-located sites to additional regions throughout the state. While the grant was not funded, many meaningful relationships were developed during the process and the local authorities and the FQHCs have continued to work together to identify innovative ways to deliver integrated services to medically underserved populations.

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

In 2009, the DSAMH began a partnership with the DOH 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.

More information about Recovery Plus can be found at <http://recoveryplus.utah.gov/>.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

“Recovery Plus” requires that tobacco use be assessed at admission, and nicotine use be included in the diagnosis when appropriate. Under a grant jointly administered by the DOH and DSAMH, several CO monitors were purchased and provided to agencies requesting them, and the DOH provided funding to purchase Nicotine Replacement Therapy supplies to assist individuals admitted to residential facilities while they enrolled in Utah’s Tobacco Quit Program. More information about Recovery Plus can be found at <http://recoveryplus.utah.gov/>.

6. Describe how your behavioral health providers are screening and referring for:

- a. heart disease,
- b. hypertension,
- c. high cholesterol, and/or
- d. diabetes.

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 following suggestions are taken from a report published by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council titled "Morbidity and Mortality in People with Serious Mental Illness," www.nasmhpd.org October 2006:

- *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 2014 Division Directive, the following language was included:

Substance Use Disorder Treatment

vi. 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. Implement a protocol for identification and referral for screening and treatment of HIV, Hepatitis C and TB.*
- 4. Evaluate all clients who are opioid or alcohol dependent for the use of 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 as needed.*

vii. 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 .

Performance Measures

“g. Tobacco Cessation: Local Substance Abuse Authorities’ scorecard will show that the percent of clients who use tobacco will decrease from admission to discharge.”

Mental Health

“vi. Local Authorities will use a Holistic Approach to Wellness. Local Authorities must provide and as appropriate document the following:

- a. Monitor weight (and height for children).*
- b. Provide or arrange for a diabetes screening, as indicated.*
- c. Identify tobacco use in the assessment.*
- d. Provide services in a tobacco free environment.*
- e. Provide training for staff in recognizing health issues.*
- f. 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.*
- g. Provide information to clients on physical health concerns and ways to improve their physical health.”*
- h. Incorporate wellness into individual Recovery Plans as needed.*

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). 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, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, 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, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

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. In order 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).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

Please see attached document titled Final IV L Health Disparities.

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?

The Utah Division of Substance Abuse and Mental Health (DSAMH) collects extensive data on individuals receiving services throughout the state in the Substance Abuse and Mental Health Information System (SAMHIS). Using data the data in SAMHIS the DSAMH can identify services by local authority, the type of service provided, client demographics including—gender, race, ethnicity, and primary, secondary, and tertiary diagnosis. Currently the state does not collect information regarding sexual orientation or language, nor is it clear that attempting to collect information at the state level would result in accurate and usable information, especially in more rural areas.

By statute and rule, the Counties, organized into Local Authorities, are responsible for planning for and providing services to their residents. The local planning and control that results from this system allows the maximum flexibility for each area to determine the needs in their area and plan accordingly. This allows San Juan County to focus on the Native American population on the Navaho Reservation; South West Behavioral Health Care to focus on the Hispanic population in St. George and the Native American groups in Cedar City; and Salt Lake County to provide diverse services to the LGBTQ population.

In accordance with State Statute, each Local Authority has to submit an annual Area Plan outlining their plan to provide services. This plan is based on their assessment of treatment needs in their area and their prioritization of programs to meet those needs. The Area Plan is reviewed by the DSAMH staff for compliance with the Statutes, Rules, Contract Language, and the Annual *Division Directives*; if necessary, Area Plans are returned to the Local Authority for revision.

During the annual Audits of each Local Authority, their operations are reviewed for compliance with their Area Plan as well as with contract and other Division requirements. Of prime importance in both the review of the Area Plan and the audit of a Local Authority's performance, is the provision of services to the specific population in their service area. This is measured by a review of the data, as well as through interviews with clients and community partners.

2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?

The DSAMH does not have this capability at this time, and sees this primarily as a function of each local authority.

3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity vulnerable subpopulations?

The DSAMH will continue to monitor Local Authorities compliance with the Division Directives and Contracts and monitor their area plans for these issues.

4. How will you use Block Grant funds to measure, track and respond to these disparities?

If Block Grant funds become available through the adoption of Medicaid expansion or other behavioral health funding becomes available, then the DSAMH will determine what funding is available to measure,

track and respond to disparities that exist. Currently, Block Grant Funding doesn't come anywhere near the needed level to provide the services needed for mandated services.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, 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.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. 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?
6. 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?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must 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 actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

Please see the attached document titled Final IV M Recovery

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

Yes, the Utah Division of Substance Abuse and Mental Health (DSAMH) has been incorporating the concepts of Recovery into both mental health (MH) and substance use disorder (SUD) services for the past four years. In 2011 Peer Support Specialists (PSS) services were added to the State Medicaid Plan and the DSAMH began conducting quarterly MH PSS trainings. In 2012, House Bill 496 was passed, which gave the DSAMH the authority to develop rules for a SUD Peer Support Specialist. That rule has been developed (R523-2) and can be found at: <http://www.rules.utah.gov/publicat/code/r523/r523-002.htm>

In addition, the DSAMH formed an SUD Recovery Oriented System of Care (ROSC) workgroup that has been meeting for the past three years to expand traditional clinical acute care SUD services into a true ROSC. The ROSC workgroup has expanded to include the Performance Development Committee, the Clinical Committee, and the Finance Director's Committee of the Behavioral Health Care Committee (the provider organization for the state). This has been reinforced by workshops and presentations at the Utah Substance Abuse Fall conference for the past three years, where innovative practices that support Recovery Support Services and activities are highlighted. Additionally, use of the Access to Recovery (ATR) funds has greatly expanded the ability of the DSAMH to provide Recovery Support Services.

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

Yes, the DSAMH is bound by State statute and rule on hiring practices, so formal documentation of a person's Recovery status is not allowed as part of the hiring process. However, over twenty percent of the DSAMH staff are in recovery themselves or have family members in recovery. The DSAMH is currently recruiting for a Peer Support Program Manager, and due to the specific requirements for the position, additional points have been incorporated into the scoring for an individual who has either a personal or family related recovery history.

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

Yes, the DSAMH moved to a Person Centered Planning system in MH five years ago, and the SUD system has adopted the principles of person centered care and is in the process of changing the SUD Practice Guidelines to reflect person centered planning and individualized care. For the past year, the DSAMH has worked with the Utah Behavioral Health Care Clinical Committee to develop principles to guide the documentation and practices around assessment, treatment planning and treatment. The Division Directive has this specific language included:

i. Substance Abuse Treatment Local Authorities will provide services that comply with the following principles:

- a. *Initial Engagement: (These principles are shared with Mental Health Treatment.)*
 - 1. *Focus is on the immediate/pertinent needs of the client.*
 - 2. *Clinician establishes rapport with clients.*
 - 3. *Clients can expect to gain something (relief, clarity, answers, hope) from the initial engagement session.*
 - 4. *Clinician's check that client's needs are being met.*
 - 5. *Clinician's 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 Mental Health Treatment).*
 - 1. *Assessment information is kept current.*
 - 2. *Clinicians gather comprehensive relevant assessment information based on the client's concern in an ongoing manner as part of the treatment process.*
 - 3. *Assessment includes an ongoing focus on strengths and supports that aid 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. *Recovery Planning Principles:*
 - 1. *The client is involved in ongoing and responsive recovery planning.*
 - 2. *Plans incorporate strategies based on the client's motivations.*
 - 3. *Where possible, the plan represents a negotiated agreement.*
 - 4. *The plan is kept current and up to date.*
 - 5. *Short term goals/objectives are measurable, achievable and within a timeframe.*
 - 6. *Planning anticipates developing and maintaining independence.*
- d. *Treatment Principles:*
 - 1. *Treatment is individualized dynamic and adjusts according to feedback and concerns of the client*
 - 2. *Treatment is recovery focused and based on outcomes, sound practice and evidence.*
 - 3. *Family and other informal and natural supports are involved as approved by the client.*
 - 4. *Treatment is provided in a culturally competent, gender appropriate and trauma informed manner.*

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

Yes, the DSAMH has used the Access to Recovery (ATR) grant to expand services in three of the most populated counties, and to expand their use of contracted providers. This has been expanded to the fourth most populated county, and the ATR Voucher system has also been adopted and funded by the Department of Corrections to provide Recovery Support Services to their clientele. This has assisted the state's ability to move forward in treating addiction as a chronic illness, but the lack of funding for priority populations restricts the diversion of funds from primary treatment to Recovery Support Services. The DSAMH is moving forward in expanding Peer Support Services, and has provided support

through contracts to both the Utah Chapter of NAMI and to Utah Support Advocates for Recovery Awareness (USARA) to provide education and recovery support services to clients and their families.

5. 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?

Yes, the DSAMH is just developing PSS services and training, and will work to train PSS to be culturally competent, trauma informed, and able to provide gender specific services. However, the actual provision of those services will be provided by the Local Authorities who are best able to target limited resources to the needs of their area. MH PSS training has been made available to the Veterans Administration, the Navaho Tribe, and to all of the local authorities.

6. 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?

Yes, the DSAMH provides training to the local mental health authorities and other community partners and stakeholders on recovery principles and recovery-oriented practice systems. The DSAMH provided training to the VA, the Navaho Tribe, and to all local authorities for mental health PSS.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

Yes, the DSAMH is incorporating the concepts of Recovery into both MH and SUD services for the past four years. In 2011 PSS services were added to the State Medicaid Plan and the DSAMH began conducting quarterly MH PSS trainings. In 2012, House Bill 496 was passed, which gave the DSAMH the authority to develop rules for a SUD Peer Support Specialist. That rule has been developed (R523-2) and can be found at: <http://www.rules.utah.gov/publicat/code/r523/r523-002.htm>

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

In 2010, DSAMH contracted with Appellation Consulting Group, one of the nation's leading experts in Peer Specialist Training and Certification, to provide Peer Support training and certification. This training consists of a comprehensive 40-hour peer specialist training, 16 hours of Whole Health and Resiliency training and a written examination. In addition, CPSSs must successfully complete 20 hours of continuing education each year in order to maintain certification. CPSSs also receive ongoing weekly individual and/or group supervision by a licensed mental health therapist. As of October 2012, there were a total of 128 CPSSs certified by Utah, with additional trainings scheduled in the near future. There are 26 CPSSs in paid positions due to joint efforts between DSAMH, the Department of Health, and the LMHAs. DSAMH, presented the first annual Utah Peer Conference on Friday, September 14, 2012. The

conference was attended by over 150 peers who have received mental health services. The second conference is scheduled for September of 2013.

In 2011, House Bill 496 passed which restructured the licensing structure for Substance Use Disorder Counselors and created the position of SUD Peer Support Specialist and granted the Division the authority to develop rules for the certification of SUD Peer Support Specialists. This rule was finalized in 2012, combining the training of MH and SUD peer support specialists into one certification process. At the same time rules were approved creating a parallel Family Resource Facilitator certification process. Currently bids are being sought to provide this combined training.

At the same time, through the ATR program and the use of the Utah Support Advocates for Recovery Awareness, which is partially funded by SAPT funds, the use of Recovery Support Services has been expanded in three of the four urban counties in what is known as the Wasatch Front. The success of this effort and the ongoing work of DSAMH and the UBHC Clinical committee to expand ROSC principles and practices across the state has created a dynamic process of change, held back primarily by the available funding.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must 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 actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

The Utah Division of Substance Abuse and Mental Health (DSAMH) reviews each of the Local Authorities annual Area Plans to ensure they are compliant with the requirement they include family members and individuals in recovery and the degree to which they include family members in the treatment process. DSAMH relies heavily on input from the main Recovery Organizations in the State, NAMI-Utah and USARA, in planning for and providing these services. Additionally, a Division Consumer Advocate Specialist in Recovery serves as an invaluable resource to family members. Finally, the DSAMH supports and funds a Family Resource Facilitator for each Local Authority. This individual is an invaluable asset to the family and provides assistance to accessing services.

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

The DSAMH has had a contract with USARA for the past five years to provide support for individuals and family members in recovery from Substance Use Disorders. Additionally, the Division is expanding its

Health Care Advisory Council from solely a Mental Health Care Council to a combined Mental Health and Substance Use Disorder council, which meets monthly.

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

Local Authorities are required to have their area plans reviewed by their county governments and many are required to hold public hearings on their area plans. The DSAMH does not solicit public input on state wide programs and initiatives, the decentralized nature of planning for services mandated by state statute and rule means there are differences among the Local Authorities based on population, level of involvement and county priorities. The DSAM requires that each Local Authority include projected Recovery Support Services in their Area Plans.

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

The DSAMH is very supportive of those activities. Along with previously discussed contracts and involvement, DSAMH has funded Family Resource Facilitators for each Local Authority, and involves them in planning and assistance visits, as well as in planning for services.

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?

DSAMH is supportive of each Local Authority's efforts in this area. Salt Lake Weber and Davis Counties have significant homeless populations and have significantly expanded their efforts to provide supportive housing and develop transitional housing programs for this population. In more rural areas like Central Utah, efforts are more individualized and isolated. The DSAMH is involved in several supportive housing initiatives and chairs a sober housing committee which is part of the Utah Substance Use Advisory Council's Behavioral Health Care Workgroup. This multi-agency committee is working with local governments and state agencies to develop rules and standards for supportive recovery housing.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

DSAMH is supportive of each Local Authority's efforts in this area. Salt Lake Weber and Davis Counties have significant homeless populations and have significantly expanded their efforts to provide supportive housing and develop transitional housing programs for this population. In more rural areas like Central Utah, efforts are more individualized and isolated. The DSAMH is involved in several supportive housing initiatives and chairs a sober housing committee which is part of the Utah Substance Use Advisory Council's Behavioral Health Care Workgroup. This multi-agency committee is working with local governments and state agencies to develop rules and standards for supportive recovery housing.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data 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?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did 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)?

Response, Part I: All programs are categorized within an IOM and CSAP 6 and tracked in our data tracking system to collect process data for reporting each fiscal year. Minimum Data Set (MDS) is federally mandated tracking system designed by CSAP and managed by DCAR and used to identify specific prevention services that has been rendered to the clients. The system is designed to record state data for each service and archived for reporting. MDS is designed to log the demographics, description of service and sessions of the Single or Recurring reported services. Reports for the programs can track how often the programs are delivered and to what population. MDS helps our state to maintain records of services to evaluate the effectiveness of services including the frequency, intensity, and duration of the used to identify specific prevention services that has been rendered to the clients. The system is designed to record state data for each service and archived for reporting. MDS is designed to log the demographics, description of service and sessions of the Single or Recurring reported services. Reports for the programs can track how often the programs are delivered and to what population. MDS helps our state to maintain records of services to evaluate the effectiveness of services including the frequency, intensity, and duration of the program, policy or practice. MDS also allows our state to effectively track our programs within the six CSAP strategies for primary prevention regarding, Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community Based Process, Environmental for individuals, schools, parents, and communities, so these target populations can receive an appropriate range and variety of prevention services that encompass both single and recurring services.

Response, Part II: Each Local Authority uses Strategic Prevention Framework (SPF) developed by the Substance Abuse Mental Health Services Administration (SAMHSA) to implement comprehensive community level prevention systems within their area. DSAMH encourages LSAA to utilize the Communities that Care model to meet this directive. Each LSAA then follows the SPF to plan and implement that process.

1. Assess local prevention needs based on epidemiological data. This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data.
2. Build prevention capacity, including assurances that all prevention personnel are certified and trained for implementation and delivery for all required programs.
3. Develop a strategic plan.
4. Implement effective community prevention programs, policies and practices.
5. Use logic models as the basis for evaluation plan and to demonstrate expected short and long term outcomes.
6. Submit an annual report that summarizes performance of prevention programs policies and strategies based on the short and long term outcomes identified in the logic models.
7. LSAA shall spend a minimum of 30% of SAPT Block Grant funds on prevention policies, programs, strategies, administration.

Evidenced-Based Indicated Prevention

- A. Block grant funding will be used for, but not limited to the development, expansion or enhancement of prevention programs to help meet or maintain evidenced-based standards. Programs, strategies and services listed on one of the following registries shall be considered eligible:
 1. Center for the Study and Prevention of Violence- Blueprints
<http://www.colorado.edu/cspv/blueprints/>;
 2. U.S. Department of Justice Model Programs Guide
<http://www.ojjdp.gov/mpg/>;
 3. Communities That Care Prevention Strategies Guide
<http://www.sdrp.org/ctcresource/>
 4. Programs determined by the Utah Evidence Based Workgroup to be Level III: Supported, Efficacious Practices, or Level IV: Well Supported- Effective Practices using the Program Assessment Rating Tool (PART) developed by the Office of Child Abuse and Neglect (OCAN).
 5. National Registry of Evidence-Based Programs and Practices

<http://www.nrepp.samhsa.gov/> (More attention will be given to those programs that have been verified through an evidenced process and can be validated through other sites)

Allowable expenses will be limited to:

1. Promotion of selected program(s)
2. Evidence-based program (EBP) program training and certification
3. Purchase of consumables and materials required to deliver EBP
4. Implementation (Direct staff time devoted to preparation and delivery of EBP)
5. Monitoring and evaluation
6. Other expenses necessary to promote, implement, enhance or bring EBP to fidelity.

The Local Substance Abuse Authority agrees to the following:

1. Implement services as described by EBP program curriculum
2. Monitor implementation of program to ensure critical elements are delivered as described by program developer (fidelity)
3. Collect process data and report on DSAMH approved data collection system (MDS)
4. Administer approved pre-post matched surveys to participants.
5. Provide matched Pre/Post tests to each program participant
6. Ensure all services are delivered by individuals certified and/or licensed for the implemented program
7. Ensure that providers are Substance Abuse Prevention Specialist Training certified

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

Response: Prevention Dimensions, Implementation of Student Health and Risk Prevention Survey, (SHARP) and other data sources that provide data on targeted populations for adequate assessment of priorities and risks. SAPST and CTC training to ensure all prevention professionals are trained and use above mentioned process for demonstrating effective outcomes.

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

Response: We will use a comprehensive strategy that involves the above-mentioned process from question one as well as coalition building and collaboration of resources where necessary. Each LSAA district will have at least one coalition where staff and volunteers are representative of the needs and resources including DWS.

4. What outcome data 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?

Response: Each LSAA develops a strategic plan and implement effective community prevention programs, policies and practices. The basis for evaluation is the use of logic models to demonstrate expected short and long term outcomes. The LSAA will also submit an annual report that summarizes performance of prevention programs policies and strategies based on the short and long term outcomes identified in the logic models. The results of these data will then be reviewed, presented and discussed with each LSAA coordinator for changes to next year's plan as needed.

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

Response: Budgets from each LSAA are submitted each year to match the allocation of funding from DSAMH. The details of these budgets categorize the programs, strategies and policies in the IOMs and CSAP 6 and then monitored throughout the state fiscal year as well as a formal annual audit.

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

Response: The prevention total for FY13 was \$3,220,663 or the total of 20% of the entire BG. \$483,099 remained with DSAMH for administration, research-evaluation, training and collaboration while \$2,737,564 was allocated to the 13 LSAA or communities to follow the above-mentioned process from question one. (The numbers for FY14 are not available at this time)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program. An estimated \$362,324 is used on the following programs: Prevention Dimensions, a K-12 substance abuse prevention program that's implemented state-wide, SHARP Survey, SAPST and CTC trainings.

Please see the attached document titled Prevention Narrative_Block Grant FY14-15

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

Please see attached document Final IV N.2 Evidence Based Prevention and Treatment Approaches for MHBG

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

The Division of Substance Abuse and Mental Health (DASMH) created a competitive three year request for proposal (RFP) with the vision of individuals, families and communities working together, using existing resources as well as additional skills to promote mental health and prevent mental illness. The first year of the RFP is broken into two parts, with part one of RFP focused on keeping the traditional advocacy, support, wellness, education and consultation services in place. Part two of the RFP requires the recipient to complete a statewide needs assessment based on the Communities that Care model. The assessment tools utilized are evidenced based models for prevention activities. In year two, based on the outcomes of the needs assessment, the recipient would submit a plan for mental health promotion and mental illness prevention, including early intervention and suicide prevention. A guiding principle of DASMH was not to create a new workforce; instead the contractor would be required to send funds through the local community substance abuse prevention coalitions. In year three the plan would be implemented by the local substance abuse prevention coalitions with ongoing evaluations.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

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 over 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.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with 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 answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with 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?

Footnotes:

Please see the attached document titled Final O children and adolescents behavioral health services.

O. Children and Adolescents Behavioral Health Services (Grant Guidance is in Blue)

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 over 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.

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Utah is in a very good position to expand System of Care statewide for children and youth from birth to age 21 and their families, regardless of their insurance coverage. This level of readiness is based on previous and current efforts in service delivery and infrastructure development:

- a. System of Care Expansion and Planning Grant, 2012 – Present (SAMHSA funding): DSAMH collaborates with the Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), and Division of Services for People with Disabilities (DSPD) to develop a comprehensive statewide strategic plan to improve and expand services using a system of care approach for children and youth from birth to 21 years of age who have, or are at risk of developing, serious mental health conditions. The comprehensive strategic plan will address the issues of:
 - i. Policy, Administrative and Regulatory Changes
 - ii. Developing Services and Supports based on System of Care Philosophy and Approach
 - iii. Financing
 - iv. Workforce Training, Technical Assistance and Coaching
 - v. Generating Support and Advocacy to Drive Implementation
 - vi. Social Marketing, and
 - vii. Cultural Competency
- b. Statewide Family Resource Facilitation, 2007 – present: Family Resource Facilitators (FRF) are family members trained to provide resource facilitation and family to family support services.

FRFs receive additional training, supervision, and mentoring to become wraparound Facilitators so they may facilitate wraparound services to children and youth with complex needs.

Through the braiding of state funding and Block Grant, there are currently 42 Family Resource Facilitators (FRF) throughout the state to provide family support services to children, youth, and families regardless of their insurance coverage. Within the public mental health and substance abuse system, these FRFs are stationed (or located) in every mental health/substance abuse provider agency. There are also FRFs stationed in the child welfare and juvenile justice systems.

- c. Healthy Transitions Initiative, 2009 – present (SAMHSA funding): This initiative provides services to support young people between the ages of 16 and 25 with serious mental health challenges to successfully transition into adulthood. It is implemented in two rural/frontier counties, each with two American Indian tribal governments within the catchment area.
- d. Child and Adolescent State Infrastructure Grant, 2004 – 2010 (SAMHSA funding): DSAMH engaged in statewide strategic planning, including the seven tribal governments, to improve the state's infrastructure in children's mental health and substance abuse services. It focused on evidence-based practices (EBP), technology, cultural competency, and financing. Through this project, DSAMH implemented pilot projects integrating behavioral health services in school and primary care settings.
- e. Partnership for Youth Transition, 2002 – 2006 (SAMHSA-funding): This project uses the System of Care principles to develop a model to assist young people between the ages of 14 and 21 and with emotional and behavioral disorders to successfully transition into adulthood. It was implemented in four urban counties.
- f. Children's Mental Health Initiative, 1998 – 2005 (SAMHSA funding): This initiative provides wraparound services for children with serious mental health conditions and their families in six rural/frontier counties. Although the evaluation demonstrated improved outcomes for both the children and their families, the SOC services were not fully sustained after the grant fund ended. However, through this initiative, DSAMH learned valuable lessons in implementing SOC and the sustainability challenges.

Through these projects, DSAMH built a strong foundation for statewide SOC expansion. DSAMH has also learned many lessons in evidence-based practices, consumer/family-driven and youth-guided approaches, cultural competency, financing and sustainability. DSAMH has always used lessons learned to improve subsequent projects.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

The Division's Children, Youth and Families team (CYF) helps shape the system of care through policy development, technical assistance, monitoring and oversight. In 2014, CYF plans to enhance the support of recovery and resilience of children and youth with mental and substance use disorders' system of care approach through following action steps:

- a. Collaborate with the Divisions of Child and Family Services (DCFS), Juvenile Justice Services (DJJS) and Services for People with Disabilities (DSPD) to develop an integrated family and youth development plan across the four divisions. The plan will address issues of staff development and family and youth leadership training.
- b. Support the Utah Family Coalition's effort to expand family involvement activities to child welfare and juvenile justice systems. Utah Family Coalition (UFC) is a network of family advocacy organizations that advance family-driven and youth-guided approaches. Members include Allies with Families (Utah chapter of the Federation of Families for Children's Mental Health), National Alliance on Mental Illness (NAMI) – Utah Chapter, and New Frontiers for Families (a family advocacy organization for rural frontier communities). In 2013, UFC intends to increase family and youth representation from the child welfare and juvenile justice systems to create a greater reach of family and youth network to advance Utah's system of care approach. DSAMH will support UFCs effort by involving DCFS and DJJS in discussion on family and youth development.
- c. Increase the number of Certified Family Resource Facilitators (FRFs). FRFs are family members who are trained to provide resource facilitation and family to family support services to children, youth, and families regardless of insurance coverage. The certification process includes initial 40-hour training, certification exam, on-going training, and 152 hours supervised practicum. In FY 2012, there were 15 FRFs throughout the state who completed the supervised practicum. By June 30, 2014, the Division plans to have 40 FRFs complete the supervised practicum.
- d. Increase the number of Certified Wraparound Facilitators throughout the state to provide wraparound facilitation services to children, youth, and families regardless of insurance coverage. Certified FRFs receive additional 152 hours supervised practicum in wraparound facilitation to become Certified Wraparound Facilitators. In FY 2013, there are seventeen (17) Certified Wraparound Facilitators. By June 30, 2014, the Division plans to increase that number to 25.
- e. Develop a Youth-in-Transition Certified Peer Support Specialist (CPSS) program: The Division is collaborating with the CPSS program to develop a supplemental training and supervision curriculum to support: i) young adults to become a CPSS, and ii) CPSS to develop the knowledge and skills to work with youth in transition age (15 to 26-years-old). In 2014, the Youth-in-Transition CPSS program will be piloted at a mental health/substance abuse center.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

In FY 2013, there are several division directives that all contract providers have to adhere to: i) Strength-Based Assessment, ii) Person-Centered Recovery Plan, and iii) Holistic Approach to Wellness. Some key elements of these directives are:

The Strength-Based Assessment:

- a. Will be an ongoing process with focus on the Initial Engagement and Ongoing Assessment.
- b. The Initial Engagement:
 1. Focuses on the immediate/pertinent needs of the client.
 2. Establishes rapport between the client and the clinician.
 3. Provides relief, clarity, answers, and/or hope for the client.
 4. Allows for clinicians to check on client needs and if they are being met.
 5. Documents relevant information in an organized way.
 6. Allows clinicians to make recommendations and negotiate with and respect the client.
- c. The Ongoing Assessment:
 1. Keeps information current through clinician's ability to continue to gather new and relevant information.
 2. Includes an ongoing focus on strengths and supports that aid the client in their recovery.
 3. Addresses motivating factors and how they impact the client.
 4. Is organized coherently and available in a readable, printable format.

The Person-Centered Recovery Plan:

- a. Contains identifying information, diagnosis, and formulation
- b. Documents treatment goals stated in the own words of the family and child and youth, when age and developmentally appropriate.
- c. Contains a safety/crisis plan for child/youth and family when clinically indicated.
- d. Identifies barriers to the achievement of goals.
- e. Identifies anticipated transition/discharge criteria.
- f. Provides copy of the plan to the child/youth and family.
- g. Incorporates evaluation data (OQ or YOQ) into the decision-making process that either supports the current direction of the treatment plan or that suggest a change in direction, excluding children age five and under.

The Holistic Approach to Wellness:

- a. Monitors basic physical health conditions (weight and height) of the child/youth
- b. Provides training for staff in recognizing health issues
- c. Provides information to child/youth and family on physical health concerns and ways to improve their physical health
- d. Incorporates wellness into individual person-centered plans as needed
- e. Provide prevention, screening and treatment in context of better access to health care
- f. For child/youth who is on atypical medications:
 - i. Monitoring of labs, AIMS and tracking of vitals.
 - ii. Coordination/communication with prescribers.

- iii. Emphasize exercise along with healthy leisure and recreational activities in youth programming.

DSAMH plans to monitor providers' adherence to these directive through annual on-site visit that includes records review, family focus groups, and staff interviews. For providers who perform at an unsatisfactory level, technical assistance plans will be developed to outline improvement strategies and timeline. For providers consistently perform at an unsatisfactory level, corrective actions will be developed for immediate attention.

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.)?

Through the System of Care Expansion and Planning Grant, the Division established a SOC XP State Steering Committee to develop a comprehensive statewide strategic plan to improve and expand services using a system of care approach for children and youth from birth to 21 years of age who have, or are at risk of developing, serious mental health conditions. The State Steering Committee membership is diverse including public agencies, private organizations, community partners, advocates, and family and youth consumers.

The Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), Division of Services for People with Disabilities (DSPD) actively participates on the Steering Committee to develop a strategic plan that addresses the issues of:

- a. Policy, Administrative and Regulatory Changes
- b. Developing Services and Supports based on System of Care Philosophy and Approach
- c. Financing – A finance map outlining the four divisions' mental health/substance abuse services funding stream is developed.
- d. Workforce Training, Technical Assistance and Coaching
- e. Generating Support and Advocacy to Drive Implementation - DSAMH, DCFS, DJJS, and DSPD are in the process to develop an integrated family and youth development plan across the four divisions.
- f. Social Marketing, and
- g. Cultural Competency

DSAMH collaborates with the Utah State Office of Education (USOE) on several projects to institutionalize school-based mental health programming through:

- a. Utilizing a Community of Practice model to improve the quality of school-based mental health programs,
- b. Developing outcome measures to assess the effectiveness of school-based mental health programs provided by Local Mental Health Authorities.

By June 30, 2015, DSAMH plans to enhance the collaboration by:

- a. Developing interagency agreements and partnerships for coordination of services and financing,
- b. Identifying opportunities for long-term sustainable support of system of care infrastructure and approach,
- c. Utilizing outcome data and evidence of cost savings or avoidance to promote investment in the expansion of the System of Care framework,
- d. Identifying opportunities to inform state implementation of health care reform in support of System of Care principles and practices, and
- e. Supporting the UFC in statewide leadership training for youth and family members to strengthen their abilities to advocate for system change.

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?

Technical assistance is integrated into the annual monitoring site visits to local mental health and substance abuse centers. The Division works with each center to identify training subjects and consultants for the training. The Division co-sponsors the annual Critical Issues Conference (on children's mental health issues) and Generations Conference (on adult mental health issues) and organizes the annual Fall Substance Abuse conference. Evidence-based practices are an integral part of these conferences. Family and youth are invited to speak at these conferences to provide their perspectives and lived experiences in recovery and resiliency.

On June 20, 2013, DSAMH collaborated with DCFS and DJJS to organize the first annual "Transition Academy" that introduced a research-based transition facilitation model so the staff from the three divisions will provide transition services based on best-practice standards. The conference included presentations and discussions from individuals who have utilized the current services available and those who have expertise in various topics including housing, education, and community living skills.

Utah Department of Human Services (DHS) is leading an effort to transform the Department into a trauma-informed organization. In January 2013, DHS Executive Director's Office, DSAMH, DCFS, DJJS, and DSPD received training from Dr. Stephanie Covington on trauma-informed care. By June 30, 2014, there will be a DHS plan to provide trauma-informed care by DHS staff and providers. By June 30, 2015, a series of training on evidence-based trauma-informed care will be provided to all staff and providers of DSAMH, DCFS, DJJS, and DSPD. In order to accomplish these goals, Dr. Covington recommended that each Division develops a "Guide Team." Dr. Covington also recommended that the Executive Director's Office develops a Trauma-Informed Care Committee with a representative from each of the Guide Teams.

As part of the SOC XP strategic plan, DSAMH will collaborate with DCFS and DJJS to: a) identify relevant workforce training curricula offered by the three Divisions, b) conduct a review of existing curricula to identify sections reflecting information about children and youth with mental health needs, c) based on the findings, make recommendations to the three Divisions for possible adaptations to existing curricula to better align with System of Care principles and practices, and d) provide technical assistance in the adaptation of the training curricula and materials if requested. The three Divisions will also explore the feasibility to jointly develop a statewide training, technical assistance and coaching team/system that provides a unified approach to workforce development in evidence-based practices.

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?

Currently, DSAMH has a Scorecard on each Local Mental Health and Substance Abuse Authority with data on:

- a. Number of children/youth served,
- b. Estimate of need at 300% poverty,
- c. # of SED served,
- d. # of unfunded children/youth served,
- e. # of children/youth served who are enrolled in school,
- f. # of children/youth served receiving juvenile justice services,

- g. Utilization of services,
- h. Time in mandated services, and
- i. Youth Outcome Questionnaire (YOQ) measures.

The utilization of services include inpatient (state hospital inpatient and community inpatient), residential treatment, and outpatient services (medication management, psychosocial rehabilitation, targeted case management, respite care, peer and family support services, assessment, and treatment therapy, emergency, school-based services, and in-home services).

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

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.

Footnotes:

See attached document titled Final IV P Consultation with the Tribes

Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Piute, Shoshone and Goshute people. Our state's cultural diversity continues to expand with minority populations increasing from 2 percent to 20 percent of the total population over the last two decades. Additionally, 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 on tribal land throughout the state, primarily located in the Northeastern and Southeastern regions of the state. Federal, State, County and Native American jurisdictions are involved in providing services to this population. Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch 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 (DHS) 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 local authorities, Utah Division of Substance Abuse and Mental Health (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. During the past year this has included presentations to the DHS Intertribal Council about the structure of the Behavioral Health Care system, and how the system is funded and organized. It included a discussion of the current statute and rules that guide the DSAMH in its operations. It also included a presentation to the entire DSAMH staff on the Native American Population and tribal organizations in Utah. There are ongoing efforts to include representatives from the tribal organizations on the Behavioral Health Consumer Advisory Council.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

There are no updates or further progress on these items from last year.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, 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, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in 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, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Please see the attached document titled Final Q data and

The Utah Division of Substance Abuse and Mental Health does not have a formal CQI plan. While the DSAMH does not have a formal CQI/TQM plan, both CQI and TCM concepts are integral to the way that DSAMH measures performance of its Behavioral Health Care. Providers and how we monitor contract compliance. The DSAMH collects and utilizes extensive data on the “health of the mental health and addictions systems.” Some of the ways we use this are described below.

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 and 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). Copies of the Mental Health and Substance Abuse scorecards are attached. 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. A copy of the 2010 report is also 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 and 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 is also attached. An example of the monitoring checklist used to monitor the Substance Abuse Agencies is also attached.

An improvement in the Division's monitoring that will be implemented in FY 12 is a quarterly review of SA and MH outcomes and data. Prior to FY 11, data was submitted only quarterly, and by the time it was entered, compiled and reviewed, it was of marginal usefulness. In FY 11 all data was required to be submitted monthly, and the review time was significantly reduced. Most data can be reviewed within 60 days of the end of the quarter, and instead of reviewing data that was often close to a year old, the Division will be able to provide feedback to the Local Authorities throughout the year on their performance.

Another new addition to the monitoring process will be the implementation of a Stakeholder survey prior to each site visit, with feedback provided to the agency during the visit. The survey will examine Stakeholders and Agency partners understanding of the services provided by the Local authorities, as well as an opportunity to provide feedback on the effectiveness and accessibility of the provided services. The initial year will be limited to agencies that the Local Authorities identify as stakeholders and partners, with future years expanding that list to additional community partners and consumers.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

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 is attached.

In March of 2013, the Utah State Legislature passed House Bill 154 which requires the State Board of Education to do the following:

- *designate a State Office of Education suicide prevention coordinator to oversee*
- *school district and charter school youth suicide prevention programs;*

- *establish model youth suicide prevention programs for school districts and*
- *charter schools that include certain requirements; and*

- *report the progress of implementation of programs related to youth suicide*
- *prevention to the Legislature's Education Interim Committee;*

- *requires school districts and charter schools to implement a youth suicide*
- *prevention program for students in secondary grades;*

The bill additionally requires the Division of Substance Abuse and Mental Health to do the following:

- designate a state suicide prevention coordinator

- requires the state suicide prevention coordinator to:
 - coordinate suicide prevention programs and efforts statewide with multiple
 - entities, including the State Board of Education; and
- report to the Legislature's Education Interim Committee, jointly with the State
- Board of Education, on suicide prevention programs and coordination with the
- State Board of Education;

DSAMH has aggressively promoted the use of Mental Health First Aid, SQPR and ASIST across the state's Behavioral Health system and has promoted education and training to improve awareness of the extent of suicide as a problem in Utah. DSAMH has worked closely with the coalition to improve services to veterans and other high risk populations.

DSAMH will continue to expand its 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.

Please see the attached document titled Final S Suicide Prevention for narrative. See attachments, 2013 Suicide Prevention Plan for the state plan.

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				
Lead: Jeff Marrott (DSAMH), Jenny Johnson (VIPP)	Start Date: Oct. 9, 2012	Review Date: Feb. 11, 2013	Target Completion Date: Feb. 28, 2013	Completion Date:
Report on Progress:				
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.				
Evaluation of Objective: Website has been established and is discoverable on popular internet search engines.				
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.				
Activity 1: Support the promotion of SPRC, USARA, NAMI print media available.				
Activity 2: Disseminate information about the National Suicide Prevention Lifeline and other local or regional crisis lines.				
Lead: NAMI, DSAMH, & VIPP	Start Date: Oct. 9, 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date: Ongoing
Report on progress:				
Feb. 11, 2013: Fact sheets concerning Suicide demographics have been developed by UDOH. Booths at various conferences will be manned by DSAMH in conjunction with various community partners to distribute population specific information for suicide prevention. 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... 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.				
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				
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.				
Objective 1.3: By January 2016, at least one professional in Utah will be certified as a Master Trainer in Mental Health First Aid and 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.				

Activity 1: Collaborate with DV to integrate Suicide Prevention into trainings.				
Lead: Barbara & Jennifer Oxborrow (partner w/ DV)	Start Date: July 9, 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date: Ongoing
Report on progress:				
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 Northeaster 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.				
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.				
Objective 1.4: From January, 2014 through December, 2016, establish initiatives which promote an understanding, among Utahans, that recovery from mental and substance use disorders are possible.				

Activity 1:

Lead: , NAMI, VIPP, & Ben Reaves (DSAMH)	Start Date: Aug. 2011	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress:				
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.				
Evaluation of Goal: Initiatives will be published and their outcomes evaluated. Process evaluation will also be conducted and stored in an Access database.				
Objective 1.5: 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.				
Activity 1: Establish social media accounts through Facebook, Twitter, Tumblr, Pinterest, etc. and				
Lead: Mary Barchett (NAMI), Katie & Jenny (VIPP), & Carol Anderson (USOE)	Start Date:	Review Date:	Target Completion Date:	Completion Date:
Report on progress :				
Feb. 11, 2013: on hold for other priorities				
Evaluation of Objective: Social media accounts will be established for the coalition and numbers of hits, connections and friends will be tracked.				
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.				
Activity 1: Work to develop a State Suicide Prevention Summit.				
Lead: Amy (DSAMH), Teresa (VIPPP) & Kim (NAMI)	Start Date: Aug 2011	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Activity 2: Work to develop an Interfaith Suicide Prevention Summit.				
Lead: Amy (DSAMH), Teresa (VIPPP) & Kim (NAMI)	Start Date: Aug 2011	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress:				
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.				
Evaluation of Objective: Outcome and process evaluation will be conducted with attendees of the Prevention Summit's.				
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.				
Activity 1: Work with Work Force Services, Faith based groups to promote suicide prevention trainings				
Lead: Amy & Teresa	Start Date: Aug 2011	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress:				
Feb. 11. 2013: Working to bring Native American Population, D.V., IHC, Local Mental Health & Substance Abuse Authorities to the table.				
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.				
Evaluation of Goal:				
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.				
Activity 1: Conduct town hall meetings and focus groups to identify community needs.				
Lead: Megan (VIPPP), Amy (DSAMH)	Start Date: Spring 2011	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
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.				

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.				
Activity 2: Fact Sheet on evidence based intervention and Postvention for suicide prevention and protective factors.				
Lead: Megan (VIPP), Amy (DSAMH), Verne Larsen (UDOE)	Start Date: Spring 2011	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
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)				
Evaluation of Goal:				
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.				
Lead: Rick, Jenn (DSAMH)	Start Date: Aug 8, 2012	Review Date: Nov. 13, 2012	Target Completion Date: Dec. 31, 2012	Completion Date: Dec. 10, 2012
Report on progress:				
Dec. 10, 2012: Recommendation to use the C-SSRS screening and assessment tools along with the Stanley/Brown Safety planning tool were formally given.				
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.				
Evaluation of Goal: Tools and consultant for tools has been identified.				
Objective 3.2: Through August 2016, train a minimum of 500 health care providers (including Behavioral Health), and first responders to utilize the Universal tools (C-SSRS Screening and Assessment and the Stanley/Brown Safety Planning Tool.				
Lead: Rick Hendy, Jennifer Oxborrow	Start Date: Aug. 8, 2012	Review Date: Feb. 11, 2013	Target Completion Date: Introduction of tools at Generations conference in April, 2013- work will continue to be ongoing.	Completion Date:
Activity 1: Promote a universal screening tool to be utilized by all behavioral health providers and first responders to better identify individuals with suicide risk.				
Activity 2: Identify and promote a universal assessment tool to be utilized by all behavioral health providers and first responders to better identify severity of risk for individuals with suicidal risk.				
Activity 3: Identify and promote a universal safety planning tool to be utilized by all behavioral health providers and first responders to better support individuals and families of individuals with suicide risk.				

Report on progress :				
Evaluation of Goal: Trainees will complete a training and presenter evaluation of all training sessions. Evaluation compilations will be used to improve the training.				
Feb. 11, 2013: Phone call with Melanie Puerto 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.				
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.				
Lead: Jennifer Oxborrow (DSAMH), Jennifer Fischer (Army National Guard), Jodi Smith (SL MCOT Team), Ginger Phillips, Barry Rose	Start Date:	Review Date:	Target Completion Date:	Completion Date:
Activity 1: Promote protocols among crisis centers, emergency departments, mobile crisis teams, and social services to provide follow up phone calls for individuals with suicide risk.				
Activity 2: Promote protocols and improve collaboration among crisis centers, emergency departments, law enforcement, mobile crisis teams, and social services to ensure timely access to care for individuals with suicide risk.				
Activity 3: 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.				
Report on progress :				
Evaluation of Goal: Written protocols will be published and shared and available for review by SAMHSA.				
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.				
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.				
Lead: Greg Hudnall, Hope Task Force, DSAMH, UDOH	Start Date: Sept. 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
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.				
Nov. 12, 2012: Discuss more in Feb. 2013				

Evaluation of Goal:				
Activity 2: Schedule suicide prevention track in two or more behavioral health provider conferences yearly. Areas of focus should be on prevention, intervention and postvention.				
Lead: Amy Buehler, DSAMH, UDOH	Start Date: Sept. 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
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 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.				
Evaluation of Goal:				
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.				
Lead: Amy Buehler, DSAMH, UDOH	Start Date: Sept. 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
Feb. 11, 2013: Suicide Track focused on use of universal tools will be included in Generations Conference in April 2013.				
Evaluation of Goal:				
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.				
Lead: Amy Buehler (DSAMH), UDOH, Barbar Higgins, Kim Myers (NAMI)	Start Date: Sept. 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
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.				
Evaluation of Goal:				
Activity 5: Promotion of training for suicide prevention, intervention and postvention within health care conferences, and other conferences specific to high risk populations.				
Lead: Amy Buehler, DSAMH, UDOH	Start Date: Sept. 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
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)				
Evaluation of Goal:				

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.				
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 using Universal Tools with Suicide Prevention.				
Lead: Jennifer Oxborrow	Start Date: Nov. 2012	Review Date: Feb. 11, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress: University of Utah College of Social Work is working to include Suicide Prevention, Intervention and Postvention information into their Curriculum for Fall 2013.				
Evaluation of Goal: Core education and training guidelines have been implemented in two Utah Colleges, Universities or trade schools.				
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.				
Activity 1: Promote and assist ongoing State Office of Education Training				
Lead: Carol (USOE), Kim (NAMI), Amy (DSAMH), Lillian (USOE)	Start Date: June, 2012	Review Date:	Target Completion Date:	Completion Date:
Report on progress :				
Feb. 11, 2013: Teachers needing recertification have been taking the 2 hr online Suicide Prevention Training created by USOE in June 2012.				
Evaluation of Goal:				
Activity 2: Include suicide prevention training in Medicaid certification training for nursing home facilities				
Lead: Robert (DSAMH)	State Date: Oct. 10, 2012	Review Date: March 2013	Target Completion Date: Oct. 2013	Completion Date:
Report on progress :				
Feb. 11, 2013: Robert has been working to include Suicide Prevention Curriculum in trainings across Utah for 2013.				
Evaluation of Goal:				
Activity 3: Promote and assist in suicide prevention training for medical community				
Lead: Kim (NAMI), Amy (DSAMH), Jenn (DSAMH), Rick (DSAMH), IHC	Start Date: June, 2012	Review Date:	Target Completion Date:	Completion Date:
Report on progress:				
Feb. 11, 2013: Work to present Universal Prevention Tools and develop training to implement and sustain improvement.				
Evaluation of Goal:				
Activity 4: BYU Nurses Training- Presents information to BYU Nurses about Suicide Prevention				
Lead: Barbara Hycee	Start Date: Ongoing	Review Date: Aug. 12, 2013	Target Completion Date: Ongoing	Completion Date:
Report on progress:				

Evaluation of Goal:				
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.				
Lead: Amy (DSAMH), and Barry Rose(UNI/State Lifeline/SLCo MCOT), DV Council	Start Date:	Review Date:	Target Completion Date:	Completion Date:
Report on progress :				
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.				
Evaluation of Goal:				
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.				
Activity 1: Weber County identified as doing well with coordinating integrated health, mental health, substance use, prevention and other community resources, and may be used as a model for other areas.				
Lead: DSAMH, Annie, Ben Reaves	Start Date:	Review Date:	Target Completion Date:	Completion Date:
Report on progress :				
Feb. 11, 2013: House Bill 57 will require DSAMH oversight of integration between health and mental health.				
Evaluation of Goal: Memorandums of Understanding or contracts will be established with each coalition willing to include suicide work into their missions.				
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: 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.				
Activity 1: Review Local Mental Health Authorities Suicide Prevention policies and procedures.				
Lead: DSAMH (monitoring teams and Doug)	Start Date: Sept. 10, 2012	Review Date:	Target Completion Date: Jan. 2014	Completion Date:
Report on progress :				
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.				

Evaluation of Goal:				
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.				
Activities 1: DSAMH Adult Mental Health review policies and procedures for suicide prevention in jails across Utah.				
Lead: Sharn (Survivor Rep), Rick, Jenn, Doug (DSAMH)	Start Date: Fall 2012	Review Date:	Target Completion Date: December 2013	Completion Date:
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 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.				
Evaluation of Goal: Guidelines on assessment and treatment of suicidal individuals will be established in a minimum of five correctional institutions.				
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.				
Lead: Taryn, Amy, Jenn	Start Date:	Review Date:	Target Completion Date: Dec. 2014	Completion Date:
Report on progress:				
Evaluation of Goal:				
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.				
Lead: Tim Cosgrove, Kim Myers	Start Date:	Review Date:	Target Completion Date: Dec. 2015	Completion Date:
Report on progress:				
Nov. 9, 2012: NAMI (Kim) will draft a letter of support for the coalition to sign off on.				
Evaluation of Goal:				
Objective 6.5: By January 2014, review Medicaid expansion for ways to improve access to services for individuals who are in need of mental health services.				
Lead: Kim Myers (NAMI)	Start Date: Nov. 9, 2012	Review Date: Feb. 11, 2013	Target Completion Date: Medicaid expansion in Utah is on hold.	Completion Date:
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.				

Evaluation of Goal: A compilation of findings and recommendations will be published.				
Objective 6.6: Work to improve rules around mental health services and education in Utah.				
Lead: Carol Anderson (UDOE), Tim Cosgrove	Start Date:	Review Date:	Target Completion Date:	Completion Date:
Report on progress :				
Evaluation of Goal:				
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.				
Lead: Ron Bruno (SLPD), Christie, Megan (VIPP)	Start Date: Aug. 2012	Review Date:	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
Evaluation of Goal:				
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.				
Lead: Ron Bruno, Megan (VIPP)	Start Date: Aug. 2012	Review Date:	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
Evaluation of Goal:				
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.				
Lead: Ron Bruno (SLPD), Detective Hoover, Barbara Higgins (Sandy PD)	Start Date: Aug. 2012	Review Date:	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
Evaluation of Goal:				
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.				
Lead:	Start Date:	Review Date:	Target Completion Date: Ongoing	Completion Date:
Report on progress:				
Evaluation of Goal:				
Objective:				

Lead:	Start Date:	Review Date:	Target Completion Date: Ongoing	Completion Date:
Report on progress :				
Evaluation of Goal:				
Goal 8: Improve surveillance, data, research and evaluation relevant to suicide prevention.				
Objective 8.1: By June 2013, create a plan to improve the timeliness, usefulness, and quality of suicide-related data in the Utah Violent Death Reporting System.				
Lead: Teresa & Anna (VIIP)	Start Date:	Review Date:	Target Completion Date:	Completion Date:
Activity 1: Collect vital records and medical examiner death data within three months of a suicide.				
Activity 2: Collect police report data 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.				
Activity 4:				
Report on progress :				
Feb. 11, 2013:				
Evaluation of Goal:				
Objective 8.2: By January 2014, increase the number of nationally representative surveys and other data collection instruments to two, that include questions on suicidal behaviors, related risk factors, and exposure to suicide.				
Lead: Anna (VIIP), DSAMH (Susannah)	Start Date: July 2012	Review Date:	Target Completion Date: ongoing	Completion Date:
Activity 1: Work to add PHQ9, ACES, K^ and other questions on the BRFSS.				
Activity 2: Review 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.				
Activity 3:				
Report on progress :				
Feb. 11, 2013:				
Evaluation of Goal:				
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.				
Lead: Anna and Teresa (VIIP), Rick (DSAMH), Jennifer Fischer (National	Start Date:	Review Date:	Target Completion Date:	Completion Date:

Guard), Commander Neilson (Hill Air Force Base)				
Activity 1: Using the emergency department, hospital, intimate partner violence, and child fatality data modules in UTVDRS, 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.				
Activity 3: Support information sharing between Hill Air Force Base with State Agencies.				
Activity 4: Support information sharing between Army National Guard with State Agencies.				
Report on progress :				
Evaluation of Goal:				
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.				
Lead: Anna, Teresa (VIPP) Rick (DSAMH), Jennifer Fischer, Commander Neilson, Lisa	Start Date:	Review Date:	Target Completion Date:	Completion Date:
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 recommendations.				
Activity 2: Identify Partners				
Activity 3: Develop and implement fatality review protocol and procedures.				
Activity 4: Encourage and support internal fatality review for public behavioral health system				
Activity 5: Share results				
Activity 6: Explore options to create more suicide fatality reviews within specific demographic communities ie. Child, VA, DV, Hill Air Force Base, and Army National Guard.				
Report on progress :				
Feb. 11, 2013: Work has begun on retrospective review of data, some data is still needed to continue process.				
Evaluation of Goal:				
Goal 9: Provide care and support to individuals affected by suicide deaths ad 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.				
Lead: Vern Larsen (USOE), Amy (DSAMH), Cathy (Hope Task Force),	Start Date:	Review Date:	Target Completion Date: ongoing	Completion Date:

Lisa, Anna (UDOH)				
Activity:				
Report on progress :				
Evaluation of Goal:				
Objective 9.2: By December 2014, recruit at least five suicide attempt survivors to participate in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups.				
Lead: Charn (family survivor rep.), Vern (UDOE), Anna (UDOH), NAMI, Robert (DSAMH), Cathy (Hope Task Force)	Start Date:	Review Date:	Target Completion Date: ongoing	Completion Date:
Activity:				
Report on progress :				
Evaluation of Goal:				
Objective 9.3: 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.				
Lead: Vern (UDOE), Anna (UDOH), NAMI, Robert (DSAMH), Cathy (Hope Task Force)	Start Date:	Review Date:	Target Completion Date: ongoing	Completion Date:
Activity:				
Report on progress :				
Evaluation of Goal:				
Objective 9.4: By December 2014, encourage health and behavioral health systems, police departments, fire departments and other entities who 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.				
Lead: Vern (UDOE), Anna (UDOH), NAMI, Robert (DSAMH), Cathy (Hope Task Force)	Start Date:	Review Date:	Target Completion Date: ongoing	Completion Date:
Report on progress :				
Evaluation of Goal:				

4/25/2013 12:14 PM 4/25/2013 11:13 AM

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

Please see attached document titled Final IV use of technology

Effective 1 July 2013, all of the Local Substance Abuse Authorities will be using an electronic health record. The decision by the Local Authority providing Substance Use Disorder services to Cache, Rich and Box Elder Counties to convert from paper charts to an electronic Health Care Record completes the process for all SUD and MH authorities in the State. All of the Local Authorities have been providing data to DSAMH's SAMHIS system, but this will improve the ability to track data across the state.

As of July 1, 2012, all Local Authority providers are required to collect and submit to DSAMH the approved EBPs being utilized in treatment at the client level. The approved list is attached. EBPs are to be included (listed) in the treatment plan for clients and reported to DSAMH throughout the treatment episode.

It is our intent to use this information for program and outcome evaluation. The measures looked at can be broad to include successful completion of treatment (discharge), GAF scores, OQ scores, intensity of services, retention (clients who remain engaged versus clients who do not return), etc. In other words EBPs used can be correlated with all other data collection elements for evaluation.

Evidence Based Practice List

- 1 = Medication Management
- 2 = OQ/YOQ
- 3 = Wraparound to Fidelity
- 4 = Assertive Community Treatment
- 5 = Supported Employment
- 6 = Supported Housing
- 7 = Family Psychoeducation
- 8 = Illness Self-Management and Recovery
- 9 = Multisystemic Therapy (MST)
- 10 = Therapeutic Foster Care
- 11 = Functional Family therapy (FFT)
- 12 = WRAP
- 13 = Mobile Crisis
- 14 = School Based
- 15 = Integrated Treatment for Co-occurring Disorder (Mental Health Substance Abuse)
- 16 = Motivational Interviewing
- 17 = Medication assisted therapy
- 18 = TREM
- 19 = Helping women recover
- 20 = Seeking Safety
- 21 = Matrix Model
- 22 = Beyond Trauma: A Healing Journey for Women
- 23 = Clubhouse
- 24 = DBT (Dialectical Behavioral Therapy)
- 25 = MET (Motivational Enhancement Therapy)
- 26 = Prime for Life-Treatment
- 27 = Peer Support
- 97 = Unknown
- 98 = Not Applicable

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

Please see attached document titled Final IV U Technical Assistance Needs.

1. What areas of technical assistance is the state currently receiving?

The Utah Division of Substance Abuse and Mental Health (DSAMH) is currently receiving technical assistance with the Community Advisory Council.

2. What are the sources of technical assistance?

The DSAMH is receiving technical assistance with the Community Advisory Council from SAMHSA.

3. What technical assistance is most needed by state staff?

Technical assistance areas most needed by the DSAMH are around implementation of the Affordable Care Act, implementation of federal Mental Health Parity requirements, and with recovery support services.

4. What technical assistance is most needed by behavioral health providers?

Technical assistance areas most needed by behavioral health providers in Utah include implementation of the Affordable Care Act, billing and contracting with third party payers, implementation of federal Mental Health Parity requirements, and with recovery support services.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG 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. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency 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 the expanded Medicaid population.
- The state justice system authorities that will work 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. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed 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.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

LOS can be found in the Attachments section.

Part IV. Section V Support of State Partners

DSAMH works closely with numerous partners at the state and county level. At the state level, we have forged working partnerships with:

The Department of Health: We routinely exchange information and work together on Suicide Prevention, Prescription Drug Overdoses, our Recovery Plus initiative to make all of the publicly funded Substance Use and Mental Health Disorder Treatment programs tobacco free, and in cooperating to identify and work together on our shared populations, given that people with SUD and MH disorders have a high percentage of co occurring health disorders. Additionally we work with the Department of Health's Medicaid office to revise and implement the Medicaid Manual for Behavioral Health Services.

Division of Child and Family Services (DCFS) : We work with DCFS in developing programs for drug court admissions, common drug testing policies and in providing education to DCFS workers about addiction and its treatment. This year we have provided scholarships to over 80 DCFS workers to our Fall Substance Abuse Conference, and have over ten specific workshops designed to improve their knowledge and our coordination in serving joint clients.

Division of Juvenile Justice Services (JJS): We work closely with JJS in developing programs for adolescent treatment and prevention.

Department of Education (DOE): We partially fund a prevention program manager for the DOE and work very closely with them in developing prevention programs in the school and after school programs. They regularly send over 80 DOE workers to attend the Prevention Track of our Fall Substance Abuse Conference, and participate actively in the planning and preparation for that conference.

Department of Corrections (DOC) : We have an extremely close working relationship with the DOD that results in close collaboration on our drug court programs, the development and implementation of the Drug Offenders Reform Act (DORA) program, which provides additional funding for both treatment and DOC supervision and has contributed significantly to reducing conflict between treatment and supervision by including the Probation and Parole Officers as part of the treatment team in decision making and increasing the cooperation between the two agencies across the state.

Utah Behavioral Health Care (UBHC) Committee of the Utah Association of Counties (UAC): UBHC meets monthly and while the DSAMH is not officially a member of UBHC, the Division Staff attends all meetings and provides input and receives feedback on proposed changes to the Division Directives and to Policies and Procedures.

Department of Human Services Tribal Affairs Council: This council meets quarterly and provides an avenue for the Tribes to provide input to the Department on the impact of policies and procedures, as well as opportunities for the Departments agencies to communicate with the tribal representatives in an open forum.

Administrative Office of The Courts (AOC): By Statute, the Division, the DOC, and the AOC have joint responsibility for oversight of the state's Drug Court Programs. This includes the

planning and supervision of the Biennial Drug Court Conference, as well as the joint Drug Court Certification process. The DSAMH contracts with the AOC for a retired Judge to conduct annual judicial visits to the courts to supplement the annual treatment visits.

Department of Human Services Office of Licensing (OL): We work closely with this office as they are responsible for licensing all residential Treatment Programs as well as all outpatient treatment programs that receive Public Funding, provide Methadone Services, or Provide DUI education programs.

Division of Occupational and Professional Licensing (DOPL): DSAMH works closely with DOPL on changes to licensing and scope of work requirements for Behavioral Health Therapists and SUD counselors, and provides a Board Member for the SUDC Board.

These are the major state partners, but there are many others with which the Division works closely with on a regular basis. Some examples include the State Department of Veteran's affairs, the Utah National Guard, and the University of Utah's Department of Social Work, as well as statewide support organizations such as NAMI-Utah, Utah Support Advocates for Recovery Awareness (USARA) and the Association of Utah Substance Abuse Professionals.



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Department of Human Services

PALMER DePAULIS
Executive Director

Division of Aging and Adult Services

NELS R. HOLMGREN
Director

Adult Protective Services

NAN MENDENHALL
Director



February 26, 2013

Virginia Simmons
Grants Management Officer
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, MD 20857

Re: Letter of Support

Dear Ms. Simmons:

Please note that Utah Division of Substance Abuse and Mental Health and the Utah Division of Aging and Adult Services (DAAS), Adult Protective Services (APS) have partnered in a unique way to provide services and protection for some of the State's most vulnerable populations. An ad hoc, multidisciplinary team of community partners meet on an as need basis to assess and plan interventions for vulnerable adults with multiple limiting conditions. The core team meets at the DAAS conference room and includes representatives from APS, DSAMH, VA Hospital, 4th Street Clinic (a local medical provider for homeless Utahans in the Salt Lake City area) and Salt Lake City Fire and Rescue. Other agencies are invited when their expertise lends itself to increase the options available for resolution or they are able to help the team in the assessment process.

Another area of support that helps to increase the possibility of positive outcomes for persons in Utah with SMI and SPMI is the close relationship that APS enjoys with the leadership team and program managers in Utah's DSAMH. This relationship has been helpful in gaining support from the Local Authorities when APS has concerns about a person with mental illness and finds barriers to service on a local level. Conversely, Utah DSAMH has been able to gain access to the APS investigative system to help persons with mental illness who are in situation that amount to neglect, abuse or exploitation.

Regards,

Thomas Dunford
Central Region Director
Adult Protective Services



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

**Utah Department of Health
Disease Control and Prevention**

W. David Patton, Ph.D
Executive Director

Robert Rolfs, MD, MPH
Division Director

Teresa Garrett, RN, MS
Deputy Director

Heather Borski, MPH, CHES
Bureau Director

February 19, 2013

Jenn Oxborrow, MSW
Adult Mental Health Program Manager
Department of Human Services
Division of Substance Abuse and Mental Health
195 North 1950 West
SLC, UT 84116

Dear Jenn:

I am pleased to write this letter in support of the Utah Department of Human Services Division of Substance Abuse and Mental Health's (DSAMH) application for the Community Mental Health Services Block Grant funding from the Substance Abuse and Mental Health Services Administration.

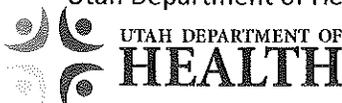
The Utah Department of Health (UDOH) Violence and Injury Prevention Program's (VIIPP) mission is to be "a trusted and comprehensive resource for data and technical assistance related to violence and injury. This information helps promote partnerships and programs to prevent injuries and improve public health." To accomplish its mission, VIIPP collaborates with many partners including other UDOH programs, state and local agencies, local health departments, private businesses, non-profit community organizations, health care providers, and others.

VIIPP staff is committed to providing epidemiology data and serving in an advisory capacity to DSAMH in this grant. We have collaborated with DSAMH on a variety of efforts to implement and strengthen prevention services and activities throughout the state. This grant funding will enable us to continue our collaborative efforts focused on primary prevention and data collection.

This grant will allow DSAMH to build on existing efforts to develop and finalize a comprehensive, data-driven suicide prevention plan. The plan may include implementing a statewide suicide assessment across public and private organizations, identifying risk and protective factors across the lifespan, and using a public health approach to suicide prevention. I strongly support DSAMH's application for this grant and look forward to continuing to work with DSAMH.

Sincerely,

Anna Fondario, MPH
Injury Epidemiologist
Violence and Injury Prevention Program
Utah Department of Health



VIOLENCE & INJURY PREVENTION PROGRAM
Mailing Address: P.O. Box 142106, Salt Lake City, UT 84114-2106
Telephone (801) 538-6864 • Facsimile (801) 538-9134 • <http://health.utah.gov/vipp/>



THE PAIUTE INDIAN TRIBE OF UTAH
440 North Paiute Drive • Cedar City, Utah 84721 • (435) 586-1112

January 23, 2013

To Whom It May Concern:

This letter is in support of Utah's Division of Substance Abuse and Mental Health. I oversee the behavioral health and social services programs here at the Tribe. Shortly after I started working here at the Tribe (two years ago) I was contacted by Jenn Oxborrow at DSAMH and invited to participate on the Utah Behavioral Health Planning and Advisory Council. Jenn and other Division staff have made great efforts to better understand the needs of our Tribal members, our services and to resolve problems or conflicts that have arisen in relation to our local mental health authorities. We appreciate our relationship with the State of Utah and especially the DSAMH and support their efforts to pursue a federal block grant and other funding.

I intend to continue to collaborate with Jenn and other Division personnel to ensure the needs of our Tribal members are met, especially the trauma, mental health, and substance use disorders that impact so many of our families. Please feel free to contact me with any questions.

Sincerely,

Tyler Goddard, LCSW
Behavioral Care Director
435-586-1112 ext 310
Tyler.goddard@ihs.gov



ADMINISTRATION

5965 South 900 East, Suite 420
Salt Lake City, Utah 84121-1720
(888) 949-4864

FAX: (801) 263-7123
www.vmh.com

Gary G. Larcenaire
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M. Steven Marsden, Attorney
Dorsey & Whitney LLP

Jean Perschon
UBS Bank USA

John C. Pingree

Cheryl C. Smith
Cheryl Smith Consulting

March 1, 2013

SAMHSA

Dear Committee Members;

Valley Mental Health, Inc., (VMH) is pleased to partner with the Division of Substance Abuse and Mental Health in Utah. VMH recognizes that DSAMH is requesting funding to provide valuable services to the state of Utah. Our organization believes that these services are vital to the mental health and substance abuse network of providers and invaluable to our clients.

VMH has a variety of programs that interface with DSAMH and that provide much needed services to individuals in need of alternatives to incarceration. VMH has a forensics outpatient unit and provides services in mental health court along with a jail diversion outreach team that provides comprehensive individualized resources and support to clients in need of this service. We also have a substance abuse treatment program for incarcerated individuals plus a residential support program that provides services to adult male criminal offenders with co-occurring disorders. In all of these programs we rely heavily on DSAMH for assistance in creating vision and policy in these areas.

VMH participates in the Utah Behavioral Health Planning and Advisory Council and we have provided input and received assistance through the council. VMH is very supportive of this DSAMH opportunity and will continue to participate in meaningful ways along with other members of the mental health community.

Sincerely,



Gary Larcenaire
President/CEO

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that 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 (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

Please see the attached document titled Final IV w State Behavioral Health Advisory Council

For the past two years, the Utah Behavioral Health Planning and Advisory Council has been in the process of restructuring and reorganizing as an Combined SUD and MH Council. This reorganization has involved an impressive effort by individual advocates, consumers and recovering individuals and community organizations to reach out and provide a broad spectrum of perspectives and viewpoints.

The Council has formed an executive and bylaws committee that is finalizing the rules and bylaws that the Council will operate under. This committee meets monthly and reports its progress at the Monthly Council meetings which are held the last Monday of each Month. The Council has also formed a block grant review committee that has provided input to the planning process and began reviewing the draft Combined Block Grant Application as early as March, 2013.

The Division provides administrative support, arranges for meeting facilities, prepares draft minutes and arranges for teleconferencing for individuals not able to travel to the meeting. Additionally, Division Staff provide monthly updates and reports to the Council as requested. In the past year the DSAMH staff has: provided information on the budgeting process; provided monthly updates on the status of legislative actions and appropriations that affect Behavioral Health; provided an overview of the statewide behavioral health care system, and responded to specific requests for information regarding programming.

During the past year, a verbal report was provided to the Council on the results of each of the Local Authority Audit/Site Visits conducted by the Division. Prior to each visit, the Council was invited to provide input on the availability and quality of services in that area.

In FY 2013, the Division assisted the Council in applying for and receiving a SAMHSA Technical Assistance Grant on Council development and has participated in the ongoing TA process in support of the Council.

DSAMH will continue to support the council and encourage its development as an independent voice and advocate for BH services in Utah.

A link to the UBCPAC page on DSAMH's web site is: <http://www.dsamh.utah.gov/ubhpac.htm>

UTAH BEHAVIORAL HEALTH PLANNING and ADVISORY COUNCIL
(Unofficial roster)

INITIAL	NAME	REPRESENTATION	MAILING ADDRESS	PHONE/FAX	E-MAIL
	Lori CERAR CHAIR	Family Member	Allies With Families 505 East 200 South STE 25 SLC, UT 84102-2075	801-433-2595 Fax 801-521-0872	lori@allieswithfamilies.org
	Carol BUFFI	LDA		801-428-1836	cbuffi@sllad.com
	Carol RUDELL	Work Ability Utah	Buffmire Building 1595 West 500 South Salt Lake City UT 84104	801-887-9388	cruddell@utah.gov
	Christina ZIDOW	Odyssey House of Utah	344 East 100 South #501 Salt Lake City UT 84111	801-428-3475 Fax 801-322-2831	czidow@odysseyhouse.org
	Dan BRAUN	Alliance House	1724 South Main Salt Lake City UT 84115	801-486-5012	danielb@vmh.com
	Eileen MALONEY	Disability Law Center Protection and Advocacy	Disability Law Center 205 North 400 West Salt Lake City UT 84103	801-363-1347 Ex.3202 Fax 801-363-1437	emaloney@disabilitylawcenter.org
	Eliot SYKES	UTE Indian Tribe/SUD Provider		801-824-1939	eliots@utetribe.com
	Eric ROUX	USOR	50 West Broadway #800 Salt Lake City UT 84101	801-238-4561	eroux@utah.gov
	George MARTIN		3895 S 700 W Apt #12 Salt Lake City UT 84119	801-750-4375	
	Ginger PHILLIPS	Peer Advocate	1964 South 900East #5 Salt Lake City UT 84105	801-503-8920	Gingerspice72@msn.com
	Heather APO-EWERS	SUD Peer			
	Janifer LLOYD	Assoc. for UT Community Health	860 East 4500 South Ste 206 Salt Lake City UT 84107	801-716-4607	janifer@auch.org
	Julie HARDLE	Consumer / OPTUM	2525 Lake Park Blvd Salt Lake City UT 84120	801-982-3217	Julie.hardle@optum.com
	Mary GULLY	Family	2542 Elizabeth Street Salt Lake City UT 84106	801-631-1086	mgully@slco.org
	Mary Jo MCMILLEN	USARA/SUD Peer	198 West 7200 South Suite D Salt Lake City, UT 84047	801-839-9950	marvjo@usara.us

	Michelle VANCE	Youth Consumer		801-414-6753	Mnicole1540@gmail.com
	Michael RAY	SUD Peer and Provider	Odyssey House		
	Peggy HOSTETTER	4th Street Clinic	4th & 4th SLC UT	801-355-3570	
	Rebecca BROWN		1020 South Main Salt Lake City UT 84116	801-694-5208	
	Rebecca GLATHAR	NAMI Utah	450 S 900 E Ste 160 Salt Lake City UT 84102	801-323-9900 Fax 801-323-9799	Rebecca@namiut.org
	Ron BRUNO	SLC Police Department CIT Utah	315 East 200 South PO BOX 145497 Salt Lake City UT 84111	801-799-3709 Fax 801-799-4311	Ron.bruno@slcgov.com
	Sam VINCENT	4th Street Clinic	404 South 400 West Salt Lake City UT 84101	801-364-0058	sam@fourthstreetclinic.org
	Scott BOYLE	UofU Social Work		801-581-4881	Scott.boyle@socwk.utah.edu
	Valerie FRITZ	House of Hope/SUD Provider	857 East 200 South Salt Lake City UT 84102	801-979-5418	vfritz@houseofhopeut.org
	Vanessa TUCKETT	Family Member	Allies with Families 505 East 500 South	801-674-7938	Vanessa@allieswithfamilies.org
	Walt MOORE	VAMH		801-673-2906	waltergm@comcast.net

IV: Narrative 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)
Eileen Maloney	Others (Not State employees or providers)	Utah Disability Law Center/Protection and Advocacy		emaloney@disabilitylawcenter.org
Jenifer Lloyd	Others (Not State employees or providers)	Association for Utah Community Health		jenifer@auch.org
Rebecca Glather	Others (Not State employees or providers)	NAMI Utah		
Mary Jo McMillen	Others (Not State employees or providers)	USARA		maryjo@usara.us
Carol Anderson	State Employees		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
Christina Zidow	Providers	Odyssey House of Utah		czidow@odysseyhouse.org
Dan Braun	Providers	Alliance House		danielb@vmh.com
Peggy Hostetter	Providers	4th Street Clinic		
Eliot Sykes	Federally Recognized Tribe Representatives		Ute Indian Tribe UT	eliots@utetribe.com
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
Heather Apo-Ewers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Julie Hardle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2525 Lake Park Blvd Salt Lake City, UT 84120	julie.hardle@optum.com
Michelle Vance	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			mnicole1540@gmail.com
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

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	16	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="0"/>	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	10	62.5%
State Employees	2	
Providers	3	
Federally Recognized Tribe Representatives	1	
Vacancies	<input type="text" value="0"/>	
Total State Employees & Providers	6	37.5%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="3"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="3"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="6"/>	

* 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?

The two Block Grant Project officers (MH and SUD) were the Liaisons from the DSAMH to the Planning and Advisory Council, and assisted the Council in their initial organizational efforts through administrative and logistical support. The Council members were kept informed of the progress of the Joint Application process, and the executive committee was briefed every two weeks. As portions of the application were prepared, they were provided to the executive committee for review by the groups formed from the council members specifically for the review. Comments were received throughout the preparation period on early drafts of the application. A copy of the final draft was provided to the executive committee approximately a week before it was posted for public comment. As a result of this thorough vetting and coordination, few comments were received during the actual comment period.

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

This is not a current priority area of the state.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) 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 BG 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 the Secretary of HHS.

Footnotes:

In compliance with Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) the Utah Division of Substance Abuse and Mental Health (DSAMH) posted a draft of the FY 2014-2015 Combined SABG/MHBG Behavioral Health Assessment and Plan for public notice on our website. We allowed 30 days for public comment. In addition to this we distributed a draft copy of the Plan to the Utah Behavioral Health Planning and Advisory Council Meeting. We reviewed key aspects of the grant with the Council. We received no feedback from the Council or the general public regarding the Plan. Attached is a screen shot of the notification for public comment that was posted on the DSAMH's website.

← → ↻ www.dsamh.utah.gov

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problem or a problem with alcohol, tobacco, or other drugs there is help available. Hope and recovery are possible.

New Content

The Division of Substance Abuse and Mental Health is pleased to provide a draft of the proposed FY 2014-15 Block Grant Application. This application includes information on both mental health and substance abuse services in the state of Utah. The FY 2014-15 Block Grant Application will be available for review and public comment for 30 days from the time of posting. Please direct all comments to Janida Emerson at jemerson@utah.gov or 801-468-4406.

- [FY 2014 15 Block Grant Sections II and IV_For Public Comment](#)
- [FY 2014 15 Block Grant Section III for Public Comment](#)

SUICIDE PREVENTION LIFELINE
1-800-273-TALK
www.suicidepreventionlifeline.org

Related Links

- ▣ EASY (off premise) and Alcohol Beverage Server (on premise) Search
- ▣ Federal Information
- ▣ Fetal Alcohol Coalition
- ▣ Just for Youth